



Cornwall Health Research Unit

Still Making a Difference:

The Stop Smoking Services in Cornwall & the Isles of Scilly

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Executive Summary

- This report represents the fourth phase of a study which firstly monitors users of the Cornwall Stop Smoking Services (SSS) in 2004/05 to assess how successful the SSS has been and secondly explores the reasons why unsuccessful clients have started smoking again.
- The methods used were a telephone survey at 52 week follow up using a specifically designed questionnaire. There were some small modifications to the questionnaire from previous years, reflecting reasons for unsuccessful quit attempts and awareness of the Service.
- Of the 531 surveyed clients who used the service in 2004/05, 23.9% were successful in quitting after 52 weeks.
- The number of successful quitters has improved over the four phases of the study. Between the first and fourth phases there has been a 5.6% increase in the success rate. However, the proportion of partial successful quitters has decreased by 1.9%.
- More males (27.0%) were successful at quitting than females (21.4%).
- There was no significant difference between age groups in being successful at quitting, although there is evidence that those in the over-60 age band achieve higher quit rates.
- There was no significant difference in the success rates of participants when grouped according to the three Primary Care Trusts in Cornwall. (These Trusts were merged into a single Cornwall Primary Trust in October 2006).
- The majority of first contacts with the SSS took place at the GP surgery (75.0%), although there is a trend towards alternative methods of community intervention such as workplaces and supermarkets.

- Nicotine Replacement Therapy (NRT) remained the most useful aid when attempting to stop smoking.
- The most frequent reasons given for having restarted smoking after attempting to quit were stress (general or in response to a specific event), lack of willpower and enjoyment. This has not changed over the four phases of the study.
- The Stop Smoking Service is still considered to be 'helpful' or 'very helpful' by the majority of clients: 89% of successful quitters; 72.5% of partially successful quitters; and 72% of unsuccessful quitters.

Introduction

This report is the fourth in a series commissioned by the Cornwall Stop Smoking Service (SSS) to examine the efficacy of the services they provide to assist those in Cornwall who have attempted to quit smoking during the period 1999-2005.

The first report was an evaluation of how well the SSS was promoted during 1999, and assessed its impact upon public awareness. The results of this assessment were provided in a report published in February 2000 (*Stop Smoking Services in Cornwall: Effect of 1999 Campaign on Awareness and Behaviour*) and the information was used by the SSS to assist policy formulation for service delivery in the following year.

The second stage of the project involved an assessment of the effectiveness of the services provided by the SSS by evaluating those who had used the service 52 weeks after their 'quit date'. This evaluation included clients who had used the service over the previous two-year period. The report of this evaluation was first published in October 2002 and updated in May 2003 (*Stop Smoking Services in Cornwall: An Assessment of the Service*). The most recent report, published in April 2005 (*Making a Difference: The Stop Smoking Services in Cornwall & the Isles of Scilly Assessment of the Service & Effect on Behaviour & Smoking Habits*), built on the earlier data and focused on clients registering with the Service between May 2003 and April 2004.

This fourth report builds on the work previously undertaken and in addition undertakes some new analysis.

Aims

This project has six main aims:

1. To monitor those people in Cornwall and the Isles of Scilly who have used SSS and assess how successful the services have been in helping them stop smoking.
2. To gather information on the reasons why people may have started smoking again after using the SSS.

3. To undertake a longitudinal analysis on the data collected between 2000 and 2005 to assess whether it is becoming more difficult to recruit smokers to the scheme as the numbers of people who are keen to stop may be diminishing, leaving a level of hard core smokers who may need a different approach.
4. To investigate whether people are returning to the SSS following previous contact.
5. To investigate differences in outcome between different SSS service provision.
6. To investigate the penetration of the SSS in areas of high deprivation, and, if possible, to compare outcomes with other areas.

Note: The work involved in aims 3, 4 and 6 above is ongoing and will be the subject of separately published reports.

Methodology

The methodology is identical to that used in the previous evaluations, and is repeated here for convenience.

Design

A telephone survey of users of the SSS 52 weeks following registration with the SSS between September 2004 and August 2005.

Sample

Quota sampling was used to stratify by age (five age bands), gender and outcome (successful or unsuccessful). A sample size of > 50 individuals per subgroup was identified as being consistent with an expected quit rate of 13% detected in each group which was the national quit rate for those using specialist services in 2001 (DoH, 2001).

Data Collection

A 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 questionnaire was piloted with 20 users of the SSS. The final version of the questionnaire contained separate sections for successful and unsuccessful quitters. The questions related to the clients' reasons for success or failure, information about cessation aids such as NRT or Zyban (originally an anti-depressant drug now seen to reduce the craving for tobacco), and the clients' views of the service provided. For this fourth phase of the project (clients with quit dates between September 2004 and August 2005) a number of small revisions were made to the questionnaire, reflecting earlier experience and the particular requirements of the current Stop Smoking Co-ordinator. These changes are referred to in the results section.

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.

Outcome

During the pilot study 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, DoH, 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’.

Results

This section has been divided into five general headings, as follows:

- i. Demographic Characteristics
- ii. Factors Around Cessation
- iii. Features of SSS
- iv. Awareness of Advertising
- v. Analysis over Time

For the most part, the detailed results relate to the most recent survey, and, under the heading ‘Analysis over Time’, an indication is given in graphical form of how selected results compare with previous years. Where such comparisons are made, reference is made to the four phases of the study, which were as follows:

Phase 1 – clients with quit dates between September 1999 and August 2000;

Phase 2 – clients with quit dates between September 2000 and March 2002;

Phase 3 – clients with quit dates between April 2003 and March 2004;

Phase 4 – clients with quit dates between- September 2004 and August 2005.

In total, 5,489 clients contacted the Cornwall SSS in Phase 4, and 531 questionnaires were completed. As was the case in previous phases, the majority of quotas were filled for age groups 30 and above; however there was some difficulty in contacting a sufficient number of clients aged between 18 and 29. This was due to a variety of reasons that included unavailability at the time of the calls, unobtainable phone numbers (often a mobile) or where the client had moved house, which occurred more frequently in the younger age bands. For the most part the information provided by

the SSS was accurate; however there were some cases where either no telephone number was given or the details provided proved to be incorrect.

(i) Demographic Characteristics

Table 1 shows the demographic breakdown of participants who completed the questionnaire.

Table 1: Questionnaires Completed by Age, Gender and Primary Care Trust 2004/05 (n=531)

Age band	Male (%) n=237	Primary Care Trust			Female (%) n=294	Primary Care Trust		
		West (%)	Central (%)	North (%)		West (%)	Central (%)	North (%)
18-29	30 (12.7)	11 (13.9)	10 (11.6)	9 (12.5)	44 (15.0)	20 (17.5)	12 (13.3)	12 (13.3)
30-39	50 (21.1)	14 (17.7)	20 (23.3)	16 (22.2)	76 (25.9)	29 (25.4)	22 (24.4)	25 (27.8)
40-49	58 (24.5)	19 (24.1)	21 (24.4)	18 (25.0)	67 (22.8)	27 (23.7)	18 (20.0)	22 (24.4)
50-59	55 (23.2)	19 (24.1)	20 (23.3)	16 (22.2)	59 (20.1)	21 (18.4)	21 (23.3)	17 (18.9)
60+	44 (18.6)	16 (20.3)	15 (17.4)	13 (18.1)	48 (16.3)	17 (14.9)	17 (18.9)	14 (15.6)
Total		79	86	72		114	90	90

Based on the definitions set out in the previous section, of the 531 clients interviewed 127 (23.9%) were successful, 40 (7.5%) partially successful and 364 (68.5%) unsuccessful. These results are almost identical to 2003/04, as Table 2 shows:

Table 2: Comparison of Quit Rates

	2003/04	2004/05
Successful	129 (23.4%)	127 (23.9%)
Partially Successful	42 (7.6%)	40 (7.5%)
Unsuccessful	380 (69.0%)	364 (68.5%)
Total	551	531

Table 3: Analysis of Quitters by Gender, 2004/05 (n=531)

	Successful	Partial	Unsuccessful	Total
Male	64 (27.0%)	15 (6.3%)	158 (66.7%)	237
Female	63 (21.4%)	25 (8.5%)	206 (70.1%)	294
Total	127 (23.9%)	40 (7.5%)	364 (68.5%)	531

Men continue to show a higher success rate than women, although the difference has narrowed from 2003/04 when men were more than twice as likely to be successful than women (31.8% vs. 15.1%). The success rate for women is higher than at any previous phase of the study.

Table 4: Analysis of Quitters by Age, 2004/05 (n=531)

	Successful	Partially Successful	Unsuccessful	Total
18-29	16 (21.6%)	6 (8.1%)	52 (70.3%)	74
30-39	27 (21.4%)	12 (9.5%)	87 (69.0%)	126
40-49	31 (24.8%)	4 (3.2%)	91 (72.0%)	125
50-59	24 (21.1%)	11 (9.6%)	79 (69.3%)	114
60+	29 (31.5%)	7 (7.6%)	56 (60.9%)	92
Total	127 (23.9%)	40 (7.5%)	364 (68.5%)	531

The results shown in Table 4 confirm the pattern observed over the last four years, namely that quitters in the over-60s age band produce higher success rates than those in other bands.

Tables 5a and 5b illustrate differences in quitting by age and gender.

Table 5a: Analysis of Male Quitters by Age, 2004-05 (n=237)

	Successful	Partial	Unsuccessful	Total
18-29	8 (26.7%)	2 (6.7%)	20 (66.7%)	30
30-39	11 (22.0%)	6 (12.0%)	33 (66.0%)	50
40-49	19 (32.8%)	2 (3.4%)	37 (63.8%)	58
50-59	10 (18.1%)	3 (5.5%)	42 (76.4%)	55
60+	16 (36.4%)	2 (4.5%)	26 (59.1%)	44
Total	64 (27.0%)	15 (6.3%)	158 (66.7%)	237

Table 5b: Analysis of Female Quitters by Age, 2004-05 (n=294)

	Successful	Partial	Unsuccessful	Total
18-29	8 (18.2%)	4 (9.1%)	32 (72.7%)	44
30-39	16 (21.1%)	6 (7.9%)	54 (71.1%)	76
40-49	12 (17.9%)	2 (3.0%)	53 (79.1%)	67
50-59	14 (23.7%)	8 (13.6%)	37 (62.7%)	59
60+	13 (27.1%)	5 (10.4%)	30 (62.5%)	48
Total	63 (21.4%)	25 (8.5%)	206 (70.1%)	294

In 2003-04 the male success rate was higher in every age band. This pattern is repeated in 2004-05, with the exception of those aged between 50 and 59.

Table 6: Analysis of Quitters by PCT, 2004-05 (n=531)

	Successful	Partial	Unsuccessful	Total
West Cornwall PCT	50 (25.9%)	19 (9.8%)	124 (64.2%)	193
Central Cornwall PCT	36 (20.5%)	14 (8.0%)	126 (71.6%)	176
North & East Cornwall PCT	41 (25.3%)	7 (4.3%)	114 (70.4%)	162
Total	127 (23.9%)	40 (7.5%)	364 (68.5%)	531

Note – From October 1st 2006 the three PCTs have merged into one under NHS reorganisation.

Although the success rate in the Central Cornwall PCT area was lower than the other two in 2004/05, there is no evidence that this is part of a trend.

(ii) Factors Around Cessation

Table 7: Main Reasons for Wanting to Give up Smoking? (more than one answer permitted)

	Successful	Partial	Unsuccessful	Total
Encouragement/pressure from family and friends	38 (29.9%)	11 (27.5%)	59 (16.2%)	108 (20.3%)
Concerns about health (self or others)	86 (67.7%)	33 (82.5%)	290 (79.7%)	409 (77.0%)
Finance	21 (16.5%)	4 (10.0%)	69 (19.0%)	94 (17.7%)

Other reasons given included pregnancy and the recognition of smoking as an anti-social habit. As smokers within the adult population have become a minority, peer pressure in many cases works in reverse – the social norm is increasingly not to smoke. The implications of the forthcoming smoking ban in public places in England are discussed later in the report.

In this phase of the survey, 89.8% of clients used some kind of product as part of their quit attempt, compared to 92.9% in 2003-04. The results from this phase are shown in Table 8.

Table 8: Products Used to Stop Smoking (more than one answer permitted)

	Successful (n=110)	Partial (n=32)	Unsuccessful (n=335)	Total (n=477)
Nicotine Replacement Therapy	101 (91.8%)	30 (93.8%)	303 (90.4%)	434 (91.0%)
Zyban	4 (3.6%)	0 (0.0%)	18 (5.4%)	22 (4.6%)
Sweets	2 (1.8%)	1 (0.3%)	14 (4.2%)	17 (3.6%)
Chewing Gum	15 (13.6%)	7 (21.9%)	59 (17.6%)	81 (17.0%)

The main reasons identified for restarting smoking are shown in Table 9.

Table 9: Main Reasons Given for Restarting Smoking

	Partial (n=40)	Unsuccessful (n=364)	Total (n=404)
Stress (specific event)	5 (12.5%)	64 (17.6%)	69 (17.1%)
Stress (general)	5 (12.5%)	105 (28.8%)	110 (27.2%)
<i>Stress (total)*</i>	<i>10 (25.0%)</i>	<i>169 (46.4%)</i>	<i>179 (44.3%)</i>
Lack of support	0 (0.0%)	7 (1.9%)	7 (1.7%)
Habit/craving/lack of willpower	28 (70.0%)	129 (35.4%)	157 (38.9%)
Enjoyment	3 (7.5%)	34 (9.3%)	37 (9.2%)
Partner or member of family smoking	0 (0.0%)	14 (3.8%)	14 (3.5%)
Peer pressure	0 (0.0%)	14 (3.8%)	14 (3.5%)
Weight gain	1 (2.5%)	12 (3.3%)	13 (3.2%)

* In previous years the options were Stress (home) or Stress (work). The combined percentage for these categories in 2003-04 was 48.3%.

Other reasons given for restarting smoking included boredom and an adverse reaction to NRT or Zyban.

(iii) Features of SSS

Table 10: Method of First Contact with the Stop Smoking Service

	Successful	Partial	Unsuccessful	Total
Pharmacy	7 (5.5%)	5 (12.5%)	23 (6.3%)	35 (6.6%)
GP Surgery	94 (74.0%)	28 (70.0%)	276 (75.8%)	398 (75.0%)
Helpline	6 (4.7%)	2 (5.0%)	17 (4.7%)	25 (4.7%)
Other*	20 (15.7%)	5 (12.5%)	48 (13.2%)	73 (13.7%)
Total	127	40	364	531

Other* includes midwives, health visitors, workplace advice and as a result of hospitalisation for other medical reasons.

There has been a trend away from GPs as the first point of contact since the previous survey (84.9% to 75.0%). The proportion contacting a pharmacy has increased from 2.4% to 6.6%, and those answering 'other' rose from 6.2% to 13.7%, due to the increasing incidence of stop smoking groups in workplaces and local supermarkets.

Table 11: First Awareness of the Stop Smoking Service

	Successful	Partial	Unsuccessful	Total
Personal recommendation	17 (13.4%)	5 (12.5%)	34 (9.3%)	56 (10.5%)
Discussion with GP or health professional	78 (61.4%)	27 (67.5%)	250 (68.7%)	355 (66.9%)
Hospitalisation	11 (8.7%)	1 (2.5%)	3 (0.8%)	15 (2.8%)
Pregnancy	1 (0.8%)	1 (2.5%)	9 (2.5%)	11 (2.1%)
Media	15 (11.8%)	6 (15.0%)	47 (12.9%)	68 (12.8%)
Other	5 (3.9%)	0 (0.0%)	21 (5.8%)	26 (4.9%)
Total	127	40	364	531

This question was rephrased from previous surveys in an attempt to break down in greater detail the factors that draw clients to the service. It is interesting to note that of those who gave up (for either medical or logistical reasons) because of an enforced stay in hospital, 11 out of 15 (73.3%) remained quitters after one year.

Table 12: Main Contact When Using the Stop Smoking Service

	Successful	Partial	Unsuccessful	Total
Pharmacist	9 (7.1%)	6 (15.0%)	25 (6.9%)	40 (7.5%)
Stop Smoking Nurse	103 (81.1%)	30 (75.0%)	296 (81.5%)	429 (80.1%)
Helpline Counsellor	0 (0.0%)	1 (0.3%)	2 (0.5%)	3 (0.6%)
Other#	15 (11.8%)	3 (7.5%)	40 (11.0%)	58 (10.9%)
Total	127	40	363	530*

* 1 respondent had no meaningful contact with the SSS

- midwives, health visitors, hospital staff, workplace counsellors

The vast majority of clients continue to access the Stop Smoking Services through the Stop Smoking Nurse at their GP surgery, although the percentage of quitters following this route has fallen slightly, from 84.9% in 2003-04 to 80.1% in 2004/05.

Table 13: Frequency of Contact with the Stop Smoking Service

	Successful	Partial	Unsuccessful	Total
Initial contact only	20 (15.7%)	8 (20.0%)	64 (17.6%)	92 (17.3%)
Irregular one-to-one contact	20 (15.7%)	8 (20.0%)	64 (17.6%)	92 (17.3%)
Regular one-to-one contact	82 (64.6%)	24 (60.0%)	216 (59.3%)	322 (60.6%)
Irregular group meetings	0 (0.0%)	0 (0.0%)	3 (0.8%)	3 (0.6%)
Regular group meetings	5 (3.9%)	0 (0.0%)	17 (4.7%)	22 (4.1%)
Total	127	40	364	531

The results presented in Table 13 show a similar pattern to 2003-04. Despite the new initiatives with stop smoking groups, the proportion of clients attending a group has increased only from 3.1% to 4.7%.

Table 14: Perceived Helpfulness of the Stop Smoking Services

	Successful	Partial	Unsuccessful	Total
Very helpful	70 (55.1%)	18 (45.0%)	136 (37.4%)	224 (42.2%)
Quite helpful	43 (33.9%)	11 (27.5%)	126 (34.6%)	180 (33.9%)
Neither helpful nor unhelpful	13 (10.2%)	8 (20.0%)	63 (17.3%)	84 (15.8%)
Quite unhelpful	1 (0.8%)	3 (7.5%)	34 (9.3%)	38 (7.2%)
Very unhelpful	0 (0.0%)	0 (0.0%)	5 (1.4%)	5 (0.9%)
Total	127	40	364	531

The results presented in Table 14 are similar to those obtained in 2003-04. The proportion of clients replying either 'helpful' or 'very helpful' rose marginally to 76.1% from 75.9%. Less than one in every hundred clients described the service as 'very unhelpful'. Reasons given for dissatisfaction were usually based on a clash of personalities or unavailability of the Stop Smoking Nurse – many clients spoke of waiting lists because of increasing interest in the service.

Table 15: Aspects of the Stop Smoking Services Considered Helpful

	Successful	Partial	Unsuccessful	Total
Counselling	100/102 (98.0%)	24/25 (96.0%)	238/257 (92.6%)	362/384 (94.3%)
Group therapy	4/4 (100.0%)	0/0 (0.0%)	20/24 (83.3%)	24/28 (85.7%)
Advice	123/125 (98.4%)	35/39 (89.7%)	321/355 (90.4%)	479/519 (92.3%)
Support	103/105 (98.1%)	28/30 (93.3%)	266/301 (88.4%)	397/436 (91.1%)

Note: Not all categories were relevant to every quitter. The percentages shown are those who replied 'helpful' as a proportion of those who answered the question

The results show that satisfaction levels are broadly consistent with levels of success.

As an addition to this phase of the study analysis was undertaken on the various forms of contact clients would have with the SSS. Each case on the SSS database is allocated a 'Support Worker' according to the type of intervention received and the location of that intervention. There are four categories, defined as:

- GP Surgery
- Midwife
- Core team (financed and managed by the Service directly)
- Pharmacy.

The following table gives success rates by intervention:

Table 16: Analysis of Quitters by Type of Intervention, 2004/05 (n=531)

	Successful	Partial	Unsuccessful	Total
GP Surgery	66 (28.6%)	16 (6.9%)	149 (64.5%)	231
Midwife	3 (15.0%)	2 (10.0%)	15 (75.0%)	20
Core Team	46 (20.2%)	13 (5.7%)	169 (74.1%)	228
Pharmacy	12 (23.1%)	9 (17.3%)	31 (59.6%)	52
Total	127 (23.9%)	40 (7.5%)	364 (68.5%)	531

(iv) Awareness of Advertising

Additional analysis focused on awareness of the SSS and respondents were asked if they were aware of the local campaign on the commercial radio station Pirate FM.

The results are tabulated by age and gender and shown in Table 17:

Table 17: Awareness of Pirate FM Campaign

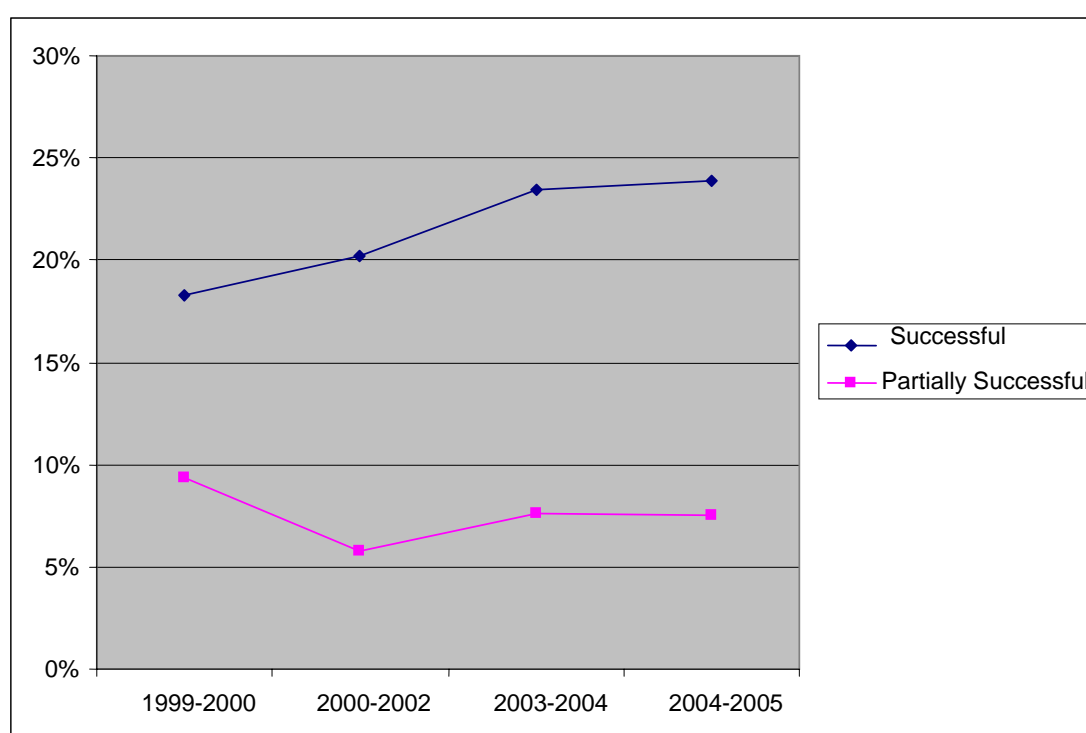
Age Band	Male		Female		Total	
	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>	<i>Yes</i>	<i>No</i>
18-29	12 (40.0%)	18 (60%)	23 (52.3%)	21 (47.7%)	35 (47.3%)	39 (52.7%)
30-39	24 (48.0%)	26 (52%)	42 (55.3%)	34 (44.7%)	66 (52.4%)	60 (47.6%)
40-49	22 (37.9%)	36 (62.1%)	32 (47.8%)	35 (52.2%)	54 (43.2%)	71 (56.8%)
50-59	18 (32.7%)	37 (67.3%)	8 (13.6%)	51 (86.4%)	26 (22.8%)	88 (77.2%)
60+	4 (9.1%)	40 (90.9%)	5 (10.4%)	43 (89.6%)	9 (9.8%)	83 (90.2%)
Total	80 (33.8%)	157 (66.2%)	110 (37.4%)	184 (62.6%)	190 (35.8%)	341 (64.2%)

Almost half (47.7%) of those under 50 were aware of the campaign, compared to 17.1% of the over-50s. The age demographic for the station is not made publicly available in the radio listening data published by RAJAR (Radio Joint Audience Research), but the station's official designation reflecting its musical offerings is 'adult contemporary', suggesting a target age group of 18-50.

(v) Analysis over Time

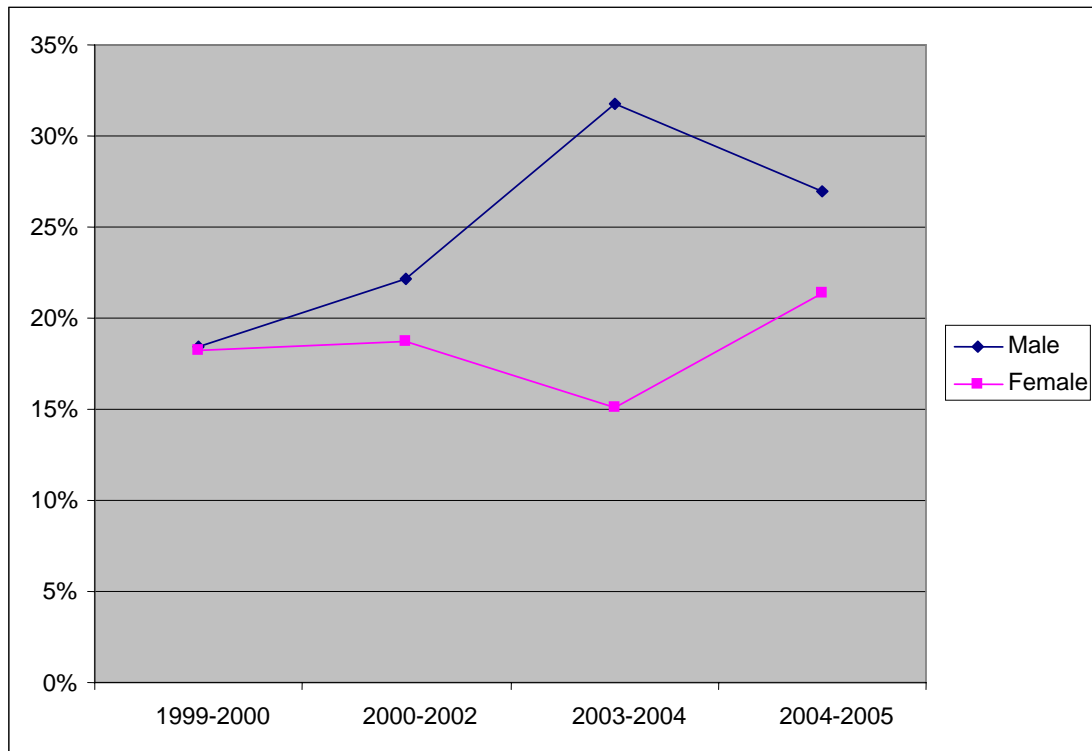
Figure 1 shows the results over the four phases of the study, illustrating the improvement in quit rates from 1999 to 2005. As would be expected after the first 3 years the percentage increase in successful quitters has slowed down. This could be due to the fact that over time the service has successfully addressed the needs of moderate smokers and those with strong motivation, and are left with the “hardcore” smokers who are the most difficult group to encourage.

Figure 1: Quit Rates from 1999-2005



The quit rate from the first phase of the study (18.3%) was compared to the quit rate from the latest phase (23.9%). The increase in quit rate was found to be marginally outside of the ranges traditionally used to indicate statistical significance in a chi-square test ($p=0.055$).

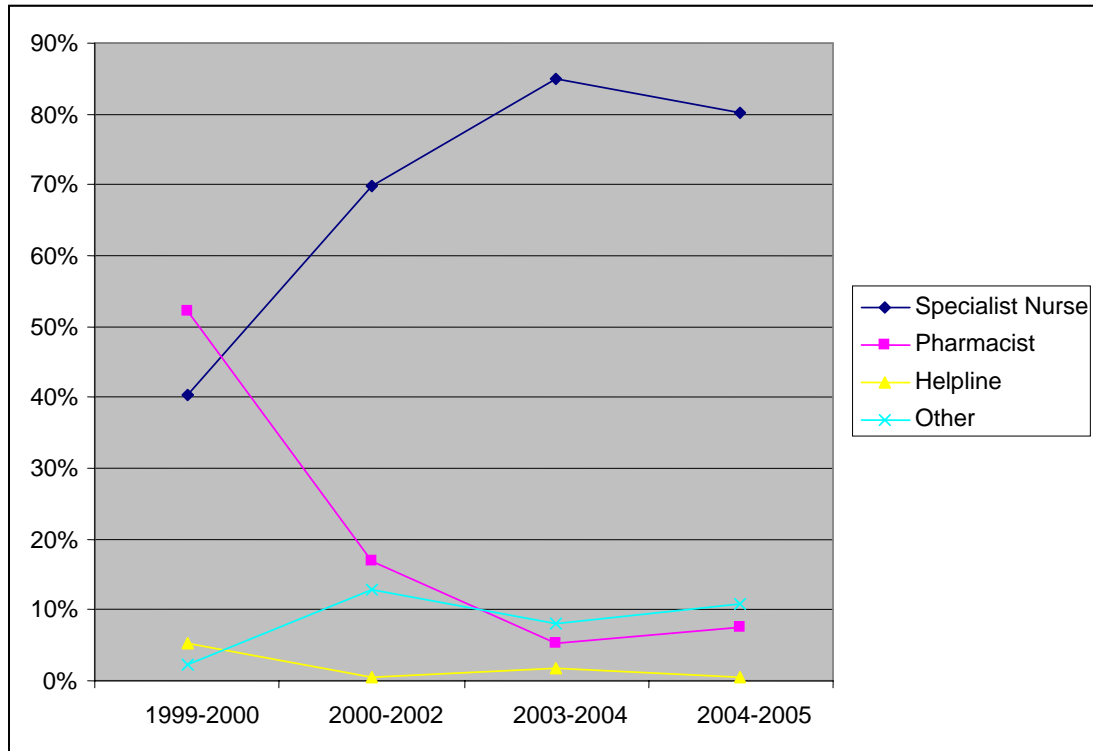
Figure 2: Percentage of Successful Male and Female Quitters, 1999-2005 (n=2461)



Quit rates for men have remained above those of women through the course of the study, and possible reasons for this are discussed later in the paper.

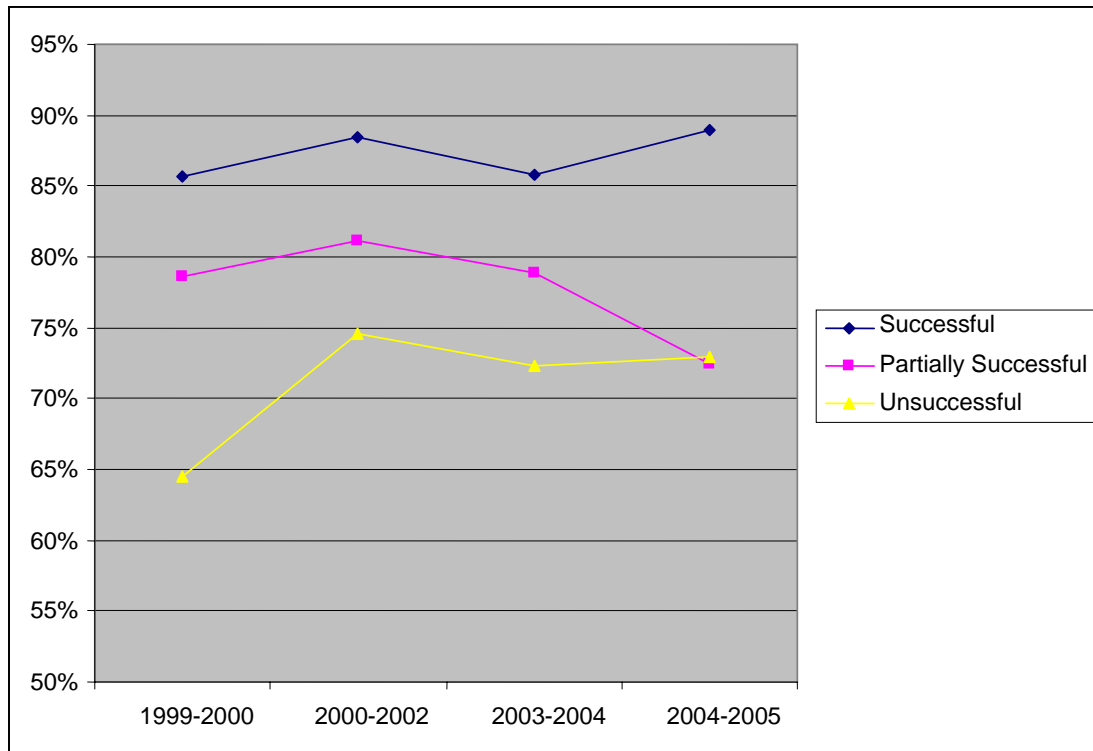
The way in which the service has evolved since its inception within the Cornwall Health Action Zone in 1999 is illustrated in Figure 3, which shows the main contact for clients during their quit attempt:

Figure 3: Main Contact, 1999-2005 (n=2461)



Since the beginning of the study, clients have been asked to indicate their level of satisfaction with the service. Figure 4 shows the trends observed over the course of the study since 1999:

Figure 4: Percentage of Clients finding the SSS either 'Very Helpful' or 'Quite Helpful', 1999-2005



Discussion

In this discussion section the key findings from the latest phase of the study are put into the wider context of smoking cessation policy and other data from the UK.

- **Of the 531 surveyed clients who used the service in 2004 - 2005, 23.9% were successful in quitting after 52 weeks.**

The recent NICE Rapid Review of NHS Smoking Cessation Treatments for England (Bell *et al.*, 2006) found five studies within the UK (including Cornwall) which measured success rates at 52 weeks or beyond. Of the success rates reported at 52 weeks, Cornwall showed the highest success rate at 23.4% (2003-04 results). However, there are number of confounding factors which make direct comparison difficult, principally the definition of success, which is more lenient in Cornwall than elsewhere (see p8). On the other hand, some studies only followed up those clients who were recorded as successful quitters at four weeks, whereas the work in Cornwall follows up a representative sample of all clients. The NICE review finds the range of quit rates reported at 52 weeks (13-23%) ‘... broadly consistent with international findings’ (Bell *et al.*, 2006).

Had the DoH’s strict definition of success (p7) been used for the Cornwall Service, the 52-week success rates would have been 17.4% (96/551) in 2003/04 and 19.2% (102/531) in 2004-05. The success rates in the other four studies identified by Bell *et al.* were 19%, 17.7%, 16.8% and 13%.

- **The number of successful quitters has improved over the four phases of the study. Between the first and fourth phases there has been a 5.6% increase in the success rate. However, the proportion of partial successful quitters has decreased by 1.9%.**

It is relevant to speculate whether quit rates, which seem now to be levelling out at 23-24%, will now begin to fall. It can be reasonably supposed that the vast majority of smokers in Cornwall are now aware of facilities offered by the SSS, whether

through their GP or pharmacy, by word of mouth or via the media. It might therefore be argued that the most motivated quitters will by now have had ample opportunity to seek appropriate support and guidance through the service, leaving a 'hard core' of smokers who, because of their social environment and personal circumstances, may find the prospect of quitting especially difficult. The service's plans to address the needs of potential quitters in deprived areas would seem to be particularly appropriate in the context of this perceived trend, with health inequalities being as evident in smoking data as with other markers of public health. The results achieved by the community workers put in place under the LAA initiative, as well as the smoking cessation role played by the newly appointed Health Trainers (community public health advisors appointed to highly deprived areas) will be of particular interest over the next few years.

Probably the biggest factor to affect quit rates in the near future will be the forthcoming ban on smoking in public places. From 1st July 2007 a ban on smoking in bars, restaurants and workplaces takes full effect in England, following the House of Commons vote in February 2006. The ban follows similar legislation passed in Ireland and Scotland, and early analysis of the reaction in those regions can be examined as an indicator of the likely effect on SSSs in England.

An early evaluation in Ireland reported encouraging results (Howell, 2005), where 95% of respondents viewed the Irish legislation as a positive health measure. Following the introduction of a similar ban in Scotland, stop smoking clinics and helplines reported increased activity, and sales on nicotine replacement products doubled in the first two weeks following the ban (Hyland, 2006). A full evaluation of the consequences of the ban has been commissioned by NHS Scotland.

Work by Bauld (2006) looked at the effect on demand for SSS in Scotland before and after implementation of the ban in March 2006. Using data from a sample of five services from different Health Trusts and comparing demand to the equivalent period twelve months before, it was found that demand built up in the three months prior to the date of the ban, was sustained for a further month, but then fell to pre-ban levels thereafter. The findings emphasised the importance of early preparation by the SSS to meet the needs of smokers making a decision to quit in advance of the ban. The

'Smokefree England' campaign was launched in December 2006 and focuses on preparing businesses for the ban by the provision of resources, signage and information. Smokefree England will dovetail with existing campaigns such as 'No Smoking Day' to reinforce the message to smokers.

- **More males (27.0%) were successful at quitting than females (21.4%).**
- **There was no significant difference between age groups in being successful at quitting, although there is evidence that those in the over-60 age band achieve higher quit rates.**

Bell *et al.*, (2006), concluded from a number of studies that age and sex were correlated with quitting success. In respect of sex, factors were identified such as lower levels of confidence by women in relation to quitting. It was found that while women were more motivated to quit, men tended to be more successful in doing so. Bell *et al.*, found that older smokers were more successful in quitting than younger smokers, although, as was the case in Cornwall, difficulty in following up younger smokers contributed to the lack of robust data.

- **There was no significant difference in the success rates of participants when grouped according to the three Primary Care Trusts in Cornwall. (These trusts were merged into Cornwall Primary Trust in October 2006)**

Although these results will no longer be of significance because of NHS reorganisation, there is much interest in the extent to which the service is able to make an impact in so-called 'deprived' areas, and the Cornwall Co-ordinator wishes to build on the existing work amongst lower-income smokers. The contribution of the service to Cornwall's Local Area Agreement with central government is to increase 12-month quit rates in the 20% most deprived areas in Cornwall, which is to be tackled by appointing '*a project worker with skills in community development ...*' (Cornwall Strategic Partnership, 2006). The work will also focus on the work of

midwives and health visitors with pregnant smokers, a client group where quit rates are historically low, and where there is an existing avenue of contact with communities through initiatives such as Sure Start. The service has identified overlap between the two targeted groups.

Bell *et al.*, (2006) cited evidence from 12 UK studies (including Cornwall) and concluded that quitters from routine and manual groups were less successful than other smokers.

Data modelled from the Health Survey for England revealed the prevalence of smoking in individual local authority wards (Neighbourhood Statistics, 2006). Although the information is somewhat out of date, being based on data from 2000-2002, it does reveal the extent of health inequalities between individual wards demonstrated by the wide range of smoking prevalence between areas. The extremes were illustrated by a ward in Restormel with an adult smoking rate of 40.3%, contrasted with a ward in Caradon with smoking prevalence of just 13.5%.

- **The majority of first contacts with the SSS took place at the GP surgery (75.0%), although there is a trend towards alternative methods of community intervention such as workplaces and supermarkets.**

A further initiative that is intended to broaden the reach of the smoking cessation services is that of Health Trainers. Health Trainers are public health community workers who are being put in place in selected areas of deprivation around Cornwall in early 2007. It is hoped that they will pick up on those in deprived communities who rarely visit the NHS or their own GP, but nevertheless have important health needs in respect of exercise, smoking and diet. A structured programme of self-improvement will be agreed between Health Trainer and client, which might include, for example, smoking cessation or a programme of exercise.

- **Nicotine Replacement Therapy (NRT) remained the most useful aid when attempting to stop smoking.**

Internationally, trials continue looking into a number of drugs that support quit attempts and provide an alternative to nicotine replacement therapy and Zyban. Two such treatments are briefly described below.

The drug Rimonabant (being marketed as Acomplia) has received attention initially for the treatment of obesity, but there are indications that the drug helps cravings associated with smoking (Times Online, 2006). Clearly the twin benefits of weight loss and smoking cessation could be a powerful weapon for the SSSs, but it is currently thought that because of cost issues, the sanctioning of the drug by the National Institute for Clinical Excellence (NICE) may still be some time away.

A nicotine substitute, Varenicline (Chantix) received newspaper attention in August 2006 based on American studies reported in the *Archive of Internal Medicine* (Nides *et al.*, 2006, and Oncken *et al.*, 2006). The trials suggested efficacy stronger than that previously reported by Bupropion (Zyban) although much of the UK media coverage failed to report the side-effects of nausea and insomnia reported by a number of users. The drug received approval from the European Commission in October 2006 and is now available on prescription in the UK. However, anecdotal evidence suggests that PCTs are choosing to wait until the drug receives approval from NICE before incorporating the provision of the drug into local smoking cessation work. The NICE review is due to be completed during 2007.

- **The most frequent reasons given for having restarted smoking after attempting to quit were stress (general or in response to a specific event), lack of willpower and enjoyment. This has not changed over the four phases of the study.**

For this phase of the study it was felt that it would be more useful to separate 'stress' into 'general' and 'specific' (direct response to a specific life event, e.g. a

bereavement or job loss). A baseline has been established and will be used for comparison in future studies.

- **The Stop Smoking Service is still considered to be ‘helpful’ or ‘very helpful’ by the majority of clients: 89% of successful quitters; 72.5% of partially successful quitters; and 72% of unsuccessful quitters.**

In September 2006 the Healthcare Commission, the health watchdog for England, evaluated all Primary Care Trusts in England for the quality of the Stop Smoking Services being delivered (Healthcare Commission, 2006). This tobacco control improvement review programme was undertaken as part of the annual check of individual NHS organisations. The results were published and are summarised in an appendix to this report.

Conclusions

The priority of smoking cessation within public health policy remains as high on the national agenda as it was when the Government produced the '*Smoking Kills*' White Paper (1998). Despite financial pressures within the NHS which have hit Cornwall particularly hard (BBC News, 2006), the continued funding of the SSS demonstrates the value placed upon it by policymakers in terms of the messages it conveys and the support it offers for those smokers who wish to put an end to their habit.

The Cornwall Stop Smoking Service continues to provide an effective service recording a 24% success rate of those clients using the service in 2004/05.

The results for male quitters continue to be better than those for women (27% to 21.4%), although the gap in quit rates has narrowed since the previous report. The results in Table 16 indicate that pregnant women find quitting particularly difficult, and the Service is right to invest additional resources in this client group.

The geographical coverage of the service within Cornwall continues to be even, with peaks and troughs in individual years not indicative of a wider trend. It is recognised that there is a concentration of work in the most deprived areas, the majority of which are found in Penwith and Kerrier.

With the SSS continuing to attract high approval ratings from its clients, it is appropriate to mention those stop smoking advisors who day in, day out, continue to provide a highly professional and worthwhile service to quitters. This is borne out by many of the comments made to the evaluators as part of the survey. At this point it should be emphasised that the results reported in Table 16, based on the data from individual support workers, are not intended to encourage a culture where one adviser is ranked over another – it is recognised that each worker will encounter different circumstances dependant upon geographical location and client group profile. For example, midwives would not be expected to produce above-average quit rates from their client group based on what is known about the smoking habits of pregnant women and new mothers.

The Cornwall Stop Smoking Service continues to address new challenges from all sides, including the forthcoming smoking ban, the continuing squeeze on NHS finances and the requirements of central Government. Amongst these challenges there are, however, opportunities through new initiatives such as the LAAs and the Health Trainer scheme. The view conveyed by this report is that the Service is well placed to address these new challenges through the efforts of its entire staff, who are to be congratulated on another positive set of results.

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Appendix – Healthcare Commission Improvement Review

All scores are on a 1-4 scale:

- 1** Weak - performance that does not meet the minimum requirements or the reasonable expectations of patients and the public.
- 2** Fair - performance that meets the minimum requirements or the reasonable expectations of patients and the public.
- 3** Good - performance that goes beyond minimum requirements or the reasonable expectations of patients and the public.
- 4** Excellent - performance that goes beyond minimum requirements or the reasonable expectations of patients and the public. A leader in this aspect of performance.

Each PCT was rated on six criteria, and in addition an overall grade was awarded.

The criteria were as follows:

Criteria 1: The PCT delivers an effective smoking cessation service

Criteria 2: The PCT reduces the prevalence of smoking particularly in vulnerable groups within the local population who are most at risk from tobacco use and exposure

Criteria 3: The PCT develops public health capacity within its workforce and that of independent contractors and their staff to reduce smoking prevalence

Criteria 4: The PCT promotes healthy lifestyles amongst the workforce and minimises the risk in relation to smoking and exposure to second hand smoke

Criteria 5: The PCT works with partners to address the needs of the local population in relation to tobacco use and control

Criteria 6: The PCT champions the tobacco control agenda and promotes the benefits of becoming smoke free

Detailed below are the results recorded for the three PCTs in Cornwall.

**Table 18: Healthcare Commission Tobacco Control Improvement Review, 2006:
Summary of scores for PCTs in Cornwall**

	Overall score	Criteria 1	Criteria 2	Criteria 3	Criteria 4	Criteria 5	Criteria 6
West	3	3	4	3	2	2	3
Central	3	2	4	2	2	3	3
North & East	3	2	4	2	3	3	3

Note: It should not be assumed that the outcomes and scores recorded by the Healthcare Commission automatically reflect on the work of the SSS itself. Many of the questions used to arrive at a score for each of the criteria reflect on the organisation of the individual PCT in terms of its policy, administration, availability of information etc. This is especially so in the case of Criterion 3 and 4, and elements of 5 and 6. Additionally, the scoring in a number of cases reflects four week quit rates, which, as has been argued in previous reports, may not be the best indicator of the success of a smoking cessation programme.