An Independent Review of the Provision of Smoking Cessation Services in Wales
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Views expressed in this report are those of the researchers and not necessarily those of the Welsh Government

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1  Introduction and background

Smoking continues to be the leading single cause of serious illness and avoidable early death in Wales.\textsuperscript{1} Smoking contributes to a wide range of diseases, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction, infertility, osteoporosis, cataracts, age-related macular degeneration and periodontitis.\textsuperscript{2} Moreover, as this National Institute for Health and Care Excellence Quality Standard ‘Smoking: reducing and preventing tobacco use’ goes on to state “getting people of all ages to quit smoking is crucial in preventing other people from taking up the habit”.

Encouraging, enabling and supporting smokers who wish to quit smoking is therefore a very important element of any public health strategy. But, as is well known, nicotine is a highly addictive substance and the majority of smokers find it very difficult to quit.

A report by ASH Wales Cymru in 2013 estimated that the economic cost of smoking was £790.66 million per year, but it could be as high as £1.04 billion per year.\textsuperscript{3} It concluded that the economic cost of people smoking in Wales is extremely high in terms of health care costs, loss of productivity to businesses, deaths from secondhand smoke and environmental costs including litter and fire. The report points out that there are some inadequacies in the data as it is difficult to allow for the economic impact to be measured in relation to children. This means that the final figure could be even higher.

The National Survey for Wales 2016/17 showed that 19% of adults smoked; a significant reduction from 25% in 2005/6.\textsuperscript{4} This exceeded the Welsh Government target of reducing smoking rates to 20% by 2016. The new plan to reduce the number of smokers in Wales to 16% by 2020 if achieved would result in significant cost savings for Wales and health benefits to the Welsh population.

**Smoking cessation and the Wellbeing of Future Generations (Wales) Act 2015**

The Wellbeing of Future Generations (Wales) Act 2015 provides the framework for national and local action to improve wellbeing in Wales, therefore allowing Wales to develop in a sustainable way.\textsuperscript{5} The Act puts in place seven well-being goals that set the vision for Wales in 2050. These are shown below in Figure 1.
Figure 1: The Wellbeing Goals of the Wellbeing of Future Generations (Wales) Act 2015

Public bodies have a statutory duty under the Act to carry out sustainable development by:

- setting and publishing objectives that are designed to maximise its contribution to achieving each of the well-being goals, and
- taking all reasonable steps (in exercising their functions) to meet those objectives

A wide range of public bodies are included in the remit of the Act, including Welsh Government, local authorities, health boards and NHS Trusts (including Public Health Wales), fire and rescue authorities, and several national agencies such as Natural Resources Wales, Sports Council for Wales and The Arts Council for Wales.

Public bodies must demonstrate that they are following the sustainable development principles, acting in a manner that seeks to ensure that the needs of the present are met without compromising the ability of future generations to meet their own needs. This requires them to think long-term, considering prevention, integration, collaboration and the importance of meaningful public involvement – known as the Five Ways of Working.
Progress towards achievement of the well-being goals is measured by the National Indicators for Wales. Smoking cessation services (as part of wider tobacco control activity) contribute in particular to:

National Indicator 3: the percentage of adults who have fewer than two healthy lifestyle behaviours (not smoking, healthy weight, eat five fruit or vegetables a day, not drinking above guidelines and meet the physical activity guidelines).

National Indicator 5: Percentage of children who have fewer than two healthy lifestyle behaviours (not smoking, eat fruit/vegetables daily, never/rarely drink and meet the physical activity guidelines).

The Public Health Outcomes Framework for Wales (PHOF) sits beneath the National Indicators for Wales, and includes specific indicators for smoking prevalence:

PHOF Indicator 20: The percentage of children aged 11-16 smoking at least once a week – using data from Health Behaviour in School-aged Children Survey.

PHOF Indicator 25: The age-standardised percentage of persons aged 16 and over who reported being a current smoker (smoking daily or occasionally) – using data from the National Survey for Wales.

**Smoking rates in Wales**

The evidence would suggest that a significant minority of the adult population of Wales is continuing to use traditional forms of tobacco.

Table 1 provides an estimate of the number of smokers in each local health board and as a proportion of the total population.

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Number of smokers</th>
<th>Proportion of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abertawe Bro Morgannwg UHB</td>
<td>92,000</td>
<td>21.0%</td>
</tr>
<tr>
<td>Aneurin Bevan UHB</td>
<td>88,000</td>
<td>18.5%</td>
</tr>
<tr>
<td>Betsi Cadwaladr UHB</td>
<td>105,000</td>
<td>18.4%</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>61,000</td>
<td>15.2%</td>
</tr>
<tr>
<td>Cwm Taf UHB</td>
<td>50,000</td>
<td>20.8%</td>
</tr>
<tr>
<td>Hywel Dda UHB</td>
<td>60,000</td>
<td>18.7%</td>
</tr>
<tr>
<td>Powys Teaching HB</td>
<td>20,000</td>
<td>18.2%</td>
</tr>
</tbody>
</table>

Source: Welsh Government

**Table 1: An estimate of the number of smokers in each local health board and as a proportion of the total population.**

The use of new forms of nicotine delivery system such as e-cigarettes may be contributing to the falling smoking rates among adults and young people.
Providing this group of smokers, as well as those who may have switched to e-cigarettes but who wish to end their dependence on nicotine, with cessation support is a very important step in reducing health inequalities and potentially reducing socio-economic inequalities across the population of Wales.

Research has demonstrated that evidence based smoking cessation services are a highly cost effective way of helping smokers to stop smoking. The majority of smokers in Wales (around 6 in 10) want to quit, and just over 4 in 10 have made an attempt to quit in the previous year, according to the National Survey for Wales. Large numbers of these individuals ‘go-it-alone’, yet this is the least effective method of quitting. Interventions that combine pharmacotherapy and behavioural support increase smoking cessation success compared to a minimal intervention or usual care.

A range of such services, provided in different settings, is already available, but coverage is highly variable. These services have similar levels of quality but differing levels of intensity of support.

The effectiveness of different levels of service has been considered in the NICE Public Health Guidelines (PH10) on smoking cessation services. A review of smoking cessation services in Scotland and guidance on commissioning smoking cessation services in England rely on similar conclusions.

**Smoking cessation services in Wales**

Pilot smoking cessation services were first established in Wales in 1999 and an independent evaluation was commissioned in April 2002, utilising and building upon the data collected by the services. The evaluation made 19 recommendations including a ‘more unified national smoking cessation service with a stronger identity and national co-ordination’.

Since 2004, the Welsh Government has commissioned Public Health Wales, and its predecessor, to deliver community-based smoking cessation services on an all-Wales basis. The service was rebranded as “Stop Smoking Wales” (SSW) in November 2007. SSW offers group based behavioural and peer support in a variety of settings across all seven health board areas. It is funded through PHW’s core allocation.

The other main providers of smoking cessation services in Wales are community pharmacies and in-house hospital services which are commissioned by health boards:

- All health boards provide community pharmacists with financial incentives to help smokers quit by providing one-to-one support (Level 3 pharmacy services). Betsi Cadwaladr UHB, Cwm Taf UHB and Powys THB have well established pharmacy services. Other health boards have introduced this service in the last three years.

- Cardiff and Vale UHB and Hywel Dda UHB have well established in-house smoking cessation services in secondary care settings. Both Abertawe Bro Morgannwg University Health Board and Aneurin Bevan University Health Board have recently developed secondary care support in a number of their hospitals.
Some GP practices offer smoking cessation support, but it appears that few offer a service equivalent to that offered by SSW, pharmacies and in-house hospital provision. Work is ongoing to encourage GPs to refer to the specialist services outlined above. A number of other projects are in place to pilot approaches to smoking cessation for particular groups, e.g. pregnant smokers and mental health patients.

**Welsh Government Expectations: Health board performance target**

A performance target has been in place for 4 years to encourage improved performance on smoking cessation by health boards in Wales. This health board target was introduced by means of a Data Set Change notice. Health boards are required to treat 5% of their smoking population via NHS smoking cessation services; with a CO-validated quit rate at 4 weeks of 40%. Data about smoking cessation services have common features and are collected in each health board area, against which performance is monitored.

Data are reported separately by a number of smoking cessation service providers that include Stop Smoking Wales, Pharmacy Level 3, in-house Hospital and GP services. They all provide evidence-based behavioural support and advice to smokers who are motivated to attempt to stop smoking. Support is also provided in conjunction with pharmacotherapy with clients followed up one month after quit date, CO-validated, with outcomes recorded. Brief interventions are not currently classified as a smoking cessation service and are excluded from data collection activities.

Since the introduction of the target there has been an increase in Level 3 pharmacy services, and in-house hospital services. Virtually no GP data have been recorded to date. The most recent data were published on 13th September 2017 and are shown in Table 2 below. None of the health boards have met the target since it has been in place. Source: Welsh Government

Table 2 provides an overview of the target for each health board and how close to achieving the target each health board has come for 2016/2017. What can be observed from these figures is that the percentage of smokers treated varies considerably by health board area. Cardiff and the Vale UHB has treated the fewest smokers in terms of percentage (1.34%) and Betsi Cadwaladr UHB and Cwm Taf UHB the most (3.79% and 3.96% respectively). In addition, quit rates for those treated vary substantially by health board area, with Hywel Dda achieving the highest quit rate at 59.4% (as measured by carbon monoxide validation at 4 weeks post quit date), and Betsi Cadwaladr the lowest at 31.1%.
Table 2: Health board smoking cessation service statistics

### Tobacco Control Action Plan

The Tobacco Control Action Plan for Wales\(^\text{17}\) (TCAP) was introduced in 2012, supported by a Tobacco Control Delivery Plan. The TCAP contained targets for a reduction in adult smoking prevalence to 20% by 2016 and 16% by 2020. The 2016 target was met ahead of schedule.

In order to reinvigorate action, the Tobacco Control Delivery Plan has been revisited, and a new plan for 2017-2020 was published in September 2017.\(^\text{18}\) The development of the new plan has been overseen by a newly-appointed Tobacco Control Strategic Board, with work on smoking cessation having been undertaken by a cessation sub-group.

As a result of the work of the cessation sub-group a new set of actions have been proposed including:

- Greater numbers of smokers using Help Me Quit, either through self-referral or referral by a health professional.
- Agreeing minimum standards for smoking cessation provision
- The delivery of an integrated smoking cessation service
- Strengthening referral pathways for maternity services, pre-operative patients, people with lung disease, people with mental health conditions, and Welsh-domiciled men
- Increase referral rates to cessation services from GP practices and dental practices.

<table>
<thead>
<tr>
<th>Health board</th>
<th>No. of Welsh resident smokers treated by smoking cessation services</th>
<th>No. of Welsh resident smokers who were CO validated as successfully quitting at 4 weeks post quit date</th>
<th>No. treated as percentage of LHB smoking population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abertawe Bro Morgannwg UHB</td>
<td>2111</td>
<td>1089</td>
<td>2.61%</td>
</tr>
<tr>
<td>Aneurin Bevan UHB</td>
<td>2946</td>
<td>1246</td>
<td>3.00%</td>
</tr>
<tr>
<td>Betsi Cadwaladr UHB</td>
<td>4613</td>
<td>1434</td>
<td>3.79%</td>
</tr>
<tr>
<td>Cardiff and Vale UHB</td>
<td>1006</td>
<td>561</td>
<td>1.34%</td>
</tr>
<tr>
<td>Cwm Taf UHB</td>
<td>2198</td>
<td>831</td>
<td>3.96%</td>
</tr>
<tr>
<td>Hywel Dda UHB</td>
<td>1408</td>
<td>836</td>
<td>2.59%</td>
</tr>
<tr>
<td>Powys Teaching HB</td>
<td>468</td>
<td>206</td>
<td>2.25%</td>
</tr>
</tbody>
</table>

Source: Welsh Government
Help me Quit

*Help me Quit* is a coherent stop smoking service for Wales. It is designed to give the largest number of smokers in Wales the best chance of quitting by helping shape their personal quit journey based on locally available quit support. It aims to tailor cessation services by referring individuals to the service which of the NHS stop smoking services best fits their needs.

Help Me Quit was supported by an initial campaign funded by Public Health Wales. It comprises a bi-lingual website and contact centre. As an all-Wales brand it is intended to replace all local smoking cessation campaigns, and it is expected that individual health board smoking cessation campaign funding will signpost Help Me Quit in the future.

**Purpose and approach of the Review**

The Welsh Government commissioned Emma George Consulting to conduct a review of the range of existing smoking cessation services being provided in Wales and to set out the commonalities of thinking of the strategic stakeholders about the best approach to their future provision both locally and nationally.

In order to achieve this a review of the literature and evidence into the best approaches to, and critical success factors for, smoking cessation across the UK was undertaken (Chapter 2). This was complemented by a series of semi-structured telephone interviews with the Director of Public Health or their nominee in each of the seven health boards in Wales, and selected staff from Public Health Wales and Welsh Government, to ascertain their views on the best approach to the provision of smoking cessation services in Wales (Chapters 3 & 4).

Together this has been used to produce options and suggestions for the future provision of smoking cessation services in Wales, for consideration by the Tobacco Control Strategic Board (Chapter 6).
2 Literature Review

Approach to the literature review

Rationale
There is a wealth of published research into the effectiveness of different approaches to smoking cessation. The primary focus of the approach used for this review was to focus on current best evidence of effectiveness, based on published systematic reviews.

High rates of smoking prevalence are found in specific population groups and communities (for example, materially deprived households, people with poor self-rated general health, and certain migrant and ethnic groups). The Tobacco Control Delivery Plan 2017-20 emphasises the need to “disproportionately increase smoking cessation rates in the communities and groups with the highest levels of smoking prevalence” as a key challenge.

In addition to the general review of effectiveness of smoking cessation interventions, we therefore undertook focussed searches to identify evidence that suggests promising approaches for successful quit attempts by smokers in these groups, and in specific institutional/service settings such as secondary care. This included, but went beyond, the systematic reviews identified in the primary search.

Search strategy
The initial search only considered systematic reviews. These studies were reviewed to identify the best approaches to smoking cessation in the UK, as applied to the general adult population. Application of these approaches to specific groups of interest and in settings was then explored, drawing on the systematic reviews already identified, and using further focussed searches where necessary to identify evidence of effective approaches in these groups and settings.

Further details can be found in Appendix 1: Detailed literature search strategy.
Keywords were developed using the PICOCS model, as shown in Table 3:

**Population(s)**
- Adult smokers in the general population.
- Smokers in specific population groups:
  - Smokers living in materially-deprived households (individual/household level deprivation)
  - Smokers who live in deprived areas (area level deprivation)
  - Smokers in migrant and ethnic groups
  - Young people who smoke
  - Pregnant women who smoke
  - Smokers in poor health (e.g. pre-operative patients, smokers with respiratory conditions, smokers with mental health conditions).

**Intervention(s)**
- Pharmacological interventions, such as: nicotine replacement therapy, antidepressants, nicotine-receptor partial agonists, combination pharmacotherapy
- Psychological interventions, such as: stage-based interventions, motivational interviewing, social support
- Combined pharmacotherapy and behavioural support interventions
- Models of intervention delivery, such as: face-to-face individual support, face-to-face group support, telephone counselling, use of mobile devices (SMS messages, apps), social media, printed or online self-help materials

*Given such a wide range of potential interventions, we used a broad MeSH heading of “Smoking cessation” to encompass all relevant papers.*

**Comparison/Control**
- For pharmacological interventions: Placebo, no treatment, comparable pharmacological interventions
- For non-pharmacological interventions: quitting without pharmacotherapy or behavioural support; comparable, less-intensive behavioural support intervention; for interventions in specific settings, receiving ‘usual care’

*Given such a wide range of potential comparators, no comparison/control keywords were used in the search, to avoid over-restriction of the papers identified.*

**Outcome(s)**
- **Benefits:** Successful quit attempts at one month/4 weeks (or similar timescale), preferably validated by carbon monoxide test; Longer-term quit rates where they were reported (e.g. 6 months or 12 months)
- **Harms:** Incidence of serious adverse events associated with the interventions.

**Context/Setting (in addition to the general population)**
- Smoking cessation services/interventions delivered in specific settings, including:
  - Community pharmacies
  - Primary care
  - Secondary care
  - Maternity services
  - Institutional settings such as care homes, prisons
  - Workplaces

Table 3: Keywords for search strategy
Effectiveness of smoking cessation interventions

Overview
In September 2017, Public Health England published a briefing paper summarising evidence of effectiveness of interventions to support smokers to stop, based on current evidence from the Cochrane Collaboration, NICE guidance and National Centre for Smoking Cessation and Training (NCSCT) service and delivery guidance. Different interventions are rated and ranked according to evidence of effectiveness as summarised in the table below:

<table>
<thead>
<tr>
<th>Rank and intervention</th>
<th>Effective implementation boosts quit rate by...</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Face-to-face group support with pharmacotherapy</strong>: weekly facilitated group sessions (approx. 1 hour for 6-12 weeks)</td>
<td>300%</td>
</tr>
<tr>
<td>2. <strong>Face-to-face individual support with pharmacotherapy</strong>: weekly sessions (approx. 30-45 minutes for 6-12 weeks)</td>
<td>200-300%</td>
</tr>
<tr>
<td>3. <strong>Supported use of pharmacotherapy</strong>: provide medication(s) of smoker’s choice, give appropriate information &amp; support (start appointment plus 1 follow-up to check progress)</td>
<td>50-100%</td>
</tr>
<tr>
<td>4. <strong>Telephone support</strong>: multiple sessions of proactive telephone support by a trained advisor (15-30 minutes for 6-12 weeks, work best with multiple sessions in first week)</td>
<td>50-100%</td>
</tr>
<tr>
<td>5. <strong>Text message support</strong>: limited evidence, use an existing programme that has been fully tested</td>
<td>40-80%</td>
</tr>
<tr>
<td>6. <strong>Online information (websites)</strong>: can be effective but websites that have been evaluated are not currently available. Should not be the only support offered.</td>
<td>Unknown</td>
</tr>
<tr>
<td>7. <strong>Mobile digital applications</strong>: limited evidence on effectiveness to date. More good quality research is required.</td>
<td>Unknown</td>
</tr>
</tbody>
</table>

Table 4: Effectiveness of smoking cessation interventions

NICE has recently consulted on a draft guideline for smoking cessation interventions and services. This guideline, when finalised and published (expected March 2018), will update and replace the existing guidelines on brief advice and referral for smoking cessation (PH1) and stop smoking services (PH10). Recommendations from the draft guideline are highlighted where relevant in this chapter.

Other evidence on intervention approaches

Interactive internet-based interventions
Smartphone ‘apps’ are covered within the table above, and the 2016 Cochrane review into mobile-phone based smoking cessation interventions included apps within its scope. Almost all the studies in this review were
based on text messaging interventions. No published trials of smartphone apps for smoking cessation met the inclusion criteria. The dynamic nature of app development, where new features are regularly added through ‘updates’ following feedback from users, does not conform to the ‘fixed intervention’ model typically used in randomised controlled trials; novel approaches to study design may be needed.

Approaches using interactive (2-way flow of information between participant and Internet) or tailored (adapted to a participant’s characteristics) can be moderately more effective than usual care or written self-help. However, there is no evidence that these approaches are more effective than other active smoking cessation interventions.22 (This Cochrane review was not published in time to be considered in the production of the Public Health England guidance summarised in the table above).

Social media interventions
A recent systematic review of social media interventions for smoking cessation identified 7 relevant intervention studies, all published since 2014.23 Although not a Cochrane Collaboration review, the review included consideration of methodological quality, but a meta-analysis was not possible due to differing study designs and outcomes measures. Engagement was promoted via a range of approaches including reminder messages by a smoking cessation counsellor, automated messages to promote discussion about quitting smoking, and financial incentives to post, comment or otherwise participate in social media discussion.

Social media interventions appear to be feasible and acceptable, with some preliminary evidence of potential effectiveness in supporting smoking cessation, though this was largely self-reported rather than biochemically validated abstinence. Large-scale, rigorously controlled studies including biochemical validation are required to establish the effectiveness of social media smoking cessation interventions.

Real-time video interventions
The Public Health England briefing does not refer to use of real-time video (e.g. Skype, FaceTime etc.) for smoking cessation counselling. A Cochrane Collaboration review protocol has recently been published24 so it is anticipated that a systematic review of this approach to intervention will be forthcoming in due course.

Interventions not supported by current evidence
The Cochrane Library was searched for reviews of other psychological and behavioural approaches to smoking cessation intervention. For the interventions summarised below, there is currently insufficient evidence to support effectiveness:

- Aversive smoking (making smoking unpleasant, e.g. rapid smoking)25
- Biomedical risk assessment on potential future effects of smoking (e.g. carbon monoxide measurement, lung function, genetic susceptibility to lung cancer)26
- Communicating DNA-based disease risk estimates27
• Enhancing partner support as part of a smoking cessation programme

• Hypnotherapy

• Relapse prevention behavioural interventions. (For extended pharmacological treatments, extended treatment with varenicline may prevent relapse, based on one trial. Extended treatment with bupropion is unlikely to have a clinically important effect. Studies of extended treatment with nicotine replacement are needed.)

• Stage-based interventions – found to be no more or less effective than non-stage-based equivalents in helping smokers to quit.

**Interventions for smokers in specific population groups**

**Deprived households and communities**

Lower socioeconomic status (SES) smokers are more likely to set a quit date with NHS smoking cessation services in the UK compared to higher-SES smokers – service reach has a positive impact on equity. However, disadvantaged smokers are less likely to successfully quit than affluent smokers, even when receiving specialist smoking cessation support. This is not because they lack motivation to quit.

An updated review of evidence of behavioural interventions in selected disadvantaged groups included several studies of low-income groups. Four studies demonstrated increased abstinence at 6-month follow-up, using a variety of interventions (mindfulness training plus NRT; telephone counselling with NRT and tailored mail-outs; telephone counselling alone; financial incentive) – suggesting that behavioural interventions using these approaches may be effective in low-income groups. However, few of the studies included intervention components that might have addressed the social and environmental barriers to abstinence (see below). These elements merit further consideration and evaluation in future trials, preferably using large-scale RCTs.

In the most recent study in England, the effectiveness of different types of intervention did not appear to differ significantly for smokers from more or less affluent groups, with open, rolling groups being the most effective form of support. The exception is for the long-term unemployed, where one-to-one counselling appears more effective – this may be because of the challenge and discomfort engaging in interventions requiring interpersonal skills. Clients who saw nurses were less likely to quit than clients who were treated by other types of advisors (e.g. specialist advisors, healthcare assistants, pharmacy staff). There was no evidence that disadvantaged smokers were less likely to quit because they were accessing less effective services (i.e. not accessing open groups, or predominantly receiving support from nurses). It is suggested that social and environmental factors are acting as barriers to successful cessation.
Possible explanations for the difficulties disadvantaged smokers encounter include:\textsuperscript{36}

- **Lack of social support** – friends and family are smokers, smoking is regarded as more common, leading to fewer social pressures not to smoke. Positive social support can make a real difference to those trying to stop (as evidenced in the impact of group support on quit rates).

- **Higher dependency on nicotine** – perhaps due to starting smoking at an earlier age and smoking more cigarettes per day, smoking each cigarette more completely and with deeper inhalations than less dependent smokers.

- **Challenging life circumstances** – lower SES is associated with more stressful/boring work circumstances, and more stressful living and neighbourhood environments. Nervousness, restlessness and depression are more often cited by less affluent smokers as a reason for relapse.

- **How smoking cessation services are delivered and used** – disadvantaged smokers are less likely to use pharmacotherapy in their quit attempt, (and more likely to discontinue pharmacotherapy early if they do use it). They are also more likely to miss sessions or fail to complete behavioural support programmes.

The overall impact on health equity of UK smoking cessation support services is positive – the negative equity impact of lower quit rates among low SES smokers is compensated for by the positive impact on equity of service ‘reach’.\textsuperscript{32,37}

Nonetheless, as smoking prevalence is concentrated in these groups, future smoking cessation service design and delivery may wish to consider the role of more flexible, tailored interventions, addressing the comorbidities, complex needs and circumstances summarised above, perhaps involving:

- long-term and combination NRT and other pharmacotherapies\textsuperscript{35} (to address higher dependency on nicotine)

- social support buddies, community-based or peer-based interventions\textsuperscript{35} (to address lack of social support and environmental factors)

- longer-term support, drop-in rolling groups at a variety of accessible venues that meet local needs\textsuperscript{36} (to address challenging life circumstances and promote use of smoking cessation services)

**Migrant and ethnic groups**

Many interventions have been culturally adapted for ethnic minority groups, particularly African-Americans. A 2013 review\textsuperscript{38} identified that adapted interventions were more acceptable to ethnic minority groups, and therefore it may be ethically desirable to use them. However, this did not translate into improvements in abstinence rates, and the review found interventions focussed on African-Americans and Chinese-origin populations; no interventions adapted to South Asian populations were found. Other studies have tended to focus on indigenous populations in the US, Australia and New Zealand,\textsuperscript{39} and may not be particularly applicable to Wales.
Toolkits to support adaptation of behaviour change interventions for minority groups have been developed and would benefit from rigorous evaluation in a variety of settings.\textsuperscript{40,41}

There is also evidence that changing population profiles over recent years have influenced smoking prevalence and distribution by ethnic and migrant groups in the UK – in particular, East European migrants have substantially higher smoking prevalence compared with most other non-UK born groups. Non-UK born ‘White’ and ‘Chinese’ groups show a strong socio-economic gradient in smoking, which is less prominent in ‘mixed’ and black groups, and not present in South Asian groups. Smoking cessation services need to assess and respond to the changing risk profiles in their areas.\textsuperscript{42}

Waterpipe tobacco smoking (e.g. shisha, hookah) is a traditional method of tobacco use, particularly in the Eastern Mediterranean Region, and use is spreading around the world. A Cochrane review of interventions for waterpipe smoking cessation found 3 studies based on behavioural interventions, all of which showed potential for benefit, but based on small samples. Cessation interventions based on well-established methods for cigarette smoking cessation, adapted for specific social and cultural aspects of waterpipe smoking, show potential and need robust evaluation.\textsuperscript{43}

NICE has published a guideline (PH39) on smokeless tobacco which covers a variety of smokeless tobacco products used by people of South Asian origin. It recommends that local needs assessment should be undertaken, working with local South Asian communities, to collate information about the use of smokeless tobacco and associated health outcomes (e.g. oropharyngeal cancers). Where local needs are identified, appropriate tobacco cessation services should be provided in partnership with local communities, healthcare providers and specialist smoking cessation services.\textsuperscript{44}

**Pregnant women**

Psychosocial interventions increase the proportion of women who stop smoking in late pregnancy, increase mean infant birthweight, reduce the number of babies born with low birthweight, and neonatal intensive care admissions immediately after birth. Impact on preterm births and stillbirths is unclear. Counselling interventions have a clear effect compared to usual care, but not when provided as one component of a broader maternal health intervention. Health education and social support interventions are not clearly effective. Effects are similar for interventions provided to women classified as having low socioeconomic status.\textsuperscript{45}

Pharmacological interventions have generally focussed around the use of nicotine replacement therapy (NRT). NRT used in pregnancy for smoking cessation increases the proportion of women who stop smoking in late pregnancy by approximately 40%. Adherence rates to the NRT regimens in the trials was low – most participants did not use a large proportion of the NRT offered to them. There is no evidence of positive or negative impacts on birth outcomes, though the only study to have followed up infants after birth indicates that use of NRT may promote healthy developmental outcomes. Further research evidence from placebo-controlled trials is needed, as
accruing data indicates it would be ethical to investigate higher doses of NRT than those tested to date.⁴⁶

NICE guideline PH26 provides recommendations about stopping smoking in pregnancy and after childbirth.⁴⁷ These are summarised below:

- Midwives should assess pregnant women’s exposure to tobacco smoke through discussion and use of a CO test, providing information about the risks of smoking to the unborn child and the health benefits of stopping. All pregnant women who smoke should be referred to a specialist smoking cessation service.

- Other practitioners working in health and support services for pregnant women should use any appointments or meetings as an opportunity to ask women if they smoke, and offer a referral to a specialist smoking cessation service.

- Specialist smoking cessation advisers should telephone all women who have been referred to discuss smoking and pregnancy using a client-centred approach. The maternity booking midwife should be advised of the outcome. Intensive and ongoing support should be provided throughout pregnancy and beyond, including regular monitoring using CO tests.

- NRT should be used only if smoking cessation without NRT fails, and only prescribe NRT for use once the woman has stopped smoking. [NB. This guideline dates from 2010 – as noted above, evidence on use of NRT has progressed further since then.]

- Smoking cessation services should be delivered in an impartial, client-centred manner and sensitive to the difficult circumstances many women who smoke find themselves in. Services should take into account sociodemographic factors such as age and ethnicity, and work in partnership with agencies supporting women with complex social and emotional needs.

- Detailed recommendations are made on the training of midwives, healthcare and other professionals. Midwives providing intensive stop-smoking interventions should be trained to the same standard as NHS stop smoking advisers.

- Specific recommendations are also made on working with partners and others in the household who may smoke.

NICE guideline PH48 also provides recommendations on smoking cessation in secondary care, including maternity services.⁴⁸ These are discussed in detail in the section on secondary care later in this chapter.

**Smokers with poor physical health**

Systematic reviews of smoking cessation interventions for smokers with a range of physical health conditions were identified:
• **Smokers due to undergo operations.** Preoperative smoking interventions providing behavioural support and offering NRT may increase short-term smoking cessation, and reduce post-operative morbidity. The evidence available is limited but suggests that interventions beginning 4-8 weeks before surgery including counselling and NRT are more likely to have an impact on complications and long-term smoking cessation.

• **Smokers with lung cancer.** People with lung cancer should be encouraged to quit and offered smoking cessation support, but there are no randomised controlled trials to provide evidence of whether any types of intervention programme for lung cancer patients are effective.

• **Smokers living with HIV/AIDS.** Evidence from studies with this population group indicates that combined behavioural and pharmacotherapy interventions do not show clear evidence of benefit in the long-term, but might help people to quit in the short-term (<6 months). Further higher-quality studies are needed.

• **Smokers with coronary heart disease (CHD).** Psychosocial interventions can help CHD patients to stop smoking if they are provided for over one month. Brief interventions (single contacts or follow up of less than one month) do not appear to be effective.

• **Smokers with chronic obstructive pulmonary disease (COPD).** High-quality evidence exists that a combination of behavioural treatment and pharmacotherapy is effective in helping smokers with COPD to quit smoking. However, there is no clear evidence that any particular pharmacological or psychosocial intervention is more effective than another.

NICE guideline PH48 provides recommendations on smoking cessation in secondary care, many of which will be applicable to smokers with poor physical health. These are discussed in detail in the section on secondary care later in this chapter.

**Smokers with poor mental health**

Systematic reviews of smoking cessation interventions for smokers with a range of mental health conditions were identified:

• **Smokers with severe mental ill-health (SMI).** This 2017 review classified SMI as schizophrenia or other psychotic disorders, bipolar disorder, and depression with psychotic features. The same pharmacological interventions (NRT, bupropion and varenicline) that are effective in the general population are effective in smokers with SMI. Evidence was mixed on specialised (i.e. tailored to the SMI target group) behavioural smoking cessation programmes with no clear evidence of one intervention or component being more effective than others. No studies showed evidence of significant worsening of psychiatric symptoms.
• **Smokers with schizophrenia:** this 2013 review focussed specifically on people with schizophrenia. It found that bupropion increases smoking cessation rates without jeopardising their mental state. Varenicline also improves abstinence rates but possible psychiatric adverse effects could not be ruled out at the time of the review. Other interventions did not provide convincing evidence of a beneficial effect.

• **Smokers with current or past depression:** cessation treatments that specifically addressed handling depression ('mood management' interventions) helped smokers suffering from depression to quit. Bupropion may benefit smokers with a history of depression, but was not shown to benefit those with current depression. There was insufficient evidence to show that other antidepressants, NRT, and standard psychosocial cessation interventions would be effective in smokers with current or past depression.

• **Smokers in treatment for or recovery from substance use disorders:** providing smoking cessation interventions targeted to smokers in recovery for alcohol and other drug dependencies appears to be effective in supporting them to quit. This was consistent across pharmacotherapy and combined counselling and pharmacotherapy, for treatment and recovery, and for alcohol and drug dependencies. Tobacco cessation interventions incorporating pharmacotherapy should be incorporated into clinical practice with people in treatment or recovery from substance use disorders. There is no evidence that these interventions affect abstinence from alcohol or other drugs, and often they can have a positive effect on substance use outcomes.

A systematic review of behavioural interventions in disadvantaged groups included consideration of studies targeting smokers with a mental illness. This identified 5 studies that demonstrated significant effect from a range of approaches:

- single strategies (enhanced telephone counselling; motivational interview)
- multi-component interventions (online programme, NRT and smoking cessation advice; motivational interviewing, printed materials, 12 weeks of NRT & 4 months of telephone counselling; contingency management and bupropion).

Smoking cessation services offered to the general population and via primary and secondary care need to be responsive to the needs of smokers with poor mental health, and the evidence of what is effective in supporting them to quit. Mental health professionals (MHPs) are well placed to deliver interventions. A 2016 review considered attitudes of mental health professionals towards smoking and smoking cessation in people with mental illnesses, based on 38 relevant studies. Quantitative findings identified perceived barriers to providing smoking cessation support included lack of knowledge, training or skills, lack of time and low confidence in ability. The review also identified negative attitudes towards cessation, including perceived negative impact on symptoms/recovery, smoking cessation not seen as a priority, patients were not interested in quitting, and that cessation interventions were not effective.
Across the studies, a minority (approximately 20%) of MHPs felt that smoking cessation was not part of the professional or service role.

There were also views that cigarettes and smoking were valuable tools in managing patients, as self-medication, boredom or stress relief, and as a social activity. Smoking with patients was also seen as a means of establishing a therapeutic relationship. Synthesis of qualitative findings was consistent with the quantitative results. Negative attitudes towards smoking cessation advice and support are held by a significant proportion of MHPs and represent a potential barrier to successful implementation of smoking cessation interventions in mental health/substance abuse services. Dedicated education and training continues to be necessary to support attitudinal change.

NICE guideline PH48 provides recommendations to address smoking in secondary care, including mental health services. These are discussed in detail in the section on secondary care later in this chapter.

**Young people who smoke (adolescents and young adults)**

The most recent Cochrane review on cessation interventions with young people was published in 2013. The quality of evidence is mixed, but there is some promising evidence that complex psychosocial interventions incorporating elements of the transtheoretical model, motivational enhancement and CBT may support abstinence in young people who smoke. There are few trials of pharmacological interventions (NRT and bupropion), none of which demonstrate effectiveness, and some reported adverse events, though most were mild. Further high-quality studies of interventions with this population are needed.

Smoking prevalence among lesbian, gay, bisexual, transgender queer and other sexual and gender minority (LGBTQ+) youth and young adults is much higher than the non-LGBTQ+ population. Estimates range around 35% prevalence. Possible explanations include risks associated with sexual minority status (e.g. internalised homophobia and reactions to disclosure of sexual orientation), as well as common smoking risk factors (stress, depression, alcohol use, victimisation) that are experienced at higher rates among sexual minorities. A scoping review of smoking cessation interventions in the LGBTQ+ population identified a paucity of high-quality controlled research studies with a sound theoretical basis, but suggests that group cessation counselling is feasible and shows evidence of potential effectiveness.

**Interventions in specific settings**

**Community pharmacy**

Community pharmacy delivered interventions for smoking cessation are effective and cost-effective when compared with self-quit or usual care. Community pharmacy is an appropriate and feasible setting to deliver smoking cessation and has the potential to reach those most in need.

A recent realist review attempted to identify influences on the successful delivery of smoking cessation support in community pharmacies. These are
summarised in the diagram below.\textsuperscript{66} White boxes represent mechanisms; coloured boxes represent contextual influences that make each mechanism more likely to have effect; the grey box is the outcome.

**Figure 2: Unifying model showing key influences on successful delivery of smoking cessation support in community pharmacies.**

**Primary care**

A systematic review of cessation interventions in primary care\textsuperscript{67} accorded with the general findings in the PHE overview: combining behavioural interventions with pharmacotherapies is clearly beneficial.

Training health professionals to provide smoking cessation interventions helps them to identify smokers, increases the number of people offered advice and support for quitting, and increases the number of people who quit smoking.\textsuperscript{68} Intensity of training provided varied in the studies in this review, but most were between 1 hour and 1 day, sometimes delivered over more than one session.

Cochrane reviews considering the role of specific primary care professionals are summarised below:

- **Physicians:**\textsuperscript{69} Brief simple advice has a small effect on cessation rates, raising unassisted quit rates of 2-3% by a further 1-3%. More intensive advice with additional components have only a small further benefit.
- **Nurses:**\textsuperscript{70} There is reasonable evidence that smoking cessation advice and counselling by nurses can be effective, but the effect is weaker where interventions are brief, or provided by nurses whose main role is not smoking cessation or health promotion.
• Dental professionals.\textsuperscript{71} Behavioural interventions by oral health professionals incorporating an oral examination component can increase tobacco abstinence rates among cigarette smokers and smokeless tobacco users. A consistent intervention component was brief behavioural counselling.

The draft NICE guideline for smoking cessation interventions and services\textsuperscript{20} includes the following recommendations relevant to the primary care setting:

• Healthcare workers should use every opportunity to ask people if they smoke and advise them to stop smoking, in a manner sensitive to their preferences and needs. People being referred for elective surgery should be encouraged to stop smoking before their surgery.

• People who want to stop smoking should be referred to a specialist smoking cessation service. Pharmacotherapy and brief advice should be offered to people opting out of a referral.

• Those who are not ready to stop smoking should be advised to consider a harm reduction approach, for which further NICE guidance exists.\textsuperscript{72} The fact that someone smokes should be recorded, and they should be asked about it again at every opportunity.

• GPs should offer pharmacotherapy plus brief advice based on individual needs or preferences.

• Healthcare professionals who offer smoking cessation advice and referral should discuss how to stop smoking with people who want to quit, and should encourage people to discuss their use of personally purchased nicotine replacement products.

• Specialist stop smoking services should offer behavioural support, in combination with pharmacotherapy, based on individual needs or preferences. Text message support should be offered as an adjunct to existing stop smoking support.

Secondary/tertiary care

People who are in hospital because of a smoking-related illness may be more receptive to help to quit smoking. Intensive behavioural interventions starting during a hospital stay, and including supportive contact for at least one month after discharge, are effective in promoting smoking cessation in hospitalised patients. Less intensive and shorter duration interventions are not shown to be effective. Adding nicotine replacement therapy (NRT) to intensive counselling significantly increases cessation rates compared to counselling alone, but there is insufficient evidence to conclude that bupropion or varenicline have a similar effect.\textsuperscript{73}

In a systematic review of cessation in the hospital emergency setting, cessation interventions appear to offer an increase in the proportion of patients quitting smoking, though it is unclear whether the difference is due to the experience of being a patient in the emergency ward or the experience of the smoking cessation intervention, or a combination of both. There is insufficient evidence to definitively support the effectiveness of one or more intervention types over others in this often time-constrained setting. Of the 13
studies in the review, 11 were based in the United States: caution should therefore be exercised in applying these findings to the Wales NHS setting.

NICE guidance PH48 provides recommendations to address smoking in secondary care, including acute, maternity and mental health services. These are briefly summarised in Table 5:

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsibility for action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide information to smokers for planned or anticipated use of secondary care</td>
<td>Primary care practitioners</td>
</tr>
<tr>
<td></td>
<td>Secondary care practitioners</td>
</tr>
<tr>
<td></td>
<td>Managers of admissions and pre-admission assessment services</td>
</tr>
<tr>
<td>Identify people who smoke and offer help to stop</td>
<td>Secondary care practitioners</td>
</tr>
<tr>
<td></td>
<td>Mental health practitioners</td>
</tr>
<tr>
<td></td>
<td>Stop smoking advisers</td>
</tr>
<tr>
<td>Provide intensive support for people using acute and mental health services</td>
<td>Doctors</td>
</tr>
<tr>
<td></td>
<td>Stop smoking advisers</td>
</tr>
<tr>
<td>Provide intensive support for people using maternity services (see NICE guideline PH26)</td>
<td>Stop smoking advisers</td>
</tr>
<tr>
<td>Provide information and advice for carers, family, other household members and hospital visitors</td>
<td>Secondary care practitioners</td>
</tr>
<tr>
<td></td>
<td>Stop smoking advisors</td>
</tr>
<tr>
<td>Advise on and provide stop smoking pharmacotherapies</td>
<td>Stop smoking advisers</td>
</tr>
<tr>
<td></td>
<td>Healthcare practitioners who advise on, supply or prescribe pharmacotherapies</td>
</tr>
<tr>
<td>Adjust drug dosages for people who have stopped smoking</td>
<td>Doctors</td>
</tr>
<tr>
<td></td>
<td>Pharmacists</td>
</tr>
<tr>
<td></td>
<td>Secondary care practitioners</td>
</tr>
<tr>
<td>Make stop smoking pharmacotherapies available in hospital</td>
<td>Hospital pharmacists and managers</td>
</tr>
<tr>
<td>Put referral systems in place for people who smoke, including consistent and accessible recording of smoking status, and robust systems for continuity of care between secondary care and local stop smoking services</td>
<td>NHS secondary care hospital/clinic managers</td>
</tr>
<tr>
<td></td>
<td>GPs and primary care practice managers</td>
</tr>
<tr>
<td></td>
<td>Stop smoking service managers</td>
</tr>
<tr>
<td>Provide leadership on stop smoking support</td>
<td>Directors and senior managers of secondary care services</td>
</tr>
<tr>
<td>Develop and communicate smoke-free policies†</td>
<td>Directors and senior managers of secondary care services</td>
</tr>
</tbody>
</table>

* Broad groups of practitioners are referred to here for reasons of brevity – refer to the NICE guideline for full details.
† The Public Health (Wales) Act 2017 includes provisions that will make all hospital grounds smoke-free premises by law, except for areas designated by hospital managers as areas where smoking is permitted (in compliance with any conditions set in regulations).
<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Responsibility for action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support staff to stop smoking (in line with NICE guideline PH5 on workplace</td>
<td>Directors and senior managers of secondary care services</td>
</tr>
<tr>
<td>interventions to promote smoking cessation)</td>
<td>Occupational health service providers</td>
</tr>
<tr>
<td></td>
<td>Hospital stop smoking services</td>
</tr>
<tr>
<td>Provide stop smoking training for frontline staff</td>
<td>Smoking cessation training organisations</td>
</tr>
<tr>
<td></td>
<td>Professional bodies for healthcare</td>
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<tr>
<td></td>
<td>Undergraduate, postgraduate and professional training providers</td>
</tr>
<tr>
<td></td>
<td>Local education &amp; training boards</td>
</tr>
<tr>
<td></td>
<td>Directors, managers and healthcare professionals in secondary care and mental health</td>
</tr>
<tr>
<td></td>
<td>services</td>
</tr>
<tr>
<td></td>
<td>Managers of stop smoking services</td>
</tr>
<tr>
<td>Ensure local tobacco control strategies include secondary care</td>
<td>Directors and senior managers of secondary care services</td>
</tr>
<tr>
<td></td>
<td>Directors of public health</td>
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<tr>
<td></td>
<td>Public health and clinical service planners</td>
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<tr>
<td></td>
<td>Local partnerships for tobacco control</td>
</tr>
<tr>
<td>Plan and provide(^\ddagger) smoke-free secondary care services</td>
<td>Providers of secondary health services</td>
</tr>
</tbody>
</table>

**Table 5: NICE recommendations to address smoking in secondary care**

Other residential institutions, e.g. prisons, care homes

Limited evidence is available in relation to smoking cessation in prisons, care homes and other residential institutions.

A review of behavioural interventions in disadvantaged groups\(^{35}\) identified two randomised controlled trials based on interventions with prisoners. One was focussed on those in community correction in Alabama, USA (i.e. in the criminal justice system but living in the community), where all participants received bupropion and brief smoking cessation advice, and the intervention group received 4 additional 20-30 minutes smoking cessation counselling sessions. There was no significant difference in quit rates between the groups, with across group abstinence of 9.4\%.\(^{74}\)

The other study was in an Australian prison setting, with all participants receiving a multi-component intervention (NRT plus 2 30-minute CBT sessions). In addition, the intervention group received active nortriptyline, whilst the control group received placebo. No significant difference in abstinence was found between the groups; but participant cessation rates were comparable to the general community, suggesting that multi-component interventions may be a viable cessation support strategy in prison populations.\(^{75}\)

\(^{\ddagger}\) The NICE recommendation is ‘Commission’ which reflects the English market-based health system. In Wales a planning-led approach is taken to health service delivery, and so we have adapted the wording of the recommendation to reflect this.
Two studies with prisoners/former prisoners who had quit whilst incarcerated (perhaps due to smoke-free prison policies) suggest that relapsing on release is extremely common (84% and 98% relapse rates reported), and may be associated with an expression of freedom and independence.\textsuperscript{76,77} The prison service appears to be a favourable context for developing smoking cessation support, but other aspects of the criminal justice system, such as police custody and probation, are variable in willingness to engage (based on a single study in England).\textsuperscript{78}

A study reviewing the forms of behavioural support with most success (based on data from 49 Stop Smoking Services in England) identified that, for prisoners, the most successful approach was one-to-one counselling (whereas for most other groups, open rolling groups were most successful). This may be for similar reasons to the same finding for long-term unemployed smokers – discomfort engaging in interventions requiring interpersonal skills. However, this was based on a relatively small number of prisoners in the study (2000 out of a total of over 132000 quit attempts).\textsuperscript{33}

A study investigating attitudes to giving advice in staff at a long-term residential care home (in the United States) suggests that staff may be missing intervention opportunities and that institutional support of cessation advice could enable improvement of residents' health.\textsuperscript{79} Elements of NICE guideline PH48 could therefore be relevant to the care home setting, and may also be relevant in other institutional settings, to provide an environment that encourages smokers to quit and supports smokers making quit attempts.

**Workplace interventions**

The workplace is a useful setting for helping people to stop smoking. Interventions based on group therapy, individual counselling, pharmacotherapy and combinations of the above are about as effective in the workplace setting as they are in other settings (see overview table previously). However, self-help methods, environmental cues, social support, relapse prevention programmes and multiple risk behaviour interventions are less effective in the workplace setting, with low absolute numbers of people quitting via these methods. Evidence is mixed for incentive-based interventions in the workplace.\textsuperscript{80}

NICE guideline PH5 makes recommendations about workplace interventions for smoking.\textsuperscript{81} These are summarised below:

**Employers should:**

- Publicise effective interventions and make information on local stop smoking support services widely available at work.
- Be responsive to individual needs and preferences, including providing on-site smoking cessation support where sufficient demand makes it feasible.
- Allow staff to attend smoking cessation services during working hours without loss of pay.
- Develop a smoking cessation policy with staff and their representatives as part of an overall smoke-free workplace policy.
• Smoking cessation services should offer one or more effective interventions.

• Ensure smoking cessation support and treatment is tailored to the employee’s needs, preferences and circumstances, offering locations and schedules to suit them.

• Offer support to employers who want to help their employees to stop smoking. Where appropriate and feasible, provide support on the employer's premises.

• If initial demand exceeds the resources available, focus on the following:
  ◦ small and medium-sized enterprises (SMEs)
  ◦ enterprises where a high proportion of employees are on low pay
  ◦ enterprises where a high proportion of employees are from a disadvantaged background
  ◦ enterprises where a high proportion of employees are heavy smokers.

• Be able to respond to fluctuations in demand.
  ◦ Note: The original context for this recommendation was anticipated fluctuations in demand around implementation of smoke-free legislation in 2007. Provisions in the Public Health (Wales) Act 2017 extending smoke-free legislation to outdoor childcare settings, school and hospital grounds, and public playgrounds could also be anticipated to lead to fluctuations in demand with certain categories of employers.

**Delivering effective smoking cessation services**

Having reviewed the literature around smoking cessation interventions and their use in specific groups and settings, we now briefly consider evidence about how these interventions may be planned, promoted and linked to other services.

**Service models**

In Wales, smoking cessation services are typically offered as a single, specialised intervention. However other models of service are being developed, particularly in England, where variation in local commissioning arrangements has increased in recent years.

Public Health England’s briefing on models of service delivery provides guidance not only on the types of intervention that might be included, but also key considerations in selecting service models:

• Ensure those in priority populations are offered, and can access, effective support

• The intensity of support on offer is a crucial factor and should be sufficient to address population needs and have the necessary impact
A minimum service offering smokers access to pharmacotherapy and support with how it can be used should be made available if commissioning intensive behavioural support is not possible.

The recommended approach continues to be the universal evidence-based service with specialist behavioural support and pharmacotherapy, the basis on which stop smoking services in England were established. In recognition of the variety of models being considered by local authorities in England, other models are described with recommendations for service commissioners.

We explore one particular approach below – integrating smoking cessation with other ‘lifestyle’ services offered by an umbrella organisation.

**Integrated (lifestyle/wellbeing) services that incorporate smoking cessation**

There are two main versions of this approach in relation to smoking cessation. In the first, the brand/organisation may act as a signposting process to a specialised smoking cessation service (in which case results similar to those summarised above might be expected), which may contribute to savings in relation to administration and promotion of the service.\(^{19}\)

The second version offers multi-behaviour change interventions, where behaviour change advice and support is delivered in relation to multiple ‘risky behaviours’ concurrently, including smoking cessation. A recent review and meta-analysis\(^ {82}\) indicates that there is little or no evidence to suggest that these multiple behaviour approaches are successful in increasing smoking cessation rates compared to usual care or basic information provision (brochures etc). Multiple behaviour interventions may dilute the effectiveness of smoking cessation interventions, particularly if they are delivered by practitioners who have not received training of the required standard. (There is some evidence that multiple risk behaviour interventions may be effective in relation to diet and physical activity, where the risk behaviour patterns cluster together). Multiple risk behaviour interventions provide worse (higher) cost-utility analysis estimates than smoking cessation interventions (i.e. cost per QALY/DALY saved).\(^ {83}\) The review concludes that smoking should be targeted in isolation:

> "Given the lack of good evidence that integrated ‘lifestyle’ services are effective and cost-effective, any decision to pair smoking cessation services with other health behaviour services should not be taken lightly. Such services would need rigorous evaluation and would benefit from a standard evaluation framework."\(^ {82}\)

**Use of electronic health records**

Changes to electronic health record systems to prompt recording and treating of tobacco use appear to provide modest improvements in documentation of status and referral to specialist cessation services. Studies have not evaluated the impact on smoking cessation rates.\(^ {84}\)

**System/organisational change interventions**

The role of healthcare professionals in helping smokers to quit has already been explored. However, it is recognised that healthcare providers may experience barriers to providing this support – recognising smokers, and having enough time, skills, training and/or resources. Changes in the wider organisation of health professionals may help to improve their involvement in
helping people to stop smoking, and so improve the likelihood of them successfully quitting. Examples of these changes include:

- Systematically asking patients if they smoke
- Recording smoking status on patient health records
- Identifying dedicated staff member(s) to provide smoking cessation support
- Introducing advice to stop smoking into routine care
- Introducing policies and rules to restrict smoking and support quitting activities
- Paying healthcare workers for delivering cessation support

There is limited research of low quality about the impact that 'system change' interventions have on smoking cessation. These interventions have shown improvements in process outcomes (e.g. documentation of smoking status, referral to smoking cessation services) but have not shown effectiveness in achieving increased cessation rates. Further high-quality research into the impact of these interventions on smoking cessation and system-level outcomes is needed.85

**Recruiting smokers into cessation programmes**

The following elements may improve recruitment of smokers into stop smoking programmes, or levels of smoking cessation: personal, tailored interventions; proactive recruitment methods (e.g. text messages indicating scarcity of places available rather than generic text message reminders); and more intensive recruitment strategies, requiring increased contact with potential participants. Providing incentives can also increase recruitment effectively.86

A trial evaluating effectiveness of a 20-minute scripted brief intervention in the community setting87 (Salvation Army sites in Wisconsin, USA) showed a significant increased rate of calls to the Wisconsin quit-line in the intervention group, suggesting that community settings and third sector organisations may have a valuable role to play in motivating smokers in low-income groups to quit.

The draft NICE guideline for smoking cessation interventions and services20 includes recommendations to organisers and planners of local, regional and national public education & communications campaigns (unchanged from the previous 2008 guideline).

Organisers of campaigns should:

- Co-ordinate communications strategies to support the delivery of stop smoking services, telephone quit-lines, school-based interventions, forthcoming tobacco control policy changes and any other activities designed to help people to stop using tobacco.
- Develop and deliver communications strategies in partnership with NHS, regional and local government, and non-governmental organisations.
Service planning and delivery

The draft NICE guideline for smoking cessation interventions and services includes the following recommendations for providing smoking cessation interventions and services to meet local needs:

- Use relevant local strategies and plans to ensure evidence-based stop smoking interventions and services are available for everyone who smokes.
- Use needs assessment to estimate smoking prevalence among the local population.
- Prioritise specific groups who are at high-risk of tobacco-related harm for intervention.
- Set targets for specialist stop smoking services, including:
  - Treating at least 5% of the estimated local population who smoke each year
  - Achieving a successful CO-validated quit rate of at least 35% at 4 weeks
- Check and confirm quit attempts using carbon monoxide monitoring (success defined as 10ppm at 4 weeks after quit date).
- Monitor performance data for specialist stop smoking services routinely and independently, and make these results publicly available.
- Audit exceptional results (e.g. 4-week quit rates below 35% or above 70%) to determine reasons for unusual performance and identify best practice.

The National Centre for Smoking Cessation and Training has issued service and delivery guidance for local stop smoking services. The guidance includes detailed recommendations on commissioning/planning smoking cessation services, which should consider the entire pathway that smokers follow. Detailed information and best practice guidance is provided in relation to:

- Information and intelligence
- Identification and referral of smokers: sources and systems
- Communications and marketing
- Branding of stop smoking services
- Methods of stopping smoking
- Use of unlicensed nicotine containing products
- Stop smoking interventions: configuration, reach, efficacy and targeting priority groups
- Delivering interventions: principles, programme content, intervention mix and pharmacotherapy
- Measuring success and return on investment
CLeaR improvement model for tobacco control

CLeaR is an evidence-based approach to tobacco control designed for use by local authorities and tobacco control alliances. It has recently been refreshed and endorsed by Public Health England. CLeaR stands for three linked domains: Challenge, Leadership and Results. The model offers a free self-assessment tool and a voluntary peer-assessment process to provide independent challenge and benchmarking, plus ‘deep-dive’ self-assessment tools to investigate focussed issues (three of which relate to smoking cessation in specific settings/groups).

Statistics from NHS Stop Smoking Services in England

In England, stop smoking services are commissioned at a local level (unitary and county local authorities). Although the policy and organisational context in England is quite different to Wales, we have considered how services in different parts of England are performing in relation to key indicators, particularly those also used in Wales. This may provide insights into how services in Wales might best be delivered in the future.

Table 6 summarises some key indicators relevant to NHS Stop Smoking Services in England for the 2016-17 financial year, aggregated to the regional level. This aggregation will mask some variation at local authority level (the statistics are reported by local authorities). A small number of local authorities (9) did not submit data for one or more quarters. Two local authorities (Isle of Wight & Manchester) no longer run a stop smoking service.

<table>
<thead>
<tr>
<th>Region</th>
<th>Estimated smoking prevalence</th>
<th>Proportion of smokers setting a quit date</th>
<th>Successful quitters (% of those setting quit date)</th>
<th>Successful quitters (per 100000 smokers)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Self-reported CO-validated</td>
<td>Self-reported CO-validated</td>
</tr>
<tr>
<td>North East</td>
<td>17.2%</td>
<td>6.78%</td>
<td>46 38</td>
<td>3112 2553</td>
</tr>
<tr>
<td>North West</td>
<td>16.8%</td>
<td>4.67%</td>
<td>46 30</td>
<td>2153 1387</td>
</tr>
<tr>
<td>Yorkshire &amp; Humber</td>
<td>17.7%</td>
<td>2.97%</td>
<td>61 46</td>
<td>1814 1371</td>
</tr>
<tr>
<td>East Midlands</td>
<td>16.1%</td>
<td>4.32%</td>
<td>53 36</td>
<td>2299 1567</td>
</tr>
<tr>
<td>West Midlands</td>
<td>15.4%</td>
<td>4.32%</td>
<td>50 40</td>
<td>2159 1738</td>
</tr>
<tr>
<td>East of England</td>
<td>14.4%</td>
<td>4.75%</td>
<td>56 39</td>
<td>2652 1830</td>
</tr>
<tr>
<td>London</td>
<td>15.2%</td>
<td>4.89%</td>
<td>50 36</td>
<td>2429 1751</td>
</tr>
<tr>
<td>South East</td>
<td>14.6%</td>
<td>3.92%</td>
<td>52 38</td>
<td>2054 1508</td>
</tr>
<tr>
<td>South West</td>
<td>13.9%</td>
<td>4.37%</td>
<td>45 33</td>
<td>1986 1429</td>
</tr>
<tr>
<td>England</td>
<td>15.5%</td>
<td>4.43%</td>
<td>51 37</td>
<td>2248 1627</td>
</tr>
</tbody>
</table>

Table 6: Key indicators for NHS Stop Smoking Services in England, 2016-17
The best outcomes, when aggregated to the regional level, are being achieved in the North East. This is the only region treating over 5% of the estimated local population who smoke (see NICE recommended target above). The North East also achieves the highest successful quit rates in England (as a proportion of all smokers, not just those setting a quit date). Estimated smoking prevalence in the North East has decreased from 22% in 2012 to 17.2% in 2016, though of course this is not solely down to smoking cessation activity.

This is not due to isolated performance in one or two local authorities with large populations: 11 of 12 local authorities exceeded the 5% target and achieved CO-validated quit rates better than the England average. The exception, Darlington, was procuring a new service in 2017, and reported that “performance dropped across the period of procurement due to existing providers winding down activity or terminating contracts prior to transition to the new service. This meant that many individuals were not followed up as actively as in previous years.”

Allocation and expenditure data have not been published at regional level in England since 2013/14 (due to incomplete data). However, all local authorities in the North East submitted data for 2016/17, which was largely complete. That local authority data is presented in Table 7, together with aggregated data for the North East region, to provide some context for the level of investment in smoking cessation services that has contributed to the outcomes described above.

**Fresh**

The North East is home to the UK’s first dedicated regional tobacco control programme, *Fresh* which was established in 2005. The programme was based on work in the United States to change social norms, and includes a small team working in partnership with the NHS and local authorities, linked to regional and national networks such as Cancer Research UK and Action on Smoking and Health. All local authorities have supported the programme from the start.

In relation to stop smoking services, Fresh provides direct support on commissioning and provision of stop smoking services, and a data benchmarking role, plus regular campaigns and public awareness to remind smokers why and how to quit. It hosts quarterly meetings of service commissioners and a forum for services to share best practice.

Given the similarities in smoking prevalence, demographics and public health challenges faced in both North East England and Wales, further investigation of the factors driving the success of cessation services in North East England, including the approach led by Fresh, may be valuable.

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5 Explanation given by Darlington Borough Council in Table 5.3 of the Statistics on NHS Stop Smoking Services England 2016-17.
<table>
<thead>
<tr>
<th>Local authority</th>
<th>% of smokers setting a quit date</th>
<th>Number of successful quitters</th>
<th>Expenditure (£) excluding pharmacotherapies</th>
<th>Expenditure (£) including pharmacotherapies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Cost per quitter†</td>
<td>Cost per quitter†</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Total</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Self-reported</td>
<td>Self-reported</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>CO-validate</td>
<td>CO-validate</td>
</tr>
<tr>
<td>Darlington</td>
<td>4.04%</td>
<td>229</td>
<td>194</td>
<td>28,860</td>
</tr>
<tr>
<td>County Durham</td>
<td>6.57%</td>
<td>2,841</td>
<td>2,453</td>
<td>1,497,620</td>
</tr>
<tr>
<td>Gateshead</td>
<td>6.41%</td>
<td>889</td>
<td>780</td>
<td>236,996</td>
</tr>
<tr>
<td>Hartlepool</td>
<td>9.63%</td>
<td>491</td>
<td>283</td>
<td>217,961</td>
</tr>
<tr>
<td>Middlesbrough</td>
<td>6.29%</td>
<td>486</td>
<td>364</td>
<td>227,393</td>
</tr>
<tr>
<td>Newcastle-upon-Tyne</td>
<td>5.57%</td>
<td>1,058</td>
<td>781</td>
<td>255,010</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>6.08%</td>
<td>587</td>
<td>499</td>
<td>52,431</td>
</tr>
<tr>
<td>Northumberland</td>
<td>5.17%</td>
<td>1,086</td>
<td>1,001</td>
<td>410,480</td>
</tr>
<tr>
<td>Redcar &amp; Cleveland</td>
<td>7.36%</td>
<td>615</td>
<td>524</td>
<td>354,048</td>
</tr>
<tr>
<td>South Tyneside</td>
<td>8.70%</td>
<td>909</td>
<td>761</td>
<td>297,167</td>
</tr>
<tr>
<td>Stockton-on-Tees</td>
<td>11.18%</td>
<td>874</td>
<td>544</td>
<td>Only total expenditure reported</td>
</tr>
<tr>
<td>Sunderland</td>
<td>7.79%</td>
<td>1,544</td>
<td>1,342</td>
<td>344,184</td>
</tr>
<tr>
<td>North East region</td>
<td>6.78%</td>
<td>11,609</td>
<td>9,526</td>
<td>*4,304,592</td>
</tr>
</tbody>
</table>

* Regional expenditure figures based on total expenditure in Stockton-on-Tees.

† The expenditure/cost per quitter data shown in this table is calculated by dividing the total spend on smoking cessation services in the year by the number of successful quitters (self-reported and CO-validated). From 2011/12 onwards, organisations have been advised to only include monies spent on smoking cessation activity, not wider tobacco control measures. There is some evidence that in practice there may be a lack of standardisation in terms of the scope of expenditure items included in some organisation’s returns; this means figures may not always be calculated on a comparable basis locally.

Source: NHS Digital Statistics on NHS Stop Smoking Services

Table 7: Smokers treated, successful quitters, expenditure and cost per quitter, North East England local authorities, 2016-17
3 Qualitative Interviews Methodology

The specification for this research stipulated that the views of selected key stakeholders was gathered via depth interviews. As the time span allotted to the data gathering amounted to approximately three weeks in October 2017, it was deemed expedient to conduct the interviews via telephone.

Qualitative data are useful in providing an in-depth and rich understanding of people’s personal perspectives. A semi-structured interview schedule was developed using broad based open questions with prompts (Annex 2). The questions explored participants’ views on what the future of smoking cessation services in Wales should look like, what role organisations should be assigned and what potential barriers there may be to preventing a successful service being introduced.

In order to help prevent bias, several safeguarding mechanisms were introduced to the process. For data gathering, participants were assured of confidentiality and anonymity, and questions were developed that were open ended and as broad as possible. For analysis, the researchers met several times to check how the data were developed into the themes outlined in the next chapter.

Participant Selection

Atypical purposive sampling was used in this review as the Welsh Government outlined those participants to be approached to take part in the research. As this was a high level review, these were the Directors of Public Health in the seven health boards in Wales and other key stakeholders in Wales’ smoking cessation services in the Welsh Government and Public Health Wales. Following an introduction from Welsh Government colleagues to potential participants, an email was sent containing the participant information sheet, participant consent form and a copy of the questions that would be asked.

In addition to these participants, the researchers identified some further participants who would be useful; a representative of primary care and secondary care services.

Ethics

The research was conducted in conjunction with colleagues from Cardiff Metropolitan University. Under university regulations, any research is required to undergo consideration by an ethics panel, the application was submitted on 27th September 2017 and approval was received on 10th October 2017.

The Interviews

A semi-structured interview schedule was agreed with the contractors which would normally have been piloted, however, the time frame allotted to the project was such that no formal testing was possible. However, as is the case with such interview schedules, many of the questions did not need to be
asked directly as they were addressed by expansive answers to previous questions. The 30 minutes to 75-minute interviews took place in October 2017 via telephone. Three participants were unable to be contacted by telephone within the project timescale, so e-mail responses to the questionnaire were obtained.

A sample number of interview notes were sent to the participants to check for accuracy, although time constraints dictated that this was not possible for all participants. A number of minor amendments were made based on the feedback received, although no significant changes were put forward by participants.

Analysis

The data were analysed using Thematic Analysis (TA), applying the standard analysis protocol recommended by Braun and Clarke. They propose that TA allows the exploration of the essentialism or realism of the participant’s experiences and compares them with those reported by others. Themes emerged such as branding, seamless service provision and quality control.

Limitations

The research was conducted under very short time constraints with implications for the rigour with which the research was conducted. While confident the work was carried out to high standards, inevitably some compromises were necessary. For example, it is common to transcribe interviews and ask participants to check for accuracy, but it was not possible in this case. Whilst interviews were recorded, notes were used rather than full transcriptions.

The sample of interviewees was drawn to reflect those with a strategic role in smoking cessation services in Wales, primarily individuals in Welsh Government, Public Health Wales and Directors of Public Health in Wales. Despite best efforts, it was not possible to reach every person identified to participate, and whilst numerous attempts were made via e-mail and telephone calls, one person could not be contacted and another declined to participate. It is reasonable to assume those agreeing to participate would speak on behalf of their organisation but inevitably it may be that individual biases influenced the responses given by those taking part.
4 Findings and discussion

Introduction

This chapter draws on the responses provided by each of the interviewees to the telephone questionnaire (n=10) and to the same questionnaire completed by the individual in person (n=3). The final sample consists of 2 individuals from Welsh Government, 3 individuals from Public Health Wales, 5 Directors and Public Health and 3 individuals from primary & secondary care.

The responses to each question were broken down to their core elements and then subject to thematic analysis. Themes emerged in the following areas: the future vision for specialist cessation services in Wales; the role of stakeholders (current and future); the role of Help Me Quit; potential barriers to the effective delivery of services; key factors for success; and ensuring a collaborative approach.

The remainder of this chapter presents these themes in further detail. This chapter presents only the views of respondents. The views and observations of the researchers are contained within the commentary and reflections that are discussed further in Chapters 5 and 6.

Themes

1.0 The future vision and how it would work

1.1 There was a general view that that changes to the current modus operandi are needed, although it is important to note that this would not necessarily result in a change in hosting arrangements.

1.2 It was explicitly noted by several respondents that health boards are the natural place for cessation services due to the health boards' knowledge of the local population and the issues it faces, and because they already have treatment and prevention roles as part of their main function. It was also noted that such an approach would fit well with the strategic planning process of health boards and that health board plans have sections relating to public health. It was also noted that such an approach would lead to a single accountable body at local level.

1.3 Representatives of all groups of respondents noted that if cessation services were to be transferred to health boards, then the needs of staff being TUPE-ed would need to be carefully addressed.

1.4 Some respondents commented on the ‘competitive’ nature of provision in some areas. The unintentional outcome of this is the creation of barriers for clients progressing their quit attempt.

1.5 The need for a clear and smooth transition of smokers from one part of the service to another is a point that occurred repeatedly.

1.6 Several respondents highlighted the fact that smokers wishing to quit cannot all be treated in the same way if they are to succeed. Some will find it relatively easy to stop smoking with minimal support whilst others
will need a more intense approach involving group or 1-2-1 support for example. The evolution of smoking cessation provision in Wales must continue to address these needs with differentiated treatment support options remaining in place.

1.7 The need to consider the development of a more targeted approach to address the cessation needs of key sub-groups was a recurring theme. Mention was made of minority sub-groups, those with particular health needs e.g. pregnant smokers and those in areas where smoking prevalence is higher. As prevalence rates change the delivery model will be flexible to focus more on those groups in which smoking is more entrenched.

1.8 Several respondents suggested that customer focus / customer orientation should be at the core of any future delivery of service

1.9 One of the important foundations of a successful cessation service at both a local and national level is the collection and use of data from the point at which a potential quitter enters the system through their quit attempt to analysis of process and outcome. Much work has been done on the development of IT infrastructure for the providers of cessation services in Wales. Respondents commented that continued evolution / development of this infrastructure should address the following:

- The system should be accessible to all health professionals who see potential quitters at their point of entry to cessation services be this in a GP practice, pharmacy, hospital or via a telephone contact etc.

- Information about the potential quitter should only be entered once. The person should not have to be re-entered to the database when they move from one part of the service to another e.g. GP to pharmacy, hospital to primary care.

- Once a person’s details have been entered into the database other providers of cessation support should be able to easily access the information and update it.

- A supportive step would be for GPs to maintain an up to date picture of a patient’s smoking / quit status, with a question on this issue being asked of patients at least once every 2 years for example.

1.10 A number of respondents put forward the point that an essential feature of the future vision would be that that individuals can easily access smoking cessation services at whatever level they need, and that maximum use is made of recruitment opportunities at each potential entry point e.g. primary care (including GPs, pharmacists, dentists, etc.), hospitals, and even from the person’s home.

1.11 In any future service delivery respondents noted that it is imperative that services are attractive to quitters and that public awareness of the services that are on offer and how they can be accessed is high. Issues that relate to this include brand awareness – a single brand that applies both nationally and locally and is promoted using all available tools. It
was felt that use of social media as a marketing tool should be increased – although there are clearly budgetary implications for this.

1.12 A number of respondents commented on the benefit of having multiple providers of cessation services. These would include primary care, secondary care, specialist services etc. These roles are further explored later in this chapter.

1.13 It was consistently held that collaborative working is an important feature of service provision. However, this necessitates good communication among providers and stakeholders with absolute clarity and mutual understanding of the role of each provider of cessation advice and support. This is especially the case in terms of how an organisation’s / individual’s role contributes to the achievement of the 5% target for that health board area.

1.14 It was recognised that the cumulative effect of the action of all cessation services should lead to the achievement of the 5% target. It is imperative therefore that each provider fully appreciates and is able to quantify how their role contributes to the achievement of the target.

1.15 Some respondents made the point that to make services more responsive to local circumstances (e.g. demographics), areas of deprivation, the geography of the area, health boards should procure all cessation services for the area they cover and have autonomy in determining allocation of resources specific to smoking cessation.

1.16 Respondents also indicated that services should provide value for money and be based on best practice.

2.0 Current and future stakeholders and their roles

2.1 A variety of stakeholders were identified by respondents. There was a high degree of consensus among respondents that primary care, including GP’s, dentists, pharmacies, opticians etc. is a key stakeholder. A majority of respondents indicated that PHW and health boards are stakeholders, with a minority mentioning Welsh Government. A variety of other organisations were named, including third sector organisations such as MIND Cymru and ASH Wales Cymru, secondary care, Occupational Health services, local communities, large employers, social services, prisons.

2.2 Table 8 provides an overview of the major roles identified by the respondents for each of the key stakeholders:
<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Roles</th>
</tr>
</thead>
<tbody>
<tr>
<td>PHW</td>
<td>Mass media campaigns / public awareness raising including the development and ownership of a national brand. Establishes service standards Establishes and manages common dataset ensuring it is accessible and usable by all involved in cessation Establishes a call centre triaging function. Note: this could be procured from an external provider. Maintains detailed information on current referral pathways Innovation e.g. horizon scanning, monitoring best global practice and emerging research. Disseminates best practice, new developments and new understanding of cessation, cessation services and processes. Marketing (all forms)</td>
</tr>
<tr>
<td>Health Boards</td>
<td>Establishes and ensures continued provision of Tier 1 services Ensures clarity of role - so that each service provider understands their role and how it contributes to the overall health board action on cessation / achievement of the cessation target(s) Holds local providers to account Ensures local providers adhere to data collection protocols Ensure collaborative approach / partnership working between local providers and with national agencies Ensures seamless transfer of person from one part of the service to another Shares experience / practice / knowledge / process with other HBs Utilises national branding and resources locally</td>
</tr>
<tr>
<td>Welsh Government</td>
<td>Leadership Establishes reporting and accountability structures Monitors the use of resources Accountability that emphasises collaborative / collective agreements / working practice at local level To provide clarity on how health boards should account for the cumulative contribution of service providers in terms of the achievement of the 5% target. To hold health boards to account for the achievement of the 5% target in their areas.</td>
</tr>
</tbody>
</table>

Table 8: Stakeholder roles
3.0 The role of Help Me Quit (HMQ)

3.1 It is important to note that it is possible to see the roles of PHW and HMQ as being one and the same / interchangeable as PHW runs HMQ. However, the role of PHW in the context of smoking cessation is not limited to HMQ, as seen above.

3.2 A number of respondents also felt that HMQ should be responsible for the development and maintenance of brand identity that would apply across cessation services in Wales. This brand should be attractive to smokers, and should signify a trustworthy service that is of high quality and people focused. The 'brand' should also form a central part of any mass media campaigns / social marketing etc. to promote cessation services in Wales. One person noted that a key message should be ‘you don't have to do it alone’.

3.3 A few respondents commented on the possibility of HMQ being a provider of accredited training on issues relating to cessation, with one mentioning the possibility of the development of on-line training materials.

3.4 Data in the context of its collection, use, management and reporting, was seen by several respondents as being a potential role for HMQ. A point considered to be of high importance is that any metrics system should be user friendly, and be an easily accessible database with an individual’s details only needing to be entered once irrespective of where the person is being registered.

3.5 Several respondents indicated that in their view HMQ should be a point of first contact. Any call handler must be able to access the database to both register individuals and also provide appropriate information on cessation and / or referral pathways etc. to those already registered and seeking additional support.

3.6 It was suggested that HMQ could facilitate consistency of service provision and this could involve it establishing and managing communication with and between different service providers, including creating networking opportunities and identifying and disseminating good practice among service providers in Wales.

3.7 Quality assurance was a role for HMQ identified by a small number of respondents.

3.8 Other points mentioned by respondents included: HMQ being a provider of support to local services; a producer of resources for use with and by potential quitters and it was also noted that the use of answering machines at the first point of contact in any future form of service delivery should be avoided at all costs.
4.0 Potential barriers to the delivery of smoking cessation services

4.1 Respondents provided a variety of potential obstacles to (current and) future service delivery. There was some consensus on two potential barriers to the effective delivery of cessation services, namely, a potential lack of capacity within specialist services that would be accentuated if marketing / branding initiatives were successful in recruiting more smokers and resource constraints, in particular time and money.

4.2 Other potential barriers that were listed were:

- A lack of (effective) communication between stakeholders.
- A lack of understanding among stakeholders of the needs and roles of other stakeholders and how they each operate. This lack of understanding can, in some circumstances, lead to a lack of trust between stakeholders and a reluctance to consider any integration of cessation services / support.
- A lack of understanding on the part of national level stakeholders of the geographic / demographic issues being faced at a local level.
- A lack of clarity in the context of the 5% target in terms of who is responsible for what in terms of its achievement.
- A lack of investment by health boards in prevention services, with their key focus being on the delivery of treatment and associated services.
- Poor use of referrals by health professionals i.e. they may not refer a potential quitter to specialist services.
- The lack of contractual basis for GPs to undertake cessation activity. This might lead to missed opportunities to refer to specialist services and even the need to address cessation not always being recognised.
- A lack of appreciation on the part of health boards of the full potential of primary care services to recruit smokers into the cessation process and provide on-going support.
- The lack of appreciation of the role of the social determinants of health on cessation attempts e.g. social norms, employment status etc.
- The lack of consistent data collection and analysis.
5.0 Key factors for success

5.1 Several respondents indicated that good communications / marketing and increasing the use of social media would facilitate success.

5.2 Several respondents mentioned adopting a collaborative approach while recognising the value of the different roles that stakeholders play in service provision.

5.3 Having an effective referral system and using it at every opportunity were considered to be important success factors, as was the importance of maintaining the engagement of those attempting to stop smoking. The provision of motivational support would contribute to maintaining engagement.

5.4 Mention was made of resources both in terms of sufficiency and making optimal use of the available resources.

5.5 Gaining greater engagement of primary care services to identify and use opportunities to raise the issue of cessation and then refer potential quitters to specialist services was considered to be a success factor. The role of pharmacy in this context was highlighted.

5.6 There was recognition of the significance of the social determinants of health on cessation rates. In this context, the continuation of other tobacco control measures and steps to reduce social and health inequality are important as both individually and collectively they could lead to an increased motivation to quit among smokers.

5.7 Other key factors for success that were suggested include:

- Reducing smoking prevalence across the population i.e. the continued ‘denormalisation’ of smoking especially in areas with higher prevalence rates, so that the resolve of those attempting to quit is not undermined by their observation and sensing of smoking around them. It was also noted that tailoring responses to better meet the needs of sub-groups, such as those experiencing socio-economic challenges would enhance outcomes.

- All health care providers using the ‘Making Every Contact Count’ approach to support conversations about smoking.

- A clear and sustained commitment to the delivery of smoking cessation services by all stakeholders, including gaining a high level of professional engagement across all services.
6.0 Ensuring collaboration

6.1 Enhancing collaboration between stakeholders in the delivery of cessation services is a recurring theme in this report.

6.2 Several respondents commented that ‘joined up working’ is needed and that the seamless transfer (from one element of the cessation service to another) enables a smoker to have consistent and unbroken support.

6.3 A major tool that would facilitate a more collaborative approach was felt to be the use of a database / metrics system that was easy to use, accessible by all involved in the delivery of cessation services and which, when interrogated, gave users quick access to meaningful information.

6.4 Factors that would ensure collaboration were considered to include:

- Open communication between all agencies engaged in the delivery of cessation services – a process that would be facilitated by the creation and maintenance of information sharing networks.

- The holding of regular meetings at which issues and experiences could be shared and discussed.

- The maintenance of good working relationships between local providers and national agencies in which all parties recognised, understood and respected the role of the others.

- Making use of existing levers to facilitate collaborative working e.g. Joint Executive Team Meetings between health boards and Welsh Government that have the delivery of cessation services on meeting agendas. Coupled with this is the importance of having a common vision and shared approach both strategically and tactically across all stakeholders – a process that might be enhanced through having common targets in Integrated Medium Term Plan IMTP and local wellbeing plans. In turn these approaches could lead to the development of a less competitive working environment within each health board area.

- Focussing on the needs of the smoker was felt to be a helpful principle underpinning a collaborative approach.
5 Conclusions

It is important to state at the outset of this chapter that Wales has a long and positive track record in the delivery of smoking cessation services and the provision of support to smokers who wish to stop smoking. Since the time when No Smoking Day and Quit and Win Campaigns were the major focus of cessation activity, through to the current provision offered by health boards, Public Health Wales and Help Me Quit, smokers in Wales have been able to access considerable support in their cessation attempts.

This review set out to examine the opinions of key individuals in terms of the future provision of smoking cessation services in Wales. A major emphasis was on gathering of information about the best approach and available options for the future delivery of services at both a local and national level.

The perspectives and opinions put forward by the respondents through the semi-structured interviews made a strong case for system level change i.e. on how services are delivered and potentially where they are hosted. Although there was not complete unanimity there was a high degree of consensus on this issue.

Whilst there was some division of opinion about the way that specialist smoking cessation services should be provided in the future, overall, respondents from all stakeholder groups tended to favour an approach in which health boards commission and provide smoking cessation services within the geographical area that they serve.

Respondents indicated a strong desire for a single, overarching brand for smoking cessation services – a brand that is trusted by the public and health professionals alike. The brand should operate equally easily at a national and a local level and all cessation services should use it. Creating and then maintaining high levels of awareness of services in the minds of the key target audience – smokers – is vitally important.

There was a clear consensus that smokers using the service must have a positive experience of a seamless process regardless of where they enter it.

People’s use of technology is rapidly evolving with ever increasing numbers of people turning to their tablet, laptop or mobile phone as a first point of reference on a wide variety of issues. Investment should be made in innovative approaches to cessation support in Wales. However these should be strongly rooted in the research base and should be carefully evaluated before being rolled out across wales.

A number of key issues that would need to addressed were highlighted by respondents should the decision be taken to move to an approach in which health boards commission / provide smoking cessation services. Very prominent among these was the issue of transfer of specialist staff from PHW to health boards. The management of this process is of the utmost importance if specialist knowledge and skills are to be retained.

The changed role of Public Health Wales / HMQ was clearly set out by respondents. It included responsibility for providing the first point of contact
(telephone / on-line provision), branding, training, the development / maintenance of a data / metrics system and quality assurance. Innovation and identifying and sharing good practice were also roles that respondents suggested should be part of the PHW / HMQ function.

In its role, Welsh Government was seen to be vital in providing leadership to the whole system and holding organisations to account. Creating opportunities and bringing organisations together to facilitate the development of a seamless service and being the final arbiter should any dispute arise were also considered to be roles for Welsh Government.

The use of data / metrics was a recurring theme mentioned by many of the respondents, although no indication was provided on any appropriate NHS system that could be used in this context. Getting data collection and management right in any future delivery of service is therefore critical and considerable attention must be paid to it. In particular, in the next stages of the development of cessation services across Wales it should be a priority to have in place a functioning data management system that:

- Allows anyone involved in referring smokers to specialist cessation services to easily enter the person’s details into the database;
- This database can and should be accessed by anyone providing a potential quitter with advice and support irrespective of where they are based;
- Progress through the cessation process and outcomes should be recorded in the individuals’ details in the database;
- It should be possible to interrogate the database so as to gain outcome information by setting, by individual provider, by Health Board area and at an all-Wales level.

From the responses provided it was apparent that there was some uncertainty around the issue of who is responsible for what in terms of the achievement of the 5% target. One service/provider will not achieve the 5% target in isolation. It is when the outputs of all the component parts are added together that the achievement of the 5% target becomes more likely. It is vital therefore that in the future development of cessation services that all services/providers involved should know exactly how what they do contributes to the cumulative effort of all.

Consideration should be given to the relative merits and demerits of adopting a targeted approach, a key element of which is providing the greatest effort where the most optimal outcomes will be achieved. Should this, for example, lead to a focus on areas where smoking prevalence is highest, or on those whose medical needs emphasise the importance of stopping smoking?

Ensuring high standards of quality and consistency in service delivery are important facets in the management of programmes at both a local and national level. Organisations involved in any form of service delivery should adhere to core quality standards. These should be set and monitored at an all-Wales level. This should include the setting of criteria against which service delivery can be benchmarked (self or by external agencies), the
identification and sharing of good practice, as well as situations where challenges have been faced and how they were overcome.

An important element of quality management relates to training and the continuing professional development of staff involved in the delivery of cessation services.

At various points in their responses, a number of respondents made reference to the existence of a ‘competitive’ spirit between providers of cessation services. In many respects there is an inevitability about this with different providers guarding their methods, approaches and clients and seeking to demonstrate the value of what is being done and the importance of their role. However, inadvertent though it might be, this ‘competitive’ edge is not helpful.

In any future model of delivery it is vitally important therefore that all providers are committed to the overall approach, know their role within it, can describe their contribution to the achievement of local and national targets and that the mind set of all involved is one of collaboration and partnership working. The creation of a vision that is shared by all providers and to which each is committed may well be a role for Welsh Government.

Opportunities to engage other potential points at which recruitment to the service might take place should be explored. PHW and health boards could identify opportunities to gain the commitment of organisations such as housing associations, workplaces, community organisations, social services, fire service (particularly when visiting homes to offer advice) and prisons so that smokers in contact with these organisations can be provided with easy to access information on where support can be obtained in a quit attempt. While this naturally forms part of a marketing process it is important to have the ‘buy-in’ of these organisations from an early stage so that they become easy to use conduits through which information can be disseminated.

The findings of the literature review provide clarity on the most effective methods of delivery of service and the engagement and support of smokers. The published evidence generally relates to specific cessation interventions rather than overall models of service delivery, though some key factors were identified for successful services based on Cochrane Reviews and NICE guidelines. These include the value of electronic patient records with consistent recording of smoking status plus any brief interventions / referrals, and the impact of ‘system change’ interventions.

No specific service delivery model in terms of organisational structures / responsibilities was identified that had ‘best evidence’ of effectiveness. However, this finding is unsurprising given the variety of different structures and systems that exist for delivering health services in different countries (even just within the UK). The service data in England were examined, and it is recommended that the long-standing partnership approach in the North East may merit further investigation.

Finally, given the extensive work that is invested in guidelines developed by NICE, it is suggested that even though these public health guidelines are not mandated in the NHS in Wales, nevertheless reference should be made to them in the review, planning and maintenance of cessation services.
There were a number of limitations arising in the process of this review that need to be considered when considering the findings and recommendations. First, the timescale allotted for the research and production of the report was limited. This led to several ‘pinch-points’ in the delivery of the work particularly in terms of the ability to be fully inclusive of all stakeholders in the provision of smoking cessation services across Wales, and as such not every Director of Public Health was able to participate in the review.

Furthermore, the scope of the review was such that participants were limited to Welsh Government, Public Health Wales, and Health Boards. Representatives from these groups were chosen to provide a high level and strategic perspective. Whilst the scope was deliberately narrow for this reason, this meant that there were some stakeholders that were not represented in this review. For example, it did not prove possible to garner an opinion from a representative of pharmacy services in Wales. It may be the case that representatives from primary and secondary care (service delivery) are more able to provide advice on the practical issues that will need to be addressed regardless of which model of service delivery is chosen. It is suggested that further opinion is sought before final decisions on service delivery are made.

The purpose of this review was to provide an independent examination of the current provision of smoking cessation services in Wales and to investigate the best approach to future provision of smoking cessation services at both a local and national level with a view to being a source, but not the only source, of information for the future development of smoking cessation. The review was designed to give a strategic rather than operational perspective, and to produce options for future service delivery in Wales.

In taking this work forward, it is recommended that the options set out in Chapter 6 are presented to all stakeholders for comment and, if at all possible, this should include representatives of primary and secondary care services including GP’s, pharmacists, those working in hospital cessation services and other allied health professionals (such as dentists, opticians etc.). Consideration might also be given to engaging representatives of appropriate third sector organisations in the process.

Next steps should include developing a full cost analysis for each of the options for service delivery presented in Chapter 6.
6 Options for the Provision of Smoking Cessation Services in Wales

Introduction

The models in this chapter are broadly rooted in the findings of the literature review as well as the views of respondents as described during the interviews. The literature review provides a clear indication about what works well in the general population. Existing services in Wales appear to largely reflect this, although this study did not look in detail at current provision as this was not within the scope of the study.

Generally, there is no stand out intervention to reduce prevalence that is currently not in place in the Welsh provision. Continued progress will be made by a multitude of small improvements and adjustments throughout the pathway of services. Improvements should be made consistently and stakeholders should work effectively together in an integrated and seamless way, whatever model of delivery is adopted.

It is worth noting that the literature review provides further rationale for tailoring approaches and enhancing flexibility to most effectively meet the needs of smokers in disadvantaged/low income groups. Further, it provides evidence that new approaches such as mobile phone apps may be helpful in supporting quit attempts, although there is a need for further research in this area. Should an app be developed in Wales, it should be thoroughly researched and evaluated using a rigorous RCT model, to contribute to the future evidence base which is currently sparse.

Key issues to be addressed

In whatever model of delivery is agreed on and implemented, ultimately it is imperative that every person and organisation providing cessation advice / services knows what their role is and how it contributes to the achievement of the 5% target in that health board. Further, there is a single data system that each individual and organisational player can put data in to and each of the key stakeholders can get information out of, without any impairment.

In addition, one of the underpinning principles of any delivery model should be that it is based on NICE guidelines. The following issues should also be taken in to account and addressed:

1. Accountability mechanisms – in its leadership role, Welsh Government must hold to account the providers of smoking cessation services to ensure effective performance and value for money. Questions for consideration might include: is the service being delivered to agreed standards? How will intended outcomes be delivered? How is performance measured? How do the services respond to change? Is there evidence of learning from service performance information?
2. Quality assurance would require the development of quality criteria against which a service provider could benchmark itself and / or be assessed against. The nature and tone of any external assessment of the quality of service delivery would need to be given careful consideration.

3. Data infrastructure – this is a critical component of a seamless and integrated cessation service. Any data system that is created must work for each of the providers, with each provider being able to both enter data into the system as well as extract data out of the system. Agreement must be reached about what is measured and how it is measured e.g. the role of the input of primary care; recording of smoking status; outcomes; feedback loop to clinicians (patient success / patient drop out). The database should facilitate the reporting of outcomes at individual provider level e.g. pharmacy, GP practice, at health board level and at an all-Wales level.

4. The adoption of a consistently applied approach based on cooperation and collaboration is important. Essential elements of this approach include stakeholder engagement, role clarity and good communication. Consideration should be given to how the roles of planning mechanisms such as the IMTP of the health boards, and / or local wellbeing plans can contribute to the delivery of a consistently applied, seamless service. The creation of a shared vision would further underpin and strengthen collaboration. Open communication between all engaged in the delivery of cessation services is essential. This could be achieved by the creation / maintenance of networks and holding regular meetings at which issues / experiences can be shared and discussed.

5. Potential transfer of staff – should the preferred model for future service delivery require movement of staff, the full implications of this at a human level are acutely recognised. There is a risk of the specialist workforce being fragmented should any future transfer take place. All those affected by any potential transfer of undertaking must be fully communicated with and engaged in the transfer process. There is also a need to manage knowledge and skills in any potential transfer and protect these for the good of the service as a whole.

6. Branding of the services – services should look and feel the same, and users should see the same message regardless of which health board area they are in, or which part of the service they are accessing. This includes the provision of one telephone number for all seeking to access the services.

7. Training and education – agreement should be sought as to the national standards to be adhered to by all those involved in the delivery of services. This must include primary care, GPs and affiliated healthcare professionals.
8. Referral and a seamless service – smokers must be able to enter the service at whichever point best meets their needs. For some this will be a cold call to a phone line, for others they may be referred by a healthcare practitioner who they come in to contact with. There is a role for the third sector in terms of recruiting to services. Duplication of services must be avoided. An effective data infrastructure will support this approach.

9. Access to services – as well as being easy to access for smokers, services should be able to see individuals who have quit but still need support. Whilst the Welsh Government / NICE target views the 4 week point as a measure of success, there is clearly a risk that beyond this timeframe there may be a need for further support in order to ensure the longevity of cessation.

10. Given the positive response to the issue of tailoring approaches to meet the needs of specific target audiences consideration needs to be given to how this can best be delivered in any future provision of cessation support including the way that such support is marketed.

**Future delivery models**

The findings of this study point to a number of potential options for the delivery of smoking cessation services in Wales. The emerging options and their relative strengths, weaknesses and practical implications are now described. The role of Welsh Government, as explored in table 8 remains consistent across all potential delivery models.

Key questions – irrespective of which option is ultimately adopted

- How is the delivery of a seamless service to be assured?
- How can collaborative working be enhanced?
- How is absolute clarity on who is responsible for what in terms of the achievement of the 5% target to be realised?
- How can clear lines of accountability / reporting be created that are ‘organisationally friendly’?
- What quality management tools should be used and how should they be used?
- How to embed cessation in short, medium and longer term plans and protect resource?
- How best can the needs of the specialist workforce be met (and what are these needs?)
- Given that skill / competency / commitment of staff is not an issue – is it the system that is impinging on optimal outcome?
Option 1 – Health Boards deliver specialist cessation services, with PHW / HMQ providing central functions and support

### Health Board

| Provides clarity of expectation in terms of: | Branding and first point of access call centre / triage |
| Service delivery (including seamless referral) | Public information across all platforms and types |
| Targets / goals | Communications (internal and external) |
| Quality management | Standards and quality assurance |
| Training / capacity building | Provider of training |
| Data collection, use and management | Establish and managing data collection activities |

**Primary and secondary care**

- Provide brief intervention
- Register potential quitters in CRM and provide cessation support
- Receive potential quitters referred from call centre / CRM and provide cessation support
- Provide specialist provision when necessary e.g. hospital, pharmacy, GP. (1)
- Be able to provide ‘follow-up’ when necessary. (1)
- Input data to CRM

Note (1) A key issue that must be addressed is the smooth transfer of data and the potential quitter from one part of the service to other.

**Table 9: Option 1 – Key stakeholder functions**
**Strengths**

- Local leaders have the relationships, connections and partnerships to enable services to meet the needs of the local population.
- Allows for a mixed provision to best meet the needs of all smokers particularly hard-to-reach groups.
- Cessation support is a clinical treatment service and therefore best placed in health boards.
- Local health boards have day-to-day contact with smokers that can be used to motivate quit attempts and refer to appropriate levels of cessation support.
- Enables PHW to be more independent from service delivery and therefore better placed to take on the role of setting standards, leading on workforce development, and monitoring and evaluating data (please see chapter 4).

**Weaknesses**

- Transfer of staff from PHW to health boards would need to be managed sensitively and with regard to legal obligations.
- Potential for fragmentation.
- Greater resource possibly required than that in options 2 or 3.

**Practical implications**

- At a national level PHW will need to provides the contact centre, be aware of referral pathways, be responsible for innovation, data collection, quality management, training branding and marketing campaigns.
- Consideration of how this will be funded; how are levels of required resource determined.
- Accountability mechanisms to be considered.
- Funding and operation of the national telephone contact centre. There are a number of options including jointly commissioning by health boards, or Welsh Government, or by PHW.
- National standards will need to be clearly defined to ensure a common quality of provision across all health boards and a standardised approach.
- A change management approach is required.
- Possibility of a short-term drop in level of service as change process takes place.
- Possibility of loss of experienced members of staff leaving due to role uncertainty. This would be overcome by being very clear about roles and future structure of service provision as soon as is practicable.

Table 10: Option 1 – Strengths, weaknesses and practical implications
**Option 2 – Public Health Wales is the sole provider of specialist cessation services**

<table>
<thead>
<tr>
<th>Health Boards</th>
<th>Public Health Wales / HMQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitate engagement of primary and secondary care</td>
<td>Employ and manage specialist staff across Wales</td>
</tr>
<tr>
<td></td>
<td>Establish and manage Call Centre / triaging</td>
</tr>
<tr>
<td></td>
<td>Branding</td>
</tr>
<tr>
<td></td>
<td>Communications across all platforms</td>
</tr>
<tr>
<td></td>
<td>Establishes and manages CRM system</td>
</tr>
<tr>
<td></td>
<td>Establishes and maintains database of service provision</td>
</tr>
<tr>
<td></td>
<td>Produces output / outcome reports</td>
</tr>
</tbody>
</table>

**Primary and secondary care**

- Provide brief intervention
- Register potential quitters in CRM
- Provide specialist provision when necessary e.g. hospital, pharmacy GP. (1)
- Be able to provide ‘follow-up’ when necessary. (1)

Note (1) A key issue that must be addressed is the smooth transfer of data and the potential quitter from one part of the service to other.

**Table 11: Option 2 – Key stakeholder functions**

---

53
**Strengths**
- Economy of scale of having a nationally run service.
- Ease of management of what is a small and specialist workforce.
- An integrated system run at a national level.

**Weaknesses**
- Limited flexibility in terms of responsiveness to local needs, possibly resulting in local needs not being fully met.
- Clear need for effective joint planning.

**Practical implications**
- Consideration would need to be given to the possible creation of tension and competition with pharmacy services which are currently commissioned by health boards and a PHW run service.
- A change management approach should be adopted resulting in meaningful stakeholder consultation and engagement. This might be achieved through the establishment of a project board.
- Clear and effective communication between PHW and health boards would be central to the effective planning of service provision.

| Table 12: Option 2 – Strengths, weaknesses and practical implications |
Option 3 Maintain the status quo with further development as necessary

The following charts provide a simplified view of current and future service provision.

In the first chart (current provision) primary and secondary care teams can provide specialist support, and can also refer smokers wishing to quit to the All-Wales specialist support service.

The second chart shows how in an enhanced provision primary care, secondary care and the call centre / online recruitment centre would input potential quitters details into a CRM database. Triaging would occur and smokers would be referred to specialist support in their area. An important question that would need to be answered is whether or not potential quitters could be referred directly to local cessation services through primary and secondary care, although their details would have needed to be entered into the CRM database first.
<table>
<thead>
<tr>
<th>Health Boards</th>
<th>Public Health Wales / HMQ</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facilitates engagement of primary and secondary care</td>
<td>Employ and manage specialist group support staff across Wales</td>
</tr>
<tr>
<td>Recruits smokers</td>
<td>Establish and manage Call Centre / triaging</td>
</tr>
<tr>
<td>Inputs data to CRM</td>
<td>Branding</td>
</tr>
<tr>
<td>Commission specialist hospital-based and pharmacy cessation services</td>
<td>Communications across all platforms</td>
</tr>
<tr>
<td>Produce output / outcome reports</td>
<td>Establishes and manages CRM system</td>
</tr>
<tr>
<td></td>
<td>Establishes and maintains database of service provision</td>
</tr>
<tr>
<td></td>
<td>Produces output / outcome reports</td>
</tr>
</tbody>
</table>

**Primary and secondary care**

| Provide brief intervention                        |                                                                           |
|                                                  |                                                                           |
|                                                  |                                                                           |
| Register potential quitters in CRM and (possibly) refer directly to local specialist support |                                                                           |

**Table 13: Option 3 – Key stakeholder functions**
### Strengths
- Some areas in Wales are getting close to meeting the 5% target with the current model
- Current system has resulted in extra investment in some areas of Wales.
- Highly dedicated and specialised staff working to deliver high quality cessation services in all parts of the current system.
- No disruption to existing staff or services due to uncertainty of re-organisation and structural/employment change.
- Evidence that smoking cessation services in Wales and the UK are effective in reaching disadvantaged groups in areas of high smoking prevalence, though not yet achieving the target of treating 5% of all smokers.

### Weaknesses
- There was a general view among respondents that system change was required.
- Does not address the competition that currently exists between some services.
- The current model is not fully enabling the achievement of the 5% target.

### Practical Implications
- Managing stakeholder expectations that system change is imminent.
- Enhanced collaboration between stakeholders would be required to meet 5% target.
- Clarity of stakeholder roles is a critical factor.
- Potential quitters would make contact with HMQ possibly via an online portal, telephone, email etc. Their details would be entered into the all Wales database, an initial assessment of their cessation needs would be undertaken and they would be referred to a local service provider who would best meet those needs.

**Table 14: Option 3 – Strengths, weaknesses and practical implications**

### Points for further consideration
During the course of this review a number of points were put forward that are pertinent and will contribute to the effective delivery of smoking cessation services in Wales in the future:

- Ensure that services are meeting the changing needs of clients. As prevalence rates drop (e.g. for every 1% drop in smoking rates or another predetermined calendar intervals) a light touch review should be undertaken to ensure that services are meeting the changing client group. This could be undertaken by PHW.

- Re-starting smoking – consider how long contact is maintained after an individual has left the service and the impact this has on the longevity of the quit.
- E-cigarettes – Continue to regularly review the evidence of the effectiveness of e-cigarettes in support smoking cessation, taking into account potential adverse effects.

- Services in North East England have, in almost all local authority areas, reached the 5% target. There are clear parallels between these regions and many Welsh regions in terms of socio-economic factors, industry, and geographical positioning. Investigating further the key success factors for reaching the target could provide valuable information to inform future direction in Wales.

- Some respondents suggested that the specialist group support service, Stop Smoking Wales, may be reaching fewer individuals than health-board commissioned services, at least in some areas, but that it is possible that they are connecting with harder to reach groups and therefore more impactful. Service performance data from Welsh Government indicates that this may be the case in some Health Boards, particularly rural areas and those covering the South Wales Valleys, though there is considerable variation in quit rates between different services and different areas. Further examination of the factors influencing service usage at local level would be beneficial, to ascertain the most effective ways to engage disadvantaged and geographically-isolated smokers. This should take into account possible explanations for the difficulties some disadvantaged smokers encounter when trying to quit, as previously discussed in the literature review.
References


87. Christiansen BA, Reeder KM, TerBeek EG, Fiore MC, Baker TB. Motivating Low Socioeconomic Status Smokers to Accept Evidence-Based Smoking Cessation Treatment: A Brief Intervention for the Community Agency Setting. Nicotine Tob Res. 2015 Aug 1;17(8):1002–11.


Appendix 1: Detailed literature search strategy

The following databases/resources were searched:

- Cochrane Library of Systematic Reviews (browsed by topic “Tobacco Control”, and searched for “Smoking Cessation” – Cochrane & Other Reviews)
- Ovid: Medline, Embase and PsycInfo, using a detailed search strategy involving combinations of MeSH terms, keywords, and search filters, as outlined above. See the appendix for full details of this strategy.
- Manual search of other relevant high-quality sources: healthevidence.org, NICE guidelines, and the National Centre for Smoking Cessation & Training website.

The search was undertaken in late September 2017, and identified papers were reviewed in October 2017.

The table below details the literature search strategy used to search the Ovid database, which incorporates Embase, Medline & PsycInfo. An additional column to the right provides brief explanatory notes.

<table>
<thead>
<tr>
<th>Search string</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. (((comprehensive* or integrative or systematic*) adj3 (bibliographic* or review* or literature)) or (meta-analy* or metaanaly* or &quot;research synthesis&quot; or ((information or data) adj3 synthesis) or (data adj2 extract*))).ti,ab. or (cinahl or (cochrane adj3 trial*) or embase or medline or psyclit or (psycinfo not &quot;psycinfo database&quot;) or pubmed or scopus or &quot;sociological abstracts&quot; or &quot;web of science&quot;).ab. or (&quot;cochrane database of systematic reviews&quot; or evidence report technology assessment or evidence report technology assessment summary).jn. or Evidence Report: Technology Assessment*.jn. or ((review adj5 (rationale or evidence)).ti,ab. and review.pt.) or meta-analysis as topic/ or Meta-Analysis.pt.</td>
<td>Ovid search filter for systematic reviews or meta-analyses (sourced from University of Texas)⁵</td>
</tr>
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<td>Various searches using MeSH terms to identify papers relating to specific groups and/or settings.</td>
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<tr>
<td>3. exp &quot;Ethnic Groups&quot;/ or exp &quot;Emigrants and Immigrants&quot;/ or exp &quot;Transients and Migrants&quot;/</td>
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</tr>
<tr>
<td>4. exp Inpatients/ or exp Outpatients/</td>
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</tr>
<tr>
<td>5. exp Adolescent/ or exp &quot;Young Adult&quot;/</td>
<td></td>
</tr>
<tr>
<td>6. exp &quot;Secondary Care&quot;/ or exp &quot;Tertiary Healthcare&quot;/ or exp &quot;Hospitals, Psychiatric&quot;/ or exp Hospitals/</td>
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</tr>
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<td>7. exp &quot;Residential Facilities&quot;/ or exp Prisons/</td>
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</tr>
<tr>
<td>8. exp Workplace/</td>
<td></td>
</tr>
<tr>
<td>9. exp &quot;Healthcare Disparities&quot;/</td>
<td></td>
</tr>
<tr>
<td>10. depriv*.mp.</td>
<td>Keyword &amp; wildcard search to identify papers relating to deprivation, deprived groups, etc.</td>
</tr>
</tbody>
</table>

⁵ http://libguides.sph.uth.tmc.edu/search_filters/ovid_medline_filters
<table>
<thead>
<tr>
<th>Search string</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>11. 2 or 9 or 10</td>
<td>Combine poverty, disparities &amp; deprivation searches</td>
</tr>
<tr>
<td>12. exp Smoking/ or exp Tobacco/ or exp Tobacco Products/ or exp &quot;Tobacco Use&quot;/</td>
<td>All papers relating to tobacco/smoking</td>
</tr>
<tr>
<td>13. exp Smoking Cessation/ or exp &quot;Tobacco Use Cessation&quot;/ or exp &quot;Tobacco Use Cessation Products&quot;/</td>
<td>All papers relating to cessation</td>
</tr>
<tr>
<td>14. 12 and 13</td>
<td>Papers relating to both tobacco and cessation</td>
</tr>
<tr>
<td>15. 1 and 14</td>
<td>Systematic reviews relating to both tobacco and smoking cessation</td>
</tr>
<tr>
<td>16. remove duplicates from 15</td>
<td>Main base set of systematic reviews</td>
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<tr>
<td>17. 11 and 16</td>
<td>Base set filtered for poverty etc.</td>
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<tr>
<td>18. 3 and 16</td>
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<td>19. 4 and 16</td>
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<td>20. 5 and 16</td>
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<td>21. 6 and 16</td>
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<td>22. 7 and 16</td>
<td>Base set filtered for institutions</td>
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<td>23. 7 and 14</td>
<td>All papers filtered for institutions (due to lack of systematic reviews)</td>
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<td>24. 8 and 16</td>
<td>Base set filtered for workplaces</td>
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<td>More MeSH term searches</td>
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<td>26. exp &quot;Primary Health Care&quot;/ or exp &quot;Community Health Services&quot;/</td>
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</tr>
<tr>
<td>27. exp Pregnancy/ or exp &quot;Pregnant Women&quot;/ or exp &quot;Maternal Behavior&quot;/</td>
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<td>28. exp &quot;Maternal Health Services&quot;/</td>
<td></td>
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<tr>
<td>29. 16 and 25</td>
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<tr>
<td>30. 16 and 26</td>
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<tr>
<td>31. 16 and 27</td>
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<tr>
<td>32. 16 and 28</td>
<td>Base set filtered for maternal health services</td>
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</table>
## Appendix 2: Interview template

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<thead>
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<th>Organisation:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of interviewee:</td>
<td></td>
</tr>
<tr>
<td>Contact No.:</td>
<td></td>
</tr>
<tr>
<td>Position:</td>
<td></td>
</tr>
<tr>
<td>Date and time of interview:</td>
<td></td>
</tr>
</tbody>
</table>

### Question 1: How would you define a successful smoking cessation service?  
*Look for how current model compares with this vision.*

**Response:**

### Question 2a: What is your vision for the future of a specialist smoking cessation service in Wales?  
*Look for clear specifics re local and central roles, who provides the service and who commissions, funding allocation, staff continuity*.

**Response:**

### Question 2b: How would it work?  
*Look for clear specifics re local and central roles, who provides the service and who commissions, funding allocation, staff continuity.*

**Response:**

### Question 2c: How do we ensure it is integrated into a wider offer of support?  
*Look for clear specifics re local and central roles, who provides the service and who commissions, funding allocation, staff continuity.*

**Response:**
<table>
<thead>
<tr>
<th><strong>Question 2d</strong></th>
<th>Is your vision shared in your organisation?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response:</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Question 3:</strong></th>
<th>Why do you consider this approach to be the most appropriate?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response:</strong></td>
<td>(This could raise questions which need to be probed re relationships with PHW / HBs, problems and how they have been addressed; what is going well that could inform future best practice)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Question 4:</strong></th>
<th>Do you know of any clear evidence that such an approach would increase the rates of smoking cessation in Wales?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response:</strong></td>
<td></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th><strong>Question 5:</strong></th>
<th>What else do you want out of smoking cessation services, not just number of quitters, what else is important?</th>
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<tbody>
<tr>
<td><strong>Response:</strong></td>
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<table>
<thead>
<tr>
<th><strong>Question 6a:</strong></th>
<th>Who do you think the key stakeholders are in delivering specialist smoking services?</th>
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</thead>
<tbody>
<tr>
<td><strong>Response:</strong></td>
<td>(prompt all stakeholders: PHW, HB, pharmacy, in-hospital, GP, primary care inc. dentistry, 3rd sector)</td>
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<tr>
<th><strong>Question 6b:</strong></th>
<th>What do you see as the optimum role for these key stakeholders in relation to smoking cessation, and what resources should be attached to this?</th>
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<tbody>
<tr>
<td><strong>Response:</strong></td>
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<tr>
<td>Question 7:</td>
<td>How can capacity be ensured? (e.g. if community pharmacists are the optimum what are the capacity issues are there in terms of training and time).</td>
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<tr>
<td>Response:</td>
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| Question 8:     | What are the pros and cons of your preferred options?                                                                                                      |
| Response:      |                                                                                                                                                     |

| Question 9:     | What is the role of Help me Quit in the delivery of this vision?                                                                                       |
| Response:      |                                                                                                                                                     |

| Question 10:    | Should we address the issue of tailoring approaches to meet the needs of specific target audiences e.g. the young, those with chronic conditions, the elderly etc.? |
| Prompt:         | Tobacco Control Delivery Plan action number 3.6 refers to a targeting strategy at a national and local level prioritising geographical areas and population groups with high smoking prevalence. |
| Response:      |                                                                                                                                                     |

| Question 11a:   | Going forward, how best are HB’s able to meet the target of treating 5% of their smoking population? What needs to happen?                              |
| Response:      |                                                                                                                                                     |

| Question 11b:   | What are the barriers?                                                                                                                             |
| Response:      |                                                                                                                                                     |

<p>| Question 11c:   | What are the key factors for success?                                                                                                                |
| Response:      |                                                                                                                                                     |</p>
<table>
<thead>
<tr>
<th>Question 12a:</th>
<th>Is there a place for a diversity of service provision / multiple service providers and should this be managed centrally or locally? Please specify what should be locally managed / provided, and what should be centrally managed / provided.</th>
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<tbody>
<tr>
<td>Response:</td>
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<tr>
<th>Question 12b:</th>
<th>In the future how could collaboration be ensured? (Between health boards, within own organisations etc)</th>
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<tbody>
<tr>
<td>Response:</td>
<td></td>
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<tr>
<th>Question 13:</th>
<th>Within your (business, corporate, action) plans for the current and future planning years please can you send us the sections that relate to smoking cessation – targets, provider role, delivery etc., and how the inputs, outputs and outcomes will be evaluated.</th>
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<tbody>
<tr>
<td>Response:</td>
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<tr>
<th>Question 14a:</th>
<th>As cessation services have evolved over time a situation has arisen whereby there are seven different cessation services being centrally managed by PHW, in your view should cessation services be centrally managed or locally managed, and why?</th>
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<tr>
<td>Response:</td>
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<table>
<thead>
<tr>
<th>Question 14b:</th>
<th>Is your view shared by your organisation?</th>
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<tbody>
<tr>
<td>Response:</td>
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### 1. For PHW

**Question 15a:** In 2015 PHW made a number of statements in relation to future options for the delivery of specialist smoking cessation services. Can we revisit those and consider if they still apply:

- A significant programme of organisational development was necessary in PHW to support effective delivery.

**Response:**

**Question 15b:**

- A smoking cessation service provided by PHW may be better managed within the Public Health Services Directorate of PHW

**Response:**

### 1. For HBs

**Question 15:** Please could you confirm the services that currently contribute to the smoking cessation provision in your Health Board area.

**Response:**

**Question 16:** What is your expectation of each of these services *in the future*?

**Response:**

**Question 17:** Looking forward, what issues do you envisage regarding the effective provision of the range of services on offer?

(prompt – integration of services, competition, handover of patients, pharmacotherapy?)

**Response:**