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SMOKING CESSATION

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WHY QUITTING IS STILL A BURNING ISSUE

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Pfizer

NEW LABOUR'S PLEDGE

New Labour prime minister Tony Blair and health secretary Frank Dobson took office in 1997, and pledged £100m over three years to fund specialist stop smoking services on the health service. It showed that there was now the political will to put smoking cessation services at the forefront of NHS plans.
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Stop Smoking is a real success story

Stopping smoking is the single most important thing smokers can do to improve their current and future health. Behavioural support and medications for smoking cessation are some of the most cost-effective interventions available to the health service. This *HSJ* Smoking Cessation supplement is timely, although the content could not have been predicted 10 years ago.

It was in 1998 that the *Smoking Kills* white paper announced the government's intention to reduce the health and economic burden of smoking, and set targets for reducing prevalence. One measure was the creation of NHS stop smoking services, the world's first national smoking cessation programme.

It is a testament to the commitment and expertise of its staff that this fledgling NHS service has dealt so successfully with ambitious targets and directives to treat hard-to-reach groups of smokers.

The following pages provide further evidence of the dedication and ingenuity of smoking cessation managers and practitioners to widen the reach of their services, to engage with other health professionals and the broader local community, and to embrace service user involvement.

Practitioners who specialise in smoking cessation are more skilled than those who include smoking cessation among other roles, such as community pharmacists and practice nurses, and abstinence rates reflect this.

Herein lies another challenge for NHS stop smoking services: to ensure that registered advisers who treat smokers in the community have sufficient support and supervision to assure the quality of the service they deliver.

There are a number of examples in this supplement of links with other health professionals, such as hospital consultants, dentists and midwives, and with the broader community – workplace smoking cessation, for example – and yet GPs are conspicuous by their absence.

Not that some services are not very successful in getting GPs to advise smoking patients to stop and to refer them if they are interested in doing so. It is just that not nearly enough doctors are intervening with their smoking patients in this way – this may be an issue for PCTs to address. Drop-in services and rolling groups are examples where services have moved away from the evidence base to meet the needs of smokers but, as with many of the case studies in this supplement, there is a strong need to evaluate as we innovate and to monitor services consistently and according to universal criteria, such as the Russell standard for abstinence rates.

The past 10 years have seen huge changes in smoking cessation with the advent of NHS stop smoking services and medications for smoking cessation available on prescription, and in society with the ban on tobacco advertising, the introduction of smoke-free policies and the raising of the minimum tobacco purchasing age to 18.

More dramatic changes are likely in the next decade, but it is also likely that the stop smoking services that flourish and deliver innovative, good-quality, evidence-based treatment to their local population will be those whose primary care trusts place a high priority on smoking cessation and back it up with resources.

That describes the services showcased in this supplement, which will, it is to be hoped, be flourishing and will have reached even more people in 10 years' time.

Andy McEwen PhD is assistant director of tobacco studies at the health behaviour research centre, University College London.

COVER: ALAMY

In 1996, 28 per cent of UK adults smoked. In 1997, New Labour prime minister Tony Blair and health secretary Frank Dobson pledged £1

SIFT THROUG

Could the death toll have been lowered by offering nicotine replacement therapy on the NHS earlier? Emma Baines looks through the policy history of smoking cessation

In 1996, 28 per cent of UK adults smoked. The decline of smoking had started to level out since the early 1980s and it looked as though the habit was here to stay. Cigarettes were responsible for 120,000 deaths a year through smoking-related illness at an estimated cost to the health service of £1.7bn each year.

When Labour came to power in 1997, a stated health policy goal was to tackle smoking. In 1998 the white paper *Smoking Kills* summarised the evidence in favour of a national stop smoking policy and set out a raft of measures aimed at reducing the damage done by the habit. The government pledged £100m over three years to fund specialist stop smoking services on the NHS. These were to be set up by health authorities and health boards in line with local needs, with a particular focus on deprived areas.

Professor Robert West, director of tobacco studies at the Cancer Research UK Health Behaviour Research Centre at University College London, helped develop the stop smoking framework that was incorporated into the white paper. He says the evidence in favour of offering smoking cessation on the health service was overwhelming, although nothing of the kind had ever been introduced on a national scale before.

"There was a strong sense that a case for smoking cessation services had already been made. It was just that it hadn't been acceptable on a political level. But when New Labour got in to power everything fell into place," he said.

First targets

The white paper also set the first smoking cessation targets for England: by 2010 the percentage of adults aged over 16 who smoke should be reduced to 26 per cent; the number of children smoking should be cut from 13 to 9 per cent; and the number of pregnant women smokers should be down to 15 per cent from 23 per cent. These targets were revised in the 2000 NHS Cancer Plan to the current targets of 21 per cent in the general adult population and 26 per cent for manual groups.

The stop smoking services were launched in 1999. Providing access to treatment and support to groups of quitters, or on a one-to-one basis, they proved to be more popular than expected. It was estimated that around 2 per cent of smokers, or around 200,000 people in England, would be interested in making use of the service, but demand was found to be much higher.

Data from the NHS information service for 2001-02 shows that 119,834 people accessing a stop smoking service in England had successfully given up at their four-week follow-up. By 2006-07 this figure had risen to 317,720, with more than 600,000 smokers accessing the service and setting a quit date.

A major part of the stop smoking strategy has been to widen access to treatments, including nicotine replacement therapy, bupropion and varenicline. Although it has been available in the UK on private prescription since the 1980s, nicotine replacement therapy was not available on NHS prescription until April 2001.

In the 1990s when it came up before the Borderline Substance Committee, a precursor to NICE, it was ruled that this should not be made available on the health service.

"I think this was a unique case where a medicine that was known to be effective and was licensed was not made available on the NHS," says Professor West.

In addition, there were widespread fears that allowing nicotine replacement therapy on prescription would break the bank. These fears have not been realised since most people are happy to buy nicotine replacement therapy themselves rather than go to the bother of getting a prescription, and in 2004 there were around two million prescriptions for it in England, at a cost of £44m.

The stop smoking services were one component of a wider strategy. Other measures included banning advertising, increasing the price of cigarettes year on year and introducing bans on smoking in the workplace. Arguably the most successful of these initiatives was the smoking ban introduced in Scotland in March 2006 and then rolled out in England, Wales and Northern Ireland in 2007, which brought to an end to smoking in enclosed public spaces.

Before it was introduced in England, there was resistance to the notion of a total ban, particularly from the health secretary at the time, John Reid. "There was strong popular support for it, even among smokers, but John Reid and the hospitality industry put up a big fight and I don't think we would have got a comprehensive

…00m over three years for specialist stop smoking services on the NHS. In 2001 nicotine patches became available on the NHS and a set of hard-hitting ads was aimed at smokers.

…H THE ASHES

smoking ban that covered all bars and restaurants if John Reid had not been replaced by Patricia Hewitt," Professor West recalls.

The effect of the ban on smoking prevalence to date has been dramatic, with a 4 per cent drop in England over the first nine months and an increase of around 20 per cent in the number of smokers accessing NHS stop smoking services.

Professor West says: "The ban is having a huge effect on smoking. The drop in prevalence in the months following the introduction of the ban is the biggest decrease this country has ever seen."

Influence of culture

The challenge facing smoking cessation services in Scotland has been greater than elsewhere in the UK. In 1995 the prevalence of smoking in adults was 35 per cent and in deprived areas was much higher.

Liz Grant, a public health pharmacist in NHS Greater Glasgow and Clyde, who pioneered a pharmacy-based smoking cessation service that has now been rolled out across all pharmacies in Glasgow and Clyde said: "The smoking rate is higher overall in Scotland, and there are pockets of the population in Glasgow where the smoking rate in the adult population is as high as 70 per cent. It's embedded in the culture."

By 2006 the stop-smoking services in Scotland had achieved remarkable results, already overshooting the 2010 adult smoking prevalence target of 29 per cent that was set by the Scottish Executive in 2004. Already in 2004, the percentage of adults aged over 16 who smoked was down to 26.5 per cent.

Ms Grant says the ban on smoking in public places was a huge success in Scotland, resulting in a 50 per cent increase in the number of patients accessing stop smoking services in the three months leading up to and after the ban: "We succeeded in helping a lot of people to quit at that time. It's been really good and even most smokers think it has been a positive thing."

Earlier this year, the Scottish government published an action plan that allocated an additional £9m over the next three years to smoking prevention and cessation services. It set a revised 2010 adult smoking prevalence target of 22 per cent.

It also introduced the Health Efficiency Access and Treatment performance targets that all local health boards in Scotland will have to meet. Under these, over the next three years 8 per cent of smokers have to have accessed smoking cessation services, and 30 per cent of them must be smoke-free at four weeks.

"It's the first time that we've had to deliver on something that is measurable," Ms Grant says. "It's now essential that we are only taking people who are serious about quitting, otherwise the outcome data will be very poor."

Whether or not the HEAT targets will be met, the NHS stop-smoking services in Scotland have already achieved a great deal.

"I don't think you'll ever have a completely smoke-free Scotland because there will always be pockets of hard-to-reach people," Ms Grant continues, "but I'd say that around 90 per cent of smokers know they should quit and want to quit. They're just finding it difficult."

The cumulative effect of the strategies to curb smoking in the UK has been very successful, and the chances of meeting the adult 2010 smoking prevalence targets look good, with prevalence in England already down to 22 per cent in 2006. In some places, the targets have been significantly overshot, with smoking prevalence in London, for instance, currently at 15 per cent despite many areas of deprivation in the capital.

Looking to the future, Professor West says that more ambitious targets will have to be set: "The UK has the capacity with everything it is doing to really move the goal posts quite a bit. At the moment we're aiming for smoking prevalence in the region of 20 per cent. I think that 15 per cent is a very realistic goal within 10 years. London is already there, despite areas of significant deprivation, and if London can do it, so can the rest of the country."

But he is amazed at how far the UK has already come in tackling smoking. "In the early 1980s none of us ever thought that we'd see the day when there would be a national stop smoking service, or that nicotine replacement therapy and these other smoking cessation treatments would be available on prescription. It's all been very surprising." ●

Find out more

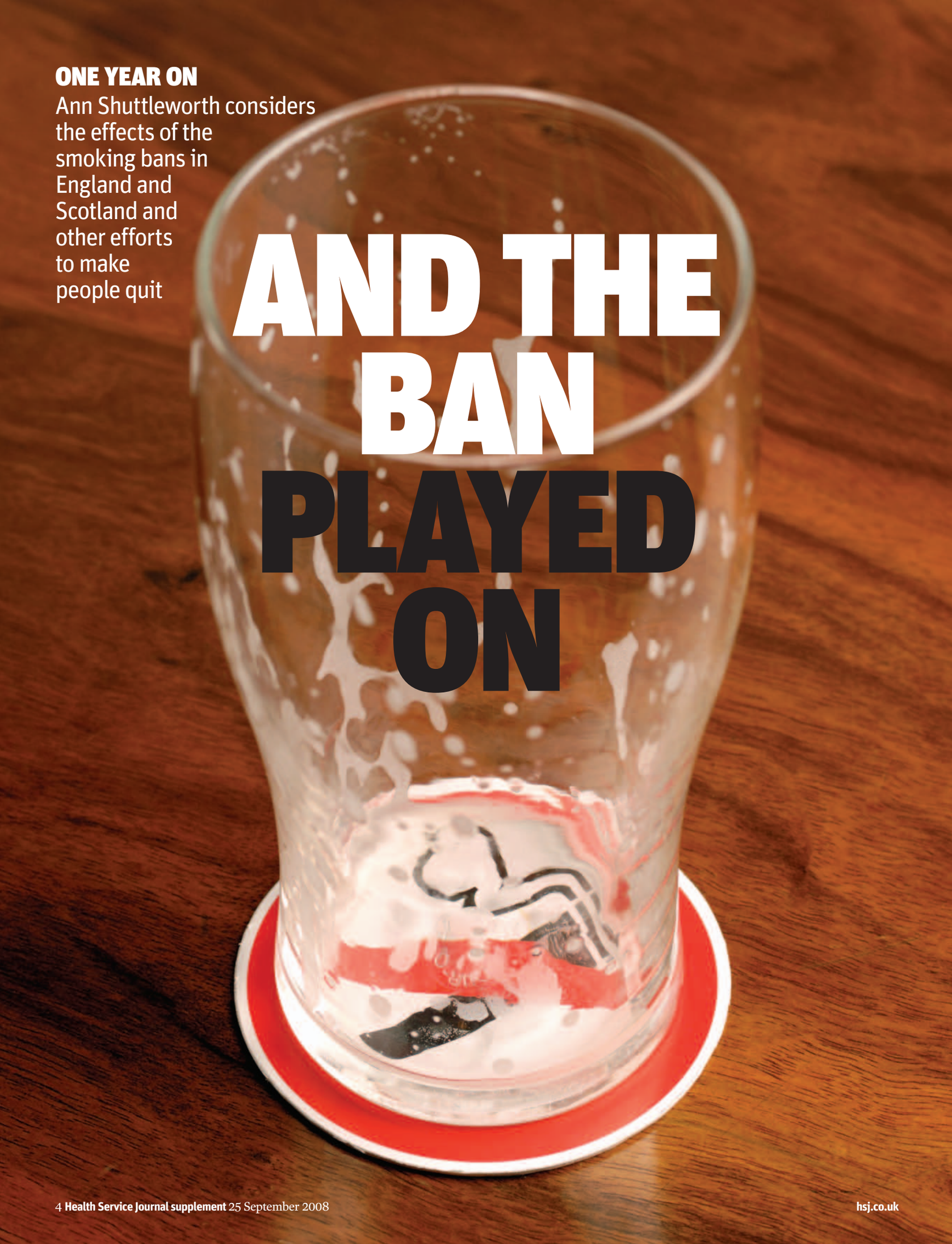
NICE smoking cessation services guideline:
➔**www.nice.org.uk/guidance/type**
Smokefree England
➔**www.smokefreeengland.co.uk**
Department of Health tobacco page
➔**www.dh.gov.uk/en/Publichealth**
Tobacco Information Scotland
➔**www.tobaccoinscotland.com**
South London and Maudsley NHS trust smoking cessation clinic
➔**www.slam.nhs.uk/services**
Cochrane Reviews
➔**www.cochrane.org/reviews**

PHOTOFUSION, PA, CORBIS, TOPFOTO

ONE YEAR ON

Ann Shuttleworth considers the effects of the smoking bans in England and Scotland and other efforts to make people quit

AND THE BAN PLAYED ON



When *Smoking Kills* was published in 1998, 32 per cent of adults in Scotland and 28 per cent of adults in England smoked. There were concerns that the decline in smoking rates over the preceding three decades was levelling out. Rates varied according to gender, social class and location: they were higher among men, manual workers and in areas of high social deprivation.

Smoking cessation services have since made steady progress towards achieving the 2010 targets for adult smokers of 22 per cent in Scotland and less than 21 per cent in England. By 2004 Scotland was down to 26 per cent and England to 22 per cent by 2006.

The bans on smoking in enclosed public places introduced in both countries are likely to have boosted recent quit rates. In England from April to December 2007 (the three months before and six months after the ban), the successful quit rate at four-week follow-up was up 22 per cent on the same period in 2006. Smoking cessation services also reported huge increases in workload in the months leading up to the bans.

Given the long-term development of many smoking-related diseases, it is too early to say how lower rates of smoking have affected their incidence. However, there have been encouraging signs that the smoking bans have had an immediate positive effect, although more research is needed to confirm the extent to which they are related to the bans.

In Scotland annual hospital admissions for heart attack have gone down by 17 per cent since the ban was introduced in 2006; nationwide figures for England are not yet available. But a survey of a number of NHS trusts revealed that many had experienced similarly positive results: one had seen a 40 per cent reduction.

Weathering the ban

While smoking bans may have prompted many people to quit, the groups of smokers standing outside public buildings suggest the main beneficiaries are probably non-smokers. And the sight of people enduring the worst weather conditions to smoke clearly illustrates the importance of offering the support of effective smoking cessation services.

Research consistently shows these services to be a cost-effective way of improving public health. An analysis by John Stapleton of the Institute of Psychiatry published in 2001 found that they are at least 40–50 times better than the National Institute for Health and Clinical Excellence benchmark of £30,000 per quality adjusted life year. Dr Stapleton concluded that smoking cessation was probably the most effective way the NHS spends money and asked why it did not spend more in this area.

The Department of Health appears to have recognised the logic of this argument and has invested heavily in smoking cessation initiatives over the past few years. Success rates are variable, but those showing the most impressive results share certain characteristics.

One main factor is the attitude of the commissioning primary care trusts, as Miriam Bell, service manager at Roy Castle Fag Ends, a community-based stop smoking service funded by Liverpool PCT points out: "We've had huge support and investment from the PCT, which has been crucial to our success."

Julia Thomas, senior public health manager, tobacco control for Medway Stop Smoking Service, funded by Medway PCT, agrees. "We have received good support from the PCT, and now that NHS finances seem to be in better shape, we are getting money to expand."

Offering a client-led service is also crucial. This means services must respond to local needs in a flexible and accessible manner. Clients need to be able to access the type of support that meets their needs at the time they decide to quit.

"This is what 'abrupt quitters' need," says Ms Bell. "These are people who wake up one day and think 'I'm going to stop smoking'. It's no good telling them they have to wait 10 weeks until the next programme with places available."

Fag Ends runs 60 group sessions a week in a wide range of settings. Fifty-five sessions are on a rolling programme so clients can walk in without an appointment and obtain immediate support; the remaining five sessions are one to one.

Another service offering a rolling programme of drop-in sessions has come up with a way of enabling clients to vary the sessions they attend but maintain continuity of care. "Clients are given a treatment card so our advisers can see exactly what they have received," says Jan Holding, who manages the service funded by Blackburn with Darwen PCT. "The card also acts as a kind of passport so they can go to any session."

'Clients can come for as long as they need and can return at any time. If they relapse we'll take them back as soon as they want to come'

The sessions split into three groups to meet the needs of different clients: first-time attenders, follow-ups and clients using a nicotine receptor partial agonist, which reduces withdrawal symptoms. The service does not stipulate how many sessions clients can attend.

"They can come for as long as they need and can return at any time – in fact they are encouraged to do so," says Ms Holding. She does not subscribe to the NICE view that clients should not be able to access services again for six months after a quit attempt. "I think that's cruel – if they relapse we'll take them back as soon as they want to come. You have to offer people support when they want it."

Offering specific services for black and minority ethnic groups is important. In Liverpool, Fag Ends is working with local mosques to organise a smoke-free Ramadan – an ideal opportunity to motivate people to quit.

Some minority groups use tobacco differently. In South Asian communities tobacco is often chewed, so stop-smoking messages can be meaningless. This highlights the importance of making services culturally sensitive, rather than assuming language is the only issue to be addressed.

Medway's expansion enabled Ms Thomas to recruit a Polish adviser and one who speaks five Asian languages. "This means we can cater for the two biggest minority groups in the area, and I can already see the difference they are making," she says.

Most services work hard to offer a range of venues, typically health and community centres and public facilities such as libraries and town halls. They also go into workplaces if employers are receptive to the idea.

Medway has taken on board the importance of using settings in which clients feel comfortable and runs sessions in local pubs and clubs.

"These are very popular with a lot of clients," says Ms Thomas. "They find them a sociable way of accessing services with their friends, while the pubs and clubs appreciate the groups bringing in customers."

With many licensed premises claiming their income is still affected by the smoking ban, any initiative that persuades customers to give up is also likely to be welcomed.

Fag Ends persuaded a shopping centre to allow its advisers to use an empty shop unit once a month. The smoking cessation service also partnered with Pfizer on the Serious Quitters campaign when it visited Liverpool, where they ran one-to-one sessions providing support and practical advice on treatment options.

Toughest groups

Timing of sessions can be as important as venues. Fag Ends offers early sessions at 8am and evening sessions up to 8.30pm. Its workplace programme has even offered sessions at 1am to Royal Mail night shift workers.

While the services are showing real success in helping people to stop smoking, as more quit, the remaining smokers are likely to be the toughest groups to help. These are the hard-to-reach groups and the heaviest smokers, both of which often live in socially deprived areas.

"Health inequalities are a major challenge," says Ms Holding. "There is a core of smokers, many living in deprived areas, who use a lot of tobacco – often in roll-up form. That's where we do well: we're very available and accessible both in our sessions and treatment approaches.

"We offer pre-quit oral nicotine replacement therapy; we have been doing so for eight years and it is extremely effective. It gives these clients support in cutting down, increases their confidence and is a chance to learn about their smoking, and it motivates them."

Blackburn with Darwen's four-week quit rate is around 70 per cent; at 52 weeks it is around 50 per cent. Ms Holding sees this as a far more realistic assessment of the quality of service. "I think all services need to move towards using the 52-week rate as the true measure. Four weeks really isn't very meaningful."

The smoking cessation services all have challenging work ahead to meet their 2010 targets. They face "competition" from illicitly imported tobacco, which sells at around a third of the price of the legal product. This removes the economic factors that may motivate less affluent smokers, and also means smokers taking risks in other unknown substances such as cow dung and sand in addition to tobacco.

Young people are also far more likely to be able to afford illicit tobacco, and this is the group that cessation services want to prevent from taking up smoking in the first place. To persuade them to avoid tobacco, health promotion messages must be engaging and age-appropriate. This means catering for a wide range of developmental stages – in Liverpool, one of Fag Ends' advisers is working with children as young as five.

Despite these challenges, services remain optimistic. Ms Holding sums the situation up. "We're not complacent, we have to keep on top of things, but as long as our commissioners continue to invest in the service, we won't have any problems meeting our 2010 targets." ●

ALAMY

CASE HISTORIES

Now the most motivated ex-smokers have stubbed out their last cigarette, Ingrid Torjesen finds out how services are reaching out to the less enthusiastic would-be quitters

As 2010 draws nearer, the job of smoking cessation services is becoming harder, as the majority of motivated and affluent smokers have already been through the service and quit. The people who remain are those with high nicotine dependency, and those in low socio-economic groups and in ethnic minorities. These services can no longer rely on smokers coming forward themselves to meet their challenging quit targets and will increasingly have to go out to recruit smokers from hard-to-reach groups.

Some services are already finding innovative ways to drive up their success rates. We look at the different approaches that four have taken.

LEEDS: MEN IN URBAN AREAS

Like most services Leeds has adopted a two-tiered approach to smoking cessation. There is a dedicated service with 19 full-time advisers plus an operations lead and a network of registered advisers who have been trained to provide services in the community. These are mainly practice nurses, pharmacists and health visitors, but also include a dental practitioner. Eighty per cent of GP practices have someone trained to provide stop smoking services.

Tobacco control lead and interim Choosing Health topics manager at Leeds primary care trust Heather Thomson says the idea is that patients are sent to an appropriate level of support. "The least dependent smokers would go to the practice nurse and the most dependent would go to the specialist service, although specialist services will take any smokers. We know practice nurses haven't got a huge amount of time to dedicate to smoking cessation, whereas the specialist service will be seeing patients for an hour a week."

Practice nurses assess patients by asking two questions: when does the patient have the first cigarette of the day and have they made a serious attempt to quit in the last year? If the answer to these questions is within 15 minutes of waking and there has been a serious quit attempt, they are supposed to send the person to the specialist service, because they obviously have high nicotine dependency and need a high level of support.

But Ms Thomson admits that some practices keep hold of the high nicotine dependency smokers, which is not in the smoker's best interest. "We get much higher quit rates with the specialised service than the registered advisers do. It's like anything: if you have a specialist service, you would expect them to have higher quit rates. Registered advisers do it as part and parcel of everything else they do."

The four-week quit rate across Leeds is 66.5 per cent, while figures for the specialist service alone show it achieves 69.3 per cent. Leeds is unusual in that it collects 52-week data by telephoning patients. For 2005-06, 18.3 per cent of patients reported that they were still not smoking a year later and the service expects a slightly higher rate this year.

The dedicated service consists of lead advisers, who head up specific service areas, and specialist advisers. There are two community teams and specific teams for the workplace, pregnancy and mental health. The service also goes into prisons, works with black and minority ethnic groups (specifically the South Asian community), young people and community and voluntary organisations.

Men make up around 40 per cent of the people seen in Leeds – a much higher proportion than in other services. Most are in the 35-45 year age group and they have a much higher success rate than women.

Ms Thomson says: "My hypothesis is that men use the service when they feel they are more ready to, whereas women will tend to come when they are not as motivated or as ready to stop."

She says take-up of smoking cessation services has been particularly high among men in Leeds because one of the specialist advisers started going out to provide support in workplaces to prepare for the smoking ban, and specifically targeted routine and manual workers. The service is attractive to workers because it is delivered in the workplace and in work time.

Karen Haw, Leeds Smoking Services operations lead, says the take-up by businesses has been "phenomenal". The specialist adviser initially goes into the workplace to do some awareness raising and to get a feel for what sort of service the employees want. "There might be a questionnaire sent out with wage slips, saying is anyone interested in stopping smoking, to find out what the uptake is going to be like. The adviser would then go in but be very flexible."

Promotions in pubs and working men's clubs to prepare for the smoking legislation have also helped to drive up the number of male clients. This included special beer mats and posters with tear-off fliers on toilet doors.

It was emphasised that this was not "a touchy-feely" service but that it was there to give support and the word "group" was avoided. Ms Haw says: "If you mention 'group', it is a massive turn-off for men, so we don't tend to mention group when we have a conversation, we mention 'sessions' and 'help and support'." But the word "drop-in" ticks a box somewhere with a man because they don't feel they are committing to anything, she adds.

Heather Thomson

RICHARD WALKER

'We have found the rolling groups and drop-ins work better in the areas of greater deprivation, as people have got more chaotic lives'

The service used to do a lot of advertising in the mass media but found this was not the best way to promote it, so it is moving much more towards community-based marketing, taking the service out to the public rather than expecting clients to seek it out.

As well as promotions in pubs and clubs, there is a smoking cessation bus which the service uses at galas and other community events. The service is also working closely with other professionals such as health trainers to reach out to socially disadvantaged groups.

Skilled advisers

To target the lowest socio-economic groups, the Leeds smoking service is working with the 44 practices in the most deprived areas of the city to develop the service. It is widely believed that success rates in such groups will be lower, but Ms Thomson says this is not the case. "We have found that in Leeds they are exactly the same."

She attributes this to the skills of the advisers and the in-depth analysis that is done. The advisers provide a complete mix of services: drop-in clinics, rolling groups and intensive one-to-one sessions for those who need them.

"We run about 60 clinics per week; we map them out, look at who is coming to each service, the day, time of day, venue and type of clinic offered. We have found that the rolling groups and drop-ins work better in the areas of greater deprivation – those that clients can just tap in and out of rather than saying you will be here every week at 7 o'clock for an hour for the next seven weeks. That does not work as well, as people have got more chaotic lives."

Many of the drop-in clinics, which are held at the same time every week, have a second adviser who will see people quickly and individually if they do not want to stay in a group for an hour. People can come for as long as they want and the rolling groups are easier for doctors to refer to because they can send the patient the next week. The support part of the group usually takes place an hour before new people are told to arrive.

Newcomers are informed about the treatments and how to prepare to stop. All the smoking cessation treatments are first line and the adviser will assess the patient to determine what is most likely to work for them and will discuss side effects and contra-indications. Once the client has decided to quit and chosen a drug treatment, they will then be given a voucher to take to the pharmacy for nicotine replacement therapy or a "dear doctor" letter if they choose a treatment that requires a prescription. The drop-in clinics tend to be linked with a pharmacist so clients can get their nicotine replacement therapy easily.

Ms Haw says the flexibility offered by the Leeds service is a major part of its success. "When I first started, it was 'we see you for this amount and that is all', but now we have brought in some flexibility, some telephone support and using texts a bit more to offer reassurance and motivation." ➔8

QUITTERS CAN WIN

HILLINGDON: HOSPITAL AND DENTIST

In preparation for the ban on smoking in enclosed spaces in 2007, Hillingdon Stop Smoking Service introduced a Stop Before the Op programme. The aims were to identify smokers due to be admitted for surgery, provide them with smoking cessation therapy while in hospital and offer them longer-term support if they wanted it.

GPs advise patients likely to require surgery when they refer them to a specialist that they will have to give up smoking, at least temporarily, because the hospital is smoke free. Patients will also be told that if they give up smoking before their surgery, they are less likely to experience complications and will have a faster recovery.

A special clinic has been set up at Hillingdon Hospital to cater for these forthcoming inpatients, so they can go and get support when they go to the hospital to see their consultant.

Life plan

Jason Tong, stop smoking co-ordinator for the Hillingdon Stop Smoking Service, says this fits with the whole rationale of the service, which is geared to reaching people at different times of their lives. "When they are pregnant we contact them, when they go for surgery we contact them, and when they go to the GP or the pharmacy, and if they are housebound we can visit them."

Also to prepare for the smoke free legislation, Hillingdon started to run six to eight week intensive one-hour group sessions in workplaces. Mr Tong says that, as well as being convenient for those who attend, these sessions are effective, as the people involved already know each other. This helps with group activities and provides additional support for them outside it.

"They see each other eight hours a day so it is very good for them to support each other," he says, adding that a colleague talking about smoking rather than a family member feels less like nagging.

The stop smoking service will also send an adviser to do home visits if needed. Pregnant women can get home support from midwives trained in smoking cessation. Other professionals have been trained to deliver smoking cessation in the community, including pharmacists, practice nurses, health visitors, district nurses, healthcare assistants and even three dentists.

The dentists' four-week quit rate is extremely high at 78 per cent, compared with 60 per cent for services delivered in GP surgeries and by pharmacists. The highest quit rates (80-85 per cent) are achieved by the dedicated smoking service, and overall Hillingdon has a quit rate of 68 per cent at four weeks.

Mr Tong believes dentists have much better rates than GP practices because they don't just see patients when they are ill, so their clientele is very different. A doctor can talk about the damage smoking does, but cannot always present the evidence. "People who go to dentists are fairly health conscious but did not know the effect smoking had had on their gums and teeth. The dentist looks at the teeth and says 'you are a smoker' and they cannot say 'it does not affect my health at all'. From a smoker's point of view they want solid proof – and decaying gums and very yellow teeth are fairly solid proof," he asserts.

Like other advisers, dentists can give patients a voucher to get nicotine replacement therapy


Jason Tong

‘There’s so much advertising on buses and the TV and it’s as if people can’t see the wood for the trees. It’s so in your face they don’t see it’

from a pharmacist or a letter to take to their doctor if the treatment requires a prescription.

People who have been through a fixed-length course, such as one in their workplace or with a pharmacist, and who need further support can go along to a rolling group at a drop-in clinic.

Hillingdon does not have any special facilities for patients who quit and then relapse, but they are encouraged to come back and use the service again after six months. Mr Tong explains: “National Institute for Health and Clinical Excellence guidelines say six months, so we actually have to refuse a lot of people once they relapse. They can’t come back for a while. That is a limitation for our services, but we are merely following the guidelines.”

Patients are sent a questionnaire a year after they have quit to get their feedback on the service and to find out how they are doing. The figures suggest 20-30 per cent are still not smoking a year later, but Mr Tong admits that the response rate is poor.

“It is not a requirement so we don’t put much effort in,” he says. “It is a way for us to monitor how they are doing and ask them about ways we can improve the service. If you complain about the service, you won’t go back again and you will tell other people it is not effective – that is negative advertising for us.”

The questionnaire also acts as a method of recycling patients, because if someone is smoking again they might want to come back.

The Hillingdon Stop Smoking Service does not do a lot of mass advertising because it has not found it very effective. Project manager Steven Walker says people have become oblivious to it.

“There is lots of advertising on buses and the TV and it’s as if people can’t see the wood for the trees. It becomes so much in your face people just don’t recognise it any more.”

He finds going out into the community and engaging with people works much better.

“What we try to do is actually go out on to the street and talk to people. If they are smoking, approach them, smile, be friendly, ask if they have thought of stopping smoking, give them a leaflet and tell them where the nearest clinic is and put some information in there about it.”

Approaching people positively and not pushing the service, just saying “it’s there if you want to use it” always gets a good reaction, he says. “Positively” means saying that stopping smoking will reduce your risk of cancer and in 10-15 years your risk of heart disease will be the same as someone who has never smoked, rather than saying smoking kills.

However, he admits that targeting hard-to-reach ethnic groups is problematic because of cultural differences. The service has been trying to establish links with groups in the Somali community, and in the process Mr Walker has realised that this group needs a completely different approach.

“They don’t read brochures and leaflets. How they communicate information is through story-telling so, if we know that, we are going to waste our money producing Somali leaflets. What we need to do is understand how they communicate, talk to people who are enthusiastic and will communicate with them, and develop stories that we can introduce into the community in a way that they are going to understand. That is going to be a much slower process.”

Mr Walker is also looking at giving rewards to people who quit because he thinks this would appeal to low socio-economic groups. This might be a free gym or swim pass for someone who has come to a group and has managed to keep off the cigarettes for a week.

“If you talk to community workers,” he says, “they say we have got to have a reward, we have got to have a reason for people to turn up, because smoking is often the only thing that is there for them.

“If we are giving GPs and chemists incentives for stopping smoking, why can’t we give incentives to the people we are reaching out to?”

The sticking point, he says, is a belief that people should be motivated to stop.

“If people have to come to us and they have kids or they are tired or its too far away, they are actually not going to make the effort, so you could say they are not motivated enough,” he explains. “[But] they may just be tired or have kids.”

“We need to make it as easy as possible for them to stop so they have no excuse, so if we remove the barriers, they are actually more likely to come to us.”

➔10

JUSTIN THOMAS

CHISWICK: PHARMACY ROLLING GROUP

Darush Attar-Zadeh, a pharmacist trained in cognitive behavioural therapy, runs a one-hour smoking cessation rolling group for Ealing and Hounslow Stop Smoking Service on Tuesday and Thursday evenings at the Chiswick Health Centre in West London. Patients do not have to come every week and can continue for as long as they feel they need support.

The group is based on the six-session evidence-based model in which a patient comes in and talks about their smoking habit and receives information the first week, quits around the second session and then gets support from four more sessions.

A common frustration for patients is that support is not ongoing, says Mr Attar-Zadeh. After six weeks they get a 12-week prescription for smoking cessation therapy, then they are on their own. He has tried an alternative model, the one-to-one drop-in clinic, but found it also had its drawbacks.

"People don't like waiting around, so what I decided to do was invite everyone in," he says. "They can come in at any stage of their quit attempt and I treat the session as a chat forum rather than a clinic. I don't like using the word clinic because people get put off by it. They get these perceptions that it's like an AA meeting. It is nothing like that.

"They come in and bounce ideas off one another and talk about smoking in general and it can be any topic that just arises on the day. My role would be to steer the group and make sure that the most important aspects are covered."

Mr Attar-Zadeh says the group has a nice atmosphere for newcomers to walk into because he will already have built up a rapport with other members. When someone joins, the first thing he will do is welcome them and ask them why they want to stop smoking, about any previous quit attempts and reasons for relapse. Then, rather than going through all the therapeutic options, he will bring in other members of the group who have already quit – the mentors or his "assistant advisers" as he likes to call them – and ask them 'how are you getting on with this or that treatment?'.

"I save myself quite a lot of time because I leave the mentors to talk about their experiences and the newcomers say 'right, I want to try that one'. Obviously, sometimes the mentors give wrong information, which is why it is so important that I am there to steer the group."

Usually newcomers are attracted to the drug that is most popular with the majority in the group at that time. The benefits of having a pharmacist like Mr Attar-Zadeh running the clinic is that he has a detailed knowledge of the drugs and can supply nicotine replacement therapy directly. However, like other advisers, he has to give patients

‘I could have 10 people who have exceeded the six sessions. Why not have them sit there just to make your life easier as an adviser?’


Darush Attar-Zadeh

who want Champix or Zyban a “dear doctor” letter.

Much of the group’s discussion revolves around the benefits and drawbacks of treatments. Mr Attar-Zadeh always ensures the flexibility of treatments is covered. An example is the fact that it is possible to smoke for the first week with Champix, Zyban and certain nicotine replacement patches, which appeals to heavy smokers because they can cut down and quit on a day of their choice.

“If you say ‘that is your quit date, you are going from 40 cigarettes all the way down to zero’ and they stick a patch on that day, a lot people find that that can be quite pressurising,” he explains.

He points out that smokers are more inclined to believe what they are told by someone who has quit rather than an adviser who has never smoked and seeing someone who has given up successfully gives them hope.

At the moment he has one patient who quit three and a half years ago but who has come back because he is finding it hard to come off the nicotine replacement spray. “He is a great asset to the group because whenever a new person comes along and they say ‘does it get easier’, I say ‘why don’t you ask this person – he has quit for three and a half years’,” he says.

On the flip side, newcomers act as a reminder to the mentors about why they are a non-smoker, because they can see how hard the struggle is in the early days, he adds. “If someone is struggling in the group, they lift each other.” The group has a 65 per cent four-week quit rate. No data is collected for longer periods, but he believes the indefinite nature of the group must be beneficial.

Relapse prevention

Like other pharmacists who provide smoking cessation services, Mr Attar-Zadeh is paid for every patient he sees over a six-week period. He receives no money for patients who still come after six weeks, but this does not bother him.

“If I have one new person in the group, I will get funding for that one person and I could have 10 people who have exceeded the six sessions. Why not have them sit there just to help make your life easier as an adviser? They can be valuable to the group and also you are doing a lot of relapse prevention,” he explains.

“The only time it is disadvantageous to me is when I have a group of five people and all five of them have exceeded the six sessions and then I am not getting any money for that particular clinic, but that has never happened.”

Although Mr Attar-Zadeh puts up posters, he finds he gets most of his patients through word of mouth. The GPs know him well and refer patients to him, and his clients also recommend him to their friends. “I have one person who came in, had a very good experience and told seven other people who are her neighbours, so I have got a clinic of neighbours at the moment, which is really nice. It really creates a lovely environment,” he says.

He has also recently had a lot of dads referred to him from the baby clinic run by health visitors just before his group. He says: “One of the health visitors stopped through my clinic, enjoyed the experience and told a few of the dads. She is really selling the fact that Darush is down-to-earth and it is not at all like an AA meeting.”

Mr Attar-Zadeh keeps in telephone contact with his patients to check they have not relapsed, and if they have, he encourages them to come back on the programme.

“Some people are embarrassed and feel they are letting me down if they come back. I always say it would be preferable if you don’t relapse for yourself, but if you do happen to have one or two, don’t feel you can’t come back.”

DONCASTER: WOMEN AND CHILDREN

When the Doncaster Stop Smoking Service started in 1999, there was a quitline, a generic service and a specialised service targeting pregnant women. It has now grown to a team of five specialist advisers supported by 16 intermediate advisers.

The service has also trained around 40 pharmacists and 50 practice nurses to work as intermediate advisers in the community, providing one-to-one support through a local enhanced service. Smokers who want to quit can choose to see one of these professionals or seek one-to-one support from a clinic at the Doncaster service’s offices. This offers booked appointments and a drop-in service Monday to Friday (early to late) and Saturday mornings.

Lisa Fendall, training project manager at the Doncaster Stop Smoking Service, who has been with the service from the start, says it used to offer group sessions but had to stop them because of dwindling referrals.

Most of the motivated, confident, affluent and educated people with transport have come through services, she says, so it is left with the hard to reach and those with specific problems, on whom the dedicated advisers concentrate.

“The department of health is telling us to look at increasing the number of referrals, but we have got to target the routine manual and most deprived groups now, and obviously we have got to look at innovative ways of reaching them.”

One specialist adviser delivers smoking cessation at Doncaster’s four prisons. Many prisoners have mental health problems and ➔12


Lisa Fendall

JUSTIN THOMAS, RICHARD WALKER

‘Children are a very difficult to reach target group and hard to work with in terms of why they start to smoke. It is down to being rebellious’

11← there is also a big black and minority ethnic population, so this service ticks a lot of the boxes in terms of accessing the hard to reach. The quit rate achieved in prisons is 50-60 per cent at four weeks, the same as the rate across the whole Doncaster service.

Another specialist adviser with a nursing background works within secondary care and sees inpatients referred to her pre-operatively. Smokers who decide they only want to abstain temporarily while in hospital can access nicotine replacement therapy short term, and those who want to quit completely are referred on to the main Doncaster service on hospital discharge.

There is also a specialist adviser who goes into workplaces to deliver services during work time, but where Doncaster really stands out is in its innovative services for pregnant women, children and young people. Ms Fendall says: “We have an extremely robust referral system for pregnant women. Every single pregnant woman fills in a smoking questionnaire on booking and every single woman smoker is referred into us. They have to opt out of the service as opposed to opting in.”

Someone from the service will call them, congratulate them on their pregnancy and add: “We understand you smoke; let’s just tell you about what we can offer you during your pregnancy.”

The pregnancy service was awarded Beacon status by the Department of Health in 2004 and Ms Fendall says this was because it is very much tailored to what pregnant women want. “We know from research that they don’t like doing groups and they don’t like to travel.”

The women can use the drop-in service at a Sure Start or Family Centre, or an adviser will come and visit them at home if it is difficult for them to get to one of the centres. The adviser can also see their partner or other family members during the home visit.

A team of four people offers a tailored service for children and young people, which Ms Fendall says is unique. “There are no clear answers about what works with children. They are a very difficult to reach target group and very hard to work with in terms of the reasons why they start to smoke in the first place. It is all down to experimentation, being rebellious and risk-taking behaviour, so the health messages don’t really work very well. The adult model doesn’t work on children, so they do need a specific service and not everyone will provide that.”

The team works closely with school nurses, youth workers, learning mentors, sexual health and drugs services and others with links to children, to try to educate young people not to start smoking in the first place and to help those who want to quit. “We will piggy back on the back of anybody who will have dealings with the hard to reach in terms of young people, because what works really well is taking the service through the back door and enhancing a service that they are already accessing,” she says.

For example, there is a free weekly support, education and training service for teenage mothers, so the smoking cessation service goes in and is available there. It also goes into seven secondary schools and into youth clubs, and children excluded from school are visited at home. Nicotine replacement therapy is offered to children from the age of 12.

Ms Fendall admits that the service does not have a huge number of BME clients. One GP practice has a Polish interpreter who comes in to help it target that community, but she says what works best is to train and support people who already work with BME communities to deliver smoking cessation services, because these communities do not access general services.

All patients presenting to a smoking cessation adviser have their needs assessed at the first visit to see if they are motivated, prepared and confident about quitting. Those who are can go away with a letter to get smoking cessation therapy, but others may need to do some preparation before they are ready to quit, so are asked to come back the next week to discuss their coping strategies and then a quit date is set.

The adviser will go through the full range of smoking cessation products and discuss what might suit them best, depending on nicotine dependency, lifestyle, what they have tried before and any contra-indications, such as an allergy to plasters (which would make a patch unsuitable). “We give them the full range of advantages and disadvantages of each product, then leave the client with the final choice,” she explains.

Direct approach

Unfortunately, some GPs will make their patients try to quit on nicotine replacement therapy before allowing them to use other products that are more expensive, she says, which is wrong. “If you have a client who has tried on NRT before and wants something else, they are not going to succeed on a patch again because their confidence is not going to lie with that product, so we do really feel strongly about it being client led.”

The service advertises through local papers, posters, the radio and fliers in GP practices and Sure Start and Family centres, and leaflet drops for specific events. It has also previously put adverts up at bus stops and produced a video advert of a patient being counselled, which was shown on a plasma screen in a shopping centre. Ms Fendall also did an eight-week radio show answering people’s smoking cessation questions.

However, she recognises that a more direct approach is often needed, so she has mapped out the 18 most deprived areas in Doncaster and developed a marketing strategy to target the hard to reach in these areas. “For example, I am going to be setting up a market stall and selling the service on the market and doing carbon monoxide readings,” she says.

There will also be promotions outside pubs, in supermarkets, at car boot sales and at gala days. “Over Christmas we will be doing regular slots in the town centre and trying to get people to sign up,” she adds. “A lot of people quit in January but won’t access the help, so we try to get them to sign up because with support and stop smoking treatments, you are four times more likely to quit.”

As well as training intermediate advisers to deliver smoking cessation services, the Doncaster service provides an hour-long training session for all frontline PCT staff to encourage them to refer patients. This training is based on a toolkit called smoking cessation in practice, which the Department of Health plans to roll out to the rest of the country.But Ms Fendall admits: “Training alone is not enough. People don’t continue to use those skills. We are going to be monitoring them, so we can tell them you have sent in x number of referrals this month and how many came and how many quit.” ●

How can stop smoking services attract people from ethnic minorities? NICE guidance may offer the answer, writes Rosie Cameron

GIVING UP IS HARD TO DO

Reaching minority ethnic and socio-economically disadvantaged communities is one of the main recommendations in the National Institute for Health and Clinical Excellence guidance on provision of smoking cessation services. But how to effectively target these groups may be one of the biggest challenges.

Dr Paul Aveyard of Birmingham University's department of primary care and general practice says evidence for how to do this may not be conclusive, making it hard to know what to do.

"It's something people agonise about: minority groups are different and the reasons why they come forward are different. Knowing how to get people to use it and to make contact may be an issue," he says. "For example, Muslim smokers feel they must stop smoking by willpower alone rather than getting help."

Dr Aveyard stresses that people, including clinicians, need to be convinced of the value of the services in order to use them. He says smoking is not necessarily brought up in all consultations, and this needs to be addressed.

Proven interventions

NICE guidance on smoking cessation services was published in February. It lists four top recommendations for implementation. These include determining the prevalence of tobacco use locally, targeting specific groups of smokers and offering a range of interventions that are proven to help people stop smoking (see box).

This means behavioural counselling, group therapy, pharmacotherapy or a combination of interventions that have proved effective, delivered by appropriately trained practitioners.

Commissioners and managers should ensure that training and continuing professional development are available for all those providing smoking cessation advice and support. Also, services should be tailored to the needs of specific groups (ethnic minorities, disadvantaged groups) and where possible, provided in the language chosen by the client. The guidance says media campaigns can be used to encourage quit attempts, and consideration should be given to targeting low income and ethnic minority groups in such campaigns, to address inequalities.

NICE also states that realistic performance targets should be set, reflecting local demographics. Services should aim to treat at least 5 per cent of those who smoke or use tobacco, and aim for a success rate of at least 35 per cent at four weeks, as validated by a carbon monoxide monitor reading of less than 10pm.

Dr Aveyard believes targets may be met by treating less dependent smokers. He says that at first, smoking cessation services emphasised group-based therapy, but most is now delivered by generalists, targeting less dependent smokers: "More dependent smokers are harder to treat. Primary care trusts are focusing on more generalist provision, which is probably a mistake." He also says stringent monitoring is crucial to ensure success: "Lots of people pass through the monitoring who don't meet the definition of success. If you don't smoke that day, you meet your CO [carbon monoxide] monitoring. It comes down to people being honest and practitioners being rigorous." He adds that the NHS Stop Smoking Services service and monitoring guidance, which was issued in October 2007 and complements the NICE guidance, is "very important".

"The NICE guidance replaces previous national guidelines in the way you treat smokers,' he says. 'It does not change a lot of what NHS services were doing. It probably has some effects in very specific areas. For example, with respect to varenicline, some PCTs have been limiting its availability, but the guidance says it is an equal first-line choice."

One of the main priorities for implementation states that clinicians should offer nicotine replacement therapy, varenicline or bupropion, as appropriate, to those planning to stop smoking, without favouring one medication over another. However, only nicotine replacement therapy should be offered to those aged below 18 years and pregnant or breastfeeding women.

Service commissioners and PCTs must ensure that links exist between contraceptive services, fertility clinics and ante and postnatal services, to allow health professionals to advise on smoking cessation at various stages of a woman's life.

Dr Aveyard says the NICE guidance sets a framework: "In some ways it does not answer the question of what should be the balance between generalist and specialist provision and what scale of payments is best, although some might argue that this is fine, as it will allow people to work out what is best for their area."

These issues remain challenges for managers, he concludes. ●

NICE GUIDANCE: PRIORITIES

- **Ensure NHS stop smoking services target minority ethnic and socio-economically disadvantaged communities.**
- **Aim to treat at least 5 per cent of those smoking/using tobacco, with a success rate of at least 35 per cent at four weeks, validated by CO monitoring.**
- **Offer behavioural counselling, group therapy, pharmacotherapy (nicotine replacement therapy, varenicline or bupropion, as appropriate) or a combination of treatments.**
- **Target women who smoke and are pregnant or are planning a pregnancy, and their partners and family members who smoke.**

ALAMY

CHAMPIX® ▼ Film-Coated Tablets (varenicline tartrate) ABBREVIATED PRESCRIBING INFORMATION – UK (See Champix Summary of Product characteristics for full Prescribing Information) Please refer to the SmPC before prescribing Champix 0.5 mg and 1 mg. **Presentation**: White, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 0.5" on the other side and light blue, capsular-shaped, biconvex tablets debossed with "*Pfizer*" on one side and "CHX 1.0" on the other side. **Indications**: Champix is indicated for smoking cessation in adults. **Dosage**: The recommended dose is 1 mg varenicline twice daily following a 1-week titration as follows: Days 1-3: 0.5 mg once daily, Days 4-7: 0.5 mg twice daily and Day 8 – End of treatment: 1 mg twice daily. The patient should set a date to stop smoking. Dosing should start 1-2 weeks before this date. Patients who cannot tolerate adverse effects may have the dose lowered temporarily or permanently to 0.5 mg twice daily. Patients should be treated with Champix for 12 weeks. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment at 1 mg twice daily may be considered. Following the end of treatment, dose tapering may be considered in patients with a high risk of relapse. Patients with renal insufficiency; *Mild to moderate renal impairment*: No dosage adjustment is necessary. *Patients with moderate renal impairment who experience intolerable adverse events*: Dosing may be reduced to 1 mg once daily. *Severe renal impairment*: 1 mg once daily is recommended. Dosing should begin at 0.5 mg once daily for the first 3 days then increased to 1 mg once daily. *Patients with end stage renal disease*: Treatment is not recommended. Patients with hepatic impairment and elderly patients; No dosage adjustment is necessary. Paediatric patients; Not recommended in patients below the age of 18 years. **Contraindications**: Hypersensitivity to the active substance or to any of the excipients. **Warnings and precautions**: *Effect of smoking cessation*; Stopping smoking may alter the pharmacokinetics or pharmacodynamics of some medicinal products, for which dosage adjustment may be necessary (examples include theophylline, warfarin and insulin). Depression, suicidal ideation and behaviour and suicide attempts have been reported in patients attempting to quit smoking with Champix in the post-marketing experience. Not all patients had stopped smoking at the time of onset of symptoms and not all patients had known pre-existing psychiatric illness. Champix should be discontinued immediately if agitation, depressed mood or changes in behaviour that are of concern for the doctor, the patient, family or caregivers are observed, or if the patient develops suicidal ideation or suicidal behaviour. Depressed mood, rarely including suicidal ideation and suicide attempt, may be a symptom of nicotine withdrawal. In addition, smoking cessation, with or without pharmacotherapy, has been associated with the exacerbation of underlying psychiatric illness (e.g. depression). The safety and efficacy of Champix in patients with serious psychiatric illness has not been established. There is no clinical experience with Champix in patients with epilepsy. At the end of treatment, discontinuation of Champix was associated with an increase in irritability, urge to smoke, depression, and/or insomnia in up to 3% of patients, therefore dose tapering may be considered. **Pregnancy and lactation**: Champix should not be used during pregnancy. It is unknown whether varenicline is excreted in human breast milk. Champix should only be prescribed to breast feeding mothers when the benefit outweighs the risk. **Driving and operating machinery**: Champix may have minor or moderate influence on the ability to drive and use machines. Champix may cause dizziness and somnolence and therefore may influence the ability to drive and use machines. Patients are advised not to drive, operate complex machinery or engage in other potentially hazardous activities until it is known whether this medicinal product affects their ability to perform these activities. **Side-Effects**: Adverse reactions during clinical trials were usually mild to moderate. Most commonly reported side effects were abnormal dreams, insomnia, headache and nausea. Commonly reported side-effects were increased appetite, somnolence, dizziness, dysgeusia, vomiting, constipation, diarrhoea, abdominal distension, stomach discomfort, dyspepsia, flatulence, dry mouth and fatigue. See SmPC for other less commonly reported side effects. **Overdose**: Standard supportive measures to be adopted as required. Varenicline has been shown to be dialyzed in patients with end stage renal disease, however, there is no experience in dialysis following overdose. **Legal category**: POM. **Basic NHS cost**:

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