Item 4) TSISG 17 June 2019

Northern Ireland Tobacco Control Annual report

2017-2018

Improving your health and wellbeing

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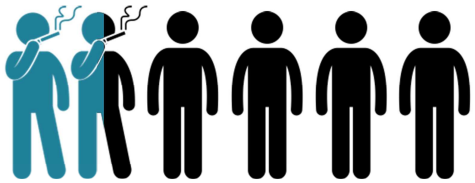
1 Introduction

It is estimated that 18% of the adult population (age 16 and over) within Northern Ireland currently smoke, equating to approximately 266,427 people, with male smoking prevalence (20%) being greater that that observed in females (18%).[1]



Almost 1 in 5 people smoke

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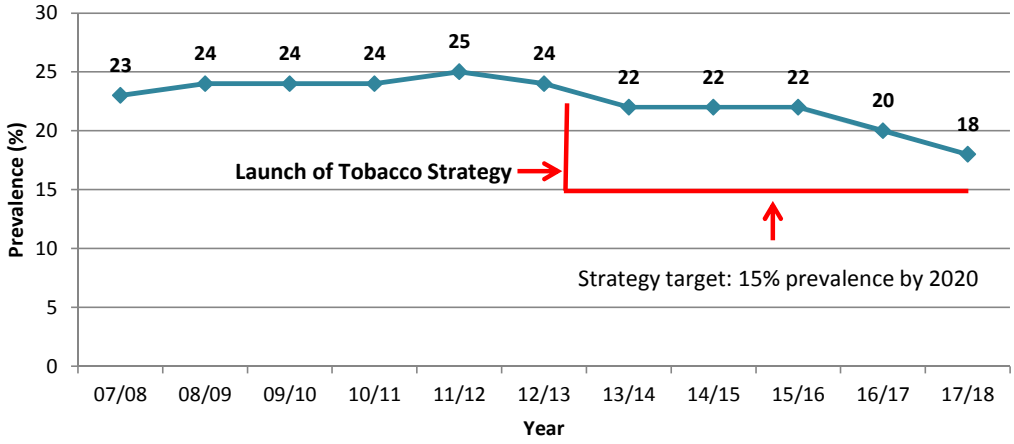
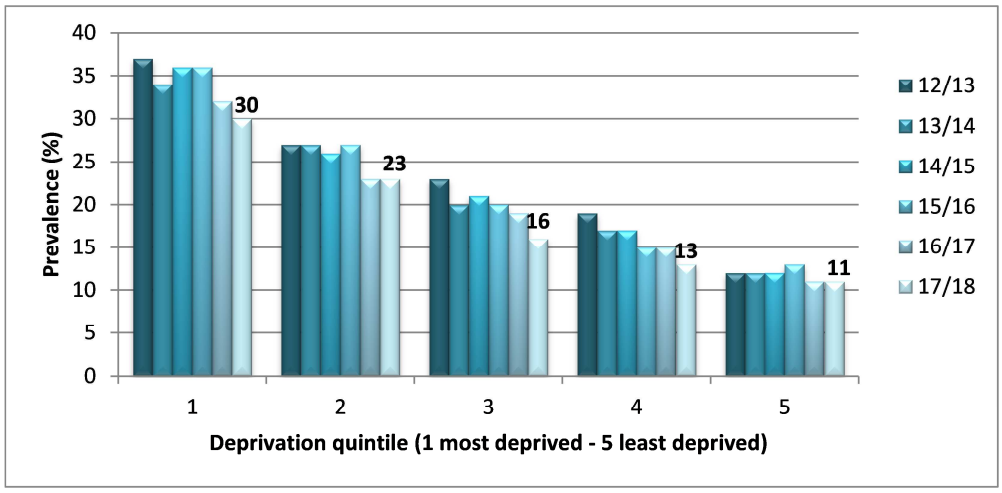
In 2017/18, smoking prevalence observed a 2 percentage point decline for the 2nd consecutive year, from 22% in 2015/16. However, prevalence remains above the 2020 target of 15% identified within the Northern Ireland (NI) Ten Year Strategy.[2]

Figure 1.1: Prevalence of smoking in Northern Ireland 2007/08 to 2017/18

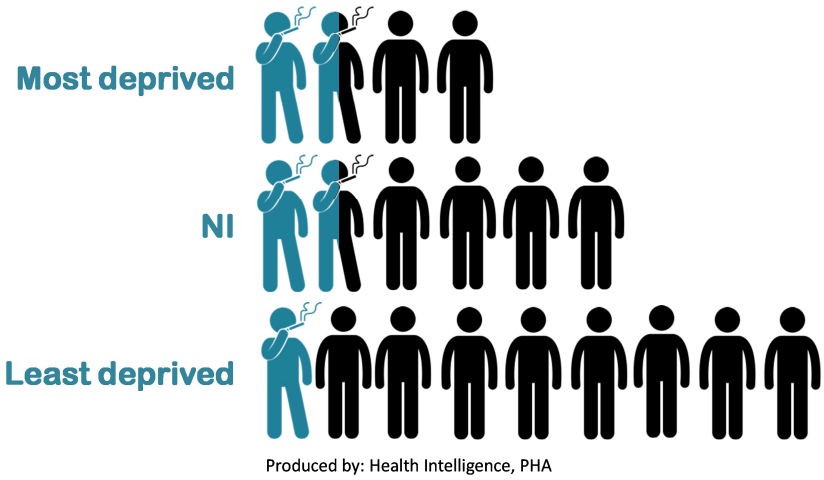


By implementing prevention and smoking cessation programmes, the Public Health Agency (PHA) endeavour to reduce smoking prevalence, and protect non-smokers by not exposing them to second-hand smoke. However, a key issue which remains is the inequality divides within our society. Evidence indicates that there is an extensive gap in smoking prevalence between areas of deprivation, with prevalence being more than twice as high among adults living in the most deprived areas compared to those adults living in the least deprived areas. As in previous years, smoking prevalence declined across the deprivation quintiles from most deprived through to least deprived (Figure 1.2).[1]

Figure 1.2: Smoking prevalence by deprivation quintile 2012/13 to 2017/18



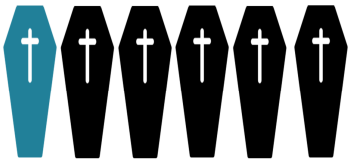
In 2017/18 smoking prevalence ranged from almost one in three people within the most deprived areas to one in nine people within the least deprived areas.



In Northern Ireland smoking remains one of the leading causes of preventable illness and premature death. Smoking causes many types of cancer, including lung and cervical cancer, with smoking being attributable for 90% of all lung cancer. Smoking can also lead to heart disease, strokes, leukaemia, serious respiratory conditions, weak bones and increases the risk of blindness.[3]

Passive smoking also puts non-smokers at risk of developing smoking related illnesses, as regular passive smoking can increase your risk of lung cancer by at least 24%, and increase your risk of heart disease by 25%.[3]

It is estimated that each year around 2,200 to 2,400 deaths in Northern Ireland can be attributed to smoking.[4] In 2015, approximately 2,417 deaths were attributed to smoking,[5] accountable for one in six of all deaths, which equates to 7 people dying every day from a smoking related illness.



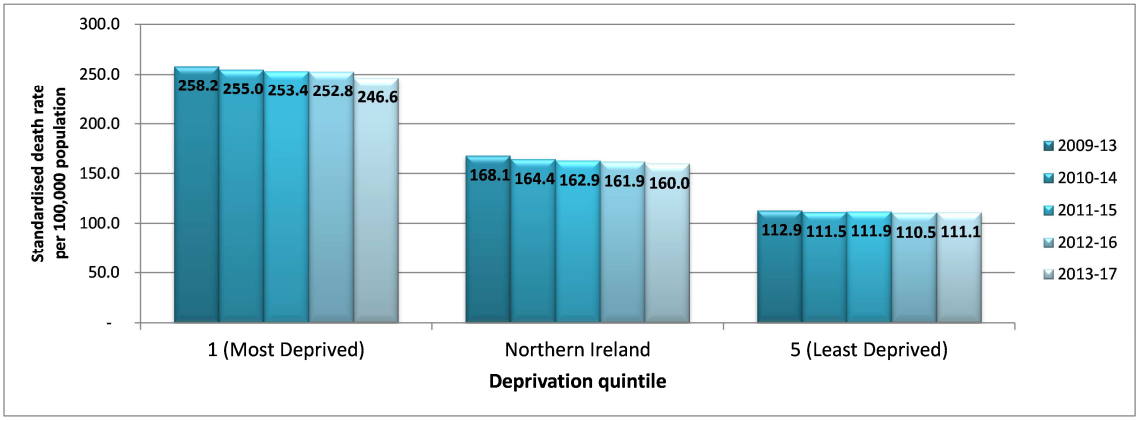
1 in 6 of all deaths

7 deaths per day

Produced by: Health Intelligence, PHA

In Northern Ireland during the five year period of 2013-2017 the standardised death rate for smoking specific mortality was 160 per 100,000 population. This smoking indicator continues to highlight sizeable health inequalities in NI, with smoking related mortality in the most deprived areas being approximately two times that observed in the least deprived areas (246.6 and 111.1 respectively). However, the inequality gap for smoking related mortality remains consistent across the various time periods (Figure 1.3).[6]

Figure 1.3: Standardised death rate from smoking related causes by most and least deprived quintiles and at NI level 2009-13 to 2013-17



The cost of smoking has a high economic impact on our health service with the hospital cost of treating smoking related illnesses in Northern Ireland being in the region of £164m each year.[7,8]

E-cigarettes

The use of e-cigarettes is often seen as an aid to help smokers to reduce or quit their use of tobacco. In 2017/18, 8% of adults aged 16 and over currently use e-cigarettes,[1] equating to approximately 118,412 people. The proportion of adults currently using e-cigarettes has observed a 2 percentage point increase from that in 2016/17 (6%).

It is important to note that in 2017/18, 16 % of adult smokers also currently use e-cigarettes. 19% of ex-smokers currently use e-cigarettes, a figure which exceeds the current proportion of adults currently smoking. Also 2% of adults, who had never regularly smoked tobacco, had used e-cigarettes.[1]

1 in 6 smokers use e-cigarettes

1 in 5 ex-smokers use e-cigarettes

2% of adults who have never regularly smoked, currently use e-cigarettes

Produced by: Health Intelligence, PHA

In a recent NI study, it is estimated that 20% of pupils aged 11-16 have ever used an e-cigarette. At the time of the study, boys were more likely than girls to have reported having recently used an e-cigarette, with 7% of boys compared to 4% of girls self-reporting that they had used an e-cigarette in the last week.[9]

1 in 5 young people aged 11-16 have ever used an e-cigarette

Produced by: Health Intelligence, PHA

2 Northern Ireland Tobacco Control Strategy 2012-2020

In February 2012, the Department of Health, Social Services and Public Safety for Northern Ireland (DHSSPSNI), now called the Department of Health, launched the Ten Year Tobacco Control Strategy for Northern Ireland.[2] The overall aim of the strategy is to create a tobacco free society by encouraging fewer people to start smoking; encouraging more smokers to quit and offering greater protection from tobacco-related harm.

The Public Health Agency (PHA) lead on the implementation of the ten year tobacco control strategy for Northern Ireland. To facilitate this role the PHA have set up a multi-sectorial strategy implementation of the tobacco strategy via five main work streams:

- Research & Information;
- Protection & Enforcement;
- Services & Brief Intervention;
- Communication & Education;
- Policy & Legislation.

Core to the strategy implementation process is the use of the MPOWER package developed by the World Health Organisation (WHO): Framework Convention on Tobacco Control.[10] The WHO package has been specifically developed to '*assist in the country-level implementation of effe3ctive interventions to reduce the demand for tobacco'*.

There are six main components of the MPOWER package:

Monitor tobacco use;
Protect people from tobacco smoke;
Offer help to stop smoking;
Warn about the dangers of smoking;
Enforce bans on tobacco advertising and promotion;
Raise taxes on tobacco products.

While the Tobacco Control Strategy for NI has an overall aim of creating a tobacco free society, the strategy identifies a number of priority groups within the overall smoking population; children and young people (aged 11-16); disadvantaged people who smoke (routine and manual workers); and pregnant women, and their partners, who smoke.[2] Furthermore, the strategy has set specific targets for reducing prevalence within these key priority groups by 2020:

- 11-16 years who smoke; target, 3% (previous prevalence: 8% at strategy onset);[2]
- Routine and manual workers who smoke: target, 20% (previous prevalence: 31% at strategy onset);[2]
- Pregnant women who smoke: target, 9% (previous prevalence: 15% at strategy onset).[2]

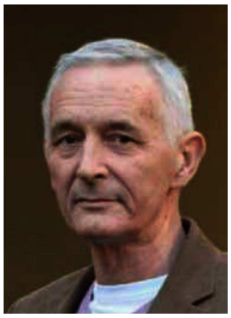
This PHA tobacco control report outlines a number of the regional programmes and services implemented by the Public Health Agency in 2016/17 and the associated impact of these strategies in tackling tobacco in Northern Ireland in regard to the Protect, Offer, Warn and Enforce elements of the MPOWER model.

3 Public Information Campaigns

A review conducted by the US National Cancer Institute established that well-funded campaigns can reduce smoking prevalence with levels of reduction being highly associated to levels of media expenditure.[11] Owing to the scale of this evidence, the National Institute for Health and Care Excellence (NICE) recommends that, as part of tobacco control measures, mass media campaigns should be used and aimed at the general population.[12]

3.1 Public Health Agency anti-tobacco mass media campaign

The PHA's anti-tobacco information campaign featuring Gerry Collins continued to run during May and June 2017. Media advertising comprised of television, radio, video on demand, press, outdoor and digital.



NICE guidance specifies that both regional and national smoking public education and communications should use both 'why' and 'how to' quit messages that are empathetic, respectful and non-judgemental.

The campaign was based on a 2-strand approach featuring two key messages depicting 'Why' and 'How to quit', in accordance with NICE guidelines.[12] The 'Why' message: **I in every 2 smokers will die of a tobacco related disease** was designed to motivate smokers to make a quit attempt and to raise awareness of the serious impact that smoking has not only on the smoker themselves but also their family, friends and loved ones.

The 'How to quit' message: **You can quit. We can help. Visit your local pharmacy or want2stop.info** was a call to action message directing smokers towards local pharmacy stop smoking services and to the PHA website for further information on quitting smoking.

Due to a reduction in campaign funding, no further mass media smoking campaigns were aired throughout July - March 2017/18. However, as one of the current challenges is the decline in numbers of smokers accessing Stop Smoking Services, the PHA took the opportunity to engage with Pharmacy based providers (our largest provider of services) to look at innovative and creative ways in which to promote and increase uptake of their services.

3.2 Promoting pharmacy stop smoking services

Pharmacists were invited to take part in an online survey to share their views and ideas on how their services could be promoted in the future. Overall, 112 pharmacists completed the survey. Pharmacists were asked a variety of questions regarding how they currently recruit smokers; methods used to promote their service; and ways to promote and improve existing services.

Results

The most common method by which smokers were recruited was when a client made a direct enquiry about accessing the service (91%), followed by word of mouth/recommendation from someone who had used the service (88%).

The most common methods used to promote and make customers aware that a stop smoking service is available within their pharmacy was posters (88%), followed by staff talking with customers about the service (80%).

When asked if they would be interested in a marketing pack which the PHA was considering to develop, the vast majority (97%) of pharmacists indicated that they were interested in receiving this pack. Pharmacists were also asked what material would be of interest to them within this pack, with the majority stating that posters (85%) would be useful, followed by leaflets (80%) and window stickers (80%).

Pharmacists were also asked what ideas and materials they would deem to be useful for future promotion. 42% of pharmacists gave comment. Common themes emerged which are detailed in Figure 3.1.3 below. It is important to note that pharmacists' contributed to more than one theme, therefore percentages do not add up to 100.

Figure 3.2.1: Common ideas and materials for future promotion

	Theme		Examples
	Intrinsic and extrinsic motivators/ promoters	37.8%	- Intrinsic: self-assessment, apps, calendars or promotion of health benefits (e.g. via leaflets) - Extrinsic: money boxes/ wealth cards or break down of costs.
	Improved referral/ recruitment channels	31.1%	- Improved referral from GPs/ healthcare professionals, e.g. via promotion in GP surgeries or increased GP awareness that pharmacies provide services. - Health promotion/ workplace events.
	Social media/ video promotion	26.7%	- Videos or videos shared on social media platforms, e.g. to promote the service or to highlight health effects/ benefits
	Eye-catching displays/ large window displays or leaflets	20%	- Full window or large (A3/ A2) window display - Leaflets or flyers - Marketing materials such as large props (e.g. giant ashtray) or badges/ logos
	Media campaign (directing to pharmacies)	15.6%	- Television, Radio or newspaper advertising/ media campaign. N.B.: Directing to pharmacies.
	Visuals props or models	15.6%	- Props or models focusing on the impact of smoking, e.g. lung and heart models

The vast majority (90%) of pharmacists were interested in providing a quit kit to clients who registered with the Stop Smoking Service within their pharmacy.

Ideas for improvement

81% of pharmacists gave comment in relation to ways in which the current services could be improved upon. Common themes which emerged are:

Overall, increasing the flexibility of service delivery was the most common recommendation made to improve the service (Table 3.2.1).

Table 3.2.1: Broad themes and subthemes regarding ideas for improvement

Broad themes	Subthemes	% within broad theme	% of total comments
1. Changes to management/ delivery of stop smoking service	Increased flexibility of service delivery	33.0	22.0
	Allow pharmacists to prescribe Champix	21.2	15.4
	Capitalise on technology	16.7	12.1
	Guidelines or policy on vaping	15.2	11.0
	Improved information/ equipment/ branding	14.0	9.9
	Alternative approaches to aid quitters	14.0	9.9
	Delivery of service by other staff	7.6	5.5
2. Improve or increase promotion	Integrated approach from GPs/ HCPs regarding referrals	51.4	19.8
	Range of promotional mediums or increase/improve promotion	45.7	17.6
	Promotion of health benefits or potential risks of vaping	14.3	5.5
3.	Increase incentive for service users	100	8.8

3.3 No Smoking Day campaign

No Smoking Day (NSD) usually falls on the second Wednesday in March each year, with 14th March being the 35th annual No Smoking Day within Northern Ireland. A number of events took place to support NSD:

- Two stop smoking service provider events with Dr Alan Curley being the key speaker for 'Motivating Smokers to Quit!' were held during February 2018.
- Social media graphics and videos were developed to encourage partners to retweet and reuse.
- The PHA supported NSD mobilisation events with Health Living Centres (HLC) across NI including HLC Award for NSD Organiser of the Year.
- Redesigned PHA Quit Kits were provided to a number of Stop Smoking service providers for NSD display purposes and registering interest.
- A pilot was also carried out with 25 pharmacies across Northern Ireland in partnership with HSCB and CPNI. These pharmacies received an enhanced marketing pack with window display and promotional items.
- 3 Champion Quitters were selected to feature in posters, media and displays. A celebration event was held in Derg Valley Healthy Living Centre within the Western Trust to celebrate the achievements of these three champion quitters.
- Promotion of NSD to All Party Group on Cancer through joint presentation with Cancer Focus.
- Distribution of NSD promotional resources were distributed across the 5 Health & Social Care Trust (HSCT) areas to support Trusts to deliver events and displays.
- Posters were circulated to all NI GP practices, Pharmacies, Dental Practices, Optometrists, HLCs, HSCT and NSD committee members and ASH Committee members.

4 Educational and campaign support materials (MPower: WARN and OFFER)

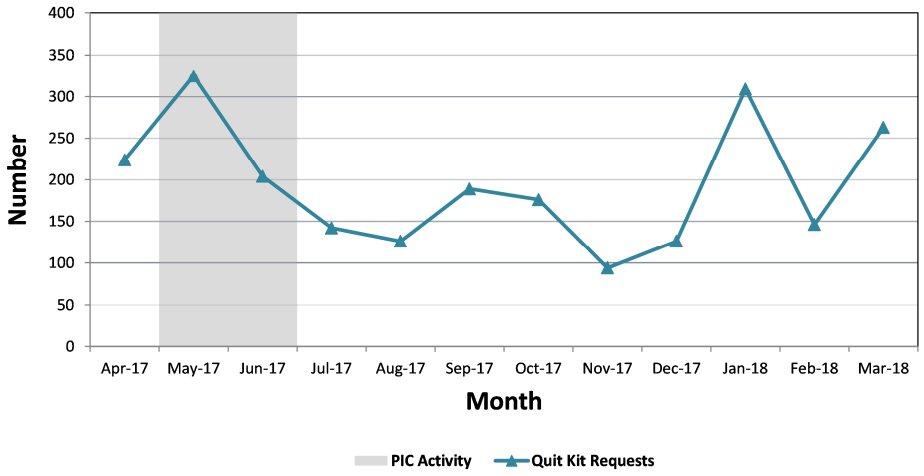
While mass media campaigns aim to motivate smokers to quit, a further aim of the PHA is to encourage people who wish to give up smoking to utilise a method that is best suited to the individual. The PHA offer a variety of educational and campaign support materials to provide information on the dangers of smoking and the health benefits of quitting. These resources also provide tips and advice on how to quit and to signpost smokers to support services which provide counselling and pharmacotherapy support.

4.1 The Quit Kit

A new and improved Quit Kit was launched in 2016. This kit was developed with the help of smokers and ex-smokers and includes practical tools and tips to help people stop smoking, especially those who would prefer a self-help approach (going 'cold turkey') rather than using conventional support. This resource is available to residents of Northern Ireland who wish to quit smoking or stay quit and can be ordered from the PHA stop smoking website (https://www.stopsmokingni). The Quit Kit can also be ordered via Quit Kit registration flyers which are available from health and social care premises, pharmacies, GP practices, libraries and council premises.

In 2017/18 there were 2,324 requests for a quit kit. As evident in Figure 4.1.1, the number of requests was highest during the months the public information campaign was aired and peaked again in January 2018 at a time when smokers may have decided to quit smoking in the New Year.

Figure 4.1.1: Monthly Quit Kit uptake and public information campaign activity from April 2017 to March 2018



4.2 Want2Stop website: www.want2stop.info

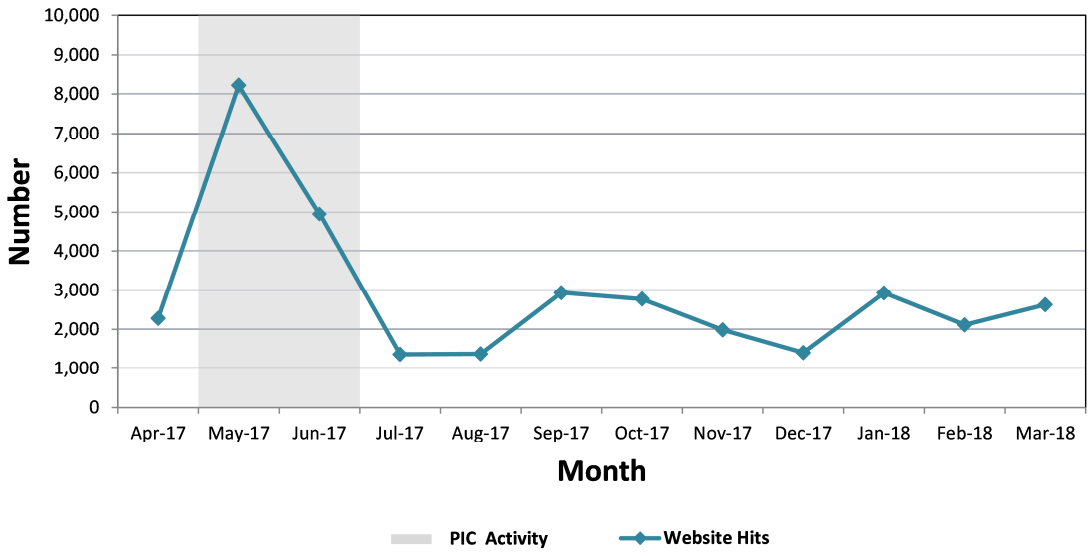
The want2stop website is a one stop repository providing information and advice on tips on how to quit and topics such as:

- Health benefits of stopping smoking
- Cessation aids such as NRT patches, gum, tablets, sprays and inhalers to help support a quit attempt
- Current anti-tobacco public information campaign
- Effects of smoking on your appearance and health
- Dangers of second hand smoke such as 'smoking and pregnancy'
- The workplace 28 day stop smoking challenge
- E-cigarettes

The website signposts the general public to self-help and advice. A number of booklets are available to download such as a guide to stopping smoking and a quit plan. Visitors to the site can watch and listen to video testimonials of inspiring real life stories about how quitting changed their lives for the better. Smokers can also access a directory of PHA commissioned Stop Smoking Services to find support services in their local area.

In 2017/18, the website received 34,932 visits, with the highest number of visits in any one month occurring during the months the public information campaign was aired (Figure 4.2.1).

Figure 4.2.1: Monthly website hits and public information campaign activity from April 2017 to March 2018



4.3 Other education resources

To assist smokers in making a quit attempt, the PHA produces a selection of education resources. These are available through Pharmacies and GP practices, and the PHA website www.publichealth.hscni.net. Figure 4.3.1 displays the variety of leaflets and flyers produced by the PHA to assist and advise smokers.

Figure 4.3.1: Examples of educational resources for smokers

The PHA has also distributed smoke free signs to all primary schools in Northern Ireland to be displayed at the school gates. These signs are aimed to encourage parents and carers to refrain from smoking near school gates to help protect their children from the harmful effects of passive smoking. This initiative aims to:

- Reduce the amount of smoking the children are exposed to, thus 'denormalising' smoking;
- Support the 'No Smoking' messages that pupils are taught n lessons;
- Create a positive 'smoke free' image for the school and its pupils;
- Empower parents to speak up about smoke around their children;
- Reduce smoking-related litter around school premises.

4.4 Regional childhood tobacco prevention programme

The PHA once again commissioned Cancer Focus NI (CFNI) to deliver the SmokeBusters programme during the 2017/18 school year, with the programme finishing in May 2018. The programme is specifically tailored for primary school children in Year 6 and Year 7 (9-11 year olds) and is delivered by both CFNI and by teachers directly.

The programme aims to:

- **Encourage children to reject the smoking habit by increasing their defences against pressure to experiment with cigarettes;**
- **Provide a means of conveying information to children about the harmful consequences of smoking;**
- **Promote 'fun' ways of involving children in activities to promote a smoke free environment in their schools, homes and communities.**

In total, 239 schools registered to participate in the programme during 2017/18, a reach of approximately 29% of all primary schools throughout NI. 2017/18 observed a considerable decline in the number of schools registered with the programme compared to 601 schools registered in 2016/17.

Of all primary schools in NI, 148 are located within the top 20% most deprived areas. Of the 239 schools registered with SmokeBusters in 2017/18, 50 were in the top 20% most deprived areas, reaching 34% of all schools, a shortfall from their target of 50% of all schools in areas of deprivation. The reason for the gap in schools participating is not yet known.

Overall, the programme was delivered to 15,397 children, exceeding the annual target of 6,000 pupils, reaching an estimated 31% of all school children in NI enrolled in Primary 6 and Primary 7 in the 2017/18 school year,. Of these 7,932 were P6 pupils and 7,465 were P7 pupils.

Following a website review, teachers can now enrol in the programme on-line and request resources. It was intended that resources could be downloaded directly from the website but due to copyright issues, an additional step to authenticate the teacher has been added, therefore resources can only be requested from registered teachers.

5 Brief Intervention (MPower:OFFER)

The main purpose of a brief intervention is to trigger a quit attempt and signpost the individual to a support service. It is an approach that can be used with all smokers regardless of their quitting intentions and is therefore a key tool for health professionals and community workers who may encounter smokers as part of their routine work. The technique used is based on the ASK, ADVISE and ACT scenario outlined in Figure 5.1 below.

Figure 5.1: Very brief advice flow chart

Figure 5.1: Reproduced from local stop smoking services, service delivery guidance 2014. NCSCT, Public Health England[18]

Each year, the five health and social care trusts within NI are commissioned by the PHA to deliver brief intervention training for a range of health professionals and community workers. Overall, 3,726 individuals received brief intervention training during 2017/18. As in previous years, this figure exceeded the annual training target of 2,080.

At least half (1,040) of the annual training target should be composed of a range of professionals who are considered to be in regular contact with smokers or those priority groups identified within the Ten Year Tobacco Strategy.[2] Training is highly recommended for these professionals who include GP's, midwives, specialist nurses, practice nurses, health visitors and looked after children's home staff. However, only 683 of these recommended professionals undertook brief intervention training in 2017/18.

6 Specialist Stop Smoking Services (MPower: OFFER)

A number of national/regional standards and recommendations are set for Stop Smoking Services. The National Institute for Health and Clinical Excellence (NICE) and the Ten Year Tobacco Control Strategy identifies that Stop Smoking Services should aim to reach 5% of the smoking population.[12, 2] Evidence shows combined pharmacotherapy and behavioural interventions to be the most effective mechanism to aid smokers to quit.[13] In line with this evidence and as recommended by NICE the Public Health Agency (PHA) commission specialist Stop Smoking Services.[13, 2]

In Northern Ireland, these services are designed especially for those smokers who are motivated and ready to quit, and who are prepared to set a quit date. Smokers can access services in a range of local settings across NI including pharmacies, GP practices, hospitals and community/voluntary settings. These services offer intensive treatment, over the course of 6-12 weeks, with structured support being available for at least four weeks after the clients quit date. Overall, since 2001/02 the provision of specialist Stop Smoking Service in NI has supported over 270,000 individuals to stop smoking, with over 50% of these clients remaining quit at 4 weeks.

Specialist Stop Smoking Services in NI are monitored centrally using a web based monitoring system. All service providers are required to input details of each individual client they register within the Stop Smoking Services[i]. This web-based system allows the PHA to monitor access to and the effectiveness of services at both a regional and sub-regional level while also allowing each service provider to self-monitor their service uptake and impact.

This section of the report provides an analysis of service uptake and 4 week quitting activity in 2017/18; and service uptake, both 4 and 52 week quitting activity in 2016/17, using data collected from the monitoring system. Data was downloaded on 16th July 2018. All data is correct as of this date unless otherwise specified.

6.1 Service availability and accessibility

Provider type

A total of 584 PHA stop smoking services operated in 2017/18, and as observed in previous years there has been a steady decline in service provision since its peak of 665 providers in 2013/14. 2017/18 observed a 5% drop in numbers from 2016/17 (n=613). The 584 services comprised of 61 GP providers, 447 pharmacies, 62 community providers and 14 hospital providers. Consistent with previous years, pharmacies delivered the highest proportion of services (76.5%) (Figure 6.1.1).

The number of GP providers continues to fall and, as in the previous year, there was a considerable decrease (-20%) in the number of GPs delivering the service in 2017/18 from 2016/17.

[i] Only those clients who are motivated to quit and ready to set a quit date may be registered with the Stop Smoking Services. Clients may not be unique and may use the service twice in any financial year.

Figure 6.1.1: Total number of service providers by provider type 2015/16 – 2017/18

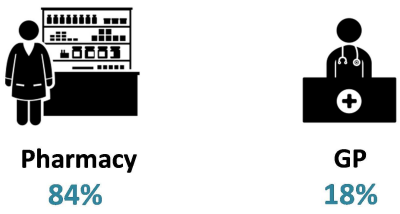
Provider Type	Number of providers 2017/18 (n,%)	Number of providers 2016/17 (n,%)	Number of providers 2015/16 (n,%)
Pharmacy	447 (77%)	456 (74%)	467 (73%)
GP	61 (10%)	76 (12%)	101 (16%)
Hospital sites	14 (2%)	15 (2%)	15 (2%)
Community^	62 (11%)	66 (11%)	61 (10%)
Total	584	613	640

^Includes schools and workplaces

Produced by: Health Intelligence, PHA

Service provision and accessibility

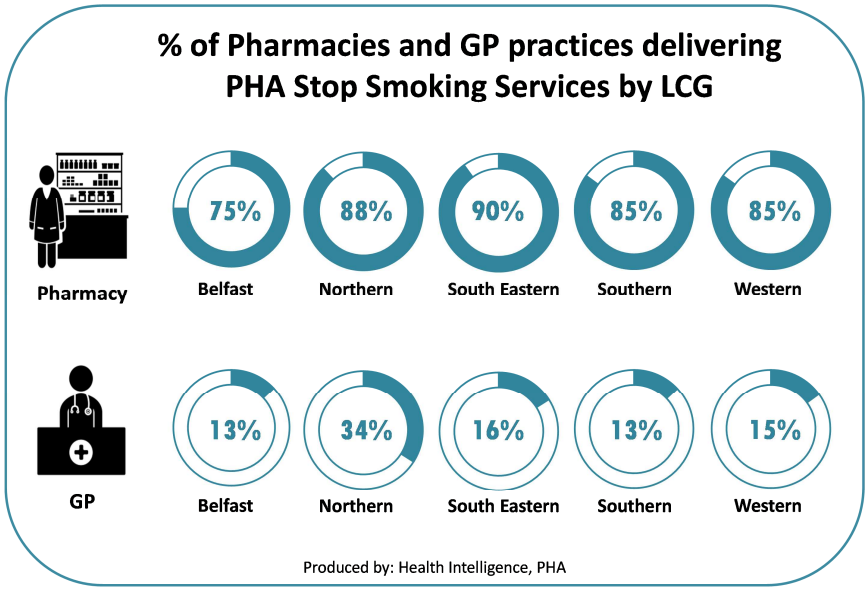
In general, 84% of pharmacies and 18% of GP practices within Northern Ireland were registered to deliver the PHA Stop Smoking Service during 2017/18.



The number of pharmacies registered to deliver the service in 17/18 varied across Local Commissioning Group (LCG) area. South Eastern LCG had the highest number of pharmacies registered to deliver the service (90%) compared to Belfast LCG with the lowest number of pharmacies registered (75%).

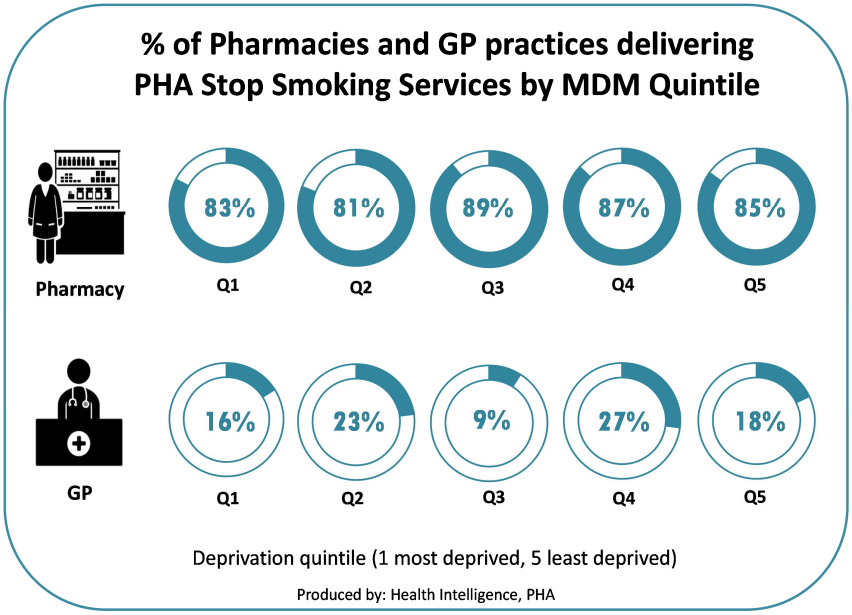
The proportion of GP practices delivering PHA Stop Smoking Services ranged from between 34% in the Northern LCG area to 13% in both the Southern and Belfast LCG areas (Please refer to Figure 6.1.2).

Figure 6.1.2: Proportion of all Pharmacy and GP practices in NI delivering PHA Stop Smoking Services within each LCG area 2017/18



On further analysis of both Pharmacy and GP data, there was variation in the proportion of Pharmacies delivering PHA Stop Smoking Services by MDM Quintile, which ranged from 81% in Quintile 2 to 89% in Quintile 3. There was a noticeable difference in the proportion of GP practices delivering these services across MDM Quintiles. Quintile 3 had the lowest proportion of GP delivering services (9%) compared to 27% in Quintile 4 (Figure 6.1.3).

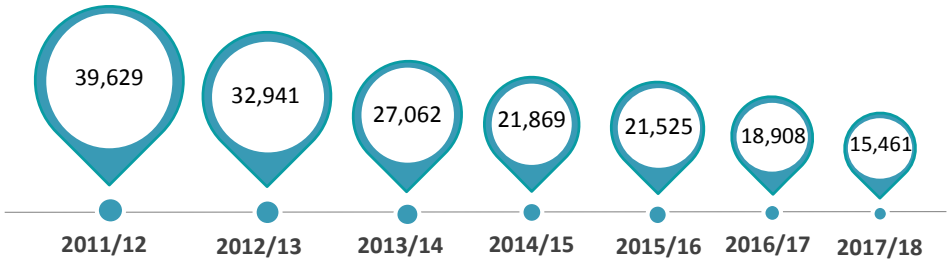
Figure 6.1.3: Proportion of all Pharmacy and GP practices in NI delivering PHA Stop Smoking Services within each MDM Quintile 2017/18



6.2 Service uptake and reach

In 2017/18, the PHA Stop Smoking Services were delivered to 15,461individuals, with the uptake of services falling for the 6th consecutive year. This represents a 18% decrease from 2016/17 and a 61% decrease since 2011/12 when numbers of those attempting to quit through our services reached their peak (Figure 6.2.1). This decline in numbers is likely to be the result of a combination of factors and may be partly due to the increased use of e-cigarettes which are widely available outside of these services, and for some smokers it may be a step towards quitting smoking. This trend in decline of uptake may also be due to a continuing decrease in the overall numbers of people smoking in NI. Due to this reduction in numbers the uptake figure did not exceed the 4% year on year target increase for Stop Smoking Services as outlined in the Tobacco Strategy.[2]

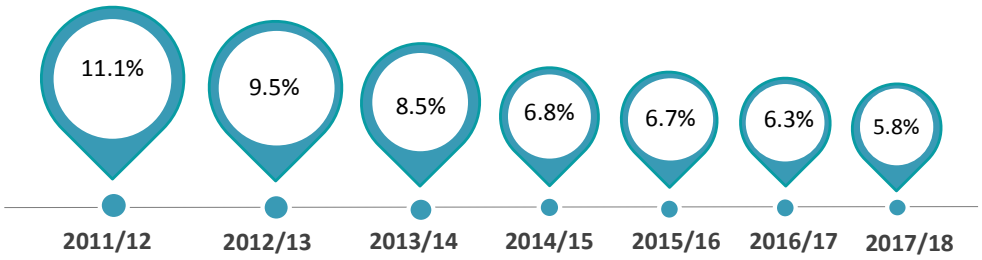
Figure 6.2.1: Uptake of Stop Smoking Services 2011/12 – 2017/18 (n)



This pattern of decline in uptake of services has also been observed in other regions of the UK, with England having an 11% decline in numbers, and Scotland seeing a 7.4% decline in uptake over the same time period. However, Wales observed a small increase of 0.2% in 2017/18 compared to a 7.3% increase in 2016/17.[14-16]

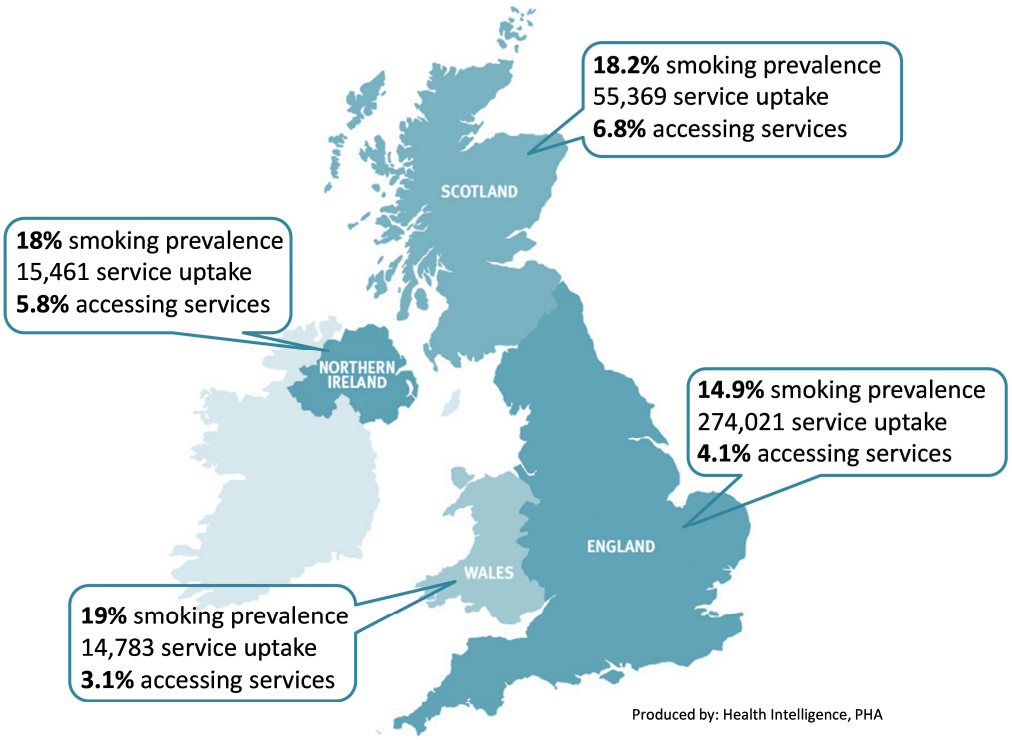
5.8% of all smokers within NI engaged with services in 2017/18, a decline of 0.5% from 2016/17. Trends show that there has been a steady decline in the estimated proportion of smokers accessing the service which is in line with the decreased service uptake over the same time period (Figure 6.2.2). The service reach figure surpassed the 5% access reach as recommended within NICE guidelines and the Tobacco Control Strategy.[12,2]

Figure 6.2.2: Estimated proportion of all NI smokers accessing Stop Smoking Services 2011/12 – 2017/18 (%)



Service reach compared favourably with the rest of the UK, with Scotland demonstrating the highest reach with 6.8% followed by NI with 5.8%. In comparison, Figure 6.2.3 shows that Stop Smoking Services in England reached 4.1% of all smokers and the services in Wales reached 3.1% of their smoking population.

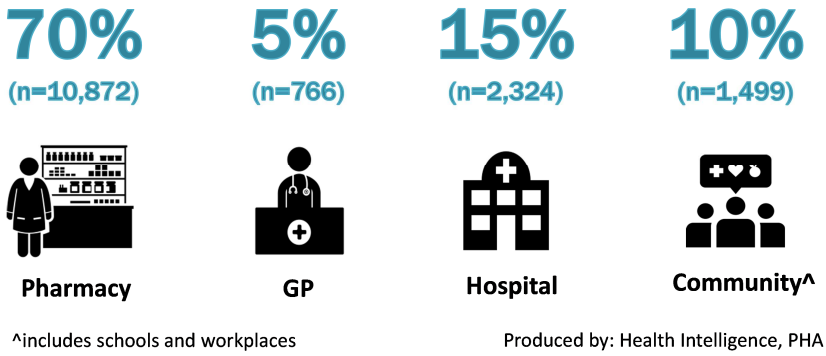
Figure 6.2.3: Stop smoking services uptake and reach by UK regions 2017/18[14-19]



NB: Smoking prevalence for England is based on a population of those aged 18+ , whereas the rest of the UK prevalence rates are based on a population of those aged 16+.

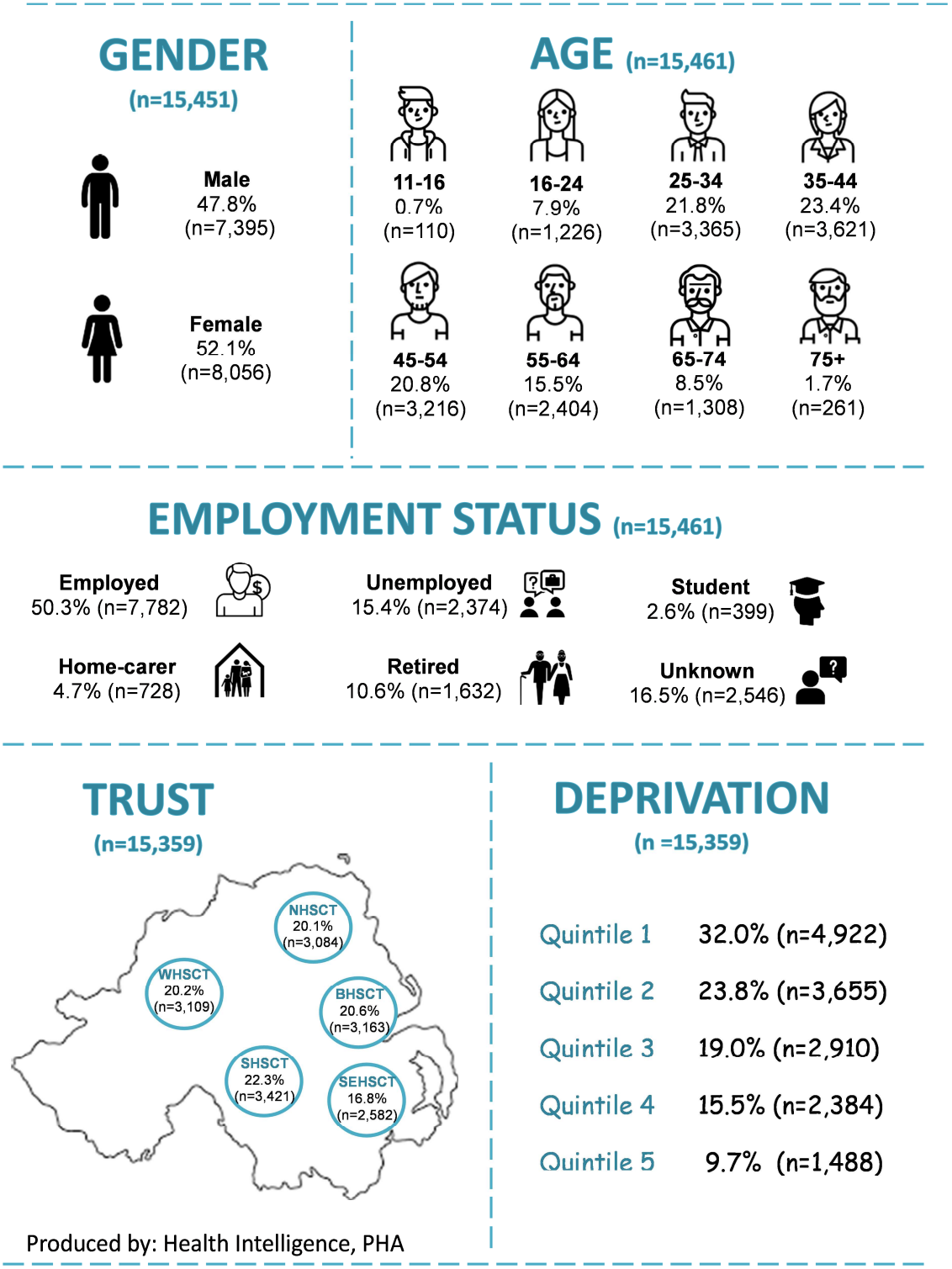
Of the clients registered with the PHA Stop Smoking Services in 2017/18, the majority (10,872) were registered with a pharmacy service, 766 with a GP service, 2,324 with a hospital service and 1,499 with community services (Figure 6.2.4).

Figure 6.2.4: Uptake of Stop Smoking Services by Provider Type 2017/18 (%)



6.3 Profile of NI Stop Smoking Service Users

Figure 6.3.1: Client demographics 2017/18



Gender

As in previous years, more females than males aged 16 and over registered with the Stop Smoking Services in 2017/18 (Figure 6.3.2). The uptake of services by both males and females continues to fall for the 6th consecutive year. This represents an 18% decline in adult males and a 19% decline in adult females accessing the service from 2016/17.

The proportion of all adult male and female smokers accessing services observed a decrease in 2017/18 from that in 2016/17, with the proportion of all adult male smokers decreasing from 6.1% to 5.1% and the proportion of all female smokers decreasing from 6.8% to 5.9%.

Figure 6.3.2: The gender profile of adult (age 16+) stop smoking service users 2017/18[ii]

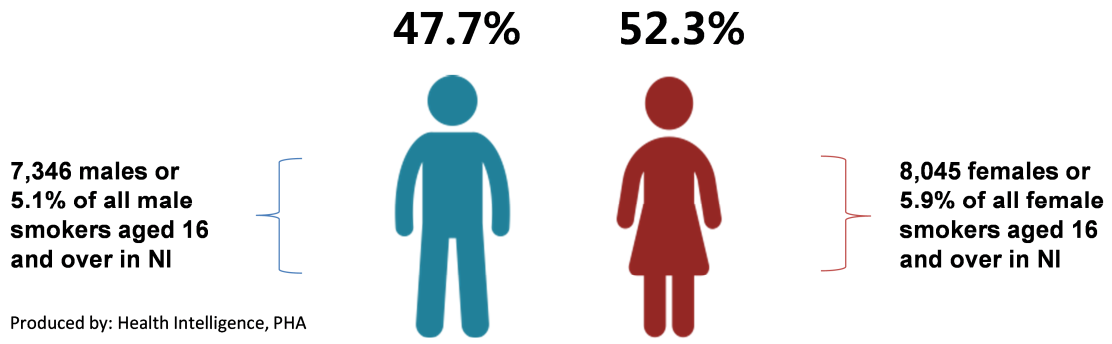
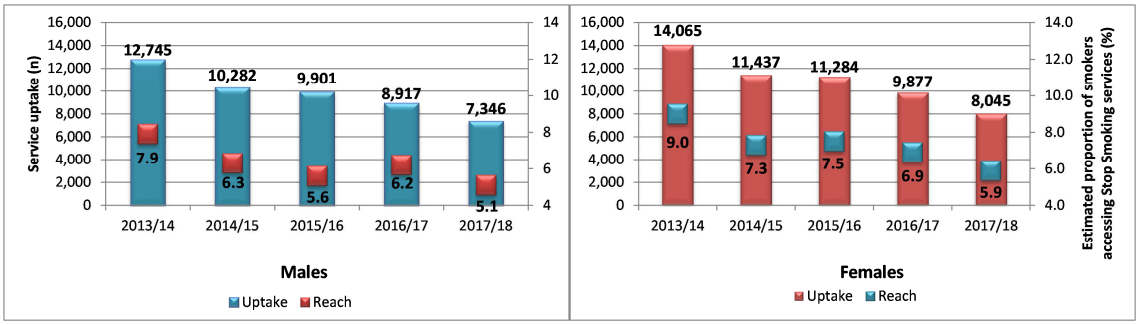


Table 6.3.1: The uptake and reach of Stop Smoking Services by gender 2013/14 to 2017/18



[ii] 10 individuals aged 16 or over did not report on gender.

Age-groups

As shown in Figure 6.3.3, the greatest service uptake was observed in the 35-44 year old age group (23.4%) followed by the 25-34 age group (21.8%). The lowest level of uptake was observed in the 11-16 age group (0.7%) followed by the 75 and over age group (1.7%).

Figure 6.3.3 also shows the estimated proportion of smokers within each age group who accessed stop smoking services in 17/18. These estimated proportions ranged from 2% of all smokers aged 11-16 to 7.2% of those aged 35-44. Estimated access to services steadily increased from the younger age-groups to a peak among those aged 35-44 and then decreased steadily with age.

Figure 6.3.3: Age profile of adult stop smoking service users and reach 2017/18

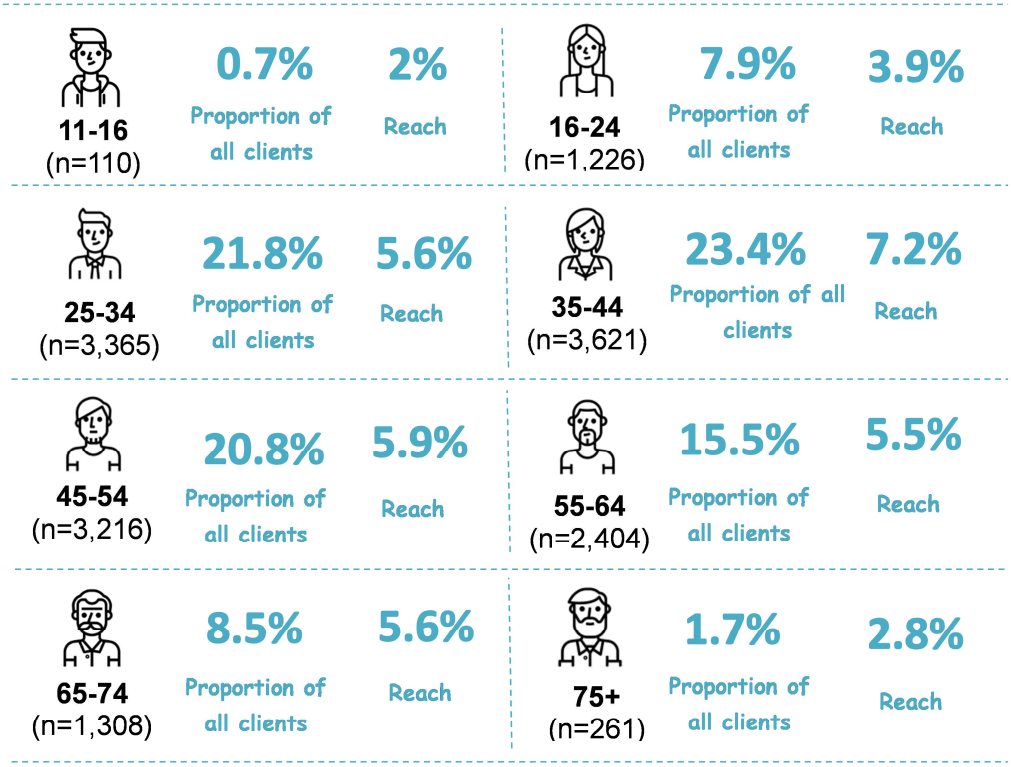


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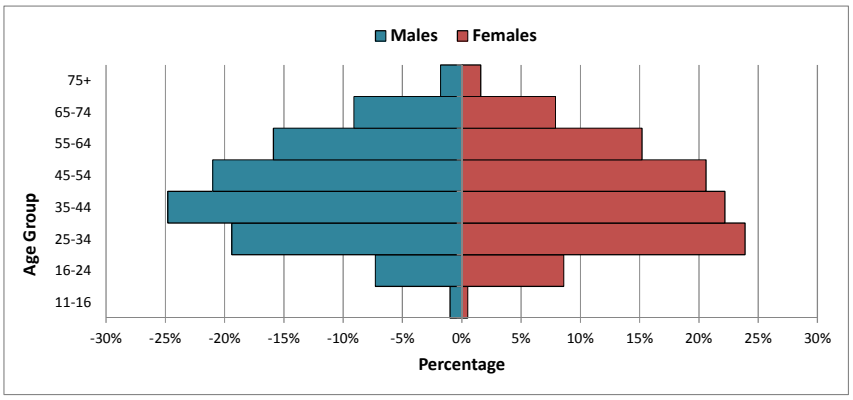
Figure 6.3.4 highlights that there was a noticeable difference in the uptake of services by age-group and gender. The uptake of services by female smokers was greatest in the 25-34 age category (23.9%) whereas the uptake by male smokers was greatest in the 35-44 age category. Overall, as in the previous year, both male and female smokers aged 25-54 were more likely to access stop smoking services than those in other age-groups.

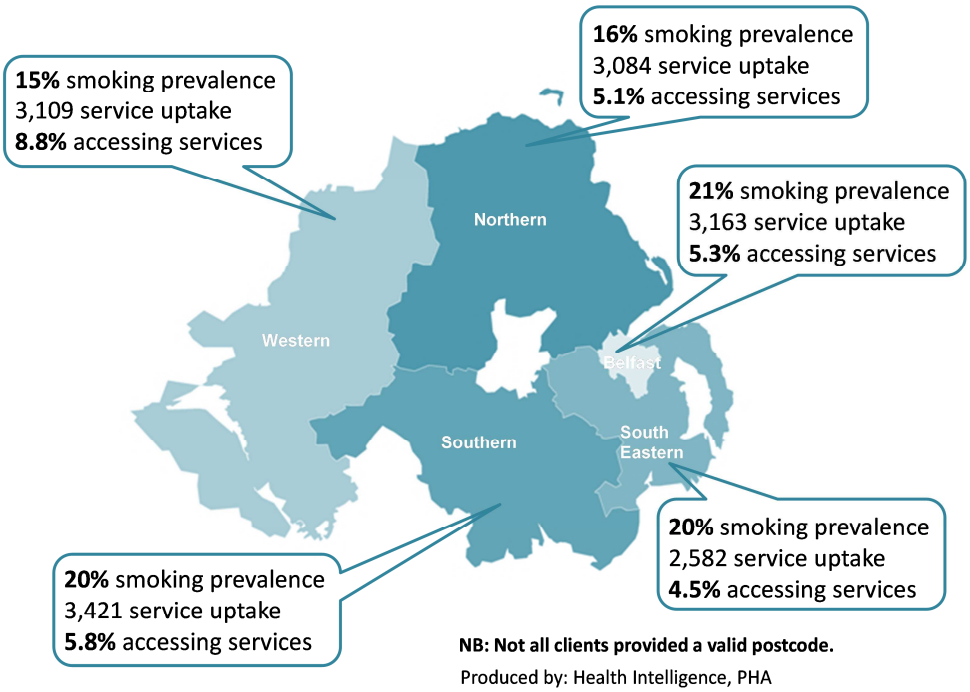
Figure 6.3.4: Age profile of adult stop smoking service users by Gender 2017/18



Local geography

As in the previous year, smoking prevalence and reach of smokers accessing services varied by Local Commissioning Group (LCG) ranging from the lowest rate of 15% within the Western LCG to the highest rate of 21% within Belfast LCG. Although, smoking prevalence decreased across four LCGs from that in 2016/17, the South Eastern LCG saw a 4% increase in prevalence from 16% to 20%. The greatest reach of smokers accessing services was in the Western LCG with a reach of 8.8% compared to the lowest reach of 4.5% within Belfast LCG (Figure 6.3.5).

Figure 6.3.5: Stop smoking services uptake and reach by Local Commissioning Group 2017/18[1]



NB: Not all clients provided a valid postcode.

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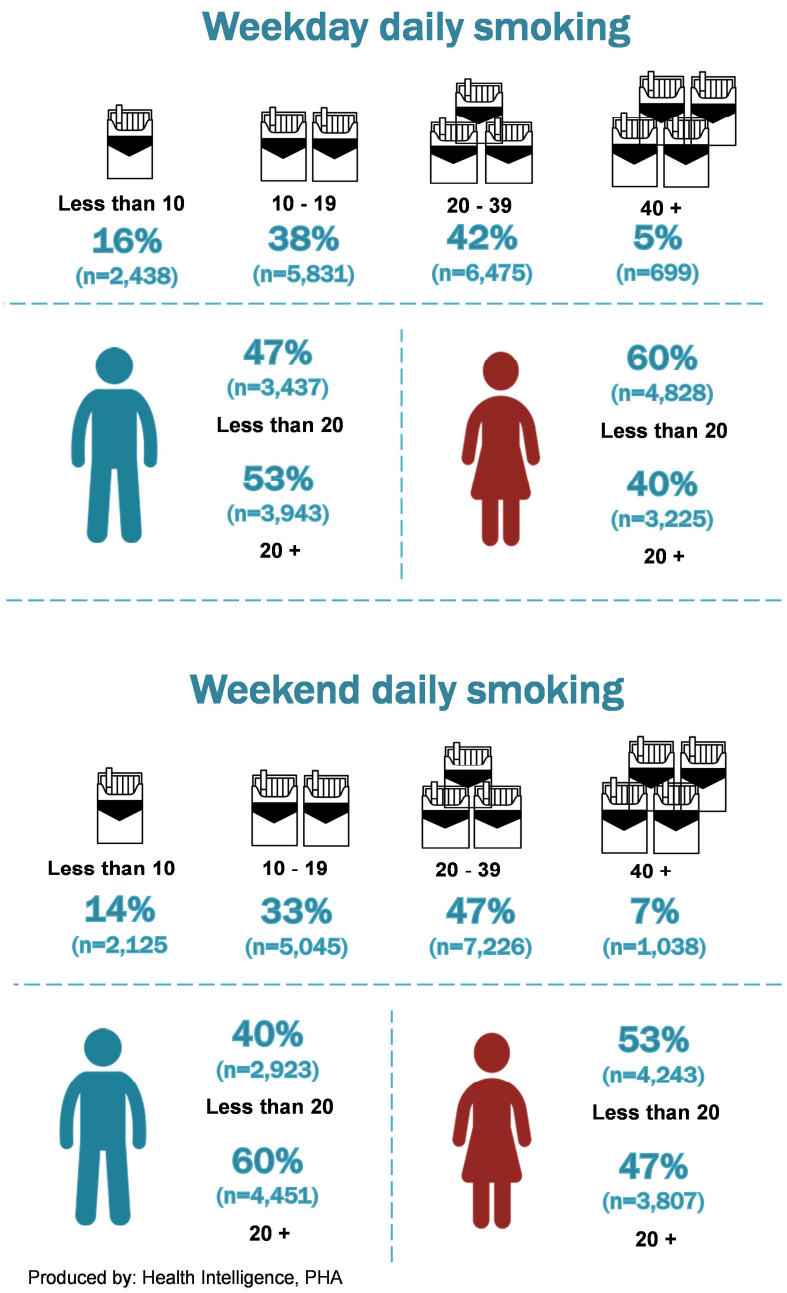
Tobacco Consumption

Figure 6.3.6 illustrates that the majority of smokers accessing services smoked on average 20-39 cigarettes each weekday or weekend day (42% and 47% respectively). Females were more likely to be lighter smokers both on a weekday or a weekend day than males with 60% of females smoking on average less than 20 cigarettes on a weekday compared to 47% of males; and 53% on a weekend day compared to 40% of males (Figure 6.3.6).

Figure 6.3.6: Daily tobacco consumption 2017/18



The majority (78%) indicated that they smoked the same amount of cigarettes on weekdays as on weekends, with 20 % smoking more at the weekend, and 2% stating that they smoked less at the weekend.

Type of tobacco smoked

The most common type of tobacco smoked was cigarettes with the majority of clients (99.7%) reporting smoking this product.

Produced by: Health Intelligence, PHA

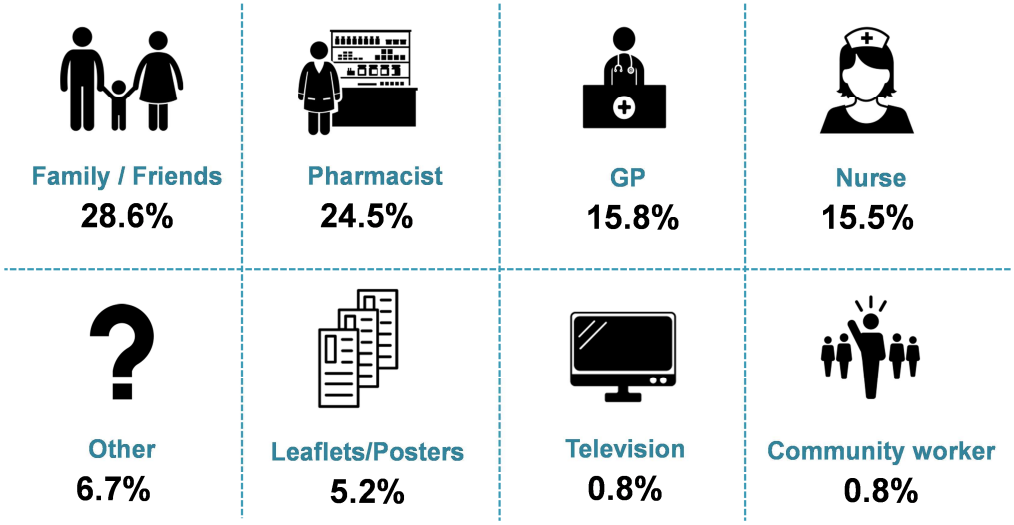
Previously participated in this service

Only 39% of clients had previously participated in a PHA Stop Smoking Service to support them with their quit attempt.

How heard about the service

The most common way in which clients had heard about the service was via family and friends (28.6%) followed by via a pharmacist (24.5%) (Figure 6.3.7).

Figure 6.3.7: How clients heard about the Stop Smoking Service 2017/18

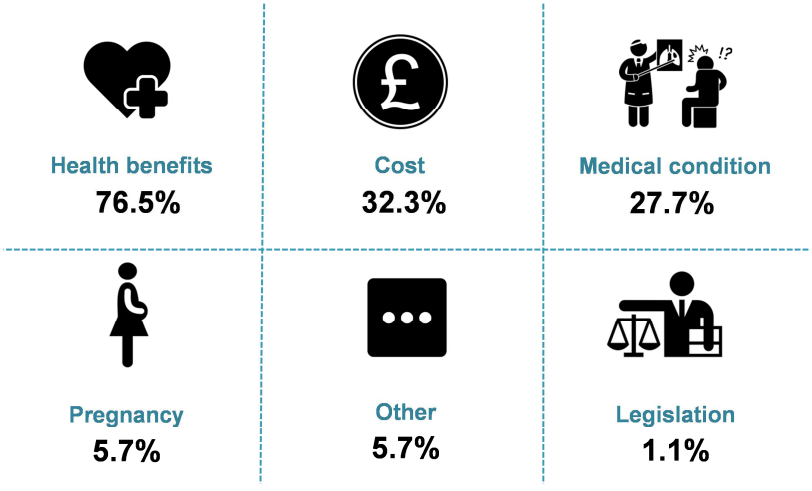


Produced by: Health Intelligence, PHA

Reason for quitting smoking

Figure 6.3.8 illustrates the most common reasons as indicated by service users for quitting smoking, with the majority of service users (76.5%) stating that it was for health benefits, followed by cost (32.3%).

Figure 6.3.8: Reasons for quitting smoking 2017/18 (multiple response)

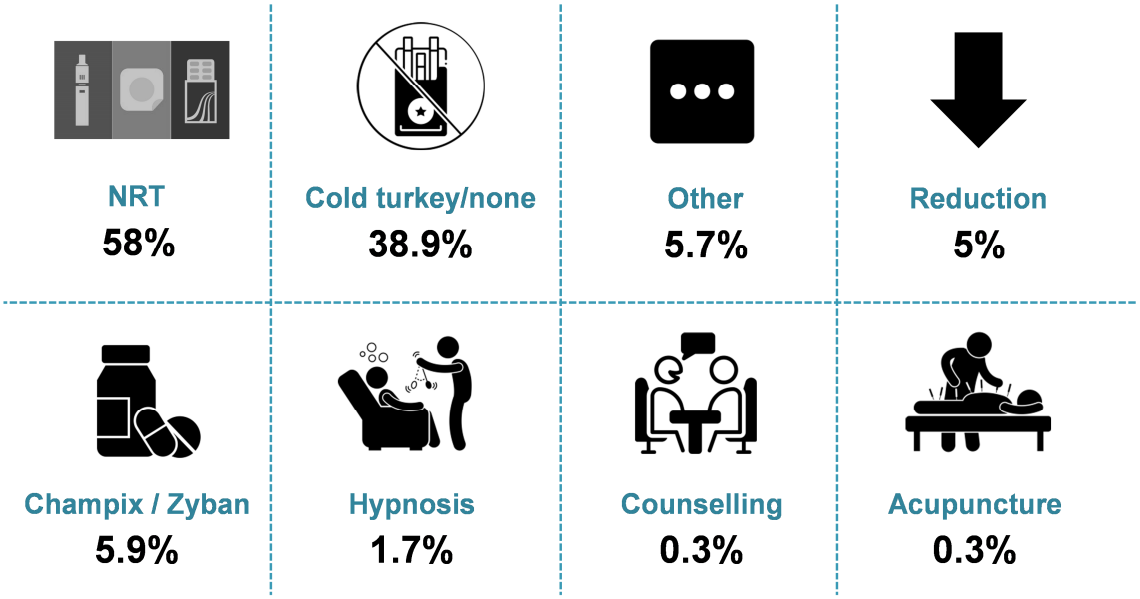


Produced by: Health Intelligence, PHA

Other methods used to give up smoking within the last 3 years

When registering with the service, clients were asked if they had tried to give up smoking using any other methods within the last 3 years. Figure 6.3.9 illustrates that of those service users (14,615) who tried to give up smoking previously, the most common method used was Nicotine Replacement Therapy (NRT) (58%), with 38.9% indicating that they had went cold turkey and/or used no other methods. Service users were less likely to use counselling or acupuncture as a quitting method. It is important to note that some clients used a combination of quitting methods in previous quit attempts.

Figure 6.3.9: Previous quitting methods used (multiple response)

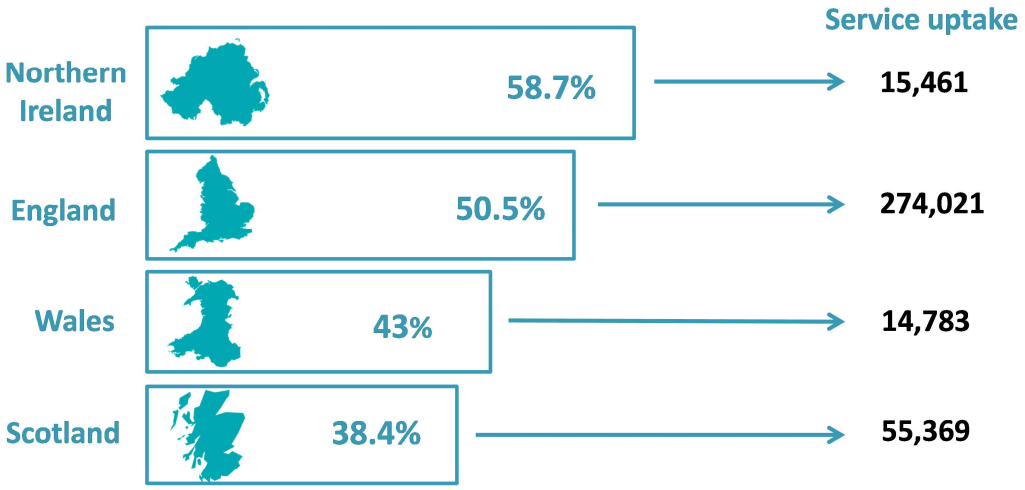


Produced by: Health Intelligence, PHA

6.4 Service effectiveness

The 4 week quit rate in NI has seen a slight decrease from 59.2% in 2016/17 to 58.7%, and remains consistent at around 58% - 59%. As in the previous year, NI has the highest 4 week quit rates when compared to the remainder of the UK, with Scotland remaining to have the lowest quit rate of 38.4% (Figure 6.4.1).

Figure 6.4.1: Four week quit rates and uptake figures within the Stop Smoking Services by UK region 2017/18[14-16]



Produced by: Health Intelligence, PHA

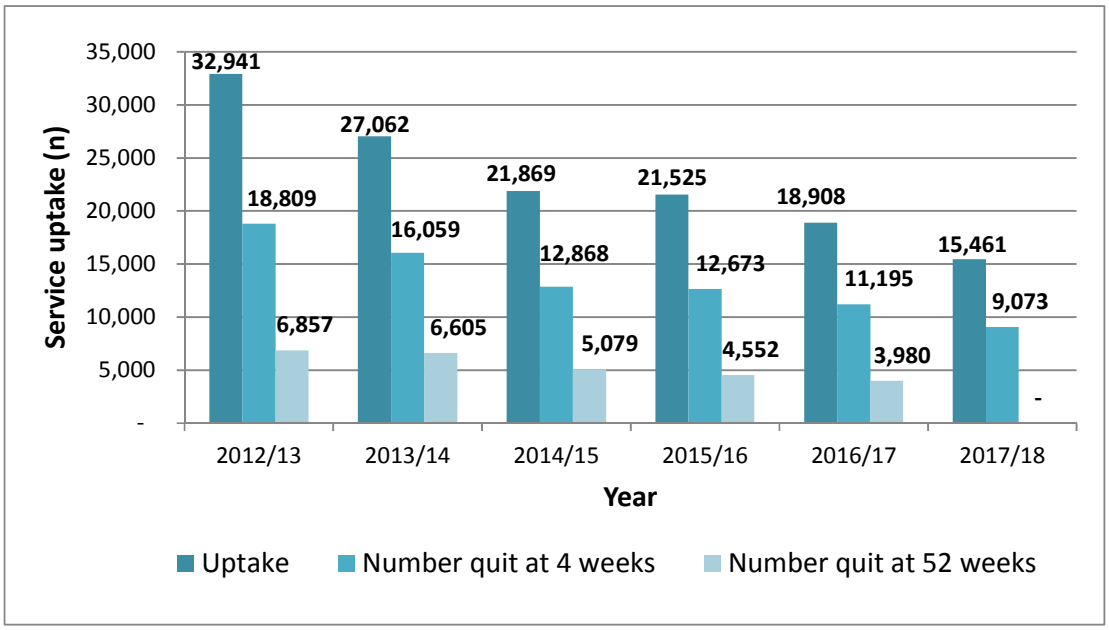
Numbers quit at 4 and 52 weeks

Figure 6.4.2 shows the trends in service uptake and numbers of clients quitting at 4 and 52 weeks over the last six years. In line with the uptake pattern the number of service users quit at 4 and 52 weeks has seen a steady decline in numbers.

As a result of this decline in clients quit at 4 and 52 weeks, the NI service framework target has not been achieved which calls for a 4% year on year increase in the number of clients quit at 4 weeks and a 2% year on year increase in the number of clients quit at 52 weeks.

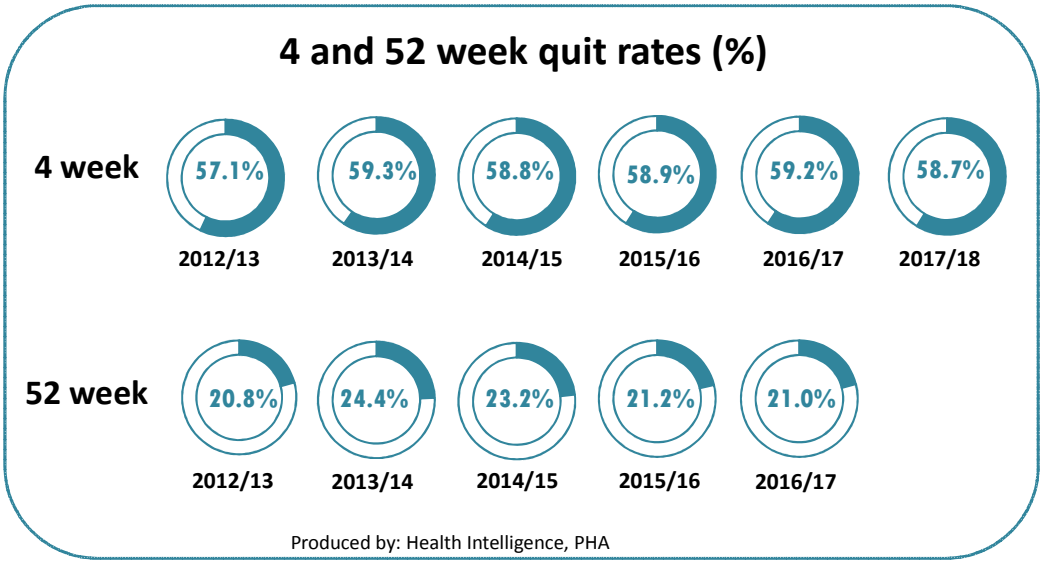
Smoking status at 4 and 52 weeks is ascertained through self-report. In addition carbon monoxide monitoring is utilised at the 4 week stage to verify a successful quit attempt. Of all service users who self-reported being quit a 4 weeks, 75.4% (n=6,840) had a carbon monoxide validation test conducted of which 74.8% verified the clients' non-smoking status. This resulted in an overall validated quit rate of all service users in 2017/18 of 43.9%.

Figure 6.4.2: Number of clients accessing and quitting at 4 and 52 weeks with PHA Stop Smoking Services 2012/13 – 2017/18



Although the most recent data (17/18 and 16/17 respectively) showed the number of clients quitting at 4 weeks and 52 weeks has declined, the actual 4 week and 52 week quit rates have remained relatively stable. 4 week quit rates having remained between 57 and 59 percent over the six year period, and 52 week quit rates remained static at around 21% over the last two years. Please refer to Figure 6.4.3.

Figure 6.4.3: 4 and 52 week quit rates in PHA Stop Smoking Services 2012/13 – 2017/18



Overall, Stop Smoking Services supported an estimated 3.4% of all smokers in NI to quit smoking at 4 weeks, and 1.4% of all smokers to stay quit at 52 weeks.

The estimated proportion of all NI smokers who quit at 4 weeks with Stop Smoking Service fell for the 6th consecutive year, with estimated proportions of all NI smokers staying quit at 52 weeks levelling at 1.4% as in 2016/17 (Figure 6.4.4).

Figure 6.4.4: Estimated proportion of all NI smokers quitting at 4 week and 52 weeks using Stop Smoking Services 2012/13 – 2017/18

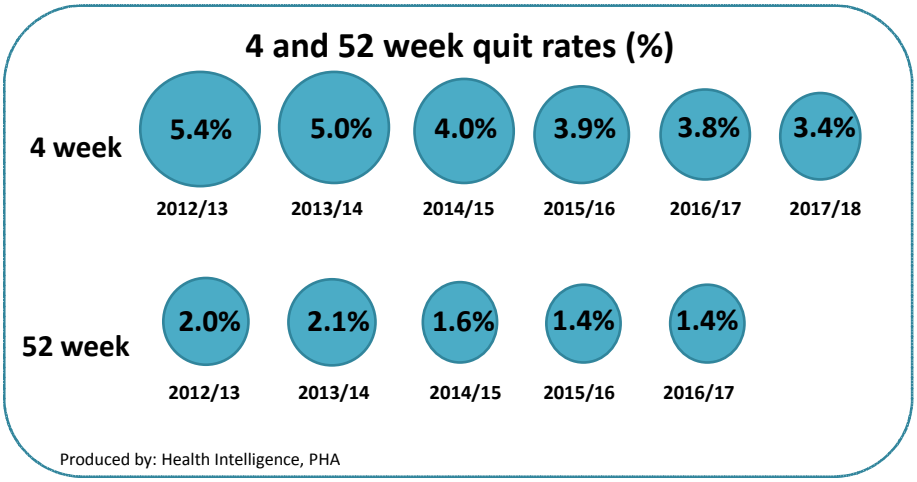
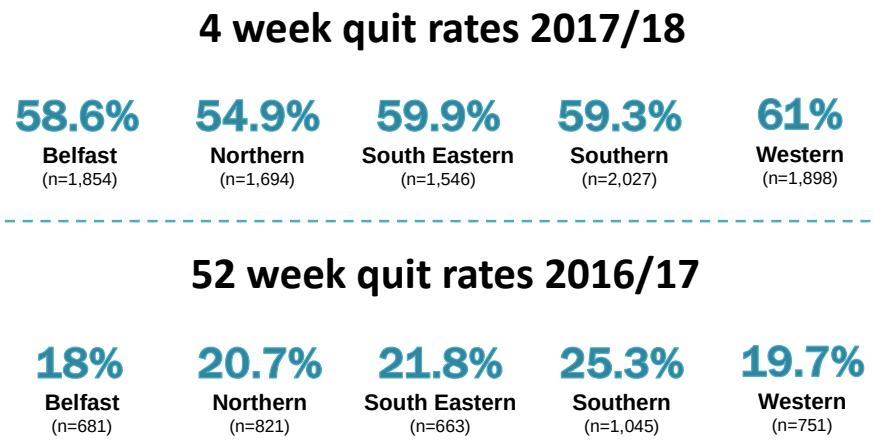


Figure 6.4.5 illustrates that the proportion of clients quitting at 4 and 52 weeks varied considerably by LCG area. Western LCG supported the highest proportion of clients to quit at 4 weeks (61%) compared to the Northern LCG with 54.9%. Southern LCG area had the greatest 52 week quit rates (25.3%) with Belfast LCG having the lowest quit rates (18%).

Figure 6.4.5: 4 week and 52 weeks quit rates by LCG area (%)



Follow up rates

In 2017/18, 18.4% (n=2,842) of all clients registered in the Stop Smoking Services were lost to follow up at 4 weeks as no information was recorded on the outcome of their quit attempt at the 4 week stage. This rate has seen an increase of 2.7 percentage points from that of 15.7% in 2016/17. The number of clients lost to follow up at 4 weeks therefore impacts on the number of clients who can viably be followed up at 52 weeks. Of all clients who had successfully quit at 4 weeks in 2016/17, 38.9% (n=4,351) did not have any information recorded on the outcome of their quit attempt at 52 weeks.

Further analysis by provider type highlighted that GP providers had the highest proportion of clients not followed up at both 4 weeks and 52 weeks (28.9% and 68.1% respectively) followed by pharmacies (21.1% and 66.1% respectively). However, when taken into account only those clients who had successfully quit at 4 weeks who had not been followed up at 52 weeks, pharmacy had the highest proportion of clients not followed up (41.7%). Please refer to Figure 6.4.6.

Figure 6.4.6: Number and percentage of clients not followed up at 4 and 52 weeks by provider type

Provider Type	Clients not followed up at 4 weeks 2017/18	Clients not followed up at 4 weeks 2016/17	Clients not followed up at 52 weeks 2016/17	Clients who had successfully quit at 4 weeks not followed up at 52 weeks 2016/17
Pharmacy	21.1% (2,297)	17.9% (2,375)	66.1% (8,790)	41.7% (3,227)
GP	28.9% (221)	20.9% (242)	68.1% (788)	37.4% (220)
Hospital sites	8.7% (202)	10% (246)	55.3% (1,357)	32.7% (532)
Community^	8.2% (122)	4.9% (98)	56.6% (1,129)	30% (372)
Total	18.4% (2,842)	15.7% (2,961)	63.8% (12,064)	38.9% (4,351)

^Includes schools and workplaces

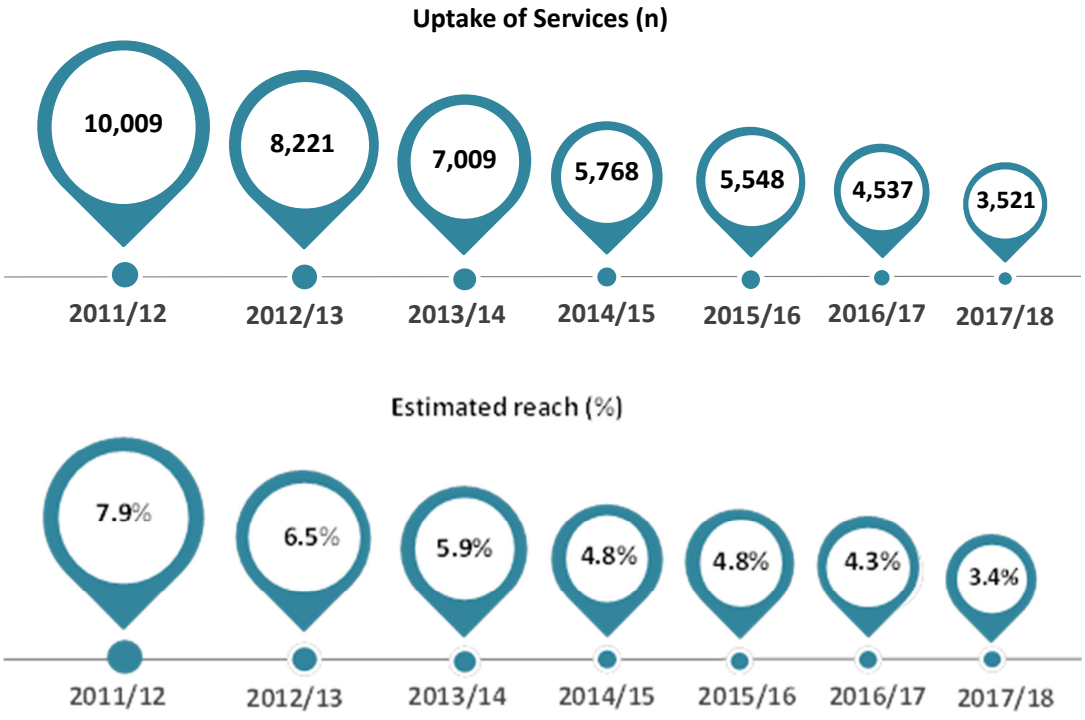
Produced by: Health Intelligence, PHA

6.5 Service uptake and effectiveness among Routine and Manual Workers

Currently the prevalence of smoking among routine and manual workers is 28%.[1]

In 2017/18, 22.8% (n=3,521) of Stop Smoking Service users stated that they had a routine and manual occupation, equating to 3.4% of all routine and manual smokers in NI.[iii] Akin to the decline in overall uptake and reach of services, the uptake of services by routine and manual workers continues to fall for the 6th consecutive year, representing a decline of 22.4% in uptake from that in 2016/17, the most substantial drop in numbers in any one year over this six year period. Reach of services observed a 0.9 percentage points decline from that in 2016/17 (Figure 6.5.1).

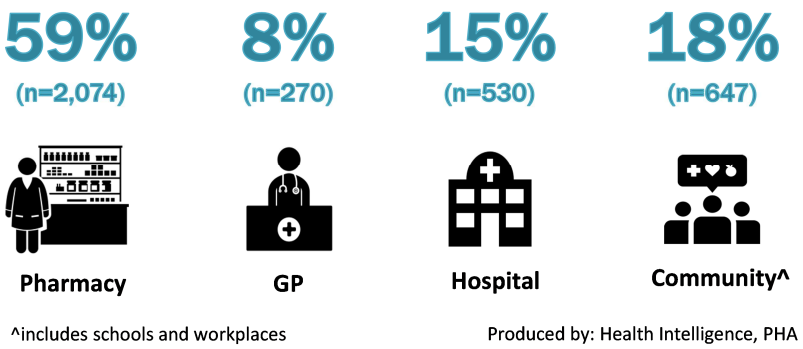
Figure 6.5.1: Uptake and estimated access to Stop Smoking Services by routine and manual smokers 2011/12 – 2017/18



[iii] 2011 census data on occupational status is used to determine population figures of routine and manual workers.

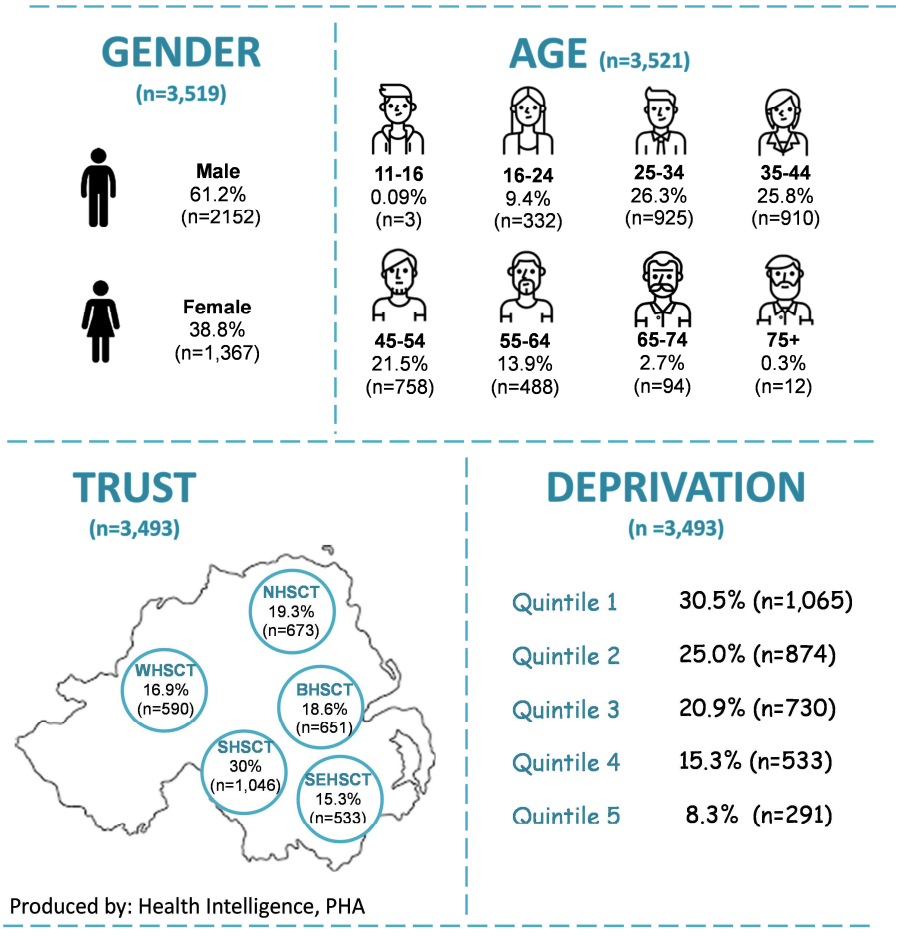
Of all routine and manual workers registered with PHA Stop Smoking Services in 2017/18, the majority (59%) were registered with a pharmacy service, 18% registered with community services, 15% with hospital services and 8% with a GP service (Figure 6.5.2).

Figure 6.5.2: Uptake of Stop Smoking Services by Provider Type 2017/18 (%)



Profile of routine and manual Stop Smoking Service users

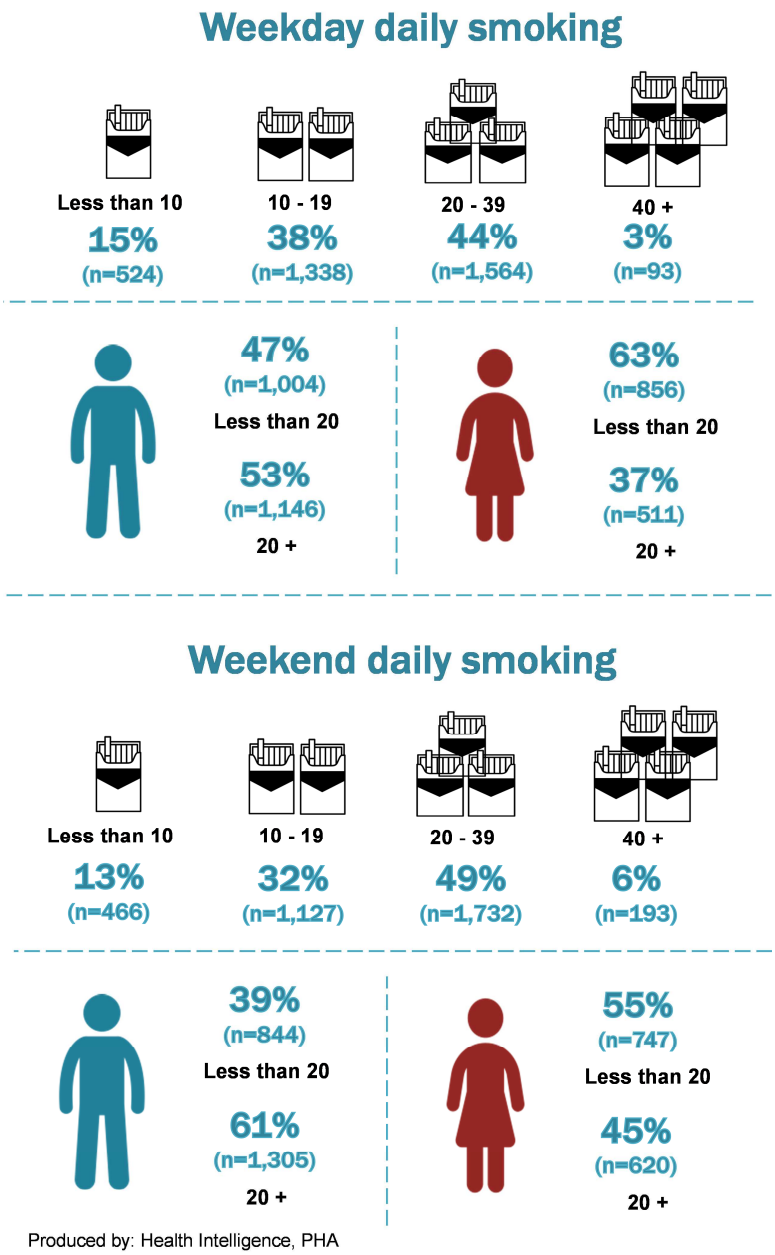
Figure 6.5.3: Client demographics 2017/18



Tobacco Consumption

As illustrated in Figure 6.5.4 the majority of routine and manual smokers accessing services smoked on average 20-39 cigarettes each weekday or weekend day (44% and 49% respectively). There was a considerable difference in the amount of cigarettes smoked daily by gender. Males were more likely to be heavier smokers both on a weekday or a weekend day than females with 53% of males smoking on average 20 or more cigarettes on a weekday compared to 37% of females; and 61% on a weekend day compared to 45% of females (Figure 6.5.4).

Figure 6.5.4: Daily tobacco consumption 2017/18



The majority (75%) indicated that they smoked the same amount of cigarettes on weekdays as on weekends, with 3% indicating that they smoked less at the weekend, and 22% smoking more at the weekend.

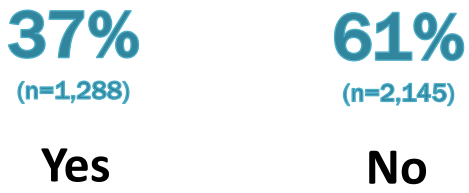
Type of tobacco smoked

The most common type of tobacco smoked was cigarettes with the majority of clients (99.7%) reporting smoking this product.

Produced by: Health Intelligence, PHA

Previously participated in this service

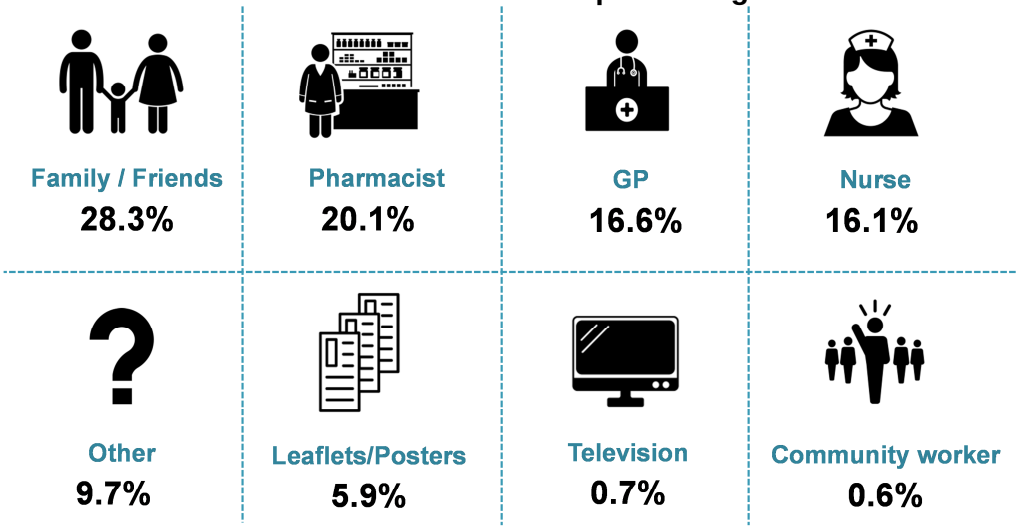
Of all routine and manual service users, 37% had previously participated in a PHA Stop Smoking Service to support them with their quit attempt.



How heard about the service

Figure 6.5.5 illustrates that the most common way in which routine and manual clients had heard about the service was via family and friends (28.3%) followed by via a pharmacist (20.1%).

Figure 6.5.5: How clients heard about the Stop Smoking Service 2017/18

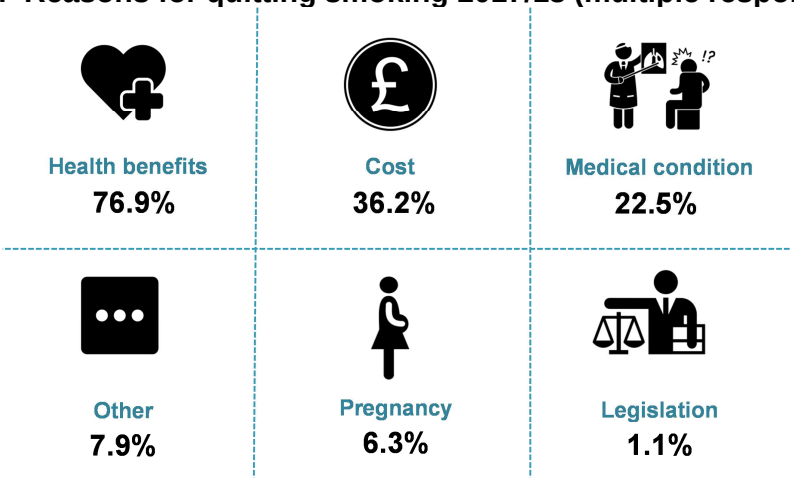


Produced by: Health Intelligence, PHA

Reason for quitting smoking

The most common reason, as stated by routine and manual service users, for quitting smoking was for health benefits (76.9%) followed by cost (36.2%) and medical condition (22.5%) (Figure 6.5.6).

Figure 6.5.6: Reasons for quitting smoking 2017/18 (multiple responses)

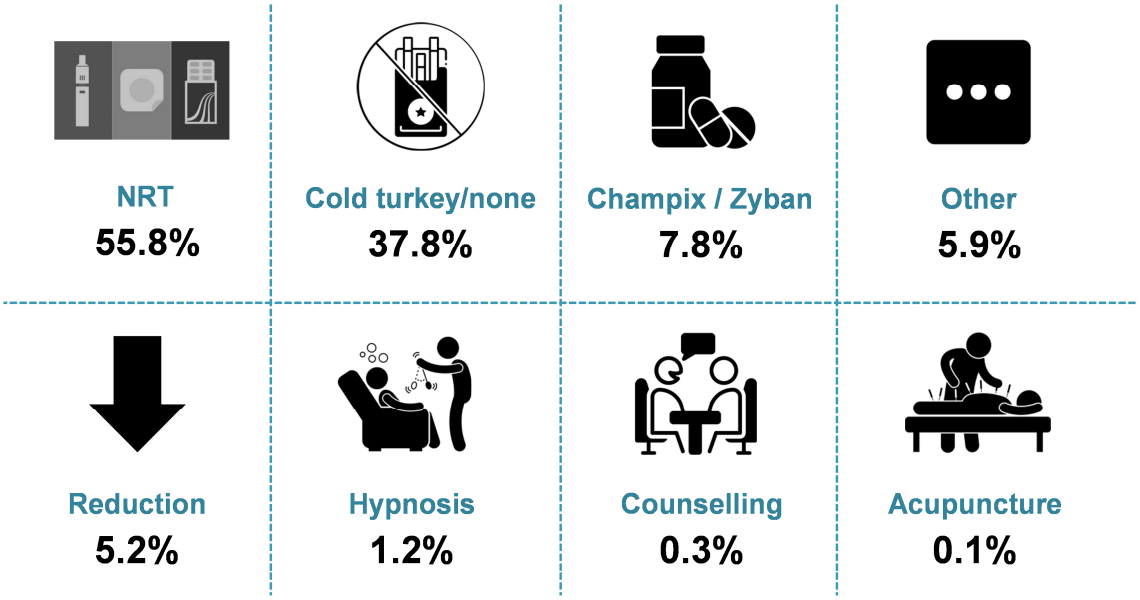


Produced by: Health Intelligence, PHA

Other methods used to give up smoking within the last 3 years

When asked if they had tried to give up smoking using any other methods within the last 3 years, 3,356 (95.3%) of all routine and manual service users indicated that yes they had tried, with NRT (55.8%) being the most common method used followed by having gone cold turkey (37.8%). It is important to note that some clients used a combination of quitting methods in their previous attempts.

Figure 6.5.7: Previous quitting methods used (multiple responses)



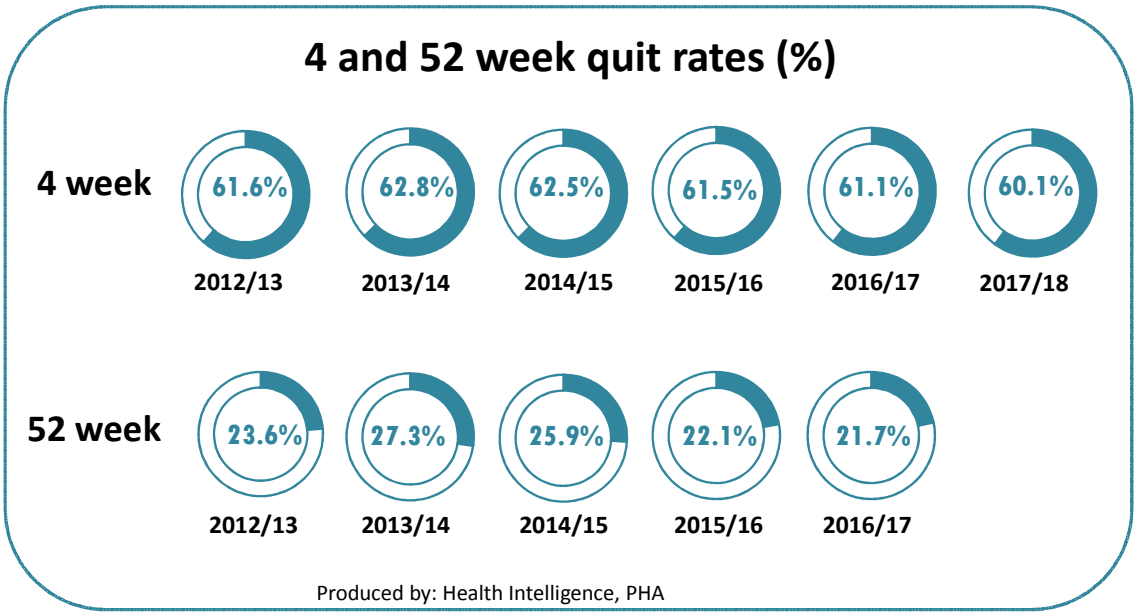
Produced by: Health Intelligence, PHA

Numbers quit at 4 and 52 weeks

Figure 6.5.8 illustrates that both 4 week and 52 week quit rates of routine and manual smokers using services have seen a steady decline over time. However, 2017/18 observed the smallest decline in 4 and 52 week quit rates in any one year since 2013/14, with 4 week quit rates declining by 0.3 percentage points and a decline of 0.4 percentage points in 52 week quit rates.

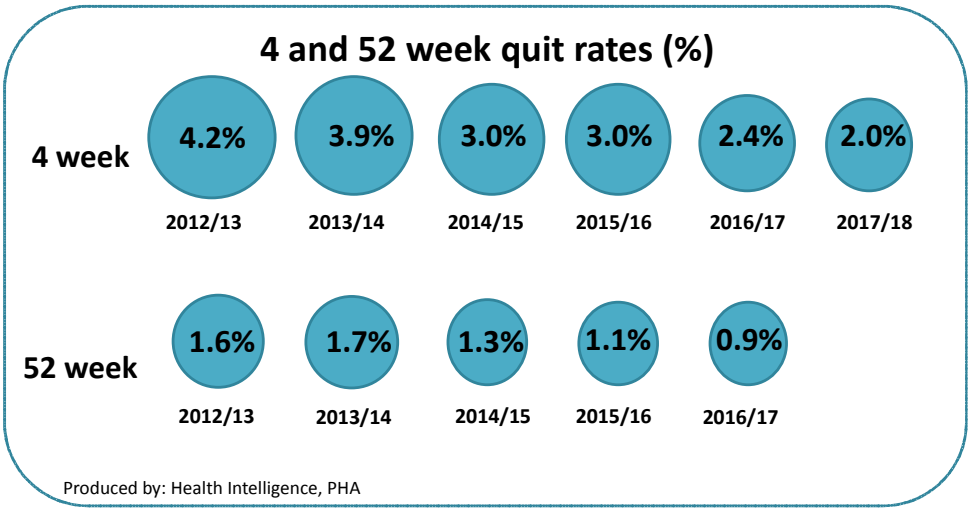
Although 2017/18 saw a decrease in quit rates the proportion of routine and manual workers quit at 4 weeks has remained consistently high over the six year period ranging from 60% to 63%.

Figure 6.5.8: 4 and 52 week quit rates of routine and manual smokers using PHA Stop Smoking Services 2012/13 – 2017/18



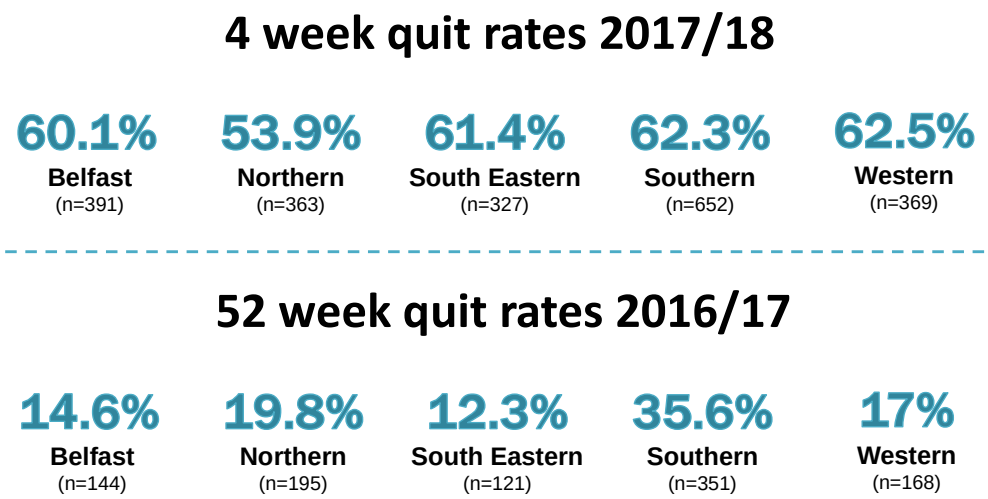
Overall, Stop Smoking Services supported an estimated 2% of all routine and manual smokers in NI to quit smoking at 4 weeks, and 0.9% to stay quit at 52 weeks. The estimated proportion of all routine and manual smokers in NI who quit at 4 and 52 weeks saw a decline in rates from those in the previous year (Figure 6.5.9).

Figure 6.5.9: Estimated proportion of all routine and manual smokers in NI quitting at 4 week and 52 weeks using Stop Smoking Services 2012/13 – 2017/18



There was variance in the proportion of routine and manual smokers quitting at 4 and 52 weeks across the LCG areas. Western LCG supported the highest proportion of clients to quit at 4 weeks (62.5%) compared to 53.9% within the Northern LCG. The Southern LCG supported the highest proportion of clients to quit at 52 weeks (35.6%), with the South Eastern LCG having the lowest 52 week quit rates (Figure 6.5.10).

Figure 6.5.10: 4 week and 52 weeks quit rates by LCG area (%)



Follow up rates

In 2017/18, 17.2% (n=605) of all routine and manual clients registered in the Stop Smoking Services were lost to follow up at 4 weeks, a 3.1 percentage point increase from 14.1% in 2016/17. Of all routine and manual clients who had successfully quit at 4 weeks in 2016/17, 38% (n=1,052) did not have any information recorded on the outcome of their 52 week quit attempt.

6.6 Service uptake and effectiveness by area of deprivation

In addition to examining the uptake and quit rates of routine and manual workers who smoke the PHA also examines the uptake and impact of services on smoking by deprivation quintile. Figure 6.6.1 illustrates that in 2017/18, the uptake of services varied across deprivation quintiles, with the majority of clients living within the most deprived quintile (31.8%, n=4,922), compared to 9.6% (n=1,488) of clients living within the least deprived quintile.

Figure 6.6.1: Uptake of Stop Smoking Services within each deprivation quintile 2017/18

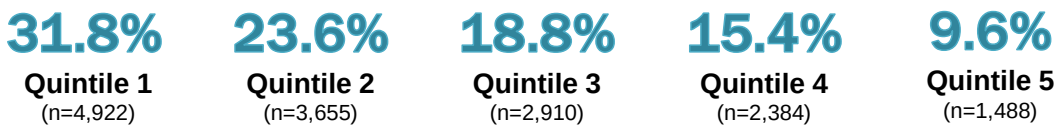
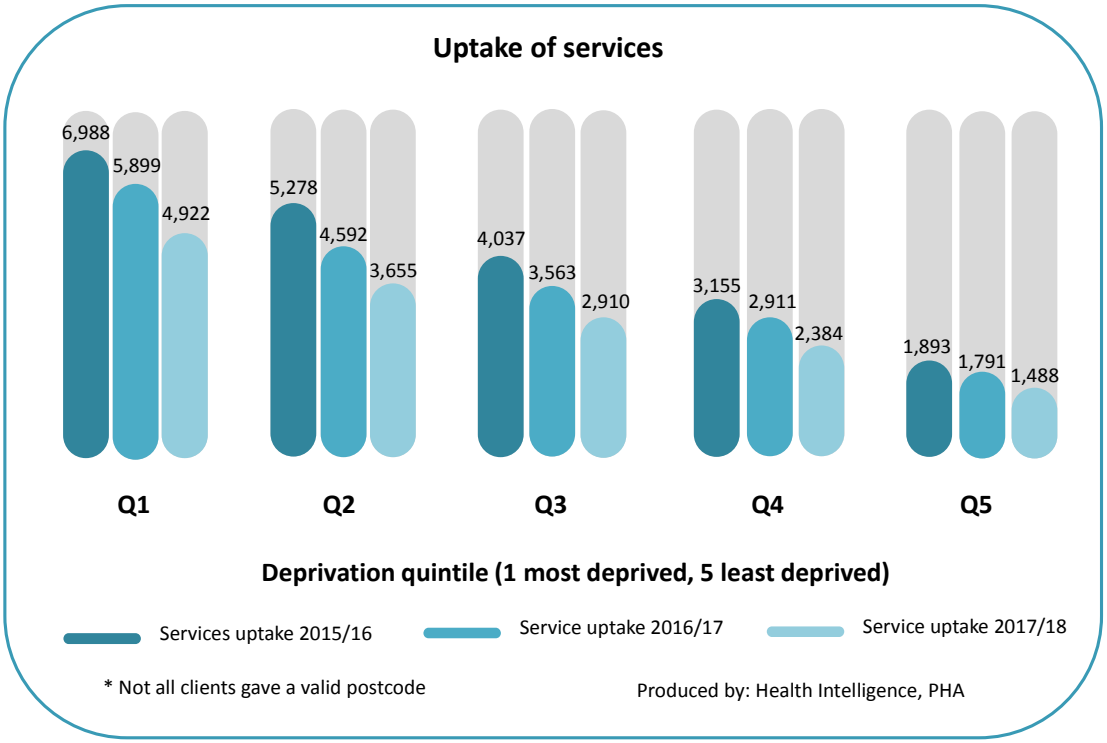


Figure 6.6.2 illustrates that there has been a decline in absolute numbers of service uptake across all MDM quintiles from that in the previous year ranging from a 20.4% decline in quintile 2 to a 16.6% decline in quintile 1.

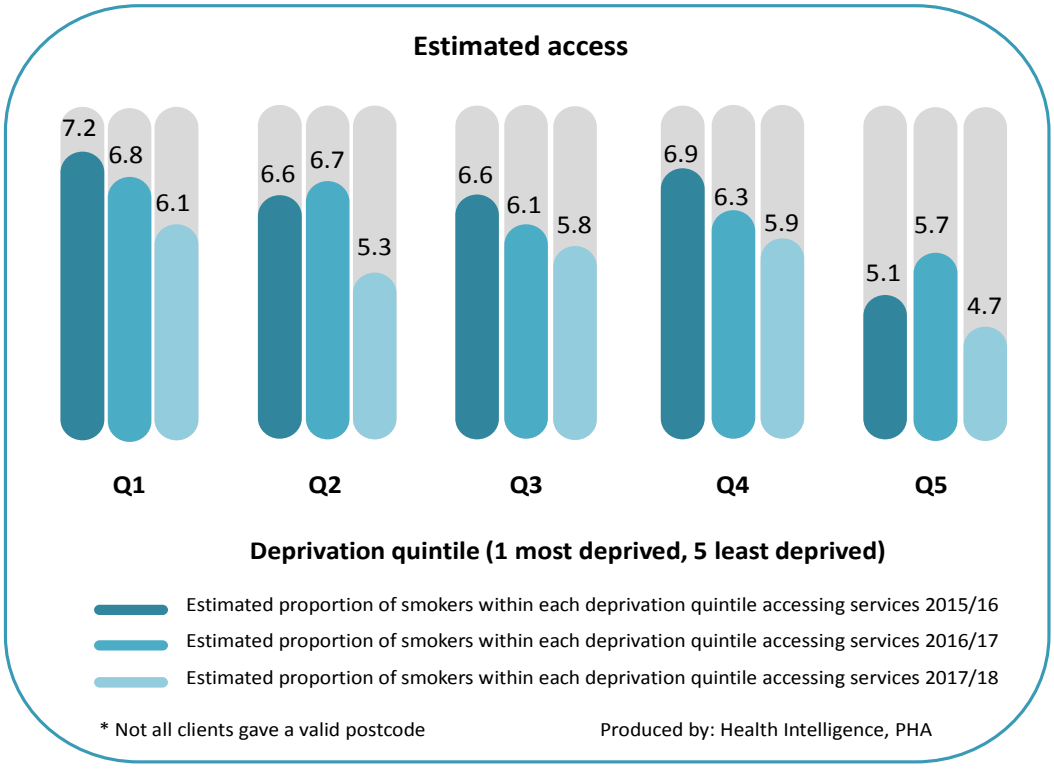
Figure 6.6.2: Uptake of Stop Smoking Services within each deprivation quintile 2015/16 – 2017/18[iv]



[iv] 102 clients registered in 2017/18, 152 of clients registered in 2016/17 and 179 clients registered in 2015/16 did not provide a valid postcode to allow deprivation analysis.

Akin to the pattern of uptake rates by MDM quintile, Figure 6.6.3 illustrates that there has been a reduction in estimated reach of service across all MDM quintiles from that in the previous year. The greatest decrease in estimated reach of services was observed in quintile 2 with a 1.4 percentage point decrease, in comparison to quintile 3 with the lowest decrease in estimated reach of 0.3 percentage points.

Figure 6.6.3: Estimated access to Stop Smoking Services within each deprivation quintile 2015/16 – 2017/18 (%)



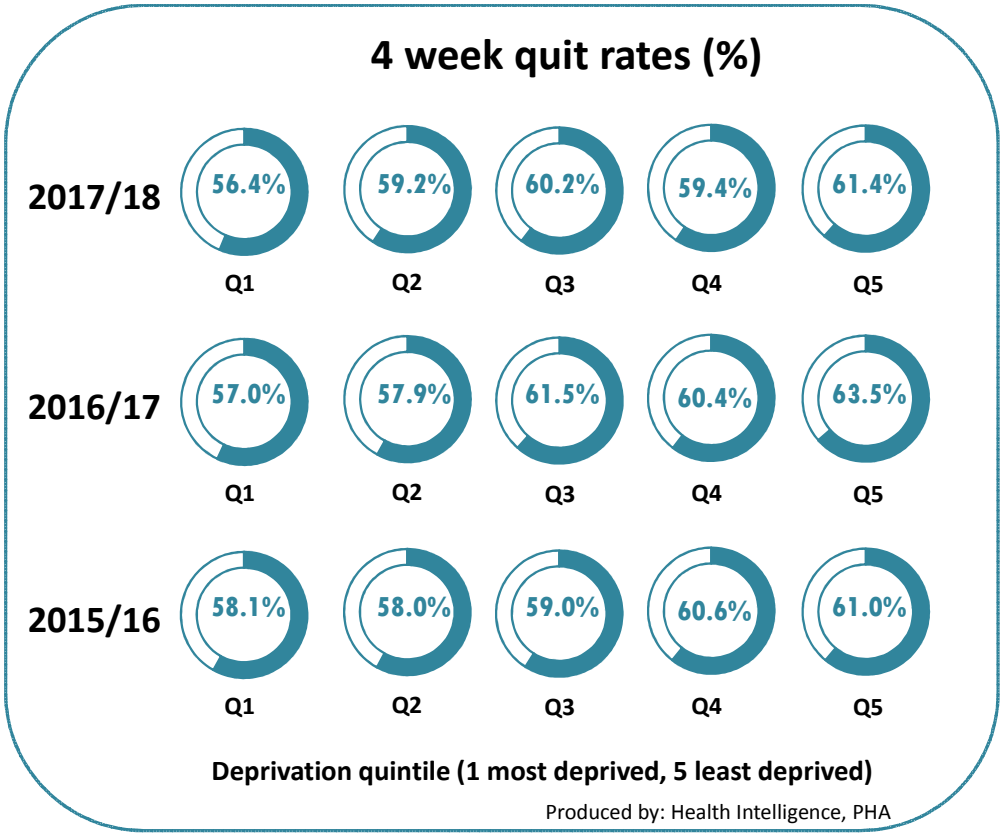
Numbers quit at 4 and 52 weeks

Although the highest proportion of clients accessing services were from the most deprived quintiles, both 4 week and 52 week quit rates were highest among clients from the least deprived quintiles. In 2017/18, quit rates varied across all quintiles with 4 week quit rates ranging from 61.4% in the least deprived quintile (Q5) to 56.4% in the most deprived quintile (Q1). 52 week quit rates ranged from 23.2% in the second least deprived quintile to 18.7% in the most deprived quintile.

Overall, 4 week and 52 week quits rates observed a decline across most quintiles from that in the previous year with the exception of the higher 4 week quit rate observed within the second most deprived quintile (59.2%) a 1.3 percentage point increase from that in 2016/17 (57.9%). A higher 52 week quit rate was observed

within the two least deprived quintiles, a 0.9 and 0.7 (respectively) percentage point increase from that in 2016/17.

Figure 6.6.4: 4 and 52 week quit rates among smokers using PHA Stop Smoking Services by deprivation quintile 2015/16 – 2017/18



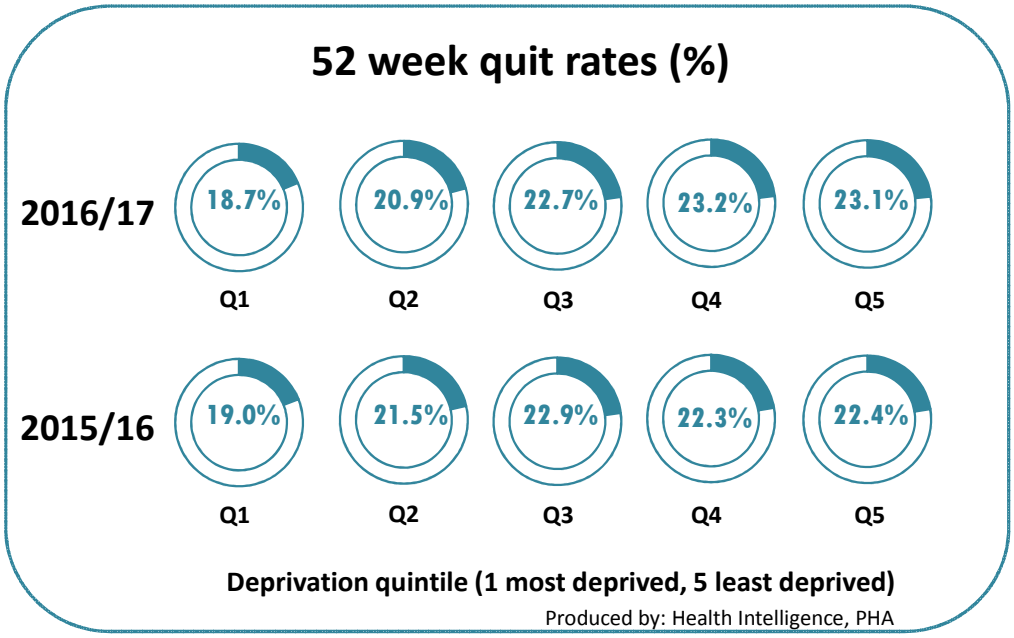
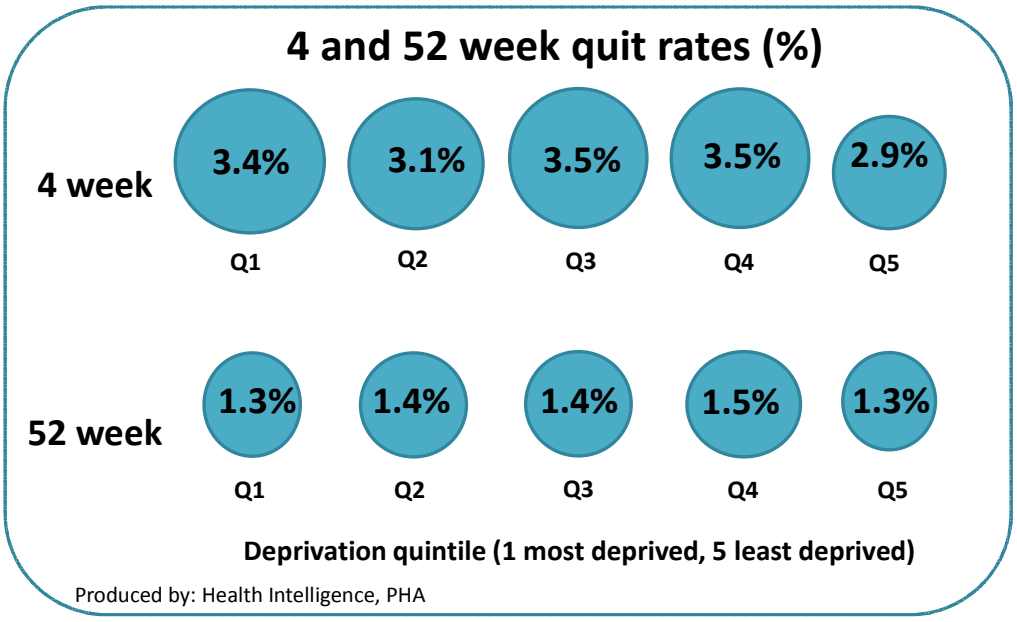


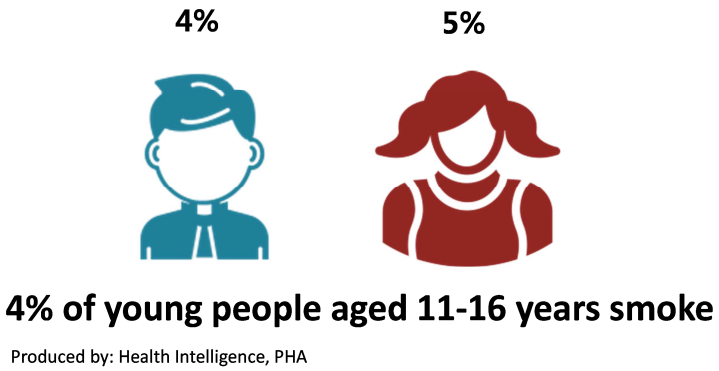
Figure 6.6.5 illustrates that over the last year, stop smoking services supported an estimated 3.4% of all smokers living within the most deprived quintile to quit at 4 weeks, and 1.3% to remain quit at 52 weeks.

Figure 6.6.5: Estimated proportion of all smokers quit at 4 and 52 weeks by deprivation quintile 2017/18



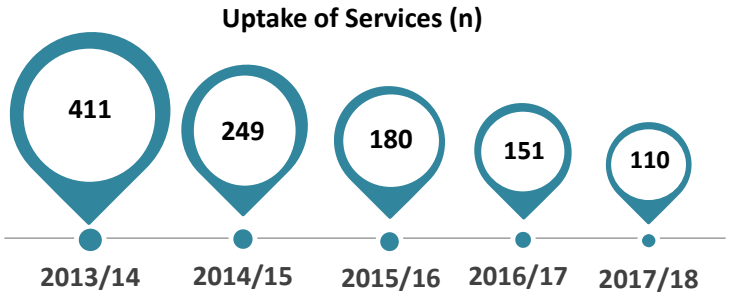
6.7 Service uptake and effectiveness among Children and Young People aged 11-16 years

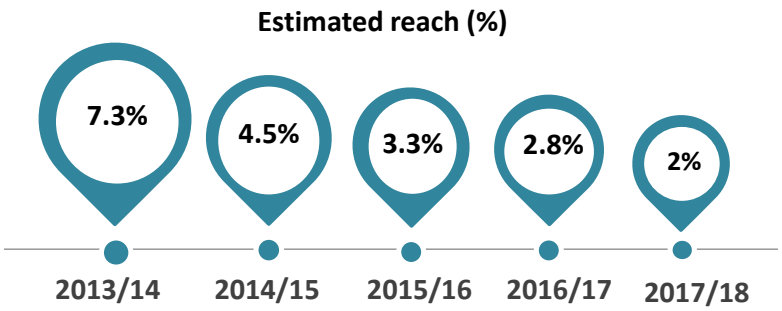
The most recent NI Young Persons Behaviour and Attitudes Survey (2016) reported that of young people aged 11-16 years, 12% indicated that they had ever smoked tobacco, of these, over half (56%) indicated that they had smoked at 13 years of age or under. Of those 12% who had indicated having ever smoked, 10% smoked at least once a week, and 21% indicated that they smoked every day. On the whole, 4% of young people living in NI are current smokers,[9,20] equating to an estimated 5,445 young people.



Overall, 110 young people aged 11-16 years accessed Stop Smoking Services in 2017/18, equating to 2% of all 11-16 year olds in NI who are current smokers. For the fourth consecutive year both uptake of services and reach of services have observed a decline from that in the previous year. Uptake of services observed a decline of 27% from that in 2016/17, the most substantial drop in numbers in any one year over this four year period. Reach of services observed a 0.8 percentage point decline from that in 2016/17 (Figure 6.7.1).

Figure 6.7.1: Uptake and estimated access to Stop Smoking Services by 11-16 year old smokers 2013/14 – 2017/18



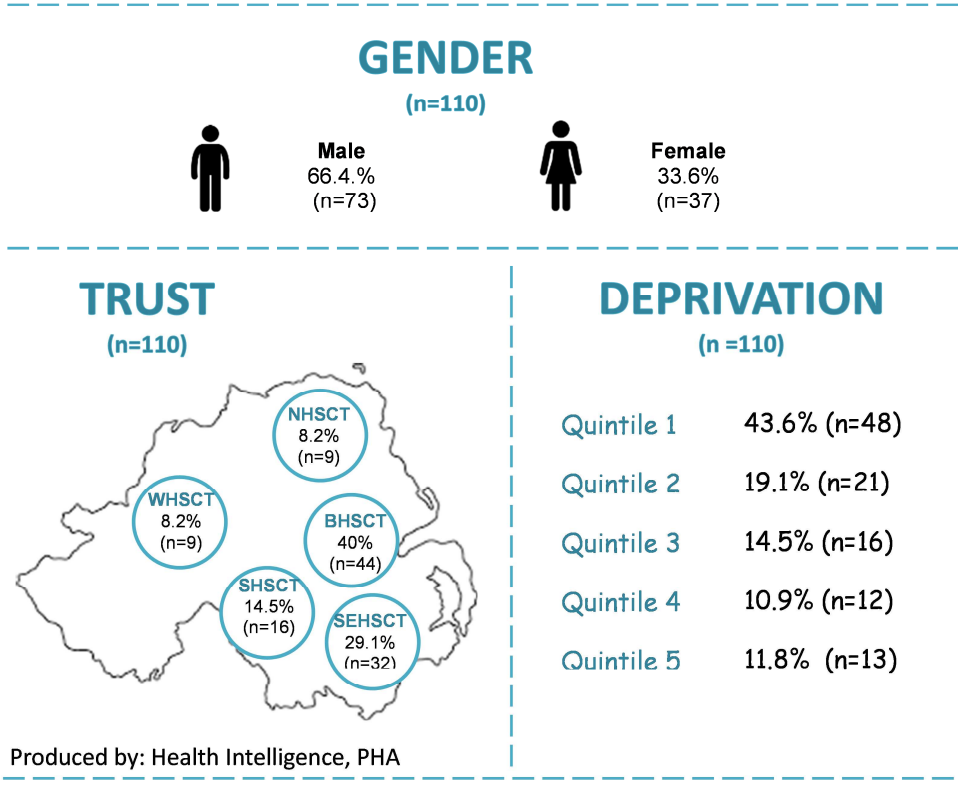


Belfast LCG had the highest proportion of clients aged 11-16 year (1.4%), with both the Northern and Western LCGs having the lowest proportion of young people (0.3%).

Belfast	Northern	South Eastern	Southern	Western
1.4%	0.3%	1.2%	0.5%	0.3%
(n=44)	(n=9)	(n=32)	(n=16)	(n=9)

Profile of young people aged 11-16 Stop Smoking Service users

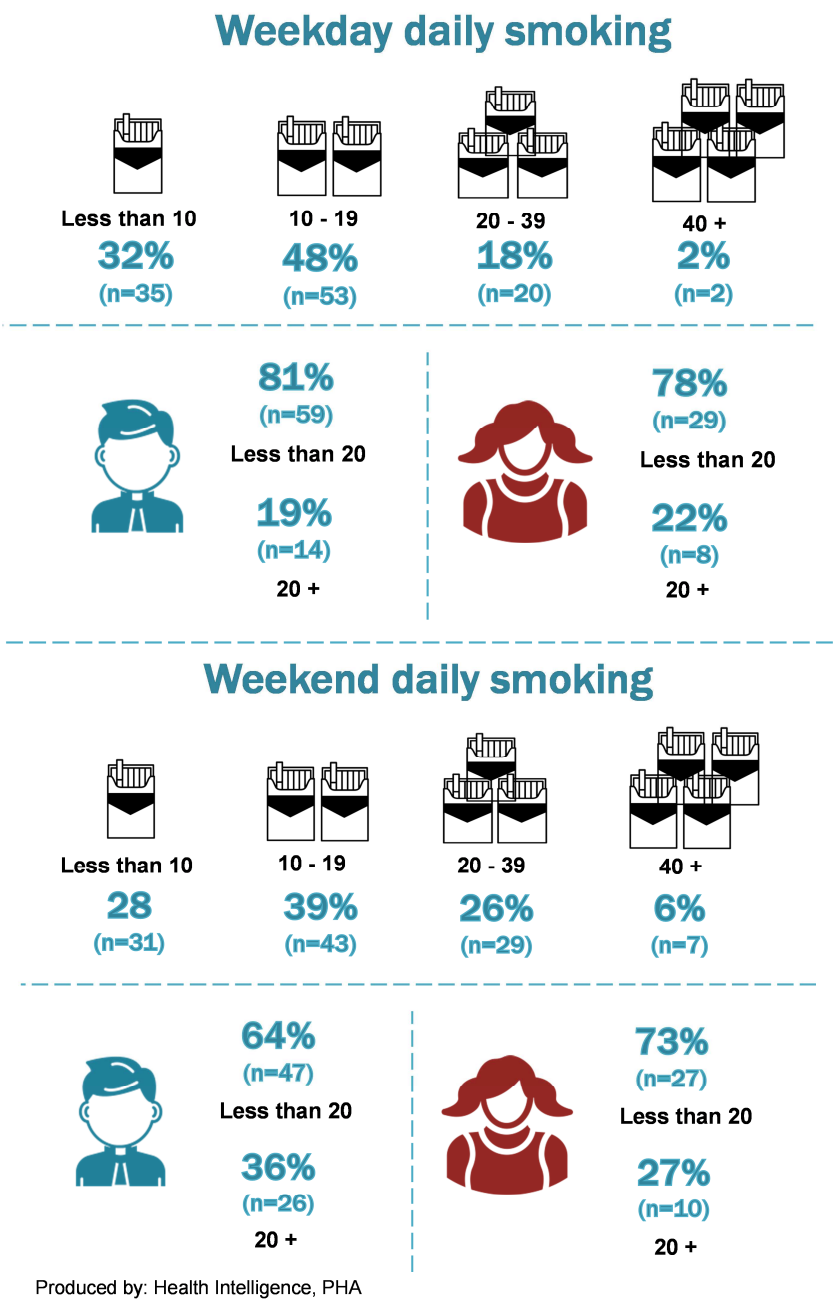
Figure 6.7.2: Client demographics 2017/18



Tobacco Consumption

The majority of 11-16 year old smokers accessing services smoked on average 10-19 cigarettes each weekday or weekend day (48% and 39% respectively). Females were more likely to be heavier smokers on a weekday smoking on average 20 or more cigarettes (22%) compared to males (19%), however males were more likely to be heavier smokers on a weekend (36%) compared to 27% of females (Figure 6.7.3).

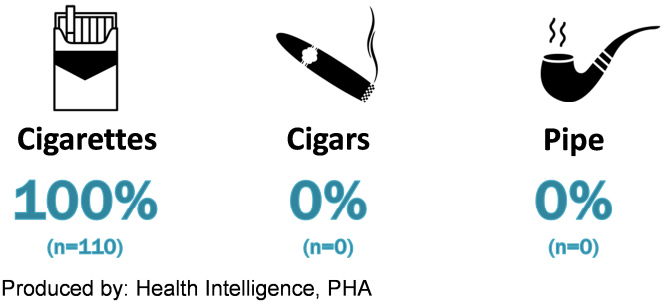
Figure 6.7.3: Daily tobacco consumption 2017/18



The majority reported that they smoked the same amount of cigarettes on weekdays as on weekends. However, males were more likely to smoke more cigarettes at the weekend (33%) in comparison to females (19%).

Type of tobacco smoked

When asked what type of tobacco they smoked, all clients aged 11-16 years indicated that they smoked cigarettes.



Produced by: Health Intelligence, PHA

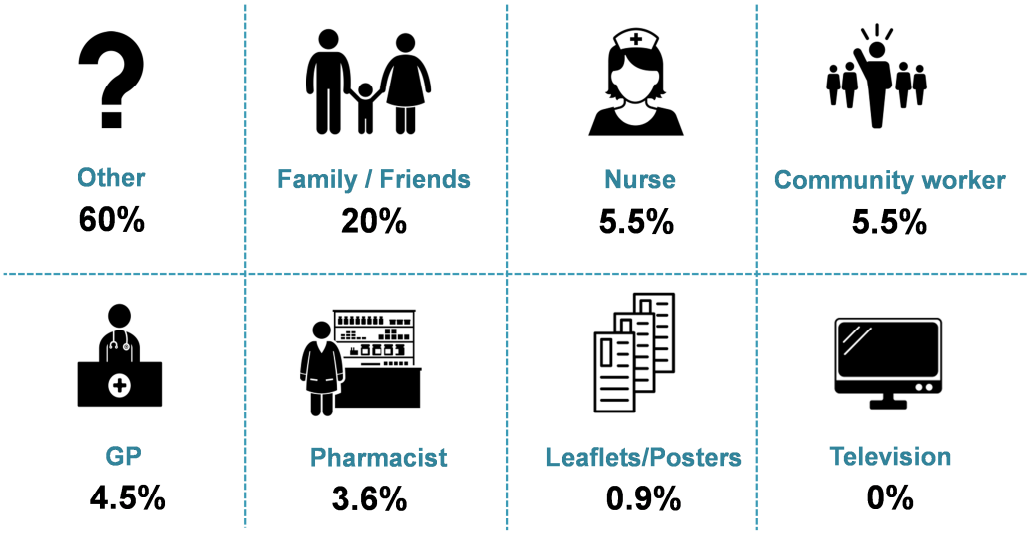
Previously participated in this service

Only 9% of service users aged 11-16 years had previously participated in a PHA Stop Smoking Service.

How heard about the service

The most common way in which young service users had heard about Stop Smoking Services was via other means (60%), followed by family and friends (20%).

Figure 6.7.4: How clients heard about the Stop Smoking Service 2017/18

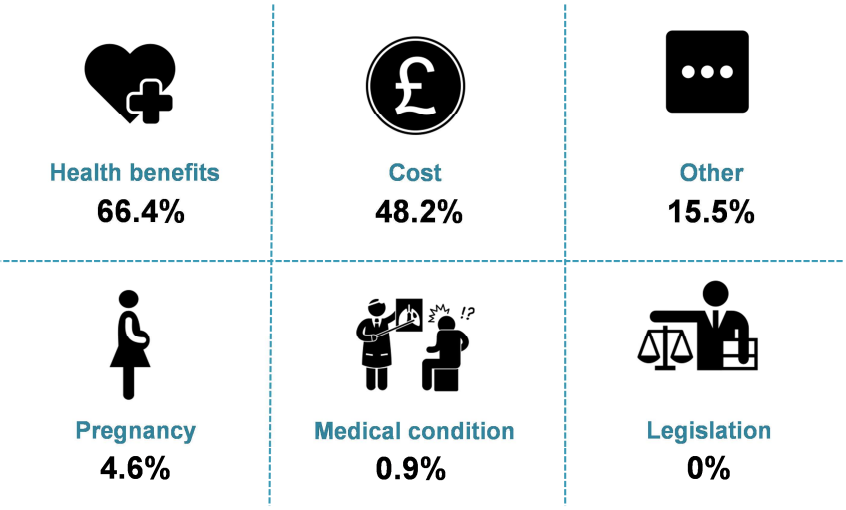


Produced by: Health Intelligence, PHA

Reason for quitting smoking

Figure 6.7.5 illustrates that of all young service users, the most common reason given for quitting smoking was for health benefits (66.4%) followed by cost (48.2%).

Figure 6.7.5: Reasons for quitting smoking 2017/18 (multiple responses)

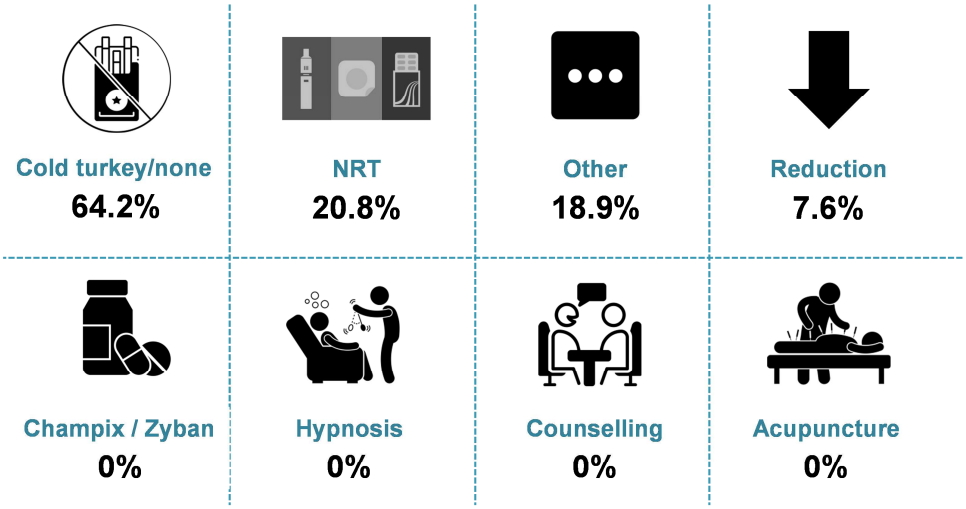


Produced by: Health Intelligence, PHA

Other methods used to give up smoking within the last 3 years

96.4% of all clients aged 11-16 indicated that they had tried to give up smoking using any other methods within the last 3 years. Going cold turkey was the most common method used for quitting (64.2%) followed by NRT (20.8%). It is important to note that some clients used a combination of quitting methods in their previous attempts (Figure 6.7.6).

Figure 6.7.6: Previous quitting methods used (multiple responses)

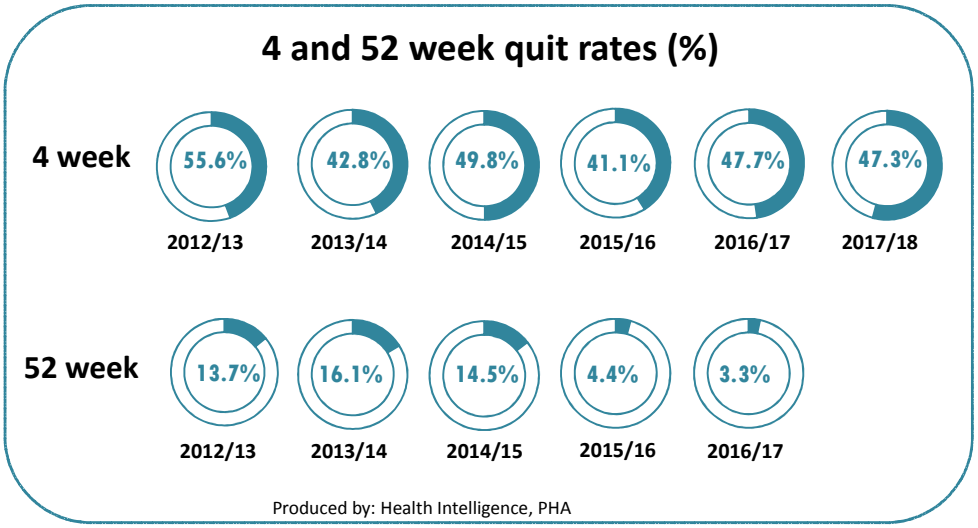


Produced by: Health Intelligence, PHA

Numbers quit at 4 and 52 weeks

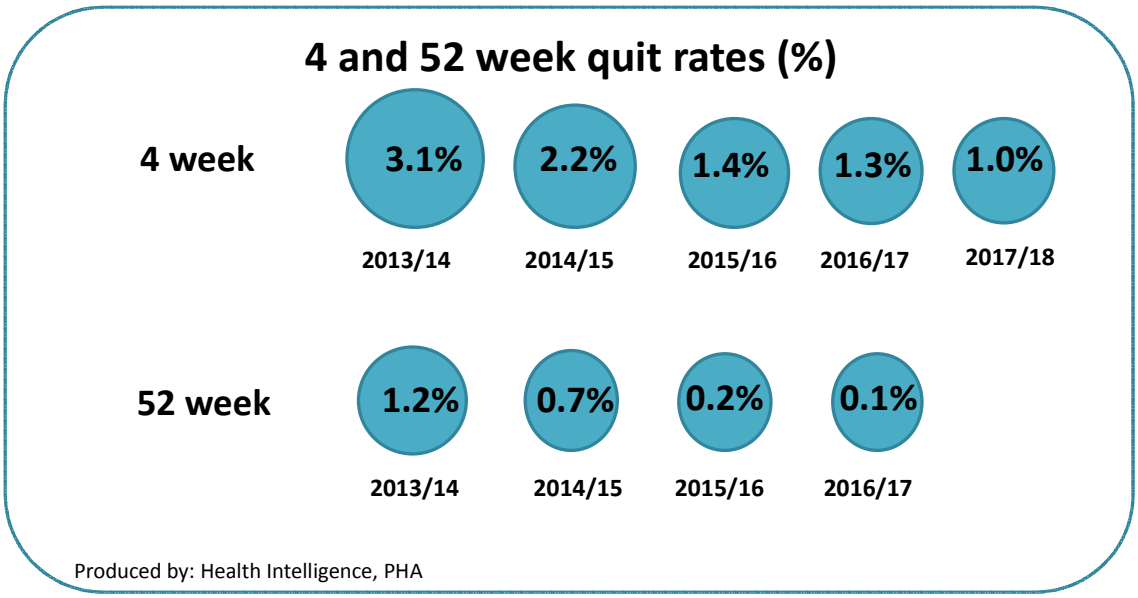
Figure 6.7.7 illustrates that 4 week quit rates among clients aged 11-16 years has observed a slight decline from that in 2016/17. 52 week quit rates observed a 1.1 percentage point decline in 2016/17 (3.3%) compared to 4.4% in 2015/16, with 52 week quit rates remaining to be considerably low among this age group.

Figure 6.7.7: 4 and 52 week quit rates of clients aged 11-16 years using PHA Stop Smoking Services 2012/13 – 2017/18



In 2017/18, Stop Smoking Services supported an estimated 1% of all smokers aged 11-16 years in NI to quit smoking at 4 weeks, and 0.1% to stay quit at 52 weeks. The estimated proportion of all smokers in NI aged 11-16 years who quit at 4 and 52 weeks saw a decline in rates from those in the previous year (Figure 6.7.8).

Figure 6.7.8: Estimated proportion of all smokers aged 11-16 in NI quitting at 4 week and 52 weeks using Stop Smoking Services 2013/14 – 2017/18



Follow up rates

In 2017/18, 23.6% (n=26) of all clients aged 11-16 years registered in the Stop Smoking Services were lost to follow up at 4 weeks. Of all clients aged 11-16 years who had successfully quit at 4 weeks in 2016/17, 80.6% (n=58) did not have any information recorded on the outcome of their 52 week quit attempt.

6.8 Smoking in pregnancy

As part of routine and data collection within all NI hospitals, smoking status of all pregnant women is recorded at the initial booking appointment (around 10-14 weeks). This information is recorded directly onto the Northern Ireland Maternity System (NIMATS), which is a regional electronic data capture system.

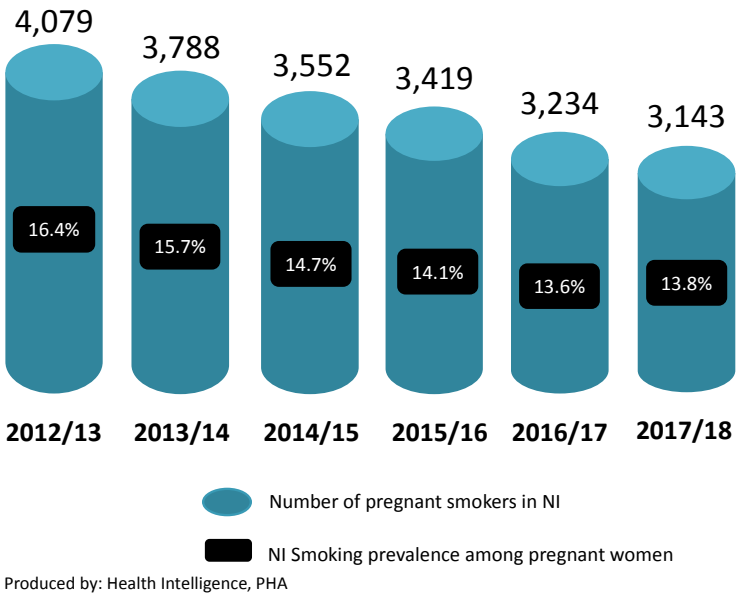
In 2017/18, at the time of their initial booking appointment, 13.8% (n=3,143) of all pregnant women self-reported being a smoker.

1 in 7 pregnant women smoke

Produced by: Health Intelligence, PHA

The number of pregnant women who smoke has fallen for the 6th consecutive year. However, the prevalence of pregnant women who smoke has seen a gradual decrease since its peak of 16.4% in 2012/13, a slight increase of 0.2 percentage points was observed in 2017/18 from 13.6% in the previous year (Figure 6.8.1).

Figure 6.8.1: Prevalence of smoking in pregnancy in NI 2012/13 – 2017/18



Produced by: Health Intelligence, PHA

Further analysis of pregnant smokers showed that there are inequality divides amongst this population group with smoking prevalence being much higher within the most deprived quintile were one in four expectant mothers smoked, compared to one in nineteen within the least deprived quintile (Figure 6.8.2).

Figure 6.8.2: Prevalence of smoking in pregnancy in NI 2012/13 – 2017/18

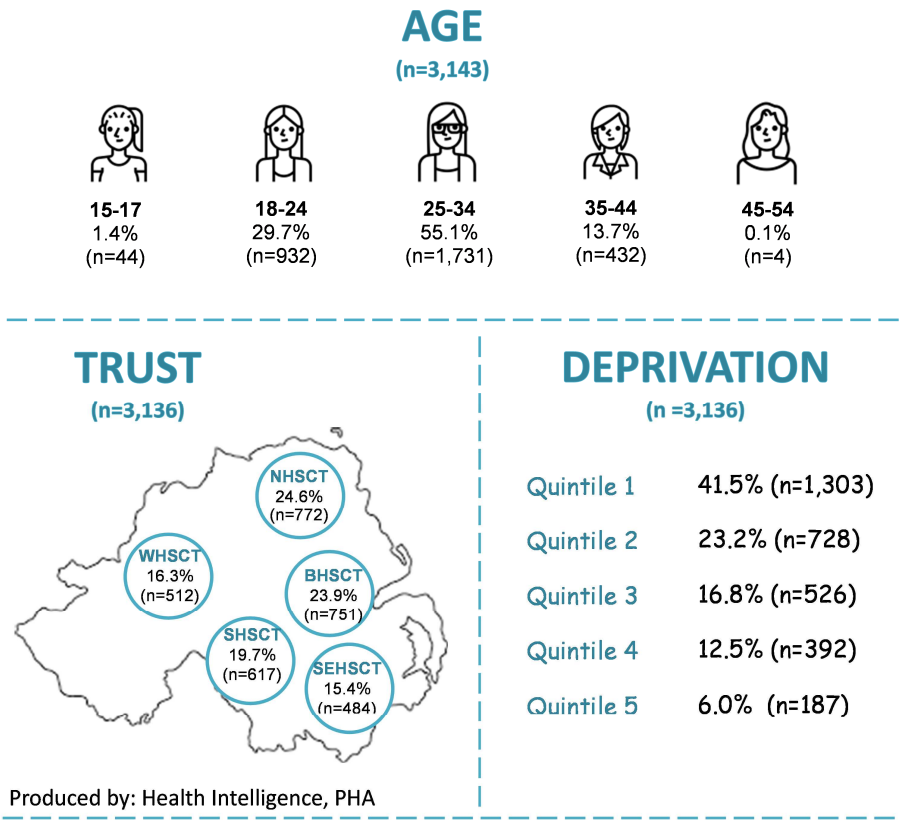
Produced by: Health Intelligence, PHA

Smoking prevalence among expectant mothers varied across LCG, with Belfast LCG having the greatest proportion of pregnant smokers (17.5%) compared to the Southern LCG with the lowest proportion (11.6%).

17.5%	14.4%	12.5%	11.6%	13.3%
Belfast	**Northern**	**South Eastern**	**Southern**	**Western**

Profile of pregnant women who smoke 2017/18

Figure 6.8.3: Demographics of pregnant women who smoke 2017/18



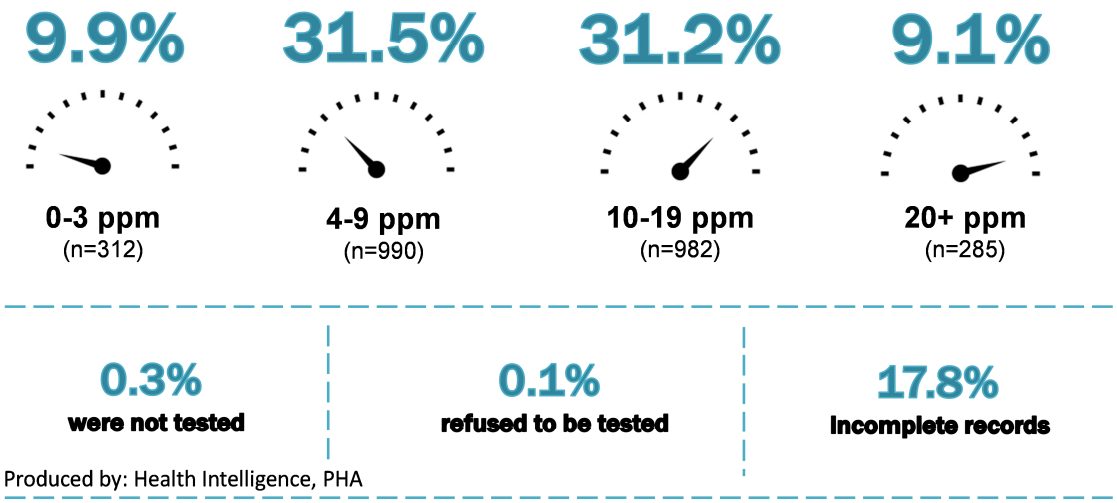
Carbon monoxide screening

As well as being asked if they currently smoke, all women are asked if they have smoked or been exposed to smoke within the last 12 hours, with 70.8% (n=2,228) of all pregnant smokers self-reporting that they had smoked within this time period.

Since September 2016, all pregnant women are now screened for carbon monoxide (CO) levels in the body at their initial booking appointment. If levels indicate that the woman is being exposed to sources of carbon monoxide, either by smoking or environmentally, they are given appropriate advice which includes information on PHA Stop Smoking Services, the risks of smoking and the health benefits to stopping or remaining quit.

Carbon monoxide screening indicated that 16.1% (n=3,686) of all pregnant women had been exposed to sources to CO (ppm level of 4 and above). Of those pregnant women who indicated that they smoked (n=3143) CO screening indicated that 71.8% (n=2,257) had a reading of 4ppm or above (Figure 6.8.4).

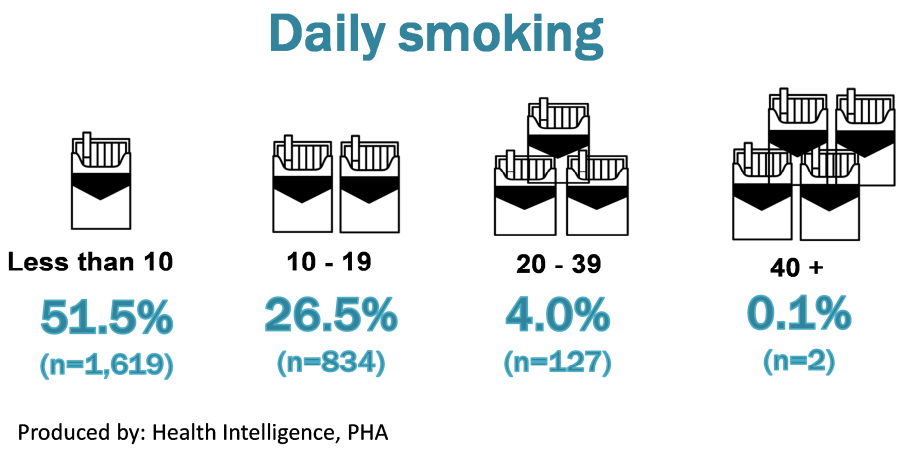
Figure 6.8.4: CO reading of all pregnant women who smoke 2017/18 (n=3,143)



Daily tobacco consumption

Of all pregnant women who smoked, when asked if they had smoked in the last 12 hours, 70.9% (2,228) reported yes that they had smoked within this time period. Information is also captured with regards to the number of cigarettes smoked per day, with the majority indicating that they smoked less than 10 cigarettes a day (51.5%) (Figure 6.8.5)

Figure 6.8.5: Daily tobacco consumption of all pregnant women who smoke 2017/18 (n=3,143)



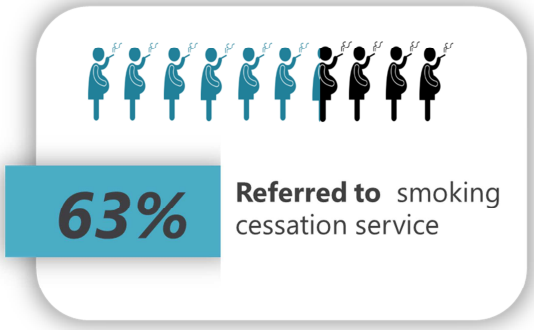
Advice given at antenatal appointment

During their antenatal appointment all expectant mothers who smoke or who are an ex-smoker (n=6,267) are given advice on the risks to the unborn child of smoking when pregnant and the risks to the child of smoking after the birth. They are also provided with advice with regards to the health benefits of stopping smoking/remaining quit. Overall, the majority where given both advice on risks to the child (97%) and the health benefits of stopping (96%).

Referral to PHA Stop Smoking Services

It is general practice that if a pregnant smoker is not currently attending a Stop Smoking Service or has never attended one healthcare staff will then refer the expectant mother to this service.

Of all pregnant women who smoked 62.8% were referred to Stop Smoking Services in 2017/18. Of these, 87.4% accepted the referral.



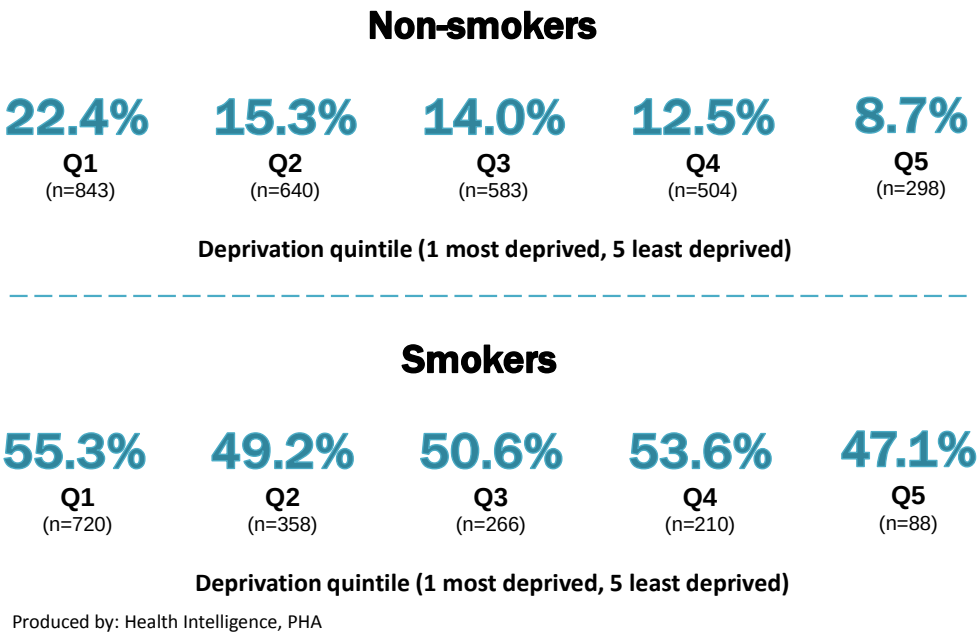
If partner smokes

During an antenatal appointment, if partners are present they are asked if they currently smoke, in the instance were their partner is not present the expectant mother is then asked if their partner smokes. 19.8% of all pregnant women had a partner who smoked. Figure 6.8.6 illustrates that pregnant women who smoked were more likely to have partners who smoked (52.4%) compared to pregnant women who did not smoke (14.6%).

Figure 6.8.6: If partner smokes 2017/18

Figure 6.8.7 illustrates that of those pregnant women who did not smoke, those living in the most deprived area were more likely to have a partner who smoked (22.4%) in comparison to those living in the least deprived area (8.7%). This was also reflected among pregnant smokers, with those living in the most deprived area being more likely to have a partner who smoked (55.3%) compared to 47.1% among those living in the least deprived area.

Figure 6.8.7: If partner smokes by MDM Quintile 2017/18



Partner referred to Stop Smoking Services

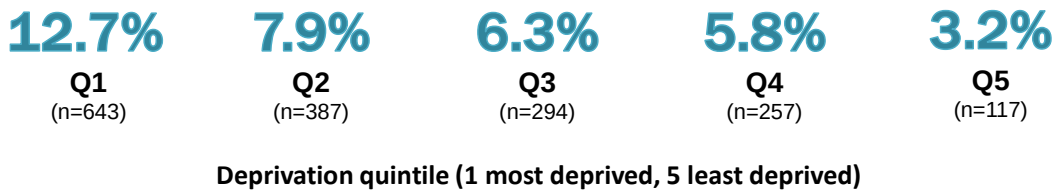
When an expectant mother's partner is present, and they are a current smoker, healthcare staff will refer them to Stop Smoking Services. Overall, 38.4% (n=773) were referred to services in 2017/18, with 83.4% (n= 645) accepting the referral.

Anyone else in household smokes

Healthcare staff also ask expectant mothers if anyone else besides their partner smokes in their household. Overall, 7.5% of all expectant mothers indicated that others within their household smoked. Figure 6.8.8 illustrates that pregnant women who smoked were more likely to have someone else in the household who smoked (20.1%) in comparison to pregnant women who did not smoke (5.4%).

Figure 6.8.8: If others in household smoke 2017/18

Pregnant women who lived in the most deprived quintile were more likely to have someone else in their household smoke compared to those living in the least deprived quintile.



6.9 Service uptake and effectiveness among Pregnant Women

Overall, 28.8% (n=905) of all pregnant women who smoke availed of Stop Smoking Services in 2017/18. Akin to the decline in overall uptake, the uptake of services by pregnant smokers has fallen for the 5th consecutive year from its peak in 2012/13, with reach of services continuing to fall for the 4th consecutive year. Uptake of services observed a 12.3% decrease from 2016/17, with reach of services decreasing by 3.1 percentage points from the previous year (Figure 6.9.1).

Figure 6.9.1: Uptake and estimated access to Stop Smoking Services by pregnant smokers 2011/12 – 2017/18

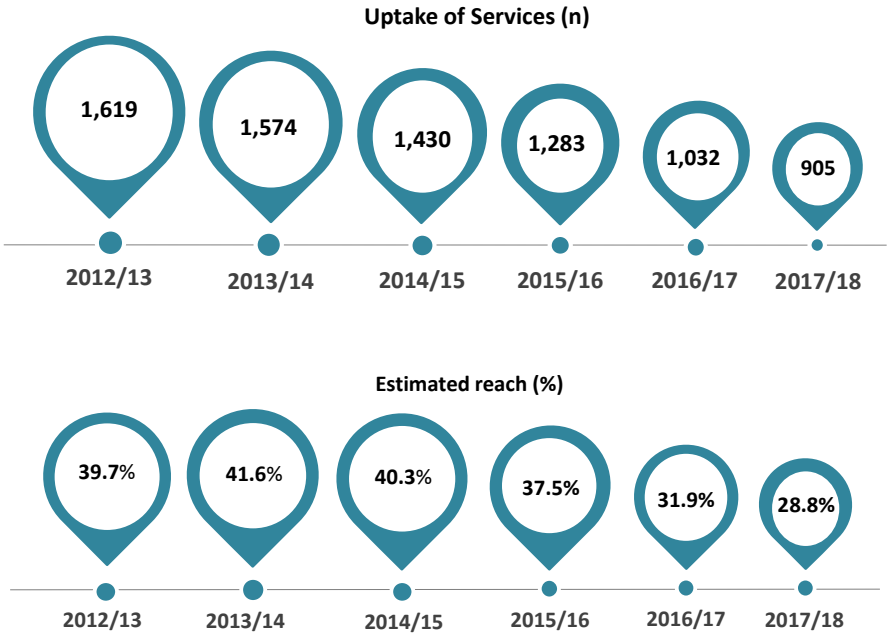
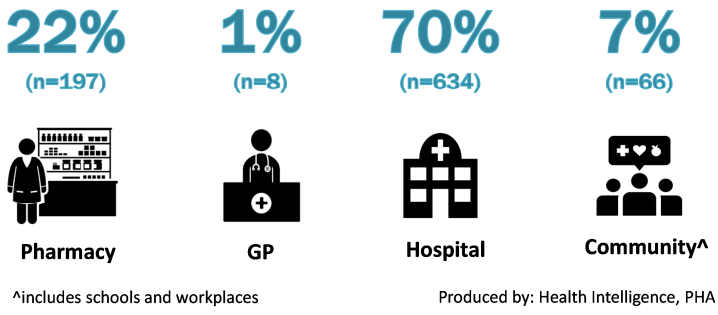


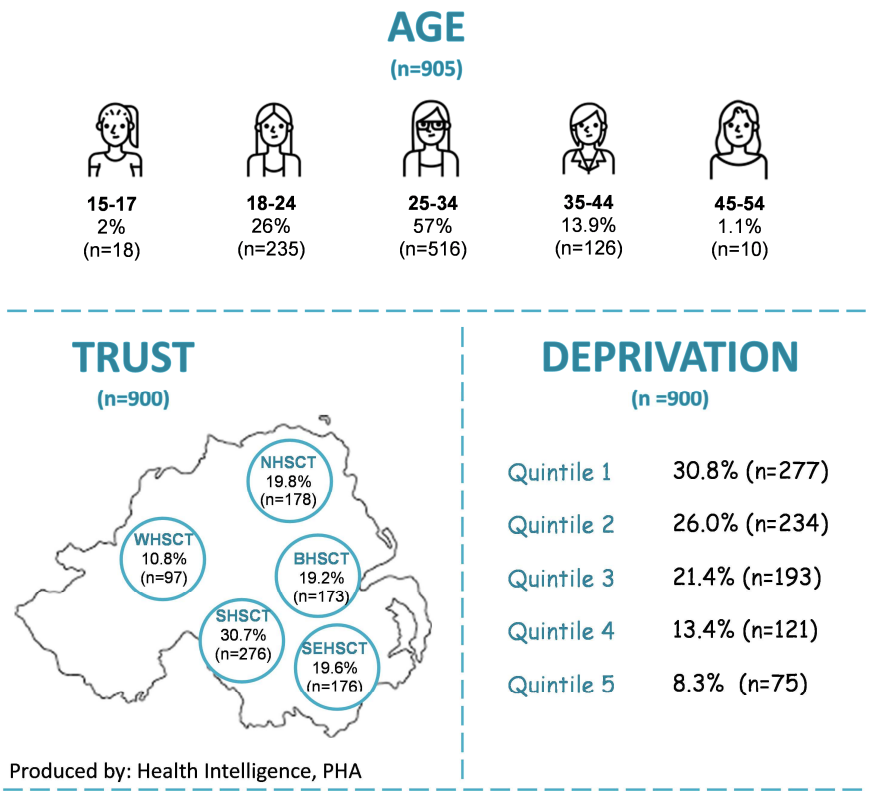
Figure 6.9.2 illustrates that of all pregnant smokers who registered with PHA Stop Smoking Services in 2017/18, the majority had registered with hospital services (70%), with only 1% of clients registered with a GP service.

Figure 6.9.2: Uptake of Stop Smoking Services by Provider Type 2017/18 (%)



Profile of Stop Smoking Service users who are pregnant smokers

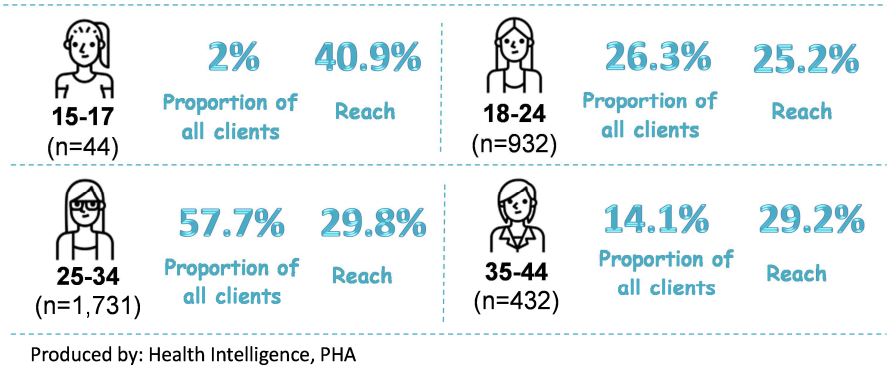
Figure 6.9.3: Client demographics 2017/18



Age-groups

The greatest service uptake was observed in the 25-34 year old age-group (55.1%) followed by those aged 18-24 (29.5%). The estimated proportion of all pregnant smokers accessing services varied by age-group, with estimated proportions ranging from 40.9% of all pregnant smokers aged 15-17 to 25.2% of those aged 18-24.

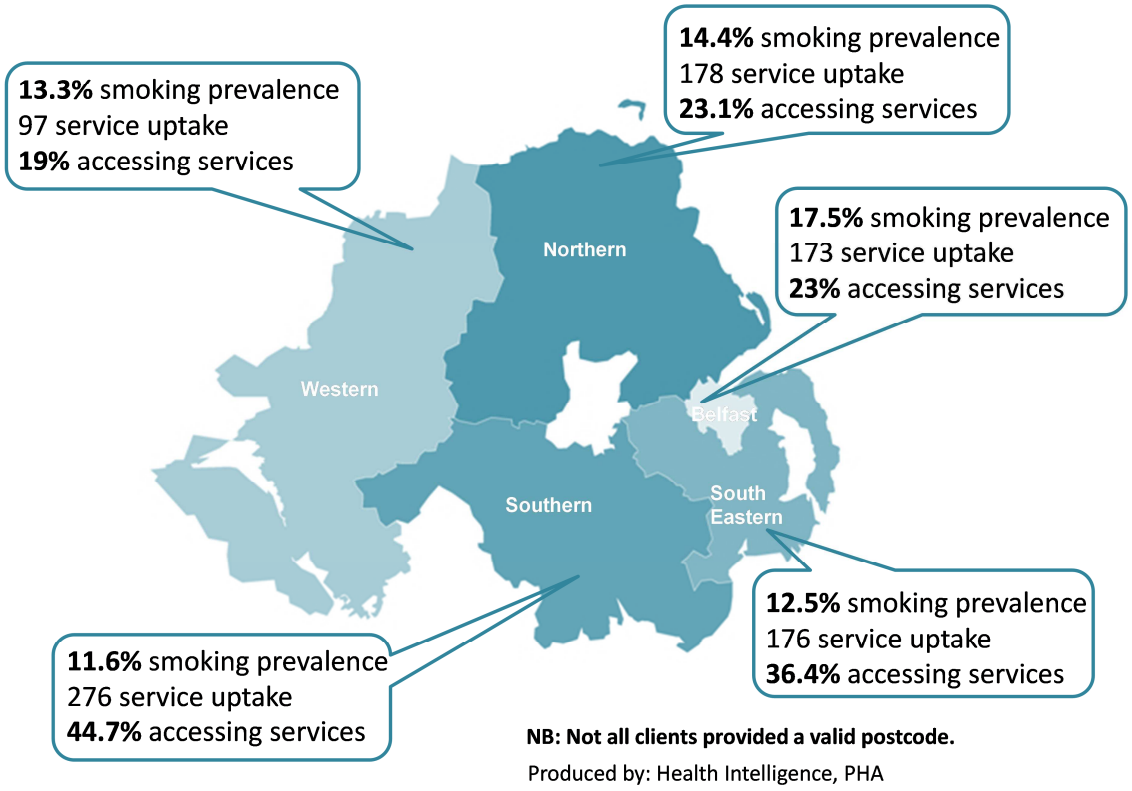
Figure 6.9.4: Age profile of stop smoking service users aged 15-44 and reach of services 2017/18 (n=895)



Local geography

Smoking prevalence and reach of pregnant smokers accessing Stop Smoking Services varied by LCG. Smoking prevalence ranged from the lowest rate of 11.6% within the Southern LCG to the highest rate of 17.5% within Belfast LCG.[1] The Southern LCG had the greatest reach of pregnant smokers accessing services with 44.7% in comparison to 19% within the Western LCG who had the lowest reach.

Figure 6.9.5: Stop smoking services uptake and reach by Local Commissioning Group 2017/18



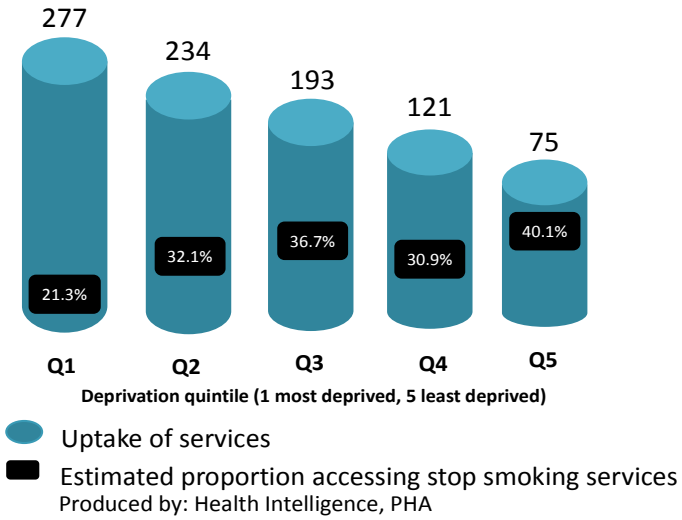
NB: Not all clients provided a valid postcode.

Produced by: Health Intelligence, PHA

Areas of Deprivation

Uptake and reach of services varied across deprivation quintile. Uptake was greatest in the most deprived quintile (n=277) with uptake declining through the quintiles to the lowest uptake in the least deprived quintile (n=75). However, the least deprived quintile had the greatest proportion of pregnant smokers accessing services (40.1%) compared to the lowest reach of 21.3% in the most deprived quintile (Figure 6.9.6).

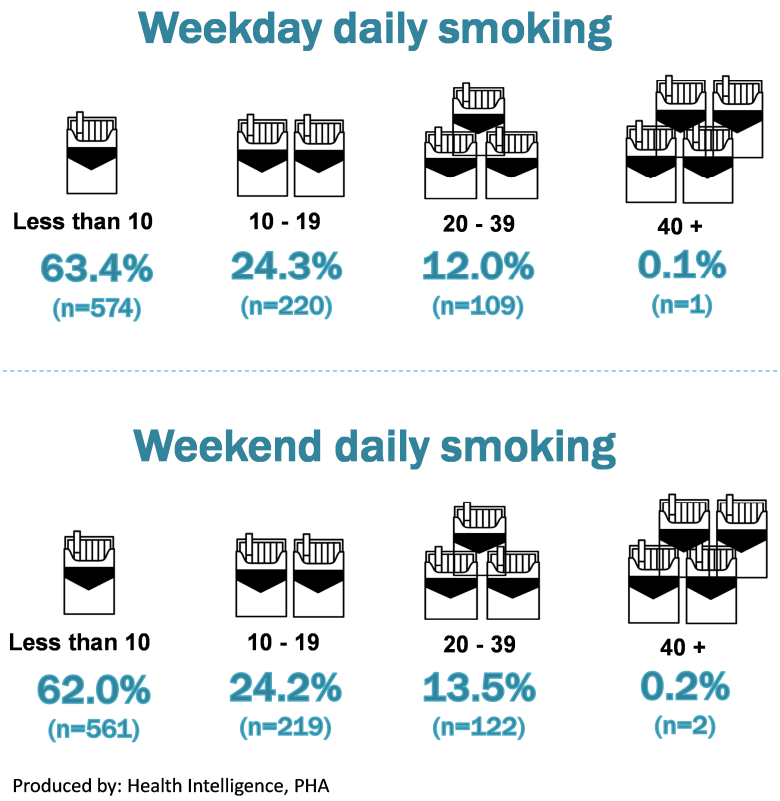
Figure 6.9.6: Uptake and reach of services by MDM quintile 2017/18



Tobacco consumption

Figure 6.9.7 illustrates that the majority of pregnant smokers accessing services smoked on average less than 10 cigarettes each weekday and on a weekend (63.4% and 62% respectively).

Figure 6.9.7: Daily tobacco consumption 2017/18



The majority (94.6%) indicated that they smoked the same amount of cigarettes on weekend days as on weekdays, with 5% smoking more at the weekend and 0.3% indicating that they smoked less at the weekend.

94.6% (n=856)	0.3% (n=3)	5% (n=45)
=	⬇	⬆
Same at weekend	Less at weekend	More at weekend

Type of tobacco smoked

All pregnant smokers accessing services indicated that they smoked cigarettes.

Cigarettes	Cigars	Pipe
100% (n=905)	0% (n=0)	0% (n=0)

Produced by: Health Intelligence, PHA

Previously participated in this service

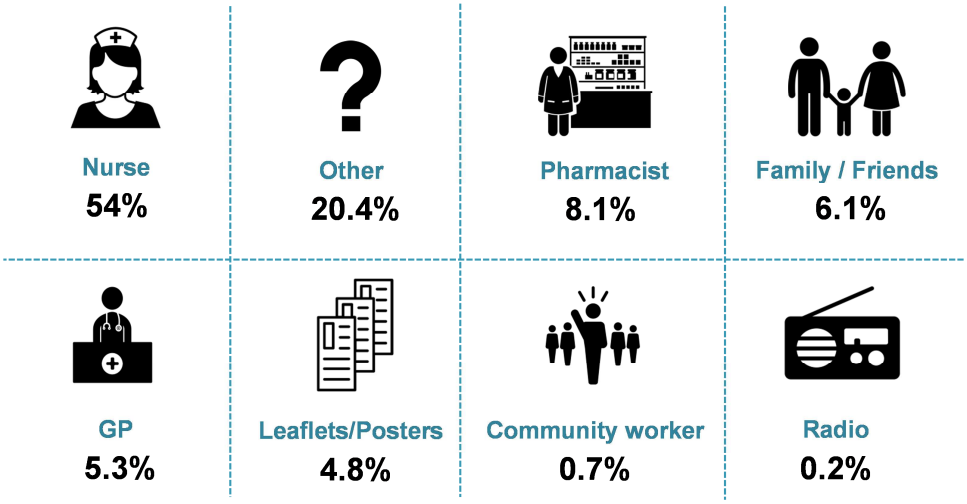
13% of service users who were expectant mothers indicated that they had previously participated in a PHA Stop Smoking Service.

13% (n=117)	83% (n=747)	5% (n=41)
Yes	No	Unknown

Heard about the service

As evident in Figure 6.9.8 the most common way in which service users who were expectant mothers had heard about Stop Smoking Services was via a nurse (54%) followed by other means (20.4%).

Figure 6.9.8: How clients heard about the Stop Smoking Service 2017/18

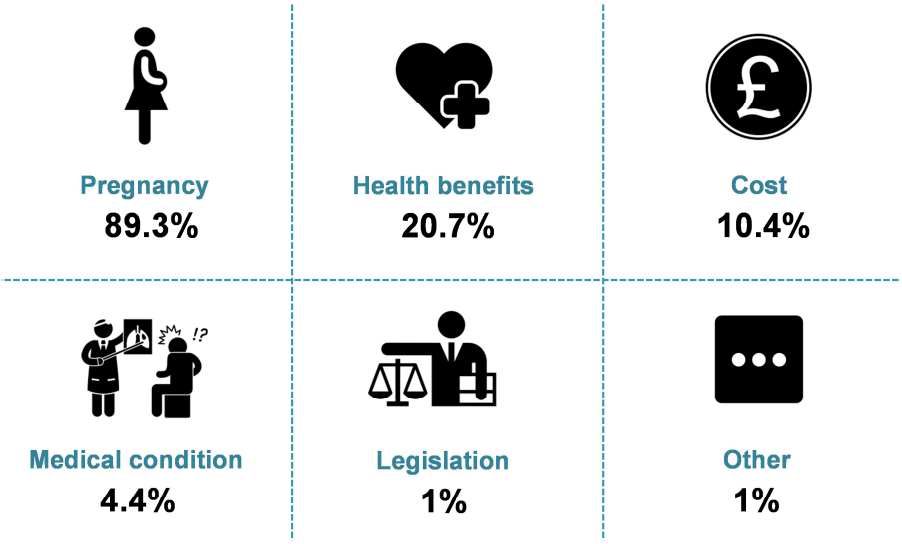


Produced by: Health Intelligence, PHA

Reason for quitting smoking

For the vast majority, the most common reason given for quitting smoking was because they were pregnant (89.3%), followed by for health benefits (20.7%).

Figure 6.9.9: Reasons for quitting smoking 2017/18 (multiple response)

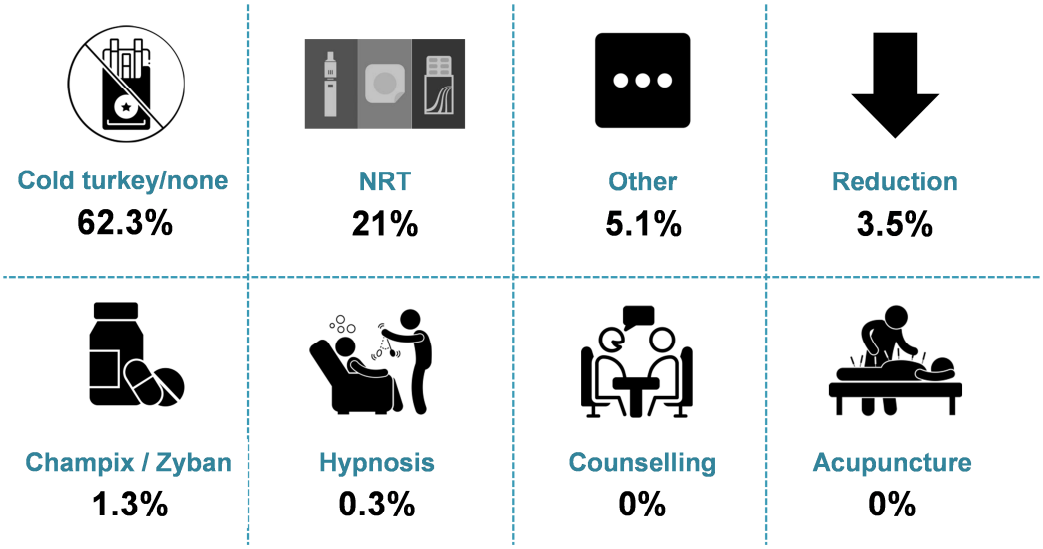


Produced by: Health Intelligence, PHA

Other methods used to give up smoking within the last 3 years

91% of all clients who were expectant mothers indicated that they had tried to give up smoking using other methods within the last 3 years. Figure 6.9.10 highlights that for the majority (62.3%) the most common method used was going cold turkey, followed by NRT (21%). It is important to note that some clients used a combination of quitting methods in their previous attempts.

Figure 6.9.10: Previous quitting methods used 2017/18 (multiple response)



Produced by: Health Intelligence, PHA

Numbers quit at 4 and 52 weeks

In 2017/18 stop smoking services supported 62.2% of expectant mothers who accessed services to successfully quit at 4 weeks and supported 24.4% of those who registered with the service in 2016/17 to remain quit at 52 weeks.

On a positive note, both 4 week and 52 week quit rates observed an increase from that in the previous year, with a 1.1 percentage points increase in 4 week quit rates and a 4.3 percentage points increase in 52 week quit rates (Figure 6.9.11). Therefore stop smoking services continue to maintain a high level of success at helping expectant mothers to quit smoking, with 4 week quit rates ranging from 57% to 62% over the six year period of 2012/13 to 2017/18.

Figure 6.9.11: Four and 52 week quit rates among pregnant smokers 2012/13-2017/18

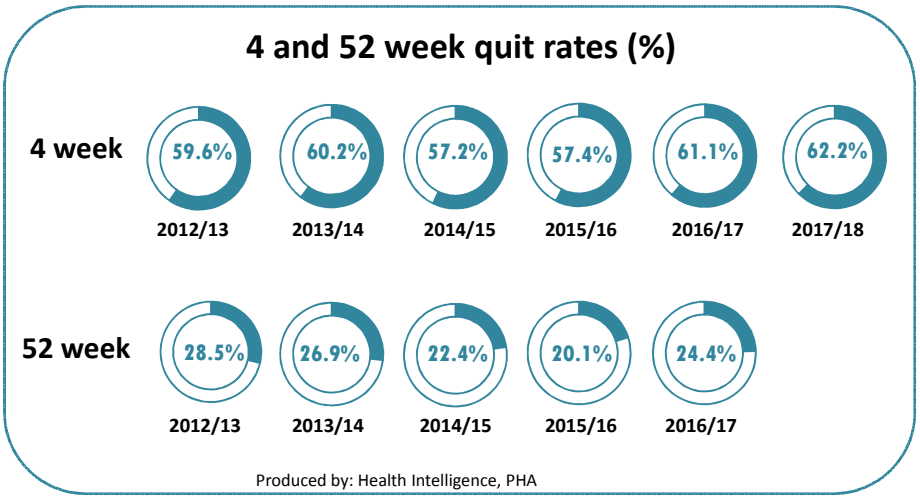
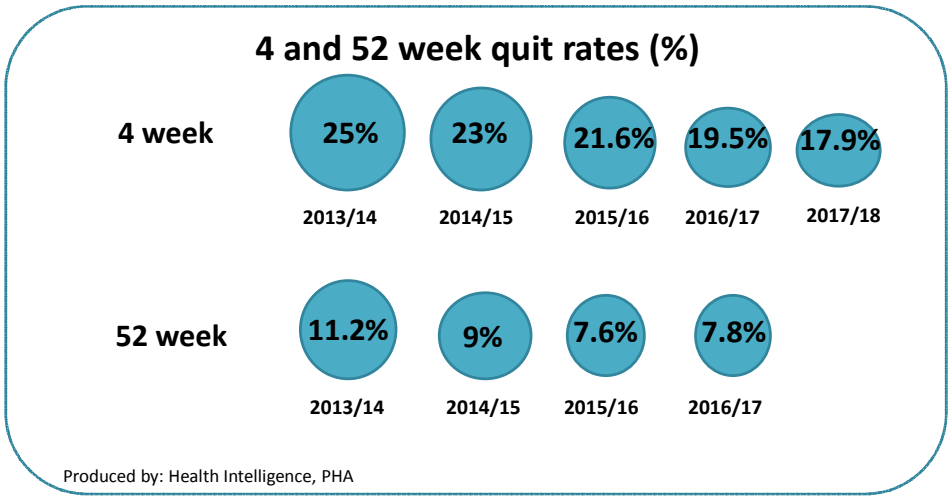


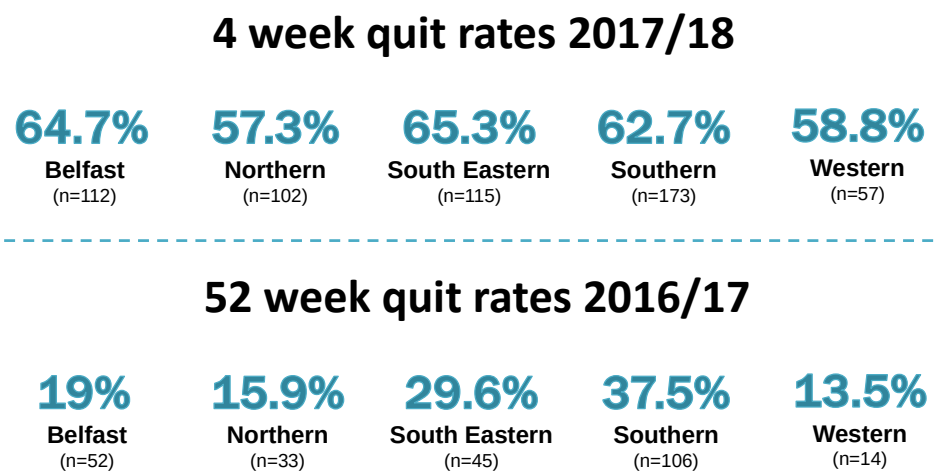
Figure 6.9.12 illustrates that overall, Stop Smoking Services supported an estimated 17.9% of all pregnant women who smoke in NI to quit smoking at 4 weeks, and 7.8% to stay quit at 52 weeks. The estimated proportion of those quit at 4 weeks observed a 1.6 percentage point decline in rates compared to 2016/17. However, the estimated proportion of those remaining quit at 52 weeks observed a slight increase of 0.2 percentage points in the quit rate compared to that in the previous year.

Figure 6.9.12: Estimated proportion of all pregnant smokers quit at 4 and 52 weeks 2013/13-2017/18



Further analysis by LCG highlighted that there was a noticeable difference in the proportion of expectant mothers quitting at 4 and 52 weeks across LCG area. South Eastern LCG supported the highest proportion of clients to quit at 4 weeks (65.3%) in comparison to the Northern LCG with the lowest 4 week quit rates (57.3%). There was a sizable difference in 52 week quit rates across the LCG's ranging from 13.5% in the Western LCG to 37.5% in the Southern LCG (Figure 6.9.13).

Figure 6.9.13: 4 week and 52 weeks quit rates by LCG (%)



Follow up rates

In 2017/18, 13.4% (n=121) of all expectant mothers who registered with a Stop Smoking Service were lost to follow up at 4 weeks as no information was recorded on the outcome of their quit attempt at the 4 week stage. On a positive note, the 4 week quit rate has declined from 14.1% in the previous year.

52 week quit rates are therefore impacted due to clients being lost to follow up at 4 weeks, as there are less clients who can viably be followed up at 52 weeks. Of all expectant mothers who registered with a service in 2016/17, 58.4% did not have any information recorded on the outcome of their quit attempt at 52 weeks. Of all clients who had successfully quit at 4 weeks in 2016/17, 32% did not have any information recorded of their quit attempt at 52 weeks.

Further analysis by provider type shows that pharmacy as the largest provider of services had the greatest proportion of clients not followed up at 4 and 52 weeks (Figure 6.9.14).

Figure 6.9.14: Number and percentage of clients not followed up at 4 and 52 weeks by provider type (%)

Provider Type	Clients not followed up at 4 weeks 2017/18	Clients not followed up at 4 weeks 2016/17	Clients not followed up at 52 weeks 2016/17	Clients who had successfully quit at 4 weeks not followed up at 52 weeks 2016/17
Pharmacy	26.4% (52)	20.7% (58)	72.1% (202)	43.1% (59)
GP	12.5% (1)	8.7% (2)	60.9% (14)	18.2% (2)
Hospital sites	9.6% (61)	14.1% (82)	59.5% (345)	36.7% (136)
Community^	10.6% (7)	2.2% (3)	28.2% (42)	4.5% (5)
Total	**13.4% (121)**	**14.1% (145)**	**58.4% (603)**	**32% (202)**

^Includes schools and workplaces

Produced by: Health Intelligence, PHA

6.10 Quality of services

As in previous years, pharmacy service providers had the greatest number of clients, supporting 70% of all clients registered with stop smoking services during 2017/18, with GP providers supporting only 5% of all clients.

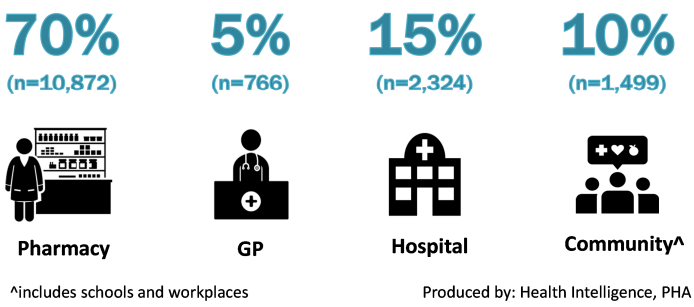
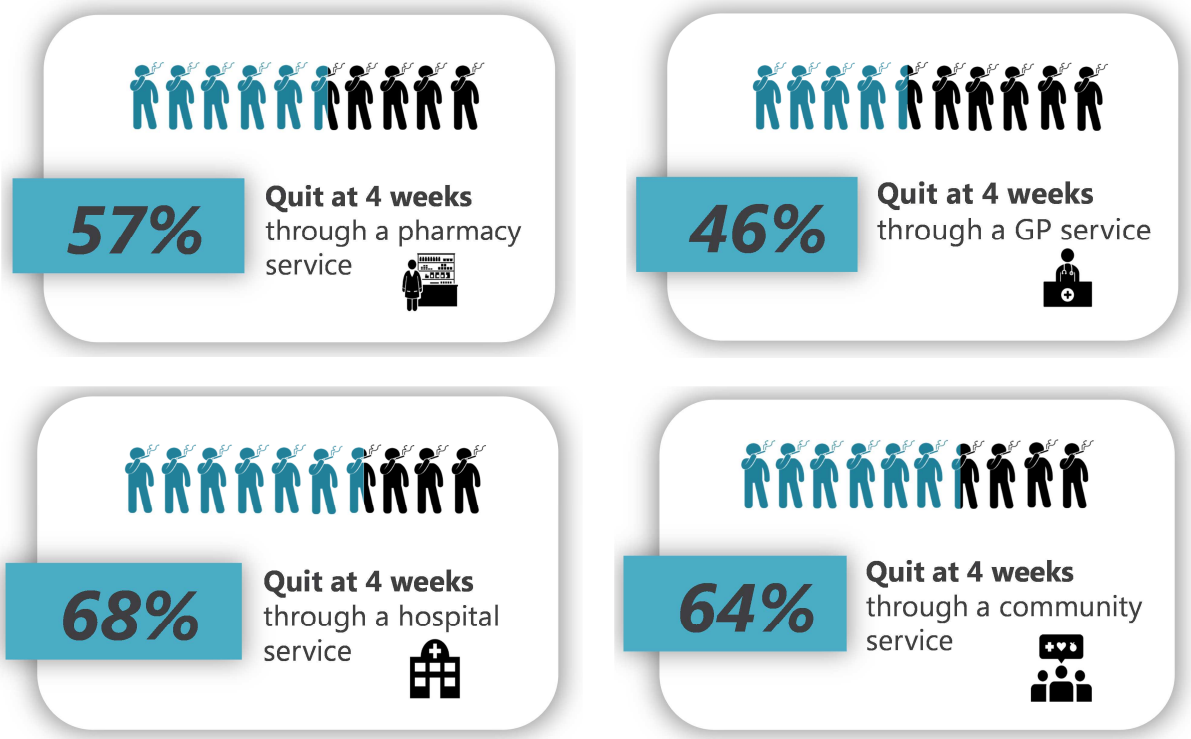


Figure 6.10.1 illustrates that there was a diverse range of 4 week quit rates across provider types, with hospitals having the highest average 4 week quit rate (68%) in comparison to GPs who had the lowest average quit rate (46%).

Figure 6.10.1: 4 week quit rates by provider type 2017/18



Recommendations within the Northern Ireland Quality Standards state that all providers of specialist stop smoking services should maintain an average 4 week quit rate of 45% or above and those providers with a 4 week quit rate below 35% will then be subject to review.[21]

As evident in Figure 6.10.2, GPs had the highest proportion of providers not meeting the recommended 4 week quit rate of 45% or above in 2017/18. Just over half (54%) of GP providers did not meet the recommendations, with 44.3% of providers having quit rates below 35% and 9.8% with quit rates between 35% - 44.9%. Hospitals had the highest proportion of providers meeting the recommendations with almost all providers (92.9%) having 4 week quit rates of 45% and over.

Figure 6.10.2: Average 4 week quit rates and percentage of providers with 4 week quit rates below and above the quality standards recommendations, by provider type 2017/18

Provider Type	Average 4 week quit rate of providers %(n)*	4 week quit rate of under 35% %(n)*	4 week quit rate of 35% - 44.9% %(n)*	4 week quit rates of 45% and over %(n)*
Pharmacy	56.9% (447)	14.3% (64)	10.1% (45)	75.6% (338)
GP	45.7% (61)	44.3% (27)	9.8% (6)	45.9% (28)
Hospital sites	67.6% (14)	7.1% (1)	0% (0)	92.9% (13)
Community^	64.4% (62)	17.7% (11)	6.5% (4)	75.8% (47)
Total	**58.7% (584)**	**17.6% (103)**	**9.4% (55)**	**73% (426)**

*n=number of providers, ^Includes schools and workplaces

Produced by: Health Intelligence, PHA

Quality improvement programme

A new quality improvement programme for the Stop Smoking Services was launched in 2012/13. As part of this programme a self-monitoring tool was developed and is displayed on the web-based monitoring system utilised by all service providers. This monitoring tool allows all providers to self-monitor the number of clients who have registered with their service, the number quit at 4 weeks and the 4 week quit rate within the current and previous years. All providers are provided with the Quality

Standards along with guidance to help them improve the overall quit rate and performance of their service.

Figure 6.10.3: Online view of service providers self-monitoring tool

The Quality Standards for Stop Smoking Services (click link to view) requires that services achieve a quit rate of 45-50% at four weeks. Services who have quit rates of less than 35% will be subject to review by the Public Health Agency / Health and Social Services Board.

Below are shown the figures for your service.

Data downloaded in April 2017 shows the following details for your service last year (1 April 2016 - 31 March 2017):

1 April 2016 - 31 March 2017	
Clients Enrolled	16
Number of Successful Quits	9
4-Week Quit Rate	56%

As of today, your service data from the 1st April 2017 shows the following:

1 April 2017 - Today	
Clients Enrolled	18
Number of Successful Quits	4
4-Week Quit Rate	22%

Given the high number of clients utilising pharmacy services and the high numbers of community pharmacies engaged with the Stop Smoking Services, an enhanced support quality improvement programme was introduced in partnership with the Health and Social Care Board (HSCB) and in collaboration with community pharmacy NI. This quality improvement support service was specifically targeted at pharmacies with quit rates of fewer than 35% given the high proportion of services delivered through this sector. This support mechanism involved a number of stages:

1. *Written notification to all pharmacy providers (prior to implementation of support system) detailing;*
   - *Explanation of new quality improvement support services;*
   - *Timelines for commencement of support service;*
   - *Necessity to ensure all client information is up to date on web based system.*

2. *Written notification to all providers with four week quit rates of 'under 35%' to indicate automatic involvement in support service and*
   - *Access to an online exercise to self-monitor overall service provision against Quality Standards;*
   - *Provision of service update training[v];*
   - *Mid-year quit rate review;*
   - *On-going support letters;*
   - *Opportunity to discuss service delivery with the PHA/HSCB.*

[v] Providers are required to undertake update training every three years following completion of Specialist training which is required at initial registration of service.

The impact of self-monitoring and quality improvement

Although 4 week quits rates had remained relatively consistent over the previous four years among pharmacy and GP providers, 2017/18 observed a decline in rates, with pharmacy providers observing a 1.3 percentage point decline and GP providers observing a 5.2 percentage point decline. However, both hospital and community providers observed an increase in quit rates in 2017/18 from the previous year, with hospital providers seeing a 1.2 percentage point increase and community providers seeing a 2.3 percentage point increase.

Figure 6.10.4: Average 4 week quit rates by provider type 2013/14 – 2017/18

Provider Type	Average 4 week quit rate 2013/14 %(n)*	Average 4 week quit rate 2014/15 %(n)*	Average 4 week quit rate 2015/16 %(n)*	Average 4 week quit rate 2016/17 %(n)*	Average 4 week quit rate 2017/18 %(n)*
Pharmacy	58.6% (456)	58.2% (459)	57.5% (467)	58.2% (456)	56.9% (447)
GP	49.8% (124)	50.6% (111)	49.4% (101)	50.9% (76)	45.7% (61)
Hospital	67.3% (11)	61.9% (12)	67% (15)	66.4% (15)	67.6% (14)
Community^	65.8% (76)	66.3% (73)	63.4% (61)	62.1% (66)	64.4% (62)
Total	59.4% (667)	58.8% (655)	58.9% (644)	59.2% (613)	58.7% (584)

*n=number of providers, ^Includes schools and workplaces
Produced by: Health Intelligence, PHA

In 2017/18 the proportion of providers achieving a quit rate below 35% has seen a considerable rise from that in the previous year, across all provider types. GP providers remain to have the highest proportion of providers achieving 4 week quit rates below 35%. GP providers also observed a substantial increase in the proportions achieving a quit rate below 35%, with a 15.3 percentage point's increase from 2016/17, the most substantial increase in any one year since 2013/14.

Figure 6.10.5: Proportion of providers with 4 week quit rates under 35% by provider type 2013/14 – 2017/18

Provider Type	Achieving 4 week quit rate of under 35% 2013/14 %(n)*	Achieving 4 week quit rate of under 35% 2014/15 %(n)*	Achieving 4 week quit rate of under 35% 2015/16 %(n)*	Achieving 4 week quit rate of under 35% 2016/17 %(n)*	Achieving 4 week quit rate of under 35% 2017/18 %(n)*
Pharmacy	6.1% (28)	5.9% (27)	8.1% (38)	9% (41)	14.3% (64)
GP	26.6% (33)	31.5% (35)	34.7% (35)	29% (22)	44.3% (27)
Hospital	9.1% (1)	16.7% (2)	6.7% (1)	6.7% (1)	7.1% (1)
Community^	15.8% (12)	11% (8)	13.1% (8)	9.1% (6)	17.7% (11)
Total	**11.1% (74)**	**11% (72)**	**12.7% (82)**	**11.4% (70)**	**17.6% (103)**

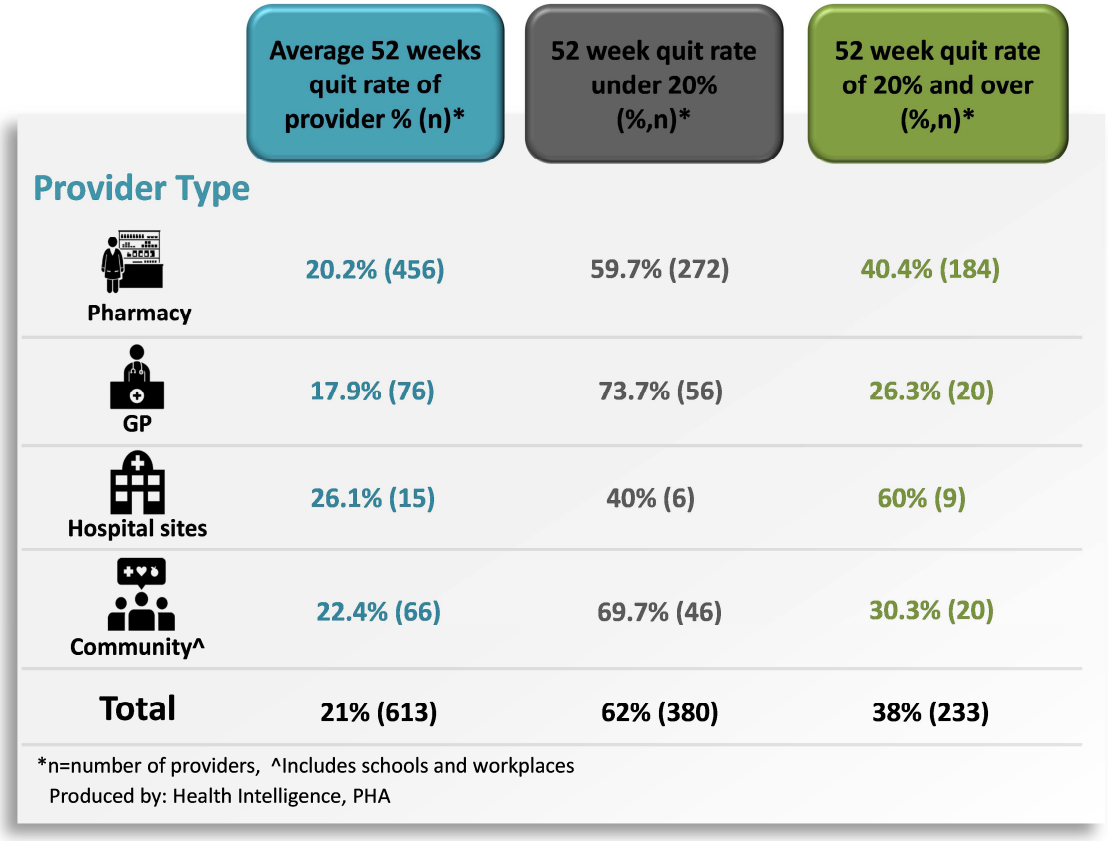
*n=number of providers, ^Includes schools and workplaces
Produced by: Health Intelligence, PHA

Examining 52 week quit rates per quality standard recommendations

Another recommendation within the Quality Standards states that service providers should also maintain a 52 week quit rate of 20% or more.[21] Overall, the average 52 week quit rate was 21% in 2016/17 which is consistent with the previous year's rate of 21.1%. However, further analysis by provider type highlighted a variance in the average 52 week quit rates across provider types, ranging from the lowest rate of 17.9% among GP providers to the highest quit rate of 26.1% among hospital providers. Akin to the previous year, GP providers were the only type of provider attaining an average 52 week quit rate below the required 20% (Figure 6.10.6).

Figure 6.10.6 illustrates that just over 1 in every 2 providers had an average 52 week quit rate below the required level of 20% (62%) an increase of 3.8 percentage points from 2015/16 (58.2%), which is cause for concern. There was a diverse range of quit rates across provider types, with GPs having the largest proportion of providers (73.7%) with a quit rate below the required 20% followed by community providers (69.7%). Hospital providers had the greatest proportion of providers achieving the required level of 20% or above (60%).

Figure 6.10.6: Average 52 week quit rates and proportion of providers with 52 week quit rates below and above the quality standards required 20% by provider type 2016/17



Provider Type	Average 52 weeks quit rate of provider % (n)*	52 week quit rate under 20% (%,n)*	52 week quit rate of 20% and over (%,n)*
Pharmacy	20.2% (456)	59.7% (272)	40.4% (184)
GP	17.9% (76)	73.7% (56)	26.3% (20)
Hospital sites	26.1% (15)	40% (6)	60% (9)
Community^	22.4% (66)	69.7% (46)	30.3% (20)
Total	**21% (613)**	**62% (380)**	**38% (233)**

*n=number of providers, ^Includes schools and workplaces
Produced by: Health Intelligence, PHA

Yearly tracking of 52 week quit rates

Overall, the average 52 week quit rate has observed a gradual decline over the three previous years from 2013/14 to 2016/17, however in 2016/17 the quit rate remained consistent with that in the previous year. On a positive note, a rise in the average 52 week quit rate was evident across provider types from the previous year with the exception of Pharmacy providers who observed a slight decrease of 0.5 percentage points compared to the previous year. Hospital providers remain to have the greatest average 52 week quit rate over the 4 year period (Figure 6.10.7).

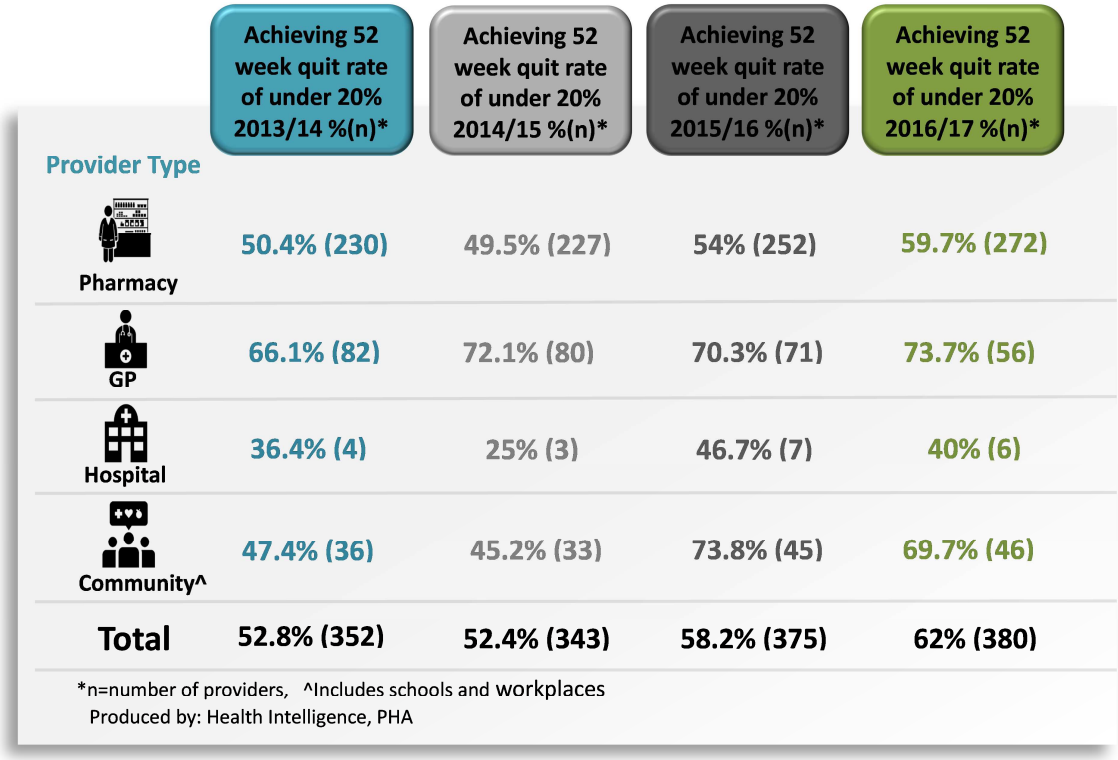
Figure 6.10.7: Average 52 week quit by provider type 2013/14 – 2016/17

Provider Type	Average 52 week quit rate 2013/14 %(n)*	Average 52 week quit rate 2014/15 %(n)*	Average 52 week quit rate 2015/16 %(n)*	Average 52 week quit rate 2016/17 %(n)*
Pharmacy	22.8% (456)	22% (459)	20.7% (467)	20.2% (456)
GP	19.2% (124)	16.1% (111)	16.9% (101)	17.9% (76)
Hospital	33.8% (11)	29.3% (12)	25% (15)	26.1% (15)
Community^	29.4% (76)	29.2% (73)	21.8% (61)	22.4% (66)
Total	**24.4% (667)**	**23.2% (655)**	**21.1% (644)**	**21% (613)**

*n=number of providers, ^Includes schools and workplaces
Produced by: Health Intelligence, PHA

As shown in Figure 6.10.8, the proportion of providers achieving a 52 week quit rate below the required level of 20% or above has observed an increase of 3.8% percentage points from that in the previous year (58.2% to 62% respectively). By provider type, both pharmacy and GP providers observed an increase in the proportion of providers demonstrating 52 week quit rates below the recommended level. In contrast, both hospital and community providers observed a decline in proportions demonstrating a quit rate below the required level of 20%. Although hospital providers appeared to demonstrate improving 52 week quit rates in 2016/17, it should be noted that the smaller number of providers within this group may overly inflate percentage changes.

Figure 6.10.8: Proportion of providers with 52 week quit rates under 20% by provider type 2013/14 – 2016/17



Provider Type	Achieving 52 week quit rate of under 20% 2013/14 %(n)*	Achieving 52 week quit rate of under 20% 2014/15 %(n)*	Achieving 52 week quit rate of under 20% 2015/16 %(n)*	Achieving 52 week quit rate of under 20% 2016/17 %(n)*
Pharmacy	50.4% (230)	49.5% (227)	54% (252)	59.7% (272)
GP	66.1% (82)	72.1% (80)	70.3% (71)	73.7% (56)
Hospital	36.4% (4)	25% (3)	46.7% (7)	40% (6)
Community^	47.4% (36)	45.2% (33)	73.8% (45)	69.7% (46)
Total	52.8% (352)	52.4% (343)	58.2% (375)	62% (380)

*n=number of providers, ^Includes schools and workplaces
Produced by: Health Intelligence, PHA

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References for icons

1. Man smoking icon by Gan Khoon Lay
2. Human icon by Gan Khoon Lay
3. Coffin icon by Iconic
4. Grave icon by Iconic
5. E-cigarette icon by David Marioni
6. No e-cigarette icon by Stephen Plaster
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