NATIONAL SURVEY OF THE NEW SMOKING SERVICES: IMPLEMENTING THE SMOKING KILLS WHITE PAPER

UNIVERSITY OF NOTTINGHAM

A Report to the Department of Health

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***Tim Coleman, Senior Lecturer**

School of Community Health Sciences,
Division of General Practice,
University Hospital,
Queen's Medical Centre,
Nottingham,
NG27 2UH.

Tel: 0115 970 9387
Email: tim.coleman@nottingham.ac.uk

Elspeth Pound, Research Associate

Department of General Practice and Primary Health Care,
University of Leicester,
Leicester General Hospital,
Gwendolen Road,
Leicester,
LE5 4PW.

Francine Cheater, Professor of Public Health Nursing

University of Leeds,
24 Hyde Terrace,
Leeds.

*** Corresponding author**

EXECUTIVE SUMMARY

Background

Smoking remains a public health problem in the UK and in 1998, the UK Government pledged £60 million for smoking cessation services to be developed in England. Services were initially implemented in Health Action Zones and were developed in other areas from April 2000. Services were targeted at all motivated smokers but the government placed particular emphasis on attracting people from specific priority groups. An evaluation investigated service implementation in HAZ areas, but to date the process has not been investigated in other areas.

Study Aim

To describe the new smoking cessation service which have been implemented in England and how these are being targeted at priority groups of smokers.

Method

A postal survey was developed using expert opinion and documentary analysis of strategic planning documents from smoking cessation services in the Trent NHS region. The questionnaire was posted to all English smoking cessation service co-ordinators with one postal and one email reminder.

Results

69% of individuals identified as smoking cessation co-ordinators responded. We received at least one survey response from 83% of English health authorities. Principle survey findings were:

- 42% of smoking cessation co-ordinators had no experience of running clinical services for patients and over half had responsibilities other than running smoking cessation services.
- 29% of smoking cessation services had difficulty recruiting smoking cessation advisors.
- All smoking cessation services reported delivering primarily evidence-based anti-smoking interventions, including a mixture of group and one to one counselling. Only a very small minority of services (6%) reported offering additional non evidence-based interventions.
- Very few smoking cessation services enjoyed accommodation dedicated solely to their use.
- Despite short deadlines for implementation, almost 60% of services reported working at full capacity.
- The vast majority of services were attempting to target priority groups of smokers. Few services, however were actively trying to target young smokers, a group identified as a priority in the UK government's white paper announcing that smoking cessation services would be implemented.
- Many services had identified people with smoking related illnesses as a priority group and were attempting to attract them.

Conclusion

This survey provides a detailed description of the new smoking cessation services implemented in England. Further commissioned research will provide qualitative data, which will help explain some of the survey findings. In particular, it will be important to investigate the reasons why young people are not being identified as a priority group by many smoking cessation services and people with smoking related illnesses are. Further work also needs to investigate how smoking cessation services are sustained once dedicated, ring-fenced funding for them is withdrawn.

Acknowledgements

This project was funded by Trent NHS Executive and is linked to the national evaluation of smoking cessation services which has been commissioned by the Department of Health. The research team has benefited from the expertise of the Project Advisory Board (see appendix for list of members) and wish to thank the smoking cessation co-ordinators who returned questionnaires and members of the Department of Health funded research team. We are grateful to Miss Laura Jones and Mrs Margaret Whateley for providing secretarial support.

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1. INTRODUCTION

1.1 Smoking: a public health problem

Smoking remains a distressingly prevalent habit in the UK, with 28% of men and 26% of women being regular smokers[1]. Smoking behaviour is strongly related to socio-economic status, and smoking prevalence highest in the semi-skilled manual occupation groups[1]. The burden of death and disease caused by cigarette smoking is substantial and mortality data indicates that approximately 2,300 people in the UK are killed by smoking every week[2]. Smoking is also expensive for society: smoking-related disease costs the NHS in England an estimated £1.5 billion annually to treat[3]. Smoking tobacco, therefore, probably represents the greatest public health problem in Britain today.

1.2 *Smoking Kills*: the health policy response

In 1998, the UK government announced a policy initiative to combat the tobacco epidemic. £100 million was pledged to anti-tobacco policy initiatives, with £60 million ring-fenced for developing and delivering smoking cessation services[2]. For the first time, health policy was committed towards treating smokers in NHS-funded services. The *Smoking Kills* white paper specified that although smoking cessation services would be aimed at all smokers wanting to stop, they should be especially targeted at the economically disadvantaged, young people and pregnant women. Funding was promised for three years in total but, in the first year was only available to Health Action Zones (HAZs), with money reaching the remaining Health Authorities in the second year. HAZs were established in 1998 in 26 areas of England and received extra funding to tackle health inequalities by encouraging partnership between the NHS and other non-health agencies[4]. By targeting HAZ areas initially, *Smoking Kills* hoped to reach economically disadvantaged smokers first. *Smoking Kills* stated health policy for

England and similar policy initiatives were intended to be developed by the Scottish and Welsh Assemblies for these countries.

1.3 Innovation in approach

Implementing a national NHS smoking cessation service was a completely new venture for the NHS. Prior to *Smoking Kills*, smoking cessation services had been available in a small minority of health authority areas, but these were local initiatives which often developed because health professionals in those areas had a particular interest in smoking cessation. Additionally, targeting NHS services at sub-groups of the population was a new idea. Previously, some NHS services had been developed exclusively for distinct groups of people (e.g. the homeless or travellers), but a different approach was required for the new smoking cessation services. These had to be accessible to all smokers who were motivated to quit, but simultaneously needed to be targeted at the priority groups mentioned in section 1.2. The Department of Health (DH) realised the novel and complex nature of the task facing Health Authorities and commissioned a study to investigate the implementation of the first smoking cessation services set up during the initial year of funding in the 26 Health Action Zones[5].

1.4 Implementing smoking cessation services in Health Action Zones (HAZs)

For the HAZ smoking cessation service evaluation[5], smoking cessation co-ordinators and smoking cessation staff working within HAZs were interviewed. It produced insight into the process of implementing new smoking cessation services and identified a number of key issues which are discussed below.

1.4.1 *Targeting of priority groups*: The rapid implementation of smoking cessation services restricted smoking cessation co-ordinators' ability to think strategically about how best to target the groups prioritised by the *Smoking Kills* white paper. Two strategies were offered as a means of targeting the economically disadvantaged: locating services within disadvantaged neighbourhoods and recruiting ex-smokers from the local population in deprived areas as smoking cessation advisers. Co-ordinators felt pregnant women were best targeted through maternity services and had invested time and effort in attempting to recruit midwives as smoking cessation advisers with variable results. Some experienced difficulty recruiting midwives and making links with maternity services. Co-ordinators reported no definite ideas of how to target young people. DH guidance indicated that the new services should only be available to those aged 16 or over, which some service co-ordinators found contradictory. Finally, in a number of HAZ areas, people from ethnic minorities were mentioned as a priority group that their smoking cessation service intended to target.

1.4.2 Interventions offered: In Smoking Kills[2], the government stated that funding would be provided for one weeks nicotine replacement therapy (NRT) to be supplied to smokers in receipt of free prescription at no cost. Subsequent DH guidance suggested that individual Health Authorities could increase this to four weeks NRT if they were prepared to fund the extra weeks themselves. The HAZ smoking cessation service evaluation found the number of weeks free NRT varied greatly between smoking cessation services. Smoking Kills also recommended that the new smoking cessation services offered group therapy to smokers rather than one-to-one interventions on the grounds of cost effectiveness. The HAZ evaluation, however, found that, at least

initially, most services offered mainly one-to-one interventions but demand for services increased, groups were implemented.

1.4.3 *Difficulties experienced when implementing services*: Smoking cessation co-ordinators in Health Action Zones experienced a range of problems when setting up new smoking cessation services. They found it difficult to appoint and retain staff and to establish good working relationships with primary care groups and trusts. Additionally, some co-ordinators reported difficulty in establishing a system for collecting, collating and reporting data which the DH requested.

1.5 Summary and rationale for study

The government has pledged significant funds to develop new smoking cessation services in a novel departure for health policy. It is important to learn how these monies have been spent and to determine whether any lessons can be learned from this process for future policy initiatives. The Health Action Zone smoking cessation service evaluation[5] provided an initial 'snapshot' of the challenges experienced by smoking cessation co-ordinators implementing these services in Health Action Zone health authorities. The experience of smoking cessation co-ordinators working in Health Authorities outside of Health Action Zones may differ. Other Health Authorities will have lower levels of economic disadvantage and deprivation, fewer smokers and less funds available for smoking cessation services. Consequently, in this report, we describe the findings of a national survey of smoking cessation co-ordinators in England. We investigate further many of the issues highlighted by the HAZ smoking cessation service evaluation and aim to give a complete picture of smoking cessation services in both HAZ and non-HAZ Health Authorities in 2001.

2. AIMS AND OBJECTIVES

2.1 Aim of study

To describe the new smoking cessation services which have been implemented in England and how these are being targeted at priority groups of smokers.

2.2 Objectives

The specific objectives of the study were to:

- Describe the characteristics and previous work experience of the smoking cessation co-ordinators running the new smoking cessation services.
- Describe the staffing and geographical locations of the new smoking cessation services.
- Quantify any difficulties experienced in recruiting staff and finding accommodation for the new smoking cessation services.
- Describe the interventions delivered by the new smoking cessation services.
- Describe the priority groups of smokers who were being targeted by the new smoking cessation services in April 2001.
- Describe the methods used by smoking cessation co-ordinators to target priority groups of smokers.
- Investigate the differences in experience of implementing services in HAZ and non-HAZ Health Authorities.
- Investigate the differences in implementing services in Health Authorities where smoking cessation services existed before *Smoking Kills* and those where none existed.

3. METHOD

3.1 Convening an Advisory Board

During November 2000 an Advisory Board to the study was assembled. Its remit was to inform and advise researchers on smoking cessation and service development issues. Additionally, the advisory board helped with the development of the smoking cessation co-ordinator questionnaire both in terms of its content and administration. The eleven Advisory Board members (see appendix) were chosen for their expertise in research and evaluation, and smoking cessation policy and practice. Members included the research team, a smoking cessation co-ordinator from Trent, Trent's regional lead for smoking cessation and experts in smoking cessation research.

3.2 Gaining ethical approval for the study

Ethical approval for the study was sought and gained from the Trent Multi-centre Research Ethics Committee (MREC) following only a minor alteration to the study protocol. The fourteen Trent Local Research Ethics Committees (LRECs) and the Leicestershire and Rutland Healthcare NHS Trust also gave ethical approval for the study.

3.3 Documentary analysis

To help identify broad 'domains' for the smoking cessation co-ordinator questionnaire, we scrutinized a number of different types of documents relevant to the implementation of smoking cessation services. Firstly, we inspected government policy documents[2] and DH circulars to smoking cessation co-ordinators which were relevant to service implementation. Secondly, we requested strategic planning documents from the eleven smoking cessation services in Trent and obtained these from ten services. Where possible, we also acquired and

studied Health Improvement Plans and Annual Reports from health authorities in the Trent region. These documents were analysed using the 'Framework' approach[6] to compile an impression of how smoking cessation services were being planned. Using this approach, we were able to develop a typology of the types of priority groups targeted and the types of venues used to deliver smoking cessation services in each health authority area. Thirdly, we used the report of the year one evaluation of the Health Action Zone (HAZ) smoking cessation services[5] to identify the challenges involved in implementing smoking cessation services in those areas. Although the subsequent smoking cessation services set up in non-HAZ health authorities faced different challenges in terms of budgetary and time constraints, we considered that they could experience many similar problems during implementation to those encountered in HAZs (e.g. difficulty recruiting staff).

3.4 Designing survey

3.4.1 *Drafting questionnaire*

The questionnaire intended to provide a 'snapshot' description of the new smoking cessation services. Based on the documentary analysis undertaken, a comprehensive range of potential 'domains' for the smoking cessation co-ordinator questionnaire were presented to the study Advisory Board and following discussion, these were modified. Subsequently, a questionnaire was drafted and distributed to the Advisory Board for comments and modified accordingly.

3.4.2 *Piloting questionnaire*

Advisory Board members agreed that individuals responsible for the day-to-day management and running of the smoking cessation service, would be the most appropriate to complete the questionnaire. It was acknowledged, however, that most but not all smoking cessation co-ordinators would have these responsibilities. Consequently, a covering letter instructed the co-ordinator (questionnaire recipient) to forward the questionnaire to the person with responsibility for the day-to-day management and running of the smoking cessation service within their health authority if he/she did not.

Questionnaires with covering letters (see appendix) were posted to the eleven smoking cessation services in the Trent Regional Health Authority area on 9 March 2001. An information leaflet about the study, with the study team's contact details, was also enclosed (see appendix for example). A reminder letter and additional copy of the questionnaire was sent on 22 March 2001. In both cases, a business reply envelope was also enclosed. Ten of the eleven questionnaires were returned.

The questionnaire was subject to only minor alterations following the pilot and all pilot responses were analysed with co-ordinators' responses from other health regions. In no case had the co-ordinator needed to forward the questionnaire to another individual in order to complete it. Nevertheless, it was considered sensible to retain the same covering letter for the subsequent national survey.

3.5 Questionnaire Contents

The questionnaire consisted of five sections, had fifty-five items and can be seen in the appendix. A brief outline of each section is given below:

Section 1: The person who leads the service

This section asked for information about the individual with day-to-day management responsibilities for the smoking cessation service. It was important to ascertain on what basis the individual managed the service (e.g. full-time or part-time), what relevant past experience they had, and to what extent they were involved in the initial setting up and implementation of the smoking cessation service.

Section 2: The people employed by the service

This section asked for information about the staff working for the smoking cessation service. Difficulties in recruiting, retaining and training staff had been evident in the year one evaluation of smoking cessation services in HAZ health authorities. It was therefore important to ask about these issues in our national survey. Questions relating to the number of staff employed by the service and the range of staff activities were devised in conjunction with an health economist in order to estimate the costs of running smoking cessation services.

Section 3: The configuration of smoking cessation services

This section sought information about the structure and location of the smoking cessation service. The survey sought to identify whether the service used a central base or outreach sites, and whether the service utilised NHS, private, other public or voluntary sector venues. Respondents were also asked to state how easy or difficult they felt it had been to find suitable accommodation for their service.

Section 4: Services delivered

This section wanted to know about the range of smoking cessation interventions delivered by the service (e.g. one-to-one or group clinics, the number and length of clinics). The survey asked what proportion of patients received one-to-one and group support, respectively. Included were questions about the smoking cessation service's referral procedures, the service's Nicotine Replacement Therapy (NRT) dispensing protocols (prior to NRT becoming available on prescription), and its policy on Bupropion (Zyban). Questions estimating how near smoking cessation services were to running at their capacity were designed in conjunction with an health economist.

Section 5: Service implementation and sustainability

This section asked how the smoking cessation services were being implemented. Of key interest to the survey was whether and how the service was targeting the priority groups as identified in the *Smoking Kills* White Paper[2] (pregnant smokers, young people and the economically disadvantaged), and whether any additional groups had been identified by the services as priorities. The survey also sought to identify whether any problems had been encountered when setting up data monitoring systems for the service. Finally, the survey assessed service leaders' attitudes regarding the likely impact on smoking cessation services of being commissioned by Primary Care Groups/Trusts (PCG/Ts) in the future.

3.6 Conducting the national survey

3.6.1 *Compiling a list of smoking cessation co-ordinators in England*

At the time of the survey, no list of smoking cessation co-ordinators in England was available so the research team had to compile one. The seven remaining (i.e. not involved in the pilot) regional smoking cessation leads for England were contacted and we asked them to provide lists of smoking cessation co-ordinators in each of their regions. In total, 133 co-ordinators were identified across England, working in 95 health authorities.

3.6.2 *Distributing the questionnaire*

Questionnaires (n = 122) for co-ordinators in the seven remaining regions (the 11 Trent co-ordinators had been surveyed in the pilot) were posted to co-ordinators with the covering letters and business reply envelopes on 20 April 2001. Six questionnaires were returned as either not known at that address or the named co-ordinator had moved away. Of the remaining 116 questionnaires, 45 (38.8 percent) were returned within a three-week period. A reminder letter, additional questionnaire and business reply envelope were posted to the remaining co-ordinators on 11 May 2001. A further 33 questionnaires were returned (46.5 percent). In addition to the postal reminder, an email reminder was also used, where email addresses were available.

4. RESULTS

4.1 Survey response rates

Of the 133 questionnaires dispatched, six were returned because the named co-ordinator was either not known at that address or had moved. Of the remaining 127 questionnaires, 69.3% (88) were returned after two postal-reminders. Smoking cessation co-ordinators from 83.2% (79/95) of English Health Authorities returned questionnaires, with 43.7% (38) from co-ordinators in Health Action Zones (HAZs) [data missing for one respondent].

4.2 Smoking cessation co-ordinators

This section reports information about smoking cessation co-ordinators who manage smoking cessation services.

4.2.1 *Smoking cessation co-ordinators: responsibilities and re-numeration*: 34.5% (29/84) of co-ordinators worked less than full-time running the smoking cessation service for their Health Authority, with 11.9% (10) of these working half-time or less [data missing for 4 co-ordinators]. 56.1% (46/82) co-ordinators reported having responsibilities other than those involved in developing and running the smoking cessation service. Table 1 summarises the responsibilities that co-ordinators described. Only 5 (6.3%) co-ordinators participated in a job share arrangement and the majority reported receiving a full-time equivalent salary of over £20,000. Table 2 indicates the distribution of co-ordinators' salaries.

Table 1 Responsibilities reported by smoking cessation co-ordinators in addition to developing and managing smoking cessation services

Responsibility	Number of co-ordinators reporting responsibility*
Tobacco control or smoke free alliance work	22
Cancer prevention or National Service Framework for Coronary Heart Disease work	10
Health promotion work	11
Writing policy or strategy documents for Primary Care Group/Trust, Health Authority or HAZ	7
Staff development or managerial role in health promotion unit	6
Public health medicine	3
Responsible for other health services	4

* Total adds up to more than number of co-ordinators who had extra responsibilities because some co-ordinators had more than one extra responsibility.

Table 2 Salaries of smoking cessation co-ordinators

Salary	% (number) of coordinators reporting salary
£20,000 or less	3.6 (3)
Over £20,000 and up to £25,000	43.4 (36)
Over £25,000 and up to £30,000	47.0 (39)
More than £30,000	6.0 (5)
Missing data	6.0(5)
Total	88

4.2.2 *Smoking cessation co-ordinators: work experience*: Eighty-one co-ordinators gave information about the length of time they had been in their current post. This varied from one week to over five years with a mean (SD) of 14.9 (11.0) months. The vast majority of co-ordinators (75%) had been in post for 20 months or less. 40.8% (31/76) of co-ordinators reported previous experience of running a smoking cessation service, and 58.3% (49/84) had experience of running other kinds of clinical services for patients. Additionally, 59.5% (50/84) of co-ordinators reported previous experience of planning or developing clinical services for patients.

Most co-ordinators had an early role in setting up services, with 82.1% (69/84) reporting being "*very*" or "*fairly*" involved in implementing smoking cessation services in their current Health Authority area.

4.3 Staff employed by smoking cessation services

This section reports information about the staff working for smoking cessation services and the range of skills that they possess.

4.3.1 *Service staff: numbers and duties*: Services employed between 0.25 and 21 full-time equivalent staff. The mean (SD) number employed was 5.02 (3.32), with 75% of services employing up to six staff [data missing for five respondents]. The mean (SD) number of staff dedicated to training others in smoking cessation methods at each service was 2.1 (1.56), with 75% of services employing up to three people for this task [data missing for eight respondents]. The information obtained regarding the number of smoking cessation advisors or counsellors employed by smoking cessation services is less easy to interpret. Co-ordinators reported a mean (SD) of 6.11 (20.6) advisors or counsellors employed by their services, with 75% employing up to 4.8 full-time equivalent staff for this task [data missing for 13 respondents]. Co-ordinators also reported, however, the mean (SD) number of advisors/counsellors that had received training in smoking cessation methods, as 26.1 (58.8), with 75% of services having trained seven or less advisors [data missing for 18 services]. It is likely that co-ordinators have included sessional workers as well as staff who are directly employed by the smoking cessation services when making this estimate.

Finding good quality training courses for smoking cessation advisors appears to have been a problem for only a minority of smoking cessation co-ordinators, with 60.6% (51/84) reporting this as being "*very*" or "*fairly*" easy (Table 3).

4.3.2 *Service staff: recruitment, retention and experience*: 28.6% (24/84) of co-ordinators had found it either "*fairly*" or "*very*" difficult to recruit smoking cessation advisors or counsellors Table 4). The following reasons were advanced by co-ordinators to explain difficulty in recruiting smoking cessation counsellors: short term contracts offered (22 co-ordinators), lack of suitably experienced or qualified candidates (19), lack of career structure for advisors' posts (13) and low salaries offered for posts (8). Once smoking cessation advisors or counsellors had been recruited, 25% (21/84) of co-ordinators reported difficulty retaining smoking cessation advisors in their posts.

Tables 5 and 6 show the previous work experience of advisors working for services run by smoking cessation co-ordinators who responded to the survey. It is clear that few (around 13%) smoking cessation services have been unable to employ advisors or counsellors with previous experience of working in this field. Around 77% of co-ordinators, however, reported that many or all of their staff had previous clinical experience (i.e. they had worked with patients or clients before). This leaves 1 in 5 smoking cessation services who reported employing smoking cessation advisors or counsellors with no previous experience in this or any other clinical field.

Table 3 **Reported ease/difficulty finding good quality training courses for smoking cessation advisors/counsellors**

Level of difficulty	**% (Number) of co-ordinators**
Very easy	19.0 (16)
Fairly easy	41.7 (35)
Neither easy nor difficult	20.2 (17)
Fairly difficult	11.9 (10)
Very difficult	7.1 (6)
Total	84

Table 4 **Reported ease/difficulty recruiting smoking cessation advisors or counsellors**

Level of difficulty in recruitment	**% (number) of co-ordinators**
Very easy	4.8 (4)
Fairly easy	45.2 (44.7)
Neither easy nor difficult	21.4 (18)
Fairly difficult	25.0 (21)
Very difficult	3.6 (3)
Total	(84)

Table 5 **Smoking cessation advisors: numbers working for each service with previous experience as smoking cessation advisors**

Amount of smoking cessation co-ordinators with previous smoking cessation experience	**% (Number) of co-ordinators**
All	7.3 (6)
Many	6.1 (5)
A few	31.7 (26)
Very few	20.7 (17)
None	32.9 (28)
Total	(82)

Table 6 **Smoking cessation advisors: numbers working for each service with previous clinical experience**

Amount of smoking cessation co-ordinators with clinical experience	**% (Number) of co-ordinators**
All	51.2 (42)
Many	26.8 (22)
A few	20.2 (17)
Very few	18.3 (15)
None	1.2 (1)
Total	(82)

4.4 Smoking cessation services: structure and accommodation

Smoking cessation services had been treating smokers for between 1 and 72 months with a mean (SD) number of months treating smokers of 13.7 (11.3) and 75% of smoking cessation services had been treating smokers for 17 months or less (data missing for 6 co-ordinators). 74.1% (63/84) of smoking cessation co-ordinators reported that no smoking cessation service had existed in their health authorities prior to the publication of the *Smoking Kills* white paper. The 21 co-ordinators working in health authorities where smoking cessation services had existed prior to *Smoking Kills* all reported that their current smoking cessation services where developed from these. Satellite or outreach bases shared between smoking cessation services and other organisations were the most frequently-reported accommodation type, with 77.6% (66/85) of co-ordinators using this kind of accommodation to deliver smoking cessation interventions. A minority [34% (29/85)] of smoking cessation co-ordinators reported working for a service that possessed a central base shared between themselves and other organisations. Only 9.4% (8/85) of co-ordinators reported working within a service that had a central base used *exclusively* or *almost exclusively* by their smoking cessation service. Fewer still however, [3.5% (3/85)] reported working in smoking cessation services that had satellite or out reach bases which were used exclusively or almost exclusively by the smoking cessation service. Finding suitable accommodation for smoking cessation services was not an easy experience for all smoking cessation co-ordinators. 46.3% (38/82) reported this task as *fairly or very difficult* with 53.7% (44/82) reporting this task as, at worst, *neither easy nor difficult.* Co-ordinators reported the following kinds of venues were used by smoking cessation advisors/councillors to deliver smoking cessation interventions: general practices 88.2% (75/85), NHS hospital premises 76.5% (65/85), Other NHS primary care premises 65.9% (56/85), local authority or voluntary organisation premises 64.7% (55/85), pharmacies 54.1% (46/85) and commercial or rented premises 50.6% (43/85).

4.5 Smoking cessation services: interventions offered

Table 7 indicates the range of smoking cessation interventions delivered in smoking cessation services. The vast majority of services offered individual and group counselling. Where services offered group sessions, these varied between 50 and 120 minutes, with a mean (SD) length of 75 (20) minutes [data missing for 10 services]. Half of the services reported group sessions lasting between 60 and 90 minutes.

The number of group sessions that constituted a complete course of treatment varied from 3 to 8 across smoking cessation services [data missing for 10 services]. Most services, however, reported 7 group sessions as a complete course and half of respondents reported that 6 or 7 sessions represented a complete course. The number of patients attending each group session varied between 4 and 35 across smoking cessation services, with a mean (SD) of 18 (6) patients attending groups. Three quarters of services reported 20 or less patients attending group sessions. Where smoking cessation co-ordinators reported that their service offered individual sessions to smokers, these varied in length between 10 and 60 minutes, having a mean (SD) length of 28 (12) minutes [data missing for 6 services]. Three quarters of services reported individual sessions lasting 35 minutes or less. The number of individual smoking cessation counselling sessions constituting a complete course of treatment varied between 2 and 8 across services, with 6 sessions reported most frequently.

Smoking cessation co-ordinators were asked to estimate roughly what percentage of patients attending their service received individual or group support. They reported that the proportion of patients receiving group support in their smoking cessation services varied from 0 to 100%, with a mean (SD) value of 52% (32) [data missing for 7 services].

One quarter of services were reported to be giving group support to 80% or more of service attendees. Similar figures were obtained for individual support: co-ordinators reported the percentage of people receiving individual support varied between none and 100%, with a mean (SD) percentage of 49% (32) [data missing for 7 services]. Again one quarter of services reported that 80% or more of service attendees received individual support.

4.6 Smoking cessation services: referral procedures

Self referrals (i.e. made by smokers themselves) were accepted by 96.5% (83/86) of smoking cessation services, with 7.1% (6/85) of services accepting referrals from those aged 16 years or under. Smoking cessation services were reported to have agreed referral procedures with the following groups of health professionals: general practitioners 89.7% (87/88), pharmacists 72.7% (64/88), community midwifes 72.7% (64/88), health visitors 70.5% (66/88), hospital consultants 65.9% (58/88), dental services 39.8% (53/88). Another 34.7% (27/88) of smoking cessation services reported that referral procedures had been agreed with other groups of people. Table 8 summarizes the other referral arrangements reported by smoking cessation co-ordinators to have been made by their services.

4.7 Smoking cessation services: treatments for nicotine addiction

In 63.5% (54/85) of smoking cessation services, a protocol for dispensing or prescribing nicotine replacement therapy (NRT) had been agreed with local GP's. Co-ordinators reported that NRT could be dispensed to smokers who were eligible for free prescriptions for up to 7 weeks, with 75% of services giving 5 weeks or less free NRT to these smokers. 21.2% (18/85) of services also dispensed free NRT to smokers who were not eligible for free prescriptions. The number of weeks free NRT that could be dispensed to these smokers varied across smoking cessation services between 1 and 6 weeks.

Most commonly, however, services offered these smokers only 1 weeks free NRT, with three quarters of services reporting these smokers being eligible for 4 or less weeks free NRT.

82.7% (67/81) of co-ordinators reported that smoking cessation advisors working for their service might recommend bupropion to smokers. In all of these smoking cessation services, a protocol or agreement for dispensing/prescribing Bupropion had been agreed with local GP's.

4.8 Smoking cessation services: training provided

Smoking cessation services have a role training health professionals in smoking cessation methods. Co-ordinators reported that their services had trained the following groups of people: practice nurses 97% (85/88), pharmacists 92% (81/88), general practitioners 68% (59/87), hospital staff 88% (77/88), non-health professional NHS staff (e.g. receptionists) 52% (46/88) and private sector health professionals 48% (42/88).

Table 7 Smoking cessation interventions delivered in smoking cessation services

Intervention	Number of smoking cessation services delivering intervention %(n)
Individual advice / counselling	95.3 (81)
Group advice / counselling	94.1 (80)
Self-help materials (e.g. booklets or leaflets)	74.1 (63)
Telephone advice / counselling	60 (51)
Peer- led sessions (i.e. led by trained ex-smoker)	4.7 (4)
Self-directed sessions using computer software	5.8 (5)
Other interventions which have no evidence for effectiveness (e.g. aromatherapy, hypnosis)	5.8 (5)

There were 85 respondents for each question (i.e. data missing for 3)

Table 8 "Other" groups with whom referral procedures had been agreed

Group with whom referral procedures agreed	* Number of smoking cessation services reporting referral procedures agreed
Other named health professional groups (e.g. cardiac rehabilitation, district or respiratory nurses, physiotherapy, podiatry, mental health, occupational health, opticians, NHS direct)	20
Non-health professional workers (e.g.. leisure officers, community groups & voluntary workers)	10
Schools	2
Workplaces	2
Prisons	1
Other (HA)	1

* Some services had greater than 1 "other" referral arrangement.

4.9 Smoking cessation services: anticipated capacity

Over half [58.0% (51/86)] of smoking cessation services were working at full capacity during the time of the survey. Of the 35 co-ordinators who reported that their service was not currently working at full capacity, 34 gave an estimate of when this was likely to occur. The mean number of months till full capacity was anticipated to be reached varied from 2 to 15 across smoking cessation services, with a mean (SD) of 5.85 (3.1) months. 75% of co-ordinators estimated that their service would be running at full capacity within the next 6 months. Smoking cessation co-ordinators also estimated the number of smokers that would be treated by their services each year when operating at full capacity. This varied between 226 and 5500 across smoking cessation services with a mean (SD) of 1999 (1242) patients anticipated at full capacity [data missing for 11 services]. Only one quarter of co-ordinators reported that their service was anticipated to run with more than 2600 patients when at full capacity.

4.10 Smoking cessation services: targeting priority groups

Not all smoking cessation services were reported by their co-ordinators to be trying to encourage particular groups of smokers (priority groups) to attend smoking cessation services, but the majority 90.9% (80/88) were doing so. The following sections indicate which priority groups were reported to be targeted most frequently and summarises the methods for targeting these groups of smokers.

4.10.1 *Pregnant women who smoke:* Of respondents who stated that their service did target certain priority groups 86.3% (69/80) said the service targeted pregnant women who smoke. Of these, 50.7% (35) rated pregnant women who smoke as the first priority, 33.5% (24/80) as the second priority, and 13.8% (11) as the third priority group.

Table 9 summarizes the methods used to target pregnant women who smoke. In many cases, a new post had been established to promote the service to smoking mothers, smoking mothers-to-be and the associated professional groups. Training midwives and health visitors was also seen as an important means of increasing referrals to the service.

4.10.2 *The economically disadvantaged:* 78.8% (63/80) of services targeted economically disadvantaged smokers. Of these, 46.0% (29/80) rated the economically disadvantaged as the first priority, 27.5% (22/80) as the second priority, and 16.3% (13/80) as the third priority group. Table 10 shows how the economically disadvantaged were targeted.

4.10.3 *People with smoking-related illnesses:* Of those respondents who stated that their service did target certain groups for smoking cessation, 42.5% (34/80) of co-ordinators indicated that their service targeted people with a smoking-related illness. Of these 17.6% (6/34) rated people with a smoking-related illness as the first priority, 32.4% (11) as the second priority, and 50% (17/24) as the third priority group. Table 11 shows the reported methods of attaching people with smoking related illnesses to services.

4.10.4 *Other priority groups:* Of respondents who stated that their service targeted specific groups, 21.3% (17) said the service targeted ethnic minorities as a priority group, and 20% (16) said they targeted young people as a priority group. Manual workers (6 services), people with learning disabilities (3 services) and prisoners (3) were also listed as priority groups that services attempted to attract.

Table 9 Methods reported for targeting pregnant women who smoke

Method used for targeting	Number of times reported by smoking cessation services
Appointment of specialist post	25
Training e.g. midwives, health visitors	21
Links with community services e.g. primary care, midwifery, health visitors	18
Links with hospital midwifery services	13
Links with existing community initiatives e.g. Sure Start, HAZ	6
Advertising and publicity	6
Delivering service in ante-natal clinic	4
Specialist programme or initiative established	4
Outreach service provided	4
Other e.g. needs assessment	4

Table 10 Methods reported for targeting the economically disadvantaged

Method used for targeting	Number of times reported by smoking cessation services
Clinic based in geographically-deprived area	30
Publicity and advertising e.g. in job centres, citizens advice centres	16
Free NRT to those eligible	11
Links with existing community initiatives e.g. Sure Start, Healthy Communities	11
Links with primary care professionals	6
Clinics in workplace setting	5
Peer-led education	4
Other e.g. community consultation	6

Table 11 Methods reported for targeting people with smoking-related illnesses

Method used for targeting	Number of times reported by smoking cessation services
Links with hospital specialists e.g. cardiac care	16
Links with primary care services	14
Advertising and publicity e.g. in hospitals, practices, pharmacies	5
Links with outpatient clinics	4
Clinics provided in hospital settings	3
Other e.g. specialist post established	4

4.11 Smoking cessation services: challenges in implementation

Almost half [48.8%(42/86)] of smoking cessation co-ordinators reported that it had been *difficult* or *very difficult* to set up a system for reporting monitoring data to the department of health. Table 12 gives details of the specific problems reported by smoking cessation co-ordinators. The vast majority of smoking cessation services 97.7% (86/88) reported making contact with either local primary care groups (PCGs) or primary care trusts (PCTs). Relationships with PCGs and PCTs were generally reported to be good and only 3.5% (3/85) of co-ordinators reported weak relationships with 61.2% (52/85) reporting these as *strong* or *very strong.*

Smoking cessation co-ordinators displayed some uncertainty when asked how they anticipated their smoking cessation service would change when commissioned by PCGs and/or PCTs. In response to this question, 26.2% (22/84) responded that they did not know, but 63.1% (53/84) thought that their service would either improve or not change.

4.12 Investigating of the role of Health Action Zones and previously existing smoking cessation services on service implementation.

Table 13 compares the implementation of smoking cessation services in Health Action Zones with those outside of Health Action Zones. This demonstrates no consistent differences in problems experienced between the two areas apart from greater reported difficulties setting up systems for reporting monitoring data to the department of health outside of health action zones. Table 14 makes the same comparison for health authorities where smoking cessation previously existed with those where they did not. It should be noted that where services previously existed co-ordinators were much more likely to have been involved in implementing the new smoking cessation services.

Table 12 Reported problems when collecting monitoring data for Department of Health

Problem	% (number) of co-ordinators reporting problem
Frequently changing data requirements from Department of Health (DH)	40.2 (35)
Difficulties obtaining monitoring forms with DH data from smoking cessation counsellors / advisors	35.6 (31)
Lack of database skills	34.5 (30)
Data required by DH too soon after service implementation	26.4 (23)
Inadequate administrative support	33.3 (29)
Lack of expertise in designing questionnaires for service attendees	10.3 (9)
Other*	24.1 (21)

87 respondents answered this question.

* Where co-ordinators explained "other" difficulties using free text, these merely re-stated categories on the questionnaire.

Table 13: Comparison of Health Action Zone (HAZ) and non-Health Action Zone smoking cessation services: difficulties in implementing services

	HAZ (n = 38) % (n)	Non-HAZ (n = 49) % (n)	P value by Chi-square
Co-ordinator involved in early stages of setting up service? Q15[a]			
Very / fairly	84 (32)	81 (39)	0.781
Not involved	16 (6)	19 (9)	
Missing values	(0)	(1)	
Difficulty recruiting smoking cessation advisors? Q23			
Not difficult	68 (26)	73 (35)	0.811
Fairly/very difficult	32 (12)	27 (13)	
Missing values	(0)	(1)	
Problems with staff retention? Q25			
No	26 (10)	23 (11)	0.802
Yes	74 (28)	77 (37)	
Missing values	(0)	(1)	
Difficulty finding accommodation for service? Q29			
Not difficult	45 (17)	55 (27)	0.659
Fairly/very difficult	55 (18)	45 (22)	
Missing values	(0)	(1)	
Difficulty setting up system for reporting monitoring data to DH? Q51			
Not difficult	37 (14)	61 (30)	0.030
Fairly/very difficult	63 (23)	39 (18)	
Missing values	(1)	(1)	
Changes to service with PCT commissioning? Q55			
No change/improve/ don't know	79 (30)	90(44)	0.167
Deteriorate	21 (6)	10 (3)	
Missing values	(2)	(2)	

[a] number of questionnaire item

Table 14: Comparison of smoking cessation services in health authorities where these previously existed with those where none existed prior to *Smoking Kills:* difficulties in implementing services

	Service existed previously (n = 23) % (n)	No previous service (n = 64) % (n)	P value by Chi-square
Co-ordinator involved in early stages of setting up service? Q15[a]			
Very / fairly	100 (23)	77 (49)	0.017
Not involved	0 (0)	23 (14)	
Missing values	(0)	(1)	
Difficulty recruiting smoking cessation advisors? Q23			
Not difficult	61 (14)	73 (47)	0.421
Fairly/very difficult	39 (8)	27 (17)	
Missing values	(1)	(0)	
Problems with staff retention? Q25			
No	82 (18)	73 (47)	0.569
Yes	18 (4)	27 (17)	
Missing values	(1)	(0)	
Difficulty finding accommodation for service? Q29			
Not difficult	35 (8)	55 (35)	0.138
Fairly/very difficult	65 (14)	45 (27)	
Missing values	(1)	(2)	
Difficulty setting up system for reporting monitoring data to DH? Q51			
Not difficult	48 (11)	52 (33)	0.808
Fairly/very difficult	52 (12)	48 (29)	
Missing values	(0)	(2)	
Changes to service with PCT commissioning? Q55			
No change/improve/ don't know	87 (20)	84 (54)	0.703
Deteriorate	13 (3)	16 (6)	
Missing values	(0)	(2)	

[a] number of questionnaire item

5. DISCUSSION

5.1 Principal findings

This survey provides a description of the new smoking cessation services implemented in England, with responses from the vast majority of English Health Authorities. Implementing these services has been a completely new venture for the NHS and the task is being conducted within a very short timetable. The following findings reflect these facts:

- Many smoking cessation co-ordinators have significant responsibilities other than setting up a new smoking cessation service.
- Large numbers of co-ordinators have no previous experience of running any type of clinical services for patients.
- A significant minority of services (30%) had difficulty recruiting smoking cessation advisors/counsellors and most services employ only a minority of counsellors with previous experience of clinical smoking cessation work.
- In the majority of smoking cessation services (64%), counsellors/advisors did have some previous clinical experience (i.e. working with patients), suggesting that health professionals from other disciplines were recruited for smoking cessation work.
- Nearly half of smoking cessation services had some difficulty finding accommodation and it is unusual for services to have their own dedicated premises.

Despite the short timescale for implementation of smoking cessation services, it is encouraging to note that:

- Nearly 60% of smoking cessation services were operating at full capacity.
- Services were providing primarily evidence-based interventions to smokers.
- Smoking cessation services reported good relationships with Primary Care Groups and Trusts.
- Referral procedures had been agreed with a wide variety of health professionals.
- There was evidence of appropriate engagement with other NHS service providers (e.g. discussing Bupropion prescribing arrangements with primary care).

Additionally, our findings provide evidence that policy statements are not being comprehensively transferred into practice. The *Smoking Kills*[2] white paper stated that young people should be a priority group whom smoking cessation services should attempt to attract, but most services did not report young people as a priority group. Many services, however, reported that people suffering from smoking related illnesses who were not identified as a priority by *Smoking Kills* were being targeted instead. Smoking Kills gave local services scope to identify people whom they believed should be priority groups and there appears to be some consensus across services that those with smoking related illness should be a priority group whilst young smokers are relatively less important to reach. The reasons why services do not prioritise young people are unclear, but confusion may have arisen because *Smoking Kills* specified that services should only be available to adult smokers.

Our analysis investigating whether implementation of services in HAZs differed from that in other health authorities suggested only that co-ordinators in non-HAZ areas experienced more difficulty setting up monitoring systems for DH data than those in HAZs[4]. Where smoking cessation services had existed before *Smoking Kills*, however, smoking cessation co-ordinators (who, presumably were working with existing smoking cessation services) were more likely to be involved at an early stage of service implementation.

5.2 Study methodology

Our response rates of 69% of those identified as smoking cessation co-ordinators and 83% of English health authorities are good for postal survey research. Nevertheless, we can say nothing about smoking cessation services set up in health authorities from which we did not receive responses. Also, interpretation of our survey findings are restricted by the limited information that is obtained from self-report postal questionnaires. Using this kind of data, it is difficult to fully explain study findings. It is also of note that we had some difficulties identifying all smoking cessation co-ordinators in England. At the outset of the study, there was no centrally-held register of smoking cessation co-ordinators and we were forced to take careful steps to identify these. It is possible (but unlikely) that some local smoking cessation co-ordinators were not known to regional smoking cessation leads. Even if this were the case, questionnaires were accompanied by specific instructions for them to be passed onto the person with responsibility for day-to-day management of smoking cessation services. It is likely that in any one health authority, this individual would have been easily identified, so questionnaires should have reached the vast majority of smoking cessation co-ordinators in England.

5.3 Further research

This survey reports part of an ongoing study investigating the implementation of smoking cessation services in the Trent NHS region which is funded by Trent NHS executive. It will be extended as part of the DH funded evaluation of smoking cessation services. The findings of this survey are currently being used to inform an analysis of monitoring data from smoking cessation services which is being conducted for the DH funded evaluation.

The next phase of this study is a qualitative investigation, which will involve interviewing smoking cessation co-ordinators and service staff throughout the Trent region. We hope to answer general questions about the implementation of smoking cessation services in England, but a number of more specific questions have been generated by this survey. Firstly, the next phase of the study needs to investigate the reasons why young people are not being identified as a priority group for smoking cessation services and the reasons for this need to be fed back to policy-makers. Secondly we need to investigate further, whether the existence of a previous smoking cessation service or a Health Action Zone in a Health Authority area influences smoking cessation service implementation. Thirdly, we need to investigate further how the long-term continuation of smoking cessation services is to be achieved once dedicated, ring-fenced funding is no longer available to them. The second phase of the study will address many other issues too and it will complement the findings of this survey to provide a clearer picture of the implementation of smoking cessation services, highlighting any lessons, which can be learnt from this process.

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APPENDIX

1. Advisory Board members

2. Covering letter and questionnaire

ADVISORY BOARD MEMBERS AND DETAILS

Catherine Adams	Research Officer, University of Glasgow
Dr Linda Bauld	Lecturer in Social Policy, University of Glasgow
Dr Tim Coleman	Senior Lecturer in General Practice, University of Nottingham
Professor Francine Cheater	Professor of Public Health Nursing, University of Leeds
Dr Catherine Exley	Lecturer in Social Policy, University of Leicester
Iain Harkess	Deputy Director of Leicester Health Action Zone and Director of Health Promotion, Leicestershire Health Authority
Rae Magowan	Trent Regional Smoking Cessation Lead, Trent NHS Executive, Sheffield
Dr Ann McNeill	Freelance Researcher
Elspeth Pound	Research Associate, University of Leicester
Dr Martin Raw	Freelance Researcher, Honorary Senior Lecturer in Public Health, King's College, University of London
Penny Spice	Smoking Cessation Co-ordinator, New Leaf, Smoking Cessation Service, Nottingham

TJC/MJW/243

20th April, 2001

«Name»
«Organisation»
«Building»
«Street»
«Town» «Postcode»

Dear «Name»,

We are members of a research team which has been commissioned to conduct an evaluation of smoking cessation services by the Department of Health. Initially, we are surveying all smoking cessation co-ordinators in England and we would greatly appreciate your help with this. The enclosed questionnaire should take no more than 30 minutes to complete, including the time taken to gather information from other people.
The table below indicates who should complete the questionnaire. We would be grateful if you could take the time to complete this task or, if appropriate, pass on the questionnaire to the appropriate person.

Yellow Questionnaire	To be completed by the person responsible for day-to-day management of smoking cessation services in your health authority.

Thank you very much for taking the time to consider this request. We hope that you can find the time to help us because it is important that your views are reported to the Department of Health.

All information given on the questionnaire is confidential. Project reports will not link individuals with their responses.

Yours sincerely,

Dr. Tim Coleman
Senior Lecturer
Tel: 0116 258 4622

Elspeth Pound
Research Associate
Tel: 0116 258 4351

Enc. Questionnaire
Business reply envelope

Printed version will have a copy of questionnaire here