

compliance with measures which may not be evidence-based and which may not reflect the quality of the lung cancer service. There is a wish for teams to be assessed less on these elements of process and more on outcomes. Measuring outcomes and comparing them between units is a longer term aim of the LUCADA audit. However, some respondents did acknowledge that peer review was an evolving process and many of the measures reflected good practice.

The results of this survey will be fed back to the National Peer Review team and hopefully the comments will inform further rounds of the peer review process, thereby engaging clinicians and ensuring that all patients with lung cancer have access to high quality services.

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Smoking cessation trial may be missing the point

The trial reported by Aveyard *et al*¹ in a recent issue of *Thorax* is a welcome illustration that primary care nurses are not being trained properly to deliver the behavioural support aspects of smoking cessation. However, the paper seems to miss this point and instead concludes that “Primary care smoking cessation treatment should provide pharmacotherapy with sufficient support only to ensure it is used appropriately, and those in need of support should be referred to specialists”.

We know from a large body of previous work and systematic reviews (as referenced in the article) that well considered and planned behavioural support doubles the increase in quit rate for smoking cessation services. In this trial, however, there was no effect. The results therefore clearly show that the current form of nurse-delivered “behavioural support” is ineffective. Indeed, I am concerned that the authors even refer to what was delivered as behavioural support. There is no evidence that any established behaviour support techniques were delivered (eg, motivational assessment, elicitation and

examination of barriers, use of action and coping plans, establishing self-monitoring regimes, use of established relapse prevention techniques). Simply asking nurses to conduct some extra telephone calls and visits without any specification of the content is pointless in terms of applying behavioural science. There is therefore a grave danger that trials such as this will be included in future systematic reviews as trials of behavioural support, even though the quality of the support offered was non-existent (or at least not established in any way). This kind of data may bias future reviews.

Furthermore, the lack of effectiveness of the nurses in this study does not mean that nurses cannot be trained to deliver this support (as the authors seem to suggest). It is my experience—and that of many other behavioural researchers^{2–3}—that almost anyone can be trained to effectively deliver simple behavioural support techniques such as motivational interviewing, which are the same techniques commonly used in smoking cessation and have proved to be effective in the NICE and Cochrane reviews.

Yes, passing patients on to specialists would produce a much needed workstream for the hundreds of graduate health psychologists qualifying each year, but another alternative would be to train the nurses properly to do the job. This trial tells us nothing about the pragmatic effectiveness of behavioural support, as no behavioural support was apparently delivered.

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Authors' reply

As we reported, this trial took place in the UK National Health Service (NHS) Stop Smoking Service. The NHS has developed standards for training in behavioural support.¹ Stop Smoking Service coordinators oversee this training and the quality of services provided in the NHS, which may involve fidelity checks and, in the region we studied, mandatory annual update training.

Greaves emphasises psychological techniques that he states are necessary for the efficacy of behavioural support. Trials in smoking cessation do not show whether or not particular forms of behavioural interven-

tion—such as cognitive behavioural interventions—are necessary for effect or whether one form is more effective than others.^{2,3} Some components that Greaves suggests are essential—such as relapse prevention—have been shown to be ineffective.⁴

Behavioural support for smoking cessation in the UK is based on withdrawal orientated therapy.⁵ This recognises that individuals come to clinical treatment services when they are highly motivated to stop but cannot do so because of nicotine dependence. The goal of therapy is to help reduce withdrawal discomfort during the first few weeks. Motivational enhancement is not usually part of treatment.⁶

Greaves assumes that by “specialists” we mean an army of health psychologists. We do not. The NHS provides two types of face-to-face NHS stop smoking support. One is by primary care nurses trained and monitored as we described. The other is by people who have undergone the same training but provide smoking cessation support as their main role. Frequently such specialists are nurses, but other professions are represented, although few psychologists do this work for the wage offered. The evidence from prospective evaluations is that the same kind of care provided by such specialists produces double the quit rate we saw in our study.⁷ The difference in efficacy is not because of different training.

Evidence from other studies showing that behavioural support is ineffective even where high quality training was given to primary care professionals^{8,9} reinforces our belief in the superiority of effectiveness of specialist over generalist support. Perhaps the other demands of the role of providing general care, or the appointment system that militates against regular support, lead to failure of trained generalists to equal the success of similarly trained specialists in smoking cessation. Until the NHS shows in independent evaluations that higher quit rates can be obtained in primary care, our advice would be for primary care professionals to refer smokers to specialist support or provide brief advice, using pharmacotherapy in both cases.

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Methods

A list of all lead lung cancer clinicians was obtained from the National Cancer Action Team at the Department of Health. Time was taken to validate this list, and telephone calls were made to all trusts to ensure that the named clinician was correct and to obtain contact details. We eventually identified 153 lung cancer MDTs. The survey was written and distributed as a form in Microsoft Word. It was sent in preference by e-mail and respondents could fill in the form electronically or print it out and fill it in by hand before returning it in the post. Where we did not have an e-mail contact, the a paper form was used. The first forms were distributed in October 2006 and the last form was received in April 2007.

Free-Text Comments

- Many of the measures deal with team structures only. There needs to be more attention to activity and outcomes, eg proportion of patients receiving radical treatment, proportion of patients completing a course of chemotherapy. Important also not to repeat what is going into LUCADA
- The peer reviews are not a worthwhile exercise. At great cost and inconvenience we learned nothing we didn't know already.
- There is much repetition of measures e.g. evidence for team measures and too much emphasis on nurse qualifications. Measures on choice also somewhat superfluous when trying to achieve better treatment times and standards.
- The Medical person was a colorectal surgeon.
- Far too many [measures], mostly irrelevant and about process; they insisted on palliative care nurse representative even though both our CNSs have a lot of such experience.
- Too many measures are achieved on paper evidence of e.g. an audit having been performed as opposed to the results and actions taken.
- Too much emphasis on paperwork. Outcome data was not demanded by the review team (although we had it available). Little analysis of the real issues affecting care (e.g. inadequate number of clinic slots due to too few doctors and too long a wait for PET scans) but focussed on evidence e.g. it was held to be a problem that the policy for one Trust was worded slightly differently from that of another although the end result was the same.
- The nit-picking approach to the paper documentation created high levels of anxiety in nurse and administrative staff. A very experienced nurse specialist is now seeking to leave which will have a large negative effect on patient care.
- Generally this is process and policy driven rather than clinical.
- We had a great deal of work on service improvement but we were criticised for not having a current action plan when I perceived that we were ahead of most trusts and it was work completed.
- The measures regarding offering Choose and Book are antagonistic to achieving waiting time targets and streamlining services. They should be removed.

- Process too prescriptive, too little room for local developments.
- It was a tick box exercise and very time consuming. There was little scope for reviewers to look outside the criteria. There was no attempt to review actual practice.
- Many [measures] irrelevant and not related to outcomes.
- Core membership requirement for palliative care at MDT unnecessary - LCNS provide very adequate line of communication.
- In general, the need to try to make measures entirely precise then inevitably leads to great loss of value from the process, because all hospitals are different and an intelligent acknowledgement of this, using the experience of the reviewers, would be vastly preferable in my opinion.
- Lead reviewer criticised us for not doing things 'his way' yet was unable to say what deficiencies in our service would be remedied by copying his methods. Lay member of the panel did not act as an advocate and made comments which simply reflected his prejudices. A very substantial amount of time was spent preparing for the Peer Review yet the draft report was scant on detail and was not in any way commensurate with this effort. I think BTS members should think twice before cooperating with this process in the future.
- Many [measures] totally irrelevant to the provision of a timely accurate and efficient service.
- Some do not reflect the real world of clinical practice. Some are aspirational but unachievable. In the visit to **** and on Peer Review visits I have made elsewhere some non-clinicians can be very process orientated. This was sometimes in the meetings but often outside the face to face meetings. The strengths of the process were to help draw attention to the quality aspect of patient care which some doctors are only too willing to ignore as they concentrate on the latest technology advances. As lung has a large component of palliative care this is a vital part of care.
- Measures don't really reflect areas of importance for patients with lung cancer.
- Peer review is an evolving process which has focussed on the MDT and nurse specialist. It encourages good practice - have a CNS, doing MDT, participating in audit, patients satisfaction and good communications. Some of this seems to have got lost in over emphasis on paper evidence and I hope the next round will be better and more patient-focussed.
- A lot of evidence included in the prepared packet was missed and the trust scored negative marks inappropriately. The whole process should be carried out with the team present during the process so that a right conclusion could be made.
- Local measures may work well even if they do not meet the arbitrary standard.
- Clinical outcomes would be more relevant, with the information they had the review was OK.
- We felt the review was helpful to us and we prompted the team to highlight our know deficiencies. The Peer Review system should be used to help trusts share the good things to help improve services. On a personal basis, our service is more difficult to run since the broad cancer guidelines were produced due to the extra pressure of other tumour groups on the CT/path services.

- Most [measures] are not evidence-based.
- As before a very buracritic process. For example, an issue was made of signing attendance sheets, because it is in the rules but it is fairly obvious that as patients were discussed, team members must have been present. The process is weakened by the fact that it does not compel trusts to fund the improvements recommended. There need to be clearer decisions from the DoH on what Trusts responsibilities are and some ring-fenced money to fund improvements.
- The measures relating to Choose & Book should be deleted - the principle of C&B is obstructive in seeing patients quickly and achieving W/T targets.
- No chest physician at panel but appropriate oncologist.
- Many [measures] are box ticking and irrelevant
- Reviewers fulfilled their remit - is that the right aspect – doubtful.
- Did not focus on resources or external factors which influence outcomes or pathways.
- Too irrelevant to service and too paper based.
- Some measures an exercise in generating paper.
- Many [measures]are flawed and don't measure what is needed.
- Spent too much time asking nurses for certificates - not how the process worked.
- I feel the assessment of some aspects of the service, especially the functioning of the MDT, was superficial and depended too much on the statements of the team. Of course, in my own case I would maintain that those comments were a true and accurate reflection of the MDT (!), but I think there would be a great advantage in the future if visiting teams were to sit in on a real MDT meeting.