APPENDIX 8

Intervention charts

This appendix follows the structure of the review. Within each section, examples are ordered alphabetically by location.

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
Birmingham	'Life Expectancy and Health Inequalities Toolkit' identifies swift implementation (quick wins) for 2010, as well as medium term actions. Selected indicators are grouped by area, and wards scoring in the worst two quartiles on a majority of indicators in the group are identified. The indicators are clustered together conceptually to identify patterns e.g. poor housing/emergency admissions of <16s for respiratory infection with high smoking prevalence. A main report includes details of data analysis, and methods for selecting priority issues and identifying areas of need as well as an audit of current practice and action plans for partners	Ward action plans have been developed. Wards are also grouped by PCT.	Birmingham Health and Well Being Partnership http://www.bhamsp.org.uk/html/healthinequalitiestoolkit.php
Blackpool	There is a scheme with Blackpool pharmacies (from September 2007), in which NHS Stop Smoking Service cards will be given out with pregnancy test kits.		Questionnaire
Bradford	In a change from previous questionnaire type surveys with a limited capacity to collect information from people whose first language is not English, a survey was carried out by face-to-face interviews with over 1,500 people in community languages. This covered		Survey carried out by Bradford City tPCT. Information available at: http://www.bradfordairedale-pct.nhs.uk/Media+Centre/Pre

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
	wider determinants of health as well as lifestyle factors.		ss+releases/2006+pre-PCT/Older+News/Lifestyle+survey+highlights+level+of+health+inequalities+among+Bradford+city+communities.htm
Brent	In 2003, GPs sent patient lists to the service and phone calls were made to smokers.	Several people were booked on to groups. With the advent of PbC and drastic changes to Brent Stop Smoking Service (BSSS) it is expected that the use of GP registers will become much more frequent and widespread. The exact way in which this will happen is currently unclear.	Questionnaire
Bury	Making use of the client database for Bingo Halls to contact their customers through questionnaires.		Interview
Central Lancashire	GPs identify through registers the number of smokers for each of the Quality and Outcomes Framework (QOF) indicators and are required to give advice or refer to specialist services. The service uses the GP contract as a lever to engage with primary care as it brings points to the practice – identifying referral pathways and developing and delivering training courses to primary care staff to increase capacity to help people stop smoking. The service continues to support primary care to meet requirements of contract.		Questionnaire

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
	Planned electronic system linking with GP for immediate intervention/referral to service. Post-code data is used to identify more smokers and how to shape service to identify where health inequalities are not being tackled.		
Croydon	Has adopted a range of methods in NRF wards (including outreach services, local participatory research, service advertising and engaging residents through primary care and pharmacy settings) because of evidence around traditionally low levels of engagement by local populations with statutory services, the areas in question being poorly served by local transport links and by local needs assessment.		Questionnaire
Derwentside	Have used GP mail-outs targeting individual smokers in GP practices in deprived communities.		Questionnaire
Dudley	Weekly drop-in session in a location identified by postcode data and local lifestyle data.		Questionnaire
Durham and Chester-le-Street	Have used GP mail-outs targeting individual smokers in GP practices in deprived communities.		Questionnaire
Ealing and Hounslow GPs	Smokers on the GP registers were invited to a drop-in at the GP practice.		Questionnaire
Ealing and Hounslow targeted advertising	Targets local community groups, local authority sites, religious sites, work places and other organizations, with targeted advertising undertaken by the SSS in the local press.		Questionnaire

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
Enfield and Haringey	Contacts maybe twice yearly all patients registered as smokers.		Questionnaire
Erewash	*East Midlands Public Health Observatory* (2005) worked with local smoking cessation services (Southern Derbyshire Fresh Start Stop Smoking Service, Erewash PCT) to develop a practical methodology to support the health equity audit of stop smoking services. 'Synthetic estimates' of smoking prevalence (to identify need) were compared with data collected by the stop smoking services and use/need ratios were calculated for all groups.		Available at : http://www.empho.org.uk/Download/Public/8755/1/smoking_packagev3.pdf
Hammersmith & Fulham telemarketing	Telemarketing scheme funded through New Deal for Communities and mailouts supported via GP Local Enhanced Services.		Questionnaire
Hammersmith & Fulham Evaluation	Regularly evaluate all services on a cost per quit and 4 wk quit success rate or successful referral rate.		Questionnaire
Harrow	Previously used GP registers to target specific groups providing those who smoke with the information to access community based services.		Questionnaire
Hartlepool Mori poll	MORI poll every two years		Hartlepool LAA
Hartlepool analysis of inequalities	Following an analysis carried out by the North East Public Health Observatory (NEPHO, 2005), it has been demonstrated that, even though targets for CVD and	The interventions which are more likely to impact on life expectancy in the shorter term are therefore those which	Hartlepool Partnership (2006) Hartlepool Life Expectancy Floor Target Action Plan.

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
	cancer for under 75s are being met, this will not prevent the life expectancy gap from widening and that what is required to hold the gap at current levels is a 20% reduction in all cause mortality spread evenly across all age groups.	improve treatment outcomes and survival rates which are being addressed through achieving standards set in National Service Frameworks.	Available at http://www.hartlepool.gov.uk/partnership/downloads/Life_Expectancy_FTAP_~_PDF_Format.pdf North East Public Health Observatory (2005) Life Expectancy in Hartlepool, Analysis supporting the development of the Floor Target Action Plan.
Hounslow and Ealing	The Hounslow and Ealing Stop Smoking Service have a number of Level 2 trained pharmacy advisers who are able to generate their own referrals and clients to deliver the Stop Smoking programme. The service will be undertaking a SWOT analysis to identify areas for service improvement and need.	A recent Commissioning Strategy Paper identified the service as one of excellence and hitting targets.	Questionnaire
Islington Health visitor data	Work with health visitor data regarding smoking in the home. Regular audits of Quality and Outcomes Framework data – diabetes / hypertension / chronic disease registers.		Questionnaire
Islington equity audit	Yearly equity audits for access and quit rates for smokers based on postcode data and ethnic group data.		Questionnaire
Knowsley	Health and Well-Being Partnership is currently		Knowsley Partnership (

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
	measuring deaths from cancer and respiratory disease at ward level, Area Forum level and Area Partnership level in order to support the targeting of neighbourhoods which are below Knowsley and the national average		Local Area Agreement
Lambeth	Findings from an equity profile informed the Tobacco Control strategy, the Stop Smoking Services (SSS) business plan and the NRF project on men's health. Equity targets were included in the SSS targets.		Public Health Annual Report 2005/6
Leicester	In Leicester, analysis by age shows that the burden of the inequalities gap is borne primarily by people over the age of 50, who contribute around 80% of such premature deaths among both men and women. They are adopting a two pronged approach: addressing the broader determinants of health through the wider public health agenda; and a more immediate focus in the next few years on specific clinical interventions which are known to reduce the risk of people dying, with a particular emphasis on those aged 50-69.		Leicester Public Health Partnership (2006) Floor Target Action Plan
Liverpool	GP surgery sent out letters to all their smokers inviting them to an evening at the surgery where they could speak to an adviser and receive a voucher for NRT and then attend a FagEnds session that suited them.	30 attended	Questionnaire
Luton	Some proactive work around GP registers.		Personal communication
Medway & Swale	A telesales approach was also used in the most deprived communities in Medway and Swale, carried		Interview

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
	out by a marketing company.		
Middlesbrough	Carries out poster promotion, at Middlesbrough Football Club, aimed at men.		NE survey
Newcastle Vitality Index	In addition to the Index of Multiple Deprivation, Newcastle uses its own Vitality Index (compiled by the Newcastle Neighbourhood Information Service) to help highlight those areas most in need of extra help to close the gaps in relation to the six Neighbourhood Renewal themes.	It is considered that this index is more effective in helping partners to target activities and initiatives at a neighbourhood level because the indicators included are focussed on measuring key policy issues in Newcastle.	Newcastle Partnership LAA (2007-10)
Newcastle	Intends to analyse variation in smoking prevalence across Newcastle using QOF data, using this to set local targets for reducing the observed variation in prevalence between practices.		Newcastle Partnership LAA (2007-10)
Newham target selection	the age group to be targeted to reduce death rates in the short term is the over 50s, through better identification and control of high blood pressure and high cholesterol levels as well as tackling smoking.		Newham Local Area Agreement 2007-10
Newham Practice-based marketing	Have carried out direct marketing to patients via GP practices - letters to smokers identified via EMIS searches through GP practices. Have also targeted specific disease groups using the various registers e.g. CHD, Diabetes etc. An end of year report is written each year, once final figures are known. This includes a brief analysis of service users in relation to age, ethnicity and gender		Questionnaire

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
	and gives us a flavour of where services should be targeted. There is also a strategy/action plan, which is essentially a mini health equity audit, which again looks at some of the issues around service uptake and specific areas to target.		
Newham Stop Smoking Equity Audit	Stop Smoking Programme Health Equity Audit identifies priorities		Newham PCT (2007) Public Health Annual Report
Newham Household Panel Survey	Household Panel Survey indicated that 46% of Bangladeshi men and 33% of Pakistani men were smokers, compared to the Newham average of 22%. Service reviews also showed that the numbers of smokers from these groups accessing the service in 2003-04 were very low considering the high prevalence rate	In response to this they created the Stop Smoking Adviser for Communities post supported by NRF funding	Newham PCT (2007) Public Health Report
North East England	NEPHO carried out an equity profile commissioned by Smoke Free North East Office. They used the Health Survey for England and post code as a proxy for deprivation.	Found that a higher proportion of smokers were quitting through these services in the more deprived areas than affluent ones. These services were therefore appropriately targeted to reduce socioeconomic inequalities.	NEPHO (2005)
North Fulham	Funding was made available through NDC in North Fulham to recruit smokers from the most deprived backgrounds. A telemarketer was involved and cooperation from 2 GP practices. The telemarketer rang		Unpublished interim report

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
	up smokers, checked whether they were still smoking (there was often discrepancy between their account and GP records) and then referred to stop smoking services or asked the service to contact them after faxing a referral sheet. However there were often delays from the SSS. Initially a pilot project, a second phase developed a tighter protocol. There was a follow up at 6 months and liaison with SSS over 4 week quitters. There were no ethical problems as long as phone calls were made from the GP surgery. There were no reported problems from patients.		
North Tyneside,	Assessment of the extent to which stop smoking services in Newcastle, North Tyneside and Northumberland were effectively reaching smokers living in the most disadvantaged areas. The method involved ranking wards according to their expected smoking prevalence and grouping them into five groups and comparing the use of stop smoking services and outcomes across quintiles.	In Newcastle there appeared to be roughly equal utilisation of stop smoking services for equal need. In North Tyneside the higher prevalence wards have a higher proportion of smokers setting quite dates (positive discrimination in favour of disadvantaged communities). In Northumberland there is also some evidence of positive discrimination.	Corris, V. & Ruta, D. (2006) North Tyne Commissioning Consortium Measuring Progress in Reducing Health and Health care Inequalities in the North of Tyne area: Stop Smoking Services.
Nottingham	An equity audit using Mosaic was carried out by EMPHO for New Leaf Smoking Cessation Service in Nottingham City. This also found that services were appropriately targeted to deprived groups.		Gruchy J, Robinson J. (2007) Stop-smoking service benefits from geodemographic profiling. (British Journal of Healthcare

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
			Computing and Information Management. 2007; (24) de Gruchy J, Robinson J, Hari I (2006) *Health Equity Audit. The New Leaf Smoking Cessation System in Nottingham City* Nottingham City Primary Care Trust Available at: http://www.empho.org.uk/pages/viewResource.aspx?id=9803.
Sandwell	Use ASH online maps showing smoking and deprivation. Equity profile produced.	Equity profile found that smokers in deprived areas were less likely to access services, as were non white groups.	Sandwell Stop smoking equity profile (2005/6).
Shropshire	Regular reports are run from practice systems to gather smoking prevalence information and readiness to quit. A template is added to each EMIS system to specifically record 'readiness to quit'.		Questionnaire
Surrey	A mapping exercise identified pockets of deprivation in Surrey, which were then targeted – e.g. community setting with a crèche provided. The work involved church community workers and police and housing groups.		Interview
Sutton and	Postcode areas have been targeted using letterbox	Limited uptake with this method	Questionnaire

Section 3.3 – Smoking cessation. Proactive case finding: identifying target populations			
Location	**Detail**	**Follow up information/Evaluation**	**Source of information**
Merton	mailouts to advertise local drop in services.		

Section 3.4.1 – Smoking cessation. Proactive case finding: client-centred approaches: social marketing			
Location	**Detail**	**Outcome**	**Source of information**
Ayrshire and Arran	A social marketing project undertaken by NHS Ayrshire & Arran in 2006 aimed to develop the Fresh Air-shire smoking cessation and prevention service in relation to pregnant women. The service markets services to communities where the need is greatest.		McKie F (2007) The development of social marketing as an effective method for reducing the rates of women who smoke before during and after pregnancy. Conference presentation, UKNSCC, 2007
Birmingham	South Birmingham PCT is working with Dr Foster's to provide social marketing information		Wilson R (2007) Inequities in Local Stop Smoking Services across Birmingham. Presentation at UKPHA conference
Greater Manchester	PCT has been working with Dr Foster intelligence to deliver a conurbation-wide social marketing project targeted at ensuring as many people as possible from the most deprived communities take the opportunity of the 1st July legislation to quit smoking. This campaign complements and supports the local services by		http://www.northwest.nhs.uk/document_uploads/News/AMENDED%20North%20West%20Ca

Section 3.4.1 – Smoking cessation. Proactive case finding: client-centred approaches: social marketing			
Location	**Detail**	**Outcome**	**Source of information**
	maximising Greater Manchester-wide media opportunity to signpost to local services, such as a single quit number for the whole of Manchester which automatically diverts people to their local service.		se%20Studies%20of%20Good%20Practice%20v2.doc
Knowsley	Systematic application of social marketing concepts and techniques and a unique partnership between Knowsley Primary Care Trust, Knowsley Council and the Roy Castle FagEnds stop smoking service. The focus of the Fag Ends campaign switched from whether smoking was bad for health, to providing a 'convenient, friendly and local support service to people who wanted to quit, backed by an advertising and media campaign promoting the service to local people, based on work with the target group to identify needs'.	Numbers accessing community stop smoking services have been described as rising dramatically since October 2006. Quarter 3 (2006/7) showed a 50 per cent increase in numbers in to the service, a 62% quit rate and an increase in quitters of 25%. In January 2007, there was an increase of 170% in to the service.	O'Brien and Owens (2007) Dramatically increasing quitters through social marketing - a practical example. Conference presentation UKNSCC.
Lambeth	The PCT worked with Dr Foster Intelligence, in 2006, to launch a major stop smoking drive with free NRT available for all Lambeth smokers and a marketing campaign aimed messages at specific groups who seemed more likely to quit. Participating newsagents placed Lambeth stop smoking information sleeves around packs of the brands known to be popular with these groups whilst pharmacists displayed publicity reinforcing the messages and the provision of NRT.		Lambeth PCT Annual Report and Summary Financial Statements, 2005/6.
Lewisham	Trialling a social marketing approach in one of the areas identified in the health equity audit which could be a model for other areas to improve how they target people in these areas.		Questionnaire
Liverpool	A company is involved in looking at targeting young men (18-35	Research stage	Questionnaire

Section 3.4.1 – Smoking cessation. Proactive case finding: client-centred approaches: social marketing			
Location	**Detail**	**Outcome**	**Source of information**
	years) from manual groups.		
Medway & Swale	The stop smoking service has worked with a commercial organisation Information by Design (IbyD) to trial a new social marketing approach to client recruitment in an effort to increase uptake and resultant quit rates. For this initial pilot, clusters of smoking prevalence in deprived wards were identified and IbyD sourced commercial data sets of named smokers in the target areas. Each of the 3,200 smokers selected received multiple communications – direct mail using appropriate messages and then follow-up outbound telephone calls from IbyD telephone centre staff who had been trained by the stop smoking services team. The key aims of the project are described as to 'determine the efficacy of recruiting smokers using a social marketing approach, to test various incentives and to establish whether this method would be effective in targeting smokers in areas of high deprivation'	The results of the pilot project are described as 'very encouraging'. A total of 198 smokers (6.2%) were booked on to group courses. 9 group courses were set up in the targeted areas running on different days, times and at different locations The recruitment rate from this pilot was described as 5 times that of traditional mail shot recruitment, and higher than anticipated in areas of high deprivation. 65% of those attending groups were quit at 4 weeks. The success of this initial project has resulted in this social marketing approach being extended to other deprived areas in Medway. A recent campaign has included low-cost door-to-door distributions rather than direct mail.	Wisher S (2007) Using social marketing to boost recruitment to smoking cessation groups. Conference poster presentation UKNSCC.
Medway PCT	A planned trial of social marketing recruitment techniques commenced May 06 with mailing to 5000 smokers in Strood offering 'gold star' service to named smokers – mailing to be followed up by telephone calls to all and booking on to groups.	Initial results show success in recruitment – 11% compared to 1% take up when mailing out via GPs.	PCT Board (July 2006) Progress report on Choosing Health in Medway.

Section 3.4.1 – Smoking cessation. Proactive case finding: client-centred approaches: social marketing			
Location	**Detail**	**Outcome**	**Source of information**
Nottingham	Following a health equity audit, New Leaf has worked more proactively with the GP practices in the 'cold spot' areas of central Nottingham; where necessary they have changed clinic times and venues; they have also set up new sessions, including at a local pharmacy. Also, an NRF-funded social marketing stop smoking campaign will be implemented this year by the PCT focused on the Mosaic groups who are the heaviest smokers in target areas.	See case study	
Oldham	Dr Foster Intelligence has been commissioned to develop a Social Marketing and Communications Strategy in order to profile the target populations according to hospital episode data and Mosaic Consumer profiles. This will provide information about the geographical location of the target groups in Oldham and a profile of the attitudes, preferences and marketing susceptibility of people in the target groups. In addition Dr Foster will carry out qualitative research with people from the target groups and with a range of service providers to better understand the needs of the target groups and how to market a service to help people in the target groups to stop smoking.		Oldham Local Area Agreement 2006-9

Section 3.4.1 – Smoking cessation. Proactive case finding: client-centred approaches: social marketing			
Location	**Detail**	**Outcome**	**Source of information**
Southwark	A small scale focus group study was undertaken to investigate why stop smoking services were not taken up or if used, not necessarily adhered to by young people (girls excluded from school), pregnant women and parents of young children, unemployed people and male manual workers. They compared and contrasted how different groups described their smoking and then analysed what characterised people's smoking resistance and resilience, which included concepts of risk taking and fatalism, doubting evidence and reliance on private stories, a focus on families /across generations and perceptions of services. Potential service changes were imagined from within an anthropological focus and were used to inform a parallel equity audit that took place over the same period.		Rickard (2007) Resistant and resilient smokers in Southwark. Conference presentation UKNSCC.
Sunderland	Barriers were identified through focus groups and were addressed through proactive recruiting (dedicated worker and home visits); new marketing information which was pre-tested with the target population; role play to engage health professionals and consumer friendly cessation support).	This has been highlighted as an example of the success of social marketing as achieving high quit rates in pregnant women. From April 2002 to June 2003, there was a 42 per cent quit rate at four week follow up. See case study.	Lowry RJ, Hardy S, Jordan C, Wayman G. (2004) Using social marketing to increase recruitment of pregnant smokers to smoking cessation service: a success story. *Public Health* 118: 239-243**.**

Section 3.4.1 – Smoking cessation. Proactive case finding: client-centred approaches: social marketing			
Location	**Detail**	**Outcome**	**Source of information**
			(National Social Marketing Conference, 2005)
Yorkshire and the Humber	Yorkshire and Humber PHO is using social marketing with GPs to investigate differences in referral rates		Interview

section 3.4.2 – Smoking cessation. Proactive case finding: client-centred approaches: other qualitative studies			
Location	**Detail**	**Outcome**	**Source of information**
Argyll & Clyde	***'Smokey Joes' Investigation into a narrative based therapeutic intervention for smoking*** This PATH-funded project (ended June 05) explored a culturally attuned method of supporting smoking cessation in a low-income community, using narrative based interventions to engage smokers in considering stopping smoking and stopping smoking.	The evaluation showed that flexibility and a tailored approach were valued by practitioners and smokers. Reduction in smoking should also be considered a success and smoking cessation groups can accommodate people at different stages in the change process.	McEleny T, Ritchie D, Schulz S and Bryce A'The Smokey Joe Story'. Exploration of an innovative approach to smoking cessation. Available at: http://www.ashscotland.org.uk/ash/files/SmokeyJoeFinalProject%20Report_Jan2006.pdf
Blackpool branding campaign	A marketing company is currently working on branding of a new campaign to be launched September 2007 (£10K non-recurrent funds allocated)		Questionnaire
Blackpool promotion officer	Marketing and Promotion Officer employed full-time. Regular attendance at workplace events (e.g. Pleasure Beach, Department of Work and Pensions, Police Force), community events (marketing at Town Hall, Family events, ASDA, Sainsbury')		Questionnaire
Central and Eastern Cheshire	Using focus groups to gather patient and public views on how they would like a stop smoking service to be provided.		Questionnaire
Croydon	Activities chosen due to evidence around traditionally low levels of engagement by local populations with statutory services, the areas in question being poorly served by local transport links and by local needs assessment.	Work taking place in two NRF wards - New Addington & Broad Green, including outreach services, local participatory research, service	Questionnaire

section 3.4.2 – Smoking cessation. Proactive case finding: client-centred approaches: other qualitative studies			
Location	**Detail**	**Outcome**	**Source of information**
		advertising and engaging residents through primary care and pharmacy settings.	
Croydon Low BME uptake	Research work looking at low uptake of services by local BME communities and around perceptions of PCT Stop Smoking Service delivery (funded through NRF). Service needs analysis and assessment carried out as part of both research projects.	Findings are being addressed and acted upon.	Questionnaire
NE Glasgow	Qualitative study into factors affecting smoking cessation outcomes in a deprived population with known coronary heart disease	Study highlighted a gap between patients' needs for smoking cessation support and the professional response.	MacDonald A and Reid M (2007) Presentation at UKPHA conference
Islington focus groups	Ran a series of focus groups targeting Somali residents, Bengali residents and Turkish residents, all of which have high rates of smoking. These groups allowed questions to be asked about attitudes to smoking and how people found out about health issues.	Later in the campaign they also signed up a number of community champions including volunteers from a Somali centre, a local Imam and a Bangladeshi women's worker.	Islington PCT Annual Report 2005/6.
Islington	Commissioned University College London (Health Behaviour Unit) to research health behaviour in the Somali community. This research was carried out in collaboration with Somali community organisations.	Little understanding of NRT or the stop smoking services and some cultural beliefs (such as cessation success due solely to personal strength of will power, plus opposition to individual counselling) may undermine conventional methods of service delivery employed by stop smoking services	Straus L, McEwen A, Croker H (2006) *A report for Islington PCT*. Cancer Research UK Health Behaviour Unit, University College London.
Lambeth	Lambeth conducted qualitative studies looking at the barriers that black adult smokers face in accessing stop		Lambeth PCT Annual Report and summary

section 3.4.2 – Smoking cessation. Proactive case finding: client-centred approaches: other qualitative studies			
Location	**Detail**	**Outcome**	**Source of information**
	smoking services and completing treatment		financial statements 2005/6.
Leicester	Leicester City has worked with Dr Foster using focus groups with the 59+ age group.		
Newham	London Borough of Newham recently carried out some focus groups to identify the needs of service users in relation to current provision.	.	Questionnaire
Southwark	A small scale focus group study was undertaken to investigate why stop smoking services were not taken up or if used, not necessarily adhered to by young people (girls excluded from school), pregnant women and parents of young children, unemployed people and male manual workers. They compared and contrasted how different groups described their smoking and then analysed what characterised people's smoking resistance and resilience, which included concepts of risk taking and fatalism, doubting evidence and reliance on private stories, a focus on families /across generations and perceptions of services. Potential service changes were imagined from within an anthropological focus and were used to inform a parallel equity audit that took place over the same period.		Rickard (2007) Resistant and resilient smokers in Southwark. Conference presentation UKNSCC.
Stockport	Stockport PCT is developing support mechanisms to reduce the drop out rate, including qualitative research to identify barriers and blocks.		

section 3.4.3 – Smoking cessation : proactive case finding: client-centred approaches: clients as stop smoking advisers			
Location	**Detail**	**Outcome**	**Source of information**
Ardoyne Shankill	Ardoyne Shankill Health Partnership was one of the first community groups in Northern Ireland to deliver smoking cessation services . It was targeted at young women, pregnant women and socially disadvantaged groups in an area where 70 per cent smoke. It also provided supporting programmes including complementary therapies and physical activity programmes.	Positive factors have included ex-smokers becoming trained as advisers and encouraging others to stop. Of the 200 smokers who accessed the programme almost 40 per cent had quit at 4 weeks and almost 20 per cent at 52 weeks	Gowdy D (2007) Smoking cessation in two disadvantaged communities in North and West Belfast. Conference presentation UKNSCC
Lewisham	A project funded through the Neighbourhood Renewal Fund involves local people in identifying their health promotion needs and developing initiatives to address such needs, including the training of local volunteers as health promoters, smoking cessation and healthy eating advisors targeting Black and Minority Ethnic communities		Lewisham PCTwebsite
Liverpool	Roy Castle Fag Ends Community Stop Smoking Service, which started in 1994 in one of the most deprived areas of Liverpool and was originally formed by people who required further support to stop smoking. It has gradually expanded to provide helplines, hospital advisers, community based advisers, workplace advisers and support groups (including evenings and weekends). Fag Ends is funded through Liverpool PCT and The Roy Castle Lung Cancer Foundation. The telephone help line is funded through Merseyside PCTs. A wide range of people work as facilitators, including some ex smokers from the community. One to one counselling may also be offered if a group setting is not appropriate for the client. Their database also allows them to text	See case study.	Owens C and Springett J (2006) The Roy Castle Fag Ends Stop Smoking Service: A successful client-led approach to smoking cessation. *Journal of Smoking Cessation* Vol 1 No 1.

section 3.4.3 – Smoking cessation : proactive case finding: client-centred approaches: clients as stop smoking advisers			
Location	**Detail**	**Outcome**	**Source of information**
	clients. In a review of the service, it is pointed out that 'All advisers study for a diploma from the National Respiratory Training Centre, which involves completion of a smoking-cessation module. Advisers also receive training in motivational interviewing, group-work facilitation, working one-to-one, presentation skills, smoking and cannabis issues, smoking and mental health issues, specific training on pharmacological interventions for smoking cessation, basic counselling skills, listening skills and training in deaf awareness'.		
Newham	Newham recruited and trained 6 local people to take Stop Smoking advice and services out to community groups and events. Following an initial successful focus on south Asian male smokers the team are looking to expand this approach out to other high risk groups		Annual Public Health report 2006/7.
West Midlands	Dudley PCT and Birmingham and Solihull Mental Health Trust - some of the staff were originally clients		Interview

section 3.4.4 – Smoking cessation – proactive case-finding: client-centred approaches: health trainers			
Location	**Detail**	**Outcome**	**Source of information**
Bradford	Health trainers in Bradford (an early adopter site) work in the most deprived areas of the city and one of their roles is to accompany people using health services such as smoking cessation. They can also provide support to the changes that people want to make. The health trainer and client meet for up to six weeks and at each session they review progress, identifying and working through any difficulties	Most common health issues addressed were losing weight, improving diet and increasing exercise levels. There were difficulties in accessing 'hard to reach' groups.	South J et al (2006) An evaluation of the Bradford District Health Trainers Programme. Leeds Metropolitan University
Camden	The health trainers take referrals from within the GP practice and from other health professionals and provide stop smoking support.		Questionnaire
Islington	Level 1 brief advice training and health trainer initiatives to sign post smokers to service.		Questionnaire
Medway	Health trainers located in existing clubs/groups. Training programme for them includes brief interventions for smoking cessation advice.		*Choosing Health* progress report
Nottingham	In Nottingham, CVD Peer Educator Health Trainers work with individuals, specific GP practices and through 'assertive outreach' to increase awareness of risk factors for CVD (smoking, diet and physical activity) as part of an integral city-wide programme for preventing CVD. They are recruited from the target communities, (men over 40, black and ethnic minority communities, those identified by GPs as high risk, and those on incapacity benefit) in targeted neighbourhoods. In this case, targeted neighbourhoods are defined as Super Output areas (SOAs) within inner Nottingham City which are within the 20% with the highest CVD mortality rate in the City. so that the most cost effective model is determined for commissioning	There is additional NRF funding for HT which has allowed different provider models to be evaluated, so that the most cost effective model is determined for commissioning after the current NRF round.	Nottingham City Health Trainer Plan 2006-8.

section 3.4.4 – Smoking cessation – proactive case-finding: client-centred approaches: health trainers			
Location	**Detail**	**Outcome**	**Source of information**
	after the current NRF round. There are specific numbers of client contacts required as part of the contract. This peer educator approach is based on the assertion that people are more likely to personalise messages and change their attitudes if they believe the messenger is similar to them.		
South Tyneside	Despite the lifestyle focus of most health trainer schemes, South Tyneside has developed a variation on this approach, addressing geographically based inequalities through six health and lifestyle advisers and six community health officers, with the latter developing community activities and groups.		Information available at: http://www.stpct.nhs.uk/services/choosing_health.htm
West Sussex	Health trainers are trained to provide brief interventions and signpost smokers to the stop smoking service		Interview

section 3.4.5 – Smoking cessation – proactive case finding: client-centred approaches: other peer group schemes			
Location	**Detail**	**Outcome**	**Source of information**
Manchester	At Longsight, SureStart, community parents work alongside the Health Visiting team. They promote smoking cessation by actively working with parents wanting to give up smoking on a 1:1 basis at the weekly clinic held at the SureStart Centre in Longsight. They also support parents at the weekly health group meetings held at the Centre where smoking cessation and the potential harmful effects and health risks of using paan is discussed in a group setting. Community Parents work alongside Health Visitors to promote no smoking and actively engage in no smoking day by holding a joint stall at Longsight Market, where information is given to members of the local community around the support that is currently available. This is also an opportunity for parents to sign up as a smoke free home and given the opportunity to attend health sessions within the centre promoting smoking cessation	An evaluation of Manchester Sure Start showed difficulties with the Longsight project. Other Sure Starts demonstrated the effectiveness of midwife support with the highest quit rates (over 50 per cent) being attained by setting quit dates and being supported by community and Sure Start midwives, Sure Start linkworkers and health care assistants.	Reid A. Sure Start smoking and pregnancy (2004/5) Manchester Public Health Development Service
Tees	Informal peer support, when clients are waiting to see staff at drop-ins, is encouraged and sometimes facilitated by the coordinators or advisers.		NE survey

section 3.5.1 – Smoking cessation. Proactive case finding: client-friendly outreach: neighbourhood -based			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Camden	Community stop smoking adviser : Bingo groups, making level II training more effective (pre-selection questionnaire, managers questionnaire, pre-training assessment)		Questionnaire
Central Lancashire	Advertising and articles are placed in community newsletters. Flyers are distributed in the community signposting smokers to venues where support can be accessed and the service links in with local activities, such as Children Centre Open Days. The service also plans to link with Job Centre plus.		Questionnaire
Cornwall & the Isles of Scilly	Project working with the community organisations working in the areas of highest deprivation, and using their local knowledge, contacts and skills to target smokers in their area. Local community venues are used to provide smoking cessation advice and support, to give everyone the opportunity to source help in a comfortable, familiar environment. In addition, key advisers have been selected to provide the support in these areas. These advisers have backgrounds in working with hard to reach groups.	The Stop Smoking Service is working to increase the 12 month quit rate across Cornwall and the Isles of Scilly, but in the most deprived areas in particular. At present the Stop Smoking Service is providing additional support in seven areas of highest deprivation, with three more being planned for 2007.	Information is available at: http://www.networks.nhs.uk/db/commissioning/lshow/1448
Isle of Man	Use of refuse trucks to publicise service. As well as covering wide areas, they move slowly so message can be read.		Personal communication
Knowsley	The Knowsley stop smoking service has launched 24 clinics across the Borough with an emphasis on community based venues.	Increased uptake and an improved quit rate. 'Initial results show an increase of 33 per cent in service attendance	UKPHA (2007)

section 3.5.1 – Smoking cessation. Proactive case finding: client-friendly outreach: neighbourhood -based			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
		compared with quarter 3 in 2005, January referrals are up by 149 per cent and an improved Quit Rate from 49 per cent in 05 to 60.3 per cent'.	
Leicester	A Smoking and Inequalities project originally funded through Neighbourhood Renewal Funding (NRF), but now funded by the PCTs • A Public Service Agreement has focussed attention on smoking cessation take up in the 10 most deprived wards in the city. • There are smoking cessation projects involving community smoking advisers in a in a number of areas of high prevalence on the west of the city.	There are some positive results in uptake in most deprived wards Smoking cessation services have made steady impact on Leicester as a whole and have achieved 3227 four week quitters over a two year period 2003/4 - 2004/5 against a Local Delivery Plan target of 2621 for week quitters. However, progress has been greater in the west of the city compared to the east and a recent audit has sought to clarify the factors influencing this, taking in to account the likely lower prevalence of smoking amongst the South Asian population living mainly to the east of the city. Initial results have highlighted the need to improve access to smoking cessation services particularly through pharmacies and to increase targeted promotion.	http://www.phleicester.org.uk/Documents/Brief%203%20LSP%20Paper.pdf
Nottingham	Following a health equity audit, New Leaf (the Nottinghamshire Stop Smoking Service) has worked more		Hari I (2007) Using Mosaic and Health

section 3.5.1 – Smoking cessation. Proactive case finding: client-friendly outreach: neighbourhood -based			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	proactively with the GP practices in the 'cold spot' areas of central Nottingham; where necessary they have changed clinic times and venues; they have also set up new sessions, including at a local pharmacy.		Equity Audit to improve Nottingham's Stop Smoking Service. Presentation at UKNSCC conference
Shropshire	Locations in community settings also offering out of hours services. This service was chosen to allow people who do not want to access the GP practice or cannot make the times another option. Out of hours services offered in community venues, lots of choice of setting.		Questionnaire
South Birmingham	In South Birmingham PCT, a new 'Stop and Quit' programme will provide selected deprived estates with 'excellent' access to smoking cessation support through a team of specialist advisers who will be on hand to support smokers to kick the habit. This programme is designed to reach at least 2,000 of the 3,262 people who smoke on 3 disadvantaged estates.		South Birmingham PCT Annual Report 2005/06
Sutton & Merton	Sutton and Merton uses community development colleagues' knowledge of area and community networks and meets community centre managers and staff prior to starting drop-ins and offering level 1 brief intervention training.		Questionnaire

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Bradford	Joint initiative between a Smoking Cessation Specialist and a Health of Men Specialist Worker. Workers visited pubs in the area targeting the resident male population. The issue of smoking was introduced in the context of informal 'MOT' checks and leaflet distribution. The group was also publicised as an option for any potential client who rang the Bradford Stop Smoking Service. The support was delivered in a group setting, in a non-threatening environment that would be easily accessible to the target group. Weekly sessions were run over a two month period and participants benefited from the group scenario, provision of pharmacological products and specialist advice. The majority of clients who attended the group were recruited through 'face to face' contact.	Anecdotal accounts of success but has proved difficult to evaluate.	http://www.healthinequalitiesdirectory.co.uk/show_detail.php?id=9 An evaluation of the broader 'Health of Men' initiative is available: Health of Men Annual Monitoring Report 2004
Brent	Working in partnership with police licensing sergeants visiting pub watch and business watch schemes and launching "Best Bar None" which aims to encourage pubs, clubs, hotels to provide a good standard of service. This includes ambience, cleanliness, health & safety.	Very productive work has resulted. A number of pubs have requested health input for staff and clients including support to stop smoking. One particular pub is in one of the most deprived areas and the service will be starting stop smoking sessions for mothers.	Questionnaire
Brent	Working in partnership with colleagues in the PCT has enabled services to be taken out to, for instance, employees in a variety of manual occupations – construction, manufacturing, mechanical	Bringing the service to the client works very well.	Questionnaire

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	engineering etc		
Brent	Email Support was launched in 2004 working with a small number of businesses. This aimed to provide support through a web application.	This was not successful as uptake was low and it was a costly pilot.	Questionnaire
Buckinghamshire	Work with District Councils to target workplaces		Questionnaire
Croydon	Targeted workplace group (Level 3) interventions.		Questionnaire
Derbyshire County	Top Ten Bingo have enlisted the help of Derbyshire County PCT's trained stop smoking advisers and are forming a new weekly group to help customers that want to quit.		Derbyshire County PCT Press Release (April 2007) http://www.derbyshirecountypct.nhs.uk/content/New%20stop%20smoking%20group%20in%20Somercotes.pdf
Doncaster	Doncaster succeeded (in 2005) in transferring the base for the stop smoking team to the town centre where it could be easily accessed. Drop in sessions are also provided.		Doncaster West PCT Annual Report 2005/6.
Durham & Chester-le-Street	Hospital -Secondment worker delivering staff support at present. Also support coronary rehab and do get referrals from respiratory team. Have trained respiratory team / coronary team / midwives to level 2.		NE survey

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Easington	Group drop-in sessions delivered in working men's clubs to target men. Quit groups also in pubs, cafes, bingo halls, community centres or any other place people meet regularly.	Highly successful.	NE survey
Gateshead & South Tyneside workplace	6 week programme 2 fortnightly follow-up visits. Group, Drop in, mixture of both. Delivered on premises, interest gauged either via workplace rep or Specialist Adviser via questionnaire. Maudsley method used (now adapted to suit), promoted internally via, e mail, flyer, posters, wage slips.	High numbers show interest, lower numbers actually attend. Time allowed to attend can often be an issue, providing NRT to out of area clients is a huge barrier that needs to be addressed. Have to adapt to individual workplace needs (shift patterns etc)	NE survey
Gateshead & South Tyneside working mens club	Drop in 2 Quit programmes promoted and Drop in clinics. Discussing delivery of Drop in 2 Quit programme from working mens club in South Tyneside.		NE survey
Hammersmith & Fulham	Local organisations asked to help set up clinics on their premises.		Questionnaire
Harrow	Smoking cessation programmes are delivered in a number of settings Royal Mail, Bus Depot, Refuse Depot etc where there is a high prevalence of smoking.		Questionnaire
Hillingdon	Provide free occupational service to companies in deprived area and companies with manual work.	Varied success and demand. Do not have formal evaluation.	Questionnaire
Leicester	Leicester is providing outreach services to pubs, clubs, workplaces and hard to reach groups. Disadvantaged high smoking prevalence populations are being targeted through • Community smoking cessation advisers in Leicester		Leicester Floor Target Action Plan

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	Partnership Priority Areas. • Piloting small scale innovations – e.g. Working Men's Clubs/Pubs smoking cessation partnerships. • Supporting effective implementation of the ban on smoking in public places.		
Lewisham Workplace	Workers and office workers - advertised first and when numbers decrease, adviser will run a stall in canteen to raise awareness, ask managers to promote it Adviser visiting top 200 businesses in Lewisham, after introductory letter sent to managers, to offer stop smoking support in the workplace if interested - these are very small businesses.		Questionnaire
Lewisham Sessions at Walk-in Centre	A local weekly session at Lewisham's Walk In Centre - the adviser offers weekly support and provides NRT via voucher from the nearby pharmacy, or Zyban or Champix by letter to GP requesting medication to be prescribed. The adviser also makes 52 week calls to 4 week quitters and encourages them to try again if they have relapsed. She uses a directory of all advisers in Lewisham to suggest their nearest service.	This adviser has seen 94 people in the year and supported 37 to quit.	Questionnaire
Lewisham Wearside Depot	One adviser offers a weekly 2 hour session in a room at the Depot. First, this was widely advertised to staff through managers, posters all around the building and a stall in the canteen run by the adviser. Numbers using this session have fluctuated but when it is quiet, the adviser does more publicity to encourage more people to use the session. It has also provided with local publicity when one of the managers used the session, quit and offered to tell his story		Questionnaire

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	to encourage others. The numbers of quits are modest (13 out of 29 using the sessions this year). They hope to open the session out to other council staff and contracted staff e.g. agency home care staff in the future.		
Liverpool pubs	A community group runs one evening a week at a smoke free pub thereby targeting manual workers.		Questionnaire
Liverpool workplace	Liverpool Smoke free Liverpool and Health at Work while supporting workplaces in going smoke free, are promoting the Stop Smoking service and suggesting that they invite the Workplace advisers to run 10-12 week groups. Workplace groups have been run at Bus depots, train depots, Royal Mail depot, building sites.		Questionnaire
Middlesbrough	Clinics in Working Mens Club	Pilot showed good quit rates.	NE survey
Newham	London Borough of Newham employs a Tobacco Control Co-ordinator to run the Smokefree Newham Alliance. Her team are heavily involved in working with local businesses and ensure that employers and employees have access to information on stop smoking services. Her team are also all trained to Level 2 and provide 1:1 support to smokers who want to quit. Service provides on site support to workplaces and have worked closely with Stagecoach, Barclays bank and East Thames to support smokers wishing to quit. In process of working with Royal Mail to support their health programme.		Questionnaire

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
North Warwickshire	NHS Warwickshire has decided to base its 'Wellness Centre' at the One Stop Shop. Amongst the services on offer are blood pressure and diabetes checks, weight management sessions and advice on stopping smoking. Also part of the service are monthly guided walks and literacy and numeracy classes. This was described a good example of partnership working Other organisations such as the North Warwickshire Credit Union, the Council for Voluntary Service and the Police also hope to hold advice sessions in the One Stop Shop.		North Warwickshire Borough Council Press Release May 8 2007
Northumberland	Hospitals -Support is 1: 1 and on site. Also looking at possibility of training/involving hospital pharmacists. Trying to set up groups linked to other events such as blood pressure clinics.		NE survey
Rotherham	Rotherham has a Stop smoking shop, located in the town centre	Has proved popular and opening hours are being extended.	Press Release. Rotherham PCT 24 January 2007
Sedgefield workplace	Runs flexible sessions in workplaces – groups, drop-ins, one-to-ones. Also try to encourage training of advisers in businesses.		NE survey
Sedgefield Pubs and clubs	Local pub. Working men's club – held group sessions	Pub - 5 staff quit Working Mens Club - limited success.	NE survey
Shropshire shop	Have just opened a shop in one of Shrewsbury's main shopping centres. It is manned by an adviser and a support worker (to give general information and advice).	It is too early for an evaluation but currently over 100 people a week wanting either more information or a consultation with the adviser. It appears to be attracting people	Questionnaire

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
		who would not otherwise be accessing the service.	
South West Essex	Advertising on shirts of the local football clubs, and on the programme with banners at the grounds. Adviser attending 2 matches during the season.		Questionnaire
Surrey	Manual workers (council, mainly refuse workers and those in parks and gardens) – targeted at 7.30a.m. Also social clubs, pubs, taxi ranks, local offices.		Questionnaire
Surrey	When visiting sites to help with smoking policy, the service specialist takes along a smokalyser to encourage people to join groups to quit.	Good response, lot of workplace groups now running successfully.	Questionnaire
Swindon	Workplace interventions include Honda – organization pays for support.		Interview
Tees	Offers information session in workplaces and occasional first assessments and also signposts to local community clinics. Some additional targeting of manual workers with information sessions e.g. refuse collectors in Stockton.		NE survey
Wakefield	Workplace-based, targeting manual workers. The project aims to assist people to stop smoking by offering advice and support through groups based in the workplace, often in "works" time. Careful ground work is undertaken to gain access to the work places: beginning with a meeting with the Managing Director or Head of Human Resources, during which a purpose made 1 minute CD Rom is shown to outline the programme. Experience has shown that using phrases such as 'Public Health' or 'The NHS' helps to gain access to senior personnel. Once agreement	It is reported that many groups have had a 100% success rate	Contact Val Bradshaw 01977 665705 Val.bradshaw@ewpct.nhs.uk

section 3.5.2 – Smoking cessation – Proactive case finding: client friendly outreach: specific locations			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	has been reached to run the programme, questionnaires are distributed within the workplace to ascertain interest amongst employees. A group is then set up to run over eight weeks.		
Wakefield	The PCT has set up a Quit shop, in Wakefield market, as a drop-in centre for would-be quitters to find out more about the support that the PCT's Stop Smoking team can offer.		Information available at Wakefield PCT website http://www.wakefielddistrictpct.nhs.uk/news/default.shtml
Wales	As part of Smoke Free Cardiff, workplaces with low income employees are targeted. Activities include information stalls in large workplaces, the development and distribution of a smokefree workplace toolkit, development of a website with free posters for workplaces and the distribution of 100,000 beer mats promoting the All Wales Smoking Cessation Service to licensed premises		Questionnaire

section 3.5.3.1 – Smoking cessation – group-specific interventions: pregnant women in disadvantaged areas			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Central and Eastern Cheshire	Clinics in local community settings including children's centres.		Questionnaire
Central Lancashire	Dedicated 1-1 clinics provided to target hard to reach groups, such as Children's Centres in disadvantaged areas - support for parents with childcare facilities Due to the clear link between smoking in pregnancy and health inequalities, plans are in place to continue to develop Outreach programmes to reach and motivate this group. In addition to this – the service will continue building capacity through training and development to encourage midwives, practice nurses and health visitors' involvement in reaching pregnant smokers and signposting for support.		Questionnaire
Dudley	Pregnant women are offered home visits. Groups set up in areas of deprivation on a rolling programme basis - no appointment needed - in local community centres.		Questionnaire
Ealing and Hounslow	Ealing and Hounslow links in to health awareness days with other agencies such as Sure Start, School promotion days and provides information and resources to health visitors and midwives.		Questionnaire
Easington	In Easington District, support is provided in all the children's centres in the district, alongside midwife clinics.		NE survey

section 3.5.3.2 – Smoking cessation – group-specific interventions: BME groups			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Barnet	Carrying out specific work with refugee communities and is involved in Refugee Day.		Questionnaire
Brent	Brent took advantage of pharmacists in Brent who spoke Somali and Polish to provide level 2 interventions.		Questionnaire
Bristol	A scheme was designed to equip members of the South Asian community with tobacco cessation skills to support others to quit smoking. The adviser scheme was an important educational tool and a boost to ethnic language health resources in Bristol. This scheme acquired a good reputation amongst local smoking cessation specialists. Health trainers provide an additional resource of this kind.		http://www.raceforhealth.org/casestudies.php?id=2&csid=4).
Bristol	Culturally appropriate services are also being developed through identifying and training lay advisers and peer education schemes.		Bristol PCT's race Equality Scheme 2006-8
Camden BME languages	Camden has a freephone Bengali line and also identifies all its Level 2 advisers by language spoken.		Questionnaire
Camden BME churches	Camden uses Church advertising for its Black Caribbean community.		Questionnaire
Cardiff	***Bangladeshi Community*** **-** Part of Smoke Free Cardiff, funded by the Big Lottery. It includes smokeless tobacco and carries out outreach work in mosques and restaurants.		Interview
Central Lancashire	Multi-lingual adviser working through links with mosques.		Questionnaire
City and Hackney	Based at Halkevi Community Centre, Stoke Newington Road, this cultural specific project focuses on supporting Hackney's Turkish /		City and Hackney PCT website.

section 3.5.3.2 – Smoking cessation – group-specific interventions: BME groups			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	Kurdish population to quit smoking. Advisers speak Turkish, Kurdish and English. All publicity material is translated into the three main languages spoken in City and Hackney in addition to English namely Turkish, French and Urdu.		
Ealing and Hounslow	Ealing and Hounslow uses local radio stations like Sunrise Radio, Desi Radio, and newspapers such as Manjeet Weekly, Asian Times, Eastern Eye. It also uses advertising in Polish magazines.		Questionnaire
Enfield & Haringey	Specific post for targeting Turkish Kurdish and Cypriot communities in Enfield. TKC adviser is a LAA project, the aim is to provide services to the large population of Turkish, Kurdish and Cypriot residents in Enfield. Targeting the N17 area in Haringey. Groups are open to everyone who is able to attend in a group setting, the group sessions are given in English. For those who do not speak English, or for another reason are not able to participate in a group, one to one treatment is provided, with the use of link workers where necessary. Turkish pharmacist targeting Turkish community, service providing leaflets and referral cards in Turkish (Haringey).		Questionnaire
Gateshead & South Tyneside	BME workers trained as intermediate advisers, service promoted and in South Tyneside working with CREST (Compact for Race Equality in South Tyneside) to deliver Drop in Service to BME Community. Have access to interpreting service and multi-lingual resources.		NE survey
Harrow	Pharmacists who speak several languages		Questionnaire
Heart of Birmingham	In conjunction with University of Birmingham Heart of Birmingham tPCT is exploring ways of reaching the Bangladeshi community.	A report for Heart of Birmingham tPCT in June 2006	http://www.hobtpct.nhs.uk/_docs/b

section 3.5.3.2 – Smoking cessation – group-specific interventions: BME groups			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	Stop smoking advisers provide culturally appropriate support.	showed that 'the 2 main venues accessed by smokers are City Centre drop-in clinic and community pharmacists. However, seeing an increase in quitters being delivered via our community clinics, general practice and workplace groups. It is in these areas that we are looking to promote and expand further during 2006/07'. 43 per cent of smokers accessed the City Centre Clinic and 23per cent accessed pharmacies.	oard/trust/2006/200606/Encl%2003%20Smoking%20Cessation%20Update.doc
Islington BME	In Islington, Turkish and Somali advisers target GP practices with high BME populations		Questionnaire
Lewisham	The stop smoking service provides an adviser at a day centre for refugees and asylum seekers.	Adviser fed back that until people had secure housing or status, they were not ready to stop smoking.	Questionnaire
Manchester	Twenty six of Manchester's mosques were involved in this initiative. Ramadan prayer time calendars personalised to each mosque were produced and distributed via mosques and community centres. A number of religious and community leaders were offered training to run awareness raising talks on tobacco cessation and signpost people into services. One-to-one appointments for those		Case study included in Fox C (2004) Heart Disease and South Asians. Delivering the

section 3.5.3.2 – Smoking cessation – group-specific interventions: BME groups			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	wanting help were offered at mosques and community centres before and during Ramadan. In addition, a number of religious and community leaders were offered training to run awareness-raising talks on tobacco and help with tobacco cessation was offered at mosques and community centres.		National Service Framework for Coronary Heart Disease. BHF and NHS.
Middlesbrough	Work closely with Community Health BME Worker – Taxi services a target group. Good link in council BME Community worker. Also Men's Health Worker in Local Authority.		NE survey
Newcastle & North Tyneside	Linked in with CHD / Diabetes services for BME groups		NE survey
Nottingham	Culturally appropriate services are also being developed through identifying and training lay advisers and peer education schemes		Nottingham New Leaf Annual Report 2005/6.
Sedgefield	Small Chinese community which PCT link into via Patient Public Involvement.		NE survey
Slough	The Cardio Wellness Charity delivers smoking cessation services to hard to reach groups including South Asian and Polish communities. The Slough project works with GPs, carries out leaflet drops and local publicity and provides services in the first language of clients and at flexible times		Sankla (2007) Generating throughput and quitters for 'hard to reach' smokers Conference presentation UKNSCC.
Southall	Southall is piloting drop-in clinics linked in to GP practices in the area. Level 1 and Level 2 training have also been offered to community groups with a view to training them to be Community		Questionnaire

section 3.5.3.2 – Smoking cessation – group-specific interventions: BME groups			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	Advisers providing Stop Smoking Service advice and support to members of the BME community. Does particular work with newly arrived refugees.		
Sutton & Merton	Attending Ethnic Minority Centre forum to meet and introduce service to their communities. Promotion on Friday after prayers at local mosques. Considers the language issue for BME pregnant women and has a project with Tamil pregnant women, providing antenatal information in their own language.		Questionnaire
Tower Hamlets Bangladeshi Tobacco Cessation Project	Provides culturally sensitive support, NRT, and male or female workers where appropriate. They provide home visits to those who cannot access the service. It is funded by Tower Hamlets Primary Care Trust and is a four week programme based on weekly meetings. The meetings are followed up with regular phone calls or further meetings if needed. The Bangladeshi Stop Tobacco Project and the PCT are working closely in collaboration with East London Mosque to provide a Stop Tobacco Service for visitors to the Mosque. The Ocean Somali Community Association provides services to support the Somali community and other local residents in Tower Hamlets. They have a number of smoking cessation advisers available.	Won 2004 QUIT Smoking Cessation Supporter Award	Source: http://www.qmul.ac.uk/media/communications/docs/bl_qmul2005.pdf
Walsall Ramadan Quit Smoking Campaign	Distributing posters, leaflets. Staff were recruited to represent the three main Muslim communities in Walsall and worked together with Walsall tPCT Smoking Reduction group to produce a Ramadan calendar. As well as showing prayer and fast breaking times, the calendar also had smoking information translated into appropriated		Minority Communities Matter. The 2005 Annual Report of the Director of

section 3.5.3.2 – Smoking cessation – group-specific interventions: BME groups			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	Asian languages. During Ramadan, 15 mosques in Walsall were targeted with promotional material.		Public Health 2005/6.
Yorkshire and Humber	The Yorkshire and Humber Smokefree Region Bus is used by all services in the region and is taken to disadvantaged areas and also visits to Asian events.		Interview

section 3.5.3.3 – Smoking cessation – group-specific interventions: other groups (includes homeless, HIV, disabled groups)			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Cambridge HIV	Working directly with HIV service provider.	Shown to decrease smoking prevalence	Interview
Camden HIV/AIDS	HIV/ AIDS tailored presentation and leaflet.		Questionnaire
Camden Homeless Link	Work with homeless in hostel.		Personal communication
Central Lancashire Homeless groups	Has links with South Ribble Key, a charity giving practical assistance and support to people aged 16-24 with housing problems.		Questionnaire
Ealing and Hounslow Homeless people	Staff at a hostel for homeless people have been Level 2 trained by the Ealing and Hounslow service, which also operates drop-in clinics in areas of deprivation where people are on benefits and living in public housing.		Questionnaire
Gateshead & South Tyneside Disabled people	Gateshead and South Tyneside carries out home visits for clients with mobility problems and other various special needs and also encourages people to use the patient transport service	Very few people make use of the patient transport service	NE survey
Hammersmith and Fulham Homeless people	Hammersmith and Fulham has advisers in a local homeless centre		Questionnaire
Herefordshire Poverty	Rely on GP contacts for referrals from people on low incomes or on benefits and living in public housing.		Questionnaire
Liverpool Deaf people	Liverpool has 3 members of staff who achieved level 1 British sign language.		Questionnaire
Tees Disabled people	Tees chooses its clinic venues with consideration for disabled access and also has leaflets available in large type, Braille and on tape and CD.		NE Survey

section 3.5.4 – Smoking cessation. Proactive case finding: client-friendly outreach: one-off events			
Location	**Detail**	**Outcome**	**Source of information**
Brent	A number of promotional stalls have been run over the years to raise awareness of the service. For example promotion on Kilburn High Road for No Smoking Day in partnership with Camden PCT.	These have varying degrees of success and it is often found that numbers interested are low for the amount of effort that goes in.	Questionnaire
Salford	For National No Smoking Day, Salford held a series of events aimed at helping those wanting to quit the habit. This included an 'If I Can Do It, You Can Do It' information stand at Salford Shopping City, where smokers could talk to successful quitters about their experiences while accessing advice, help and support. GP surgeries and pharmacies across the City also marked the day with special sessions offering information on the help and support available to those who want to give up.		Salford PCT Annual Report
South Manchester	Manchester SureStart activity has included regular smoking cessation meetings for staff, 'roadshows' in the civic centre, with a midwife and other Sure Start staff available in the main supermarket to talk about smoking and other issues.		Reid A. Sure Start smoking and pregnancy (2004/5) Manchester Public Health Development Service
South West Essex	Workplace roadshows, involving trained Occupational Health nurses to offer support.		Questionnaire
Stockton on Tees	In Stockton a partnerships initiatives across the PCT, Borough Council and Fire Service provide a trailer in the town centre		http://www.northteespct.nhs.uk/newsfol

section 3.5.4 – Smoking cessation. Proactive case finding: client-friendly outreach: one-off events			
Location	**Detail**	**Outcome**	**Source of information**
	where people could receive advice on stopping smoking, advice on the dangers of smoking in the home and the benefits of smoke alarms, check their breathing capabilities on a smokalyser machine and receive advice on healthy lifestyles		der/2006/PRNT94

section 3.6.1 – Smoking cessation. Improving access: expansion in numbers and locations of staff			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Blackpool	Provides free training to all health professionals.		Questionnaire
Central Lancashire	Provides level 2 training for practice nurses and health visitors in line with evidence-based practice to build capacity of support to smokers, with targeted support for pregnant women – providing brief intervention training for midwives, and others who come into contact with this group (e.g. SureStart, Children Centre and Dental staff) with the aim of building alliances to reach pregnant smokers and signpost into the service for support.		Questionnaire
City and Hackney	City and Hackney tPCT is training staff in organizations that come in contact with smokers with level one advisers in a wide range of settings in a range of statutory community and voluntary organizations, including benefits agencies and voluntary workers.		City and Hackney PCT Ready Steady Quit Action Plan 2005/6.t
City and Hackney	In City and Hackney, a map of existing advisers was produced (2006) to identify areas of poor coverage and organisations then targeted.		As above
County Durham & Darlington	Additional support sessions are available in pharmacies, community settings and leisure services, including increased out of hours support at weekends and evenings. This has been developed with LAA grants.		Tackling Inequalities in County Durham and Darlington. Annual Report of the Director of Public Health (2006/7)
Gateshead & South Tyneside	The SSS has 280 Intermediate Advisers providing stop smoking support from a variety of settings including G.P. practices, Pharmacies, SureStarts and Community settings.		NE Survey
Homerton	Homerton Hospital has an NRF-funded in patient project.		City and Hackney tPCT website

section 3.6.1 – Smoking cessation. Improving access: expansion in numbers and locations of staff			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Liverpool	Provides ongoing brief intervention training for all primary and secondary care workers, including front-line staff.		Questionnaire
Newcastle	Hundreds of NHS staff in Newcastle have already been trained by the service to deliver cessation support (including GPs, community nurses, school health advisers pharmacists and dentists).		NE Survey
Newham	Newham provides one-to-one interventions in the community through a network of over 170 Level 2 Advisers who are essentially pharmacists and practice nurses. They also provide intensive group support, which is particularly suitable for more heavily dependent smokers. These groups are run by Level 3 trained advisers from within the core Stop Smoking team based at the PCT. They attribute the success of Stop Smoking service in Newham in achieving national targets on a willingness of pharmacists and practice nurses in particular to undergo further training to become Stop Smoking Advisers.	Reported to be successful. Smokers who want to quit can find professional support in every neighbourhood.	Newham stop smoking strategy and action plan 2005/6
Salford	Nearly all GP practices have at least one smoking cessation adviser, usually one of the practice nurses, but it may be an assistant practitioner or a health visitor.		Salford PCT website
St Helens	St Helens provides a bespoke smoking cessation service, called SUPPORT. A team of 5 whole time equivalent staff specialise in providing tailored support in smoking cessation from a variety of accessible venues throughout the community. The Public can access the service via a free phone help number, via their GP, Pharmacist or through another professional such as a nurse or occupational health therapist trained to deliver brief smoking	Between April 2004 and March 2005 SUPPORT has helped more than 1,577 people to stop smoking. Out of those, 861 people were still quit at their four-week follow-up. This represents a quit rate of 55%.	Halton and St Helen's Public Health Report 2005.

section 3.6.1 – Smoking cessation. Improving access: expansion in numbers and locations of staff			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	cessation interventions. The service provides either one to one, or group counselling alongside Nicotine Replacement Therapy or Zyban, which are proved to be effective methods of helping people to stop smoking.		
Walsall	Sessional advisers to increase service provision in the evenings and at weekends.		Walsall tPCT LDP
Wirral GP practice specialists	PCT funded specialist stop smoking advisers to support GP practices with the highest rates of smoking. Every practice also has an intermediate stop smoking adviser.		Bebbington and West Wirral PCT Public health Annual report 2004/5.

section 3.6.2 – Smoking cessation. Improving access: Drop-in models and rolling programmes			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Barnsley	Developing town centre drop-ins		Interview
Bradford	Developing town centre drop-ins		Interview
Chiswick	Chiswick Health Centre runs rolling groups using CBT - there is a pharmacy on site.	Four week quit rates are on a par with the national average (collated via Ealing and Hounslow), but as clients continue to visit after 4 months it is assumed that 52 week quit rate is higher.	Attar-Zadeh D (2007) Chiswick Health Centre Rolling Groups using CBT language. Poster presentation UKNSCC conference.
Croydon	Drop-ins targeted at deprived communities, provided in NRF areas.		Questionnaire
Ealing & Hounslow	Hounslow's drop in clinics and motivational groups are located in areas where there are disadvantaged groups across the boroughs.		Questionnaire
Gateshead & South Tyneside	South Tyneside Pilot of drop-in sessions Drop in 2 Quit	See case study	Questionnaire
Hampshire	Combining drop-in centres with a group	Suggests that rolling drop-ins are more successful in urban than rural areas.	Interview
Hull	Whistle Stop drop-in sessions in town centre		Personal communication
Islington	Provides drop-in clinics in deprived wards		Questionnaire
Liverpool	Roy Castle Fag Ends	See case study	www.roycastle.org/fagends
Newcastle	Drop-ins as separate events with media coverage. In Newcastle city centre people could drop in to see a		News release 4.06.07 www.northtynesidepct.

section 3.6.2 – Smoking cessation. Improving access: Drop-in models and rolling programmes			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	trained adviser without an appointment on each Saturday in January (building on New Year resolutions).		nhs.uk
North Tyneside	Drop in sessions in North Tyneside were held prior to the non smoking ban and at the end of the seven week period, people were referred to on-going drop-in clinics should they still need support. Drop-ins combined with incentives such as free NRT for up to 7 weeks.		News release 4.06.07 www.northtyneside pct.nhs.uk
Sedgefield	Community groups are primarily on a rolling drop-in basis and some take place out-of-hours.		NE Survey
South Birmingham	Developed a less formal drop in service over 2003-4, with NRT provided free. Participants set a quit date on week one and attended weekly for 4 weeks.	The drop in attracted men and women equally, whereas groups attracted more women; a greater proportion of quitters were manual workers than in the regular groups and the model of delivery was cost effective (£233 per quitter compared to £118 for the Drop In)	Adams J et al (2005) Evaluation of drop in to quit. Poster presentation at UKNSCC conference.
Southampton	Combining drop-in centres with a group.	Suggests that rolling drop-ins are more successful in urban than rural areas.	Interview
Sutton & Merton	Merton offer drop in services with free NRT for those not registered with GPs.		Questionnaire
Tees	Almost totally drop-in service.	Reported to be highly successful.	Questionnaire
Tower Hamlets	Drop-ins outside normal hours (LAA target).		Tower Hamlets PCT LDP

section 3.6.3 – Smoking cessation. Improving access: mobile services			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Cornwall & Isles of Scilly	Because of the rural nature of the area, Cornwall Stop Smoking Services are not delivered at specialised clinics, but generally in one of three ways: through Stop Smoking Nurses in every GP surgery; at pharmacies; and by dedicated roving staff.	A telephone survey of service users twelve months after quit date showed results of 20.7 for men and 18.5 for women. Those who saw specialist stop smoking nurses reported higher success rates than those who saw GPs, pharmacists or used a helpline.	Bennett S (2005) Stop smoking services in Cornwall. Poster presentation UKNSCC conference.
Croydon	Partnership with older people (POP) mobile unit (POPstop bus) in Croydon (one year DH funding). The POP stop bus was launched in May 2007,and is a mobile unit set up to held identify older people at risk and will provide health and social care support, and smoking cessation is included amongst its activities. The POP team include a pharmacist who will conduct medication reviews and support patients with medication management and will identify risk factors for a range of conditions including CHD.		Questionnaire
Hartlepool	NDC: 'Drop-in for Health' Health Bus is a mobile health service part funded by the local NDC. The overall aim of the project is to enhance opportunities for health improvement and to increase the uptake of mainstream health services by NDC residents. The project offers a drop-in health facility at four sites in the NDC area (sometimes more if there is demand) and is staffed by six part-time practice nurses from local GP	The health bus is used by approximately 40 people per two-hour session. The project has been successful in providing access to health services to residents who would not ordinarily access mainstream health provision. Anecdotal evidence suggests that men tend to use the service more than they	CRESR (2005) *New Deal for Communities 2001-2005: An Interim Evaluation.*

section 3.6.3 – Smoking cessation. Improving access: mobile services			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	practices, who workaround their GP practice timetable in an outreach capacity. The bus provides an easily accessible venue for smoking cessation clinics, national promotional campaigns such as National Heart Week and demonstrations on healthy eating, oral and personal hygiene.	would their GP. Assessments of the service suggest that the mode of delivery is successful due to the ease of accessibility and the informal, non-threatening atmosphere.	Research Report 17. Sheffield Hallam University. p179.
Herefordshire	An outreach bus operates visiting travellers' sites, giving healthcare information and service. At least one staff member is a trained stop smoking adviser.		Interview
Sandwell	Mobile Lifestyle Awareness Unit delivers a service in targeted areas of the borough.		Sandwell Floor Target Action Plan
Shropshire	Help 2 Quit Mobile Clinic was a joint initiative by the PCT and the County Council, offering an advice service in the workplace for any company that wanted it	Attracted hundreds of people to set quit dates and the quit rate (87%) was very high. Ran for three years but funding ended 2006 so could no longer operate.	Questionnaire
Yorkshire and Humber	The Yorkshire and Humber Smokefree Region bus is used by all the services in the region, and is taken to disadvantaged areas. It also goes to events such as Asian festivals. Sometimes stop smoking groups are also run on the bus. It has been operating for five years. Drivers are trained in cessation.	Example of success – Dewsbury market was 'overwhelmed with clients' when the bus went there.	Interview

section 3.6.4 – Smoking cessation. Improving access: community pharmacies			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Birmingham East and North	Involved in major health improvement initiatives as part of the new Pharmacy Contractual Framework. One of these initiatives has been the delivery of smoking cessation services. Pharmacies either carry out the service themselves or signpost patients where appropriate.	Previously there had been 31 sites in the former East and five in the former North areas. With the introduction of the new Service Level Agreement for Smoking Cessation it is expected that the final figures will be 30 in the East and 14/15 in the North of the area.	Birmingham East and North PCT Annual Report 2006/7
Camden	Through LAA funding, a pharmacy is working to target Somali, Bangladeshi and White Irish groups. LAA targeted BME work is linked to disadvantaged areas.		Questionnaire
City and Hackney	There is a named stop smoking lead in every pharmacy.		Ready Steady Quit Action Plan 2005/06, City and Hackney PCT
Croydon	Over 70 pharmacists are involved in Croydon PCT Stop Smoking Services.	Pharmacists provide approx. 60% of all activity. Some pharmacists are extremely proactive in identifying and engaging smokers in their local areas, others less so.	Questionnaire
Ealing and Hounslow	The Hounslow and Ealing Stop Smoking Service have a number of Level 2 trained pharmacy advisers who are able to generate their own referrals and clients to deliver the Stop Smoking programme. Pharmacists are well positioned to identify smokers in their daily work environment.	A recent Commissioning Strategy Paper identified the service as one of excellence and hitting targets.	Questionnaire

section 3.6.4 – Smoking cessation. Improving access: community pharmacies			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	The service will be undertaking a SWOT analysis to identify areas for service improvement and need.		
Harrow	Harrow reports that pharmacists are their main service providers and referrers alongside GPs. Pharmacies were chosen because of their patient trust, knowledge base, ease of supply, ease of access, flexibility, personal development and the financial implications of the service. In return pharmacists ask for recognition of their contributions, a simple easy to follow system, easy paperwork, referrals from GPs and other healthcare professionals, support from a central base, mentors and continued training and development. The service is now delivered by 51 out of 57 pharmacies in Harrow with them able to supply a full range of NRT through a PGD. Access to the service has been made as easy as possible and clients do not have to phone a helpline first to register. Many of the pharmacists who deliver the service can speak a number of languages and relate to the community they are servicing.	Helped over 2000 people stop smoking since its launch at the end of 2004. Scheme has been adopted by a number of PCTs throughout the country	Hone S (2006) Pharmacists to deliver stop smoking programmes - a success story. Poster presentation UKNSCC conference Questionnaire
Hull	All community pharmacies support NRT voucher scheme run by the stop smoking services.		Questionnaire
Islington Peer support scheme for community pharmacy	Trained pharmacists to offer stop smoking advice and dispense NRT to their clients as a one-stop-shop. However there were considerable variations between pharmacists in terms of the number of people using the service and quit rates. A peer-support project was set up to improve the	The proportion of quitters coming from pharmacists increased. Ten new pharmacists trained as Level 2 advisers and joined the scheme during the project. Communication between	Kayikci S (2007) Evaluation of a peer support scheme for community pharmacy smoking cessation.

section 3.6.4 – Smoking cessation. Improving access: community pharmacies			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
smoking cessation	service.	the PCT and pharmacists improved immensely. The PCT produced pharmacy specific promotional materials. A database was developed to reduce paperwork and to ensure accurate payments.	Conference presentation UKNSCC.
Knowsley	Patient Group Directions allowing certain pharmacies to prescribe NRT or provide it in return for vouchers Pharmacies dispense NRT vouchers issued by Roy Castle Fag Ends Counsellors, if appropriate through a service level agreement with the PCT (the protocol is available). They can also offer in house smoking intermediate services if appropriate (including two 24 hour pharmacies)		Questionnaire
Lambeth	In Clapham Park New Deal for Communities Healthy Living Programme smoking cessation has been active since April 2004. A local pharmacist offers twelve weeks extended support to all residents. In the new project carrying forward this work in 2007 there is in addition: targeted support through GP referrals; a stop-smoking training programme for residents to offer peer group support; and tracking of effectiveness after 6 months.		LAA 2007
Liverpool	A drug company recently funded for a leaflet (with a list of the groups in that specific area) to be put in prescription bags at the local pharmacies.		Questionnaire
Newcastle	Alliance pharmacy in Newcastle (trained by Newcastle SSS) has more than 30 staff in 12 of its branches across		News release 16.04.07

section 3.6.4 – Smoking cessation. Improving access: community pharmacies			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	Newcastle, Kenton, West Denton, Killingworth, Whitley Bay, Longbenton and Wallsend who were fully trained to provide stop smoking advice and support in time for the smoking ban in public places on 1 July. Would be quitters can make an appointment, or just pop in, at any one of the branches where they will have a consultation with a member of the pharmacy team. This involves a discussion about the person's general health and about what methods they may have used in the past to give up smoking.		www.northtyne sidepct.nhs.uk
Newham	Has encouraged all pharmacists in two specific localities to provide level 2 stop smoking services and examples were found for PCTs planning to extend smoking cessation advice in pharmacies in high rate wards as far as could be afforded.		Questionnaire
North East of England	Stop Smoking Services and PCT pharmaceutical advisers, working with community pharmacists to develop: • Direct supply of nicotine replacement therapy to clients who are exempt and non-exempt from prescription charges • Local enhanced service specifications • Publicising services and identifying referral pathways • Complementing stop smoking services provided by GP practices		Loggie J (20060 Successful and accessible Stop smoking services provided by community pharmacies Poster presentation at UKNSCC conference.
Northumberland	The Pharmacy Direct Scheme is a partnership between the Northumberland Stop Smoking Service, PCT pharmacy leads and local community pharmacies, to improve access to		Report of the Director of Public Health 2005/6.

section 3.6.4 – Smoking cessation. Improving access: community pharmacies			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
	nicotine replacement therapy (NRT) products. The scheme is supported by local GP surgeries which, prior to its inception, were responsible for generating all NRT prescriptions for patients seen by a Stop Smoking Specialist. Under the Pharmacy Direct scheme, the specialist can issue a Pharmacy Direct form, which the client takes directly to a participating pharmacist. The pharmacist discusses the product and its use, building on the advice given by the Stop Smoking Specialist and issues the product. GPs are informed of the client's involvement in the process and their quit-smoking outcome. The scheme is more efficient for patients and has saved time in both the Stop Smoking Team and the GP practices. It has been piloted in the Central Northumberland locality and will be rolled out county-wide		
Salford	Salford PCT has continued to work with local pharmacies to help Salford residents who want to quit smoking.	29 pharmacies are taking part in a voucher scheme that enables people to easily access nicotine replacement therapy.	Salford PCT Annual Report
South Staffordshire	One to one stop smoking clinics by appointment at a local ASDA pharmacy		South Staffordshire PCT Annual Plan 2007-9
Suffolk	Undertaking audit on pharmacists around stop smoking services		Interview
Warwickshire	Has made some use of information in prescription bags.		Questionnaire

section 3.6.5 – Smoking cessation. Improving access: dental practices			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Dundee	A PATH-funded project (*preventing oral cancer – a smoking cessation intervention in a dental setting for patients with potentially malignant lesions*) will offer smoking cessation advice to a cohort of patients with potentially malignant lesions attending Glasgow and Dundee Dental hospitals. Patients would be randomly allocated to receive; a) advice based on the 5As (ask, Advise, Assess, Assist, Arrange follow up for patient), or, b) Behaviour Change Counselling - taking into consideration average alcohol intake.		Muir M and Craven D (2006) *Dundee Smoking and Pregnancy Project. Final Project report.* NHS Tayside.
Central Lancashire	Working in collaboration with dental practices to incorporate brief interventions and referral into routine care. As part of the targeted support for pregnant women, provide level 2 training for dental staff who come into contact with them.		Questionnaire
Leeds	A three year project is under way to understand the range of services related to smoking cessation in dental practices in Leeds (funded through Leeds PCT research Consortium).		
Salford	A pilot project has been established where a dental nurse has been trained to provide intermediate advice to patients wanting help to quit smoking. This has been running in one Dental Practice in Salford since June 2005. If the results of this are favourable, they will be used to encourage other dental practices to be involved.		Salford Tobacco Control Strategy 2006-10
Wales	8 coordinators work as part of the dental team smoking cessation training programme		Personal communication

section 3.6.6 – Smoking cessation. Improving access: times and locations of clinics			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Camden	Organizes open groups in the day time, targeting people who are retired, unemployed or mothers with young children.		Questionnaire
Central Lancashire	Makes use of hospital outpatient clinics, where appointments can be made around other hospital visits.		Questionnaire
Easington	Transport networks are poor and there is low car ownership, therefore a service is provided in every GP practice. Drop-in groups are offered throughout the district to provide accessible sessions.		NE survey
Herefordshire	Offers evening drop-in clinics and group sessions in rural areas.		Questionnaire
Liverpool	The number of people (new and returning) attending sessions are monitored and if sessions continue to be poorly attended, despite targeted advertising, they look at moving to another venue or altering the time of the session.		Questionnaire

section 3.6.7 – Smoking cessation. Improving access: home visits, telephone support and other technologies			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Blackpool	Regularly carries out telephone consultations with clients who cannot come to a one-to-one clinic appointment.		Questionnaire
Buckingham-shire	Has links to web-based support for patients who work shifts or are unable to attend groups.		Questionnaire
Central Lancashire	Has a telephone support programme in place for disabled or housebound clients, with daytime calls agreed on a weekly basis.		Questionnaire
Dudley	The Dudley Quit Smoking Programme, a two year project, provided one to one intensive support at home for pregnant women, partners and families through a full time midwife smoking cessation specialist and support is provided throughout the pregnancy, which helped to prevent relapse and a smoking activity is updated and kept in the hand held notes.		http://www.renewal.net/ Documents/RNET/ Case%20Study/ Dudleyquitsmoking.doc
Hull	Trialling home visits more widely.		Personal communication
Islington	As part of a wider range of client centred interventions (e.g. quit stalls, drop-in sessions in housing estates and shopping areas) they are planning to provide a telephone support service for house-bound smokers).		Questionnaire
Manchester	Community midwives have been trained to intermediate level and can provide interventions in the home or the clinic within a few days.		http://www.gmsha.nhs.uk /nhsawards/nominations/ 1_eileenstringer_ph.pdf
North Staffordshire	Home visits are provided in North Staffordshire (YOU Two Can QUIT) along with text messaging and telephone support.		O'Gorman C (2005) Working with pregnant smokers. Presentation at UKNSCC conference.
Birmingham	Intensive support for pregnant women from a stop smoking specialist involving weekly home visits, NRT prescription and CO monitoring.		North and East Birmingham PCT stop smoking website

section 3.6.8 – Smoking cessation. Improving access: service realignment			
Location/ Project name	**Detail**	**Outcome**	**Source of information**
Lewisham	Lewisham has a weekly town centre stalls on Saturday, a health bus visiting a disadvantaged estate, a NDC project to begin Fulham style telemarketing to smoking clients on GP lists and Stop before the Op programme in preparation..		Questionnaire
Liverpool	Roy Castle Fag Ends (Liverpool) is a flexible client centred service which includes ex smokers from the community as advisers, offers drop ins in a wide range of community venues and at different times and provides NRT vouchers. Their database allows then to text clients and they are also using social marketing techniques.	See case study	

section 3.7.1 – Smoking cessation. Encouraging access through incentive schemes: GPs and dentists			
Location	**Detail**	**Outcome**	**Source of information**
Barking & Dagenham	PCT set a target to ensure that 78% of the population had their smoking status recorded in the previous 15 months, but unfortunately, records showed that only 48% of the population were checked in this period and the PCT intends to work with local practices to improve this figure in future years.		
Bury	Bury has a GP phased incentive scheme (using Choosing Health monies) for quit dates plus CO validation. It also has an incentive scheme for dentists, again with CO validation.		Personal communication
City and Hackney	In City and Hackney, each practice has a stop smoking lead , relapse and longer term follow up is also provided and monthly monitoring of quit rates and level three referrals.		Ready Steady Quit Action Plan 2005/06, City and Hackney PCT
East Midlands	East Midlands has some locally enhanced agreements for GP case-finding, plus work with acute trusts on referral systems.		Interview
Islington	Islington is planning to develop an enhanced service under nGMS to complement the QOF (see PSA08b) and incentivise achievement of practice based targets of number of quitters.		Islington LDP 2005-8
Rotherham	Rotherham is proposing to radically revise the LES to give a flat payment for smoking quitters with practices informing the PCT of take-up. Audit measures would be put in place to ensure this was being done properly.	LES practices have higher than average quit rates	Public Health Annual Report 2006/7.
Walsall	Implementation of the LES in 2003/2004.	A 104% increase in the number of quit dates set compared to 2002/2003. Improvements in service	Walsall tPCT (News) http://www.walsall.nhs.uk/communications/ne

section 3.7.1 – Smoking cessation. Encouraging access through incentive schemes: GPs and dentists			
Location	**Detail**	**Outcome**	**Source of information**
		uptake of primary care based smoking cessation services continue to be demonstrated year on year since the introduction of the guidance.	ws/Walsall_award.asp

section 3.7.2 – Smoking cessation - encouraging access to services through incentive schemes: community pharmacists			
Location	**Detail**	**Outcome**	**Source of information**
Birmingham	The Pharmacists in the Birmingham East and North PCT area are involved in major health improvement initiatives as part of the new Pharmacy Contractual Framework. One of these initiatives has been the delivery of smoking cessation services. Pharmacies either carry out the service themselves or signpost patients where appropriate.		Birmingham East and North PCT Annual Report 2006/7
England	Boots has a personalised quitting plan (with QUIT's stop smoking counsellors giving additional support)		Interview
England	Lloyd's pharmacies are planning to offer a cessation service across the country.		Interview

section 3.7.3 – Smoking cessation - incentive schemes for smokers and businesses			
Location	**Detail**	**Outcome**	**Source of information**
Bury/Greater Manchester	Umbrellas (for pub shelters etc) were provided for good smoking cessation numbers.		Personal communication
Camden	Refer-a-friend scheme for people who have used the service and for local businesses, under which cinema tickets are provided for every person who attends and another if they quit.		Questionnaire
Central Lancashire	Has a voucher scheme, targeting clients without referral to GP and providing a more streamlined service.		Questionnaire
Manchester	Both pregnant women and staff that support them have been offered prizes on quitting.		www.stopsmokingmanchester.co.uk
Newham	Newham has looked at an income maximization approach with the local social inclusion unit, which would have been linked to credit unions. The idea would have been that smokers wishing to quit could open a savings account with their local credit union and if they were successful at 4 weeks, 3 months and 6 months they would get a cash bonus to add to their savings. Participants would have been encouraged to save the money they would normally have spent on cigarettes.	Unfortunately they were unable to gain funding for this.	Questionnaire
North Tyneside	Seven weeks free nicotine replacement therapy was made available by a 'join in to quit' held every Saturday in June prior to legislation. Trained stop smoking advisers can provide nicotine replacement therapy (NRT) direct and free of charge for up to seven weeks, when people will be referred to on-going drop-in clinics should they still need support.	At the first meeting over 50 people came along to take advantage of free NRT and get expert support from stop smoking advisers.	News release 4.06.07 www.northtynesidepct.nhs.uk
Rochdale	In Rochdale (2007) home match tickets (meeting the players and VIP treatment) were made available for those quitting for over 4 weeks and		Rochdale PCT website

section 3.7.3 – Smoking cessation - incentive schemes for smokers and businesses			
Location	**Detail**	**Outcome**	**Source of information**
	timed to coincide with New Year resolutions.		
Sandwell	Although the remit is wider than for smokers, the Sandwell Healthy Passport Programme is an incentive scheme, aimed at over 50s, with health targets (which include stopping smoking or health checks) in return for points which can be exchanged for prizes. This was funded through NRF.		Sandwell PCT LDP 2007/08
South West Essex	Offers 8 week of NRT for the price of one script, so for those on benefits it is free.		Questionnaire

section 3.7.4 – Smoking cessation - smokefree homes			
Location	**Detail**	**Outcome**	**Source of information**
Ealing and Hounslow	The Smoke Free Homes pilot project aims to recruit adult smokers to commit to a smoke free home. This project has been implemented in areas of areas of high social deprivation. As part of the Smoke Free Homes initiative, a large area of a Northolt Housing Estate was targeted which resulted in recruiting over 1000 households who signed up to be Smoke Free. Also a drop in was set up in new housing development in Northolt-Grand Union Village.		Questionnaire
Harrow	Running a Smokefree Homes campaign to protect people from the harmful effects of second hand smoke although primarily delivered through school children it is up to the parents to sign up to the scheme – over the past 15 months have signed up over 1400 homes with the majority being totally smoke free.		Questionnaire
Lowestoft	North Lowestoft SureStart offers a pack of freebies and, for those who sign the smoke-free promise, entry into a series of £100 prize draws. This project relies upon SureStart workers and health professionals to promote the initiative to all 'clients'.		Information available at: http://www.surestart.gov.uk/_doc/P0001395.doc
Manchester	A report on Smoke free homes in Manchester (2004/5) demonstrated that the majority of people referred on to the scheme joined through SureStart and midwives across Manchester. People who were not ready to make the commitment, to a smoke free home could sign up as smoking in one room only - as a first step towards smoke free status. In this instance people were contacted by the Stop Smoking Service after 6 months to see whether they were ready to go smoke free. The Smoke Free Homes scheme is	The Smoke Free Homes scheme is described as expanding, with almost 750 registering over a twelve month period. Midwives are encouraging pregnant women to sign up at the booking visit. On line applications were also popular. This report claims that there is evidence that the Smoke Free Homes scheme	http://www.manchesterpublichealthdevelopment.org/mphds/download-files/pdf/smoking/Manchester%20Smoke%20Free%20Homes%20Report.pd

section 3.7.4 – Smoking cessation - smokefree homes			
Location	**Detail**	**Outcome**	**Source of information**
	described as expanding, with almost 750 registering over a twelve month period. Midwives are encouraging pregnant women to sign up at the booking visit. On line applications were also popular. This report claims that there is evidence that the Smoke Free Homes scheme provides a useful strategy to help reduce second hand smoke exposure in the home and to help people to change their behaviour. An audit of SureStart stop smoking initiatives in Manchester showed that the smoke free homes initiative also provided an opportunity for the issues of passive smoking and potential fire hazards to be addressed and advice on smoke alarms.	provides a useful strategy to help reduce second hand smoke exposure in the home and to help people to change their behaviour See also case studies	f
Newham	Newham is currently beginning to look at ways of working more effectively with Early Start around the Smokefree Homes agenda. With the smokefree homes initiative they will be working with the East London Business Alliance (ELBA) to look at ways of linking in to possible financial incentives to change. For example, companies providing home insurance may be able to offer lower premiums to households who sign up to provide a totally smokefree home as they would be reducing the risk of fires in the home environment.		Questionnaire

section 3.8 – Smoking cessation. Encouraging access through working through other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
Birmingham	Birmingham's service works in partnership with Sure Start and NRF. They are trained to raise the issue with smokers and on how to refer them. Some also are involved in providing services.		Questionnaire
Camden	Enforcement (LBC) are targeting high risk businesses and giving information about cessation "Holborn Rangers" are distributing cessation posters to local businesses Housing offices are distributing promotional material within council housing.		Questionnaire
Central Lancashire	Central Lancashire service works with SureStart Childrens Centres, providing a family service drop-in support. Dedicated 1-1 clinics provided to target hard to reach groups, such as Children's Centres in disadvantaged areas.		Questionnaire
Gainsborough	In Gainsborough SureStart, the Smoke Free Zones project encouraged families to sign up to being smoke free in the presence of children – promoted through rewards scheme.		http://www.surestart.gov.uk/publications/?Document=955
Herefordshire	Herefordshire liaises with SureStart to identify and help lone parents and poor families.		Questionnaire
Hammersmith and Fulham	Carrying out targeted programmes within NDC, SureStart and Children Centre Programmes.		Questionnaire
Hillingdon	Work closely with charities and local communities and		Questionnaire

section 3.8 – Smoking cessation. Encouraging access through working through other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
	companies to set up stop smoking service. They were chosen because of their relationship with the local communities.		
Islington	Working with SureStart through mother and toddler groups etc		Islington LDP 2005-8
Lewisham	Have funded Voluntary Action Lewisham and a training project in a deprived area of Lewisham. VAL is encouraging member organisations to apply for funding to run stop smoking groups for their members.		Questionnaire
Lewisham North Downham Training Project	North Downham Training Project works with its local networks to advertise its stop smoking adviser and trainees from the project. The Project won a bid for LPSA funding to start offering stop smoking advice. To date, the adviser has run 2 small groups and offered one to one support for people who could not wait for a group to start - one for its own staff and trainees and one for 5 women who asked for support from the project. They all had health problems and were advised they needed to stop smoking e.g. one was warned by the hospital that she would face amputation of her legs if she continued to smoke. They had all used primary care level 2 services and not found them supportive enough. The adviser gives vouchers for quitters to take to the nearest pharmacy for NRT. They reimburse the costs of this directly to the pharmacy.	The project adviser is about to start its third group at a newly opened local leisure centre There are small numbers so far but in an area of high deprivation and smoking rates, being accessible and very supportive. The project has provided publicity for local papers and is very proactive in recruiting smokers to try to quit	Questionnaire

section 3.8 – Smoking cessation. Encouraging access through working through other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
Liverpool	Archdiocese of Liverpool asked for literature to put in all of their social clubs		Questionnaire
North Lowestoft	In North Lowestoft, SureStart, the Pregnancy Project actively approaches all pregnant smokers in the SureStart post-code area. A letter is sent by the SureStart midwife, detailing the service available, and that they will receive a phone call from the smoking cessation worker if they are interested. Medication and support are made available by smoking worker for the duration of the pregnancy and beyond, as appropriate. The smokers' group is run by community parents.	'Lowestoft has a culture of non-participation, many workers are viewed with suspicion, and group-work is frowned upon. Using the community parents to run the smokers' group goes a long way to overcoming these hurdles. In this project it is claimed that 'groups using community parents are now running with an average 7 or 8 participants compared to groups that started with 3 and dwindled to 1 or no participants within a week or two'.	http://www.surestart.gov.uk/_doc/P0001395.doc)
Sunderland	Specialist Pregnancy Smoking Adviser was employed to solely work within the Sunderland SureStarts (funded by Sure-Start) across 04/05.		
East London	Positive East is working at improving the health and quality of life for all individuals and communities infected and affected by the virus, offering one-to-one support to stop smoking.		http://www.positiveeast.org.uk/fresh/index.html

section 3.9 – Smoking cessation combined with other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
Barnsley Fit for the Future	'Fit for the Future' works with a wide range of partners including local community groups and the general public. There are six main areas that Fit for the Future focuses on. One of which is lifestyle factors such as smoking.	2005/06 saw a reduction in people smoking	Barnsley LAA and www.barnsleyfit4thefuture.co.uk
Berkshire East Cardio Wellness Charity	Berkshire East PCT commissioned smoking cessation services from this charity as part of an LPSA project. As part of this service, smokers concerned about gaining weight following quitting were referred to the LPSA weight loss referral scheme, which involved 12 weeks free attendance at Slimming World groups. Smoking Services, in order to determine the location of services and target the most deprived wards in Slough. A pump priming grant (from the former ODPM) helped provide free NRT. As part of this service, smokers concerned about gaining weight following quitting were referred to the LPSA weight loss referral scheme, which involved 12 weeks free attendance at Slimming World groups. A Stop Smoking Kiosk is available every Saturday in the Slough Observatory Shopping Centre, running from 11am-4 pm and run by the Cardio Wellness Charity and Berkshire East Primary Care Trust. Languages spoken are English, Polish, Hindi, Punjabi, Guajarati, Urdu, and Swahili.	Targets were met (101 quitters against a target of 91).	Royal Borough of Windsor and Maidenhead website. Carter R (2007) Commissioning a charitable organisation to provide smoking cessation services to deprived communities in Slough: a local public sector agreement. Conference presentation, UKNSCC
Birmingham	*Male Life Expectancy (funded through LAA and delivered across Birmingham);*		Birmingham

section 3.9 – Smoking cessation combined with other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
East and North	The MLE project delivered on a city wide basis has an ambitious programme of work for 2007/08 targeted at improving MLE; this is supported by £2.6m of NRF funding. An analysis of the cause of death in men considered along side current initiatives identified the following two key areas for immediate action The identification and systematic management of circulatory diseases in primary care, paying particular attention to men aged 40-65 and the most deprived areas of the city; the Birmingham Own Health Project which delivers a targeted care management programme is being extended across Birmingham in 2007/8 Improvements in the targeting and delivery of smoking cessation and tobacco control services; a city wide call centre has recently been commissioned with significant investment in publicity and advertising to encourage smokers to access stop smoking services.		East & North PCT LDP 2007/08
Birmingham Health Exchange	Birmingham's Health Exchange is a new service offering information, advice and collaboration over health and healthy living. The remit of the Health Exchange is to change the context in which health information is delivered to and accessed by all communities. The fundamental principle is the concept that people learn from interaction with others who share the same experience as themselves. Account needs to be taken of the social reality in which people live and through which they construct health messages and information. Health messages must be derived from and tested against the cultures of the people for whom this information is intended. The service can be delivered through a range of venues including existing community locations as well as health facilities. Health promotion services, including smoking cessation, are provided at a range of venues and events across the area.		Heart of Birmingham PCT Strategic Service Development Plan 2006/07
Calderdale	Healthy Lifestyles Media Campaign developed in conjunction with Halifax		Calderdale LDP

section 3.9 – Smoking cessation combined with other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
	Evening Courier, Regular media coverage raising awareness of issues such as physical activity, healthy eating and smoking from January 2005.		
Camden	Badminton "Quit and Get Fit" tournament – Bangladeshi community		Questionnaire
Central Lancashire	One –to –one support in Sports/Leisure Centres, thereby reaching smokers who need access to out of hour clinics in a safe environment and also works in partnership with Activity for Life teams, providing a fast track referral pathway to support smokers with weight issues or managing long term conditions that are presenting as barriers to quitting.		Questionnaire
Ealing & Hounslow	Ealing and Hounslow stop smoking service works in partnership with the Southall Healthy Living Initiative (SHLI), where there are projects set up to address health inequalities: The SHIP (Southall Health Improvement Project), Asian Family Counselling Service, DAAP (Drugs and Alcohol Project), Mind, Active Ealing (Keep Fit Programme).		Questionnaire
Greater Manchester	Greater Manchester/Bury PCT is offering training for fire officers in giving intermediate advice.		Personal communication
Guernsey Quit and Get Fit courses	A trained exercise instructor tailors a personal exercise programme in relation to level of fitness. There is ongoing support from Quitline Advisers and the opportunity to have up to eight weeks FREE Nicotine Replacement Therapy.	Most participants remain non-smokers nearly eight months after their quit date	http://www.bbc.co.uk/guernsey/content/articles/2004/09/15/quit_and_get_fit_feature.shtml
Islington	Carries out joint marketing with strategic partners – e.g. fire service and community police schools work with primary care teams to enhance referrals. The Fire Service has occasional opportunities to assess the smoking status of a		Questionnaire

section 3.9 – Smoking cessation combined with other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
	household, following a fire, and to recommend the stop smoking service.		
Kirklees	Advisers from the Kirklees Stop Smoking Service have teamed up with the Chickenley Partnership to support local residents to stub out their cigarettes and get fit for summer. The specialist advisers will be running tailored sessions from the community centre in Chickenley where they will be offering residents the advice and information they need to stop smoking. The advisers are able to provide ongoing support to break the habit of smoking as well as helping quitters make healthy lifestyle changes such as gentle, informal exercise and keeping the weight off after quitting. Patients looking who would like to attend one of the stop smoking drop-in sessions and who are looking to get fit over the summer will get free use of pedometers.		http://www.kirklees-pct.nhs.uk/news/news-item/article/167/7/link//d153e8b3dc/
Lancashire	Lancashire Fire and Rescue makes use of its Home/Fire Safety checks to raise awareness and refer clients to the stop smoking service.		Questionnaire
Liverpool	When fire officers carry out home visits to fit smoke alarms in Liverpool, they ask whether there are any smokers living on the property and give out appropriate information.		Questionnaire
Middlesbrough	Group exercise schemes in Middlesbrough focus on diet and fitness but have the potential to look at smoking behaviour as well.		Personal communication
Sheffield	The Sheffield NHS Stop Smoking Service and Sheffield International Venues (SIV) have joined forces to encourage smokers to move on to a healthier lifestyle. (2004 information) Smokers who successfully quit with the Sheffield NHS Stop Smoking Service are being given the opportunity to take up a new leisure activity to complement their smoke-free healthier lifestyle. Successful quitters will receive vouchers		Sheffield NHS Stop Smoking Service

section 3.9 – Smoking cessation combined with other initiatives			
Location	**Detail**	**Outcome**	**Source of information**
	redeemable at SIV. The vouchers entitle them to free activities at any of SIV's four venues choosing from swimming, ice skating, exercise classes or tea dancing.		
St Helen's	Healthy Living Programme and Health Improvement Team have developed a Community Passport to Health course to support local people with advice and education about diet, physical activity, stress management, sexual health and smoking. The course and materials have been adapted for people with learning disabilities and additional needs		St Helen's PCT Annual Report of the DPH 2005
Wakefield *Vent-Elate*	Scheme enabled clients using the Wakefield Stop Smoking Services to access leisure facilities at any of the Council run swimming pools. The clients paid £1.10 for any activity at each pool and the Wakefield Stop Smoking Service subsidised the rest of the costs. Clients were allowed one subsidised visit per week of attendance. The scheme aimed to encourage people to engage in an active and healthy lifestyle (no longer in operation).		Available at: http://www.healthinequalitiesdirectory.co.uk/show_detail.php?id=11
Warwick	*Warwick* weekly walks are for people who want to stop smoking. They are groups that might help people stay active and provide extra support for quitting. Welcome pack includes supporting information about quitting. A smoking cessation adviser will attend some walks to offer further advice		www.warwickshire.gov.uk
West Fife *QUIT FIT (You can't get fitter than a Quit Fit quitter)*	This project supported smoking cessation within an area of high deprivation, linking local health visitors, community pharmacists and the local leisure centre. The target group was offered an 8-12 week smoking cessation programme, seeing a health visitor and pharmacist for motivational support. This ran in parallel with an individually tailored exercise programme to help develop and support a healthy lifestyle with the provision of family discount cards for access to leisure facilities. The project was funded until May 2006. A 30 month report is available.		http://www.ashscotland.org.uk/ash/files/Funded_Projects_Information.doc

section 3.10 – Smoking cessation: preventing relapse			
Location	**Detail**	**Outcome**	**Source of information**
Barnet	Uses phone calls and text message reminders.		Questionnaire
Birmingham	Birmingham assesses each individually and invites them back into treatment as appropriate. They also have regular mailouts inviting them to specific services, e.g. drop-ins (if they have done a group or vice versa).	They have recently targeted Champix at this group and have found that this has been particularly successful.	Questionnaire
Blackpool	It is advertised that patients can come through the service as many times as they require.		Questionnaire
Brent	Uses 13 week and 52 week follow-up calls. A satisfaction survey is also conducted to identify any patterns to drop-out and areas for improvement. This has been very useful. However the service tends to leave a 6 month gap in between quit attempts so clients have an opportunity to re-assess their motivation and willpower.	The methods have been very successful as people who have relapsed receive contact from the service so they are not put off re-joining and giving it another go.	Questionnaire
Bristol & North Somerset	In 2002, Bristol and North Somerset began sending motivational postcards to clients who quit with the aim of providing ongoing support and prevent relapse.	A retrospective analysis was carried out and it was argued that '*the cards have a positive effect, preventing relapse and/or increasing response rates, mainly among men, people over the age of 40 and more vulnerable groups. A cost effectiveness analysis indicates that this effect is*	Burton C (2006) Investigating the effectiveness of sending postcards to people who have quit smoking. poster

section 3.10 – Smoking cessation: preventing relapse			
Location	**Detail**	**Outcome**	**Source of information**
		sufficient to justify continued use of the cards'	presentation UKNSCC conference.
Buckinghamshire	Buckinghamshire's direct supply protocol means that patients need to come back weekly to get their NRT		Questionnaire
Burnley, Pendle and Rossendale	Sends DNA letters still offering services if needed.	Found to be a successful approach.	Questionnaire
Central and Eastern Cheshire	Several methods have been adopted to reduce the drop out rate: • service level agreements have a specification which states that Pharmacist and GP services must achieve fall within a maximum 'lost to follow up' rate of 20% or payment may not be made; • there is ongoing training for all advisers to stress importance of follow up; • data collection methods are regularly revised; • clients are encouraged to make a new quit attempt as soon as possible, if they relapse, and will be fully supported.		Questionnaire
Central Lancashire	The following methods have been adopted : • telephone follow-up offered as part of the programme of support; • agreeing text, email and mobile phone communication methods; • terms of agreement – discussed and agreed at the outset; • clients reminded they can re register for further support; • accessible clinics in local communities day and evening; • easy access to drop in clinics; • clear information/expectation given at first point of service by admin staff	A high number of clients who relapse access the service for further support:	Questionnaire

section 3.10 – Smoking cessation: preventing relapse			
Location	**Detail**	**Outcome**	**Source of information**
	• 52 week follow-up offers further support – this encourages many smokers who have relapsed to access the service and set a new quit date. The 52 week follow up has encouraged smokers to feel comfortable about accessing the service again as this acts as an invitation to return for support (form of a letter with tear off slip and sae). • all smokers who have accessed the service are invited to contact for further help and support in event of relapse.		
Croydon	Encourages Level 2 advisers to be proactive in contacting lost-to-follow-up clients and has instigated a "no quit no fee" payment scheme.		Questionnaire
Dudley	3,6,12 text messages service, letters and post card approach	Seems to be successful at certain times of the year.	Questionnaire
Ealing & Hounslow	Stop Smoking Service operates a 6 week programme whereby each week the client is very much encouraged to attend the following weeks session, the client is given weekly reminders to attend in order to minimise the drop out rate. When possible, the facilitators build a rapport with their clients by monthly telephone calls to follow up the client. At the end of the six week sessions, clients are reminded that should anything happen in the future where they feel like they may start smoking again to immediately come back or ring the service for support and advice. The service follows up clients at four weeks and 52 weeks to discourage relapse. Telephone follow up are carried out 1 year after a client as quit with the service and approximately 30% of those client have continued to stay quit. This then give the service yet another opportunity to successfully motivate and invite those that have not been able to sustain their non smoker status	The methods have been successful. Although the methods are difficult to quantify, the service regularly receives clients that previously quit but who may be on the border of relapse and require extra advice and support. The telephone follow-up has been particularly successful. Clients are appreciative of the continuum of care provided by the service. As a	Questionnaire

section 3.10 – Smoking cessation: preventing relapse			
Location	**Detail**	**Outcome**	**Source of information**
	for a year to come back to the service and try again, thus minimizing the number of those would have continued in their relapse.	result, many of the clients who have relapsed return to the clinic to receive further support and then go on to quit.	
Enfield and Haringey	Those who book on to clinics and do not attend the first session are telephoned and invited to still attend the second session. To prevent drop out of those attending in community settings they have encouraged advisers to offer some sessions as telephone consultations, this can help to keep the client from giving up on the quit attempt.	Telephoning non-attenders inviting to the second session has led to an improvement in those who fail to attend.	Questionnaire
Gateshead & South Tyneside	Advisers are encouraged to discuss relapse prevention throughout quit programmes, clients are provided with leaflet information, a helpline number is provided at end of session, postcards are sent at specific times throughout the quit attempt (for pregnant smokers only)		NE Survey
Hammersmith & Fulham	Uses a no success, no reward approach, decommissioning the service if success rates drop to less than 10%.		Questionnaire
Haringey	Monthly relapse prevention is offered in Haringey to all 4-week quitters to maintain long-term quit rates.	52 week follow up to provide data, currently 26-28% quit rate at one year.	Questionnaire
Lambeth	A Lambeth stop smoking website was set up and motivational text messages were sent to quitters who felt it might help.		www.lambethpct.nhs.uk
Lewisham	Trying to improve standard of support offered by update training for L2 advisers and emphasise the importance of time. 52 week calls to all 4 week quitters to check if relapsed or not. All those who have, are encouraged to try again, with the same adviser or a different one if any doubt about the advisery service used before. Advisers are asked to		Questionnaire

section 3.10 – Smoking cessation: preventing relapse			
Location	**Detail**	**Outcome**	**Source of information**
	encourage quitters to return to them if they have any difficulty in the future. The Smokers' clinic commissioned by Lambeth, Southwark and Lewisham offers a monthly relapse prevention service. Research to identify reasons for dropping out of programmes.		
Liverpool	If relapsed quitters are still attending sessions then advisers will continue to offer support, look at using combination therapy or changing method of quit. Advisers will try to contact a client if they fail to attend a session either by a phone call, text or email. Text is also being used to motivate and support clients through their quit attempt. All quitters are offered extra support via a free telephone help line. All clients who have set a quit date are contacted at 6months and then again at 12months and if they have relapsed are invited back in to the service.	The 4 week quit rate has risen and so too have results at 12month follow up.	Questionnaire
Scotland buddy projects	ASH Scotland trialled the use of peer support through three 'buddy' projects (2001-5), which was designed to help the most disadvantaged groups. Forty eight volunteers recruited and trained by the project provided most of the services.	The project evaluation noted that '*The buddying method added value to other smoking cessation services. It was effective in reaching hard-to-reach groups such as those with caring responsibilities, full-time workers, shift workers, and people with disabilities and mental health difficulties. It also consolidated the effect of*	ASH Scotland 2005 http://www.ashscotland.org.uk/ash/files/Final%20Evaluation%20Report%20Aug%2005.doc)

section 3.10 – Smoking cessation: preventing relapse			
Location	**Detail**	**Outcome**	**Source of information**
		other services'. However, the project proved difficult to evaluate and it was recommended that buddying should be offered alongside other smoking cessation services.	
Shropshire	Efforts are being made to improve the assessment of the client's motivation at the time the client wants to set a quit date.		Questionnaire
Shropshire	Shropshire expects clients to come to 12 weekly consultations and more if needed. They prescribe only 1 week of product for the first 4 weeks to encourage clients to come back and stay in contact. They aim to keep clients on the programme until they are 1 year quit.	The regular consultations have been the cornerstone of the H2Q service for many years and are very successful.	Questionnaire
South West Essex	Texts clients before sessions to remind them.		Questionnaire
South West Essex post quitting	Sends text messages or cards post quitting at 3, 6 and 9 months in an attempt to increase the 52-week quit rate. It also re-invites clients lost-to-follow-up.	It reports that many clients do re-enrol after contact.	Questionnaire
Stockport	Research to identify reasons for dropping out of programmes.		
Sunderland	Sends a postcard to all clients at 6 months to say if relapsed they can try again with the service.	Reports only poor attendance with the relapse service.	NE Survey
Tees	Offers support for a minimum of three months at clinics. Non returners at 4 weeks are followed up by phone three times and then by letter and their problems are discussed and they may be recommended to return or wait a while and then try again, depending on their circumstances. Clients are followed up by letter at 3 months and a year.		NE Survey

section 3.10 – Smoking cessation: preventing relapse			
Location	**Detail**	**Outcome**	**Source of information**
West Essex	Telephone follow up in the evenings of quitters by health promotion team	Claimed to be successful	
Worcestershire	Worcestershire telephones to check clients are going to attend appointments.		Questionnaire
National pilot study (txt2stop)	Mobile phone based smoking cessation support. Pilot (2006) funded through Cancer Research UK, main study through MRC.	Pilot showed doubling of self reported quit rate in the short term. Relapse prevention aspects are being strengthened for the main trial	Free et al A randomised controlled trial of mobile phone based smoking cessation support. Conference presentation UKNSCC 2007.

section 4.3.1 – Statin utilisation – Identifying target populations, Health equity audit (examples)			
Location/ project name	**Detail**	**Outcome**	**Source of information**
Brent tPCT	An analysis of prescribing trends for lipid lowering drugs by ward, as part of an equity audit of CHD.	Showed differences (and a widening gap) between wards. In this case, the area with the highest rate of prescribing had the lowest level of deprivation.	http://www.brentpct.nhs.uk/item17BRENTCHDHEAammended.doc (2005)
County Durham and Tees Valley, Mending Hearts	The first stage of a HEA of hospital treatment for CHD. Information on the equity gap between provision and need was provided for each of the PCTs, which then developed plans including primary prevention, improved screening to identify patients at risk of heart disease through GP practices and improved patient flows from early identification of symptoms to diagnostic tests and, if necessary, secondary care. In Derwentside, practices were asked to produce an action plan prioritizing patients from the 7 wards identified in the equity audit as having low electives but high emergency admissions. In another of the (former) PCTs, emphasis was also placed on primary causes of CHD including exercise and mobile gyms (Dales).		Public Health Intelligence Service of the County Durham and Tees Valley Public Health Network, 2005
Hammersmith and Fulham	A CHD equity audit was carried out.	Showed considerable under-diagnosis of CHD by practices as determined by QOF data against expected prevalence.	PCT (2005)
Rotherham	Equity audits were carried out annually (2004-6) including comparisons between the 20 per cent most deprived areas and the rest of Rotherham. Each practice is given feedback about how data	This showed that improvements were also being delivered to the more deprived areas.	Rotherham Public Health Annual Report

section 4.3.1 – Statin utilisation – Identifying target populations, Health equity audit (examples)			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	for CHD compare with other parts of Rotherham.		2006/7
Stockton on Tees	The audit was being used by North Tees tPCT to inform targeted work in wards, neighbourhoods and GP practices, as well as through 'community health champions' to raise awareness and including advice and heart checks in community health sessions in Neighbourhood Renewal priority areas.	The audit showed equitable access to hospital treatment services via GP practices, but there were difference in access to elective and day case treatments by patient's ward of residence, with low rates of elective hospital admissions for patients in the most disadvantaged wards. The audit demonstrated that people resident in some of the most disadvantaged wards were not 'presenting their symptoms to the GP'.	North Tees tPCT DPH report 2004/5
West of Berkshire PCT	An equity audit was carried out in 2005.	The audit found that 'provision of preventive services for CHD (smoking cessation and prescription of statins) does not appear to reflect the increased need of patients from more deprived practices'.	http://www.york.ac.uk/yhpho/documents/hea/Website/CHD_West%20of%20Berkshire_HEA.pdf

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
Bedfordshire and Hertfordshire (A)	Some drug companies are training nurses and providing them to practices. (One practice in Bedfordshire has made use of these nurses).		Personal Communication, interview (cardiac network lead for primary care) June 2007
Bedfordshire and Hertfordshire (B)	High risk registers are being developed, identifying patients to call into GP surgeries – 35-75 year olds, anyone on statins or coded as high risk, those with a BMI over 30%, family history of heart disease under 55/60, hypertension, diabetes, smokers.		Personal Communication, interview (cardiac network lead for primary care) June 2007
The Birmingham Sandwell and Solihull Cardiac Network (BSSCN)	Is developing a network-wide approach to CVD prevention, favouring a systematic approach by practices to identifying those at highest risk, and supported by the PCT, case studies and 'clinical champions'. It is argued that reliance on an opportunistic approach to screening is likely to exacerbate inequalities.	In a workshop report (2007), they note that only one of the PCTs in the network had earmarked funds in the LDP to support a PCT-wide CVD assessment and management programme. The report also includes a decision-support tool for practices in this area.	BSSCN workshop report, 2007
Birmingham	One of the CVD related interventions was audit medication reviews for all patients over 70 years in GP practices in high priority wards.		
Bromley PCT	Technicians are identifying those at risk with a risk calculator This is currently being done in a few practices using a JBS2 disc with the JBS		Questionnaire

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	tool for assessing primary prevention. The practices will be given a list of patients for them to evaluate for treatment.		
Central Lancashire	All three locality areas hold a CVD register and a scheme operating across Chorley and South Ribble locality to identify patients at risk is to be rolled out across the PCT subject to positive evaluation and funding approval.		Questionnaire
Central Southern Cardiac Network	Launched system software into GP practices, using GP population registers, to help them dredge their systems to find patients at high risk.		Personal Communication, interview (cardiac network lead for primary care) June 2007
Croydon	Pharmacy advisors advise the PCT IT team on the extraction of data from GP systems for example the analysis of MIQUEST data and development of appropriate MIQUEST queries. They advise on the appropriate coding of patients which allows the practice to identify at risk patients. The team supports the Croydon CVD Risk assessment strategy to identify those requiring primary prevention. This strategy initially targets patients with diabetes and hypertension.		Questionnaire
Essex	Cardiac network funds practices to search	No, but will be sending out a voluntary audit	Personal

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	computer systems to find patients at risk. Previously looked at 35-74 year olds on hypertension register, with raised cholesterol, smokers and the overweight. About to ask GPs to re-run new criteria to update their risk registers - all aged 35-74 with hypertension, (excludes those already managed under secondary care). Primary Care Project manager goes in to surgeries and does searches or sits with a member of staff while they do search. Practice invoices the network for payment and project manager monitors how many of the patients identified came in, and chase up if the number is low. The Network funds an extra appointment with the Practice nurse. Over 6000 patients have been identified to date.	to practices to see if they have identified any diabetics.	Communication, interview (cardiac network lead for primary care) June 2007
Greater Manchester and Cheshire	Describes support available to PCTs on managing the implementation of predictive registers in primary care. They comment that LDPs for 2005-8 include a target for the numbers of GP practices with PCT-validated registers of patients without symptoms of cardiovascular disease but who have an absolute risk of CHD events greater than 30% over the next 10 years to increase with time. The SHA negotiated a stretch target with PCTs		The Greater Manchester and Cheshire Cardiac framework (2006)

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	to achieve 100% completion in 2007. This report summarises all PCT plans in the network in relation to predictive registers, including whether any incentive schemes are in existence; the nature of PCT support; processes for validating the register, promoting consistent READ codes and recall systems and ways for measuring long term outcomes (as of 2006).		
Halton	PCT has gone through registers and called patients in to surgeries.		Personal Communication, interview (Cheshire and Merseyside cardiac network director) June 2007
Leicester Risk register	Wants practices to demonstrate systematic use of a register for identifying patients with a 10 year 20% risk of a CVD event with a target of at least 75% of practices with validated risk registers by March 2008. Risk can be identified by extracting data from a GP system with all of following: HDL reading in last 5 years; total cholesterol reading in last 5 years; smoking status code in last 24 months or never smoked code in record; systolic and/or diastolic reading in last 24 months. It is believed that approximately 25% of patients over 50 have a		Leicester 2007/8 LDP

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	complete risk as defined above; PRIMIS+ will provide MIQUEST queries incorporating the risk scoring tool for local use. PCTs to have at least 75% of practices with validated at risk registers by Mar 2008.		
Leicester Risk factor management	(implemented from April 07) it is planned to better manage risk factors in CHD, in this case cholesterol monitoring and management, by focusing on practices where identification and control is low, particularly in priority areas of the City, based on indices of deprivation and poor health, and identifying 'all levers possible to facilitate and incentivise improved practice'.		Leicester 2007/8 LDP
Manchester, the Health Inequalities Partnership	Has conducted an exercise to identify priority wards for focused attention and additional investment. The Partnership selected 5 indicators, of which SMRs for CHD was one. A simple tallying system was used to identify the 10 wards that appeared in the worst 10 for each indicator over time, with an additional focus on an additional ward with particularly high levels of CHD.		Manchester LAA 2006
NE London	Cardiac Network recommends screening to create risk registers. Focus on getting levels of statin prescribing up, have guidelines (produced in Oct 2006 for clinicians, advising them to		Personal Communication, interview (cardiac network lead for

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	check Framingham risk, in what circumstances to multiply this risk, in which cases to treat with a statin, and subsequent monitoring). Network staff are working at borough and practice level. Representatives from the network are going round Local Implementation Teams, they conduct training for GPs, and they hold GP forum meetings.		primary care) June 2007
North Staffordshire	A primary prevention template has been piloted in a number of practices. The audit of the template has identified practices not pro-actively targeting those at risk of CVD.		Questionnaire
North West London, Oberoi Clinical Observations Pilot	The North West London Cardiac Network commenced a pilot of Oberoi Clinical Observations – Framingham/CHD/CVD Risk Model software in 2007 to explore its potential as a tool to produce primary prevention registers in general practice. The purpose of the Oberoi Clinical Observations software is to enable practices to audit their entire practice populations for CHD/CVD risk and subsequently produce primary prevention registers. The software extracts all patients between the ages of 32 and 74. Modification factors can be added for different ethnic groups. Those with	The software has been piloted in nine practices across North West London to identify its suitability for the development of primary prevention registers. The consensus is that the software is 'fit for purpose'. Once the LESs are in place, the potential impact on at-risk patients is considerable through both medication and lifestyle change. See case study.	Personal Communication, interview (cardiac network lead for primary care) June 2007

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	existing CHD risk are filtered out, and default values are entered for patients with missing data and the risk estimated. The key treatment information is provided on the screen for each patient. Furthermore, during a consultation, the software can be manually adjusted to demonstrate the effect on the risk. The CHD and CVD risks can be saved back on to the clinical system with the appropriate Read-code.		
The Northern Cardiac Network	Has produced a comprehensive toolkit to help GP practices to identify those at high risk of CHD, from GP population registers. It includes GP computer templates, video tutorials and a cardiovascular risk assessor.		www.nncc.nhs.uk/toolkit/default.asp April 2007
Nottingham	Identified the 20% of Super Output Areas (SOAs) with the highest CVD premature mortality rate which needed to be targeted by NHS services and partnership health promotion interventions. They also provided more detailed maps of the target LSOAs (Lower Layer Super Output Areas). The LAA recognizes that a focus on the over-50s would offer the greatest short-term impact on life expectancy.		Nottingham Floor Target Action Plan Nottingham LAA (2006-9)
Oldham	Setting up predictive case registers for people at risk of CVD. By having a register in each general practice, it will be possible to intervene		Oldham Annual Public Health report, 2006

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	earlier to address risks for heart disease by referral to Stop Smoking Services, an exercise programme or for management of blood pressure or blood cholesterol levels. This is described as an example where the PCT is "investing to save".		
Rochdale	Increase the number of general practice patients aged 50-75 years who are either smokers or hypertensive or have cholesterol above 5mmol/l who have been risk assessed as having a CVD risk of 20% or greater over 10 years, who have been called for an annual review (to include a range of lifestyle advice).		Rochdale LAA 2007
Salford, The Salford Heart Strategy 2006	Aims to encourage GPs to record BMI, blood pressure, lipids, glucose and abdominal circumference in all those over 45 (and also carry out an equity audit). It also advocates screening of those with risk factors to calculate their ten year CHD risk. Salford PCT will support preventative prescription of statins to those vulnerable to CVD (2007/8)) as well also registers to identify people at high risk of CVD. The strategy aimed for GP practices to achieve 80 per cent of CHD QOF points and QOF points for patients with CHD risk factors by March 2006 (and 90 per cent of QOF points by		Salford LDP 2005/08 Salford Heart Strategy: a joint plan for the future

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	March 2007); it also plans structured case finding of those most at risk of CVD, which includes ranking patients aged between 35 and 74 years who were not currently on an disease registers and then inviting then for a review.		
Sandwell Risk calculation	CVD risk factor data are extracted from the GP electronic medical records on all patients in the relevant age groups (35-74years), excluding those patients already on existing registers. Calculation of a ten-year CVD risk is based on age, gender, smoking status, blood pressure, cholesterol levels and diabetes data. Default values (from the Health Survey for England) based on national averages were used where data were missing. This assigned a probable CVD risk to all patients. The patients with the highest risk were then invited for an assessment in descending order. Eligible patients were offered appropriate treatment – either pharmacological and / or referral to a number of local lifestyle services i.e. stop smoking, dietician or exercise referral programmes. Initially, the review was undertaken by a dedicated CVD Nurse in four practices and two practices were given the ranked list to screen as they felt appropriate. This is a priority in the	The evaluation of this project focused on case finding from GP records, showed that patients in practices visited by the project nurse were twice as likely to be assessed, found eligible for treatment and started on at least one appropriate treatment compared to practices that did not have the project nurse. 41% of patients in project nurse practices compared to 13% with no project nurse were eligible and on treatment. As a result of this evaluation, two further dedicated staff are being appointed.	Sandwell PCT LDP 2007/08

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	LDP.		
Sandwell Risk factor software	The PCT has commissioned a software package (through the University of Birmingham) that identifies and ranks the practice population according to their percentage risk. The software package searches GP systems on all risk factors, but if absent it substitutes values obtained from national values (based upon the Health Survey for England data). Risk is calculated upon attendance at designated clinics. A PCT- funded nurse manages the assessment process within the individual practice. This model of work is currently being spread to Solihull. The software also contains management protocols for each patient based on their individual needs/ risk factors identified.		BSSCN workshop report, 2007
Sedgefield	The model proposed is an incentive based scheme to select patients at risk from all those over 40 who did not currently have heart disease (criteria based on the Framingham Tables, but also ensuring the nGMS at-risk group depending on BMI, smoking status and hypertension were identified). The at-risk group would then be invited to attend for a health check once every three years, and added to the		Sedgefield LDP 2005/08

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	risk register. In the process of identifying the population with a 15% risk of CHD over 10 years for this one-off personal health advice, the more serious group at 30% risk would also be identified and referred into treatment programmes.		
Sefton PCT	Identifying patients from GP population registers.		Personal Communication, interview (cardiac network director) June 2007
Sheffield	People are considered for a risk assessment if they are; i) over 60 or ii) over 40 with hypertension (excluding those with symptomatic disease). Group (i) have opportunistic screening; for (ii) the practice generates lists of names.	Tracking mortality is ongoing, does seem to be an effect on premature CV mortality, highlights the importance of registers.	Personal Communication, interview (Sheffield PCT CHD lead) July 2007
South Birmingham CVD Primary Prevention Project.	Using GP population registers, work was recently undertaken to develop a robust identification and screening programme for those patients who have a greater than 20% risk of developing cardiovascular symptoms within the next 10 years. The service is still in its proposal stage and is currently being reviewed by South Birmingham's Professional Executive Committee before it is rolled out across the		Questionnaire

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	Trust. The draft service proposal to use GP registers for case finding consists of two phases, initial identification and recall process – practices being expected to call patients into the surgery for a full assessment and an updated CVD risk calculation. Patients calculated to have an absolute >20% CVD risk will be treated appropriately and managed accordingly. Practices will use the Framingham risk assessment tool (with the risk score uplifted by 1.5 for people of South Asian/Indian sub continent origin. (This will be funded through a Local Enhanced Service.) Practices will be expected to adopt a vascular approach and use the recall process to opportunistically screen patients by blood test for both diabetes and Chronic Kidney Disease.		
Southwark	Aiming to increase the number of people aged 15-75 on GP registers, recorded as having BMI 30+ in the last 15 months. They are supporting early and accurate diagnosis of patients with and at risk of CHD by working with GPs to increase the number of GP practices with a validated at risk CHD register.		Southwark's LAA, March 2007 Southwark LDP 2005-08
St. Albans	Invites all patients between 35-75 years in for screening.		Personal Communication,

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
			interview (cardiac network lead for primary care) June 2007
Stockport	Stockport PCT started a total population screening programme in 1989 whereby everyone in the PCT aged between 35 and 70 gets a letter from the PCT inviting them to ring their GP to make an appointment for a heart health check.	Initial findings are looking very positive, and appear to show that the screening programme has had an impact on those at high risk. See case study.	Personal Communication, interview (cardiac network lead for primary care and Public Health Specialist (Health Promotion) Stockport PCT) June 2007 European Journal of Cardiovascular Prevention and Rehabilitation (2005) 12:63-67
Stoke on Trent	Working to ensure that practice based registers and systematic treatment regimes also cover the majority of patients at high risk of CHD, particularly those with hypertension, diabetes and BMI over 30.		LDP 2006/09 – South Stoke tPCT and North Stoke PCT
Warrington	Pilot for identifying “at risk” populations and		Warrington PCT

section 4.3.2 – Statin utilisation - Identifying target populations, Practice-based approaches			
Location/ project name	**Detail**	**Outcome**	**Source of information**
	works with practices through QOF to ensure completeness of GP registers and support roll-out of identification of "at risk" populations. The pilot explores a mechanism for extracting relevant GP data and using it to invite high risk patients for screening, although some components of at risk registers are already in place.		LDP 2005-2008
West Hertfordshire and Bedfordshire	Pilot project asking people with diabetes or heart disease in areas with large South Asian communities/deprivation if they can invite their families into GP practices for a health check.		Personal Communication, interview (cardiac network lead for primary care) June 2007
Wirral PCT	Identifying patients from GP population registers.		Personal Communication, interview (cardiac network director) June 2007

Section 4.4.1.1 – Statin utilisation – Pro-active case finding, community-based clinics and proactive outreach			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Coventry and Warwickshire Cardiac Network	Supported health visitors in North Warwickshire going into travellers' sites to do health screening. Developed a card for health visitors to record a person's weight, cholesterol, blood sugar, and then health visitors helped them get registered with a GP.	It was felt that this was a good method of reaching this group as the health visitors were invited back	Personal Communication, interview (cardiac network manager) June 2007
Devonport, proactive case finding and improved access	A project (jointly funded by the PCT and a local regeneration company which is funded through NRF) is currently being developed in Devonport, Plymouth, which has the worst morbidity/mortality in the city and widening inequalities. It will include a data collection clerk validating all the CVD registers in the deprived neighbourhood, and a cardiac trained nurse working with practices to ensure that all necessary secondary coronary interventions have been implemented. The nurse will see and interview patients with gaps in their records (for example, not on statins or not complying) and see them in a specific clinic or see hard to reach patients at home. There is also a cardiology GPWSI available to see these patients. As the deprived neighbourhood has high rates of DNA for elective out patients, it has been decided to house the extensive community cardiology service of 3 GPWSIs and the heart failure team in premises in the heart of the neighbourhood to facilitate access. Also included is increased local		Questionnaire

Section 4.4.1.1 – Statin utilisation – Pro-active case finding, community-based clinics and proactive outreach			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	access to obesity and smoking cessation clinics and there is an exercise physiologist specifically designated to implement exercise on prescription. (CVDQ).		
Hammersmith and Fulham: Lifestyle Session	An NDC shop provides a weekly Lifestyle Session where cholesterol, blood glucose, blood pressure, body mass index and body fat percentage can be checked. There is a health advisor, a registered nurse, a dietician and an exercise specialist at each session, offering a range of advice and support providing access to local people. (This project was shortlisted for the HSJ inequalities award in 2006).		Hammersmith and Fulham PCT Annual report 2003/4
Hull, The Hull Healthy Hearts initiative	Launched in Hull in June 2005 with the aim of taking health services out into the community and identifying those people at risk of developing coronary heart disease. A portable booth has been touring around shopping centres, workplaces and other community settings and the specially trained nursing team has been offering free, comprehensive coronary risk assessments. Those undergoing the test have been given their own personal Heart Heath Plan and directed, if necessary, to a range of health promoting activities and services dependant upon their specific risk factors. In addition, where necessary, people have been referred to their GP for further advice or medication. This is now being	See case study.	Personal Communication, interview (cardiac network manager & Service Planning and Improvement Assistant Director, Hull PCT) June 2007 and Questionnaire

Section 4.4.1.1 – Statin utilisation – Pro-active case finding, community-based clinics and proactive outreach			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	further developed through a local enhanced service.		
Manchester, UK-wide risk assessment pilot by British Heart Foundation (due to commence in September 2007 funded through the British Heart Foundation)	Will take advantage of Biobank's prospective epidemiological study which aims to include 500,000 people in the UK aged 40-69, and carry out a detailed follow-up of cause-specific morbidity and mortality, Biobank targets clients through GP registers, inviting people aged 40-69 to take part in an assessment. Although Biobank does not give out information, clients will be able to see a BHF nurse to find out their cardiovascular risk and have a health check (blood sugar, cholesterol) and given advice.		Personal Communication, interview (Primary Care Cardiovascular Society Chairperson & local project worker) July 2007 www.ukbiobank.ac.uk
Middlesbrough PCT, Cardio metabolic risk assessment clinic	A community-based cardio metabolic risk assessment clinic was piloted over a six week period in two locations (Lifestore and a benefits office) in the centre of Middlesbrough, supported with a media and publicity campaign. The intention was to identify adults with undiagnosed CVD or at higher risk of CVD (defined as a greater than 20 per cent CVD risk over 10 years) and thereby to reduce inequalities in CHD and CVD mortality. The assessments were carried out by appointment by a CHD nurse. Full lipid profiles and blood glucose were assessed. The pilot was evaluated and this included a qualitative evaluation (report in preparation). Life Store, provided by Middlesbrough PCT, opened	An evaluation found that access to services was facilitated for those who might otherwise not attend. The pilot identified a high proportion at risk of CVD but was not as successful in targeting disadvantaged groups It is now intended to provide this service in a range of locations including Benefits Offices, stop smoking clinics, community pharmacies and working men's clubs See case study.	Personal communication

Section 4.4.1.1 – Statin utilisation – Pro-active case finding, community-based clinics and proactive outreach			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	in the town centre shopping mall in January 2006. It provides health advice and information, signposting and service provision in close liaison with partner organisations as well as Health Checks in line with the 'Small Change, Big Difference' initiative.		
Paisley, Have a Heart Paisley (2000-2008)	This project is one of the Scottish Executive's four national health demonstration projects, and it is aimed at those most at risk of developing heart disease and those who have already been diagnosed with heart problems lessons. Over the first few months of 2006, people aged between 45and 60 who lived in Paisley and had a Paisley GP, received an invitation to have a free heart health check, at a choice of venue. The target population was reached through a combination of methods, including direct mail and the local media and areas of high deprivation were specifically targeted. Participants could also take part in a Health Coaching initiative where baseline measurements would be repeated and information gathered on lifestyle.	While an evaluation of Phase one of the project concluded that 'there is limited evidence that indicates that HaHP has managed to achieve a shift in total CHD risk or in key risk factors or behaviours at a population level, or amongst key targeted sub-groups' partly explained by 'use of evidence, intervention intensity, and scope for saturation', later phases appear to have adopted the more targeted approach.	Blamey A et al (2004). *The Independent Evaluation of Have a Heart Paisely*. Final report. University of Glasgow
Stockton-on Tees	Stockton Health 4 Life. This is an NRF-funded project (which started at the end of 2006 and is due to finish in 2008) which provides a health check (including cholesterol screening) for men and women aged 45-74) mainly within the NRF area. There is a combination of open access and invitation to	The project is being evaluated.	Interview

Section 4.4.1.1 – Statin utilisation – Pro-active case finding, community-based clinics and proactive outreach			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	participate, working with GP practices. Sessions will be held in a variety of community settings including community centres. Patients are provided with a personal health record which is proving popular.		

Section 4.4.1.2 – Statin utilisation – Pro-active case finding, community pharmacies			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Birmingham, Lloyds Pharmacy	Commissioned by the NHS, as part of the Birmingham Health and Well Being Partnership, to pilot an opportunistic screening service (Heart MOT) for men aged over forty at risk of heart disease in the most deprived areas and in areas of highest CVD mortality. The pilot began in two pharmacies in 2006, and it is planned to cover almost 30 pharmacies by 2008. The new Heart MOT measures cholesterol, blood pressure, blood glucose and body mass index as well as a full lifestyle assessment for men over forty years old. The customer will then receive a percentage score of developing heart disease, with a personal action plan and summary of the test results. For high-risk customers a support pack will be supplied. This service integrates the services of fitness staff healthcare professionals, pharmacists and technicians to provide advice and support.	An evaluation will be carried out in September 2007.	Questionnaire, http://www.southbirminghampct.nhs.uk/_news/PressReleaseLocal.asp?TitleID=892
Dudley	Pharmacist-led initiative to increase the awareness of medicines and their use in black and ethnic minority communities and includes outreach activities. Screening activities focus on identification of hypertension.		Questionnaire
Knowsley PCT (2006)	Following collaboration with the local pharmaceutical committee eight pharmacies were identified to take part in a pilot of free health checks (men aged 50-65 years who had not had any health check via their GP or Practice Nurse in the last 12 months). The pharmacy health check involved a 25-30 minute assessment, including cholesterol measurement and	An evaluation showed that this was popular with clients as it was convenient and local and pharmacists were successful in identifying undiagnosed conditions and signposting other services. A review of the intervention notes: We believe that the main	Questionnaire plus additional information provided by Knowsley PCT

Section 4.4.1.2 – Statin utilisation – Pro-active case finding, community pharmacies			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	smoking status. Lifestyle advice (verbal and written) was provided. It was operated on a mix of pre-booked appointments or drop ins. The PCT provided equipment as well as a software programme to record details. Pharmacy contractors received £25.00 for each health check carried out to the standard specified in the service level agreement. The total expenditure (including equipment, software training etc) was £30,000 and 159 health checks were carried out. The project was funded through Neighbourhood Renewal Funds (further extended in 2006-7) to reduce health inequalities. The service was mainstreamed and just under half the community pharmacies in Knowsley offer free health checks. It has now been extended to women and the age range broadened from 40-75. By the end of February 2007, 440 health checks had been carried out. The PCT has now made a commitment to continue funding the health checks as part of an enhanced community pharmacy service.	reason for the success of this project was strong leadership and commitment of all partners to deliver a project to demonstrate community pharmacists' potential to support a reduction in health inequalities in a Borough of relatively high health and social care need.	
North Tyneside	Men over 50 can access a service provided by local pharmacists in disadvantaged areas of North Tyneside. Patients with a CVD risk of over 20 per cent will be referred to the GP (with appropriate patient consent) for further management.		Questionnaire
Sutton and Merton	As part of Merton Horizons, a Healthy Living Initiative, community pharmacists undertake general health checks and screening, for example blood pressure, cholesterol, BMI, smoking and medicines management		Questionnaire

Section 4.4.1.3 – Statin utilisation – Pro-active case finding, sporadic initiatives			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Barking and Dagenham PCT	In a new partnership with the Barking Mosque, Barking and Dagenham PCT held the first of a series of health events in February 2006. The event, which had the theme of diabetes, was "very successful and will be followed by other sessions throughout the year on coronary heart disease, respiratory health and sexual health". Clinical Nurse Specialists concentrated on the management of Diabetes, gave help and advice on footcare and exercise; a District Nurse Team Co-ordinator carried out blood glucose monitoring and others gave help and advice on diet. The Diabetes Team Leader gave help and advice on understanding Diabetes. Also have South Asian Health Champions who have gone into mosques to do BP checks.		Barking and Dagenham PCT Annual report 2005/06
Barnsley	Offered a free Healthy Heart MOT at various community settings over a set period.		http://www.bhnft.nhs.uk/documents/Viewer/documentframe.aspx?d=105
Bradford 'Health of Men' project	Health MOTs offered on a weekly basis in a Barber's shop mainly used by Asian men, as well as a wide range of specific men's services. The project also offers weight management programmes to men, to run in the workplace. This lottery funded healthy living centre takes a public health approach to work that it delivers in barbers shops, community centres, pubs and other places that men of different ages from the different groups in Bradford spend their		www.menshealthforum.org.uk/ Ongoing (Prof. Alan White, Leeds Metropolitan University)

Section 4.4.1.3 – Statin utilisation – Pro-active case finding, sporadic initiatives			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	time. The aim of Health of Men is to be a network of individuals and groups whose primary aim is to encourage and facilitate the development of health promoting and illness prevention services, which are accessible and attractive to boys and men.		
Cheshire and Merseyside, Heart of Mersey	Heart of Mersey is England's biggest coronary heart disease (CHD) prevention programme. It was launched in 2003 to help tackle the very high levels of CHD in Greater Merseyside, where the disease kills 30% more women and 20% more men than in most other parts of the country. To enable it to commit fully to the challenges ahead, Heart of Mersey became a registered charity in 2005. It is supported by the PCT and borough council monies. It organises primary prevention initiatives, e.g. a bus advertising campaign was implemented, with two adverts being carried on the region's buses. Both adverts used the Heart of Mersey phone line number and website address. Aim is to improve people's health and encourage them to go into their GP for checks – however these are more to do with lifestyle than medication.	The bus campaign did not result in a significant increase in the usage of the phoneline subsequent to this campaign.	Personal Communication, interview (cardiac network director) June 2007 & 'The Beat Goes On – Report of Activity and Evaluation 2003-05' (Nov '06) www.heartofmersey.org.uk
Coventry and Warwickshire	Cardiac Network-wide, developed a card for people, telling them to go to hospital if they had certain symptoms. These were sent to all GP surgeries in Coventry and Warwickshire who will send these out to those at high risk of CHD. The network also sent them to be displayed/available in libraries, hospitals, and after the Trust held a press release, most newspapers in Coventry and	No evaluation, but network is monitoring uptake of cards, (has already had people asking for a card because a relative received one and they think they should have one too).	Personal Communication, interview (cardiac network manager) June & Aug 2007

Section 4.4.1.3 – Statin utilisation – Pro-active case finding, sporadic initiatives			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	Warwickshire put an article in about the initiative. Public places picked for distribution as somewhere other leaflets are available, don't know yet if this will be effective. Network was told anecdotally by a race equality worker that in one area, certain ethnic minority groups use the library because they have newspapers in various languages.		
Doncaster	June 2005 - Celebrated National Heart Week at Health Focus, a town centre information shop, where scores of people dropped in to pick up information about having a healthy heart. A special machine with touch screen monitor enabled visitors to assess their risk of developing heart disease based on their answers to health and lifestyle questions. Nursing staff from the PCT and Doncaster Royal Infirmary were on hand to offer body mass index assessments, which gauge if someone is overweight by comparing their body fat to their height and build. District nursing teams took part in health fairs at a number of libraries to offer free blood pressure checks. The teams were on hand to raise awareness of the dangers of having high blood pressure.		Doncaster Central PCT Annual report 2005/06. Doncaster West PCT Annual report 2005/06.
Knowsley, PITSTOP	More than 1,500 Knowsley men (50-65) had health checks in pubs, clubs, workplaces and pharmacies under the PITSTOP Men's Health Scheme, carried out through 2005. This was a joint initiative by Knowsley PCT and Knowsley MBC. Men's health has been given a high priority, and men have been offered health checks in accessible venues, to help them take more control of	Eighty five per cent of men followed up cited lifestyle changes	(Presentation by Ben O'Brien http://www.menshealthforum.org.uk/uploaded_files/SFOct05Pitst

Section 4.4.1.3 – Statin utilisation – Pro-active case finding, sporadic initiatives			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	their own health. A social marketing campaign was adopted which consisted of 300 street interviews, focus groups, pilot heath checks and action research.		op.pdfi) Health & Social Care in Knowsley. Joint Public Health Annual Report 2006.
Newham University Hospital NHS Trust and Newham PCT Healthcare	Have been providing local residents with Healthy Heart MOTs since 2002. Between 2002 and 2004, 1708 received these health tests in the community at 12 different events and 23% were subsequently referred to their GPs for follow-up checks.		Press releases University Hospital Newham http://www.newhamuniversityhospital.nhs.uk/press.php?c1d5b4451acf91d7e4a3fdc1a60ec745
North East Camden, PITSTOP	The Pitstop Health Check programme, was one of 22 local authority led 'Communities for Health' Pilots. Checks were delivered in six community locations, one of which was a smoking cessation group and a range of checks was carried out including blood cholesterol.	Analysis of the results showed that there were 'many more cases of people at risk of ill health than was initially acknowledged'.	Department of Health. Health Inequalities Unit (2007) *Communities for Health: Learning from the pilots.*
North Tyneside,	A campaign to get men aged 50-70 to have a free health check on		http://www.northt

Section 4.4.1.3 – Statin utilisation – Pro-active case finding, sporadic initiatives			
Location/ Project name	**Details**	**Outcome**	**Source of information**
PITSTOP	the NHS was launched in North Tyneside in June 2007 to coincide with the annual Men's Health Week, (week beginning June 11) 'PITSTOP' is the name for a series of health checks especially for those aged 50 to 70.. PITSTOP health checks are being carried out by local community pharmacists and there is a PITSTOP sign. PITSTOP has been planned and the campaign materials developed to directly appeal to men. There was a launch event at a Miners Welfare Hall and all men aged 50 plus were welcome to attend. Free refreshments and snacks were also offered.		ynesidepct.nhs.uk/story.asp?p_id=260
Sandwell PCT	'Healthy hearts' this is a team of doctors/nurses who do opportunistic screening in targeted locations i.e. for ethnic minority communities, business parks etc. This in done in partnership by securing funding from the private sector.		Questionnaire
Southwark PCT	Held a Health Fair focused on prevention of CHD including smoking cessation Southwark carries out free Men's MOT health checks for me aged over 18 who live or work in Southwark. They can have a 30 minute check with a male nurse for basic health checks (blood pressure, cholesterol & glucose) health information and advice– smoking, exercise, healthy eating and any other issues.		Southwark PCT LDP 2005-08
St Helen's	Commissioning strategy envisages MOTs for all those aged 55 and over. All those aged over 55 should receive a personal health plan through the Health Trainer programme.		St Helen's LAA 2006-9
Stockton on Tees	Health Fair Sept 2005 – public able to have BP checked, sought		N.Tees tPCT

Section 4.4.1.3 – Statin utilisation – Pro-active case finding, sporadic initiatives			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	advice on how to stop smoking, obtained dietary advice and heard about organised healthy walks.		Annual Report 2005/06
Telford and Wrekin, NHS FiT Primary Care Outreach clinics	These clinics are being developed to target middle aged men living or working in the Telford and Wrekin area. The area has black and ethnic minority communities so recruits men from local factories with a high representation of these groups. They provide regular screening services at venues where men are more likely to attend, such as lunchtime clinics on industrial estates. (Relaunched in June 2007)		Personal Communication, interview (CV lead in health promotion) June 2007
Wakefield PCT	Health checks in libraries and community centres. Going into Barber shops to target men 50+, available around post office around 9am when people are going in for benefits. Offer basic BP checks, focus on reduction in salt intake.		Personal Communication, interview (CV lead nurse, June 2007
West Hertfordshire	Health Stores/Markets, staff suggest people go and see nurse if they have risk factors.		Personal Communication, interview (cardiac 4network lead for primary care) June 2007
Wirral	Reduce risk factors for major causes of CVD by implementing 'Health through Organizations' in workforces to improve screening and immunisation, tobacco exposure, physical activity participation and healthy eating choices.		LAA 2006

Section 4.4.2.1 – Statin utilisation – Proactive case finding, targeting GP practices			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Birmingham, Rochdale,	A number of PCTs are focusing their attention on practices below the optimum in areas such as register prevalence, appropriate prescribing, or calling patients for annual reviews. PCTs are providing varying levels of support and facilitation, as well as regular audit and validation of risk registers.		Birmingham Health and Well Being Partnership. Life Expectancy and Health Inequalities Project Tookit;Rochdale LAA 2007
Blyth and Wansbeck	Northumberland is supporting primary care teams to identify people at high risk of CVD and agree on a management plan. This includes 'stretch' targets for smoking cessation advice, the control of high blood pressure and lipid lowering drugs.		UKPHA 2007 conference display
Central Southern Cardiac Network	Has compared use of statins by proxy population figures, then targeted low usage areas		Personal Communication, interview (cardiac network lead for primary care) June 2007
Ealing Coronary Risk Prevention Programme	In 2001, Ealing hospital set up a collaboration with a nurse-led coronary prevention service based in primary care in Southall and then Hounslow. It aims to undertake systematic assessment of the CHD risk in all men and women aged 35-75 years from the participating practices. Cholesterol screening is included. The risk prevention service is currently involved in a large scale screening programme to target high risk patients among the	.	In her review of good practice Fox (2004) draws attention to the above programme. She notes that while 30 per cent of the population of Ealing

Section 4.4.2.1 – Statin utilisation – Proactive case finding, targeting GP practices			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	patients of 40 local GPs (200 patients per week).		is of Asian origin the majority of GPs are single handed and it is difficult to achieve standards 3 or 4 of the NSF CHD
NHS Lanarkshire and North Lanarkshire Council, Keep Well pilots, Scotland	The aim of 'Keep Well', a national pilot for anticipatory care in Scotland, is to reduce health inequalities in (CVD) by the year 2010 by increasing the rate of health improvement among high risk, hard to reach groups living in the most deprived communities. Targeted at communities with the greatest health needs, the first of five Keep Well pilots assessed 45-64 year olds for the risk factors associated with heart disease. Those who may be at risk are identified through local GP registers (involving 34 GP practices) and invited to attend a health check looking at factors such as blood pressure, diabetes and cholesterol, as well as lifestyle issues such as smoking, diet, alcohol and weight management. Initially focused on GP practices it is also proposed to take case finding and risk assessment into community centres in the evenings and at weekends. This pilot is a partnership between NHS Lanarkshire and North Lanarkshire Council. The location of the five pilots was decided by using the Scottish Index of Multiple Deprivation and focusing on NHS Board areas with high concentrations of the most deprived 15 per cent. This followed a commitment to provide such services in Delivering for Health, the Executive's long-term vision for the	A national evaluation is being carried out.	http://www.scotland.gov.uk/News/Releases/2006/10/24095720

Section 4.4.2.1 – Statin utilisation – Proactive case finding, targeting GP practices			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	NHS.		
Liverpool	Has adopted the Sheffield approach to reducing CVD mortality through (a) calculating the expected numbers of people with CHD and comparing it with the QOF; and (b) working with practices with a focus on practices with a big gap between those expected and those on registers, to identify those 'missing'. The aim is that practices will have identified 90 per cent of expected cases and have 85 % on effective secondary prevention.		Liverpool LDP 2007/08
Nottingham	Has recruited a heart health facilitator (a short term externally-funded post) to work with practices in the most deprived areas to address access to primary care; training for practice staff and links to health promotion.		Nottingham LDP 2005-8
Sheffield, CIRC (City Wide Initiative for Reducing Cardiovascular Disease)	This project, now mainstreamed, has been widely publicised (through *Tackling Health Inequalities: Status Report on the Programme for Action* (DH 2005) and through the DH health inequalities directory). It was set up to maximise impact on overall premature death rates with an emphasis on those with highest need through a systematic and targeted secondary prevention programme in practices with higher CHD prevalence and high risk ethnic minorities. Interventions included: • setting up a CIRC 'Task Force' team in each PCT to include a CHD nurse specialist, physical activity specialist, dietician, clinical psychologist, ethnic minorities worker, PCT prescribing advisor and PRIMIS facilitator for clinical IT support; • training and mentoring programme for primary care	Between 2000 and 2003 a faster decline in premature death rate from heart disease was observed in the more deprived fifth of the population than in the city as a whole.	Personal Communication, interview (Sheffield PCT CHD lead) July 2007 Fox, 2004

Section 4.4.2.1 – Statin utilisation – Proactive case finding, targeting GP practices			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	nurses; • additional practice nurse clinics; • locally agreed protocols and manuals for secondary prevention of CHD and heart failure; • electronic templates for CHD clinics; • patient information materials; • programme for high-risk ethnic minorities. The project led to 8,000 more people with CHD identified (87% of the expected number), included in practice registers, and being seen, than at the start of the programme. The project was mainstreamed, as planned, into the Sheffield PCTs. Other initiatives which were developed as part of CIRC and intended to identify previously undiagnosed CHD and diabetes included screening services in community pharmacies and within local mosques in deprived areas of Sheffield where people were failing to access services. The team consisted of a nursing consultant, pharmacists, dietician, nutritionist, smoking cessation worker and a community development worker (also an interpreter) (the project did not provide cholesterol screening). Patient satisfaction surveys were carried out (2004 information). A project carried out as part of the CIRC in Sheffield (in 2002) in collaboration with the former North Trent CHD Collaborative, provided additional support to a practice with a high proportion of people from black and minority ethnic groups through a PCT		

Section 4.4.2.1 – Statin utilisation – Proactive case finding, targeting GP practices			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	employed black and minority ethnic support worker. A clinical system template and data collection tool were also developed. As a result of the ethnic profiling the practice employed bilingual receptionists and link workers. Also the use of the local interpreter service was increased dramatically to provide language support to the practice. The project became part of mainstream funding and expanded to provide health promotion within BME communities (see Fox, 2004)		
Somerset PCT	There is a an LAA target to increase statin use in GP practices in deprived areas and in 2007 /08 the practice prescribing budgets have been adjusted for the level of disease prevalence.		Questionnaire
South Birmingham PCT, Healthy Heart Workers in Selly Oak	Have been commissioned by the Birmingham Health and Wellbeing Partnership to work in areas that have low life expectancy, high deprivation rates and high numbers of people from ethnic backgrounds. The healthy heart workers are attached to individual practices and have access to IT links. Their work is focused on helping those men most at risk of developing heart disease. Clients are supported to make lifestyle changes and attend opportunistic screening appointments. Healthy Heart Workers also advise clients of the options available to help them achieve their health goals. This could include information on stop smoking services or opportunities for physical activity and/or signposting to specialist services.		Questionnaire
Southwark PCT	Has as one of its LAA targets that all practices in the most deprived wards achieve the maximum QOF points for CHD and hypertension management.		Southwark LAA 2007

Section 4.4.2.1 – Statin utilisation – Proactive case finding, targeting GP practices			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Stockport	Building on the screening programme, (described in appendix 7, section 5.3.2), six GP surgeries in Stockport were identified as having poor outcomes (high death rates from CHD, diabetes and stroke), despite having good QOF points (that is, managing cases they are aware of, but are not picking up those at risk). A local enhanced scheme is in place to encourage them to case find, and it is suggested they search for people who have not had a CVD risk score calculated (for example, those who did not respond to PCT letter), those with a family history of premature CHD and stroke (includes under 35 year olds), smokers, those with BMI >30, and those of South Asian origin.		Personal Communication, interview (Public Health Specialist (Health Promotion) Stockport PCT) June 2007
Tameside and Glossop Connect 4 Life. (C4L))	Programme forms part of the Health Improvement and Inequalities strategy. A 6 month pilot health improvement programme was established by a partnership led by the PCT and a private sector agency, involving GPs, two local authorities and the voluntary sector. The pilot targeted people aged 50-64 with 2 or more risk factors for CHD. People meeting the criteria were contacted via their GP, 172 signed up and completed a personal on line health and well being assessment with the assistance of a health coach and were supported to set lifestyle goals. Participants received relevant monthly health packs and telephone support and were reassessed after 6 months. Life checks through the Connect 4 Life programme were rolled out in deprived areas in 2006/7and are being developed through the health trainer programme with a target age extended to 40.	The 6 month pilot attracted 172 people with two or more risk factors for heart disease aged between 50 and 64**.**	Tameside LAA 2007 Tameside and Glossop PCT Public Health Report 2005/6

Section 4.4.2.1 – Statin utilisation – Proactive case finding, targeting GP practices			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Tower Hamlets	Focus on general practices with performances below optimum levels in areas including register prevalence, prescribing and annual reviews of people with CVD.		Tower Hamlets PCT LDP 2005/08
Warrington	Is completing a pilot for extracting relevant GP data and using it to invite high risk patients for screening. This also involves developing an education programme for practices to implement the at risk tool and ensure that identified high risk patients receive regular reviews (PQ)		Warrington PCT LDP 2005-2008 Standards for Better Health

Section 4.4.2.2 – Statin utilisation – Proactive case finding, incentive schemes			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Blyth Valley and Wansbeck	As part of a programme to achieve a local area agreement stretch target, GPs have been offered an enhanced contract by *Northumberland Care Trust* for screening those over the age of 40 for CVD risk, if they also have hypertension, a family history of premature CVD or are current smokers. The payment system for level 2 stop smoking interventions has been changed so that a greater financial reward is given if CVD risk calculation is combined with the stop smoking intervention. Mini templates have been developed for computer systems to facilitate the use of the Joint British Societies' CVD risk calculator. The stretch target involved reducing the death rate in those under 75 by 30 per cent in Wansbeck and Blyth Valley.		UKPHA 2007 conference display
Bury PCT	A local enhanced services (LES) contract was agreed (January 2007) with local GPs for the identification, assessment and management of patients at high risk of developing CVD. It covers men (35-80) and women (40-80) who should be offered an assessment of CVD risk (or a clinical assessment for those with existing disease). Payments cover patients with an assessment giving a CVD risk of over 15% for the next ten years that has been assessed in the previous 3 years and are provided for each patient assessed in excess of 50 per cent of patients registered with a practice (given that a proportion is already covered through QOF payments). The point is emphasised that a CHD risk score is not equivalent to a CVD risk score and that CVD registers would take longer to complete. The LES also states that "Practices delivering CVD care management through the CVD		Based on information sent from Bury PCT

Section 4.4.2.2 – Statin utilisation – Proactive case finding, incentive schemes			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	Local Enhanced Service must have a named nurse with a CHD module/diploma or equivalent qualification or evidence of competence or continuing professional development to ensure best clinical practice. This nurse must be allowed to attend a minimum of 2 annual CVD high-risk training sessions. This nurse will lead the development of CVD registers locally with the practical support of health care assistants and assistant practitioners (where available)".		
City and Hackney	A local enhanced service has been established in primary care identifying people at risk of CVD who are not on any other disease register. These individuals receive annual review and are targeted for lifestyle management, especially smoking cessation and anti-obesity services.		Questionnaire
Greater Manchester and Cheshire Cardiac Network	Several PCTs in the Network intend to develop incentive schemes.		
Hull Healthy Hearts	A LES has been developed covering both risk assessment and intervention and management of high risk individuals, to ensure coverage of the whole population of Hull. LES covers 1) risk assessment and 2) intervention and management of high risk individuals, to ensure coverage of the whole population of Hull. The LES is to be offered to local GP practices as well as pharmacies. In addition a nurse-led service will continue to operate in the community (as already described above) and will focus on hard to reach groups. While the project has been targeted at the more	See case study.	Personal Communication, interview (Service Planning and Improvement Assistant Director, Hull PCT) June 2007 and Questionnaire

Section 4.4.2.2 – Statin utilisation – Proactive case finding, incentive schemes			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	deprived locations within the PCT, such as shopping centres, community centres and workplaces employing male manual staff, the LES will ensure universal coverage of 40-64 age group. It is to be offered to local GP practices in order to incentivise practices to invite all patients on their list in the 40-64 age group who are not already on CVD-related disease register in for assessment (see case studies). Evaluative data will be available following the evaluation of the Local Enhanced Service Agreement.		
North Tyneside	There is a project with local pharmacists in selected areas to assess and calculate risk in men over 50 years.		Questionnaire
Northampton-shire PCT	Has funding (2007) for a CVD risk facilitator post. The CVD risk facilitator will visit GP practices setting up primary prevention registers, also look at other existing registers, e.g. hypertension, against expected prevalence to inform practices where more case finding is required.		Personal Communication, interview (cardiac network lead for primary care) July 2007
Nottingham	Community Heart Nurses team up with Nottingham pharmacies to offer free health checks during Heart Health Week.		Nottingham LDP 2005-8
Redbridge	In process of agreeing a LES with GPs to increase those at risk of CVD and guidance will be given for appropriate interventions.		Questionnaire
Rochdale, Heywood and Middleton	Incentive schemes are also in place.		Questionnaire
South Birmingham PCT	Local Enhanced Service for identifying those patients on GP registers who have a greater than 20% risk of developing cardiovascular symptoms within the next 10 years.		Questionnaire

Section 4.4.2.2 – Statin utilisation – Proactive case finding, incentive schemes			
Location/ Project name	**Details**	**Outcome**	**Source of information**
South Tyneside	Information collated regarding population at risk of developing CHD is being incorporated into an enhanced service for local GPs, to facilitate further appropriate screening/prevention measures in 2007/08 as necessary.		South Tyneside PCT – LDP 2005/08
Wigan PCT	Practice based registers of patients at high risk of developing CHD (enhanced services implementation plan linked to find and treat programme; Primary Care Quality Group to develop template for use within GP IT systems)		Ashton, Leigh and Wigan PCT LDP board report May 2007

Section 4.4.3 – Statin utilisation – Proactive case finding, peer educators			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Leicester, Project Dil	A Leicester-wide primary care and health promotion programme, set up in 1998, which aims to increase understanding of CHD and improve primary and secondary prevention of CHD in the South Asian community via interventions in general practices and in the target population. Peer educators are recruited from the community. A training programme for peer education was developed and accredited through the open College network and forty five peer educators were recruited from across the South Asian Community.	This peer education has proved successful in Leicester and is now mainstreamed by the PCT.	Leicester FTAP
Lothian, Khush Dil (Happy heart)	A primary care-led, NHS Lothian funded, community health project (2002-4) set up to develop culturally sensitive CHD prevention and control services for South Asians and address inequalities. A fundamental premise was to 'create a test-bed for the development of culturally appropriate services that could then be incorporated into the mainstream helping to bridge the current access and inequalities gap' (Matthews 2004). It also provided training and employment for South Asian community workers. Among a wide range of health-related activities was a one-to-one cardiac health assessment using health questionnaires designed for Asian patients. It provided a visual image of their individual heart health profile and a pictograph was then used to facilitate goal setting and behaviour change using motivational interviewing techniques and referral on to project activities. Clinics also operated at various community venues on request – this was considered to work well and joint working with the	An in service evaluation was carried out (Mathews et al 2007) which showed that the project had an impact as indicated by self report, physical measures and laboratory tests (including a reduction in cholesterol levels of 0.19 mmol/l; 95% CL, 0.1-0.37) . Men were less likely to attend for screening and to return.	http://www.lothianchdmcn.scot.nhs.uk/network_groups/documents/CHDMinorityEthnicAG080207minsv1.0.pdf Mathews G et al (2007) Impact of a cardiovascular risk control project for South Asians

Section 4.4.3 – Statin utilisation – Proactive case finding, peer educators			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	voluntary sector was a key factor (Fox, 2004). Aspects of Khush Dil are to be progressed through the 'Keep Well' initiative mentioned above, with a community worker from Khush Dil employed as an outreach worker for 10 ½ hours per week to link with 16 practices across the city for BME support. Other key aspects highlighted include exploring the feasibility of increased resources for linkworkers, developing a targeted training programme, and establishing partnership agreements with the voluntary sector. There is some debate, however, over the role of linkworkers as opposed to interpreters.		(Khush Dil) on motivation, behaviour, obesity, blood pressure and lipids. Journal of Public Health (published online August 2 2007)

Section 4.5 – Statin utilisation – Retention/concordance with statin therapy			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Somerset PCT	Has ad hoc internal practice audit and review through the GMS contract and the QOF. Patients are supported in complying with treatment by community matrons where the patient is on their caseload, by the practice nurse, by community pharmacist intervention and through the cardiac rehabilitation team.		Questionnaire
West Lancashire, Cheshire and Merseyside Cardiac Network Audit	An audit of statins provides data in respect of those patients on the CHD register in practices in West Lancashire that are not being prescribed statins. This audit was carried out in October 2006. The prescribing volume of statins continues to indicate an upward trend and as mentioned a greater proportion of statins prescribed are lower cost statins in line with NICE Guidance.		Questionnaire

Section 4.5.1 – Statin utilisation – Retention/concordance with statin therapy: medicine usage reviews and audits			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Croydon PCT	The pharmacy team supports GPs in coding CVD risk and diagnosis and this helps in the identification of non compliance and those not at target using QOF data . They encourage medication review and repeat prescribing processes to highlight compliance issues.		Questionnaire
Sandwell PCT	Patients have access to a team of community pharmacists allocated to support individual GP practices.		Questionnaire
Somerset PCT	Patients are supported in complying with treatment by community pharmacist intervention.		Questionnaire

Section 4.5.2 – Statin utilisation – Retention/concordance with statin therapy: pharmacy-based schemes			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Greater Manchester	The following interventions have been developed: • prompts for compliance through text messaging (mobile phone ownership is 80% of 50-60 year, and 50% of 60 plus age group); • a planned intervention with mobile phone companies – mobiles provided and then texts sent to remind people to take statins; • they are reinforcing the message to GPs that if cholesterol levels have not reduced then there is a lack of compliance (some PCTs also have a statins officer); it is possible that compliance with statins will be included in the local incentive scheme.		Interview
Knowsley PCT	Audits of statin usage have been carried out, based on the work carried out in Warrington PCT and Halton and St Helen's PCT in order to improve knowledge of prescribed statins and appropriate lifestyle modifications and to improve concordance with the prescribed therapy. This checked that people understood why statins had been prescribed and advice and literature were offered. Training in health promotion aspects is also carried out for staff carrying out audit training.		Questionnaire plus additional information from Knowsley PCT
North and East Devon LPC	Won a community pharmacy development award in 2004 for their work on improving concordance of statin therapy for obese men, a targeted high risk group. This intervention also involved community dieticians and GPs.		Questionnaire

Section 4.6 – Statin utilisation – Examples of what respondents consider works well			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Doncaster	All practices now have at least one nurse who has been trained to British Heart Foundation standards to manage the care of patients who have coronary heart disease. The prescribing of cholesterol lowering drugs (statins) has doubled in the last five years.	Heart health is described as improving faster here than it is across England and Wales as a whole, with this success attributed to more people in deprived areas accessing heart investigations, the success of the quit smoking initiative, and the efforts of doctors and nurses to encourage more people to lead a healthier lifestyle.	Doncaster PCT Annual report 05/06
Hull Healthy Hearts	Taking health services out into the community and identifying those people at risk of developing coronary heart disease. A portable booth has been touring around shopping centres, workplaces and other community settings and the specially trained nursing team has been offering free, comprehensive coronary risk assessments. Those undergoing the test have been given their own personal Heart Heath Plan and directed, if necessary, to a range of health promoting activities and services dependant upon their specific risk factors. In addition, where necessary, people have been referred to their GP for further advice or medication.	1,055 assessments have been undertaken on individuals aged 30-74 (for whom the risk assessment tool is validated). The proportion of males aged 40-49 with a CVD risk of >20% is 14.5% (95% CI 9.3% - 22.0%) compared to an England average of 2.6% and the proportion of females aged 50-59 at high risk is 9.9% (95% CI 6.0% - 15.9%) compared to an England average of 4.9%. This indicates that the service is reaching those communities at highest risk of developing CVD. See case study.	Questionnaire
Middlesbrough PCT	A community-based cardio metabolic risk assessment clinic was piloted over a six week period in two locations (Lifestore and a benefits office) in the centre of	A cardiovascular risk assessment pilot project over 6 weeks showed that it successfully achieved the target of assessing 100 individuals with very low DNA rate; identified high proportion of individuals at significant risk	Evaluation report

Section 4.6 – Statin utilisation – Examples of what respondents consider works well			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	Middlesbrough, supported with a media and publicity campaign. Age-standardized death rates from heart The intention was to identify adults with undiagnosed CVD or at higher risk of CVD (defined as a greater than 20 per cent CVD risk over 10 years) and thereby to reduce inequalities in CHD and CVD mortality. The assessments were carried out by appointment by a CHD nurse. Full lipid profiles and blood glucose were assessed.	of CVD and made referrals to patient's GP for further assessment where appropriate. These referrals and assessments will be followed up as part of the evaluation to describe more specifically outcome measures such as the number who were prescribed a statin or treated for hypertension. However, the project did not specifically identify people living in the most deprived areas who are potentially at greatest risk. It also identified low numbers of individuals who were current smokers (7%), inconsistent with a smoking prevalence in Middlesbrough of 34%. A qualitative evaluation will inform the way that the project will be rolled out. See case study.	
Sandwell	CVD risk factor data are extracted from the GP electronic medical records on all patients in the relevant age groups (35-74years), excluding those patients already on existing registers. Calculation of a ten-year CVD risk is based on age, gender, smoking status, blood pressure, cholesterol levels and diabetes data. Eligible patients were offered appropriate treatment – either pharmacological and / or referral to a number of local lifestyle services i.e. stop smoking, dietician or exercise referral programmes.	Focusing on the six practices involved, 909 patients were identified as probably at high risk. Over two years, 855 of these were invited for screening and 578 (68%) attended a nurse led clinic for screening. Of the 578 screened 399 (69%) were found to be eligible for preventive treatment. This resulted in 392 (68%) patients receiving medical intervention and 134 (23%) being referred for lifestyle intervention such as smoking cessation / physical activity or diet. Sandwell has a total registered population of 314,000. Using this method, a total of 15,592 people need screening. Assuming that attendance and treatment rates remain comparable with the pilot practices 9,966 patients will be screened. 6,777 will be eligible for preventative	Questionnaire

Section 4.6 – Statin utilisation – Examples of what respondents consider works well			
Location/ Project name	**Details**	**Outcome**	**Source of information**
		treatment and 2,292 for lifestyle interventions. However, it is estimated that 678 CVD events could be prevented and 260 deaths prevented over a period of 10 years. Qualitative work has also been undertaken with recipients of this programme. Patients reported that: they liked the formal invitation for assessment; were not worried when they received the initial letter; liked the fact that someone from outside of the practice was reviewing their medical records; valued the explanations provided during assessment and liked a check without having to 'bother' their GP. The evaluation of this project focused on case finding from GP records, showed that patients in practices visited by the project nurse were twice as likely to be assessed, found eligible for treatment and started on at least one appropriate treatment compared to practices that did not have the project nurse. 41% of patients in project nurse practices compared to 13% with no project nurse were eligible and on treatment. As a result of this evaluation, two further dedicated staff are being appointed.	
Sheffield, CIRC initiative	Developed a systematic and targeted approach for practices with high CHD prevalence and high risk populations, and which was mainstreamed after three years.	Reported that between 2000 and 2003 a faster decline in premature death rate from heart disease was observed in the more deprived fifth of the population than in the city as a whole.	Personal Communication, interview (Sheffield PCT CHD lead) July 2007

Section 5 – Combined interventions			
Location/ Project name	**Details**	**Outcome**	**Source of information**
Barnsley, Fit for the Future	Aims to tackle the causes of CHD, strokes and cancer and works with a wide range of partners including local community groups and the general public. One of the areas that Fit for the Future focuses on are lifestyle factors, although the programme also looks at the wider determinants of health This programme is described as a key element in the focus on addressing health inequalities with activities being focused on the most disadvantaged areas.		Barnsley's LAA 2005/08 www.barnsleyfit4thefuture.co.uk
Bolsover, NE Derbyshire, NRF Wellness Project	A physical activity project targeted at those at risk of stroke, CHD and diabetes targeting the most at risk groups, aiming to improve life expectancy across the area		North Eastern Derbyshire PCT Annual Report 2005-06
Birmingham, Male Life Expectancy project	A city-wide project, supported with £2.6 million of NRF funding. An analysis of the causes of death in men, considered alongside current initiatives, identified for immediate action: (1) the identification and systematic management of circulatory diseases in primary care, paying particular attention to men aged 40-65 and the most deprived areas of the city (and the Birmingham Own Health Project which delivers a targeted care management programme is being extended across Birmingham in 2007/8); and (2) improvements in the targeting and delivery of smoking cessation and tobacco control services (and a city wide call centre has recently been commissioned with significant investment in publicity and advertising to encourage smokers to access stop smoking services). Other areas for 2007/8 include social marketing campaigns, a roll out of the	The programme will be evaluated.	Birmingham East and North PCT LDP 2007/08

Section 5 – Combined interventions			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	pharmacy screening pilot; a mobile health screening unit and neighbourhood healthy heart workers.		
Doncaster's Healthy Living Project	Funded through Big Lottery (2003-8) this project consists of twelve schemes aimed at decreasing deprivation and inequalities in health, For example, an Asian women's scheme, reaches out to women from BME communities who face multiple disadvantages, many of whom are refugees. The services are designed as a direct response to the women's requests.		Doncaster East PCT annual report 2005/06
Kingston, Fit for Life programme	Available to residents who are at risk of developing heart disease (CHD) over the next 10 years can attend these programmes (some of which have been targeted to Asian Muslim women). The course provides patients with information on CHD risk factors, healthy eating and the benefits of physical activity in addition to imparting them with the skills to make the necessary lifestyle changes and information about stop smoking service (The future of this project is uncertain).		Personal Communication June 2007
Leicester, the Men's Health Programme, Braunstone Community Association	A NDC- funded project, this provides advice guidance and information on men's health with specific reference to coronary heart disease, smoking, obesity, mental health, and cancer. Innovative measures include the incorporation of health messages on beer mats, and the active engagement of the local newspaper and the radio station.		CRESR 2005
North Staffordshire	City wide Lifestyle Programme for tackling obesity. Interventions will include: effective thinking skills, nutrition, physical activity and smoking cessation as a combined holistic package. Includes lifestyle coaches to help individuals with personal lifestyle change plans and goal setting. The City wide Lifestyle Programme will be initially piloted in 2 areas in Sept and		Questionnaire

Section 5 – Combined interventions			
Location/ Project name	**Details**	**Outcome**	**Source of information**
	November 2007 and then phased roll out from April 2008.		
Nottingham City	Physical activity programmes are targeted by age, gender, ethnicity, deprivation and area, with prioritisation in the identified groups and areas.		Questionnaire
Sandwell	Lifestyle teams target specific groups, so that physical activity team works with children and young people, black and minority ethnic communities, over 50s as well as specific geographical localities with high SMRs.		Questionnaire
South Birmingham, Fit 4 Life	An initiative for priority ward areas to support men over forty make simple health related lifestyle changes. Fit 4 Life Workers opportunistically target men in the local community by visiting public houses, social clubs, places of work and other centres. The workers carry out a range of health based initiatives, which include: free health and fitness assessments; motivational support; individual goal setting; signposting to health related services.	See case study.	Questionnaire
Sunderland, Wellness Centres	Being established across the city with the aim of increasing the numbers of people participating in activity.		Sunderland LAA 2006
Walsall Healthy Hearts Project	Was developed as part of New Deal for Communities in partnership with Walsall PCT, Walsall Metropolitan Borough Council and Groundwork, to address the primary risk factors for coronary heart disease: physical activity, smoking, poor diet and obesity. As part of the smoking cessation programme, there are quit smoking groups, a smoke free homes initiative and support for pregnant smokers.		Ellis, E., Peters, J., Goyder, E. and Blank, L. (2005) *Healthy Lifestyle Interventions – Research Report 57*