EVIDENCE SUMMARY

1. **Activities undertaken by NHS stop smoking services to engage and provide smoking cessation support to employers and employees.**
2. **The impact of smoke-free legislation on the demand for and uptake of smoking cessation support.**

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1 Introduction

This study was conducted in order to assist the National Institute for Health and Clinical Excellence (NICE) develop public health intervention guidance on workplace health promotion with reference to smoking and what works in motivating and changing employees' health behaviour the promotion of good health and the prevention and treatment of ill-health.

2 Research objectives

The study had two objectives.

- to explore the types of activities undertaken by the NHS stop smoking services to encourage and support workplaces to sign-post and/or provide smoking cessation support for their employees.

- to collate and précis evidence on the impact of the new legislation in Ireland, Scotland and Guernsey on the demand for, uptake of and, where possible, impact of smoking cessation support.

3 Methodology

The study involved a range of methods, including the following:

- An online survey of NHS Stop Smoking Service Coordinators, to develop a picture of practice across the country
- Case studies of good practice within NHS Stop Smoking Services – to identify what works and why in developing work place based smoking cessation services
- Telephone and face to face interviews, and document analysis to collate and synthesise evidence of the impact of smokefree legislation in Ireland, Scotland and Guernsey.

4 Findings

Survey of NHS Stop Smoking Service coordinators

A response rate of at least 71% was observed on this internet survey, with 128 responses from smoking cessation coordinators.

Nearly all the respondents reported a workplace arm to their service, most of which was built up over the last 3 years. However, this aspect of the service was not well serviced with over two-thirds of respondents saying that less than 1 FTE was dedicated to the workplace activity. The most important aspect for those running workplace activities was delivery ie running interventions, followed by marketing and raising awareness of the service, and coordination and management.

The size of the workplace was the most important determinant of the focus of the service offered to them. As the size of the business increased, so the proportion of services offering both marketing AND delivery of cessation services increased. Smaller workplaces were less likely to be offered cessation support onsite. The most important factor influencing whether they offered workplace services at all was whether they had the resources to do so, very few asked for funding from the businesses they worked with.

Smokers recruited via workplaces represented a very small minority (most said less than one fifth) of the smokers the service treated overall. More than three quarters (76%) reported that they were planning changes in anticipation of the ban, the most frequently mentioned changes including increasing their capacity to deliver workplace based services in terms of staff, time, training and funding.

Case studies

From the case studies representing good practice, most linked their workplace cessation support with support for the implementation or strengthening of the employer's smoke-free policy. Most had worked with intermediaries eg Environmental Health Departments or Local Authorities. Although some tried to target workplaces with employees drawn from lower socio-economic groups this aspect seemed less successful. Once again size appeared to be the key discriminating factor. Most had also developed a successful strategy to raise awareness of what services they offered through the media or through participation in meetings where employers were present. Most did not charge employers for their services.

The case studies offered flexible support. Most offered in-house cessation support in the form of groups or 1 to 1 onsite (one provided a mobile clinic which was sited near the business). Training staff in-house to then go on and provide support to smokers seemed less likely to succeed. It was important to identify an ambassador for the service within the business.

The perception among some of those in the case studies was that quitters recruited via workplaces were more likely to quit than those entering the services via other routes. This is possibly because the service staff worked to ensure only those highly motivated attended, but one also said that the fact that the smokers knew each other meant that they were able to provide more support to one another.

Key learning from the case studies

How to target local employers, and partnership activities

- Making the link with workplaces who were either implementing or strengthening their smoke-free policy and linking the cessation support to this.
- Promoting the National Clean Air Award
- Working with Environmental Health Departments who have direct contact with (and regular visits to) local businesses – to promote the Stop Smoking Service
- Working with the Local Authority and Chamber of Commerce to identify local businesses by size and type
- Targetting businesses with a predominance of lower socioeconomic workers did not appear to be a highly successful strategy in these case studies. Better to focus on those having larger staff workforces or where there was an identified need from the business in terms of further development of their smoking policy.

Profile raising

- Networking and profile raising: attending Business in the Community and Chamber of Commerce meetings
- Making good use of the local media: nurturing a relationship with key newspapers, radio and news media. Ensuring that local success stories are covered and that contact details of the Stop Smoking Service are included
- Promoting and exploiting the NHS brand – national media campaigns help to raise the profile of local services, and enables local services to ‘follow through’ to local businesses

Delivery: providing what the customer wants

- Flexibility, innovation and being responsive to 'customer need' – many different approaches were used to target and contact local businesses. Once contact is established, services found it was vital to understand the needs of the business – whether it be providing groups, training in-house staff, support with development of smoking policies etc.
- Finding an in-house ambassador for the service seemed to be helpful.
- In-house training seemed to be a less successful strategy in the case studies we interviewed.
- Innovation in the delivery of workplace services: using bank staff 'as and when' to cover extra demand – providing incentives to staff to establish demand for the service.
- It appeared in these case studies that offering support within the business where possible was the preferred strategy.
- Quitters recruited via workplaces were considered to be more likely to quit, because of the high level of motivation afforded by colleagues and management. Also, the reliability of quit rates from workplaces was thought to be better than that provided by community based pharmacies for instance.
- Having dedicated staff for the workplace activities within the stop smoking service is a prerequisite for running this work effectively.
- Most services do not charge businesses for their services. This is obviously something that could be considered although we would recommend this be done nationally with best practice guidance provide.

Experience from Ireland and Scotland

Data from the national helplines, NRT sales and information from the smoking cessation services where available, show a consistent picture. Demand for cessation support from both workplaces and smokers is linked to media activity which in these countries happened in the months leading up to the bans as well as the announcement of the bans. Demand therefore increased markedly before the ban and seemed to drop off quite rapidly following implementation. We could not get access to prescription data in the time available, but one service in Scotland reported a rise in this in the year leading up to the ban suggesting that in Scotland in addition smokers might have been quitting using support from primary care rather than services. Sales of NRT in Ireland (from manufacturers to retailers) showed a significant rise in the few months leading up to the ban with a fall afterwards. These data might be skewed by stockpiling in anticipation of the ban but are likely to indicate a significant proportion of smokers making cessation attempts without professional support.

Ireland

Legislation to prohibit smoking in the majority of workplaces, including bars and restaurants was introduced in the Republic of Ireland on 29 March 2004. The smoking cessation infrastructure in Ireland was – and still is – not as extensive as that in England and Wales. There are no data available on uptake of primary care services in Ireland before or after the introduction of the legislation.

The main sources of information are from the National Smokers' Quitline, sales of NRT, reported behaviours of smokers and expert opinion. The Quitline was set up to coincide with the launch of a high profile media campaign: this ran for the 6 months prior to the 29 March 2004.

Evidence from the Quitline data and NRT sales indicates that demand for smoking cessation services peaked in the period *prior* to the introduction of the ban, driven mainly by the media campaign, together with pharmaceutical industry sponsored media promotion of NRT.

The high volume (19,800) of calls to the Quitline in the 6 month prior to the introduction of the ban, was not sustained after the introduction of the legislation, and sales of NRT appear to have decreased in the year following the ban.

Evidence from the ITC cohort survey of reported behaviour by smokers indicates that among smokers, just under half (46%) felt that the smokefree legislation had made them more likely to quit, and 60% reported that they had reduced their consumption of tobacco as a result of the ban. Of those who had quit (n=119), 80% reported that the law helped them to quit and 88% said it helped them to stay quit. Unpublished ITC data reported at the National Smoking Cessation conference in 2006 indicated that there had not been a significant change in quitting behaviour as a result of the ban but that the baseline wave might have been carried out too late to catch quitting behaviour happening in anticipation of the ban given the long build up to the policy being implemented

Explanations for the early peaking of smoking cessation activity in Ireland prior to the ban are as follows:

a) the impact of the media campaign – which was not continued after the introduction of the ban
b) high level promotion of NRT by pharmaceutical companies prior to the ban
c) a drawn out – and delayed – introduction of the legislation, meaning that the impact was spread out over a longer period after the initial announcement of the Irish Government's intention to introduce the legislation.

Scotland

Legislation to prohibit smoking in the majority of workplaces, including bars and restaurants was introduced in Scotland on 26 March 2006. There is a comprehensive programme of research to examine the implementation and impact of the ban. Some data will also emerge from

the ITC evaluation next year as the first wave of data collection post the ban is being carried out in February 2007.

The smoking cessation infrastructure in Scotland has been developing and expanding in recent years. Although the data monitoring system for the cessation services began to be put in place before the legislation, this took longer than anticipated and is still being fully implemented in some areas of Scotland. Reliable national data before and after the ban therefore do not exist in the immediate pre and post ban periods. However some analysis will be performed at a local NHS Board level.

The main sources of information are from the Smokeline, NRT sales, and the views of some smoking cessation coordinators as well as expert opinion. As the ban was only brought in earlier this year, it is too early to investigate the longer term impact of the ban.

Smokeline calls increased in the lead up to the ban and seemed to be associated with media advertising and the announcement of the ban. NRT data showed a similar increase in the lead up to the ban but there may be a small sustainable increase over earlier years.

The services were experiencing an increase in capacity in the year before the policy was implemented due to increased funding from the Scottish Executive initiatives so the exact impact of the policy is hard to measure. To some extent increases of demand may have been met by the increase in capacity. Most of the increase in demand from both workplaces and smokers appeared to happen in the build up to the ban. Like Ireland this is likely to be linked to the media campaign.

5 Overall implications

Experience from the other countries suggest that demand for the services will increase in the run up to the ban. Depending on when media advertising commences, this could happen soon in the new year. Most of the workplaces we surveyed indicated that they were aware that demand

would increase and that they hoped to increase capacity in anticipation of that demand. Given that most services have less than 1 FTE dedicated to workplace support this increase in capacity is much needed.

Services will face two different demands. An increase in employers wishing to use their services and an increase in demand from smokers. It will be important to be able to absorb the extra demand from both routes. Some smokers may go to GPs or purchase NRT themselves but with a high profile the services should be able to attract some of these smokers so as to optimise their chances of successful quitting.

Whilst the case studies of good practice indicate that services ran interventions onsite, this might not be possible in the run up to the policy being implemented, particularly if smaller employers contact them. It might be feasible therefore to recruit advisers who can work across the service (workplace and community) so that there can be flexibility in responding to the demand.

Finally, the increase in demand will have an impact on the resources needed by the services.