

Meeting Department of Health smoking cessation targets

Recommendations for primary care trusts

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About the HDA

The Health Development Agency (HDA) is an NHS special health authority, established to support and enhance national efforts to improve health in England, with a particular focus on reducing health inequalities. In partnership with others, it gathers evidence of what works, advises on putting health into practice, and develops the skills of all those working to improve people's health.

About this publication

This publication provides primary care trusts with information designed to help them plan how to continue offering high quality, evidence-based smoking cessation services to their population, and meet the targets set in the government's *Priorities and Planning Framework 2003–2006*. It is complemented by a separate publication, ***Meeting Department of Health smoking cessation targets: Recommendations for service providers***, which contains recommendations to staff involved in providing treatment through the smoking cessation services.

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Introduction

The need for these recommendations

The Department of Health's *Priorities and Planning Framework 2003–2006*, published in October 2002, includes targets for primary care trusts (PCTs) to achieve over the next three years across a range of health service provision (Department of Health, 2002a). These include key targets for smoking cessation:

- **Reduce the rate of smoking, contributing to the national target of reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the four-week stage by 2006**

To meet the new NHS targets, the 'average' PCT will have to produce at least 900 smokers per year who have been treated by their smoking cessation service and who stopped smoking at the end of four weeks of treatment.

To set this in context:

- The target for 2001–02 was 50,000 nationally (equivalent to 167 per average PCT)
- The target for 2002–03 was 100,000 nationally (equivalent to 333 per average PCT).

Thus the new target represents a 170% increase on the current figure. This will require a considerable increase in activity among all members of the primary care team in recruiting smokers into the smoking cessation services, and expansion of those services. Individual PCTs will have different targets depending on size and demographic characteristics – those with large numbers of low-income smokers will have higher targets. Strategic health authorities will be responsible for setting the targets.

In setting these targets the Department of Health has signalled that it places a high priority on smoking cessation, and that the funding allocation to PCTs from 2003 onwards will reflect this.

Smoking cessation rates per 100,000 are also one of the seven key PCT performance indicators for health improvement. The annual rate achieved is banded (1–5), reflecting performance relative to other PCTs throughout the country.

Aim

This publication is designed to provide PCTs with information to help them continue to develop high quality smoking cessation services in accordance with national smoking cessation guidelines (West *et al.*, 2000) in order to meet the targets set in the *Priorities and Planning Framework 2003–2006*.

Using this publication

This publication considers the range of possible ways in which smoking cessation treatment services can be structured, and makes recommendations taking account of local conditions. Case studies of existing services are presented to help guide the development of different service arrangements. The main recommendations are given (page 2), followed by a brief outline of the context and an explanation of the targets and their implications for PCTs. This is followed by evidence and analysis supporting the recommendations. The key features of a successful smoking cessation service are summarised immediately following the recommendations (page 3).

Recommendations

Much of the evidence used in this document comes from the first three years' experience of setting up and delivering smoking cessation services. The original smoking cessation

guidelines were based on rigorous analysis of the scientific data from randomised controlled trials (Raw *et al.*, 1998; West *et al.*, 2000).

The HDA recommends that:

- 1 PCTs take on and continue to develop the specialist smoking cessation services that serve their populations
- 2 PCTs fund a single service – coordinated at least at the level of a large PCT, or combining resources from several PCTs – preferably continuing existing services
- 3 The service is funded on a permanent basis to avoid losing key personnel due to job insecurity
- 4 Services offer both group treatment and individual, face-to-face counselling where possible (but group treatment may not be practical in sparsely populated areas or where transport is limited) and ensure that all treatments offered are evidence based
- 5 Services are coordinated by a full-time equivalent (FTE) to act as point of contact with other services and agencies, to commission and organise training, to oversee monitoring, and to ensure the service adapts to changing needs
- 6 Services employ a minimum core staff of three FTEs per averaged sized PCT, in addition to the coordinator, to provide treatment to smokers and/or support a larger cadre of community smoking cessation specialists and primary care teams
- 7 Substantial efforts are made to increase referral/recommendation rates via GPs and other members of the primary care team, who are a major source of clients for specialist smoking cessation services
- 8 Nicotine replacement therapies and bupropion continue to be an integral part of the treatment package offered by services
- 9 Each service has a strategy to reach all smokers, but with a focus on low-income and pregnant smokers, and to develop links with local community groups to ensure the needs of minority ethnic populations are catered for
- 10 Each service has links with acute hospital trusts and mental health trusts to ensure its patients receive treatment for smoking cessation (eg prior to undergoing elective surgery, and while in hospital)
- 11 Services continue rigorous monitoring, using nationally agreed indices, to contribute to the maintenance and development of standards, and develop routine mechanisms for reporting to local stakeholders and policy-makers
- 12 Services maintain and develop the smoking cessation skills of all staff through a programme of training and continued professional development
- 13 Services maintain and develop links with other local and national tobacco control initiatives, which should promote treatment services at all appropriate opportunities

A successful smoking cessation service will:

- 1 Span enough PCTs to cater for at least 200,000 head of population – preferably 500,000*
- 2 Employ on a permanent contract at least three FTEs of core clinical staff per PCT, and a full-time (or full-time equivalent) smoking cessation coordinator
- 3 Have close links with primary care teams to generate at least ten referrals/self-referrals per 100 smokers per year
- 4 Have an efficient system for ensuring clients receive the appropriate medication (nicotine replacement therapy or bupropion) to support their attempt to quit
- 5 Offer a comprehensive service including both group-based treatment provided by core staff, and individual support provided by both core staff and part-time community stop-smoking specialists based in primary care; and in sparsely populated areas offer individual support provided by community specialists based in primary care, fully supported by core staff
- 6 Have a local strategy to encourage all smokers, but with a focus on low-income smokers and pregnant smokers, to use the service, and to link up with community groups to encourage use of the service by minority ethnic populations
- 7 Have links with acute hospital and mental health trusts to ensure the needs of their patients are catered for
- 8 Ensure all staff, including community advisers, are trained for their role according to an approved programme of study, and receive continued supervision and updates to their training
- 9 Engage in rigorous monitoring to enable continued development of the service
- 10 Have links with wider tobacco control initiatives at local and national levels

*The average population of the health authorities which have formed the main catchment for the services.

The smoking cessation treatment services are one element of broader tobacco control initiatives – organised at local and national levels – which together are designed to contribute to an overall reduction in premature mortality in the population, and to reduce health inequalities. What follows is based on the learning from the first three years of the services and reviews of the evidence.

Smoking cessation targets

The Department of Health has set challenging targets for the number of smokers to be treated by services, and to have stopped smoking by the four-week follow-up. This section briefly outlines the background to these targets and the context in which they were developed.

Priorities and Planning Framework 2003–2006: Improvement, Expansion and Reform (Department of Health, 2002a)

This is the key document that sets out targets for delivery of the NHS Plan for 2003–2006. Targets specifically related to smoking cessation are as follows (highlighting added to emphasise what PCTs themselves can deliver):

- **Reduce the rate of smoking, contributing to the national target of reducing the rate in manual groups from 32% in 1998 to 26% by 2010; 800,000 smokers from all groups successfully quitting at the four-week stage by 2006**
- In primary care, update practice-based registers so that **patients with coronary heart disease (CHD) and diabetes continue to receive appropriate advice and treatment in line with National Service Framework (NSF) standards.** By March 2006, **ensure practice-based registers and systematic treatment regimes, including appropriate advice on diet, physical activity and smoking, also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and a body mass index greater than 30**
- Deliver a **one percentage point reduction per year in the proportion of women continuing to smoke throughout pregnancy.** This should focus especially on **smokers from disadvantaged groups** as a contribution to the national target to reduce by at least 10% the gap in mortality between 'routine and manual' groups and the population as a whole by 2010, starting with children under one year.

Planning requirements throughout the NHS are to be replaced by a single three-year local delivery plan developed for each strategic health authority. The local delivery plan is to be based on PCT-level plans and should identify expected progress or milestones (most commonly quarterly or annual) for each priority area, supported by a financial strategy. Local delivery plans are 'live' documents which can be amended if delivery goes off course, new initiatives are taken, or new opportunities arise.

Further guidance from the Department of Health notes that 'if [the] national target for prevalence of smoking among manual groups is to be achieved, a high proportion of smokers in manual groups must successfully quit. All PCTs will need to meet a challenging target for successful quitters, not least because smokers in manual groups are to be found in all areas. However, targets for PCTs in areas of highest deprivation will need to be relatively more demanding. It is planned that allocations will reflect this, and the target envelopes for strategic health authorities (which is available at www.doh.gov.uk/ldp2003-2006) will be calculated accordingly. Strategic health authorities will need to set targets for their PCTs on this basis'.

Smoking Kills: A White Paper on Tobacco (Department of Health, 1999) and *Smoking cessation guidelines for health professionals* (Raw *et al.*, 1998)

The *Smoking Kills* white paper announced funding for a three-year programme to develop smoking cessation treatment services in the UK. These services were to follow the recommendations of National Smoking Cessation Guidelines, sponsored by the HDA and endorsed by the key professional bodies and agencies with an interest in smoking and health (Raw *et al.*, 1998; West *et al.*, 2000).

In the first year, 1999, health action zones (HAZs) were funded to establish a service across their area for smokers who wanted help with quitting. The services used a combination of behavioural support and medication – nicotine replacement therapy (NRT) – the latter to be provided initially on a voucher scheme. In the second and third years the programme was extended to the whole of England. Similar models were developed in Scotland, Northern Ireland and Wales.

National Service Framework for Coronary Heart Disease (Department of Health, 2000a)

The *NSF for CHD* was published in March 2000 and focused on reducing undesirable variations and inconsistencies in service delivery and access, and improving the overall quality of care for CHD (www.doh.gov.uk/nsf/coronarynsf.htm). Standard 2 indicated that the NHS and partner agencies should contribute to a reduction in the prevalence of smoking in the general population; Standard 1 highlighted the need to reduce inequalities in the risks of developing heart disease. The need for smoking cessation services was emphasised, and targets were set for smoking cessation clinics. The NSF was accompanied by more detailed guidance on smoking cessation services along with other elements of local tobacco control strategies (HDA, 2000).

The NHS Plan (Department of Health, 2000b)

The NHS Plan, published in July 2000, added further impetus to the development of smoking cessation treatment services. The key elements were:

- From April 2001 NRT was to be made available on prescription
- The National Institute for Clinical Excellence (NICE) was asked to provide guidance on prescribing regimes for NRT and bupropion
- Most NRT products were to go on general sale – this happened in May 2001
- Primary care groups/trusts were to take the lead in commissioning the services.

The NHS Cancer Plan (Department of Health, 2000c)

The NHS Cancer Plan was published in September 2000. It set up new national and local targets to address inequalities in smoking rates between socio-economic groups, and set out a number of initiatives to meet these targets, including:

- PCTs to take the lead in commissioning and, where appropriate, providing smoking cessation services
- By 2002 every PCT to have a trained healthcare professional to support smokers wishing to quit
- Up to £1 million to be put into funding new local alliances for action on smoking to work with the most deprived sections of their communities
- £250,000 to support a national initiative to help major employers develop smoking policies for their employees

- Funding for smoking cessation work with black and minority ethnic groups to be increased to £1 million
- New pilots in ten deprived areas to reduce smoking prevalence in communities where there are particular opportunities for focused support, such as prisons and hospitals
- Funding of £3.04 million per annum for the development of specialist smoking and pregnancy services for years 2001–02 and 2002–03.

National Service Framework for Older People (Department of Health, 2001a)

This framework was published in March 2001 (www.doh.gov.uk/nsf/olderpeople.htm). Standard 8 (The Promotion of Health and Active Life) states that by April 2004 local health systems should be able to demonstrate year-on-year improvements in measures of health and wellbeing, including flu immunisation, smoking cessation and blood pressure management.

Nicotine Replacement Therapy (NRT) and Bupropion for Smoking Cessation (NICE, 2002)

NICE carried out a technology appraisal of NRT and bupropion, published in March 2002. It concluded that NRT and bupropion were among the most cost effective of all healthcare interventions, and should be recommended to smokers who have expressed a desire to quit. Recognising the enhancing role of more intensive support in increasing cessation rates, NICE also recommended that health authorities should offer smokers the option to attend for specialist help where practical (Section 4.3.6).

Shifting the Balance: Reforms and monitoring for 2002/03 (Department of Health, 2002b)

This series of documents sets out the major change in the way NHS services are funded, with the emphasis firmly placed on PCTs as budget-holders. The abolition of the health authorities meant that the smoking cessation services had to be organised and funded by PCTs. This has meant considerable upheaval for the services, which had only just become established. These services have had to make a case to the PCTs for their continuation in some form. The response of the PCTs has been varied, with some already placing the service on a permanent footing, others not committing themselves, some grouping together to maintain a service spanning a wide region, and others seeking to set up their own services.

NHS Smoking cessation services: Service and monitoring guidance (Department of Health, 2001b)

Department of Health guidance indicated that advisers should:

- Have received appropriate training for their role
- Carry out the four-week follow-up promptly in accordance with the guidance
- Complete the minimum data set (the individual client data monitoring forms) for each client fully and accurately, and return the information required to the coordinator in good time
- Offer weekly support for at least the first four weeks of a quit attempt
- Attempt to confirm the smoking status of all clients reporting having quit at four weeks by use of an expired-air carbon monoxide (CO) monitor, except where follow-up is carried out by telephone.

Other guidance on quality standards was suggested following a small expert group meeting which focused on the optimal configuration for the services (Bates *et al.*, 2000), including:

- An initial consultation lasting 20–30 minutes, involving assessment of motivation and readiness to quit, agreement on a quit date, and advice on and provision of NRT/bupropion if appropriate
- Weekly support face-to-face (wherever practically possible) for at least the first four weeks
- Follow-up at 12 months from the quit date to assess whether the patient is still not smoking
- Support should not consist simply of a one-off, brief session with the practice nurse or pharmacist – this is regarded in the same category as ‘brief advice’, which should already be within the remit of health professionals.

Recommendation 1: Take on and continue to develop the specialist smoking cessation services

Key points

1. Structured behavioural support, together with NRT or bupropion, are effective and cost-effective treatments to aid smoking cessation
2. Services offering this treatment package increase a smoker's chances of stopping by a factor of four

3. All smokers who are considering trying to stop should be strongly encouraged to make use of this service
4. At present fewer than 2% of smokers do so each year; this will need to increase to 4–5% to meet NHS targets
5. This service requires specialist staff who are experienced in the area and properly trained to deliver it; a service relying solely on staff mainly committed to other duties is not sustainable or effective
6. Clinical governance dictates that PCTs fund services that follow evidence-based practice and can show success rates based on standard Department of Health monitoring criteria.

Detail

Evidence for the effectiveness of structured behavioural support programmes together with medication is very strong and well documented (Fiore *et al.*, 2000; West *et al.*, 2000). The combination is twice as effective as either alone, and leads to a fourfold increase in smokers' chances of success in stopping.

Smoking cessation treatment is extremely cost effective compared with many other health service interventions. The cost per life year saved of a fully integrated, comprehensive cessation service has been calculated at about £800, which is much cheaper than most other medical interventions (Stapleton, 2001). The median cost of a range of 300 medical interventions has been estimated at £17,000 per life year gained (Parrott *et al.*, 1998). There are also potential savings to be made from treating cigarette dependence. Helping people stop smoking who have not yet developed heart disease can preclude statins prescription later on.

Evidence from the smoking cessation services that have been operating in England since 1999 indicates that they have matched expectations from the scientific studies (L. Bauld and co-workers, unpublished data). In the first full year of operation, the specialist services were achieving end-treatment (four-week) abstinence rates verified by checking clients' expired-air CO concentrations of 43% (Department of Health, 2001c). We know from extensive experience and research that this translates into a long-term (12 months or more) continuous abstinence rate of 15–20%, and relapse after one year is rare (Krall *et al.*, 2002).

A word of caution – studies of the referral of smokers to in-house, practice-based nurses or counsellors operating independently, outside a wider structure and without appropriate support and supervision, have not found this

approach to be effective or sustainable (eg Lancaster *et al.*, 1999; Steptoe *et al.*, 1999). The available evidence points strongly to the need for a coordinated service, with behavioural support provided by specially trained personnel supervised by staff for whom this is their central role.

Also, PCTs should be cautious about funding commercial service providers who do not follow evidence-based practice as set out in national smoking cessation guidelines, and who claim high success rates using criteria different from those set out in Department of Health monitoring guidance (see Recommendation 11).

Recommendation 2: Fund a single service operating at the level of a large PCT or combining resources across several PCTs

Key points

1. From April 2003 all PCTs will have responsibility for commissioning smoking cessation services
2. Decades of experience of trying to run smoking cessation treatments organised at individual practice level, without adequate core support and outside a larger structure, show that this approach is unsustainable and ineffective
3. The services set up at health authority level or, more broadly, have been able to deliver high quality provision coordinated and run by staff trained and paid for the purpose – future development of services should build on these successes
4. Where two or more PCTs combine resources, one PCT can host the service/service management
5. Many services have already negotiated (or are currently negotiating) such an arrangement, where the PCTs resulting from the old health authority have banded together to continue funding and developing the existing service.

Detail

Shifting the Balance (Department of Health, 2002b) requires that from April 2003 PCTs will commission the smoking cessation services. This has caused considerable upheaval, given that both PCTs and smoking cessation services were relatively new and still developing. It is natural that practices and PCTs should wish to have control over provision, but disintegrating the services will mean losing the features that have made them successful so far. Organising services at practice level has a long history of failure (see eg Turner *et al.*, 1993).

The benefits of organisation at PCT level, or across a number of PCTs, include the ability to:

- Fund core staff to coordinate and run the service, liaise with other agencies and organisations such as acute hospital trusts, engage in training, produce essential monitoring reports, and support primary care-based smoking cessation counsellors
- Set up group treatment programmes in many geographic regions, by virtue of having a sufficiently large population to draw from.

There are good models for sharing resources across PCTs, with one PCT hosting the core staff (see case studies, page 15). The quality of provision and efficiency appears to be enhanced considerably by these arrangements. This approach also permits PCTs to interact more effectively with acute hospital trusts, maternity services, etc. Common sense dictates – and evidence supports the view – that services become more effective as they become ‘bedded in’. Thus the services that have been in existence longest have the best success rates (L. Bauld and co-workers, unpublished data).

Recommendation 3: Fund the service on a permanent basis

Key points

1. Short-term funding and resulting job insecurity have led to key personnel leaving the service, and caused difficulty with recruiting
2. The clinical and technical aspects of the job mean that running services and delivering specialist smoking cessation interventions require high calibre, experienced staff
3. Preliminary evidence suggests that difficulties in recruiting and retaining staff are already having an adverse effect on success rates.

Detail

Short-term funding will affect staff recruitment and retention, and there is evidence to support this. A survey of coordinators carried out in the spring of 2001 identified that many coordinators were experiencing difficulties in recruiting and retaining staff, one of the most common reasons being short-term funding (Coleman *et al.*, 2002; Fullard, 2002). Other reasons given were lack of suitably experienced or qualified candidates, lack of a career structure for advisers’ posts, and the low salaries offered. The lack of an appropriate

career structure was also identified in qualitative research with coordinators (C. Adams and co-workers, University of Leicester, unpublished report).

Providing specialist support requires using skills on a regular basis and keeping up-to-date with smoking cessation research. A high turnover of specialist advisers will not enable appropriate expertise to be developed and sustained, and will result in a considerable waste of investment of resources and skills.

There is some evidence that these issues have an impact on the effectiveness of the services. Services that had encountered staffing problems (specifically recruiting or retaining trained smoking cessation advisers) were less able to reach smokers, with smaller proportions of the adult population accessing the services and setting quit dates (L. Bauld and co-workers, unpublished data).

Recommendation 4: Offer both group treatment and individual counselling where possible

Key points

1. Groups are highly cost efficient and can achieve high success rates
2. Individual treatment is more labour intensive, but offers greater flexibility for clients in terms of location and timing of sessions
3. Achieving smoking cessation targets will require a substantial throughput of smokers and high success rates – evidence from case studies and formal research shows this is best achieved by offering both group and individual treatment
4. For group treatment to be sustainable it requires a throughput of at least 20 smokers per month, which requires a local population of some 100,000 head of population (20,000 smokers) – otherwise it takes too long to accumulate enough smokers for a reasonably sized group
5. Running effective group treatment requires particular experience and skills, and is usually best undertaken by core staff employed as smoking specialists
6. Individual counselling also requires experience and training – it can be undertaken on a sessional basis by community specialists such as practice nurses, pharmacists and other clinical staff, as long as they are well supported by core staff.

Detail

There have been numerous attempts over recent decades to set up smoking cessation treatment services in primary care without core staff. Often these have been championed by highly enthusiastic and dedicated staff, such as practice nurses. As it has proved all but impossible to sustain these (Turner *et al.*, 1993) this policy has been a failure.

There have been no definitive studies showing groups to be more effective than individual face-to-face treatment (Stead and Lancaster, 2000). However, services that tended to use group-based treatment have had higher four-week success rates than those using primarily individual treatment, controlling for other factors (L. Bauld and co-workers, unpublished data). Where services have offered both group and individual support, the success rates of groups have typically been higher (see case studies, page 15). The potential cost effectiveness of groups is high, given that as many as 40 smokers can be treated at one time.

However, many smokers prefer individual treatment and it is important to capitalise on the fact that most contacts between patients and the NHS take place in primary care, providing an enormous opportunity for delivering smoking cessation advice to most smokers over the course of a year. As is evidenced by the case studies, many localities are too sparsely populated to support group-based treatment. Individual counselling is effective as long as it is structured and given by adequately trained and experienced personnel working to a protocol (West *et al.*, 2000). Ensuring that services match the needs and preferences of smokers will be critical in delivering targets, and the experience of the services is that individual advice is important in that respect.

Recommendation 5: Appoint or continue employing a full-time coordinator

Key points

1. Initial government guidance proposed that dedicated staff need to be recruited or redeployed to coordinate the smoking cessation services
2. Without a smoking cessation coordinator to provide leadership, services cannot be sustained or developed
3. The smoking cessation coordinator performs essential functions in ensuring the service runs effectively, and acting as a link with the primary care teams, PCTs, other NHS bodies, local tobacco control alliances, cancer networks, public health networks, Department of Health, etc.

4. Research indicates services that have not managed to retain a full-time coordinator have not been as successful in recruiting and treating smokers
5. Coordinators should ideally continue to be involved in treating smokers to maintain and develop their skills and be in a position to assist with training.

Detail

When the smoking cessation services were initiated, government guidance proposed that dedicated staff needed to be recruited or redeployed to coordinate them (Department of Health, 1999). The guidance indicated that the role of the coordinator was to ensure that:

- All parts of a comprehensive service were working to the same end
- Protocols for NRT availability and supply were in place
- Appropriate training was given
- Services were adequately publicised
- All aspects of the service were monitored
- Services worked closely with a range of health professionals and other agencies.

Qualitative research with coordinators indicated that, at an early stage, they were also involved in recruiting advisers, delivering training, setting up groups, liaising, developing links with key stakeholders including the PCT leads, and developing service referral criteria and systems; and that many were directly involved in delivering smoking cessation interventions (C. Adams and co-workers, University of Leicester, unpublished report).

In April 2001 some 35% of coordinators worked less than full time in running the service, and over half (56%) had responsibilities other than developing and running the service (Coleman *et al.*, 2002). The ability to recruit and retain a full-time coordinator has had an impact on the effectiveness of services provided. Lower levels of cessation (four-week self-reported quit rates) were found if the smoking cessation coordinator had responsibilities other than running the service (L. Bauld and co-workers, unpublished data).

If the coordinator takes on a purely management role, there is a risk that he or she will lose important clinical skills and not be in a position to give authoritative advice and support to the team.

Recommendation 6: Set appropriate staffing levels

Key points

1. Current staffing levels of services nationally are about 600 full-time equivalents (FTEs), five per former 'Health Authority', excluding the coordinator – this translates to about two FTEs per PCT
2. Current staffing levels are just managing to keep pace with demands placed on the service in terms of treating smokers, training, coordination, liaison and administration
3. Meeting the 170% increase in the target of four-week treatment successes will require a substantial expansion in staff – additional effort will be required to meet targets for specific groups such as pregnant smokers and disadvantaged groups
4. Bearing this in mind, a reasonable figure for an average sized PCT (population of adults aged 16 and over around 130,000) is three FTEs in addition to the coordinator
5. If PCTs combine forces as recommended, they could share a coordinator.

Detail

Initial government guidance (Department of Health, 2001b) indicated that dedicated staff were needed to coordinate the smoking cessation service, treat dependent smokers and take forward professional development work, and that one person would not be able to fulfil all roles.

The case studies show that current staffing levels are just sufficient to maintain the current level of activity, but in many cases are not sufficient to develop initiatives to meet targets for pregnant smokers or low-income groups. Effort has been focused almost exclusively on meeting the overall target numbers.

It is clear that the expansion required to meet Department of Health targets will require substantial additional staff. If PCTs collaborate this expansion need not be pro rata, and analysis suggests that in many areas three FTEs per average-sized PCT would be a reasonable target figure. With economies of scale, this would translate to an optimum level of seven to eight FTEs for a service catering for 500,000 head of population.

Recommendation 7: Increase GP referrals or recommendations to the service

Key points

1. GP referrals or recommendations to the service are a crucial source of clients, although referrals from all healthcare professionals will be important
2. The current rate of attendance at services is estimated at approximately 2% of smokers in a given year – this requires approximately 4% of smokers to make initial contact because only about 50% will attend the quit date
3. An increase in GP referrals or recommendations will be the primary means of increasing numbers – attendance at the services will need to rise to around 5% of smokers in a given year, which will require approximately 10% of smokers to make initial contact.

Detail

The services rely heavily on GP referrals or advice from the GP to make a self-referral (see case studies, page 15). According to a recent national survey of GPs, approximately five smokers request a prescription for NRT or bupropion per GP per month (A. McEwen *et al.*, 2002a). Some will have come from treatment services (because of the need for a GP prescription as part of the treatment); some will have approached the GP as the first port of call. Whatever their origin, if just a third of these patients were to attend treatment services, this would produce a throughput of 2,000 smokers per average PCT per year – sufficient to meet the target of 900 four-week successes per year. However, realistically, the proportion willing or able to attend face-to-face treatment is likely to be much lower; so it will be necessary for GPs and the primary care team to be proactive in actively recruiting smokers into services using opportunistic advice, not to rely on responding to approaches from patients. The national smoking cessation guidelines suggest that GPs should seek to raise the topic of smoking about once a year with all smokers, and this appears to be an attainable goal (West *et al.*, 2000).

In a second national survey, 30% of GPs reported that they did not refer smokers to the services (A. McEwen *et al.*, 2002b). To achieve an increase in referrals and recommendations, service coordinators will need to sustain or enhance their level of activity in promoting the services to GPs, but this is an area where transfer of funding and targets to PCTs should help.

Of patients initially contacting the services, experience indicates that approximately 50% actually set a quit date and start treatment. Assuming most contacts with the services will be via GP referral, this means that up to 10% of smokers will need to be referred or advised to use the service, of which about 5% will attend and 2% will stop smoking for four weeks.

In line with the emphasis on initiating smoking cessation in primary care, the new GP contracts are likely to include smoking cessation advice as part of the core activity of GPs (Milner and Bates, 2002).

Recommendation 8: Use pharmacological treatments for smoking cessation as appropriate

Key points

1. The NICE appraisal (NICE, 2002) confirmed that NRT and bupropion are highly cost effective, life-preserving treatments and should form a key element of any programme aimed at helping smokers to quit
2. Prescribing arrangements should follow the NICE guidance, ensuring that smokers who sustain their quit attempt receive the full course of treatment
3. PCTs should ensure that specialist services, which may be based in hospitals rather than primary care, receive adequate independent prescribing budgets.

Detail

NRT and bupropion should now receive priority in the PCT prescribing budget, in accordance with the NICE guidance. The decision on whether or not to prescribe should be based on clinical considerations relating to eligibility and need.

In general, a regular smoker who displays evidence of nicotine dependence (such as a declared inability to stop smoking), for whom the medication is not contra-indicated, and who shows a clear determination to make a serious quit attempt and ideally attend the treatment services, should be prescribed the medication.

The NICE guidance is clear in stating that both NRT and bupropion should be regarded as first-line treatments, and does not set a lower limit on the number of cigarettes per day the patient must smoke to be eligible.

NICE has made clear recommendations concerning the prescribing regimen. These should involve an abstinence-contingent treatment programme involving an initial course of two to four weeks, followed by further prescriptions if the quit attempt is continuing, to take the user up to the full course of treatment. NICE allows for users to continue to take NRT for three months or more if they need to.

According to a recent national survey of GPs, approximately 12% reported not prescribing NRT or bupropion (A. McEwen and co-workers, unpublished data). This suggests that there is still some work to be done in educating a minority of GPs about the clinical utility of these medications. The availability of the services as a source of referral and support for smokers reduces the workload for GPs when recommending the use of NRT or bupropion to smokers.

Problems have arisen with ensuring that hospital-based cessation services have the resources to engage in efficient and effective prescribing practices. Prescribing arrangements can be made much more efficient through use of patient group directions (HDA, 2003; www.ash.org.uk/html/cessation/pgd.html). These have a number of major benefits, including ensuring patients receive detailed and expert advice on medication from specialists who are also acting as the prescribing agent, convenience for clients, and reduced bureaucracy for service providers. Patient group directions also provide guidance for prescribing outside the indication, and with special groups such as pregnant smokers. The resourcing of patient group directions needs to be appropriate to the demand.

Recommendation 9: Develop a local strategy to reach special target groups (low-income smokers and pregnant smokers) and link up with local community groups

Key points

1. Smoking is highly concentrated in low-income groups
2. Smoking in pregnancy carries a serious and immediate risk
3. It has proved difficult to attract smokers from the ethnic minority population as clients for the services
4. The Department of Health has set specific targets for the first two of these
5. Meeting the Department of Health's overall target for numbers, as well as the targets for special groups, will require adequate resourcing and staffing as well as special steps to ensure services are flexible and attractive.

Detail

The socio-economic gradient in smoking is wide and growing (Jarvis and Wardle, 2000). It accounts for a substantial part of the socio-economic variation in premature mortality (Jarvis and Wardle, 2000). In Great Britain, the overall prevalence of cigarette smoking among those in non-manual households fell from 38% in 1974 to 21% in 1998. Over the same period, smoking among those in manual households fell from 45 to 31% (National Statistics, 2001). Recent studies suggest that smoking levels have remained virtually unchanged among those in the poorest groups, and have risen among lone mothers (Marsh and McKay, 1994; Dorsett and Marsh 1998, Jarvis, 1998). In a detailed study, lone parents living in rented accommodation and relying on social security benefits were found to have smoking levels in excess of 75% (Dorsett and Marsh, 1998).

The Department of Health has set specific targets for reducing smoking prevalence in this group. Experience from the services to date shows that they do attract a significant proportion of low-income smokers, and that these smokers are just as likely to be successful with treatment as other smokers. The North West Lancashire Smoking Cessation Service is one example of good practice in this area (see case studies, page 22; Lowey *et al.*, 2002). However, to meet Department of Health targets more needs to be done to attract low-income smokers into treatment. This is an under-researched area, but increasing flexibility and accessibility appear to be important. This may involve helping patients with transport costs, taking the services to the smokers or involving community organisations. Funding and targets for PCTs will vary as a function of estimates of the numbers of low-income smokers in their catchment area.

The harmful effects of maternal smoking on the foetus are well documented, and translate into miscarriage, neonatal death, increased use of neonatal intensive care facilities, increased rates of sudden infant death syndrome, and learning difficulties and problem behaviour in offspring (West, 2002b). Among pregnant women in young and deprived groups smoking levels are particularly high (Owen and McNeill, 2000). This makes reducing smoking in pregnancy a particularly urgent problem. The evidence indicates that pregnant smokers respond well to behavioural cessation treatments. However, the experience of the services is that only a very small minority are willing to use them (Taylor and Hajek, 2001). The Department of Health has provided funding for special projects to enhance cessation rates in pregnancy, and has also established a minimum data

set requirement to monitor smoking cessation in pregnancy (www.nhs.uk/dscn/pages/default.asp). Efforts to increase throughput have in most places met with limited success. However, one case study illustrates what can be achieved with dedicated, highly qualified specialist staff working closely with the maternity services. In this case the specialist offered a flexible service involving home visits combined with the offer of NRT and one-to-one support (see North Staffordshire case study, page 28). It is likely that the cost of achieving smoking cessation in pregnant smokers will be higher than in the services as a whole because of the greater effort involved in recruitment. Cost effectiveness may therefore appear to be relatively low compared to smokers in the general population – however, the health benefits are greater.

Some attempts have been made to engage with community groups to encourage use of treatment services. It is too early to say how successful these are, but efforts will need to continue if services are to meet the needs of the whole community. Some services have established links with Sure Start (www.surestart.gov.uk), a well-funded initiative in low-income areas designed to address health inequalities (see case studies, page 15).

Recommendation 10: Link up with acute hospital and mental health trusts

Key points

1. Inpatients and outpatients at acute and mental health hospital trusts are important client groups with specific needs
2. The anaesthetic risks and rate of post-operative complications in smokers are higher than in non-smokers, and stopping smoking prior to entering hospital reduces those risks
3. Many categories of patients attending outpatient clinics, eg chronic obstructive pulmonary disease patients, and patients with asthma, cancer and CHD, have a pressing and immediate need to stop smoking and would benefit from help in doing so
4. Psychiatric patients have a very high smoking prevalence, their levels of dependence are generally high, and a substantial proportion are interested in trying to stop
5. With funding for smoking cessation services moving to PCTs, it is difficult to plan and coordinate smoking cessation services for these groups of patients, so smoking cessation coordinators will have to take steps to ensure their needs are catered for.

Detail

Smoking cessation treatment delivered prior to, during or immediately after an inpatient stay can have important short-term as well as long-term health benefits (Munafi *et al.*, 2001; Moller *et al.*, 2002). There are particular groups of outpatients who would benefit from formal smoking cessation treatment programmes tailored to their needs, such as respiratory patients (Anthonisen *et al.*, 1994).

The move to PCT funding will require special steps to be taken to maintain or develop these treatment services and coordinate them across PCTs. The enhanced use of practice-based registers for CHD and diabetes outlined in the *Priorities and Planning Framework* will be an important tool in this regard.

Psychiatric patients' smoking rates are much higher than in the rest of the population, and many will die from smoking-related diseases. Smoking cessation treatment for this group is viable and there is some evidence that it may be effective (El-Guebalay *et al.*, 2002; McChargue *et al.*, 2002), so the special requirements of this group need to be addressed. As with acute hospital trusts, the current funding arrangements make development of services for this group problematic.

Some services have managed to set up programmes for acute hospital trusts and have begun to meet the needs of psychiatric patients. It is clear that special steps need to be taken to ensure this happens.

Recommendation 11: Continue a rigorous programme of monitoring

Key points

1. Rigorous monitoring is required to ensure the smoking cessation services develop according to best practice
2. The Department of Health has defined the elements that need to be included in a minimum data set, and from April 2003 a new set of monitoring criteria will be specified which will include all *Priorities and Planning Framework* targets
3. It is recommended that each service routinely collect some further information that will provide a crucial basis for establishing and developing best practice.

Detail

Translating the clinical trial evidence into practice involved important pragmatic judgements about the delivery of treatments based on limited information. Therefore no single blueprint could be offered that would apply in all cases. Monitoring success rates was and continues to be crucial in identifying what approaches to treatment delivery are proving effective.

It is vital that monitoring be undertaken in a way that allows the success of different PCTs to be compared like-for-like. The current Department of Health monitoring requirements (Department of Health, 2001b; www.doh.gov.uk/ldp2003-2006) include the following:

- Numbers setting a quit date with the service
- Basic demographic characteristics of the client group
- Numbers using medication
- Numbers self-reporting not smoking after four weeks of treatment
- Numbers in whom CO verification is attempted
- Numbers recorded as not smoking with CO verification.

The Department of Health recommends, but does not require, CO verification and 52-week follow-up. Evidence from the first year of operation of the services, and reports from current services, indicate that there can be large differences between apparent four-week success rates where CO verification is or is not comprehensively used. The 52-week cessation rate is much more predictive of long-term success in stopping.

To ensure reliable data are used to establish best treatment practice, for comparison between performance of elements of the cessation services, or for comparison between different PCTs, it is recommended that CO verified four-week cessation rates should be the primary criterion for success, and where feasible a random sample of smokers should be followed up for 52 weeks.

As success rates are markedly influenced by smoker characteristics, services should consider routinely collecting information on nicotine dependence and smoking patterns that will help in establishing success rates for different elements of the services among comparable client groups. In addition, given the importance of throughput it is recommended that services should record numbers initially contacting the service, and how they heard about it.

Recommendation 12: Adequately fund training and continuing professional development

Key points

1. Smoking cessation is a rapidly developing field, with major new findings emerging almost every month
2. The smoking cessation services are very new and there is a crucial need to ascertain and disseminate good practice using the clinical experience of those engaged in the work
3. There is a rapid turnover of staff involved in smoking cessation in many areas because of lack of stable funding and job insecurity
4. Healthcare staff can deliver best where they have had quality training about very basic aspects of smoking and smoking cessation, and there are many misconceptions that need to be addressed
5. All these factors mean that training and continued professional development in smoking and smoking cessation must remain a high priority.

Detail

In the first ten months of 2002, more than 1,000 articles were published containing the term 'smoking cessation' in the abstract. These range from studies on new treatment methods to updated guidance for specific patient groups and patient surveys.

Research is now emerging on the delivery of the treatment in practice, and this is at least as important as the more basic research.

Smoking cessation specialists need to be kept up-to-date with these developments, and new personnel need to be properly trained to fill their role. Those with access to computers now have a range of Internet-based smoking cessation networks they can join for general support and information on new developments.

The Health Development Agency is establishing key content areas for training which will lead to a national standard for training in smoking cessation and ultimately to accreditation of training courses. While this is being done, it is important for PCTs to maintain a training programme for their staff consisting of brief opportunistic advice (applying to all staff), and more specialist training for core staff and community advisers to enable them to fulfil their roles.

There is a need for continuing professional development for those working in the smoking cessation services.

Recommendation 13: Maintain links with wider tobacco control initiatives

Key points

1. Specialist treatment services are one element of a national tobacco control strategy needed to deliver mortality targets
2. Some concerns have been expressed that wider tobacco control initiatives have been neglected with the setting up of cessation services
3. The cessation services need to maintain links with the wider national and local tobacco control framework, and to ensure they benefit from and influence that wider framework
4. Services should link with local tobacco control alliances
5. Services should be promoted through other tobacco control activities in the local area.

Detail

It is widely accepted (eg Fichtenberg and Glantz, 2000) that a comprehensive tobacco control strategy, at national, regional and local levels, is needed to reduce smoking prevalence rates significantly. This should include a ban on tobacco advertising, regular tobacco price rises, workplace and public place smoking restrictions, mass media and publicity campaigns on smoking-related issues, and smoking cessation interventions (Department of Health, 1999). Details of action that can be taken at the local level can be found in the smoking sections of the Health Development Agency's publications on Cancer and CHD (HDA, 2000; HDA 2002).

Interventions such as price rises and smoke-free workplaces have a very large reach and encourage smokers to make quit attempts (Ranson *et al.*, 2002; West, 2002a). These interventions will motivate smokers to seek out support in quitting, and are important in supplying an appropriate proportion of smokers ready to make an attempt to stop. The availability of smoking cessation services complements these other measures by enhancing the chances of quit attempts succeeding.

Although coordinators believe collaboration with others on wider tobacco control issues is important, there is concern among some that other tobacco control work may be downgraded and that staff who previously worked on

tobacco control have taken up posts in the new cessation services without being replaced. Conversely, there is concern that with the move to PCT commissioning of services, those working in the smoking cessation services might be called on to do wider tobacco control work at the expense of the treatment services (Crosier, 2002). It is important that health promotion staff who have moved to the treatment services are replaced so that broader tobacco control work is maintained and treatment staff can focus on treatment.

A national network of local tobacco control alliances has been set up, and the local smoking cessation services should link with them. For an example of how the services can be integrated into broader tobacco control initiatives, see the Warwickshire case study (page 26). Services should be promoted through all other tobacco control activities in the local area. The services should also link with the national cancer networks, CHD networks and public health networks.

Case studies

The following case studies have helped to form the recommendations. They describe the services operating in a number of the old health authorities, and have been selected to represent a range of conditions:

- Health action zones and non-health action zones
- Urban, rural and mixed localities

- Geographical spread (north/south)
- A range of service provision models
- Different levels of deprivation.

Information on the services was provided by the coordinators, and has been edited only minimally.

	HAZ	Locality	Region	Type of service	Deprivation
Durham	✓	Mixed	North	PCT specialist advisers provide intensive group and one-to-one support in various settings. A large number of primary care advisers located mainly in GP practices provide one-to-one support.	Mixed
Gateshead and Tyneside	✓	Mainly urban	North	Group and one-to-one intensive support offered in various community settings including primary healthcare; most GPs and many pharmacies also provide counselling	Very high
Merton, Sutton, and Wandsworth	✓	Urban	South	Intensive support through core and satellite clinics, plus support through community advisers in primary healthcare	Mixed
North Birmingham PCT		Urban	Midlands	Groups and one-to-one support offered in various community settings and in local hospital	Mixed
North Staffordshire	✓	Mainly urban	Midlands	Dedicated smoking and pregnancy service delivered by a full-time specialist midwife	High
North West Lancashire		Mixed	North	Specialist advisers working only in smoking cessation provide individual support in a variety of settings in the community	Mixed
Nottingham	✓	Mixed	Midlands	Specialist advisers provide group and one-to-one support in a variety of settings throughout the community	High
Oxfordshire		Mainly rural	South	Intensive group support run in some towns, plus support from nurses in general practice	Low
Plymouth	✓	Urban	South	Intensive group and one-to-one support offered, plus support in health and community settings	High
Shropshire		Rural	South	Most support offered by trained nurses working one-to-one in general practice	Low
Warwickshire		Mixed	Midlands	Most support offered by practice nurses working one-to-one in general practice, with other staff offering a similar service in other settings, eg hospital, workplace	Low

County Durham and Darlington Smoking Cessation Services

There are six smoking cessation services in the county providing intensive support through groups and one-to-ones by specialist advisers. Each service employs a specialist adviser who primarily runs the service using group support based on the Maudsley model, and also provides support to the primary care professionals trained to deliver help on a one-to-one basis. The services are local and managed directly by PCTs (formerly PCGs), which has resulted in no disruption through organisational transition. Central allocation funding was devolved directly to PCGs from April 2000 to develop their own services, which has resulted in significant additional investment in the services.

PCT(s) now covered	Six: Durham and Chester-le-Street, Derwentside, Durham Dales, Easington, Sedgfield, Darlington
Strategic health authority	County Durham and Tees Valley
Service established	2000
HAZ	No
Population	608,100
Adult smoking prevalence	28%
Rural/urban/mixed	Mixed
Level of deprivation	Medium-high overall (62% of electoral wards among the most deprived in the country)
Service provision	There are six smoking services across the county, one based in each PCT. They all have specialist advisers who run groups and see people one-to-one. All six services have established primary care provision – five through GPs and one through a team of health visitors
Current staffing in FTEs	Coordinators/advisers 5.8 – one service currently recruiting a new adviser
Total staff in service	Most practices have at least one 'intermediate' adviser and many have more than one
2001-02 budget	Central allocation of £189K plus project funding, £50K for lower socio-economic groups, £32K for pregnancy. PCTs have made considerable additional funding with overall expenditure of £605K
2001-02 throughput	5,646 – combined specialist and primary care provision
2001-02 four-week successes	Majority CO validated
Description of service	Six PCT services provide group and one-to-one service and extensive primary care provision, largely through GPs. One PCT delivers service through a team of health visitors.
Comments	Having services based in PCTs from the outset has been a huge advantage. It has enabled the services to develop through GPs and contribute to these six PCTs having the second highest number of quitters per 100,000 population in the 2001-02 Primary Care Organisations' performance indicators (July 2002). Two of the services are Neighbourhood Renewal areas and have attracted funding to expand service provision through neighbourhood renewal funds and through the Sure Start programme. All services have attracted funding from Cancer Plan money to target lower socio-economic workers and have extra Department of Health funding to target pregnant women.
Future plans	All services are continually providing training for advisers at specialist, primary care and community levels to expand capacity. They all continue to develop services to reach pregnant women and manual workers, with a programme of staff recruitment and training of midwifery staff.

Gateshead and South Tyneside Smoking Cessation Service

This HAZ offers a comprehensive, widely advertised service in a variety of locations, with nine full-time staff for a population of 350,000 as well as 130 additional trained advisers. All advisers are given ongoing training and support. The four-week CO-validated cessation rates are high. In 2001–02, the service had the highest number of four-week quitters per 100,000 population in England (691 compared to a national average of 196).

PCT(s)	Two: Gateshead, South Tyneside
Strategic health authority	Northumberland and Tyne and Wear
Service established	1999
HAZ	Yes
Population	350,000
Adult smoking prevalence	34%
Rural/urban/mixed	Mixed, though predominantly urban
Level of deprivation	Very high
Service provision	Full-time specialist clinics in primary and secondary care; specialist groups in various community settings; home visiting service to pregnant women and housebound clients (75% one-to-one; 25% group). Community adviser support available in 92% of South Tyneside and 78% of Gateshead general practices, and in 12 community pharmacies, all one-to-one
Current staffing in FTEs	Nine: one FTE coordinator; four FTE specialist advisers (also two FTE vacancies, about to recruit); two FTE administrators. (Note – all staff about to go permanent.)
Total staff in service	Nine as above, plus 130 intermediate advisers
2001–02 budget	£332,000 (£270K core; £32K pregnancy; £30K manual workers)
2001–02 throughput	4,965 set quit dates
Core service	681 set quit dates (over 1,000 referrals)
Primary care	4,284 set quit dates
2001–02 four-week successes	2,570 CO validated (52%) from 2,758 self-reported quitters
Core clinic	400 CO validated (59%) from 401 self-reported quitters
Primary care	2,170 CO validated (51%) from 2357 self-reported quitters
Description of service	<p>Established in November 1999, and fully operational from February 2000. Integrated smoking cessation model. Team of specialist advisers and coordinator, with large team of trained community advisers. Deliver intensive weekly behavioural support linked with NRT and bupropion; abstinent contingent prescribing protocols in place. All four-week NRT quitters are then followed up fortnightly (face-to-face) for up to 12 weeks (abstinent–contingent model). All short-term quitters from core service are routinely followed up to 52 weeks.</p> <p>Backed up by brief advice within primary and secondary care, expanding this brief advice into education and community development settings (the latter being used as a signposting service).</p> <p>The service is widely promoted (paid press, promotional materials in general practices, hospitals, community centres, local colleges, PR in council newsletters, paid advertising in community leisure guides) throughout the boroughs and is open to all motivated smokers, no age restrictions. Smokers can self-refer to the service – telephone line (not free call) available Mon to Fri, 9am–5pm, and staffed by an administrator. Callers are advised where they can get support, and the service arranges the most suitable option, eg one-to-one, group, home. Clients can also approach advisers direct within primary care.</p> <p>Community advisers are all trained to deliver intensive support, adhering to the Department of Health standards. From the beginning all advisers have offered face-to-face weekly support for at least the first four weeks of quit attempts (telephone support is allowed in week 3, although the majority of advisers make face-to-face appointments). All advisers have been provided with CO monitors and from day one it has been routine to take CO readings at each appointment.</p> <p>Specialist advisers have been concentrating on service developments and seeing clients who are manual workers, pregnant, young, suffer from smoking-related illness or who are at high risk of developing one, or have not succeeded in quitting following community support. Clearly defined roles, although very flexible when needed.</p> <p>In 2002–03 the specialist advisers have opened up to all motivated smokers and increasing numbers of groups are being offered, mainly to increase capacity to meet growing demand.</p>

Gateshead and South Tyneside – continued

Description of service (continued)

The service offers training for new community advisers three times a year (either a daytime or two evening sessions). Intensive course followed by one-to-one session shortly after with coordinator to run through any issues. All community advisers have to attend at least one of the three half-day update sessions run each year, which have proved very popular. These are becoming more like workshops now. All community advisers receive a smoking update letter from the coordinator every six weeks, which keeps smoking high on the agenda.

Community advisers receive remuneration (into the practice or pharmacy) for all clients setting a quit date; scaled fee of up to £20 per client supported for first four weeks.

The service also offers regular brief advice training in secondary care – soon to be monthly sessions in both local hospitals. Also runs quarterly brief advice workshops for people working with young people, and one-hour brief advice sessions for all midwives.

Comments

The success of this service is due to a number of factors: stable workforce (no recruitment/retention problems within specialist team); committed/dedicated team; close working with neighbouring smoking cessation services to avoid duplication; involving primary care from outset, including local medical and local pharmaceutical committees; regular updating of team of intermediate advisers (keeps smoking high on their agenda, allows them to offload worries, disseminates information and new research, inspires them when figures are shared, etc); support for intermediate advisers (call service number and can be rung back by coordinator or specialist smoking cessation adviser (SSCA) urgently); being flexible with clients (eg offering information sessions about stop smoking groups); paying the primary care counsellors; involving pharmacists (opens up access at weekends and late at night); making systems as easy as possible (weekly free dispatch of ordered materials – large range available, prepaid envelopes to return forms, appointment cards); linking the service to other initiatives, eg National Healthy School Standard Scheme and work of Council Community Health development teams.

Future plans

Core staff contracts are about to be made permanent. Service will remain cross-district in 2002–03 with dedicated specialist team on permanent contracts. Central coordination and administration will be maintained. (Closer working with senior management in both PCTs will be necessary.) The six full-time SSCA posts will be: secondary care x2, community/young people x2, workplace x1, pregnancy x1. We will still provide intermediate adviser training so both boroughs have 100% practice involvement. We will continue offering a range of support: one-to-one, groups and, where necessary, home visits. We will also expand support for workplaces and potentially become more involved in workplace policies. We will expand brief advice training and will be involved in setting up more effective systems for smoking status data collection in both primary and secondary care.

Merton, Sutton, and Wandsworth Smoking Cessation Service

This service in London is based on the research evidence and closely follows the model described in the original English guidelines, with core clinics and community advisers (Raw *et al.*, 1998). All four-week quitters are validated, and the service shows a higher cessation rate from specialist support. This case study also illustrates the destabilising effect of uncertainty about the future, which is avoided in some of the other studies. The budget appears very small for the population.

PCT(s) now covered	Two: Wandsworth, Sutton & Merton
Strategic health authority	South West London
Service established	2000
HAZ	No
Population	625,000
Adult smoking prevalence	32% (1994–96)
Rural/urban/mixed	Urban
Level of deprivation	Medium
Service provision	Comprehensive service with core service offering mainly group treatment and community advisers offering one-to-one
Current staffing in FTEs	One FTE coordinator; 2.4 FTE counsellors; one FTE administrator; one FTE tobacco issues adviser
Total staff in service	Six clinic staff, 49 community advisers
2001–02 budget	£193,000
2001–02 throughput	1,163
Core clinic/service	324
Primary care counselling	839
2001–02 four-week successes	490 (42%) all CO validated
Core clinic:	186 (57%) all CO validated
Primary care counselling	304 (36%) all CO validated
Description of service	Core clinic with satellite clinics offering primarily group treatment. Staff manage community advisers. Network of community advisers delivering individual treatment according to standardised protocol. Adviser on prevention, health promotion and treatment in schools and colleges.
Comments	The Merton, Sutton, and Wandsworth Smoking Cessation Service has, since its inception, attempted to deliver evidence-based treatment and to organise itself in accordance with the Smoking Cessation Guidelines for Health Professionals. The core clinic delivers mainly group treatment at a central site and through satellite clinics; it is run by staff who specialise in smoking cessation. These staff train, supervise and support a number of community advisers who deliver individual treatment in community settings according to an agreed treatment protocol.
Future plans	Funding for service only confirmed until March 2003. Uncertainty about the future of the service contributed to loss of the smoking cessation coordinator.

North Birmingham Smoking Cessation Service

This service has been established within one PCT, but all advisers are managed and employed by the service. Treatment – group support and one-to-one – is offered at various locations in the community (no central clinic).

PCT(s)	One: North Birmingham
Strategic health authority	Birmingham and Black Country
Service established	2001
HAZ	No
Population	175,000
Adult smoking prevalence	24%
Rural/urban/mixed	Urban
Level of deprivation	Mixed
Service provision	One-to-one and group sessions, all community based; day and evenings
Current staffing in FTEs	3.4
Total staff in service	18 (three permanent staff, 15 advisers, sessional basis)
2001–02 budget	£66,248
2001–02 throughput	603 set a quit date
2001–02 four-week successes	339 (56%) not CO validated
Description of service	The team includes a coordinator, a part-time adviser who has developed group work and other services, one part-time administrative assistant, and 15 community advisers. The service offers clients a choice of individual appointments or group sessions at 12 venues across the PCT, plus home visits where appropriate. Referrals are received from GPs, practice nurses, district nurses and health visitors, and clients can also self-refer. The service also offers a fast-track service for urgent referrals from primary care, and the cardiac and respiratory departments from Good Hope Hospital. This is also being offered to City Hospital for patients within this PCT.
Comments	1,123 referred into service April 01–March 02.
Future plans	Training for all doctors and nurses on effective brief opportunistic interventions; developing services for young people in partnership with youth and community services; the service is about to appoint a midwife to develop services for pregnant smokers; working with exercise on prescription to assist with relapse prevention.

'You Two Can Quit' Smoking Cessation Service (Smoking in Pregnancy)

The North Staffordshire smoking cessation service set up a dedicated smoking in pregnancy service, run by a single full-time specialist who has been in post since its inception. This service shows what can be achieved by dedicated, highly qualified specialist staff working closely with maternity services.

PCT(s) now covered	North Stoke, South Stoke, Staffordshire Moorlands, Newcastle Under Lyme
Strategic health authority	Staffordshire and Shropshire
Service established	1999
HAZ	Yes
Population	260,000 (5,000 live births per year)
Adult smoking prevalence	27% smoking and pregnancy prevalence (SAFF)
Rural/urban/mixed	Mainly urban, with some rural parts
Level of deprivation	High
Service provision	Specialised smoking in pregnancy service
Current staffing in FTEs	One
Total staff in service	One
2001-02 budget	£32,000
2001-02 throughput	182 setting quit dates (out of estimated 1,350 smokers)
2001-02 four-week successes	80 (44%) quit at four-week follow-up (CO validated); 52-week follow-up indicates 10-20% long-term successes
Description of service	
<p>An effective and efficient system for identifying smokers has been established using the booking visit and computerised records. Smokers identified at booking are written to by the smoking cessation specialist. This is followed up with a telephone call offering home visits. The specialist is a midwife who is employed solely to provide this service, and this may help establish trust on the part of the client. Smokers are offered NRT and about 70% take up the offer. NRT is prescribed by their GP. Clients can choose which form of NRT they wish to use. The specialist provides one-to-one support to pregnant women, their partners and family who want to quit. Support generally lasts for 6-8 weeks.</p>	
Future plans	
<p>The continuation of the service is dependent on national funding from 2003 onwards. However, there is an attempt to move the service into mainstream hospital funding.</p>	

North West Lancashire Smoking Cessation Service

This is a long-established (long before the new national funding), centrally run and managed service with permanent contracts and a budget for continuing training and education. There was a considerable skills base already in place when the new national funding started. Most of its counsellors are employed solely to advise smokers; it is not part of another job, and management has focused on training and professional development and establishing permanent contracts. This is to build stability, continuity and avoid the staff loss that has bedevilled many services.

PCT(s)	Four: Blackpool, Fylde, Preston, Wyre
Strategic health authority	Cumbria and Lancashire
Service established	1993
HAZ	No
Population	468,200
Adult smoking prevalence	Respectively for the 4 PCTs: 36, 30, 36, 31%
Rural/urban/mixed	Blackpool and Preston urban, Fylde rural, Wyre mixed
Level of deprivation	Medium overall: Blackpool and Preston high, Fylde low, Wyre mixed
Service provision	Core service in which all advisers are managed by the 'central' service, although counselling delivered in many locations
Current staffing in FTEs	One FTE Coordinator, 6.5 FTE advisers, 0.7 FTE smoking in pregnancy, 1.5 FTE administration
Total staff in service	Total as above – 11 staff
2001–02 budget	£219,000 (central £146K, PCTs £73K)
2001–02 throughput	3,860 set a quit date
2001–02 four-week successes	1,691 (44%; only a few validated if client requests this, otherwise follow-up is by phone or letter)

Description of service

Nine specialist adviser posts – sole jobs, not as part of another job, all running clinics in a total of 17 locations. Some are in GP practices where it is agreed that clients from any practice can attend. All are G grade nurse or A&C grade 6/7, and totally responsible for their own clinics and location. All clients self-refer to a central telephone number. As part of the service's quality standards, over the past 12 months clients have been offered the choice of a group or one-to-one planned appointment (45-minute appointments). No-one has chosen groups. Service has no intermediates, no practice-based staff, no patient group directions for NRT, no special pregnancy clinics and no hospital clinics. All these have been rejected as distractions from the core business of providing high quality behavioural therapy to smokers in the community in which they live/smoke. GPs do prescribe to all groups only on instruction from advisers after client appointment or telephone counselling. Advisers use a behavioural therapy approach. Every client (who wants one) also receives a copy of a book or tape to consolidate the information given at the appointment with the adviser. Repeat appointments are available, but the main aim is to progress the smoker to self-responsibility and self-reliance. NRT/bupropion is prescribed but does not have a high profile in creating a demand for the service. The service uses a direct marketing strategy to create demand. Advertising in local press, free newsletter for the public available through many outlets in the community.

Comments

Smoking cessation advisers are treated as a separate professional group with particular professional development skills. The coordinator has top sliced our budget for external training costs and encourages staff to seek out conferences and training courses that will build on their current skills and knowledge. Funding has been set aside for this, and may include further training and education (including conferences) outside the UK.

The service works as a whole across the four PCTs (which share the costs and contracts with advisers), and with central management. The staff have formed a team so that staff absences can be covered without loss of service to any one PCT. Their quality standards go across all four PCTs, so staff can cover any other area.

Having one central registration number means the service has full postcode data on all clients. This has made monitoring and follow-up extremely easy, and enabled us to establish that our clinics are being run in the areas that need them.

Future plans

To persuade PCTs to fund proactive smoking cessation work, to include tobacco control projects, and increase the demand for the service. Wyre PCT is an example of good practice, giving advisers permanent contracts now and bidding for monies for proactive work.

Two Sure Starts in Preston have funded a joint proactive/smoking cessation post which will be part of our service. Two more Sure Starts have plans for the same; hope to persuade Blackpool Sure Starts also.

New Leaf (Nottingham)

This is another service that has continued to cover its original health authority area, now serving four PCTs. The service is notable for the effort devoted to meeting the needs of special groups.

PCT(s)	Four: Nottingham City, Broxtowe and Hucknall, Rushcliffe, Gedling
Strategic health authority	Trent
Service established	1999
HAZ	Yes
Population	610,910
Adult smoking prevalence	27% (estimate – 1994 General Household Survey and 1991 census data)
Rural/urban/mixed	Mixed
Level of deprivation	High
Service provision	Core one-to-one service Mon–Fri, city centre; groups am, pm, evening, city centre; one-to-one community/primary healthcare clinics; group community clinics; one-to-one services account for approximately 90% of total provision
Current staffing in FTEs	15 (advisers, administrators and managers)
Total staff in service	30 paid staff and approximately 20 associate advisers (unpaid)
2001–02 budget	£465,000 (includes £32K pregnancy monies)
2001–02 throughput	Approximately 4,000 smokers accessed the service, 3,233 set quit date
2001–02 four-week successes	1,774 [1,511 CO validated (47%)]
Core clinic	New Leaf protocols and programme are the same for the core service and the New Leaf services in the primary healthcare/community
Primary care	Not currently available – associate advisers see a small percentage only
Description of service	
<p>A comprehensive and inclusive New Leaf service provides one-to-one clinics and group sessions in a number of health and community locations across the Greater Nottingham health area. Advisers have specific responsibilities to ensure services are appropriately provided for each of the four Nottingham PCTs. To ensure the service addresses the needs of and access required by vulnerable groups, some advisers have specialist roles to further work in these areas and to communicate best practice to the whole team through training. Specialist areas include black and ethnic minorities, young people, pregnant women, users of mental health services, people with learning disabilities, prisoners and hospital patients. Two advisers also provide the service lead for integrating and developing CHD and cancer services with New Leaf. A major factor in the service's success is the ability to adapt to local community and individual needs, yet continue to provide the high standard of care the public and our partners expect.</p>	
Comments	
<p>Evidence demonstrates that New Leaf is reaching disadvantaged communities; over 80% of clients from the Nottingham City PCT area are from the two postcode deciles ranked most deprived.</p> <p>Training programme: half-day brief intervention, pregnancy; full-day complete course, young people, minority ethnic groups, nurse prescribing; three-day (min.) adviser-level training. In service, cultural awareness, health and safety, motivational interviewing, relapse prevention, etc. Various tailor-made training for basic nurse and postgraduate English Nursing Board nurse training, medical training, link nurse training, friends of New Leaf training, GP surgeries, dentists, and other allied health professional groups.</p>	
Future plans	
<p>Secure future funding of service: New Leaf is at present a non-recurrent service, and staff contracts expire on 31 March 2003. This is the second consecutive year that the team have had uncertainty over their future, and in order to retain experienced staff and meet this year's increased target an early decision as to the future of New Leaf needs to be secured.</p> <p>Ensure full staffing complement; training development; increase prison and mental health provision; more Sure Start partnerships; rework pregnancy strategy and practice; young people's strategy and provision development; black and minority ethnic group development, etc.</p>	

Oxfordshire Smoking Advice Service

This is one of the more recently established services. Mainly a rural area, but offering groups in towns and cities as well as one-to-one support in primary care/community settings. Funding currently guaranteed until 2004.

PCT(s)	Five: Cherwell Vale, North-East Oxon, Oxford City, South-East Oxon, South-West Oxon
Strategic health authority	Thames Valley
Service established	2000
HAZ	No
Population	605,900
Adult smoking prevalence	27%
Rural/urban/mixed	Mixed
Level of deprivation	Low (but pockets of high deprivation)
Service provision	Both: stop smoking courses and one-to-one consultations by practice/community based nurses, health visitors, etc.
Current staffing in FTEs	2.9
Total staff in service	Four (plus 10 hours a week administrative support not included in this figure)
2001-02 budget	£182,000 (includes a £32K smoking and pregnancy budget)
2001-02 throughput	2,230 set a quit date
Core clinic	106
Primary care	2,124
2001-02 four-week successes	1,129 (not CO validated)
Core clinic	65
Primary care	1,064
Description of service	Stop smoking groups are offered (in Oxford, Banbury, Bicester, Witney and Abingdon), as well as one-to-one counselling by practice nurses and health visitors, with 193 advisers trained altogether, working in 78 (93%) of the 84 practices in the five PCTs. The core team has also done brief advice training for 320 professionals during the year.
Future plans	The smoking cessation service will be retained as a county-wide resource until March 2004, with a review taking place in June 2003 when the long-term future will be determined.

Plymouth Smoking Advice Service (South and West Devon Health Authority)

This was the first service in the country to receive permanent contracts, in 2001, and the cost effectiveness data and arguments were central in persuading the primary care group to secure the service. They also work closely with the Tobacco Alliance Network, so they are aware of and linked to wider tobacco control initiatives.

PCT(s)	Plymouth
Strategic health authority	South West Peninsula
Service established	1999
HAZ	HAZ
Population	250,000
Adult smoking prevalence	32%
Rural/urban/mixed	Urban
Level of deprivation	High
Service provision	Groups and one-to-one in core service (three to five groups running each week, two to three one-to-one sessions per week, with patients slotted in to meet demand); community advisers work in health and community settings with specific provision for pregnant women, young people and their families. Training in brief and level 2 interventions for all health professionals (including dentists, pharmacists), non-medical staff, youth workers, school nurses, teachers, etc. Training sessions in effective use of treatments, updates, weight control and other allied topics. Facilitation for medical students and nursing students; awareness-raising/publicity.
Current staffing in FTEs	3.8
Total staff in service	5
2001-02 budget	£17,000 smoking cessation plus £18,500 pregnancy money
2001-02 throughput	2,333
Core clinic	311
Primary care	2,022 (there are currently 224 registered level 2 advisers)
2001-02 four-week successes	1,128 (511 CO validated)
Core clinic	208 (67%)
Primary care	920 (45%)
Description of service	The service provides a range of advertised smoking cessation services that offer choice and equity of access to all smokers and their families living in Plymouth. It provides a comprehensive range of training at levels 1 and 2 for anyone in a position to help people give up smoking. It aims to meet government targets and use their documentation to aid the cause (eg CHD, NSF, Cancer Plan). It works closely with the Tobacco Alliance Network and local partners to look at tobacco and the wider issues. It offers support at level 3 within secondary care.
Comments	In August 2001 the service was given permanent contracts by Plymouth PCT. The smoking advice service is a proactive, self-managing team, placed in the PCT within the Public Health Directorate. It is well respected and supported by the PCT. The staff are enthusiastic and dedicated to providing a quality service. Staff continually update and look ahead for new opportunities. They wholeheartedly believe that the work they are doing will make a difference in terms of both life-saving and cost effectiveness. They have now been funded to extend the service to incorporate South Hams and West Devon PCT, which will bring new challenges as it is predominately rural and semi-urban.
Future plans	Develop stronger links with secondary care. (We aim to employ a dedicated adviser). Work together with local partners to tackle inequalities. (Regeneration schemes, New Deals, Sure Start, etc). Develop links with Dartmoor prison, industry and commerce. Continue to find ways to prevent young people taking up smoking, and look for new ways of working with them to help them quit.

Help 2 Quit (Shropshire & Telford HA)

Like North West Lancashire, this service was well established long before the new national funding. It is notable also because its core service is provided in the primary care setting, including pharmacies and all general practices in Shropshire which now have nurse advisers. The service is run by a central management team who provide all training.

PCT(s)	Two: Shropshire County, Telford & Wrekin
Strategic health authority	Shropshire and Staffordshire
Service established	1995
HAZ	No
Population	440,000
Adult smoking prevalence	20%
Rural/urban/mixed	Rural
Level of deprivation	Foci of high deprivation, but overall below average
Service provision	Clinics in all general practitioner surgeries. All community pharmacies also participate. No central clinic, but services in both acute hospital trusts.
Current staffing in FTEs	Four FTE staff in central specialist team
Total staff in service	>100 H2Q nurses in surgeries
2001-02 budget	£230,000
2001-02 throughput	
Primary care	3,474
2001-02 four-week successes	
Primary care	1,946 (1,744) (50%) 98% of patients in whom CO was taken were confirmed as quitters (CO < 10)
Description of service	
The service has a central management team that includes a clinical director, primary care coordinator, and special projects coordinator. One-to-one treatment is provided in GP surgeries, pharmacies and hospitals. Liaison nurses in the hospital trusts ensure that when patients return to their general practice, treatment is continued if needed. There is no central core clinic.	
Comments	
The service started in 1995 (before establishment of the national services).	
Future plans	
To develop treatment in accessible settings for young people, pregnant smokers, and the disadvantaged; to develop electronic smoking records in general practice.	

Warwickshire Stop Smoking Service

This service has continued to cover the old Warwickshire Health Authority area, now serving three PCTs, with the budget and management continuing centrally. Core service provision is based in GP surgeries, with all 76 general practices (115 buildings) in the county offering intensive one-to-one support. A key feature of the service is its integration with the Smoke Free Warwickshire Alliance, which has been essential to the cessation service's success.

PCT(s) now covered	Three: North Warwickshire, Rugby, South Warwickshire
Strategic health authority	West Midlands South
Service established	Q3 2000
HAZ	No
Population	507,900
Adult smoking prevalence	29% (Public Health Annual Report 2000–01)
Rural/urban/mixed	Mixed
Level of deprivation	Low – but includes wide variation with some deprived wards, including one in the top 10% of deprived areas nationally
Service provision	The core service is delivered through every GP practice in the county (76 practices, 115 buildings) and consists of one-to-one intensive support, mainly carried out by practice nurses. Staff in other disciplines/settings offer a similar service, eg occupational health staff, acute hospital staff, health visitors, workplaces. The specialist smoking and pregnancy service offers home visiting on a flexible basis.
Current staffing in FTEs	6.9 FTEs: one FTE coordinator (secondment), 3.4 FTE smoking cessation advisers (fixed-term contracts), 1.5 FTE smoking and pregnancy advisers (fixed-term contract), one FTE administrator (temp). In addition, we estimate one FTE in primary care for every 1,000 persons setting a quit date (including intensive support, administration and brief interventions). So for 2001–02, four FTEs in primary care (see next box). Support is also provided by the public health lead for tobacco control and a health promotion specialist (tobacco control).
Total staff in service	Nine contracted staff, plus most practices have at least one active staff member trained to offer intensive support (many have more than one), approximately 140 in total. Other active trained staff in other settings number approximately 10. Health visitors offering smoking and pregnancy service number approximately 10. Support is also provided by the public health lead for tobacco control and a health promotion specialist (tobacco control).
2001–02 budget	Total for both smoking cessation and tobacco control = £442,000 Breakdown: Department of Health central allocation = £131,000 PCT Service and Financial Framework (SAFF) allocation = £245,000 Department of Health smoking and pregnancy allocation = £32,000 Department of Health Tobacco Control Alliance allocation = £34,000 Additional <i>ad hoc</i> project funding also received from time to time. Approximate split: £280K cessation, £162K tobacco control (not including prescription costs). (It is difficult to separate all costs as the tobacco control strategy is designed to promote the cessation services.)
2001–02 throughput	4,034
Primary care	3,934 plus 100 through other service providers and smoking and pregnancy service
2001–02 four-week successes	1,955 (48%)
Primary care	1,900 (55 through other service providers and smoking and pregnancy service)

Warwickshire Stop Smoking Service – continued

Description of service

The service is an integral part of the Smoke Free Warwickshire Alliance. It has been developed according to national guidelines and research evidence in the context of local circumstances. The service is centrally coordinated and has smoking cessation advisers for each of five PCT localities whose role is to facilitate development of smoking cessation services, and to contribute to the wider tobacco control agenda in the county.

Core services are delivered by all 76 general practices in the county (115 buildings), and consist of one-to-one intensive support mainly provided by practice nurses. Payment is made to general practices for each quit attempt that is followed up at four weeks and for which the monitoring form is fully completed (£20).

One-to-one intensive support is also offered in other settings, such as occupational health, hospitals, etc. No payment is made where providers carry out smoking cessation within their existing work.

The smoking in pregnancy service is delivered by health visitors with referrals from midwifery. A separate steering group (with different partners from the adult service, such as Midwifery Services and Sure Start) oversees this service but coordination/administration is shared.

Service guidelines have been issued to all service providers, based on research evidence and best practice. A comprehensive training programme offers the choice of a half-day workshop to raise the issue of smoking and referral to intensive support, or a two-day workshop to offer intensive support, or sponsorship on the National Respiratory Training Centre's distance learning course. Training on smoking and pregnancy is also offered on demand.

All monitoring data are collated centrally. All four-week quitters are followed up at 52 weeks via a questionnaire. A relatively high response rate is achieved, partly due to innovative incentives.

Promotion of service is wide – a key feature is the promotion of national helpline numbers via press advertising, bus advertising, street furniture, billboards, etc. This advertising directs smokers to the helpline – should the smoker then wish to access the Warwickshire service they are advised of the Warwickshire freephone number. Smokers can also approach the primary care services directly. Promotional materials for the service, such as leaflets and posters, are widely distributed across the county.

Ongoing press activity is an essential part of the overall tobacco control strategy, and wherever appropriate details of the service are included.

Comments

The success of the service can be attributed to a number of factors, including strong leadership/commitment at a senior level; dedication and commitment of smoking cessation workers and service providers; involving primary care from the start; flexible, ongoing support for service providers; regular updates to service providers; a varied and high quality training programme; and a willingness to respond to local needs. The service has always taken a pragmatic approach, minimising administration where possible.

As an integrated part of the Smoke Free Warwickshire Alliance, the cessation service benefits from a strong local media presence; links with a variety of partner organisations and settings (eg local authorities and businesses); campaigning expertise and high levels of calls to national helplines. The Alliance has been recognised for its campaign activities (Europe Against Cancer Week 2001 competition winner, highly commended in the Communicating Health Awards 2002, CHD category). The Smoke Free Warwickshire Alliance benefits from a close relationship with the cessation service that provides role models/case studies for media stories and a practical, positive alternative for smokers. The Alliance and the Warwickshire Stop Smoking Service play an active role in the West Midlands Regional Tobacco Control and Smoking Cessation Network.

Future plans

Secure permanent funding for the service.

Extend support with secondary care, workplaces, young people.

Further develop smoking and pregnancy service.

Develop relapse prevention initiatives.

Extend work with local partners to tackle inequalities.

Continue to be an integral part of the Smoke Free Warwickshire Alliance.

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