Health Equity Audit
Of
Lewisham’s Stop Smoking Service
2007-2012

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Executive Summary

Background
Smoking is the primary cause of preventable morbidity and premature death in England\(^1\). In 2010 Marmot highlighted tobacco control as central to any initiative looking to reduce health inequalities\(^5\). The Department of Health’s tobacco control plan 2011 publication encourages local areas to tailor their stop smoking services to the needs of their communities and reach out to those in high prevalence groups, in particular those in routine and manual jobs.

As an inner London borough Lewisham is ethnically diverse, has a high level of deprivation (it is 31\(^{st}\) most deprived borough in the country\(^8\)) and 25% of adults are in routine and manual work. Smoking prevalence in the borough is estimated to be 22%.\(^{10}\)

The Stop Smoking Service in Lewisham was set up in 2000 and provides smoking cessation support in a variety of settings through its network of over 100 trained advisers.

This health equity audit looks at the use and success of Lewisham’s Stop Smoking Service from April 2007 to March 2012 by age, gender, ethnicity, socioeconomic group and location. In addition the views of a small number of service users and advisers were sought on factors that may affect the use and success of the service.

Results
During the five years almost 18,000 quit dates were set by 13,000 smokers and 46% of those resulted in a successful quit. The number of quit dates set per year has increased but the success rate (the proportion of the quit dates set that result in a successful quit) has fallen, this is in line with the situation nationally. The majority of quit dates were set in GP practices, followed by pharmacies, with the highest success rates in GP practices and specialist services.

Although more women than men set quit dates men were more likely to quit successfully. Contrary to popular assumption men were more likely to use GP-based stop smoking advisers than women. Men were also more successful in quitting than women when using a GP-based service, though women were more successful than men when using pharmacy-based services. Older women seem to be underrepresented in users of the service when taking into account their smoking prevalence.

As is the case nationally younger smokers are both less likely to use Lewisham’s Stop Smoking Services and less successful. Smokers aged 50-59 are five times more likely to quit (using the SSS) than those aged 15-19.

Smokers from ethnic minorities are overall better represented amongst users of the service than in 2000-2005. Indian men, Chinese men, white Irish men and black Africans of both genders are least represented amongst users of the service currently. White Irish male smokers have a higher success rate than other ethnicities.

More quit dates are set by smokers from more deprived areas, though they are less likely to be successful in quitting. Similarly the greatest number of quit dates set was by those who are unemployed or in routine and manual jobs; however students and the unemployed have the lowest success rate amongst users of the service.
Over the last five years the rate of increase in the number of smokers using the SSS has been highest in those from most deprived areas. The importance of the role of specialist level three stop smoking advisers in reducing inequalities is evident as smokers from deprived areas and black African smokers are more likely to quit with their support in comparison to other providers of support.

There is some geographical variation in the number of smokers setting quit dates and their success in quitting, however it is most likely this is linked to deprivation rather than location.

Ensuring the service is easy to use and communicating the ease of use are seen as important by users of the service. Provision of information about the Stop Smoking Service to smokers is also important, but the content and timing of that need for information varies (some smokers may keep the information until they are ready to use it). In addition users and advisers of the service revealed that there are a number of personal attitudes of smokers that it would be very difficult for the Stop Smoking Service to influence.

Conclusions
Since the last equity audit more smokers from black and ethnic minority groups are using the service. In addition this health equity audit shows that over the last five years the Stop Smoking Service is reaching an increasing number of people from deprived areas. More quit dates are set by smokers from deprived areas than from less deprived areas.

Overall this health equity audit shows that there is not equity across Lewisham’s smokers in the use and success of Lewisham’s Stop Smoking Service in terms of the need for stop smoking services. The population groups that seem to be underrepresented in their use of the service are: younger smokers, older women, Indian men, Chinese men, white Irish men and black African smokers. Additionally smokers from more deprived areas, routine and manual workers, students and unemployed smokers are less likely to successfully quit smoking.

Recommendations
Following a brief literature review for stop smoking interventions amongst the underrepresented groups and discussion with Stop Smoking Service advisers and the Tobacco Free Future Delivery Group, about the findings of the health equity audit, a number of recommendations are proposed to improve the equity of Lewisham’s Stop Smoking Service. These recommendations address the marketing of the service (in terms of both the message and how it is disseminated), targeted interventions by the service and the need for further data collection and analysis of some groups not included in this audit.
Background

Smoking

Smoking is the primary cause of preventable morbidity and premature death in England.\(^1\) Currently about 21% of people over 18 smoke in England.\(^2\) This has fallen since a peak in the 1940s, but shows signs of levelling off more recently. Increasingly smoking is also one of the most significant causes of health inequalities. There is a strong link between cigarette smoking and socio-economic group, with those in lower socio-economic groups being more likely to smoke, least able to afford it and least able to give it up.\(^3\) Since the 1960s the social gradient in smoking prevalence has widened as quit rates have been lower amongst the least affluent.\(^4\) Currently smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.\(^5\)

Smoking prevalence also differs between other population groups, for example smoking prevalence is higher amongst Bangladeshi and Pakistani men, Irish men and women and lesbian and gay people.\(^4\) The London Boost of the 2006 Health Survey for England found that White Londoners were significantly more likely to be current smokers (25%) than people from Black and Black British (14%) and Asian and Asian British (12%) groups.\(^6\) Smoking is also strongly associated with mental health, it is estimated that psychiatric patients have a smoking prevalence of two to three times higher than the general population.\(^7\)

In 2010 Marmot highlighted tobacco control as central to any initiative looking to reduce health inequalities.\(^5\) And the Department of Health’s tobacco control plan 2011 publication encourages local areas to tailor their stop smoking services to the needs of their communities and reach out to those in high prevalence groups, in particular those in routine and manual jobs.\(^4\)

Lewisham

Lewisham is the 31st most deprived borough in the country\(^8\) by the index of multiple deprivation score (IMD).\(^5\) The prevalence of smoking in the most deprived areas of London is higher than in the least deprived areas, in 2006 prevalence in the most deprived areas was estimated as 27% but only 16% in the least deprived.\(^6\) Lewisham also has a larger black and minority ethnic (BME) community than England overall, which is likely to affect the overall smoking prevalence for the borough. As black Africans and Caribbeans, who make up a majority of Lewisham’s BME population, have a lower smoking prevalence than the population as a whole. The prevalence of mental illness, usually associated with higher smoking prevalence, is higher than the England as a whole.\(^8\) In 2010/11 the overall adult smoking prevalence in Lewisham was not significantly different from England at about 22% (though with 95% CI 19.0% - 25%).\(^9\)

Compared to England Lewisham had significantly more smoking attributable deaths in 2008-10 and hospital admissions in 2010/11. It also had significantly fewer successful quitters at 4 weeks in 2011/12. However, surprisingly, the rates of smoking in pregnancy in 2010/11 were significantly lower than the national average.\(^10\)

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\(^1\) See definitions section
Stop Smoking Services in Lewisham

In 2006 the London Health Observatory undertook an analysis of the equity of access to London’s Stop Smoking Services (SSS). They used prevalence data from the London boost of the Household Survey England 2006 as well as modelled estimates from 2004-6. They collected data on the use of stop smoking services from 24 London Primary Care Trusts (PCTs), including Lewisham from 2005-2007. Across the PCTs included, 60.7 per 1000 estimated smokers accessed a Stop Smoking Service, and 31.9 per 1000 smokers successfully quit at 4 weeks. The figures for Lewisham residents were lower at 39.8 per 1,000 estimated smokers accessing and 19.2 per 1,000 quitting.9

![Figure 1 - Access Rate – number per 1,000 estimated smokers aged 16 years and over setting a quit date by PCT of residence (2005-7)](image)

This study has not been repeated more recently. However it is possible to compare the number of quit dates set per borough per year to the number of estimated smokers to gain an estimate of the % of smokers accessing the Stop Smoking Service. (Figure 2 and Figure 3)
Figure 2 - % of Smokers Setting a Quit Date with Stop Smoking Services 2011-12 by London borough

Figure 3 - Success rate of smokers using Stop Smoking Services 2011-12 by London Borough

Lewisham (shown in red) has a higher proportion of smokers using the SSS than London as a whole, however the success rate (% of those setting a quit date who have successfully quit after four weeks) of those smokers is lower than London as a whole. Generally, though not universally, the success rate is lower in London boroughs that are more deprived.

\footnotesize
\begin{itemize}
  \item[i] Taken from NICE Tobacco Return on Investment (ROI) Tool using Stop Smoking Services data from Department of Health Returns and Integrated Household Survey smoking prevalence by borough
  \item[ii] Taken from Department of Health Stop Smoking Services information
\end{itemize}
Lewisham’s Stop Smoking Service was established in 2000. It is currently commissioned by Lewisham Public Health and provided by Lewisham Healthcare Trust. Smokers wishing to quit are offered up to 12 weeks of a combination of behavioural support and medication. This is provided by a network of over 100 trained advisers delivered in a variety of settings.

- **Primary Care** - Trained advisors are from a variety of backgrounds, including nurses, health care assistants, pharmacists, pharmacy staff offer one to one support to smokers.
  - Provided by almost 30 GP practices
  - Provided by over 30 pharmacies
- **Specialist Service** – Experienced level three advisors, employed and managed by the Stop Smoking Service, provide stop smoking services in a number of ways:
  - Group sessions (a seven week evening group programme runs continually at Lewisham Hospital)
  - One to One Sessions (provided in a variety of settings including health centres and community and leisure centres)
  - Drop in sessions (one to one sessions that do not require a pre-booked appointment)
  - Community Outreach, including within workplaces
  - Advisers working with specific groups:
    - Mental health (provides advice on nicotine replacement for inpatients as well as seeing smokers with mental health problems directly)
    - Secondary Care (at University Hospital Lewisham)
    - Pregnancy (contacts all pregnant smokers and parents of children under five)
    - Young People (including sessions run in youth groups)
    - Vietnamese community

There is also a dedicated freephone, text, email service and website from the Lewisham Stop Smoking Service.

The details of every individual who uses Lewisham’s Stop Smoking Service to set a quit date are recorded on the “Quit Manager” database.
Aim of Current Health Equity Audit

Assess and describe how the resources of the Stop Smoking Service are distributed in relation to different population groups in Lewisham.

Objectives

- To describe the prevalence of smoking in Lewisham in different population groups
- To extract and collate relevant information from the Quit manager database of the Stop Smoking Service
- To analyse the use and success of the Stop Smoking Service since 2006 by age, gender, residence, ethnicity and socioeconomic group and consider the influence of type of provider
- To compare the smoking prevalence of different population groups with their access to and use of the service
- To gather and understand information on the Stop Smoking Service from the perspective of users
- To identify gaps between smoking prevalence and access to the service and make recommendations as to how the service could address these inequities

Methodology

The concept of equity in health services considers the needs that ought to affect use of healthcare and those that should not; for example the differences in smoking prevalence (a need variable) and language difficulties (a non-need variable). “Horizontal inequity” is used to describe different use of the service amongst those with the same needs. It is this type of equity that is most relevant when considering the equity of a health service.

A health equity profile of the service was carried out in 2006, covering the period from 2000-2005. This demonstrated that there was underrepresentation of black and minority ethnic groups, pregnant women, young people and men. Analysis of socioeconomic status/occupation was not a part of the profile as this data was only collected after 2007. Since then the SSS has expanded and introduced the work with targeted groups described above, hence the decision to complete a new health equity audit of the service by the Tobacco Free Future Delivery Group and Public Health Consultant lead for tobacco control.

Health Equity Audit

A health equity audit identifies how fairly services or other resources are distributed in relation to the health needs of different groups and areas and the priority action required to provide in relation to need. Actions required to create more equitable services are agreed and incorporated into local plans and practice. The overall aim is to distribute resources not equally but in relation to health need.
The steps of a health equity audit are outlined below.

Figure 4 – Cycle of health equity audit

In doing a health equity profile of the Stop Smoking Service there are three concepts that need to be taken into account:

- The differing healthcare need across different population groups. (Smoking prevalence in population groups supplies information on the need for stop smoking services in that population.)
- Access – do all smokers have equal access to stop smoking services (SSS)?
- Success – is there a difference in the success rate amongst different population groups using the SSS?
a) Equity Profile

i) Estimation of Prevalence
Smoking prevalence data is available from a number of sources using a variety of methods. It is mainly collected from surveys; in particular the Integrated Household Survey (IHS) which combines answers from a number of Office of National Statistics (ONS) surveys containing questions about smoking. This increases the sample size and hence accuracy of prevalence estimates at a national level. It is also possible to look at smoking prevalence from GP practice records, although this excludes those who are not registered and relies on accurate data entry within practices.

The Association of Public Health Observatories (APHO)/ONS publish prevalence data at local authority level. At this level the sample size is relatively small, for example in Lewisham there were 875 respondents in 2009-10\(^8\). Given this sample size the accuracy of this smoking prevalence is limited and has wide confidence intervals.

For this equity audit it is important to be able to compare smoking prevalence for different groups within the population, as an indication of their differing needs for stop smoking services. Given the small sample size of the IHS in Lewisham analysing these by subcategory is unlikely to be meaningful. Therefore in order to estimate the number of smokers in a subgroup in Lewisham national smoking prevalence rate for that subgroup has been applied to the local population. For example the 2004 Health Survey England focused on black and ethnic minority individuals and provides the most recent estimates of smoking prevalence in BAME groups. Using this prevalence information and local data on the size of BAME populations in Lewisham it is possible to estimate the number of smokers for each ethnic category in Lewisham. (There are limitations to this approach, which are outlined below).
ii) Analysis of Quantitative Data from the Stop Smoking Service

Quits dates set from April 1st 2007 to March 31st 2012 were extracted from Quit Manager (the database of Lewisham’s Stop Smoking Service) on 30th August 2012 into an excel file and anonymised. The data was analysed using Excel 2003.

Data on each variable/population group identified in the aim above (age, gender, residence, ethnicity and socioeconomic group) were analysed by some or all of the following ways:

- **Number of quit dates set** – the number of quit dates set in the Lewisham SSS in the specified period (usually five years from April 2007 to March 2012). A quit date is the date a smoker plans to stop smoking altogether with support from a stop smoking adviser as part of an NHS-assisted quit attempt.

- **Success rate** - % quit dates set that result in a successful quit at four weeks (meeting Department of Health definition of a quit)\(^1\)

\[
\text{number of quits} \quad \frac{\text{number of quit dates set}}{}\]

- **Access rate** – Number of quit dates set per 100 smokers in Lewisham over specified time period (ie estimation of the % of smokers who accessed the service)

\[
\frac{\text{number of quit dates set (in Lewisham SSS)}}{\text{estimated number of smokers in Lewisham}}\]

- **Quit rate** – Number of quits per 100 smokers in Lewisham over specified time period (ie estimation of the % of smokers who quit using the service)

\[
\frac{\text{number of quits (in Lewisham SSS)}}{\text{estimated number of smokers in Lewisham}}\]

- **Breakdown by type/location of service used** – % of all quit dates set by a particular population group that are in a particular location/intervention type

\[
\frac{\text{Number of quit dates set in particular intervention setting/location}}{\text{Total number of quit dates set}}\]

- **Success rate by location/type of service used** – success rates calculated for each type/location of service used

\[
\frac{\text{number of quits in setting type/location}}{\text{number of quit dates set in setting type/location}}\]

Residence data was analysed in two ways; firstly geographically, the number of quit dates set per lower super output area (LSOA) was calculated and mapped using MapInfo Professional 7.5. Secondly the Index of Multiple Deprivation (IMD) ranking of the LSOA of residence of each user of the service was calculated.

\(^1\) A client is counted as having successfully quit smoking at 4 weeks if he/she has not smoked at all between 2 and 4 weeks after setting the quit date.
iii) Qualitative Data from SS Service

The views of some current users and providers of the Stop Smoking service were sought.

Users
Views of 15 smokers were collected during brief face-to-face interviews when they were using the service, using the questions included in appendix B.

- Three users of the drop in service at the Waldron Health Centre were approached once they had completed their session with the SSS and asked if they would like to answer a few questions to help with service improvement.
- Twelve users of the group session (held at University Hospital Lewisham on a Monday evening) were also included; their views were sought both as a group and individually.

Advisers
Similarly views of some advisers were sought, this was done during session times in gaps between seeing clients. They were asked to consider the same questions and also asked to reflect on views that users have expressed to them as well as their own views on the service. Six advisers were interviewed, all level three trained.

b) Identify effective local action to tackle inequalities
The results of the equity profile were shared with the Tobacco Free Future Delivery Group in Lewisham and at a team meeting of the Stop Smoking Service (comprising level three advisers). After identifying the groups of smokers underrepresented in the health equity profile a brief literature search was also performed to identify stop smoking interventions targeted at those groups. The most relevant of these interventions were presented to and discussed with the Stop Smoking Service Team. The recommendations are a synthesis of the literature reviewed, the health equity profile and discussions at these meetings.
Limitations

Prevalence, Access Rate and Quit Rate

There are limitations around the accuracy of smoking prevalence figures overall. The data relies on having a representative sample and accurate self-reporting in surveys. Sample sizes at national level help to minimise these potential limitations. However with smaller sample sizes, ie at borough level or limited to a particular demographic, these potential errors, particularly having a sample that is representative of the group as a whole, become more significant.

Smoking prevalence data by demographic attributes is limited and often several years old and what is available is only at national level. Where possible, prevalence figures for each demographic characteristic (gender, age and ethnicity) have been applied to the same population group in Lewisham. This gives an estimated number of smokers for that group in the borough which can be used as the denominator for the access or quit rate in the borough. This method makes the assumption that a group of, for example, women, in Lewisham have the same smoking prevalence as women throughout the UK. It does not take into account other characteristics of that group in Lewisham such as ethnicity, age or deprivation which have an effect on the likelihood of them smoking. For each characteristic, only one prevalence figure can be applied which assumes that on all other characteristics the group in Lewisham is the same at that group nationally. This probably reduces the accuracy of the exact number of smokers of a particular group in the borough. However the number of smokers is still helpful as a comparison between groups (i.e. male and female smokers) within the borough as other characteristics such as ethnicity and deprivation are likely to apply to both groups. It does though mean that comparisons across demographic characteristics i.e. between one ethnicity and one socioeconomic group are not possible.

In addition for demographic groups the various national figures for smoking prevalence by group are a number of years old, for example the ethnicity data was collected in 2004. These have been applied to more recent population data, again limiting the accuracy of the actual number of smokers.

Number of quit dates set and success rates

Data are recorded onto Quit Manager for each quit date set, if more than one quit date is set by an individual these are recorded as two separate events. Therefore the number of quit dates set is not equal to the number of smokers. It is assumed though that it is when access and quit rates are calculated. Although this limits the accuracy of the actual quit/access rate it should have an equal impact across all groups and hence not affect comparisons.

Deprivation Data

It is assumed that the deprivation (by IMD) ranking of their lower upper output area (LSOA) of residence applies to each smoker. However an individual in that LSOA may experience significantly more or less deprivation as the overall ranking represents an average for the LSOA as a whole. An attempt to minimise this by using the smallest possible area (LSOA) at which IMD ranking data is available.
Quit Manager
The data entered onto Quit Manager is not complete and this varies by field. Some characteristics such as gender are almost universally recorded (missing in only 16 of over 18,000 records). In other fields there is more missing data, this has been highlighted in the relevant results section.

Qualitative
There are a number of limitations of the qualitative data collected from smokers using the SSS and advisers:
- Small sample size
- Majority of the users of the service questioned used the SSS group, which is used by a minority of smokers accessing the service.
- Only users of the service were asked rather than smokers in general
- Advisers from GP practices and pharmacists were not included

Groups not included
It is not possible to determine whether smokers using the service have disabilities or mental illness or what their sexual orientation is using quit manager. Hence within the scope of this audit it is not possible to look at the equity of those smokers in using the service.
Results

1) Use and Success of the Lewisham Stop Smoking Service 2007 - 2012

Over the five year period reviewed there were over 18,000 quit dates set by almost 13,000 individuals, the number of individuals who had more than one episode with the stop smoking service is detailed below. Overall the success rate amongst those setting a quit date was 46%.

<table>
<thead>
<tr>
<th>Number of Episodes with Stop Smoking Service (2007/8-2011/12)</th>
<th>Number of Individuals</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>12840</td>
</tr>
<tr>
<td>2</td>
<td>3573</td>
</tr>
<tr>
<td>3</td>
<td>1171</td>
</tr>
<tr>
<td>4</td>
<td>434</td>
</tr>
<tr>
<td>5+</td>
<td>273</td>
</tr>
</tbody>
</table>

Table 1 - Number of episodes per individual using Lewisham's Stop Smoking Service

The majority of quit dates were set in primary care either in GP practices or pharmacists. Almost 20% of quit dates are set through specialist advisers. Success rates are variable across these settings, they are lower in the pharmacy setting and higher in specialist services and GP practices.

<table>
<thead>
<tr>
<th></th>
<th>Number of quit dates set (2007-12)</th>
<th>Success Rate (2007-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Practices</td>
<td>8713</td>
<td>48%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>3833</td>
<td>39%</td>
</tr>
<tr>
<td>Specialist Services</td>
<td>3348</td>
<td>47%</td>
</tr>
<tr>
<td>Not recorded</td>
<td>2288</td>
<td>44%</td>
</tr>
<tr>
<td>All</td>
<td>18182</td>
<td>46%</td>
</tr>
</tbody>
</table>

Table 2 - Number of quit dates set and success rate by intervention setting in Lewisham’s SSS 2007-2012
Over the five years reviewed the number of quit dates set has fluctuated but overall has increased in 2011/12 compared to 2007/8. The success rate shows a slight downward trend. This decline in the success rate is not unique to Lewisham, over the same timeframe the success rate across Stop Smoking Services nationally has fallen from 52% in 2007/8 to 49% in 2011/12.}

![Figure 4 - Number of quit dates set, number of quits and success rate in the Lewisham Stop Smoking Service by year 2007/8-2011/12.](image)

- Over 18,000 quit dates were set by over 13,000 smokers in five years
- The number of quit dates set per year has fluctuated but increased from 2007/8 to 2011/12
- The success rate has fallen over the five year period
- The majority of quit dates were set in GP practices, followed by pharmacies and then specialist services
- GP-based and specialist advisers had higher success rates than pharmacy based advisers
2) Use and Success of Stop Smoking Service by Gender

More quit dates were set by women than men in the Lewisham Stop Smoking Service every year from 2007/8 to 2011/12. This is in line with the national picture in 2011/2, although interestingly, in London as a whole more quit dates were set by men.\textsuperscript{14} The national prevalence of smoking is higher in men than women, 22% against 20% in 2009.\textsuperscript{15} This would imply that the need for Stop Smoking Services is greater amongst men and hence if the service is equitable in terms of access more men should be setting quit dates. Borough-level smoking prevalence data by gender is not available.

Figure 5 - Number of quit dates set in the Lewisham Stop Smoking Service by gender and year, 2007/8-2011/2.

Male service users were more likely to quit than female both nationally and in London, with a national success rate of 51% for men and 48% for women for 2011/12.\textsuperscript{14} In Lewisham over the five years the success rate for men was 46% and 45% for women. Over time the success rate has fallen for both genders.
In general there is little difference in where male and female users are accessing the stop smoking service and in the intervention type used. A higher percentage of men setting quit dates do so in a GP practice (49%) than women (46%). 21% of men and 20% of women setting a quit date do so in a pharmacy setting.

Women seem to be slightly more successful in quitting in pharmacy settings than men (40% vs 38% success rate), whereas men seem more successful in GP settings (49% vs 47% respectively).

There is little difference in the type of intervention used by male and female smokers. Slightly more female quit dates are though drop-in clinics, 10% against 9%. 77% of quit dates set by men are set in one to one (excluding drop in) services, but only 74% of quit dates set by women. The success rate for men in drop in clinics is slightly higher than women at 48% compared to 45%. The success rate for other one to one services is similar at 46% for men and 45% for women.

- More women than men are setting quit dates in the Lewisham SSS (despite a lower smoking prevalence)
- Male users of the service are more likely to quit successfully
- Male users of the service are more likely to use Stop Smoking Services in GP practices than women
- The success rate is higher in female users of the service than male in pharmacy based services
- The success rate is higher in male users of the service than female in GP practice based services
3) Use and Success of the Lewisham Stop Smoking Service by Age

There is variation in the numbers of quit dates set by different age groups in Lewisham, with most quit dates set by adults in their 30s and 40s. The number of quit dates set is lowest at both extremes of the age range, in the under 20s and over 70s.

![Figure 7 - Number of quit dates set by age in Lewisham’s Stop Smoking Service, 2007/8-2011/2](image)

There is also variation in how successful different aged users of the service are at quitting once they have set a quit date, generally older smokers are more successful. The success rate increases with age until after about 65 years old when it remains fairly stable. This pattern is similar, although perhaps more pronounced, than the national trend, in 2011/12 the success rate for under 18s was 32% whereas it was 57% for those over 60.\(^{14}\)

![Figure 8 – Success rate by age for Lewisham’s Stop Smoking Service 2007/8 – 2011/2](image)
Smoking prevalence varies markedly by age and gender, it is therefore useful to consider the numbers of people using the SSS in terms of the number of smokers of each age/gender in Lewisham.

<table>
<thead>
<tr>
<th>Age</th>
<th>Smoking Prevalence (%)</th>
<th>Estimated Smokers in Lewisham 2011</th>
<th>Number of Quit Dates Set 2011/2</th>
<th>Number of Quits 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M  F</td>
<td>M  F</td>
<td>M     F</td>
<td>M     F</td>
</tr>
<tr>
<td>15-19</td>
<td>20  17</td>
<td>1289  1139</td>
<td>49    60</td>
<td>14    13</td>
</tr>
<tr>
<td>20-24</td>
<td>27  30</td>
<td>2680  3206</td>
<td>128   183</td>
<td>36    44</td>
</tr>
<tr>
<td>25-34</td>
<td>27  25</td>
<td>7411  6782</td>
<td>395   506</td>
<td>165   171</td>
</tr>
<tr>
<td>35-49</td>
<td>24  21</td>
<td>7814  7169</td>
<td>694   775</td>
<td>322   330</td>
</tr>
<tr>
<td>50-59</td>
<td>20  19</td>
<td>2540  2645</td>
<td>332   310</td>
<td>137   155</td>
</tr>
<tr>
<td>&gt;60</td>
<td>13  13</td>
<td>2002  2523</td>
<td>234   229</td>
<td>115   115</td>
</tr>
</tbody>
</table>

Table 3 - National Smoking Prevalence, Estimated Number of Smokers in Lewisham, Number of Quit Dates Set and Number of Quits Using the Lewisham Stop Smoking Service by Age and Gender

Older male smokers are over three times more likely to access Stop Smoking Services than younger male smokers. (Figure 9) The difference is smaller for female smokers, with older women being about twice as likely to access the Stop Smoking Service.

Figure 9 - Number of Quit Dates Set per 100 Estimated Smokers by Age and Gender for 2011/2.

---

1 Taken from Smoking Statistics for England 2012, which gives smoking prevalence rates for 2010 by gender and age from sources including the General Lifestyle Survey 2010
2 Calculated using population data from 2011 Census and smoking prevalence as above
3 Calculated as Table 3 above
However, when the number of quits per estimated smoker is considered this difference is increased. (*Figure 10*) In both men and women older smokers (aged 50-59) are about five times more likely than younger smokers (aged 16-19) to successfully quit. However both the access and quit rate fall for female smokers over the age of 60.

![Figure 10](image-url)  
*Figure 10 - Number of successful quits in the Lewisham Stop Smoking Service during 2011/12 per 100 estimated smokers*  

The difference, therefore, between the ages is starker when looking at quits against the smoking population than access. I.e. not only are young people (especially men) less likely to access the service but they are also less likely to quit once they have accessed it.

---

1 Calculated as table 3 above
Over the five year period the success rate has declined for all age groups, though this is more pronounced amongst the younger age groups.

- Younger smokers and female smokers over 60 seem to be underrepresented in those accessing the service
- Smokers aged 50-59 are five times more likely to quit (using the SSS) than those aged 15-19
4) Use and Success of the Lewisham Stop Smoking Service by Ethnicity

Self reported ethnicity is recorded for users of the Stop Smoking Service using the standard sixteen category format. There is also a free text section to record other ethnicities or more detailed information. Between 2007/8 and 2011/12 the free text section was completed in only 97 quit attempt records. There were a wide variety of “ethnicities” recorded, including other London boroughs or British countries! The most frequently recorded nationality was Polish with eleven entries, most of which were recorded towards the end of the five year period. *(Table 5)*

There have been some changes in the ethnicity of those accessing the stop smoking service in 2000-2005 compared to 2007/8 - 2011/12. Overall a higher number of people declined to give their ethnicity in the period covered in the current audit compared to the previous one. However during this audit fewer people declined to give their ethnicity in the later part of the period compared to the earlier part. In addition there has been a reduction in the proportion of white British accessing the service, and an increase across almost all other ethnicities.

However the ethnic mix of the population of Lewisham overall has changed between 2000-2005 and the current period.

<table>
<thead>
<tr>
<th>Ethnicity (Broad categories)</th>
<th>% of Population 2010</th>
<th>% of quit dates set 2007/8 – 2011/12</th>
<th>% of population 2004</th>
<th>% of quit dates set 2000-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>59</td>
<td>67.33</td>
<td>66</td>
<td>79.27</td>
</tr>
<tr>
<td>Black African</td>
<td>11</td>
<td>3.32</td>
<td>9</td>
<td>2.00</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>13</td>
<td>8.36</td>
<td>11</td>
<td>7.11</td>
</tr>
<tr>
<td>Black Other</td>
<td>6</td>
<td>5.12</td>
<td>4</td>
<td>3.64</td>
</tr>
<tr>
<td>Indian</td>
<td>2</td>
<td>0.83</td>
<td>2</td>
<td>0.74</td>
</tr>
<tr>
<td>Pakistani</td>
<td>1</td>
<td>0.36</td>
<td>1</td>
<td>0.22</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>1</td>
<td>0.26</td>
<td>1</td>
<td>0.22</td>
</tr>
<tr>
<td>Chinese</td>
<td>1</td>
<td>0.67</td>
<td>2</td>
<td>0.28</td>
</tr>
<tr>
<td>Other Asian</td>
<td>3</td>
<td>1.48</td>
<td>2</td>
<td>1.04</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>6.92</td>
<td>2</td>
<td>2.69</td>
</tr>
</tbody>
</table>

*Table 4 - Breakdown of the population of Lewisham and users of the SSS by ethnicity 2004 and 2010*

Looking at the 5 years from 2007/8 to 2011/12 individually there has been some change in this pattern, mainly the number of quit dates set by people who declined to give their ethnic group fell (from 341 to 152) as did the number of “others”. There has been a rise in the numbers across all other ethnic categories as a result of this improved recording.

---

1. See appendix C for mapping of 16 to 10 category ethnic classification
2. “Taken from Lewisham JSNA 2010
3. ONS 2009
4. Health Equity Audit 2006
Table 5 – Quit dates set in the Lewisham SSS by ethnicity
2004 and 2010, including most frequently recorded freetext entries

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>% of All Quit Dates Set 2007/8 - 2011/12</th>
<th>% of All Quit Dates Set 2000-2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>White British</td>
<td>54.71</td>
<td>73.85</td>
</tr>
<tr>
<td>White other</td>
<td>9.78</td>
<td>3.19</td>
</tr>
<tr>
<td>Black/Black British Caribbean</td>
<td>8.36</td>
<td>7.11</td>
</tr>
<tr>
<td>Declined</td>
<td>5.3</td>
<td>1.37</td>
</tr>
<tr>
<td>Any Other Ethnic Group</td>
<td>4.09</td>
<td>1.93</td>
</tr>
<tr>
<td>Black/Black British African</td>
<td>3.32</td>
<td>2.00</td>
</tr>
<tr>
<td>White Irish</td>
<td>2.84</td>
<td>2.23</td>
</tr>
<tr>
<td>Mixed Other Background</td>
<td>2.83</td>
<td>0.76</td>
</tr>
<tr>
<td>Mixed White and Black Caribbean</td>
<td>2.64</td>
<td>1.43</td>
</tr>
<tr>
<td>Black/Black British Other</td>
<td>1.65</td>
<td>1.82</td>
</tr>
<tr>
<td>Asian Other Background</td>
<td>1.04</td>
<td>0.78</td>
</tr>
<tr>
<td>Mixed White and Black African</td>
<td>0.83</td>
<td>0.39</td>
</tr>
<tr>
<td>Indian</td>
<td>0.83</td>
<td>0.74</td>
</tr>
<tr>
<td>Chinese</td>
<td>0.67</td>
<td>0.28</td>
</tr>
<tr>
<td>Mixed White and Asian</td>
<td>0.44</td>
<td>0.26</td>
</tr>
<tr>
<td>Pakistani</td>
<td>0.36</td>
<td>0.22</td>
</tr>
<tr>
<td>Bangladeshi</td>
<td>0.26</td>
<td>0.22</td>
</tr>
<tr>
<td>Polish</td>
<td>0.06</td>
<td>n/a</td>
</tr>
<tr>
<td>Turkish</td>
<td>0.04</td>
<td>1.43</td>
</tr>
</tbody>
</table>

Although looking at the ethnicity of users compared to the ethnicity of the population is helpful, it does not fully assess the equity of access as smoking prevalence (and hence need for the Stop Smoking service) varies by ethnicity.

The most recent data available on smoking prevalence by ethnicity dates from 2004, when Health Survey England had a special focus on the health of black and minority ethnic people nationally.

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Smoking Prevalence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>All</td>
<td>24</td>
</tr>
<tr>
<td>White British</td>
<td>24</td>
</tr>
<tr>
<td>White Irish</td>
<td>30</td>
</tr>
<tr>
<td>Indian</td>
<td>20</td>
</tr>
<tr>
<td>Black Caribbean</td>
<td>25</td>
</tr>
<tr>
<td>Black African</td>
<td>21</td>
</tr>
<tr>
<td>Chinese</td>
<td>21</td>
</tr>
</tbody>
</table>

1 Health Survey England 2004
Applying the above national smoking prevalence figures to the local population by ethnicity it is possible to estimate the number of smokers of each ethnicity in Lewisham. (As already discussed there are limitations to this approach. It assumes the prevalence of smoking in a particular ethnic population in Lewisham is the same as the population nationally and does not take into consideration other factors that affect smoking prevalence such as age and deprivation.) Combining this with the number of quit dates set/quits by that ethnicity provides the access and quit rates respectively. These allow a comparison of ethnicity use of and success using the SSS by their need for the service.

Figure 12 - % of estimated smokers accessing the stop smoking service by ethnicity and gender 2007/8 - 2011/12

This suggests that Indian men, white Irish men, black African men and Chinese men and women are underrepresented amongst service users.
Overall the pattern of success of users of the SSS is similar to that of all smokers accessing to the service. Again, Indian men, white Irish men, black African men and Chinese men and women appear underrepresented; in addition black African women are also underrepresented amongst those successful in quitting using the SSS when considered in terms of need.

Considering specifically the underrepresented groups highlighted above (limited to those with more than 50 quit dates set), it may be helpful, where possible, to understand where and how they are accessing the service and their success in various interventions. (Table 6 and Table 7)

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Pharmacy 1:1</th>
<th>GP 1:1</th>
<th>SSS Drop in</th>
<th>SSS 1:1</th>
<th>SSS Group</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>21%</td>
<td>48%</td>
<td>9%</td>
<td>7%</td>
<td>2%</td>
<td>100%</td>
</tr>
<tr>
<td>Black African</td>
<td>30%</td>
<td>37%</td>
<td>12%</td>
<td>10%</td>
<td>1%</td>
<td>100%</td>
</tr>
<tr>
<td>Black African Males</td>
<td>30%</td>
<td>35%</td>
<td>12%</td>
<td>10%</td>
<td>1%</td>
<td>100%</td>
</tr>
<tr>
<td>White Irish Males</td>
<td>20%</td>
<td>48%</td>
<td>8%</td>
<td>8%</td>
<td>4%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Table 6 - % of Quit Dates set by each ethnic group by setting/intervention type 2007/8 – 2011/12

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Pharmacy 1:1</th>
<th>GP 1:1</th>
<th>SSS Drop in</th>
<th>SSS 1:1</th>
<th>SSS Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>39%</td>
<td>48%</td>
<td>46%</td>
<td>42%</td>
<td>66%</td>
</tr>
<tr>
<td>Black African</td>
<td>33%</td>
<td>37%</td>
<td>41%</td>
<td>47%</td>
<td>86%</td>
</tr>
<tr>
<td>Black African Males</td>
<td>34%</td>
<td>40%</td>
<td>40%</td>
<td>54%</td>
<td>100%</td>
</tr>
<tr>
<td>White Irish Males</td>
<td>44%</td>
<td>50%</td>
<td>61%</td>
<td>65%</td>
<td>63%</td>
</tr>
</tbody>
</table>
White Irish men used GP-based services almost two and a half times more than pharmacy-based services. They used dedicated community drop in and appointment-based services a similar amount to all users, though used the group sessions more. However black African men and women are more likely to pharmacy-based services and less likely to use GP-based services than all users. They are also more likely to use specialist services, both drop in and appointment-based one to one sessions and seem less likely to use group sessions (though the numbers for this are small). (Figure 14)

![Figure 14 - % of quit dates by each ethnic group by intervention type of Lewisham's Stop Smoking Service 2007/8 – 2011/12](image)

In terms of success, black African men and women seem to be more successful in one to one (appointment) based community Stop Smoking Services than all users, but less successful in GP and slightly less successful in pharmacy settings. The success of Irish men using the service is generally higher than all users, though this is most pronounced in the drop in sessions. (Figure 15)
Figure 15 – Success rate for each ethnic group by intervention setting/type Lewisham’s Stop Smoking Service 2007/8 – 2011/12

- Indian men, Chinese men, white Irish men and black Africans of both genders are least represented in users of the SSS in the context of the estimated number of smokers
- White Irish men using the service are more likely to quit than other ethnicities
- Black Africans are more likely to use and be successful using the one to one sessions provided by community advisors than other ethnicities
5) Use and Success of the Lewisham Stop Smoking Service by deprivation

The Index of Multiple Deprivation (IMD) is a compound measure of deprivation that is used to compare levels of deprivation between areas. It can be applied to local super output areas (LSOAs) which are sub-ward level areas of about 1500 people. The IMD score for each LSOA in Lewisham is ranked and the LSOAs are divided into ten groups (or deciles) from the most deprived in the borough (ranked 1) to the least deprived (ranked 10).

The LSOA of residence (and its corresponding deprivation ranking) can be found for each user from their home postcode, which is recorded on Quit Manager.

More quit dates were set by those living in more deprived LSOAs. (Figure 16) However the success rate was lower amongst users from more deprived LSOAs. (Figure 17)

---

1 See appendix A
The rate of increase in quit dates set over time has been greatest amongst those living in more deprived areas; as demonstrated by the steeper gradients of the most deprived LSOAs (1-5) lines compared to the least deprived. *(Figure 18)*

*Figure 17 – Success rate of users of Lewisham’s Stop Smoking Service by IMD ranking of LSOA of residence of service user, 2007/7 – 2011/12  
(Deprivation increasing left to right)*

*Figure 18 - Number of Quit Dates set in Lewisham’s Stop Smoking Service by of IMD ranking of LSOA of residence of service user for each year 2007/8 – 2011/12  
(1 – most deprived LSOA, 10 – least deprived)*
IMD ranking by LSOA can be done nationally as well as locally by comparing the IMD score for a local LSOA to all LSOAs in the country. This is useful as data from Health Survey England 2004 estimates smoking prevalence by national IMD ranking.

<table>
<thead>
<tr>
<th>IMD Ranking (National Quintile)</th>
<th>Smoking Prevalence (%)</th>
<th>Number Accessing Lewisham’s SSS 2007-12</th>
<th>Success Rate (%) (Lewisham’s SSS 2007-12)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (most deprived)</td>
<td>35</td>
<td>7030</td>
<td>42</td>
</tr>
<tr>
<td>2</td>
<td>28</td>
<td>6314</td>
<td>47</td>
</tr>
<tr>
<td>3</td>
<td>23</td>
<td>1268</td>
<td>48</td>
</tr>
<tr>
<td>4</td>
<td>17</td>
<td>93</td>
<td>44</td>
</tr>
<tr>
<td>5 (least deprived)</td>
<td>16</td>
<td>0</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Table 8 - National smoking prevalence, number of people accessing and quitting Lewisham’s Stop Smoking Service by national quintile of deprivation (IMD) 2007/8 to 2011/12 (1 – most deprived, 5 least deprived)

This significant difference in smoking prevalence means that there is a marked difference in need (for stop smoking services) between populations at different deprivation levels. It is appropriate that more people from deprived areas are accessing the service. However given the lower success rates amongst those from more deprived areas it may be helpful to understand where they are most likely to access the service and where they are most successful at quitting.

<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>IMD 1</th>
<th>IMD 2</th>
<th>IMD 3</th>
<th>IMD 4</th>
<th>IMD 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP 1:1</td>
<td>49</td>
<td>56</td>
<td>60</td>
<td>60</td>
<td>60</td>
</tr>
<tr>
<td>Pharmacy 1:1</td>
<td>26</td>
<td>20</td>
<td>23</td>
<td>24</td>
<td>24</td>
</tr>
<tr>
<td>SSS Drop In</td>
<td>14</td>
<td>12</td>
<td>9</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>SSS 1:1</td>
<td>10</td>
<td>10</td>
<td>6</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>SSS Group</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
</tbody>
</table>

Table 9 - % of quit dates set in each setting by local quintile of deprivation (IMD) 2007/8 to 2011/12

1 There are no LSOAs in Lewisham in the least deprived national quintile
Users resident in more deprived areas are less likely to use GP SSS and more likely to use 1:1 and drop-in sessions provided by specialist advisors.

<table>
<thead>
<tr>
<th>Intervention Type</th>
<th>IMD 1</th>
<th>IMD 2</th>
<th>IMD 3</th>
<th>IMD 4</th>
<th>IMD 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP 1:1</td>
<td>45</td>
<td>42</td>
<td>50</td>
<td>50</td>
<td>50</td>
</tr>
<tr>
<td>Pharmacy 1:1</td>
<td>38</td>
<td>41</td>
<td>41</td>
<td>36</td>
<td>39</td>
</tr>
<tr>
<td>SSS Drop In</td>
<td>45</td>
<td>42</td>
<td>49</td>
<td>41</td>
<td>52</td>
</tr>
<tr>
<td>SSS 1:1</td>
<td>46</td>
<td>41</td>
<td>40</td>
<td>48</td>
<td>21</td>
</tr>
<tr>
<td>SSS Group</td>
<td>50</td>
<td>53</td>
<td>67</td>
<td>68</td>
<td>72</td>
</tr>
<tr>
<td>Overall</td>
<td>43</td>
<td>42</td>
<td>48</td>
<td>46</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 10 - Success rate in each intervention setting by local quintile of deprivation (IMD) 2007/8 - 2011-12

Success rates in all intervention types are lower in smokers resident in more deprived areas. Those from most deprived areas are most likely to be successful in specialist services, particularly group sessions. But those from less deprived areas are more likely to be successful in GP setting (as well as group sessions).

- More residents of deprived areas are accessing the SSS than less deprived areas, in line with their comparatively higher prevalence of smoking. However those from more deprived areas are less likely to quit successfully
- Over the last five years the rate of increase in the number of smokers using the SSS has been highest in those from most deprived areas
- Service users from more deprived areas are more likely to quit successfully using specialist SSS over other intervention types/settings
6) Use and success of the Lewisham Stop Smoking Service by occupation/socioeconomic category

Lewisham’s Stop Smoking Service began to collect data on socioeconomic group (based on the user’s occupation) in 2007. Anecdotally providers have reported that it can be difficult to decide into which category a client’s job title fits. Close to half the quit dates set did not have an occupation recorded of those that did the majority of quit dates set were amongst those who had never worked/were long-term unemployed.

![Figure 19 - Number of quit dates set by occupation in Lewisham’s Stop Smoking Service 2007/8 - 2011/12](image)

In 2011 those who were living in households in which the reference member of the household\(^1\) is long-term unemployed/never worked made up only 8% of Lewisham’s adult population. (*Table 11*)

<table>
<thead>
<tr>
<th>Occupation (of reference household member)</th>
<th>% of 16-74 year olds Lewisham 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managerial and Professional</td>
<td>35</td>
</tr>
<tr>
<td>Intermediate</td>
<td>20</td>
</tr>
<tr>
<td>Routine and Manual</td>
<td>25</td>
</tr>
<tr>
<td>Never worked/long-term unemployed</td>
<td>8</td>
</tr>
<tr>
<td>Fulltime Students</td>
<td>12</td>
</tr>
</tbody>
</table>

*Table 11 - % of Lewisham adult population by socioeconomic category, 2011*

\(^1\) Usually the person responsible for paying the accommodation costs
There is no local data available on smoking prevalence by socioeconomic group, but nationally it is higher amongst those in routine and manual jobs than those in managerial and professional. *(Table 12)*

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Smoking Prevalence, England 2010 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
</tr>
<tr>
<td>All</td>
<td>21</td>
</tr>
<tr>
<td>Managerial and Professional</td>
<td>14</td>
</tr>
<tr>
<td>Intermediate</td>
<td>19</td>
</tr>
<tr>
<td>Routine and Manual</td>
<td>28</td>
</tr>
</tbody>
</table>

*Table 12 - National smoking prevalence by socioeconomic group 2010*

In Lewisham success rates are higher amongst smokers from higher socioeconomic classifications, and lowest in students and the unemployed. *(Figure 20)* In 2012 nationally the success rate amongst students was 36%, 39% for unemployed and 57% for those in managerial and professional occupations.  

*Figure 20 – Success rate Quit rate by self-reported occupation, 2007/8-2011/12*
Information on whether a smoker is eligible for free prescriptions is recorded on Quit Manager. This may provide further clues on the success of smokers in using Lewisham’s SSS by area of deprivation and socioeconomic group. Unfortunately in many cases the field was not completed, but those that were, showed that the success rate is lower amongst those who do not pay for prescriptions. (Table 13) Again this is in line with the national trend, which in 2012 showed a success rate of 46% for those eligible for free prescriptions and 53% for those not.

<table>
<thead>
<tr>
<th>Pays for Prescriptions?</th>
<th>Success Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>49</td>
</tr>
<tr>
<td>No</td>
<td>39</td>
</tr>
<tr>
<td>Unknown</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 13 - Success rates of quitters by whether they pay for prescriptions (Lewisham SSS 2007/8 - 2011/12)

- The greatest number of quit dates set was by those who are unemployed or in routine and manual jobs
- Students and the unemployed have the lowest success rate amongst users of the service
7) Use and success of the Lewisham Stop Smoking Service by location

In the five-year period from 2007-2012 15,573, or 85% of all encounters with Lewisham’s Stop Smoking Service were with smokers living within the borough of Lewisham. The number of quit dates set and successful quits per ward varied. (Table 14) Given the variation in demographics across the borough it is likely that smoking prevalence is also variable. There is no data widely available to look at smoking prevalence at sub-borough level; however some bespoke data based on the integrated Household Survey data 2009/10 was provided to Lewisham’s public health team by the ONS. The modelling method does not easily allow for confidence intervals at this level of detail, so there will be considerable uncertainty in any individual figure.

<table>
<thead>
<tr>
<th>Ward</th>
<th>Estimated Smoking Prevalence 2009-10 (%)</th>
<th>Quit Dates Set (2007/8 to 2011/12)</th>
<th>Success Rate 2007/8 to 2011/12 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bellingham</td>
<td>31</td>
<td>1555</td>
<td>39</td>
</tr>
<tr>
<td>Blackheath</td>
<td>22</td>
<td>535</td>
<td>46</td>
</tr>
<tr>
<td>Brockley</td>
<td>16</td>
<td>827</td>
<td>49</td>
</tr>
<tr>
<td>Catford South</td>
<td>29</td>
<td>530</td>
<td>49</td>
</tr>
<tr>
<td>Crofton Park</td>
<td>24</td>
<td>992</td>
<td>46</td>
</tr>
<tr>
<td>Downham</td>
<td>27</td>
<td>1175</td>
<td>44</td>
</tr>
<tr>
<td>Evelyn</td>
<td>14</td>
<td>895</td>
<td>43</td>
</tr>
<tr>
<td>Forest Hill</td>
<td>12</td>
<td>417</td>
<td>52</td>
</tr>
<tr>
<td>Grove Park</td>
<td>25</td>
<td>888</td>
<td>43</td>
</tr>
<tr>
<td>Ladywell</td>
<td>15</td>
<td>668</td>
<td>48</td>
</tr>
<tr>
<td>Lee Green</td>
<td>26</td>
<td>651</td>
<td>45</td>
</tr>
<tr>
<td>Lewisham Central</td>
<td>21</td>
<td>1068</td>
<td>47</td>
</tr>
<tr>
<td>New Cross</td>
<td>20</td>
<td>866</td>
<td>44</td>
</tr>
<tr>
<td>Perry Vale</td>
<td>13</td>
<td>972</td>
<td>47</td>
</tr>
<tr>
<td>Rushey Green</td>
<td>23</td>
<td>1039</td>
<td>42</td>
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<tr>
<td>Sydenham</td>
<td>27</td>
<td>723</td>
<td>55</td>
</tr>
<tr>
<td>Telegraph Hill</td>
<td>24</td>
<td>815</td>
<td>46</td>
</tr>
<tr>
<td>Whitefoot</td>
<td>17</td>
<td>957</td>
<td>47</td>
</tr>
</tbody>
</table>

Table 14 - Estimated smoking prevalence, number of quit dates set and success rate by ward

Given the uncertainty over the prevalence figures above it is hard to comment on the equity of access by ward.

Lewisham wards have between 6,000 and 8,000 adult residents. It is also possible to consider the use and success of the SSS by the smaller lower super output areas (LSOAs), these typically contain around 1500 people (in Lewisham LSOAs in 2011 this ranged from 1200 to 2100). There are 166 LSOAs in Lewisham and between 2007/8 and 2011/12 quit dates were set by smokers living in all of them. The mean number of quit dates set per LSOA was 89 with a range of 242 to 8.

---

1 ONS Census 2011
There are several areas across the borough where a collection of neighbouring LSOAs has high numbers of quit dates set, these areas are spread across the borough. *(Figure 21)* However in looking at the success rates by LSOA the pattern is reversed, with the LSOAs with high numbers of quit dates set having low quit dates. *(Figure 22)*

![Map of Lewisham borough showing number of quit dates set by residents from each LSOA 2007-2012](image)

*Figure 21 - Map of Lewisham borough showing number of quit dates set by residents from each LSOA 2007-2012*
Generally the LSOAs with the higher number of quit dates set but lower quit dates are the more deprived LSOAs, and hence the pattern looks similar to that of deprivation by LSOA. *(Figure 23)*

Suggesting that it is likely the deprivation levels of an area a smoker is from has more of an impact than solely the geographical location, though it is difficult to separate these two factors.
Figure 23 - Map of LSOAs in Lewisham borough by national quintile of Index of Multiple Deprivation 2010

Looking at where quit dates were set rather than where the smoker setting the quit date lives reveals quit dates set throughout the borough. The location of most Stop Smoking Services is dictated by major roads and commercial areas, which contain pharmacies and general practices. (Figure 24)
Further analysis of where quit dates were set, including by type of setting is included in appendix C.

- Some LSOAs in Lewisham have higher numbers of quit dates set by resident smokers but often a lower success rate.
- It appears that this is more likely to be explained by differing levels of deprivation than geographical location.
8) Views of smokers using the service and stop smoking advisers

The views of a small number of smokers using the service and stop smoking advisers were sought (see methodology section for details).

A total of fifteen smokers (users of the service) were included, three at one to one drop in sessions and twelve at a group session, the users represented both genders, a variety of ethnicities, jobs and spread of ages. In addition the views of six level three SSS advisers were sought, they were asked mainly to reflect on feedback they have received from users in answering the questions. The comment of both users and advisers were analysed together, some broad themes emerged, which are outlined below. The full results are available in appendix E.

Personal Attitude of smoker
Everyone commented that a smoker’s personal attitude was the most important factor in whether (and when) they accessed the SSS. There were a number of different elements of this attitude that was mentioned:

- Independence – some users feel that they want to quit smoking on their own rather than help.
- Feeling ready – in particular that some life events meant smokers put off quitting
- Motivation – overestimation of the difficulty of accessing/using the service (rather than quitting) by smokers.
- Health scare – important in some individuals as a motivator for quitting smoking.

In many of these examples it was felt that there was relatively little that the SSS as a whole is able to do to address these. Though users mentioned the importance of smokers understanding how simple the service was to access (i.e. provision of drop in services at convenient times) and ensuring that smokers have the relevant information about the service to ensure that when they are ready or have a health scare they have the information to access the service.

Stop Smoking Service Factors

- Finding out about the service – personal recommendations/referrals from a variety of healthcare professionals and cross-promotion from other healthy lifestyle providers were highlighted as being important. Several users reported having received information on the service and keeping it for sometime before they felt ready to use it.
- Location – the smokers consulted were all happy with the location at which they were accessing the service. Users and advisers highlighted that having a service that was nearby and easy to get to was important in attracting those smokers with limited motivation to access the service.
- Venue – again users liked the venue that they were accessing the service in, though were less sure about other venues. Advisers highlighted the importance of appropriate venues in particular for smokers from lower socioeconomic groups, avoiding those that could appear intimidating or judgemental.
- Timing – users questioned were happy with the times offered by the SSS, being able to go during the day being important to some and in the evening to others.
- Being part of the community – advisers gave several examples of how being seen as part of the community has helped the service target hard to reach groups in communities.
• Personal attitude of advisers – all users questioned were positive about the attitude of the SSS advisers – persistent encouragement and being non-judgemental were two particular attributes that were appreciated.

Suggestions
Users and advisers were also asked for any suggestions that had to increase the uptake of SSS by smokers locally, these included:

• Marketing – there were a variety of opinions as to what would be successful in encouraging more smokers; including highlighting the ease of using the service and variety of support offered to potential users, and ensuring a variety of stop smoking messages, such as those focusing on the financial benefits as well as those focusing on the health benefits.
• Use of a mobile stop smoking van – to make it easier for smokers to access the service closer to home.

- There are a number of personal attitudes of smokers that it will be very difficult for the SSS to influence, but ensuring the service is easy to use and communicating the ease of use are seen as important.
- Provision of information about the SSS to smokers is important, the content and timing of that information need varies. (But some smokers may keep that information until they are ready to use it)
- Healthcare professionals and other healthy living programmes promoting SSS are important to some smokers
- Community outreach and in particular being seen as part of the community is seen as helpful in targeting groups.
Summary of Results of Health Equity Profile

This health equity audit shows that there is not equity across Lewisham’s smokers in the use and success of Lewisham’s Stop Smoking Service in terms of the need for stop smoking services. However it does show that since the last equity audit more smokers from black and ethnic minority group are using the service. In addition it shows that over the last five years it is reaching an increasing number of people from deprived areas.

The population groups that seem to be underrepresented in their use of the service are
- Younger smokers (under 35, though more pronounced with decreasing age)
- Older women
- Indian men
- Chinese men
- White Irish men (access but not success)
- Black African men and women

With the exception of white Irish men these groups also tend to be less likely to be successful in quitting smoking once they have set a quit date. In the case of the following groups of smokers their reduced success rate compared to other smokers is more pronounced than any differences in their use of the service
- Smokers from deprived areas
- Routine and manual workers
- Students
- Unemployed

The majority of the reasons the smokers interviewed gave for not using the service related to personal events and motivation and it was felt that there was relatively little that the SSS as a whole is able to do to address these. Though users mentioned the importance of smokers understanding how simple the service was to access (i.e. provision of drop in services at convenient times) and ensuring that smokers have the relevant information about the service to ensure that when they are ready or have a health scare they have the information to access the service
Results of Brief Literature Review

Younger smokers
A Cochrane review\textsuperscript{16} considered interventions aimed at helping young smokers to quit. The interventions they included ranged from pharmacotherapy to more complex strategic interventions including people around the smoker or even the wider community. They looked at all trials assessing interventions aimed at regular smokers under 20 that recorded smoking cessation in individuals as an outcome. Overall they found that motivational enhancement interventions are more effective than brief interventions on young smokers quitting at 6 months. Interestingly they found limited evidence on the use of pharmacological aids. They suggest that generally complex interventions are more successful, those which include motivational enhancement and support and social cognitive theory. In particular the “Not-on-Tobacco” programme in the USA which is a voluntary programme for young smokers wishing to quit and focuses on YP understanding their reasons for smoking and learning skills to help them quit. A higher proportion of smokers quit when in this programme compared to brief interventions. (However this was not statistically significant with an odds ratio of 1.77 but with a confidence interval of 1.0 – 3.11, this is probably because the study was underpowered). The authors conclude that recruitment, mode of delivery (some internet-based interventions were included), and follow-up are more important than the intervention type itself. And there was not enough evidence to recommend one model over another.

The apparent benefit of the complex interventions highlights the importance of one to one support but raises the question of how it might be delivered more innovatively such as using social media and mobile devices.

Older female smokers
There are few studies looking at smoking cessation in older women specifically. However a group in Switzerland in 2007 looked at the smoking cessation attitudes and behaviours of a group of female smokers/recent ex-smokers over 70.\textsuperscript{17} Women were more likely to attempt to quit smoking if they:

- Started smoking over the age of 25
- Had previously made an attempt to quit

And surprisingly:

- Had not had a college education
- Thought it was difficult to quit

And the following were associated with being less likely to attempt to quit smoking:

- Being a light smoker
- Smoking “light cigarettes”

Of the smokers that went on to quit about 75% did so unaided. And smokers were more likely to be successful in quitting if they smoked less than one cigarette a day and if they thought quitting was not hard. The barriers to women not making quit attempts were linked to incorrect health information or beliefs; thinking that smoking light cigarettes is not harmful and that there is no health gain in quitting at their age.
Black and minority ethnic smokers

Much of the information available about smoking cessation activities targeted at BAME communities in the UK is amongst south Asian communities. However for Lewisham those targeting black African smokers are particularly pertinent given the larger size of that community in the borough. Much of the information on health promotion interventions in this group is based in the USA amongst their African American population.

There is some qualitative information available about the attitude of BAME smokers to smoking and stop smoking services. Research with a Somali group in London found a lack of awareness amongst Somali smokers of local stop smoking services and a lack of knowledge of nicotine replacement therapy. A similar study of Bangladeshi and Pakistani smokers found that they were aware of the dangers of smoking, were motivated to quit but were more focused on the use of willpower and were uncertain of the value of support and medications.

In the UK there are a number of examples of targeted interventions:

- In 2011 a pilot trial using Pakistani and Bangladeshi trained outreach workers against standard smoking cessation in Birmingham. This small study showed this intervention was feasible and acceptable to smokers; however it was too small to show a statistically significant difference in quit attempts. And it was targeted at small geographical area with a south Asian population of more than 10%.

- Studies have shown a lack of awareness of NHS SSS amongst ethnic minority smokers, including a study in Somali smokers. The STOP! Project in Leicester increased uptake of Stop Smoking services by BAME smokers from 14% to 21% over a three year period and the STOP! Brand had 80% brand recognition in a recent survey. They achieved this through forming partnerships with local community groups/advocates and ran a targeted media campaign during Ramadan.

Considering any health promotion interventions rather than just the smoking cessation interventions and including studies from outside the UK yields some more studies. An NIHR health technology assessment in 2012 by Liu et al found six systematic reviews of health promotion interventions that focused on the African American population. Two of the reviews they identified made adaptations for the ethnicity of the population and found increased short-term but not long-term effectiveness. However the other four studies did not report on adaptations. And the two that did do not evaluate which of the adaptations were effective.

In Lewisham there are a number of black African churches and a sizeable black African Christian population. Looking at stop smoking interventions using churches to reach out to these communities there is one paper available from 1996 based in rural USA. It is hard to know how comparable it is to a UK urban population 17 years later. They trained smoking cessation advisers from the church community and provided one to one counseling, self help literature and community-wide activities. The success rate was higher in the intervention group but it was not statistically significant. There was also higher awareness of and contact with services and progression along the stages of quitting amongst the intervention group.
Lower Socioeconomic Group/More Deprived Smokers
In England and Wales, figures show that those in routine and manual occupations are two and a half times more likely to be heavy smokers.\textsuperscript{15} And heavy smokers are less likely to be able to quit successfully. Additionally qualitative research has shown that smoking tends to be more deeply embedded in the lives of smokers from lower socioeconomic groups/more deprived areas; and that living, working and socialising with other smokers makes it harder to quit smoking. This group also tend to have higher levels of stress and many smokers use smoking to cope with stress.\textsuperscript{23}

In 2007 a NICE review looked at Stop Smoking interventions to reduce the rates of premature death in disadvantaged areas. Unfortunately many of the papers they identified had not separated disadvantaged smokers in their analysis, thereby limiting the information available. The authors found limited evidence of some of potentially useful interventions, including using a variety of venues accessible to disadvantaged smokers, providing drop-in services and potential for incentive schemes such as provision of free NRT.\textsuperscript{24} (All of these are in place in Lewisham.)

In 2009 another review looked at increasing the access of disadvantaged smokers to stop smoking services. Additional interventions they suggested as potentially effective included:

- Using social media techniques
- Tailoring interventions to populations to make the approach more client-centred
- Combining smoking cessation interventions with other (health-care) interventions
- One study they included pointed to the potential effectiveness of workplace interventions.\textsuperscript{25}

More recently Barking and Dagenham SSS combined two of these approaches and set up a workplace targeted intervention. They recruited businesses with a large number of routine and manual workers, a healthy lifestyle check and awareness event were provided. And for smokers wanting to quit an in house stop smoking service was offered. As a result of the programme one of the businesses subsequently has a member of staff trained to become a level 2 advisor to provide ongoing smoking cessation advice.\textsuperscript{26}
Discussion
The health equity profile provides information on which groups of smokers are underrepresented in either accessing or succeeding using the SSS. Without interviewing smokers from these population groups who are not using the service in Lewisham it is not possible to know why they may be less likely to use the service and/or less likely to succeed in quitting smoking. However the health equity profile is able to identify the interventions that are most used by and successful for underrepresented groups. For example the specialist level three advisors are more successful in achieving quits in black African ethnicity smokers. This will assist in planning targeted services for particular groups of smokers in the future. In addition talking to advisers and smokers who have used the service and reviewing the literature available provides some suggestions, both of why these groups are less likely to use the service successfully and how to improve this.

Young smokers
Whilst it is important to ensure the SSS is accessible to young smokers it may be more effective to focus on preventing young people starting smoking, as described in Lewisham’s Smokefree Future Delivery Plan.

However there is ample evidence nationally, from both surveys and telephone helplines, to demonstrate that a significant proportion of young smokers want to stop smoking, and are willing to seek help to do so.\(^\text{27}\) Reflecting on the view of users and advisers (though there were no young people interviewed) cross promotion through other programmes aimed at young people (including tobacco control/prevention activities such as the schools peer education programme), the use of the internet/telephone for one to one support if possible and aiming to ensure young smokers understand the variety of support offered by the Stop Smoking Service may be key, for those young people who have already started smoking.

Older Female Smokers
It is hard to know if the results of the study of older female smokers in Switzerland are applicable to the older female population of Lewisham. It may offer a useful strategy in the messages to include in encouraging older women to stop smoking; specifically around any number/type of cigarettes being associated with health risks and the advantages of quitting being present at any age. Additionally feedback from users/advisers suggested possible modes of delivering this message; firstly through the Lewisham carers group and secondly considering targeting grandmothers, using the motivation of them not wanting to expose their grandchildren to smoke and in many cases with the support of their children.

Black African Smokers
In Lewisham the SSS have in previous years attempted to attract Muslim smokers during Ramadan. However there was little, if any uptake, the Muslim population in Lewisham is relatively small compared to some parts of the UK and the SSS felt they were limited not having level three advisors from that background in their team. In Lewisham there are a number of African churches and a sizeable black African Christian population.

In discussion with the SSS level three advisers considering using black African churches to reach out to smokers from this community could be explored. Additionally using a similar approach to the Leicester STOP! model to reach out particularly during lent could be considered.
Lower Socioeconomic Group/More Deprived Smokers
Smokers from lower socioeconomic groups, more deprived areas and routine and manual jobs are underrepresented in their success rather than use of the service.

In presenting the findings of the audit to the level three advisors they were not surprised that more smokers from deprived areas were setting quit dates but that those smokers were less successful at quitting. They acknowledged that on an individual level it often felt that it was more difficult for disadvantaged smokers to quit. They wondered to what extent the level two GP and pharmacy providers were aware that there is evidence that smokers from deprived areas are less likely to quit successfully. They suggested that telling/reminding them of this may be useful in motivating them to support disadvantaged smokers and in particular in supporting them in subsequent quit attempts. (In Lewisham from 2007-2012 routine and manual smokers were two and a half times more likely to have made at least five previous quit attempts with the service.)
Recommendations

Marketing
The message
- Ensuring messages advertising the SSS are varied appealing to the different motivations of different groups of smokers:
  - encompassing health messages (including challenging incorrect health beliefs such as benefits of quitting at any age/however many cigarettes are smoked)
  - the financial implications of smoking
  - the ease and variety of support available from the Stop Smoking Service, in particular including the availability of Champix and drop in services.

Where it is delivered
- Advertising the SSS in places that the underrepresented are more likely to see the messages, for example including Lewisham Carers and other community groups as described above.
- Increasing cross-promotion of services, ensuring partnerships with other health promotion, health and lifestyle programmes in the borough.

SSS Interventions
- Approach African churches in the borough to promote the SSS and consider feasibility of a Stop Smoking for Lent campaign.
- Present some of the findings of this health equity audit to level 2 advisers to motivate them to help reduce inequalities in the SSS.
- Consider increasing or targeting the use of level 3 advisers for underrepresented groups who are most successful in quitting with those advisers
- Explore the possibility of using innovative means of supporting smokers to quit, particularly young smokers, through use of telephone, text and internet support.

Further Analysis/information
- Consider surveying smokers in some of the underrepresented groups to understand any barriers there are to their use of the service.
- Investigate how it may be possible to evaluate the equity of smokers with disabilities, and mental illness using the service as well as considering the equity by sexuality. (the provision of a specialist mental health adviser recently is likely to assist in this)
Appendices

Appendix A - Definitions

**Quit date** - Date a smoker plans to stop smoking altogether with support from a stop smoking adviser as part of an NHS-assisted quit attempt.

**Treatment episode** - At the point of attending one session of a structured, multi-session intervention, consenting to treatment and setting a quit date with a stop smoking adviser, a client becomes a treated smoker and the treatment episode begins. The treatment episode ends either when a client has been completely abstinent for at least the two weeks prior to the four-week follow-up (see flow chart below) or is lost to follow-up at the four-week point, or when a four-week follow-up reveals that a client has lapsed during the two weeks immediately prior to the follow-up and is therefore recorded as a non-quitter. *Error! Bookmark not defined.*

**Quit** - A client is counted as having successfully quit smoking at 4 weeks if he/she has not smoked at all between 2 and 4 weeks after setting the quit date. (The reason for adopting the "2 weeks after quit date" definition is to allow a period of "grace" in recognition of the fact that some smokers initially struggle but then manage to quit.) (Some quits will be verified by means of Carbon Monoxide levels)

**Quit Rate** – Quits (as defined above) as a percentage of quit dates set

**Access Rate** – Number of quit dates set over the estimated number of smokers of a defined population (This gives an indication of the proportion of smokers reached however it considers quit dates set rather than number of quitters)

**Index of Multiple Deprivation (IMD)** – A measure of the level of deprivation of an area. It is calculated from indicators from the following areas; income, employment, Health and Disability, Education Skills and Training, Barriers to Housing and Other Services, Crime and Living Environment. Typically areas are then ranked by score and grouped according to this ranking; usually into five or ten groups (known as quintiles or deciles).

**Lower level Super Output Area (LSOA)** – Super Output Areas are a set of geographical areas developed following the 2001 census. They were produced to maintain a set of geographical areas with consistent size that were not subject to boundary changes (unlike electoral wards). There are two tiers of super output areas, the lower level (LSOAs) typically contain 1500 people.
Appendix B – Questions used to interview smokers and advisers of the Stop Smoking Service

(Advisers were asked to reflect on feedback they have received from users of the service as well as their own views)

Why did you choose to use the Stop Smoking Service? (in particular compared to other ways of quitting)

How did you find out about the service?

What helped you to access the service?

Did you have any problems accessing the service?

(If so) What helped/would have helped you access the service?

Is there any other support you would have liked?

How did you find the following aspects of the service:

- Location
- Staff (attitude etc)
- Medication advice
- Times/Days
- Atmosphere

(i.e. particular consider things that were good and encouraged you to use the service, or were less good/discouraged you?)

Do you have friends and family members who are smokers and want to quit? Have they accessed the service? What do you think would dissuade/encourage them from doing so?

What would make it easier to use the service?

If you could do something to encourage more people come to the service what would you do?
## Appendix C – Mapping of Ethnic categories

<table>
<thead>
<tr>
<th>ONS 2001 Census Ethnic Category</th>
<th>GLA Aggregated Ethnic Group (AEG)</th>
</tr>
</thead>
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<tr>
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<td></td>
</tr>
<tr>
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</tr>
<tr>
<td>Black or Black British: Caribbean</td>
<td>Black Caribbean</td>
</tr>
<tr>
<td>Black or Black British: African</td>
<td>Black African</td>
</tr>
<tr>
<td>Black or Black British: Other Black</td>
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<td>Mixed: White &amp; Black Caribbean</td>
<td>Black Other</td>
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<td>Indian</td>
</tr>
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</tr>
<tr>
<td>Asian or Asian British: Bangladeshi</td>
<td>Bangladeshi</td>
</tr>
<tr>
<td>Chinese or Other: Chinese</td>
<td>Chinese</td>
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<tr>
<td>Mixed: White &amp; Asian</td>
<td>Other Asian</td>
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<tr>
<td>Asian or Asian British: Other Asian</td>
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</tr>
<tr>
<td>Mixed: Other Mixed</td>
<td>Other</td>
</tr>
<tr>
<td>Chinese or Other: Other</td>
<td></td>
</tr>
</tbody>
</table>
Appendix D – Additional mapping of SSS use and location of services

Figure 25 - Map of Lewisham borough showing number of quits by residents of each LSOA 2007-2012 and location of type of SSS provider
Figure 26 - Location of quit dates set 2007-2012 in Lewisham by type of provider (size of marker equates to number of quit dates set at that location)
Appendix E – Full results of SSS user and adviser views

The views of a small group of users and advisers was sought to enhance understanding of the quantitative element of the health equity audit. Details of how this was done are included in the methodology section and the questions asked are in appendix B.

Fifteen users were asked, three at one to one drop in sessions and twelve at a group session, the users represented both genders, a variety of ethnicities, jobs and spread of ages. In addition the views of six SSS advisers were sought, they were asked mainly to reflect on feedback they have received from users in answering the questions. The comment of both users and advisers were analysed together, some broad themes emerged which provide the subheadings for the results below.

Personal Attitude (of user)
Everyone commented that an individual’s personal attitude was the most important factor in whether(and when) they accessed the SSS. There were a number of different elements of this that were mentioned:

- **Independence and wanting to “go it alone”** – This meant that smokers were reluctant to access the service as they felt they could just quit alone if they wanted to. This was most commented on most by the group members (in particular as a barrier to using the group in addition to using the SSS at all). Two alternative opinions were raised in the group about this independence – one that people didn’t want to access services as they feared failing in front of others and others that they would rather do it alone as there were no witnesses to any slip ups or failures…

- **Feeling ready/in “right place” to give up** – Some users gave examples of life events or attitudes that had prevented them from accessing the service earlier such as major life events, stressful periods in their work or personal lives. Those that mentioned this felt that there was nothing the service could do to address this for individuals. But that individuals knowing where and how to access the service when they were ready was key. In particular one user talked about deciding that he wanted to quit and the following day being handed a leaflet by a SSS adviser – this coincidence gave him the push he needed to access the service. Something about being in the right place at the right time and therefore being able to provide that “coincidence” push… ie think about times of life/places when people are motivated and tap into these…

- **Motivation/ “being “bothered”** to use the service – one (drop-in service) user when asked to think about the barriers for her previously or friends and family now said “you just can’t be bothered to do it, it seems a real effort” (though she then went on to comment on how easy it was to access the service and that she had thought it would be more difficult). And that getting location and drop ins were important in reducing the amount of effort needed to access the service – and something about how those were advertised too…
• **Health scare** – one group user reported that he had accessed the SSS after he had begun to have health problems and on the advice of his hospital team. The advisers also felt that in a number of users this was a key driver for accessing SSS.

**Finding information on the Service**

• **Referrals** (from healthcare professionals) – Of the users interviewed some had been referred to the SSS by healthcare professionals, including secondary care physicians, GPs and dentists. Those that were referred in this way found it easy to access the service and valued the recommendation/referral. In particular the person who was given details of the SSS by his dentist found that a positive way of finding out about the service.

• **“Cross Promotion”** – several people found out about the SSS whilst accessing another service i.e. health trainers or participating in health walks. Those that had felt this was a powerful method of recommendation as it tapped into changes they were already making towards improving their health.

• **Timing and location of information** – several users reported seeing information about the SSS at the Waldron, others through personal recommendation and a couple were personally handed a leaflet. An advisor described one user who had seen a banner and information table at the at the Waldron one week, then returned the following week intending to ask about it only to find the table wasn’t there. Unfortunately he did not realise that there was a drop in service there and so went away, accessing the service some time later after asking his GP.

• **“Signing Up”** Some users reported having see information on the SSS at a health promotion stand and that they signed up to receive further information. They felt the idea of being able to (to some extent) commit there and then was positive. (they then also went on to speak positively about the follow up phone call they received from the SSS).

• **“Understanding what the SSS can offer”** One of the users of the drop in service mentioned that had she understood from the promotional material that she could have just walked in she would have accessed the service earlier. Several other users felt that the promotional information they had seen did not fully explain what was available, for example they may not understand the full variety of nicotine replacement therapy or that Champix is available. However when asked to think about how that could be promoted people acknowledged that trying to get that across in an advert would be difficult and may confuse the “Stop smoking” message.

• Come users said that they liked the fact they had been able to get information on the SSS and keep it until they were ready to use it. (in contrast to two of the drop-in users who liked being able to access the service straight away).
National Campaigns

- The users questioned had mixed views about “Stoptober”, some felt that it had acted as a prompt for them to stop smoking. Others actively felt that they did not want to stop in October because it felt that they were being told to. (these were the same group who highlighted people’s independent attitude as a barrier to them accessing services)

Other users (at the drop in) liked the idea that they could access advice and (in one case) quit there and then without having to wait any longer.

Location

- **Geographical** - There was a mix of views about the location of the service, users of the group based at UHL liked the fact that it was central with good bus links. A number of them needed to take one or two methods of public transport to get there but were happy to do this. The users of the drop in service at the Waldron reported that they found the location convenient, including one who found it convenient near the train station she used to commute into central London for work. The group users in general seemed to be willing to travel further to access the service than the drop in users. In general the advisers felt that a location close to home was more important for smokers in more deprived areas. One of the drop in users felt that having a service that was easy for her to get

- **Type of location** – views on the type of location amongst users were mixed. Considering healthcare based settings some users saw this as bring potentially daunting, others felt reassured by the fact the service was within a trusted healthcare setting. When asked the group users reported that they did not really view the location of the meeting as in the hospital as the room itself did not resemble a hospital and they did not need to travel through the hospital to get to the room. Users in the drop in centre were less positive about the thought of attending a session in the hospital, though this was also because of geographical location. Advisers with experience of outreach work reported that some users found some locations intimidating, being concerned that they would be “judged” as not being well enough dressed or about how they can afford to buy cigarettes, but that using community centres/libraries helped with this.

- **Being part of the community** - Advisers with experience of doing outreach highlighted the importance of the service being seen almost as part of the community, particularly in more deprived areas. They felt that this was important in encouraging people to access the service through positive word of mouth messages. In addition it became easier to target advertising at harder groups as community groups, local businesses etc were more receptive to helping (ie with allowing advertising leaflets).
**People**

All users and advisers highlighted the importance of the people providing the service and the impression they give to users/the relationships something...

- Within SSS – all users were positive about the individuals they had met in the SSS and cited them as important in their success (to date) in quitting smoking. The qualities they particularly mentioned were being encouraging, flexible, non-judgmental and friendly and positive (particularly on first meeting, whether in person or by telephone). One person mentioned the importance of other staff around the SSS, including receptionists (depending on location) as they may be the first point of contact with the service. Many users seemed to value the relationship they developed with their SSS adviser, both within the group setting and in one to one. For some this relationship was with an individual and they valued the continuity of contact, for others, it was with the service as a whole. One service user who had accessed the service several years previously could recall the names of the advisers she met at the time and had positive memories of their support.

- Outside the SSS - Several users again highlighted individuals outside the SSS who had been influential in their decision to/success in quitting. Mostly this was people who had suggested/referred them to the service (dentists, health trainers, GPs).

**Timing**

Several users mentioned the challenges of finding time to attend SSS sessions, one felt that had she opted for a drop in session she may not have returned for repeat visits; but found it easier to get to the group as the timing and day of the week was consistent over the programme and so she was able to develop a routine. One of the users at eh drop-in session valued the flexibility of not having appointments and being able to come at a convenient time at short notice (she has a young child). Many people in both the group and drop-in session valued the timing of the sessions to be outside the working day. When asked if there were other times that would have been convenient a few thought lunchtimes might have worked for them, others felt that would have been difficult. Most of the service users questioned used the service outside of working hours, but the advisers report that some users find the sessions during the day preferable as, for example, their children are at school. The group users all seemed to feel that Monday was a good day of the week to have the group.

**Atmosphere**

Several users and advisers mentioned the importance of the overall atmosphere of the SSS, from the location through to the individual advisers. The important attributes are similar to those already highlighted above; non-judgmental, friendly and welcoming.
Pregnancy/Specialist Services
Unfortunately I was not able to interview any users of the targeted specialist services (pregnancy, young people and those with mental health problems). But talking to one of the pregnancy specialist advisers she felt that the opt out policy was helpful in encouraging more people to access the service. Anecdotally she felt this not only increased the number of people accessing the service at the time of referral but also afterwards as those women who did not want to use the SSS at the time were still given information which some make use of in the future and access the service when they are ready to do so.
Several specialist advisers highlighted the importance of flexibility to their target group, including location (they reporting meeting service users in children’s centres, at the hospital around appointments, local cafes as well as doing home visits.

Other Barriers
A one:one session with a number of users who did not attend their appointments highlighted another potential barrier to smokers accessing the service. When people do not attend their appointments they are generally telephoned to check how they are doing and arrange another appointment. Anecdotally in some cases if the service user has no credit on their mobile phone they are then unable to phone back to make a follow up appointment.

Ideas/Suggestions
- Mobile Stop Smoking Van – Two people (one adviser and one service user (at different locations) suggested the use of a mobile van/lorry that could be taken from place to place with a SSS “clinic” inside.
- Advertising ideas – several users has suggestions to help with advertising – both for the concept of quitting generally and for the local SSS specifically.
  - Using a focus on the financial savings associated with smoking, for example featuring an advert of an ex-smoker enjoying a holiday they have been able to take with the money they have saved by not smoking for a year.
  - Being able to communicate the variety of services on offer from the SSS (ie to get over the ‘I’ve tried the patches and they didn’t work’ attitude of some smokers) (a specific suggestion of including what happens at a session on the website or evening a video of a session). (There is already information on the SSS website about what to expect in a session)
  - Considering specific groups who may not hear about the service through other avenues, specifically Carers of Lewisham was mentioned.
  - Increasing/widening the use of “cross-promotion” – ie advertising the SSS on the Lewisham Healthy Walks, children’s centres, IAPT and others.

Anecdotally several advisors highlighted the challenges faced by some service users who have contact with multiple services/agencies or have other apparently unrelated concerns that come to light during a SSS session, for example housing problems or domestic violence. They felt that having increased integration of these services and cross-referral pathways as well as some training for advisers in how/when to refer/first steps to take would be helpful.
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