Abstracts From the UK National Smoking Cessation Conference (UKNSCC)
14–15 June 2007
London

What Next After Smoke Free?

Deborah Arnott, Director, Action on Smoking & Health (ASH)

Once smokefree legislation has been introduced in summer 2007 the UK will have pulled all known levers to cut smoking prevalence. The government's current tobacco control strategy is evidence based and needs to be maintained, but it is not sufficient. The most disadvantaged in society still have the highest rates of smoking prevalence and these have not declined significantly in the last 30 years. At current rates of decline, it will take us 25 years to halve the numbers smoking and there will still be over 5 million smokers in the UK.

So what next? The Royal College of Physicians is shortly to publish a new report that calls for a revision of nicotine regulation to enable smokers who can't quit to have access long term to safer forms of nicotine than smoked tobacco.

While quitting will always be the gold standard, over 70% of smokers are not yet ready to quit. In the interim it is better that they use less harmful forms of nicotine rather than carry on smoking. A harm reduction strategy is required which would give smokers access to less harmful forms of nicotine in a form and a price that is attractive as an alternative to smoking. A switch of only 1% of the population a year from smoking to less harmful nicotine sources, a conservative target, would save around 60,000 lives in only 10 years.

Such a strategy would encourage the development and sale of new, low harm nicotine products competitive to cigarettes in their nicotine delivery. This strategy would be a market-based, low-cost public health intervention. But it needs the strong support of those working in smoking cessation, who have contact with smokers who want to quit but are not yet able to. Smoking cessation advisors could ensure that long-term nicotine users are advised that it is better to carry on using medicinal nicotine products than to relapse back to smoking.

We would like to ask the meeting to support the release of a statement that says: "The UK National Smoking Cessation Conference supports the RCP's call for an overhaul of nicotine regulation to give smokers long-term access to less harmful forms of nicotine as a real alternative to smoking. We call on the government to take steps to implement such a strategy now".

Cut Down Then Stop Programs. How Do They Run? How Effective Are They and How Costly? What is Their Place in the NHS? Results From a Review for the NICE Guidelines

Paul Aveyard, Senior Lecturer, Department of Primary Care and General Practice, University of Birmingham

Background: There is insufficient and conflicting evidence about whether more intensive behavioural support is more effective than basic behavioural support for smoking cessation and whether primary care nurses can deliver effective behavioural support. *Methods:* In this randomised controlled trial in 26 UK general practices, 925 smokers of 10 or more cigarettes per day were randomly allocated to basic or weekly support. All participants were seen prior to quitting, telephoned around quit day, and seen one and four weeks after initial appointment (basic support). In weekly support, participants had an additional telephone call at 10 days and three weeks after initial appointment and an additional visit at 2 weeks to motivate adherence to nicotine replacement and renew quit attempts. 15mg/16-hour nicotine patches were given to all participants. The outcome was assessed by intention to treat analyses of the percentage confirmed sustained abstinence at 4, 12, 26, and 52 weeks after quit day. *Results:* Of the 469 and 456 participants in the basic and weekly arms, the numbers (percentages) quit and the percentage difference (95% confidence intervals) were 105 (22.4), 102 (22.4), 0.1 (–5.3–5.5) at 4 weeks, 66 (14.1), 52 (11.4), –2.6 (–6.9–1.7) at 12 weeks, 50 (10.7), 40 (8.8), –1.9 (–5.7–2.0) at 26 weeks, and 36 (7.7), 30 (6.6), –1.1 (–4.4–2.3) at 52 weeks. *Conclusions:* The absolute quit rates achieved are those expected from nicotine replacement alone, implying that neither basic nor weekly support were effective. Primary care smoking cessation treatment should provide pharmacotherapy with sufficient support only to ensure it is used appropriately and refer those in need of support to specialists.

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A Randomised Controlled Trial of Weekly Versus Basic Smoking Cessation Support in Primary Care

Paul Aveyard, Senior Lecturer, Department of Primary Care and General Practice, University of Birmingham

Background: There is insufficient and conflicting evidence about whether more intensive behavioural support is more effective than basic behavioural support for smoking cessation and whether primary care nurses can deliver effective behavioural support. *Methods:* In this randomised controlled trial in 26 UK general practices, 925 smokers of 10 or more cigarettes per day were randomly allocated to basic or weekly support. All participants were seen prior to quitting, telephoned around quit day, and seen one and four weeks after initial appointment (basic support). In weekly support, participants had an additional telephone call at 10 days and three weeks after initial appointment and an additional visit at 2 weeks to motivate adherence to nicotine replacement and renew quit attempts. 15mg/16 hour nicotine patches were given to all participants. The outcome was assessed by intention to treat analyses of the percentage confirmed sustained abstinence at 4, 12, 26, and 52 weeks after quit day. *Results:* Of the 469 and 456 participants in the basic and weekly arms, the numbers (percentages) quit and the percentage difference (95% confidence intervals) were 105 (22.4), 102 (22.4), 0.1 (–5.3–5.5) at 4 weeks, 66 (14.1), 52 (11.4), –2.6 (–6.9–1.7) at 12 weeks, 50 (10.7), 40 (8.8), –1.9 (–5.7–2.0) at 26 weeks, and 36 (7.7), 30 (6.6), –1.1 (–4.4–2.3) at 52 weeks. *Conclusions:* The absolute quit rates achieved are those expected from nicotine replacement alone, implying that neither basic nor weekly support were effective. Primary care smoking cessation treatment should provide pharmacotherapy with sufficient support only to ensure it is used appropriately and refer those in need of support to specialists.

NICE Review of NHS Smoking Cessation Services

Kirsten Bell, Tobacco Research Coordinator/Research Associate, British Columbia Centre of Excellence for Women's Health, Canada

The National Health Service (NHS) stop smoking services provide invaluable assistance for smokers trying to quit and recent evaluations have found them to be an effective means of facilitating smoking cessation. However, to date, information has been lacking on which service formats are most effective. This presentation discusses the current state of evidence on the effectiveness of NHS intensive treatments for smoking cessation, as well as pharmacy and inpatient services, and is based on the findings of a systematic review of the literature conducted for the National Institute for Health and Clinical Excellence (NICE) in 2006. In particular, this presentation focuses on the evidence regarding the differential impact of NHS interventions for specific subpopulations such as pregnant women, men and women from deprived areas, and black and minority ethnic groups (BMEG).

NRT in the Real World of Smoking Cessation

Renee Bittoun, Director of the Smokers Clinic, University of Sydney and Royal Prince Alfred Hospital, Australia

Smokers are not an homogenous group. Nicotine levels derived from smoking vary. Responses to NRT vary. This may depend on baseline nicotine blood levels, metabolic factors, gender, ethnicity, comorbidities, concomitant medications and socioeconomic status; the 'wherewithal' to quit. When using one form of NRT most smokers do not do well. Clinical practice guidelines are based on trials on the 'oxymoronic' well smoker and exclude the smokers we are most likely to treat and who are the most cost effective: the unwell. Guidelines lead to conflicting imperatives to the patient from pharmacists, doctors, Quitlines and smokers' clinics. Psychological input in guidelines is minimal, often not evidence based, though substantiated behavioural advice does exist. Harm minimisation/temporary abstinence strategies are not included nor guides on how to better inform patients on the principals of NRT. A combination therapy algorithm, a description explaining the basis of nicotine addiction, NRT and behavioural changes to the lay smoker have been developed and will be described. The 3 (four) As: Analogy of an Allergy (explains the problem), Allegory of 'The Swimming Pool of Life' (explains the process) and Algorithm (explains the NRT treatment.)

Varenicline: Implications for the Field

Alex Bobak, Wandsworth PCT, London

Varenicline (Champix) is the first in a new class of therapy for smoking cessation and has been available on NHS prescription since December 2006. It binds specifically to a subtype of nicotinic receptor (·4, 2) implicated in nicotine addiction. It has a greater affinity to the receptor than nicotine and acts by partly blocking the receptor and partly stimulating it. Studies comparing safety and efficacy with bupropion (Zyban) have been favourable and a study comparing nicotine patch is due for publication this year. Despite offering an important new treatment option to UK smokers there have been numerous issues that have effected its use. *PCO Approval:* In a climate of cost cutting any new product faces considerable scrutiny by PCOs. This has meant delay in approval in some regions and variable recommendations for use across the country. The Scottish Medicines Consortium and The National Institute for Health and Clinical Excellence have now both approved varenicline. *Access to Prescriptions:* Being a prescription only medication is a particular barrier to its use given that very few stop smoking advisers are able to prescribe. There is a reliance on GPs to prescribe which at least makes the patient pathway more complicated and can be a barrier in itself. Patient group directions (PGDs) and improved communication with GPs could help the situation. *Side Effects:* Varenicline is generally well tolerated; the most common side effect is nausea which occurs in about a third of those who take it. Measures can be taken to reduce nausea.

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TXT2STOP: Evaluation of Text Message Content as a Stop Smoking Intervention

Ruth Bosworth, Director of Services, QUIT and Cari Free, London School of Hygiene and Tropical Medicine

Introduction: Mobile phones provide a new channel for individualised programs to be delivered inexpensively wherever the person is located, especially for young adults. Mobile phone-based interventions can provide the anonymity that young people like, enabling them to participate over the phone without others knowing and without having to 'front up' anywhere. Hence, mobile phones present an important but as yet largely unused medium to deliver age appropriate public health measures. *Method:* A single-blind randomised control pilot trial of mobile phone-based smoking cessation support. The intervention is delivered by computer with the allocation being unknown to the investigators. Radio and Internet media advertising encouraged smokers interested in quitting to text or call the LSHTM centre from where the participants were being recruited. The intervention is a community-based intervention. *Results:* Out findings at 6 months were consistent with a benefit. RR 1.28 (0.46–3.53). The outcome was measured using postal salivary cotinine. Information was collected to allow future economic modelling based on the effective results. *Conclusion:* The pilot was a success. Follow-up was excellent with 98% following up for the short term outcome and 92% follow up for the long-term outcome. We demonstrated a statistically significant increase in self-reporting quitting at 4 weeks RR (95%CI) 2.02 (1.08–3.76). While the impact on health can not be measured in this pilot it is possible to model the impact on survival and health related quality of life of successful quitting.

Helping Teenagers Stop Smoking: Comparative Observations Across Youth Settings in Cardiff

Hannah Bowles, Youth Health Development Officer and Alison Maher, Marine Chambers, Cardiff

Smoking rates in young people aged 11 to 18 have not declined at the same rate as in the adult population in the UK and Wales. Initiatives aimed at reducing the number of young people smoking are primarily school based; however, these interventions are often thought to fail to reach high-risk young people, as they are more likely to reject school-based information, truant or be excluded from school. This has led to calls for adolescent smoking cessation programs to also focus on 'out-of-school youth'. This paper presents comparative observations between schools/colleges, youth centres, specialist youth provision and residential homes, in relation to delivery of a 6-week smoking cessation & awareness program (2Tuff2Puff) to young people in Cardiff. Sessions were attended by 204 young people in 24 different youth venues between 2005–2006. The primary outcomes used were reduction in weekly cigarette consumption and changes in attitude, CO monitoring was used as a tool in the study but not for validation. Reduction in average weekly cigarette consumption was greatest in Schools/Colleges (52% fewer per week) and positive change in attitude toward quitting was greatest in specialist youth settings (86% of attendees more determined to quit). Overall, when both practical delivery issues (access to young smokers, acceptability to young people, supportiveness of environment for quitting) and outcome measures were considered, specialist youth venues were the most effective settings for delivery of this program. Delivery of smoking awareness as part of a wider health curriculum for groups of excluded young people is recommended.

Pre-Operative Smoking Cessation

Gillian Bruce, Lead Smoking Cessation Nurse Specialist, Acute Services Smoking Cessation Service, Forth Valley NHS Falkirk and District Royal Infirmary

Introduction: Smoking cessation before an operation reduces cardiopulmonary complications and length of stay (1, 2, 3). Referral rates to the Smoking Cessation Service (SCS) of the surgical preoperative patients were low in Forth Valley; a spot survey demonstrated zero referrals in September 2005. *Methods:* A multidisciplinary team agreed to improve smoking cessation advice and access to the SCS for elective surgical patients attending preoperative assessment clinics. Referrals to the SCS and outcomes were audited after introduction of changes. *Results:* During the 11 months April 2006 to February 2007, 74 surgical pre-operative patients were referred to the SCS. 61 were initially contacted by telephone. 34 agreed to a clinic appointment with the SCS and 27 preferred not to. 13 patients were contacted by letter. 47 patients were given information to inform future decisions. 13 patients agreed to pursue smoking cessation discussions with primary care smoking cessation services. 12 patients (20% of those initially referred) agreed to a quit attempt under the supervision of the secondary care SCS. Of these, 7 patients received NRT (nicotine replacement therapy) (4 patches, 3 inhalator). At the 4-week patient follow-up, 5 reported cessation (7 % of the total patients initially referred), 2 reported ongoing smoking (one of reported cutting down and preparation for another quit attempt). Data from the remaining 4 patients are incomplete. Follow-up data on patients attending primary care cessation services are not available. *Conclusion:* Referrals to our secondary care smoking cessation service have increased. A small number of patients have reported quitting following specialist smoking cessation support. Targeting surgical preoperative patients is likely to be effective and efficient.

Early Findings From the Tobacco Control National Support Team

Keith Burnett, Delivery Manager (North), Department of Health Tobacco Control National Support Team & Marie Meredith, Department of Health

Since 2006 the Department of Health has developed National Support Teams (NSTs) to inform and assist improvement in a number of public health fields, tobacco control being the second. The Tobacco Control NST, established in October 2006, is now carrying out intensive support inputs in the 'most challenged' areas of England as well as starting to build a picture of successful holistic models of tobacco control at a local level reflecting the national '6 strands of tobacco control'. Intensive support visits involve interviews with a wide range of stakeholders including tobacco control experts and senior strategic officers, in NHS trusts, local authorities and other relevant agencies to assess scope for strengthening performance, followed by immediate recommendations for enhancements. In response to widespread requests for feed-

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back from our work thus far, the Tobacco Control NST offer an opportunity to share the key themes and findings including common barriers, predictors of success and proven routes of enhancing effectiveness. These will include some practical answers to the challenges of:

- making a success of performance improvement in contexts that can appear dominated by performance management
- differentiating between smoking cessation and tobacco control without creating division
- sustaining the profile of tobacco control following implementation of smoke-free workplaces
- ensuring that multi-agency partnerships are truly strategic and able to maintain tobacco control as a shared priority.

This parallel session will also constitute an early opportunity to hear and comment upon developing work to identify and highlight high-impact changes in tobacco control and smoking cessation.

Commissioning a Charitable Organisation to Provide Smoking Cessation Services to Deprived Communities in Slough: A Local Public Sector Agreement

Russell Carter, Berkshire Tobacco Control Coordinator, Upton Hospital, Slough

This paper describes the experiences of Berkshire East PCT in commissioning smoking cessation services from a local charity as part of an LPSA project in addition to NHS Stop Smoking Services. A target of 280 extra 4-week quitters over 3 years was agreed between Slough Borough Council, the PCT and the Office of the Deputy Prime Minister (ODPM). Upon agreement of these targets a pump priming grant was received from the ODPM of £69k, part of which allowed for the provision of NRT without prescription charges. The focus of the project was to target the most deprived wards in Slough. The provider organisation chosen had experience of working with BME communities and the ability to provide a multilingual service. This was vital for targeting deprived communities in Slough given its diverse population. As part of this service, smokers concerned about gaining weight following quitting were referred to the LPSA weight loss referral scheme, which involved 12 weeks free attendance at Slimming World groups. Despite some problems with running two parallel services in the same area, such as initial confusion among GPs and the public over the difference between them and perceived competition for clinic locations, the experience was a positive one and targets have been met — 101 quitters against a target of 91 to date. The contract has allowed the PCT to determine clinic locations and therefore target the services at deprived areas and engage hard to reach communities. A good example of this has been the Polish community that is growing rapidly in Slough and has now started to access services. Overall the process of tendering smoking cessation work to external organisations while continuing to regularly monitor and direct the work has shown potential as a future means of providing local services.

Monitoring the Impact of Stop Smoking Services: Exploring the Geography of Demand and Supply

Graham Clarke, School of Geography, Leeds

The UK government has set ambitious targets for reducing the number of smokers. Currently the aim is to reduce the number of smokers by around 20% by 2010. To aid this process health authorities are in the process of operating a number of stop smoking services, often in different locations around our towns and cities. The aim of this research is to evaluate the effectiveness of these services in reaching the population that smokes. To achieve this aim a number of steps are proposed. First, it is necessary to estimate the distribution of smokers across a city or region (the area chosen is the City of Leeds). A model has been built which estimates smokers across the City based on age, sex, social class and ethnicity. The second stage is then to look at how many smokers visit different centres and thus to estimate the market penetration of such centres — that is how much of the population that smokes is being reached under current levels of provision. Third, the research looks at optimal locations for such services based on a number of different scenarios concerning existing and future patterns of smoking. This should help to decrease the current inequalities in access for different population groups. The new scenario modelling will also include modelling the impacts of major changes in legislation, such as the likely impacts of the smoking ban in public places due in July 2007.

Developing Best Practice in Smoking Cessation

Steve Crone, Chief Executive, QUIT

Overview: The European Network of Quitlines (ENQ) brings members across Europe together to develop and promote quitlines as a proven and effective stop smoking service. ENQ develops best practice and ensures all members have access to current training, research, technology and counselling protocols. *Methods:* Recent research has shown that of all the forms of psychological support available to smokers, telephone counselling has the strongest evidence base to support its use. ENQ works to promote best practice in quitlines, telephone counselling and their use as a smoking cessation support method across Europe. ENQ also assists developing quitlines to incorporate telephone counselling into their existing service provision. ENQ works to promote evidence-based methods of smoking cessation and published 'The European Guide to Best Practice for Quitlines' in English, French and German. Current research is also being undertaken across Europe to establish evidence on the most effective and cost effective quitline model for future development and implementation. ENQ has developed research into best practice in web based smoking cessation and also develops policy recommendations on a pan-European basis. In 2007, ENQ will launch new initiatives including a social exclusion program and an accessible information database on European quitlines. *Results:* Through the continued promotion and development of quitlines and telephone counselling as a method of smoking cessation, ENQ effectively helps more smokers to stop. ENQ research has enabled the development of an effective quitline model and demonstrated best practice in web based smoking cessation. ENQ has been awarded a WHO World No Tobacco Day

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Award in recognition of the networks role in strengthening national action and international collaboration. Future projects will ensure the further development of quitlines in Europe. The detailed and accessible information database on European quitlines will act as a platform for future ENQ research into tobacco use and quitline delivery while the social exclusion program will help quitlines provide support to a variety of minority groups across Europe.

Irish Tobacco Legislation Increases Smoking Cessation in Hospital Patients

Kirsten Doherty, Researcher, School of Public Health and Population Science, University College, Dublin

Population policies such as smoking restrictions may help persuade smokers to stop smoking. A hospital admission is seen as an ideal opportunity to provide smoking cessation interventions and hospital smoking restrictions may aid quitting. The Irish smoking ban came into effect during the follow-up phase of a cohort study examining factors related to smoking cessation following hospital discharge. This enabled the impact of the ban on smoking cessation to be assessed. A quasi-systematic sample of 1086 smokers admitted to an urban teaching hospital was interviewed, with follow-up after 7 months. Reported smoking cessation at follow-up was bio chemically validated. 72% were contactable for follow-up. The overall validated point prevalence smoking cessation rate was 11.4%. Patients whose follow-up interview took place after the introduction of the smoking ban were significantly more likely to have quit than those followed up before the ban (OR: 1.9; 95%CI: 1.3–2.9). Agreement with the ban increased after implementation, from 53.1% to 69.6% (p = .002). Agreement was associated with quitting (OR: 2.2; 95%CI: 1.4–3.6). Those followed-up after the ban reported lower passive smoke exposure, an average of 8.5 hours/week compared with 11.3 hours/week before the ban (p = 0.066). The introduction of the Irish smoking ban increased the rate of quitting in this group of discharged hospital patients and appears to have reduced their passive smoke exposure. This study adds to the evidence of the impact of such bans on the ability of individuals to stop smoking.

Mental Health: Smoking, Treatment and Going Smoke Free

Eden Evins, Director, Addiction Research Program, Massachusetts General Hospital and Assistant Professor of Psychiatry, Harvard Medical School, Boston, USA

Smokers with major mental illness want to, can, and should be encouraged to quit smoking. People with psychiatric illness such as schizophrenia smoke with greater prevalence, have a higher level of dependence, and are less likely to quit smoking on a given try than smokers in the general population. That said, standard behavioral and pharmacologic treatments with few modifications are moderately effective for smoking cessation in smokers with psychiatric illness. These will be discussed. Treaters should be aware of several special considerations. Nicotine withdrawal symptoms are similar to symptoms that preceed psychotic decompensation. Thus patients should be educated in detail that they can expect withdrawal symptoms such as anxiety, irritability and insomnia, and informed that these are time limited. Second, smoking increases metabolism of many medications, including psychotropic medications, and many patients will need to reduce their dose of antipsychotic or antidepressant medication when they quit smoking in order to avoid adverse effects of increased serum medication concentrations. Third, whether smokers with a history of major depressive disorder are at increased risk of a depressive episode in the year following smoking cessation remains controversial. Finally, relapse rates are especially high following discontinuation of nicotine dependence treatment, and nicotine may reduce some cognitive dysfunction associated with illnesses such as schizophrenia. Strategies for prevention of relapse to smoking following brief abstinence will be discussed.

How Early is Early?

Lisa Fendall & Marlyn Stothard, Choosing Health Development Worker, Doncaster PCT

The Stop Smoking Service in Doncaster was set up to respond to the government targets to reduce the number of young smokers to 9% by 2010 Latest figures suggest that this target has been reached; however, if the figures are broken down, they reveal a more complex picture. It is estimated that 2% of 11-year-olds smoke, compared with approximately 41% at 16 years. Many services for young people were set up within the generic service and sadly became an add-on to existing services. Evidence shows that it is not cost effective to target young people as potential quitters as they do not possess the maturity or skills to quit smoking, especially if not smoking makes them different to their peers. Instead, resources should be channelled into providing information and advice about the dangers of smoking, the benefits of quitting and preventing children and young people from starting smoking in the first place. A recent reconfiguration of Children and Young People, and the integration of Smokefree Pregnancy, has allowed the opportunity for innovative change and the development of a service fit for purpose. The team now provides pre-conceptual information, advice and training into schools, colleges, Youth Services and training programs, in order to work towards reducing the number of young people who start to smoke and ultimately the number of parents to be who smoke. Intervention is delivered in a cycle from pre conception to birth, through childhood to preconception

Motivation for Smoking Uptake and Effective Intervention Strategies: A Qualitative Study of Adolescents

Jennifer Fidler, Research Psychologist, Health Behaviour Unit, Department of Epidemiology and Public Health, University College, London

What motivates adolescents to start smoking is an area that has been extensively investigated yet remains poorly understood. This presentation summarises findings from a qualitative study of adolescents' views as to why people their age smoke, and their opinions regarding effective smoking advice. Forty-four 13- to 14-year-old students, 55% female, both smokers and nonsmokers, from 2 South London schools participated in 7 focus groups. Framework analysis of discussions highlighted several proposed reasons for smoking uptake. Smoking as a method of stress reduction, particularly

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among students experiencing problems with family and home life, was a frequently raised theme. Peer smoking was also seen as important, especially in terms of adapting behaviour to fit in with certain groups. The role that smoking plays in portraying an attractive and grown-up image was raised as was the view that young people smoked because it was different, risky or was something to be experienced. There was no indication that smoking was used to control weight at this age, although weight gain was cited as a reason why smokers might not want to give up. It was acknowledged that smoking damages health and sportier students saw smoking as incompatible with sporting success. Effective methods of intervention were considered to be interactive and run by nonschool personnel, with both boys and girls preferring visual 'gory' details about the effects of smoking on health. Some students also had a strong interest in the impact of sociopolitical factors on their smoking behaviour. These findings, recognising some methodological limitations, could have implications for formulating future interventions.

Increased Referrals Following Routine Carbon Monoxide in Antenatal Clinics

Ann Fitchett, Stop Smoking Specialist Nurse Advisor, Pregnancy and Child Health, Public Health, Birmingham

Smoking during pregnancy is linked with major adverse consequences for both the mother and baby. The risks of pre-term birth, low birthweight, perinatal death and sudden infant death are all reduced if the woman stops smoking when pregnant. The risks of ectopic pregnancy and miscarriage are also greatly reduced by smoking cessation during pregnancy. The West Midlands region unfortunately has one of the highest perinatal death rates in the United Kingdom; consequently reducing smoking during pregnancy is high on the public health agenda. There had been a steady flow of referrals into the South Birmingham PCT specialist pregnancy stop smoking service since it was first established in 2003. However, there were many pregnant smokers not being referred into the service who if given the opportunity may successfully stop smoking. The specialist service offers individual tailored intensive support with accurate information on the use of nicotine replacement during pregnancy if required. So how could we get more referrals into the service? Two community midwifery teams were contacted by the pregnancy specialist advisor. Following very successful and positive meetings they agreed to undertake a 4 month pilot project of inviting every pregnant woman, smoker and non smoker alike, attending any antenatal clinic appointment to have their carbon monoxide level recorded. Evaluation of the project revealed that carbon monoxide monitoring in the antenatal clinic was very well received by both midwives and patients alike. The outcome of the project was a dramatic increase of referrals into the specialist service from 60 successful contact referrals during 2004–2005 to 112 during 2005–2006 and 178 during 2006–2007.

QUIT's Smoking and Mental Health Project: An Overview of the Service User Involvement in the Development of a Free Motivational Resource

Terri Forward, Smoking & Mental Health Project Coordinator, QUIT

Cigarette smoking has become increasingly concentrated in the most deprived groups. A clear inverse relationship exists between smoking prevalence and social class. People with mental health problems are among some of the most socially excluded and economically deprived members of the population.

QUIT in partnership with The Sainsbury Centre for Mental Health and Cancer Research UK have developed the Smoking and Mental Health project. An exciting new initiative providing specialist and tailor made stop smoking support to smokers with enduring mental health problems through proactive telephone counselling. It was important that service users were proactively involved in the development of the resource. This provided a new and exciting element to the project and has resulted in a brand new stop smoking resource, developed for and by smokers with enduring mental health problems. A main focus of the project was to develop a stop smoking resource for smokers with enduring mental health problems that include tailor made and individual stop smoking plans that compliment the proactive telephone helpline counselling. Initially the content was written using the advice and guidance of smoking cessation and mental health experts, and 2 mock versions developed using variations in colour, design and imagery. During the development stage of the project 3 focus groups were run with outpatient service users in order to gain their views and opinions. This enabled service users to develop and shape the resource. During the life of the pilot project 'good news' and 'success stories' will also be gathered. Summary reports were prepared for each focus group and the results were collated in order to progress the final draft of the stop smoking resource. As the project progresses, ongoing success stories will be incorporated to provide longer term motivation and support for smokers with mental health problems.

Experiences From the First Two Years of the National Smoking Cessation Monitoring/National Smoking Cessation Database in Scotland

Linsey Galbraith, Principal Information & Development Officer, ISD, Scotland

Introduction: April 2005 saw the introduction in Scotland of a national minimum dataset for NHS smoking cessation services. The dataset was developed by Partnership Action on Tobacco and Health (PATH) part of ASH Scotland, following consultation with services and others. In July 2005, Information Services Division (ISD) Scotland established a web-based information system that would allow NHS smoking cessation services to capture the minimum dataset information, plus local data items, and provide additional functionality such as statistical reports and letter generation. The database would also allow ISD to produce the national monitoring reports.

Progress to date:

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- 13 out of 14 NHS board areas in Scotland now using the national database and plans for the remaining board to switch to the national system. Over 200 registered database users across Scotland
- Positive feedback from services on the value of the system for local service management purposes
- On March 26, 2007, the first anniversary of the smoke-free legislation in Scotland, the first statistics from the national smoking cessation monitoring were published.
- These statistics highlighted wide variation in service uptake and quit rates across NHS board areas. Reasons for this included differences in the types of services provided across board areas, differences in the services being included in the national monitoring and differences in definitions used.
- In contrast to the English monitoring, the national monitoring in Scotland is based upon client follow-up at 1, 3 and 12 months post quit date. Variations in the proportion of cases lost to follow-up/smoking status unknown, however, has a major impact upon differences in quit rates across boards.

Future developments:

- An Expert Review Group for the National Minimum Dataset has been set up and will meet during 2007/2008 to monitor and review the dataset to ensure it remains 'fit for purpose'.
- The national database is available at present only over the NHS-net, but will likely become available over the wider internet, giving potential access to more agencies.
- Interest from outside of Scotland in buying into the national database/selling the system to others.
- Plans for more detailed topic-based analyses and research based on the minimum dataset

Incorporation of a Point-of-Care Cotinine Test Into Routine Community Antenatal Care to Reduce Smoking in Pregnancy: A Pilot Study

Jane Giles, Specialist Stop Smoking Adviser, Buckinghamshire Stop Smoking Service c/o Public Health

Background: Integrating novel methods into routine antenatal community care is important to reduce smoking in pregnancy. A rapid urine cotinine test called SmokeScreen®, which correctly identifies smokers and provides feedback to the smoker, has been shown to improve smoking cessation advice in hospital-based antenatal care. *Aim:* For community midwives to carry out the rapid test at the first antenatal visit and to assess the response of both the midwives and pregnant women to the test and whether it influenced smoking during the pregnancy. *Method:* Trained midwives ($n = 8$) from two community midwifery bases were issued with 200 semi-quantitative test kits for use on consecutive pregnant women in their homes. A questionnaire detailing attitudes to smoking in pregnancy and whether the test helped or hindered the dialogue were completed by the midwives, and questions were answered by the women about the test, whether it influenced their subsequent smoking. *Results:* Significant differences were observed between the two community bases: over 60% of midwives from the first group found the test easy to use and 75% thought the test motivated pregnant smokers to stop; whereas all of the other group reported the tests were not easy to carry out, mainly due to time constraints; although 67% still felt it enriched their intervention. Over half of the midwifes thought the test should be introduced as a routine screen and in the event of a positive result, repeated at the next appointment (50% and 67% respectively). An interesting finding combining the two groups was that midwifes detected significant exposure to nicotine, indicating active smoking in 47% of their mothers, significantly higher than the 17% reported as the national prevalence of smoking in pregnancy. *Discussion:* Motivated midwives found the point-of-care cotinine test helped in identify pregnant smokers and increased awareness and motivation among some pregnant smokers to change their smoking habit.

Smoking Cessation in Two Socially Disadvantaged Communities in North and West Belfast

Darren Gowdy, Community Health Development Worker, Ardoyne Shankill HLC, Belfast

Ardoyne Shankill Health Partnership was one of the first community groups in Northern Ireland to deliver smoking cessation services. Research in 1999 amongst women in Ardoyne showed that 72% of the women in the area smoked, which is consistent with socially disadvantaged areas. The areas have also been severely affected by 'The Troubles', with many killings taking place within one square mile of the areas. People have resorted to smoking as a coping mechanism and as a result relative poverty levels continue in a vicious circle. The effects are generational as there here have also been major issues around access to tobacco in terms of shops selling single cigarettes to children as young as 5 years old and also paramilitary influences have led to cigarette smuggling. To date over 200 smokers have came through the service in 4 years. Approximately 40% have quit at 4 weeks and 20% have quit after 52 weeks. Positive factors have included ex-smokers becoming trained as advisors, encouraging others to stop and also having the benefit of availing of alternative/complimentary therapies to reduce stress and anxiety when quitting. The service has made people look at their health holistically in terms of diet, exercise and alcohol consumption, and so on.

Factors in Successful Delivery Models: North East NHS Stop Smoking Services

Andy Graham, Regional coordinator, Fresh Smoke Free North East

NHS Stop Smoking Services have been in place across the North East (population 2.5 million) since 2000, and have consistently been the best performing services in England, achieving 1145 4-week quitters per 100,000 in 2005/6 compared to the national average of 818. The services were also rated highly in the 2006 Health Care Commission Improvement Review of Tobacco with 68.8% of North East Primary Care Organisations achieving an excellent rating — the highest in the country. In April 2007, the Regional Director of Public Health commissioned Fresh (through its Regional Tobacco Policy Manager function) to undertake a

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thorough mapping of each of the 12 services. This was to identify key features of the most successful services and assist in the development of a core service model for the North East ensuring that the examples of innovative and good practice are delivered region wide where appropriate. Work was already underway to ensure greater consistency through the adoption of national smokefree branding by all the local services. This presentation will discuss the process of mapping the models of provision across 12 North East services, identification of the key components for success and how this led to key planning events and the development of a core service model viewed as most effective for delivery across the region.

Using Mosaic and Health Equity Audit to Improve Nottingham's Stop Smoking Service

Indu Hari, Operational Coordinator, New Leaf Stop Smoking Service, Directorate of Health Equality, Nottingham

Reducing smoking in the population as a whole and in manual groups in particular is a key government target. Nottingham City Primary Care Trust's New Leaf Stop Smoking Service provides an evidence-based smoking cessation service with trained advisors at a variety of locations across the city, including GP practices, pharmacies, community centres and leisure centres. Nottingham City PCT recently undertook a health equity audit (HEA) that used Mosaic Public Sector and Geographic Information Systems (GIS) mapping to help to ensure the local PCT was providing its smoking cessation service to those who needed it most and identify any gaps for action. First, we used Mosaic to look at who smoked the most, and where in Nottingham these heavy smokers lived. Geographic information systems (GIS) mapping and Mosaic Public Sector were then used to:

- map the postcodes of those attending the New Leaf service, to identify areas in the city where populations were least and most likely to take up the service
- produce a Mosaic profile and map of the Groups of people who attended the service.

By combining this information, we were able to determine that, on the whole, New Leaf is targeting areas and groups where smoking is high. We were also able to identify those smaller areas where, given the expected high level of smoking by the Groups of people who lived there, there was low uptake of the service — and take action to address these gaps. Following these findings, New Leaf has worked more proactively with the GP practices in the 'cold spot' areas of central Nottingham; where necessary we have changed clinic times and venues; we have also set up new sessions, including at a local pharmacy. Also, an NRF-funded social marketing stop smoking campaign will be implemented this year by the PCT focused on the Mosaic groups who are the heaviest smokers in target areas.

Health equity audit was valuable in ensuring that we target our resources equitably to reduce smoking and tackle health inequalities. Following these findings, New Leaf has worked more proactively with the GP practices in the 'cold spot' areas of central Nottingham; where necessary we have changed clinic times and venues; we have also set up new sessions, including at a local pharmacy. Health equity audit was valuable in ensuring that we target our resources equitably to reduce smoking and tackle health inequalities. For further information: De Gruchy J, Robinson J. Stop-smoking service benefits from geodemographic profiling. *British Journal of Healthcare Computing and Information Management*, 2007, 24, 1.

Where Next for Smoking Cessation?

Gerard Hastings, Director of the Institute for Social Marketing and Centre for Tobacco Control Research, University of Stirling and Open University

High Impact Actions to Reduce Smoking in Pregnancy

Patricia Hodgson, Regional Tobacco Program Manager, Regional Public Health Group — Government Office for Yorkshire & the Humber

Smoking rates during pregnancy is not decreasing in Yorkshire & the Humber as it is for England as a whole. To tackle the problem, a comprehensive review of the literature was undertaken to identify pragmatic high impact actions to reverse the trend. The review identified actions that potentially could make a significant and measurable improvement if integrated into routine health care practice. The 8 high impact actions are:

1. Promoting cessation to women of child bearing age
2. Improving data collection
3. Reaching pregnancy smokers as soon as possible and throughout pregnancy
4. Increasing effectiveness of current interventions
5. Supporting continuing smokers
6. Involving partners/families
7. Maintaining postpartum cessation
8. Promoting smokefree families

Healthcare cost of maternal smoking: The Department of Health Sciences and Centre for Heath Economics, University of York in collaboration with the Yorkshire and the Humber and North Public Health Observatories are developing a model that yields an estimate of the additional costs to society of a mother continuing to smoke during pregnancy compared to a non smoking mother. The model will be incorporated into the report when finished.

Regional task force: A regional smoking and pregnancy task force has been set up to identify ways of integrating the high impact actions into routine healthcare and to share examples of good practice. The regional director of public health has presented the report to the NHS Y0rkshrie & Humber and asked for its approval and to encourage relevant partners to take the actions forward.

Setting Up and Running Business-Based Work Clinics

Neda Hormozi, Tobacco and Smokefree Coordinator & Lynn Stanley, Parsons Green health Centre

The current national average quit rate for group clinics is accepted as 67%. Between October 2006 and April 2007, we have achieved an average 75% success rate for work-placed stop smoking clinics in Hammersmith and Fulham. This presentation attempts to compare (a) the quit rate of work-placed stop smoking clinics with traditionally managed

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group clinics in Hammersmith and Fulham and (b) the cost per quit for work-placed stop smoking clinics in Hammersmith and Fulham with the national estimated average. We will describe key areas of focus when setting up business-based stop smoking group clinics in Hammersmith and Fulham, how we set about the identification and selection of appropriate organisation and of the right person to contact within the selected organisations, how we prepared our marketing and sales pitch, developed support tools to ensure that local enterprise played a key role in recruiting motivated smokers and developed the PGD that further simplified the patient pathway. The presentation of set-up and delivery of this project will be supported with samples of marketing material including sample speculative letter to businesses, hints and tips on your sales pitch and subsequent follow-up, samples of support tools for local businesses as well as sample PGD template. Further evidence for the financial success of the project will be demonstrated in terms of numbers signed up versus numbers quit, and time dedicated to set up and delivery of project.

The Global Smoking Cessation Effort: Where the UK Stands

Paul Hooper, Regional Tobacco Policy Manager for the West Midlands

How does the UK compare with other countries with respect to smoking cessation and tobacco control? Considerable advances have been made in the UK over the last decade but advances have been made elsewhere too. This presentation uses data gathered by an EU-funded project using a detailed assessment tool and information from experts in the field outside Europe to examine some of the evidence for the often-used statement 'stop smoking services in the UK are the best in the world'. The EU Assessment Tool was based on completed questionnaires from country representatives and examples of interesting or unusual practice are used to illustrate the various elements of the assessment process including strategies, policies, programs and guidelines. Information on the relative usage of nicotine replacement therapy is used as a cross reference to expert opinion. Last year the 'Tobacco Control Scale' developed by Luc Joosens and Martin Raw was published in *Tobacco Control Journal* and compared country activity on a variety of measures including price, smoke free workplaces, spending on campaigns, health warnings, advertising bans and treatment services. In the light of recent and forthcoming changes the UK's relative position to other countries on this scale is also evaluated. The presentation concludes with some comments on the how this information should be interpreted and its relevance to the conference as a whole.

Redefining the Role of Cessation Specialists: What Needs to be Done

John Hughes, Professor of Psychiatry, Psychology and Family Practice at the University of Vermont, USA

Although smoking cessation specialists often get little respect in their organization, data show that, in fact, they save more lives each year that almost all other providers. For smoking cessation treatment to be taken seriously, specialists need to act as professionals: i.e. know the scientific literature, practice evidence-based medicine that includes knowledge other than from randomised trials, always be learning, educate other professionals, and so on. Specialists also need to resist arguments that cessation services are valuable only if they decrease smoking prevalence or are cost-effective. Cessation services are valuable because they save lives. Specialists need to stop seeing their role as a one-night stand and rather see it, like most clinicians, as a long-term care giver; that is, providing advice across repeated attempts to quit and working with patients whatever their motivational state. Finally, specialists need to organise; that is, form a professional organisation that promotes improved cessation treatment both via improving the skills of specialists (e.g., via a continuing education scientific journal) and via advocacy. They also need to form a credentialing body so the public can distinguish evidence-based and non-evidenced based therapies and can access skilled therapists. Finally, specialists need to work to transform the image of smoking cessation from 'breaking a bad habit' to 'overcoming a drug dependence' by learning from similar image transformations for depression, anxiety disorders, and so on. In summary, specialists need to proactively assert evidence-based practice by acting as a professional, by organising, and by challenging the paradigms others have promoted. Like AIDS, smoking cessation is too important to play by the rules.

An Algorithm for Optimal Smoking Cessation Treatment

John Hughes, Professor of Psychiatry, Psychology and Family Practice at the University of Vermont, United States

A box and arrow algorithm for allocating treatments to smokers who have decided to quit is presented. Often seeing an entire program via a visual aid is helpful for teaching or to monitor the comprehensivity and quality of care. The algorithm is based on the UK, US and WHO guidelines. The algorithm suggests an assessment of past quitting and treatments, interest in gradual versus abrupt cessation, cigs/day, psychiatric history and medication cautions. This is to be followed by a discussion of the pros and cons of the 7 validated, first-line medications and the 3 validated psychosocial treatments. The algorithm suggests combined use of a long-acting and short-acting medication or use of varenicline plus use of the most intensive psychosocial treatment acceptable. If a smoker relapses, the algorithm suggests an assessment of the reason for relapse and then use of a different or more intense or second-line treatment. This algorithm can be useful as a teaching aid or to monitor the quality of treatment.

Harm Reduction: Lessons From the Drugs Field and SNUS: A Practical Workshop

Neil Hunt, Senior Research Associate, The European Institute of Social Services, University of Kent and Director of Research for KCA

Although rarely seen in the UK, the oral tobacco 'snus' is increasingly discussed as a product with the potential to reduce nicotine related harm. 'Harm reduction' is an established philosophy within treatment for illicit drug problems — notably needle and syringe programs; examples of harm reduction strategies also exist for alcohol — for example,

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campaigns to reduce bottle and beer glass injuries in city centres. Just as smoking heroin is less hazardous than injecting, promoting a transition from a more harmful route of nicotine administration — smoking — to oral use may be associated with fewer harms among those people who would otherwise not quit their tobacco use. However, within Europe the sale of snus is currently illegal in countries other than Norway and Sweden. This session aims to allow participants to assess the potential role of snus for nicotine harm reduction and will (a) review harm reduction theory, (b) provide an overview of the evidence concerning snus and public health, and (c) enable participants to examine a range of snus products and see how they are used.

The Prevalence of Shisha Smoking Among British University Students, Smoke Intake, and Symptoms of Addiction

Daniel Jackson, Medical student, Department of Primary Care & General Practice, University of Birmingham

Background: Waterpipe/shisha smoking is a form of smoking common in the Middle East, but relatively uncommon in the west. Recent anecdotal reports suggest that it is becoming common among young British people, particularly those whose ethnic background is Asian. *Methods:* We conducted a prevalence survey among Birmingham University students. Additionally, we contacted a subgroup who smoked at least monthly and asked them about symptoms of addiction, attempts to stop smoking, and their views on the health impacts and desirability of shisha smoking. We also surveyed smokers in a shisha café measuring exhaled carbon monoxide (CO) before and after smoking. *Results:* 937 students participated in the survey. Of these, 38% had tried shisha. 8% of students were smoking shisha at least monthly (defined by the WHO as current use), of which half smoked weekly or more frequently. 9% of students were cigarette smokers, and of these, 30% were current shisha smokers, so most shisha smokers smoked shisha as their only form of tobacco. Of the regular smokers followed up, most smoked at home not in the cafes and would continue after the smoking ban is implemented. 29% had experienced strong urges to smoke shisha, 14% had tried to stop and reverted to smoking again. Nearly all thought shisha smoking was socially acceptable, enjoyable, and healthier than cigarette smoking. There were some small ethnic group differences. The café survey of 64 people showed that 90% had C0s in the nonsmoker range before smoking, with a mean (standard deviation) rise of 31 (25) parts per million (ppm). The sessions lasted a mean (standard deviation) of 29 (11) minutes. *Conclusions:* Regular shisha smoking is nearly as common as cigarette smoking in university students but is not viewed in the same way. However, only about 3% are smoking several times a week and few of these have experienced symptoms of addiction. Intakes of CO are very high, suggesting substantial toxin exposure. We may be seeing the start of a new form of smoking epidemic in the UK.

Evaluation of a Peer Support Scheme for Community Pharmacy Smoking Cessation

Seher Kayikci, Smoking Cessation and Prevention Manager, and Delphine Grynszpan, Islington PCT

Islington PCT has been operating a scheme since 2000 that allows trained pharmacists to offer stop smoking advice and dispense NRT to their clients as a one-stop-shop. However there were considerable variations between pharmacists in terms of the number of people using the service and quit rates. A peer-support project was set up to improve the service. The project aimed to increase the number of 4-week quitters and to enhance communication between the PCT and front line pharmacists. Three pharmacists were trained as mentors to provide support to other pharmacists and their staff. Mentors were well-respected members of the Local Pharmaceutical Committee. The training included communication skills, the service protocol and expected outcomes. Each mentor was allocated 10 pharmacists. Mentors were required to provide regular updates following visits to each pharmacist, including quit rates, an action report and feedback. The project was evaluated between April 2006 and March 2007. We analysed mentors' 'feedback sheets' and quit rates. A questionnaire was distributed to the pharmacists who received peer-support. Mentors were asked to provide reflections on their learning from the process. The proportion of quitters coming from pharmacists increased. Ten new pharmacists trained as Level 2 advisers and joined the scheme during the project. Communication between the PCT and pharmacists improved immensely. The PCT produced pharmacy specific promotional materials. A database was developed to reduce paperwork and to ensure accurate payments.

Smoking Cessation in Later Life: What Difference Does Brief Intervention Training Make?

Susan Kerr, Senior Research Fellow, School of Nursing, Midwifery & Community Health, Glasgow Caledonian University

Background: The need for tailored smoking cessation training for professionals who have a high level of contact with older people has been identified (PATH/ASH 2003; ASH 2004). The aim of this study was to develop and evaluate tailored brief intervention training for members of the primary care team. *Development of the training:* The training program was developed by an experienced smoking cessation trainer. Findings from a previous qualitative study helped to inform the content (Kerr et al., 2006 & 2007). The training was formally approved by Partnership Action on Tobacco & Health, which has a remit for standards in smoking cessation training in Scotland. *Evaluation of the training:* An experimental design was used to measure any changes in knowledge, attitudes and practice following the training. In addition, qualitative interviews were used to explore, in-depth, the intervention group's practice, following the training. *Sample:* 73 members of the primary care team were initially recruited from NHS Greater Glasgow and Clyde. Participants were randomly allocated to the intervention or control group. *Data collection*: Data on the knowledge, attitudes and practice of the participants were collected from both groups prior to

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the training, 1 week posttraining and 3 months posttraining. Statistical testing was undertaken to determine whether there were any differences between the groups (two factor repeat measure ANOVA). Face-to-face semi-structured interviews were conducted with members of the intervention group to further explore the impact of the training on practice c. 5 months after the training. *Results:* The quantitative results demonstrate the effectiveness of the training on the knowledge and attitudes of the participants (statistically significant difference, maintained over time). While practice appeared to be enhanced, the results did not reach statistical significance. The qualitative interviews highlight positive changes to practice. We believe that this study has made a positive contribution to the current evidence-base, with information being gathered that will help to inform practice.

Stop Smoking Projects for Pregnant Women and People Faced With Inequalities: Evaluation of the Impact of the PATH Support Fund

Susan MacAskill, Senior Research, Institute for Social Marketing, University of Stirling and Open University

Amanda Amos, Professor of Health Promotion, Public Health Sciences, Medical School, Teviot Place, Edinburgh

While smoking among adults is declining in the UK, key target groups, including pregnant women and disadvantaged groups, continue to present challenges in smoking cessation. In 2003 the Scottish Executive established a National Support Fund (around £0.9 million) to fund a range of projects that aimed to inform future cessation work with these groups. The fund was managed by Partnership Action on Tobacco and Health (PATH), which is also funded by the Scottish Executive and based in ASH Scotland. Eleven projects were funded for up to three years. The majority were interventions taking varying approaches with key groups (pregnant smokers, low-income populations, mental health groups, prisoners, dental hospital patients). Three projects were more research based, focusing on ethnic minorities, older people and low-income communities.

The presentation will outline the projects and describe key themes and findings from the external evaluation. The evaluation examined the delivery and impact of the program at both local and national levels and encompassed process, outcome and program impact. Overall promising approaches included exercise-linked projects and the use of specialist cessation providers in pregnancy along with engagement of generalist midwives. Useful research tools were also developed. Key themes and issues included: quit rates and issues around data collection; additional positive impacts such as reduced smoking consumption, attracting hard to reach clients and engaging with other professionals; the importance of organisational issues and resources. Program level issues included the difficulty of drawing lessons from diverse projects and projects which used flexible approaches.

The Accessibility and Responsiveness of a Nurse Prescriber-Led Service

Gillian McIlhinney, Smoking Cessation Specialist Adviser and June Porrit, Queensway House, Middlesbrough

This presentation describes the development of the Tees nurse prescriber-led stop smoking service, which ranks highly nationally in terms of quitter numbers, offers clinics in accessible community settings and is cost effective. The nurse-led model was initiated by a health visitor in Hartlepool in 2002 and has since been 'rolled out' across 3 PCT areas with a concomitant increase in quitter numbers. The model was rooted in the recommendations of 'Making a Difference' (DoH, 1999), which advocated extending both the health promotion and prescribing role of health visitors and building on their local knowledge of health needs. The Tees Service currently runs 30 drop-in clinics, staffed mainly by health visitors working alongside smoking cessation specialist advisers and Surestart staff. The clinics serve as 'one-stop shops', at which clients receive a package of advice, support carbon monoxide monitoring, dependency assessment and, if appropriate, a prescription for nicotine replacement therapy. Clinics are based in community settings and are chosen, not only with a knowledge of deprivation hot spots, but also with account taken of local 'savvy', qualitative reports of how people live their lives — where they like to go and to meet. Venues include leisure centres, pubs and church halls. In addition to national media, which raises awareness of smoking issues, the value of local publicity and support through the operation of a local helpline and the promotion of clinics within local neighbourhoods and networks is also recognised by the Tees Service. The Tees model was cited in 'Choosing Health' (Chapter 6, p. 135; DoH, 2005) as a good practice example of partnership working, engaging people and communities.

The Development of Social Marketing as an Effective Method of Reducing the Rates of Women Who Smoke Before, During and After Pregnancy

Fiona McKie, Tobacco Prevention Officer, Boswell House, Ayr

This social marketing project undertaken by NHS Ayrshire & Arran aims to develop the Fresh Air-shire smoking cessation and prevention service in relation to one of its key target groups: pregnant women. NHS Ayrshire & Arran have been set the target to reduce the number of women recorded as smoking at first booking to 20% by 2010. Latest figures suggest there is still a long way to go to reach this. In 2004 our organisation recorded 25% of women stating smoking at first booking, higher than the Scottish average. It is fundamentally understood that smoking in pregnancy is harmful to mother and baby and that a tailored approach specific to the needs of the women is key. By using the principles of social marketing; segmenting and targeting the audience, understanding their needs through research and consultation and developing the social marketing mix it is anticipated this social marketing intervention will reduce this figure considerably by offering women a service they want, will relate to and have a genuine impact on their lives. Through the development of this technique, it is anticipated that social marketing will be used to inform the further development of this service with other target groups.

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NICE Review of Brief Interventions: What Does It Mean For You?

Hayden McRobbie, Research Fellow, Clinical Trials Research Unit, School of Population Health, University of Auckland, New Zealand

Brief advice to stop smoking works. For every 40 people who smoke that are advised to stop by a doctor one will stop smoking long-term who would have otherwise not have managed to do so. While the effect is smaller than more intensive interventions, if delivered to all people who smoke it has great potential to have an impact at a population level. Brief advice can be given quickly and easily. Assessment of stage of change is unnecessary as advice can be provided to all smokers irrespective of whether they express a wish to stop smoking or not. Brief advice appears to work by triggering a quit attempt, so wherever possible it should be followed by a recommendation to use pharmacotherapy or referral to a smoking cessation service. The 5As (ask, advise, assess, assist and arrange) is widely used to promote the provision of smoking cessation advice and treatment. A new memory aid — ABC — has recently been integrated into the New Zealand Smoking Cessation Guidelines. ABC is a simple and easy tool for all healthcare workers to guide their action. It prompts healthcare workers to Ask about smoking status; give Brief advice to stop smoking to all smokers; provide evidence-based Cessation support for those who wish to stop smoking. Healthcare workers need to be aware of the potential they have to help smokers to stop and ultimately save lives.

Could the Key to Quitting Lie in the Genes? A Pragmatic Clinical Evaluation of the NicoTest in Primary Care

Lisa Miles, Projects Manager, g-Nostics Ltd

A multitude of medical products are available to equip medical professionals when supporting smokers in their cessation attempts. However, individuals can react differently to any single drug and much of this unpredictability is due to individual genetic variation. Individual responses to drugs constitute a substantial clinical problem since the medical professional may need to try several medicines on a patient before they find one that is suitable. Simple, decisive genetic testing of individual patients to guide treatment choices is referred to as pharmacogenetics. Pharmacogenetics has the potential to address patient-centred problems and revolutionise drug prescribing. Through provision of an advance indication of which drug and dosage would be best for the specific patient, taking into account their individual metabolic idiosyncrasies, Pharmacogenetics has the potential to offer significant cost savings from avoided adverse reactions and ineffective treatments. There is also a considerable cost to the patient of receiving ineffective or poorly-tolerated drugs. The NicoTest, one of the first point-of-care personalised testing platforms, combines genetic, biochemical and biometric data into a computerised expert algorithm to support clinical decision making through generation of a personalised treatment recommendation. Through introducing a new language of 'probability' to medical care, The NicoTest has the potential to offer a low-cost, high-reach solution to improving quit rates. A 12-month study is underway to assess the clinical utility and cost-effectiveness of the NicoTest in augmenting the NHS Stop Smoking Services both in primary care and in workplaces. Indicative data from this study will be presented at the meeting.

Conference Rapporteur: Conference Highlights and Implications for Practice

Russ Moody, Training & Development Coordinator, Plymouth Stop Smoking Service

A team of clinicians and researchers led by Russ Moody will observe plenary and parallel presentations to uncover new information relating to the provision of smoking cessation treatments. In the final plenary session on Day 2 Russ will summarise these key messages from the conference and make recommendations for changes in clinical practice that NHS Stop Smoking Services may wish to consider.

Quit and Win Smoking Cessation Workplace Competition

Debbie Nelson, Health Promotion Officer, Health at Work, Festival Business Centre, Glasgow

Health at Work is part of NHS Greater Glasgow and Clyde. We promote employee health by supporting companies with health promotion, occupational health and safety, vocational rehabilitation, employability, and the impact of work on the wider community and environment.

Our new Healthy Working Lives Award will replace the original SHAW Award. Organisations participating in this award can attain Bronze, Silver & Gold levels

Quit and Win: With 80% of Scotland's population in the workplace, what better place to access and support those who wish to stop smoking. Health at Work run an annual Quit and Win smoking cessation competition, which is open to all workplaces within the NHS Greater Glasgow and Clyde area. The aim of the competition is to work in partnership with workplace organisers to encourage and motivate individuals already contemplating stopping smoking, with prize incentives. Participants will receive information on smoking cessation support, participation in prize draws at 4-weekly intervals throughout the competition, in conjunction with providing information on the benefits of stopping smoking, and ongoing tips and advice on controlling temptation and signposting sources of support.

Health at Work coordinate the competition centrally and workplace organisers coordinate the competition within their individual workplaces. Organisers receive a pack containing an outline of the their responsibilities and additional information on smoking cessation support services. However, it is recognised that facilitation of the competition may vary between individual workplaces. Workplace organisers are encouraged to promote smoking cessation services along with the competition and can order free resources for participants. Organisers also have a responsibility to complete and return registration forms for the workplace. Participants complete and sign an entry form with a witness (colleague of the employees) signature confirming they are smoke free. Workplace organisers submit names of those colleges who have remained smoke free for each 4 weekly prize draw. *Background information:* The competition has been further developed to create more emphasis on the promotion of smoking cessation services

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with the evidence-based message that individuals' chances of becoming smoke free double with the use of nicotine replacement therapy. From 2006 the competition has further incorporated the Starting Fresh Pharmacy Programme as another support system for those wishing to stop smoking. Weekly email support messages were also built upon to create a themed approach (first prize draw, stress and relaxation, when stopping smoking) and incorporating tips and advice on avoiding temptation and signposting sources of support, as well as outlining the benefits of being smoke free. *Outcomes:* This competition has proved to be highly successful gaining more momentum each year. With the new smoking legislation coming into place last March we had a high entry rate for the competition last year with over 100 employees taking part. At the end of the competition 44 participants were smoke free.

Dramatically Increasing Quitters Through Social Marketing: A Practical Example

Ben O'Brien, Head of Marketing & Communications, Knowsley Health & Social Care

The numbers of people accessing community stop smoking services in Knowsley, Merseyside has risen dramatically since October 2006. Between October and December 2006 numbers were up 49% on the same period the previous year. In January 2007, an increase of over 150% was achieved compared with the previous January, from 258 to 707 individuals. Quit rates have reached 62% overall. In early 2006 a smoking prevalence survey in the borough revealed adult smoking rates in some areas of Knowsley to be almost double the national average at 46%, with approaching 70% having smoked at some point in their lives. Health inequality between Knowsley and the rest of the UK in smoking related disease areas reflects this. While service targets were being achieved previously, Knowsley needed to go further, faster in reducing the number of smokers in the borough. This paper will demonstrate how the systematic application of social marketing concepts and techniques and a unique partnership between Knowsley Primary Care Trust, Knowsley Council and the Roy Castle FagEnds stop smoking service is succeeding in attracting significantly more smokers in to community stop smoking services and increasing both the numbers quitting and quit rates. In particular it will give practical and theoretical insight to commissioners and practitioners as to how investing in understanding smokers' behaviours, attitudes, beliefs, motivations and environment and putting that insight at the centre of developing and implementing an integrated service and promotional approach can deliver significantly improved performance.

Innovations in Smoking in Pregnancy

Mary O'Connor, Midwife Specialist, Nobles Hospital, Isle of Man

A new stop smoking in pregnancy service commenced in the Isle of Man 2006, incorporating the best of the NHS and worldwide best practice, based upon the 7 pillars of clinical governance and 12 essential elements. The action plan was created and service implemented only when all elements had been achieved. All women referred to the service receive an inhalator and gum/lozenge at first appointment as standard and asked to replace a few cigarettes each day with the NRT. Over a 3- to 4-week period their self-belief in their ability to go for a full quit increases and other forms of NRT are then dispensed directly to the women (they do not receive a prescription or a voucher). An emergency supply of NRT is given to all women on the program at 37 weeks gestation for postnatal use in an attempt to reduce relapse rates. CO readings are taken at each appointment using the micromedical baby CO as a motivational tool. Initially as part of the service urinary cotinine samples were taken for analysis; however, that has now been discontinued as we found that if we encouraged the woman to disclose the amount she truly smoked in the first few weeks then the difference was marginal in the disclosure rates and we were able to treat her successfully without the need for expensive laboratory testing. CO levels are recorded for all pregnant women at their first antenatal booking appointment. Monitoring of data occurs at preconception, booking, 3 months, delivery, 4 weeks postnatal and 3 months postnatal. An electronic database was created for pregnant smokers to monitor not only their smoking/medical/obstetric history but a complete demographic template and obstetric outcome. Automated text messaging/emailing for appointments, as well as for motivational support, was provided for all women, particularly in the first 4 weeks. Community visits and workplace visits were offered, and partners, family members and friends were also treated into the postnatal period. Relaxation, dietary, and dental support was provided. Social marketing was used; for example, refuse collection trucks wrapped in advertising for the service — 'Take it to the People'. Validated quit rates were 52%. All benefited from the cut down to quit and the emergency supply of NRT. The emphasis of service was on the woman and not the fetus and being there to help and support and not to judge. There was a successful shift in identity from smoker to nonsmoker.

Resistant and Resilient Smokers in Southwark

Wendy Rickard, Reader in Public Health, Institute of Primary Care and Public Health, London South Bank University

Like other boroughs across the UK, Southwark Primary Care Trust is required to help people stop smoking. In 2005, its record on service uptake and the achievement of service targets was poor. Inequities in stop smoking service provision, access and take-up were suspected. A small-scale focus group study was undertaken to investigate why stop smoking services were not taken up or, if used, not necessarily adhered to by young people (girls excluded from school), pregnant women and parents of young children, unemployed people and male manual workers. First, we compared and contrasted how different groups described their smoking, mining themes such as growing, hiding, being bad or bored, staying the same, enjoying and being invulnerable. We then analysed what characterised people's smoking resistance and resilience, which included concepts of risk taking and fatalism, doubting evidence and reliance on private stories, a focus on families/across generations and perceptions of services. Potential service changes were then imagined from within an anthropological focus (on shared values and meaning systems that embed the individual behaviour choices of members of a cultural group) and were used to inform a parallel equity audit that took place over the same period.

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Smoking Cessation With Hospital Inpatients

Nancy A. Rigotti, MD Director, Tobacco Research and Treatment Center, Massachusetts General Hospital, Harvard Medical School, Boston, United States

Hospitalisation provides a window of opportunity for initiating smoking cessation interventions. Smoke-free hospital policies require smokers to abstain temporarily from tobacco use. Illness, especially if smoking related, increases smokers' motivation to attempt to quit. Hospital-based tobacco treatment services can access smokers at this teachable moment. A substantial body of evidence demonstrates that initiating tobacco treatment in the hospital increases smoking cessation rates after hospital discharge, but only if the intervention contacts continue for at least one month after hospital discharge. Hence, what used to be called hospital-based intervention is now more appropriately labeled hospital-initiated intervention. The evidence supports the use of both counselling and pharmacotherapy for hospitalised smokers and indicates that interventions are effective when applied broadly to all hospitalised smokers, regardless of admitting diagnosis. The evidence was recently reviewed by Dr Rigotti and colleagues for an updated Cochrane Collaboration systematic review of hospital smoking intervention that will be released in summer 2007. The findings of this report will be summarized in the presentation. In the US, offering smoking cessation advice or counselling to smokers admitted for acute myocardial infarction, congestive heart failure, and pneumonia became a hospital quality of care standard in 2002. Hospital regulatory organisations and Medicare (government payor for the elderly) now monitor and publicly report this information. This regulatory change has stimulated unprecedented and widespread interest by US hospitals in addressing smoking. Nonetheless, translating the evidence into routine hospital practice has several challenges. The presentation will describe Dr Rigotti's experience implementing a model system designed to surmount these challenges.

Generating Throughput and Quitters for 'Hard to Reach' Smokers

Leena Sankla, Project Director, Cardio Wellness Charity

This presentation will discuss techniques, best practice in generating high throughput and in getting patients to quit and to stay quit. This is predominately based upon the experience of delivering smoking cessation services to the deprived and hard to reach groups, these include groups in highest deprivation, certain ethnic groups (South Asian and Polish communities), patients suffering from certain cancers, asylum seekers and illegal immigrants. This paper will outline how, when and where to set up clinics to get maximum throughput, generate publicity and interest through the media.

Response to Offer of Hypnotherapy and Success Rates in Smokers Who Have Relapsed After Treatment by the NHS Stop Smoking Service

Maria Spellacy, Community Smoking Advisor, Leeds

Very little is known about the motivation of clients to return to receive further help from the NHS Stop Smoking Services (SSS). Neither is much known about their relapse rates after the end of treatment. Hypnotherapy has not been found to be more effective than conventional behavioral support in randomised trials but if it is broadly as effective and also attractive to smokers who have returned to smoking after receiving help from the NHS Stop Smoking Service, it might have a role to play. This paper reports findings from a pilot study that followed up 165 smokers who had received one-to-one counseling at least 12 months and up to 4 years later; 110 had been abstinent at the end of the treatment and 55 had not. The current smoking status was recorded and those that were smoking were offered a single session of hypnotherapy plus NRT and those that underwent this treatment were followed up for 6 months. Of 110 clients who had been abstinent at the end of treatment 28 (26%) were still abstinent, 25 (23%) had relapsed but tried again and were now abstinent while 57 (51%) were smoking. Of the 55 who had not succeeded initially, 8(15%) had tried again and were still abstinent while 47 (85%) were smoking. Of those that were smoking 84 (81%) were interested in receiving further help of whom 73 (87%) accepted the offer of hypnotherapy while 11 (13%) wanted conventional treatment. Of those wanting hypnotherapy, 66 (90%) attended and 53 (73%) were judged suitable and had the session of hypnotherapy treatment. Of these 22 (42%) were abstinent at 4 weeks and 9 (17%) were abstinent at 6 months. Bearing in mind that the client group consisted of smokers who had all ultimately relapsed following treatment by the SSS, this success rate seems to be in line with what might be expected from behavioral support. The result suggest that offer of a single session of hypnotherapy for smokers who have relapsed following behavioral support may be attractive to many smokers and that success rates are within the range that would be expected from more conventional counseling even though it involved only one session. While hypnotherapy may be no more effective than conventional counseling, it may be worth considering as a cost-effective alternative in smokers that find it attractive. This is an issue that merits further study.

Changing Minds: A Tobacco Treatment Best Practice Initiative for Addiction Professionals

Dan Steeves, Community Outreach Worker, Addiction Prevention & Treatment Services, Capital Health, Nova Scotia, Canada

Canada has made great strides in reducing national smoking rates. Unfortunately, clients who access addiction treatment settings represent a disproportionately large number of those still smoking in Canada. Tobacco-using clients in addiction treatment settings suffer high morbidity and mortality and are more likely to die of a tobacco-related illness than anything related to their drug of choice. While best practice tobacco treatment approaches are available, they are not effectively translated into practice within addiction treatment settings across the country. In other words, there is a 'research-to-practice-gap'. This gap has largely been explained in peer-reviewed studies as resulting mainly from the influence of contextual factors on policy development and implementation in organisations. Through the creation of tobacco capacity building programs and denormalisation strategies within healthcare and addiction treatment settings, this research-

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to-practice gap can be eradicated; barriers to change can be reduced, staff and client education and training can be provided, and the review and implementation of mandated guidelines for policy and treatment can be established. One such tobacco capacity building program is the 'Changing Minds: A Tobacco Treatment Best Practice Initiative for Addiction Professionals'. Originally created as a Health Canada grant project, 'Changing Minds' is an evidence-based, dynamic and interactive presentation that outlines and challenges the contextual factors contributing to the research-to-practice-gap. Sharing concrete collaborative strategies, the presentation seeks to increase the capacity of healthcare professionals to build a foundation in their own work setting for a complete tobacco control environment that is supported by effective tobacco control policies.

Cost-Effective Ways of Improving Referrals From Acute Trusts and Foundation Hospitals

Maggie Thornton, Smoking Cessation Lead (South Wiltshire), Wiltshire PCT, Barcroft Medical Centre

A short presentation to explain how in South Wiltshire close partnership working has resulted in an increase in the number of referrals to the local NHS Stop Smoking Service. Explanation of the best ways to engage hospital medical and nursing staff. A computer referral system was put in place and regular attendance by members of the service to departmental meetings to update new junior doctors and nursing staff. The enthusiasm of the doctors resulted in a full lecture theatre at the annual conference with 8 consultants from each of the specialties: vascular surgery, respiratory, general surgery, plastics, ENT, cardiac, obstetrics, and diabetes, each speaking for the time it takes to smoke a cigarette. We also managed to attract an outstanding guest speaker in Alex Bobak. In Salisbury, once the trust and efficiency of the service had been established, the referrals started coming through in increasing numbers from a variety of hospital departments. The regular updates to staff via all communication means — hospital radio, web info, hospital newsletters and regular brief intervention and level 2 training continues to ensure referrals to the service. Targeting hospital doctors and nursing staff who smoke often results in them becoming great supporters of the service. A close working relationships between NHS Stop Smoking Services and acute trusts can result in a substantial increase in the number of referrals to the service and is extremely cost effective.

Smoking Cessation and Radon Remediation: Efficacy and Cost-Effectiveness. Modeling Using Data From an NHS Smoking Cessation Program

Karen Timson, Health Improvement Coordinator, and George Shield, Northamptonshire Teaching PCT

Radon is a naturally occurring radioactive gas, which is found in varying amounts geographically. It contributes around 50% of the average background radiation dose received by the UK population and concentrates in buildings, including domestic properties. Studies suggest that radon and smoking have a synergistic, multiplicative effect on lung cancer rates such that smokers are at greater risk from radon levels than nonsmokers. Our work draws on demographic data describing an extensive population of 52-week quitters in Northamptonshire. Proprietary radon risk-assessment software is being used to quantify the relative efficacy and cost-effectiveness of radon remediation and smoking cessation programs in combating lung cancer. Initial results indicate significant life-year savings from either remediation or smoking cessation programs. More detailed analysis is underway and further details will be presented at the meeting. DEFRA has scoped promoting pro-environmental behaviour change to effect policy development in addressing exposure to radon. There could be major advantages in using social marketing techniques to inform effective changes in behaviour resulting in smoking cessation in high radon areas. The research raises the tantalising question of whether, for example, health and wellbeing programs in schools might be important to raise awareness of the synergistic effect of smoking and lung cancer rates in high radon areas? And whether new build house regulations should be more stringent to incorporate postoccupancy radon measurement? Irrespective of the final detail, a key policy message must be that the NHS could be working more closely with local authorities in investigating and addressing health issues associated with radon exposure.

Exploring the Process of Quitting Smoking and Staying Stopped: A Qualitative Study of Long-Term Quitters

Eleni Vangeli, Research Psychologist, Health Behaviour Research Centre, University College London

NHS stop smoking treatments have been demonstrated to be effective in the short term, but unfortunately around 70% of quitters relapse by 12 months. Our efforts to help people to avoid relapse have not proved fruitful, as reflected in a recent Cochrane review that concluded that there was insufficient evidence to recommend any of the relapse prevention approaches evaluated to date. There is an urgent need to find more effective methods of reducing the relapse rate, but this requires a more complete understanding of the process. The study to be presented is the first of a 3-part project, examining the variety of causes and processes which lead smokers who are initially abstinent to relapse back to smoking. The current study explored the experiences of 10 long-term quitters to gain insight into the psychological processes which may serve to protect quitters from relapse. Participants were ex-smokers who had quit with South East Stop Smoking Service reporting abstinence at 4 weeks and 52 weeks from their quit-day (expired carbon monoxide readings were taken at the 4-week end-of-treatment point and also at the time of interview to verify abstinence). An in-depth interview was conducted with each participant and this was structured according to the 5e themes of the PRIME theory (West, 2006) which highlight the importance of considering all levels of the motivational system (plans, responses, impulses, motives and evaluations), the fundamental role of the immediate situation, the role of experience in developing dispositions, the importance of identity, and the 'chaotic' nature of motivational change. Interpretative Phenomenological Analysis (Smith, 1995) was used to examine the interview data. A summary of the findings, in particular the role of identity and how its various guises appear to influence both motivation to quit and to stay stopped will be discussed in relation to PRIME theory.

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The Year Ahead for UK Smoking Cessation

Robert West, Professor of Health Psychology and Director of Tobacco Studies at the Cancer Research UK Health Behaviour Research Centre, University College, London

Approximately 25% of adults in the UK smoke. Some 50% tried to stop in 2006 and 2.5% will end up stopping permanently. The NHS Stop Smoking Services will have probably contributed approximately 25,000 to this figure (about 0.2% of smokers) and use of NRT bought over the counter probably contributed about 50,000 (0.4%). The year 2008 is the 10-year anniversary of the 'Smoking Kills' White Paper and represents an opportunity to take stock of past achievements and to assess how we can improve the support provided to smokers wanting to stop. We will make progress by (1) encouraging more smokers to try to stop, (2) getting more of them to use effective help that is available, and (3) increasing the effectiveness of those methods. The introduction of the ban on smoking in indoor public places, the development and introduction of new treatments and improved ways of using existing ones, removal of VAT from NRT products, and new NICE guidance on the Stop Smoking Services should all have a positive impact. However, to take full advantage of these opportunities the UK would benefit from a new strategic plan: a new 'Smoking Kills' policy document. Some ideas for what such a policy document might contain will be presented based on the 3Ts (Tension, Triggers and Treatment) model for promoting behaviour change. These include establishing a national tobacco control task force as an alliance of governmental agencies, NGOs, researchers and professionals, putting more effort and resources into increasing the financial cost of smoking to deter smoking in the young and encourage cessation, focusing advertising campaigns more closely on triggering quit attempts using effective methods, and developing smoking cessation specialists as a cadre of professionals within the NHS.

IC Screaming Statistics. Reporting on the Temptation of Smoking Cessation

Alyson Whitmarsh, The Information Centre for Health and Social Care

The Information Centre (IC) is an NHS special health authority created in April 2005 from the former NHS Information Authority and the Department of Health Statistics Unit. The IC has taken over the collection, analysis and dissemination of stop smoking services statistics from the DH. Not many people are aware of this — we want to make them aware! We would like to introduce The IC and the role of stop smoking services within the Lifestyles Statistics team. The data we collect not only informs DH targets but also provides essential monitoring data to the Healthcare Commission. Lots of changes surrounding data collection have been happening, affecting services, and more changes are inevitable. Local services and PCTs often do not have the opportunity to provide input into these changes. We want to give all those involved in stop smoking services, from service advisors and information analysts to public health managers the opportunity to share their views and experiences on their own data collection and information needs. With the need for timelier and higher quality data becoming more important, The IC is keen to share future plans with service leads and ensure views are collected. The UKNSCC seems like the ideal time and place to utilise the skills and experiences of delegates.

A Smoke Free Experience Just Across the Water

Alun Williams, Project Manager, GASP and Diane Lawrence, Manager, GASP

One year ago the Channel island of Guernsey introduced smokefree legislation similar to that which will be implemented in England in July. Representatives of GASP (the Guernsey Adolescent Smokefree project) — a local charity that aims to reduce smoking amongst young people in Guernsey — can share its experiences of the past year. In a brief presentation we can look at the island response to the ban including the inevitable smokers' revolt, dramatic headlines blaming us for the decline in the island's pub culture, huge increases in demand for smoking cessation support and a quiet revolution in the general public's attitude to second-hand smoke. We can also report on a significant research exercise that we have undertaken of the 1000+ teenagers to gauge their response to the ban. In Guernsey we unashamedly borrowed from the expertise and experiences of our colleagues in Scotland and Ireland and know that colleagues can learn from our 1 year of being smoke free. It will be an informative and inspiring presentation.

Challenges and Opportunities in Supporting Smokers to Stop

Nicky Willis, Team Leader, Supporting Smokers to Stop, Tobacco Policy Team, Department of Health

The opportunity currently exists for stop smoking services in the UK to maximise the impact of smokefree legislation and build on the network's record of success. New delivery models that improve reach and efficacy are being trialled in many areas and have the potential to take the services to a new level but we need to address data quality and consistency issues in order to achieve this goal and safeguard the future of this unique, life-saving service. The Healthcare Commission Report on Tobacco Control emphasised the wide variation in data collection and data management practice across the network and identified this as a real area for concern. If we cannot compare service performance on a level playing field then we cannot identify and share best practice for the good of the network as a whole, nor can we have confidence in the integrity of the data we produce. In 2007/08 a number of projects are underway that are designed to address these challenges, including the work of the National Support Team for Tobacco, forthcoming NICE program guidance on smoking cessation and the revision of the Service Monitoring Guidance for stop smoking services. These initiatives will help services to serve the needs of local populations appropriately, while maintaining high clinical and management standards. They will help commissioners to make informed decisions about service structure, appropriate resourcing and the outcomes they can realistically expect based on the evidence. National mass media campaigns are stimulating more quit attempts and smokefree legislation will help to change public attitudes to smoking. Now, more than ever, services need to cement strong local partnerships and work with the national campaign team to promote the most effective stop smoking interventions to the public. The challenges we face are very real and we work in a highly dynamic area, this means that we may have to adapt in order to evolve and progress but the opportunity to make a unique contribution at national and international level is also very real and should be grasped.

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