NHS Bradford and Airedale
Tobacco Control Health Equity Audit
2010
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1. Introduction

Smoking is the single biggest preventable cause of illness and premature death in the UK, causing a range of diseases including:

- cancer
- coronary heart disease
- stroke
- chronic obstructive pulmonary disease

An estimated 80,000 people in the UK die each year because of smoking. Smoking causes a third of all cancer deaths, including 80% of lung cancer deaths, 17% of all heart disease deaths and 80% of all deaths caused by bronchitis and emphysema. The smoking epidemic is a root cause of health inequalities.

The prevalence of smoking amongst adults in England was estimated to be 21% in 2007 (32% in the 20-24 year age group). Estimated rates are highest in adults with routine & manual occupations (26%)\(^1\) and in Pakistani, Irish and Bangladeshi men. The prevalence of smoking is forecast to rise as a consequence of the recession, with higher stress levels a contributing factor.

The benefits of quitting smoking can be summarised as:

**Benefits to Smokers and their families**

- Improved quality and quantity of life for those stopping smoking
- Improved quality and quantity of life for those living with smokers through a reduction in the harm from passive smoking

**Benefits to Society**

- Lower healthcare expenditure on treatment of smoking induced disease
- Less workplace absenteeism due to smoking related disease
- Less harm from passive smoking in public places
- Reduction in costs related to cleaning up after smokers (cigarette ends, ash, etc and damage from these to floors and furnishings)

Within Bradford we continue to meet our 4 week quit targets and rates of prevalence continue to decline. However, major challenges remain to ensure that we achieve the 2020 target of a 10% prevalence rate of tobacco usage across the whole population. There is also great inequalities in smoking prevalence within Bradford and within tobacco usage subgroups (i.e routine and manual, mental health service users, pregnant women).

This health equity audit will present the current smoking prevalence and performance of smoking cessation services, describe the evidence base for cessation and tobacco control, audit local services against this evidence and give recommendations to ensure we continue to meet the national targets for tobacco.

This equity audit reflects the new evidence and guidance from the 2010 National Tobacco Strategy (DH 2010).

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(1) See appendix D definitions.
2. Targets

NHS Bradford and Airedale have a number of smoking related targets to achieve:

National Targets (up to April 2010)

- To reduce adult smoking rates from 27% in 2002 to 21% or less by 2010
- To reduce smoking amongst pregnant smokers from 23% to 18% by 2005 and 15% by 2010
- To reduce smoking prevalence among routine and manual groups from 31% in 2002 to 26% or less by 2010
- To reduce smoking rates among manual groups from 32% in 1998 to 26% in 2010

Smoking in Pregnancy targets

- World Class Commissioning (WCC) target to reduce the number of women smoking at booking-in by 2% year on year
- NHS target to reduce number of women smoking at delivery to 15% by 2010
- To increase the number of validated smoking status measurements for quitters
- To increase the validated 4-week quit rate within smoking cessation services by 50% over two years

The 2010 National Tobacco Strategy develops these targets aiming to ensure a continuing decline in prevalence. As of April 2010 the focus and actions nationally will be as follows:

New targets and guidance from the 2010 National Tobacco Strategy

Assisting every smoker to stop their dependence on tobacco:
- Reduce adult smoking rates to 10% or less by 2020.
- Halve smoking rates within the most disadvantaged localities
- Reduce smoking rates in pregnant women to 7% or less by 2020

Stopping the inflow of young people recruited as smokers
- Reduce 11-15 year old smoking rates to 1% or less.
- Decline in smoking rates for 16 and 17 year olds to 8% by 2020

Protecting our families and communities from tobacco related harm
- Increase the proportion of homes that are ‘smokefree’ where both parents are smokers from 21% in 2007 to 33% by 2020 as validated through population level salivary testing in children and adults
To achieve these new national targets the following actions will be undertaken:

**Stopping the inflow of young people recruited as smokers**

*To achieve this nationally the government will:*

- Make tobacco less affordable by reducing the amount of illicit tobacco smuggled into the country by half and increasing the duty on cigarettes
- Remove tobacco products from sight
- Introduce plain packaging for all tobacco products
- Introduce a voluntary code to stop the advertising of tobacco accessories to young people and consider what further action and evidence is needed
- Raise awareness about the dangers of smoking and equip young people with the skills necessary to resist peer pressure and not smoke
- Remove tobacco vending machines that are currently a big source of underage sales
- Review the current system for ensuring retailers do not sell tobacco to under 18s in 2010 and consider what further action is needed to reduce the supply tobacco to children

**Assisting every smoker to stop their dependence on tobacco**

*To achieve this nationally the government will:*

- Continue to deliver hard hitting mass media campaigns
- Double the number of successful quits supported by the NHS Stop Smoking Service by 2012
- Introduce a new NHS service that attracts more quitters by offering longer term use of Nicotine Replacement Therapy (NRT) including partial substitution
- Through the Medicines and Healthcare Regulatory Agency invite applications for Over the Counter NRT on a ‘harm reduction’ basis, allowing NRT to be marketed and sold for more extended use and to partially cut down as a route to quitting

**Protecting our families and communities from tobacco related harm**

*To achieve this nationally the government will:*

- Support the creation of ‘smokefree communities’ through media campaigns and national guidance and by working with an alliance of public sector organisations, private business and communities to protect children from secondhand smoke in the home and private vehicles
- Consider within the 2010 review of the Health Act 2006 what further action is needed to protect people, particularly children, from secondhand smoke exposure
- Ensure the 2012 London Olympics is entirely smokefree without the sale of tobacco within the Olympic Park
- Improve local data to accurately target communities with high smoking rates
- Develop holistic interventions to tackle health inequalities caused by smoking
- Develop more effective methods of identifying and preventing smoking in pregnancy
Delivering the new goals set out above will mean that millions of smokers will stop over the next decade, improving their health and quality of life and that of their family and friends.

3. Commissioning

3.1 Adults who smoke

Smoking causes a third of all cancer deaths, one in seven cardiovascular deaths and four-fifths of Chronic Obstructive Pulmonary Disease (COPD) deaths in adults. It leads to four out of five lung cancer hospital admissions, a quarter of respiratory admissions and one in six admissions for cardiovascular disease. The table below shows what this means for Bradford with an estimated 8,100 admissions attributable to smoking per year and 820 deaths.

Table 1. Smoking attributable hospital admissions and deaths by cause for Bradford District, and costs to the local NHS (per year)

<table>
<thead>
<tr>
<th>Disease</th>
<th>Admissions</th>
<th>Smoking attributable admissions</th>
<th>Smoking attributable %</th>
<th>Death</th>
<th>Smoking attributable deaths</th>
<th>Smoking attributable %</th>
<th>NHS costs attributable to smoking (£m)²</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancers</td>
<td>13291</td>
<td>1621</td>
<td>12</td>
<td>1050</td>
<td>302</td>
<td>29</td>
<td>5</td>
</tr>
<tr>
<td>Trachea, Lung, Bronchus</td>
<td>1023</td>
<td>839</td>
<td>82</td>
<td>260</td>
<td>214</td>
<td>82</td>
<td>2.2</td>
</tr>
<tr>
<td>All respiratory diseases</td>
<td>9192</td>
<td>2317</td>
<td>25</td>
<td>702</td>
<td>244</td>
<td>35</td>
<td>11</td>
</tr>
<tr>
<td>COPD</td>
<td>1387</td>
<td>1096</td>
<td>79</td>
<td>273</td>
<td>217</td>
<td>79</td>
<td>11</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>1930*</td>
<td>425</td>
<td>22</td>
<td>279</td>
<td>50</td>
<td>18</td>
<td>19.8</td>
</tr>
<tr>
<td>All circulatory diseases</td>
<td>10091</td>
<td>1615</td>
<td>16</td>
<td>1507</td>
<td>209</td>
<td>14</td>
<td>41</td>
</tr>
<tr>
<td>Total **</td>
<td>162063</td>
<td>8104</td>
<td>5</td>
<td>4529</td>
<td>819</td>
<td>18</td>
<td>41</td>
</tr>
</tbody>
</table>

* Estimated from total admissions
** Total includes other diseases not listed in the table

The new tobacco strategy forms the Government’s aims to reduce smoking rates in the adult population to 10% by 2020, halving smoking rates in the most deprived areas. This would lead to a dramatic impact on the NHS, with immediate savings of around £60m in 2011/12 due to reductions in hospital stays as smokers increasingly quit before their operation. This means NHS Bradford and Airedale would save £ 600, 000 every year, reaching £26 million by 2020 (due to reduced hospital admissions).

The Bradford and Airedale Health and Lifestyle Survey 2007/08 estimated a smoking prevalence of 20% amongst adults in the District (80,000 adults). The impact of smoking legislation in pubs, restaurants and public places may have had an impact in Bradford. The success of future legislation and interventions will require careful evaluation if robust forecasts are to be made.
The Lifestyle survey also revealed that:

- Overall 15% of Pakistani residents smoke (24% of men, 5% of women). 56% of Bangladeshi men and 15% of Bangladeshi women smoke.
- 22% of adults reported smoking in City Care and South and West Alliance compared to 17% and 15% respectively in Airedale and Bingley and North Commissioning Alliance (BANCA) respectively.
- Smoking prevalence gradually falls with age from 27% in the 18-24yr age group to 10% for those over 65 years.
- Men aged 25-34 have a particularly high smoking prevalence (31%), and women aged 18-24 (27%) are more likely to smoke than women on average.
- Wards with smoking prevalence significantly higher than the Bradford average are Bowling and Barkerend (27%), Keighley West (28%), Royds (24%), Thornton and Allerton (25%), Tong (28%), and Wyke (26%). However there are other areas with high numbers of men of South Asian origin who smoke (e.g. Manningham and Bradford Moor).
- The average age at which Bradford residents start smoking regularly is 16.5 years, with 42% starting at under 16 years of age.
- 41% of men and 43% of women start smoking before the age of 16.
- 27% start smoking by age 14.
- Men in Bradford smoke an average of 16.5 cigarettes a day, women smoke an average of 12.5 compared with national averages of 14.0 for men and 12.4 for women.

The Bradford and Airedale Health and Lifestyle Survey 2007/08 may slightly under report the prevalence of smoking as it assumes all respondents who smoke are truthful in their answers. Another method of measuring smoking prevalence is via information collected on prevalence registers in GP practices. An analysis of this data for the Bradford district shows that the overall prevalence of smoking for adults over 16 is 19.2% (Table 2). However the smoking register only counts the smoking status of patients with long term conditions and the smoking status of approximately 30% of the adult population goes unrecorded. These figures can only be used to measure the registered smoking prevalence in the Bradford district (19%) rather than true prevalence. They do, however, tell us that the highest registered prevalence is in South and West Alliance (22% of the total adult population) and 75,000 of the District’s smokers have been offered some type of smoking cessation advice.
Table 2. Smoking status of adults recorded in GP practices (2009)

<table>
<thead>
<tr>
<th>Alliance</th>
<th>Ex smokers</th>
<th>Smokers</th>
<th>Never smoked</th>
<th>Status not recorded</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No</td>
<td>%</td>
<td>No</td>
<td>%</td>
<td>No</td>
</tr>
<tr>
<td>Airedale</td>
<td>13,969</td>
<td>20.9%</td>
<td>11,624</td>
<td>17.4%</td>
<td>22,312</td>
</tr>
<tr>
<td>BANCA</td>
<td>20,841</td>
<td>21.9%</td>
<td>17,497</td>
<td>18.4%</td>
<td>30,847</td>
</tr>
<tr>
<td>City Care</td>
<td>10,188</td>
<td>9.2%</td>
<td>20,173</td>
<td>18.2%</td>
<td>47,911</td>
</tr>
<tr>
<td>Independent</td>
<td>1,130</td>
<td>21.0%</td>
<td>480</td>
<td>8.9%</td>
<td>1,376</td>
</tr>
<tr>
<td>S&amp;W</td>
<td>20,913</td>
<td>18.5%</td>
<td>25,273</td>
<td>22.4%</td>
<td>33,618</td>
</tr>
</tbody>
</table>

Bradford District 67,041 17.1% 75,047 19.2% 136,064 34.8% 112,933 28.9% 391,085

The smoking ban came into force in England in July 2007 and early indications of its effect are positive. Local population growth, however, will offset some of this effect in Bradford. If it is assumed that a smoking prevalence of 20% will persist, there will be an extra 21,160 smokers in Bradford as a result of population increase alone by 2030.

Figure 1. Projected number of smokers through 2030, assuming no change in prevalence

Key messages

- Smoking causes a third of all cancer deaths, one in seven cardiovascular deaths and four-fifths of COPD deaths in adults in the UK
- There are an estimated 8,100 admissions attributable to smoking per year and 820 deaths in Bradford District
- 20% of the adult population reported that they smoke in the Bradford and Airedale Health and Lifestyle Survey 2007/08. 41% of men and 43% of women start smoking before the age of 16
- Data recorded by GPs estimates smoking prevalence to be 19% in adults but some patients do not have their smoking status recorded so this may be an underestimate.
4. Epidemiology of Smoking in Bradford.

Comparison against other areas

NHS local Stop Smoking Services have supported over 2 million people nationally to stop smoking in the short term and 500,000 to stop smoking long term since their foundation a decade ago. These achievements have saved 70,000 lives (NHS Stop Smoking Services Guidance, 2009). Stop smoking services provide around a quarter of all successful quits per annum and have been praised by the Care Quality Commission for the contribution they make to the national health inequalities agenda.

Bradford’s own Stop Smoking Service has historically performed very strongly against the increasingly challenging 4 week quit targets monitored by the Department of Health. In addition to local performance monitoring we are able to benchmark our performance against other local Stop Smoking Services regionally, nationally and in comparison to our ‘statistical neighbours’, ie those areas with a similar social, economic and demographic profile.

Figure 2 below demonstrates our historical performance against annual 4 week quitter targets up to and including Quarter 2 2009/10.

Figure 2

Performance Against Target - 4 Week Smoking Quitters, 2007/8 - Q2 2009/10

[Graph showing quarterly actual and target numbers for 4 week smoking quitters from 2007/08 to Q2 2009/10]
Figure 2 illustrates that the introduction of Smokefree legislation in 2007 generated a boom in quitters as smokers took the opportunity to stop in light of the change in acceptability that came with the smoking ban. In 2007/08 our target of 4,071 was exceeded by 264. The target for subsequent years has been lower in numbers but much more challenging to achieve as the most committed smokers are targeted. However, performance has remained strong with the target once again exceeded in 2008/09 and the performance at Q2 2009/10 indicating that the target is likely to be achieved.

Department of Health guidance recommends that to work most effectively the focus of local Stop Smoking Services should be on reaching smokers from Routine & Manual groups and, as detailed elsewhere in this Audit, Bradford is very successful in reaching smokers in this category. Bradford’s quit rates fall well within the expected range of 35-70% set by the Department of Health (Figure 3).

Whilst our performance against the 4 week smoking quit rate target has been very strong, success with pregnant smokers has been much more challenging to achieve. Figure 4 demonstrates Bradford’s performance compared to our statistical neighbours in 2008/09. In response to poor quit rates with pregnant smokers, Bradford’s Local Stop Smoking Services have redesigned the pathway for pregnant smokers and local (unvalidated) data indicates an improved quit rate of 24.4% Q1-Q3 2009/10.
As part of Bradford’s drive to reduce smoking prevalence and the harmful effects of smoking on children there has been a focus on encouraging families to sign up to the Smokefree Homes initiative resulting in 3,011 homes signing up to the Smokfree pledge since 2006.

### 4.2 Access to stop smoking services

Stop smoking services aim to help smokers quit through a combination of interventions including counselling and nicotine replacement therapies. Whilst a cost is accrued in setting up these services, several studies have shown that their costs are minimal in contrast to the treatment of smoking related illnesses such as cancer, COPD and cardiovascular disease. The following section examines the smoking cessation data for NHS Bradford and Airedale. This analysis is based on 20 months (April 2008 – November 2009) of data collected by the NHS Bradford and Airedale Stop Smoking Service. The data covers all services (including Bradford and Airedale Community Health Services (BACHS) and Primary Care).
**Figure 5.** The cost of smoking cessation interventions compared to treatments for coronary heart disease, expressed as the cost per year of life saved (£000s)

**Patients setting quit dates**

**Age and Gender:** Between April 2008 and November 2009 a total of 11,406 patients were referred to the Stop Smoking Service (SSS) and set a quit date. A further 962 patients received a referral but set no quit date. 54% of those setting a quit date were female, 46% male.

**Ethnicity:** The majority of the patients accessing the service and setting a quit date were white (88.6% compared to 78% of the Bradford district population), whilst around 9% were Asian (18% of the District population (Table 3)). The remaining 2.6% were black, mixed or classified as other. The level of ethnicity reporting is high (only 14 individuals out of 11,406 did not have their ethnicity recorded).

**Table 3. Ethnic groupings of patients accessing the service and setting a quit date**

<table>
<thead>
<tr>
<th>Ethnic Group</th>
<th>Frequency</th>
<th>% of Patients</th>
<th>% of Bradford Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asian</td>
<td>1001</td>
<td>8.8</td>
<td>18.9</td>
</tr>
<tr>
<td>Black</td>
<td>74</td>
<td>0.6</td>
<td>0.9</td>
</tr>
<tr>
<td>Mixed</td>
<td>157</td>
<td>1.4</td>
<td>1.5</td>
</tr>
<tr>
<td>Other</td>
<td>72</td>
<td>0.6</td>
<td>0.4</td>
</tr>
<tr>
<td>White</td>
<td>10102</td>
<td>88.6</td>
<td>78.3</td>
</tr>
</tbody>
</table>
**Occupation:** Around 18.5% of patients are classed as working in routine and manual jobs, an area of focus for government and PCT targets around smoking cessation. However, occupation data is unavailable for many records due to the ‘phasing in’ of the new smoking cessation database, as the levels of reporting have improved recently. Therefore, we may be significantly underestimating quit rates for target groups due to the large volume of incomplete entries.

### 4.3 Quit Rates

Between April 2008 and November 2009 45.5% of patients who had set a quit date had quit at 4 weeks. 75.6% of these quitters were verified through carbon monoxide measurement. Evidence shows that tobacco abstinence reduces with time and quit rates after 12 months are typically between 25% and 35%.

*Figure 6. Proportion of patients quitting, not quitting, and lost to follow up at 4 week quit date.*

Quit rates were slightly higher amongst men than women, with those lost to follow up (patients who enter the service but leave before quitting and cannot be traced) about equal (Figure 7).

*Figure 7. Quit, non-quit, and lost to follow up % by gender*
**Quit Rates by Referral Method:** The most common referral methods were “Self Referral” (37%) and referral via GP (21%). “Self Referral” indicates that a patient has contacted the smoking cessation hotline in the first instance. Table 4 shows that referrals via specialists, pharmacists and funded GP practices produced quit rates at about the average for Bradford. Freelance workers (person employed by Stop Smoking Service (SSS) on an ad hoc basis) whilst only reaching comparatively small numbers of patients, had a statistically high quit rate when compared to the overall rate. In addition to the services in Table 4, a small number of patients (12) access smoking cessation via non-funded GP practices.

*Table 4. Numbers of patients and quit rates by service level referral.*

<table>
<thead>
<tr>
<th>Service</th>
<th>Lost to Followup</th>
<th>Not Quit</th>
<th>Quit</th>
<th>Total</th>
<th>Quit Rate %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental</td>
<td>56</td>
<td>45</td>
<td>57</td>
<td>158</td>
<td>36.1</td>
</tr>
<tr>
<td>Freelance Worker</td>
<td>18</td>
<td>5</td>
<td>41</td>
<td>64</td>
<td>64.1</td>
</tr>
<tr>
<td>Funded GP Practice</td>
<td>2650</td>
<td>1646</td>
<td>3374</td>
<td>7670</td>
<td>44.0</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>398</td>
<td>206</td>
<td>546</td>
<td>1150</td>
<td>47.5</td>
</tr>
<tr>
<td>Specialist</td>
<td>715</td>
<td>464</td>
<td>1170</td>
<td>2349</td>
<td>49.8</td>
</tr>
<tr>
<td>Not Recorded</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>3</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Definitions of above:**
- Freelance worker – person employed by SSS on an ad hoc basis
- Funded GP practice – funded by NHS Bradford and Airedale to provided level 2 cessation service.
- Pharmacy – specialist level 2 pharmacy provider
- Specialist – specialist provider stop smoking service.

**Quit Rates by age and employment/economic classification:** Significantly high quit rates were achieved with patients from an intermediate economic status, those in managerial and professional work, and those patients who are retired.

Lower than average quit rates were observed in full time students, home carers, the unemployed, and long term sick. Psychosocial factors associated with deprivation, motivations to quit and wellbeing may be driving this pattern.

Quit rates for routine and manual workers were about average for Bradford overall, and in line with the national target of reducing prevalence in this group from 33% to 26% in 2010. This is an achievement given the higher smoking prevalence amongst routine and manual workers and the fact that patients in this group are typically less likely to quit.
Table 5. Numbers of patients and quit rates by employment/economic status

<table>
<thead>
<tr>
<th>Employment/Economic Classification</th>
<th>Lost to Followup</th>
<th>Not Quit</th>
<th>Quit</th>
<th>Total</th>
<th>Quit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blank/Missing</td>
<td>834</td>
<td>476</td>
<td>1040</td>
<td>2350</td>
<td>44%</td>
</tr>
<tr>
<td>Full Time Student</td>
<td>209</td>
<td>103</td>
<td>134</td>
<td>446</td>
<td>30%</td>
</tr>
<tr>
<td>Home Carer</td>
<td>246</td>
<td>153</td>
<td>254</td>
<td>653</td>
<td>39%</td>
</tr>
<tr>
<td>Intermediate</td>
<td>367</td>
<td>233</td>
<td>651</td>
<td>1251</td>
<td>52%</td>
</tr>
<tr>
<td>Managerial/professional</td>
<td>377</td>
<td>216</td>
<td>683</td>
<td>1276</td>
<td>54%</td>
</tr>
<tr>
<td>Never Worked/Long Term Unemployed</td>
<td>499</td>
<td>277</td>
<td>401</td>
<td>1177</td>
<td>34%</td>
</tr>
<tr>
<td>Retired</td>
<td>207</td>
<td>272</td>
<td>640</td>
<td>1119</td>
<td>57%</td>
</tr>
<tr>
<td>Routine &amp; Manual</td>
<td>722</td>
<td>415</td>
<td>976</td>
<td>2113</td>
<td>46%</td>
</tr>
<tr>
<td>Sick/disabled and unable to work</td>
<td>217</td>
<td>173</td>
<td>244</td>
<td>634</td>
<td>38%</td>
</tr>
<tr>
<td>Unable to Code</td>
<td>163</td>
<td>53</td>
<td>171</td>
<td>387</td>
<td>44%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3841</strong></td>
<td><strong>2371</strong></td>
<td><strong>5194</strong></td>
<td><strong>11406</strong></td>
<td></td>
</tr>
</tbody>
</table>

Key

- Significantly Below Average
- Average
- Significantly Above Average

**NB:** Intermediate occupations - examples include: call centre agent, clerical worker, nursing auxiliary, nursery nurse, office clerk, secretary.

**Patients Quitting by Age:** In general, quit rates increase with age range, but the number of patients also falls. This may reflect a more determined pattern of quitting amongst older people, who may be motivated by comorbidities and advancing age to quit.

*Fig. 6. Quit rates by age group*
4.4 Pharmacological Interventions

Prescribing rates and expenditure are highest for varenicline, which is to be expected given its clinically demonstrated effectiveness, National Institute for Health and Clinical Excellence (NICE) recommendation and an aggressive marketing campaign by Pfizer. £325,000 was spent on varenicline between April 08 and November 09.

Of the 5194 patients quitting successfully after 4 weeks, 48% were prescribed varenicline. 1% were prescribed bupropion, and 3% were prescribed NRT, although more patients may have accessed NRT from their pharmacy ‘over the counter’ without prescription.

Table 6. Pharmacological treatment and quit rates

<table>
<thead>
<tr>
<th>Drug</th>
<th>Number of Patients</th>
<th>Number of quitters</th>
<th>Quit Rate%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varenicline</td>
<td>4547</td>
<td>2364</td>
<td>52</td>
</tr>
<tr>
<td>Bupropion</td>
<td>142</td>
<td>77</td>
<td>54</td>
</tr>
<tr>
<td>NRT</td>
<td>381</td>
<td>141</td>
<td>37</td>
</tr>
</tbody>
</table>

The packaging of varenicline (2-week or 4-week packs) allows it to be prescribed according to the same regime that NICE recommends for NRT. Bupropion is prescribed in 4 week packs. Assuming that 70%, 50% and 40% of patients return for additional medication after 2, 4, and 8 weeks respectively, gives an average cost per quit for varenicline of about £96. For Bupropion the average cost-per-quit would be about £60, and for NRT about £79. In practice a successful quit with varenicline should therefore cost about 60% more than Bupropion and 20% more than NRT (figures based on Stapleton, 2006)

See appendix for further drug descriptions and information

4.5 Tobacco and Pregnancy

Reducing the number of women who smoke throughout their pregnancy is considered the most important intervention required to reduce health inequalities in the total population. Smoking during pregnancy increases the risk of spontaneous pre-term birth. Babies born to women who smoke are on average 200 – 250g lighter than those born to mothers who do not smoke; the more cigarettes smoked, the greater the probable reduction in birth weight. This can increase the risk of death and disease in childhood; smoking in pregnancy increases infant mortality by about 40% (DH 2007) and more than a quarter of the risk of sudden unexpected death in infancy is attributable to smoking (British Medical Association 2007). Interventions that impact on reducing

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1 Health Development Agency
2 DH (2007) Reducing smoking, pre-conception, during pregnancy and postpartum – Integrating high impact actions into routine healthcare practice
smoking prior to or during pregnancy have the potential to affect health gain for both mother and infant.

**Specialist Smoking Services (SSS) to women prior to and during pregnancy**

During 2008/9 1,200 women were smoking at delivery and the smoking cessation success rates for ante-natal services are the lowest in the Region. Of these, only a handful received intensive support from Smoking Cessation services. We are unsure whether this is due to a failure in the existing pathway, whether women choose not to take up the offer of a referral, or whether once referred women do not benefit from the existing service offered. There is a need to design local services with the wider needs of women living in these areas in mind. The Bradford District Infant Mortality Commission (2006) recommended a review of the effectiveness of stop smoking services and the development of midwifery workforce to ensure maximum effect from mainstream services.

**Data from maternity and smoking cessation services indicate that:**

- In Bradford district during 2008/9 approximately 16% women reported that they were smoking at booking-in with the midwife
- 14.3 % reporting that they were smoking at the time of delivery.
- Compared to national levels, the percentage of pregnant women in Bradford who smoke is lower than average, but smoking in pregnancy is predominantly within the White population.
- 28% of White women reported they smoked at booking-in compared to only 1.9% of Asian and British Asian women.
- Over 40% of White British women aged 15 – 24 were smoking at booking-in during 2008/09.
- The most disadvantaged mothers are more likely to smoke and less likely to quit.
- In Tong, Wyke, Eccleshill and Keighley West wards smoking during pregnancy is more than double the national average.
- One fifth of pregnant women are reported as either routine and manual workers (22%) or home carers, with a further 18% a significant number long term unemployed (18%).
- The majority of pregnant women who entered the stop smoking services (182 during 2008/2009) were lost to follow-up at 4 weeks and the overall quit rate is 19%.

*Figure 8. Breakdown of pregnant women successfully quitting at 4-weeks, not quitting, and being lost to follow up.*
Pregnancy Referral Pathway

Midwife faxes referral to the Stop Smoking Service (01274 202803 safe haven) for all pregnant smokers unless decline referral (see fax referral form)

No contact made

Admin rings client within 24 hours by telephone at least 2 attempts

Yes contact made admin establishes whether the client does want support with stopping smoking

No Support required

Yes support required

Brief advice given to client using the crib sheet

If client has already stopped send out congrats pack (outcome needs to be communicated to referring midwife to amend antenatal records)

Send letter to client along with pregnancy information pack

Copy of letter to be put in admin folder awaiting contact from client

If the client does not contact the service, outcome will be faxed/ phoned to the referring midwife

Yes contact made admin establishes whether the client does want support with stopping smoking

If none of the clinics are suitable the client will be asked if they would like to speak to a Stop Smoking Specialist

An appointment will be offered at one of the generic clinics

Referral form passed to the appropriate specialist along with pregnancy pack

Pregnancy lead to get data from database to report to partners/ find gaps in service

Once outcome is complete i.e. 4 wk quit, relapse or lost to follow-up fax/phone the outcome to the referring midwife

Specialist to contact client by telephone - at least 3 attempts.

Yes contact made

No contact made

Fax (or telephone if Airedale) outcome to the referring midwife

Specialist to discuss other options i.e. antenatal care, local children’s centre, and if no other arrangement can be made a home visit.

Once outcome is complete i.e. 4 wk quit, relapse or lost to follow-up fax/phone outcome to the referring midwife
Key messages

- Reducing smoking during pregnancy is a priority action for reducing infant mortality
- 28% of White women reported they smoked at booking-in across the Bradford District compared to only 1.9% of Asian and British Asian women
- 49% of women referred to Bradford and Airedale Stop Smoking Service are lost to follow up

4.6 Developing an epidemiology of smoking prevalence, smoking cessation uptake and quit rates in Bradford

Smoking prevalence from the Bradford and Airedale Health and Lifestyle Survey 2007/08 was combined with patient data from the stop smoking service database regarding service uptake and quit rates. From this data, use/needs ratios were calculated (uptake rates) based on the number of patients setting a 4 week quit date and the estimated smoking prevalence (numbers) from 2008/2009 lifestyle survey.

Use/need ratio = number of patients entering the service / number who smoke

Use/need ratios (uptake rates) were calculated for each ward and by age-group, sex and ethnicity. Uptake rates were calculated for each group.

In order to determine statistically significant differences between groups 95% confidence interval was used to calculate significantly high or low values for prevalence, service uptake and quit rates.

The results for Bradford and Airedale wards are presented in two ways:

Firstly, the RAG table (Red/Amber/Green - Table 6) shows the smoking prevalence, service uptake, and quit rate for each Bradford ward and classifies it relative to the Bradford average. A red cell for a given ward, for example, indicates a high smoking prevalence, low level of service uptake, and low overall quit rate compared to the rest of the district.

Secondly, the thematic map (Fig.9) shows a 5 category classification derived from the RAG table. By grouping wards together based on their values for prevalence, uptake and quit rate, it is possible to identify areas of particular concern and help plan the distribution of smoking services accordingly. The 5 categories are:

1) High Prevalence, Low Uptake/Quit Rates
2) High Prevalence, High Uptake/Quit Rates
3) Low Prevalence, Low Uptake/Quit Rates
4) Low Prevalence, High Uptake/Quit Rates
5) Mixed Prevalence, Uptake/Quit Rates

Key messages

- Reducing smoking during pregnancy is a priority action for reducing infant mortality
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4) Low Prevalence, High Uptake/Quit Rates
5) Mixed Prevalence, Uptake/Quit Rates
Little Horton, Manningham, Keighley Central, Keighley West and Bowling and Barkerend wards are areas of concern as the exhibit high smoking prevalence but low service uptake and low quit rates (Table 6, Figure 9).

Tong, Wyke, Royds and Thornton wards were areas of high smoking prevalence but also high service uptake and quit rates.

Other areas, notably Bradford Moor, City, Toller and Heaton wards have low uptake and quit rates and low smoking prevalence. This is misleading because the smoking prevalence is high the South Asian male population.

Smokers who are of South Asian origin are less likely than the White population to access smoking cessation services and less likely to quit (Table 7). This is backed up by the uptake rate of 6% in this group compared to 16% for Whites.

In general, young men and women (24yrs and younger) are less likely to access stop smoking services compared to older men and women. Women of all ages have higher uptake rates than men, and have an overall lower level of smoking prevalence.

There is a clear correlation between low service uptake and high South Asian population. This suggests that the service is less successful at reaching the South Asian community.

Caveats to this work

There is currently no reliable way of ascertaining smoking prevalence. The figures here are based on the Bradford and Airedale Health and Lifestyle Survey 2007/08 self reported smoking status, with numbers of smokers calculated from applying prevalence to GP registered populations. There is likely to be an under reporting of smoking status.

No local estimates of smoking prevalence amongst routine and manual workers exist and the data here is based on national estimates. These are likely to be conservative given Bradford’s deprivation profile.
Table 6. RAG table of Bradford Wards by smoking prevalence, service uptake and quit rate. See appendix for raw data.
Figure 9. Thematic Map of classifications derived from RAG rating

Categorisation of Prevalence, Service Uptake and Quit Rates

- **Red**: High Prevalence, Low Uptake/Quit Rates
- **Green**: High Prevalence, High Uptake/Quit Rates
- **Blue**: Low Prevalence, Low Uptake/Quit Rates
- **Light Blue**: Low Prevalence, High Uptake/Quit Rates
- **Yellow**: Mixed Prevalence, Uptake/Quit Rates
Figure 10. Maps to show deprivation, South Asian population, smoking prevalence and smoking related deaths (deaths are crude rates and not age standardised)
Figure 9 Scatter plots showing the negative correlations of quit rate and service uptake with % S Asian origin population and deprivation. All are statistically significant at \( p = 0.05 \), but only the correlation between service uptake and ethnicity shows a clear correlation \( (r = -0.78) \). This suggests that the service is less successful at reaching the South Asian community.
Table 7. Use/need ratios by age, sex and ethnicity.

<table>
<thead>
<tr>
<th>All Patients</th>
<th>Smoking Prevalence (%)</th>
<th>Est. Number of Smokers</th>
<th>Number Setting Quit Date</th>
<th>Use Need Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Patients</td>
<td>20.0</td>
<td>83954</td>
<td>11392</td>
<td>14%</td>
</tr>
<tr>
<td>South Asian</td>
<td>17.80</td>
<td>16786</td>
<td>1001</td>
<td>6%</td>
</tr>
<tr>
<td>White</td>
<td>20.30</td>
<td>64979</td>
<td>10102</td>
<td>16%</td>
</tr>
<tr>
<td>Routine and Manual Workers</td>
<td>26%**</td>
<td>13338</td>
<td>2113</td>
<td>16%</td>
</tr>
<tr>
<td>All persons by age range</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>up to 24</td>
<td>25</td>
<td>18458</td>
<td>1357</td>
<td>7%</td>
</tr>
<tr>
<td>25-34</td>
<td>24</td>
<td>19782</td>
<td>2572</td>
<td>13%</td>
</tr>
<tr>
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<td>13563</td>
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<td>55-64</td>
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<td>65+</td>
<td>10</td>
<td>6994</td>
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</tr>
<tr>
<td>Total</td>
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<td>83954</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men by age range</td>
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</tr>
<tr>
<td>up to 24</td>
<td>22</td>
<td>8304</td>
<td>556</td>
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<td>25-34</td>
<td>31</td>
<td>12934</td>
<td>1189</td>
<td>9%</td>
</tr>
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<td>35-44</td>
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<td>14%</td>
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<td>19</td>
<td>5013</td>
<td>718</td>
<td>14%</td>
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<td>65+</td>
<td>12</td>
<td>3501</td>
<td>408</td>
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<td>Women by age range</td>
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<td>up to 24</td>
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<td>801</td>
<td>8%</td>
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<td>25-34</td>
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<td>9</td>
<td>3492</td>
<td>482</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>36424</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prevalence for Routine and Manual workers based on national estimate.
Key messages

- Between 2007 and 2009 Bradford exceeded its targets for the number of 4 week quitters through stop smoking services
- The performance of our Stop Smoking Service is inconsistent through the year showing slow performance in the first quarter reaching a maximum in quarter four
- Bradford’s quit rate for adults is above the national average. Our quit rate for pregnant smokers is below the national average but improving
- During 2008/2009 45% of patients who set a quit date had quit at 4 weeks. Quit rates are slightly higher amongst men than women and increase with age
- The majority of patients accessing smoking cessation services and setting a quit date are White: 88.6% compared to 78% of the District population. 9% are Asian (18% of the District population)
- 34% of those setting a quit date are lost to follow up
- Freelance workers, whilst only reaching comparatively small numbers of patients, have a statistically higher quit rate than the overall rate.
- In Bradford district during 2008/9, approximately 16% of pregnant women reported that they were smoking at booking-in with a midwife. 14 % reporting that they were smoking at the time of delivery
- 28% of White women reported they smoked at booking-in compared to only 1.9% of Asian and British Asian women
- Mothers in the most disadvantaged areas are more likely to smoke and less likely to quit.
- Smokers who are of South Asian origin are less likely than the White population to access smoking cessation services and less likely to quit. This is backed up by the uptake rate of 6% in this group compared to 16% for Whites.
- In general, young men and women (24yrs and younger) are less likely to access stop smoking services compared to older men and women. Women of all ages have higher uptake rates than men, and have an overall lower level of smoking prevalence.
- Little Horton, Manningham, Keighley Central, Keighley West and Bowling and Barkerend wards are areas of concern as the exhibit high smoking prevalence but low service uptake and low quit rates.
- Tong, Wyke, Royds and Thornton wards were areas of high smoking prevalence but also high service uptake and quit rates.
- Other areas, notably Bradford Moor, City, Heaton and Toller wards have low uptake and quit rates but high male smoking rates.
- We need to recruit more GP practices/ Pharmacies and Dental practices to provide Smoking Cessation services in specific areas.
5. Funding for tobacco control and cessation.

The chart below describes the total spend on smoking cessation services in 2009/10 within the Bradford District.

Key messages

- The Primary Care figure of £286,500 is divided between the 55 practices on a cost per hour basis for specialist cessation support
- The BACHS budget includes the current contract areas of work that includes smoking cessation and tobacco control
- The Pharmacy figure of £40,000 is for the level 2 services delivered via 82 pharmacies

Total Spend = £1,979,982

![Smoking Cessation Service Spend](chart.png)
6. Tobacco and Young people

6.1 Smoking in young adults

The focus for childhood tobacco within the region and in the Bradford district is on underage sales and the de-normalisation of tobacco.

Data from the Bradford and Airedale Health and Lifestyle Survey 2007/08 about smoking prevalence shows that an estimated:

- 41% of young men and 43% of young smokers start to smoke under the age of 16 years, compared to 41% of men and 36% of women nationally
- the average age at which Bradford residents start smoking regularly is 16.5 years,
- 41% of male smokers and 43% of female smokers start before the age of 16 (these figures are slightly higher than the national average)
- 27% start smoking by age 14

Data about smoking prevalence under the age of 16 years will be obtained from the 2009 Children and Young Peoples Lifestyle Survey. There is little evidence published of the effect of interventions that focus on cessation activity with adolescents. Nationally, only 3% of the service users who set a quit date are 18 years or under.

Smokefree Homes in England examined data from a series of Health Surveys for England from 1996 to 2007 and has identified a marked trend towards smoke free homes as well as a decline in cotinine concentrations in children living within smoke free homes.

The 2010 Smokfree Future national tobacco strategy describes a number of actions to take forward the childhood tobacco agenda. The Healthy School enhancement programme will also give a local focus to the tobacco alliances work with children and young people. Details within the tobacco action plan.

Key messages.

- 27% of smokers across the district start smoking by age 14
- The evidence base for preventative strategies aimed at young people is improving and wider tobacco controls aimed at denormalising smoking should be driven by the local tobacco alliance
7. National Guidance on Best Practice

This section of the health equity audit will use the 2010/2011 NHS Stop Smoking Service and Monitoring Guidance and the New National Strategy for Tobacco Control (2010) as the evidence base for best practice and service re-design. Both these publications suggest key areas commissioners can develop their provider services to ensure that provide high quality, evidence based services that targets area of high inequality.

7.1 Targeting groups.

- Many smokers will need to make multiple attempts to quit before achieving long-term success; it is important that those who are motivated receive repeat interventions following a relapse.
- In line with NICE best practice recommendations, service providers should aim to treat a minimum of 5% of their local population of smokers in the course of a year.
- To work most effectively, services should focus on specific segments of the population – in particular, increasing access for smokers from routine and manual groups, as quit rates are still lower for these groups than for those in higher socio-economic groups.
- Services also need to increase access for black and minority ethnic groups with high smoking rates. Prisoners and those with mental illness also have very high levels of smoking and it is important that appropriate services are made available to these groups as well as pregnant smokers.
- Primary and secondary care as well as mental health and prison care play a key role in referring people to NHS Stop Smoking Services, and referral opportunities need to be maximized.
7.2 Delivering services.

- Four-week quit smoking rates are the local measure to reflect smoking prevalence as set out in Tier 2 Vital Signs in the NHS Operating Framework. They are also a National Indicator (N123) in the Local Area Agreement (LAA) process. They provide a useful performance measure for NHS Stop Smoking Services and a means of tracking service performance against local operating plans.

- Smokers attempting to stop without additional support have a success rate of 25% at four weeks (for carbon monoxide (CO) validated quits) and a success rate of about 35% at four weeks (for self-reported quits). Therefore to show an effect, services must achieve success rates in excess of these.

- Evidence-based guidelines and NICE guidance should inform how services are delivered and the availability of smoking cessation aids.

- To optimise success, all NICE recommended pharmacotherapies need to be offered as a first-line intervention.

- All GPs, pharmacists, dentists and all other frontline staff should be made aware of their local NHS Stop Smoking Service and its referral mechanisms.
7.3 Data and monitoring.

- The full and accurate completion of individual client data monitoring forms, and their timely submission to the service, is a condition for qualifying as an NHS Stop Smoking Service provider.

- Four-week quit data is required in order to assess the cost-effectiveness of defined stop smoking interventions. This may not include information on people who have stopped smoking (‘four-week quits’) without interventions delivered by stop smoking adviser.

7.4 Maintaining standards.

- Commissioning is a key lever for meeting service requirements.

- Commissioners and providers need to work together to achieve optimum outcomes using evidence-based interventions, focusing jointly on increasing reach and access for smokers from target groups, improving data quality and ensuring that resources are allocated appropriately.

- All stop smoking advisers need to receive specific training to carry out their role. Any training should conform to the standards set out by the Health Development Agency’s (HDA’s) training standard.

- To achieve best practice, all service delivery models should also conform to established quality principles.

- As part of the Government’s commitment to modernise and improve treatment for smokers who wish to stop, the NHS Centre for Smoking Cessation and Training (NCSCT) was set up in 2009/10. The NCSCT will provide a number of key products and services, including national training standards and nationally accredited training programmes for stop smoking practitioners and best practice delivery models based on the latest research evidence.

8. Provider Services

8.1 Bradford and Airedale Stop Smoking Service (BASSS)

The main specialist provider within the Bradford District is the BACHS Bradford and Airedale Stop Smoking Service. Historically, this team has covered all aspects of smoking cessation and tobacco control, however since the commissioner/provider split the tobacco control function now sits with NHS Bradford and Airedale. The Bradford and Airedale Stop Smoking Service consists of a specialist team which includes stop smoking specialists, health promotion specialists, freelance workers and administration support currently based at Listerhills Business Park.

The current service contract states their aims:
- To provide a co-ordinated approach to smoking prevention and the achievement of the national and local stop smoking targets
- To provide a comprehensive treatment service for smokers wishing to quit
- To promote smoke free environments which protect non-smokers from the effects of second hand smoke
- To promote tobacco control activities

The Bradford and Airedale Stop Smoking Service provide co-ordination and stop smoking support for all the residents of the Bradford Metropolitan District. It currently provides co-ordination of funding, training, data monitoring, practice liaison, dissemination of evidence based practice and research, audit and review of service provision.

The Bradford and Airedale Stop Smoking Service is currently divided into two elements
- Provision of a direct service to clients via group or individual interventions
- Co-ordinated themed areas such as young peoples work, pregnancy and tobacco, illicit tobacco.
  (These themed workers are often of a higher grade and rarely have client contact)

The team currently runs a paper based reporting, client tracking and diary system. This makes it difficult to co-ordinate the booking of clients and then track clients through a number of cessation attempts.

The brief intervention training is provided by Bradford and Airedale Stop Smoking Service (BASSS) and PCT learning and development. There is no central database of individuals who have been trained.

A number of other BACHS teams have received brief intervention training these include district nursing, school nursing, health visiting and long-term condition teams. There is little evidence regarding the quality and consistency of brief interventions offered by these teams or whether these new skills are being used.
### 8.2 Primary Care Services

Primary Care is a key setting for stop smoking interventions with the majority of four week quits across the district coming via this service, it is also an important source of referrals to Bradford and Airedale Stop Smoking Services. Helping smokers to quit is a key part of the remit of all primary care staff via brief interventions. In Bradford the majority of practices offer a level 2 cessation service.

The Bradford District has 84 Primary Care general practices. A specialist funded smoking cessation service is provided by 55 of these practices with the. Currently each of the 55 practices is issued with a SLA (Service Level Agreement) by BACHS. Bradford and Airedale Stop Smoking Service work is currently being undertaken by NHS Bradford and Airedale to put in place a new Locally Enhanced Service (LES) agreement to ensure the commissioning of primary care Stop Smoking Services is the responsibility of the commissioning organisation.

The service consists of:

- Staff trained to provide smoking cessation advice (Stop Smoking Advisors) at a total cost of £286,500
- The distribution of practices across the district is based on those willing to be registered
- Practices only provide 1:1 cessation to individuals within their practice
- Each GP practice is allocated a specified number of hours to provide smoking cessation following the DH guidelines on targeting 5% of the practice population (smoking). Each GP practice is paid on an hourly basis. (£18 per hr)
All practices are audited by the Stop Smoking Services through the year using information from the data returns to the stop smoking services, and performance managed according to the current Services Level Performance for Practice based Services. The Bradford and Airedale Stop Smoking Service supports work in primary care with a 1.0 WTE specialist worker.

(1) see appendix 3 definitions

**Smoking Cessation pathway for specialist and Intermediate Service**

- **Smoker receives brief intervention in primary care setting – dental; pharmacy; G.P.**
  - Receives support plus NRT in primary care setting

- **Contact with health care professional and given brief intervention**
  - Self-refers to stop smoking service
  - Offered appointment at one of generic clinics/groups or informed of local service offered in primary care – GP, dental practice or pharmacy

- **Smoker contacts DH smoking helpline**
  - Referred to stop smoking service

- **Attends for full programme of support and successfully quits for at least 4 weeks**
- **Attends appointments but relapses before reaching four weeks. Letter sent inviting them to make future appointments**
- **Fails to attend any appointments. Letter sent inviting them to contact us to make future appointment**
8.3 Quality and Outcomes Framework (QOF)

In relation to tobacco QOF payments of £976,500 are currently made for recording the following:

SMOKE 3 The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, asthma, CKD, schizophrenia, bipolar affective disorder or other psychoses whose notes record smoking status in the previous 15 months

SMOKE 4 The percentage of patients with any or any combination of the following conditions: coronary heart disease, stroke or TIA, hypertension, diabetes, COPD, asthma, CKD, schizophrenia, bipolar affective disorder or other psychoses who smoke whose notes contain a record that smoking cessation advice or referral to a specialist service, where available, has been offered within the previous 15 months.

8.4 Pharmacy Cessation Services.

Pharmacies in Bradford have a good track record of providing stop smoking services to the general public. They are ideally placed to provide this service being based in the heart of communities and are accessible to people who may not access NHS services. Pharmacies within NHS Bradford and Airedale currently provide two levels of smoking cessation services through a locally commissioned enhanced service.

i) Nicotine Replacement Therapy Voucher Pharmacy Access scheme

This scheme is provided by 82 pharmacies out of a total of 117. The pharmacists taking part in the scheme are evenly spread throughout the district. Pharmacies supply NRT to clients of the Bradford Stop Smoking Service on presentation of a voucher completed by a Stop Smoking Adviser. The service has improved access to NRT for people who would otherwise have to attend their GP for a prescription. There is a need to provide refresher training for the tier 1 service to ensure all pharmacies are dispensing appropriately against the vouchers and claiming appropriately.

ii) Individual trained members of staff

Staff provide one-to-one stop smoking support for patients who want to stop smoking. Currently 19 pharmacies provide the tier 2 service. When the tier 2 service was analysed in 2008, pharmacies demonstrated a success rate of 46.5%

8.5 Dental Services

Dental teams raise the issue of smoking with their patients and refer to the Stop Smoking Service. Brief intervention in smoking cessation training is being delivered along with an E-learning resource to dental practices. Referrals from dental teams into the Stop Smoking Service have increased over the last 4 years, in 2007-2008 there were 146 patients referred.

In-house services to support patients through a full quit attempt within dental practices have been commissioned, there are now 12 services guided by a Locally Enhanced Service agreement. As dental teams do not have NRT on their prescribing list, they utilise the voucher scheme which enables patients to take their voucher directly to a local pharmacist in the scheme to redeem for their NRT. Evaluation showed quit rates were initially low but the 2008/09 data show that dental services achieved a quit rate success of 37.6%, this still remains below GP and pharmacy tier 2 rates.
8.6 Voluntary Sector

The PCT invest in a number of voluntary sector projects that provide a brief interventions service to identify smokers who can then be referred to the Stop Smoking Service and provide brief interventions. The PCT investment is difficult to calculate exactly as the service is often part of a general health and wellbeing package provided by the commissioned voluntary organisations.

8.7 Secondary Care

Being admitted to hospital has been shown to increase a patient’s motivation to stop smoking. A Cochrane Review found that patients offered support to stop smoking as part of their inpatient activity, including community follow-up for at least four weeks post-discharge, improved abstinence rates significantly.

Referral pathways are in place for inpatients in BTHFT and ANHST but the number and quality of stop smoking interventions made in the districts hospitals and departments varies greatly. Nationally the majority of hospitals have no system or guidance in place to aid health care professionals in offering stop smoking support to patients.

Although the aim of secondary care interventions is to encourage all patients to stop smoking, it is recognised that there will be patients who do not wish to stop smoking and who are likely to experience nicotine withdrawal symptoms during their hospital stay. With this in mind, the new approach is recommended to provide pathways for both patients wishing to stop smoking, and for patients not wishing to stop, but requiring nicotine withdrawal symptom management.
Smoking Cessation pathway for Secondary Care

- Contact with health care professional and given brief intervention – Ask, advice & Act

  - Self-refers to stop smoking service
  - Referred to stop smoking service by health professional

  - Contact made within 2 working days of receipt of referral.
    Appointment offered at community venue, clients’ home or in hospital if still an inpatient

- Attends for full programme of support and successfully fully quits for at least 4 weeks.
  Ongoing support and treatment arranged

- Fails to attend initial appointment -
  1. Telephone call
  2. Telephone call
  3. Letter sent inviting them to contact us to make future appointment

- Attends appointments but relapses before reaching four weeks. Letter sent inviting them to make future appointments
8.8 Mental Health Services

Given that 70% of people in mental health units smoke, (Jochelson et al, 2006) mental health services are an important source of referrals to the SSS. The majority of those with mental illness are managed in primary care through the primary care pathways; however, the number of quit attempts are low.

Currently within the Bradford District a number of mental health service areas do provide brief intervention these include the community health teams, inpatient services within Lynfield Mount and some private sector providers.

Key messages

- Pharmacies are ideally placed to provide stop smoking services being based in the heart of communities and are accessible to people who may not access NHS services
- The Bradford and Airedale Stop Smoking Service team has up until this year covered all aspects of smoking cessation and tobacco control including commissioning primary care
- A large proportion of overall PCT spend on tobacco is for QOF payments
- Referral pathways are in place for inpatients in BTHFT and ANHST but there are variable referral rates, for example high from cardio-vascular but low in other areas
9. Illicit tobacco and smoke free legislation

Illicit tobacco comes in many forms, namely: smuggled and counterfeit cigarettes; violation of smokefree legislation (e.g. from Shisha smoking); smokeless tobacco; and underage sales of tobacco. As a whole, illicit tobacco generally increases the accessibility of tobacco in all age groups, especially those in lower socioeconomic groups, thus adversely affecting health and increasing health inequalities. The North of England is a major area of demand for illicit tobacco due to its high smoking prevalence and low levels of income.

In 2008, the Department of Health published its Consultation on the Future of Tobacco Control (Department of Health, 2008) which outlined the key problems and possibilities for reducing illicit tobacco. HM Revenue and Customs and the UK Border Agency are the lead agencies responsible for tackling the illicit trade in tobacco products.

We will ensure that tobacco control includes multi agency leadership and agree on what is needed, encourage diversity, performance manage progress, identify common issues and jointly commission for quality. The purpose of the Bradford District Tobacco alliance is to promote an integrated approach to meeting population needs across services. This partnership arrangement will enable tobacco control to retain a high priority and profile within the Bradford District. The alliance will produce and monitor an action plan based on this HEA. The group will continue to work with the Regional Tobacco Control Network and Government departments.

9.1 Counterfeit and smuggled cigarettes.

Counterfeit and smuggled cigarettes are thought to hold 8-18% of the tobacco market in the UK. Therefore it poses a large problem for UK government as it impacts both the economy and health of the population. One in six cigarettes smoked is illicit and this is thought to cost taxpayers £3 billion per year in lost revenue (North of England: Tackling Illicit Tobacco for Better Health, 2009).

In 2008, national Trading Standards received a years funding from Department of Health to work on controlling the illegal supply of tobacco to complement the 'Smokefree' legislation and the NHS smoking cessation services. A substantial proportion (over £200,000) of this was distributed to the local Trading Standards agency. Regionally, this funding was used to actively look for illicit tobacco through visiting retailers and training police on identifying illicit tobacco. Recently, a premise in Bradford has been found to sell Jin Ling (cheap whites), and this is believed to be fairly widespread within the region.

9.2 Smokefree legislation

Smokefree legislation has been in place across the UK since July 2007 to protect the population from the harmful effects of second-hand smoke. Department of Health research has found that 75% of adults in England support the smokefree legislation (Smokefree England, 2007).

Enforcement of smokefree legislation is managed by environmental health alongside the police although in practice it is largely self-regulated by the general public. The relatively small number of complaints made by members of the public (one to two per month) are followed up by environmental health officers. In some establishments such as working men’s clubs, pubs in areas of deprivation and communal areas in apartment blocks, self-regulation is not working and smoking does take place on the premises.
Shisha originates from the Middle East and Asia and involves inhaling tobacco smoke which is cooled and filtered by passing through water. It is covered by smokefree legislation. Although Shisha smoking is fairly uncommon, local environmental health officers report that the vast majority of work done by their agency in Bradford on enforcing smokefree legislation is within Shisha bars.

### 9.3 Smokeless tobacco

The term ‘smokeless tobacco’ refers to over 30 different products worldwide, the main products used in the UK are betel quid (paan) with tobacco, gutkha and niswar. These products are mainly used by the South Asian community. A National Survey (2004) recorded the highest self-reported use of smokeless tobacco among Bangladeshi women (16%) and men (9%), followed by Indian men (4%), Pakistani men (2%) and Indian and Pakistani women (both 1%). In West Yorkshire, 95% of Bangladeshi women aged over 25 years were recorded as chewing ‘paan’, with 60% of the total sample adding tobacco. The age at which the habit (with or without tobacco) was first introduced ranged from 3 to 35 years of age (mean 17 years).

All forms of smokeless tobacco, whether or not combined with other ingredients, increase the risk of mouth cancer, pancreatic cancer, gum disease and heart disease. In India, squamous cell and verrucous carcinomas of the oral cavity and pharynx are more prevalent in smokeless tobacco users. Compared with abstainers, the estimated odds ratio for oral cancers in India among smokers is 7.3, compared with 1.3 in alcoholics and 11.4 in long-term regular users of smokeless tobacco.

The Tobacco Control and Dental Teams groups commissioned a smokeless tobacco specialist to work with smokeless tobacco users who wish to quit. This service is in its early stages and has developed training for healthcare professionals in brief interventions in smokeless tobacco cessation.

### 9.4 Underage sales of tobacco

Smoking often begins in childhood (85% of smokers begin under the age of 16) although the health impacts are only felt later in life. There is much legislation to reduce the levels of underage smoking including: raising the age of sales from 16 to 18; strengthened sanctions against sellers; nicotine replacement therapy on prescription for under 18s; and increased education within school curricula.

Children are taught about risks of smoking within the school curriculum. Training has been provided to specialist Stop Smoking Services and members of the community on illicit tobacco and underage sales. Stop Smoking Services act as a source of intelligence for Trading Standards with regards to shops that may sell cigarettes to underage customers. Trading Standards will follow-up every complaint, whether from Stop Smoking Services or a member of the public.

**Key messages**

- Managing smuggled and counterfeit tobacco is complex and requires a multi-agency approach.
- Bradford is thought to have high levels of smokeless tobacco use.

1. That the data and evidence contained within this HEA be used to redesign services

2. That a new Tobacco Alliance be established to drive the Districts Tobacco Control agenda

3. That the number of funded specialist primary care practices increases to 90% of all practices by 2011

4. That we commission a central stop smoking service which complements services delivered in primary care. This service should focus on smoking cessation targeting areas of high prevalence and low primary care uptake.

5. That we develop as commissioners and providers better IT systems to support cessation

6. That we consider social marketing interventions to increase uptake of service by South Asian men, routine and manual workers and pregnant women

7. Improve performance against target in the first two quarters of the year

8. That we increase the number of specialist cessation pharmacies in areas of greatest need

9. That the use of brief intervention be industrialised

10. That a new plan to increase cessation for mental health service users be developed by Sept 2010

11. That the redesign of maternity cessation services be driven by the social marketing insight research

12. That further work is undertaken to update the analysis of epidemiological and performance data

13. That new performance targets are developed for all cessation service providers
11. Tobacco action plan

A complete list of recommended actions, based on the conclusions from the Health Equity Audit, will be published in the tobacco action plan for Bradford and Airedale (Sept 2010). The action plan will include a tobacco social marketing strategy.
Appendix A - Pharmacological Interventions

Three different pharmacological interventions are used in Bradford’s smoking cessation service.

**Nicotine Bitartrate** (therapeutic nicotine) – is found in patches, lozenges, gums and inhalators. It reduces the cravings for nicotine in smoked tobacco and can thus help patients reduce their daily consumption of tobacco in phases, helping them to quit.

**Bupropion (Zyban)** is an atypical antidepressant and smoking cessation aid. It acts as a weak norepinephrine and strong dopamine reuptake inhibitor, as well as $\alpha_3\beta_4$-nicotinic receptor antagonist. Initially researched and marketed as an antidepressant, bupropion was subsequently found to be effective as a smoking cessation aid.

Bupropion lowers seizure threshold and its potential to cause seizures was widely publicized. However, at the recommended dose the risk of seizures is comparable to that observed for other antidepressants. In contrast to many other antidepressants, bupropion does not cause weight gain or sexual dysfunction.

**Varenicline (Champix)** is a prescription medication used to treat smoking addiction. Varenicline is a nicotinic receptor partial agonist. In this respect, it different from the nicotinic antagonist, bupropion, and nicotine replacement therapies (NRTs) like nicotine patches and nicotine gum. As a partial agonist, it both reduces cravings for and decreases the pleasurable effects of cigarettes and other tobacco products, and through these mechanisms it can assist some patients to quit smoking. A randomised control trial showed that after one year, the rate of continuous abstinence was 10% for placebo, 15% for bupropion, and 23% for varenicline. NICE recommends varenicline for smoking cessation, although it should normally be used only in conjunction with counselling and support services to help patients quit smoking.
Appendix B – Prevalence, uptake and quit rate by ward

<table>
<thead>
<tr>
<th>WARD</th>
<th>PREVALENCE (% SMOKERS)</th>
<th>UPTAKE OF SERVICE (% SMOKERS SETTING QD)</th>
<th>QUIT RATE (% SUCCESSFUL QUIT AT 4 WEEKS)</th>
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<tbody>
<tr>
<td>Baildon</td>
<td>15</td>
<td>11</td>
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<tr>
<td>Bingley</td>
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<td>10</td>
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<tr>
<td>City</td>
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<td>Wyke</td>
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</table>

KEY

- **Significantly Above Bradford Average**
- **Not Significantly Different to Bradford Average**
- **Significantly Below Bradford Average**
Appendix C

Cost per 4wk Quit June 08 – March 09 (no more recent information available at time of writing)

<table>
<thead>
<tr>
<th>Spend</th>
<th>Q/E 30/06/08</th>
<th>Q/E 30/09/08</th>
<th>Q/E 31/12/08</th>
<th>Q/E 31/03/09</th>
<th>Total</th>
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</thead>
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<tr>
<td>Stop Smoking Service</td>
<td>£ 193,943</td>
<td>£ 176,500</td>
<td>£ 238,112</td>
<td>£ 177,873</td>
<td>£ 786,427</td>
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<td>NRT</td>
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<td>£ 23,210</td>
<td>£ 23,210</td>
<td>£ 40,679</td>
<td>£ 110,307</td>
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<tr>
<td>Total</td>
<td>£ 217,153</td>
<td>£ 199,710</td>
<td>£ 261,321</td>
<td>£ 218,551</td>
<td>£ 896,734</td>
</tr>
</tbody>
</table>

4wk Quitters 5194

£ per 4wk Quit £ 172.65
Appendix D - Definitions

Bank staff
Indicates staff involved in the delivery of NHS stop smoking interventions who have been trained to HDA standards (until 1 April 2010, when these will be superseded by the NCSCT standards www.ncsct.co.uk) and who are paid to provide these services outside their normal working hours.

CO verified four-week quitter
A treated smoker whose CO reading is assessed 28 days from their quit date (-3 or +14 days) and whose CO reading is less than 10ppm. The -3 or +14 day rule allows for cases where it is impossible to carry out a face-to-face follow-up at the normal four-week point (although in most cases it is expected that follow-up will be carried out at four weeks from the quit date). This means that follow-up must occur 25 to 42 days from the quit date (Russell standard).

Clients whose follow-up date falls outside this time span may not be counted for the purposes of quarterly data submissions to the IC. CO verification should be conducted face to face and carried out in at least 85% of self-reported four-week quitters.

The percentage of self-reported four-week quitters who have been CO verified should be calculated as shown below:

Number of treated smokers who self-report continuous abstinence from smoking from day 14 to the four-week follow-up point, and who have a CO reading of less than 10ppm.

All self-reported quitters

Exception reporting system
A data verification and checking system designed to improve data quality and identify the reasons for outlying data (i.e. data that falls outside the expected success rate range derived from the evidence base on smoking cessation).

Lost to follow-up (LTFU)
A treated smoker who cannot be contacted either face to face or via telephone, email, letter or text following three attempts to contact at different times of day, at four weeks from their quit date (or within 25 to 42 days of the quit date). The four-week outcome for this client is unknown and should therefore be recorded as LTFU on the monitoring form.

Monthly monitoring
Voluntary monthly collection and reporting system for which local stop smoking services collect and report data on the numbers of smokers entering treatment and setting a quit date and the numbers recorded as quit. This return is now optional (as of November 2008)

NHS Stop Smoking Service
An NHS Stop Smoking Service is defined as a locally managed, co-ordinated and provided service, funded by DH nationally, to provide accessible, evidence-based, cost-effective clinical services to support smokers who want to stop. Service delivery should
be in accordance with the quality principles for clinical and financial management contained within this guidance.

**Non-treated smoker**
A smoker who receives no support or is given brief or very brief advice and/or supplied with leaflets, helpline cards or pharmacotherapy only, and does not set a quit date or consent to treatment. Examples may include smokers seen at a health fair or community event, during a GP consultation or during a hospital stay where a quit date is not set and a quit attempt is not made.

**Quarterly dataset**
Stop smoking service data that is submitted to the IC on a quarterly basis.

**Quit date**
Date a smoker plans to stop smoking altogether with support from a stop smoking adviser as part of an NHS-assisted quit attempt.

**Renewed quit attempts**
A quit attempt that takes place immediately following the end of one treatment episode. A new treatment episode should be commenced in the database/service records.

**Routine and manual smoker**
A smoker whose self-reported occupational grouping is as a routine and manual (R/M) worker, as defined by the National Statistics Socio-Economic Classification. Smoking prevalence among the R/M socio-economic grouping is significantly higher than among other groupings. This has a major impact on the health and life expectancy of this grouping.

**Self-reported four-week quitter**
A treated smoker whose quit status at four weeks from their quit date (or within 25 to 42 days of the quit date) has been assessed (either face to face or by telephone, text, email or postal questionnaire). The percentage of self-reported four-week quitters should be calculated as shown below:

Number of treated smokers who self-report continuous abstinence from smoking from day 14 post-quit date to the 4-week follow-up point

**All treated smokers**

**Smoked product**
Any product that contains tobacco and produces smoke is a smoked product, including cigarettes (hand-rolled or tailor-made), cigars and pipes. Pipes include shisha, hookah, narghile and hubble-bubble pipes.

**Smokeless product**
There is evidence to show that the use of smokeless tobacco products (e.g. chewing tobacco, paan, khat) can have negative health effects, including oral cancers. There is some evidence to suggest that behavioural support can be effective.
Smoker
A person who smokes a smoked product. In adulthood this is defined in terms of daily use, whereas in adolescence (i.e. for those aged 16 or under) it is defined in terms of weekly use.

Smoking cessation
In clinical terminology, used to denote activities relating to supporting smokers to stop.

Spontaneous quitters
Smokers who have already stopped smoking when they first come to the attention of the service may be counted as having been ‘treated’ for local accounting purposes (e.g. to justify resources used or analyse performance) only if they have quit within the 14 days prior to coming to the attention of the service and have attended the first session of a structured multi-session treatment plan within 14 days of their spontaneous quit date (which should be recorded as the quit date).

Services should note that these patients should not be included in the data submitted to the national dataset. The results of spontaneous quitters may be recorded for local monitoring only.

Examples of such quitters include clients who experience unplanned admission to hospital and stop smoking before receiving support or pregnant smokers who have already stopped smoking before approaching their local NHS Stop Smoking Service or one of the service’s trained agents.

While it is recognised that it is desirable to offer as many smokers as possible support to quit and maintain abstinence, local commissioners will need to balance the needs of their smoking population against available service resources.

Stop smoking
Preferred term to denote patient-facing communications relating to smoking cessation activity.

Stop smoking adviser
An individual who has received stop smoking service training that meets the published HDA standards147 (until 1 April 2010 when these will be superseded by NCSCT standards www.ncsct.co.uk) for one-to-one and/or group support and is either an NHS Stop Smoking Service core team member or a trained associate of an NHS Stop Smoking Service.

Time between treatment episodes
(see Treatment episode)
When a client has not managed to stop smoking there is no definitive period of time required between the end of a treatment episode and the start of another. The stop smoking adviser should use discretion and professional judgement when considering whether a client is ready to receive support to immediately attempt to stop again. If this is the case, the client must start a new treatment episode, i.e. attend one session of a structured, multi-session intervention, consent to treatment and set a quit date with a stop smoking adviser in order to be counted as a new data entry on the quarterly return.
**Treated smoker**
A smoker who has received at least one session of a structured, multi-session intervention (delivered by a stop smoking adviser) on or prior to the quit date, who consents to treatment and sets a quit date with a stop smoking adviser. Smokers who attend a first session but do not consent to treatment or set a quit date should not be counted.

**Treatment episode**
At the point of attending one session of a structured, multi-session intervention, consenting to treatment and setting a quit date with a stop smoking adviser, a client becomes a treated smoker and the treatment episode begins. The treatment episode ends either when a client has been completely abstinent for at least the two weeks prior to the four-week follow-up (see flow chart below) or is lost to follow-up at the four-week point, or when a four-week follow-up reveals that a client has lapsed during the two weeks immediately prior to the follow-up and is therefore recorded as a non-quitter. Good practice dictates that, if the client wishes to continue treatment after a lapse, treatment should be continued if it seems appropriate, but the client will not count as a four-week quitter for the purposes of that treatment episode.
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Data analysis provided by: Bradford Observatory - Public Health

http://www.bradford.nhs.uk/observatory/Pages/Default.aspx
http://www.bradford.nhs.uk/observatory/Pages/JSNA.aspx