Cornwall Health Research Unit

Cornwall's Local Area Agreement for Stop Smoking Services: Targeting Clients in Deprived Areas

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Executive Summary

- The 20% most deprived areas in Cornwall and the Isles of Scilly were identified using postcodes and an overall deprivation score using the English Indices of Deprivation.
- Between 2000 and 2005, 29% of a sample of clients (n=712) of the Stop Smoking Service were from the 20% most deprived areas.
- The 12 month quit rate between 2000 and 2005 for the same sample was 19% overall, with the results from separate surveys in the range of 14% to 24%.
- A telephone interview of a sample of 86 clients who resided in identified deprived areas and used the Stop Smoking Service indicated a 12 month quit rate of 28% for 2007-2008.
- Females and those over 60 were more likely to be successful at stopping smoking.
- Although the results were not statistically significant, clients living in North and East Cornwall had greater success in quitting smoking and those living in West Cornwall were least successful.
- Ninety-four per cent of all clients used some kind of product as part of their quit attempt. The majority (91%) used Nicotine Replacement Therapy.
- Seventy-six per cent of clients had their first contact with the Stop Smoking Service through their GP surgery.
- The vast majority of clients (86%) used a GP practice nurse with specialist training as their main contact when using the Stop Smoking Service.

1. Introduction

This report arises from the central government initiative of Local Area Agreements (LAAs) – public service contracts put in place to focus on areas of specific need, fully funded and backed by transparent targets.

LAAs are an initiative designed to give more freedom to local agencies in managing key issues in their area. Initially, 21 pilot agreements were established, each focusing on safer communities; children and young people; and healthier communities:

> *"Local Area Agreements are a new way of working to build a more flexible and responsive relationship between central government and a locality on the priority outcomes that need to be achieved at local level."* (Office of the Deputy Prime Minister website, 2004a)

No new money as such was committed to the initiative; rather there was a pooling of existing funding covering a wide range of departmental priorities, designed to reap the benefits of partnership and cross-sectional working across local statutory organisations.

In order to quantify the priority outcomes demanded by the Government, policymakers were required to agree medium- and long-term targets, using available data. In the case of smoking prevalence and cessation rates, a wealth of data is now available, for example, via the Local Intelligence Network Cornwall (LINC) database formerly maintained by Cornwall County Council (LINC, 2005). Such data can be used by health professionals to target particular sections of the population as part of an overall strategy to improve public health.

The first round of LAAs applied to the three-year period between April 2006 and April 2009. The full agreement contains 32 outcomes spread over the three strategic areas outlined above as well as a fourth strand - economy and enterprise (Cornwall Strategic Partnership, 2006). The seven outcomes

identified under the strategic area of 'Healthier Communities and Older People' are as follows:

- Improve health by reducing the number of smokers in Cornwall
- Improve the sexual health of the people living, working and visiting Cornwall
- Halt the rise in obesity
- Reduce health inequalities
- Improve mental health in the workforce and reduce suicides
- Improve the quality of life and independence of older people
- Increase the independence of vulnerable people through the provision of high quality housing related support in order to attain, maintain and extend their independence

The first LAAs to be completed for the 21 pilot areas in England were signed off by the Minister for Local and Regional Government in March 2005. Of the 20 LAAs published on the Government's website (Improvement and Development Agency, 2006), all but two had established targets relating to smoking cessation (one held the view that the available baseline data was inadequate). The most common targets proposed to address health inequalities caused by smoking were: increasing the number of quitters at four weeks (ten authorities); reducing the prevalence of adult smoking (nine); and addressing the number of women smoking during pregnancy (eight). Other targeted groups included older people in Neighbourhood Renewal (deprived) Areas, BME (Black Minority Ethnic) groups and those in manual socio-economic groups.

Cornwall Health Research Unit (CHRU), through its work with the Stop Smoking Services (SSS) in Cornwall, has built up a substantial amount of local data over the period 2000-2005, measuring not only the numbers of smokers recruited by the service, but also quitting success at both four-week and (for a representative sample of clients) 12 months (Watt *et al.,* 2002, 2005, 2007a). From the database of the 12-month follow-up surveys, together with the database of clients maintained by the SSS, it was possible

to analyse 12-month quit rates by age, gender, geographical location and form of intervention and to measure and compare quit rates in specified postcode areas.

Smoking prevalence has been shown in a number of studies to be higher in manual classes than for the adult population as a whole. For example, the General Household Survey for 2001 (Office for National Statistics, 2002) reported that smoking prevalence was 27% for the adult population overall, but 31% in manual groups. Later figures have shown a steady decrease in the proportion of adult smokers, with the General Household Survey for 2006 (Office for National Statistics, 2008) reporting overall adult prevalence declining to 22%. The equivalent figure for manual groups was 28%, suggesting that the gap was widening and that smokers in more deprived areas should be targeted with support. It was suggested by the Cornwall Stop Smoking Co-ordinator that a suitable target for the Cornwall LAA would be to increase (or maintain) current 12-month quit rates amongst clients resident in deprived areas in Cornwall and the Isles of Scilly which was consistent with the Government's strategy for tackling health inequalities (e.g. Department of Health, 2003).

Successful outcomes by the SSS in deprived areas can be measured by quantifying the degree to which the SSS is able to recruit clients from these areas; and by recording the percentage of clients recorded as abstinent from smoking at the time of the follow-up.

2. Aims

The first aim was to identify the 20% most deprived areas in Cornwall and the Isles of Scilly and then to identify the current quit rates in these areas. These rates would then be used to set achievable targets for the future (Watt *et al.,* 2007b).

The second aim involved assessing whether the SSS had achieved a 52 week target quit rate as set by the LAA for clients of the SSS who lived in the 20% most deprived areas.

3. Methods and Results

3.1 Identification of 20% Most Deprived Areas in Cornwall

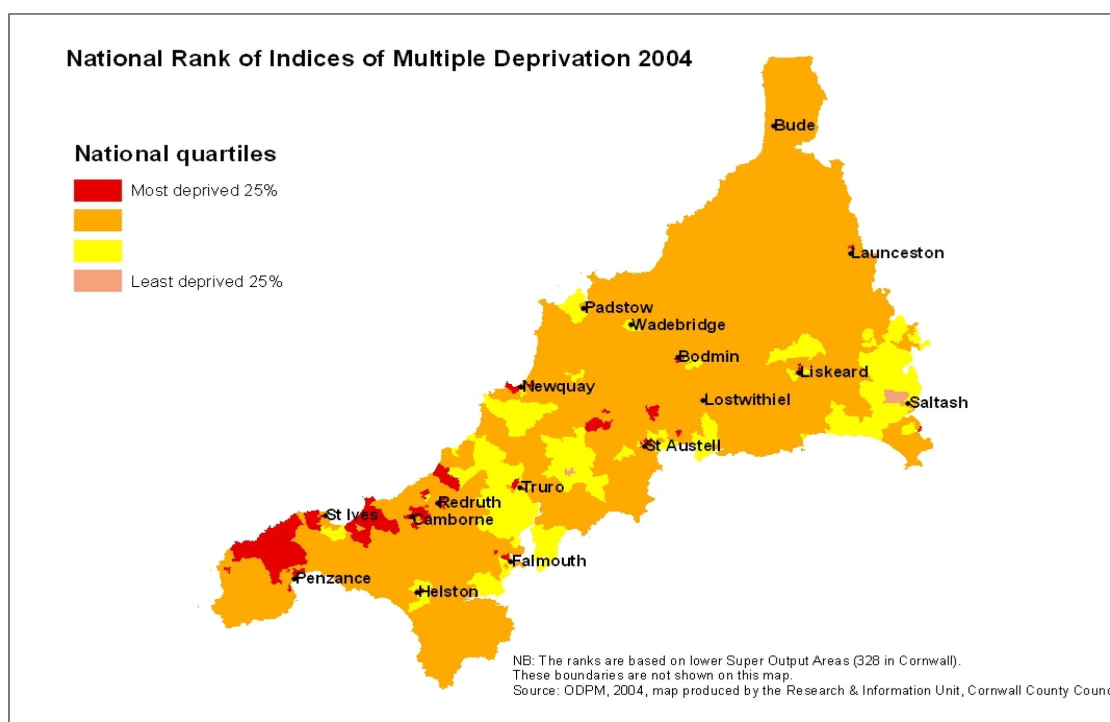
To establish a baseline for quit rates of the target client group it was necessary to identify which Stop Smoking clients fell into the 'deprived' category. The data recorded for each client contained no specific questions that would establish the status of the individual client by deprivation indicator, e.g. income, housing, employment etc. Therefore, address by postcode area was used as a proxy for determining deprivation status.

The Indices of Multiple Deprivation 2004 (Office of the Deputy Prime Minister, 2004b) bring together a multitude of data sources at Super Output Area (SOA) level and therefore it is possible to rank small areas either by individual deprivation indicators, or domains (income, employment etc.); or by an overall deprivation index that combines all the individual domains (income; employment; health; education, skills and training; barriers to housing and services; living environment). As there was little difference between the two scores used to identify deprivation it was decided that the overall deprivation score would be used to determine the 20% most deprived areas.

An SOA is a geographical unit with a minimum population of 1,000 and a mean population of 1,500[1]. For analysis purposes, each SOA is grouped into a quartile or quintile giving an overall indication of its level of prosperity. By way of illustration, the map overleaf shows which areas of Cornwall fall into which quartile for England overall:

[1] This is sometimes referred to as a Lower Layer Super Output Area, with larger units referred to as Middle and Higher Layer Output Areas.

Figure 1 – Deprivation Map of Cornwall



The map illustrates that in general, Cornwall avoids the serious deprivation evident in some inner-city areas such as those found in London and Liverpool. However, most of the county falls below the average. Of the 328 SOAs in Cornwall just two (in Probus and Saltash) are among the 25% least deprived SOAs in England.

The 66 most deprived SOAs (20% of 328) are listed in Appendix 1, together with deprivation score and rank amongst all English SOAs.

3.2 Identification of Clients who Lived in Deprived Areas

The SSS client database that consisted of all clients interviewed as part of the 12-month follow-up survey between 2000 and 2006 (n=2471), was then analysed; and all cases that did not have postcodes corresponding to the 20% list of the most deprived areas were extracted. A variety of mapping software[2] was then used on the remaining dataset to establish whether each client was resident in a nominated deprived area. The software allowed matching of post codes to SOAs, thus allowing residency status by deprivation area to be

[2] Neighbourhood Statistics and GeoConvert

established. The information extracted from the dataset was recorded on to a Microsoft Excel database to tabulate the results into the following categories:

- Total cases
- Deprived cases – total number of cases identified as resident in one of the 66 most deprived SOAs
- % Deprived – percentage of SSS clients resident in deprived areas
- Quit – numbers of deprived cases recorded as successful quitters after 12 months[3]
- Non-quit - numbers of deprived cases recorded as unsuccessful quitters after 12 months
- Partial - numbers of deprived cases recorded as partially successful quitters after 12 months
- Quit %/Non-quit %/Partial % - the three categories above expressed as a percentage of the overall number of deprived cases

3.3 Quit Rate for Clients Identified as Living in Deprived Areas

The results of the analysis are summarised in Table 1 from which it can be seen that the overall quit rate was 19% but ranged between 14% and 24% over the five year period of the follow-up surveys.

Table 1 - Quitting Outcomes at 12 Month Follow-up: 2000-2005 (% in brackets)

Year	Total Cases	Deprived Cases	Quit	Non-quit	Partial
2000-01	563	168 (30)	23 (14)	129 (77)	16 (9)
2001-02	551	171 (31)	31 (18)	128 (75)	12 (7)
2002-03	275	85 (31)	21 (24)	59 (69)	5 (6)
2003-04	551	147 (27)	31 (21)	112 (76)	4 (3)
2004-05	531	141 (27)	28 (20)	99 (70)	14 (10)
Total	**2471**	**712 (29)**	**134 (19)**	**527 (74)**	**51 (7)**

It is relevant to note that over the five year period of the surveys, 29% of the clients of the SSS were drawn from the 20% most deprived areas of the

[3] The definition of a successful quitter for the purposes of reporting results is described in section 3.4.5 of this report.

population. This result replicates similar findings by Bauld and Martin (2006), which covered a number of Stop Smoking Services elsewhere in England. The overall quit rate of 19% compares to a rate of 21% for the full sample of 12 month follow-up surveys carried out in Cornwall over this period (Watt *et al.,* 2002, 2005, 2007a). A quit rate of 19% by 2008/09 was the stretch target (a demanding target requiring innovative changes in working practices if it is to succeed) set for those living in the 20% most deprived areas in Cornwall (Cornwall Strategic Partnership, 2006).

3.4 Telephone Survey to Establish Whether Target Quit Rate of 19% was Achieved at 52 Week Follow-Up

3.4.1 Design

A longitudinal telephone survey of a sample from the 515 smokers who resided in the 20% most deprived areas of Cornwall and registered with the Stop Smoking Services between August and November 2007.

3.4.2 Sample

To detect a 19% improvement in the quit rate a minimum sample of 70 (90% power, $p<0.05$) was needed. This was calculated using SPSS SamplePower2.

3.4.3 Data Collection

A short questionnaire was designed to describe the success of those attending the SSS in Cornwall, and to elicit reasons for either successful or unsuccessful attempts to give up smoking. The questions related to the clients' reasons for success or failure and information about cessation aids such as Nicotine Replacement Therapy (NRT), Zyban or Champix (Appendix 2).

3.4.4 Procedure

When contacting the SSS for the first time, each client was asked to sign a declaration stating that they agree to be contacted by representatives of the SSS, and for the data collected to be used for evaluation purposes.

Telephone numbers for the survey were provided in the database for the SSS; if these were incorrect or not available, the local telephone directory was used. Three attempts were made to clients to ask if they would participate in the interview. All calls were made on a weekday in one of the following time periods: 10am – 12 noon; 2pm – 4pm; 6pm – 7pm. The interviews lasted between 5 and 25 minutes depending on the willingness of the clients to talk in detail about their experience in attempting to quit.

3.4.5 Definition of 'Quit'

During an earlier study (Watt *et al.,* 2002) it was clear that the Department of Health definition of a successful quitter (not smoked at any time since two weeks after the original quit date, Department of Health, 1999) was insufficiently discriminating at the 52 week follow up to recognise the progress of many clients. For example, the definition excluded those who believed they had broken their smoking habit, but did still smoke the occasional cigarette in a social situation; also those who had made repeated attempts to quit in the early stages, eventually stopping for good, not having smoked for, say, nine months. To accommodate these types of clients, the following definition was employed after consultation with the Cornwall SSS Co-ordinator: a successful quitter was not smoking at the time of the follow up **and** had not relapsed from the quit attempt for more than 30 days over the 12 month period. Clients found to have given up smoking at the time of follow up, but who did not otherwise meet this definition were classified as 'partially successful'.

3.4.6 Results of Telephone Survey

Table 2 shows the demographic breakdown of clients who completed the questionnaire. The geographical areas relate to the Primary Care Trust (PCT) boundaries before these were merged into a single Cornwall PCT in October 2006.

Table 2: Demographic Characteristics by Primary Care Trust (PCT) (n=86) (% in brackets)

	West	Central	North & East	Total
Male (n=38)				
18-29	3 (17)	(3 (20)	0	6 (16)
30-39	2 (11)	2 (13)	2 (40)	6 (16)
40-49	3 (17)	2 (13)	0	5 (13)
50-59	4 (22)	4 (27)	1 (20)	9 (24)
60+	6 (33)	4 (27)	2 (40)	12 (32)
Female (n=48)				
18-29	5 (17)	5 (36)	1 (20)	11 (23)
30-39	5 (17)	2 (14)	2 (40)	9 (19)
40-49	8 (28)	4 (29)	0	12 (25)
50-59	4 (14)	2 (14)	0	6 (13)
60+	7 (24)	1 (7)	2 (40)	10 (21)

It can be seen that more females than males were interviewed; and that fewer clients from North and East Cornwall PCT were interviewed. However, it should be noted that, of the 66 deprived SOAs, only 10 (15%) were located in the area covered by this PCT.

Based on the definitions set out in the previous section, of the 86 clients interviewed 24 (28%) were successful, 7 (8%) partially successful and 55 (64%) unsuccessful. These results were compared with the findings from a similar study carried out on all the users of the SSS in 2005 (Watt *et al.,* 2007a) and showed a higher success rate in the deprived area. Comparable figures for all users from this study (n=531) were: successful 24%, partial successful 8% and unsuccessful 68%.

Table 3 presents the success rates recorded in various sub-groups of the overall sample. Chi-square calculations show the statistical significance of any differences between groups.

Table 3: Success Rates by Gender, Age Band and Location (n=86) (% in brackets)

	Successful (n=24)	Partial (n=7)	Unsuccessful (n=55)	Value of p
Gender				
Male	9 (24)	4 (11)	25 (66)	
Female	15 (31)	3 (6)	30 (63)	0.623
Age				
18-29	4 (24)	1 (6)	12 (71)	
30-39	3 (20)	0 (0)	12 (80)	
40-49	5 (29)	2 (12)	10 (59)	
50-59	2 (13)	2 (13)	11 (73)	
60+	10 (45)	2 (9)	10 (45)	0.402
Location				
West Cornwall	9 (19)	3 (6)	35 (74)	
Central Cornwall	10 (34)	4 (14)	15 (52)	
North & East Cornwall	5 (50)	0 (0)	5 (50)	0.115

The results illustrated in Table 3 indicate that females achieved a higher success rate (31%) than males (24%), which reverses the trend found in previous studies which found that men consistently achieved higher quit rates than women (Watt *et al.,* 2007a). However, the results were not statistically significant and the sample size was small.

With regard to age, the results confirm the pattern observed over the last four years that quitters in the over-60s age band achieved higher success rates than those in other bands. Again the results were not statistically significant.

With regard to clients by PCT, North and East Cornwall had a higher success rate than those living in other areas, although the observed differences were not statistically significant.

Table 4: Main Product Used to Stop Smoking (n=81*) (% in brackets)

	Successful (n=21)	Partial (n=7)	Unsuccessful (n=53)	Total (n=81)	Value of p
Nicotine Replacement Therapy	19 (26)	7 (9)	48 (65)	74	
Zyban			1 (100)	1	
Chewing Gum	1 (50)		1 (50)	2	
Champix	1 (25)		3 (7)	4	
Total	21 (26)	7 (9)	53 (65)	81	0.058

* 4 clients did not use a product and there was missing data from 1 client

The majority who took part in the survey used nicotine replacement therapy (91%) and of these 19 were successful in quitting.

In terms of first contact with the SSS, the most frequent contact was via the client's GP surgery (n=64); and 19 (30%) who made contact in this way were successful quitters. Other methods of contact were via the Helpline (n=6) of whom none were successful; and via the pharmacy (n=3) of whom all were successful.

Table 5: Main Contact When Using the Stop Smoking Service (n=86) (% in brackets)

	Successful	Partial	Unsuccessful	Total
Pharmacist	3 (100)	0 (0)	0 (0)	3
Stop Smoking Nurse	18 (24)	7 (9)	49 (66)	74
Helpline Counsellor	0 (0)	0 (0)	0 (0)	0
Other#	3 (33)	0 (0)	6 (67)	9
Total	**24**	**7**	**55**	**86**

** 1 respondent had no meaningful contact with the SSS*
 # - midwives, health visitors, hospital staff, workplace counsellors

It is of value to note the main contact made by clients whilst they used the SSS. The majority of clients (86%) continued to access the SSS through the GP practice nurse with specialist training at their local surgery.

4. Conclusions

The aims of this study were to assess whether the Stop Smoking Service in Cornwall was reaching clients in areas of deprivation and to evaluate how effective the service was at helping people stop smoking. The main outcome was a 12 month quit rate with a target set by the LAA of 19%. The results indicate that the 12 month quit rate for residents of the 20% most deprived areas was 28%; and that females and those aged over 60 were most likely to be successful.

With an increasing body of evidence suggesting that those resident in the poorest areas and those in lower paid occupations have most difficulty in giving up smoking (e.g. Bauld *et al.,* 2007), together with the latest prevalence rates showing a larger gap between the numbers of smokers in this group compared to the adult population overall (Office for National Statistics, 2008), the Department of Health have taken a policy decision to target this group in media campaigns (Primarolo, 2008). In Cornwall, the opening of additional Stop Smoking clinics in key areas was an attempt to target the same groups as those identified by central marketing strategies.

The evidence reported here suggests that there has been some success following this change of emphasis. In earlier surveys (Watt *et al.,* 2002, 2005, 2007a) the average quit rate for those in the 20% most deprived areas was 19% - for the sample interviewed for this study there was an increase to 28%.

What is not reviewed here is the cost effectiveness involved in putting additional resources into the identified areas, and whether there has been a diversion of attention from the large majority of clients that generally access the services via their GP surgery. Additionally, it is difficult in a study of this kind to separate the many factors that contribute to a successful quit attempt. For example, the attempts monitored in this report followed the ban on smoking in all public places and workplaces in England and Wales, and data (West, 2008) suggest that the ban has had a dramatic effect in reducing smoking prevalence. It is perhaps reasonable to assume that, based on this

wider evidence, quit success rates would have increased in any case following the ban.

Further research in this area might look more deeply into the motivations behind a quit attempt, which may include health concerns, finance, inconvenience, the influence of family and friends and increasingly the social impact as smokers become more of a minority group. Outside factors such as advertising, the price and availability of tobacco, pack warnings and public bans also contribute to this complex issue. In order to draw more fundamental conclusions it is recommended that any future studies consider both the cost effectiveness of new interventions as well as these wider determinants of a quit attempt.

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Appendices

Appendix 1

20% Most Deprived SOAs in Cornwall - IMD 2004

Local Rank	IMD Ref	SOA	Post Town	IMD Score	National Rank
1	E01018997	Penzance East	TR18 3	61.24	819
2	E01018910	Redruth North	TR15 1	55.69	1406
3	E01018870	Camborne South	TR14 7	54.15	1580
4	E01018995	Penzance Central	TR18 2	50.23	2256
5	E01019041	Mount Charles	PL25 4	48.75	2528
6	E01018875	Camborne West	TR14 7	47.03	2849
7	E01019056	St Blaise	PL24 2	45.57	3166
8	E01018996	Penzance East	TR18 3	44.03	3519
9	E01018841	Penwerris	TR11 2	43.40	3650
10	E01018930	Bodmin St Marys 1	PL31 1	41.87	4064
11	E01019029	Gannel	TR7 1	41.60	4130
12	E01018898	Illogan South	TR15 3	41.10	4274
13	E01018911	Redruth North	TR15 1	40.66	4396
14	E01019004	Penzance South	TR18 5	40.55	4431
15	E01019028	Gannel	TR7 1	39.75	4686
16	E01018897	Illogan South	TR15 3	39.44	4791
17	E01018868	Camborne North	TR14 8	39.37	4817
18	E01018999	Penzance East	TR18 2	39.36	4821
19	E01018860	Trescobeas	TR11 2	39.00	4929
20	E01019033	Gover	PL25 5	38.83	4971
21	E01019046	Poltair	PL25 4	38.49	5062
22	E01018933	Bodmin St Petroc 1	PL31 2	38.38	5097
23	E01018767	Liskeard North	PL14 3	37.56	5382
24	E01018878	Camborne West	TR14 7	36.30	5769
25	E01018836	Penryn	TR10 8	36.27	5780
26	E01019020	Edgcumbe North	TR7 2	36.01	5861
27	E01018867	Camborne North	TR14 8	35.35	6111
28	E01019001	Penzance Promenade	TR18 4	34.89	6272
29	E01019008	St Ives North	TR26 1	34.85	6278
30	E01018984	Hayle South	TR27 4	34.62	6354
31	E01018865	Camborne North	TR14 8	34.42	6429
32	E01018857	Trehaverne and Gloweth	TR1 3	34.24	6484
33	E01018888	Helston South	TR13 8	33.86	6637
34	E01018838	Penwerris	TR11 2	33.37	6826
35	E01018949	Launceston 1	PL15 8	33.20	6896
36	E01019022	Edgcumbe South	TR7 2	32.56	7127
37	E01018797	Torpoint East	PL11 2	32.53	7139
38	E01019069	St Stephen	PL26 7	31.95	7344
39	E01018991	Morvah, Pendeen and St Just	TR19 7	31.84	7390
40	E01018873	Camborne South	TR14 8	31.63	7455
41	E01018809	Boscawen	TR1 2	31.57	7478
42	E01018978	Gwinear, Gwithian and Hayle East	TR27 5	31.54	7492
43	E01018893	Illogan North	TR16 4	31.31	7588
44	E01019009	St Ives North	TR26 3	31.29	7594
45	E01018928	Bodmin St Mary's 2	PL31 1	31.28	7595

46	E01018982	Hayle North	TR27 5	31.02	7712
47	E01018993	Morvah, Pendeen and St Just	TR19 7	30.97	7729
48	E01018998	Penzance East	TR18 2	30.94	7736
49	E01018825	Mount Hawke	TR4 8	30.94	7740
50	E01018977	Gulval and Heamoor	TR18 3	30.92	7750
51	E01018913	Redruth South	TR15 2	30.92	7751
52	E01019074	Treverbyn	PL26 8	30.80	7801
53	E01018980	Gwinear, Gwithian and Hayle East	TR27 5	30.74	7829
54	E01018771	Liskeard South	PL14 3	30.58	7890
55	E01019051	Rialton	TR7 3	30.45	7958
56	E01019047	Poltair	PL25 5	30.23	8053
57	E01018989	Madron and Zennor	TR20 8	30.16	8071
58	E01019055	Rock	PL26 8	30.10	8090
59	E01019012	St Ives South	TR26 1	29.82	8206
60	E01019034	Gover	PL25 5	29.69	8255
61	E01018869	Camborne South	TR14 7	29.35	8415
62	E01018770	Liskeard South	PL14 4	29.32	8435
63	E01018990	Marazion and Perranuthnoe	TR17 0	29.26	8470
64	E01018979	Gwinear, Gwithian and Hayle East	TR27 5	28.73	8696
65	E01018961	Poughill & Stratton 1	EX23 8	28.53	8795
66	E01019070	St Stephen	PL26 7	28.52	8798

The range of populations of the 66 SOAs above was between 1,160 and 2,170 (Census 2001 data). The sum of the populations of the 66 areas was 100,010, representing 19.95% of the population of Cornwall.

Appendix 2

Questionnaire Used in Telephone Survey

Cornwall & Isles of Scilly Stop Smoking Services

52 Week Follow-Up Questionnaire

LAA Study 2007-2009

Date………………Name…………………………………ID ☐☐☐☐

Questions:

1. Have you stopped smoking?

Yes ☐ Answer questions 6-11

No ☐ Answer questions 2-5, 11

UNSUCCESSFUL QUITTERS (q. 2–5)

2. How did you first contact the Stop Smoking Services?

Pharmacy ☐

GP Surgery ☐

Helpline ☐

Other (please state)
…………………………………………………………………………

3. Before your initial contact, how did you become aware of the Stop Smoking Service?

- Personal recommendation ☐
- Discussion with GP or health professional ☐
- Hospitalisation ☐
- Pregnancy ☐
- Media ☐
- Not previously aware ☐
- Other (please state)

……………………………………………………………………

4. Did you try using any products to help you stop smoking?

Yes ☐ No ☐

If yes, what did you try?

- Nicotine Replacement Therapy ☐
- Zyban ☐
- Sweets ☐
- Chewing Gum ☐
- Other (please state)

……………………………………………………………………

5. Who was your main contact at the Stop Smoking Service?

Pharmacist ☐

Stop Smoking Nurse ☐

Helpline Counsellor ☐

Other (please state)
…………………………………………………………………………

I'm sorry that your attempt to give up was unsuccessful. Many people make a number of attempts to give up before they eventually quit. Would you like to speak to someone from the Stop Smoking Service again? (Give number or note details as necessary)

Reply
……………………………………………………………………………
……………………………………………………………………………
……………………………………………………………………………
………………………………………

GO TO QUESTION 11

SUCCESSFUL QUITTERS (q. 6-11)

6. How did you first contact the Stop Smoking Services?

Pharmacy ☐

GP Surgery ☐

Helpline ☐

Other (please state)
…………………………………………………………………………

7. Before your initial contact, how did you become aware of the Stop Smoking Service?

Personal recommendation ☐

Discussion with GP or health professional ☐

Hospitalisation ☐

Pregnancy ☐

Media ☐

Not previously aware ☐

Other (please state)
……………………………………………………………………

8. Did you try using any products to help you stop smoking?

Yes ☐ No ☐

If yes, what did you try?

Nicotine Replacement Therapy ☐

Zyban ☐

Sweets ☐

Chewing Gum ☐

Other (please state)
……………………………………………………………………

9. Who was your main contact at the Stop Smoking Service?

Pharmacist ☐

Stop Smoking Nurse ☐

Helpline Counsellor ☐

Other (please state)
…………………………………………………………………………

10. Did you have any relapses during the last 12 months?

Yes ☐ No ☐

If yes how long did these last for? (convert into no. of days)

………….. days

11. Is there anything else about your experience in giving up smoking that you would like to comment upon?

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Thank you for taking the time to answer these questions.