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Self-reported practices, attitudes and levels of training of practitioners in the English NHS Stop Smoking Services

Mairtin S. McDermott

University of Wollongong, mairtin@uow.edu.au

Robert West

University of Leeds, University College London

Leonie S. Brose

University College London

Andy McEwen

University College London

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Abstract

The primary aim of the current study is to investigate the self-reported practices, attitudes and levels of training of stop smoking practitioners (SSPs) working at the English National Health Service's (NHS) Stop Smoking Services (SSSs). A secondary aim was to investigate differences between 'Specialist' and 'Community' SSPs. An online survey was conducted with 484 SSPs. Most (94%) SSPs offered one-to-one appointments to smokers, only 43% always used the abrupt quit model and 30% reported ever recommending particular medication to clients. SSPs reported an average of 3.7 days training when starting work and 26% reported never observing an experienced practitioner before seeing clients of their own. Over half (56%) never received clinical supervision. SSPs reported having generally positive attitudes towards their jobs, but reported feeling less positive about their prospects for future employment within the field. 'Specialist' SSPs reported receiving more days training (4.1 vs. 3.0, $p = 0.002$), more days observing an experienced practitioner when starting work (12.9 vs. 6.6, $p < 0.001$) and were more likely to receive clinical supervision (48.9% vs. 34.9%, $p < 0.05$) than 'Community' SSPs. Gaps between SSPs' current practices and evidence-based guidelines may be due to inadequate training. Similarly, differences in training between specialist and community SSPs may contribute to the observed difference in these practitioners' success rates. As recommended by the Department of Health for England, standardized training in evidence-based smoking cessation interventions should be implemented for both specialist and community SSPs.

Keywords

stop, smoking, services, practices, self, attitudes, reported, levels, training, practitioners, english, nhs

Disciplines

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Title page

Self-reported practices, attitudes and levels of training of practitioners in the English NHS Stop Smoking Services

Máirtín S. McDermott ^{1, 2*}, **Robert West** ^{1, 3}, **Leonie S. Brose** ¹ & **Andy McEwen** ^{1, 3}

¹ NHS Centre for Smoking Cessation and Training (NCSCT), Department of Educational, Clinical and Health Psychology, University College London, WC1E 6BT, UK

² Centre for Outcomes Research and Effectiveness, Dept of Educational, Clinical and Health Psychology, University College London, London, UK

³ Cancer Research UK Health Behavior Research Centre, Department of Epidemiology and Public Health, University College London, WC1E 6BT, UK

*** Corresponding author**

Corresponding author at:

NHS Centre for Smoking Cessation and Training (NCSCT)

Room 445

Research Department of Clinical, Educational and Health Psychology

University College London

1-19 Torrington Place

London, WC1E 7HB,

UK

Phone: 020 3108 3097

Fax: 020 7916 8511

Email: mairtin.mcdermott@ncsct.co.uk

Abstract

The primary aim of the current study is to investigate the self-reported practices, attitudes and levels of training of stop smoking practitioners (SSPs) working at the English National Health Service's (NHS) Stop Smoking Services (SSSs). A secondary aim was to investigate differences between '*Specialist*' and '*Community*' SSPs. An online survey was conducted with 484 SSPs. Most (94%) SSPs offered one-to-one appointments to smokers, only 43% always used the abrupt quit model and 30% reported ever recommending particular medication to clients. SSPs reported an average of 3.7 days training when starting work and 26% reported never observing an experienced practitioner before seeing clients of their own. Over half (56%) never received clinical supervision. SSPs reported having generally positive attitudes towards their jobs, but reported feeling less positive about their prospects for future employment within the field. '*Specialist*' SSPs reported receiving more days training (4.1 vs. 3.0, $p=.002$), more days observing an experienced practitioner when starting work (12.9 vs. 6.6, $p<.001$) and were more likely to receive clinical supervision (48.9% vs. 34.9%, $p<.05$) than '*Community*' SSPs. Gaps between SSPs' current practices and evidence-based guidelines may be due to inadequate training. Similarly, differences in training between specialist and community SSPs may contribute to the observed difference in these practitioners' success rates. As recommended by the Department of Health for England, standardized training in evidence-based smoking cessation interventions should be implemented for both specialist and community SSPs.

Keywords: smoking cessation, professional education, stop smoking practitioner, evidence-based guidelines, online survey

1. Introduction

This paper reports on the self-reported practices, attitudes and levels of training of stop smoking practitioners (SSPs) working at the English National Health Service's (NHS) Stop Smoking Services (SSS). The SSSs were established in 1999 following the publication of the UK government's tobacco control strategy in the White Paper 'Smoking Kills' (Department of Health, 1998) to ensure that every smoker in the country would have access to free, evidence-based treatment for smoking cessation. The SSSs comprise one of the most highly developed behavioral support programmes and provide the 'blue-print' for smoking cessation programmes across the world. Initial guidance issued following the establishment of the services recommended that the primary treatment model (specialist support) should comprise group support plus NRT with weekly meetings covering six weeks. The provision of one-to-one support was also specified in community settings to extend the reach of services (McNeill, Raw, Whybrow, & Bailey, 2005). In line with this, central to each service was a group of full-time '*Specialist*' SSPs employed directly by the SSS to deliver behavioral support in addition to a number of trained '*Community*' SSPs, typically practice nurses or community pharmacists, who deliver support for the SSS as part of or in addition to their main role. Although initially designed to supplement specialist support, one-to-one support delivered by community SSPs has become the dominant treatment model (L. Bauld, Coleman, Adams, Pound, & Ferguson, 2005; The NHS Information Centre, 2011)

The SSSs' combination of evidence-based pharmacological and behavioral treatments have been shown to significantly improve smokers' chances of successfully quitting smoking (West, McNeill, & Raw, 2000) and since their foundation have helped over 625,000 people to stop smoking long term, saving 70,000 lives . There is, however, a wide variation in success rates across SSSs. In 2009/ 2010, 4-week biochemically validated quit rates ranged from 3-58%, with an average of 34% (The NHS Information Centre, 2011). Smoker characteristics provide explanation for some of this

variation (Judge, Bauld, Chesterman, & Ferguson, 2005) but some may also result from variation in rates of biochemical validation and the delivery of the services. These differences could be explained in terms of SSP type (specialist vs. community), treatment model (e.g. one-to one support versus groups) and content (e.g. specific behavior-change techniques (BCTs) or medication used). The specific organization of each SSS and treatments offered varies as they are under the direction of their Primary Care Trust (PCT), of which there are around 150, which are local organizations responsible for commissioning health and social care to serve the needs of their local population and are free to configure their own SSSs under broad guidelines from national bodies such as the National Institute for Health and Clinical Excellence (NICE) and the Department of Health (DoH). Whilst such freedom has allowed services to be responsive to local needs, it may also have contributed to the observed wide variation in success rates across services.

The interventions delivered by SSPs will typically be guided by treatment protocols created by the local SSS which will ideally be based on evidence-based national guidelines (i.e. Department of Health, 2011; National Institute for Health and Clinical Excellence, 2008) but may also reflect local knowledge and any training the SSS manager has received (West, Walia, Hyder, Shahab, & Michie, 2010). National guidelines reflect the evidence base which confirms the superiority of group treatment delivered by specialist SSPs over one-to-one support delivered by community SSPs (Bauld, et al., 2011; Lancaster & Stead, 2005; McEwen, West, & McRobbie, 2006; Stead & Lancaster, 2005) and varenicline or combination NRT over other forms of pharmacology or no medication (Cahill, Stead, & Lancaster, 2007; Stead, Perera, Bullen, Mant, & Lancaster, 2008). Guidelines also recommend abrupt over gradual cessation, although there is evidence that either method may be equally efficacious (Lindson, Aveyard, & Hughes, 2010). There is also evidence supporting the efficacy of specific BCTs (systematic procedures designed to change behavior) used

by SSPs during one-to-one interventions (West, et al., 2010). Little is known, however, about the extent to which these guidelines and protocols are adhered to in practice.

There is also currently no data on the training SSPs receive, either in terms of the initial training received prior to seeing clients or on their continuing professional development and maintenance of skills. The ability of SSPs to deliver high quality evidence-based behavioral support also depends on them being trained to a minimum standard and being able to demonstrate and maintain the knowledge and skills for effective job performance. Currently, recommendations both by NICE (National Institute for Health and Clinical Excellence, 2008) and DoH (Department of Health, 2011) state that SSPs working at the SSSs should be trained in line with the NHS Centre for Smoking Cessation and Training (NCSCT) Training Standard (NHS Centre for Smoking Cessation and Training (NCSCT), 2010). The standard however, merely details a set of learning outcomes that need to be met in order that SSP's receiving training can deliver evidence-based interventions. The current study was carried out as part of a programme of research conducted at the NCSCT, the goal of which is to establish what constitutes best practice in treatment to aid smoking cessation and the competences required of SSPs, and to develop and implement assessment and training to ensure that all practitioners possess those competences (see www.ncsct.co.uk).

The aims of the current study, therefore, are to detail the current work practices and adherence to evidence-based guidelines of SSPs working at the SSS in England, to determine the current levels of training, supervision and continuing professional development amongst SSPs and to investigate differences in current practices and levels of training between specialist and community SSPs.

2. Methods

2.1 Study Design

An online survey was administered.

2.2 Participants and survey administration

The survey was available via a hyperlink sent out in an electronic flier to all SSS managers in the NCSCT database with a request that they forward it on to all staff involved in delivering smoking cessation interventions. A number of online surveys of managers of SSS have occurred to date (e.g. Agboola, Coleman, Leonardi-Bee, McEwen, & McNeill, 2010; McNally & Ratschen, 2010) and the database of managers of SSS in England was informed by these. All those who had signed up for the online NCSCT Stage 1 Training Programme for SSPs at the time of launching the survey (n=1213) were also contacted via email. As an incentive, all respondents were entered into a draw to win a prize which comprised free registration, transport and accommodation for the UK National Smoking Cessation Conference (UKNSCC) to be held in London on the 13th and 14th June 2011. Reminders were sent at 10 and 20 days after the initial contact, with a final reminder sent 3 days preceding the survey's close. The online survey was open between 29th November and 24th December 2010.

In total, 686 responses were recorded to the online survey. Of these, 50 reported that they did not see smokers on behalf of an NHS Stop Smoking Service and were not eligible to take part. Of the 636 remaining respondents, 86 entered no data, 33 had one duplicate entry, two had two duplicate entries and 29 entered their contact details only. For the duplicated entries, the most complete set of answers was retained. Seventy one percent (n=484) of respondents completed the survey and it is on these data that the findings are reported.

2.3 Survey content

SSPs completed an 84-item survey covering a range of topics (see Appendix A). The first part of the survey related to adherence to evidence-based guidelines. We asked SSPs to report the treatment models they offered based on the categories reported in SSS statistics (The NHS Information Centre, 2011) along with some specific questions regarding their attitudes towards group-based interventions. In addition we asked about SSPs' adherence to the abrupt cessation model, whether they ever recommended specific medications to clients and the extent to which they practiced and their attitudes towards CO-monitoring (as a further potential source of variability in CO-validated quit rates). We also asked SSPs to rate their estimated use of 16 BCTs, the inclusion of which in SSS treatment protocols was associated with short term quit rates recorded in practice (West, et al., 2010), on a five point scale (1 = 'never'; 5 = 'always'), how many clients SSPs had seen in the past 12 months (0-10, 11-25, 26-50, followed by increments of 50 to a maximum of 401+) and what percentage of these clients were CO-validated four-week quitters (increments of 10% ranging from 0% to a maximum value of 60%+). The survey then asked for details of SSPs' levels of training and continuing professional development, their attitudes towards their role as SSPs, as well as for contact details and basic demographic data. A combination of closed and open questions were used. Where participants were presented with a range of categories to choose from, an 'other' option was also presented in order to allow for the widest range of answers. Attitudinal items were answered on five-point Likert scales ranging from 'strongly disagree' (1) to 'strongly agree' (5). Drafts of the questionnaire were circulated amongst NCSCT staff for the purposes of refinement prior to launching online.

2.4 Data analyses

Data were transferred to SPSS (Version 14) where they were anonymized, coded and analyzed. Rates of missing data varied between 3% and 23% per variable. No attempt was made to estimate

missing values. Respondents' free-text responses were analyzed using a content analysis approach whereby text was analyzed by looking at the frequency of matching responses and converted into categorical variables. Categorical variables were then analyzed using descriptive statistics. Some categories were combined for analysis and to ease interpretation and presentation. For the item asking SSPs to report the proportion of their clients that were CO-validated four-week quitters, response categories were collapsed into 0-30%, 31-60% and >60%. As smokers attempting to stop without additional support have a success rate of around 25% at four weeks (Department of Health, 2011), these categories can be classed as 'below average,' 'above average' and 'excellent'. Differences between specialist and community SSPs were investigated using independent samples t-tests for continuous and chi-squared tests for categorical variables. Continuous variables with significant skew (i.e. n days 'off the job' training received when started working at SSS; n days observing an experienced practitioner when started employment) were log transformed prior to analysis. Analyses were restricted to those working at the SSS for at least 12 months where appropriate (n clients seen in the past 12 months, the proportion of clients that were CO-validated four-week quitters, frequency of attending 'off the job' update training, frequency of receiving clinical supervision).

3. Results

3.1 Participant characteristics

Participant characteristics are shown in Table 1. A total of 71% (n=332) of practitioners were ‘specialist’ SSPs, 21% (n=97) were ‘community’ SSPs and 9% (n=41) responded ‘other’.

3.2 Current work practices of stop smoking practitioners

Table 1 details SSPs’ current work practices. One-to-one appointments were the most commonly cited treatment model offered, followed by telephone advice/ counseling and self-help materials. Only 43% (n=190) of SSPs agreed (chose either ‘agree’ or ‘strongly agree’) that group treatment for smoking cessation is more effective than one-to-one and a further 29% (n=129) were unsure. Sixty-three percent (n=274) agreed that it is difficult to recruit enough clients at one time to run successful groups and 84% (n=389) that running groups requires additional skills to delivering one-to-one interventions.

Forty-three percent (n=190) of SSPs said they always used the abrupt cessation model, i.e. they encourage smokers to smoke as much as they wish until the quit date and then stop abruptly at that point, 53% (n=238) encourage abrupt cessation but allow smokers to cut down gradually if they do not feel they can manage to stop abruptly and 4% (n=19) encourage smokers to cut down gradually before stopping. When asked whether they ever recommend a particular medication to clients, 30% (n=132) answered yes. The most frequently recommended medications were combination NRT (34%, n=39), varenicline (32%, n=36) and the 16-hour nicotine patch (20%, n=23).

The vast majority (99%, n=465) of SSPs said that they were provided with a carbon monoxide (CO) monitor for use with clients and 91% (n=441) that they regularly monitored clients’ CO levels to validate their self-reported abstinence. Nearly all (96%, n=443) SSPs agreed that CO-testing is an

important part of the assessment process, 95% (n=446), that all SSPs should be trained in CO-monitoring and provided with the necessary equipment to carry it out and 88% (n=411) that CO validation is an important marker of data quality. In spite of this, 23% (n=97) did not know how many of their clients were CO-verified 4-week quitters in the past 12 months (see Table 1).

INSERT TABLE 1 HERE

A total of 93% (n=419) of SSPs said that their SSS had treatment protocols telling them how to conduct sessions for one-to-one stop smoking support. SSPs reported very high use of most BCTs, in each case reporting that the BCT was used ‘always’ was the most frequently chosen response. A number of key BCTs, however, did not appear to be used routinely. For example, only 54% (n=255) reported always advising on use of social support, 66% (n=309) reported always emphasizing the importance of the ‘not a puff’ rule (to discourage smokers from seeing any smoking as an option) and 66% (n=308) reported always providing a summary to clients at the end of each session (see Figure 1).

INSERT FIGURE 1 HERE

3.3 Current training levels of stop smoking practitioners

SSPs’ reported levels of training are shown in Table 2. The data for the number of days ‘off the job’ training received when starting work at the SSS was highly skewed and so the modal response of two days (35%, n=157) may be more instructive. The most frequently mentioned training provider mentioned in free-text responses was in-house or other locally organized training (e.g. SSS or PCT, 41% of responses). When asked how many days they observed an experienced practitioner before seeing clients on their own, the modal response was zero days (26%, n=110). Most practitioners reported that they never received clinical supervision (56%, n=208), followed by every month (12%,

n=45), every two months (9%, n=33) and every three months (9%, n=33). Only 66% (n=247) reported that they had ever been observed in practice and received feedback.

INSERT TABLE 2 HERE

3.4 Attitudes of stop smoking practitioners towards their role

SSPs were asked to rate their agreement with a number of statements about working as stop smoking practitioners. SSPs reported having generally positive attitudes towards their jobs. The majority (93%, n=419) agreed that they gained a lot of satisfaction from their current role, 73% (n=329) that they feel valued in their current role by other health professionals or the NHS and 75% (n=333) that they feel valued in their current role by society. SSPs also agreed that they had good knowledge and skills about tobacco control (87%, n=383) and about smoking cessation (97%, n=439). SSPs felt less positive, however, about their future prospects within the field, only 27% (n=121) agreed that there was good opportunity for career progression within smoking cessation and tobacco control, 34% (n=149) that there was good opportunity for career progression to other areas of related work (e.g. public health) and 24% (n=105) that they have job security in the long term. In spite of these reservations, 82% (n=368) of SSPs reported that they intended to continue working within smoking cessation.

3.5 Differences between specialist and community SSPs

Finally, differences between specialist and community SSPs were investigated. There was a significant difference in the number of smokers setting a quit date with the practitioner in the past 12 months ($\chi^2(3) = 31.66$, $p < .001$) with specialist SSPs more likely to have seen a greater number of clients. Specialist SSPs were also significantly more likely to report having a greater proportion of clients that were CO-validated quitters at four weeks ($\chi^2(2) = 10.16$, $p = .006$) and to offer the

majority of treatment models (see Table 1). Specialist SSPs also received a significantly higher number of days 'off the job' training prior to starting work ($t(378) = 3.18, p=.002$), spent more days observing an experienced practitioner prior to seeing clients of their own ($t(281) = 3.99, p<.001$) and were more likely to receive clinical supervision ($\chi^2(1) = 4.00, p<.05$) (see Table 2).

4. Discussion and conclusion

4.1 Discussion

To our knowledge, this is the first published study to investigate the self-reported practices, attitudes and levels of training of stop-smoking practitioners (SSPs) working at the English National Health Service's (NHS) Stop Smoking Services (SSS). Results of the survey show that there are gaps between SSPs' current practices and evidence-based guidelines, that SSPs' reported levels of training, continuing professional development and professional supervision are low and that there are differences in current practices and levels of training between specialist and community SSPs

One of the main reasons for conducting the current study was to shed some light on SSPs' current practices, of which there is no current data, and to provide some insight into the observed wide variation in success rates across SSSs in England. Although it remains possible that some of the variation between SSSs in CO-validated quit rates is due to varying rates of biochemical validation, the vast majority of SSPs in the current study reported that they regularly monitored clients' CO-levels and held positive attitudes about the importance of CO-monitoring. It seems, therefore, that the greatest potential to explain variability in outcome may come from SSPs' reported practices.

SSPs reported very high use of 16 evidence-based (West, et al., 2010) BCTs. For each BCT, reporting that it was used 'always' was the modal response. Whilst this finding is encouraging, it is also possible that this very high rate of use of BCTs may be an overestimate. Future research, therefore, should investigate concordance between self-reported use of BCTs and observed practice. Aside from this positive finding, a number of gaps between current practices and evidence-based guidelines were apparent. Less than one third of SSPs reported that they ever recommended a particular medicine to clients despite evidence (reflected in SSS guidelines, i.e. Department of Health, 2011) that varenicline in particular and combination NRT may have greater efficacy (Cahill,

et al., 2007; Stead, et al., 2008). Similarly, SSPs were most likely to offer one-to-one support, as would be expected, given that this is the treatment model by which most smokers at the SSS set a quit date in 2009/2010 (The NHS Information Centre, 2011). However, it is less efficacious than group-based support (Bauld, et al., 2011; Lancaster & Stead, 2005; McEwen, et al., 2006; Stead & Lancaster, 2005) the superiority of which is also reflected in SSS guidelines (Department of Health, 2011). Some insight into why SSPs do not offer group support was also found. SSPs were unaware of the superior efficacy of group support, agreed that it is difficult to recruit enough clients at one time to run successful groups and that running groups requires additional skills to delivering one-to-one interventions.

The observed gap between evidence-based guidelines and practice could be due to inadequate training; the modal amount of two days 'off the job' training prior to starting work seems low for a specialized, life-saving intervention and SSPs also report receiving low levels of continuing professional development which would make it difficult to maintain or update knowledge levels and affect their ability to apply in practice the most up-to-date evidence. The predominance of locally organized, in-house training may also have contributed to the observed deviations from guidelines. There were significant differences in training received between specialist and community SSPs, with community SSPs receiving significantly fewer days 'off the job' training prior to starting work, spending fewer days observing an experienced practitioner prior to seeing clients of their own and being less likely to receive clinical supervision. As it is possible that low levels of training generally have contributed to the gap between SSP practices and evidence-based guidelines, it is further possible that this disparity in training between the two practitioner types has contributed to the observed difference in success rates between the interventions offered by these SSPs found in the present survey and in previous research (Bauld, et al., 2011; McEwen, et al., 2006). These observed

differences in success rates may also be due to having less experience, as community SSPs were also found to have treated fewer smokers in the past twelve months.

It is positive that SSPs reported feeling satisfied with their work, valued in their roles and that they had good knowledge and skills in smoking cessation and tobacco control. However, in spite of being willing to continue working in the area of smoking cessation, most SSPs felt that there was little scope for career progression or job security in the long term. This indicates that little progress in SSPs' job satisfaction has been made in the past five years. A similar finding was reported by Bauld and colleagues (Bauld, et al., 2005) who attributed the lack of security to the short-term contracts available to SSPs as a result of funding arrangements.

4.2 Strengths and weaknesses

Due to the lack of previous research or reliable method for contacting all SSPs working in England, it is difficult to determine either the effective response rate of the survey or the representativeness of the current sample of SSPs. Whilst no national database of SSPs exists, as mentioned above, the NCSCCT has a database of those signed up for the online NCSCCT Stage 1 Training Programme, which as of April 2011 contained 1475 SSPs (out of a total of 2697 registrants). Compared to those on the database, the overall study sample and subsamples of specialist and community SSPs appear more experienced than those in the larger database, both in terms of years working as an SSP and number of clients setting a quit date. In addition, given community SSPs represent the majority of those working as SSPs in England (Bauld, et al., 2005); it is clear that specialist SSPs were over-represented in the current sample. This is possibly due to our contacting SSS managers to recruit participants, who would be more likely to pass details of the study on to those specialist SSPs based at their SSS. Given that the study sample contains more experienced practitioners and an excess of

specialist SSPs, it is possible that the information presented in this study may present a more positive slant than is the case amongst the total population of SSPs working at the English SSSs.

Another limitation is the amount of missing data in the survey, which was as much as 23% for some items. Future online research using this population should seek to minimize this, perhaps by making responding to each item compulsory before allowing progress through the questionnaire. Despite these limitations, however, we believe these results to be important, as no other studies exist that have investigated such a broad range of practices, attitudes and levels of training of this highly important group of health care professionals.

4.3 Conclusions

Based on the results of our survey, we conclude that there are gaps between SSPs' current practices and evidence-based guidelines and that this may be due to inadequate training. Considering that they offer a life-saving intervention to hundreds of thousands of smokers each year, levels of initial and continuing professional training for these practitioners seem low, with many receiving no professional supervision or feedback. In spite of high levels of perceived knowledge and skills, and high job satisfaction, these SSPs reported low levels of job security and opportunities for progression within smoking cessation or tobacco control which may be due to the lack of secured funding for the services. Finally, there are differences between specialist and community SSPs in the amount and frequency of training and supervision received which may contribute to the difference in the success rates of the interventions delivered by these practitioners seen here and in other research (Bauld, et al., 2011; McEwen, et al., 2006).

4.4 Practice implications

Current recommendations for training SSPs (NHS Centre for Smoking Cessation and Training (NCSCT), 2010) specify only the learning outcomes that SSPs should attain this should be expanded to include specifications for supervision and continuing professional development to ensure that not only do all SSPs reach the desired standard of skills and knowledge, but maintain the ability to carry out their work according to the latest evidence-based guidelines. As recommended by the Department of Health for England and the National Institute for Health and Clinical Excellence, standardized training in evidence-based smoking cessation interventions should be implemented for both specialist and community SSPs. Finally, as it may be difficult to increase the amount or frequency of training community SSPs' receive given delivering smoking cessation interventions represents only part of their professional role, it may be prudent to direct smokers to more evidence-based treatments, i.e. to specialist SSPs whenever possible.

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Appendix A: Study questionnaire

NCSCT Annual Survey of Smoking Cessation Practitioners: 2010

The NHS Centre for Smoking Cessation and Training (NCSCT) has been commissioned by the Department of Health to provide training and resources for those that deliver, manage and commission Stop Smoking Services. This is the second annual survey of smoking cessation practitioners conducted by the NCSCT, which gives you the chance to give us an up to date view of the issues, barriers and systems that are important in your area and will help us to plan the delivery of NCSCT services over the coming years for maximum benefit.

The survey should take no more than 15 minutes to complete. Questionnaire responses and any other information given during the course of the research will be anonymous. All information will be used for research purposes only. Please note that confidentiality will be maintained and it will not be possible to identify you from any report about this study.

For more information on the work of the NCSCT see: www.ncsct.co.uk

Contact details:

Note: This information will not be passed onto anyone but will ensure that we have your correct details and will allow us to contact you in the future about resources and training that may be relevant to your needs.

Do you see smokers on behalf of an NHS Stop Smoking Service? Or are you about to? [If no, do not continue]	Yes	No
Name:		
Job title:		
Name of Stop Smoking Service:		
Employing organisation:		
Email address:		
Telephone number:		
Postal address:		

Some questions about you:

Are you:	Male	Female	No answer
How old are you? (please write age in box)	Years		
How long have you been working in NHS stop smoking services? (please write in box)	Years.....Months		
Are you employed as a specialist stop smoking practitioner (employed directly for the / working directly for the Stop Smoking Service) or as a community stop smoking practitioner (delivering stop smoking support in the community, eg GP surgeries, pharmacies, dentists, children's centres)?	Specialist SSP	Community SSP	Other

Some questions about the services you provide:

Please indicate whether you offer the following treatment models:		
One-to-one appointments	Yes	No
One-to-one drop-in sessions	Yes	No
Closed group programmes	Yes	No
Rolling group programmes	Yes	No
Telephone advice/counselling	Yes	No
Self-help materials	Yes	No
Peer led sessions	Yes	No
Home visits	Yes	No
Other:	Yes	No
Other: please give details		

Please indicate how much you agree with the following statements:	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
Group treatment for smoking cessation is more effective than one-to-one					
It is difficult to recruit enough clients at one time to run successful groups					
Running groups requires additional skills to delivering one to one interventions					
Carbon Monoxide testing is an important part of the assessment process					
Carbon Monoxide validation is an important marker of data quality					
All stop smoking advisers should be trained in CO monitoring and provided with the necessary equipment to carry it out					

Are you provided with a carbon monoxide (CO) monitor for use with clients? [radio button]	Yes	No
Do you regularly monitor client's carbon monoxide (CO) levels to validate their self-reported abstinence?	Yes	No

What is your approach to gradual versus abrupt cessation? (please select one answer) [radio button]	
I always use the abrupt cessation model i.e. smokers smoke they wish until the quit date and stop abruptly at that point	
I encourage abrupt cessation but allow smokers to cut down gradually if they do not feel they can manage to stop abruptly	
I encourage smokers to cut down gradually before stopping	

Do you ever recommend a particular medication to clients?	Yes	No
If Yes , which medication do you most frequently recommend that clients use? (Please select one only)		
Varenicline (Champix)		
Bupropion (Zyban)		
Nicotine patch (16 hour)		
Nicotine patch (24 hour)		
Nicotine gum		
Nicotine lozenge		
Nicotine microtab		
Nicotine nasal spray		
Nicotine inhalator		
Combination NRT		

Does the Stop Smoking Service for which you work have any treatment manuals, protocols, or guidance documents telling you how to conduct or deliver your sessions for individual-based (1:1) stop smoking support?	Yes	No	I Don't know
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Thinking about all of the smokers that you have seen over the last 3 months, how often do you estimate that <u>you</u> performed the following activities when delivering your stop smoking support sessions?	Never	Rarely	Sometimes	Often	Always
Measure expired-air carbon monoxide					
Prompt the client to give views on smoking, smoking cessation and any aspects of the behavioural support programme					
Explain the importance of regarding smoking as something that is 'not an option,' including the 'not a puff' rule, and construct a new identity as someone who 'used to smoke'					
Give information about options for additional support where these are available (e.g. websites, self-help groups, telephone helpline)					
Give praise or rewards if the person has not smoked					
Advise on ways of changing daily or weekly routines to minimize exposure to smoking cues					
Help the smoker understand how lapses occur and how they lead to relapse and to develop specific strategies for preventing lapses or avoiding lapses turning into relapse					
Explain the benefits of medication, safety, potential side effects, contra-indications, how to use them most effectively, and how to get them; advise on the most appropriate medication for the smoker and promote effective use					
Assess usage, side effects and benefits experienced of medication(s) that the smoker is currently using					
Describe to smokers what are, and are not, nicotine withdrawal symptoms, how common they are, how long they typically last, what causes them and what can be done to alleviate them					
Explain to the smoker the reasons for measuring CO at different time points, e.g. before and after the quit date					
Advise on or facilitate development of social support from friends, relatives, colleagues or 'buddies'					
Give general reassurance to the smoker that his/her experiences are normal and time limited, and provide positive expectations of success based on experience with other smokers in the same situation					
Provide a summary of information exchanged and establish a clear confirmation of decisions made					

and commitments entered into					
Give encouragement and bolster confidence in ability to stop					
Advise on ways of minimizing stress and other demands on mental resources (activities that require mental effort)					

How many smokers set a quit date with you in the past 12 months? (please select one answer)	
Don't know	
1-10	
11-25	
26-50	
51-100	
101-150	
151-200	
201-250	
251-300	
301-350	
351-400	
<400	
What percentage of these were CO-verified 4-week quitters? (please select one answer)	
Don't know	
0-10%	
11-20%	
21-30%	
31-40%	
41-50%	
51-60%	
>60%	

Some questions about training, personal development and supervision:

How many days 'off the job' training did you receive when you started working for the NHS Stop Smoking Service? (Please write number in box)	 days
Who provided the training for you? (Please write name of training organisation in box)	
For how many days after your training did you observe an experienced practitioner before seeing clients of your own? (Please write number in box; if 'none' enter '0')	 days
How often do you attend 'off the job' update training? [radio button]	
Twice a year	
Once a year	
Once every two years	
Other (please list):	
How often do you receive clinical supervision? (Please write number in box; if you do not receive regular clinical supervision write '0' in box)	I receive clinical supervision every..... months

Have you ever been observed in practice and received feedback?	Yes	No
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Some questions about working in the field of smoking cessation:

Please indicate how much you agree with the following statements: [radio button]	Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
I gain a lot of job satisfaction in my current role					
I feel valued in my current role by other health professionals/ the NHS					
I feel valued in my current role by society					
There is good opportunity for career progression within smoking cessation and tobacco control					
There is good opportunity for career progression out from smoking cessation and tobacco control to other areas of related work (e.g. public health)					
I have good knowledge and skills about tobacco control (e.g. smokefree environments)					
I have good knowledge and skills about smoking cessation					
I intend to continue working within smoking cessation?					
Smoking cessation practitioners need a body that they can be registered with to demonstrate their competence and ongoing commitment to professional development					
Smoking cessation practitioners need a professional organisation to represent their interests					
I feel that I have job security in the long term					