

*Smoking Cessation Services:  
Early Experiences from Health Action Zones*

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## Introduction

The December 1998 White Paper, *Smoking Kills*, put forward a wide range of measures on smoking and health. A central component of the reforms is the provision of new monies to develop smoking cessation services across the country. In the first year of implementation, the new resources have been limited to health authorities within Health Action Zones, as part of the government's strategy to target disadvantaged communities where smoking prevalence is particularly high. Along with introducing a monitoring system for the new services in HAZs, the Department of Health has commissioned a one year study which aims to look at a range of strategic issues relating to service development. This report presents findings from the first five months of this study.

In October 1999 we submitted an initial analysis of HAZ smoking cessation plans and commentaries to the Department of Health. Based on this summary, we agreed a range of research questions with colleagues in the Tobacco Policy Unit. This interim report begins to address some of these questions and examines the following themes:

- Context
- Getting started
- Training and development
- Key issues
- Assessing impact
- Interim Conclusions

Our work thus far has aimed to provide a picture of the early development of smoking cessation services across Health Action Zones. In many instances, our findings pose more questions than they answer. However, we hope that by capturing some of the key issues at this preliminary stage in the life of the new services, we can begin to identify questions for the next stage of our study, and indeed highlight a number of issues that need to be considered as the new services are rolled out to all health authorities this spring.

## Methods

This interim report draws on information from three main sources:

- semi-structured interviews with smoking cessation co-ordinators;
- first and second quarter monitoring returns submitted by HAZs to the Department of Health (DH); and
- written plans and commentaries which accompanied those monitoring returns.

Interviews were conducted in all 26 Health Action Zones between early November 1999 and mid January 2000. In all but five HAZs, the individual interviewed was the smoking cessation co-ordinator. The five exceptions were primarily due to the fact that the co-ordinator had only been in post for a few weeks and it was felt that, in order to obtain the necessary information, it would be preferable to conduct the interview with someone who had been involved in planning and implementing the new services. Thus, in two instances the interviewee was an assistant director within the health authority. In another HAZ a co-ordinator had not been appointed, and in an another co-ordination activities had been divided up between existing staff. In both these

cases we interviewed managers in the health promotion department who were leading on smoking cessation. In a final case, the interview was conducted with the co-ordinator plus a manager/director within the health authority, again in order to obtain a more complete picture of the development of services to date. All the interviews were tape-recorded and transcribed, and analysed thematically by two members of the research team. This report draws heavily on the interview material and uses a range of quotations from the transcripts. Naturally none of the interviewees, or their respective HAZs, are identified in conjunction with the quotations.

As outlined in our original research brief, we are using the monitoring returns primarily as a source of contextual material which informs our analysis of the interviews and written commentaries. Thus, we have entered first and second wave monitoring data onto Excel spreadsheets in order to get a broad sense of which HAZs have smokers setting quit rates in the first months of the service, and what each HAZs' staffing and budgetary arrangements are. We have not undertaken any detailed analysis of the monitoring returns as we are aware that this is being conducted by the Department of Health. However, during our visits to HAZs we made a concerted effort to obtain verbal or written information about *additional* monitoring data that HAZs were intending to collect. This will allow us to comment on the capacity for future, more detailed evaluation at the local level, in order to assess the new services against criteria not included in the minimum data set required by the DH.

When we submitted our first report in October 1999 we outlined the variable and often poor quality of HAZ smoking cessation strategy documents. At that time, just half of HAZs had submitted a detailed action plan for the year. Since then, considerably more material has been produced, and all but one HAZ has produced at least a brief plan and summary of their service structure and objectives.<sup>1</sup> The majority of these new documents were submitted along with the second quarter monitoring return. We entered all the relevant information from this new material into the Access Database which we have been developing since September. The structure of the database is now complete. We are committed to its ongoing development and will continue to enter material from commentaries and plans submitted each quarter. The database is already proving to be a useful tool for comparing and contrasting interventions across HAZs.

## Context

It is clear from the research we have conducted over the past few months that the new services established as a result of *Smoking Kills* are beginning from very different starting points. The fact that they are being developed within Health Action Zones means they are located in varied communities. While all HAZs share problems of deprivation, poor health and high smoking rates, they vary considerably in terms of size, organisational complexity and population profile (Bauld and Judge, 1998, Judge et al, 1999). HAZ communities range from parts of inner London to rural Northumberland. Some HAZs consist of co-terminous health and local authorities, others encompass just part of a larger health authority and several include multiple health and local authorities. In population terms, some HAZs have sizeable ethnic minority communities while others have more homogeneous populations. The differences between HAZs have important implications for the way in which the new monies for smoking cessation have been used, both in terms of service planning and implementation. One model of provision is not

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<sup>1</sup> A further plan had not been received at the time of this report, but we understood it had been produced and were waiting to receive it.

suitable to all HAZs. Findings from our review of plans, monitoring returns and our interviews with smoking cessation co-ordinators all emphasise how understanding the context in which services are being developed is crucial when attempting to assess the effectiveness, efficiency and sustainability of services.

## Pre-White Paper Services

Pre-existing services constitute one of the most important contextual conditions in HAZs. Prior to the publication of the white paper, health authorities and health professionals were already providing a range of smoking cessation services in some communities. In others however, there was little or no smoking cessation activity. These varied starting points have clearly had an impact on new patterns of provision, and the speed with which HAZs have been able to get services up and running.

With respect to pre-white paper services, HAZs appear to fall into three main categories. In a number of HAZs, there was no pre-existing provision beyond opportunistic advice offered by health professionals. In others, some smoking cessation activity was taking place, usually provided by health professionals who had received some training in running groups or providing one-to-one interventions, or in some cases through existing stop-smoking community groups. A third group of HAZs had more well-developed and long standing smoking cessation services, and were able to build on existing provision and learn from previous experiences.

Those HAZs that reported little or no smoking cessation activity prior to the new monies being available were in most cases either those with large rural areas or small HAZs in urban areas without extensive secondary care services. A smoking cessation co-ordinator in one of these areas described the absence of pre-existing provision:

*There wasn't a lot out there really. There's one service that is in X in clinical psychology that had been going for a few years. That was the only thing I am aware of...people did the normal opportunistic smoking cessation work but as for a smoking service, there has not been one.*

Developing new smoking cessation services in HAZs with no pre-existing provision has clearly been a challenge for those involved in planning and implementing services. Although pharmacists, GPs, practice nurses and others in these communities had been providing brief advice and agencies had been engaged in implementing a broader tobacco strategy, there was little or no local expertise to build on in terms of setting up specialist services. The smoking cessation co-ordinators we interviewed in these areas clearly felt they had been disadvantaged due to this lack of local experience and found the tight time scale for service development particularly difficult. As another interviewee commented:

*...there wasn't any service as such, so this has been completely built from scratch, which has been one of the bugbears of the system really because we haven't got anything to build on.*

In another group of HAZs, there was evidence of some smoking cessation services prior to the publication of the white paper. The type and extent of existing services varied considerably

however. In most cases, HAZs with moderate levels of existing provision had discrete projects with time-limited funding. As one co-ordinator told us:

*There didn't seem to be a huge amount, there is a smoking in pregnancy project and one of their colleagues would go out and train midwives and health visitors....I think there was [also] some piece meal work going on with different practice nurses, we do our bits and pieces in GP surgeries but there was no sort of actual strategy.*

The benefit of even limited existing provision is that the HAZs with these projects already had a number of professionals trained in smoking cessation interventions before the new monies were made available. This meant that there was a skill base to build upon, particularly in the development of intermediate interventions. As a co-ordinator in a Northern and Yorkshire region HAZ reported:

*We have for a number of years run smoking cessation training for practice nurses, health visitors, for school nurses, for occupation health nurses and in one case for groups of school teachers and youth workers... We've had a track record of running in primary care and in work places, smoking cessation support services, the traditional smoking cessation groups as it were.*

A significant number of HAZs had some smoking cessation services located in both the community and secondary care settings before *Smoking Kills* resources became available. These HAZs were Merseyside, Manchester, Salford and Trafford, the London HAZs and HAZs located within the West Midlands NHSE region. In Merseyside and Manchester, there was no HAZ-wide smoking cessation strategy, but there were existing hospital clinics and some projects in primary care. In addition, Merseyside is home to the a small community group funded by the Roy Castle foundation called Fagends. The early work done by this group has provided a launching pad for new services through a telephone self-referral system. In the London HAZs, access to specialist clinics such as the Maudsley was possible, and there were a number of existing community-based interventions. As one London co-ordinator told us:

*Prior to the changes under the White Paper, we're lucky that in [our HAZ] we did have quite a history of smoking work. There was...a lot of stuff based in Primary Care, and the support ranged from co-training to providing resources, so there was smoking cessation as part of that as well as wider smoking work.*

In the West Midlands, an early commitment from the mid 1990s onwards to tackling smoking led by the regional office resulted in a fairly cohesive package of interventions across the region, which provided the three HAZs in the area with a firm foundation upon which to build. This strategy involved specialist clinics in secondary care in some hospitals in the region, combined with a programme of subsidised NRT, which the health authorities funded with recurring monies. A health promotion manager in the region described the set-up in his locality:

*We have had a smoking cessation co-ordinator in S since December 1995. This was the result of West Midlands regional funding money...It started really as a hospital based service with the key targets being referrals from Consultants...they were also taking referrals from GPs, specifically for pregnant women..Also self-referrals as well before the new money came in. We [also] already had a PC pilot with the practice nurses and a few practices.*

## Effect of existing services on new arrangements

The pattern of pre-existing provision in Health Action Zones has had a clear impact on the way health authorities and their partner agencies have decided to establish their new smoking cessation services. In most cases, existing services have had a positive influence on the new structures. The only negative effects reported appear to be around previous interventions which were perceived as ineffective (such as smoking cessation support groups in primary care which had formed and then disbanded with few successful quitters) and therefore may have undermined the willingness of some health professionals to become involved in smoking cessation.

The clearest positive effect of pre-existing services was the advantage of being able to build on existing success:

*We looked at what was working and could we build on and make those services fit in, rather than end up with going for a totally blank sheet and duplication and funding a whole new service in the middle of the city. We looked at all the costings and it just made more sense to use what was here and build more into it.*

A second key advantage was the availability and willingness of trained staff to become involved in new services. In many areas, this meant there was an existing group of core professionals who had contact with those in the health authority who were setting up the new services. This core of supportive practitioners were able to continue their work under the new smoking cessation programme, with the benefit of access to additional training and resources. A third advantage associated with pre-existing services was described as the opportunity to learn from previous projects which had piloted various approaches to smoking cessation in the area. As one co-ordinator reported:

*We'd piloted work with pharmacists before the White Paper came out, which was a great advantage when it came to looking at the initiatives because the pilot was showing that the work with pharmacists was coming out very successful – good uptake of the service and also quit rates were good.*

Thus, building on existing services, drawing on a pool of committed professionals and learning from previous projects were advantages shared by those HAZs who had a history of smoking cessation work within their communities. In some cases, existing provision appears to have provided a 'head start' in the development of new services. The evidence-base and guidelines associated with the new monies also encouraged those HAZs with pre-existing services to review their current practices and re-evaluate and restructure their activities along new lines:

*What Smoking Kills has done in my view is told us to step back, and reflect on our current practice against existing evidence....people were always interested in coming on courses, but it's actually then, when they go back to their own workplaces, it's actually doing something about it. Quite often people would come back and say 'oh, I haven't had time to do any smoking cessation or I tried to set up a group and everybody dropped out'...but I think [the reforms] has given us just a little bit of extra evidence to be able to say to people, look, this will work, we're taking it further, like we are developing an infrastructure and a referral pathway, it's going to be more structured.*

The majority of smoking cessation co-ordinators we spoke to were convinced that the new services provided ‘added value’ to any existing provision. Professionals and organisations who had in some cases been struggling to continue to provide a dedicated cessation service or maintain varied sources of funding now had their contribution reaffirmed and resourced by a more co-ordinated approach to tackling smoking. Despite some of the complexities and barriers to progress in which we shall raise later in this report, it was evident from our interviews that there is huge enthusiasm for the reforms amongst those planning and delivering services. The new monies have encouraged the continuation of existing good practice and acted a catalyst to encourage new activity.

## Getting Started

As with the development of any new service, a range of initial activities have been undertaken by Health Action Zones to begin to establish the infrastructure necessary to deliver smoking cessation interventions. The first and perhaps most important of these is establishing *staffing arrangements*. Negotiation with agencies outside the health authority through *partnership working* has also taken place; and finally efforts have been made to *publicise and launch* the service.

### Staffing

The guidance issued to health authorities in April 1999, following the publication of the White Paper, asked HAZs to ‘consider identifying key staff for the specialist smoking cessation service and aim to provide a service from June 1999.’ (HSC 1999/087). The expectation was that dedicated smoking cessation staff would be appointed to run the services, with accompanying administrative support. The key appointment would be that of smoking cessation co-ordinator; an individual who would organise, manage and implement the new services.

Staffing the new services has proved far from straightforward for most HAZs. Only a tiny minority had any new staff in post by June, and it is clear now (in February 2000) that a number of specialist staff and some support staff are still not in post. The inability of health authorities to get staff in place quickly has been a major factor in the slow development of services.

Two issues are of primary interest in relation to staffing at this early stage in the life of the new services. The first is the variety of staffing arrangements being established by HAZs, which reflect their local service needs and other factors such as population size and the nature of the communities served. The second staffing issue involves the delays experienced in putting staff in post, the cause of these delays, and some of the alternatives HAZs have explored to overcome the recruitment problems they have encountered.

### *Staffing Structure*

Health authorities within HAZs have used smoking cessation funds to recruit, redeploy and pay a variety of staff to deliver the new services. There is considerable variation between the HAZs both in terms of the number and backgrounds of staff. Some of this variation is apparent from

the monitoring returns submitted to the DH, in which HAZs are asked to list the number of posts funded by the new monies and identify whether they are co-ordinators, trainers, nurses, psychologists, other counsellors or administrative staff. What we found from our interviews, however, was that there are a number of additional staff, either from existing smoking cessation services or part-funded in other health authority posts, who are directly supporting and contributing to the management and delivery of the new services. In addition, some HAZs are paying intermediate advisers directly to deliver the new service, while others are training these advisers but not using the new monies to directly pay for their time when recruiting and treating smokers. Because of these variations, it is difficult to describe 'typical' staffing arrangements for the new services.

Despite this variation, however, it is possible to outline some common elements in relation to staffing. As of February 2000, all HAZs had the equivalent of a smoking cessation co-ordinator in post<sup>2</sup>. In some HAZs, this was a job share or a post divided between two seconded individuals who combine it with other activities within the health authority. Co-ordinators were in most cases responsible for organising and implementing the service and developing and running training sessions for intermediate advisers. In some HAZs, co-ordinators were also responsible for collecting monitoring information and writing commentaries for the Department of Health, whereas in other areas these tasks were done by more senior managers within the health promotion departments of the health authority. The vast majority of smoking cessation co-ordinators have a health promotion background, and many have had experience of delivering or organising prevention or cessation services in the past.

The co-ordinators are supported by a range of other smoking cessation staff. In smaller HAZs, this commonly consists of an administrator and one or two smoking cessation advisers who run the specialist clinics and often offer training to health professionals interested in becoming intermediate advisers. As one co-ordinator told us:

*There are two full time smoking cessation advisers. One of them came into post in September, so she is up and running, seeing clients now and everything. The other one came into post just two weeks ago, so she is not yet seeing clients... there is also an office manager and there is a part-time admin person...so really 5 people, including me.*

Other HAZs have chosen to arrange the new services in conjunction with primary care groups, and thus the co-ordinator and usually an administrator are supported by a named adviser for one or more of each of the PCGS in the area. In larger Health Action Zones, the staffing arrangements are more varied. Some HAZs have recruited one or more smoking cessation specialist or clinic managers, usually individuals with a counselling or psychology background, who are responsible for training and for delivering a number of the specialist clinics or group sessions in the area. In urban HAZs this specialist adviser may be hospital based, or at least provide a service in secondary care some of the time. Other advisers – again often with counselling and in a minority of cases, nursing backgrounds - have been recruited by HAZs to work in a variety of health care settings. In one northern HAZ, for example, two advisers were in post; one had a background running stop smoking groups in a voluntary capacity, while the other had previously worked for a stroke association as a counsellor. Again in larger HAZs, efforts have been made or are currently being made to recruit midwives to act as advisers within

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<sup>2</sup> The one exception to this is Sheffield, who attempted to recruit a co-ordinator but encountered a range of difficulties. As a result, they have chosen to devolve the tasks of co-ordinator to two health promotion managers within the health authority, supported by a smoking cessation lead for each PCG in the HAZ.

the new services (in order to target pregnant women who smoke), but progress has been slow in bringing these staff on board.

### *Staffing Delays*

Delays in recruiting staff for the new services is one experience that all HAZs share. While hiring clinic managers and smoking cessation advisers has been difficult and in some cases is still not complete, findings from our interviews focussed largely on delays in recruiting smoking cessation co-ordinators themselves. In some HAZs, these posts were advertised up to three times before an appointment was made. In other HAZs, early efforts at recruitment were abandoned in favour of secondment arrangements. A few HAZs did manage to have a co-ordinator in post by late June or July, but these were largely recruited from within health authorities with well-developed smoking prevention or cessation programmes. The timing of HAZ smoking cessation co-ordinator appointments therefore ranged from June to December 1999.

When asked to explain the delays in these appointments, the co-ordinators identified a range of contributing factors. In areas where there was little or no established smoking cessation work, developing a strategy and plan for the new services had delayed the process of recruitment. This was particularly the case in areas that had committed themselves to consultation about the shape of new services; waiting for PCGs or even HAZ partnership boards to approve consultation documents had taken time. Other HAZs were not as concerned with strategy development and attempted to advertise the co-ordinator's post as soon as possible, but found themselves hampered by the nature of the post advertised and competition for people with similar skills across the country. Limited applicants were clearly more of a problem in some regions than others:

*There were some difficulties in the first place in appointing the managers because everybody was looking for the same sort of person at the same time within Trent, within the space of about a month, there were 5 adverts, so the competition was stiff and so they failed to recruit first time round.*

Due to the nature of the funding provided for smoking cessation and the provision of future funds being dependent upon satisfactory performance, co-ordinators are appointed on short term contracts. This limited the attraction of the post for some qualified candidates and contributed to recruitment difficulties. As a result, a number of health authorities have committed themselves to funding the post or its equivalent for a longer period, commonly two or three years. As one manager within a health authority told us:

*You can imagine if you are trying to recruit someone into a 6 months job, pending a review of effectiveness, and you don't even know whether you will get the service and the patients through it, that's a problem. And we asked for more clarity about how long we could recruit people for. But I think inevitably that has resulted in the region and district's risk taking, because we have recruited our service manager up to March 2002.*

Some HAZs circumvented recruitment difficulties by deciding, from the beginning, that the co-ordinator's post would be filled by someone on secondment from another part of the health authority or a partner agency. HAZs in Northern and Yorkshire region particularly appear to have decided on this particular course of action. Other HAZs turned to secondment when open recruitment failed to deliver after one or two rounds of advertising. Finally, a small group of

HAZs have filled the smoking cessation co-ordinator post by redistributing the workloads of existing staff, as one co-ordinator described:

*So, we came to an agreement – I came to an agreement with our Associate Director here – to amend various people’s workloads here – put things on hold basically – and to move some of the work to other people in the Directorate. So that there was myself and two programmes leaders who, as part of our responsibilities, have taken on quite a lot of the management of the service this first year.*

The challenges HAZs have faced in finding and retaining qualified staff to fill key smoking cessation posts need to be overcome if other health authorities are going to be able to develop effective services within the first year of rolled-out funding. Because many services will have to be built from the bottom up and will rely on inter-agency co-operation to be successful, all health authorities will require staff with a co-ordinating function. There is clearly a role for the Department of Health through the regional offices in assisting year 2 health authorities to facilitate the recruitment or secondment process, if early progress is to be made.

## Partnership Working

The smoking cessation guidance makes it clear that health authorities, with their PCGs, should develop local strategies for smoking cessation services in partnership with local authorities and other agencies. In reality, very few health authorities within HAZs were able to consult widely with other agencies while developing their plans and some have managed to launch their service with little or no involvement from PCGs in the area. The biggest barrier to interagency planning was the time frame for developing the new services, as one co-ordinator explained:

*I suppose whilst we clearly delivered it within time, we had to work very quickly in order to do that and I think we shortened a lot of the discussions that we might otherwise have had ... PCGs they've not been as involved in the strategy development as one would want .*

Timing was a problem both in terms of the need to get the smoking cessation service up and running quickly and due to the early stage of PCG development. When *Smoking Kills* was published, PCGs were just beginning to be formed and since then have had to deal with a multiplicity of issues at the local level, of which smoking cessation was only one. The process of PCG formation has also meant that there is considerable variation between PCGs in individual HAZs, in terms of their capacity to engage in partnership working and their views about how and where smoking cessation services should be developed. Some PCG members, particularly GPs, have disagreed with the way in which the new monies for smoking cessation have been allocated and this may have affected their willingness to become involved. A number of co-ordinators told us that one or more PCGs in their area were proving difficult to work with, while others were very supportive. This variation between PCGs may continue to cause difficulty, particularly in multiple health authority Health Action Zones, as one co-ordinator explained:

*I think we are going to have the biggest challenge from the PCGs because we are dealing with - we know that we want to have more community based services - the PCGs have to own those services and we are dealing with maybe eight different*

*points of view. So from a strategic point of view trying to get consistency - if it was difficult even within 2 HAs, we have got to try really to get a consistent approach among the PCGs.*

In terms of broader interagency working in the planning and delivery of new services, a small number of HAZs benefited from inter-agency steering groups to plan the new services. Most of the health authorities within Health Action Zones (despite the multi-agency focus of HAZs themselves) did not engage in early consultation and were instead attempting to build links with other organisations after specialist staff were in post and after a basic service had been launched. Building links with education, community groups and social services was something smoking cessation co-ordinators were beginning to do when we interviewed them at the end of 1999 and early in 2000. As one co-ordinator indicated:

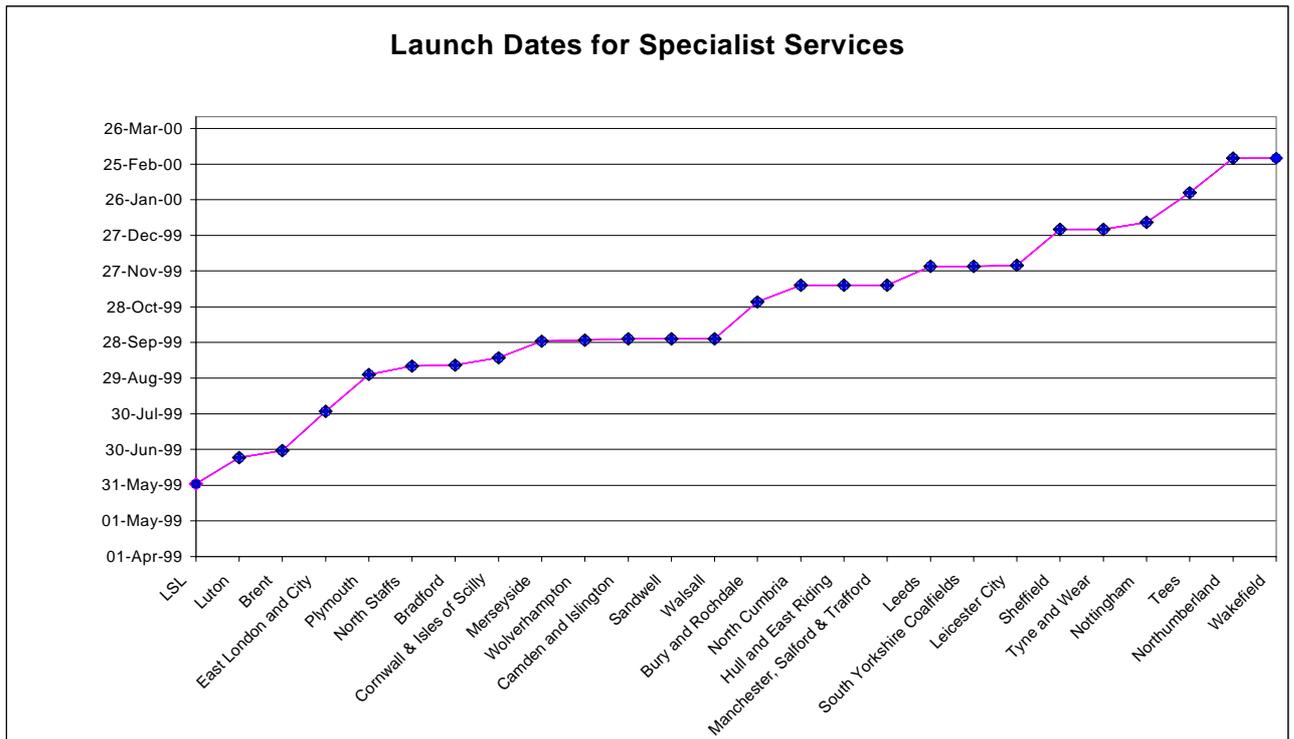
*I would also like to highlight our intention to tap into a lot of the other initiatives that are going on. And I think those often are the most successful and the most sustainable when they can be drawn into existing initiatives. So for example, contact with our healthy living centres adviser, and wanting to link in to say, things like sure start and new deal as there are an awful lot of things happening in [our area].*

It is worth highlighting one final form of partnership working which has taken place across a number of HAZs in relation to smoking cessation. This concerns alliances between HAZs within the same region. A number of HAZ have joined forces on this basis to deal with the more challenging aspects of implementing the new services, such as purchasing NRT and setting up the voucher system (a point we return to below), establishing monitoring systems and piloting particular aspects of the new services. This type of partnership has varied from important informal support between smoking cessation co-ordinators new in post to active co-ordination of efforts. Where formal co-ordination has taken place, the regional office smoking cessation leads have had a clear leadership role to play. Some regions have been more active than others in facilitating co-ordination, with the West Midlands emerging as one area in which there are a number of clear examples of the benefits of adopting joint approaches to the development of new services. One of the co-ordinators from this region described the importance of this type of support from her perspective:

*One of the things that has been very helpful for somebody like me who is doing it alongside other things, is working with colleagues from other areas, ... particularly the ones from the West Midlands. That sort of sharing and co-operation I have really appreciated. I think you know, we had a number of years in the NHS when that was not the culture and it is very refreshing to have it back again. It is not just about making life easy for me but it is also good to be able to show what you have done with other people.*

## Launch Dates

Due to delays and a range of other factors, smoking cessation services in HAZs have been launched at different times. In most cases, launching the service involved investing in publicity and attempting to inform professionals and smokers about the service, often culminating in a public launch event. Figure 1 illustrates when each HAZ launched their specialist services.



**Figure 1**

As Figure 1 shows, Lambeth, Lewisham and Southwark were the first to launch their specialist service on 1<sup>st</sup> June 1999, whereas Northumberland and Wakefield have not yet had a formal launch and indeed will not have their service up and running in all areas of the HAZ until 1 March 2000. There are a number of reasons for these variations. Some HAZs stated in the interviews that they had aimed to build a firm foundation for services, which often involved running the service in pilot form before formally launching it. This seemed to be particularly true of some of the HAZs in the Trent and Northern and Yorkshire Regions where few previous services were in place. The Regional executives in these HAZs seem to have supported them in their decision to postpone the launch of services. However in other Regions, greater pressure was put on HAZs to implement the new service quickly, and to demonstrate early successes.

Not surprisingly, another factor influencing launch dates appears to be the presence of pre-White paper services. This might explain why the London-based HAZs all had comparatively early launch dates, as they all had some form of pre-existing smoking cessation services. Others such as Sheffield and Nottingham stated in the interviews that they were setting up the service from scratch, and this would explain why their launch dates are later. Finally, some HAZs had placed greater focus on implementing intermediate services and this is reflected in later launch dates for the specialist service.

## Publicity

HAZs have allocated a certain proportion of their smoking cessation budget to publicity and advertising for the service. However, there are interesting variations in the amounts allocated for this purpose.

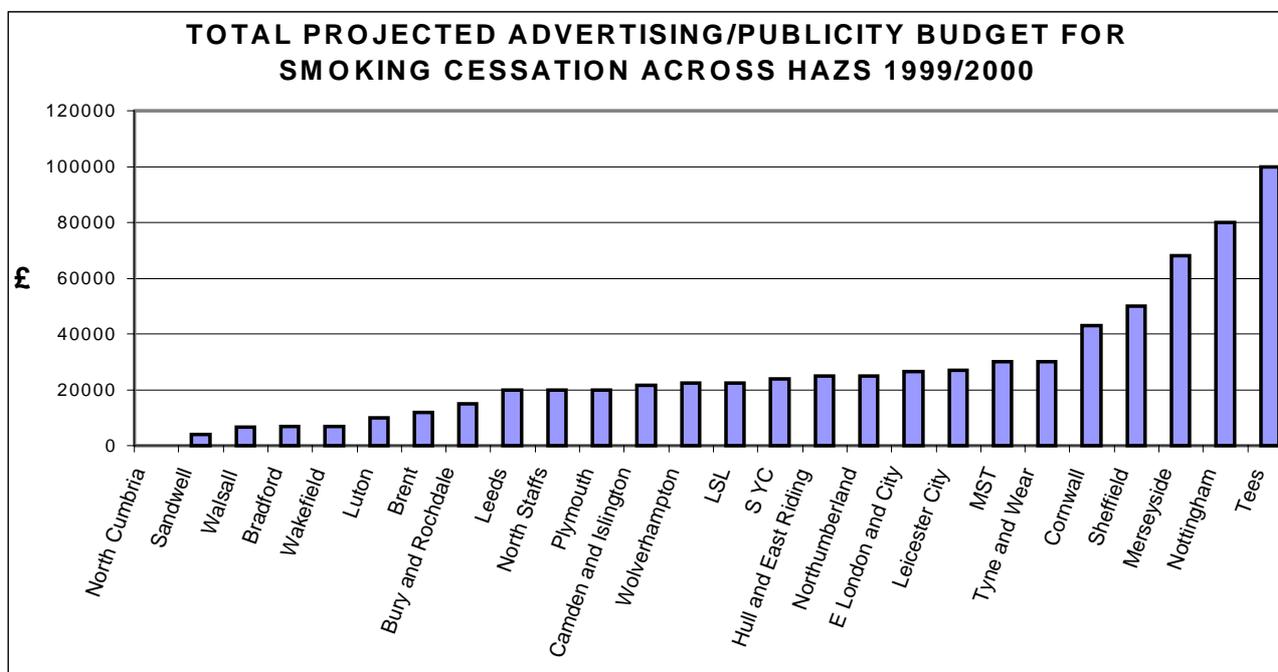


Figure 2

**NB.** North Cumbria had not calculated a projected budget for 1999/2000. However, they are still intending to allocate funds for this purpose.

As Figure 2 illustrates, Tees have allocated the largest proportion of their budget to advertising (£100,000), whereas Sandwell had only allocated £4,000. There appears to be no correlation between publicity budget and population size. HAZs such as Merseyside would be expected to spend a greater amount of their budget on publicity as they have a wider area covering a number of health authorities to address. However, Tees which allocated the largest amount covers a far smaller population area. This suggests that different HAZs give different priorities to advertising their smoking cessation services.

HAZs were using their advertising budgets in a variety of ways. A number of HAZs supplied details of these services in their plans and monitoring returns. The most commonly mentioned approaches were to advertise in local newspapers, on local radio/television and in cinemas. In addition, the majority had produced leaflets and posters for publicity displays and events in a variety of public places. A number had also set up telephone helplines, and one (Cornwall) had set up an internet site. Walsall, Sandwell and Wolverhampton had jointly organised a Black Country advertising scheme in which local buses would be used to advertise services. These would run from 1/12/00 to 31/3/2000 to cover New Year and No Smoking Day.

It was clear that some HAZs had developed a clearly defined strategic approach for their publicity programme, and saw it as an essential component of their overall smoking cessation strategy. For example, Hull and East Riding has a multi-agency group to develop and co-ordinate the publicity required for advertising the service. This includes articles in newspapers,

radio advertising, a quarterly newsletter, telephone helpline, a Millennium Smoking Cessation campaign, and a conference to promote the actions of the Hull and East Riding Tobacco strategy.

## Training and Service Development

Having made the most basic start to the establishment of a new service by identifying key members of staff and establishing links where possible and appropriate with suitable partners the next priority for all health action zones was to begin the process of putting services in place. Two aspects of service development were common to almost all of the zones. First, new and existing staff had to be trained to deliver and support the new service structures. Secondly, central guidance about how services should be delivered had to be interpreted and then adapted and moulded to a certain extent to suit local circumstances.

### Training

Training is a priority issue for most HAZs as they clearly need to develop the skills and knowledge base of staff delivering smoking cessation interventions. Research evidence has shown that smokers are more likely to stop if seen by a health professional trained in smoking cessation (Silagy et al, 1998). The level at which training is offered in HAZs is usually dependent on the type of intervention to be offered. For example, the smoking cessation specialist team is usually trained by organisations outside the HAZ, as the type of skills required necessitates a recognised form of training such as the Maudsley model. Within HAZs the specialist team will then either provide training themselves at a brief or intermediate interventions level, or will bring in external trainers.

Although training is an important element in the provision of a smoking cessation service, the amount allocated from the smoking cessation budget varies widely as illustrated in Figure 3.

Figure 3

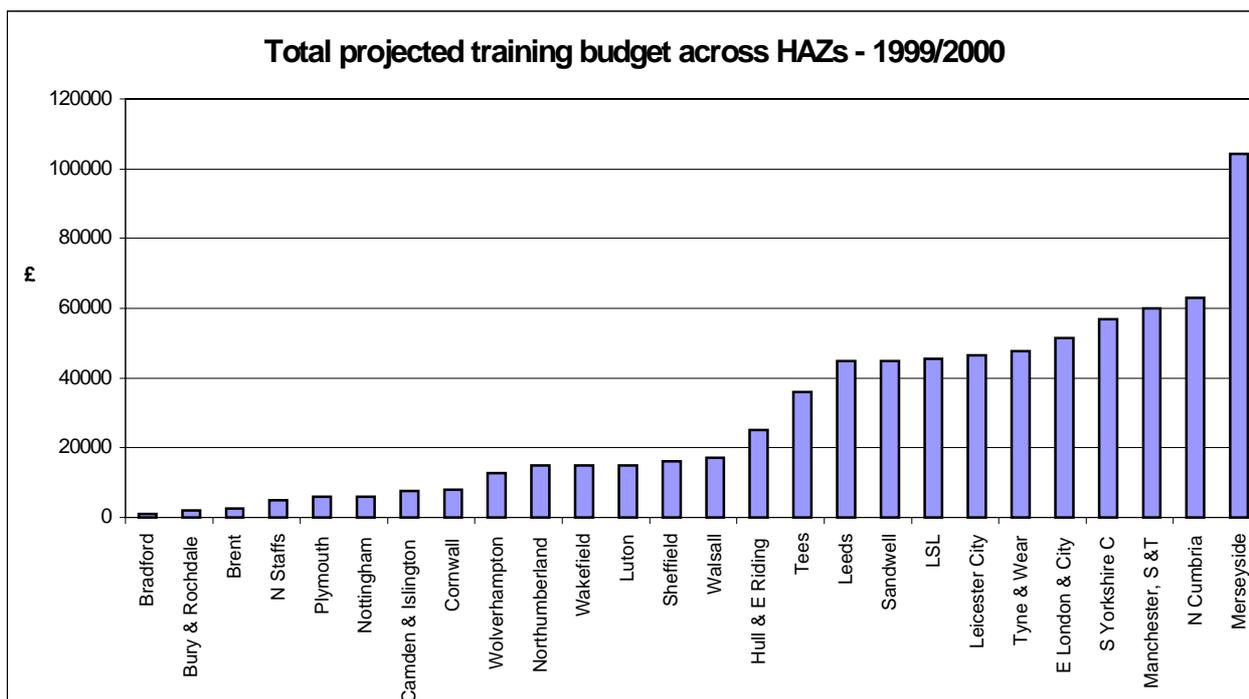


Figure 3 shows that Merseyside has the highest projected expenditure on training at £104,300 in comparison with Bradford which has allocated only £1000. Although the higher expenditure in areas such as Merseyside is a function of the sheer size of the HAZ and the number of advisers that will be required to reach smokers, the relationship between size and training budget is not apparent for all HAZs. Instead, some HAZs have clearly made training a priority, perhaps due to a lack of skilled staff in the area and the absence of pre-existing services. North Cumbria, for instance, has the second highest projected training budget but is ranked just 10<sup>th</sup> in population size. Lambeth, Southwark and Lewisham in contrast is one of the largest HAZs in terms of population but has a significantly smaller training budget.

Other factors will affect expenditure on training, as smoking cessation co-ordinators informed us. Factors such as the availability of in-house training and health service venues to hold session are relevant. Although our research did not address the issue of training in detail, it is apparent from the commentaries we have read and the interviews we conducted that a number of HAZs have encountered difficulties in accessing adequate training. Specialist staff have in most cases been able to attend courses, but the training of intermediate advisers (as well as part-time specialist advisers) has been much more haphazard. Some HAZs have brought in external trainers such as Martin Raw and Pip Mason. Most however have relied on their own staff to provide intermediate training; in many cases the smoking cessation co-ordinators themselves are conducting this training. This does raise issues of quality and consistency.

## Service Structure

Following the publication of *Smoking Kills*, HAZs were issued with guidance through HSC 1999/087 that outlined an appropriate structure for the new services. These recommendations were firmly rooted in the available evidence base, particularly that set out in the 'Thorax' supplement, *Smoking Cessation Guidelines and their cost effectiveness* (Raw et al, 1998). The evidence called for a service based on a range of interventions - from opportunistic interventions by health care professionals through to specialist clinics, group work and one-to-one counselling.

HSC 1999/087 describes two levels of service. These are firstly 'opportunistic smoking cessation interventions' which are brief interventions by a variety of health professionals based on the four "A"s. The second level of service involves a dedicated specialist smoking cessation service delivering more intensive interventions which would generally involve group support over a period of five to six weeks, and NRT. However, a second round of guidance was issued to HAZs in June 1999 that introduced a third level of intervention - 'intermediate services'. The description of what constituted intermediate services was outlined in a letter to HAZ leads (28<sup>th</sup> June 1999) whose primary purpose was to explain the monitoring requirements for the new services. Intermediate interventions were described in this document as those that would aim to provide support on a 'one-to-one basis by specialist practitioners who will have undertaken some form of accredited/recognised training'.

The discrepancy between these two sets of guidelines appears to have caused considerable confusion in some HAZs. The distinction between intermediate and specialist interventions has not been fully understood. In one HAZ, what appears to be the intermediate service is referred to as a specialist service in strategy documents, and no details are provided as to what might be defined as intermediate services in that area. In other HAZs, individuals working within the new

services are encountering problems identifying the distinction between the two levels. As one smoking cessation co-ordinator stated:

*I suppose the way we saw it was that it was a wide network of services and within that, there would be different levels of intervention. To be honest, sometimes it is difficult to distinguish between what specialist is and what intermediate is. And we've had to make arbitrary decisions sometimes based on the guidance from the Department of Health.*

This is clearly something which will need to be resolved. The guidance itself lacks some clarity in that it describes intermediate interventions as being provided on a 'specialist' basis by health care professionals. Whether or not these issues of definition will make much difference in terms of the future success of services is debatable. What is clear is that, at the developmental stage, there has been a lack of clarity.

The overall configuration of services differs between HAZs. Some had all three levels of service established and running by the second quarter, whereas others had only one or two levels. Some had elected to begin intermediate services first, whereas others had introduced the specialist service first. As previously mentioned, a small minority were not planning to launch their specialist service until March 2000.

Approaches to the development of the overall structure of services have also varied. The majority of HAZs had attempted to follow DH guidelines:

*We have the 3 levels that are recommended in the national documentation. People who give brief interventions, which are our primary care teams, pharmacists and dentists. All of which are undertaking training provided by our staff here. And at each one of those stages, any one of those individuals providing the ... advice might commend NRT to the client. When they get to the specialist service, we will be strongly reinforcing the efficacy of NRT treatment and those people who are on free prescriptions will be given a voucher for a weeks worth of free supply.*

However, a few HAZs have developed a slightly different approach to service development based on perceived local need and circumstances.

*I think our model and our approach has been quite different to other HAZs and has been one that has required a lot of considerable time and effort in planning it. Rather than just recruiting our own specialist staff to run the service, we have adopted a model which requires significant amount of training and a significant amount of co-ordination and organisation.*

The most common source of variation is the location of services. The evidence base and DH guidance explicitly advocate a model of specialist service clinics based in secondary care, although the guidance does recognise that local circumstances may make this impractical. HAZs have been encouraged to locate services where they would be most able to recruit smokers, and this has resulted in a clear focus on community settings. As deprived smokers are one of the main target groups, most HAZs have tried to make services as accessible as possible to them. A co-ordinator explained the choice of locations in her area:

*We have our groups being run out of the community on a peripatetic basis. So, even though they are not being run from a Hospital, we still see them as part of a specialist service. The clinics are located within Community Centres, Health Centres, you know, public buildings. We obviously targeting them at high areas of deprivation. So, quite often it's where community development projects are already and there's well known community centres and that's where we set up the services.*

The geography of HAZs also has an important role to play in deciding the structure of services. Whereas in the London HAZs a more traditional model of specialist clinic is possible, secondary care-based services are just not practical in rural Cornwall or North Cumbria. Smoking Cessation staff in these areas have to provide services on a peripatetic basis, distributed across the HAZ.

In order to provide a more detailed picture of the types of services which HAZs are providing at all three levels of service, Table 1 sets out a few examples of brief, intermediate and specialist interventions.

Table 1: Examples of Interventions

Level 1 – Brief	Level 2 - Intermediate	Level 3 - Specialist
<p><b>North Staffs</b> Pilot project with gay men, lesbians and bisexuals. Lesbian and gay helpline will be offering brief interventions &amp; information. Leaflets and poster also developed (In addition a Quit smoking support group will be set up).</p>	<p><b>Northumberland</b> Service based in maternity wards of hospitals. It will consist of a 20-30 minute initial appointment where dependency and commitment to change will be assessed. This will be followed by a quit plan if patient is sufficiently motivated. In addition all midwives involved in antenatal and postnatal care to be trained to give advice and support.</p>	<p><b>Hull and East Riding</b> Clinics to be held in a number of settings across the East Riding health authority area. 2 types of clinic - a drop-in clinic where self-referrals can attend, and 'programmed clinics' which offer a structured five week programme of advice, support and monitoring. The smoking cessation specialists will employ a person-centred approach and behavioural therapy.</p>
<p><b>Wolverhampton</b> GP Health Promotion committee agreed that all GPs adopt smoking as their health promotion priority. To support this a Resource Pack which builds on the 'New approach for health professionals' will be developed in Q3. Similar pack for hospitals in Yr 2000.</p>	<p><b>Tyne and Wear</b> Specialist from Healthy Hearts in North Tyneside seconded 2.5 days a week to co-ordinate this pilot project and introduce SCIP (Smoking Cessation in Practice) protocols. 5 participating pharmacies and 2 GP practices in Wallsend district which has high social deprivation, will provide brief and intermediate advice.</p>	<p><b>Tees</b> The specialist service will be based on the Maudsley model. It will be based in the Addictive Behaviours Service but will run on a peripatetic basis to meet the particular needs of population of Teeside.</p>

### *Specialist*

The guidance states that the specialist services should be run by those who have had specific training in providing intensive interventions. Intensive treatment is to be offered "in the form of group support over the course of five to six weeks, including the use of NRT". One-to-one treatment might also be offered "if group sessions are judged not to meet their needs".

The extent to which HAZs have been able to implement a specialist service varies widely (see section on launch dates). The configuration of specialist services is also variable across HAZs. The main difficulty encountered by HAZs seems to have been that of reconciling the model of specialist service recommended in the guidelines with local needs and circumstances. This again involved distinguishing what constituted a specialist service from intermediate level interventions:

*Well, I would still call ours a specialist service. They have received the same training; it's just that we don't have nurses doing it. In terms of specialist service, when you look at the guidance, it specifies that that will be group support - one-to-one if the person really did want one-to-one ... I mean, reading through the White Paper, it seems like the Maudsley Clinic is regarded as the specialist service whereas the Government might refer to ours as an intermediate, but in our district it's classed as the specialist service which is where people who want more intensive help will be referred to.*

Adapting the recommended model to local needs has also led to concerns about pressure to provide group support to smokers. In some HAZs there are indications that demand for one-to-one support has been greater than expected. Very early evidence suggests that group sessions not attracting as many smokers as had been hoped and in some the drop-out rate is high. There are also early evidence from some HAZs that the target groups the service is aimed at (particularly disadvantaged groups) are more likely to find attending group sessions discouraging. We return to these points in the final section of our report.

### ***Intermediate***

An analysis of the second quarter monitoring returns show that most intermediate level activity in HAZs is focused around certain key areas. In the main these involve the training of health care professionals who may already have a role in providing brief interventions to allow them to offer more intensive advice usually on a one-to-one basis. The main setting for these interventions is primary care, although community pharmacies, secondary care and community locations are also involved in intermediate interventions in some areas. These staff once trained and accredited are then able to issue NRT vouchers.

One of the aspects of the intermediate service that was particularly welcomed was the possibility of paying staff for providing a more intensive input. There is evidence that some HAZs are paying intermediate advisers who submit monitoring forms detailing the number of smokers they have seen who have set a quit date. As a co-ordinator explained:

*So we are building on that by giving additional training and I think the most positive thing is that they are now going to get payments for the time that it involves, whereas before it was just expected to be done.*

There seemed to be a distinction between HAZs that had a clear idea of what their intermediate service would look like (and who had devised clear protocols for this service) and those who had focussed on the specialist service. Services at both levels are at an early stage of development and thus distinctions between intermediate and specialist interventions may become clearer once a more substantial number of smokers are being seen.

## **Brief**

Brief interventions, although not funded as part of the new services, nevertheless provide an important foundation for smoking cessation work and serve as a point of referral to more intensive support. Brief interventions have posed fewer problems for HAZs as a range of health professionals were usually already providing this type of support and advice to smokers, particularly in primary care. The current challenge is to make sure these professionals are aware of the new services and able to advise smokers how to access them. As a result, many HAZs have arranged seminars to educate a range of professionals about intermediate and specialist interventions:

*I think one of the main things that we want to do is make sure that everybody is delivering smoking cessation or smoking education, which is what a lot of the health visitors and practice nurses do. Even if they are not actually running clinics for people to stop, they are doing sort of an education bit.*

However, there is an awareness that brief interventions are reliant on motivated staff. In our interviews with co-ordinators, practice nurses and health visitors were usually described as keen to offer support and were consistent in their efforts but GPs were often regarded as less committed and more reluctant to become involved, due to a range of factors. One co-ordinator described her experience:

*There is a lot of resistance to spending the time doing the work, and what I would love to see really is that doctors had longer appointments ... I have been going around doing on-site training's for GP's in practice teams.....and they were all sitting there saying 'yes, yes, yes; time, time, time,' ... They do not want to change their practice.*

Across HAZs, there have also been attempts to expand brief interventions into areas that had not traditionally offered smoking cessation services. Some examples of these include: recruiting community activists as advisers; training teachers and dentists in brief interventions, developing services for gay men and lesbians; and training those working with homeless people to provide brief advice.

## **Key Issues**

The tobacco strategy outlined in the White Paper explicitly aims to provide 'support in stopping, and help for the most affected' (Cm 4177). This implies that cessation services are to be targeted on individuals and communities where smoking prevalence is at its most widespread. In targeting specific groups, the reforms have made available one week's free nicotine replacement therapy for those who are least able to afford it. These two issues - *targeting* and *providing NRT* - have posed particular challenges for those developing the new services.

### **Targeting Services**

A key component of the government's strategy to tackle smoking and smoking-related diseases is the focus on particular target groups. As smoking prevalence rates are particularly high in deprived communities, reaching smokers in these areas is a priority, evidenced by the provision

of year one funding to health action zones. In addition to disadvantaged smokers, *Smoking Kills* also identifies young people and pregnant women as target groups, in an attempt to limit the harmful effects of smoking on future generations. Clear long term targets for smoking reduction amongst these three groups are set out in the white paper. Quit rates from year one funding in HAZs have a potentially important contribution to make towards the achievement of these national targets. Our analysis of HAZ smoking cessation plans and interviews with co-ordinators thus addressed the issue of target groups and we have begun to assess to what extent the new services are reaching these types of smokers.

### ***Disadvantaged Smokers***

Even within HAZs there is considerable variation in levels of deprivation. In a large areas such as Manchester, Salford and Trafford for instance, there are relatively affluent wards in close proximity to some of the most deprived areas in the country. As a result, many HAZs have begun to adopt a selective approach to the use of their resources, targeting programmes and projects on the most deprived wards. It is clear from our research that this selective approach is also being used within HAZ smoking cessation programmes to focus more resources on reaching disadvantaged smokers. One co-ordinator described this approach:

*Population-wise, we have pockets with high levels of deprivation, so through the health action zones they have identified fourteen wards that have been identified with particular need, so, for smoking cessation work and strategies we ought to be looking at those wards as well as making sure we have services set up in those areas trying to have an accessible service there for all.*

It is fairly clear at this stage in the development of the new services that the vast majority of HAZs are committed to trying to reach disadvantaged smokers, and intend to use targeting localities as a key method for achieving this. What is less clear is how consistent they have been in translating that approach to influence service configuration, or what type of coverage they are achieving by now. In those HAZs where staff are still being recruited and arrangements for NRT are still being put in place, it is doubtful that services have been particularly successful in reaching disadvantaged smokers in any numbers, particularly given the well-documented challenges in encouraging these smokers to consider quitting (Graham, 1998; Whitehead, 1999). However, there are encouraging signs in terms of service configuration. For example, one HAZ is aiming to recruit at least one intermediate adviser for the 55 most deprived wards in their area. Others have specifically appointed part-time advisers who live in priority wards to the specialist service. Another group of HAZs are locating group sessions in community halls or other appropriate settings in deprived areas, as we outlined above. However, it will be a task for the next stage of the DH Smoking Research programme to determine whether this particular target group is really being reached. This should be achievable through an analysis of postcode data, which the majority of HAZs have indicated they are collecting as part of their local monitoring arrangements.

### ***Other Target Groups***

In addition to focussing their efforts on reaching disadvantaged smokers, HAZs are aiming to target other groups. However, the evidence we have gathered suggests that progress has been slow both in developing a strategy and in recruiting smokers from any of these groups. HAZs

have been faced with so many delays in getting their cessation services up and running, that the early priority has been to make the services accessible and recruit as many smokers as possible, irrespective of whether they belong to one of the target groups. As one co-ordinator put it:

*We also intend to target pregnant women and young people [in addition to priority wards] but my feeling is that we can't do everything at the same time and what we want to do is get the service up and running successfully, before we start trying to reach other groups.*

The majority of HAZ co-ordinators we interviewed outlined their intention to develop services targeted at young people and pregnant smokers, but emphasised that these were still primarily in the planning stages. This was particularly the case in relation to younger smokers. In one of the largest HAZs, for instance, discussions had taken place with local colleges and youth services but no direct action was planned until well into 2000. Some HAZs felt they needed greater clarity about the relationship between specialist services for adults and services for young people, as well as issues such as precisely who constituted a 'young smoker'. In a few HAZs, existing projects funded from other sources existed which aimed to prevent or reduce smoking amongst young people, which could provide a foundation for future developments.

In relation to pregnant smokers, slightly more progress had been made in some HAZs. A small number had successfully recruited midwives as part of the specialist service, such as one rural HAZ:

*We have got a midwife in post in each Trust. But the nature of our population is that most of the people are not seen at the hospitals for their ante-natal care, so the midwives will travel out to the booking clinics and the ante-natal clinics to offer smoking cessation help there.*

Most HAZs were also managing to train some midwives as intermediate advisers, but it was too early to say whether pregnant women were setting quit dates as a result.

Smokers from ethnic minorities are another priority group for the new services, particularly as there is now a considerable body of evidence that highlights the high smoking prevalence amongst some groups and the limited success of traditional services in reaching these smokers. From the smoking cessation plans and our interviews, it is clear that the London HAZs are already leading the way in designing services for some ethnic minority communities. These HAZs have agreed to jointly fund a Turkish/Kurdish quit line (building on earlier work) and advisers funded from the new monies are also currently supporting a number of targeted projects, such as one focussed on the Bangladeshi community that addresses the relationship between the use of chewing tobacco and oral health.

In other HAZs with sizeable ethnic minority groups, plans were underway to tailor services to their needs. As one co-ordinator explained:

*We have got a large percentage of ethnic minorities [here]. They are a really big target group in terms of help and prevention as well. At the moment we have not got any Asian people into the service, so we are looking at adapting the service to target those communities as well. What I would like to do is employ a community development worker...to have a role in training up other people that work within those communities .*

A number of co-ordinators emphasised the need to consult with ethnic minority groups as to the types of support that would be suitable, as well as the need to recruit advisers from within these communities. This type of consultation takes time, and therefore services were very much in a developmental stage.

Finally, it is worth noting that a number of HAZs are either currently pursuing or intending to pursue innovative approaches to targeting particular groups of smokers. In North Staffordshire, for example, existing expertise in working with the gay community has allowed a pilot project to be set up which trains staff currently working with gay men to be intermediate smoking cessation advisers. In another HAZ, advisers are providing smoking cessation support to prisoners.

The most common examples of innovative approaches to targeting are around workplace health. Given the broader emphasis within *Smoking Kills* on reducing the incidence of smoking in public places including some workplaces, a number of HAZs are intending to target large employers as part of their smoking cessation strategy. One co-ordinator described aspirations in her HAZ:

*We are particularly interested in smoking and work places, particularly the big work places, like the LA, Health Care Trust and what have you. That partly is about raising their awareness and working with them as smoking advisers, as well as re-visiting the no-smoking policy etc.*

Partnerships between employers and the health authority in relation to workplace smoking are also being discussed in a number of HAZs. In some HAZs, these discussions involve a large private sector employer that intends to fund NRT for their staff. In others, they are public sector employers. In one HAZ, for example, £8,000 from the smoking cessation budget has been allocated to a health at work in the NHS project within one of the local Trusts. The Trust is funding one week's free NRT for staff, and the smoking cessation service is providing training for advisers who will offer advice and support.

## NRT

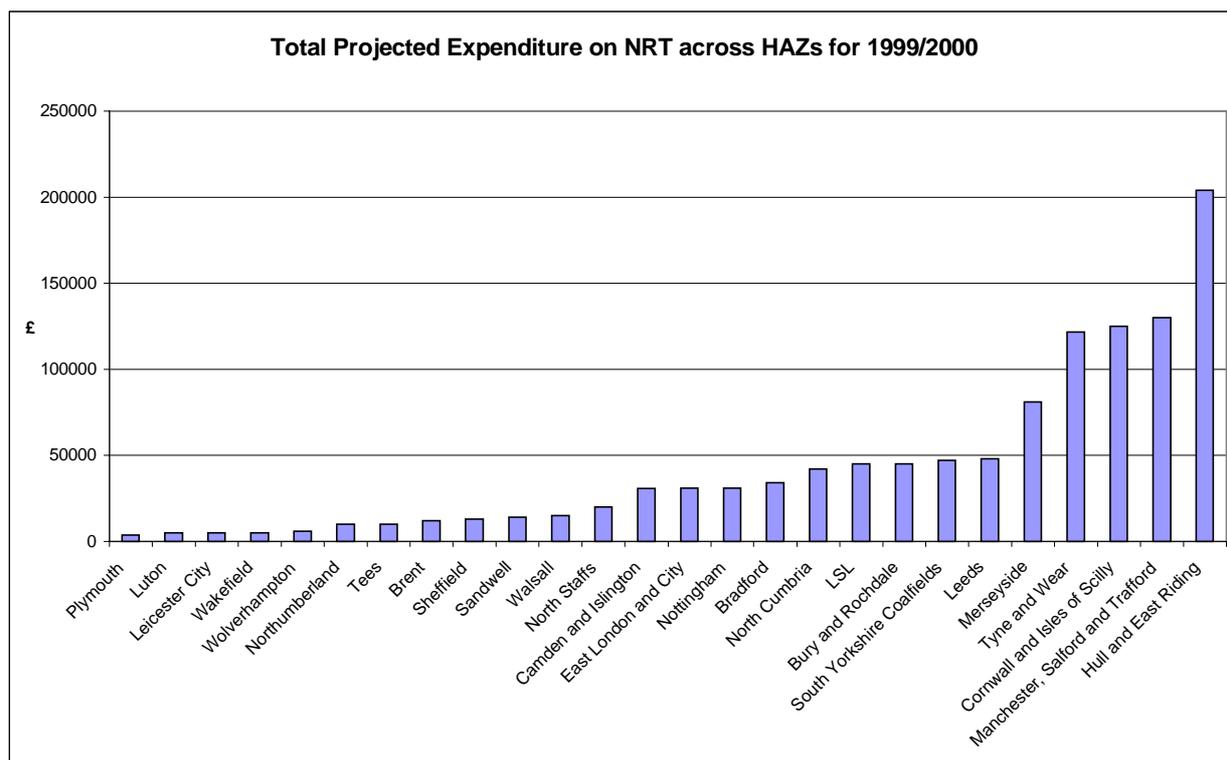
*Smoking Kills* stressed the importance of Nicotine Replacement Therapy as part of the new smoking cessation services, emphasising the firm research evidence that NRT can be instrumental in helping people to quit (Raw et al, 1998). In the first year of the new services, Health Action Zones have been expected to put in place arrangements for the distribution of one week's free NRT, available to those who qualify for free prescriptions. This means that low income smokers in particular have the opportunity to try NRT, with the aim of encouraging them to continue using it as a means to sustain their quit attempt.

Our research evidence suggests that there have been significant problems with the use of NRT within the new smoking cessation services. Negotiating the supply of NRT and setting up the voucher system for its distribution has proved to be complicated and time consuming. Co-ordinators and others working in smoking cessation are highly sceptical about the impact that one week's free will have on quit rates. Although it is too early to draw final conclusions, initial evidence does point to the need for a more well-developed and strategic approach to the future use of NRT within smoking cessation services.

## Structure and Progress

By February 2000, the majority of HAZs had just begun to make free NRT available to eligible smokers. A minority were still setting up the system required to distribute the vouchers. In practice, this means the projected expenditure on NRT envisaged by HAZs, as illustrated in Figure 4, will not be spent in year one.

**Figure 4**



The gap between projected NRT expenditure and the amount that HAZs will realistically spend in their first year will be substantial. For example, the HAZ intending to spend the largest amount on NRT (Hull and East Riding, at over £200,000 in year one) had not had any smokers eligible for free prescriptions using the service by January 2000. At least one HAZ, again in the Northern region, had still not managed to put a voucher system in place by the end of January.

What factors have contributed to the delay? Obviously NRT provision has been affected by the same issues as the rest of the service, such as delays in staffing and confusion over service structure. In addition, however, a number of factors specifically to do with the provision of NRT have proved problematic. These centre around the negotiation required to establish the voucher system. Firstly, the guidance made it clear that NRT would not be purchased centrally and thus HAZs had to make their own arrangements to obtain a sufficient supply. Due to early difficulties around negotiating this supply, most of the NHSE regions have stepped in and arranged bulk purchasing of NRT (often at a reduced price), but this process has taken a number of months, particularly in the north. Secondly, setting up the voucher system involves establishing a network of local pharmacists who will agree to accept the vouchers (obtained by the smoker at the specialist clinic or from an intermediate adviser) and exchange them for NRT. In some areas,

negotiating with pharmacists, especially around a suitable handling fee for each voucher, has been difficult and time-consuming as one co-ordinator explained:

*There has been a significant problem in a sense of not taking the strong line on some particular issues and the best examples of that is the pharmacist's scheme. They were not prepared to negotiate nationally with pharmacists about the payment system for dispensing of NRT products. So it has been left for local negotiation. Well as you can imagine, we fix a figure, 2 weeks later they hear about another figure in another district and they want to negotiate.*

Finally, some confusion clearly existed during the early months of services about who was entitled to one week's free NRT. Some smokers had heard about the offer through local and national publicity and were asking for the vouchers at a time when the infrastructure was not yet in place to provide them. The guidance on who could receive the vouchers changed at the end of 1999 to include pensioners and more explicitly exclude people who received free prescriptions for conditions such as diabetes. A number of co-ordinators we spoke to were still unclear about eligibility issues as a result. However, once these initial barriers were overcome and a voucher system was in place, early evidence suggests that eligible smokers are taking up the offer of one week free and are pleased to have the opportunity to try NRT. Some questions remain, however, regarding the utility of just one week of free provision and the impact, if any, it will have on helping people to quit.

### ***One week free***

There was consensus amongst the smoking cessation co-ordinators we interviewed that one week's free NRT for low income smokers was welcome but would be insufficient. As one interviewee explained:

*My only comment here would be that, if there is a problem with it, it is the fact that, and I am sure other people have probably said this, why is it only one week, why isn't it for the full course. And I think that's been the main feedback. .... We do get quite a lot of stick about that. And we say it is not down to us. You know that is a huge problem, particularly in the Wednesday group, there is quite a lot of elderly people and single mums.*

Co-ordinators were clear about why they felt one week was not enough to be instrumental in helping disadvantaged smokers to quit. They felt the principle behind limited free provision was flawed and were suspicious that one week's free supply had been decided purely on the basis of cost implications to the NHS. The idea of offering a first week free appears to hinge on the proposition that if low income smokers are given the chance to try NRT with no cost to them, they will continue to use it, purchasing subsequent weeks themselves, while they were being supported to quit. Our interviewees described a number of barriers to this taking place. Firstly, they pointed to the idea that these smokers would use the money they were saving on cigarettes to continue to buy NRT. They felt this made assumptions about expected behaviour. As one interviewee told us:

*I mean the idea is that basically you are meant to save up your money from the first week. But we know that that won't happen. They'll use it to pay the bills. They are disadvantaged groups: they are going to use it for something else.*

Secondly, they told us that the cost of additional weeks of NRT was in actual fact significantly higher than the price many smokers were paying for cigarettes, particularly given the wide availability of black market tobacco. Finally, co-ordinators pointed to all the social factors which research has shown preclude NRT from being an acceptable substitute for tobacco, particularly amongst unemployed or low income smokers. These factors, when combined with the cost after the first week, made them highly sceptical about the potential of the current policy to make any real difference. One co-ordinator summarised some of these doubts:

*But the way a smoker looks at their smoking, they get enjoyment out of their smoking but they are not getting enjoyment out of NRT. It might be staving off the nasty symptoms they might otherwise get, but of course that is a negative thing rather than the enjoyment and support they feel they get from their smoking. The other factor is that when you buy a packet of cigarettes it is £3.50 - £3.80, whatever it is if they are not black market. If you buy some nicotine, certainly patches, you are talking £15 - £20 in one go. So I think there is still that barrier of getting over that... OK we can introduce them to NRT, but then there is the barrier, will they continue with it after that? Certainly our SC adviser feels that it will not be enough to get them to continue with NRT. Even she thinks four weeks would not be enough.*

### ***Extending One Week Free***

Given the ambivalence amongst smoking cessation staff regarding one week's free NRT, it is not surprising that a number of HAZs are experimenting with ways of extending free provision either to a wider group of smokers or for a longer period of time. This expansion appears to take one of three forms. The first involves HAZs, primarily in the West Midlands, who had a pre-existing subsidised NRT scheme before the white paper was published. These HAZs are continuing with the scheme and adapting it in light of one week free. The second group of HAZs are involved in one or more pilot studies which involve the use of free or subsidised NRT in an area within the HAZ. In two cases, these pilots are part of an SRB scheme which will link with the new specialist service and provide free NRT to eligible clients for a fixed period of time. In at least two additional HAZs, there are local pilot projects based in primary care which involve free NRT. These small pilots will allow future comparison of the impact of a longer period of free NRT on quit rates.

The third and final form in which free NRT is being expanded is through direct local funding of additional NRT to smokers using the new services. In other words, health authorities are using part of their own budget to widen access to the free prescriptions provided through the reforms. While it is possible that our research has not picked up all the incidences of this happening, we are aware of at least one HAZ in which one or more health authorities in the area is expanding the free scheme. A co-ordinator in this area explained the set-up:

*We're going to provide one week's free supply of NRT for everyone in [our health authority area]. Now, what we are going to do, for the people that should really be paying for it - who aren't eligible for free prescriptions - the Director of Public Health is actually going to pick up the budget for that.*

The fact that some health authorities have adapted pre-existing subsidised NRT schemes, some are running pilots using more free NRT and some have managed to find funds to extend free NRT to everyone means that it is going to be difficult to judge the impact of the current system

in the longer term. It has also resulted in some resentment and confusion amongst those working in smoking cessation. Faced with requests from ineligible smokers for free prescriptions or for an extension of provision beyond one week, cessation staff are justifiably irritated when they hear that NRT is more accessible in some parts of the country than others. As one co-ordinator put it:

*We are always so frustrated when I hear about other HAZs who are, I don't know how they are doing it, but are supplying for example, 8 weeks free. And where I have been told categorically, you must not use the money for anymore than one week..... I think we would get better results if we could offer it for at least 6 – 8 weeks.*

## Assessing Impact

It is too early in the life of the new smoking cessation services to examine issues of impact, at least not in any depth. However, the monitoring system introduced by the Department of Health does allow early analysis of both expenditure and throughput of smokers setting a quit date. Thus we have begun to address quit rates and monitoring in our research, both by reviewing quarterly returns and asking smoking cessation co-ordinators about their experience of the monitoring process.

### Quit Rates

Health Action Zones are currently in the process of completing their third quarter monitoring return for the new services. These returns should provide evidence of smokers setting quit rates in the vast majority of HAZs. However, due to delays in setting up the service and establishing the NRT voucher scheme, smokers did not begin using the service in most areas until the autumn of 1999, and in some cases co-ordinators informed us that the first smokers would be using the service in early 2000. Thus it is not surprising that a sizeable proportion of HAZs submitted a nil return for the second quarter. Table 2 below illustrates the breakdown.

Table 2: Smokers Setting a Quit Date: Second Quarter Monitoring Return

No quit rates - staffing and finance returns only	Evidence of smokers setting quit dates for specialist service only	Evidence of smokers setting quit dates for intermediate service only	Evidence of smokers setting quit dates for both specialist and intermediate service
Bury and Rochdale	Bradford	Camden and Islington	Brent
Leeds	LSL	Northumberland	Hull and East Riding
Leicester City	Luton	Plymouth	Cornwall & Isles of Scilly
Manchester, Salford & Trafford	Merseyside	Walsall	East London & City
North Cumbria	S Yorkshire Coalfields		North Staffs
Nottingham	Tyne and Wear		
Sandwell			
Sheffield			

Tees			
Wakefield			
Wolverhampton			

Table 2 divides results from the second quarter monitoring return into four categories. The first category includes HAZs who had no smokers setting a quit date between the 1<sup>st</sup> of July and the 30<sup>th</sup> of September 1999. Eleven HAZs – just under half - fall into this category. The second category consists of HAZs who had launched their specialist clinic in this quarter and were able to report that some smokers had set a quit date. Numbers for the specialist service were however very small – one HAZ reported that two smokers had set a quit date through their service, while another (one of the largest HAZs) had just one smoker setting a quit date. The third category in the table includes HAZs who were supporting smokers through their intermediate service only. These HAZs had, by September, trained a number of advisers in primary and secondary care despite not yet having their specialist service off the ground. These advisers were then able to encourage small numbers of smokers to set a quit date. The final category in the table includes those HAZs who made earliest progress in recruiting smokers, and had individuals setting quit dates in both the specialist and intermediate services. Again the total number of smokers involved was small, with the exception of East London which appears to have made very early progress and had 119 smokers setting quit dates by the end of September.

It is worth noting, as the Department is undoubtedly aware, that the number of quitters listed in the monitoring returns is also affected by the data management systems HAZs have needed to develop, often on a regional basis. Progress on getting these systems up and running has, like so many other elements of the service, been slow. For instance, the West Midlands HAZs have invested in the development of a joint database to record monitoring information, both that required by the Department of Health and other information that will prove useful in evaluation. As this database was not fully developed by the time the second quarter returns were due, smokers setting a quit date before September 30<sup>th</sup> will be entered retrospectively and appear on subsequent returns (this is certainly the case with Sandwell).

It is really too early for our research to be commenting in any detail on the factors affecting quit rates. Once HAZs begin to have a number of smokers setting quit dates, staff should be able to tell us about some of the factors which they believe are affecting the success or failure of the services. Early indications suggest that the use of CO monitors is proving successful in some HAZs, that group vs. one to one support may be an important factor in quit rates, and that some approaches to targeting specific communities may be more successful than others. We hope to be able to address these and other factors in more detail during the next stage of our study, and would welcome suggestions from the Department about specific questions that should be posed.

## Monitoring

The new smoking cessation services are expected to demonstrate evidence of effectiveness, and the main mechanism for determining this will be the monitoring system introduced by the Department of Health. HAZs are to establish systems to collect information on smokers using the service, based on a compulsory minimum data set. During our interviews with smoking cessation co-ordinators, we asked about the process of establishing this new system and completing the monitoring returns. Most interviewees recognised the value of having comparable national data and were broadly supportive of the monitoring process. As one co-ordinator put it:

*I actually think that the comprehensiveness of the data set that we're asked to collect is helpful... I think by the department dictating that's what they want, we are able to direct the advisers to collect data to enable us to evaluate ...I think that the framework will in the long term be helpful in being able to prove the effectiveness of the service that we're providing, which is always the challenge, if we're talking to secondary care clinicians, for example, who want to know are they a waste of money or should we really be investing in them.*

Despite support for the concept of monitoring, the process of setting up appropriate systems and beginning to collect the data has been challenging. Delays have occurred in setting up a database in some areas, as we mentioned earlier in the report. Developing and distributing data collection forms (which usually include the minimum data set plus other information) has been time-consuming for smoking cessation co-ordinators new in post. A number of HAZs have encountered problems in recruiting administrative staff who could have relieved some of the burden at an earlier stage. In addition to these relatively minor difficulties, some co-ordinators have felt demoralised by the experience of having to submit nil returns for the first, and in some cases, second quarter. As the monitoring forms focus on smokers setting quit dates and budget expenditure, rather than including measures of service development, nil returns give the impression that staff have been inactive whereas they have actually been involved in developing the infrastructure necessary to deliver new services. A nil return implies failure, or at least that is how some co-ordinators felt it would be perceived.

HAZs are now in the process of actively collecting data and thus it is possible to comment on some emerging issues in relation to monitoring. Three issues are worth noting at this stage in the life of the new services:

- difficulties collecting data in multiple health authority HAZs
- gaps in monitoring at the intermediate service level
- questions about the definition of a successful quit attempt

At the beginning of this report we offered some thoughts about the varied communities that are health action zones. Professionals delivering services within multiple health and local authority HAZs face particular challenges of co-ordination. This applies to the collection of monitoring data. In Tyne and Wear, Merseyside, South Yorkshire Coalfields and Manchester, Salford and Trafford, compiling a quarterly monitoring return across the HAZ involves collating data from each health authority and it is clear that there have been some early difficulties in achieving this. As a co-ordinator in one of these areas told us:

*In terms of completing the form, what should have been a simple job turned out to be a nightmare because I had to wait for the other districts to send me their information and certain people refused to give me information saying that it would be a no-return but from my point of view, you know how many staff you plan to have in - they might not be in post yet, but you should know by now how many staff.*

An additional issue in data collection involves the completion of monitoring returns by intermediate advisers. These advisers are seeing smokers in a range of settings – in primary and secondary care, pharmacies and other locations in the community. Although in some HAZs they are receiving a fee for each monitoring return completed and returned to the specialist service, there are early concerns that not all intermediate advisers are doing this consistently. Although it

is too early to say how widespread this problem is, the implication is that it will be difficult to evaluate the through-put of quitters at this level of intervention, both locally and nationally.

A final emerging issue in relation to the monitoring forms concerns the definition of a quit attempt. Some professionals working in the new services, particularly those with considerable experience in smoking cessation, are questioning whether the minimum data set will provide an accurate reflection of successful quit attempts. Research evidence does suggest that defining a successful quit attempt can be problematic, as many smokers require repeated attempts to quit before cessation is achieved (APA, 1996). A health promotion manager explained his doubts:

*I have some quite marked problems with how the guidance sets out what they are monitoring....What they are saying is that people have to be completely abstinent from week two to week six to be counted [as quitters] They then have to be completely abstinent from week two to week fifty four to be counted as being abstinent for a year...Now if you look at smoking cessation behaviour theory, this does not fit at all, because people lapse and they don't just lapse in the first few weeks, they can lapse after quite a period of abstinence.*

It will be important to review the monitoring process, and the minimum data set, in order to decide whether they will generate enough reliable and valid information to evaluate the efficacy of the new services. Monitoring smoking cessation in Health Action Zones should provide the Department with the opportunity to reflect on the strengths and weaknesses of the system they have established and refine it for roll-out in years two and three.

## **Interim Conclusions**

In conclusion, it is worth emphasising that there have been a number of barriers to progress in developing the new smoking cessation services. This report has already detailed many of them, including: lack of clarity about the structure of services and the distinction between intermediate and specialist interventions; the range of problems encountered in setting up the voucher system for NRT and then supplying NRT to eligible smokers; issues around availability of adequate training for advisers; establishing monitoring systems; involving PCGs and other agencies in planning and delivering services; and perhaps most importantly, recruiting and retaining qualified staff. In addition to these initial problems, the two most immediate and significant challenges encountered by the new services in their first months of development were *time*, and *reconciling guidance and the evidence-base with local knowledge and practice*.

There is also an important challenge facing those responsible for evaluation and learning. We believe that the entirely understandable pressure to gather evidence about the impact of smoking cessation services could easily become self defeating unless careful thought is given to obtaining a better understanding about the process of designing and implementing new service delivery systems. It is becoming increasingly apparent that the promotion of genuine learning about innovative approaches to complex social problems requires new approaches to evaluation. We want to take this opportunity therefore to provide an indication of the evaluation framework that seems most appropriate in the circumstances that we have outlined.

## **Time and Expectations**

From our research to date, it is clear that there is a general sense of disbelief amongst those working in smoking cessation that the government expected new services to be up and running within a few months of funding becoming available. As one co-ordinator put it: "the implementation of the service has been ... the real problem. We should have had a more realistic time frame." The expectation that services would be seeing clients and that quit dates would be set and reported in the monitoring return for the period April to July appears to have been particularly problematic. Before smokers could obtain support and NRT from the specialist services, a range of developmental activities had to take place. Setting up the service infrastructure involved tangible outputs like hiring staff and locating premises, as well as less easily measured but equally important activities such as network and relationship building between individuals and agencies. Another co-ordinator described how she thought the policy should have been implemented:

*But it would have been nice to have actually said, the first 6 months is purely for planning and organising and co-ordinating and getting a good base. So that you can actually make sure that you are setting off on the right road and are going to end up with sustainable service. Whereas, we had to sort of plough in, get clinics going and now step back and sort of do some planning work that we might have done originally in the first few months.*

The main casualty of such a tight time frame has been strategy development. Despite firm central guidelines and a solid evidence base, the new services need to adapt to local circumstances and determine what is possible and appropriate in each HAZ. It was evident even from our initial trawl of the available plans and commentaries in the autumn that very few HAZs were able to write an initial action plan for the new services. With the exception of HAZs in the West Midlands and a small number of others across the country, few had any plans based on local needs-assessment and few had been able to set any realistic targets for their local services. Although this documentation is now being provided, the planning involved should have been done before services were launched.

## Guidelines, Evidence and Local Practice

A second significant challenge facing HAZs is how to reconcile the existing guidelines and evidence-base with local needs and practice. There are a number of elements of the recommended service structure which co-ordinators and others are finding difficult to implement. These appear to fall into three main categories: problems establishing specialist clinics according to the recommended model; issues concerning the emphasis on group support in the service guidelines; and concerns about limited opportunities to explore innovative approaches to smoking cessation.

Earlier in this report we commented on the varied nature of communities within Health Action Zones and the limitations that factors such as population distribution place on the capacity to develop smoking cessation clinics in secondary care, or even in one fixed location within the HAZ. The research evidence does demonstrate the success of the Maudsley model in encouraging smokers to quit. However, its direct application to smoking cessation interventions across the country is being questioned by those now faced with the task of developing services. As an assistant director of public health explained:

*It's a real public health challenge, because actually the Maudsley have got very strict entry criteria, therefore, by definition they're going to have fairly high success rates, and then you come into this debate between efficacy and impact. Do we go for something which we know has got a proven high level of efficacy by strictly determining use coming through the specialist clinics or do we go for a broader population based approach at the intermediate level and only have smaller numbers coming to the specialist clinic through the referral pathways.*

The evidence-base does demonstrate the efficacy of offering intensive group support to smokers trying to quit (Hajek, 1989, Hajek and West, 1998). As a result, guidelines for the new services emphasise that this is the preferred approach for specialist interventions. Again, however, there is resistance in most HAZs to applying this model (although more cost-effective than one to one treatment) across the board. In some HAZs, this resistance comes from staff (often primary care staff) with previous training and experience in offering one to one support who are reluctant to run groups. In others, pre-existing projects have demonstrated that recruitment and retention to groups is a real problem. Some HAZs are already finding this with the new services, as one co-ordinator explained:

*Within discussions with my colleagues who are running it... they are saying that many people don't want to enter the group. They were saying that many people wanted to see the specialist one to one. That was a kind of a bit of, well I suppose it wasn't a surprise, but that happened more than I thought.*

Group treatment appears to be a particular problem for the population groups that the government's tobacco strategy is most determined to reach. Smokers from disadvantaged communities are reluctant to travel to or attend group sessions, particularly unemployed men. As one co-ordinator put it: "I can't envisage ex-steel workers, 55 plus, out of work, going into any smoking cessation group. It just doesn't fit." The evidence-base does recognise that group support can be ineffectual for some smokers. Clearly it is too early to comment on this aspect of the reforms in any detail, but it is an issue which a number of smoking cessation co-ordinators are concerned about.

Finally, while many aspects of the guidelines put forward for service development have been welcomed in HAZs, there is a concern that useful and innovative local solutions may be subsumed in a larger, more rigidly structured set of services. North Staffordshire's project treating gay smokers, for instance, has no existing evidence base to build on, but may in fact prove to be very successful and provide examples for similar efforts in other parts of the country. It will be important, as new services develop, for local solutions to be examined and disseminated if the results are encouraging. Health Action Zones themselves were intended to be trailblazers for new approaches to tackling health problems. It will be important to balance this capacity for innovation with the delivery of effective and sustainable smoking cessation services in the months to come.

## Approaches to Evaluation

One of the most important roles of independent researchers who are commissioned to investigate service development in complex community-based initiatives such as HAZs is to make an assessment of the extent to which programmes and their component parts lend

themselves to being evaluated. For example, Owen & Rogers have summarised a common set of social policy experiences that greatly hinder effective evaluation and learning.

*In the past, inadequacies in the specifications of many social and educational programs emerged when evaluators were asked to carry out traditional outcome evaluations of these programs. Evaluators in these circumstances found that they were asked to evaluate ‘non-events’ – programs with little or no documentation. Sometimes programs existed with vague goals which provided little direction for those responsible for program delivery. From the point of view of evaluators undertaking impact evaluations, there was little or no basis for developing outcome measures ... (1999, p. 192).*

This kind of situation creates a need for what Owen & Rogers describe as ‘clarificative evaluation’, which has as its main components:

- Description of programs
- Analysis of the logic or theory of programs
- Consistency between program design and implementation
- Providing a basis for subsequent program monitoring or impact evaluation

More specifically the widespread experience that many public policies and initiatives are very poorly specified has resulted in a growing role for evaluators in the ‘construction and testing of program logic, or program theory’ (Owen & Rogers, 1999, p. 194).

What have become known as theory-driven approaches to evaluation are based on a central set of assumptions articulated by Chen (1990).

*A social or intervention program is the purposive and organised effort to intervene in an ongoing social process for the purpose of solving a problem or providing a service. The questions of how to structure the organised efforts appropriately and why the organised efforts lead to the desired outcomes imply that the program operates under some theory. Although this theory is frequently implicit or unsystematic, it provides general guidance for the formation of the program and explains how the program is supposed to work (Chen, 1990, p. 39).*

The pioneering work by Chen and his colleagues in the American Evaluation Association has been taken forward in a number of different ways. But in our broader work with Health Action Zones, we have found the approach being developed by the Aspen Institute’s *Roundtable on Comprehensive Community Initiatives for Children and Families* to be particularly compelling in its advocacy of the critical importance of understanding ‘theories of change’.

### ***Theories of change***

Originating from the work of Carol Weiss and colleagues in the 1970s, a theory of change approach is defined as ‘a systematic and cumulative study of the links between activities, outcomes and contexts of the initiative’ (Connell & Kubisch, 1998). The approach aims to clarify the overall vision or theory of the initiative, meaning the long-term outcomes and the strategies that are intended to produce change. In generating this theory, steps are taken to explicitly link the original problem or context in which the programme began with the activities planned to address the problem and the medium and longer-term outcomes intended. Theory

generation is conducted by and with those involved in planning and implementing an initiative. The approach encourages stakeholders to debate how an initiative can best produce desirable outcomes by asking them to make explicit connections between the different components of how a programme works.

Weiss and colleagues provide a number of convincing reasons why this approach to evaluating service development in complex and evolving initiatives is an attractive one (Connell et al, 1995; Aspen Institute, 1997; Fulbright-Anderson et al, 1998). Firstly, a theory of change can *sharpen the planning and implementation of an initiative*. When used during the design phase, it can increase the likelihood that stakeholders will have clearly specified the intended outcomes of the initiative, the activities that need to be implemented in order to achieve those outcomes, and the contextual factors that are likely to influence them. Secondly, with a theory of change, *the measurement and data collection elements of the evaluation process will be facilitated*. An evaluation based on a theory of change identifies what to measure – final and intermediate outcomes, and the implementation of activities intended to achieve those outcomes – and helps to guide choices about when and how to measure these elements.

Thirdly, and perhaps most importantly, articulating a theory of change *helps to reduce problems associated with causal attribution of impact*. A theory of change specifies how activities will lead to immediate and long-term outcomes and identifies the contextual conditions that may affect them. Although this strategy cannot eliminate all alternative explanations for a particular outcome, it aligns the key participants in the initiative with a standard of evidence that will be convincing to them. Indeed, at the most general level, the theory of change approach contends that the more the events predicted by theory actually occur over the lifetime of an initiative, the more confidence evaluators and other stakeholders should have that the initiative's theory is valid.

However, there are problems. One of the most striking is the challenge of gaining consensus among the many parties involved in implementing services in complex community initiatives such as HAZs. The approach requires an analytical stance that is different from the empathetic, responsive and intuitive stance of many practitioners. Despite these problems, our experience with the national HAZ evaluation to date, combined with evidence from other studies, suggests that skilled evaluators can and should overcome these difficulties and by doing so they enrich both the programme and the lessons to be learnt from it.

We plan to develop the approach we have outlined by seeking to gain a broader appreciation of the programmatic theory and logic that lies behind the development of smoking cessation services in all 26 health action zones. However, we propose to investigate the process of change in somewhat greater detail in a small, reasonably representative, sample of zones. The evaluation of smoking cessation services in this sample of zones will constitute the next stage of our research.

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# Appendix

## Monitoring: Data HAZs are collecting in addition to the Minimum Dataset

The guidance specifies that certain information must be provided by HAZs as part of their monitoring procedures. This forms a minimum dataset for quarterly and annual returns. In addition, there are other items of information which, although not mandatory, are strongly recommended. This includes clients' names, addresses and full postcode. As far as we have been able to determine, all HAZs are intending to collect postcode data. However, it became clear during our research that a number of HAZs were also planning to collect *additional* local monitoring information. Examples of this type of information are included below:

Camden and Islington: (NB: We understand that all the London HAZs will be collecting similar information)

- Client's name, address, postcode and telephone number.
- Intermediate service - specifying who the intermediate adviser who saw the client was, for example practice nurse, pharmacist, GP.
- Referral information - source of referral for example self referral, GP, practice nurse, pharmacist etc.
- Number of cigarettes smoked by client per day.
- Type of NRT to be used.

Bradford:

- Client's name, address, postcode, and telephone number
- Group or one-to-one support offered.
- Referral information - source of referral for example self referral, GP, practice nurse, pharmacist etc.
- Age of first cigarette.
- Brand of cigarettes smoked by client.
- Number of cigarettes smoked by client per day.
- Parental smoking - whether mother or father smoke.
- Dependency score (Fagastrom)
- Number of previous quit attempts.
- Longest period of abstinence.
- Reason for past failure to quit.
- Problems using NRT
- Type of NRT to be used.

Merseyside

- Client's name, address, postcode, telephone number. Plus NHS number.
- Client's GP name and address
- Client medical conditions.
- Referral information - source of referral for example self referral, GP, practice nurse, pharmacist etc.

Walsall (NB: We understand that all West Midland HAZs will be collecting similar information)

- Client's name, address, postcode, telephone number.
- Referral information - source of referral for example self referral, GP, practice nurse, pharmacist etc.
- Stage of change at referral. For example, pre-contemplation, preparation, contemplation - based on Cycle of Change model. This is also assessed at 4 week follow up and 52 week follow up.
- Type of intervention - group or one-to-one.
- Type of tobacco used - cigarettes, cigar, roll you own.
- Number of cigarettes smoked by client per day.
- Smoker for how many years?
- Number of previous quit attempts.
- Reasons for failure to quit on previous occasions.
- Time to smoke after first waking?
- At four week follow up - Number of weeks subsidised NRT? Number of weeks NRT was used in total. Type of NRT used.

These are examples of the types of additional information HAZs are intending to collect. The usefulness of this information will become more apparent as the smoking cessation programme proceeds. An example of Walsall's Smoking Cessation monitoring form is attached for information.