# Smoking Insight Evaluation: Leeds South and East CCG area

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## Key findings summary

***Background and context:***

- LSE CCG have set a local target of reducing smoking prevalence rates to 25% by 2015/16.
- In March 2015, the Centre for Health Promotion Research, part of the Institute for Health and Wellbeing, at Leeds Beckett University were commissioned by LSE CGG to undertake the Smoking Insight Evaluation.
- The overarching aim of the evaluation was to gain a comprehensive understanding of how stop smoking interventions can be tailored to reduce smoking prevalence in the LSE population.

***Methodology:***

- To gain a holistic view of stop smoking support in LSE, the evaluation sought the views from a range of stakeholders and utilised a mixed methodology. In total, 143 respondents completed the Smoking Questionnaire (including smokers and non-smokers in LSE), 18 completed the health practitioners questionnaire (designed for those involved in stop smoking support) and interviews were conducted with 41 participants (8 smokers who were non-service users, 22 service users in different stages of their quit attempt, 11 with health practitioners).

***Key findings:***

- Data from the Smoking Questionnaire showed that 29% of respondents currently smoked.
- Current and ex-smokers offered a range of motivational factors for previous or current quit attempts. Most prominent factors included health concerns, financial reasons and children.
- 86% of smokers surveyed intended to quit smoking in the future. Less than half (44%) of smokers intending to quit planned to access support from a health professional (including their GP, practice nurse, pharmacist or stop smoking service).
- The main barriers to attending a stop smoking service were motivation to quit and lack of knowledge of services (e.g. not knowing what to expect from the service, not wanting to attend group support or being aware of other support on offer, as well as concerns about being *"lectured"*).
- Data demonstrates a diverse range of stop smoking support is available in LSE, from promoting campaigns and providing brief interventions to delivering intermediate or specialist stop smoking services.
- Overall, 38% of smokers and respondents who had quit within the last 12 months had received advice/support about stopping smoking from a health professional (excluding specialist stop smoking advisors) and 55% had accessed a specialist stop smoking service. Notably, of those that had received advice from a health professional, nearly two thirds (63%) also accessed support from the stop smoking service. Interview data highlighted service users often self-referred to a stop smoking service after consultation with health professionals.
- Stop smoking support in LSE is largely viewed positively and considered valuable in helping people to quit smoking.

- The main strengths of stop smoking services in LSE were identified as: range of service formats on offer, access to services, service content (information, objective measures to track progress and products on offer) as well as service staff.

***Recommendations:***

- Stakeholders provided a number of recommendations to improve uptake of stop smoking services which should be considered in future stop smoking service specifications to encourage local people living in LSE CCG area to quit.
- *Access.* It was suggested stop smoking support should include daytime, evening and weekend provision and the diverse range of support options available be delivered at variable times (e.g. daytime and evening home visits). Moreover, to support deprived groups it is recommended that services are delivered in locations that are accessible for target groups. Targeted marketing should be used and specific to localities. Community engagement and outreach work should also be considered as an option to aid recruitment of target groups, and facilitate smokers' motivation to quit.
- *Menu of support options*. Offering a range of support formats that could be tailored to individuals' needs was considered essential to increase service access. It was suggested by health practitioners that this should include harm reduction strategies as well as support for abrupt quits. Improved marketing strategies highlighting support options available and financial benefits to attending is recommended. Increased highlighting of the menu of options would enable service users to feel the support was more tailored to their needs which would assist in engagement within the service.
- *Integrated services*. Further joined up working was considered important to improve access to the service, with stakeholders suggesting widespread BIT with health practitioners is needed with clear referral routes into stop smoking services in place. The impact of wider social issues on smoking behaviour was also widely acknowledged by smokers and health practitioners. Providing 'wrap around support' for service users by linking with other services is considered important. In relation to this, concerns and experiences of weight gain during a quit attempt were apparent. Weight management services are already integrated with stop smoking support and the Health Trainer Service is available to offer support with healthy eating and physical activity. Marketing surrounding how to access this support alongside the stop smoking service is needed.
- *Relapse prevention.* Peer support received within the group setting was considered a facilitator to quitting. Offering additional peer support strategies such as an informal 'buddy' system and peer led groups for long term support is suggested. Relapse prevention may also be aided by additional telephone/text support between appointments and a follow-up appointment 6 months to one year after quitting to motivate service users to remain smoke free.
- *Additional support for targeted groups.* Overall, stop smoking support services are deemed appropriate to meet the needs of different target groups. To improve service uptake, the use of incentives for target groups such as pregnant women and deprived groups, in the form of vouchers or gym discounts/passes, should be considered. In addition to targeted marketing for specific groups, further efforts to ensure the service is appropriate for target groups, including BME groups, children and young people as well as smokers with learning difficulties is recommended.

## Glossary of terms

| | |
|---|---|
| ASH | Action on Smoking and Health |
| BIT | Brief Intervention Training |
| CCG | Clinical Commissioning Group |
| LSE | Leeds South and East |
| NCSCT | National Centre for Smoking Cessation and Training |
| NHS | National Health Service |
| NRT | Nicotine Replacement Therapy |
| SPSS | Statistical Package for the Social Sciences |
| WHO | World Health Organization |

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# 1. Background and context

## *1.1 Smoking rates and stop smoking support in Leeds South and East*

The use of tobacco is the primary cause of preventable disease and premature death (World Health Organization, 2011). The latest figures show that 79,100 or 18% of deaths in adults aged 35 years and over in England can be attributed to smoking (The Information Centre for Health and Social Care, Lifestyle Statistics, 2012). It is not only harmful to smokers but also to the people around them through the damaging effects of second-hand smoke (ASH, 2015a).

Smoking rates are much higher in some social groups, including those with the lowest incomes. These groups also suffer the highest burden of smoking-related illness and death. This is the single biggest cause of inequalities in death rates between the richest and poorest in our communities (ASH, 2015b). Leeds South and East CCG (LSE CCG) has the highest prevalence rates of smoking across the city (26% in LSE compared to 21% in Leeds West and 17% in Leeds North) (GP Audit Data, 2013/14). As a result, referrals into stop smoking services are highest in LSE CCG area in comparison to North and West Leeds, and increased further in 2013/14 compared to the previous year. The number of smokers attending the stop smoking service following a referral has, however, declined, as well as the numbers setting a quit date, and subsequently the total number of people quitting smoking through NHS stop smoking services. However, of those that do attend the stop smoking service and set a quit date, the quit rates remain high at over 65% success at 4 weeks following the quit date.

The main support currently offered to local residents in the LSE CCG area to help them stop smoking is via a referral to the Leeds NHS Stop Smoking Services. Smokers may also be referred to the healthy lifestyle service to gain support in relation to stopping smoking. Furthermore, many GP Practices offer in-house smoking cessation advice and support from a trained smoking cessation advisor.

LSE CCG have set a local target of reducing smoking prevalence rates to 25% by 2015/16. To meet this target it is important to gather local intelligence in relation to what additional interventions, projects or incentives local people and local professionals feel could support and encourage people living in the LSE CCG area to attempt to stop smoking.

## *1.2 Aims and objectives*

In March 2015, the Centre for Health Promotion Research, part of the Institute for Health and Wellbeing, at Leeds Beckett University were commissioned by LSE CGG to undertake the Smoking Insight Evaluation.

The overarching aim of the evaluation was to gain a comprehensive understanding of how stop smoking interventions can be tailored to reduce smoking prevalence in the LSE population. The evaluation also included specific objectives, which were:

1. Conduct a survey to ascertain perceptions surrounding smoking and current smoking cessation support available within the LSE population.

2. To gain an in-depth understanding of views surrounding smoking and smoking cessation support available in LSE, lead interviews with:
    - smoking cessation service users (including those who have accessed pharmacy advisors, GP advisors or smoking specialist advisors) who have had a successful quit attempt
    - smoking cessation service users (including those who have accessed pharmacy advisors, GP advisors or smoking specialist advisors) who have had an unsuccessful quit attempt or undertaking an ongoing (less than 28 days smoke free) quit attempt
    - smokers who have not accessed smoking cessation support services

3. Utilising a quantitative and qualitative methodology, explore the views of local health practitioners (including deliverers and non-deliverers of smoking cessation services in LSE) and LSE CCG members in relation to current local smoking cessation services and how they could be improved/identify other services that should be offered to support individuals stop smoking.

### *1.3 Organisation of the evaluation report*

A brief overview of the methodological approach to the evaluation follows; this outlines the process by which evidence was gathered and how the data were analysed. Findings from the evaluation are then presented. The final section draws together issues emerging across the data collection processes, including quantitative and qualitative data, outlining recommendations for stop smoking support in LSE.

# 2. Methodology

The evaluation sought to gain a holistic view of stop smoking support in LSE. To do so, it was necessary to ascertain the views from a range of stakeholders, including non-smokers, ex-smokers, current smokers and professionals involved in stop smoking support. 'Triangulation' of data has been proposed as a means of achieving validity in evaluation (Green and Tones, 1999, Torrance, 2012) and is particularly relevant to this project. This approach relies on collecting evidence of processes and impact from a variety of different sources and making conclusions based on the overall data collected. Triangulating various data sources allows robust conclusions and recommendations to be made. All aspects of the evaluation were approved by the Faculty of Health and Social Sciences Ethics Committee, Leeds Beckett University. Researchers involved in recruitment and data collection on NHS sites obtained Research Passports from Yorkshire and Humber NHS Commissioning Support Service.

The following section briefly outlines the approach to gathering data for this evaluation.

## *2.1 Smoking questionnaire*

The smoking questionnaire was constructed using items from questionnaires previously designed to measure smoking behaviour and/or stop smoking support (including the Office for National Statistics Opinions and Lifestyle Survey (2009), YouGov Population Survey (2010), Health Survey for England (2012) and Smoking Toolkit Study (2014)). Additional items were developed to address the research objectives as required.

Questionnaire items measured demographics, smoking behaviour, intentions to quit, motivators for quitting and reasons for relapse, perceptions of stop smoking support, additional stop smoking support required and willingness to participate in further research. The questionnaire was uploaded to the online survey tool SNAP and took respondents approximately 5 minutes to complete. Various methods were used to recruit respondents from LSE, including texts to stop smoking service users in LSE (those who accessed the service in the 12 months prior to the evaluation), leaflet distribution (by the stop smoking service, a GP surgery, and community organisations), online promotion through Voluntary Action Leeds and Twitter, and face-to-face completion at community venues, resulting in a convenience sample.

## *2.2 Questionnaire for health practitioners*

The questionnaire for health professionals was developed using items adapted from a previous stop smoking service evaluation (Ice Creates, 2014). Additional items were developed to address the research objectives as required.

Questionnaire items explored: roles in stop smoking support, perceptions of in-house stop smoking services and specialist stop smoking services, additional support required and willingness to participate in further research. The questionnaire was uploaded to the online survey tool SNAP and took respondents approximately 10 minutes to complete. Various

methods were used to recruit health practitioners based in LSE, including letters/emails (to the stop smoking service, GP practices, dental surgeries, pharmacies, midwife team, Health Trainer service, LSE CCG and community organisations), online promotion through Voluntary Action Leeds and Twitter, as well as awareness raising of the questionnaire at GP members meetings.

### *2.3 Interviews*

Interviews were conducted with various stakeholders to explore their views of stop smoking support in LSE CCG area. Telephone interviews were undertaken with smokers living in LSE who have not previously attended stop smoking services, users of the stop smoking service [including participants who had recently had an unsuccessful quit attempt and currently smoked, participants undertaking a quit attempt (less than 28 days smoke free) and participants who had completed a successful quit attempt within the last 12 months]. Semi-structured interview guides were developed for service and non-service users and covered: reasons for smoking/quitting, barriers to smoking/reasons for failed quit attempts, perceptions of stop smoking support in LSE and recommendations for improving access to stop smoking support. Interviews lasted approximately 10 to 30 minutes. Service and non-service users were recruited via the questionnaire, the stop smoking service waiting rooms and community organisations, resulting in a purposive sample.

Telephone and face-to-face interviews were also undertaken with health practitioners involved in stop smoking support. Semi-structured interview guides were developed and covered the following topics: roles in stop smoking support, perceptions of stop smoking support available in LSE and recommendations for improving stop smoking support. Interviews lasted 15 to 45 minutes. Health practitioners were recruited through the questionnaire and direct invitations from the research team and project steering group.

### *2.4 Data preparation and analysis*

Quantitative data were analysed in the software package SPSS and descriptive and inferential statistics were performed as appropriate. A p value of 0.05 or less was taken to be significant for inferential tests. In addition:

- For analyses based on age, the data were merged into 2 groups (i) 16 to 35 years old (ii) 36 years and over.

- For analyses based on ethnicity, the data were merged into 2 groups (i) White: British/White Irish & White other (ii) BME: Asian/Asian British; Black/Black British; Mixed; Chinese; Other. The 1 respondent who preferred not to give their ethnicity was removed from the sample when undertaking inferential statistics.

- For analyses based on employment status, data were merged into 3 groups (i) in full time or part time employment (ii) unemployed or not working due to disability or ill health (iii) all others: (student; retired; volunteering; staying at home to look after

children; other). The 1 respondent who preferred not to give their employment status was removed from the sample when undertaking inferential statistics.

- For analyses based on smoking status, data were merged into 3 groups: (i) current smokers (I smoke cigarettes every day; I smoke cigarettes, but not every day; I do not smoke cigarettes at all, but I do smoke tobacco of some kind) (ii) former smokers (I have stopped smoking completely in the last year; I stopped smoking completely more than a year ago) (iii) never smoked.

Thematic analysis was used to organise qualitative data. All interview recordings were transcribed verbatim, the data were coded and themes identified (Marshall and Rossman, 2006). The individually identified themes were then discussed and agreed between the evaluation team, before being organised into larger categories based on the evaluation's primary objectives.

## 3. Findings: The perspectives of service and non-service users

Data from the smoking questionnaire and interviews with service and non-service users will be reported below.

### *3.1 Sample demographics*

In total, 143 respondents completed the smoking questionnaire (62% were completed face-to-face with a member of the research team). Fifty-nine percent of respondents were female and 67% aged 16 to 45 years. The majority of respondents were White British (76%). Approximately half (51%) of respondents were in full or part time employment and a further 22% unemployed. Over three quarters of respondents had postcodes in areas ranked amongst the worst 40% for deprivation in England (quintiles 1 and 2) (Department for Communities and Local Government, 2011). For a full breakdown of questionnaire respondents demographics see Appendix 1.

Thirty semi-structured telephone interviews were also conducted to explore the views of service and non-service users of stop smoking support. Of these 30 interviews, 8 were undertaken with smokers who have not previously attended stop smoking services and 22 with service users [10 with participants undertaking a quit attempt (less than 28 days smoke free) or had recently had an unsuccessful quit attempt; 12 who had completed a successful quit attempt within the last 12 months]. Overall, 63% of participants were female, 27% aged 26-35 years and 30% aged 36-45 years. Ninety-three percent of participants identified themselves as White British. A full breakdown of demographics can be found in Appendix 2.

### *3.2 Smoking status (questionnaire data)*

The questionnaire explored the smoking status of respondents. Overall, 39% of respondents 'had never smoked'. In total, 71% of respondents were current non-smokers, compared to 29% who smoked cigarettes or other forms of tobacco. Nearly a fifth (19%) of respondents had stopped completely in the last year, and a further 13% stopped more than 12 months ago. A quarter of respondents (25%) smoked cigarettes daily (see Figure 1 for a full breakdown of smoking status).

**Figure 1. Current smoking status of respondents**

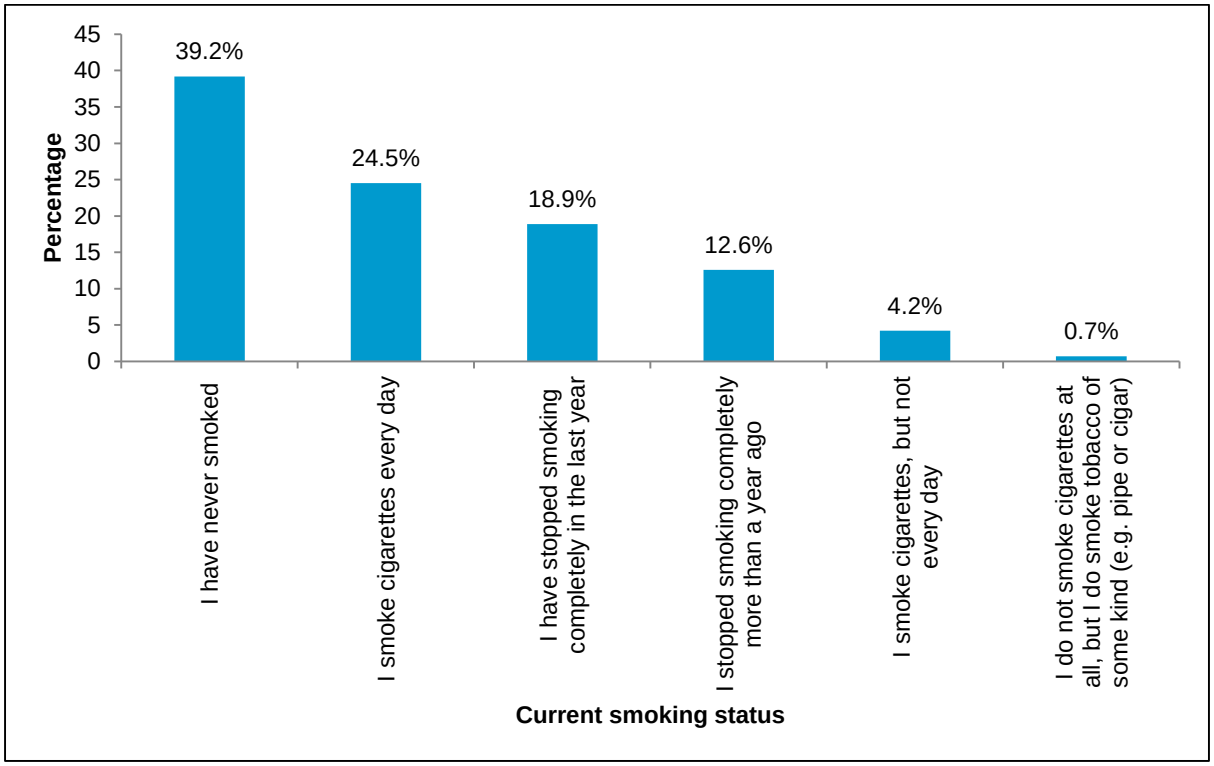



Table 1 provides a breakdown of smoking status by demographics. Gendered analysis revealed that 37% of males (22 out of 59 men) were current smokers compared to 24% of females (20 out of 84). The proportion of current smokers amongst respondents aged 16 to 35 years was 31% compared to 28% amongst individuals 36 years old and above.

Out of the 118 respondents identified as white, 33% were current smokers compared to just 9% of BME respondents (2 out of 23 individuals). Furthermore, 87% of BME individuals had never smoked compared to just under a third of white respondents (30%). The relationship between smoking status and ethnicity was statistically significant ($x^2$ =26.67, df=2, p<0.001).

There was a significant relationship between current smoking behaviour and employment status. Unemployed/not working respondents were significantly more likely to be current smokers than those working full/part time. Furthermore, full/part time workers were significantly more likely than unemployed/not working individuals to have given up smoking ($x^2$ =10.288, df=4, p=0.036).

**Table 1. Smoking status by demographics (%)**

| | | Current Smokers | Former smokers | Never smoked |
|---|---|---|---|---|
| *Sex* | Females | 23.8 | 34.5 | 41.7 |
| | Males | 37.3 | 27.1 | 35.6 |
| *Age* | 16-35 years | 31.3 | 26.9 | 41.8 |
| | 36 years + | 27.6 | 35.5 | 36.8 |
| *Ethnicity** | White | 33.1 | 37.3 | 29.7 |
| | BME | 8.7 | 4.3 | 87 |
| *Employment** | Full/part time employment | 20.8 | 40.3 | 38.9 |
| | Unemployed/not working due to illness or disability | 46.2 | 17.9 | 35.9 |
| | Other | 29 | 25.8 | 45.2 |

*p<0.05

### *3.2.1 Length of time since stopped smoking completely*

Twenty-seven respondents had stopped smoking completely in the last year. As can be seen from Table 2, two thirds (n=18) gave up longer than 3 months ago, with 10 respondents stopping completely between 3 to 6 months ago, and 8 between 6 months and 1 year.

**Table 2. Length of time since stop smoking completely**

| Length of time | Frequency |
|---|---|
| In the last week | 1 |
| More than 1 week up to 1 month | 2 |
| More than 1 month & up to 2 months | 2 |
| More than 2 months & up to 3 months | 4 |
| More than 3 months & up to 6 months | 10 |
| More than 6 months & up to 1 year | 8 |

### *3.2.2 Electronic cigarette (e-cigarette) use*

Overall, the analysis revealed that two thirds of respondents (66%) had never tried an e-cigarette. Whilst only 9% of respondents currently smoked e-cigarettes, nearly 18% had tried e-cigarettes in the past 12 months but did not currently use them and just less than 8% had tried e-cigarettes longer than 12 months ago but did not currently use them. Of the 13 current e-cigarette users, 4 were smokers (31%), 8 were ex-smokers (62%) and 1 had never smoked (8%). Furthermore, out of the 36 respondents who had tired an e-cigarette, 22 were smokers (61%) and 13 (36%) were ex-smokers. Notably, 96% of respondents (n=54) who had never smoked had also never used an e-cigarette.

Table 3 provides a breakdown of e-cigarette use by demographics. Further analysis revealed only 8 females (10%) and 5 males (9%) currently smoked e-cigarettes. Just under a quarter of females (23%) and 29% of males had tried an e-cigarette. Over two thirds of female respondents (68%) had never tried e-cigarettes compared to 63% of males.

Out of the 67 individuals aged 16 to 35 years old, only 5 currently used e-cigarettes (8%) compared to 8 out of 76 respondents aged 36 years old and above (11%). A notably higher proportion of the 16 to 35 years age group had tried e-cigarettes (31% vs 20%). Over two

thirds of individuals (70%) in the 36 years and above age group had never tried e-cigarettes, compared to 61% aged 16 to 35 years.

Interesting results were found when e-cigarette use was broken down by ethnicity. Just less than a third of white respondents (30%) had tried e-cigarettes and 11% currently used them (n=13). None of the 23 BME respondents had ever tried e-cigarettes. The relationship between e-cigarette use and ethnicity was statistically significant ($x^2$ =14.19, df=2, p=0.001).

In terms of employment status, 15% of those unemployed or not working due to ill health/disability currently used e-cigarettes compared to 10% of full/part time workers, and 0% of those of other statuses. Around a third (31%) of those unemployed or not working due to ill health/disability had tried e-cigarettes compared to 19% of full/part time workers and 29% of individuals with another employment status. Approximately 71% of full/part time workers had never tried an e-cigarette compared to 54% of unemployed or not working due to ill health/disability.

**Table 3. E-cigarette use by demographics (%)**

| | | Current e-cigarette user | Tried e-cigarettes in the past 12 months, do not currently use them | Tried e-cigarettes longer than 12 months ago, do not currently use them | Never tried e-cigarettes |
|---|---|---|---|---|---|
| *Sex* | Females | 9.5 | 16.7 | 6 | 67.9 |
| | Males | 8.5 | 18.6 | 10.2 | 62.7 |
| *Age* | 16-35 years | 7.5 | 19.4 | 11.9 | 61.2 |
| | 36 years + | 10.5 | 15.8 | 3.9 | 69.7 |
| *Ethnicity** | White | 11 | 21.2 | 8.5 | 59.3 |
| | BME | 0 | 0 | 0 | 100 |
| *Employment* | Full/part time employment | 9.7 | 12.5 | 6.9 | 70.8 |
| | Unemployed/not working due to illness or disability | 15.4 | 23.1 | 7.7 | 53.8 |
| | Other | 0 | 19.4 | 9.7 | 71 |

*p<0.05

### *3.2.3 Previous quit attempts/harm reduction strategies*

Of the 42 respondents who currently smoked cigarettes or tobacco, 64% had made a serious quit attempt in the past 12 months compared to 36% who had not (for a full breakdown by demographics, see Table 4).

The 27 respondents who had made a serious quit attempt in the past 12 months were asked to give the number of times they had tried to give up smoking. Two did not know, but out of the remaining 25 individuals, 11 had tried once, 9 had tried twice, and 5 had made 3 or more attempts.

Overall, 46% of smokers reported smoking about the same 'compared with this time last year', 37% smoked less and 17% more.

**Table 4. Previous quit attempts by demographics (%)**

| | | Made serious quit attempt in the past 12 months | Not made a serious quit attempt in the past 12 months |
|---|---|---|---|
| *Sex* | Females | 60 | 40 |
| | Males | 68.2 | 31.8 |
| *Age* | 16-35 years | 61.9 | 38.1 |
| | 36 years + | 66.7 | 33.3 |
| *Ethnicity* | White | 64.1 | 35.9 |
| | BME | 100 | 0 |
| *Employment* | Full/part time employment | 73.3 | 26.7 |
| | Unemployed/not working due to illness or disability | 66.7 | 33.3 |
| | Other | 44.4 | 55.6 |

### *3.2.4 Intentions to quit*

In total, 36 out of 42 smokers (86%) expressed an intention to give up at some point in the future. A third of respondents (n=14, 33%) intended to give up but were not sure when and approximately one fifth (n=9, 21%) intended to quit within the next 6 months. Fourteen percent (n=6) of smokers had no future intentions to give up smoking.

Further analysis revealed that 8 out of 22 males (36%) intended to give up within the next 6 months, compared to 1 out of 20 females (5%). Nine females (45%) intended to give up but were not sure when, compared to 5 males (23%). Four males (18%) and 2 females (10%) did not intend to give up.

Ten percent of individuals aged 36 years and over (n=2) said they did not intend to quit, compared to 19% of those 16-35 years old (n=4).

A breakdown of results by employment status revealed that 4 out of 18 people who were unemployed/not working due to ill health or disability (22%) did not intend to give up in the next year compared to none of those working full or part time.

### *3.3 Motivational factors for previous and current quit attempts*

Eighty-one respondents who completed the questionnaire provided reasons for quitting smoking or wanting to stop smoking in the future (see Table 5). The data shows that health reasons dominated the responses; with almost three quarters (73%) indicating they believed quitting would be better for their health in general. Over a third stated that the quit decision was taken to reduce the risk of getting smoking related illness (36%) or for financial reasons (36%). Just under a third of respondents had or wanted to quit because they were worried about the effect on children (30%). Of the 9 who said "other" 4 gave pregnancy as an answer. Additional responses in this category were: to improve fitness; religious reasons; hygiene; recover from operation.

**Table 5. Main reasons for wanting to give up smoking**

| | Frequency | Percentage |
|---|---|---|
| Better for my health in general | 59 | 72.8 |
| To reduce the risk of getting smoking related illness | 29 | 35.8 |
| Financial reasons | 29 | 35.8 |
| Worried about the effect on my children | 24 | 29.6 |
| Because of a health problem I had | 18 | 22.2 |
| Family friends wanted me to stop | 16 | 19.8 |
| Worried about the effect on other family members | 11 | 13.6 |
| Other | 9 | 11.1 |
| Because of the smoking ban in all enclosed places | 2 | 2.5 |

Similarly, during interviews, current and ex-smokers offered a range of motivational factors for previous or current quit attempts. Predominately, current and ex-smokers cited health concerns and financial reasons for wanting to give up smoking.

Current and ex-smokers were aware of the negative health implications associated with smoking. Participants discussed how wanting to improve their general health and fitness or suffering from a health complaint (including cancer, respiratory problems, cardiovascular disease and diabetes) motivated their quit decision.

> *"And my health. Because I'm getting older now, so I need to start looking after myself". (Ongoing quit attempt, service user)*

Smoking was often viewed by current and ex-smokers as a *"waste of money".* Participants recognised they could save money by quitting smoking and considered this a motivator to quitting.

> *"We've saved an actual fortune over the last three weeks. Nearly £300". (Ongoing quit attempt, service user)*

Additional reasons for quitting smoking were pregnancy and children. Female smokers reported ill health during pregnancy, and concerns that smoking would affect the unborn child impacted positively on smoking behaviour. Similarly, parents reported quitting smoking because of their child; parents stated they did not want their child to see them smoking, were unable to leave their child unattended to go outside to smoke and/or their child had asked them to quit smoking.

> *"My son, I've got a 9 year old son, and I was on holiday last year, and he said that he didn't want me to die, so I just said 'right, okay, that's it, the final straw'". (Ex-smoker, service user)*

Social support in the form of encouragement from family and friends was also thought to aid a quit decision. Specifically, participants reported quitting with a partner had facilitated a quit attempt as well as knowing someone who had been successful in quitting smoking.

> *"Like I say, I went [to the service] – because my friend, she'd recently stopped on the Champix. And I thought if she could do it, I can do it. Because she's a worse smoker than me, you know. But I watched her over the weeks stopping and not bothering… even people smoking around her, so I thought I'm going to try this as well". (Ongoing quit attempt, service user)*

It was also recognised that social influences on smoking, including efforts to de-normalise smoking (e.g. smoking ban) and reductions in smoking rates aided participants' own quit attempts.

> *"When you're drinking and everyone else is smoking, which is getting less and less now, because obviously you've got no smoking areas. You can't smoke in pubs and things. I mean most of our friends have kind of stopped now. So you're not around it as much". (Ex-smoker, service user)*

### *3.4 Barriers to quitting smoking and reasons for unsuccessful quit attempts*

In total, 21 questionnaire respondents gave reasons for smoking again after a serious quit attempt. The most common reason given was stress, often associated with life events or relationship troubles. For example:

> *"started again after miscarriages"; "split with partner"; "stress of newborn"; "it was the one year anniversary of my mum dying. I struggled at the time and ended up re-starting" (Questionnaire respondents)*

Several respondents found stopping *"too hard"* and reported receiving inadequate/a lack of support.

> *"Not enough support and needed to be on the Champix longer and quit on my own terms not when the support worker says so, that's just too much pressure". (Questionnaire respondent)*

During interviews, smokers and ex-smokers identified similar barriers to quitting smoking and reasons for unsuccessful quit attempts. Comparable to questionnaire respondents, most interview participants had previously had at least one failed quit attempt. Participants did not view this as a barrier to quitting in the future or remaining smoke free. Barriers and reasons for relapse included:

- *Lack of motivation.* A lack of motivation to stop smoking was considered the main barrier to quitting smoking/remaining smoke free. Participants recognised they smoked because they found it enjoyable and must want to stop smoking for a quit attempt to be successful.

*"And because my heart wasn't in it and I was still enjoying cigarettes, it didn't work [quit attempt]". (Ex-smoker, service user)*

- *Stressful situations.* Participants stated they often smoked as a means to relieve stress. As a result, stressful events (e.g. miscarriage, relationship breakdown, death of a family member, exams and work life) were considered a barrier to remaining smoke free.

  *"And then I stopped again when I got pregnant this time, before I lost it [baby] in December. And then I started smoking again after that. That was purely… just because of everything that had gone on. I just wanted to really". (Current smoker, non-service user)*

- *Social situations*. In particular, participants reported finding it difficult to avoid smoking on holiday or whilst socialising with friends and family, especially when consuming alcohol.

  *"I went out with the lads on the booze and went to the pub and just had a cig and that was it". (Ongoing quit attempt, service user)*

- *Weight.* Both males and females cited binge eating during quit attempts and considered weight gain a barrier to quitting in the future as well as a reason for previous unsuccessful quit attempts. Moreover, smoking to suppress appetite and lose weight was also considered a barrier to remaining smoke free.

  *"One – the first time I think it was weight related. I'd gained a lot of weight and I'd sort of convinced myself that if I started smoking again I'd lose weight. So that was a biggie for me". (Ex-smoker, service user)*

- *Dealing with withdrawal symptoms.* It was widely recognised by smokers and ex-smokers that smoking is an addiction and quitting would lead to withdrawal symptoms, for example mood changes, nicotine cravings, binge eating and restlessness. Notably, using NRT and other stop smoking medication such as Champix was considered to aid quitting by helping to manage withdrawal symptoms.

  *"Yeah, very bad withdrawals, very bad, affected me emotionally, very bad tempers; just couldn't see me myself doing the, getting it out of my system. I binge ate, just everything went upside down really. It was a very difficult ordeal, so, I needed some help". (Ex-smoker, service user)*

- *Lack of support.* Not accessing or receiving sufficient support from a health professional during a quit attempt was believed to be a reason for relapse. One participant described how despite being motivated to quit during her pregnancy, a lack of support resulted in failed attempts.

  *I tried [to quit] while I was pregnant. And it just wasn't happening. And then I found out… because I didn't know about the service until [child was born]. So that, you know, I'd end up smoking through the pregnancy. And me and my partner were really*

*stressed about that. We didn't find out about this service until after. And then, it's worked.*

***…Did you receive support from a health professional to quit during your pregnancy?***

*Not really. I just got told I couldn't have any kind of nicotine replacement or anything like that. I'd just have to do it on my own. It got to the point where I was stressing about that, that I ended up smoking anyway. (Ex-smoker, service user)*

- *Perceived negative side effects of stop smoking medication.* Participants experienced a range of side effects they attributed to stop smoking medications, such as sore skin from patches, as well as sickness, vivid dreams and mood changes from using Champix. Side effects experienced made participants hesitant to re-start a quit attempt or in some cases was a reason for relapse.

  *"And at first they gave me Champix and it sent me into a bit of a lunatic". (Ex-smoker, service user)*

- *Experiencing ill health attributed to quitting.* A minority of participants reported experiencing ill health during/after quitting, including respiratory problems and difficulties controlling diabetes.

  ***"**Because I found that my coughing actually got worse to begin with. I'm guessing my body was trying to clear all the rubbish out of my lungs and stuff. So sometimes it can feel like I'm actually getting less fit rather than more fit with all this… because I've never really had a smoker's cough. But then I started with the cough when I stopped smoking". (Ongoing quit attempt, service user)*

- *Illicit tobacco*. Purchasing cheap illicit tobacco was considered a barrier to quitting smoking, because the cost of smoking is then less of a facilitator to quitting.

  *"If you can get a packet of twenty cigarettes for £3. It doesn't give you much reason to quit smoking, does it? Because you're not even spending that much. You know it's three quid". (Ex-smoker, service user)*

### *3.5 Barriers to attending stop smoking services*

Questionnaire data showed 88% of current smokers who have not accessed stop smoking services in the last 12 months but intend to quit in the future, did not plan to visit specialist stop smoking support services in the next year. Similarly, during interviews smokers who had never accessed stop smoking support services were divided as to whether they would go to stop smoking services in the future. Smokers who would consider accessing stop smoking support services in the future, recognised the importance of professional support to aid quitting.

*"I need all the help I can get. It's not going to be, it's not going to be an easy one to do". (Smoker, non-service user)*

However, the main barrier to attending a stop smoking service was motivation to quit. Smokers and ex-smokers felt the person had to be ready to quit before accessing the service.

> *"People always know that I am not interested in stopping smoking yet. I know there's help out there if I want to… all of these clinics and all of these patches and all of these chewing gums. I know that they're out there and I just don't want them". (Smoker, non-service user)*

Insufficient knowledge of the service was also a barrier to attending. Non-service users described not knowing what to expect from the service, not wanting to attend group support or being aware of other support on offer, as well as concerns about being *"lectured"* by a health professional put them off attending.

> *"Well personally, only because I suffer from panic and anxiety, so I don't really go anywhere other than like [name of community group] and things like that and stuff… so I wouldn't be able to go to groups or anything. That wouldn't be something for me". (Smoker, non-service user)*

Concerns surrounding stop smoking medication offered at stop smoking services were also given. Smokers discussed concerns surrounding addiction and health implications associated to stop smoking medications.

> *I have thought about it [attending a stop smoking service], yes. But I think what's putting me off it is, you know, the nicotine replacement.*
> ***What is it about the nicotine replacement that's put you off attending?***
> *Well, I think it's … because they have the patches and the gum, don't they? These kind of things, and I'm just concerned about, you know, what further issues they might cause really.*
> ***So you're concerned about the products?***
> *Yes, I mean, they're likely to have chemicals and what have you in them. Obviously it won't be as bad as smoking, the chemicals from smoking, but still like, you're just going to feel bad replacing one drug dependency with another really.*
> *(Smoker, non-service user)*

Others felt the service was not *"for people like them",* referring to their status as an *"occasional"* smoker or having the perceived motivation to quit without professional support.

### *3.6 Evaluation of the stop smoking service*

Users of stop smoking services attended them to receive professional support to quit. Participants thought by accessing free professional support they could get the relevant information, stop smoking medication (free or for the cost of a prescription), as well as the necessary psychological support.

### *3.6.1 Service delivery*

- ***Format***

Service users had accessed a range of support from the stop smoking service, including group support, one-to-one support, drop-in, home visits and telephone support.

Questionnaire data revealed that 55% of current smokers and ex-smokers who had quit within the last year had used the Leeds NHS Stop Smoking Services (n=69). As Table 6 shows, over 60% had accessed advice/support from NHS stop smoking one-to-one support sessions (39%) and/or drop in sessions (22%). Approximately 15% had used stop smoking support group(s), 7% had utilised telephone support offered and 6% had received at least one home visit.

**Table 6. Proportion of smokers and recent quitters receiving advice/support from Leeds NHS stop smoking services**

| | Frequency | Percentage |
|---|---|---|
| Stop smoking support group(s) | 10 | 14.5 |
| One-to-one support session(s) | 27 | 39.1 |
| Drop-in session(s) | 15 | 21.7 |
| Telephone support | 5 | 7.2 |
| Home visit(s) | 4 | 5.8 |

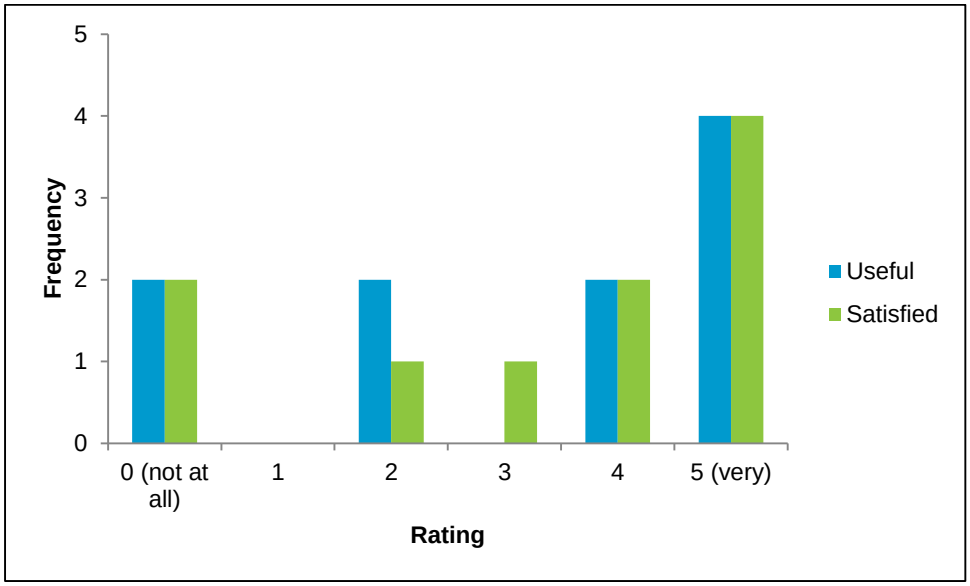
***NHS stop smoking support group***

During the questionnaire, smokers and ex-smokers who had quit within the last year were asked to rate:

1. how useful they found Leeds NHS Stop Smoking Services (0=not useful at all to 5=very useful)
2. how satisfied they were with the services they had used (0=not satisfied at all to 5=very satisfied)

Overall, the mean usefulness rating of NHS stop smoking support groups was 3.2 (SD=2.04) with a mean satisfaction rating of 3.3 (SD=2.0). A breakdown of the ratings is provided in Figure 2. Notably, 6 out of the 10 respondents who used the support group rated both usefulness and satisfaction at 4 or above.

**Figure 2. Ratings of NHS stop smoking support group**




Similar to the questionnaire data, interview respondents who accessed group support often viewed the support positively. Group support was considered beneficial in terms of: having the opportunity to share experiences, get support from others, feeling motivated by the group environment to continue with the quit attempt and not wanting to let others down.

> *"And there might be times where you have a little weak spot and you can bounce that off people in the team and they give you encouragement. Vice versa, you can give them your experiences because Champix doesn't agree with everybody. So you know it's an opportunity to share. Sharing is caring, isn't it? But you get lots of encouragement. You know, pick you up when you're down". (Ex-smoker, service user)*

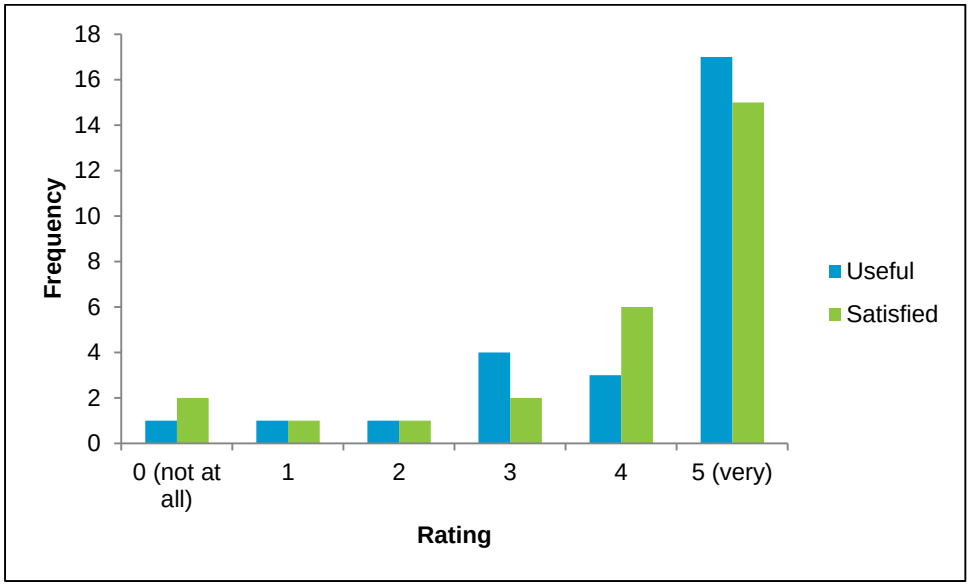
Negative comments were also given and related to negative attitudes within the group, other group members, and the group environment being too structured.

> *"They weren't really up to much [group sessions]. It was all just sit in a room and moan about smoking… it was a bit poor. We were a group, of like people I've never shared the light of day with. I remember being in…like thinking, 'oh god, I don't want to be here'". (Ex-smoker, service user)*

***NHS stop smoking one-to-one sessions***

The mean usefulness rating of NHS stop smoking one-to-one sessions was 4.15 (SD=1.38) with a mean satisfaction rating of 4 (SD=1.54). A breakdown of the ratings is provided in Figure 3. This form of support was rated highly overall with 17 out of 27 individuals (63%) giving it the highest possible rating for usefulness. In total, 20 individuals (75%) rated the usefulness of one-to-one sessions at 4 or above. Furthermore, 21 (78%) rated satisfaction with the sessions at 4 or above, with 15 (56%) giving the maximum rating.

**Figure 3. Ratings of NHS stop smoking one-to-one support sessions**




Questionnaire respondents rated the service positively due to the support received and the approach of staff:

> *"They helped me learn and understand my habit by discussing in detail when I most want one and what triggers it". (Questionnaire respondent)*

However, not everyone expressed positive comments about the support given, stating the service was *"too generic"* and did not meet their individual needs.

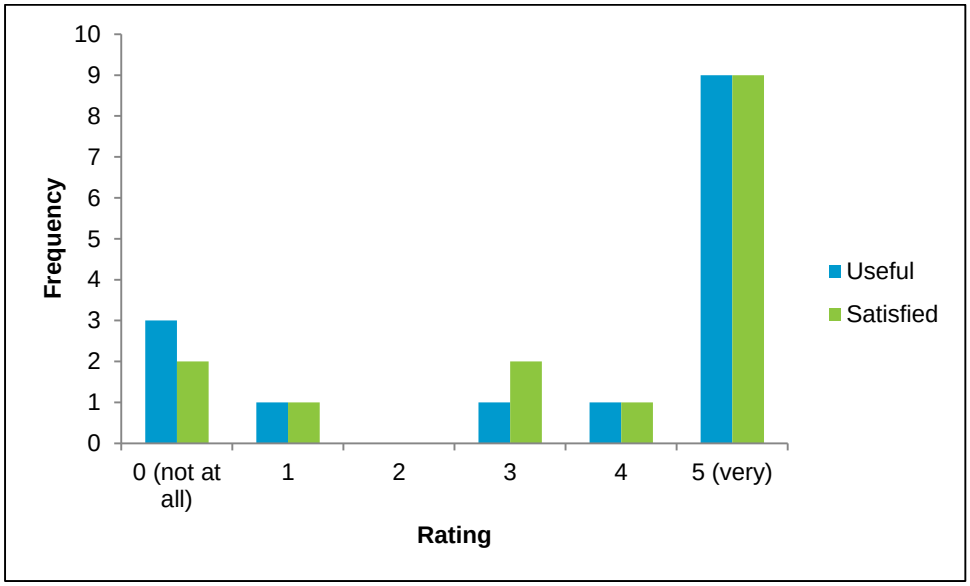
Perceptions of one-to-one support sessions were explored further during interviews with service users. Overall, service users were satisfied with the one-to-one support style, and viewed it as beneficial when participants would feel uncomfortable in a group environment and preferred individual support.

> *"Well, I think it's good that you can have a one-to-one. I think that's brilliant, because, I know a lot of people might like group, but, being able to just speak to somebody, you know, like one-on-one, and talk about, like, how you're feeling and you know I think is a lot better". (Ex-smoker, service user)*

***NHS stop smoking drop in session(s)***

Overall, the mean usefulness rating from the drop-in sessions was 3.53 (SD=2.13) with a mean satisfaction rating of 3.73 (SD=1.91). A breakdown of the ratings is provided in Figure 4. The service also received high ratings, with two thirds of respondents rating both usefulness and satisfaction at 4 or above, with over half (9 out of 15) giving a top rating of 5.

**Figure 4. Ratings of NHS stop smoking drop in sessions**




Positive ratings of the service from questionnaire respondents were largely attributed to the support received, in particular the flexibility of drop-in sessions, and approach of staff.

> *"Very helpful when I had to miss a one-to-one session and the drop in filled the gap". (Questionnaire respondent)*

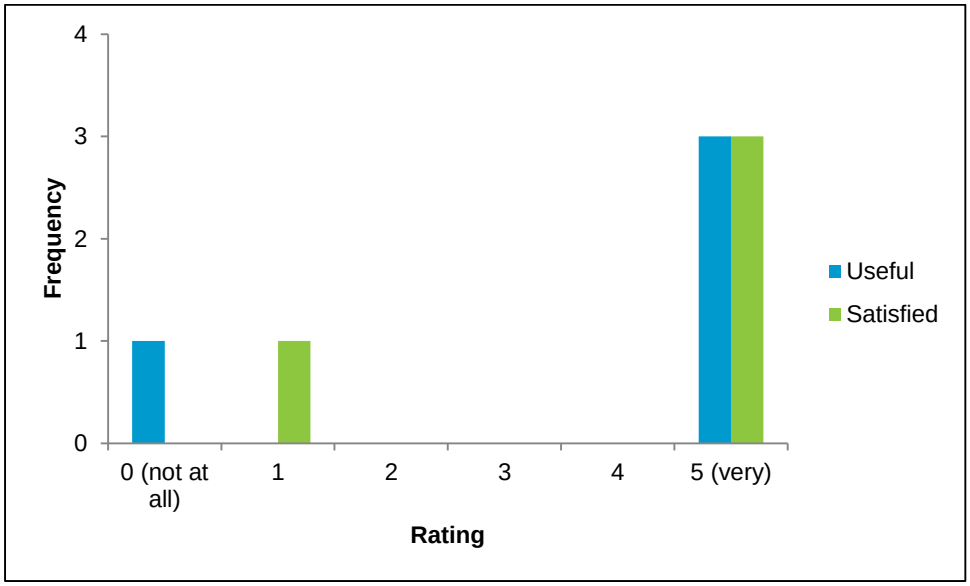
Similarly, interview participants felt the main benefit of the drop-in sessions were that they could receive immediate help, which was considered essential when a decision to quit has been made, as well as flexibility to attend the service.

> *"Yeah, they do… taking into account that I do work shifts and most of the time I can't turn up at the same place at the same time every week. So they do tell you, and they do give you information, we have a clinic or whatever you want to call it there, this time. They write it all down for you, or they give you leaflets or whatever. It is quite helpful". (Smoker, unsuccessful service user)*

***Home visit(s) from the Leeds NHS stop smoking service***

Overall, the mean usefulness rating of home visits was 3.75 (SD=2.5), with a mean satisfaction rating of 3.75 (SD=2.5). A breakdown of the ratings is provided in Figure 5. Three out of four individuals gave home visits the highest rating for both usefulness and satisfaction.

**Figure 5. Ratings for home visits from the Leeds NHS stop smoking service**



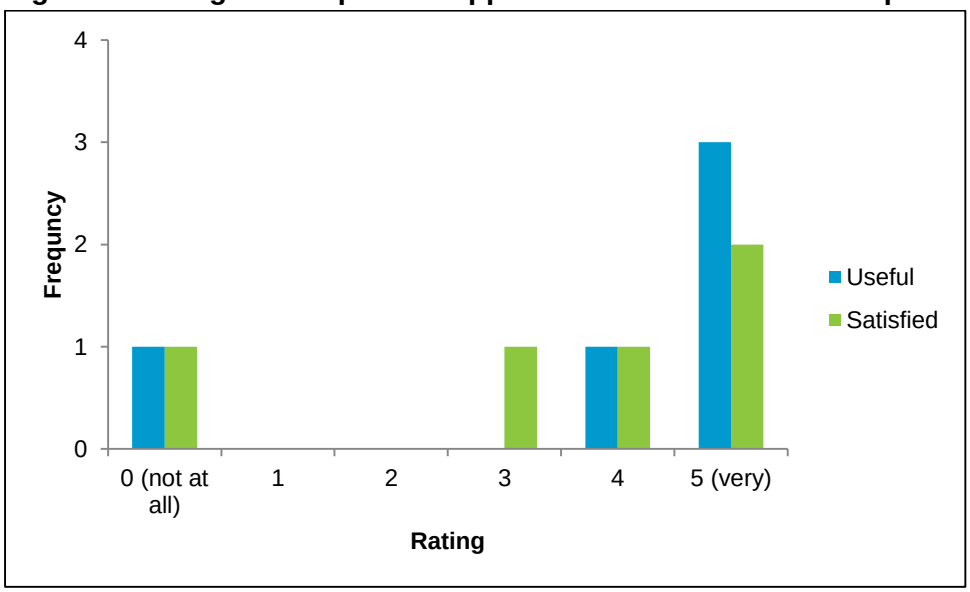

Positive rating of home visits from questionnaire and interview participants related to ease of accessing support as well as usefulness of help received. Reasons for home visits included ill health and pregnancy.

> *"Makes it a little easier and more rewarding to know someone will come each week and you can tell them you ain't had none or if struggling. They encourage you in other ways to help". (Questionnaire respondent)*

***Telephone support from the Leeds NHS stop smoking service***

Overall, the mean usefulness rating for telephone support received from the service was 3.8 (SD=2.17), with a mean satisfaction rating of 3.4 (SD=2.07). A breakdown of the ratings is provided in Figure 6. Four out of 5 individuals rated telephone support at 4 or higher for usefulness. Three out of 5 rated it at 4 or higher for satisfaction.

**Figure 6. Ratings of telephone support from the Leeds NHS stop smoking service**



Questionnaire and interview respondents perceived telephone support to be a strength of the service. The telephone calls and texts advisors sent to clients helped them to remain motivated. Moreover, having a dedicated number clients could call when they felt like they needed support between appointments was considered essential. Telephone support also allowed for flexibility, supporting clients when attending the service face-to-face was impractical.

> *"The greatest thing is there's always a telephone number. You can always talk to someone". (Ex-smoker, service user)*

- **Access**

Service users primarily viewed the stop smoking service as accessible to all. Most service users had self-referred to the service after speaking with their GP, nurse, friends, finding the contact details on the internet or seeing a stop smoking leaflet or poster. Service users reported noticing leaflets and posters at the doctor's surgery, dentist, pharmacy and supermarket. One service user contacted the service after receiving a stop smoking card through the post. Only a minority of service users were referred by a health professional directly to the service.

> *"… I take medication anyway for anti-depressants, and it was just a check-up, a 2-yearly check-up for my medication, and I saw the leaflet [at the doctors] and I said 'can I see the nurse' and I explained to the nurse that I want to quit smoking. She said 'right, when do you work, when's the best time', and gave the drop-in centres details of where it was, gave me directions and it was pretty straightforward really". (Ex-smoker, service user)*

The service was seen to be delivered in suitable locations that were *"easy to get to".* Two respondents reported attending an NHS stop smoking support group at their workplace during working hours and stated this was a motivator to attend.

In general, service users felt the timing of groups was adequate, catering for both those who could attend in the day or evening and being delivered multiple times a week. A minority of service users felt the service was difficult to access based on timings of sessions (examples included: not having sufficient day time sessions, closing the service at 7pm and no weekend support).

- **Content**

Overall, service users felt the advisors were informative, giving clients relevant and useful information throughout their quit attempt. Service users were given information about the benefits of quitting, products available, side effects of products, coping strategies and an opportunity to ask questions.

> *"Well the first day we went sort of as a group of people, they were telling us about different types of you know cessation, the nicotine replacement stuff that was available. Things that we'd not even heard of before. And also some different sort of tips, so what to do when you're having cravings and how long cravings generally last*

*for. Different health benefits. And something I wasn't really aware of was the whole carbon monoxide thing and how that affects your body. Obviously you hear about the tar and everything else. But I've not really heard much mention of carbon monoxide, so that was useful as well". (Ongoing quit attempt, service user)*

Attending the service and being able to monitor health benefits through objective measures such as carbon monoxide readings was considered a strength of the service and motivated service users to continue with their quit attempt.

*"But I definitely found it really encouraging to see the numbers dropping on the carbon monoxide reading… it's really hard to stop and it feels that you're not actually getting any benefits. Because obviously the health benefits can take a long time… you know the various different things take months and years to get back to normal. But you can see the things immediately that start to improve, then that's really important". (Ongoing quit attempt, service use)*

This was deemed particularly useful for pregnant women.

*"She would like come round to the house and doing the best thing to see how much carbon monoxide the baby were getting… it would go down. It just made you feel so much better." (Smoker, unsuccessful service use)*

Having a range of products on offer was considered beneficial, and the ability of advisors to signpost them towards the most appropriate product was highlighted by service users. Being offered a choice of products was noted.

*"I was offered a whole range of things; patches, Champix, nicotine replacement and all the other stuff". (Ongoing quit attempt, service user)*

Moreover, being able to get medication on prescription was considered a positive of the service even if prescriptions had to be paid for, and facilitated the quit attempt by removing the barrier of cost.

*"Some of these nicotine replacement things are very expensive. If people knew that you're going to go to the service... you get a prescription, which you might have to pay for your prescription. But even so, it is so much cheaper and you get more support by going to the service, and you're more likely to quit because you've got professionals involved. Maybe that… that might help, especially people of low income. Because I think the price of these products are pretty much, people look at it and think, 'well, what's the point in quitting. I'll still have to pay a load of money for this?'" (Ex-smoker, service user)*

In addition to stop smoking products on offer, two participants (one questionnaire respondent and one interview participant) reported receiving gym passes when accessing the service.

*"I think the gym thing that they did, because they gave me like… if people are worried about putting weight on like I was… They gave me a gym membership that was £5*

*for the first three months. I thought that was quite encouraging". (Ex-smoker, service user)*

- **Staff**

Mostly, advisors were viewed positively and a key component of the service, offering a "*non-judgemental", "caring", "understanding"* and *"non-pressurised"* approach to supporting clients. Due to the non-judgemental attitude of staff, service users felt they could return to the service if they had experienced a non-successful quit attempt.

> *"The first thing I tried didn't work for me. I mean it was a case of go back and say, 'look, I'm finding this is not working because of… for this and this reason. And they were fine with it. And it wasn't a case of being disappointed, 'oh god, he's failed'. It was basically, 'never mind, let's be positive. What else can we try?' And that's what I found really good about it. It wasn't a negative thing… And that's what I think gave a bit more confidence to me to actually keep going at it. They don't give up on you". (Ex-smoker, service user)*

A minority of participants offered negative comments about staff members, stating they had an adverse experience due to unsupportive staff members.

> *"I thought the first two I saw were great but I had a slip and the third lady lectured me like a child and said I would not be allowed to have any more support if I smoked again. I had spoken to second lady on the Monday before and I was upset I had smoked. She was great and said to visit Wednesday and that they would support me …" (Questionnaire respondent)*

- **Ongoing support**

Service users felt the on-going support offered by the service was beneficial. Ex-smokers who had used the service felt they could re-contact the service if they needed additional support to prevent relapse.

> *"Well I can drop into the drop-in centre any time. I know it continues and will continue". (Ex-smoker, service user)*

### *3.7 Other stop smoking support accessed from health services*

Questionnaire respondents were asked if they had been given advice or support to quit smoking from the following health professionals: GP, practice nurse, consultant or hospital doctor, dentist, midwife, pharmacist or other health professional (excluding NHS stop smoking advisors). Data revealed that primary care professionals were the most common source of advice and support to give up smoking amongst those who responded (see Table 7). Over a quarter had received advice/support from a GP (27%) and a further 10% from a practice nurse. Pharmacist was the least used source, with only 3 individuals (4%) citing this professional group. Four individuals stated another professional, but only 2 provided further details. One said "specialist at White Rose" and another said "Health Professional".

**Table 7. Proportion of smokers and recent quitters receiving advice/support from each professional group**

| | Frequency | Percentage |
|---|---|---|
| GP (n=68)* | 18 | 26.5 |
| Practice nurse (n=69) | 7 | 10.1 |
| Consultant or hospital doctor (n=68)* | 6 | 8.8 |
| Dentist (n=68)* | 4 | 5.9 |
| Any other professional (n=68) | 4 | 5.9 |
| Midwife (n=69) | 4 | 5.8 |
| Pharmacist (n=69) | 3 | 4.3 |

NB. n refers to sample size. * 1 respondent gave a "Don't know" response, which was excluded from the analysis

During interviews, participants were asked if they had been given advice or support by a health professional to stop smoking, excluding advisors from the NHS stop smoking specialist service. Most interview participants reported previously receiving brief interventions on stopping smoking from a health professional, including their dentist, GP, pharmacist, midwife, and practice or hospital nurse.

> *"My dentist has. I know my dentist talks… because I go to the dentist very regularly and they say that, you know the carbon monoxide from cigarettes and stuff, it stops the blood flow to your gums, which can cause all kinds of gum problems. And, yes, so they've talked to me about giving up". (Smoker, non-service user)*

> *"Yeah, my nurse, every time I go for my Depo-Provera injection, she always mentions it [quitting smoking]...you know, she just says, 'you realise it's not good for you, there is help here if you want it.' She said 'I'm not going to lecture you, but just to let you know there is help here if you want it'". (Smoker, non-service user)*

### *3.7.1 Usefulness of other smoking advice/support from health services*

Respondents who had received advice or support from a health professional were asked to rate on a scale of 0 to 5 how useful they found it (0=not useful at all, 5=very useful). The mean ratings for each professional group are described below. A breakdown of usefulness ratings for each health professional are in Table 8.

**Table 8. Rating of usefulness of smoking advice/support from health services**

| | | Frequency | | | | | |
|---|---|---|---|---|---|---|---|
| | | **GP (n=18)** | **Practice nurse (n=7)** | **Midwife (n=4)** | **Pharmacist (n=3)** | **Consultant or hospital doctor (n=6)** | **Dentist (n=4)** |
| Rating | 0 | 3 | 1 | 2 | 2 | 1 | 1 |
| | 1 | 3 | 1 | 0 | 0 | 0 | 0 |
| | 2 | 3 | 1 | 1 | 0 | 1 | 1 |
| | 3 | 3 | 1 | 0 | 0 | 2 | 1 |
| | 4 | 2 | 2 | 0 | 0 | 1 | 0 |
| | 5 | 4 | 1 | 1 | 1 | 1 | 1 |

***GP (n=18):*** The mean usefulness rating was 2.56 (SD=1.82). Half of the respondents (n=9) rated GP advice/support at 3 or above.

There was a mixed response to GP provision, some respondents rated the GP highly because they found the information provided helpful:

> *"I just got a letter from my doctor asking me if I was still smoking and if I'd like to stop and gave me a text number to text and I haven't looked back since that day". (Questionnaire respondent)*

Conversely, other participants were frustrated by the process of accessing GP support and the outcomes when they did access such provision:

> *"I had to wait 3 weeks to get an appointment. Then when I went in the GP said she can't do anything for me and gave me the number for the Leeds stop smoking clinic. Was such a waste of time". (Questionnaire respondent)*

***Practice nurse (n=7):*** The mean usefulness rating was 2.71 (SD=1.80). Four out of the 7 respondents rated practice nurse advice/support at 3 or above.

All comments provided about support from the practice nurse were positive and participants noted that the nurse was a useful source of support and felt they were invested in their quit attempt:

> *"Knowing there was someone there to talk to and support me made a great difference to me and helped me to remain steadfast. The thought of telling the nurse I'd slipped back to my old habits just wasn't an option". (Questionnaire respondent)*

***Midwife (n=4):*** The mean usefulness rating of advice or support received was 1.75 (SD=2.36).

The midwife was mostly discussed by participants negatively, with the midwife being seen more as an intermediary in terms of signposting to other services:

> *"I was given brief advice of where to go for the help I needed". (Questionnaire respondent)*

Respondents either did not find midwife support useful for stop smoking, or felt that the support the midwife was signposting too was not actually accessible:

> *"Didn't like it, wasn't useful". (Questionnaire respondent)*

> *"I was given a number to text for advice/support about stopping from my midwife whilst pregnant and multiple times I did text the number but received no reply". (Questionnaire respondent)*

***Pharmacist (n=3):*** The mean usefulness rating of the service was 1.67 (SD =2.89).

The two individuals who provided information about the advice or support given by pharmacists provided was mixed. One respondent commented positively that "*pharmacist was always there for support and advice".* The other had a more negative perception of the pharmacist advice, feeling that the pharmacist was incorrectly signposting them which was a barrier to them accessing stop smoking services:

> *"I asked the pharmacist about stopping smoking in Leeds, she said I had to see my GP, which was wrong. She should have given me the right advice which was to contact the stop smoking clinic directly. It was a Leeds based pharmacy so should have known". (Questionnaire respondent)*

***Consultant/hospital doctor (n=6) or Dentist (n=4):*** The mean usefulness rating for consultant/hospital doctors was 2.83 (SD =1.72) and dentists 2.50 (SD =2.08). Positive comments provided about these medical professionals related to the helpfulness of advice.

Interview respondents were also asked to comment on the advice and support given from other health professionals regarding quitting smoking. Predominately, interview participants reported receiving brief interventions in the format of: information regarding the health implications attributed to smoking, information on stop smoking medication and/or were signposted to the stop smoking service. One participant reported receiving intermediary stop smoking support from a stop smoking specialist nurse at their GP surgery.

Contact with health professionals was on occasion criticised for the approach taken (e.g. feeling 'lectured' or utilising scare tactics), as well as not providing direct support in quitting.

> *"It was crap really. It was absolutely terrible. I think midwives are more focused on… they just scare the crap out of you… And it's just… they're more focused on that, scaring you to death rather than helping you [quit smoking]". (Ex-smoker, service user)*

### *3.7.2 Use of non-NHS services and products (including prescribed medication) to help stop smoking in last 12 months*

The 54 respondents who had stopped smoking completely in the last year or who made a serious quit attempt during this time were asked whether they had tried a range of different aids/services to help them stop. Table 9 shows that over a third had used Champix (37%), 22% had tried nicotine replacement products they bought themselves (22%) and 20% used electronic cigarettes. One in 5 individuals had not used any service or product to aid their quit attempt (20%).

**Table 9. Proportion of respondents using services/products (n=54)**

| Services/products | Frequency | Percentage |
|---|---|---|
| Champix | 20 | 37 |
| Nicotine replacement product(s) (e.g. patches, gum, inhaler) you have bought yourself (i.e. without a prescription) | 12 | 22.2 |
| Electronic cigarettes | 11 | 20.4 |
| Have not used a service or product to help me give up smoking | 11 | 20.4 |
| Attended a non-NHS stop smoking service (e.g. support group or one-to-one support session) | 10 | 18.5 |
| Nicotine replacement product(s) on prescription or given to you by a health professional | 9 | 16.7 |
| Visited www.nhs.uk/smokefree | 6 | 11.1 |
| Used an application ('app') on a handheld computer (smartphone/tablet/PDA) | 6 | 11.1 |
| Zyban | 3 | 5.6 |
| Phoned smoking helpline(s) | 1 | 1.9 |
| Visited a website other than Smokefree | 1 | 1.9 |
| Hypnotherapy | 1 | 1.9 |
| Don't know | 1 | 1.9 |
| Acupuncture | 0 | 0 |
| Book or Booklet | 0 | 0 |
| Other | 0 | 0 |

Three out of the 6 individuals using an app provided further details about which one they used. Two said NHS stop smoking app/Smokefree, and a third said:

> *"Stop smoking app. Not the NHS one. That was crap. I just use Smoking Beta". (Questionnaire respondent)*

Interview data also revealed smokers and ex-smokers had used a range of non-NHS services and over the counter products when undertaking a quit attempt. These included:

- *Over the counter NRT.* Respondents reported purchasing NRT therapies from pharmacists including, patches, gum, lozenges, inhalers and nasal sprays.

- *Hypnotherapy*. Two service users previously tried hypnotherapy in order to help them stop smoking. Both service users stated they would not recommend it as a method to stop smoking, with one participant commenting:

  > *"It was wonderfully relaxing. Totally useless at stopping smoking, but other than that a very pleasant experience". (Ongoing quit attempt, service user)*

- *Phone Apps.* Phone apps were considered as motivators during the quit attempt. Apps were used to track progress of the quit attempt, counting the days spent smoke free, calculating financial savings and showing health benefits. App names were unknown.

*"I put a picture of my son on it and I wrote the words. It was a reminder, daily reminder, and I wrote the words, 'I love you Daddy, I don't want you to die of cancer, stop smoking' and the picture of my son; I used the countdown calendar as well, and that's what got me through it really". (Ex-smoker, service user)*

- *Books.* Respondents reported reading Allen Carr's book on smoking cessation. The value of the book was mixed, with one respondent not finding the book useful whilst the other reported it was *"really good",* offering insight into the *"psychology of quitting".*

- *E-cigarettes.* Whilst questionnaire data showed that 60% of current or ex-smokers had previously used an e-cigarette, perceptions of the usefulness of e-cigarettes were diverse. Several participants spoke of the increased role for e-cigarettes in stop smoking support.

  *"Vaping is a highly effective method of quitting tobacco and should always be recommended for harm reduction". (Questionnaire respondent)*

  Conversely, during interviews, concerns arose surrounding the use of e-cigarettes. Concerns related to a lack of knowledge surrounding the health implications of using e-cigarettes, increased dependency on nicotine and safety issues (e.g. *"oil spilling"*).

  *"I feel it was possibly a bit of the fact that you, well you had a cigarette when you smoked. You light the cigarette. You smoked it and that was it, done. You stepped it out and it was gone. But I found with the electronic cigarette, you charged it up. You filled it full of fluid and you sat there watching television not realising you had it in your hand for an hour". (Ex-smoker, service user)*

### *3.8 Intention to try services/products in the next 12 months*

The 36 respondents who indicated that they would like to give up smoking listed the services/products they intended to try in the next 12 months to aid their quit attempt. Table 10 shows that the largest number (n=11, 31%) intended to visit the GP. One quarter (25%) of respondents indicated they would attend a NHS stop smoking service (based at their GP practice/not based at their GP practice) and a further 19% intended to try e-cigarettes to assist them to quit smoking. A fifth stated they did not know which services/products they would try. Accessing healthcare professionals, either GPs or stop smoking specialist advisors were therefore a major resource smokers perceived they would use in a quit attempt.

**Table 10. Proportion of respondents intending to use services/products in the next 12 months (n=36)**

| Services/products | Frequency | Percentage |
|---|---|---|
| GP | 11 | 30.6 |
| Electronic cigarettes | 7 | 19.4 |
| Attend a NHS stop smoking service based at your GP practice | 7 | 19.4 |
| Don't know | 7 | 19.4 |
| Champix (varenicline) | 6 | 16.7 |
| Nicotine replacement product(s) | 6 | 16.7 |
| Attend an NHS stop smoking service not based at your GP practice | 4 | 11.1 |
| Will not use a service or product | 4 | 11.1 |
| Phone smoking helpline(s) | 3 | 8.3 |
| Visit www.nhs.uk/smokefree | 2 | 5.6 |
| Zyban (bupropion) | 2 | 5.6 |
| Practice nurse | 2 | 5.6 |
| Pharmacist | 2 | 5.6 |
| Attend a non-NHS stop smoking service (e.g. support group or one-to-one support session) | 1 | 2.8 |
| Visit a website other than Smokefree | 1 | 2.8 |
| Acupuncture | 1 | 2.8 |
| Use an application (‘app’) on a handheld computer (smartphone/tablet/PDA) | 1 | 2.8 |
| Hypnotherapy | 0 | 0 |
| Other | 0 | 0 |
| Book or Booklet | 0 | 0 |
| Other health professional | 0 | 0 |

### *3.9 Recommend a product or service to a friend*

Over three quarters of respondents (78%) had family or friends that smoked. Table 11 shows the services/products that respondents would recommend to family and friends to help them stop smoking. Similar proportions would recommend either attending an NHS stop smoking service (based at their GP/not based at their GP practice) (43%) or visiting the GP (38%). Notably, 59% (n=19) of respondents who have used an NHS stop smoking service in the last 12 months and have a family member or friend who smokes, would recommend accessing an NHS stop smoking service to quit smoking.

**Table 11. Services/products that respondents would recommend to family and friends to help them quit smoking**

| Services/products | Frequency | Percentage |
|---|---|---|
| Visit GP | 31 | 38.3 |
| Attend a NHS stop smoking service based at your GP practice | 30 | 37 |
| Use nicotine replacement product(s) | 22 | 27.2 |
| Attend an NHS stop smoking service not based at your GP practice | 22 | 27.2 |
| Use an electronic cigarette | 17 | 21 |
| Use Champix (varenicline) | 17 | 21 |
| Visit www.nhs.uk/smokefree | 12 | 14.8 |
| Visit pharmacist | 11 | 13.6 |
| Attend a non-NHS stop smoking service | 10 | 12.3 |
| Visit practice nurse | 9 | 11.1 |
| Phone smoking telephone helpline(s) | 7 | 8.6 |
| Try an application ('app') on a handheld computer (smartphone/tablet/PDA) | 7 | 8.6 |
| Try Hypnotherapy | 7 | 8.6 |
| Other | 7 | 8.6 |
| Read a book or booklet | 7 | 8.6 |
| Don't know | 6 | 7.4 |
| Visit other health professional | 6 | 7.4 |
| Would not recommend a service or product | 3 | 3.7 |
| Use Zyban (bupropion) | 3 | 3.7 |
| Try Acupuncture | 2 | 2.5 |
| Visit a website other than Smokefree | 0 | 0 |

### *3.10 Service improvements/additional support needed to prevent relapse and increase access to service*

The majority of participants felt there was sufficient support available for smokers wanting to quit. Nevertheless, smokers and ex-smokers offered a range of recommendations to encourage uptake of stop smoking services or prevent relapse:

- *Ensure the stop smoking service is accessible to all.* Service and non-service users stated services should be delivered on a weekday and weekend as well as during the day and in the evening. It was suggested services should be easy to get to and available in the most deprived areas, e.g. *"council estates".* Offering a mobile service or further interventions at the workplace were also considered a means to improve access to stop smoking services.

> *"And I think the other thought on accessibility, making them… if they are at particular places, making them easier for people to get to, you know, on good bus routes or whatever. And just making sure that people can access them at times that suit them. If people are working during the day, then there needs to be lots of evening availability or weekend availability for people". (Smoker, non-service user)*

- *Improve marketing.* Insufficient knowledge of the service on offer was considered a barrier to attending. Participants recommended advertising the service more widely (e.g. at bus shelters, supermarkets, dentists, doctors, billboards and via radio and leaflet drops) and publicising different types of support available as well as what to expect from the service.

  *"Perhaps describe the process that you go through… Well you don't know what's going to happen when you get there. And, it's all the same, you're apprehensive, because you're going to be apprehensive no matter what". (Ex-smoker, service user)*

  Moreover, participants recommended advertising the financial benefits attributed to attending the service, including free attendance, stop smoking medication on prescription, free NRT and money saved on not purchasing cigarettes.

  *"I couldn't afford the nicotine patches and things. And the fact that they're willing to prescribe them for you, it helps. I mean that's your main incentive… you can quit now. It doesn't cost you". (Ex-smoker, service user)*

  Ensuring marketing materials are tailored to different socio-demographic groups was also recommended. Participants stated the materials used were *"impersonal"* and messages should target different demographics, e.g. by age and sex.

  *"I think that a lot of smokers, particularly my age, think that any smoking-related health issues come to people who are significantly older, and it would be nice to understand a little bit more about what could happen earlier in life. It's kind of like that, 'it'll never happen to me' because it doesn't feel relatable, it feels quite a distance". (Smoker, non-service user)*

- *Incentives.* Participants had mixed views as to whether incentives should be offered to quit smoking. Some participants felt incentives should not be offered to quit smoking because they would not be doing it for the right reasons and improving their own health should be a sufficient incentive. However, other suggested incentives may help motivate people undertake a quit attempt and access stop smoking support. Diverse incentives were suggested including cash/vouchers, assistance with gym membership because of the associated health benefits as well as paid time off work from employers to attend the service.

  *"I would say membership or some sort of assistance in getting into exercise… So I would say, a gym promotion, discount or something like that… The exercise is a massive thing; it substitutes the smoking, it gives you all sorts of benefits". (Ex-smoker, service user)*

- *Offer additional telephone and text support*. Regular contact with the service between appointments via text and telephones was suggested as a mean to motivate service users and to maintain support levels between face-to-face appointments.

*"The only thing that I would say could make it better, you could get more regular phone calls. Like get a phone call a week, even if you're not meant to see 'em that week, just a phone call just to say… 'how are you doing with your tablets, and you haven't been having a cigarette, and how you been feeling'… do you know what I mean, just a more regular phone call". (Ex-smoker, service user)*

- *Prescription waiting time.* A minority of service users reported delays in getting prescriptions for stop smoking medications. Due to the perceived risk of relapse, service users suggested system changes to ensure they were always able to get stop smoking medication.

  *"…for someone who is a smoker to not have that prescription is danger zone. Do you know what I mean? It needs to be essential that they can get their hands on it". (Ex-smoker, service user)*

- *Follow-ups by the stop smoking service.* Clients felt follow-up appointments would help prevent relapse, knowing there was a support system in place after quitting and ongoing investment from professionals would help to motivate them to stay smoke free.

  *"Yeah, I think they should have follow-up systems, because I know it's a three month programme, and that's all good and well. But I've not had any contact now after… I mean I stopped in two months… So I think they should have a follow-up system and I think they should keep that follow-up system going for twelve months even if it's just a text or a phone call, or you know, we're really interested to see how you're doing… Just something to acknowledge, and sort of I think praise as well. Because I think that goes a long way". (Ex-smoker, service user)*

- *Integrated services.* Participants felt the stop smoking service should improve how they work with other health services. In particular, it was recommended the service work more closely with GPs. A number of participants suggested they would prefer to get prescriptions for stop smoking medication directly from their GPs and only attend the stop smoking service if their felt additional psychological support was needed. Furthermore, referring clients back to their GP for a health check following a quit attempt would help motivate them to remain smoke free. In addition to working alongside GPs, service users suggested the stop smoking service work with weight management/exercise schemes to help prevent weight gain during a quit attempt or to help improve their health in general. Service users reported relapses due to stressful life events and a number of participants felt counselling alongside stop smoking support would be beneficial to prevent smoking being used to navigate and manage emotional needs.

- *Community engagement (informal peer support/health champions).* Smokers and ex-smokers discussed the importance of receiving informal support from others who have quit or are in the process of quitting. Moreover, it was suggested (ex) service users should be invited to become champions for the service, sharing their experience with others, assisting with recruitment and supporting others during a quit attempt.

*"I think possibly if there was such a thing as a drop-in centre, and somebody felt like they needed a little bit of help, or they needed a little bit of encouragement; maybe they could just, either anonymously or not, but buddy up with somebody in their area. So if they felt like, I don't know, they were having a little bit of temptation, they could contact that local person… just somebody that's also going through it; so maybe there would be a list of people on the drop-in centre, in your area". (Smoker, non-service user)*

- *Outreach work*. Outreach provision was considered to aid recruitment and should be tailored for target groups. For example, it was suggested work with local football teams and sport centres should be carried out to recruit young males as well as further work with employers.

  *"There might be some need to encourage young men, but I don't quite know how that would happen; for example, my son smokes and he doesn't… I mean he's aware that I go to a non-smoking service but he doesn't kind of have an awareness that it would be for young men. You know they're not renowned for joining stuff anyway. So I think possibly, you know, outreach through football teams or sports centres or something". (Ongoing quit attempt, service user)*

## 4. Findings: The perspectives of health practitioners involved in the delivery of stop smoking support

Data from the questionnaire and interviews with health practitioners will be reported below.

### *4.1. Sample demographics*

In total, 18 respondents completed the questionnaire for health practitioners. Respondents comprised of GPs (n=7), Stop Smoking Advisors (n=3), Practice Managers (n=2), Pharmacists (n=2), a Midwife (n=1), Health Trainer (n=1), CCG Commissioner (n=1) and Community Projects Co-ordinator (n=1). Five respondents were trained to deliver stop smoking interventions. Training undertaken is listed in Table 12.

**Table 12. Stop smoking training undertaken**

| | Frequency |
|---|---|
| 2 day registered advisor training | 3 |
| Face-to-face Brief Intervention Training (BIT) | 4 |
| NCSCT Brief Advice E-Learning Module | 3 |
| Level 3 Specialist Advisor Training | 1 |

A further 11 interviews were conducted with health practitioners involved in stop smoking support in LSE. Five participants worked for the Stop Smoking Service, 2 for the Health Trainer Service, 2 for Sure Start Centres (Family Outreach Workers), 1 participant was a Dentist and 1 a GP.

### *4.2 The context of stop smoking services in the LSE CCG*

Several health practitioners discussed the social and economic context of the LSE CCG area and respondents consistently highlighted the challenging nature of delivering stop smoking services in this area. The backdrop of poverty, debt and housing problems were all felt to be a contributory factor to the high smoking prevalence:

> *"I do think though that for the South and the East, people have more complex problems; so maybe more poverty, more housing problems, debt, mental health problems". (Interview participant, Stop Smoking Service)*

Health practitioners recognised that smoking was frequently deployed as a coping mechanism for many individuals in LSE. Smoking practices were reported to be embedded in many of the communities and estates in the LSE area. This meant that professionals seeking to support communities to stop smoking needed to be mindful of the social and economic landscape in order to work effectively:

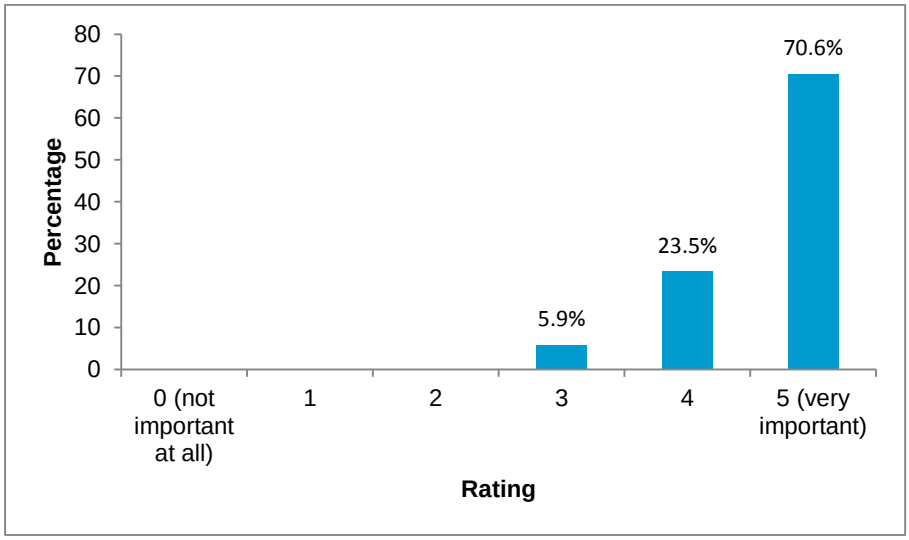
> *"It's just very [economically] poor. They're all really close-knit people. They won't let many people in, do you know what I mean? You've got to be the right kind of person to sort of be able to speak with the community. I think anybody going in with sort of all guns blazing…they just won't listen. They're not going to take any notice". (Interview participant, Stop Smoking Service)*

Given that LSE has the highest prevalence rates of smoking across the city, it was unsurprising that the questionnaire data demonstrated the importance health practitioners placed on smoking services in LSE CCG. Figure 7 shows how the majority of the respondents surveyed (71%, n=12) rated stop smoking services in LSE as 5 out of 5 for importance, with scores ranging from 3 to 5 (mean=4.6, SD=0.6). This was exemplified further in questionnaire and interview data:

> *"We regularly get told by clients that they wouldn't have stopped smoking without our support, and many say they probably wouldn't even have tried. They lack confidence and coping skills and are often given bad advice about how to give up smoking prior to coming to the service from family/friends and even other health professionals". (Questionnaire respondent, Stop Smoking Service)*

> *"I think very important [stop smoking services in LSE]… I know that a lot of people do want to make that decision [to quit], but often feel a little bit powerless, so it's really good to have that service there; a number to ring and then there's that support available if they do want to make that decision". (Interview participant, Health Trainer Service)*

**Figure 7. Perceived importance of stop smoking services in helping people to quit smoking**




### *4. 3 Stop smoking support in LSE*

Stop smoking support available in LSE is diverse and offered by a range of health practitioners. In addition to the delivery of stop smoking services (intermediate and specialist services), questionnaire and interview respondents reported undertaking the following roles in stop smoking support: promoting national and local campaigns (e.g. Sure Start Centres involvement in the delivery of the Take Seven Steps Out campaign), offering brief intervention (through the delivery of health related smoking information and signposting to stop smoking services), as well as providing information and provision of over the counter and prescribed stop smoking medication (by pharmacists). The quotes below demonstrate

the roles taken by a diverse range of health practitioners involved in delivering stop smoking support outside of stop smoking services:

> *"Opportunistic intervention during patient consultations". (Questionnaire respondent, GP)*

> *"Signposting to Stop Smoking Advisor; sales of OTC [over the counter] NRT products; dispensing vouchers filled by Stop Smoking Advisor". (Questionnaire respondent, pharmacist)*

> *"We mainly signpost them to the stop smoking service. Some people are not ready to do that, so we would maybe ask them if they want to think about writing down how many cigarettes they smoke in a day and seeing if they… it's almost setting goals about trying to reduce, but mainly it's signposting to stop smoking service". (Interview participant, Health Trainer Service)*

> *"We obviously give out that kind of information [stop smoking information] to people when they're in outreach about being healthy, and we have got all these local clinics and how people can get support. So we signpost for that. But also I've been trained in the Take Seven Steps Out". (Interview participant, Sure Start Centre)*

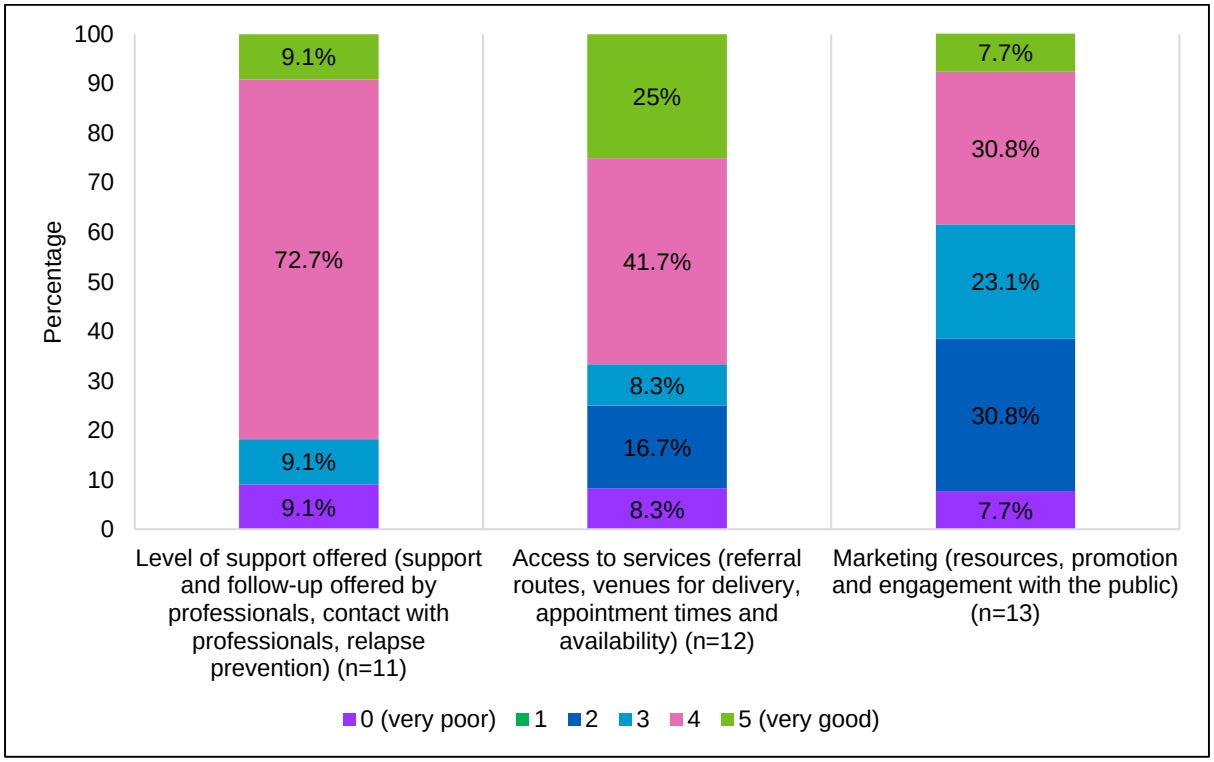
In regards to the intermediate and specialist stop smoking services on offer, most professionals suggested that there was an extensive 'menu' of support which allowed service-users choice and autonomy to decide which type of support would best suit, i.e. drop-in clinics, one-to-one and group support, home visits and telephone contact. Those working for stop smoking services were clearly able to articulate the full-range of interventions on offer, but those more peripherally involved in smoking support (e.g. GPs, Dentists, and Family Outreach Workers) also had a wide knowledge of the smoking support services available in LSE CCG area. Whilst these professionals recognised the specialist stop smoking service as the main source of support for individuals wanting to quit, they have previously referred patients/clients to their GP or the Health Trainer Service to quit smoking.

> *"I just signpost them to our local health trainers and then onto the local stop smoking clinics". (Interview participant, Sure Start Centre)*

### *4.3.1 Intermediate stop smoking support*

'Intermediate' stop smoking support is offered in LSE. This service comprises of in-house stop smoking advice and support, often provided by GPs, practice nurses and pharmacists who have attended a minimum of 2 days' training with the stop smoking service to deliver evidence based stop smoking interventions and are registered with the stop smoking service. Overall, the role of the intermediate advisors was considered subsidiary to the specialist service by interview participants and questionnaire respondents. Questionnaire data revealed that the level of support offered by intermediary stop smoking services was rated moderately with a mean score of 3.6 out of 5 (SD=1.2, range=0-5), similar to perceived access to the service (mean=3.5, SD=1.5, range=0-5). Marketing materials used were viewed less favourably (mean=2.9, SD=1.3, range=0-5) (see Figure 8 for a full breakdown of results).

**Figure 8. Ratings of intermediate stop smoking services**




The main benefits to offering intermediary services was allowing patients to feel more comfortable accessing a known service or health practitioners as well as weekend support (offered by pharmacists). Weaknesses of the service related to capacity issues, resulting in a shortage of appointments, as well as limited contact time, specialist knowledge and experienced.

> *"Limited time when trying to fit smoking cessation in amongst their other roles and limited knowledge around this specialist area. Do not understand the diverse challenges heavily dependent smokers face. Also, unaware of how mental health patients, young people and pregnant smokers need a different approach". (Questionnaire respondent, Stop Smoking Service)*

### *4.3.2 Specialist stop smoking service: support*

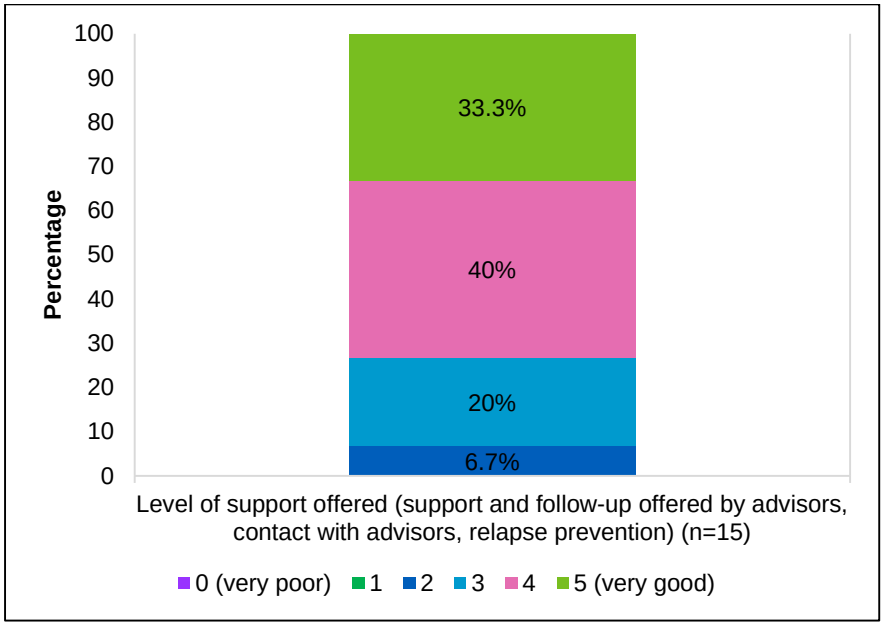
Overall, the support offered by the stop smoking service was rated positively by questionnaire participants, with a mean score of 4 (SD=0.9) (see Figure 9).

The service was rated positively due to the range and frequency of support on offer, availability of appointments, and experience of qualified staff to assist service users with their quit attempt. This level of support was in contrast to support delivered through brief interventions or by intermediate advisors:

> *"So we're sort of, intensive; this is all we do on a day-to-day basis… We've got more experience to draw upon. We've got clinics specially set up, so more clinic provision, so more appointments available; more types of support structures available…It's a bit more flexible if people can't sort of, make a set appointment. We've just got more time and resources to be able to offer, you know, wider range of clinics, different*

*days of the week, different places, and we can offer the telephone support too and home visits as well. (Interview participant, Stop Smoking Service)*

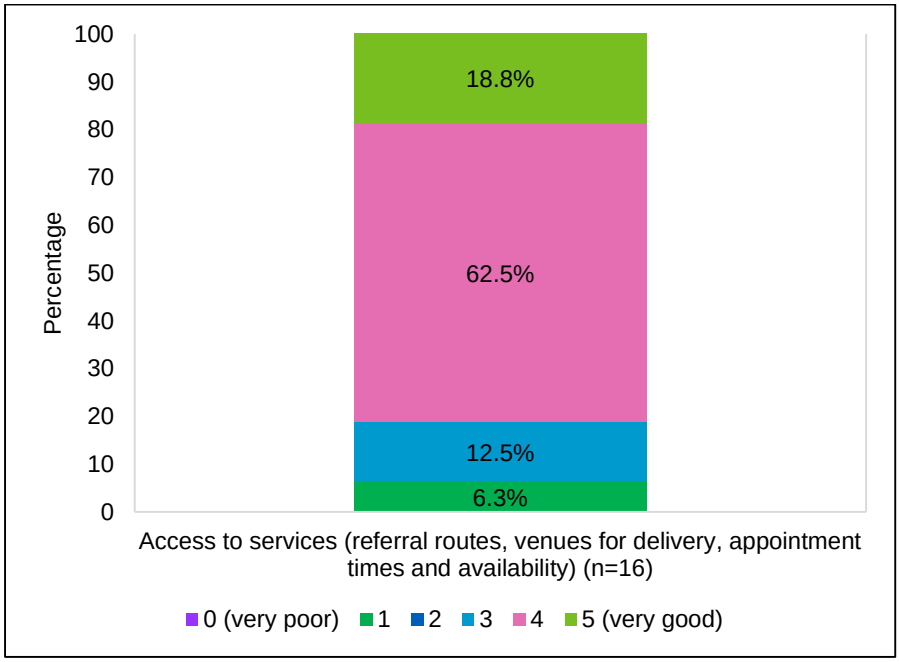
**Figure 9. Rating of the level of support offered by Leeds Stop Smoking Service**




### *4.3.3 Specialist stop smoking service: access to service*

Overall, access to the service was viewed positively, with a mean score of 3.9 (SD=0.8). Scores provided ranged from 2 to 5, with 81% of questionnaire respondents providing a rating of 4 or 5 out of 5 (see Figure 10).

**Figure 10. Rating of access to the Leeds Stop Smoking Service**




While self-referral was deemed the main route into the stop smoking service and considered advantageous to service-users, several health practitioners, including GPs, suggested that

referral mechanisms between GP practices and specialist smoking support services could be more effective and clear. A GP interviewed claimed that referral pathways to stop smoking support were not always clear or obvious in their experience. This was reiterated by smoking cessation advisors, suggesting ways in which referral pathways could be improved:

> *"Referral routes could be improved if GPs could make an e-referral or they could make an appointment from their system." (Questionnaire respondent, Stop Smoking Service)*

> *"I think that we could do lots more work with a much better referral service; particularly GP practices and other healthcare professionals. I think we could figure out some sort of online referral system, where they can click a couple of buttons and refer somebody straight to us, and then we can contact them". (Questionnaire respondent, Stop Smoking Service)*

Interview participants reported a diverse range of venues, appointment times and availability of services are already offered by the service. In order to improve access, it was suggested weekend support, more diversity in evening services delivered (including home visits and one-to-one support) and extended evening opening hours be provided.

> *"I think we need to offer more one-to-one provision in the evenings or out of hours; we mainly do drop-ins or group sessions out of hours, and actually, some people work, but aren't appropriate for a drop-in or a group. For example a pregnant woman who works 9 to 5 wouldn't be able to get a home visit, but probably wouldn't want to come to a group either". (Interview participant, Stop Smoking Service)*

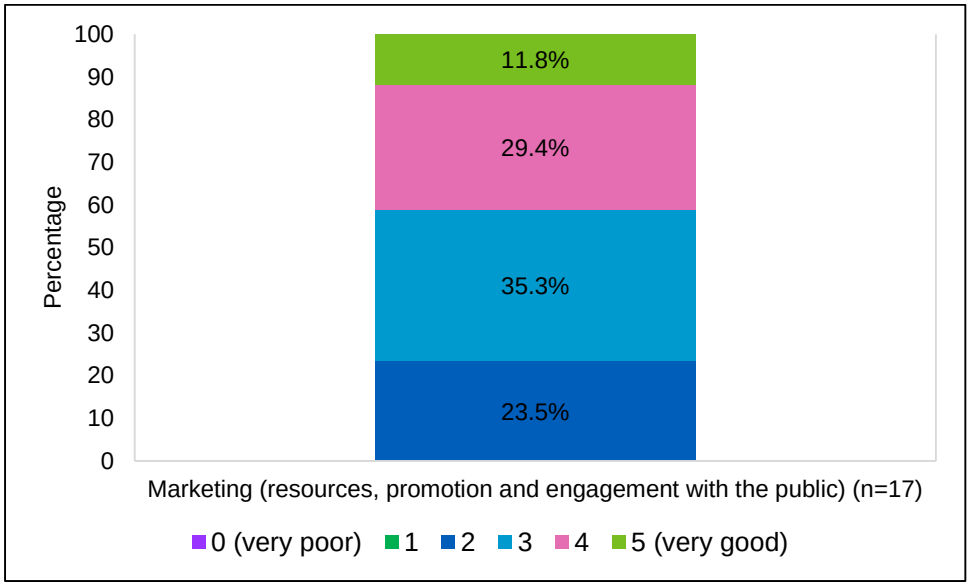
Additional venue locations including One-Stop shops and GP surgeries on housing estates were suggested as a means to improving access for deprived groups.

### *4.3.4 Specialist stop smoking specialist service: marketing*

The marketing of the stop smoking services and national campaigns was discussed. Figure 11 demonstrates the variability of health practitioners' perspectives on the marketing of stop smoking services in Leeds. The marketing used by the service had a mean rating of 3.2 out of 5 (SD=1, range=2-5), with 59% of questionnaire respondents rating the marketing at 3 or below.

The qualitative data also revealed a variety of positions on service marketing. Whilst some professionals suggested that service marketing was ineffective and too generic, others praised the diversity of strategies, including the use of radio advertisements, leaflets and posters and supporting national campaigns (e.g. Stoptober and National Stop Smoking Day).

**Figure 11. Ratings of the marketing for the Leeds NHS stop smoking service**




To improve marketing materials, it was suggested materials should be area specific (highlighting localised support), offer greater insight into what the service has to offer and undertake more promotional activities.

> *"I think the local clinics… it would be good if they could have their own leaflets, you know, local services". (Interview participant, Sure Start Centre)*

> *"… what is the offer? Is that about harm reduction as well abrupt quitting- what does that look like? I think often people are worried that we're going to get people to sit in a circle and declare that they smoke 20 a day, and actually, what it is, it's much more of a supportive programme that we offer and I think once people access that, they understand it better and feel much more confident at coming through the service. So I think more awareness of what's on offer". (Interview participant, Stop Smoking Service)*

It was recognised by the stop smoking service that smokers using e-cigarettes are not accessing the service because they are using e-cigarettes to quit, with unknown success rates. As a result, marketing strategies are needed to encourage e-cigarette users to access the service, including *"embracing e-cigarettes a bit more".*

### *4.4 Providing a more integrated service*

Despite widespread praise for the myriad of services open to individuals in LSE and acknowledgement of joined up working, there were suggestions that the stop smoking service could integrate further with other services, offering a more holistic service and improving access.

The importance of health practitioners not working directly for the stop smoking service (including GPs, midwives, pharmacists, dentists, Health Trainers and Family Outreach

Workers) in offering brief intervention (including signposting smokers to stop smoking services) was widely recognised.

> *"You know, we're the people on the ground. We're the people that see families on a day-to-day basis. We're the people that go into people's homes. Not everybody wants to share that they smoke, or that they smoke around their children, or something like that. But when you're actually going to people's homes, you see that first hand. So we are the people, we're saying, 'you know well, have you thought about not smoking? Have you got any support to stop smoking? Would you like to stop smoking?'" (Interview participant, Sure Start Centre)*

In addition to widespread BIT across health services, professionals advocated for more neighbourhood-based approaches to smoking support. This would include adopting a greater community development approach in the LSE area, for example ensuring practitioners working in the community, e.g. health trainers and family outreach workers, undertake BIT:

> *"I think we need a community approach to this, and it's not just about stop smoking services. I think organisations have been very reliant on just the stop smoking service delivering the reduction in smoking prevalence, and it's much more of a community approach or a neighbourhood approach, so that we have support from health trainers as well as the stop smoking advisors. So if you're looking at you know, if you look at a systematic approach, what I believe is everybody should have brief-intervention training and be able to talk about stopping smoking. The next level is some key workers to be able to build confidence around quitting, and then the next layer is advisors that can support quitting, so that we've got support wrapped around the smoker". (Interview participant, Stop Smoking Service)*

> *"I think it should be a part of an integrated service and I think they play a key role, in helping with footfall through the service. Being brief-intervention trained, even if they're not intermediate advisors… my belief is that everybody should have some low-level training, like BIT; be able to raise the issue of smoking, with every single patient that walks through the door, and also to try and increase confidence with accessing services". (Interview participant, Stop Smoking Service)*

Notably, practitioners involved in signposting smokers to stop smoking services, welcomed the idea of receiving training in stop smoking support.

> *"For maybe one or two of my nurses [BIT]. I'm aware the nurses can undergo smoking cessation training and stuff. I think for them it would be useful". (Interview participant, Dentist)*

> *"We've had like one day, one day training; so I kind of vaguely know that there are patches and chewing gum and things like that… I think ongoing training would be good". (Interview participant, Health Trainer Service)*

Participants who worked in Sure Start Centres discussed that whilst they currently felt adequately supported to deliver brief interventions due to recently undertaking training for

the Take Seven Steps Out campaign, prior to this training they sometimes felt uncomfortable approaching service users about smoking. The value of the Take Seven Steps Out training was recognised and suggested this or similar training is rolled out across all centres.

> *"I think the Take Seven Steps Out campaign is very good and I really enjoyed that training and felt that I did feel comfortable about approaching it, because it's a sensitive subject. But I think up until then, I don't think we have [had sufficient training]. Because it's almost, you know, as if you're criticising people in the past when sometimes, you know when you're giving the things out [stop smoking leaflets], you feel a little bit critical. But the Take Seven Steps Out, you know it's not a no-smoking campaign, it leads you in. It's giving you that… it opens the doorway I feel, so that you can discuss that. But then, you're going to… 'look if you want to stop smoking, we can get you some support.' And it's sometimes with things, it's that broaching the subject in the first place. So apart from that, I think we have been lacking in support for that, only because it's… it's one more thing that you have to approach somebody on, and you know, you're trying to build relationships, so you don't want to feel like you're criticising". (Interview participant, Sure Start Centre)*

Moreover, professionals were mindful of the wider health determinants and cognisant that smoking was often a manifestation of stressors, such as debt. It was suggested that to effectively reduce smoking prevalence in LSE a focus on wider social issues was also needed:

> *"Maybe like a holistic approach…to sort out their debt problems, their housing issues-so it's not just smoking…so I think it's not just about smoking, it's about the whole wider package really". (Interview participant, Stop Smoking Service)*

Similarly, it was widely recognised that weight gain during a quit attempt is a barrier to quitting and reason for relapse. GPs, Health Trainers and Family Outreach Workers suggested having smoking support services delivered in parallel with weight-management services (e.g. refer to the Health Trainer Service or Healthy Lifestyles Service) to support those individuals who may gain weight during or after a quit attempt. Notably, the delivery of weight management services alongside stop smoking support is currently available but unknown to all participants with signposting roles.

> *"Undoubtedly some people struggle as soon as they stop smoking with weight gain. And so then they come in having given up and they've gained three stone. And that's not great either. So, you know, as a positive thing that can be offered alongside the smoking cessation is there something that can go hand-in-hand with that to try and really focus on preventing that weight gain situation." (Interview participant, GP)*

### *4.5 Targeting specific groups*

Health practitioners discussed the work within LSE to target smoking support to specific groups in the community. Figure 12 provides a full breakdown of perceived appropriateness of the service for target groups. In general, perceptions of appropriateness of service were scored high, with mean scores ranging from 3.9 to 4.6 out of 5. Overall, services were considered most appropriate for service users with long term conditions (mean=4.6,

SD=0.6), individuals living in deprived wards (mean=4.5, SD=0.7) and pregnant women (mean=4.5, SD=0.7). The service was considered least appropriate for individuals with learning disabilities (mean=3.9, SD=1.1).

During interviews, participants discussed numerous ways in which services were tailored to meet the needs of target groups. For example, 'Fresh Air Babies' which targets pregnant women was consistently mentioned. Whilst supporting pregnant women to stop smoking was deemed a challenge in the LSE area, 90% of professionals (n=13) rated the appropriateness of stop smoking support 4 or 5 out of 5. However, delivering an opt-out referral scheme (led by midwives) and home visits was considered a useful approach to accessing and supporting pregnant women during a quit attempt. Home visits were also considered a useful mechanism for individuals with long term health conditions as well as outreach work in hospitals.

One issue to emerge both from the interviews with health practitioners and the survey data (see Figure 12), was the appropriateness of services for some members of LSE, particularly BME groups. The survey suggested that only 36% of respondents believed that smoking support services were 'very appropriate' for BME groups. Those working directly in specialist smoking services suggested that not enough attention was being paid to this group and that more work is required to engage BME smokers:

> *"We have had training on 'niche' tobacco, which some ethnic minority groups might use; like the chewing tobacco; gutka, paan, are some of the words that it's called. So we do have knowledge on that. But in terms of targeting that group I suppose and making the service look accessible to those groups, I think that there's more work that we could do". (Interview participant, Stop Smoking Service)*

When engaged with smoking services, specialist workers reported that individuals from BME backgrounds were less likely to be successful in their quit attempt. This was for several reasons and sometimes related to issues regarding adequate translation services being provided. There were calls for greater training and capacity to address the smoking support needs of the BME community in LSE:

> *"We do use interpreters and we use language line sometimes to book appointments with people who don't speak English, but the interpreting service for our organisation is quite unreliable; recently we had quite a few interpreters not turn up when they've been booked, so I wouldn't say it's a robust service for BME communities, and we're not trained in using, you know, really in advising people to quit things such as shisha pipes or smokeless tobacco". (Interview participant, Stop Smoking Service)*

There were other sections of the community that health practitioners suggested could be more effectively supported in their quit attempts. Young people and children were one group where provision was not always tailored appropriately:

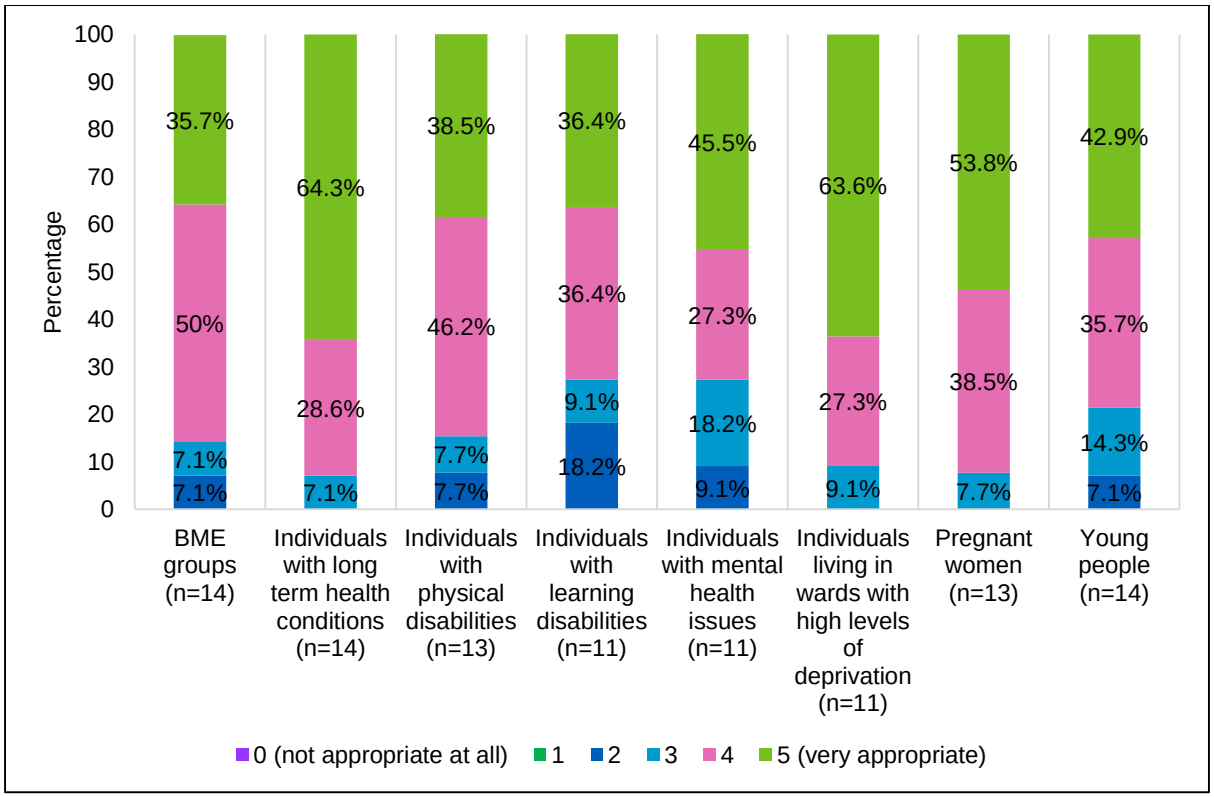
> *"I feel the specialist service should have a young people's advisor as they will develop the specialist skills needed to work with this client group and they can run sessions specific to this age group rather than asking them to attend an adult clinic". (Stop smoking specialist, questionnaire respondent)*

*"Maybe, more flexible clinics, more one-to-one clinics- after school time. So, a lot of the time, the clinics that we have in the evening tend to be drop ins or groups; and I think that a lot of young people might be a bit scared or feel a bit intimidated, coming into a clinic where there's… quite a lot of people in the waiting room; and the drop ins, everybody's sort of seen at once for that first session, to get information, and then they're seen individually, but it's never sort of like a one-to-one… So I wonder if having more one-to-one clinics available, outside of school time, if that might help". (Interview participant, Stop Smoking Service)*

It was also thought that the support mechanisms and training for staff in relation to people in the community with learning disabilities could be improved:

*"Just going back to the learning disabilities. I think there's more that we could do there, some more training, because I don't think we've ever had any training…I think that's something that would help with the intervention on that person; if the team were more, sort of, geared towards learning disabilities." (Interview participant, Stop Smoking Service)*

**Figure 12. Appropriateness of stop smoking services for target groups**




### *4.6 Suggested service improvements*

Health practitioners provided a number of suggested improvements they would like to see implemented to improve smoking cessation support in LSE. These included:

- Expanding the provision of flexible clinics for smoking support, including evening and weekend provision. This may include providing on-line one-to-one support through Skype.

- Providing more localised support, using demographic data to deliver services in additional venues and providing local-specific marketing.

- Referral mechanisms from GPs to specialist smoking support need to be clear and unambiguous to benefit both the referrer and service-user.

- Increasing the 'menu of support options' offered by the stop smoking service, including greater focus on harm reduction strategies in addition to abrupt quit attempts, and peer support groups delivered by ex-smokers for long term support.

- A more strategic and co-ordinated approach to ensure that all members of the community benefit from stop smoking services, for example widespread delivery of BIT to health practitioners and community organisations. This would include a greater focus on BME communities, young people and individuals with learning disabilities.

- Stop smoking services should be provided with further 'wrap-around' support. This service would acknowledge the wider determinants of people's health (i.e. poverty, housing etc.) and how these impact on health behaviours in LSE.

- Considering the use of incentives to encourage quit attempts and prevent relapse. Some health practitioners felt incentives could be used to target specific groups. Proposed target groups included pregnant women and individuals living in deprived areas, with recommended incentives of: baby-related items (i.e. clothes, Moses baskets etc.), vouchers or free/discounted gym passes.

# 5. Discussion and recommendations

The aim of the evaluation was to gain a comprehensive understanding of how stop smoking interventions can be tailored to reduce smoking prevalence in the LSE population. Data were gathered from a range of methods, including questionnaires and interviews with key stakeholders, and demonstrated stop smoking support available in LSE is largely viewed positively and considered valuable in helping people to quit smoking. The main strengths of stop smoking services in LSE were identified as: the range of service formats on offer, access to services, service content (information, objective measures to track progress and products on offer) as well as service staff.

Data from the Smoking Questionnaire showed that 29% of respondents currently smoked, a higher proportion than published prevalence figures for LSE (26%, GP Audit Data 2013/14). Current and ex-smokers offered a range of motivational factors for previous or current quit attempts, with the most common reasons including health concerns, financial motives and children.

Overall, 38% of smokers and respondents who had quit within the last 12 months had received advice/support about stopping smoking from a health professional (excluding NHS stop smoking advisors) and 55% had accessed the specialist stop smoking service. Notably, of those that had received advice from a health professional, nearly two thirds (63%) also accessed support from the specialist stop smoking service. Whilst from questionnaire data we are unable to determine whether advice from a health professional was received before accessing the stop smoking service, interview data revealed service users often self-referred to the stop smoking service after consultation with health professionals, highlighting the importance of brief intervention in motivating smokers to quit and access support services.

Although data revealed 86% of smokers surveyed intended to quit smoking in the future, less than half (44%) of those intending to quit planned to access support from a health professional (including their GP, practice nurse, pharmacist or stop smoking service). Since accessing support from stop smoking support services significantly increases the chances of a successful quit attempt (Stead and Lancaster 2005; Lancaster and Stead, 2005), strategies to increase uptake of stop smoking services in LSE are needed.

Stakeholders provided a number of recommendations to improve uptake of stop smoking which should be considered in future stop smoking service specifications to encourage local people living in LSE CCG area to quit. These recommendations are listed below.

### *5.1 Service recommendations*

- *Access.* Ensuring the service is accessible to all was important across stakeholder groups. It was suggested stop smoking support should include daytime, evening and weekend provision and the diverse range of support options available be delivered at variable times (e.g. daytime and evening home visits). Moreover, to support deprived groups it is recommended that services are delivered in locations that are accessible for target groups (e.g. one-stop shops for the unemployed, work place intervention for those in employment). In relation to this, targeted marketing (e.g. highlighting health

implications for younger smokers) should be used and specific to localities. Community engagement (e.g. the use of lay health champions) and outreach work should also be considered as an option to aid recruitment of target groups, and facilitate smokers' motivation to quit.

- *Menu of support options*. Offering a range of support formats that could be tailored to individuals' needs was considered essential to increase service access. It was suggested by health practitioners that this should include harm reduction strategies as well as support for abrupt quits; this is supported by questionnaire data that found 37% of smokers are smoking less in comparison to 12 months ago, thus signifying an acceptance of harm reduction strategies among smokers not ready to quit smoking.

  Moreover, a lack of knowledge of what the stop smoking service offers, for example range of support available, cost of medication and appropriateness for e-cigarette users, was considered a barrier to quitting and service uptake. Therefore, improved marketing strategies highlighting support options available and financial benefits to attending (including free service, free/prescription cost stop smoking medication) is recommended. This should also include improved marketing of intermediate support on offer for smokers wanting to access support directly from their GP practice. Increased emphasis on the menu of options would enable service users to feel the support was more tailored to their needs which would assist in engagement within the service, as exemplified in the quote below:

  > *"I think they just need to emphasise that there are different ways to do it… you know it's not a standard thing. It's not a standard care pathway. It seems tailored to your needs". (Ex-smoker, service user)*

- *Integrated services*. Evidence of joined up working was reported by stakeholder groups, e.g. the opt-out referral process for pregnant women by midwives. Further joined up working was considered important to improve access to the service, with stakeholders suggesting widespread BIT with health practitioners is needed with clear referral routes into stop smoking services in place. Whilst health practitioners were acknowledged as an important source to deliver brief interventions (or become intermediary advisors), the importance of gaining the support of community based organisations was also recognised, particularly in order to reach target groups. For example, 30% of ex-smokers or smokers intending to quit surveyed reported their children as a motivator for quitting, thus highlighting the important role community based organisations (e.g. Sure Start Centres, Dads groups) have in delivering brief intervention to parents.

  Furthermore, the impact of wider social issues on smoking behaviour was widely acknowledged by smokers and health practitioners, with stress cited as a prominent barrier to quitting smoking and reason for relapse. Providing 'wrap around support' for service users by linking with other services is considered important. Concerns and experiences of weight gain during a quit attempt were also apparent. Weight management services are already integrated with stop smoking support and the Health Trainer Service is available to offer support with healthy eating and physical activity. Marketing surrounding how to access this support alongside the stop smoking service is suggested.

- *Relapse prevention.* Peer support received within the group setting was considered a facilitator to quitting. Offering additional peer support strategies such as an informal 'buddy' system and peer led groups for long term support is recommended. Relapse prevention may also be aided by additional telephone/text support between appointments and a follow-up appointment 6 months to one year after quitting to motivate service users to remain smoke free.

- *Additional support for targeted groups.* Overall, stop smoking support services are considered appropriate to meet the needs of different target groups. In particular, support for pregnant women and service users with long term conditions was viewed positively, with the use of an opt-out referral scheme for pregnant women and the option of home visits for both target groups. To improve service uptake, the use of incentives for target groups such as pregnant women and deprived groups, in the form on of vouchers or gym discounts/passes, is an option. The use of gym passes was suggested by service users and health practitioners to tackle concerns surrounding weight gain. In addition to targeted marketing for specific groups, further efforts to ensure the service is appropriate for target groups, specifically BME groups, children and young people, as well as smokers with learning difficulties should be considered. This may include, for example, additional training to assist BME smokers and smokers with learning disabilities to quit and tailored one-to-one after school clinics delivered by a specialist young person advisor.

### *5.2 Limitations of the evaluation and recruitment considerations*

Whilst this evaluation has offered a comprehensive insight into stop smoking support in LSE, limitations of the evaluation must be recognised. Research tools were developed for the purpose of this evaluation and due to time constraints questionnaires did not undergo pilot or validation testing. However, where appropriate previously tested questions were used in both questionnaires and research tools were circulated to the evaluation team and project steering group for comments regarding suitability prior to data collection.

Sample sizes for each stakeholder group were small, particularly for different occupational roles of health practitioners. Caution should therefore be taken when generalising findings from the evaluation, as results may not reflect the experiences of all from these stakeholder groups.

### *5.3 Recruitment and data collection considerations*

- *Timeframes*. The project duration was 6 months (inclusive of time taken to obtain ethical approval and research passports to recruit and undertake data collection on NHS property), leading to implications for the recruitment of participants. The short timeframe resulted in limited time to build relationships with organisations (e.g. community groups to access vulnerable populations) and individuals. Recruitment for the evaluation was therefore aided by the project steering group who regularly put the evaluation team in contact with organisations or made contact/circulated recruitment literature on behalf of

the evaluation team. Where no existing relationship was in place, attempts were made by the evaluation team to contact these organisations/individuals.

- *Methods.* The service specification proposed undertaking focus groups with service and non-service users to address objective 2. However, participants contacted regarding taking part regularly reported not wanting to participate in a focus group due to feeling uncomfortable discussing their smoking behaviour and/or their experiences of stop smoking support within a group setting. Therefore, to aid recruitment one-to-one telephone interviews were conducted with service and non-service users.

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# 7. Appendices

**Appendix 1. Demographics of respondents who completed the smoking questionnaire**

| | | Frequency (%) |
|---|---|---|
| *Sex* | Female | 84 (58.7) |
| | Male | 59 (41.3) |
| *Age* | 16-25 | 35 (24.5) |
| | 26-35 | 32 (22.4) |
| | 36-45 | 29 (20.3) |
| | 46-55 | 28 (19.6) |
| | 56-65 | 15 (10.5) |
| | 66-75 | 2 (1.4) |
| | 76+ | 2 (1.4) |
| *Ethnicity* | White or White British | 118 (82.5) |
| | Black or Black British | 16 (11.2) |
| | Asian or Asian British | 5 (3.5) |
| | Mixed ethnic groups | 2 (1.4) |
| | Missing data | 2 (1.4) |
| *Employment status* | In full time employment | 55 (38.7) |
| | Unemployed | 31 (21.7) |
| | In part time employment | 17 (11.9) |
| | Look after children full time | 14 (9.8) |
| | Not working due to disability or ill health | 8 (5.6) |
| | Student | 6 (4.2) |
| | Retired | 4 (2.8) |
| | Other | 4 (2.8) |
| | Volunteering | 3 (2.1) |
| *IMD* | Quintile 1 (most deprived) | 81 (56.6) |
| | Quintile 2 | 24 (16.8) |
| | Quintile 3 | 9 (6.3) |
| | Quintile 4 | 11 (7.7) |
| | Quintile 5 (least deprived) | 7 (4.9) |
| | Missing data | 11 (7.7) |

**Appendix 2. Demographics of service and non-service users interview participants**

| | | Frequency (%) |
|---|---|---|
| *Sex* | Female | 19 (63.3) |
| | Male | 11 (36.7) |
| *Age* | 16-25 | 4 (13.3) |
| | 26-35 | 8 (26.7) |
| | 36-45 | 9 (30) |
| | 46-55 | 5 (16.7) |
| | 56-65 | 1 (3.3) |
| | 66-75 | 1 (3.3) |
| | Missing data | 2 (6.7) |
| *Ethnicity* | Asian or Asian British | 1 (3.3) |
| | Black or Black British | 1 (3.3) |
| | White British | 28 (93.3) |
| *Employment status* | In full time employment | 19 (63.3) |
| | Unemployed | 5 (16.7) |
| | In part time employment | 3 (10) |
| | Look after children full time | 2 (6.7) |
| | Retired | 1 (3.3) |
| *IMD* | Quintile 1 (most deprived) | 15 (50) |
| | Quintile 2 | 9 (30) |
| | Quintile 3 | 2 (6.7) |
| | Quintile 4 | 2 (6.7) |
| | Quintile 5 (least deprived) | 2 (6.7) |