GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

# Help Me Quit Service Review

## Main Report

**Date: 13 October 2025**

# Contents

# 1. Foreword

Smoking is uniquely lethal. It remains the single biggest preventable cause of ill health and death in Wales. It hits our poorest communities hardest, and most smoking related deaths come from more deprived communities. These harms are preventable, unfair and driven by the tobacco industry. It doesn't have to be this way.

Wales has been at the forefront of tobacco control internationally. It has enacted groundbreaking legislation to protect the public and prevent tobacco harms. It also has smoking cessation services that align to international best practice and are ahead of many other European countries in their effectiveness and reach.

The COVID-19 pandemic had a huge impact on smoking cessation services. Many staff were redeployed to contribute to the emergency response and those that remained did all they could to maintain a service with reduced resources. As we move away from the pandemic, it is timely to consider how to make smoking cessation services in Wales fit for the future.

In this comprehensive review, the team worked with colleagues from local government, NHS, national government and the third sector to take stock of where services are at and chart a course of action for the years ahead. The group have examined every part of the smoking cessation system and identified a series of recommendations that will reach every part of the country.

It has been a pleasure to work with such a dynamic and expert group who have brought their different expertise and experience together to set out a step change for smoking cessation in Wales. It is crucial that this review acts as the blueprint for change that is then enacted, and I have every confidence that the group that have worked for the past eight months will stay together to put the recommendations into action.

**Garth Reid**

Consultant in Public Health

Public Health Scotland

Chair, Help Me Quit Service Review Project Board

# 2. Executive Summary and Recommendations

## Overall Findings

- Help Me Quit is effective in supporting smokers across Wales to quit, with good and improving outcomes that compare well with other cessation services
- Help Me Quit provides equitable support to smokers in Wales, with service provision broadly reflecting the underlying smoking population and comparable outcomes across diverse groups, particularly those who may be marginalised in relation to deprivation
- The data reinforce evidence from practice that current smokers in Wales are at least as likely to access HMQ and to benefit from the service as smokers in previous years
- There is clear evidence that investment in smoking cessation services is associated with a greater proportion of smokers accessing services and achieving successful outcomes
- A key factor in the continued success of HMQ is stable and sustainable funding arrangements to support strategic service planning and sufficient capacity to meet service demand
- Help Me Quit continues to be delivered in line with current service standards and the evidence base, as set out by NICE guidance and other key sources of guidance
- As smoking prevalence has reduced, the population of smokers is changing as are their needs and preferences for different models of cessation support and modes of service delivery
- The COVID-19 pandemic had a major impact on the delivery of support through HMQ, with some challenges (e.g. CO monitoring of quits) continuing. However, there is also evidence of innovative approaches to meeting these challenges across the system
- The landscape in which Help Me Quit is delivered is changing, with factors including communication technology, evidence on emerging models of cessation support and the commercial availability of vapes and other nicotine products
- To continue to support smokers effectively, Help Me Quit should continue to develop a service offering that reflects client needs and current evidence of effectiveness
- HMQ is effective as an integrated system, with services delivered across hospitals, community services and community pharmacy. However, there are opportunities to deepen integration, in particular through the use of common data systems

- In general staff demonstrate a clear understanding of the importance of their work and consistently show a strong commitment to supporting smokers to quit. They value long-term stability in support for services and support to work effectively with an increasing proportion of clients with complex issues

## The Service Review

- The Service Review was commissioned from Public Health Wales by Welsh Government "to ensure the current and continued effectiveness of the Help Me Quit system in supporting smokers who engage with the service to quit; and to strengthen the smoking cessation system in Wales"
- The Service Review included an audit against the HMQ Minimum Service Standards and NICE guidance, a service mapping exercise, four staff engagement events and analysis of data on the four Client Management Systems used by HMQ services

→ For details on the aims and objectives of the Service Review, see **Section 3**
→ For details on project management, see **Section 7**
→ For membership of the Project Board overseeing the Service Review, see **Appendix 1**: Project Board and Task and Finish Group

### Help Me Quit: the national smoking cessation service for Wales

- Help Me Quit (HMQ) was created in 2017 as a national NHS service for Wales, building on the established Stop Smoking Wales service. HMQ aims to provide cessation support to all smokers in Wales that is high quality, evidence-based, seamless, efficient and equitable
- HMQ provides smoking cessation support based on NICE guidance and the HMQ Minimum Service Standards, most recently updated in 2019. The pathway includes multiple sessions of behavioural support and free pharmacotherapy, including Nicotine Replacement Therapy
- The majority of smoking cessation was devolved to the seven Welsh Health Boards in 2019, with Public Health Wales managing the HMQ Hub, processing referrals and providing the National Telephone Support Service
- A significant proportion of cessation support is provided by community pharmacy, commissioned by Health Boards to a national service specification
- In recent years, the Help Me Quit in Hospital Programme and Smoking in Pregnancy programme have co-ordinated efforts to increase engagement and support for patients in secondary care and pregnant smokers

- Public Health Wales also provides system-level support and co-ordination, including managing and reporting on HMQ data

→ For details of the history and organisation of HMQ, see **Section 5**

**Smoking in Wales**

- Smoking remains the single greatest preventable cause of disease and mortality in Wales.
- An average of 3,845 deaths amongst adults aged 35 and over between 2020-22 were attributable to smoking, more than one in ten of all deaths in this population
- Over the same period, more than 17,000 admissions were due to smoking related illness on average every year
- These harms are socially patterned, with rates of mortality from smoking more than three times as high amongst those living in the most deprived fifth of areas in Wales compared with the least deprived
- The rate of smoking in Wales according to the National Survey for Wales was 12.8% of adults in 2022-23. There are estimated to be over 330,000 adult smokers in Wales

→ For data and analysis on the prevalence and harms of smoking in Wales, see **Section 4**

**The population accessing HMQ and their outcomes**

- In 2023-24, there were over 33,000 referrals into HMQ, the highest number recorded for any year. Self-referral from the HMQ website was the most frequent source of referral
- Across the different Client Management Systems in current use, figures for 2023-24 were between 34% and 52% higher than in the previous year. A key source of this increase was rising numbers of referrals from secondary care settings
- Whilst referrals from professionals (e.g. primary care and third sector) are increasing, they represent a relatively small proportion of the smokers likely to be accessing these services
- There has been a shift following the COVID-19 pandemic in the balance of the provision of support in community settings, with a greater proportion of HMQ clients now seen by Health Board HMQ community teams
- A 'treated smoker' is a smoker who has attended at least one Assessment/Treatment session with HMQ and set a quit date. In 2023-24,

HMQ recorded 17,104 treated smokers, an increase of 18.4% compared with the previous year

- This figure included 7,561 treated smokers supported by Health Board HMQ community teams, 2,433 smokers referred from hospital settings (which saw a rise of 50.9% year-on-year) and 803 pregnant smokers (most of whom would have also been supported by community teams) and 6,307 treated smokers supported in pharmacy settings
- A total of 8,617 smokers in Wales had quit smoking 4 weeks after becoming a 'treated smoker' in 2023-24
- This figure includes 5,103 quits from community services, 1,459 through HMQ in Hospital, 313 clients supported through maternity services and 1,742 supported by community pharmacies
- The overall quit rate (the proportion of treated smokers who are recorded as having quit 4 weeks after their quit date) was 50.4%. This is above targets set in national guidance and is comparable to the rate reported by NHS England in the same period
- Across Wales, 5.2% of the estimated smoking population became 'treated smokers' in 2023-24, with 2.6% of the estimated smoking population recording a quit four weeks after their agreed quit date. These figures are higher than those reported by NHS England
- There was considerable variation between Health Boards in the proportion of the smoking population who became treated smokers and recorded a quit at four weeks. These variations were associated with differences in reported staff numbers
- The proportion of treated smokers in older age groups (45+ and particularly 65+) has risen in recent years, particularly amongst clients seen by Health Board HMQ community teams. The number of smokers in age groups under 35 has fallen
- The profile of the HMQ client population in terms of deprivation reflects the population of smokers in Wales, with 32% of clients for whom data was available living in the most deprived fifth of areas
- For clients for whom data was available, 4.8% described their ethnicity as other than 'white British' or 'white Welsh'. The majority of these were resident in Cardiff and Vale UHB
- For clients with a referral recorded on the QuitManager system, 2.2% requested support in the medium of Welsh, the majority resident in Betsi Cadwaladr UHB
- The proportion of smokers accessing HMQ services provided by Health Board HMQ community teams and attending an Assessment Session who became a treated smoker was 60% in 2023-24 and the proportion of treated smokers

who recorded a 4-week quit was 66% for services recording data on the QuitManager system. These figures are similar to those recorded for all years from 2017-18 onwards

- There was very little variation in outcome for treated smokers living in areas with different levels of deprivation or for smokers of different ethnicities. There was some evidence that attrition was higher amongst younger smokers, but numbers were smaller in these age categories
- Smokers identified in hospital and supported through HMQ were more likely to be older than smokers who self-referred or were referred by professionals in the community
- Smokers who were identified in hospital and recorded on the Welsh Nursing Care Record were almost all offered NRT and a referral to HMQ
- The proportion of all pharmacies providing a full HMQ (behavioural support and pharmacotherapy) varied by Health Board from 22.8% to 78.3%

→ For detailed data and analysis of the population accessing HMQ, see **Section 9**

→ For detailed data and analysis of outcomes within HMQ, see **Section 10**

**Service mapping, audit and stakeholder engagement findings**

- Findings from these workstreams were organised around five domains

→ For details of the output of the service mapping, audit and stakeholder engagement activities, see **Section 12**

→ For specific findings in relation to support for pregnant smokers, **see Section 12.9**

- **Governance and Service Planning**
    - HMQ services delivered by Health Board HMQ community teams are funded from their budget allocation transferred from Public Health Wales in 2019. Most Health Boards use Prevention and Early Years funding, agreed annually, to fund additional HMQ posts. This has resulted in issues with planning HMQ capacity
    - There is variation in governance arrangements, service planning and reporting between Health Boards reflecting local structures, with some examples of excellent / innovative practices
    - Nationally agreed funding for provision of HMQ in community pharmacy has remained static for many years, and pharmacies are providing more public health services. Work on a new smoking

cessation national service specification aims to address these challenges

- **Service content**
  - There is clear evidence that services continue to use evidence-based smoking cessation support consistently to provide an equitable service across Wales to all smokers accessing HMQ, including children and young people
  - COVID-19 created serious problems in relation to CO validation of quits, a core part of the evidence base for smoking cessation interventions, and these have persisted
  - Several Health Boards are using a 'harm reduction' approach with some HMQ clients. There are examples of innovative and evidence-based practice, but inconsistencies in how 'harm reduction' is conceptualised, designed and implemented between HMQ services
  - Harm reduction is most likely to be implemented in support for pregnant smokers, as reducing exposure to smoking has the largest impact on health for these clients
  - A lack of clear national guidance on the use of vapes by smokers, including in relation to smoking cessation, is leading to inconsistencies in advice given on this issue

- **Service fidelity**
  - Maintaining service quality at a time of rising demand for smoking cessation and emerging demand for vape cessation support was identified as a challenge for HMQ with current capacity. Current and future waiting times for service were identified as an issue
  - When the current HMQ restructured in 2019, it was based on Health Board HMQ community teams delivering the majority of support face-to-face, and in groups. Following COVID-19, and for a range of reasons, the majority of support delivered by these teams is now telephone-based
  - There are examples of emerging 'hybrid modes' of support that are reported as improving service delivery by meeting client preferences for a mix of telephone and face-to-face
  - The guiding principle for agreeing the mode of delivery of support with a client should be meeting their needs in relation to supporting a successful quit

- Further work needs to be done to develop the range of modes of support available to clients beyond face-to-face and telephone (e.g. online)
- There may be benefits to some clients in terms of quit success in offering more flexibility in the models of support (e.g. number of support sessions provided) available through HMQ. Developments in this area need to be considered in relation to the effectiveness of HMQ in supporting smoking cessation at a population level

- **Service integration**
  - Enhancing integration and communication between service settings, in particular between pharmacy and community and secondary care and community would improve the efficiency and effectiveness of HMQ
  - A particular issue for some services in relation to integration of community and pharmacy support is provision of appropriate NRT in a timely way. Improved integration of Client Management Systems would support improvement in this area
  - There is scope to improve referral pathways between primary and community care and HMQ
  - HMQ Health Board teams are often involved in a range of activities beyond supporting clients, including working with partners to support smokefree hospitals and community education

- **Training and support**
  - Staff understand the importance of their work and consistently express a strong commitment to supporting smokers to quit. They value opportunities to network, collaborate and innovate. Many staff report frustration with service and system level issues, in particular uncertainty on service funding arrangements
  - There is clear evidence that training through the National Centre for Smoking Cessation and Training (NCSCT) is consistently accessed and completed by HMQ advisors in Wales
  - Many HMQ advisors report that they are working with an increasing number of clients who have more complex needs, in particular in relation to disability and mental health. Supporting these clients effectively can be challenging
  - There are several examples across HMQ services of staff mentoring and supervision developed to support advisors in meeting these increasing demands. Staff value support to develop their skills in

working with a client group reporting more challenging circumstances and to maintain their own wellbeing

## Key Recommendations

### Funding and system leadership

Key Recommendation 1: Health Boards and Welsh Government should agree an approach to funding that provides stability and equitable service provision across Wales, reflects the high value of smoking cessation in preventing illness, mortality and high healthcare use, and gives due consideration to health inequalities

Key Recommendation 2: Health Boards and PHW should collaborate to establish an HMQ National Leadership Group to discuss and adopt recommendations that relate to the HMQ system as a whole, such as changes to reporting protocols, amendments to national service standards, etc.

Key Recommendation 3: Health Boards and PHW should ensure performance measures for smoking cessation services are agreed, clearly documented and quality assured. Health Boards, PHW and Welsh Government should ensure that all measures reported nationally are documented and calculated consistently

### Vaping and harm reduction

Key recommendation 4: PHW should update their vaping position statement and produce a practice note aligned with this to support the HMQ system in providing consistent and evidence-based advice in relation to vapes, including their use in smoking cessation

Key recommendation 5: Where HMQ services are providing specific harm reduction interventions, these should be documented, to include definition of the population of smokers being offered the intervention specific harms they aim to reduce, the evidence base and how they record and measure success

### Evidence-based service delivery

Key Recommendation 6: PHW and HMQ Pharmacy Leads should explore options for CO validation in pharmacy, including recording these on client management systems accessible to HMQ advisors within national smoking cessation Service Level Agreements

Key Recommendation 7: PHW should review the evidence and options for increasing remote and hybrid delivery of support and how this can be integrated into the current HMQ service, making the best possible use of technologies to deliver services in ways that meet client need

Key recommendation 8: When discussing a discharge from HMQ for clients who have not achieved a quit but wish to re-engage with the service, those providing support through HMQ should discuss reasons why this attempt was not successful, the range of support options available and their current motivation for quitting. This should be made clear in all HMQ guidance

**System integration**

Key Recommendation 9: PHW should work with other HMQ providers and the QuitManger provider to allow recording of HMQ client data on a single Client Management System

## Additional Recommendations

**Improving access to HMQ**

Recommendation 1: Health Boards should engage locally with primary care providers to increase awareness and referral rates into HMQ

Recommendation 2: PHW should engage with national teams working with the primary care to identify ways to increase referrals into HMQ

Recommendation 3: Health Boards should consider how organisations and settings within their local areas who are working with vulnerable populations of smokers who are not currently accessing HMQ

Recommendation 4: PHW should review evidence for engaging with and providing services to vulnerable populations in order to develop, support and evaluate effective engagement and support for vulnerable smokers

**Governance and service development**

Recommendation 5: HMQ services should ensure clear governance structures are in place for smoking cessation services, including facilitating engagement between community and pharmacy services, involvement of a named clinical lead and lines of reporting to relevant Health Board governance bodies

Recommendation 6: HMQ services should have an annual quality plan in place, aligned with their organisation's policies and strategies in relation to the Health and Social Care (Quality and Engagement) (Wales) Act 2020

**Children and young people who smoke**

Recommendation 7: HMQ services should review the support available for smokers under 18 to ensure governance, safeguarding procedures and recording of data are consistent across Wales

Recommendation 8: PHW and other providers of Client Management Systems for HMQ smoking cessation services should ensure that vape use, including the reason for use, can be recorded and that harm reduction approaches can be recorded and their success measured

**Harm reduction interventions**

Recommendation 9: PHW should carry out an evidence review for harm reduction interventions and their effectiveness in reducing harms from smoking to clients accessing HMQ services

**Outcome measurement**

Recommendation 10: PHW should facilitate work to develop consensus across the system on measuring outcomes to ensure these are documented and comparable

**Service delivery**

Recommendation 11: HMQ community services should ensure that the length of both in-person and telephone sessions reflect guidance in the HMQ Minimum Service Standards where these are delivered as 'high intensity sessions'

Recommendation 12: All HMQ services offering telephone support should ensure their system supports call recording for quality, monitoring and staff safeguarding

Recommendation 13: All HMQ services should review their processes for identifying and engaging with family members of smokers to ensure that opportunities for support are not missed

Recommendation 14: All HMQ services which provide in person support should ensure that there are clear and documented processes for identifying who within their teams needs CO monitors and supplying, monitoring functionality and replacing this equipment

Recommendation 15: PHW should analyse the effectiveness of current and future models of service delivery in terms of the outcomes for smokers accessing HMQ, ensuring these reflect the best available evidence on behavioural science

Recommendation 16: PHW should partner with a Health Board team to agree a pilot model with increased flexibility which can be implemented locally and evaluated

Recommendation 17: PHW should produce a report on evidence for improving cessation support for those experiencing particular barriers to successfully completing smoking cessation treatment with HMQ

**Client Management System**

Recommendation 18: PHW should establish a national Client Management System User Group within HMQ national governance structures to enable possible

amendments to the QuitManager system to be raised by CMS users, discussed and where agreed, implemented

**Welsh language**

Recommendation 19: All HMQ services should ensure that they are included within their organisation's Welsh Language Clinical Consultation Plan

**System integration**

Recommendation 20: PHW should work with other HMQ providers and the QuitManger provider to explore and where possible implement improvements to reduce paper flows within the HMQ system

Recommendation 21: HMQ providers should collaborate to ensure that clear protocols for the seamless referral and transfer of clients between hospital and community HMQ support are in place and clients are identified as the client for a specific service in a consistent way

Recommendation 22: PHW should assess how to improve referral into the QuitManager Client Management System to improve ease of professional referral into HMQ

**Improving access to HMQ**

Recommendation 23: PHW and Health Boards should co-ordinate liaison with primary, secondary and social care services locally and nationally to highlight availability of HMQ services

Recommendation 24: Health Board HMQ providers should share current models of mentoring and clinical supervision and support and agree best practices that can be adopted nationally

Recommendation 25: PHW and Health Boards should collaborate to ensure that services to provide appropriate support to clients identified as having wider health and social care needs are identified and referral pathways are made available locally or nationally

**Training and support**

Recommendation 26: PHW and Health Boards should collaborate to identify what NCSCT training is currently available beyond the core modules and relevant to services and make this available where appropriate

Recommendation 27: PHW and Health Boards should explore options for providing more frequent networking opportunities for HMQ staff and ensure that insights gathered at these events are assessed and acted on where opportunities for service improvement exist

Recommendation 28: PHW and HMQ Pharmacy leads should explore providing, recording and monitoring access to NCSCT resources for those delivering HMQ support in pharmacy and integrating this within existing governance arrangements for pharmacy training in Wales

**Recommendations specific to pregnant smokers**

*Note that recommendations identified elsewhere in this report also relate to pregnant smokers.*

Recommendation 29: Opt-out consent should be consistently documented across all services supporting pregnant smokers

Recommendation 30: Financial incentives should be implemented only where evidence suggests that protocols and processes for supporting pregnant smokers within the current system have been effectively implemented

# 3. Project Background, Aims, Objectives and Outcomes

**Liz Newbury-Davies and Chris Emmerson**

Help Me Quit (HMQ) is Wales's national smoking cessation service. HMQ was established in 2017, based on the national Stop Smoking Wales service to provide cessation support to all smokers in Wales that is high quality, evidence-based, seamless, efficient and equitable.

The Help Me Quit Service Review was developed in response to Welsh Government's High Level Objectives for 2024-25, which required Public Health Wales to:

> *"Undertake a review of the tobacco cessation system in all Health Boards, akin to the All Wales Weight Management Pathway review, and provide Welsh Government with recommendations to ensure a common baseline service across Wales".*

The Service Review was developed with the support and agreement of the Executive Directors of Public Health in Wales and the Project Board established to manage the project.

The **aim** of the Service Review was agreed as:

***"to ensure the current and continued effectiveness of the Help Me Quit system in supporting smokers who engage with the service to quit; and to strengthen the smoking cessation system in Wales".***

The **objectives** of the project were agreed as:

- To describe the current HMQ system in terms of structures, activities and outcomes in ways that support improvement and development by stakeholders across the system
- To document the use of evidence-based approaches to smoking cessation service delivery and their consistent use across HMQ services (against defined HMQ Minimum Service Standards[1])
- To provide evidence on the degree to which HMQ operates as a seamless, efficient and simple to navigate service
- To document compliance within HMQ with all relevant corporate standards, including information governance
- To review HMQ performance against recognised benchmarks (e.g. the Russell Standard[2] and HMQ Minimum Service Standards[1])

The **outcomes** of the project were agreed as:

- Welsh Government is provided with assurance that HMQ is providing a consistent and effective smoking cessation service
- Any areas for development required to ensure HMQ services remains an effective, consistently delivered evidence-based service are identified
- Any areas for development required to strengthen the integrated smoking cessation framework and smoking cessation system are identified

# 4. Smoking in Wales

**Chris Emmerson**

The purpose of this section is not to give a comprehensive overview of data on smoking in Wales, but to highlight analysis that is relevant to cessation service resourcing and configuration and can provide context for insights into the population accessing those services.

## 4.1. Smoking Harms

Smoking remains the single greatest preventable cause of disease and mortality in Wales. An average of 3,845 deaths amongst adults aged 35 and over between 2020-22 were attributable to smoking, more than one in ten of all deaths in this population[3]. Over the same period, more than 17,000 admissions were due to smoking related illness every year, illustrating the tremendous burden smoking places on healthcare services in Wales[3].

These harms are socially patterned, with Figure 1 showing rates of mortality from smoking are more than three times as high amongst those living in the most deprived fifth of areas in Wales compared with the least deprived.

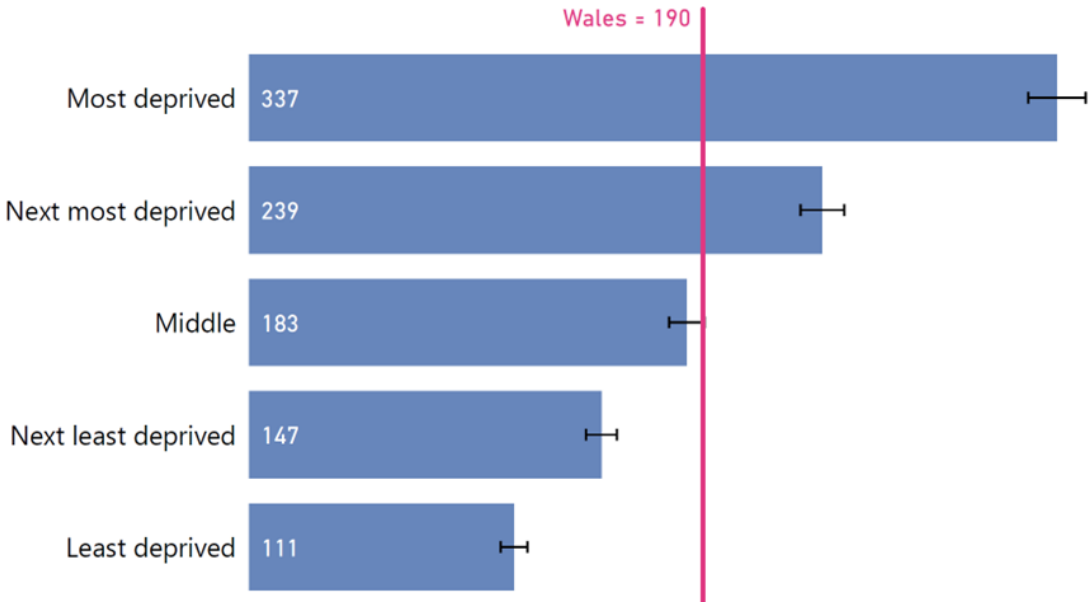



*Figure 1: Smoking attributable mortality, European Age Standardised Rate (EASR) per 100,000, persons aged 35+ by deprivation fifth, Wales, 2020-22. Source: Public Health Wales*

## 4.2. Smoking Prevalence[a]

The National Survey for Wales (NSfW) reported the prevalence of smoking amongst adults in Wales as 12.8% (95% Confidence Intervals 11.6% to 13.9%) for 2022-23. Rates amongst men were reported as 13.2% compared with 12.4% amongst women, but 95% confidence intervals overlapped and so this difference may have been due to chance alone.

Rates of smoking have fallen over time, although changes to the methods used to gather data in population surveys, in particular during and following the COVID-19 pandemic mean that comparisons between years may be difficult to interpret. Figure 2 shows the smoking rate amongst all adults aged 16+ in Wales from 2016-17 to 2022-23.

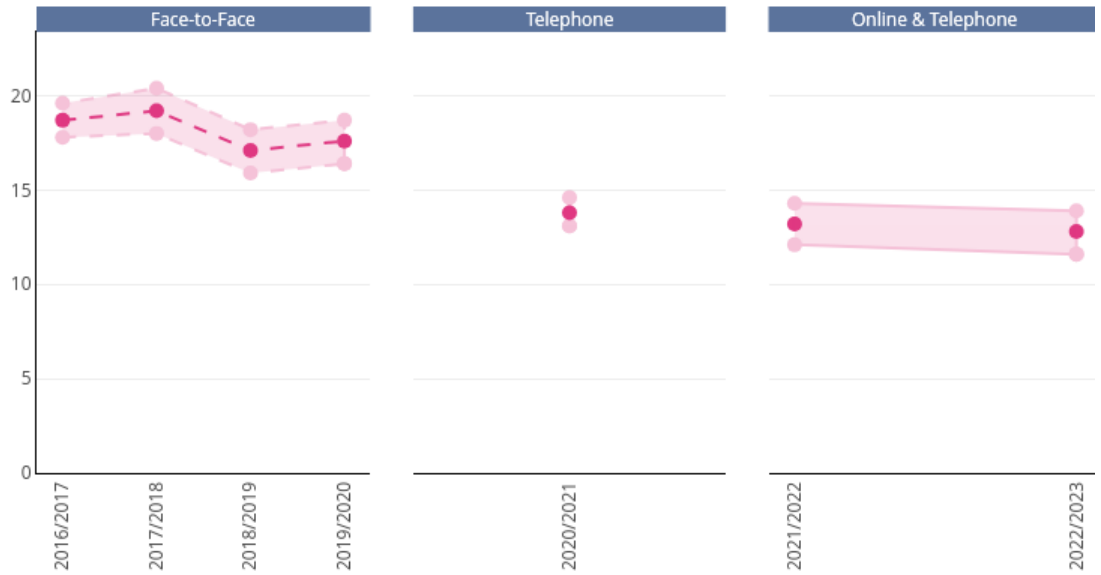



*Figure 2: Adults who smoke, age-standardised percentage, persons aged 16+, Wales, 2016-17 to 2022-23, including 95% Confidence Intervals and method of data acquisition. Source: Public Health Wales using NSfW (Welsh Government)*

[a] Note that data from two sources are used in this Report. The main source for smoking prevalence figures is the National Survey for Wales (NSfW), which includes information on smoking and deprivation. The Office for National Statistics also reports smoking prevalence, based on the Annual Population Survey (APS), which provides comparable data between UK areas and allows for more detail on key epidemiological factors such as age, due to a larger sample size. Smoking prevalence for Wales was reported amongst those aged 16+ by the NSfW as 12.8% (95% Confidence Intervals 11.6% to 13.9%) for 2022-23[4] and by the APS for adults aged 18+ as 12.6% (11.7%-13.6%) for 2023[5].

Based on ONS estimates of the adult population of Wales and the proportion who smoke, we can estimate that if smoking rates had not changed in the past ten years, the population of Wales would include more than 170,000 additional smokers aged 18 or over.

Smoking prevalence by age is shown with data taken from the APS for 2013, 2018 and 2023 for all persons in Figure 3 and by age and sex in 2023 in Figure 4.

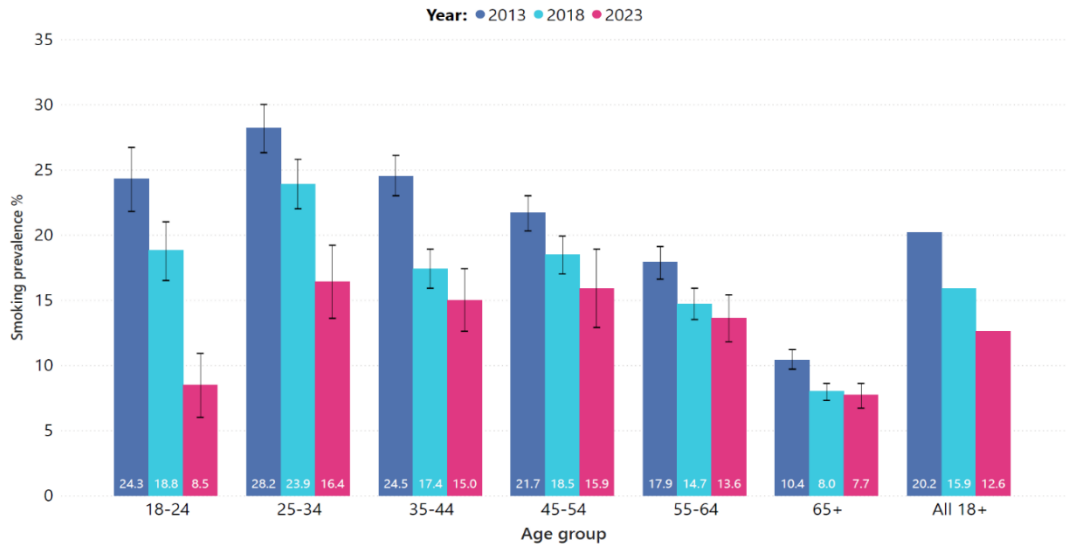



*Figure 3: Proportion of adults who were current smokers, by age and year, Wales, 2013, 2018 and 2023 (Source: ONS, APS)*

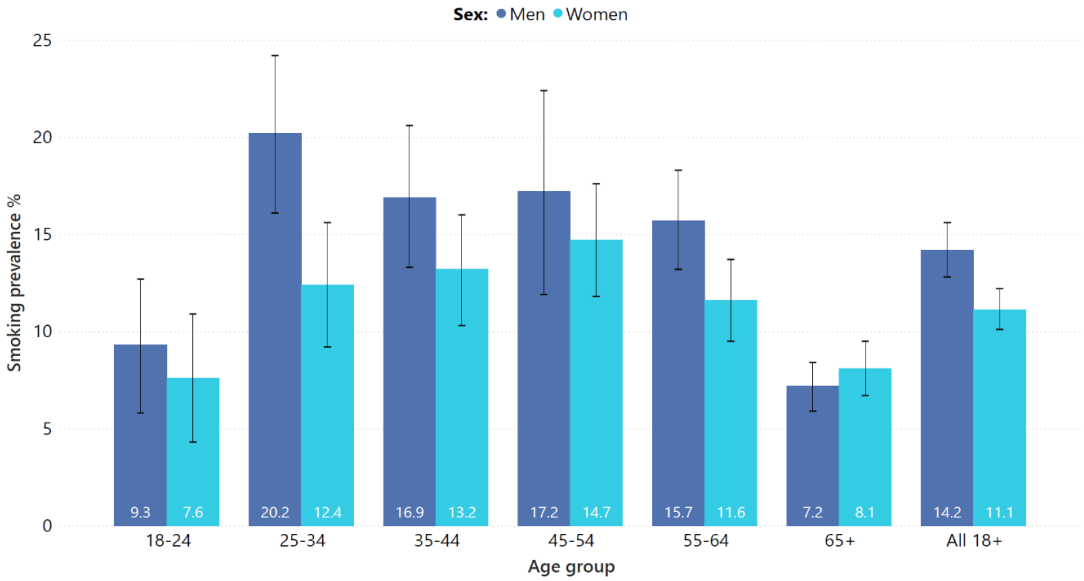



*Figure 4 : Proportion of adults (18+) who were current smokers, by age and sex, Wales, 2023 (Source: ONS, APS)*

In 2023, the age group with the highest proportion of smokers overall was 25-34 – year-olds, but this is most marked in men, amongst whom smoking is more marginally more concentrated in younger age groups over time. This is consistent with previous years for Wales and with other countries of the UK and with England and Northern Ireland, although Scotland has been more likely to report higher proportions of smokers in older age bands over the past 10 years. The estimate for the rate amongst those aged 18-24 is substantially lower than that seen in previous years in Wales and for the rate observed in this age group in other nations of the UK in 2023. It is not clear whether this difference (for which 95% Confidence Intervals narrowly overlap with 2022 for this age group) is a real reduction or a statistical artifact.

HMQ can support smokers from 12 years of age upwards. Data from the 2023 Welsh Student Health and Well-being (SHW) survey showed 2.7% of learners in years 7 to 11 reported smoking at least weekly. There was an age gradient in smoking rates, with 5.5% of learners in Year 11 reporting smoking at least weekly[6].

Rates of smoking show a strong association with deprivation, as shown in Figure 5.

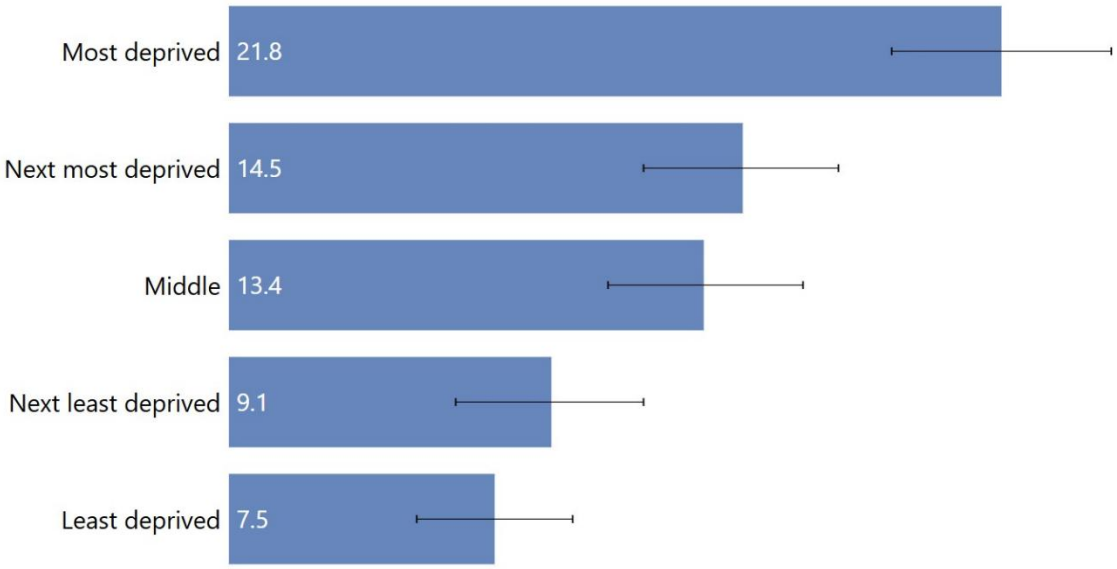



*Figure 5: Adults who smoke, age-standardised percentage, persons aged 16+, Wales by deprivation fifth, 2022-2023. Source: Public Health Wales using NSfW (WG) & WIMD (2019)*

Those living in the most deprived fifth of areas in Wales are 50% more likely to smoke compared with those living in the next most deprived fifth and almost three times as likely to smoke as those in the least deprived areas.

Figure 6 shows variation in smoking by Health Board.

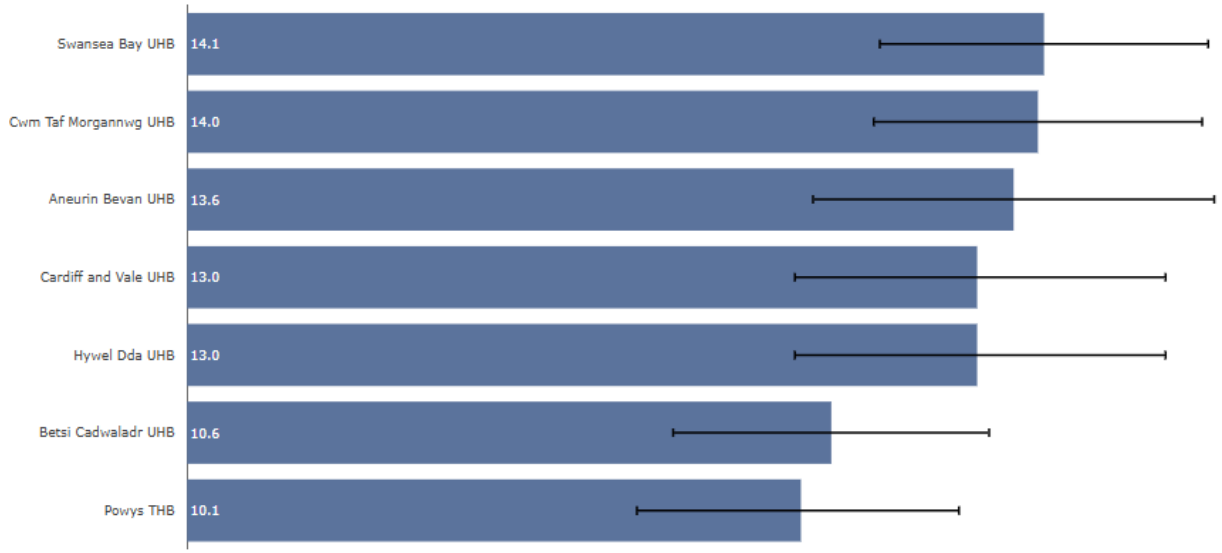



*Figure 6: Adults who smoke, age-standardised percentage, persons aged 16+, Wales, Health Board, 2022-2023. Source: Public Health Wales using NSfW (WG)*

Whilst the Confidence Intervals in the data presented in this Figure suggest that real differences between Health Board populations may be limited, data from the NSfW and APS over time suggest that Powys THB, Hywel Dda UHB and Cardiff and Vale UHB tend to have lower smoking prevalence, whilst Cwm Taf Morgannwg UHB and Aneurin Bevan UHB typically have relatively high rates.

In terms of the configuration of HMQ nationally to support smokers most effectively, it can also be useful to think not only about the rates of smoking by deprivation, but the distribution of the total number of smokers across different deciles of deprivation, as shown in Figure 7.

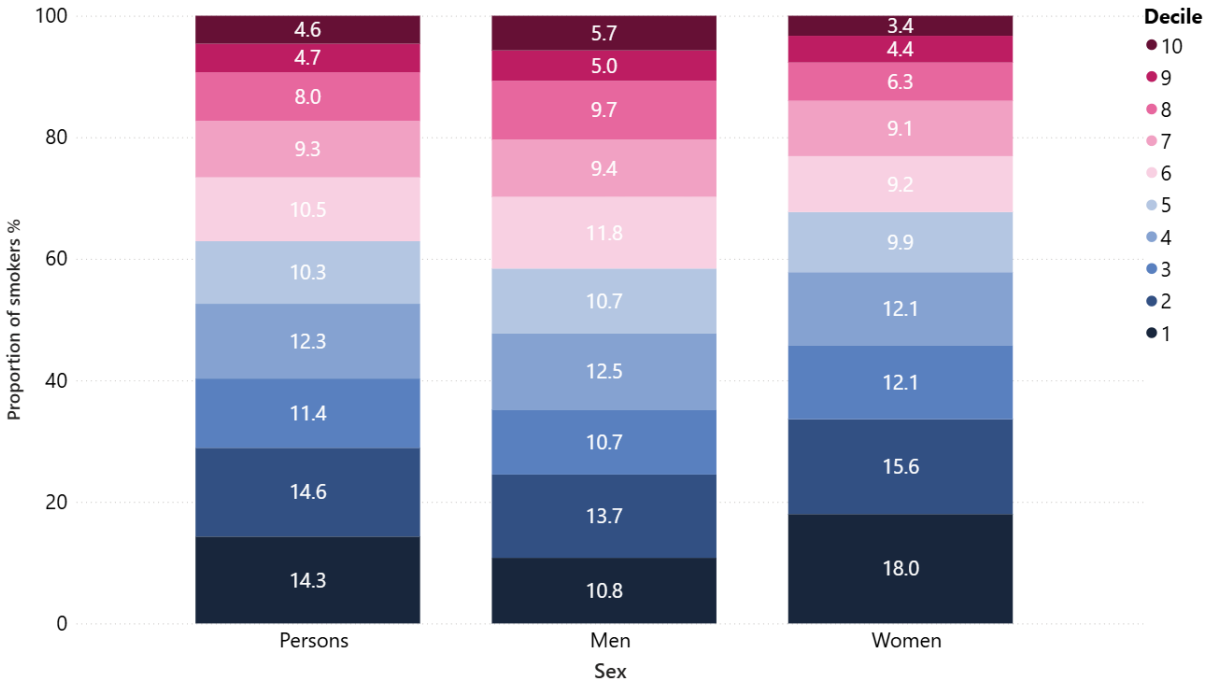



*Figure 7: Breakdown of adult smoking population by deprivation tenths, adults aged 18+, shown separately for men, women and all persons, Wales, 2021. Decile 1 = most deprived (Source: ONS, APS)*

As shown in Figure 7, more than 40% of all smokers live in the most deprived 30% of areas, but women appear to be more concentrated than men in areas of deprivation, with more than 45% of all women who smoke in Wales living in the 30% most deprived areas compared with just over 35% of all male smokers. This pattern was consistent between 2017 and 2021 for Wales and for England for most of this period.

Smoking prevalence is generally higher amongst other groups that may face social or economic marginalisation. Smoking rates in Wales are higher for those who are unemployed (i.e. not in work but actively looking for work: 30.5% in 2023 as reported by the APS) compared with those in employment (11.6%) or economically inactive (i.e. not looking for work, including students, retired persons, etc: 13.2%). There are two notable features of differences in smoking prevalence by employment status in Wales.

First, whilst rates amongst unemployed people were consistent with other UK nations in previous years, falls in recent years seen in England (where the rate was 18.8% amongst unemployed people in 2023), Scotland (22.5%) and Northern Ireland (22.8%) have not been recorded in Wales. It is not clear why this difference has

emerged and whether it will remain stable in future years, in particular given the uncertainty associated with estimates in any given year due to sample sizes.

Second, despite the continued gap between smoking rates in these populations, there is evidence that smoking has reduced at a quicker rate amongst those who face the greatest barriers to quitting. The rate of smoking in Wales has fallen 7.1 percentage points (18.7% to 11.6%) in 10 years amongst employed people, but by 12.6 percentage points (43.1% to 30.5%) amongst unemployed people in the same period.

A similar pattern, although less pronounced, can be seen when comparing those in occupations of different socioeconomic classification. The proportion of those in Wales in occupations classified as 'routine and manual' who smoke was almost three times higher (22.2%) than amongst those in managerial and professional occupations (7.8%) in 2023. This compares to rates of 30.6% and 12.8% respectively in 2014. These rates, and the changes observed over time, are comparable to those reported in the other UK nations.

No data on smoking and ethnicity are routinely reported at a Wales level, due to the small sizes of the non-white population relative to other parts of the UK. In 2023, the overall rate of smoking reported by the APS amongst adults aged 18 and over in the UK was 12.4% amongst people of identifying as white, compared to 6.7% amongst those identifying as black, 6.6% amongst those identifying as Asian and 14.8% amongst those identifying as of mixed ethnicity.

Relatively small populations and sample sizes also mean that no Wales level data is reported for smoking by sexuality, but for the UK as a whole, those who identify as gay or lesbian (20.5%) or bisexual (20.1%) reported higher smoking rates than those who identified as heterosexual or straight (14.9%).

## 4.3. Vaping and Smoking

Whilst support for vapers who wish to quit is not within the scope of this Service Review, the increasing prevalence of vaping in Wales and the UK in recent years provides important context for understanding smoking and providing effective smoking cessation services.

The NSfW reported 8% of the population aged 16+ were vaping ("using an e-cigarette at all nowadays") in Wales in 2022-23, an increase from 6% reported in 2021-22. More recent evidence (from the Smoking Toolkit Study), a monthly telephone survey systematically sampling the populations of England, Scotland and Wales) has supported this figure as a robust current estimate and also suggested that it is comparable to the proportion vaping in Scotland (8.5%) but less than reported in England (11.8%)[7]. The same study reported that 2.5% of the Welsh adult population were using disposable vapes regularly, and that across Great Britain as a

whole, vaping was concentrated amongst younger age groups, with 23.3% of all 16-24-year-olds vaping compared with 9.6% of 45–54-year-olds. Amongst vapers, 45.2% were current smokers, 9.8% smokers who had quit in the past year, 31.1% smokers who had quit more than 1 year ago and 13.8% had never smoked[7].

The SHW survey reported that in 2023, 7% of learners in Years 7-11 vaped at least weekly, an increase on 2021 when the figure was 5.4%. Girls (8.6%) are more likely to vape than boys (5.1%) and learners in Year 11 are most likely amongst this population to vape (15.9%). A total of 5.2% of all learners in Years 7 to 11 reported vaping but not smoking.

Evidence on the impact of increases in vaping on smoking in Wales is still emerging, variation in vaping between demographic groups, the use of vapes to support cessation by some smokers and vape use amongst adults who do not and have never smoked.

# 5. Help Me Quit: Wales's National Smoking Cessation Service

**Liz Newbury-Davies and Chris Emmerson**

This section provides a brief overview of Help Me Quit (HMQ) for context.

As described in Section 2, an objective of the project has been to describe HMQ as it currently operates.

→ The output of this work to map the current HMQ system is presented in **Section 12**.
→ Details of data, measures and targets within HMQ are shown in **Section 10**.

## 5.1. HMQ Funding and Governance

As an NHS Wales service, HMQ is ultimately funded by Welsh Government. Budgets (including staff and non-staff costs) for services delivered directly by Health Boards or Trusts (including community services, support for hospital inpatients through HMQ in Hospital and the HMQ Hub delivered by Public Health Wales) are set by those Health Boards or Trusts, typically on an annual basis. Health Board core funding for community HMQ is based on the funding and staff allocation transferred from PHW in 2019.

The costs of support delivered in community pharmacy include reimbursement for NRT provided to HMQ clients and consultation costs. These costs are also met from Health Board budgets.

→ A more detailed description of costs and funding is provided in Section 12.2

Nationally, HMQ is under the governance of the Executive Directors of Public Health. Local services have their own governance in line with Health Board arrangements. Support delivered in community pharmacy is formally governed by the agreed service specifications and the Service Level Agreements that reflect them.

## 5.2. HMQ Guidance and Standards

Help Me Quit is Wales's national smoking cessation service dedicated to providing high quality, evidence-based support that maximises the chances of all smokers who access the service to quit. This definition reflects well-established NICE guidance on provision of smoking cessation services at a population level[8].

Help Me Quit has been developed based on the HMQ Minimum Service Standards (MSS) developed in 2019. The MSS were an essential element underpinning the devolution of smoking cessation support from a centralised service to locally

focused delivery to ensure that support would remain consistent, equitable and evidence based for all clients.

In addition to the MSS, HMQ has been developed based on NICE Guidance (Guideline NG209[8] published 2021 and Quality Standard QS207[9], published 2022) and the Russell Clinical Standard[2]. The support provided within community pharmacy is defined in detail in the Service Specifications agreed between Community Pharmacy Wales and Welsh Government[10,11,b] and in local governance arrangements between Health Boards and community pharmacy providers.

## 5.3. Core Elements of HMQ Support

The MSS defined a number of core elements of an evidence-based, high quality smoking cessation service:

- **Behavioural support**, which should involve:
  - A series of scheduled meetings (face to face or virtual; individual or in a group) between someone who smokes and a counsellor trained to provide stop-smoking support
  - Behavioural components may include information, practical advice about goal setting, self-monitoring, dealing with the barriers to stopping smoking, encouragement, anticipating and dealing with the challenges of stopping smoking
  - The client setting a target quit date by which they will have completely stopped smoking ("not a puff")
- **Nicotine replacement or other pharmacotherapy**:
  - Clients should be supported to access these treatments in the context of the behavioural support they are receiving
  - The choice of NRT should be discussed with cessation advisor and pharmacist and will usually include one long acting and one short acting product, with provision monitored over time and adjusted according to preference, need and benefit
  - Typically clients will be provided with a number of weeks' supply of NRT, typically 8 weeks[1]
  - A number of other prescription pharmacotherapies are also available to support a quit attempt through HMQ, see Section 5.7 for details

[b] Note that the service specifications for provision of smoking cessation support within pharmacies are currently being renegotiated, with a target of April 2025 for implementation. Public Health Wales has been supporting this process and findings and discussion from the Service Review and service specification work have informed each other.

- **Monitoring of success in quitting**:
  - Where possible this will be done through using a Carbon Monoxide (CO) monitor, otherwise to be recorded as 'self-reported'
  - Monitoring acts as a motivator for the client, as a tool for the cessation advisor to discuss experiences of quitting and a source of key data for service managers and commissioner

Behavioural support is delivered by cessation advisers in community teams, by the National Telephone Support Service (NTSS) and by pharmacists in pharmacies that have the relevant Level 3 Service Level Agreement in Place.

## 5.4. The HMQ System

Help Me Quit is delivered in partnership between Welsh Health Boards and Public Health Wales (PHW). HMQ is delivered as an integrated smoking cessation system, which includes[c]:

- Local services, managed by Health Boards, providing behavioural support via teams of dedicated cessation advisers, who may work in community or hospital settings.
- The central HMQ Hub, managed by PHW, processing referrals at a national level and providing behavioural support from dedicated cessation advisors via the National Telephone Support Service (NTSS)
- Pharmacists and other pharmacy staff, working in community pharmacy sites, dispensing free Nicotine Replacement Therapy and prescribed medications to HMQ clients and (in Level 3 pharmacies) providing both behavioural support and free pharmacotherapy

### 5.4.1. The Help Me Quit in Hospital programme

The Help Me Quit in Hospital programme is a structured smoking cessation intervention embedded within secondary care settings across Wales. Whilst a number of Health Boards have provided support in hospital and other secondary care settings for many years previously, the national Help Me Quit in Hospital Programme was established in 2022-23. Currently in its third year of roll out, the core objective of the HMQ in Hospital programme is to systematically identify and support smokers during hospital encounters, recognising that hospital admission presents a unique opportunity to initiate cessation interventions. By implementing an end-to-end smoking cessation pathway, the programme aims to ensure that all

[c] When reporting on HMQ the term 'community' (e.g. 'community clients') can refer to those supported directly by dedicated local Health Board smoking cessation teams and those supported within community pharmacy settings. For clarity, in this report 'community' refers to services delivered by Health Board HMQ teams within community settings

admitted patients who smoke receive evidence-based interventions, including nicotine replacement therapy (NRT), behavioural support during their in-patient stay (through HMQ in Hospital cessation services), and follow-up care after discharge.

This Service Review considers the HMQ in Hospital pathway: i.e. evidence related to the identification of smokers, provision of NRT, referral to structured HMQ support and transition to community services on discharge. A more detailed evaluation of the HMQ in Hospital Programme will be published in 2025 assessing the overall effectiveness of implementation across Health Board hospital settings, and the extent to which it has been integrated into routine clinical care since its launch in 2022-23. This programme evaluation will also identify key enablers that have influenced successful programme implementation over the last three years, and barriers that have hindered its progress.

→ For data on smokers identified in hospital, see Section 10.8

## 5.5. Support for Pregnant Smokers

Pregnant smokers are recognised as a priority group for smoking cessation support as a successful intervention will also reduce harm to the developing foetus. In Wales, the protocol for pregnant smokers is that they will be encouraged to engage with services through opt-out referral at the first point of contact with maternity services, with data on smoking and cessation support gathered throughout the pregnancy. In some Health Boards, support for pregnant smokers is delivered under a specific Help Me Quit for Baby model. In 2023-24, a review of support for pregnant smokers identified a number of improvements which are currently being implemented within the Reducing Smoking in Pregnancy Improvement programme. As with Help Me Quit in Hospital, the focus of this Service Review in relation to pregnant smokers is to consider evidence in relation to the current service pathway, with evaluation of the pathway as a whole conducted as a component of the Reducing Smoking in Pregnancy Programme

→ For a review of the support pathway for pregnant smokers, see **Section 1.1**

### 5.5.1. The wider HMQ system

In addition to these core elements of support, the HMQ system could also be considered to interface with or include:

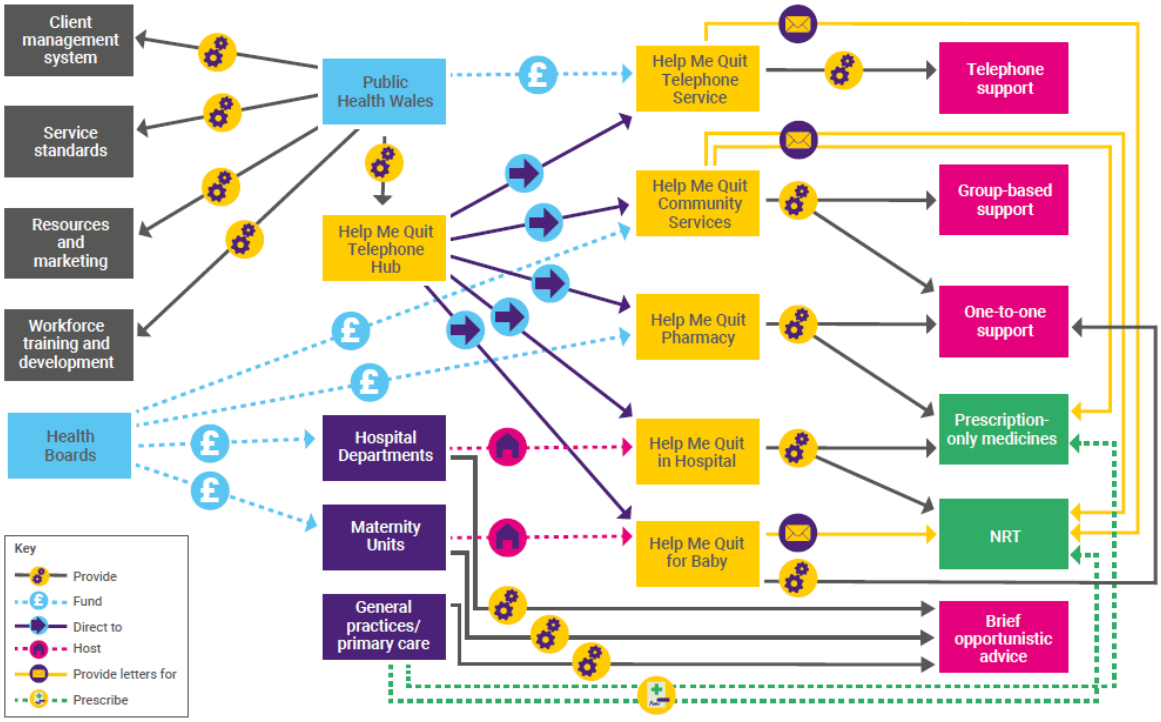
- Hospital nursing staff, who identify smokers, provide free NRT and offer referrals to HMQ. Support delivered within hospital settings is as part of Help Me Quit in Hospital
- Maternity staff, who are expected to provide advice and 'opt out referral' to pregnant smokers

- The Behavioural Change and Social Marketing team in the Health Improvement Division within PHW, who are responsible for researching, developing and delivering marketing and communications for the HMQ System

→ For a summary of national HMQ marketing and communication strategy and activities, see **Section 8**

Health Boards provide structured cessation support based in the community (including pharmacy) and hospital settings. PHW provides the HMQ Hub, which manages referrals Wales-wide, the National Telephone Support Service (NTSS) and provides support and co-ordination, such as marketing, client management systems and data analysis.

The structure of Help Me Quit is shown in Figure 8.




Note: Specified actions refer to actions that may only apply in some cases (e.g. most community pharmacists will only provide varenicline if it is in fulfilment of a prescription from a general practitioner)

*Figure 8: Overview of the structure of Help Me Quit. Source: HMQ Minium Service Standards*

## 5.6. The HMQ Client Journey

The HMQ 'client journey' can have a number of starting points, set out in Table 1.

*Table 1: HMQ 'client' journey by stage and relevant team, service or contact point*

| Stage | Team or contact point | Notes |
|---|---|---|
| Referral | HMQ website ([www.helpmequit.wales/](www.helpmequit.wales/)) Online web forms | Clients can self-refer (name, phone number, time of day to contact) Professionals working in primary care or community settings can refer clients |
| | Telephone Freephone number 0800 085 2219 | Clients can self-refer Professionals can refer clients<br><br>Some Health Boards have local referral pathways that link directly to their HMQ team via dedicated telephone numbers and emails |
| | SMS Text HMQ to 80818 Email helpmequit@wales.nhs.uk | |
| | Hospital | The Help Me Quit in Hospital programme aims to identify all smokers and vapers in secondary care (e.g. hospital, pre-operative clinics, outpatient settings) in Wales and provide them with NRT within 4 hours. All smokers should also be offered an opt-out referral to HMQ |
| | Maternity | Pregnant smokers are identified within maternity services, with an opt-out referral to smoking cessation support |
| Contact | Help Me Quit Hub National team working within PHW | Call handler will attempt to call all smokers referred via website, SMS, email, telephone call out of hours Call handler will receive incoming calls in hours Call handler will carry out brief assessment, have 'choice conversation' and book into appropriate service |
| | Pharmacy | Engagement with smoker asking for support to quit in person |

| | | |
|---|---|---|
| | | For pharmacies providing Level 3 service, including behavioural support (see 'Support') |
| | HMQ in Hospital | Where direct HMQ support in hospital available, adviser will attempt to contact |
| | Maternity | The majority of referrals from maternity services are contacted by Health Board HMQ teams directly |
| Support | HMQ Community Services | Providing behavioural support<br>Delivered one-to-one or group / in person or by telephone by adviser working in local Health Board team<br><br>HMQ Community Services will also support pregnant smokers who are identified within maternity services and referred to HMQ |
| | National Telephone Support Service (NTSS) | Providing behavioural support by telephone, one-to-one by adviser working in HMQ<br>Delivered within the National HMQ Hub |
| | Pharmacy (Level 2) | Providing NRT or prescribed medication for clients engaged with HMQ Community Services or NTSS |
| | Pharmacy (Level 3) | Providing behavioural support, delivered one-to-one in pharmacy setting<br>Providing NRT or prescribed medication |
| | HMQ in Hospital | In some Health Boards, support for inpatients is provided by HMQ advisors on wards for smokers and vapers who have accepted the referral to quit. Other Health Boards refer clients to community services for support on discharge |

| | |
|---|---|
| Maternity | Some Health Boards provide support for pregnant smokers through dedicated 'HMQ for Baby' services. In other Health Boards, support is provided through mainstream community services<br><br>Note that figures for pregnant smokers are typically reported within 'HMQ Community Services' |

→ For details of the Help Me Quit in Hospital programme, see **Sections 5.4.1** and **10.8**
→ For details of support for pregnant smokers through HMQ, see **Sections 5.5** and **12.9**

## 5.7. Pharmacotherapy Available through HMQ

Support through HMQ is evidence-based, as set out in the HMQ Minimum Service Standards1 and NICE guidance[8]. HMQ clients are offered structured behavioural support in combination with pharmacotherapy. Pharmacotherapy may include Nicotine Replacement Therapy (NRT), which provides a substitute source of nicotine or prescribed medication which reduces cravings.

Historically varenicline (marketed under the brand name Champix) and bupropion (Zyban) have been available to smokers in Wales, both requiring a GP consultation to obtain a prescription fulfilled in community pharmacy. In 2021, Champix was withdrawn by the manufacturer over concerns of problems in the production process (these did not relate to safety of varenicline as a treatment). In 2024, a generic version of varenicline was licensed in the UK. As this was the same medication as previously described in NICE guidance, it became an option for prescription immediately following licensing. In 2024, cytisine, a medication with a similar action to varenicline was recommended by the All Wales Medicines Strategy Group (AWMSG) for smokers in Wales. PHW has been working with colleagues in the HMQ system and community pharmacy services over 2024-25 to develop guidance and support to ensure access and provision of these medications to smokers in Wales who would benefit from them.

## 5.8. Model of Service Delivery within HMQ

Guidance on the structure of support is provided across a number of documents, including the MSS, HMQ Service Manuals and the pharmacy service specification.

The model set out for clients supported face-to-face by a community adviser is:

- 7 sessions (one assessment, six treatment) over 12 weeks
- At their Assessment Session, the adviser will discuss pharmacotherapy options.
    - If NRT is assessed as most appropriate, the client will be given a letter to take to a pharmacy; the pharmacist will review in relation to any conditions or medications the client is using and provide
    - If prescribed medication is assessed as most appropriate, the client will be directed to their GP to prescribe, and will pick up at their pharmacy
- The client will be provided with 'Passport to Smokefree', a printed booklet containing advice on quitting and sections where the client can record progress including any CO monitor readings
- The client should set a quit date at either their first or second treatment session
- To be considered as having quit, a client must be not smoking at all, 'not a puff'
- Clients' quit success may be monitored at every session, if possible with a CO monitor, but the key measure for success of the intervention is the result from monitoring 4 weeks after their quit date
- Guidance is that Group sessions should be approximately 60 minutes with options for 30-minute sessions with small numbers. One-to-one sessions are expected to last 30 minutes
- In addition to this 'high intensity' approach, the MSS describes a 'low intensity' approach for those who are not willing to accept the standard 'high intensity' offering, with most sessions lasting 15 minutes and focusing on effective use of pharmacotherapies

The model for those receiving support from the National Telephone Support Service is:

- 7 sessions (one assessment, six treatment) over 7 weeks
- Identical processes in relation to setting a quit date, assessing NRT or other pharmacotherapy and providing Passport to Smokefree, but documents are provided by post
- All monitoring is by self-report
- Guidance is for the Assessment Session to last 30 minutes and for the treatment sessions to last 15 minutes

The model for those receiving behavioural support from Level 3 pharmacies is[d]:

- 8 consultations (one assessment, seven treatment) over 12 weeks

[d] As noted above, the service specifications for smoking cessation in pharmacy are being redeveloped, with a target for implementation in 2025-26

- At the first (assessment) consultation:
  - Quit date is set
  - Passport to Smokefree is provided at the first (assessment) consultation
  - NRT is provided
- Support must be delivered in a private area of the pharmacy
- No guidance is given on the length of consultations.

## 5.9. History and Development of HMQ

### 5.9.1. Establishing a national system and development to 2019

Pilot smoking cessation services were established in 1999. An independent evaluation was undertaken in April 2002[12], utilising and building upon the data collected by the services. The evaluation made 19 recommendations including a 'more unified national smoking cessation service with a stronger identity and national co-ordination'. This was implemented by the newly formed National Public Health Service for Wales in 2004, initially named the All Wales Smoking Cessation Service later, Stop Smoking Wales (SSW) in 2007. SSW offered group based behavioural and peer support in a variety of settings across all seven Health Board areas. It was funded through PHW's core allocation. The other main providers of smoking cessation services in Wales at that time were community pharmacies and in-house hospital services which were commissioned by Health Boards, with some areas having GP cessation provision. Welsh Government introduced a target in 2014 to treat 5% of the estimated number of smokers each year, with a CO-validated quit rate at 4 weeks of 40%.

In order to reinvigorate action, the Tobacco Control Delivery Plan was revisited, and a new plan for 2017-2020 published in September 2017. The development of the new plan was overseen by a newly appointed Tobacco Control Strategic Board, with work on smoking cessation having been undertaken by a cessation sub-group. As a result of the work of the cessation sub-group a new set of actions were proposed including: The delivery of an integrated smoking cessation service called Help Me Quit (HMQ); and an integrated smoking cessation framework for Wales

### 5.9.2. Transfer of services to Health Boards, 2019

To achieve this, in 2018 Welsh Government commissioned a review[13] of the range of existing smoking cessation services being provided in Wales and recommend the best approach to their future provision both locally and nationally. The review concluded that:

- Health Boards should be responsible for commissioning and providing smoking cessation services within the geographical area that they serve and appropriate to population need
- There should be a single, overarching brand for smoking cessation services which should operate at a national and a local level and all cessation services should use it.
- There should be a changed role of Public Health Wales / HMQ to provide the first point of contact (telephone/online provision), branding, training, the development/maintenance of a data/metrics system, quality assurance and marketing. Innovation and identifying and sharing good practice were also roles that respondents suggested should be part of the PHW/HMQ function.
- There should not be competition between Health Board services and the future model of delivery would be one where all providers worked as integrated services with the 5% cessation target being the responsibility of the Health Boards to meet by all services working together

Following this independent review the agreed option was for Health Boards deliver specialist cessation services, with PHW/HMQ providing central functions and support. Public Health Wales would continue to provide a range of central functions and support, including the development of HMQ as the first point of contact to the cessation system and providing low intensity support via telephone/online provision. The development of the HMQ Hub and HMQ National Telephone Support Service (NTSS) was then established. With the transfer of SSW community services to Health Boards in October 2019 enabled Health Boards to direct and manage all smoking cessation delivery at local level. There was also an opportunity to develop a more systematic process for service planning across the HMQ smoking cessation system to ensure that service accessibility, uptake and efficiency were maximised; the move to all smoking cessation services in Health Boards to use and align with HMQ as the single overarching brand; and agreement of developing the Integrated Smoking Cessation System Framework for Wales (Figure 9), with its key components:

- Single Brand and marketing
- HMQ Minimum Service Standards
- A common minimum dataset
- Single Client Management System
- National Hub and telephone support
- Range of services in range of settings.

The aim being to provide an integrated service provision and infrastructure on which to operate and provide the smoker with a more flexible quit journey and improved outcomes, through improved retention, and therefore giving the maximum number of smokers the best chance to quit.


*Figure 9: Key components of the smoking cessation system for Wales. Source: Help Me Quit*

### 5.9.3. The impact of COVID-19 on Help Me Quit

The model of Service provision has been described in previous chapters, and method of delivery based on Minimum Service Standards.

Both the HMQ Hub as single point of contact and HMQ NTSS provide support to clients using non face to face methods of communication i.e. via telephone.

HMQ Services operating across Health Board geographical areas i.e. HMQ Community, HMQ in Hospital, HMQ Community Pharmacy and HMQ for Baby predominantly provided support to clients via face to face means on a 1:1 or group basis.

With the COVID-19 pandemic in 2020, there was a need to review service provision across all service providers in order to reduce the significant risk of infection of COVID-19 through face-to-face contact. There was the need to adhere to Infection prevention and control (IP&C) measures, to guidance issued to Cessation services by the National Centre for Smoking Cessation Training (NCSCT) and by Welsh Government on ceasing face to face delivery, whilst still continuing to maintain service delivery where possible to support smokers who wished to quit. HMQ Community Pharmacy services ceased to operate the behavioural aspects of cessation support (Level 3) due to significant demands on them in response to COVID-19 emergency response measures; however, their Level 2 service provision (NRT supply) continued to support other HMQ services operating.

All other services (community, hospital and maternity) admirably maintained service delivery in response to the challenges of COVID-19 by adapting to remote smoking cessation consultations, with significant increase in telephone support provided by services; and in combination with an increased demand on services from smokers wanting to quit for reasons related specifically to respiratory health, including COVID-19. CO monitoring was paused for all smoking cessation interventions and the requirement for reporting CO-validated quit performance to Welsh Government was paused.

Following the pandemic, when services were safe to resume face to face contact, Welsh Government reinstated the requirement for CO monitoring/CO validation to be carried out at 4 weeks post quit from April 2024. However, services found that the nature of service provision had changed. During Covid recovery, both the HMQ Hub as single point of contact and HMQ NTSS continued to provide support to clients using non face to face methods of communication i.e. via telephone. HMQ services operating across Health Board geographical areas have needed to flex and adapt approaches to their service models and provision based on client need. Project Board members with experience of working with services in England reported that this issue was widespread amongst those services and data form NHS England indicates that the rate of CO monitoring for 4 week quit reporting in services in England for 2023-24 was 20.2% for 2023-24[14], compared with 70% in 2018-19, pre-pandemic[15].

For example, HMQ Hospital, HMQ Community Pharmacy and HMQ for Baby have resumed face to face contact on a 1:1 basis. Whilst many HMQ Community services have attempted to resume face to face activity both on 1:1 and group basis, many areas have found clients no longer wish to engage in face-to-face support to quit, requesting the telephone offer of support as their preferred service option. This has required a change in the way that services need to operate and are configured to meet new population demands for service provision. These are described in more detail in the following sections of the Service Review. Post Covid, HMQ community services also provided a significant amount of support to community pharmacies to reestablish their HMQ Community pharmacy services; and continue to work very closely with these services in their areas.

# 6. Barriers to Accessing Smoking Cessation Services: People Living with Deprivation in Wales

**Dr Pamela Smith**

The PROCESS study was a UK-wide mixed-methods study commissioned by Cancer Research UK to understand the appeal, acceptability and accessibility of Stop Smoking Services (SSS) for low socioeconomic (LSE) groups[16]. This study included Wales-specific qualitative research to explore barriers and facilitators to SSS engagement and uptake in Wales, with twenty-five interviews with potential and current service users from LSE backgrounds[e].

**Flexibility in service delivery** was viewed as important by participants and offering **flexible hours, including evening or weekend appointments**, as well as **various formats** such as in-person, online, or telephone support made the HMQ service more accessible. However, practical barriers to accessing HMQ included **having to wait** for appointments and the **lack of availability of in-person appointments local** to the individual. Issues specific to accessing cessation support and medication in pharmacy included difficulty and some delay in accessing NRT and lack of privacy for behavioural support in pharmacy.

Some participants who had previously accessed the service discussed the need for a **longer treatment programme**, feeling that 12 weeks of support wasn't sufficient to complete and subsequently maintain a quit. Additionally, many participants who had never accessed HMQ before were **unaware** of the service, its components (free NRT, pharmacotherapy and behavioural support) and how to access the service if they wanted to in the future. Participants mentioned feeling that they had **not previously had discussions with healthcare professionals** relating to the availability of the service and had not been exposed to service advertisements.

**Psychological barriers** included not wanting to talk to someone about smoking, smoking-related stigma and social anxiety. These factors were often discussed in relation to participants feeling that they would not access the behavioural support component of the service. Finally, lifestyle barriers such as **work commitments, family responsibilities and mental health challenges** complicated the capacity of participants to access or engage with HMQ. These factors increased the complexity of quitting and demonstrate the need for tailored approaches to address the unique

[e] In addition to the full report of the PROCESS study cited, Wales-specific findings can be found at https://www.cancerresearchuk.org/about-us/we-develop-policy/our-policy-on-preventing-cancer/the-cancer-policy-research-centre-cprc#CPRC_prevention1

needs of those from LSE backgrounds. **Not wanting to let anyone down** if they were to relapse was also identified as a barrier.

Other findings covered a range of areas and included uncertainty surrounding re-accessing the service, interest in digital support delivered via an app and easier access to other cessation tools including e-cigarettes.

# 7. Project Management, Scope and Exclusions

**Liz Newbury-Davies**

The project has involved undertaking a review of the NHS commissioned HMQ Services operating within the integrated smoking cessation system in Wales.

## 7.1. Scope and Exclusions

### 7.1.1. Smoking Cessation Services

A smoking cessation service provides evidence-based behavioural support and advice to smokers who are motivated to attempt to stop smoking[8]. This includes the dedicated specialist national Help Me Quit service, Level 3 smoking cessation services delivered in community pharmacies and any 'in-house' services which are available in hospitals.

The following are integral components of a smoking cessation service[8] as described in section 2:

- Is an NHS supported service
- Behavioural support
- Dedicated time to deliver group and/or 1:1 support which includes:
    - A series of planned/scheduled sessions
    - Requires setting a target quit date
    - Support provided throughout the quit attempt through multi-session, structured behavioural support
    - Follow-up of the client at one month post quit date with outcomes recorded.

NHS commissioned HMQ Services operating within the integrated smoking cessation system in Wales and are included in the review include:

- hosted by PHW:
    - HMQ Hub
    - HMQ National Telephone Support Service (NTSS)
- hosted by Health Boards:
    - HMQ Community Health Boards
    - HMQ in Community pharmacy (Level 2 and Level 3)
    - HMQ in Hospital /hospital smoking cessation services
    - HMQ for Baby

Support and services that are out of scope of the Review:

- Very Brief Advice and Brief Intervention:
    - Brief interventions are simple opportunistic advice and encouragement to stop smoking, which usually last for around 5 to 10 minutes, and are provided by a wide range of health professionals (including nursing and hospital staff, midwives and midwifery teams). This includes an assessment of the patient's current commitment to attempt to quit, provision of information about the availability of pharmacotherapy and behavioural support, and referral to more intensive support from a smoking cessation service. Brief interventions are not classified as a smoking cessation service and are excluded from this review.
- Services and interventions not described in current national standards
- Interventions to support those who are only vaping
- Any cessation services that are not directly commissioned within NHS Wales (e.g. support provided directly by GPs, or by third sector organisations)

## 7.2. Project Management

The Project Lead for this Service Review is the Consultant in Public Health for the PHW Tobacco, Vapes and Nicotine Addiction Programme, supported by a Principal Public Health Practitioner within the Programme.

Project Management has been undertaken in line with agreed Project Management principles within Public Health Wales and as outlined within the Project Governance to ensure that the project has been conducted to quality standards and transparency; and aligns with the requirements of the Duty of Quality Standards.

Governance and Project Management strucures were established by the Project Leads as follows:

- Project Board
    - The Project Board has operated under the Terms of Reference
    - The Project Board has had oversight of the Project, agreed the final remit, approach and programme of work, reviewed work at key points, held the project team to account and signed off the final report
    - Members have included representatives from Health Boards, pharmacy, clinicians, the third sector, and external expertise
    - The Project Board first met in September 2024 to review and sign off the project remit, approach, plan, membership and terms of reference
    - The Project Board then met bi monhty to receive udpates and provide steer on the work
- Task and finish group
    - The Task and Finish Group has been responsible for delivering the agreed programme of work

- The membership of the group has included:
  - Representatives from the national PHW Tobacco, Vapes and Nicotine Addiction Programme and HMQ team, including the National Co-ordinator
  - Representatives from Health Boards, including from Tobacco Control and Service leads
  - The Project Lead and the Task and Finish Group has co-opted other members with additional expertise relevant to the project to support the work

Project Management including project governance, information governance and records management was established and overseen by the Project Leads.

Risk management has included development and maintenance of a Risks and Issues Log in accordance with Public Health Wales' protocols. The Risks and Issue Log has been discussed at each Project Board meeting. Risks or issues requiring immediate decision or action have been escalated to the Director of Health Improvement PHW or appropriate channel.

A detailed Project Plan was developed, agreed at the first Project Board meeting and has been reviewed on an ongoing basis by the Project Leads; progress against the plan is reported at every Board meeting.

→ For Project Board membership, meeting dates and Terms of Reference, see Appendix 1: Project Board and Task and Finish Group

## 7.3. Project Approach

The approach for the HMQ Service Review was agreed at the Project Board on 16 September 2024. Four activities to deliver the Review were agreed.

### *Mapping the HMQ System*

This activity involved engaging with the HMQ Service Leads to understand the current service offer, models of delivery and services management and governance. This was identified as particularly important given that HMQ is designed to enable Health Board teams to develop their services in ways that reflect the needs of their specific populations and that COVID-19 has had a long-term impact on local populations, their needs and expectations and the contexts within which Health Board teams are operating. The Project Board specifically requested that Service Mapping included requests for current and historic budgets for service delivery and details of staff resourcing.

Questions related to Service Mapping were agreed with the Task and Finish Group and included in a questionnaire emailed to Service Leads for both community and

pharmacy HMQ services as a Microsoft Forms link on 27 November 2024, with forms returned by 13 December.

- Further background on the structure of HMQ and the impact of COVID-19 are in **Section 5.4**
- A detailed overview of the method used in Service Mapping is presented in **Section 11.1** and the output of this work is presented in **Section 12**

### Audit of HMQ services

The Project Board agreed a process for the auditing of HMQ services on 16 September 2024. The audit involved developing an audit tool based on the key standards on which HMQ services were established, specifically:

- The HMQ Minimum Service Standards[1]
- Guidance on smoking cessation from the National Institute for Health and Care Excellence (NICE)[8,9]
- The Russell Standard for assessing performance in smoking cessation services[2]
- A detailed overview of the method used in the Audit is presented in **Section 11.1** and the output of this work is presented in **Section 12**

### Analysis of HMQ clients and their outcomes

Public Health Wales provides performance data from the QuitManager Client Management System to Health Board partners. Historically, this has focused on monthly data on key reporting measures such as the number of client episodes created and the number of treated smokers supported.

It was recognised by the Project Board that data gathered by HMQ could be mobilised to provide a more strategic overview across the breadth of national cessation services. Therefore one activity for the Service Review was to create resources to permit a consolidated analysis in more depth and data over time to better understand:

  - The demographics of the client group accessing HMQ
  - The outcomes of clients accessing different services

This involved working with HMQ partners who use different data systems to identify where data are held and how different sources relate to each other.

- A detailed description of data sources for HMQ data is available in **Section 9.1**
- Analysis of the demographics of HMQ clients is presented in **Section 1**
- Analysis of the outcomes for HMQ clients is presented in **Section 10**

## Development of recommendations

It was recognised by the Project Board that a core output of the Service Review was recommendations to strengthen the HMQ system and that some recommendations were likely to require more discussion than others. In particular, it was recognised that given variation in the contexts within which different services were operating (e.g. differences between populations served, funding, service constraints) and the emerging nature of evidence in key areas (e.g. models of 'harm reduction', evolving modes and models of service delivery) there was a need to make effective use of the Project Board to identify areas of uncertainty, and to draw on the experience and expertise of members to ensure thorough and open discussion to develop consensus positions on recommendations.

# 8. HMQ National Brand: Marketing, Communications and Website

**Rachel Howell and Rachel Turner**

## 8.1. Overview

National brand, marketing and communications strategy and activity are not wihtin the remit of the Service Review. However, given the relevance of this work to the expectations and experience of smokers contemplating quitting and choosing to accessing support through HMQ, this section summarises current work in this area.

The Help Me Quit brand is the single public facing identity for smoking cessation services provided by NHS Wales. The brand features across the website, marketing campaigns and service communications to ensure a consistent national presence for HMQ across Wales.

As part of the integrated Help Me Quit system, PHW has responsibility for marketing to maximise reach and engagement with smokers who are motivated to quit. This includes the development and delivery of national mass marketing campaigns to promote and drive sign up to the service. Most smokers access via the Help Me Quit website. This activity is led by the Social Marketing Team (SMT) within the Health Improvement Division (HID) with technical support and public health insight provided by members of the Tobacco, Vaping and Nicotine Addictions Programme (TVNAP) team.

## 8.2. The Changing Media Landscape

Over the past decade, changes in media consumption habits have significantly altered the landscape of public health communication. Traditional broadcast television audiences have declined, while time spent engaging with digital and social media, video gaming, and streaming platforms has increased[17]. These trends are particularly pronounced among younger generations but have also been observed among Generation X and baby boomers. However, for individuals aged 50 and above, broadcast television remains the dominant medium[18].

In response to these changes, the Help Me Quit social marketing strategy has increasingly utilised online platforms such as Facebook, Instagram, Twitter and YouTube alongside digital channels including paid google searches, catch-up television and pre-roll advertisements on online streaming platforms. While traditional media—such as television, radio, billboards, and print—continues to play a role, digital platforms necessitate a variety of video and static formats, leading to more fragmented yet highly targeted and personalised exposure to messaging

## 8.3. 'Feel The Difference'

In 2022, Public Health Wales (PHW) commissioned development of a new campaign to promote the HMQ to the target audience across a range of mass communication channels. The campaign approach was rooted in the key features and benefits of the HMQ service, aiming to resonate with smokers' motivations for quitting.

The resulting campaign, titled *Feel the Difference* (FTD), focuses on three core pillars identified through evidence as important motivators for quitting smoking:

- **Health** – highlighting the immediate and long-term health benefits of giving up smoking (Stop smoking, break free).
- **Family and Social** – emphasising the opportunity to enjoy more quality time with loved ones and not miss out on special moments.
- **Financial** – promoting the significant cost savings from quitting, with the potential to save up to £380 per month (Stop smoking, start saving).

Since its launch, the FTD creative has been featured across five bursts of pan-Wales activity and has encouraged thousands of smokers to take the step towards quitting for good. The campaign has also been recognised nationally, being shortlisted for two major awards, including the Health Service Journal's *NHS Communications Initiative of the Year 2024*, where it was the only finalist in the category from outside England.

### 8.3.1. Campaign Delivery

FTD used a bilingual, data-driven communication strategy, with targeted messaging tailored to key motivators for quitting smoking: health benefits, financial savings, and improved quality of life. The campaign was delivered through a series of high-impact media bursts, supported by sustained digital activity to maintain engagement between bursts. A wide range of media channels was utilised, including:

- Television advertising slots across ITV, S4C and Sky
- Video-on-demand (VOD) advertising on channels such as Amazon Prime Video, ITVX, Sky One and All 4)
- Digital marketing (Meta Ads and Google Ads)
- Social media engagement via organic channels
- Out-of-home (OOH) advertising, strategically placed based on local expertise with a focus in bus streetliner advertising during later bursts
- An 'always-on' digital presence to maintain awareness and saliency with an uplift for campaign periods

To maximise the campaign's impact, substantial preparatory work was undertaken during the planning phase. This included:

- Audience segmentation, using behavioural insights to identify and target key demographic groups, particularly individuals from C2DE socio-economic backgrounds, where smoking prevalence is highest.
- Tailored messaging development, informed by qualitative research and stakeholder consultation, to ensure cultural and linguistic relevance, particularly for Welsh-speaking communities.
- Performance tracking, incorporating web analytics, conversion metrics, and qualitative feedback from service users to monitor campaign effectiveness and inform refinements.

Collaboration was central to the successful delivery of the FTD campaign. PHW engaged key stakeholders—including the PHW Tobacco, Vapes and Nicotine Addiction Programme, local Health Boards (LHBs), Welsh Government and marketing agencies—to refine campaign strategies and maximise outreach effectiveness. This partnership approach has since been applied to other Public Health Wales initiatives, including campaigns focused on nutrition, obesity, and mental wellbeing.

## 8.4. Collaboration with Health Board Local Public Health and Communications Teams

Local public health teams and Health Board communications teams play a critical role the national HMQ campaigns developed by PHW. Their efforts are twofold:

- **Amplifying National Communications**
  These teams are instrumental in extending the reach of centrally developed messages and campaigns. By disseminating national assets across local networks and tailoring delivery to resonate with local audiences, they ensure that national messaging achieves optimal impact across diverse communities.

- **Developing Bespoke Communications and Case Studies**
  In addition to amplifying national efforts, local teams often create their own communications materials and case studies. These are designed to complement national campaigns by addressing specific local contexts, challenges, and success stories, thereby enhancing relevance and engagement at the community level.

However, it is recognised that there are some potential risks associated with the increasing local activity in relation to HMQ marketing. In particular, the development of overlapping or competing campaigns can lead to inefficiencies, especially in the digital space, such as increased expenditure on paid search terms (e.g., Google Ads) or social media advertising (e.g., Meta platforms). Such competition may

inadvertently drive-up advertising costs across the system. It is therefore essential to coordinate efforts and adopt a prudent approach to spending, ensuring maximum return on investment and alignment with strategic public health goals.

The 2023 FTD campaign successfully met its strategic objectives, demonstrating a measurable impact on smoking cessation engagement. Key achievements include:

- 26% increase in website visitors YoY (75,700 in 2023 vs. 60,150 in 2022).
- 34% increase in website self-referrals YoY (11,081 vs. 8,282).
- 23% increase in people joining the HMQ service from website self-referrals (4,638 vs. 3,775).

Further analysis of the campaign's April-May 2023 burst, where no previous-year comparator existed, revealed a 61% increase in website self-referrals (1,583 in 2023 vs. 981 in 2022). Among those who engaged with HMQ, 71% reported being smoke-free at the four-week follow-up stage.

## 8.5. Next Steps: Break its Hold Brand Platform and New Social Marketing Strategy

Over the course of 2023 – 2024 PHW have developed a new long-term social marketing strategy for *Help Me Quit* (HMQ). A key outcome of this work is the creation of a new brand platform—Break Its Hold—to underpin future service campaigns.

The development of the new strategy and brand platform was informed by extensive research and testing, including:

- In-depth analysis of Help Me Quit user journey data, covering every touchpoint from the initial website visit through to 52-week follow-ups
- Qualitative segmentation research, conducted by behavioural science market researchers Emotional Logic, to identify distinct smoker profiles in Wales and the behavioural barriers they face when trying to quit (see Section 5 – Target Audience)
- Quantitative research via the Beaufort Research Wales Omnibus, capturing smoker awareness, attitudes, and behaviours towards smoking and the Help Me Quit service
- Qualitative creative testing with the target audience, also conducted by Beaufort Research, to test potential campaign directions and identify appealing features and functionality for the service. This research led to the selection of Break Its Hold as the successful new creative direction.

The aim of the Break Its Hold brand platform is to provide a unifying and enduring message for future campaigns, acting as a springboard for ongoing engagement. The intention is for Break Its Hold to underpin HMQ's messaging and creative direction for at least the next five years.

Break Its Hold speaks to the idea of breaking free from the grip of tobacco addiction, empowering smokers to become healthier and happier. It acknowledges the powerful hold that smoking can exert, while offering a hopeful and supportive message of liberation and positive change.

### 8.5.1. Break its Hold - Target Audience

Our primary audience remains adults in Wales who smoke tobacco and wish to quit, recognising that smoking rates are disproportionately higher among individuals in the C2, D, and E socio-economic groups.

Break its Hold will focus future campaigns on three identified smoker personas. While we anticipate using above-the-line channels (e.g., TV) to reach a general audience of smokers across Wales and resonate broadly across all personas, we plan to tailor Video on Demand (VOD), Out of Home (OOH), and digital activity to each specific persona.

- Work Stress - This group smokes as a way of securing breaks during their busy and stressful workdays or evening shifts. It includes both shift workers and office employees who use smoking to cope with workplace stress.
- Me Time - These individuals view smoking as a reliable and comforting routine amid their busy lives. Smoking offers them a moment of solitude and a way to decompress when facing life's struggles.
- Poor Quality of Life - Smoking provides pleasure and comfort for this group, who often face challenging life circumstances, including poor living arrangements, health issues, or past trauma. They are likely to be from the least advantaged socio-economic backgrounds.

Work is now underway during 2025–2026 to develop new creative and marketing assets to support the implementation of the new brand platform.

## 8.6. Help Me Quit Website Refresh and Success Story Development

The Help Me Quit websites – helpmequit.wales and the Welsh-language equivalent, helpafiistopio.cymru – serve as the central hub for information about the Help Me Quit service. They also act as key conversion tools, hosting the online referral form that enables individuals to request a callback and begin their quit journey.

Having been live for over five years, PHW commissioned an in-depth audit and review of the current platform's functionality and user experience, followed by a user-centred front-end redesign to encourage more people in Wales to take their first step towards becoming smoke-free.

The objectives of the website refresh were to:

- Enhance the site's functionality to improve overall user experience.
- Implement a user-centred design approach to better support and motivate users to access the Help Me Quit service.
- Optimise the site for mobile, recognising that over 70% of visitors access the platform via mobile devices.
- Develop tailored landing pages for specific audience segments, to increase sign-ups by offering content that resonates with their motivations and behaviours.
- Expand the site's value-added content to support a wider audience of smokers, including those looking to quit independently or maintain a quit attempt.

Following an extensive audit of the existing website, incorporating analysis of user behaviour and stakeholder consultation, the refreshed Help Me Quit website was officially launched on 15 January 2025.

Key enhancements include:

- Improved referral forms for both individual users and healthcare professionals.
- Updated content with clearer pathways to quitting support.
- New interactive tools, including a *Cost of Smoking* calculator.
- A streamlined, mobile-optimised interface that provides a more engaging experience.

Data?

To complement the website refresh and further enhance campaign impact, a series of powerful new testimonial assets have been developed. These *success stories* feature real *Help Me Quit* service users and align with the behavioural insights and motivational pillars of the *Feel the Difference* (FTD) campaign – health, family and social connection, and financial benefits.

These stories have been drawn from interviews, focus groups, and social media engagement, which consistently show a high level of trust in the service. Our latest

survey data indicates that 92% of previous Help Me Quit service users trust us to provide good support to stop smoking.

Advocacy from former service users is one of the most compelling ways to encourage others to seek support. These testimonials provide authenticity, emotional resonance, and diversity – featuring individuals from a range of backgrounds, including varied ages, ethnicities, gender identities, and those with additional accessibility needs.

Three client video testimonials have been produced and will be made available bilingually via the website and wider public health platforms. These assets have already been showcased at stakeholder events and received particularly positive feedback from frontline advisors, many of whom felt personally moved by the stories' reflection of their work's impact. As part of the May 2025 FTD campaign, a 60-second version of one of these stories will be aired on national television and across digital platforms.

The 60 second advertisement can be viewed via this link - PHW_HMQ_T_Emma_TVC-60_CD3

# 9. The Population Accessing HMQ

**Medwyn Griffiths, Tania Jones, Rebecca Hughes and Chris Emmerson**

## 9.1. Data Available in the HMQ System

Data available on activity within HMQ are recorded on a variety of systems:

- The QuitManager Client Management System is used to record data for all community and hospital services across Welsh Health Boards, except for community and hospital services in Hywel Dda UHB and hospital services in Cardiff and Vale UHB. QuitManager also includes all data captured by the HMQ Hub. The QuitManager system was implemented in 2016-17, and data from the first full year of operation in 2017-18 has been included in this System Review
- Data on smoking cessation activity within all pharmacies in Wales is recorded on the National Electronic Claim and Audit Forms (NECAF) dataset. NECAF is primarily designed to manage payment to pharmacists for providing smoking cessation services, and therefore less data on individuals is captured. Data reported in Section 10 relates to Level 3 pharmacy support: i.e. provision of behavioural support and NRT, unless otherwise noted. Following discussion with pharmacy colleagues, data has been included from 2018-19 onwards, when data quality can be sufficiently consistent for client level analysis
    1. Further details of Level 2 and Level 3 pharmacy are described in Sections 5.4 and 5.45.6
- Hywel Dda UHB use the QM10 system to capture client data across all smoking cessation services in the community and hospital. Data from this system is available from 2021-22
- Cardiff and Vale UHB capture data on clients supported in hospital on a separate clinical database. This is labelled CVUHB hospital dataset in the text.

Work to integrate data flows from different systems is ongoing, but it has not been possible to integrate sources for visualisations in this report.

### 9.1.1. Service provision and client classification in HMQ

HMQ clients can be classified in a number of different ways depending on the service model supporting them. For the purposes of this Service Review, we used the following classifications:

- Community: clients supported by Health Board teams and the NTSS within the community, including those accessing group, face-to-face and telephone support. These clients typically remain with the same Health Board HMQ team advisor or group throughout their quit journey

- Hospital: clients who are first identified and supported in hospital settings. All hospital inpatients should be asked if they smoke and provided with NRT within 4 hours whether or not they intend to quit. In addition, the HMQ in Hospital model specifies opt-out referral for smokers to HMQ. Some Health Boards provide behavioural support to clients referred to HMQ if in hospital for sufficient time to carry out sessions, and/or clients are referred to community services on discharge.
    - → Provision of support for HMQ clients identified in secondary care, including hospital settings, varies between Health Boards, and therefore Health Boards may classify clients referred from these settings in slightly different ways. See Appendix 2: Data Definitions for Reporting of HMQ Figures for detailed definitions on reporting these HMQ clients
- Maternity: pregnant smokers who are referred for support via 'opt out referral' by maternity staff. These clients may receive support within mainstream community support models, or may be offered specific or additional support
    - → HMQ clients are classified as 'maternity' clients on the QuitManager and QM10 CMS systems where there is a record on their referral, assessment or support records that they were pregnant. Pregnancy status is not recorded on the NECAF system

→ A review of HMQ support for pregnant smokers is presented in Section 12.9

- Pharmacy: clients who receive behavioural support and NRT within a pharmacy setting ('Level 3 pharmacy')
    - → Some data is also reported for 'Level 2' pharmacies, which provide NRT only to HMQ clients being support by other parts of the system. This is clearly marked where reported

→ For a more detailed description of the different service models within the HMQ system, see Section 5.6 and Section 5.7

## 9.2. Key Metrics in HMQ

A number of key metrics are defined in the Russell Standard[2], which sets out common measures for measuring the effectiveness of smoking cessation services. Health Boards report key measures to Welsh Government, with some measures additionally routinely collated and provided to HMQ teams by Public Health Wales to support planning and performance management.

For the purposes of this report, common definitions have been agreed with all data providers in line with national standards:

- The basis for reporting of most figures is **'treated smokers'**: i.e. a smoker who has attended at least one treatment session and set a quit date.

→ Treated smoker numbers are reported in **Table 3**

- '**Quits**' refers in all cases to smokers who are recorded as having quit within 4 weeks of their agreed quit date.
  → Quit numbers are reported in **Table 7**
- The **'quit rate'** is calculated as the proportion of treated smokers who have quit within 4 weeks of their quit date. The Russell Standard
  → Quit rates are reported in **Table 8**

Note that:

- NECAF data are described in terms of 'claim', which is the equivalent of 'treated smoker' for the purposes of this report. In the national service specification for HMQ in pharmacies that was in place during the period covered in this review, the quit date was set during the initial session with the smoker, rather than during the second (assessment) session which is the model for community services. Therefore measures such as quit rate may not be directly comparable between services. A new service specification for HMQ in pharmacy which would recommend quit dates to be typically set at the second session with the client is expected to come into effect in 2025-26
- The basis for reporting in the data presented here is the date on which the individual became an HMQ client, except for QM10, which is based on the date of the Assessment Session and Cardiff and Vale UHB hospital services, which is based on referral date. Other reporting procedures may use different metrics (e.g. client episodes) and different reporting periods (e.g. by date of discharge rather than date of service acceptance), therefore figures presented here may differ from other sources

→ For details of definitions used in this System Review, see Table 28

## 9.3. HMQ Website Activity

The HMQ website is the central online presence for HMQ. The website provides resources and guidance for smokers as well as online forms for self and professional referral.

→ The HMQ website address is https://www.helpmequit.wales/ for the English site and https://www.helpafiistopio.cymru/ for the Welsh site
→ For details on work to develop the website within the context of the wider HMQ brand, see **Section 8**
→ For details of referrals originating from the HMQ website, see **Section 9.4**

The number of HMQ website visitors, the number of associated referrals and the conversion rate of visitors to referrals is shown in Table 2.

*Table 2: Help Me Quit website visitors, associated referrals and conversion rate, 2018-19 to 2023-24. Source: PHW Social Marketing Team*

| | HMQ website visits | Associated referrals | Conversion rate |
|---|---|---|---|
| **2018-19** | 78,777 | 6,215 | 7.9% |
| **2019-20** | 103,472 | 8,054 | 7.8% |
| **2020-21** | 91,264 | 11,029 | 12.1% |
| **2021-22** | 68,230 | 8,482 | 12.4% |
| **2022-23** | 84,523 | 11,224 | 13.3% |
| **2023-24** | 88,273 | 13,258 | 15.0% |

Notes: 'Associated referrals' =self form completed on website OR phone call originated from website visit
Figures prior to 2020-21 are derived from less accurate data sources

The number of visitors and the number and proportion of referrals originating in the website has risen in recent years. The increase in smokers seeking online support for smoking cessation during the early part of the COVID-19 pandemic is consistent with patterns seen across the UK[19]. Whilst the number of visits has not yet reached its pre-COVID-19 level of 103,472 annually, the number of referrals and the conversion rate are currently at their highest recorded levels. Following work to develop the HMQ website, the most recent monthly conversion rates have been recorded at around 20%.

## 9.4. Referrals into HMQ

Key routes for referring smokers into HMQ include:

- Self-referral via phone (during HMQ Hub working hours), SMS or a form on the homepage of the HMQ website
- Professional referral (e.g. GP or other primary care provider, social and community services) via phone or a form in the Professionals section of the HMQ website
- Referral via engagement with hospital or maternity services
- Note that the HMQ Hub and QuitManager record all referrals, some other systems only record referrals if the individual becomes an HMQ client, therefore figures in this section may underestimate total referrals

→ For more details of the HMQ website, its development and associated work to promote the HMQ service, see Section 8

The number of referrals recorded on QuitManager are shown in Figure 10. In addition to those recorded on the QuitManager system, 3,706 calls to the HMQ Hub (35.4% of all referrals processed by the HMQ Hub) were recorded as 'new call from a smoker wanting to quit'.

| Year | Number of referrals |
|---|---|
| 2017/18 | 11,450 |
| 2018/19 | 12,988 |
| 2019/20 | 15,340 |
| 2020/21 | 13,942 |
| 2021/22 | 15,078 |
| 2022/23 | 16,136 |
| 2023/24 | 23,254 |

*Figure 10: Number of referrals to HMQ recorded on QuitManager, 2017-18 to 2023-24. Source: Public Health Wales*

In addition to referrals recorded on QuitManager and shown in Figure 10, 5,227 referrals were recorded on Hywel Dda UHB's QM10 system in 2023-24, and 1,300 referrals from Cardiff and Vale UHB HMQ in Hospital service. Including QuitManager recorded referrals, inbound HMQ Hub calls and referrals captured on other systems, there were 33,487 referrals into the HMQ system in 2023-24. This means there was approximately one HMQ referral for every ten smokers in Wales in 2023-24.

Referrals rose notably in 2023-24, with an increase of 44% across QuitManager and QM10 compared to 2022-23. Across QuitManager and QM10, professional referrals rose by 52%, from 11,608 to 17,589 and self-referrals by 34%, from 8,130 to 10,892.

The most common referrals recorded on the QuitManager system and/or processed by the HMQ Hub in 2023-24 were self-referrals via the HMQ webpage (9,537, 35.4% with a further 184 (0.7%) text self-referrals. Including the telephone self-referrals noted above, there were a total of 13,427 self-referrals processed by the HMQ Hub, 49.8% of the total referrals processed.

A further 7,615 (28.2%) were recorded as being from hospital settings. The majority of the remaining referrals were from professionals referring patients or clients. Excluding referrals recorded from dedicated stop smoking cessation services (e.g. smoking cessation services in England referring in Welsh residents), maternity clients and sources recording fewer than ten referrals, the most frequently recorded professional referral sources are shown in Figure 11.

| Referral source | Number of referrals |
|---|---|
| GP | 1,299 |
| Dental | 595 |
| Mental Health Team | 173 |
| Optometry | 92 |
| District Nursing | 23 |
| Podiatry and Orthotics Service | 23 |
| HMP Berwyn | 11 |
| Substance Misuse Team | 10 |

*Figure 11: Referrals from professionals recorded on the QuitManager system, excluding hospital, maternity, other smoking cessation services and sources reporting fewer than ten referrals, 2023-24. Source: Public Health Wales*

It is important to recognise that these figures do not necessarily represent the total number of referrals that are likely to be related to interactions with these professionals. For example, a GP may signpost a smoker to the HMQ website for self-referral. It was also noted by Project Board members with experience of working with smoking cessation services in England that referral rates from Substance Misuse services, which are expected to have high rates of smoking amongst clients, were low and that there was considerable interest in exploring ways to address this issue.

Given that smokers are more likely to be older and in worse health, and therefore more likely than the general population to access primary care services, the evidence Figure 11 suggests that even given likely undercounting of cessation referral interactions, there is scope to increase referrals into HMQ from primary care sources.

*Recommendation 1: Health Boards should engage locally with primary care providers to increase awareness and referral rates into HMQ*

*Recommendation 2: PHW should engage with national teams working with the primary care to identify ways to increase referrals into HMQ*

It is also notable that referral rates from social care and third sector providers working directly with individuals are low nationally. Referrals from these organisations are recorded on QuitManager, but at very low levels. Fewer than ten referrals were recorded from each of named community third sector organisations,

those supporting asylum seekers, housing associations and nursing homes, which all support populations where smoking rates are higher than in the general population.

*Recommendation 3: Health Boards should consider how organisations and settings within their local areas who are working with vulnerable populations of smokers who are not currently accessing HMQ*

*Recommendation 4: PHW should review evidence for engaging with and providing services to vulnerable populations in order to develop, support and evaluate effective engagement and support for vulnerable smokers*

## 9.5. Provision of Smoking Cessation Support through HMQ

### 9.5.1. HMQ support by service

The number of treated smokers (see Table 28 for definitions) by Health Board (including NTSS), year and service are shown in Table 3.

*Table 3: Treated smokers recorded by Health Board, year and service. Source: QuitManager, QM10, C&V hospital dataset, NECAF; Public Health Wales, Hywel Dda UHB LPHT, Cardiff and Vale UHB LPHT, NHS Wales Shared Services Partnership*

| **Community** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **AB** | **BCU** | **C&V** | **CTM** | **HD** | **PT** | **SB** | **NTSS** | **Total** |
| **2021-22** | 1,128 | 1,483 | 630 | 1,301 | 1,150 | 262 | 923 | 964 | 7,841 |
| **2022-23** | 1,290 | 1,312 | 721 | 1,352 | 1,119 | 214 | 922 | 238 | 7,168 |
| **2023-24** | 1,133 | 1,683 | 575 | 1,397 | 1,275 | 422 | 715 | 361 | 7,561 |
| **Hospital** | | | | | | | | | |
| **2021-22** | 0 | 530 | 113 | 1 | 538 | 4 | 120 | 0 | 1,306 |
| **2022-23** | 249 | 367 | 113 | 26 | 700 | 2 | 155 | 0 | 1,612 |
| **2023-24** | 152 | 844 | 101 | 3 | 1,103 | 6 | 224 | 0 | 2,433 |
| **Maternity** | | | | | | | | | |
| **2021-22** | 261 | 216 | 0 | 97 | 63 | 27 | 0 | 0 | 664 |
| **2022-23** | 281 | 239 | 0 | 85 | 144 | 18 | 0 | 0 | 767 |
| **2023-24** | 178 | 290 | 1 | 125 | 205 | 4 | 0 | 0 | 803 |
| **Subtotal: community, hospital and maternity** | | | | | | | | | |
| **2021-22** | 1,389 | 2,229 | 743 | 1,399 | 1,751 | 293 | 1,043 | 964 | 9,811 |
| **2022-23** | 1,820 | 1,918 | 834 | 1,463 | 1,963 | 234 | 1,077 | 238 | 9,547 |
| **2023-24** | 1,463 | 2,817 | 677 | 1,525 | 2,583 | 432 | 939 | 361 | 10,797 |
| **Pharmacy (Level 3)** | | | | | | | | | |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **2021-22** | 1,022 | 1,309 | 260 | 969 | 561 | 158 | 663 | 0 | 4,942 |
| **2022-23** | 901 | 1,434 | 258 | 1,077 | 568 | 158 | 508 | 0 | 4,904 |
| **2023-24** | 1,237 | 1,831 | 333 | 1,281 | 641 | 180 | 804 | 0 | 6,307 |
| **GRAND TOTAL** | | | | | | | | | |
| **2021-22** | 2,411 | 3,538 | 1,003 | 2,368 | 2,312 | 451 | 1,706 | 964 | 14,753 |
| **2022-23** | 2,721 | 3,352 | 1,092 | 2,540 | 2,531 | 392 | 1,585 | 238 | 14,451 |
| **2023-24** | 2,700 | 4,648 | 1,010 | 2,806 | 3,224 | 612 | 1,743 | 361 | 17,104 |

Notes:

- → All clients are reported by Health Board of residence where this is recorded except for Hywel Dda UHB and Cardiff and Vale UHB clients supported in hospital. This is due to differences in recording on different systems. Pharmacy clients are reported by the location of the pharmacy in which they accessed services, as client address data are not recorded on the NECAF system. A very small number of other clients may be supported by a service in a different Health Board area to the one in which they reside.
- → All NTSS clients are reported under 'Community'.
- → Powys THB does not have hospitals within its borders, and Powys THB residents may be treated by hospitals in England, where HMQ does not operate
- → Cardiff and Vale and Swansea Bay UHBs have historically provided support for pregnant smokers using models which did not result in data being recorded on HMQ, or which resulted in those clients being recorded as supported by community services
- → Prior to 2024-25 those accessing cessation support in hospital in Cwm Taf Morgannwg UHB were recorded within figures for community support. From 2024-25 these clients have been recorded as hospital clients
- → Figures presented in this table may differ from those presented in other sources, see Section 9.2

2023-24 saw the highest number of treated smokers ever recorded annually across smoking cessation services in Wales, at 17,104, with 10,797 recorded across community, hospital and maternity services and 6,307 supported via pharmacy. These figures represent a substantial year on year increase, with an 18.4% increase in the number of treated smokers compared with 2022-23. Each of community, hospital and maternity services recorded a growth in treated smoker numbers compared to the previous year, with the rise of 50.9% in the number of treated smokers identified through Help Me Quit in Hospital showing the greatest increase. Pharmacy recorded an increase of 28.6% for treated smokers.

### 9.5.2. Availability of HMQ support through community pharmacy

The total number of community pharmacies active and the provision of Level 2 and Level 3 support for 2023-24 is shown by Health Board in Table 4.

*Table 4: Number of Community Pharmacies and provision of Level 2 and Level 3 smoking cessation support via HMQ, 2023-24, by Health Board. Source: NHS Wales Shared Services Partnership*

| Health Board | Pharmacies active at end of financial year[20] | Pharmacies offering Level 2 smoking cessation | | Pharmacies offering Level 3 smoking cessation | |
|---|---|---|---|---|---|
| | | No. | % | No. | % |
| **Aneurin Bevan** | 125 | 111 | 88.8% | 70 | 56.0% |
| **Betsi Cadwaladr** | 144 | 128 | 88.9% | 104 | 72.2% |
| **Cardiff and Vale** | 101 | 39 | 38.6% | 23 | 22.8% |
| **Cwm Taf Morgannwg** | 109 | 97 | 89.0% | 82 | 75.2% |
| **Hywel Dda** | 96 | 84 | 87.5% | 51 | 53.1% |
| **Powys** | 23 | 19 | 82.6% | 18 | 78.3% |
| **Swansea Bay** | 91 | 72 | 79.1% | 51 | 56.0% |
| **Total** | **689** | **550** | **79.8%** | **399** | **57.9%** |

Availability of pharmacy provision has varied over time and continues to vary by geography, in terms of both the number of pharmacies and the level of activity. Figures for pharmacies offering Level 3 (behavioural and NRT) support, claim ("treated smokers") in pharmacy settings and the number of consultations delivered to these clients are shown in Figure 12 by year and Figure 13 by Health Board.

| Year | Number of different pharmacies with one or more claims | Total number of claims | Total number of consultations | Average number of claims per pharmacy | Average number of consultations per pharmacy |
|---|---|---|---|---|---|
| 2018/19 | 408 | 8,902 | 33,280 | 22 | 82 |
| 2019/20 | 447 | 9,804 | 35,827 | 22 | 80 |
| 2020/21 | 370 | 3,478 | 13,226 | 9 | 36 |
| 2021/22 | 401 | 4,942 | 18,493 | 12 | 46 |
| 2022/23 | 371 | 4,904 | 18,452 | 13 | 50 |
| 2023/24 | 399 | 6,307 | 23,372 | 16 | 59 |

*Figure 12: HMQ Level 3 pharmacy provision in Wales, 2018-24, by year. Source: NECAF, NHS Wales Shared Services Partnership*

| Health board | Number of different pharmacies with one or more claims | Total number of claims | Total number of consultations | Average number of claims per pharmacy | Average number of consultations per pharmacy |
|---|---|---|---|---|---|
| Aneurin Bevan | 70 | 1,237 | 4,755 | 18 | 68 |
| Betsi Cadwaladr | 104 | 1,831 | 6,724 | 18 | 65 |
| Cardiff & Vale | 23 | 333 | 1,181 | 14 | 51 |
| Cwm Taf Morgannwg | 82 | 1,281 | 4,669 | 16 | 57 |
| Hywel Dda | 51 | 641 | 2,386 | 13 | 47 |
| Powys | 18 | 180 | 718 | 10 | 40 |
| Swansea Bay | 51 | 804 | 2,939 | 16 | 58 |
| **Total** | **399** | **6,307** | **23,372** | **16** | **59** |

*Figure 13: HMQ Level 3 pharmacy provision in Wales, 2023-24, by Health Board. Source: NECAF, NHS Wales Shared Services Partnership*

The number of pharmacies in which smoking cessation support through HMQ was available was substantially lower in Cardiff and Vale UHB than in other Health Boards in 2023-24, apart from Powys THB, which has a substantially smaller population of smokers than other Health Boards. The number offering Level 3 support overall and by Health Board has remained broadly stable since 2018-19, but the number of claims (treated smokers) and consultations fell substantially from the onset of the COVID-19 pandemic and has not recovered to previous levels.

## 9.6. Demographic Summary of Clients Accessing HMQ

For simplicity, this section will present data from QuitManager and NECAF only, with data from QM10 presented only for Health Board specific analysis. Data from all sources is presented in the Supplementary Material.

### 9.6.1. Demographic trends

#### *Age*

The total number of treated smokers for the seven years to 2023-24 by age group is shown for QuitManager data in Table 5 and for NECAF data in Table 6. There were 8,122 treated smokers recorded in 2023-24.

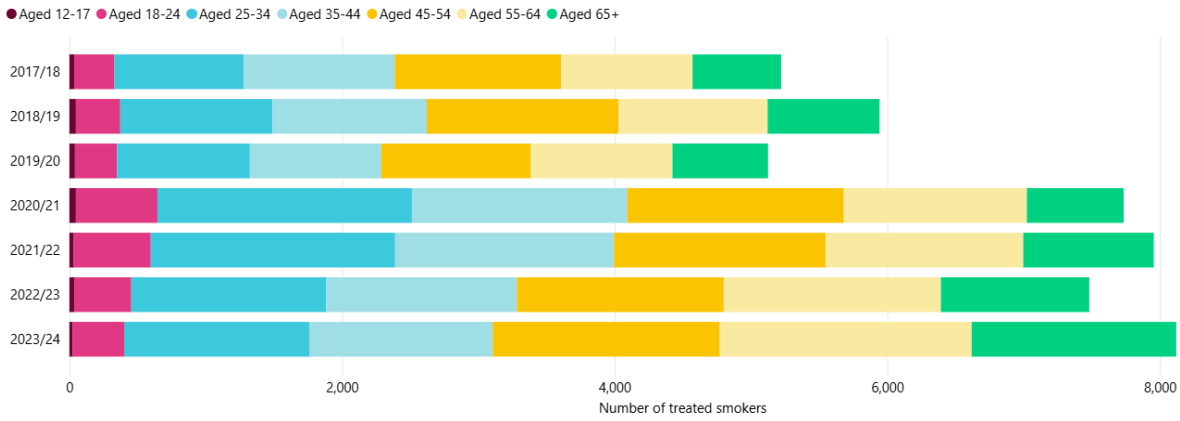



*Table 5: Total number of treated smokers recorded on QuitManager by age, 2017-18 to 2023-24, excluding clients where date of birth was not recorded (n=25). Source: QuitManager, Public Health Wales*

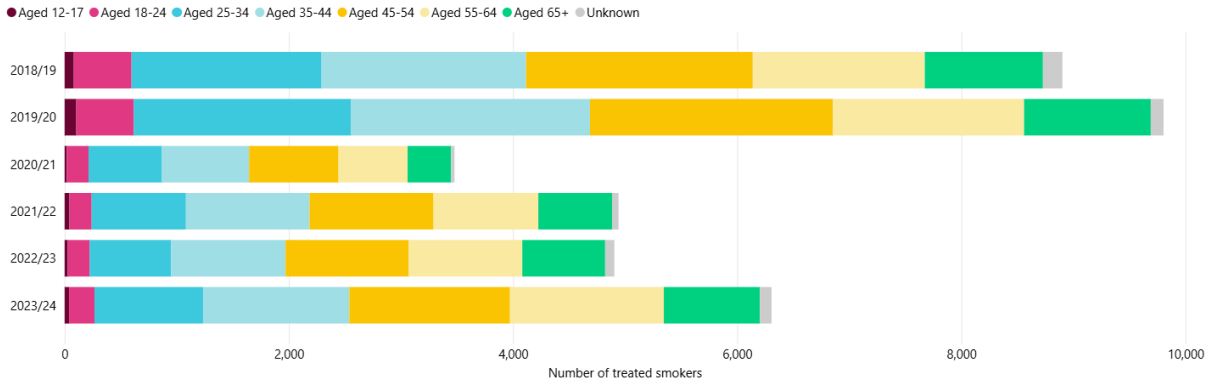



*Table 6: Total number of treated smokers recorded on NECAF by age, 2018-19 to 2023-24. Source: NECAF, NHS Wales Shared Services Partnership*

Figure 5 and Figure 6 illustrate that in addition to a shift during and following the COVID-19 pandemic towards a greater proportion of HMQ clients being supported by community services compared with pharmacy, there have also been some changes in the demographic patterns of those accessing the service. On QuitManager the numbers of treated smokers in all age groups under 45 fell between 2020-21 and 2023-24, with the largest decline seen amongst 25-34 –year-olds, who accounted for 1,867 (24.1%) of all treated smokers recorded in 2020-21 compared with 1,361 (16.8%) in 2023-24. The absolute number of treated smokers and the proportion of all treated smokers rose for most age groups over 45, most notably amongst those over 65, with numbers in this age category more than doubling between 2020-21 (710, 9.2% of all treated smokers) and 2023-24 (1,501, 18.5% of all treated smokers).

There was much less evidence of a change in client demographics amongst treated smokers supported in pharmacy, with approximately 60% of all clients split evenly between the 35-44, 45-54 and 55-64 age categories. Overall therefore, the cohort of smokers accessing HMQ has aged slightly, with a larger proportion of older clients accessing services, most frequently through community services but the majority of clients in middle age. This may reflect changes in smoking prevalence: whilst younger age groups still account for a substantial proportion of smokers, their numbers are falling faster relative to older age groups (see Figure 3). The change is also likely to reflect the implementation of the HMQ in Hospital programme and the increase in the number of smokers referred from secondary care, with older smokers more likely to experience more serious health problems.

### *Deprivation*

Excluding the 22 clients (0.3%) whose address details could not be linked to deprivation data[f], 2,590 (32.0%) were recorded on QuitManager as living in the most deprived fifth of areas in Wales, with a further 1,967 (24.3%) living in the next most deprived fifth. Those accessing HMQ in 2023-24 were three times as likely to live in one of the most deprived fifth of areas as the least deprived (859 clients, 10.6%). Comparing data on access to HMQ to data on smoking prevalence set out in Figure 5 suggests that in relation to deprivation, HMQ clients reflect the smoking population of Wales. The proportion of treated smokers by deprivation fifth recorded on QuitManager has remained stable since 2017-18.

There is considerable variation between the numbers and proportions of treated smokers recorded on QuitManager by Health Board. As area level deprivation is based on ranking small areas on a number of measures across the whole of Wales, some Health Boards will contain a greater number of deprived areas than others. The number of treated smokers by Health Board and deprivation fifth in 2023-24 is shown in Figure 14.

[f] Deprivation is measured using the 2019 Welsh Index of Multiple Deprivation, which ranks each of Wales's 1,909 lower super output areas (LSOA, a geographical area with approximately 1,500 residents) based on indicators including income, employment, education and health, then analyses them by fifths, from the most to the least deprived[21]

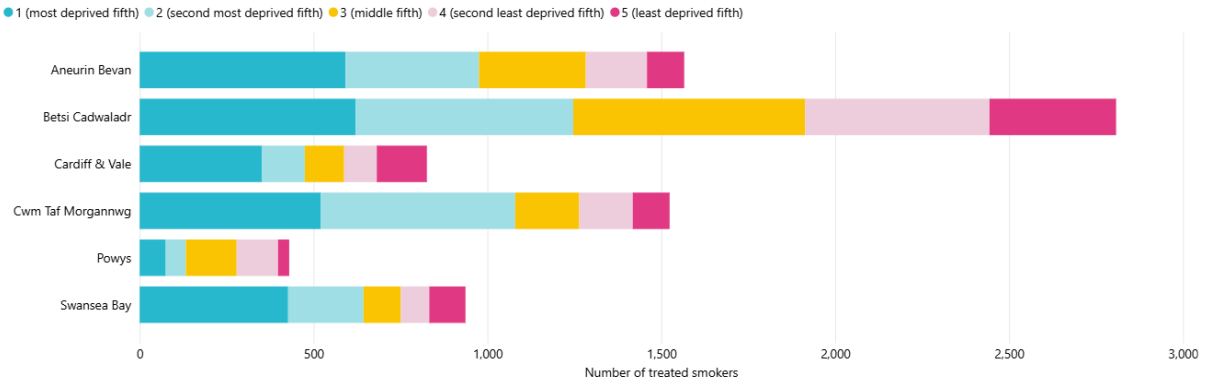



*Figure 14: Total number of treated smokers recorded on QuitManager by Health Board and WIMD deprivation fifth, 2023-24. Source: QuitManager, Public Health Wales*

Swansea Bay UHB recorded the greatest proportion of treated smokers in the most deprived fifth of areas (45.6%, 427 individuals) and Powys THB the smallest proportion (17.4%, 75 individuals). For reference, QM10 data from Hywel Dda UHB recorded the proportion of treated smokers from the most deprived fifth of areas in 2023-24 as 12.5% (315 individuals).

### *Gender, ethnicity and sexuality*

In 2023-24, 55.8% of treated smokers recorded on the QuitManager system were female and 44.1% were male. However, when pregnant treated smokers are excluded, the proportion recorded as female decreases to 52%. These figures are representative of all years for which data is recorded. A total of 13 treated smokers have been recorded as non-binary since 2017-18. The proportion of treated smokers recorded as female on the NECAF system was 51.9% in 2023-24. The proportion of females recorded on NECAF has decreased each year from 2018-19 (56%) to 2023-24 (52%).

Ethnicity was recorded for 88.8% of all treated smokers on the QuitManager system for 2023-24. 95.2% of all those for whom data is available self-described as recorded as 'white British', with the next largest group recorded as being of other white ethnicity (2.4%). The only Health Board to record significant variation from this figure was Cardiff and Vale UHB, with 85.7% of treated smokers self-reporting as 'white British', 5.2% as other white ethnicity, 3.7% as mixed ethnicity, 2.5% as Asian or Asian British and 1.6% self-describing as being Black, African, Caribbean or Black British. NECAF does not record client ethnicity.

Data on sexuality were recorded for 71.9% of treated smokers recorded on the QuitManager system. Amongst clients for whom data were recorded, 97.4% self-described as heterosexual or straight, 1.9% as lesbian or gay and 0.6% as bisexual. Sexuality is not recorded on the NECAF system.

# 10. HMQ System Outcomes

**Medwyn Griffiths, Tania Jones, Rebecca Hughes and Chris Emmerson**

→ For details of the data available in HMQ, see **Section 9.1**
→ For details of definition and metrics used in analysis of HMQ data, see **Section 9.2**

## 10.1. Number of 4 Week Quits and Quit Rates

The number of 4 week quits recorded by different service type and by Health Board/NTSS for 2021-22 to 2023-24 is shown in Table 7.

*Table 7: 4 week quits recorded by Health Board, year and service. Source: QuitManager, QM10, C&V hospital dataset, NECAF; Public Health Wales, Hywel Dda UHB LPHT, Cardiff and Vale UHB LPHT, NHS Wales Shared Services Partnership*

| **Community** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **AB** | **BCU** | **C&V** | **CTM** | **HD** | **PT** | **SB** | **NTSS** | **Total** |
| **2021-22** | 789 | 1,049 | 478 | 860 | 751 | 184 | 665 | 737 | **5,513** |
| **2022-23** | 842 | 1,038 | 558 | 898 | 674 | 139 | 639 | 172 | **4,960** |
| **2023-24** | 737 | 1,133 | 438 | 998 | 743 | 267 | 505 | 282 | **5,103** |
| **Hospital** | | | | | | | | | |
| **2021-22** | | 327 | 83 | 1 | 333 | 1 | 81 | 0 | **826** |
| **2022-23** | 126 | 290 | 93 | 11 | 394 | 2 | 84 | 0 | **1,000** |
| **2023-24** | 82 | 517 | 81 | 1 | 622 | 4 | 152 | 0 | **1,459** |
| **Maternity** | | | | | | | | | |
| **2021-22** | 105 | 77 | 0 | 25 | 34 | 3 | 0 | 0 | **244** |
| **2022-23** | 84 | 102 | 0 | 29 | 58 | 8 | 0 | 0 | **281** |
| **2023-24** | 56 | 144 | 1 | 47 | 63 | 2 | 0 | 0 | **313** |
| **SUBTOTAL - COMMUNITY, HOSPITAL, MATERNITY** | | | | | | | | | |
| **2021-22** | 894 | 1,453 | 561 | 886 | 1,118 | 188 | 746 | 737 | **6,583** |
| **2022-23** | 1,052 | 1,430 | 651 | 938 | 1,126 | 149 | 723 | 172 | **6,241** |
| **2023-24** | 875 | 1,794 | 520 | 1,046 | 1,428 | 273 | 657 | 282 | **6,875** |
| **Pharmacy level 3** | | | | | | | | | |
| **2021-22** | 337 | 342 | 56 | 193 | 181 | 41 | 171 | 0 | **1,321** |
| **2022-23** | 323 | 383 | 46 | 236 | 178 | 47 | 145 | 0 | **1,358** |
| **2023-24** | 426 | 506 | 96 | 231 | 201 | 75 | 207 | 0 | **1,742** |
| **Grand total** | | | | | | | | | |
| **2021-22** | 1,231 | 1,795 | 617 | 1,079 | 1,299 | 229 | 917 | 737 | **7,904** |
| **2022-23** | 1,375 | 1,813 | 697 | 1,174 | 1,304 | 196 | 868 | 172 | **7,599** |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **2023-24** | 1,301 | 2,300 | 616 | 1,277 | 1,629 | 348 | 864 | 282 | **8,617** |
| For notes on these data, see Table 3 | | | | | | | | | |

4 week quit rates recorded by different service type and by Health Board/NTSS for 2021-22 to 2023-24 are shown in Table 8.

*Table 8: 4 week quit rates recorded by Health Board, year and service. Source: QuitManager, QM10, C&V hospital dataset, NECAF; Public Health Wales, Hywel Dda UHB LPHT, Cardiff and Vale UHB LPHT, NHS Wales Shared Services Partnership*

| **Community** | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | **AB** | **BCU** | **C&V** | **CTM** | **HD** | **PT** | **SB** | **NTSS** | **Total** |
| **2021-22** | 69.9% | 70.7% | 75.9% | 66.1% | 65.3% | 70.2% | 72.0% | 76.5% | 70.3% |
| **2022-23** | 65.3% | 79.1% | 77.4% | 66.4% | 60.2% | 65.0% | 69.3% | 72.3% | 69.2% |
| **2023-24** | 65.0% | 67.3% | 76.2% | 71.4% | 58.3% | 63.3% | 70.6% | 78.1% | 67.5% |
| **Hospital** | | | | | | | | | |
| **2021-22** | - | 61.7% | 73.5% | 100.0% | 61.9% | 25.0% | 67.5% | - | 63.2% |
| **2022-23** | 50.6% | 79.0% | 82.3% | 42.3% | 56.3% | 100.0% | 54.2% | - | 62.0% |
| **2023-24** | 53.9% | 61.3% | 80.2% | 33.3% | 56.4% | 66.7% | 67.9% | - | 60.0% |
| **Maternity** | | | | | | | | | |
| **2021-22** | 40.2% | 35.6% | - | 25.8% | 54.0% | 11.1% | - | - | 36.7% |
| **2022-23** | 29.9% | 42.7% | - | 34.1% | 40.3% | 44.4% | - | - | 36.6% |
| **2023-24** | 31.5% | 49.7% | 100.0% | 37.6% | 30.7% | 50.0% | - | - | 39.0% |
| **SUBTOTAL - COMMUNITY, HOSPITAL, MATERNITY** | | | | | | | | | |
| **2021-22** | 64.4% | 65.2% | 75.5% | 63.3% | 63.8% | 64.2% | 71.5% | 76.5% | 67.1% |
| **2022-23** | 57.8% | 74.6% | 78.1% | 64.1% | 57.4% | 63.7% | 67.1% | 72.3% | 65.4% |
| **2023-24** | 59.8% | 63.7% | 76.8% | 68.6% | 55.3% | 63.2% | 70.0% | 78.1% | 63.7% |
| **Pharmacy level 3** | | | | | | | | | |
| **2021-22** | 33.0% | 26.1% | 21.5% | 19.9% | 32.3% | 25.8% | 25.8% | - | 26.7% |
| **2022-23** | 35.8% | 26.7% | 17.8% | 21.9% | 31.3% | 29.4% | 28.5% | - | 27.7% |
| **2023-24** | 34.4% | 27.6% | 28.8% | 36.0% | 15.7% | 41.7% | 25.7% | - | 27.6% |
| **Grand total** | | | | | | | | | |
| **2021-22** | 51.1% | 50.7% | 61.5% | 45.6% | 56.2% | 50.7% | 53.8% | 76.5% | 53.6% |
| **2022-23** | 50.5% | 54.1% | 63.8% | 46.2% | 51.5% | 49.7% | 54.8% | 72.3% | 52.6% |
| **2023-24** | 48.2% | 49.5% | 61.0% | 59.0% | 42.2% | 56.9% | 49.6% | 78.1% | 50.4% |
| For notes on these data, see Table 3 | | | | | | | | | |

The target for quit rates set out in the Russell Standard[2] is 40% for 4 week quits that are verified by CO monitoring and 50% for self-reported 4 week quits. There are a number of challenges in interpreting these data. The figures in Table 8 represent a

mixture of CO and self-reported quits. As described in **Section 5.9.3**, services have faced serious challenges in CO monitoring following the COVID-19 pandemic. CO monitoring is likely to be higher in pharmacy and maternity services, as sessions in these models are more likely to be face-to-face. As described in Section 9.2, the different model of delivery in place in pharmacy settings during the period covered by the report means quit rates are likely to be lower than in community services.

There is notable variation between Health Boards for different service models and overall. There may be many reasons for this variation that do not relate to the effectiveness of service delivery, including differences in the characteristics of the underlying smoking population and differences between Health Boards that may affect service access or availability, such as rurality, community pharmacy density and secondary care provision.

Despite these challenges in interpreting the data, the evidence is that HMQ continues to be effective in supporting smokers to quit. Whilst comparisons between services in different regions can be difficult to make, the quit rate reported for services in England in 2023-24 was 53.8%, with 20.2% of quits verified by CO monitoring[14].

## 10.2. HMQ Outcomes in Relation to the Smoking Population

The total number of treated smokers and quit rates recorded for 2023-24 are shown by Health Board, including the NTSS are shown with the percentage of the estimated smoking population in Table 9, with the number of whole time equivalent (WTE) staff working in smoking cessation at full complement and average waiting times for community, hospital and maternity clients.

Across all services, HMQ reached 5.2%[g] of the estimated smoking population in Wales in 2023-24, with 2.6% of the estimated smoking population recording a quit at 4 weeks. There was considerable variation between Health Boards in average waiting time to Assessment Session, treated smokers recorded and proportion of smokers who achieved a 4-week quit. The data suggest an association between staff complement and service outcomes.

→ For more detailed analysis of variation in these data over time and between Health Boards, see **Sections 10.5 and 10.6**

→ For more detailed analysis of service staffing by Health Board, see **Section 12.2**

[g] Note that figures for the proportion of the smoking population reached by services may vary slightly from figures published elsewhere due to variations in methodologies (e.g. time periods used)

*Table 9: Estimated number of resident adult smokers, 2024; Treated smokers total and as % of estimated population of smokers and average wait time (days) for Assessment Session in community services; recorded 4 week quits total and as % of estimated population of smokers, 2023-24. Sources: StatsWales, Public Health Wales (QuitManager), HDUHB (QM10), NHS Wales Shared Services Partnership (NECAF)*

| | | | Treated smokers (% of all smokers) | | | | | | 4 week quits (% of all smokers) | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Smokers | WTE staff | Community, hospital and maternity | | | Pharmacy | | Total | | Community, hospital and maternity | | Pharmacy | | Total | |
| | | | Ave wait for Assess. Session (days) | | | | | | | | | | | | |
| AB | 60,231 | 12.45 | 5.5 | 1,463 | 2.4% | 1,237 | 2.1% | 2,700 | 4.5% | 875 | 1.5% | 426 | 0.7% | 1,301 | 2.2% |
| BCU | 66,138 | 27.05 | 2.4 | 2,817 | 4.3% | 1,831 | 2.8% | 4,648 | 7.0% | 1,794 | 2.7% | 506 | 0.8% | 2,300 | 3.5% |
| CV | 54,752 | 7.33 | 7.2 | 677 | 1.2% | 333 | 0.6% | 1,010 | 1.8% | 520 | 0.9% | 96 | 0.2% | 616 | 1.1% |
| CTM | 53,421 | 17 | 3.5 | 1,525 | 2.9% | 1,281 | 2.4% | 2,806 | 5.3% | 1,046 | 2.0% | 231 | 0.4% | 1,277 | 2.4% |
| HD | 39,746 | 20.53 | - | 2,583 | 6.5% | 641 | 1.6% | 3,224 | 8.1% | 1,428 | 3.6% | 201 | 0.5% | 1,629 | 4.1% |
| PT | 11,082 | 3.61 | 5.9 | 432 | 3.9% | 180 | 1.6% | 612 | 5.5% | 273 | 2.5% | 75 | 0.7% | 348 | 3.1% |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **SB** | 45,226 | 9.7 | 10 | 939 | 2.1% | 804 | 1.8% | 1,743 | 3.9% | 657 | 1.5% | 207 | 0.5% | 864 | 1.9% |
| **NTSS** | | 3 | 7.8 | 361 | | | | 361 | | 282 | | | | 282 | |
| **Wales** | **330,596** | **105.37** | | **10,797** | **3.3%** | **6,307** | **1.9%** | **17,104** | **5.2%** | **6,875** | **2.1%** | **1,742** | **0.5%** | **8,617** | **2.6%** |

**Notes**:
Percentages may not sum due to rounding
Figures are based on Health Board of residence in the majority of cases. See notes to Table 3. A small number of HMQ clients may be supported by a service located in a Health Board they do not live in
WTE staff reflects staff complements in Health Boards: i.e. it does not account for any unfilled posts, long-term sickness absence etc
The HMQ Hub supports referrals for the whole HMQ system. Only Telephone Support Advisors (TSAs) and the Hub Manager are included in figures for the National Telephone Support Service (NTSS)
HD provides cessation within a 'Health Coach' model, therefore the WTE is not directly comparable to figures for other services
Figures presented in this table may differ from those presented in other sources, see Section 9.2

The data in Table 9 suggest HMQ is an effective cessation service, achieving good outcomes in terms of reaching and supporting smokers across Wales. Whilst it can be challenging to compare smoking cessation services in different countries, NHS England reported that an estimated 3.3% of smokers in England were treated through cessation services in 2023-23, with 2.2% recording a quit at 4 weeks.

The data also suggest an association between the staffing level in HMQ services and the outcomes across the smoking population, although it is again important to note that many factors beyond the HMQ service (e.g. demographic and geographical characteristics) may be associated with service access and outcomes.

## 10.3. HMQ Clients Re-accessing HMQ Support

Clients may access HMQ more than once. In some cases this may be because they have been discharged from the service and return at a later date. Some services may also consider a client as commencing a new episode if they have not been successful in achieving a 4 week quit, but are considered sufficiently motivated that they would benefit from continuing support with a new quit date. Table 10 presents the number of treated smoker episodes (i.e. all records of a client episode where the client became a 'treated smoker') and distinct individuals who became treated smokers) recorded on QuitManager from 2017-18 to 2023-24.

→ For definitions of clients and client episodes see Section 9.2

*Table 10: Treated smoker episodes and individual treated smokers recorded on QuitManger, 2017-18 to 2023-24. Source: Public Health Wales*

| Year | Number of treated smoker episodes | Number of different treated smokers | Different treated smokers as a proportion of treated smoker episodes |
|---|---|---|---|
| 2017-18 | 5,230 | 4,799 | 91.8% |
| 2018-19 | 5,954 | 5,545 | 93.1% |
| 2019-20 | 5,129 | 4,732 | 92.3% |
| 2020-21 | 7,736 | 7,151 | 92.4% |
| 2021-22 | 7,957 | 7,209 | 90.6% |
| 2022-23 | 7,484 | 6,819 | 91.1% |
| 2023-24 | 8,122 | 7,358 | 90.6% |
| **Average** | | | **91.7%** |

## 10.4. Prescribed Medication Used in HMQ Quit Attempts

→ For details of pharmacotherapy available to HMQ clients, see **Section 5.7**
→ For definition of a client episode see **Table 28**

The number of client episodes in which varenicline or bupropion were recorded on QuitManager is shown in Table 11.

*Table 11: Prescribed medication supplied to HMQ clients by client episode, 2017-24, as recorded on QuitManager. Source: Public Health Wales*

| Creation Date | Client episodes | Varenicline recorded | | Bupropion recorded | |
|---|---|---|---|---|---|
| **2017-18** | 13,955 | 1,671 | 12.0% | 86 | 0.6% |
| **2018-19** | 13,989 | 1,963 | 14.0% | 72 | 0.5% |

| | | | | | |
|---|---|---|---|---|---|
| **2019-20** | 13,274 | 1,722 | 13.0% | 51 | 0.4% |
| **2020-21** | 13,625 | 2,489 | 18.3% | 28 | 0.2% |
| **2021-22** | 14,904 | 643 | 4.3% | 1,232 | 8.3% |
| **2022-23** | 15,207 | - | | 1,012 | 6.7% |
| **2023-24** | 18,929 | - | | 184 | 1.0% |

The impact of the withdrawal of varenicline from the market in the UK in 2021 is clear from the changes between years. Prescribing of bupropion has generally been low; it is possible that the increases seen in 2021-22 and 2022-23 were related to the unavailability of varenicline.

## 10.5. HMQ Outcomes by Year

Available data on the outcomes for HMQ clients are presented below by year, for all services, as recorded on QuitManager in Figure 15 and on NECAF in Figure 16.

| Year | Attended assessment session (AS) | Treated smokers | 4-week quitters | % of AS attendees who became treated smokers | % of treated smokers who became 4-week quitters ('quit rate') | Of the treated smokers who had a successful 4-week follow-up within the valid follow-up period, what proportion had a 4-week CO reading taken? | Average AS waiting time (days) |
|---|---|---|---|---|---|---|---|
| 2017/18 | 8,443 | 5,230 | 3,283 | 62% | 63% | 69% | 7.1 |
| 2018/19 | 9,079 | 5,954 | 3,919 | 66% | 66% | 67% | 7.0 |
| 2019/20 | 8,105 | 5,129 | 3,266 | 63% | 64% | 60% | 6.8 |
| 2020/21 | 11,044 | 7,736 | 5,439 | 70% | 70% | 0% | 5.1 |
| 2021/22 | 12,023 | 7,957 | 5,390 | 66% | 68% | 0% | 3.8 |
| 2022/23 | 12,052 | 7,484 | 5,028 | 62% | 67% | 5% | 4.3 |
| 2023/24 | 13,561 | 8,122 | 5,371 | 60% | 66% | 15% | 4.7 |

*Figure 15: Assessment sessions, treated smokers, 4 week quits, CO validation and Assessment Session waiting times, recorded on QuitManager, 2017-18 to 2023-24. Source: Public Health Wales*

| Year | Treated smokers | 4-week quitters | % of treated smokers who became 4-week quitters ('quit rate') |
|---|---|---|---|
| 2018/19 | 8,902 | 3,039 | 34% |
| 2019/20 | 9,804 | 3,021 | 31% |
| 2020/21 | 3,478 | 992 | 29% |
| 2021/22 | 4,942 | 1,321 | 27% |
| 2022/23 | 4,904 | 1,358 | 28% |
| 2023/24 | 6,307 | 1,742 | 28% |

*Figure 16: Treated smokers and 4 week quits, for Level 3 pharmacies, 2018-19 to 2023-24. Source: NHS Wales Shared Services Partnership*

Care needs to be taken in comparing figures for community and pharmacy support. As described in Sections 9.1 and 9.2, pharmacy clients are all supported in person, meaning the effective rate of CO validation of quitters is 100% and these clients typically set their quit date during their first session, meaning they become 'treated smokers' on first contact with the HMQ service. Reporting for community services uses 'treated smoker' as denominator, therefore quit rates are likely to reflect a client population who are more motivated and/or face fewer barriers to service access compared to pharmacy clients[h].

→ For details on expectations ('targets') for quit rates see Table 28. The data for community services shows that the number of smokers attending an Assessment Session and becoming a treated smoker rose by 12.5% and 8.5% respectively between 2022-23 and 2023-24. The overall trend across the seven years for which data are available is upwards, although there is some variation in that trend between specific years.

→ Note that caution needs to be exercised in relating trends in referrals to trends in Assessment Sessions. With current Client Management Systems, tracking of clients from referral to Assessment Session (e.g. to pharmacy) is not possible, therefore there may be factors such as changes in choice of service that affect this relationship

The proportion of HMQ clients becoming treated smokers and achieving a four-week quit have been consistently above the targets set out in the Russell Standard[2]. The proportion of those attending an Assessment Session who become a treated smoker and the proportion of treated smokers who achieve a 4-week quit has also remained very stable over time, despite substantial changes in both the number of smokers accessing the service and the impact of the COVID-19 pandemic.

During the COVID-19 pandemic, the requirement for CO validation of 4 week quits was suspended, and these rates reduced to almost zero in community services. Since the reinstatement of this requirement in 2023, services have reported serious challenges in returning to previous rates of CO monitoring.

→ For details of the challenges described by services in returning to pre-pandemic rates of CO monitoring, see **Section 5.9.3**

Waiting times fell substantially during the COVID-19 pandemic, as a proportion of practitioners across the public health system in Wales who could no longer deliver services that required face-to-face contact were re-assigned temporarily to provide telephone support for smoking cessation. However, waiting times have begun to rise following the return to usual service provision post-pandemic.

[h] This is described in epidemiology as 'immortal time bias', where only those clients who reach a certain point in treatment are included in calculations of the effectiveness of that treatment[22]

## 10.6. HMQ Outcomes by Health Board

Available data on the outcomes for HMQ clients are presented below by Health Board in 2023-24, for all services (unless otherwise stated), as recorded on QuitManager in Figure 17 (excluding clients supported by the NTSS) and in NECAF in Figure 18.

| Health Board | Attended assessment session (AS) | Treated smokers | 4-week quitters | % of AS attendees who became treated smokers | % of treated smokers who became 4-week quitters ('quit rate') | Of the treated smokers who had a successful 4-week follow-up within the valid follow-up period, what proportion had a 4-week CO reading taken? | Average AS waiting time (days) |
|---|---|---|---|---|---|---|---|
| Aneurin Bevan | 2,234 | 1,463 | 875 | 65% | 60% | 10% | 5.5 |
| Betsi Cadwaladr | 5,188 | 2,817 | 1,794 | 54% | 64% | 19% | 2.4 |
| Cardiff & Vale | 983 | 576 | 439 | 59% | 76% | 54% | 7.2 |
| Cwm Taf Morgannwg | 2,610 | 1,525 | 1,046 | 58% | 69% | 2% | 3.5 |
| Powys | 605 | 432 | 273 | 71% | 63% | 18% | 5.9 |
| Swansea Bay | 1,406 | 939 | 657 | 67% | 70% | 9% | 10.0 |
| **Total** | **13,026** | **7,752** | **5,084** | **60%** | **66%** | **16%** | **4.5** |

*Figure 17: Assessment sessions, treated smokers, 4 week quits, CO validation and Assessment Session waiting times, recorded on QuitManager, by Health Board of residence, excluding clients supported by the National Telephone Support Service, 2023-24. Source: Public Health Wales*

| Health Board | Treated smokers | 4-week quitters | % of treated smokers who became 4-week quitters ('quit rate') |
|---|---|---|---|
| Aneurin Bevan | 1,237 | 426 | 34% |
| Betsi Cadwaladr | 1,831 | 506 | 28% |
| Cardiff & Vale | 333 | 96 | 29% |
| Cwm Taf Morgannwg | 1,281 | 231 | 18% |
| Hywel Dda | 641 | 201 | 31% |
| Powys | 180 | 75 | 42% |
| Swansea Bay | 804 | 207 | 26% |
| **Total** | **6,307** | **1,742** | **28%** |

*Figure 18: Treated smokers and 4 week quits, for Level 3 pharmacies, by Health Board, 2023-24. Source: NHS Wales Shared Services Partnership*

In addition to the figures provided in Figure 18, Hywel Dda UHB reported 3,216 Assessment Sessions, 2,574 treated smokers (80% of those attending an Assessment Session) and 1,423 4-week quitters (a 55% quit rate) for 2023-24. Cardiff and Vale UHB hospital services reported 101 treated smokers and 81 1-month quits (an 80% quit rate) for 2023-24.

For the NTSS, 504 clients attended an Assessment Session with 361 (72%) becoming treated smokers. There were 282 4 week quits, a rate of 78%. No NTSS clients had their 4-week quit CO validated and the average wait time for an Assessment Session was 7.8 days.

There is some variation in rates of attrition between attending a first Assessment Session and becoming a treated smoker between Health Board community services,

but the quit rates for treated smokers are broadly similar across Wales. Rates of CO validation are highest in Cardiff and Vale UHB; this may be because a lower proportion of clients supported by HMQ services receive support via telephone. There is considerable variation in waiting times for community support across Wales, although again, the proportion of clients supported by telephone (who are typically able to engage more rapidly) may underlie some of this variation.

The quit rates for pharmacy clients varied considerably by Health Board. Whilst quit rates appear lower for these clients than those reported for Community Services, note that the different service model means these figures are not directly comparable to those for community services.

## 10.7. HMQ Outcomes by Demography

The proportions of smokers attending an Assessment Session who became a treated smoker as recorded on QuitManager was similar for males (62%) and females (59%). There was a larger difference in the proportion of treated smokers who achieved a four-week quit (70% for males and 63% for females). Hywel Dda UHB also reported very similar proportions of males (81%) compared with females (79%) who attended an Assessment Session and went on to become a treated smoker, attending an Assessment Session and becoming a treated smoker, but there was a bigger gap between the proportion of male treated smokers achieving a four-week quit (60%) compared with female treated smokers (51%). The proportion of male smokers accessing HMQ support in Level 3 pharmacy who achieved a four-week quit (28%) was almost identical to the proportion of female smokers (27%).

HMQ client outcomes recorded on QuitManager in 2023-24 by age are shown in Figure 19 and outcomes recorded in Level 3 pharmacies are shown in Figure 20. Figures for Hywel Dda UHB from the QM10 system are not shown in these and following figures in this section due to low numbers in some categories, but are comparable to those recorded on QuitManager.

| Age group | Attended assessment session (AS) | Treated smokers | 4-week quitters | % of AS attendees who became treated smokers | % of treated smokers who became 4-week quitters ('quit rate') | Of the treated smokers who had a successful 4-week follow-up within the valid follow-up period, what proportion had a 4-week CO reading taken? | Average AS waiting time (days) |
|---|---|---|---|---|---|---|---|
| Aged 12-17 | 55 | 24 | 12 | 44% | 50% | 7% | 3.9 |
| Aged 18-24 | 692 | 378 | 219 | 55% | 58% | 19% | 4.3 |
| Aged 25-34 | 2,249 | 1,361 | 781 | 61% | 57% | 15% | 4.8 |
| Aged 35-44 | 2,239 | 1,343 | 899 | 60% | 67% | 15% | 5.4 |
| Aged 45-54 | 2,568 | 1,666 | 1,141 | 65% | 68% | 12% | 5.0 |
| Aged 55-64 | 3,015 | 1,848 | 1,297 | 61% | 70% | 16% | 4.6 |
| Aged 65+ | 2,739 | 1,501 | 1,021 | 55% | 68% | 16% | 3.8 |
| Unknown | 4 | 1 | 1 | 25% | 100% | 0% | 3.5 |
| **Total** | **13,561** | **8,122** | **5,371** | **60%** | **66%** | **15%** | **4.7** |

*Figure 19: Assessment sessions, treated smokers, 4 week quits, CO validation and Assessment Session waiting times, recorded on QuitManager, by age group, 2023-24. Source: Public Health Wales*

| Age group | Treated smokers | 4-week quitters | % of treated smokers who became 4-week quitters ('quit rate') |
|---|---|---|---|
| Aged 12-17 | 40 | 4 | 10% |
| Aged 18-24 | 227 | 28 | 12% |
| Aged 25-34 | 968 | 227 | 23% |
| Aged 35-44 | 1,305 | 354 | 27% |
| Aged 45-54 | 1,433 | 406 | 28% |
| Aged 55-64 | 1,373 | 428 | 31% |
| Aged 65+ | 857 | 275 | 32% |
| Unknown | 104 | 20 | 19% |
| **Total** | **6,307** | **1,742** | **28%** |

*Figure 20: Treated smokers and 4 week quits, recorded on NECAF, by age group, 2023-24. Source: NHS Wales Shared Services Partnership*

In general, there are only slight differences by age in relation to HMQ clients attending Assessment Sessions who go on to become treated smokers for the age categories related to the majority of smokers accessing pharmacy, but a clearer age gradient emerges in the transition to four-week quit, with older clients more likely to achieve this in both community and pharmacy services.

HMQ client outcomes by deprivation fifth as recorded on QuitManager in 2023-24 are shown in Figure 21 and outcomes recorded in Level 3 pharmacies are shown in Figure 22.

| WIMD fifth | Attended assessment session (AS) | Treated smokers | 4-week quitters | % of AS attendees who became treated smokers | % of treated smokers who became 4-week quitters ('quit rate') | Of the treated smokers who had a successful 4-week follow-up within the valid follow-up period, what proportion had a 4-week CO reading taken? | Average AS waiting time (days) |
|---|---|---|---|---|---|---|---|
| 1 (most deprived fifth) | 4,364 | 2,590 | 1,679 | 59% | 65% | 16% | 5.0 |
| 2 (second most deprived fifth) | 3,371 | 1,967 | 1,290 | 58% | 66% | 14% | 4.3 |
| 3 (middle fifth) | 2,494 | 1,525 | 994 | 61% | 65% | 15% | 4.6 |
| 4 (second least deprived fifth) | 1,933 | 1,159 | 792 | 60% | 68% | 12% | 4.5 |
| 5 (least deprived fifth) | 1,364 | 859 | 604 | 63% | 70% | 17% | 4.9 |
| Unknown | 35 | 22 | 12 | 63% | 55% | 42% | 2.8 |
| **Total** | **13,561** | **8,122** | **5,371** | **60%** | **66%** | **15%** | **4.7** |

*Figure 21: Assessment sessions, treated smokers, 4 week quits, CO validation and Assessment Session waiting times, recorded on QuitManager, by deprivation fifth, 2023-24. Source: Public Health Wales*

| WIMD fifth | Treated smokers | 4-week quitters | % of treated smokers who became 4-week quitters ('quit rate') |
|---|---|---|---|
| 1 (most deprived fifth) | 1,911 | 513 | 27% |
| 2 (second most deprived fifth) | 1,845 | 487 | 26% |
| 3 (middle fifth) | 1,347 | 393 | 29% |
| 4 (second least deprived fifth) | 819 | 255 | 31% |
| 5 (least deprived fifth) | 368 | 89 | 24% |
| Unknown | 17 | 5 | 29% |
| **Total** | **6,307** | **1,742** | **28%** |

*Figure 22: Treated smokers and 4 week quits, recorded on NECAF, by deprivation fifth of pharmacy location, 2023-24. Source: NHS Wales Shared Services Partnership*

There are only small differences in the proportion of HMQ clients becoming treated smokers having attended an Assessment Session and treated smokers achieving a four-week quit by the deprivation fifth of their area of residence or pharmacy site. This suggests HMQ is currently providing an equitable service in terms of outcomes in relation to clients experiencing deprivation.

Client outcomes by ethnicity are shown for HMQ data recorded on QuitManager in 2023-24 in Figure 23.

| Ethnicity | Attended assessment session (AS) | Treated smokers | 4-week quitters | % of AS attendees who became treated smokers | % of treated smokers who became 4-week quitters ('quit rate') | Of the treated smokers who had a successful 4-week follow-up within the valid follow-up period, what proportion had a 4-week CO reading taken? | Average AS waiting time (days) |
|---|---|---|---|---|---|---|---|
| White British | 11,523 | 6,862 | 4,580 | 60% | 67% | 14% | 4.6 |
| White Other | 274 | 173 | 117 | 63% | 68% | 27% | 5.8 |
| Mixed/multiple ethnic groups | 111 | 71 | 50 | 64% | 70% | 25% | 5.9 |
| Asian/Asian British | 86 | 50 | 37 | 58% | 74% | 27% | 6.1 |
| Black/African/Caribbean/Black British | 30 | 22 | 16 | 73% | 73% | 18% | 7.6 |
| Other ethnic group | 49 | 33 | 20 | 67% | 61% | 22% | 7.4 |
| Unknown | 1,488 | 911 | 551 | 61% | 60% | 18% | 4.8 |
| **Total** | **13,561** | **8,122** | **5,371** | **60%** | **66%** | **15%** | **4.7** |

*Figure 23: Assessment sessions, treated smokers, 4 week quits, CO validation and Assessment Session waiting times, recorded on QuitManager, by self-reported ethnicity, 2023-24. Source: Public Health Wales*

There is no evidence that HMQ clients from non-white ethnicities experience worse outcomes in terms of the transitions between Assessment Session and becoming a treated smoker, or in 4-week quit rates. The data suggest that those identifying as black, African, Caribbean, black British or recorded as 'other ethnic group' faced longer waiting times to access an Assessment Session. The majority of these clients were accessing services in Cardiff and Vale UHB, which had waiting times higher than the average for community services.

Of the 162 HMQ clients identifying as lesbian or gay in 2023-24 who attended an Assessment Session, 70% became a treated smoker and 73% of those treated smokers achieved a four-week quit. For the 51 clients identifying as bisexual, the figures were 73% and 65%. These figures compare with 60% of those identifying as heterosexual or straight who attended an Assessment Session becoming a treated smoker, 66% of whom achieved a four-week quit. Note that data on sexuality was only available for 71.4% of HMQ clients recorded on QuitManager who attended an Assessment Session in 2023-24.

## 10.8. HMQ in Hospital

→ For details on the HMQ in Hospital programme, see **Section 5.4**
→ For details of definitions relating to smokers identified in hospital, see **Table 28**

HMQ in Hospital cessation services are a key component of the HMQ in Hospital programme and providing support to inpatient smokers. Health Boards have implemented cessation models linking identification and support in hospital and continuing support in the community in different ways, reflecting different secondary care and wider HMQ service configurations. Figures for 'hospital' clients generally reflect those who have been identified, referred, and in some cases offered direct support in hospital, but have in most cases continued and completed their quit journey in the community. Data for these clients were included in figures reported in **Sections 10.5 and 10.6**, and are reported separately here.

### 10.8.1. Protocol for identifying smokers in secondary care settings

On admission to a secondary care setting, patients are assessed by nursing staff. Assessment includes a module on breathing with questions on current smoking. If a patient indicates they are a smoker, the HMQ in Hospital protocol dictates that they should be:

→ informed that all hospital sites in Wales are smokefree, so they will not be able to smoke during their inpatient stay
→ offered NRT within 4 hours (whether or not they plan to remain abstinent from smoking after discharge)
→ offered a referral for structured support from HMQ, either in hospital and/or on discharge, depending on the model implemented in the Health Board

Data from this assessment is captured digitally on the Welsh Nursing Care Record (WNCR). By the end of December 2024, the WNCR had been rolled out to all wards in Welsh hospitals with the exception of Cardiff and Vale UHB, where it was available in 42% of wards. Note that Powys THB has relatively few secondary care settings. All data on reported in this Service Review is based on the hospital or other secondary care site in which treatment took place and includes admissions to the Velindre University NHS Trust which manages cancer care.

There is some variation in the model implemented by Health Boards to support smokers identified in secondary care settings, with some figures including outpatients and staff members.

→ For current Health Board-defined definitions of a 'hospital client' in HMQ, see Appendix 2

In 2023-24, 185,929 admissions were recorded on the WNCR and available for analysis. Breathing assessments were carried out in 167,601 (90.1%) of admissions. A total of 19,608 individuals were recorded on the WNCR as smokers (11.7% of all those who had a breathing assessment), of whom 1,715 also reported vaping. In 4,551 (2.7%) breathing assessments, the patient was recorded as only vaping.

Smokers identified in secondary care were 53% male and 47% female. There was a clear concentration of patients who smoke in the more deprived fifths of areas in Wales. The gradient by deprivation fifth higher was greater than in the general population, with 32% of all smokers living in the most deprived fifth of areas compared with 6% in the least deprived. The age categories of individuals identified as smokers on admission in 2023-24 is shown Figure 24.

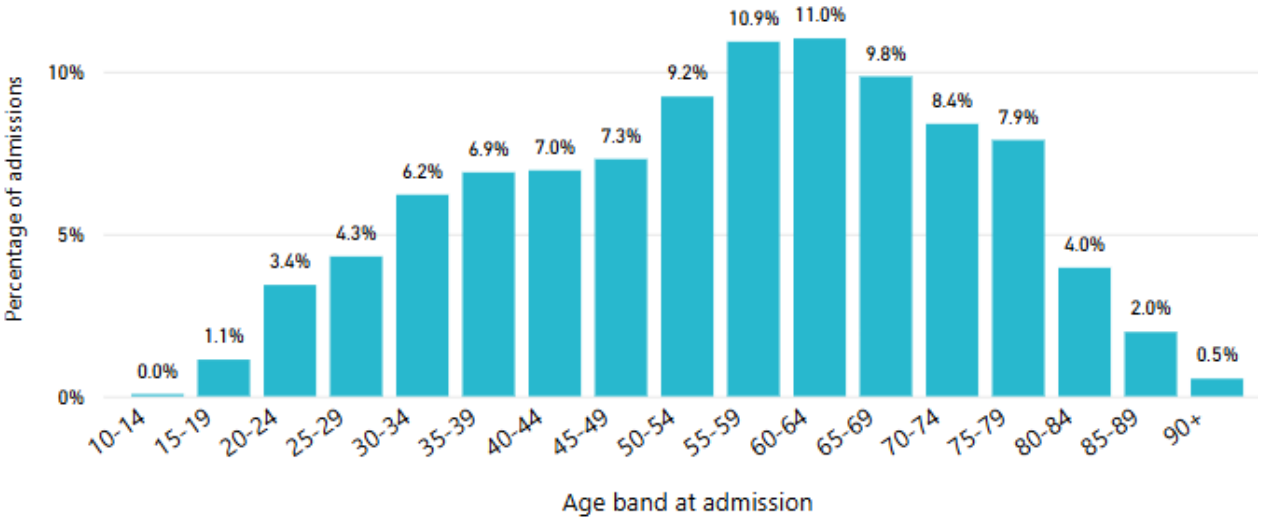



*Figure 24: Age of smokers admitted to secondary care in Wales identified on the WNCR, 2023-24. Source: Welsh Nursing Care Record, Digital Health and Care Wales*

The proportion of smokers identified in hospital is lower than the proportion recorded in population surveys (see Figure 3) up to the age of 65. The concentration of smokers in patients at this age is likely to reflect the severity of long-term smoking harms, with separate analysis carried out by the Public Health Wales Observatory suggesting that half of all smoking attributable admissions were recorded in those aged 55-74. However, as smoking is more prevalent amongst those with other characteristics also associated with hospital admissions (such as living in areas of high deprivation) it may also suggest under-ascertainment of smokers in younger age groups.

### 10.8.2. Admissions, breathing assessments, smokefree information, NRT provision and referral to HMQ

Admissions recorded on the WNCR are shown in Figure 25, with the proportion of those recorded who had a breathing assessment, smokefree policy explained and reported as a smoker and/or vaper.

| Health board/Trust | Number of admissions | % of admissions in which a breathing assessment was carried out | % recorded as smoker* | % recorded as vaper* | % informed of hospital smoke-free policy* |
|---|---|---|---|---|---|
| Aneurin Bevan | 34,694 | 86% | 11% | 2.9% | 30% |
| Betsi Cadwaladr | 52,521 | 93% | 12% | 3.9% | 42% |
| Cardiff and Vale | 842 | 75% | 2% | 0.5% | 52% |
| Cwm Taf Morgannwg | 38,623 | 86% | 12% | 4.2% | 42% |
| Hywel Dda | 28,868 | 92% | 10% | 3.0% | 33% |
| Powys | 855 | 98% | 4% | 0.4% | 45% |
| Swansea Bay | 28,359 | 93% | 13% | 4.7% | 42% |
| Velindre | 1,167 | 96% | 9% | 4.4% | 50% |
| **Total** | **185,929** | **90%** | **12%** | **3.7%** | **39%** |

**as a proportion of those who had a breathing assessment carried out*

*Figure 25: Number of admissions to secondary care recorded on WNCR in 2023-24, % recorded as smokers/vapers and % informed smokefree hospital policy. Note WNCR only available in 42% of wards in CVUHB. Reported by site of care. Source: Wales Nursing Care Record, Digital Health and Care Cymru*

For Health Boards in which WNCR was fully implemented by the end of 2024, the proportion of smokers identified is reasonably consistent between Health Boards. There was greater variation in the number recorded as having been informed of the smokefree hospitals policy, with none of the hospitals with full WNCR implementation reporting over 50%.

The number of smokers identified, offered NRT and/or a referral to HMQ and accepting these offers is shown for 2023-24 in Figure 26.

| Health board/Trust | Number of admissions of smokers | % asked if use NRT | % asked if require NRT | % offered HMQ referral | % use NRT* | % required NRT* | % agreed to HMQ referral* |
|---|---|---|---|---|---|---|---|
| Aneurin Bevan | 3,300 | 99.4% | 99.0% | 99.0% | 10% | 21% | 6% |
| Betsi Cadwaladr | 6,095 | 99.9% | 99.7% | 99.6% | 7% | 18% | 10% |
| Cardiff and Vale | 15 | 100.0% | 100.0% | 100.0% | 20% | 47% | 7% |
| Cwm Taf Morgannwg | 4,002 | 99.7% | 99.3% | 99.1% | 7% | 19% | 6% |
| Hywel Dda | 2,679 | 99.6% | 99.4% | 99.1% | 8% | 21% | 9% |
| Powys | 37 | 100.0% | 100.0% | 100.0% | 19% | 19% | 8% |
| Swansea Bay | 3,376 | 99.5% | 98.9% | 98.6% | 7% | 19% | 7% |
| Velindre | 104 | 100.0% | 100.0% | 100.0% | 11% | 30% | 4% |
| **Total** | **19,608** | **99.7%** | **99.3%** | **99.1%** | **8%** | **20%** | **8%** |

**The denominator excludes those who were not asked the question/offered a referral (as applicable)*

*Figure 26: Smokers admitted to secondary care in Wales, % asked if they require NRT, offered HMQ referral, accepted NRT and agreed to HMQ referral, 2023-24, by site of care. Source: Welsh Nursing Care Record, Digital Health and Care Wales*

Smokers admitted to hospital across Wales were offered NRT and a referral in almost all cases. There was relatively little variation in the proportion of smokers accepting NRT. Whilst absolute differences in the proportion accepting referral to HMQ were small, the variation observed may translate into a difference of several hundred smokers accessing services if the highest rates recorded were replicated across all sites in Wales.

# 11. HMQ System Mapping, Auditing and Stakeholder Engagement: Methods

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## 11.1. Audit and Service Mapping

With the support of the Project Task and Finish Group and the PHW Improvement and Innovation Hub, an audit tool was developed based on the HMQ Minimum Service Standards[1], NICE guidance[8,9] and the Russell Standard[2]. The audit tool was created as a spreadsheet, based around 47 questions organised around 14 standards. Three levels, 'excellent' (exceeds minimum standard, example of good practice), 'good' (meets minimum standard) and 'for improvement' (requires further work to achieve minimum standard) were defined in relation to each question.

In addition to the audit tool, key questions to 'map' services were developed, in line with the key areas and issues identified at project initiation. The service mapping exercise did not include standards or level definitions.

A similar process was developed for HMQ services delivered in pharmacy, with 19 audit questions and 12 service mapping questions.

The content of the audit tool and service mapping were confirmed at the Project Board on 18 November 2024. At the request of the Project Board, HMQ community services and the HMQ Hub were asked to provide data on budgets since the transfer of HMQ to Health Boards in 2019 and their staff complement for 2023-24.

The audit and service mapping tools were combined into a single Microsoft Form, which was emailed to HMQ service leads and Pharmacy Smoking Cessation leads on 19 November 2024, with all responses received by the end of December 2024. Budgets and staff complements were further reviewed by Service Leads in March 2025 to ensure figures were as comparable as possible.

PHW practitioners reviewed the evidence presented in the audit and service mapping exercises and collated the output within five domains:

- Governance and service planning
- Service content
- Service fidelity and delivery
- Service integration
- Training and support

Material from the audit, service mapping and stakeholder engagement has been combined under these headings, summarising strengths, areas for improvement and

opportunities for improvement. Each of these sections includes a high-level summary of key points and recommendations arising from that analysis.

The collated audit and service mapping questionnaires have been made available to HMQ Service and Pharmacy leads. The detailed collated output of the audit and service mapping is available in the Supplementary Material. The audit and service mapping tools can be provided on request.

## 11.2. Stakeholder Engagement

### 11.2.1. Rationale, approach, and methodology

The stakeholder engagement events were designed to capture the insights and experiences of HMQ service delivery staff to help inform service improvements. The rationale for this work was to ensure that frontline staff had the opportunity to share their perspectives on what works well, areas needing improvement, and identify potential development opportunities. The approach taken was participatory and inclusive, ensuring that all voices were heard and that data collection methods allowed for both qualitative and thematic analysis.

The methodology included a combination of structured discussions, small group activities, and interactive tools (such as post it notes and virtual Miro boards) to collect detailed feedback. The engagement process was co-designed by the Health Improvement Division in collaboration with the Improvement and Innovation Hub, ensuring a robust framework for capturing valuable insights.

### 11.2.2. Stakeholder events development and delivery

A total of four stakeholder engagement events were held:

- **Three in-person events** covering different regions:
  - North & Mid Wales
  - Southwest Wales
  - South Wales
- **One virtual event** to accommodate those unable to attend in person

Each event was structured to encourage participation and open dialogue, with facilitators guiding discussions to ensure a focused and productive conversation. Staff from the Health Improvement Division and the Innovation Hub played an active role in planning and facilitating these events. A detailed overview of the format of the events in provided in the Supplementary Material.

Date, location and numbers attending each event are provided in Table 12.

*Table 12: Location, date and numbers attending each system engagement event carried out for the HMQ Service Review*

| Event | Date | Attendance |
|---|---|---|
| St Asaph | 04/12/2024 | Total:13<br>Hub: 0, LHB: 10,<br>Tobacco/Service Leads: 2,<br>Pharmacy: 1 |
| Cardiff | 10/12/2024 | Total: 30<br>Hub: 10, LHB: 16 ,<br>Tobacco/Service Leads: 3,<br>Pharmacy: 1 |
| Carmarthen | 12/12/2024 | Total: 12<br>Hub: 0, LHB: 10,<br>Tobacco/Service Leads: 2,<br>Pharmacy: 0 |
| Virtual | 28/01/2025 | Total: 30<br>Hub: 1, LHB: 24,<br>Tobacco/Service Leads: 2,<br>Pharmacy: 3 |

Material from these events was collated into a template, organised around key domains. This output was then summarised alongside work from the audit and service mapping workstreams. The document collating the engagement event output is available in the Supplementary Material.

→ For a description of how material from the audit, service mapping and stakeholder engagement events has been organised in this Report, see Section 11.1

Finally, with further support from the PHW Improvement and Innovation Hub, a 'Driver Diagram' was developed to illustrate the key 'drivers for improvement' identified by HMQ teams across Wales.

→ The Driver Diagram developed from the stakeholder engagement sessions is presented in **Section 1.1**

# 12. HMQ System Mapping, Auditing and Engagement: Findings

**Chrissie Parker, Tania Jones, Medwyn Griffiths, Liz Newbury-Davies, Lydia Davies, Clara Barnes and Chris Emmerson**

## 12.1. Introduction

At the request of the Project Board, figures were requested for Health Board services for their pay and non-pay budgets, and for their staff complement, presented as whole time equivalent (WTE) staff. It is important to note that Health Boards have implemented different models of service delivery and this may make figures difficult to compare. For example, Hywel Dda UHB delivers smoking cessation within a 'Health Coach' model, with practitioners delivering a range of interventions including smoking cessation, whilst Cardiff and Vale UHB manage cessation support within hospitals as a separate service.

It is also important to note that staffing figures provided for community services delivered by Health Boards reflect staff complement, and do not reflect issues such as long-term illness or recruitment delays. In particular, a number of services noted that 'recruitment freezes' implemented at a Health Board level meant that they had been unable to recruit to posts that become vacant.

## 12.2. Funding, Staffing and Service Planning

### 12.2.1. Community, HMQ Hub and hospital services

As described in Section 5.9.2, HMQ community cessation support services were transferred from Public Health Wales to Health Boards. The budgets agreed at the time of transfer are shown in Table 13.

*Table 13: Budget for Health Board smoking cessation teams on transfer of services to Health Boards, 2019. Source: PHW Board paper, 26.09.2019, Table 3*

| Team | Pay (£) | Non-Pay (£) | Total budget at transfer (£) | Est smoking prevalence (%) |
|---|---|---|---|---|
| **Aneurin Bevan** | 183,253 | 21,717 | 204,970 | 18.9 |
| **Betsi Cadwaladr** | 210,307 | 16,611 | 226,918 | 21.8 |

| | | | | |
|---|---|---|---|---|
| **Cardiff and Vale** | 129,260 | 15,972 | 145,232 | 13.6 |
| **Cwm Taf Morgannwg** | 145,403 | 16,449 | 161,852 | 15.3 |
| **Hywel Dda** | 109,545 | 15,968 | 125,513 | 11.8 |
| **Powys** | 47,500 | 9,344 | 56,844 | 4.1 |
| **Swansea Bay** | 136,908 | 14,780 | 151,688 | 14.5 |
| **Total Funds to be Transferred from Public Health Wales** | | | **£1,073,017** | |

The number of HMQ staff transferring from PHW to Health Board teams is shown in Table 14.

*Table 14: Staff headcount and Whole Time Equivalent (WTE) for Health Board smoking cessation teams on transfer of services to Health Boards, 2019. Source: PHW Board paper, 26.09.2019, Table 2*

| Health Board | Receiving | WTE |
|---|---|---|
| **Aneurin Bevan** | **7 staff members**<br>(5 Advisors, 1 Senior Advisor, 1 Admin Support Officer) | 5.84 |
| **Betsi Cadwaladr** | **9 staff members**<br>(6 Advisors, 1 Senior Advisor, 1 Admin Support Officer- 1 maternity cover) | 7.75 |
| **Cardiff and Vale** | **4 staff members**<br>(2 Advisors – 1 maternity cover, 1 Senior Advisor)<br>1 Vacancy (1 Advisor) | 4.61 |
| **Cwm Taf Morgannwg** | **4 staff members**<br>(3 Advisors, 1 Admin Support Officer)<br>1 Vacancy (1 Advisor) | 3.29 |
| **Hywel Dda** | **4 staff members**<br>(3 Advisors, 1 Admin Support Officer)<br>3 vacancies (2 Advisors, 1 Senior Advisor) | 3.48 |
| **Powys** | **2 staff members**<br>(2 Advisors) | 1 |
| **Swansea Bay** | **5 staff members**<br>(4 Advisors, 1 Admin Support Officer)<br>2 vacancies (1 Advisor, 1 Senior Advisor) | 4.5 |
| **TOTAL** | | **30.47** |

Service Leads for each Health Board were requested to provide details of pay and non-pay between the transfer of services and 2023-24. Figures provided are shown in Table 15.

*Table 15: Pay and non-pay budgets, 2020-21 to 2024-25 for local HMQ teams. Source: HMQ Health Board Service Leads*

| | Year | Budget (pay) | Budget (non-pay) | Total |
|---|---|---|---|---|
| **Aneurin Bevan** | **2020-21** | £170,815 | £48,006 | £218,821 |
| | **2021-22** | £180,294 | £48,006 | £228,300 |
| | **2022-23** | £186,190 | £48,006 | £234,196 |
| | **2023-24** | £209,426 | £0 | £209,426 |
| | **2024-25** | £159,635 | £38,082 | £197,717 |
| | | | | |
| **Betsi Cadwaladr** | **2020-21** | £466,695 | £36,008 | £502,703 |
| | **2021-22** | £619,015 | £35,990 | £655,005 |
| | **2022-23** | £574,668 | £35,990 | £610,658 |
| | **2023-24** | £619,923 | £35,990 | £655,913 |
| | **2024-25** | £601,916 | £35,990 | £637,906 |
| | | | | |
| **Cardiff and Vale (Community)** | **2021-22** | £149,663 | | |
| | **2022-23** | £172,208 | £11,751 | £183,959 |
| | **2023-24** | £178,419 | £13,406 | £191,825 |
| **Cardiff and Vale (Hospital)** | **2024-25** | £174,374 | £15,423 | £189,797 |
| | | | | |
| **Cwm Taf Morgannwg** | **2022-23** | £551,785 | £63,722 | £615,507 |
| | **2023-24** | £719,254 | £24,347 | £743,601 |
| | **2024-25** | £707,811 | £24,341 | £732,152 |
| | | | | |
| **Hywel Dda** | **2020-21** | £518,893 | £119,401 | £638,294 |
| | **2021-22** | £530,880 | £117,290 | £648,170 |
| | **2022-23** | £772,694 | £217,897 | £990,591 |
| | **2023-24** | £925,665 | £119,696 | £1,045,361 |
| | **2024-25** | £1,059,282 | £120,562 | £1,179,844 |
| | | | | |
| **Powys** | **2021-22** | £47,500 | £9,344 | £56,844 |
| | **2022-23** | | | |
| | **2023-24** | | | |
| | **2024-25** | £175,372 | £47,397 | £222,769 |
| | | | | |
| **Swansea Bay** | **2021-22** | £264,911 | £15,484 | £280,395 |
| | **2022-23** | £271,916 | £11,784 | £283,700 |
| | **2023-24** | £294,344 | £11,784 | £306,128 |
| | **2024-25** | £490,677 | £32,884 | £523,561 |

Note:
Hywel Dda UHB operate a 'Health Coach' model, with staff supporting a range of health improvement interventions. It is not possible to separate out costs specific to smoking cessation from these figures, therefore figures for Hywel Dda UHB are not comparable to other services

Funding for the HMQ Hub is not directly comparable to funding for Health Board HMQ teams. The funding includes staffing and non-pay costs for:

- Telephone Support Advisors (TSAs) who support smokers to quit, supervisors and the Hub Manager and the resources need for these activities. These roles are similar to those found in Health Board HMQ services
- HMQ Hub call handlers, who contact the majority of smokers in Wales who self-refer through the HMQ website or are referred through that route by a professional.
  → For details of the activities that call handlers carry out, see **Table 1**
- The HMQ National Co-ordinator and Data Analyst
- Annual licensing of the Client Management System
- Annual licensing of National Centre for Smoking Cessation Training (NCSCT) training and assessment modules.

This Report does not include details of costs relating to the HMQ website, or service costs. It also does not cover costs associated with printing and distribution costs for HMQ Resources, such as the Passport to Smokefree booklet that is provided to all clients

The HMQ Hub budgets for 2020-21 to 2024-25 are shown in Table 16.

*Table 16: Pay and non-pay budgets, 2020-21 to 2024-25 for HMQ Hub. Source: HMQ Hub, Public Health Wales*

| Year | Budget (pay) | Budget (non-pay) | Total |
|---|---|---|---|
| **2020-21** | £386,466 | £32,561 | £419,027 |
| **2021-22** | £386,466 | £26,936 | £413,402 |
| **2022-23** | £400,719 | £26,936 | £427,655 |
| **2023-24** | £418,775 | £23,268 | £442,043 |
| **2024-25** | £455,235 | £23,268 | £478,503 |

Service Leads for each Health Board service and the HMQ Hub were requested to provide details of the staff complement for their HMQ service, including details of banding and area of work, for 2023-24. Figures for staff complement by area of work are shown in Table 17 and by NHS Wales Agenda for Change banding in Table 18. Note that, as described above, these figures reflect the number of staff if all posts are filled, and do not reflect issues such as long-term illness and recruitment restrictions.

*Table 17: HMQ staff complement, Whole Time Equivalent (WTE) by Health Board and area of work, 2023-24. Source: Help Me Quit Service Leads; HMQ Hub, Public Health Wales*

| | **Area of work, WTE Staff Complement** | | | | | | |
|---|---|---|---|---|---|---|---|
| **Health Board** | Management | Admin | Community | Maternity | Hospital | Mental Health | **TOTAL** |
| **Aneurin Bevan** | 1.80 | 1.00 | 4.85 | 4.80 | | | **12.45** |
| **Betsi Cadwaladr** | 1.00 | 2.00 | 7.45 | 4.60 | 9.00 | 3.00 | **27.05** |
| **Cardiff & Vale** | 1.00 | 1.20 | 4.60 | | 0.53 | | **7.33** |
| **Cwm Taf Morgannwg** | 3.60 | 1.60 | 2.80 | 3.00 | 6.00 | | **17.00** |
| **Hywel Dda** | 2.80 | 1.60 | 9.39 | 3.20 | 3.54 | | **20.53** |
| **Powys** | 0.8 | 0.6 | 2.21* | | | | **3.61** |
| **Swansea Bay** | 1.38 | 2.40 | 2.20 | 1.00 | 2.72 | | **9.70** |
| **HMQ Hub** | 2.00 | 7.00 | 2.40 | | | | **11.40** |
| **Totals** | **13.70** | **16.20** | **37.68** | **19.20** | **21.99** | **3.00** | **108.35** |

*Table 18: HMQ staff complement, Whole Time Equivalent (WTE) by Health Board and NHS Wales Agenda for Change band, 2023-24. Source: Help Me Quit Service Leads; HMQ Hub, Public Health Wales*

| **Health Board** | **8a** | **7** | **6** | **5** | **4** | **3** | **2** | **Total WTE** |
|---|---|---|---|---|---|---|---|---|
| **Aneurin Bevan** | | 0.80 | 1.00 | 8.85 | 0.80 | 1.00 | | **12.45** |
| **Betsi Cadwaladr** | 1.00 | | 1.00 | 23.05 | | 2.00 | | **27.05** |
| **Cardiff & Vale** | | | 1.80 | 4.33 | | | 1.20 | **7.33** |
| **Cwm Taf Morgannwg** | | 2.00 | 1.60 | 8.80 | 0.60 | 4.00 | | **17.00** |
| **Hywel Dda** | | 2.80 | 2.80 | 13.33 | | 1.60 | | **20.53** |
| **Powys** | | 0.8 | | 2.21 | | 0.6 | | **3.61** |
| **Swansea Bay** | | 0.90 | 0.48 | 5.92 | | 2.40 | | **9.70** |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **HMQ Hub** | | 1.00 | 1.00 | 2.00 | 2.40 | 5.00 | | **11.40** |
| **Totals** | **1.00** | **8.30** | **9.70** | **70.57** | **3.80** | **15.40** | **1.20** | **108.35** |

As Table 15 and Table 17 show, there is considerable variation in staffing for smoking cessation between Health Boards in 2023-24.

HMQ services are funded by the organisation which delivers them, i.e. the seven local Health Boards and Public Health Wales. Health Boards have funded HMQ services in recent years from two sources: core funding (i.e. from the overall budget allocated to the Health Board by Welsh Government) and Prevention and Early Years (PEY) funding, monies allocated annually by Welsh Government to Health Boards to fund work related to these specific areas. The split between core and PEY funding is shown in Table 19.

*Table 19: Funding for HMQ posts by source, Health Board core funding and Prevention and Early Years funding (PEY), 2023-24. Source: Help Me Quit Service Leads; HMQ Hub, Public Health Wales*

| **Health Board** | **Core Funded WTE** | **PEY** (Protection & Early Years) **WTE** | **Total** |
|---|---|---|---|
| Aneurin Bevan | 5.85 | 6.60 | **12.45** |
| Betsi Cadwaladr* | 17.55 | 9.50 | **27.05** |
| Cardiff & Vale | 6.53 | 0.80 | **7.33** |
| Cwm Taf Morgannwg | 5.40 | 11.60 | **17.00** |
| Hywel Dda | 9.97 | 10.56 | **20.53** |
| Powys | 1.27 | 2.34 | **3.61** |
| Swansea Bay | 5.82 | 3.88 | **9.70** |
| HMQ Hub | 11.40 | 0.00 | **11.40** |
| **Total** | **64.28** | **44.69** | **108.35** |

*** The funding for one post in Betsi Cadwaladr UHB is funded** from both core (0.6 WTE) and PEY funding (0.2 WTE). This post has been included under 'Core' in this table.
****** HMQ Core - 3.4, Medicines Directorate - 2.73 WTE, Other PH - 0.8 WTE

As shown in Table 19, PEY funding is annual and using this funding for smoking cessation, where service delivery budgets are mostly accounted for by staff costs, has created challenges in planning cessation services in the long-term, in particular in relation to staff recruitment and retention.

***Key Recommendation 1: Health Boards and Welsh Government should agree an approach to funding that provides stability and equitable service provision across Wales, reflects the high value of smoking cessation in preventing illness, mortality and high healthcare use, and gives due consideration to health inequalities***

→ For further evidence rated to budgets and governance, see **Section 12.3**

### 12.2.2. Pharmacy costs

- For details on the model of provision of smoking cessation in pharmacy see **Sections 5.6 and 5.8**
- For details on treatments and medication available to smokers in Wales see **Section 5.7**

Community Pharmacy support for HMQ clients is delivered to a national specification as set out in Service Level Agreements agreed between Community Pharmacy Wales and Welsh Government. Health Boards commission HMQ pharmacy support for their own area, with service models and funding reflecting these national agreements.

Pharmacy costs for smoking cessation are met through Health Board budgets. Community pharmacists are reimbursed for NRT provided to HMQ clients and receive a consultation fee. Pharmacy consultations fees are set out in the NHS Electronic Drug Tariff[23]. For the period covered in this report, in addition to reimbursement for products provided, Level 2 support attracted a fee of £5.25 for each consultation and Level 3 support £16.56 for the initial consultation, £6.61 for consultations two to four, £11.91, plus £12.94 for a CO-validated quit for the fifth consultation, £4.63 for consultations six to eight, with an additional £6.48 if the client was CO validated as being smokefree at the eighth consultation. These fees had last been reviewed in 2017, but new Service Level agreements for smoking cessation in pharmacies in Wales are expected to be agreed nationally in 2025.

Note that costs associated with prescribed medications are not captured with HMQ data systems and are not analysed here.

The total amounts paid in relation to smoking cessation in community pharmacy in Wales are shown for Level 2 and Level 3 pharmacies by year in Table 20 and

Table 21, and by Health Board for 2023-24 in

Table 22 and

Table 23.

*Table 20: Consultations and total costs (consultation fees and reimbursement for NRT products) for HMQ delivered in Level 2 community pharmacies in Wales, 2018-24, NECAF data. Source: NHS Wales Shared Services Partnership*

| Year | Number of different pharmacies with one or more claims | Total paid (£) | Total number of claims | Total number of consultations | Average number of claims per pharmacy | Average number of consultations per pharmacy |
|---|---|---|---|---|---|---|
| 2018/19 | 459 | £802,737 | 7,111 | 18,774 | 15 | 41 |
| 2019/20 | 455 | £729,282 | 6,465 | 16,286 | 14 | 36 |
| 2020/21 | 515 | £1,108,251 | 7,589 | 19,021 | 15 | 37 |
| 2021/22 | 561 | £1,210,182 | 8,674 | 21,346 | 15 | 38 |
| 2022/23 | 538 | £1,165,229 | 8,759 | 20,774 | 16 | 39 |
| 2023/24 | 550 | £1,120,221 | 9,945 | 24,660 | 18 | 45 |

*Table 21: Consultations and total costs (consultation fees and reimbursement for NRT products) for HMQ delivered in Level 3 community pharmacies in Wales, 2018-24, NECAF data. Source: NHS Wales Shared Services Partnership*

| Year | Number of different pharmacies with one or more claims | Total paid (£) | Total number of claims | Total number of consultations | Average number of claims per pharmacy | Average number of consultations per pharmacy |
|---|---|---|---|---|---|---|
| 2018/19 | 408 | £1,297,232 | 8,902 | 33,280 | 22 | 82 |
| 2019/20 | 447 | £1,428,294 | 9,804 | 35,827 | 22 | 80 |
| 2020/21 | 370 | £565,564 | 3,478 | 13,226 | 9 | 36 |
| 2021/22 | 401 | £776,962 | 4,942 | 18,493 | 12 | 46 |
| 2022/23 | 371 | £821,484 | 4,904 | 18,452 | 13 | 50 |
| 2023/24 | 399 | £806,855 | 6,307 | 23,372 | 16 | 59 |

*Table 22: Consultations and total costs (consultation fees and reimbursement for NRT products) for HMQ delivered in Level 2 community pharmacies in Wales in 2023-24, by Health Board, NECAF data. Source: NHS Wales Shared Services Partnership*

| Health board | Number of different pharmacies with one or more claims | Total paid (£) | Total number of claims | Total number of consultations | Average number of claims per pharmacy | Average number of consultations per pharmacy |
|---|---|---|---|---|---|---|
| Aneurin Bevan | 111 | £180,184 | 1,475 | 3,424 | 13 | 31 |
| Betsi Cadwaladr | 128 | £271,606 | 2,631 | 5,785 | 21 | 45 |
| Cardiff & Vale | 39 | £112,024 | 1,063 | 2,445 | 27 | 63 |
| Cwm Taf Morgannwg | 97 | £141,259 | 1,463 | 3,468 | 15 | 36 |
| Hywel Dda | 84 | £253,221 | 1,893 | 5,445 | 23 | 65 |
| Powys | 19 | £57,250 | 498 | 1,323 | 26 | 70 |
| Swansea Bay | 72 | £104,677 | 922 | 2,770 | 13 | 38 |
| **Total** | **550** | **£1,120,221** | **9,945** | **24,660** | **18** | **45** |

*Table 23: Consultations and total costs (consultation fees and reimbursement for NRT products) for HMQ delivered in Level 3 community pharmacies in Wales in 2023-24, by Health Board, NECAF data. Source: NHS Wales Shared Services Partnership*

| Health board | Number of different pharmacies with one or more claims | Total paid (£) | Total number of claims | Total number of consultations | Average number of claims per pharmacy | Average number of consultations per pharmacy |
|---|---|---|---|---|---|---|
| Aneurin Bevan | 70 | £176,554 | 1,237 | 4,755 | 18 | 68 |
| Betsi Cadwaladr | 104 | £226,960 | 1,831 | 6,724 | 18 | 65 |
| Cardiff & Vale | 23 | £46,991 | 333 | 1,181 | 14 | 51 |
| Cwm Taf Morgannwg | 82 | £153,084 | 1,281 | 4,669 | 16 | 57 |
| Hywel Dda | 51 | £84,109 | 641 | 2,386 | 13 | 47 |
| Powys | 18 | £20,927 | 180 | 718 | 10 | 40 |
| Swansea Bay | 51 | £98,230 | 804 | 2,939 | 16 | 58 |
| **Total** | **399** | **£806,855** | **6,307** | **23,372** | **16** | **59** |

Figures are also available disaggregating consultation from NRT reimbursement fees for Level 3 pharmacies in 2023-24 by Health Board. These figures are shown in Table 24.

*Table 24: Consultation fees for HMQ clients supported in Level 3 community pharmacies in Wales, 2023-24, by Health Board. Source: Community Pharmacy Wales*

| Health Board | Consultation fee, Level 3 pharmacies |
|---|---|
| **Aneurin Bevan** | £48,241.65 |
| **Betsi Cadwaladr** | £67,644.12 |
| **Cardiff and Vale** | £12,799.40 |
| **Cwm Taf Morgannwg** | £51,779.18 |
| **Hywel Dda** | £22,856.78 |
| **Powys** | £7,080.10 |
| **Swansea Bay** | £26,654.69 |
| **Total** | £237,055.92 |

The total cost of consultation fees in Level 2 pharmacies for 2023-24 was £132,497.

Costs reflect the changing patterns of HMQ use of pharmacy in Wales over the course of the past six years and differing pharmacy provision across Wales.

- For analysis of patterns of HMQ client pharmacy use over time and between Health Boards see **Section 9.5.2**

## 12.3. Governance and Service Planning

### 12.3.1. Summary and recommendations

The Governance and Service Planning Domain considered structures and processes by which HMQ services are governed and planned. Both the audit and service mapping workstreams addressed issues of governance across HMQ, with responses including details of how engagement with services and systems outside of, but related to, HMQ are managed. These highlighted a number of strengths, including examples of clear and well-documented governance structures at a local level, establishment of systems (in terms of technological integration and service engagement) and management of clinical governance.

Key areas for development are system co-ordination, strengthening governance at local levels and integration between services.

***Key Recommendation 2: Health Boards and PHW should collaborate to establish an HMQ National Leadership Group to discuss and adopt recommendations that relate to the HMQ system as a whole, such as changes to reporting protocols, amendments to national service standards, etc.***

***Key Recommendation 3: Health Boards and PHW should ensure performance measures for smoking cessation services are agreed, clearly documented and quality assured. Health Boards, PHW and Welsh Government should ensure that all measures reported nationally are documented and calculated consistently***

*Recommendation 5: HMQ services should ensure clear governance structures are in place for smoking cessation services, including facilitating engagement between community and pharmacy services, involvement of a named clinical lead and lines of reporting to relevant Health Board governance bodies*

*Recommendation 6: HMQ services should have an annual quality plan in place, aligned with their organisation's policies and strategies in relation to the Health and Social Care (Quality and Engagement) (Wales) Act 2020*

### 12.3.2. Strengths

The audit has highlighted how the **governance structures** can vary across Health Boards, with three out of seven boards having a dedicated programme board to provide strategic oversight for smoking cessation services. Two Health Boards report to broader governance groups, such as Tobacco Control Boards or Maternity Assurance Boards, ensuring some level of strategic oversight for the service. In terms of clinical leadership, five Health Boards have named clinical leads, with some attending Health Board meetings to provide input on service management.

The service mapping indicated that services sit **within different corporate structures** in different organisations. Four services exist within the public health

structures of their respective Health Boards, whilst two services are based within the primary care structures and another one within the respiratory service structure. Services reported a range of factors being considered during service budget planning, such as population level outcomes, impact on health inequalities, needs of rural populations, return on investment and cost benefit. The additional comments provided by services indicated that in some cases budgets were historic or based on the service's performance in the previous year.

Regarding **quality improvement**, one Health Board has implemented a structured quality improvement plan, including a performance dashboard to track service delivery metrics, for example, waiting times. Additionally, four out of eight services (Health Board and HMQ Hub) have engaged with their organisations regarding implementation of the Duty of Quality[24], however, formal quality measures have not yet been established.

The staff engagement events also highlighted that governance structures for the HMQ smoking cessation services vary across Health Boards. Some boards have **clear accountability structures**, with the delivery of the smoking cessation services incorporated into existing pathways, processes, and leadership frameworks. In certain areas, there is good **strategic oversight and alignment** with public health initiatives, ensuring service continuity and integration within Health Board systems.

Additionally, there is **strong leadership** within certain Health Boards, with established reporting structures and engagement from national (PHW) and local (HB) levels. Some teams have access to electronic referral systems, which help to support governance by enabling the tracking and reporting of the HMQ service performance.

Responses from Pharmacy Leads highlighted a key strength as being that pharmacies are recognised as **convenient and accessible points of service**, allowing for **flexible client support**, including CO validation and NRT provision. Pharmacies also play a role in promoting smoking cessation services by starting conversations with clients and facilitating referrals.

Pharmacy Leads consistently highlighted a **lack of financial incentive to prioritise smoking cessation in pharmacy** given rates of reimbursement for other services provided. Rates for smoking cessation consultations in pharmacies in Wales have not been reviewed since 2017 and are seen as relatively low compared to those in England. This was seen as being a particular issue for smoking cessation given the more intensive support, including multiple sessions, required within the Level 3 pharmacy specification.

- For details of pharmacy consultation rates in Wales and data on costs of providing HMQ support in pharmacies, see **Section 12.2.2**

### 12.3.3. Areas for improvement

Governance remains **inconsistent across Health Boards**, with two out of seven boards lacking formal governance processes. Additionally, three boards do not have a dedicated programme board and rely on broader organisational groups for strategic oversight. One Health Board is in the process of reviewing and establishing governance structures.

While most Health Boards have a **named clinical lead**, two Health Boards have not stated an identified lead role, and it is unclear whether existing leads regularly attend formal governance meetings. Additionally, three Health Boards do not have a specific quality improvement plan, instead they have the service quality embedded within broader organisational plans without specific targeted performance measures for the HMQ service.

One service reported that being based within the Primary and Community Care structures created some challenges. This service was managed as part of the Reablement/Occupational Therapy services structure, which covered only part of the Health Board footprint. Thus, the smoking cessation service which serves the whole Health Board footprint was not aligned to the other services in their management structure.

At a system level, Help Me Quit is under the **governance of the Directors of Public Health**. This has limitations, including challenges on agenda capacity during monthly meetings of DsPH and lack of specialist smoking cessation input (e.g. clinical, academic, pharmacy) to support decision-making. Regular meetings between the Tobacco Control Leads, including the PHW Tobacco, Vapes and Nicotine Addiction Programme, support sharing of information and issues between partners in the tobacco cessation system, but do not provide a forum for decision-making.

Regarding the **Duty of Quality**, three out of eight services (Health Board and HMQ Hub) have not engaged with their organisations on this matter, while another four have engaged but not yet agreed on the formal quality measures, indicating a gap in standardised service monitoring.

Staff attending the engagement events also noted that **governance can be inconsistent** across different Health Boards, leading to variation in service delivery and accountability. There is **a lack of clear accountability structures** in some areas, with governance responsibilities not always well-defined. This results in **variability in reporting and oversight**, making it difficult to ensure consistency across all regions.

Leadership gaps were also identified in Health Boards where **clinical and executive support is lacking** in some areas. The working relationship between national (PHW) and local (HB) leadership teams could be strengthened to ensure **better coordination, strategic oversight, and decision-making** at all levels to improve HMQ service delivery outcomes.

Details from Pharmacy Leads highlighted that some challenges exist around service integration with other healthcare providers.

There are **inconsistencies in communication between pharmacies and smoking cessation services**, including issues with delays in receiving NRT prescriptions, lack of timely CO validation, and conflicting information regarding medication availability. Some Health Boards report that community pharmacies struggle with capacity issues, impacting their ability to consistently provide smoking cessation support.

Governance structures around pharmacy engagement appear to lack standardisation across Health Boards, leading to variability in service delivery.

Some pharmacies are **reportedly competing for clients** rather than working collaboratively with smoking cessation services. There is also insufficient training for pharmacy staff on smoking cessation processes, which may contribute to inconsistencies in service provision.

Work on data has highlighted that there may be **variation in the way that measures of performance are calculated** due to different service models (e.g. the definition of treated smoker means that attrition rates in client engagement may be difficult to compare between community and pharmacy services) and different data systems.

### 12.3.4. Opportunities for improvement

There are several **learning opportunities** that have been identified – Health Boards and the HMQ Hub could learn from those with strong governance structures, particularly the three that already have a **programme board** in place. Sharing best practices could also assist the Health Board currently developing governance processes.

The benefits of a **named clinical lead** could be discussed with the two Health Boards without one, and all leads could actively participate in **governance meetings** to provide strategic direction.

Clear **documentation of performance measures** should be agreed across the system, with any sources of variation between services or data systems noted.

To improve **quality monitoring**, Health Boards could adapt the performance dashboard approach being undertaken by one Health Board, which has helped to track service delivery outcomes. Additionally, **expanding existing data collection systems** to incorporate **quality improvement measures** in relation to service delivery (e.g. waiting times, consistent and evidence-based advice) could enhance service evaluation.

Finally, Health Boards could work towards agreeing on a set of **quality measures** as part of their **duty of quality**, ensuring a more standardised service oversight across

all regions. By addressing these governance gaps, the HMQ smoking cessation services can achieve more consistent oversight, leadership, and quality assurance.

Pharmacy Leads noted that opportunities for improvement include **enhancing communication pathways between pharmacies and smoking cessation teams**, introducing **electronic prescription systems** for NRT to reduce delays, and strengthening governance structures to ensure a more cohesive and integrated approach. Addressing these issues would improve efficiency, accessibility, and the overall effectiveness of pharmacy-led smoking cessation support.

## 12.4. Service Content

The Service Content domain considers specific interventions that are offered within Help Me Quit, including identifying and gathering evidence on innovations that go beyond the core service described in the HMQ Minimum Service Standards.

The most important issued raised in relation to interventions was around 'harm reduction' for smokers, in particular in relation to smokers using (or considering using) vapes and their reasons for doing so (e.g. as a short-term smoking cessation aid; as a long-term substitute, etc). This issue, with recommendations, is discussed in a separate section below. In addition, there was evidence of some variation in engagement with children and young people.

*Recommendation 7: HMQ services should review the support available for smokers under 18 to ensure governance, safeguarding procedures and recording of data are consistent across Wales*

### 12.4.1. Harm reduction

As set out in the current Service Manual providing guidance for all HMQ cessation advisors, "HMQ Community Service is an abrupt stop smoking service" organised around supporting clients to set a quit date, after which they will completely stop smoking (the 'not a puff' rule)[25]. The aim is to eliminate smoking harms entirely through complete and permanent abstinence.

Harm reduction may refer to a number of different approaches that aim to reduce smoking harms where a smoker is unwilling or feels themselves not capable of stopping smoking completely. These include reducing the number of cigarettes smoked without an end goal of cessation; 'cutting down to stop', where the goal is abstinence, but without an agreed future quit date; and substituting smoking, entirely or in part, for vaping or other commercially bought nicotine products which may be used in the long-term (as distinct from NRT which is provided free by a cessation service and intended as a short-term substitute for smoking).

Key reasons for organising cessation in HMQ around the 'abrupt quit' model have included:

- Lack of, or uncertainty around, evidence that harm reduction models support long-term abstinence from smoking (i.e. whether those who are supported to cut down smoking are more likely to quit permanently)
- Lack of, or uncertainty around, evidence that harm reduction models reduce the harm from smoking (i.e. whether reducing smoking but not completely quitting has much impact on harms of smoking, given that smoking is harmful at any level of consumption)
- Lack of, or uncertainty around, evidence regarding the impact of encouraging product substitution on motivation and capacity to quit

smoking in the long-term, including its impact on relapse amongst those who become abstinent from smoking and the harms of substitutes for smoking, especially if used long-term; whether long-term use increases the likelihood of relapse
- The need to use resources, in particular service capacity and advisor time to maximise the reduction of harm at a population level

The HMQ Minimum Service Standards does not specifically describe harm reduction interventions but does note:

> *"While abrupt cessation generally gives better results, some smokers will only engage with a reduction programme and there is strong evidence that a combination of face-to-face behavioural support and NRT or prescription only medication can aid smoking reduction and lead to subsequent quitting"*[1]

NICE Guideline NG209 defines harm reduction as:

> *"Measures to reduce the illnesses and deaths caused by smoking tobacco among people who smoke and those around them…. People who smoke and currently do not want, or are not ready, to stop in one go can reduce their harm by smoking less and abstaining from smoking temporarily. The benefits of harm reduction itself are uncertain, but it may mean people are more likely to stop smoking altogether in the future."*[8]

The Guideline provides advice on discussing cutting down to stop, reducing smoking and temporary abstinence with smokers who wish to reduce harm but are not willing to consider an abrupt quit. There is discussion of provision of medicinally licensed products in harm reduction approaches, which does not include vapes or other unlicensed products.

Evidence from the Service Review (presented in detail in the following sections) shows that a number of services have implemented advice or intervention(s) described as 'harm reduction' for some smokers they are supporting within HMQ. There is variation between these approaches, including what specifically is offered, what evidence base has been used to define them and how they are recorded and analysed to evaluate their effectiveness in reducing smoking harm.

The Project Board reviewed evidence gathered from the Service Review and discussed harm reduction as an intervention for smokers at the meeting on 13 January 2025. A number of key factors to take into account in considering, developing, implementing and evaluating harm reduction approaches were identified:

- 'Harm reduction approaches' can refer to many kinds of advice and intervention, from brief advice to smokers who are exiting the service without having quit, to specific interventions for smokers that do not involve

an abrupt quit. These approaches have different implications for services, particularly in terms of effective allocation/use of resources

- Any harm reduction approach must be supported by evidence in terms of its effectiveness in reducing harm at an individual level (i.e. does the support provided reduce harm for the individual client?)
- The case for providing harm reduction may vary between settings (e.g. clients in hospital may be offered harm reduction advice on discharge if they do not wish to access HMQ services in the community) and different population groups (e.g. pregnant smokers wishing to reduce exposure to the developing foetus)
- There is a need to distinguish between harm reduction advice and specific harm reduction interventions
- Harm reduction approaches should only be incorporated as part of a service where there is no risk that the capacity of the service to reduce harm at a population level is affected (i.e. the support provided must not divert resources from activities with a high impact on population health to activities with a lower impact, including by reducing capacity for new referrals and/or increasing waiting times and attrition)
- The evidence base for the effectiveness of specific harm reduction interventions at an individual level may have developed since the HMQ Minimum Service Standards were published in 2019
- A lack of clarity across HMQ around the evidence on the harms of vaping, vapes as a cessation aid (and the different ways in which vapes might be used for this, e.g. as a short-term aid to complete nicotine cessation, as a long-term substitute, etc) and provision for vaping cessation also contribute to perceived complexity of harm reduction and what it means in practice. There is a vaping position statement produced by PHW produced in 2019, but most services consider this not to be reflective of the evidence base as it has developed since then

→ For discussion on flexibility within the current service model, which is also relevant to the issue of harm reduction, see **Section 12.5.2**

***Key recommendation 4: PHW should update their vaping position statement and produce a practice note aligned with this to support the HMQ system in providing consistent and evidence-based advice in relation to vapes, including their use in smoking cessation***

***Key recommendation 5: Where HMQ services are providing specific harm reduction interventions, these should be documented, to include definition of the population of smokers being offered the intervention specific harms they aim to reduce, the evidence base and how they record and measure success***

*Recommendation 8: PHW and other providers of Client Management Systems for HMQ smoking cessation services should ensure that vape use, including the reason for use, can be recorded and that harm reduction approaches can be recorded and their success measured*

*Recommendation 9: PHW should carry out an evidence review for harm reduction interventions and their effectiveness in reducing harms from smoking to clients accessing HMQ services*

### 12.4.2. Strengths

In terms of **providing advice on vaping and e-cigarettes**, services draw on a range of evidence sources, including guidance from Public Health Wales, NICE guidelines, the NCSCT, ASH Wales, and other professional bodies. Staff also attend relevant webinars and training events to remain up to date.

Some Health Boards have introduced **local agreements allowing pharmacists to provide advice to individuals who vape**, offering flexibility in service provision.

**Harm reduction advice for smokers not planning to completely stop smoking** is provided by three out of the eight services (Health Boards and HMQ Hub), with all advice following national guidance and incorporating behavioural advice, nicotine replacement therapy (NRT) use, and support for short-term abstinence in hospitals. The approach emphasises positive reinforcement, promoting progress rather than perfection.

**Hywel Dda UHB has implemented a specific harm reduction pathway** with a particular focus on specific groups (e.g. pregnant smokers), definition of goals and ways of working to support those on that pathway.

Where services are using harm reduction approaches, a key resource is the **National Centre for Smoking Cessation and Training (NCSCT)'s guidance** for local smoking cessation services[26].

The current Client Management System **does not facilitate recording of harm reduction activity** (e.g. effectively requiring a quit date to be input for every client) that is taking place, meaning that it is difficult to measure outcomes even when success measures have been defined.

There was considerable discussion on harm reduction approaches at the **engagement events**, with a number of practitioners sharing views on how HMQ services could provide these pathways and the importance of consistent advice.

Some services also report providing **harm reduction advice for hospital patients**, with temporary abstinence programmes and CO monitoring helping clients track progress.

**Harm reduction support is not offered within pharmacy settings** in any Health Board, as it is not included within the national specification. Pharmacy Leads in two Health Board areas indicated that they offered **support to those who only vape**, but that this was not specified in the service manual. A need for guidance on advice and support for vapers was identified as a requirement for consistent and equitable support across Wales. No pharmacy service indicated that they offered any advice in relation to vaping generally.

Smoking cessation support, including behavioural support and NRT, is **available to all smokers aged 12 and over**, with all staff supporting those under 18 undergoing enhanced DBS checks. There are examples of good practice in supporting young people, with six out of seven Health Boards ensuring that smokers aged 12-18 can access both behavioural support and NRT, provided they meet the necessary competency assessments.

Through the service mapping, one Health Board described **providing services to probation, approved premises such as bail hostels, the prison service (staff and prisoners)** as well as to acute and community mental health settings.

Some Health Board areas have initiated **harm reduction advice within Level 3 pharmacies**, which has included behavioural guidance on reducing smoking and the use of NRT.

The availability of behavioural support for smokers aged 12-18 years is also a positive aspect, with **six out of seven Health Board areas confirming that young people have access to support and NRT** where appropriate, although as described below, the offering may not always be clearly articulated.

Services are also **inclusive**, with strong links to community midwives and mental health teams, ensuring access for all groups including vulnerable groups.

### 12.4.3. Areas for improvement

Whilst provision of support for vapers who wish to quit is outside the terms of reference for this Service Review, it should be noted that there is **inconsistency in the provision of support for people who vape or use e-cigarettes**, as many Health Boards do not currently provide advice, citing the absence of national guidance. This inconsistency includes advice for those who are using vapes as a short-term smoking cessation aid, as a long-term tobacco substitute and advice for only-vapers who wish to quit. The Hub and one Health Board service indicated that they deliver services to vape-only clients. The Health Board service reported offering behavioural advice as a one off or longer if requested (potentially matching the length of service offered to smokers). The current QuitManager Client Management System does not allow for recording vaping status.

One Health Board did not provide clear information on **whether their services include support for young people**, therefore it is difficult to establish if this service is consistent across Wales.

There are several areas where consistency and coverage could be improved across services. Currently, **four of the eight services (Health Boards and HMQ Hub) do not provide harm reduction advice to smokers not planning to fully quit**, either in the community or within hospital settings. Where this support is provided, there is **inconsistency in the resources and materials used**, indicating the need for standardised materials.

Also, support for **younger smokers is unclear, with limited mention of age-specific services and no clear references to enhanced DBS checks for staff working with under-18s**.

### 12.4.4. Opportunities for improvement

There are clear opportunities to enhance service provision by ensuring that where harm reduction advice is offered, it is **evidence-based, documented and recorded**. This could include clear, standardised materials and resources, with stronger evidence-sharing across Health Boards to promote the benefits of reducing smoking, even if complete cessation is not immediately achieved.

In order to improve the consistency of advice regarding vaping and e-cigarettes, **standardised guidance** should be developed and adopted across all services, ensuring all Health Boards provide accurate, evidence-based advice to service users.

Governance procedures to ensure **clearer safeguarding for younger smokers**, in particular to needs consideration to provide clearer policies on staff DBS checks was highlighted.

## 12.5. Service Fidelity and Delivery

The Service fidelity and delivery domain incorporated the most audit and service mapping questions. The domain considered the degree to which service delivery reflected the HMQ Minimum Service Standards, NICE guidance and the Russell Standard. This domain also considered variation in how services are delivered across Wales, in particular in the context of the COVID-19 pandemic and subsequent service recovery. Particular challenges in delivering the HMQ service at consistently high level of quality, including managing waiting times, were identified by staff, with consistency of funding and staffing often described as an issue. There are also some differences between the way that smoking outcomes are measured within specified service models (e.g. between community and pharmacy, as highlighted in Section 9.2).

Following review and presentation of the evidence from the Service Review to both the Task and Finish Group and the Project Board, there was particular discussion on two issues. The first was the mix of delivery mode, between telephone and face-to-face support. The second was the level of flexibility supported in service delivery.

These issues are discussed in separate sections below. Provision of the HMQ service in Welsh and languages other than English is also discussed in a separate section.

***Key Recommendation 6: PHW and HMQ Pharmacy Leads should explore options for CO validation in pharmacy, including recording these on client management systems accessible to HMQ advisors within national smoking cessation Service Level Agreements***

*Recommendation 10: PHW should facilitate work to develop consensus across the system on measuring outcomes to ensure these are documented and comparable*

*Recommendation 11: HMQ community services should ensure that the length of both in-person and telephone sessions reflect guidance in the HMQ Minimum Service Standards where these are delivered as 'high intensity sessions'*

*Recommendation 12: All HMQ services offering telephone support should ensure their system supports call recording for quality, monitoring and staff safeguarding*

*Recommendation 13: All HMQ services should review their processes for identifying and engaging with family members of smokers to ensure that opportunities for support are not missed*

*Recommendation 14: All HMQ services which provide in person support should ensure that there are clear and documented processes for identifying who within their teams needs CO monitors and supplying, monitoring functionality and replacing this equipment*

### 12.5.1. Models of delivery: telephone, face-to-face and hybrid

On transfer of most HMQ services from PHW to Health Boards in 2019, delivery of smoking cessation support by Health Board teams was expected to be predominantly through face-to-face engagement[27]. As set out in the HMQ Minimum Service Standards[1], there was an expectation that face-to-face sessions (group or individual) would typically be 'high intensity' (typically 60 minutes for the initial session, 30 minutes for subsequent sessions) with telephone support expected to be 'low intensity' (30 minutes and 15 minutes respectively).

During the COVID-19 pandemic, services across Wales shifted to telephone provision. Following the pandemic, the majority of service delivery by local teams has remained telephone-based, but with considerable variation between Health Boards.

→ For details of the transfer of HMQ services in 2019, changes during the COVID-19 pandemic and post-pandemic service recovery, see **Section 5.9**

During the course of the Service Review, HMQ teams reported a number of challenges in returning to delivering face-to-face support:

- Client expectation: client unwillingness to attend services face to face, with a preference for remote delivery
- Wider social or economic issues: e.g. transport costs, fragmented work patterns
- Changing client population: e.g. higher levels of disability
- Service capacity and capability: lack of available venues, in particular venues free to HMQ services to use, especially in large or rural areas

Services also reported an expectation on the part of clients that a wider range of remote support should be on offer, via platforms such as Teams and Zoom.

During the Service Review, HMQ Health Board teams reported that:

- Phone support is usually delivered according to the 'high intensity' model
- The NTSS and Health Board services have developed arrangements to liaise and share support for clients to reduce waiting times if one service sees rising waiting times
- Hybrid models had emerged, with HMQ clients supported via a mix of telephone and face-to-face sessions. Health Board HMQ services believe this has improved engagement, with clients reporting benefits from not having to link service delivery to a single mode of contact (e.g. if clients cannot make an in-person session for two weeks, they can have a session by telephone during that time)

A key issue is that CO validation, in particular for 4 week quits, has substantially reduced across community services. CO validation is a core part of the pathway for smoking cessation support, as set out in HMQ Minimum Service Standards and NICE guidance.

→ For data on CO validation rates in HMQ community services, see **Section 9.5.1**

To understand patterns of HMQ service delivery by mode of engagement, analysis was carried out on QuitManager data for 2023-24 to consider the mode of delivery (face-to-face only, telephone only or mixed) for all treated smokers who were followed up at 4 weeks post quit date.

For the six Health Boards with data recorded on QuitManager, 9.4% of client episodes included in the analysis recorded support entirely through face-to-face support, 69.8% only through telephone support and 20.9% through a mixed model. Data by Health Board for 2023-24 are shown in Figure 27. Note that current data do not permit robust analysis of group versus individual in person session provision.

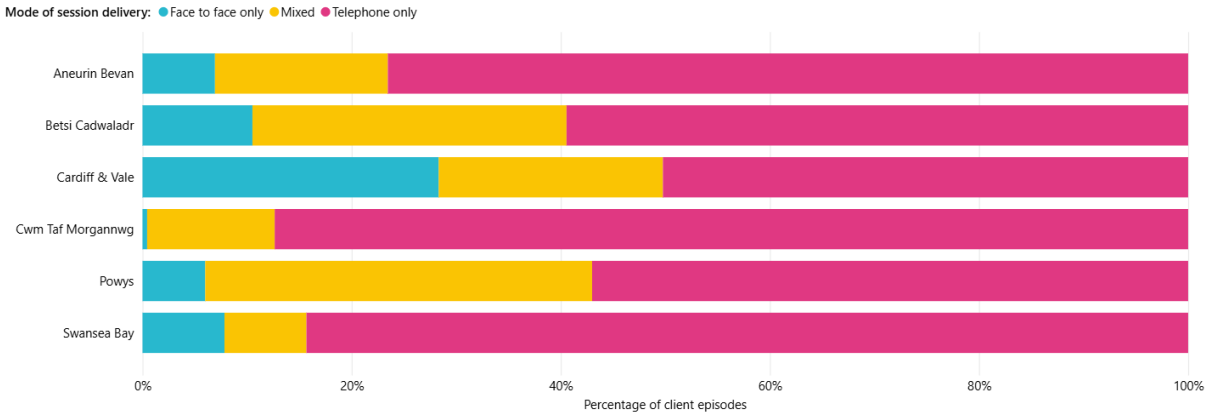



*Figure 27: Mode of session delivery for client episodes of treated smokers who had a 4-week follow-up recorded on QuitManager within the valid follow-up period, by Health Board, 2023-24, 2023-24. Source: Public Health Wales*

The Project Board discussed these findings on 13 January 2025. Key points raised by Board members were:

- Evidence from PROCESS study (see Section 6) was mixed in relation to the preferences for mode of delivery amongst HMQ clients living with deprivation. There was not a consistent preference for a specific mode of service delivery with some reporting benefits from easier engagement via remote means but some reporting that in-person, especially groups, gave them peer support they really valued
- Wales has a substantial population of smokers in rural areas who are also often experiencing deprivation. In addition to the challenges they face in reaching services, staff often have to spend a great deal of time travelling between locations to deliver services. It is important to consider both efficiency of service delivery and equity of provision from this perspective
- These findings reflect experiences of cessation services and wider healthcare support in other parts of the UK
- The current evidence on modes of delivery of service is that remote cessation support can be as effective as face-to-face
- The focus in relation to the mode of service delivery should be on the needs and capacity to benefit from support of the individual, especially as services attempt to reach more smokers who may face barriers to access; remote opportunities can bring in individuals who might not have accessed previously
- There is a need to consider emerging media support options, beyond synchronous face-to-face and telephone
- There is also a need to consider how service delivery is integrated with effective provision of pharmacotherapies and how this is monitored across the system

- As with all smoking cessation services, it is critical that delivery is effective in supporting cessation for individuals and reducing harm across the population, and the HMQ offer in terms of the modes of delivery should be considered against those measures

***Key Recommendation 7: PHW should review the evidence and options for increasing remote and hybrid delivery of support and how this can be integrated into the current HMQ service, making the best possible use of technologies to deliver services in ways that meet client need***

*Recommendation 15: PHW should analyse the effectiveness of current and future models of service delivery in terms of the outcomes for smokers accessing HMQ, ensuring these reflect the best available evidence on behavioural science*

### 12.5.2. Flexibility of HMQ service delivery

HMQ developed at a time when smoking rates in Wales were considerably higher than they are currently. In 2014, almost one in five adults aged 18 and over living in Wales smoked[5]. As rates have declined, there is evidence of widening in the relative risk of smoking amongst those experiencing some form of marginalisation in society[5]. HMQ teams consistently reported to the Service Review that an increasing number of clients are experience a range of issues (notably poor mental health) that presents barriers to successfully completing smoking cessation treatment with HMQ.

A key suggestion from HMQ teams was to consider what level of flexibility should be available within the HMQ service model. Particular areas for consideration were the requirement to set a quit date by a specific date, the expectation that a client would be discharged from the service if they were unsuccessful in achieving a quit within a specific timeframe, the restriction on provision of service to a set number of sessions, the length of time for provision of NRT and issues around rapid re-booking clients who had been unsuccessful in a quit attempt.

→ For discussion on harm reduction approaches, which are also relevant to the issue of service flexibility, see **Section 12.4.1**

These issues were discussed with both the Task and Finish Group and the Project Board. Key points emerging from that discussion were:

- As any changes to make the HMQ model more flexible would almost certainly involve the average amount of advisor time per client rising, any changes would have to include consideration of overall service capacity and effectiveness at reducing harm at a population level
- There is a lack of clarity around provisions for service re-access. Previous NICE guidance[28] recommended a restriction on smoking service re-access of 6

months from the point of discharge. Although this guidance was superseded some time ago, and current NICE guidance[8] does not recommend any set period for re-access restriction, this stipulation may still be found in some smoking cessation documentation in Wales

- It was agreed that ensuring HMQ was accessible to all those who are motivated to stop smoking was essential, even if they have been unsuccessful on previous engagement
- However, it was recognised both that there are several models of service delivery within HMQ (e.g. community, pharmacy, NTSS) and some may be more appropriate than others for any individual client and that repeated episodes of support which do not end in a quit are likely reduce rather than increase the long-term likelihood of quitting
- Project Board members who have been involved in the development of NICE guidance on smoking cessation services noted that whilst previous evidence had generally shown very poor quit rates for those re-accessing support after short periods of time, more recent data suggests clients re-accessing after a short period of time may in fact have similar quit rates to first-time service users. There are very successful models of continuous engagement for smoking cessation in other parts of the world.
- Overall, the evidence tends to support giving advisors some discretion on rapidly re-booking clients back into HMQ, and considering re-treatment as a normal procedure, but also ensuring that if clients are being re-booked in for support, there is a clear understanding of how support for a new quit attempt will reflect what has been learned during previous attempts

***Key recommendation 8: When discussing a discharge from HMQ for clients who have not achieved a quit but wish to re-engage with the service, those providing support through HMQ should discuss reasons why this attempt was not successful, the range of support options available and their current motivation for quitting. This should be made clear in all HMQ guidance***

*Recommendation 16: PHW should partner with a Health Board team to agree a pilot model with increased flexibility which can be implemented locally and evaluated*

*Recommendation 17: PHW should produce a report on evidence for improving cessation support for those experiencing particular barriers to successfully completing smoking cessation treatment with HMQ*

*Recommendation 18: PHW should establish a national Client Management System User Group within HMQ national governance structures to enable possible amendments to the QuitManager system to be raised by CMS users, discussed and where agreed, implemented*

### 12.5.3. Service provision in Welsh and other languages

All clients can choose to receive support to an identical standard via the medium of Welsh or English. All those referred who become HMQ client following engagement with the HMQ Hub are asked for their preferred language of support, and this is the language in which community and telephone national and local services will be delivered in. This reflects legislation on provision of NHS services in the medium of Welsh[i].

Community pharmacies are not legally required to provide services in Welsh but are expected to indicate to the relevant Health Board that they have Welsh speaking staff and for those staff to identify themselves as Welsh speakers in pharmacy[j].

Under the Welsh Language (Wales) Measure 2011 and associated regulations, NHS organisations in Wales providing services to the public are required to produce a Welsh language consultation plan. As part of the audit, it was established that not all services were clear that they were identified within their **organisation's Welsh Language Clinical Consultation Plan**.

In 2023-24, 405 individuals recorded on QuitManager indicated their preferred language was Welsh, of whom 92% were resident in BCU. The proportion of client episodes by Health Board and by the service which supported them is shown in Table 25.

[i] Welsh Language Standards as set out under Section 44 of the Welsh Language (Wales) Measure 2011
[j] National Health Service (Welsh Language in Primary Care Services) (Miscellaneous Amendments) (Wales) Regulations 2019

*Table 25: Proportion of client episodes for which preferred language was Welsh, as recorded on QuitManager, 2023-24. A total of 405 clients requested support in Welsh. Source: Public Health Wales*

| Health Board of residence | Community Service | Hospital Service | Maternity Service | National Telephone Support Service | Pharmacy Service | Total |
|---|---|---|---|---|---|---|
| **Aneurin Bevan** | 0.1% | 0.0% | 0.5% | 0.6% | 0.1% | 0.1% |
| **Betsi Cadwaladr** | 4.4% | 10.3% | 2.0% | 0.0% | 2.1% | 6.1% |
| **Cardiff and Vale** | 0.2% | - | 0.0% | 0.0% | 0.3% | 0.2% |
| **Cwm Taf Morgannwg** | 0.2% | 0.0% | 0.2% | 0.0% | 0.2% | 0.2% |
| **Hywel Dda** | 1.0% | 0.0% | | | 0.5% | 0.9% |
| **Powys** | 0.6% | 0.0% | 0.0% | 0.0% | 2.2% | 0.7% |
| **Swansea Bay** | 0.1% | 0.2% | | | 0.6% | 0.2% |
| **Total** | **1.3%** | **7.7%** | **0.9%** | **0.2%** | **0.7%** | **2.2%** |

For clients indicating a preference for support in a language other than English or Welsh, the HMQ service is delivered with the support of a translation service. The only language other than English or Welsh for which more than 50 client episodes were recorded on QuitManager in 2023-24 was Polish (57 client episodes, 0.3% of all client episodes).

*Recommendation 19: All HMQ services should ensure that they are included within their organisation's Welsh Language Clinical Consultation Plan*

### 12.5.4. Strengths

Key findings highlighting service strengths included that **all HMQ services**:

- achieve a **mean time to quit date** of well below the Russell standard of 14 days
- achieve 100% compliance of smoking status verification
- report that more than 50% of their treated smokers were abstinent at four weeks (self-reported outcome)
- report **availability of CO monitors** for staff supporting clients face-to-face
- use some form of **staff meeting to cascade information** and most describe a written process to update staff

- report routine provision of Passport to Smokefree to all clients
- offer **Language Line support** to clients who prefer the service to be delivered in a language other than Welsh or English.

In terms of the **proportion of treated smokers followed up at 4 weeks,** one service achieved an excellent rating and four services achieved a good rating. In terms of **treated smokers reporting abstinence at four weeks,** two of the services achieved an excellent rating of over 70% and four services achieved a good rating. All services for which data were available achieved an excellent rating for the audit question about **the proportion of clients who, on the first session at which NRT was recorded, had a slow and fast acting form of NRT indicated** and only two services narrowly missed an excellent rating.

In addition, most services reported a formal process of **logging provision, availability and maintenance of CO monitors** and six services offer HMQ support to families who smoke.

All seven Health Board Community Services offer group and one-to-one support. One-to-one support may be delivered in person or by telephone. The service mapping confirmed that across the system there are a **range of delivery modes** including, one-to-one (in person), one-to-one (phone), one-to-one (online/virtual) and group (in person) and that no services deliver virtual group sessions. Some services offer support via digital platforms and SMS motivational messages in addition to their group work offer. One service responded with a comment that they endeavour to make their service as accessible as possible and would offer email support if that was requested by a client.

All Health Boards offer **in-person group sessions**, with sessions lasting between 45 to 60 minutes, and all provide in-person high-intensity one-to-one support. Five of the seven Health Board services also provide low-intensity one-to-one support, demonstrating a varied and accessible service. Where both low and high intensity support are offered, the balance typically favours high-intensity support at a ratio of 80:20.

All Health Boards and the National Hub provide **telephone-based one-to-one support**, with initial calls ranging between 20 to 40 minutes and follow-ups generally between 10 to 20 minutes, though some Health Boards reported longer or more flexible call patterns.

The HMQ Hub and Health Board HMQ community services report close liaison to **balance waiting lists for telephone support** between services to minimise waiting times.

Hywel Dda UHB uses a **Health Coach model**, in which smoking cessation support is delivered in the context of addressing multiple health behaviours, including healthy eating and physical activity.

One service described **working with a heath improvement co-ordinator within a prison setting**. They offer training to the practitioner who then directly delivers sessions and is subsequently supported by the wider HMQ team in that area.

Several services report their **usual venues** as including primary care settings, GP surgeries, hospital wards, outpatients and emergency departments and other NHS premises such as offices.

**Venues that were less usual** included mainstream schools, leisure centres, libraries, private business premises, job centres, community halls, probation and prison settings.

The staff engagement sessions identified some strengths in service delivery; these include the increase in client-facing staff in some areas as a result of Prevention and Early Years funding, which has improved service accessibility.

Some services have implemented a more **unified referral processes** between hospital, community and pharmacy services.

The staff engagement sessions identified some strengths in service fidelity, particularly in the **accessibility and monitoring of smoking cessation support**. It was discussed that many Health Boards routinely validate smoking status using CO monitoring. Telephone support was also reported to be widely available, helping to track client progress.

Additionally, many reported that **staff communication and training on updates to practice** are in place, ensuring that practitioners stay informed about service developments.

Some services also offer **support to family members** who smoke, which aligns with a broader approach to reducing tobacco use within households.

The **Passport to Smokefree** is available in some areas, providing structured guidance for clients.

### 12.5.5. Areas for improvement

The service audit highlighted that only one service reported above 30% of all **4-week quits validated by CO validation** and supplied a service manual as supplementary evidence. One service, with just under 20% of all 4 week quits CO validated, and which had supplied a service manual, narrowly missed achieving a good rating. For the purposes of auditing **CO validation,** there was not enough detail provided by services citing HMQ Minimum Service Standards or referring to service flow charts. Therefore, services which do not currently have a service manual could adopt the standard PHW manual and amend it to reflect any variation in service.

In relation to group sessions, while all Health Boards offer them, **the time allocated for these sessions varies**, highlighting a lack of standardisation across services. In-person low-intensity one-to-one support is not provided by three of the seven Health Boards, raising questions about whether this type of provision should be more widely adopted.

Telephone support is consistently available across all services, but the **length and frequency of follow-up calls varies considerably,** indicating the need for clearer, standardised guidance to ensure equity in service delivery. Similarly, while all services rely on a variety of evidence sources to guide advice on vaping and e-cigarettes, there is inconsistency in exactly which sources are used, further reinforcing the need for consistent, centrally agreed guidance.

Additionally, the **balance between high and low-intensity support** needs clearer definition to ensure all clients have access to the right level of intervention.

The service mapping highlighted **common difficulties with meeting service demands**, including the size of the team even at full complement, staff sickness, staff recruitment, lack of venues for face-to-face delivery and CO validation, increased client needs, demands and expectations.

Where services often reported difficulties, **staff resource and lack of venues were the main issues** resulting in some cluster areas not being accommodated and **difficulty providing CO validation** for telephone support clients. Other consequences included **increasing waiting times** for support, **not being able to offer virtual sessions** and **not being able to support probation, homeless, workplace and school setting requests**. The services that reported sometimes experiencing difficulties only mentioned staffing problems. The services that reported occasional difficulties linked this to staff sickness and the lack of administrative support. The consequences were that proactively finding cases and making 52-week follow-up calls would be dropped in favour of prioritising booking calls and support sessions.

The staff engagement sessions identified some challenges in service delivery, including staff shortages, venue availability, increasing demand and some services struggling to meet client needs. In addition, **administrative barriers, such as paper-based prescriptions and delays in NRT provision** have also hindered service efficiency.

The staff engagement sessions identified areas for improvement in service fidelity which included inconsistencies in CO validation, particularly regarding monitoring 4-week quits.

Also, some services **lack structured quality assurance processes** for telephone support, and guidance on call length is unclear, which could impact service consistency. A number of Health Boards providing telephone support lack systems

to record calls, which reduces capacity to monitor and quality assure service. There have also been incidents where lack of recording has made it more difficult to address staff safeguarding issues.

### 12.5.6. Opportunities for improvement

**Sharing of good practice** could occur to improve the audit ratings of some services in relation to **HMQ support to family members who smoke,** the **logging of CO monitors** and the **CO validation strategy.**

All services across the HMQ system would benefit from a **review of their quality assurance processes** in place for their telephone systems and call quality as well as updating their guidance and training on call length.

In relation to group sessions, clearer guidance based on best evidence could ensure consistency in how long these sessions last and what content they cover. The provision of in-person, low-intensity one-to-one support should be reviewed across the services that currently offer it to evaluate its effectiveness. If found to be beneficial, this type of support could be expanded across all Health Boards. In terms of telephone-based support, the opportunity exists to develop national guidance ensuring consistent timing, follow-up patterns, and quality across all services.

Other areas in which staff suggested action could be taken included considering **introducing or reintroducing group sessions** and **improving telephone and in-person support integration**, which may help to enhance service delivery.

The staff engagement sessions identified several opportunities for improvement in service delivery, in particular **recruitment and funding stability**, with many advisors and Service Leads reporting struggles with staffing shortages, affecting their ability to meet demand and maintain consistent service provision.

The staff engagement sessions also suggested developing **more detailed service manuals**, **improving record-keeping for CO monitor distribution and maintenance**, and ensuring that clients **receive the Passport to Smokefree consistently** across all services. Addressing these gaps will improve standardisation, quality assurance, and service accessibility across Health Boards.

## 12.6. Service Integration

This domain considered how different parts of the HMQ service are integrated. Smokers are identified and supported in a range of service settings, with many accessing HMQ in multiple settings (e.g. community, pharmacy, hospital). However, from the client perspective, HMQ is intended to be a seamless service. This domain also addressed the wider range of activities that HMQ services are often engaged in; for example, supporting smokefree hospital strategies.

***Key Recommendation 9: PHW should work with other HMQ providers and the QuitManger provider to allow recording of HMQ client data on a single Client Management System***

*Recommendation 20: PHW should work with other HMQ providers and the QuitManger provider to explore and where possible implement improvements to reduce paper flows within the HMQ system*

*Recommendation 21: HMQ providers should collaborate to ensure that clear protocols for the seamless referral and transfer of clients between hospital and community HMQ support are in place and clients are identified as the client for a specific service in a consistent way*

*Recommendation 22: PHW should assess how to improve referral into the QuitManager Client Management System to improve ease of professional referral into HMQ*

*Recommendation 23: PHW and Health Boards should co-ordinate liaison with primary, secondary and social care services locally and nationally to highlight availability of HMQ services*

### 12.6.1. Strengths

Most services reported that services in their areas were **co-ordinated or integrated** through regular meetings (informal, unminuted) including representatives of all services (e.g. community, pharmacy, hospital etc.). One service reported they engaged through existing structures and processes (e.g. primary care directorate structures), one reported ad hoc meetings to discuss specific issues and another reported both regular minuted meetings and informal and ad hoc meetings.

→ For evidence relating to formal governance structures for HMQ, see **Section 12.3**

HMQ community services are often involved in **supporting cessation and tobacco control activity beyond provision of service to individual clients**. Most services indicated that they were involved in these activities, including supporting smokefree hospital sites, marketing of services to smokers, education in school and education in settings other than schools. Where additional information was provided, services

also reported they were involved in policy groups, collaborations with communications on generic marketing materials and participating in task and finish groups. Staff also attended directorate meetings and undertook various pilot projects with different departments and submitted reports to various levels in their Health Board. They also supported requests from education settings, colleges, universities, providing health stand/resource packs, and taught medical and cardiac nursing students.

A number of integrations with other services were described, including work to identify and support smokers within Emergency Departments and liaison with homelessness services.

The stakeholder sessions highlighted some strengths in terms of service integration; these include that there are some **strong working relationships** between some smoking cessation teams across community, hospital, and pharmacy services, particularly where regular meetings and communication channels are in place.

In areas where integration has been effective, this has **included collaboration which has extended beyond direct smoking cessation support**, with services actively contributing to smokefree site policies, educational outreach in schools and wider public health initiatives.

Some teams described well-established referral pathways that allow clients to transition smoothly between hospital, community and pharmacy support, ensuring continuity of care.

### 12.6.2. Areas for improvement

**Referral and transfer of smokers between HMQ services in hospital and the community** were recognised as being an issue in some places, with particular concerns about variation in the recording of data and definitions of clients and how success was measured between different parts of HMQ services.

There was evidence of **considerable variation in referral pathways**, particularly where these came from professionals, with multiple pathways sometimes in place (including both central and local teams). Some HMQ staff considered referral pathways to be inefficient, causing delays in client support being delivered.

Both HMQ staff and pharmacy representatives highlighted issues with integration between these services. In particular, issues with consistent availability of pharmacy support, capacity issues, especially where locum pharmacists who did not have a clear understanding of HMQ policies and procedures, and consistent following of processes to access and provide support between services were described.

A particular issue was raised consistently in relation to the **challenges of managing clients without a single Client Management System linking community services and pharmacy**. This means that pharmacists do not have access to information on

client sessions with HMQ advisors, meaning that clients cannot be tracked through the system. There are also long-standing issues with paper-based methods of transferring information around the system. These are seen as inefficient, often requiring substantial amounts of advisor time to resolve issues (delayed or non-arriving letters) and expensive, with Health Boards often spending thousands of pounds per year on postage.

Specific issues highlighted also included the fact that what has been suggested to clients as preferred NRT during their session with a HMQ advisor may not be available in pharmacy, but clients will not agree to substitutes the pharmacies considers reasonable because they believe that only products discussed with their advisor are acceptable. Pharmacists refusing to fulfil hospital prescriptions for cessation pharmacotherapy was also mentioned.

Some HMQ teams and providers also noted confusion over what level of **permission/consent** needed to be elicited and recorded for a professional referral to HMQ.

A lack of **consistency in the 'service choice conversation'** between the HMQ Hub and other services was noted by some HMQ teams.

### 12.6.3. Opportunities for improvement

HMQ services highlighted a number of specific opportunities to improve service integration.

Transferring as **much paperwork into integrated, electronic systems** was frequently highlighted. Some HMQ teams believed that some modes of delivery should be prioritised, in particular face-to-face support (community and pharmacy).

Increased **rigor in documenting and reporting measures** was also requested.

The staff engagement sessions identified several opportunities for improvement in service delivery, in particular on **improving administrative processes**. Paper-based processes are common and inefficient, with frequent examples of staff being diverted from support activities to resolve issues around letters not arriving and consequent hold-ups in service provision to clients.

**Better coordination with pharmacies** is required to ensure timely NRT provision, particularly for hospital discharge patients, with **improving the integration of the current Client Management Systems** identified as a key way to achieve this.

Enhancing collaboration between hospital, community, and pharmacy teams through **regular meetings and shared data systems** was identified as a potential way to improve service continuity and integration.

## 12.7. Training and Support

This domain considered the training and support that those providing HMQ support, in particular advisors in community settings, are provided with to support smokers seeking to quit. HMQ advisors are currently given access to training provided by the National Centre for Smoking Cessation and Training (NCTST), which is recognised UK-wide as the leading organisation for cessation training. PHW manages a contract with the NCSCT to provide online access to training on a Wales-wide basis. This training can also be accessed for free by individuals providing cessation support outside HMQ.

*Recommendation 24: Health Board HMQ providers should share current models of mentoring and clinical supervision and support and agree best practices that can be adopted nationally*

*Recommendation 25: PHW and Health Boards should collaborate to ensure that services to provide appropriate support to clients identified as having wider health and social care needs are identified and referral pathways are made available locally or nationally*

*Recommendation 26: PHW and Health Boards should collaborate to identify what NCSCT training is currently available beyond the core modules and relevant to services and make this available where appropriate*

*Recommendation 27: PHW and Health Boards should explore options for providing more frequent networking opportunities for HMQ staff and ensure that insights gathered at these events are assessed and acted on where opportunities for service improvement exist*

*Recommendation 28: PHW and HMQ Pharmacy leads should explore providing, recording and monitoring access to NCSCT resources for those delivering HMQ support in pharmacy and integrating this within existing governance arrangements for pharmacy training in Wales*

### 12.7.1. Strengths

The audit mapping of smoking cessation support training highlights several positive practices across Health Boards. Regarding **mentoring and clinical supervision**, two out of seven Health Boards have well-established organisational structures ensuring regular supervision for client-facing staff. Additionally, two Health Boards provide senior staff support, while one Health Board has external supervision and wellbeing support. Peer reviews and shadowing are also available in one Health Board, fostering knowledge-sharing and professional development.

All Health Boards reported that all staff delivering HMQ support **access NCSCT training** through the online portal as part of their induction procedures.

For **staff training on using CO monitors**, four out of seven Health Boards provide informal training, with one Health Board citing a low staff turnover as a reason for not requiring frequent formal training. One Health Board has implemented mandatory formal training as part of staff induction, while another offers comprehensive training that extends to pharmacy staff, midwives and other healthcare personnel.

Staff engagement highlighted several positive aspects of **team support and supervision**. Teams benefit from strong internal relationships, good teamwork and structured **wellbeing support** from management and service leads. The HMQ service is well-structured, providing a national approach to smoking cessation, with experienced staff who demonstrate expertise in handling complex cases. Staff also receive informal peer support, and there is a strong culture of collaboration within the teams.

Service leads were asked to comment on **staff morale** as part of the service mapping exercise, and there was frequent discussion of this issue in staff engagement events.

Most services reported that all or **most staff understand the importance of their work and are deeply committed** to supporting their clients to stop smoking. This was reinforced strongly at staff engagement events, with descriptions of their service as a good place to work where they were supported and supported each other to resolve issues arising day-to-day quickly. Innovations to support this included a successful buddying service where other advisors cover the clients of any support staff that need to step away at any point. As a result, this service has not cancelled a single patient in the last five years.

### 12.7.2. Areas for Improvement

Many HMQ teams reported that they felt they **lacked appropriate training to support increasing numbers of smokers with complex issues** such as addiction to other substances and mental health issues. Both agreeing appropriate support within HMQ and understanding appropriate and available **referral opportunities** were highlighted, as was **managing their own wellbeing** when engaging with those who were sharing experiences of trauma.

Despite some structured arrangements, the audit identified variation in **mentoring and clinical supervision**. While two Health Boards provide informal support, three mentioned its availability without specific details. Another Health Board offers senior staff availability for support but lacks a structured, ongoing system for staff.

Despite the positive aspects, **training and supervision gaps** remain. Training is not mandatory across all roles, and there is a **lack of structured training for certain staff groups**, including pharmacy, hospital, and healthcare staff.

Staff turnover also impacts training consistency. Additionally, there is a need for **better communication and collaboration** across different healthcare sectors, including hospitals and pharmacies, to ensure staff understand their roles within the wider smoking cessation service.

Regarding **CO monitor training**, informal training is prevalent, but details on its consistency and effectiveness are lacking in some Health Boards. Only one Health Board has a structured training programme, suggesting a need for more formalised and standardised training.

Whilst (as noted in the section above) services generally reported that staff felt the service is a good place to work and they understood the value of the service they are providing, they **often expressed frustration with structural and process issues**, and the perception that these issues were not being addressed despite often being long-standing. Key issues identified included uncertainty around continued PEY funding and the potential loss of staff. The lack of staff resources often left staff feeling frustrated and demoralised that they were unable to effectively support smokers and a wider audience. More specific issues that impacted on staff morale were identified as having to deal with staff resource issues or problems navigating their clients through the HMQ system.

### 12.7.3. Opportunities for improvement

There is potential to enhance **mentoring and clinical supervision** by sharing best practices from the two Health Boards that have established formal systems. Other Health Boards could benefit from adopting structured mentoring programmes to ensure consistent support.

For **CO monitor training**, Health Boards could explore a shift towards formalised training models, learning from the one Health Board that has already implemented such a system.

There is an additional opportunity to develop a **cascade training framework,** using the expertise of the Health Boards that have expanded their training provision to include the training of other healthcare staff. Opportunity to improve knowledge dissemination and standardisation across all Health Boards.

By addressing these gaps, Health Boards can strengthen their smoking cessation support, ensuring staff are well-equipped with the necessary skills and supervision to provide effective patient care.

At engagement events, staff discussed a perceived need to **formalise and expand training efforts** to enhance the service and ensure all staff receive consistent and mandatory training.

Introducing a **dedicated training role** could help improve access and delivery. Creating an **All-Wales peer support group** for advisors could further strengthen skills and experience sharing.

**Leadership engagement** was also identified as an area for development; this could provide an opportunity to reinforce the value of smoking cessation services within hospitals and ensure high-level buy-in for structured training and supervision initiatives.

HMQ community and Hub staff also noted that they enjoyed the annual HMQ Workforce Development Network day, but would like **more opportunities to network** and share learning and to see how insights gathered at these events were translated into change.

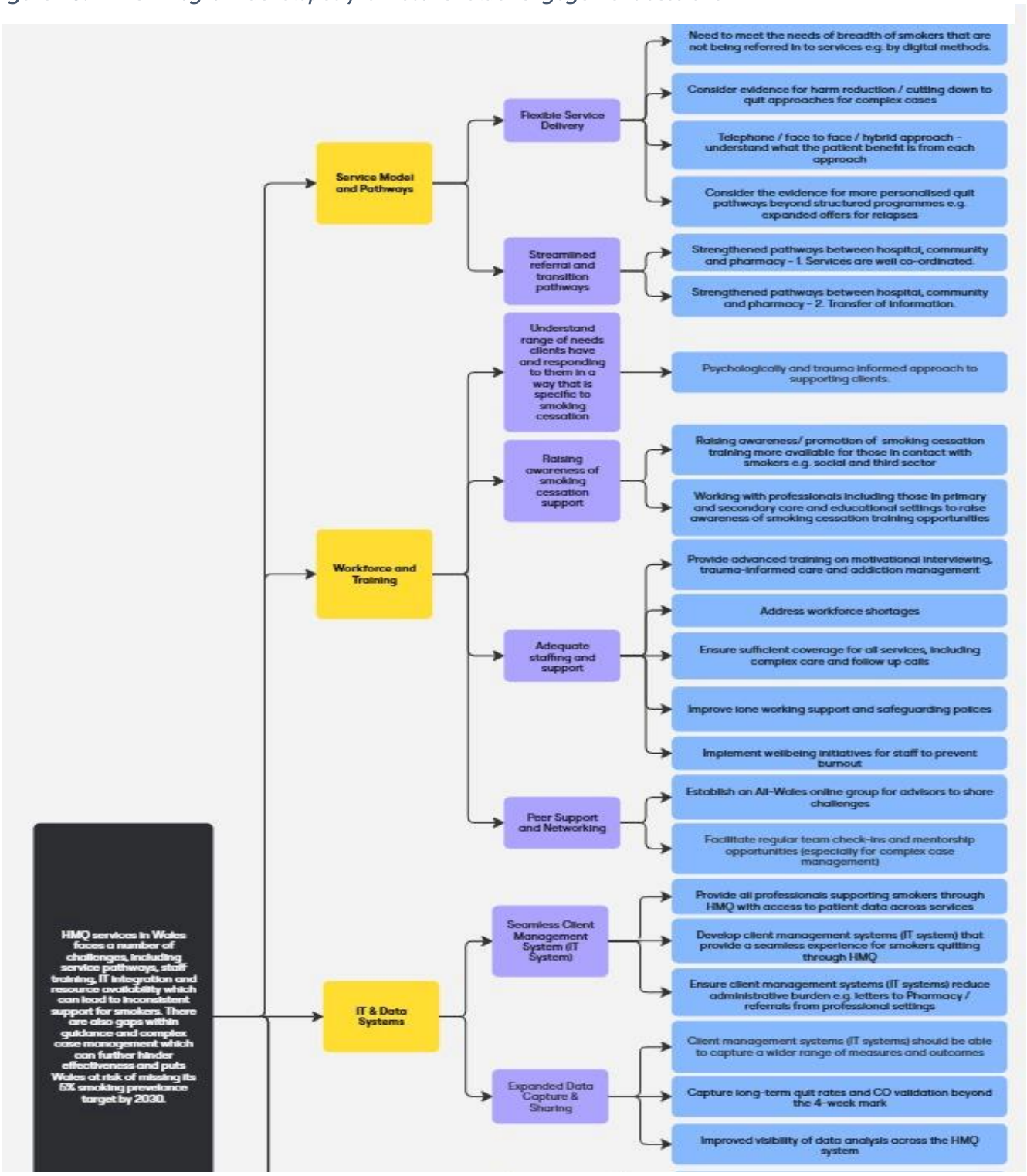
## 12.8. Stakeholder Engagement: Driver Diagram

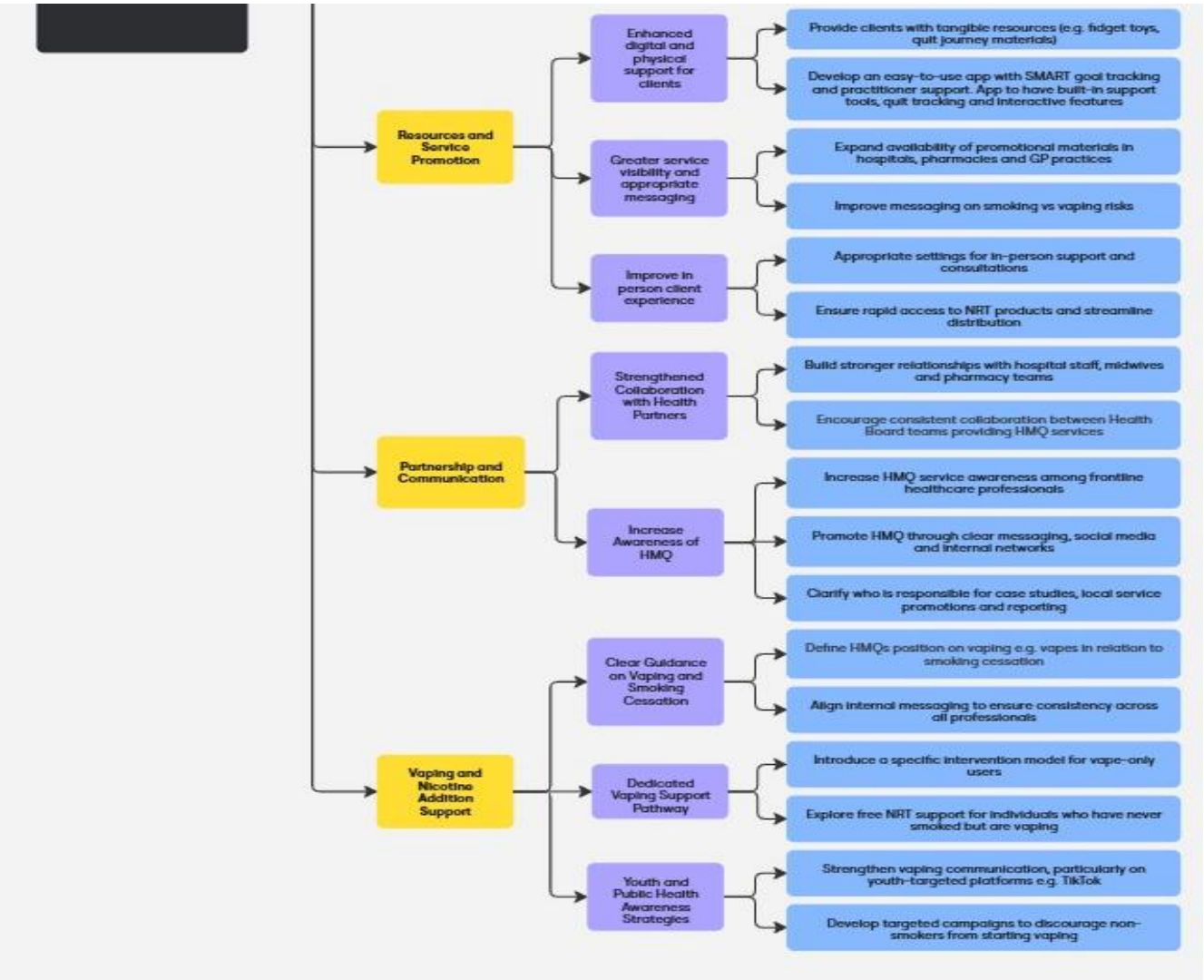
The output captured during stakeholder engagement sessions was developed into a Driver Diagram with the support of the PHW Improvement and Innovation Hub. A Driver Diagram is a visual tool that translates the output of improvement analysis and breaks it down into a series of parts. These parts are what drive improvement in a service or organisational area. A Driver Diagram is made up of a single aim, which is broken down into drivers, followed by change ideas (potential solutions).

→ For details of the stakeholder engagement sessions, see **Section 11.2**

The Driver Diagram is presented in Figure 28.

*Figure 28: Driver Diagram developed from stakeholder engagement sessions*




Resources and Service Promotion
Enhanced digital and physical support for clients
Provide clients with tangible resources (e.g. fidget toys, quit journey materials)
Develop an easy-to-use app with SMART goal tracking and practitioner support. App to have built-in support tools, quit tracking and interactive features
Greater service visibility and appropriate messaging
Expand availability of promotional materials in hospitals, pharmacies and GP practices
Improve messaging on smoking vs vaping risks
Improve in person client experience
Appropriate settings for in-person support and consultations
Ensure rapid access to NRT products and streamline distribution
Partnership and Communication
Strengthened Collaboration with Health Partners
Build stronger relationships with hospital staff, midwives and pharmacy teams
Encourage consistent collaboration between Health Board teams providing HMQ services
Increase Awareness of HMQ
Increase HMQ service awareness among frontline healthcare professionals
Promote HMQ through clear messaging, social media and internal networks
Clarify who is responsible for case studies, local service promotions and reporting
Vaping and Nicotine Addition Support
Clear Guidance on Vaping and Smoking Cessation
Define HMQs position on vaping e.g. vapes in relation to smoking cessation
Align internal messaging to ensure consistency across all professionals
Dedicated Vaping Support Pathway
Introduce a specific intervention model for vape-only users
Explore free NRT support for individuals who have never smoked but are vaping
Youth and Public Health Awareness Strategies
Strengthen vaping communication, particularly on youth-targeted platforms e.g. TikTok
Develop targeted campaigns to discourage non-smokers from starting vaping

## 12.9. Help Me Quit for Baby

**Shameela Chucha and Liz Newbury-Davies**

### 12.9.1. Summary and recommendations

There is evidence of excellent implementation of specialist services to address smoking cessation in pregnancy across Wales. This includes development of specialist pathways, including processes in place to identify and treat pregnant smokers in line with NICE guidance.

Areas for improvement are for the development of locally appropriate resources for all staff supporting pregnant smokers to quit, such as service manuals, standard operating procedures and pathway documents where these are not available.

Addressing these gaps may contribute to improving other barriers related to implementation of core elements of an evidence-based service, such as advice on first contact, engagement with maternity teams and opt out referrals. The national reducing smoking in pregnancy programme of work priorities align with improving processes and resources for those supporting smoking cessation in pregnancy, including maternity teams and smoking cessation advisors. The programmes include a review of resources, evidence-based intervention and a national training offer with supporting resources.

***Note that recommendations identified elsewhere in this report also relate to pregnant smokers.***

*Recommendation 29: Opt-out consent should be consistently documented across all services supporting pregnant smokers*

*Recommendation 30: Financial incentives should be implemented only where evidence suggests that protocols and processes for supporting pregnant smokers within the current system have been effectively implemented*

### 12.9.2. Background

In 2023-24 PHW undertook a review of smoking cessation support for pregnant smokers across Wales and found that whilst significant progress had been made with development of specific pathways, there was little evidence of systematic implementation of the approaches advocated by NICE[8] and other UK level evidence. These findings, alongside NICE guidance and Welsh specific evidence from the MAMMS study[29] informed a two-year implementation plan to improve consistency with application of best practice evidence. This plan resulted in the formation of the national reducing smoking in pregnancy programme of work and is currently ongoing.

### 12.9.3. Data on support for pregnant smokers within HMQ

Pregnant smokers reported in this section were identified as those whose status is recorded as 'pregnant' on either QuitManager or QM10. NECAF does not allow for the recording of pregnancy status.

In 2023-24, 822 pregnant smokers became treated smokers within HMQ. This number has been relatively stable on QuitManager since 2020-21, with substantially smaller numbers recorded prior to this year.

Over half of pregnant treated smokers recorded on QuitManager in 2023-24 were aged 25-34 (59.8%), with a further 24.5% aged 18-24. Comparable figures were recorded on QM10.

There was a stronger association with deprivation for pregnant treated smokers than for the overall population accessing HMQ with between 10.6% (Hywel Dda UHB) and 61.0% (Swansea Bay UHB) living in the most deprived fifth of areas in Wales.

The number of HMQ clients recorded by Health Board of residence and deprivation fifth is shown for QuitManager data in Table 26 and for QM10 data in Table 27. Note that these figures exclude 8 clients whose deprivation fifth could not be ascertained.

| WIMD fifth | Aneurin Bevan | Betsi Cadwaladr | Cardiff & Vale | Cwm Taf Morgannwg | Powys | Swansea Bay | Total |
|---|---|---|---|---|---|---|---|
| 1 (most deprived fifth) | 76 | 83 | 14 | 43 | 3 | 25 | 244 |
| 2 (second most deprived fifth) | 37 | 49 | 3 | 51 | 3 | 10 | 153 |
| 3 (middle fifth) | 36 | 52 | 4 | 15 | 5 | 3 | 115 |
| 4 (second least deprived fifth) | 16 | 41 | 4 | 6 | 2 | 1 | 70 |
| 5 (least deprived fifth) | 8 | 23 | 8 | 10 | 2 | 2 | 53 |
| **Total** | 173 | 248 | 33 | 125 | 15 | 41 | 635 |

*Table 26: Number of pregnant treated smokers supported by HMQ by Health Board of residence recorded on QuitManager for 2023-24 by deprivation fifth. Source: Public Health Wales*

| WIMD fifth | Number of treated smokers |
|---|---|
| 1 (most deprived fifth) | 19 |
| 2 (second most deprived fifth) | 51 |
| 3 (middle fifth) | 56 |
| 4 (second least deprived fifth) | 39 |
| 5 (least deprived fifth) | 14 |
| **Total** | 179 |

*Table 27: Number of pregnant treated smokers supported by HMQ recorded on QM10 for 2023-24 by deprivation fifth. Source: Hywel Dda UHB LPHT*

### 12.9.4. What works well

#### *Specialist pathways*

A specific **pathway** for smoking cessation in pregnancy is an essential component of an effective smoking cessation service for pregnancy, around which evidence-based interventions – with both pharmacological and behavioural elements – are centred. Such a pathway is distinct from the broader HMQ community smoking cessation pathway and incorporates an evidence-based approach to enable early identification and treatment of pregnant smokers. This includes as per NICE guidance, the **opt out referral of pregnant smokers to cessation support.**

The majority of Health Boards across Wales (five out of seven) evidence a **specific pathway** for smoking cessation in pregnancy, with documentation in service manuals and/or pathway documents to support this.

Of those Health Boards that do evidence a specific pathway, four out of five (Aneurin Bevan UHB, Betsi Cadwaladr UHB, Cwm Taf Morgannwg UHB, Powys THB and Swansea Bay UHB) have adopted the HMQ for Baby service branding and approach within their service documentation, which means that whilst there is local variation in how cessation services are structured and delivered there is some consistency in branding and approach across these Health Boards. Briefly, specialist HMQ for Baby pathways are informed by NICE guidance on treating tobacco dependence in pregnancy[8] and incorporate Carbon Monoxide (CO) testing to assist with early identification of smokers on the antenatal pathway, opt out referral into a specialist smoking cessation service for pregnant smokers and continued engagement with those who are unable or unwilling to engage with a service. One Health Board offers a specific pathway with Health Board branding, that incorporates elements as described above, also based on NICE guidance.

#### *Engagement*

The entry point into a specialist antenatal smoking cessation pathway is through referral from maternity teams. Health Boards in Wales reported two main ways in which **maternity teams engage** with specialist smoking cessation advisors and their respective services. The first model, evidenced by two Health Boards, includes specialist maternity smoking cessation advisors embedded within maternity teams. One of these Health Boards adopted the HMQ for Baby service branding and one has alternative Health Board branding. Advisors within these Health Boards work collaboratively with maternity teams and receive direct referrals from midwives into their service. There is variation in how these services are staffed and operated across these Health Boards but there is consistency in their fundamental approach. The second model, evidenced by three Health Boards includes a specific pathway with direct referrals from maternity teams into a specialist smoking cessation service, all of which have also adopted the HMQ for Baby service model and branding. These processes are evidenced in referral pathway documents and/or

service manuals, reflecting excellent measures in place for early identification and referral of pregnant smokers into a specialist smoking cessation service.

### *Service manuals*

A number of Health Boards provide a **dedicated service manual** as a guide for practitioners supporting pregnant smokers to quit. All three Health Boards that offer a service manual adopted the HMQ for Baby approach and branding for the service and corresponding manuals have been adapted to align with local protocols and practices. Key themes within these manuals include setting out standard operating procedures, a Service Delivery Model and associated protocols to guide HMQ smoking cessation specialist practitioners to deliver intensive behavioural support for pregnant smokers and either referring other members of their household into a HMQ community smoking cessation service or providing the service directly. A dedicated service manual is consistent with practices that reduce inappropriate variation across services and the associated advantages of this, such as ensuring equity in access to high quality evidence-based services across Wales. This represents excellent practice.

### *Harm reduction*

**Harm reduction** principles applied to smoking cessation include measures to reduce the illness and deaths caused by smoking tobacco among people who smoke and those around them. These principles include supporting people who currently do not want to or are not ready to stop smoking abruptly to reduce the amount they smoke or to abstain temporarily. Whilst benefits of harm reduction itself are uncertain, it may mean people are more likely to stop smoking completely in the future[8]. One Health Board in Wales evidenced a specialist harm reduction approach and pathway for selected patient groups, including pregnant women. As with the standard smoking cessation offer, this harm reduction offer includes behavioural support and access to pharmacotherapy, with a key difference of offering a more flexible treatment programme, including extending the length of intervention to 12 weeks. A number of alternative outcome measures for this service include reduction in CO readings and number of cigarettes smoked over the intervention period and qualitative measures of improved health and broader outcomes. Process outcomes are also included, such as number of sessions attended. This approach was informed by best available evidence, including NICE guidance.

### *Financial incentives*

The addition of **financial incentives** to usual care has been shown to be more effective than usual care interventions on their own. In this context, usual care includes accessing services that are available as standard as part of a smoking cessation offer for pregnancy and includes early identification and a combination of behavioural and pharmacotherapy interventions. One Health Board reported roll out of a financial incentivisation scheme for pregnant women in addition to usual care. This pilot was delivered between 2023 and 2025, is ongoing and is currently

being evaluated. This approach highlights an evidence based and innovative approach to supporting smoking cessation in pregnancy and has attracted attention from other Health Boards in Wales and from equivalents at a UK level.

### 12.9.5. What could be better?

***Pathway development***

Development of existing integrated pathways by considering specific branding and close working with maternity teams would mean a consistent evidence-based approach to identifying and treating pregnant smokers, in line with national priorities as set by the reducing smoking in pregnancy programme of work. Where this is not currently evidenced or partially evidenced, prioritisation of development of such pathways and associated documentation would strengthen this specialist service provision.

***Engaging with maternity teams***

Two Health Boards describe a direct referral process from their maternity teams into a specialist smoking cessation service. Development of formal pathway documents that set out guidance for engagement with maternity teams may contribute to improved consistency in implementation of services. Additionally, smoking cessation services across five Health Boards reported difficulty with consistent advice and opt out referrals at first contact when engaging with maternity services. Dedicated service manuals and training for maternity teams may contribute to addressing some of these challenges. Other barriers, such as pressures on midwifery teams and inconsistent IT services that do not support routine opt out referrals as per evidence base into smoking cessation services, would need to be addressed within individual Health Boards.

***Guidance for practitioners***

Completion and publication of any **service manuals** currently under development would further support specialist smoking cessation advisors in their role to provide an evidence-based consistent service. One Health Board reported current development of a manual for HMQ for Baby, in conjunction with a public health midwife, representing good practice for supporting advisors in their role.

***Training***

**Specialist training** is routinely undertaken for those working with pregnant smokers. All seven Health Boards describe provision of NCSCT training, which is in line with NICE guidance and meets minimum training requirements for those supporting pregnant smokers to quit. A systematic approach to recording and monitoring training completion would assist in identifying any gaps in those accessing training and provide a consistent mechanism to ensure minimum standards are met across respective Health Boards. Broader training currently available to maternity teams may strengthen engagement with smoking cessation services, by increasing confidence in processes essential to early identification,

referral into services and ongoing support where referrals are refused. The national Reducing Smoking in Pregnancy programme of work is currently developing a national training offer following identification of gaps in training provision. This may also be valuable to smoking cessation services in their role and engagement with local teams.

***Incentives***

Where Health Boards meet all standard service recommendations to support smoking cessation in pregnancy, the addition of an incentivisation scheme to expand interventions on offer would represent an evidence-based development of the service. It is acknowledged that this may not currently be possible for all Health Boards.

### 12.9.6. Areas for improvement

***Guidance for practitioners***

Where there is no current evidence of guidance in a **dedicated service manual** or document, development of this would be a priority to support maternity teams and smoking cessation advisors in their role to provide an evidence-based consistent service.

***Harm reduction***

There is currently little specialist harm reduction provision for smoking in pregnancy reported across Health Boards in Wales. Development of an evidence-based model to support a harm reduction approach for those most at risk of harms from smoking in pregnancy and who are unable to successfully achieve an abrupt stop may improve outcomes in this high-risk population. Components of this approach would include development of a standard operating procedure (SOP) and data and reporting arrangements, to include a minimum data set, with an appropriate set of outcome measures. This might include approaches such as additional monitoring of CO levels or measures to assess nicotine dependency, such as the Fagerström test. Where national guidance on vape use is available, this may also be incorporated. An agreed national approach would reduce inappropriate variation and improve monitoring and evaluation of any intervention.

→ For more details on harm reduction approaches in HMQ, see **Section 12.4.1**

# Appendix 1: Project Board and Task and Finish Group

## Project Board Membership

| Name | Position | Role | Organisation |
|---|---|---|---|
| Dr Garth Reid | Consultant in Public Health | (Chair) | Public Health Scotland |
| Chris Emmerson | Consultant in Public Health | Project Lead | Health Improvement Division, Public Health Wales |
| Liz Newbury-Davies | Principal Public Health Practitioner | PHW Tobacco, Vapes and Nicotine Addiction Programme representative | Health Improvement Division, Public Health Wales |
| Rachel Howell | Principal Public Health Practitioner | Lead for oversight of HMQ system | Health Improvement Division, Public Health Wales |
| Richard Quatermass | National HMQ Co-ordinator | National HMQ Co-ordinator | Health Improvement Division, Public Health Wales |
| Clare Sage | PHW Tobacco, Vapes and Nicotine Addiction Programme Co-ordinator | Project Co-ordinator | Health Improvement Division, Public Health Wales |

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| Prof Robert West | Professor of Health Psychology | External advisor | Professor Emeritus in University College London |
| Mererid Bowley | Director of Public Health | DPH representative | Powys THB |
| Prof Keir Lewis | Consultant in Respiratory Medicine | Clinical representative | Hywel Dda UHB |
| Delyth Jones | Principal Public Health Practitioner | Tobacco Control Lead representative | Betsi Cadwaladr UHB |
| Amar Patel | HMQ Hub and NTSS Manager | HMQ Hub and NTSS representative | Health Improvement Division, PHW |
| Cath Einon | Service Development Manager Smoking Cessation | HMQ Community Service Lead representative | Hywel Dda UHB |
| Suzanne Williams | HMQ Services Strategic Lead | HMQ in Hospital Service Lead representative | Betsi Cadwaladr UHB |
| Adam Mackridge | Strategic Lead for Community Pharmacy | HMQ in Community/Community Pharmacy lead representative | Betsi Cadwaladr UHB |

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| Louise Allen | Head of Community Pharmacy | Community Pharmacy lead representative | Cardiff and Vale UHB |
| Jason Carroll | Community Pharmacy Lead | Community Pharmacy lead representative | Aneurin Bevan UHB |
| Suzanne Cass | CEO, ASH Wales | Third Sector representative | ASH Wales |
| Rhodri Thomas<br><br>Kayleigh Williams | Associate Director for Contractor Engagement<br><br>Contractor Engagement | Community Pharmacy representative | Community Pharmacy Wales |
| Andy McEwen<br>Louise Ross | Chief Executive<br>Clinical Consultant | National Centre for Smoking Cessation and Training representative | National Centre for Smoking Cessation and Training |
| Wayne Jepson | Head of Quality, Engagement and Collaboration | Quality Improvement representative | Quality Team, PHW |
| Dr Pamela Smith | Research Associate and Academic Lead for Patient and Public Involvement at the Wales Cancer Research Centre | Academic representative | Division of Population Medicine Cardiff University |

## Project Board Meeting Dates

The Board met bi monthly on the following dates:

16 September 2024, 18 November 2024, 13 January 2025,17 March 2025

## Task & Finish Group Membership

| Name | Position | Role | Organisation |
|---|---|---|---|
| Chris Emmerson | Consultant in Public Health | Project Lead | Health Improvement Division, Public Health Wales |
| Liz Newbury-Davies | Principal Public Health Practitioner | PHW Tobacco, Vapes and Nicotine Addiction Programme representative | Health Improvement Division, Public Health Wales |
| Richard Quatermass | National HMQ Co-ordinator | National HMQ Co-ordinator | Health Improvement Division, Public Health Wales |
| Clare Sage | PHW Tobacco, Vapes and Nicotine Addiction Programme Co-ordinator | Project Co-ordinator | Health Improvement Division, Public Health Wales |
| Delyth Jones | Principal Public Health Practitioner | Tobacco Control Lead representative | Betsi Cadwaladr UHB |
| Amar Patel | HMQ Hub and NTSS Manager | HMQ Hub and NTSS representative | Health Improvement Division, Public Health Wales |

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|---|---|---|---|
| Cath Einon | Service Development Manager Smoking Cessation | HMQ Community Service Lead representative | Hywel Dda UHB |
| Suzanne Williams | HMQ Services Strategic Lead | HMQ in Hospital Service Lead representative | Betsi Cadwaladr UHB |
| Rhodri Thomas | Associate Director for Contractor Engagement | Community Pharmacy representative | Community Pharmacy Wales |

## Task & Finish Group Meeting Dates

The Task and Finish group met on the following dates; 24 September 2024, 21 October 2024, 5 November 2024, 7 January 2025, 19 February 2025, 12 March 2025, 6 May 2025

# Appendix 2: Data Definitions for Reporting of HMQ Figures

## Reporting Period

Unless otherwise stated, the reporting period is based on the date of episode creation. For most clients, this is the date on which they first spoke to an HMQ call handler or advisor, or a pharmacist, and accepted the HMQ service. For pharmacy clients, this is usually also the date on which they had their first session of behavioural support. Definitions and metrics for HMQ performance reporting

*Table 28: Definitions and metrics used to report on smoking cessation service effectiveness in Help Me Quit*

| Measure | Definition and notes | Reporting |
|---|---|---|
| Referral | Self-referrals by smokers may be via the HMQ website, SMS or telephone<br>Professionals can refer via the HMQ website or by telephone<br>Data on referrals in this report relates to analysis of QuitManager unless otherwise stated | Routine reporting to stakeholders |
| Client | A client is a smoker who (following a professional referral or self-referral to Help Me Quit) accepts the offer of support to stop smoking from Help Me Quit and has a client episode created. | Data is typically reported as 'client episodes' |
| Session<br><br>Assessment Session<br><br>Treatment Session | An event where a smoking cessation advisor engages with a client is described as a 'session'. The first session with an advisor is described as the 'Assessment Session'.<br>Subsequent sessions are described as 'Treatment Sessions'. | |
| Consultation | An engagement with a pharmacist or other pharmacy staff is described as a 'consultation' | |
| Client episode<br><br>Claim | A client episode includes all contacts with the client ('sessions' for community services, 'consultations' for 'pharmacy') between becoming a client and discharge from the service.<br>One client may have multiple episodes within a reporting period | Routine reporting to stakeholders |

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| | Over the period 2017-2024, the total number of individual clients beginning an episode in a given year was around 15% lower than the number of episodes created.<br>In community pharmacy, the equivalent of a client episode is a 'claim' | |
| Treated smoker | A treated smoker is a client who has had at least one session/consultation AND has set a quit date<br>Note that community clients will typically do this at their first or second treatment session, which will be their second or third session overall. Pharmacy clients will usually set their quit date at the first session. Therefore, for pharmacy clients, 'client episode' is equivalent to 'treated smoker' for data reported here. These issues need to be considered when comparing figures between services. | Russell Standard<br>Welsh Government reporting<br>Routine reporting to stakeholders |
| Quit Date<br>Quit<br>Quit rate<br>4 week quit / quit rate<br>CO verified 4 week quit / quit rate<br>Self-reported 4 week quit / quit rate | A Quit Date is the date after which the smoker aims to be no longer smoking.<br>Community clients will typically set a quit date at their first Treatment Session (i.e. their second session overall with the advisor). This allows time to acquire NRT.<br>Pharmacy Level 3 clients will typically set a quit date during their first Consultation.<br>A smoker is counted as having 'quit' if they are no longer smoking <u>at all</u> ('not a puff')<br>The key measure is whether or not a client has quit at the treatment session occurring four weeks after the quit date (any session in the window -3 to +14 days of this four week follow up date).<br>The quit should be verified using a CO monitor, with a reading below 10ppm confirming the quit. | Russell Standard<br>Routine reporting to stakeholders |

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| | Where verification cannot be carried out with a CO monitor, it will be self-reported<br>The quit rate is calculated as the proportion of treated smokers (denominator) who had quit at four weeks (numerator)<br>The Russell Standard sets 40% as a target for the CO validated quit rate and 50% for the self-reported quit rate<br>Note that current HMQ reporting protocol is to consider a 'treated smoker' as someone who has had at least one session with an advisor and has set a quit date. The Russell Standard does not include the requirement for a quit date to have been set to be counted as a 'treated smoker' |

## Recording of HMQ in Hospital Clients

*Table 29: Definitions of HMQ in Hospital clients, as reported by Health Board HMQ Service Leads*

| | How identified on QuitManager for analysis | Definition of 'Hospital Service' Client |
|---|---|---|
| AB | Service Provided = Hospital<br><br>OR<br><br>Service Name =<br>Abbi Lloyd - Hospital Support<br>Cameron Gray - Hospital Support Michelle Morgan – Hospital Support<br>Scott Jenkins - Hospital Support<br>(since April 2022) | Clients identified as 'hospital clients' on QuitManager will have either come as direct referral as part of HMQ in Hospital work and would have been put on QuitManager under 'Hospital' as the referrer. All referrals are logged on a local spreadsheet and also onto QM under hospital but when a client accepts, they are transferred to 'Community'. |
| BCU | Service Provided = Hospital | Clients under the hospital service on QuitManager could be a mix of clients, they will have either come as direct referral as part of our HMQ in Hospital work and would have been put on QuitManager under HMQ in Hospital as referrer, they could also be a staff member within the |

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| | | hospital setting receiving support on-site delivered by one of the on-site practitioners and in some cases they may be hospital out-patients All referrals are logged on a local spreadsheet and also onto QuitManager. If the client wishes to receive support either as a full quit or smoke-free hospital stay, then an episode is created. Upon discharge from hospital if the patient wishes to continue with support, they would receive a choice conversation detailing the ongoing support options in their area. If they wish to continue with the hospital practitioner and workload allows, then they can remain with the practitioner in the hospital clinic. They may want to be transferred to community so this would be done by changing their service to community within QuitManager, meaning that these clients would be counted as 'community' in the data. If they opt for pharmacy their hospital episode would be closed as referred to pharmacy and patient would be provided with the L3 details in their area. If they are only receiving support as part of their smoke-free hospital stay then the episode will remain open until they are discharged, in-patient support will continue and then upon discharge if they do not want ongoing support their episode is closed down as smoke-free hospital stay. |
| C&V | N/A | Data for all inpatients supported entirely in hospital are captured on hospital data systems and not recorded on QuitManager. Patients who are discharged and engage with support in the community are closed down on hospital data systems and |

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| | | not reported, to avoid double counting.<br><br>All clients who are first identified as hospital inpatients but are discharged and engage with support in the community, are recorded on QuitManager but are identified as 'Community' clients, not 'Hospital', and details of sessions are only recorded on QuitManager from the point at which they access services in the community. |
| CTM | Service Provided = Hospital | Historically CTM hospital clients have not generally had Service Provided = Hospital on QuitManager and have instead been entered in such a way that they're reported as community. |
| HD | Not recorded on QuitManager | For Welsh Government reporting, 'hospital' would be those referred via the following routes: Inpatient, Outpatient, Pre-op, Rapid access, Specialist nurse, Gorwellion Mental health |
| PT | Service Provided = Hospital | |
| SB | Service Provided = Hospital<br><br>OR<br>Service Name contains the word 'Hospital'<br>(since September 2021) | All clients that are referred to SBHMQ whilst in hospital are treated by the Hospital service. If the client/patient is treated in hospital but declines support when discharged, we are recording these as smoke free hospital stays with no quit date (as this is an enforced quit). If the client/patient wants further support when discharged they are offered all of the services including L3, so community venues and telephone support. We then open a new record with the service provision of their choice, referred by Hospital but could have any support within the service as they choose. If they wish to remain with the Hospital Practitioner on telephone support, we do have dedicated |

Hospital telephone appointments for discharged patients. Referrals from outpatients would not be recorded as a treated patient in the Hospital service, as again would be offered community, telephone, L3.

# References


1. West, R. *Help Me Quit Minimum Service Standards*. (2020).

2. West, R. *Assessing Smoking Cessation Performance in NHS Stop Smoking Services: The Russell Standard (Clinical), Version 2*. https://www.ncsct.co.uk/library/view/pdf/assessing-smoking-cessation-performance-in-nhs-stop-smoking-services-the-russell-standard-clinical.pdf (2005).

3. Emmerson, C., Cosh, H., Patterson, B. & Hughes, R. *Smoking Attributable Mortality and Hospital Admissions for Wales, 2020-22*. https://phw.nhs.wales/news/over-10-percent-of-deaths-in-wales-due-to-smoking/ (2024).

4. Welsh Government. *National Survey for Wales*. https://www.gov.wales/national-survey-wales (2023).

5. Office for National Statistics (ONS). *Adult Smoking Habits in the UK: 2023*. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2023 (2024).

6. Emmerson, C., McKibben, M.-A., Hughes, R. & Bishop, J. *Vaping and Smoking amongst Learners in Year 7 to 11 in Wales: Analysis from The School Health Research Network (SHRN) Student Health and Well-Being (SHW) Survey in Secondary Schools, 2023*. https://phw.nhs.wales/news/new-vaping-regulations-welcomed-as-vape-use-rises-among-young-people/vaping-amongst-children-and-young-people-in-wales-in-2023/ (2024).

7. Jackson, S. E. *et al*. Who would be affected by a ban on disposable vapes? A population study in Great Britain. *Public Health* (2024) doi:10.1016/j.puhe.2023.12.024.

8. NICE. *Tobacco: Preventing Uptake, Promoting Quitting and Treating Dependence*. https://www.nice.org.uk/guidance/ng209 (2021).

9. NICE. *Tobacco: Treating Dependence, Quality Standard QS207*. https://www.nice.org.uk/guidance/qs207 (2022).

10. NHS Wales. *Smoking Cessation Level 2 Service Specification*. https://cpwales.org.uk/wp-content/uploads/2022/11/Smoking-Cessation-Level-2-National-Service-Specification-October-2020.pdf (2020).

11. NHS Wales. *Help Me Quit @ Pharmacy: Level 3 Enhanced Service Specification*. https://cpwales.org.uk/wp-content/uploads/2022/11/Help-Me-Quit-@-Pharmacy-Service-Specification-31-Jan-2020-1.pdf (2020).

12. Moore, L. *et al. Evaluation of Specialist Smoking Cessation Services in Wales*. https://eprints.gla.ac.uk/183228/ (2003).

13. George, E., Tomlinson, A., Scholey, V., Williams, J. E. & Griffiths, J. *An Independent Review of the Provision of Smoking Cessation Services in Wales*. (Government Social Research, Welsh Government, 2018).

14. NHS England. Statistics on NHS Stop Smoking Services, 2023-24. (2024).

15. NHS England. Statistics on NHS Stop Smoking Services, 2018-19. (2019).

16. Jayes, L. *et al. Understanding How Smoking Cessation Services Can Be Adapted to Improve the Uptake and Success of Smoking Cessation for People in Low Socioeconomic Status Groups. A Mixed Method Exploratory Study*. https://www.cancerresearchuk.org/about-us/we-develop-policy/our-policy-on-preventing-cancer/the-cancer-policy-research-centre-cprc#CPRC_prevention1 (2024).

17. Ofcom. *Adults' Media Use and Attitudes Report*. https://www.ofcom.org.uk/siteassets/resources/documents/research-and-data/media-literacy-research/adults/adults-media-use-and-attitudes-2024/adults-media-use-and-attitudes-report-2024.pdf?v=321395 (2024).

18. Ofcom. *Media Nations*. https://www.ofcom.org.uk/siteassets/resources/documents/research-and-data/multi-sector/media-nations/2024/media-nations-2024-uk.pdf?v=371192 (2024).

19. Johnston, E., Bains, M., Hunter, A. & Langley, T. The Impact of the COVID-19 Pandemic on Smoking, Vaping, and Smoking Cessation Services in the United Kingdom: A Qualitative Study. *Nicotine & Tobacco Research* **25**, 339–344 (2023).

20. NHS Wales Shared Services Partnership. Community pharmacies by local health board and year. StatsWales (2024).

21. Statistics for Wales. Welsh Index of Multiple Deprivation (WIMD) A guide to analysing indicator data, 2019 onwards. (2023).

22. Lévesque, L. E., Hanley, J. A., Kezouh, A. & Suissa, S. Problem of immortal time bias in cohort studies: example using statins for preventing progression of diabetes. (2010) doi:10.1136/bmj.b5087.

23. NHS Business Services. *DrugTariff*. https://www.nhsbsa.nhs.uk/pharmacies-gp-practices-and-appliance-contractors/drug-tariff.

24. Welsh Government. *The Duty of Quality Statutory Guidance 2023 and Quality Standards 2023*. https://www.gov.wales/sites/default/files/consultations/2022-10/the-duty-of-quality-statutory-guidance-2023-and-quality-standards-2023.pdf (2022).

25. Public Health Wales. *Help Me Quit Community Service Manual, Version 4.0*. (2019).

26. Papadakis, S., Robson, J. & McEwen, A. *Local Stop Smoking Services and Support: Commissioning, Delivery and Monitoring Guidance*. (National Centre for Smoking Cessation and Training (NCSCT), 2024).

27. Public Health Wales. *Stop Smoking Wales Service Transfer*. (2019).

28. National Institute for Health and Care Excellent (NICE). *Stop Smoking Services,Public Health Guideline PH10*. https://www.nice.org.uk/guidance/ph10 (2008).

29. Bennett, L. *et al.* Models for Access to Maternal Smoking cessation Support (MAMSS): a study protocol of a quasi-experiment to increase the engagement of pregnant women who smoke in NHS Stop Smoking Services. *BMC Public Health* **14**, 1041 (2014).