ABC of smoking cessation

Setting up a cessation service

Penny Spice

In 1998, when the UK government announced the introduction of smoking cessation services throughout the NHS, few such services already existed. In most areas, therefore, the services had to be set up quickly and from scratch. This article reflects on some of the difficulties and challenges experienced in establishing and maintaining a cessation service, the Nottingham "New Leaf" service.

What is the likely demand?

Nottingham has a population of about 650 000—and therefore about 200 000 smokers. If (as expected from national data) 30% of these were to make a quit attempt in the same year, and all sought help from the cessation service, the demand would be overwhelming. In the event, however, initial demand rose fairly slowly. Some of the reasons for this slow start were:

- Smokers were initially suspicious of the new service. Many remarked that they expected to be "told off" about their smoking but were pleasantly surprised when encouraged instead to decide if the time was right for them to quit
- Health professionals were sceptical about the likely effectiveness of the service and had little understanding of what was offered
- There was also general suspicion, in an NHS based largely on a medical model, of services that relied on a health promotion approach, including client empowerment and behaviour change.

As a result, one of the major pressures in the early months was not the level of demand but the political pressure to meet high quit rate targets set by government.

Demand soon rose, however, as a result of various influences, such as the service's feedback of performance results to primary care teams. Although variable, the service currently deals each month with about 200 smokers who agree to set a quit date, of whom half are not smoking four weeks later.

Recruiting staff

Interest in joining the service was relatively low at first, though this changed considerably once New Leaf began to be known and respected.

It has since recruited staff from a wide range of backgrounds, including nursing, health promotion, community work, and counselling. Staff joining from a non-health background, however, have had to learn very quickly about working practices in the NHS and have at times been very frustrated over seemingly unnecessary hurdles of protocol and approval.

Although staff recruitment has become easier over time, retention has become increasingly difficult because the initial funding allocated by government expired after three years. Guarantees of continued salary support have subsequently tended to be short term and be delayed well into the financial year. Many staff move to other jobs because of the financial insecurity this causes.

Reasons for increasing use of New Leaf service

- Recommendations to others by smokers who have used the service
- Increasing familiarity, trust, and use of the service by health professionals
- Feedback of performance results to primary care team
- Spread of publicity through other partners, such as pharmacists
- Gradual incorporation of referral to cessation services into routine pathways and protocols
- Return of former clients who quit but started smoking again

Numbers of smokers seen by New Leaf, by quarter, since launch of service in April 2000

Recruitment of staff from a wide range of backgrounds brings a rich mix of skills, experience, and perceptions into the service, with no established culture of "custom and practice"

Model of service provision

Within smoking cessation models there are three key approaches: high intensity with low coverage; medium intensity with medium coverage; and low intensity with high coverage.

Each of these has its relative advantages and disadvantages, and will reach different populations of smokers. New Leaf's policy from the outset was to try to provide services across the full range of these approaches, and to plan and recruit staff accordingly. Currently, 10 smoking cessation specialists and 15 sessional workers provide an intensive service, seeing about 4000 smokers a year. In addition, a network of 16 associate advisers based in primary and secondary care (many working part time for New Leaf) provide brief interventions as part of their normal work and offer support for former smokers who have completed the cessation programme. Overall, the service achieves an average quit rate, at four weeks, of 56%. In line with government guidance, it monitors the exhaled carbon monoxide levels of all clients.

Location

Two of the guiding principles for the service were that it should be accessible and that it should target smokers from disadvantaged areas.

To achieve these goals, New Leaf tried to ensure that its services were available at locations in the centres of local communities. It used deprivation indicators to identify disadvantaged areas of the city and the staff spent much time and effort finding venues in the right place, for the right amount of money, where staff would feel safe, that were accessible for people who used wheelchairs, and were on bus routes.

Thus New Leaf uses libraries, community centres, family centres, church halls, scout huts, a drop-in centre for homeless people, schools, prisons, colleges, and young people's centres. These are in addition to conventional healthcare sites, such as health centres, antenatal clinics, general practice surgeries, and hospitals.

Advertising

In the health community and the relevant statutory and voluntary sectors, New Leaf used briefings, presentations, reports, newsletters, and any other suitable internal means to promote the service wherever possible. It also ensured that the service was included in various "patient pathways," protocols, and policies.

For the general public, it organised an intensive publicity campaign around the launch and to advertise early successes of New Leaf. The campaign had various elements, including articles in local newspapers (including the free press); many radio appearances; flyers, posters, and credit cards; a New Leaf logo and phone number painted on a local bus; and displays and attendance at local health and community fairs.

Independence

It has proved important in Nottingham that the New Leaf cessation service was closely integrated into primary and secondary care while maintaining financial independence. This has ensured that funding allocated for smoking cessation has indeed been spent on the service and also encourages expertise and innovative ways of working. This autonomy also means that risks can be taken more easily and changes made more quickly than in larger administrations.

Three key approaches

High intensity with low coverage—"Closed" smoking cessation groups (usually for six to eight weeks), with follow up

Medium intensity with medium coverage—"Open" smoking cessation groups or clinics for smokers, usually on a one to one basis or with couples or families. This model allows the client to negotiate the length of time of the contact with the service, which may be shorter than the usual eight weeks

Low intensity with high coverage—Brief interventions, usually as part of another consultation or intervention

Groups or one-to-one services?

- The initial guidance on service development from the UK government focused primarily on group based, high intensity services
- This later changed to include "intermediate" services (interpreted to mean one to one sessions of shorter duration)
- New Leaf offered both services from the outset

In poor areas, smoking prevalence can be high, although people's motivation to quit is no lower than in more affluent areas

An effective way to advertise a new cessation service

Funding

Funding for cessation services is especially vulnerable to diversion into other services, but some measures can be taken to help to protect the service.

Funding must be “ring-fenced” or allocated specifically for cessation services. Cessation services must have challenging and auditable targets. The funding allocated for services must allow for the provision of more than just the bare minimum—there has to be capacity to develop and offer tailor made services for particular client groups with special needs. Funding also needs to be committed for the medium rather than short term to provide reasonable job security for staff.

It is important to give fundholders, through accurate and regular updates about the successes of the services, evidence about the services’ effectiveness and efficiency, and to prove that they provide added value to what existed before or what would exist if they disappeared. Quantitative information about throughput, quit rates, relapse, loss to follow up, and developments to support smokers with special needs (such as pregnant women, young smokers, and hard to reach groups) is also important.

The annual budget for New Leaf in Nottingham for 2002-3 was £465 000 (\$790 000; €677 000), serving a population of about 650 000. This level of funding has been adequate for the delivery of basic needs and to provide some support for development of new and special initiatives. Less than this would provide a basic service—that is, for well motivated and mobile smokers—but little more.

How long to establish a service?

In Nottingham it took over two years to establish an effective and efficient core service, and there is still a long way to go to meet the diverse range of smokers’ needs. As the service develops, there are new discoveries and different ways of streamlining the existing systems, and a high quality service will always learn from mistakes, its staff, other services, and, most importantly, its clients.

Further reading

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The photograph showing a run-down block of flats is published with permission from Matthew Butler/Rex.

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Why funding may be diverted from smoking cessation services

- Smoking cessation is a preventive intervention; other more immediate demands may be perceived to be more deserving or important
- Perception that smokers “choose” to smoke, so their addiction to smoking (and consequent disease) is not a medical problem and should not compete for medical funds
- Belief that smokers should pay for their own services, offsetting the cost against long term savings on cigarette purchase
- Smoking cessation therapy is behavioural so is not medical

Persuading fundholders to prioritise cessation services is vital to ensuring the future of the services

Challenges for smoking cessation services

- Strategy with employer and partners
- Staff recruitment
- Accommodation for offices and clinics
- Policies and protocols
- Evaluation methods
- Purchase of furniture, office equipment
- Design and printing of paperwork for administration, evaluation, information for clients
- Engagement and joint working with partners in primary and secondary care
- Full partnership with local pharmacists
- Publicity strategy
- Training programme for cessation staff
- Awareness raising and training programme for existing health, statutory, and voluntary sector workers
- Financial planning
- User feedback
- Follow up systems
- Joint working with health professionals and the voluntary sector to ensure continued support of former clients
- Synthesis within wider tobacco control agenda—for example, tobacco control strategy
- Regular reports and communication with the Department of Health, primary care trusts, local health services, colleagues in the statutory and voluntary sector
- Training for health professionals and workers from the statutory and voluntary sectors in how to give brief opportunistic smoking cessation advice
- Establishment of “special” services—for example, for pregnancy and family service, young people, smokers from deprived communities and excluded groups, ethnic minority communities, people with learning disabilities, homeless people, people with mental health problems
- Programme of monitoring and evaluation
- Supporting former clients

Key points

- Setting up a smoking cessation service is challenging but can be done quickly and effectively
- A service needs to be autonomous in terms of funding and overall administration
- There will be a substantial demand once it is established
- A service needs to be accessible, responsive, and adaptable
- Funding and autonomy need to be guaranteed for the medium term to ensure efficient staff recruitment and service development