healthwatch Norfolk

Smoking Cessation 25/26

An evaluation of the smoking cessation services in Norfolk

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Who we are and what we do

Healthwatch Norfolk is the independent voice for patients and service users in the county. We gather people's views of health and social care services in the county and make sure they are heard by the people in charge.
The people who fund and provide services have to listen to you, through us. So, whether you share a good or bad experience with us, your views can help make changes to how services are designed and delivered in Norfolk.
Our work covers all areas of health and social care. This includes GP surgeries, hospitals, dentists, care homes, pharmacies, opticians and more.
We also give out information about the health and care services available in Norfolk and direct people to someone who can help.

At Healthwatch Norfolk we have five main objectives:

1. Gather your views and experiences (good and bad)
2. Pay particular attention to underrepresented groups
3. Show how we contribute to making services better
4. Contribute to better signposting of services
5. Work with national organisations to help create better services

We make sure we have lots of ways to collect feedback from people who use Norfolk's health and social care services. This means that everyone has the same chance to be heard.

Summary

Smoking remains a significant public health issue both nationally and within Norfolk, despite continued declines in prevalence over recent years. While local smoking rates are lower than the national average, and a substantial proportion of people have successfully stopped smoking, smoking continues to contribute to poor health outcomes, inequalities and preventable harm. Smoking rates vary across the county and are higher among some groups of people. This highlights the ongoing importance of ensuring effective, accessible and equitable smoking cessation support.

This evaluation explored the views and experiences of people in Norfolk via a survey, two focus groups with local residents and a focus group with community matrons. It provides insight into awareness of services, experiences of accessing support, barriers to stopping smoking, and what people felt would help them stop smoking successfully.

Overall, awareness of stop smoking support in Norfolk appears to be limited. Around half of survey respondents were aware of Smokefree Norfolk and GP-based support, while awareness of other services was lower. Findings from focus groups support this, with participants often unsure about what help was available or how to access it. This suggests that many people may not be accessing support simply because they are unaware of it.

Experiences of smoking cessation services were mixed. Some people reported positive outcomes, particularly when they received ongoing support, regular contact with advisors, access to nicotine replacement therapy or medication. However, many others described challenges, particularly in relation to the Smokefree Norfolk service.

Key issues included long waiting times, lack of face-to-face support, limited treatment options and inability to access prescription medications.

A strong theme across the findings was inconsistency in access to support. Participants described a “postcode lottery”, where the type of help available depended on their location or GP practice involvement. These inconsistencies can reduce confidence in services and may discourage people from seeking help.

Participants identified a wide range of barriers to stopping smoking. Personal factors were commonly reported, particularly the fear of stopping, as well as the role that smoking played as a coping mechanism. Practical barriers included long waiting times, limited appointment availability, travel difficulties and support ending too soon.

Several factors were identified that support people to stop smoking. Health concerns were a key motivator, as well as the desire to protect others, especially children. Financial savings and personal motivation also played a role, although not everyone felt ready to stop smoking, highlighting the importance of supporting people at different stages of readiness.

Many participants expressed a preference for in-person support, with telephone support being the least preferred option. There was a desire for more holistic and personalised approaches to smoking cessation as many participants felt that current support focuses too much on nicotine replacement without fully addressing the underlying reasons for smoking, such as stress or poor mental health.

Views on treatment options varied. Nicotine replacement therapy and prescription medications were reported as helpful by many, although access to medication was difficult and some reported side effects.

Vaping was the most commonly accepted harm reduction option in the survey, but overall views were mixed. Many participants expressed concerns about replacing one addiction with another, the unknown long-term health impacts, and the lack of support available for people who want to stop vaping after stopping smoking.

In summary, while smoking cessation support is available in Norfolk, a combination of limited awareness, inconsistent access and gaps in how services are delivered is affecting engagement and outcomes. Addressing these challenges through improved communication, more consistent and flexible service delivery and a greater focus on personalised and holistic support could help more people to successfully stop smoking.

Recommendations:

1) Improve access and consistency of smoking cessation support across Norfolk.
2) Improve ability to re-engage with services following relapse.
3) Improved responsiveness and communications within Smokefree Norfolk.
4) Expand and diversify models of smoking cessation support, including holistic approaches.
5) Improve awareness and advertisement of smoking cessation.
6) Address gaps in support for those wanting to stop vaping.
7) Work to improve participation amongst 18-24-year-olds in future projects.

Why we looked at this

Smoking remains a significant public health issue, causing harm not only to people who smoke, but also those exposed to second hand smoke. Cigarette smoke contains more than 5000 chemicals, including nicotine which is highly addictive (Asthma + Lung UK, 2024). Many of the other chemicals present in tobacco smoke are toxic or can cause cancer, contributing to a wide range of preventable illnesses and long-term conditions. Over recent years, sustained national and local efforts have been made to reduce smoking prevalence and support people to stop smoking. In the UK, an estimated 10.6% of adults, approximately 5.3 million people, were current smokers in 2024 (Office for National Statistics, 2025). While this represents a substantial number of people, it is the lowest smoking prevalence recorded since data collection began in 2011, indicating continued progress in smoking prevention and cessation. However, with around one in ten adults still smoking, it remains a population-wide public health concern, highlighting the importance of continued prevention and cessation efforts.

Despite these overall improvements, smoking prevalence is not evenly distributed across the population. Smoking rates remain higher among men than women, with 12.3% of men reporting that they smoke, compared to 9.0% of women (Office for National Statistics, 2025). Smoking prevalence is also significantly higher in more deprived communities and among people living with certain health conditions. Between 2022 and 2024, adults living in the most deprived areas of England were considerably more likely to smoke than those in the least deprived areas (Office for Health Improvement & Disparities, 2025). In addition, around 40.5% of adults living with a serious mental illness (SMI) are reported to be smokers (Department of Health & Social Care, n.d.). These disparities highlight ongoing health inequalities and the continued need for targeted and accessible support.

In Norfolk, smoking prevalence is lower than the national average. In 2024, 8.7% of adults in the county were reported to be smokers, which is less than the UK average of 10.6% (Department of Health & Social Care, n.d.). Additionally, 34.4% of adults in Norfolk are ex-smokers, compared to 26% across England, suggesting that significant progress has been made locally in supporting smoking cessation. However, smoking prevalence varies across the county. Norwich has

the highest proportion of current smokers at 14.6%, while North Norfolk as the lowest at 5.2% (Office for National Statistics, 2025). Despite these positive trends, smoking continues to have a substantial impact locally, with the estimated cost of smoking-related harm in Norfolk reaching approximately £872 million a year (Norfolk County Council Public Health, 2024).

Reducing smoking prevalence among children and young people has been a particular focus of recent public health policy, reflecting the importance of preventing smoking initiation and therefore long-term smoking at a young age. In 2026, new legislation was agreed which aims to introduce a lifelong ban on the purchase of cigarettes for anyone born on or after 1 January 2009, with the long-term aim of creating a smoke-free generation (Department of Health and Social Care, 2026). This approach is supported by evidence showing that most people who become long-term smokers first try smoking before the age of 18 (ASH, 2025). Despite progress, smoking and nicotine use among children and young people remain a concern. In 2023, around 11% of children aged 11-15 reported that they had tried smoking at least once, with 3% identified as regular smokers (NHS England, 2024). Local data mirrors this national picture. In Norfolk, recent insight found that over one in ten children aged 10-18 reported having smoked at least once, while just under 4% of children currently smoke (Norfolk County Council Public Health, 2025). These findings suggest that continued preventative action and youth-focused support remain vital at both national and local levels.

Smoking is the leading cause of preventable illness and premature death in England. It is estimated that around half of all lifelong smokers die prematurely as a result of a smoking-related disease (Public Health England, 2019). Smoking is linked to a wide range of serious and long-term health conditions, including several types of cancer (such as lung cancer), cardiovascular disease, chronic obstructive pulmonary disease (COPD), infertility, dementia and complications during pregnancy and childbirth (NICE, 2026). In addition to its physical health impacts, smoking can also have a significant effect on mental wellbeing. Nicotine dependence can contribute to a cycle in which symptoms of anxiety and depression are reinforced rather than relieved, as withdrawal symptoms set in between cigarettes (NHS Better Health, n.d.). This can increase reliance on smoking and make it more difficult for people to stop, further aiding addiction.

The harms caused by smoking extend beyond the individual who smokes to those around them. The majority of cigarette smoke is released into the surrounding air, rather than being inhaled directly by the smoker, increasing the

risk of exposure for others. Second-hand smoke is a known carcinogen (substance that causes cancer), and exposure has been linked to an increased risk of coronary heart disease, stroke and lung cancer, as well as the worsening of asthma symptoms (CDC, 2025). Babies and very young children are particularly vulnerable to the effects of second-hand smoke. Exposure during infancy and early childhood has been associated with an increased risk of developing asthma, lung and ear infections, meningitis and sudden infant death syndrome (SIDS) (Asthma + Lung UK, 2025). These wider impacts underline the importance of addressing smoking not only as an individual health behaviour, but as a broader public health issue that affects families, communities and the wider population.

Smoking rates among adults in the UK have continued to decline over a number of years, with an increasing number of people choosing to stop smoking. Despite this progress, smoking is highly addictive and stopping can be challenging for many people. Over half of people who smoke in the UK report that they would like to stop, but many experience tobacco withdrawal symptoms when they attempt to do so (NICE, 2026). These can include strong cravings, increased appetite, irritability, low mood and difficulties with concentration (Norfolk County Council, n.d.). In addition to nicotine dependence, there are social and psychological factors which can also discourage people from stopping. Some individuals perceive smoking as a way of managing stress or view it as an important part of their social interactions. However, stopping smoking offers significant benefits. People who stop smoking experience both immediate and long-term improvements to their health, such as breathing more easily, having increased energy levels, and reducing their risk of developing serious conditions including heart disease and cancer (Norfolk County Council, n.d.). Stopping smoking can also lead to substantial financial benefits. A 2023 report found that the average smoking household spends over £3300 each year on cigarettes, equating to almost 8% of annual household income (ASH Scotland, 2023). Stopping smoking therefore not only supports better health but can also help people save money which can be used to improve their overall quality of life.

There are a range of methods available to support people to stop smoking, and different approaches may be more suitable or effective for different individuals. While some people choose to stop smoking without formal support, either by gradually reducing the amount they smoke, or by immediately stopping altogether, many people benefit from additional services and treatments to help them stop. Smoking cessation support is available in a variety of formats and can vary depending on where someone lives. These services typically aim to

provide information, advice and practical support, particularly during the early weeks and months after stopping. Support may be delivered through one-to-one sessions, group-based programmes, online services or through digital platforms such as apps and websites.

Alongside behavioural support, there are a number of treatments available to help manage nicotine dependence. One of the most commonly used is nicotine replacement therapy (NRT), which works by reducing cravings and withdrawal symptoms through the delivery of low doses of nicotine without the harmful chemicals found in cigarette smoke (Better Health, n.d.). NRT is available in several forms including patches, gum, lozenges, sprays, tablets and inhalators. In addition to NRT, three medications are currently approved for use in smoking cessation: varenicline, cytisinicline and bupropion hydrochloride (NICE, n.d.). Varenicline and cytisinicline work by reducing the pleasurable effects of nicotine in the brain and lowering cravings, where bupropion hydrochloride affects brain chemistry to help reduce withdrawal symptoms and the urge to smoke (Better Health, n.d.)

E-cigarettes, also known as vapes, were introduced in the UK in the mid-2000s as an alternative to smoking and have since become a widely used smoking cessation aid, with their use having increased substantially over time (Britton & Bogdanovica, 2014). In October 2013, when e-cigarettes were still relatively new, only 2% of ex-smokers reported vaping. By 2025, this had risen to 18%, with a further 19% of ex-smokers reporting that they had previously vaped but no longer do so (Jackson, Brown, Kock, & Shahab, 2024) (ASH, 2025). Unlike cigarettes, e-cigarettes do not burn tobacco and therefore do not produce tar or carbon monoxide. Instead, they work by heating a liquid which typically contains nicotine along with other ingredients, to create a vapour that is inhaled (NHS, 2022). As of 2024, an estimated 5.4 million adults aged 16 and over in Great Britain reported using e-cigarettes either daily or occasionally, exceeding the figure for the number of people who currently smoke cigarettes for the first time (Office for National Statistics, 2025). Perceptions of e-cigarette use as an acceptable or approved alternative to smoking are also widespread. Research has found that over half of UK respondents who vape, felt that e-cigarette use was approved by the government, while almost one quarter believed healthcare professionals held positive views towards vaping (Machado, Feldman, Menezes do Anaral, Ronzani, & Richter, 2022).

Evidence from clinical trials suggests that e-cigarettes can be an effective aid for smoking cessation when used as part of an attempt to stop smoking (Ashour,

2023). However, emerging evidence indicates that e-cigarette use is not limited to people who smoke or who are trying to stop. Between 2021 and 2024 the number of adults who vape but have never regularly smoked cigarettes increased rapidly, with around one million people regularly using e-cigarettes (Jackson, Shahab, Tattan-Birch, & Brown, 2024). Of particular concern is the rise in vaping among children and young people. In 2023, 9% of children aged 11-15 reported current e-cigarette use and around one in four had tried vaping. Among those who had tried e-cigarettes, only 5% had previously smoked tobacco (NHS England, 2024). This suggests that for some groups, e-cigarettes are being used independently of smoking cessation and raises concerns about the potential for nicotine dependence among people who have never smoked.

Between April and June 2025, 88,776 people were referred into stop smoking services in England and 71.6% of these referrals led to the individual attempting to stop (NHS England, 2025). In Norfolk, smoking cessation support is provided through a range of commissioned and locally available services. REED Wellbeing delivers the county wide stop smoking service, SmokeFree Norfolk, which offers tailored support to help people stop smoking. This can include one-to-one sessions with a trained advisor, group support, an online programme, access to free nicotine replacement therapy products and a free vape starter kit (SmokeFree Norfolk, n.d.). In addition, NCC Public Health has funded a limited number of places on Allen Carr's Easyway (ACE) stop smoking seminars, which are available to people who currently smoke cigarettes (Allen Carr's Easyway, n.d.). Some GP practices and community pharmacies across Norfolk also provide stop smoking support, including access to NRT and prescription smoking cessation medications (Norfolk County Council, 2026).

In 2025 we were asked by NCC Public Health to deliver an independent evaluation of smoking cessation services in Norfolk through engagement with residents on their views, experiences and barriers to stopping smoking. The evaluation aimed to include the views of current smokers, those who had recently stopped and those who have attempted to stop but relapsed.

How we did this

The aim of this project was to provide an independent evaluation of smoking cessation services in Norfolk by engaging with local residents to understand their views, experiences and barriers to stopping smoking. We aimed to engage with current smokers, those who have stopped in the last five years and those who have attempted to stop but relapsed.

Survey:

Healthwatch Norfolk worked collaboratively with NCC Public Health to develop a survey aligned with the aims and objectives of this evaluation. To maximise reach and accessibility, the survey was made available in both online and paper formats, with the online version being available on SmartSurvey. In addition, respondents were offered the option to complete the survey by telephone by calling Healthwatch Norfolk. The full survey is included in the appendices of this report. All survey data was collected between the 21 November 2025 to 28 February 2026.

The survey was promoted through multiple channels, including the Healthwatch Norfolk website, social media platforms and the organisation's newsletter. To ensure the inclusion of people who may be digitally excluded, Healthwatch Norfolk also undertook targeted community engagement sessions. This involved attending community locations where individuals could complete the survey on site or take away a paper copy to return by post. Engagement took place across a range of settings, including supermarkets, libraries, GP surgeries and leisure centres.

Focus Groups:

In addition to the survey, Healthwatch Norfolk conducted three focus groups to gather in depth feedback and ensure we engaged with those who are digitally excluded. We held two focus groups with members of the public to gather insights into residents' views and experiences of smoking cessation services within Norfolk, and one focus group with local community matrons to gather the perspectives of clinical staff and their views. Community matrons are

experienced healthcare professionals who act as a single point of contact for a patient and work with their carers, doctors and other services to organise and help manage a person's care. The focus groups with members of the public were held on 28 January 2026 and 17 February 2026, with one being held in a local community venue and the other online via Zoom. There were three public participants in the in-person focus group and four in the online focus group. The community matron focus group was held on 12 March 2026 via Microsoft Teams, and four community matrons attended.

Participants were recruited through advertisements on Healthwatch Norfolk's social media channels and through an expression-of-interest option included at the end of the survey. Individuals who indicated that they were willing to participate were subsequently contacted and invited to attend a focus group.

Each focus group lasted approximately 90 minutes. Sessions were facilitated by members of Healthwatch Norfolk staff, who aimed to create a relaxed and supportive environment to encourage open discussion. A discussion guide was used to structure the session and ensure key topics relevant to the evaluation were explored. Open questions were used to introduce new key topics, while facilitators encouraged all participants to contribute by asking whether if they had anything to add. Clarifying and follow up questions were also used to explore topics raised by participants or to seek further information. However, facilitators also allowed space for participants to share their experiences freely with natural discussion and debate encouraged to develop throughout the sessions.

Participants' involvement and consent in line with General Data Protection:

Informed consent was obtained from all participants. Clear information was provided about the purpose of the research, how data would be used, how long it would be retained, and participants' right to withdraw consent at any time prior to publication of the final report. All survey questions were optional, allowing participants to skip any they did not wish to answer. Participants were assured that responses would be anonymised, with any identifiable information removed before inclusion in the report. Digital data were stored securely on password-protected hard drives, and paper responses were kept in a locked drawer at the Healthwatch Norfolk office. For participants taking part in the focus groups, informed consent was obtained at the start of each session, including consent to audio recording for the purpose of transcribing to aid with report writing. Recordings were made using dictaphones for in person sessions, which

were stored securely in a locked cabinet at the Healthwatch Norfolk office when not in use, and via Microsoft Teams for online focus groups. All data collected as part of the project will be securely deleted at the end of the project in accordance with relevant data protection regulations and Healthwatch Norfolk's data retention policy.

Limitations:

One limitation of the report is that it may not fully represent the views of young people. There were no survey respondents under the age of 18, and only 11% (13 of the 120 participants who answered the age question) were aged 18–24. A lot of the views that we gathered were from older individuals, often who had been smoking for multiple years. Therefore, it would have been beneficial to try engaging with a younger audience to understand their views regarding smoking and harm reduction approaches, particularly vaping. It is unknown whether the lack of responses from young people was a reflection of not enough targeted engagement with this demographic, or potentially more a reflection that there are few young people who smoke and this could be explored further in any future project work in this area.

While the data gathered from the focus groups provided in-depth insights and each participant's views and experiences were valuable, it is important to note that only seven members of the public and four community matrons took part. The relatively small number of participants limits the range of experiences that could be explored and means that the findings should not be considered representative of the wider population. For future work, Healthwatch Norfolk can reflect on ways to increase focus group participation, including through targeted recruitment and consideration of the timing and location of sessions.

What we found out

Survey

A total of 197 responses were received from the smoking cessation survey. Following data cleaning to remove responses from people who had never smoked, responses where no survey questions had been completed or did not currently live in England, 122 remained for analysis. As most survey questions were not compulsory, the number of responses may vary between individual questions. Additionally, some questions allowed respondents to choose multiple responses meaning percentages do not always add up to 100%.

Survey Demographics

- The survey respondents had a wide range of ages from 18 to 84 years old. We received no responses from people under the age of 18.
- The majority of survey respondents (75%, 88) identified as heterosexual (straight), with smaller numbers identifying as homosexual (9), bisexual (10) or pansexual (2). Due to the small numbers, findings have not been broken down by sexuality.
- The majority of survey respondents (83%, 97) identified as White British / English / Northern Irish / Scottish / Welsh.
- 30% (36) of respondents identified as having a disability and 38% (46) identified as having a long-term condition. Additionally, 7% (9) identified as being a carer.

Below can be found a series of graphics that depict the demographic data described above in more detail.

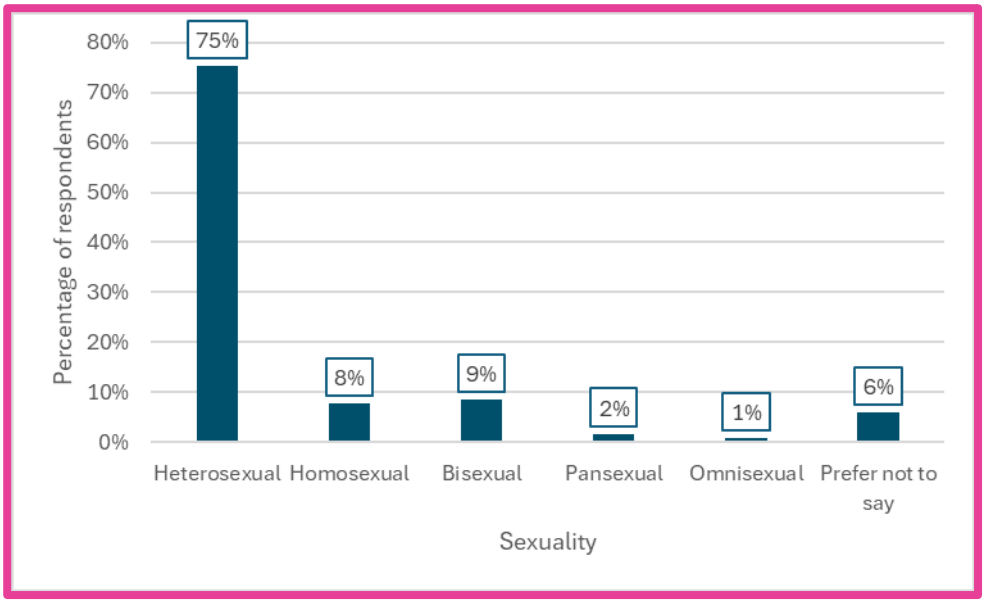


Figure 1 - A graph to show respondents' self-reported sexuality. Total responses for this question numbered 117.

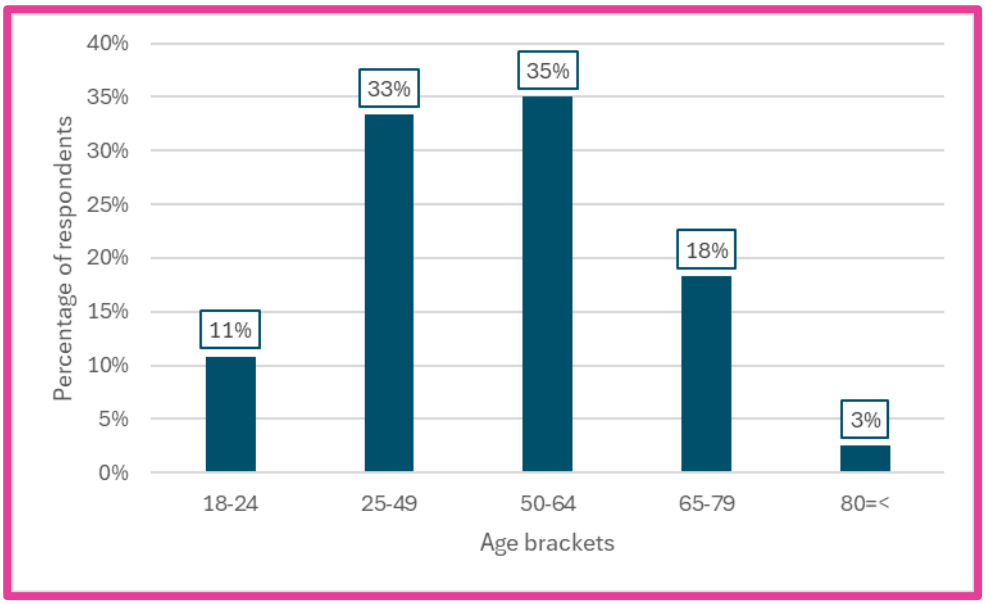


Figure 2 - A graph to show the age distribution of respondents. Total responses for this question numbered 120. There were 13 respondents aged 18-24, 40 aged 25-49, 42 aged 50-64, 22 aged 65-79 and 3 aged 80 or above.

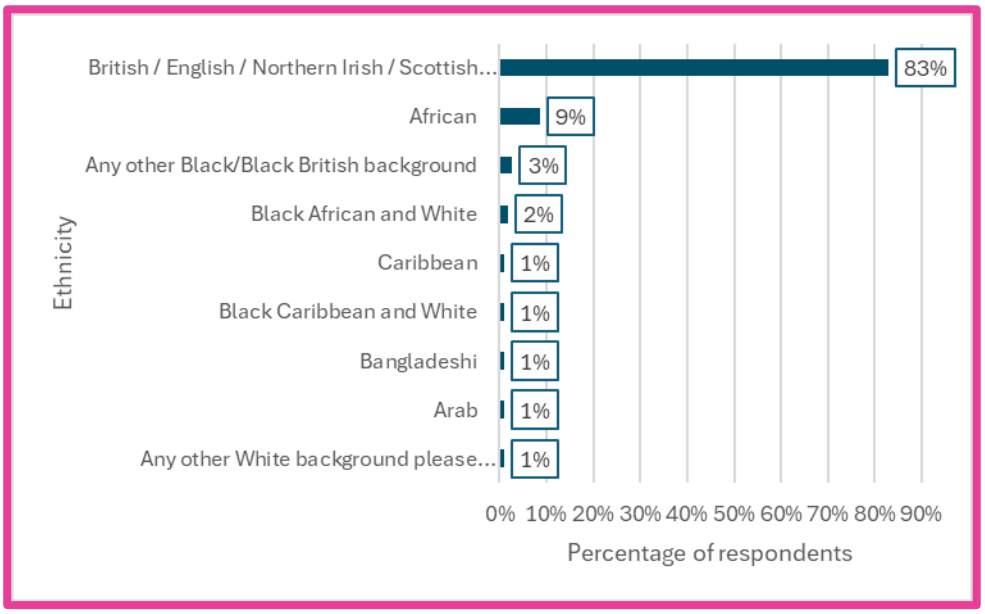


Figure 4 - A graph to show the ethnicity of survey respondents. Total responses for this question numbered 117.

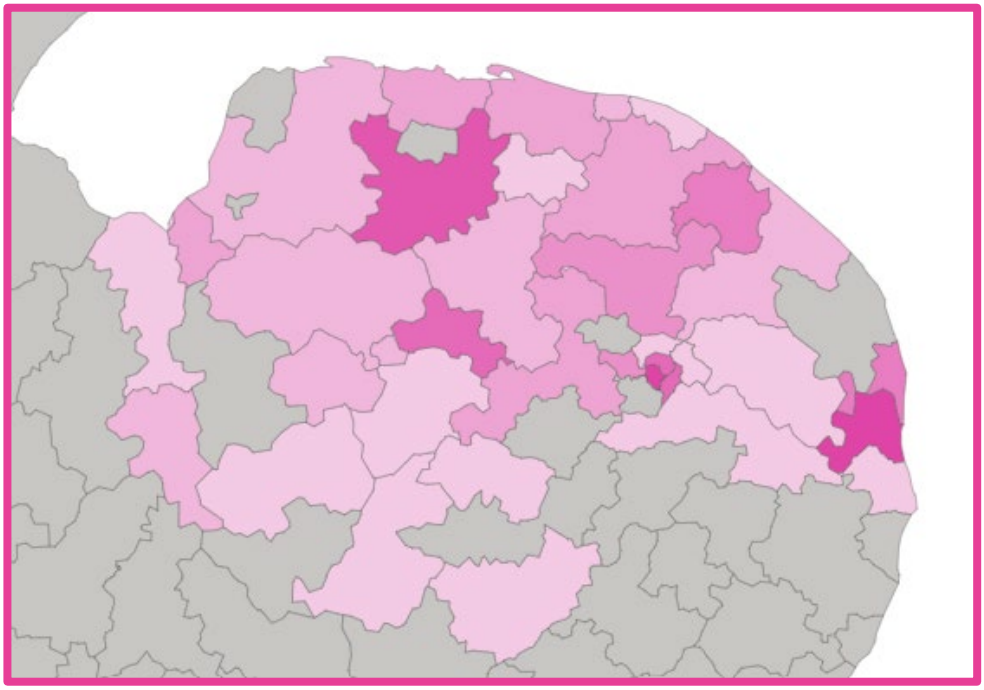


Figure 3 - A heatmap to show the geographical distribution of survey respondents based on the first half of their postcode.

Participants smoking status

Of the 122 survey respondents, 46% (56) were current smokers of cigarettes. A quarter of respondents (31) had attempted to stop smoking but had relapsed, and 29% (35) had stopped smoking within the last 10 years. When analysed, older

respondents were more likely to have quit smoking than younger respondents. For example, 53% (17) of respondents aged 18-44 were current smokers, compared with 43% (17) of those aged 60 or over. Younger respondents were also more likely to have tried to quit and relapsed. For example, 34% (11) of respondents aged 18-34 (alongside the one participant aged 12-17), had tried to quit and relapsed, compared with 20% (8) of those aged 60 or over.

We also looked at smoking status among respondents who identified as having a disability, long-term condition and/or as a carer. The highest proportion of current smokers were those who did not identify with any of these characteristics, accounting for 38% (23) of current smokers, followed by those who identified as having a long-term condition, at 33% (20). Those with long-term conditions also had the highest proportion of respondents who had quit smoking, at 42% (18).

Postcode data was collected to explore potential trends and differences by area. However, the small number of respondents within each postcode area means that it is difficult to draw meaningful conclusions from the data. Five postcode areas had 100% of respondents reporting that they had been smoking for more than 20 years: NR11 (3), NR19 (6), NR23 (3), NR25 (3) and NR5 (4). These findings could be explored further in future work to better understand any geographical patterns.

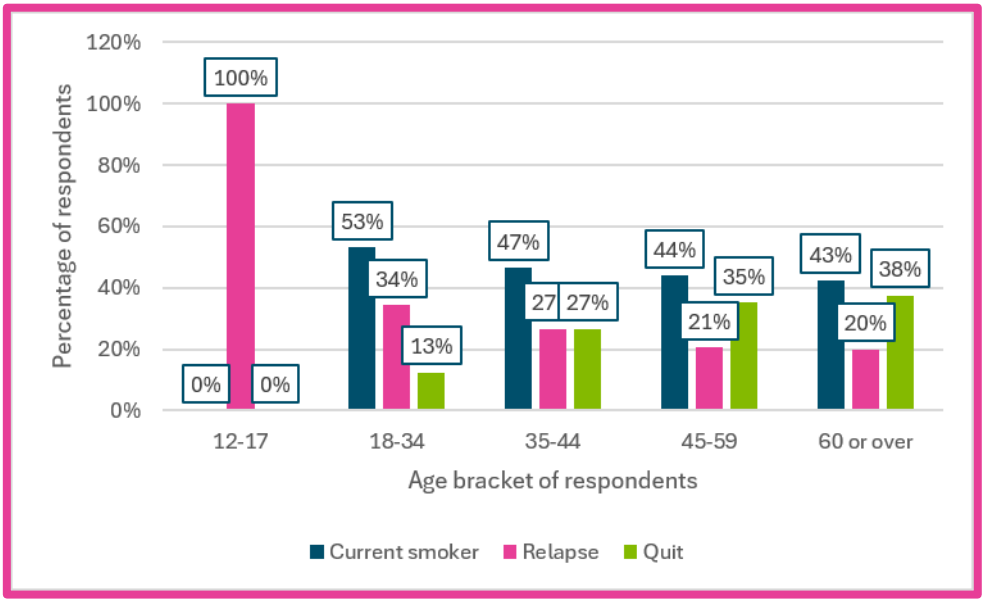


Figure 5 - A graph to show a breakdown of respondent's current smoking status by age. Total responses for this question numbered 122

For those who still smoked, the majority of survey respondents (56%, 65) had been smokers for over 20 years. There were no respondents who had been smoking for 6 months or less, and very few who had only been smoking for 6-12 months (4%, 5). The majority of respondents who had been smoking for more than 20 years were aged 60 or over (51%, 65). The proportion of respondents who had smoked for more than 20 years increased with age, with only 2% (1) of those aged 18-34 reporting that they had smoked for more than 20 years.

The data also showed that most respondents who had started smoking within the previous six to 12 months were aged 18–34. Of those who had started smoking during this period, 80% (4) were aged 18–34, and no participants aged 45 or over reported having started smoking within the previous six to 12 months.

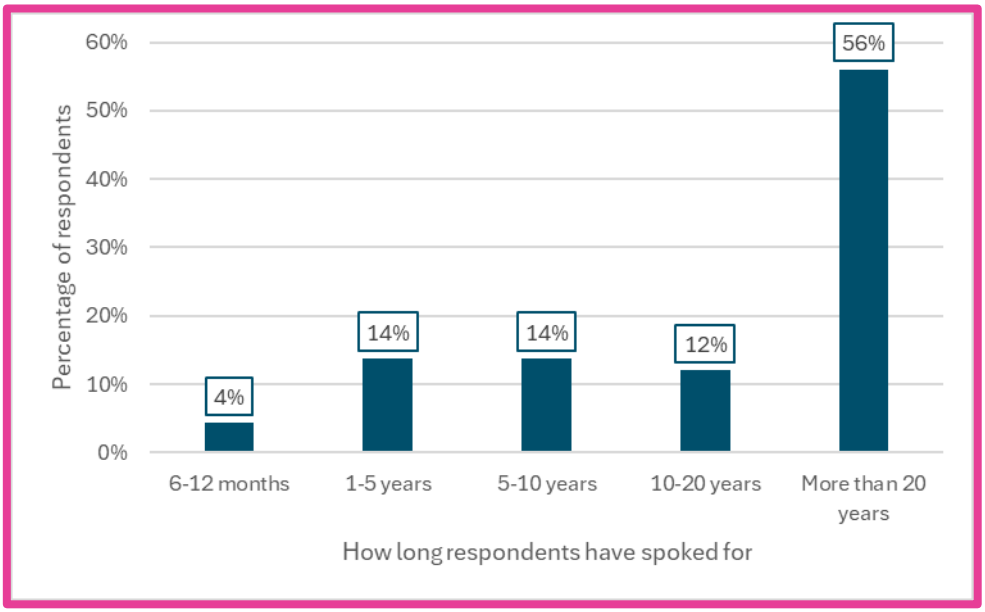


Figure 6 - A graph to show how long respondents had been smokers for. Total responses for this question numbered 116.

We also explored whether there were differences by gender in how long respondents had smoked. A higher proportion of female respondents reported having smoked for more than 20 years, at 70% (35), compared with 45% (28) of male respondents. Conversely, 21% (13) of male respondents had smoked for one to five years, compared with 6% (3) of female respondents.

For those respondents who had given up smoking, this most often had been between one and five years ago (42%, 23). There was a wide distribution of time periods that respondents had given up in, ranging from less than one month ago to more than ten years ago. There was relatively little difference between male and female respondents in terms of when they had stopped smoking. For example, 9% (2) of female respondents had stopped smoking less than six months ago, compared with 10% (3) of male respondents. The largest difference

was among those who had stopped smoking six to 10 years ago, with 23% (5) of female respondents and 16% (5) of male respondents reporting that they had stopped during this period.

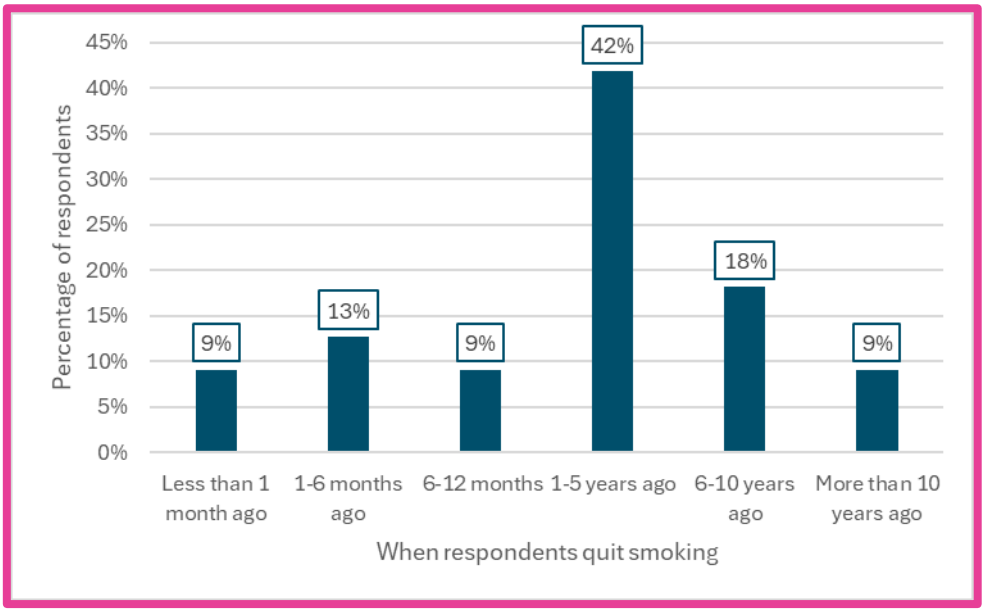


Figure 7 - A graph to show when respondents had quit smoking. Total responses for this question numbered 55.

Across the two focus groups, the seven participants were at different points in their smoking journey. Three participants were still smoking, although all described wanting to stop. A further three participants had stopped smoking entirely, with stop dates ranging from a few months ago to three years ago. One participant had stopped smoking cigarettes and transitioned to vaping and described finding it difficult to stop vaping.

Participants commonly reflected on how their smoking behaviour had changed over time. Several described starting as occasional smokers, often in social settings and at weekends, before gradually smoking more frequently, sometimes without even noticing this shift had occurred. For others, changes in smoking behaviours appeared linked to wider life circumstances. For example, one participant reported becoming a heavier smoker following a sudden decline in their mental health.

Reasons for starting smoking were often linked to misconceptions, including the belief that smoking reduces stress, or suppresses appetite to support weight loss. Overall, participants described smoking as being shaped by a combination of factors including mental health, current life stressors and the people around them, all of which influenced both how often and how much they smoked.

"You know, when I first started when I was 16, 17, it was just a weekend thing … It wasn't like I was a full-time smoker, it's only as I've got older…"

Why people stopped or wanted to stop smoking:

Participants described a range of reasons for wanting to stop smoking, with concerns around health emerging as a key motivator. For two participants, the desire to stop coincided with reaching a milestone age and feeling that the health impacts of smoking could worsen as they got older. For one of these participants, this was combined with a diagnosis of a condition that is worsened by smoking, alongside ongoing breathing difficulties. In one focus group, participants also discussed personal identity as a factor in their decision to stop.

Some described feeling that smoking no longer "*fit*" with how they saw themselves, especially in the context of personal growth, wanting to become a better version of themselves and improving their mental wellbeing. For these participants, stopping smoking was linked to aligning their behaviour with a new or evolving sense of identity.

"The version of me that smoked, smoked as a coping strategy and I didn't want to associate myself with those strategies anymore, I wanted to associate myself with a different form of identity"

The participants across both focus groups showed awareness of the health risks associated with smoking, although the level of concern varied. For some, these risks were a motivator to stop, particularly where they had seen the impact of smoking on others, such as knowing a smoker who had become unwell or died. However, some participants described how it could feel easy to view smoking-related health problems as something that happens to other people, rather than seeing themselves as personally at risk, which reduced their desire to stop.

Participants also demonstrated a level of awareness of the potential impact of smoking on others, particularly their children. In one focus group, all participants reported stopping smoking during pregnancy. Across both groups, participants described their children as a motivating factor for wanting to stop smoking, including concerns about causing harm, as well as the children themselves reporting that they did not like the smell and the fact their parent smoked.

"To get into my head that smoking has caused that [illness], because I'm like, something else has caused that, because I've been smoking for years."

One focus group discussed public health messaging around smoking. Two of the participants described feeling desensitised to these messages, particularly the images on cigarette packaging, which they felt no longer had an impact on them because these had become so familiar. Participants suggested that health messaging might be more effective if it felt more immediate and personal. For example, they felt that hearing directly from people who had experienced serious health consequences from smoking could have a stronger impact.

Participants also reported being more responsive to campaigns that highlight the risks that smoking poses to others, particularly children. One example they referenced was a campaign showing a baby bottle filled with tar, used to illustrate the risks of second-hand smoke to children. This reflected wider discussions across the focus group where family members were described as an important influence on decisions to stop smoking.

"I think another thing, it's not going to suit everyone, it might not even suit me, but you know like when they do the drink driving campaigns, the ads, it's in your face and it's like you remember that drink driving campaign because it's so graphic and so awful. And if you had real statistics, real pictures, like I know they're on the cigarette packets, but you see one black lung, you've seen them all on the black teeth, you've seen them all on the cigarette packets."

Stopping smoking services

We asked survey respondents whether they had ever sought help from smoking cessation services and the results showed a nearly even split with 45% (52) respondents reported that they had, and 48% (55) had not. There appeared to be no gender difference in seeking help as 46% (21) of female respondents had sought help from smoking cessation services compared to 45% (29) of male respondents. When analysed by how long people had been smoking, those who

had been smoking for six to 12 months were most likely to have sought help quitting with 80% (4) having done so. Only 29% (7) of those who had been smoking for one to five years, and those who had been smoking for five to ten years had sought help from smoking cessation services. And almost half of those who had been smoking for over 20 years (48%, 31) sought help from smoking cessation services.

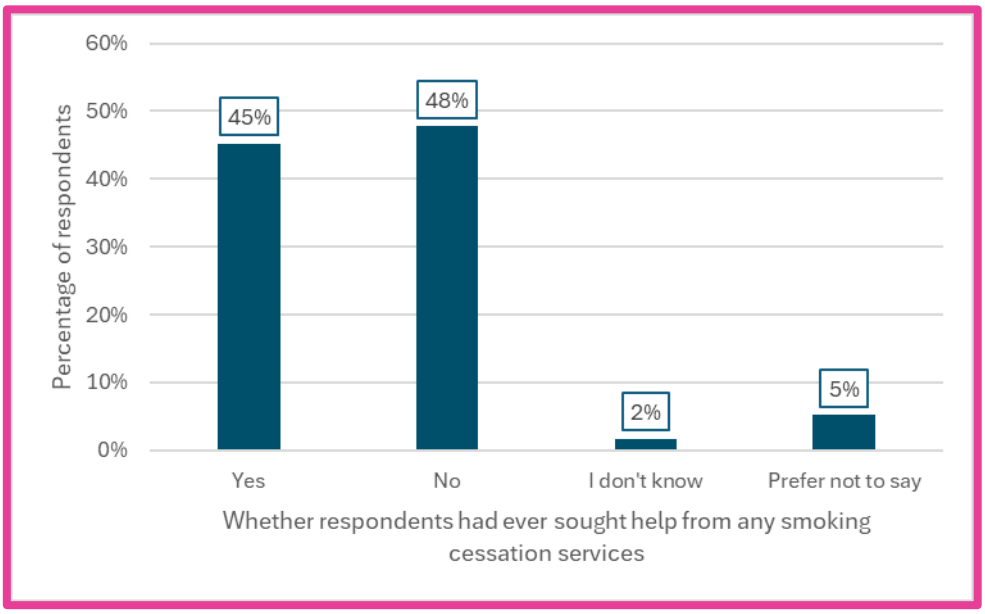


Figure 8 - A graph to show whether respondents had ever sought help from smoking cessation services. Total responses for this question numbered 115.

We analysed the data by current smoking status to compare respondents who had accessed smoking cessation services with those who had not. While results were similar between the three groups, there was a higher percentage of respondents who had accessed smoking cessation services in those who had stopped smoking within the last 10 years (50%, 17). Alongside this, those who had attempted to stop and relapsed had the highest percentage of respondents who had not accessed any smoking cessation support services (52%, 15).

Table 1

Percentage of survey respondents who had and hadn't accessed smoking cessation services.

Have you accessed smoking cessation services?	Current smokers (52 respondents)	Smokers who attempted to stop smoking and relapsed (29 respondents)	Stopped smoking within the last 10 years (34 respondents)
Yes	42%	45%	50%
No	46%	52%	47%
I don't know	4%	0%	0%

Prefer not to say	8%	3%	3%

Respondents were asked to explain what services they had accessed and how they found these. The most common service people reported accessing was Smokefree Norfolk. Other services people sought support from included GP surgeries, local support groups, pharmacies, ACE, private therapies and apps.

Smokefree Norfolk

Both survey and focus group respondents had mixed feelings regarding Smokefree Norfolk. A few found the service to be helpful and supported them to successfully stop, often for multiple years. Respondents reported support including phone calls and being provided with NRT and/or medication.

However not everyone had a good experience with issues raised including a lack of face-to-face appointments, not being given medication, too strong an emphasis on vaping and then being discharged with no support. Some participants felt that support would be more helpful If instead of offering NRT it took a more holistic approach, including exploring the wider factors in their life that contributed to smoking.

It was also discussed how there appears to be a variation in the quality of support offered once patients were in contact with the service. One community matron described a patient who found their initial interaction with a Smokefree Norfolk practitioner to be patronising, which reduced their motivation to stop smoking. However, when the patient was referred again, they had a more positive experience with a different practitioner and were able to engage with the support offered.

> "Smoke free Norfolk for the first successful attempt approximately 5 years ago when I was prescribed champix [varenicline] which worked brilliantly"

Long wait times were also raised as a concern by both the public focus groups and the community matrons. It was highlighted that there are inconsistencies in waiting times, with some patients waiting several months for initial contact whereas some are seen much sooner. These delays were seen as particularly concerning by the community matrons given the needs of the patient groups they support, many of whom have long-term heart or lung conditions that are worsened by smoking. The matrons explained that they often invest significant time in motivating patients to consider stopping and agreeing to a referral.

However, by the time patients are contacted by Smokefree Norfolk, this motivation may have reduced, resulting in some no longer wanting to engage with support.

> "Smoke free were a nightmare. It took months to get help. They tried Patches & spray which I failed with. Rather than offering the tablet form. They Just kicked me off the help support. Sounds like they are more worried about meeting targets of people waiting rather than [genuinely] trying to help people that are in contact with them. Far from impressed with the service they offered"

The community matrons reported that they are currently only able to refer patients to Smokefree Norfolk and described predominantly negative experiences with this service. A key concern raised by all of the matrons was the lack of acknowledgement following a referral. They reported that they do not receive confirmation whether a referral has been received, accepted or if a patient has been placed on a waiting list. This lack of feedback was described as frustrating, particularly when patients ask for updates as matrons are unable to provide further information.

> "I emailed myself. Personally, never got any response, nor did my patient"

Some matrons also described instances where referrals appeared not to have been processed. One community matron reported submitting multiple referrals for the same patient, over several weeks, using a range of methods including SystmOne (a clinical software system used in GP surgeries), email and an online form, as well as following this up directly via email. Despite this neither they nor the patient received any response from Smokefree Norfolk.

> "At the moment referrals just go into the abyss."

The participants reported that, even when referrals were accepted, some patients continued to face barriers accessing support. For example, one community matron described referring a patient who did not speak English and clearly indicated that support needed to be provided in their preferred language. However, the patient was subsequently sent an assessment form in

English, which they were unable to complete. As a result, the patient disengaged with the process and continued smoking.

"It's disappointing because he is someone we had to work really hard with to even agree to consider quitting smoking and when we got there and couldn't provide [translated resources] he then just sort of thought screw it, what's the point … now he won't even entertain the idea as in his opinion he has been messed around and delayed and thinks what's the point."

GP surgery

Some respondents reported their GP surgeries were supportive, provided forms of NRT, medication and even provided appointments with a dedicated smoking cessation nurse. However, it is apparent that people's experiences of services in GP surgeries were not consistent and also seemed to change over time, often with smoking cessation services no longer being offered by GP surgeries, leaving people without support.

"I initially used the stop smoking service via my GP more than 15yrs ago. I was offered Champix [varenicline] which worked very well and was supplemented by regular in person appointments with the smoking cessation nurse whereby my CO2 levels & B/P were monitored, I found this very helpful and stopped smoking within 1 week of beginning the medication. I stayed as a non smoker for about 3yrs and stupidly started again"

"Was refused this help as my GP surgery no longer sign up to the service so could only be offered NRT /vapes or Alan Carr- none of which are suitable due to my health issues"

Group Support

In one focus group, all three participants had previously taken part in a smoking cessation programme delivered at a local community venue. The programme combined peer support with input from a facilitator who provided education and guidance on stopping smoking. The participants gave mixed feedback on their experience of this group. Participants particularly valued the peer support element, reporting that often they would have informal conversations with other

attendees before and after the sessions to speak about their experiences and the challenges of stopping smoking. While the presence of a facilitator was seen as helpful, views were mixed on the content delivered, with some feeling that much of what was presented was information they already knew, such as the health risks associated with smoking, and that the sessions did not always address the underlying reasons that they smoked.

In the second focus group, only one participant had tried group support. They reported having found this helpful but had accessed this while living in another county. Despite wanting to access group support again, they were not aware of similar support being offered in Norfolk and therefore had not attempted to access this.

"They're telling you how to suck eggs clearly, the same as the doctors do. We know it's bad for our health, we know it's not good, we know we smell, but we still do it. It's like that thing that we need something that will take the distraction away"

Coaching

One focus group participant described accessing a one-to-one coaching service that was offered when they purchased NRT products online. They reported that this was particularly helpful because it did not focus solely on smoking. Instead, it explored wider aspects of their life, which helped them to process stressors and better understand why they were smoking. Other participants agreed that a more holistic approach to support would be helpful. They highlighted that smoking is often linked to underlying factors such as stress or poor mental health, and they felt these issues need to be addressed alongside nicotine dependence to help people stop smoking successfully.

"She was the most wonderfully caring empathetic person, and it [the smoking cessation support] wasn't about the smoking, it was about everything else going on. Having her helped process and understand and gave me hope that this was possible for me"

Allen Carr's Easyway (ACE)

Some focus group participants were aware of the ACE programme but described several reasons why they felt discouraged from accessing it. They felt they struggle to find enough uninterrupted time to take part and were reluctant to spend long periods of time sitting at a computer. Participants also felt they would be distracted by their phones, and one person said that attending an online session felt too similar to being at work, which reduced the appeal and therefore their desire to attend. One participant had tried the ACE audio book but felt this "*didn't sink in*". However, they had signed up for an upcoming in-person seminar to see whether this format would be more beneficial for them.

> "Zoom calls just remind me of work a lot, my old job … I'd rather in-person [support]."

Therapies

Both focus groups discussed the different therapeutic approaches that can support smoking cessation, including cognitive behavioural therapy (CBT) and hypnotherapy. In one focus group, all participants said they would be open to trying these approaches if they were available through the NHS. However, they felt these options were largely inaccessible when only offered privately due to the associated costs. In the other group one participant had tried private therapy to help stop smoking but reported that it did not help them. A survey respondent had tried private hypnotherapy twice to help stop smoking and reported this to be unhelpful.

Barriers to accessing support

We asked respondents if there were any barriers preventing them from accessing smoking cessation support. The most common barrier that respondents identified was the stress/anxiety/fear of stopping smoking, reported by 39% (48) of respondents. Other personal factors were cited such as not wanting to stop smoking with 20% (24) respondents and lack of support from friends and family which 19% (23) said. A number of barriers specific to support services were identified such as availability of appointments (20%, 25), location (9%, 11) and waiting lists (7%, 9). Some of the barriers reported appeared to vary according to how long people had been smoking. For example, 63% (15) of those who had been smoking for over 20 years said that they did not want to stop

smoking. This was a higher proportion than among respondents in the other smoking duration groups, including those who had been smoking for six to 12 months, where 8% (2) reported this as a barrier.

Those who had been smoking for more than 20 years were also the largest group to report that stress, anxiety or fear of stopping smoking prevented them from accessing support. This was reported by 55% (24), compared with 18% (8) of those who had been smoking for one to five years.

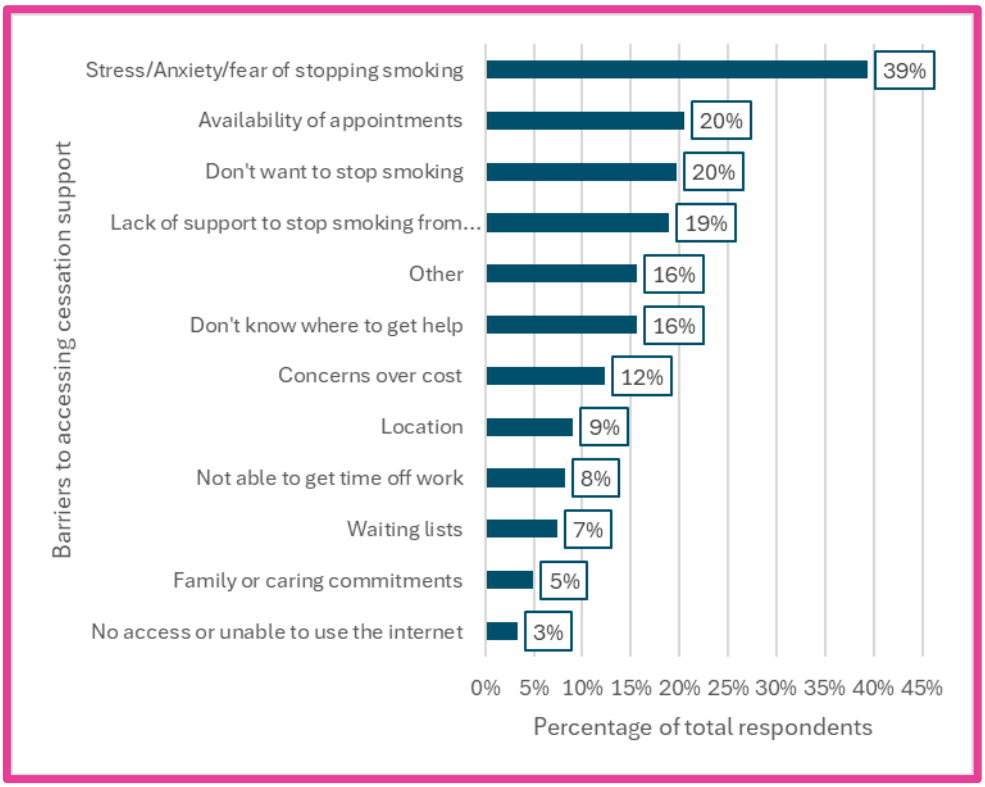


Figure 9 - A graph to show the barriers respondents faced when accessing smoking cessation support. Total responses for this question numbered 122.

Many respondents identified inconsistencies in access to support, with some describing it as a "*postcode lottery*". There were multiple respondents who cited concerns with the availability of certain services, often prescription medication such as varenicline, as this was not available from Smokefree Norfolk and some GP surgeries. Some reported this lack of access to medication leaving them feeling hopeless as they felt it was the only thing that worked for them. There were also some concerns raised about the services that were offered, such as having to wait multiple months before getting help from Smokefree Norfolk or there being no in-person support.

"I am pretty shocked & disgusted really to be informed by PHN [Public Health Norfolk] who commissions SFN [Smokefree Norfolk] service that they cannot help me to obtain a prescription of Champix/Varenicline despite being fully aware of my health issues. Of the 100 or so GP practices in Norfolk, mine is one of about 20 who do not subscribe to the stop smoking service. So effectively it is now a post code lottery as to who can get the actual help they need to quit smoking."

Worries were also raised regarding the discharge from services. Some raised that they felt support was withdrawn too early, often before they were ready, which led to them relapsing. And others raised that they had been able to access support, but if they relapsed during this support, even with just one cigarette, they were immediately discharged from the service and left with no support at all.

Concerns about discharge was also raised by the community matrons who said that they do not get informed about a patients progress following referral to Smokefree Norfolk and therefore are not made aware when someone is discharged. They explained that having this information would allow them to provide more coordinated support such as helping patients access NRT. Without this communication, they felt it would be difficult to provide effective ongoing care, particularly after patients had been discharged from Smokefree Norfolk

"The stop smoking service I used within Norfolk was completely unhelpful and has made me no longer wish to access these types of services, after my first appointment, and gaining a prescription for an inhalator, I still relapsed - which I thought would be normal for having never attempted before, and had only just started, instead, I was immediately discharged from the service for relapsing."

Some respondents made comments regarding both advertising of smoking cessation services and the current messaging around smoking as a whole. People felt that there was not enough awareness of smoking cessation services near them and that these needed to be better publicised as it can be a barrier if people do not know where to access support.

"I hadn't heard of a lot of the services so more publicity would be good - in online news and newspapers."

There were conflicting opinions regarding the current messaging around smoking. For example, two respondents commented on how cigarette packaging contains disturbing imagery, which one respondent felt made them scared to get the conditions pictured and this encouraged them to stop, whereas another respondent described this as "fearmongering" and felt it will make people less likely to stop smoking. Many were in agreement that there needs to be further education around the risks of smoking, especially from an earlier age, and that this needs to look at the emotional side of addiction and cessation rather than just the physical health side as this often plays a large role.

"I think there should be more of a push towards the harmful effects of smoking being taught at a younger age"

Multiple participants highlighted that a fear of failure was also a barrier to stopping smoking. Participants described the process of stopping smoking as daunting, and some felt that sharing their intention to stop with others could create additional pressure. Concerns were raised that relapsing after telling others that they planned to stop could lead to feelings of shame and failure. This was often linked to participants delaying starting, due to not feeling ready yet but feeling that they could start soon, but that this day never came.

"I always think tomorrow, I'll do it tomorrow. I'll just get today over with and I'll start tomorrow or start Monday."

Finally, there were both survey and focus group respondents who reported that there were multiple personal factors which discouraged people from stopping smoking. For many, smoking was frequently described as part of a long-established habit or daily routine, and that by disrupting this routine it could increase stress or create an uncomfortable sense that something was missing.

Others saw smoking as a coping mechanism to help manage life stressors including caring responsibilities and therefore felt that stopping smoking would reduce their ability to cope with these pressures, increase stress levels and contribute to worsening mental health. Additionally, some survey respondents

reported not wanting to stop smoking because they felt healthy and therefore were not concerned about the potential health risks of smoking.

"At the moment I'm not giving up because of other things going on in my life. I have spoken to my GP about getting support in the future when I'm ready."

Awareness of smoking cessation services

Respondents were asked what smoking cessations services they had heard of. The most well-known service was Smokefree Norfolk, which 49% (60) respondents knew about. This was followed by GP services which 46% (56) knew about. Despite it being a service with places offered in Norfolk, only just over a quarter of respondents (26%, 32) had heard about ACE. For respondents who selected other, services they knew of included the smoke free app and acupuncture, as well as a few who said they could not remember what the service they accessed was called.

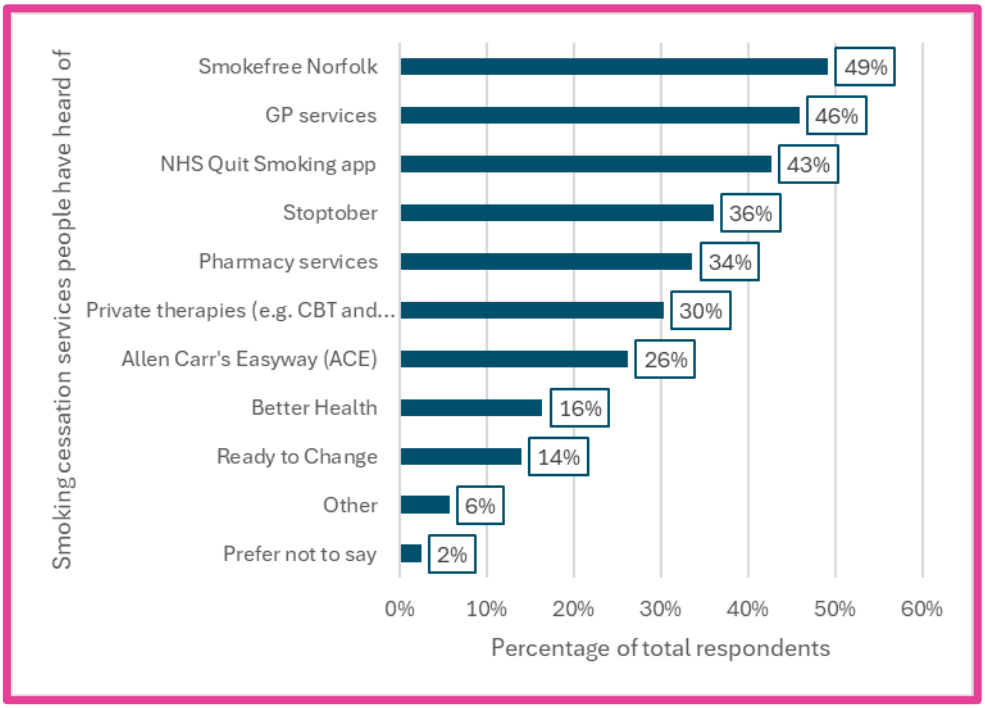


Figure 10 - A graph to show the different smoking cessation services that respondents had heard of. Total responses for this question numbered 122.

We asked focus group participants about their awareness of local stop smoking support and if they knew how to access this. In one focus group, all three

participants reported some uncertainty about where to go for help. They said they would feel most comfortable approaching their GP but raised concerns about long wait times for appointments, or that the reception team would refuse to give them an appointment for smoking cessation advice. Two participants were aware that a local stop smoking service existed in Norfolk but did not know the name of this service or how to access it directly. In the other focus group, participants had heard of Smokefree Norfolk but were hesitant to access this as they were unsure if they could access the help they wanted (group-based support and prescription medication) from this service.

What people would like from smoking cessation support

We asked respondents what format they would prefer for support to stop smoking. Respondents were able to choose more than one option, so percentages do not add up to 100%, meaning these findings indicate participants preference and acceptability as opposed to a ranked order of preference. Over half of all respondents reported that they would prefer in person support (52%, 64). The second most popular format was group support which 34% (41) people preferred. The least preferred format for support was telephone with only 21% (26) choosing this. For those who selected other, three said they did not mind the format of the services as long as they could access prescribed medication, and one person said that they would prefer to give up smoking on their own, without support.

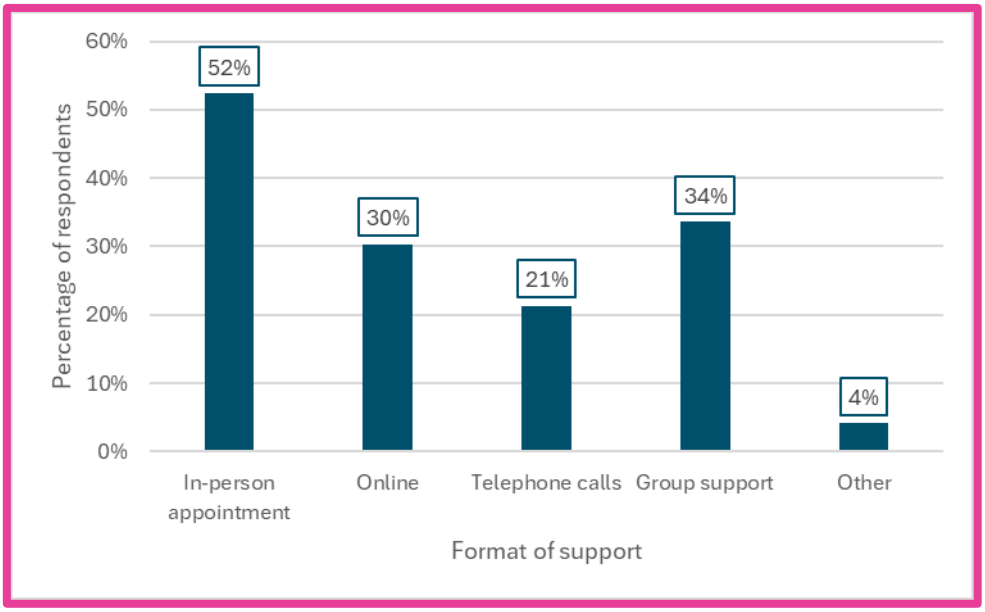


Figure 11 - A graph to show the different formats people want from smoking cessation. Total responses for this question numbered 122.

The focus group participants discussed alternative types of smoking cessation support and shared views on how helpful these might be. Views differed between the two focus groups, which may reflect the different types of support participants had previously accessed. One focus group felt group-based support could create a sense of accountability, with participants describing being more motivated to not let others down. Some also felt that group support could be less daunting than one-to-one support because taking part alongside others could reduce anxiety, although they noted this would be dependent on the individual. Familiarity with group members could also affect confidence to attend. All three participants in one group knew each other before the sessions which they felt made it easier to engage, compared with if they had not known anyone. Many participants, within both groups would be open to one-to-one support and felt this could be a better option for people who experience anxiety, as it may be less intimidating.

Participants expressed mixed views about how stop smoking sessions should be delivered. One focus group felt that in-person support would be more beneficial than remote support but emphasised that sessions would need to take place in a familiar location. This was because travelling to an unfamiliar location could increase anxiety, such as worries about navigating new driving routes and feeling uncomfortable in unfamiliar environments, which could lead to cancelled or missed appointments. Participants also highlighted that they felt in person support was more motivating and enabled peer support through conversations before and after sessions.

Both focus groups agreed that telephone support was their least preferred option and was seen as likely to be the least beneficial. Participants felt this format was less personal and that not being able to see the other person made it harder to build a connection. Some participants also felt that telephone sessions could feel more rushed, which reduced the opportunity to have in depth conversations. One group also felt that it was easier to be dishonest about smoking behaviour over telephone support due to there being no visual contact. However, one group noted that the most suitable format for support could change from person to person and week to week and therefore offering hybrid support would be the most beneficial. They felt this would reduce stress and remove practical barriers, such as work commitments or illness, by allowing people to choose the format that works best at different times.

> “They can't see your face [when accessing telephone smoking cessation services] and I'm sitting there with a cigarette in my hand.”

One group highlighted that regardless of how the support was delivered, the background of the person leading the stop smoking sessions mattered. While participants acknowledged that trained professionals had relevant knowledge, they expressed a preference for someone who could draw on personal experiences of stopping smoking, including both challenges and successors. They felt that this would lead to support that was more relatable and meaningful rather than relying solely on generic advice.

> “To have two or three people to be like, this is my story, these are my failures, these are my achievements … I've got the lived experience.”

The importance of follow-up support across all formats of stop smoking interventions was emphasised by participants. They felt that the challenges of stopping do not end when structured support finishes and that people can be left without help at a point when cravings or stressful life events may increase the risk of relapse. Participants suggested that this gap in ongoing support could contribute to people returning to smoking. They felt that continued check-ins or access to a named contact after initial support ends, could help people feel less isolated and better supported, which may reduce the likelihood of relapse.

The community matrons identified improved communications as the main change that would enhance their experience of the Smokefree Norfolk service. They felt that it would be beneficial to receive an automatic acknowledgement email after submitting a referral to confirm that it had been received safely. This would provide reassurance and enable them to respond more effectively to patients seeking updates.

Harm reduction approaches

Respondents were given a list of harm reduction approaches and asked to tick which ones that they had used in the past. Vaping was the most commonly used harm reduction approach, with 57% (69) of respondents reporting that they had used it. Many people (39%, 47) had stopped with no support.

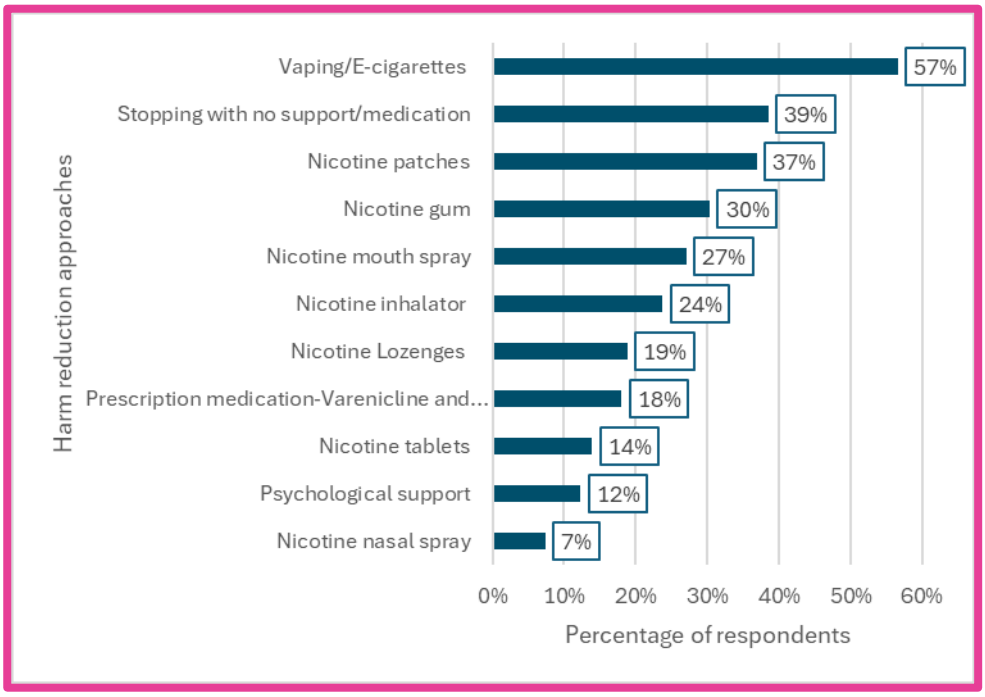


Figure 12 - A graph to show the harm reduction approaches that respondents had tried in the past. Total responses for this question numbered 122.

We looked further at respondents who had stopped smoking without support. We analysed the barriers they reported as preventing them from accessing smoking cessation support, focusing only on those who had not yet sought support. The three most commonly reported barriers were not knowing where to get help, stress, anxiety or fear of stopping smoking, and not wanting to stop smoking.

While some people reported positive experiences with harm reduction approaches and felt these supported them to stop smoking, not everyone had a positive experience with them. As is the case with most medications, there can be side effects and not all treatments work for everyone. Respondents reported side effects of reactions to forms of NRT and prescription medication. And for some, they reported that these treatments did not work for them at all.

> "The [nicotine replacement] patches I was given were far too strong and I had really severe, graphic nightmares"

Focus group participants discussed a range of harm reduction approaches they had previously used, with mixed experiences across the two focus groups. One participant reported that NRT patches had been effective for them and supported six years without smoking. Others had tried different forms of NRT including gum, throat spray and lozenges, and reported negative experiences such as an unpleasant taste which discouraged continuous use. One participant described previously being prescribed medication and found it "absolutely brilliant and fantastic". However, after relapsing and trying to access medication again, they were told this was no longer available on the NHS. This was echoed by another participant who described a friend having success with varenicline but then had it withdrawn which they felt contributed to a relapse.

"I was prescribed Champix [varenicline]. That was absolutely brilliant, that was fantastic."

Respondents were given a list of harm reduction approaches and asked to tick which they would and would not be open to using in the future. The most common approach respondents would be open to using was vapes with 51% (62) saying they would be open to using these.

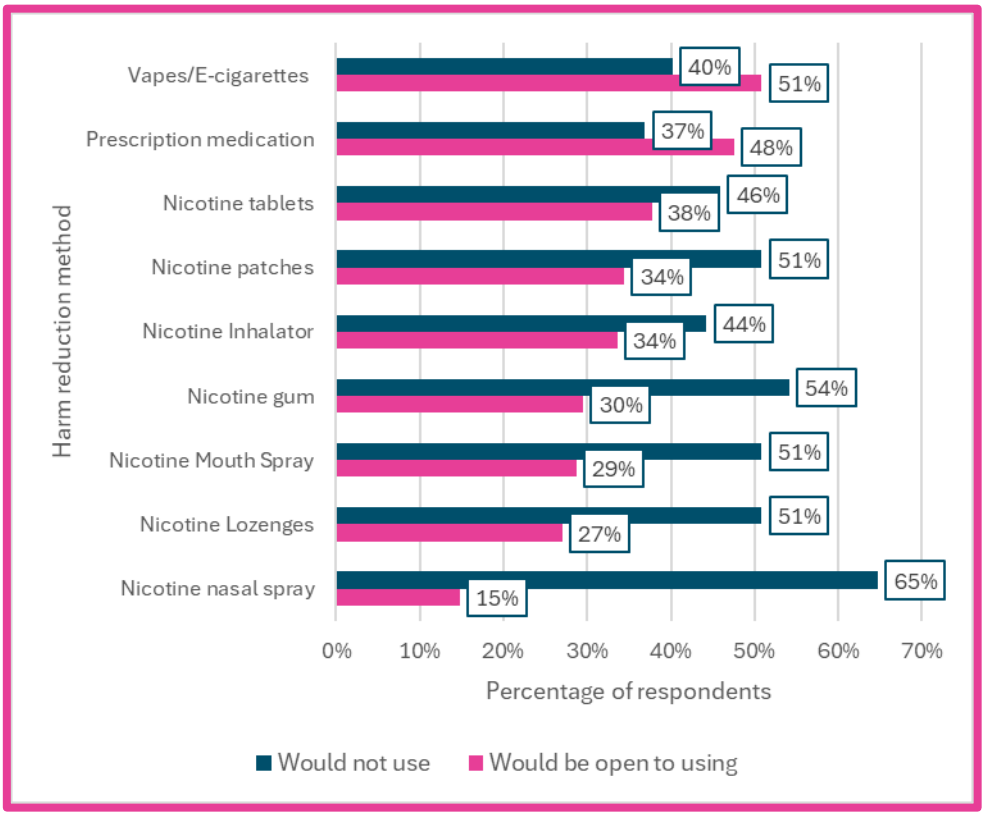


Figure 13 - A graph to show the harm reduction methods that respondents would and would not be open to using in the future. Total responses for this question numbered 122.

This was closely followed by prescription medication (48%, 58) and NRT tablets (38%, 46). The methods with the highest proportion of respondents saying they would not use them were NRT nasal sprays (65%, 79), and NRT gum (54%, 66). Although vaping was the most popular option that respondents said they would be open to using, 40% (49) of respondents said they would not be open to using a vape. This suggests there are mixed attitudes towards vaping.

One focus group raised concerns about access and affordability of certain harm reduction methods. For example, one participant wanted to try NRT such as patches but felt that this was inaccessible to them due to the associated cost.

Vaping

> "I wish I'd never started vaping."

The two groups shared a range of views on vaping as a harm reduction approach to support smoking cessation. Overall participants expressed negative perceptions of vaping. Experiences varied across the two focus groups, with three participants having never vaped while four had vaped to some extent. Of these, two had tried vaping infrequently, one had used vaping as a way to stop smoking and then also stopped vaping, and one had switched from cigarettes to vaping but described ongoing difficulties with stopping vaping itself. A key concern was dependence as many participants felt that vaping could be more addictive than smoking cigarettes and as a result harder to stop. One participant described regretting starting to vape, feeling they had replaced one addiction with another and were now struggling to stop vaping. They also raised concerns that flavourings used in vapes may increase the appeal and make it harder to stop as people could become attached to particular flavours as well as the nicotine.

> "The amount of harm it does for children and in a lot of cases adults, it doesn't actually seem to stop them smoking, they seem to just swap from one addiction to another."

Concerns were also raised that vaping could be easier to do more often than smoking, which they felt made it harder to stop. One focus group explained that they would not smoke inside their homes and would not allow others to do so. As a result, practical barriers such as cold or wet weather sometimes reduced how

frequently they smoked, because smoking required going outside. In contrast, vaping was seen as having fewer restrictions. Because it does not produce an unpleasant smell, some participants described feeling comfortable vaping indoors and allowing others to do the same. This meant that they were then tempted to vape during activities they would not usually smoke during, such as vacuuming or washing up.

Participants also noted that a single vape contains more "*puffs*" than one cigarette and therefore felt it was easier to consume more nicotine in a short period of time because there is no clear endpoint like finishing a cigarette. One participant described how this removal of boundaries around where and when they could vape led to much more frequent use than when they smoked, including waking up during the night to vape. They felt that this demonstrated how increased accessibility contributed to the difficulty of stopping.

"But if I was to smoke five cigarettes now, in 100 puffs, everyone would look at me like, what are you doing? Whereas if you were to have 100 puffs [of a vape], nobody would question it, because it really is accessible."

Participant's concerns about accessibility also extended to children and young people. Both focus groups expressed worries about the risks associated with young people vaping and described a perception that vaping products are widely available. Many felt that lots of vaping products appear to be marketed towards children rather than adults due to their sweet flavours and colourful packaging. It was also suggested that the widespread availability of vaping products makes them difficult to avoid. The number of shops selling vapes was seen as increasing exposure, and in turn, temptation for both adults and children. These concerns were reinforced by one participant who is a teacher, who reported that many school children now vape, more so they felt than the number of children who smoked around ten years ago.

"I work in a school, and it is very noticeable how … 10 years ago there were a few children who smoked, then there weren't really any children who smoked. But now there's quite a few children who vape. For me personally I don't like vaping, I don't think it should be a thing … the amount of harm it does to children."

Participants also raised concerns about the potential health impacts of vaping. One participant described experiencing a range of physical symptoms which they attributed to vaping, including a dry and bleeding nose, weight gain, worsening breathing and a sore, dry throat. This was reinforced by another account shared within the group of someone being admitted to hospital, which they believed was linked to vaping. More broadly, participants expressed concerns about the unknown long-term health risks of vaping. They felt the full contents of vaping products and the effects of using them over time, are not yet well understood.

Comparisons were made to the early introduction of cigarettes, when health risks were not widely recognised and smoking was initially promoted. Participants were concerned that similar long-term consequences could emerge for vaping and felt this had not been fully considered at a policy level. These views were echoed by the community matrons. While all the community matrons recognised that vaping may carry fewer risks than smoking, they emphasised that it is not risk-free and expressed concerns about the unknown potential long term health impacts of vaping.

> "The general consensus is those that are vaping think that it is a safer alternative to smoking, and it is trying to educate them that you are still putting chemicals into your body and we don't know what vaping is going to do to you in years to come."

> "Vaping is better than smoking but at least with smoking you know what you are doing. With vaping there is still that unknown. Further down the line they might say it's really bad."

Some participants also highlighted a perceived gap in support for people who want to stop vaping. While vaping was recognised as a harm reduction approach for stopping smoking, participants felt that support to stop vaping itself was limited. One participant described seeking help to stop vaping but said support was not offered as they were no longer smoking cigarettes and their vaping therefore was not seen as a concern. This left them feeling isolated and without clear options for further help. This was also raised by the community matrons who said that they were unable to refer individuals who vape to Smokefree Norfolk, despite recognising that they still require support to address

their nicotine dependence and stop vaping. Some participants expressed frustration and anger, reflecting the view that vaping had been promoted as a route to stop smoking but that there is now insufficient support for people who want to stop vaping. They felt this could result in ongoing dependence without a clear pathway to access support.

"I just think there's no help out there."

What helped people stop smoking

We also asked respondents that if they had either tried to stop before, or successfully stopped smoking, what approaches helped them. We received 74 responses which were analysed thematically.

Professional and structured cessation support

Many respondents reported having accessed a range of support services to help them stop smoking which some found helpful. These included GP support, Smokefree Norfolk, ACE, private therapy and group support. People reported that peer support was beneficial and having structured and professional support aided them in changing their mindset around smoking. However, a couple of participants did raise concerns regarding availability of appointments and what help could be offered. Multiple people cited that they benefited from group support sessions, particularly when these were facilitated by a professional. This allowed people to not only get peer support but could also gain valuable knowledge, such as a session someone mentioned was held for their group on nutrition to help manage cravings

"I initially used the stop smoking service via my GP more than 15yrs ago. I was offered Champix which worked very well and was supplemented by regular in person appointments with the smoking cessation nurse whereby my CO2 levels & B/P were monitored, I found this very helpful and stopped smoking within 1 week of beginning the medication. I stayed as a non smoker for about 3yrs."

Pharmacological and nicotine-based aids

Respondents reported a wide range of NRTs and medications that helped them. NRT's were a popular method to aid smoking cessation, and this took many forms including patches, gum, inhalators, lozenges and vapes, with patches and vaping seeming to be reported as the most effective. Respondents said they liked that vapes are available in a range of flavours and can be used with 0% nicotine liquid, however one person did raise concerns about a perceived potential health risk associated with vaping which led to them stopping.

Many respondents reported benefiting from prescription medication, most commonly Champix, the brand name for Varenicline, with some saying this was the only method that worked for them. However, two people did raise difficulties in re-accessing medication after having relapsed back into smoking.

"What I did was transfer to vaping. I did this several times but this time I really wanted to quit. I then after about a year went down to 0mg nicotine vapes and nicotine gum. I then stopped the vaping, and switched to normal chewing gum."

"Only Champix [varenicline] ever worked in the past but am unable to access it this time as my GP surgery no longer sign up to the smoke free Norfolk service and SFN [Smokefree Norfolk] & PHN [Public Health Norfolk] have informed me they cannot do anything to help me get a prescription despite my significant health issues"

Health driven motivation to stop smoking

For some respondents, it was a health scare or similar health problem that urged them to stop smoking. This could be anything from a coughing fit while smoking a cigarette, all the way to hospitalisation due to struggling to breathe. Being diagnosed with a condition that was caused or worsened by smoking was seen as a wakeup call and it was also reported that pregnancy helped one respondent give up, in order to not put themselves and their baby at risk. Even if a hospitalisation was for unrelated issues, this still provided good motivation to stop due to being unable to go outside to smoke while staying in hospital.

Social influences on smoking behaviour

Some respondents either reported being able to stop smoking because of the support they received from their friends and family, or as a way to protect others. People reported that loved ones were people they could talk to and get advice from as well as someone to help support them through it. Additionally, the risk of smoking to others, and the risk of getting cigarettes during lockdown were also cited as reasons for supporting people stopping.

> "I quit a fortnight before covid lockdown... this meant I would have to ask my children.... who didn't smoke to put themselves at more risk of catching covid to get my tobacco. Food was a necessity. Tobacco was not."

Individual motivation and self-control

There were many respondents who cited that they themselves were the reason they were able to stop smoking and that for them it was a case of finding the willpower to do it. Often what worked for people was stopping outright rather than slowly reducing how many cigarettes they were having a day. Some reported that they were able to help themselves stop by doing exercise or calculating how much money they were spending on cigarettes to use as a motivator to stop smoking.

> "I have set myself a date to stop. So far just over 3 weeks cold turkey"

What this means

This section brings together findings from the survey and focus groups to explore people's awareness, experiences and perceptions of smoking cessation support in Norfolk. Overall, the findings highlight a range of challenges affecting engagement with services including limited awareness, inconsistent access and variation in how support is delivered. Participants also described a number of personal and practical barriers to stopping smoking alongside key factors that can support behaviour change. Taken together, these insights point to the need for more accessible, consistent and personalised approaches to smoking cessation support to better meet the needs of local people.

Focus groups with members of the public identified that many people start smoking casually and infrequently, often only at weekends or social occasions, with the amount they smoke increasing over time and developing into an addiction, sometimes without them realising. This suggests that smoking cessation interventions should consider targeting occasional and weekend smokers, before smoking becomes a more frequent habit, rather than focusing solely on those who smoke regularly. Further work could also explore whether different cessation approaches may be appropriate at different stages of smoking duration.

Awareness of smoking cessation services in Norfolk appears to be limited. Survey findings show that only around half of respondents were aware of Smokefree Norfolk, the main service in the county, with a similar level of awareness reported for GP based support. This suggests that a significant proportion of people may not know what help is available to them and are therefore less likely to access support. Feedback from focus group participants reinforces this, with many describing uncertainties about where to go for help or whether certain types of support existed at all. Together, these findings highlight a clear gap between service provision and public understanding, which is likely to act as a barrier to engagement with smoking cessation services.

People's experiences of smoking cessation support in Norfolk suggests inconsistency in how services are delivered. Participants often described this as a "*postcode lottery*", with the type and availability of support varying depending on where they live and whether their GP practice participates in local

programmes. This variation can make access pathways feel fragmented and unreliable, which may reduce confidence in the support available. As a result, inconsistent service provision may make people unsure about what help they can expect or could cause frustrations if certain services are not available to them but are to others.

Most of the feedback received focused on Smokefree Norfolk, the main local smoking cessation service, and highlighted mixed experiences. Some survey respondents and focus group participants reported positive outcomes, valuing the support they received, including regular follow-up appointments and in the past, access to prescription medication. Community matrons also shared anecdotal evidence of individuals benefitting from the service. However, these positive experiences were not consistent with everyone we spoke to. Participants also raised a number of concerns, including long waiting times, limited or no face-to-face support and a lack of holistic or personalised care. These concerns were echoed by the community matrons, who described delays in referrals, a lack of response and poor communication from the service. Taken together, these findings suggest that while Smokefree Norfolk can be effective for some, inconsistencies in delivery may affect overall confidence in the service and limit its accessibility.

Less feedback was received about other smoking cessation services, making it more difficult to draw firm conclusions about their impact. For example, awareness of the ACE service was relatively low, with only around one in four participants knowing about this service. Among those who were aware, some expressed hesitation about attending online seminars, feeling these may not be interactive or engaging enough. However, there were also more positive views, with one participant having signed up for an in-person session and expressed that they felt that this would be beneficial. These findings suggest that both a limited awareness of the services available alongside mixed perceptions of the delivery methods may influence engagement.

Our engagement identified a range of barriers that can make it difficult for people to stop smoking, which can be broadly grouped into personal and practical factors. The most commonly reported personal barrier was the stress, anxiety and fear associated with stopping smoking. Participants described concerns of both the physical effects of nicotine withdrawal and the emotional impact of giving up a behaviour which they use to help manage stress and poor mental health. Many also highlighted the habitual nature of smoking, particularly its connection to social situations, raising concerns that stopping

could lead to reduced social interaction or feelings of isolation. These findings reinforce that smoking is not only a physical addiction, but one that is closely linked to emotional wellbeing and social behaviours, which can make stopping smoking more complex.

Practical barriers to smoking cessation are often linked to challenges in accessing and engaging with support services. Participants highlighted issues such as limited appointment availability, long waiting times and difficulties travelling to appointment locations. Concerns were also raised about how some services are delivered, including limited formats available and challenges around discharge. For example, both survey respondents and focus group participants described support ending too quickly, with little or no follow-up, leaving individuals feeling unsupported during the early stages of stopping smoking when the risk of relapse is high. Some also reported that Smokefree Norfolk may discharge individuals following a relapse, despite them still wanting support. This approach may discourage people from being open about their experiences and reduce continued engagement with services. Together, these issues suggest that gaps in service accessibility and continuity of care can act as significant barriers to successfully stopping smoking.

Alongside these barriers, several facilitators were identified that encourage people to access smoking cessation support. A key motivator was the desire to improve personal health and reduce the risk of smoking-related harm. For some, this extended to protecting the health of others, with participants highlighting the influence of family members, particularly children, in their decision to stop smoking. Financial considerations also played an important role, with some respondents recognising the potential savings associated with stopping smoking. However, not everyone felt motivated to stop, particularly those who perceived themselves to be in good health, and therefore not someone who is at risk of harm caused by smoking. These findings suggest that while health, family and financial factors can support engagement with services, differences in risk perception may limit their impact for some individuals.

Preferences for how support is delivered also plays an important role in engagement with smoking cessation services. Over half of survey respondents expressed a preference for in-person appointments, while telephone support was the least favoured option. This was echoed by the focus group participants who described telephone support as impersonal and less effective, compared to in-person support which was seen as more engaging and motivating. Participants also highlighted the value of offering both one-to-one and group-

based support, recognising that different formats suit different individuals. For example, some may find group settings overwhelming, whereas others benefit from peer encouragement and accountability. However, focus group discussions also emphasised the importance of flexibility. While in-person support was preferred, factors such as illness, poor weather or holidays were identified as potential barriers to attendance. As a result, participants highlighted the need for flexibility or hybrid delivery models, allowing people to switch between formats as needed. These findings suggested that offering adaptable and personalised approaches to service delivery may improve engagement and support more successful stop smoking attempts.

Focus group participants highlighted the need for more holistic and personalised approaches to smoking cessation support, rather than a sole focus on harm reduction methods such as NRT. Many felt that smoking is not only a physical addiction, but it is closely linked to underlying factors such as stress and poor mental health, and therefore smoking cessation requires a broader, more tailored approach. Participants suggested that this could include a combination of coaching and behavioural support, such as talking therapies, to better address the root causes of smoking. In addition, some felt that the existing messaging and advice given by smoking cessation support services was too generic and repetitive, limiting its impact. There was a preference for more personalised and relatable communication, including messages that draw on lived experiences of smoking and its effects. Together, these insights suggest that more individualised, holistic approaches to both support and communication may help improve engagement and outcomes.

Many respondents felt that both prescription medication and NRT can play an important role in supporting people to stop smoking, although experiences of access and effectiveness were inconsistent. Participants who had used prescription medication, particularly varenicline, often described it as a highly effective and valuable tool to support their attempts to stop smoking. However, some also reported difficulties in accessing these medications, which led to frustration, and in some cases, a sense of hopelessness, particularly where individuals felt this was the only option that had worked for them. Experiences of NRT were more varied. While some found it helpful in managing cravings, others reported limited effectiveness or unpleasant side effects. These findings suggest that a range of treatment options is needed, alongside improved access to treatments, and that support should be tailored to the individual to reflect what works best for them.

Views on vaping as a harm reduction approach were mixed. While around half of survey respondents indicated they would consider using vaping, a substantial proportion said they would not, highlighting a clear divide in opinion. This was reflected in the public focus groups, where attitudes towards vaping were largely negative. Participants raised concerns about the risk of ongoing addiction, replacing one dependency with another, and uncertainty about the potential unknown long-term health effects of vaping. In addition, both public participants and community matrons identified a gap in support, noting that there was limited, if any, help available for individuals who have successfully stopped smoking but now want to stop vaping. These findings suggest that while vaping may be a viable option for some, concerns about its risks and a lack of follow-on support may limit its acceptability and effectiveness as a smoking cessation tool.

Some participants felt that public health messaging on smoking cessation has a limited and inconsistent impact. While certain approaches, such as graphic warning images were a motivator for some individuals, others described becoming desensitised to repeated messages or perceived them as fear-based and ineffective. Participants suggested that messaging may have greater impact if it is more personal and relatable, for example by highlighting the effects of smoking on others, such as the risks of second-hand smoke to children. In addition, while participants were generally aware of national smoking-related messaging, there was notably less recognition of local stop smoking services. Given the wider lack of awareness identified across this engagement, this suggests that promotion of available support in Norfolk may not be reaching the public effectively. Strengthening how services are communicated alongside wider health messaging may therefore help improve awareness and encourage greater uptake of support.

A key finding from both the survey and the focus groups was the need for sustained support and continuity of care. Many participants highlighted that stopping smoking is a long-term process, with the risk of relapse remaining even after initial support has ended, and in some cases persisting for years. Participants therefore emphasised the importance of ongoing follow-up and better coordination between services to ensure consistent support, effective information sharing, and smooth transitions in care. However, current provision, based on participants' experiences, was often described as time-limited and not always aligned with individual needs. These findings suggest that strengthening continuity and extending the duration of support may improve long-term outcomes and help people maintain smoking cessation. This however would

come with a significant cost of extending support services, although if it contributes to improving smoking cessation rates, it may mean that there will be less financial burden on the health impact of long-term smoking.

In conclusion, these findings suggest that while a range of smoking cessation support is available in Norfolk, inconsistent access, limited awareness and a lack of flexible and holistic approaches are reducing overall engagement and effectiveness. These challenges appear to particularly affect individuals who have more complex needs or those who are less ready to stop smoking. Addressing these issues through improved access, clearer communication and more personalised, adaptable models of support may help strengthen uptake of services and support more successful long-term outcomes.

Recommendations

1) Improve access and consistency of smoking cessation support across Norfolk:
   NCC Public Health should work with primary care and commissioned providers over the next 12 months to improve the consistency and accessibility of smoking cessation support around the county, focusing on reducing variation between GP surgeries so that residents are not disadvantaged based on where they are registered. This can be measured by auditing the number of GP surgeries that offer smoking cessation services before and after any changes are made.

2) Improve ability to re-engage with services following relapse:
   Smokefree Norfolk and other services in the county should take steps to create specific pathways to easily allow people to re-engage with smoking cessation services if they relapse while, or after engaging with services. This will provide supportive, non-judgemental support and reduce the need for people to be re-referred into the service, helping to minimise unnecessary barriers to accessing support.

3) Improved responsiveness and communications within Smokefree Norfolk:
   Smokefree Norfolk should make improvements to the timeliness and clarity of its communication process, ensuring that referrals, queries and service user contacts are managed in a responsive and transparent way. Over the next 12 months they should explore implementing automatic acknowledgement emails for all referrals and ensure all patient and professional enquiries are dealt with within a reasonable timescale (e.g. 3 working days). As a longer-term goal, over the next year Smokefree Norfolk can aim to make initial contact with all patients referred to the service within an agreed timeframe (e.g. within 2-3 weeks of the referral being made). Improvements could be measured via audits into waiting times, and also patient satisfaction surveys to see if there have been improvements.

4) Expand and diversify models of smoking cessation support, including holistic approaches:

NCC Public Health should expand and diversify the models of stop smoking support they commission, ensuring people can access support that reflects their individual needs and circumstances. This could include a wider range of support options, flexible delivery methods, longer-term follow-up, and support that recognises the role of factors such as stress, mental wellbeing and social circumstances in smoking behaviour. Additionally, support should be tailored to individual needs and include opportunities for ongoing support such as groups, drop-ins and the ability to re-engage following relapse.

5) Improve awareness and advertisement of smoking cessation services:
NCC Public Health and smoking cessation providers should work together over the next 12 months to improve the awareness of local smoking and vaping information, cessation services and how and where people can access this. This can be achieved by increased and more effective advertising, including advertising campaigns on social media and local media as well as visual advertisements in local GP practices, pharmacies and community venues. NCC Public Health could work with members of the public to co-produce advertising materials to ensure that these are engaging and interesting to people. The impact can be monitored via changes in public awareness of support and therefore referral rates to services.

6) Address gaps in support for those wanting to stop vaping:
NCC Public Health should work to address the current gaps in support for individuals wanting to access support to stop vaping. Over the next 12 months they should consider commissioning or piloting targeted support pathways for people who want to stop vaping, as well as ensure appropriate guidance is given to local services and clinicians so that they can identify and appropriately signpost and advice individuals seeking help for this.

7) Work to improve participation amongst 18-24-year-olds in future projects:
Healthwatch Norfolk should seek to increase participation among 18–24-year-olds in future projects through targeted recruitment and promotion in settings and channels that are relevant to this age group. This could include targeted engagement on university campuses and through other organisations and platforms that reach younger adults.

Response from NCC Public Health

Thank you for taking the time to speak with people about their experiences of stop smoking support in Norfolk and for sharing this thoughtful report with us. We are especially grateful to the residents and professionals who contributed so openly. Their experiences provide valuable, practical insight that will help us strengthen the support we commission.
We will now work with our providers and partners to:

- **Review the commissioning and delivery model** to ensure support is locally accessible, flexible and offers an appropriate balance of face-to-face, telephone, digital and group-based options.
- **Set clearer referral and communication standards**, including timely acknowledgement, initial contact, progress updates and feedback to referring professionals.
- **Investigate variation in access** across Norfolk, including differences in behavioural support and stop smoking medication, and act where provision is inconsistent.
- **Make it easier for people to return after relapse** by reviewing follow-up, discharge and re-entry arrangements.
- **Improve awareness and navigation** so residents and professionals can clearly understand what support is available, who is eligible and how to access it.
- **Review emerging evidence on vaping cessation** and determine what advice or support can appropriately be offered to adults who have stopped smoking and now wish to stop vaping.

We are committed to taking these actions forward with commissioned providers and partners, alongside our wider work on prevention, smokefree environments and the factors that influence tobacco dependence. Importantly, we will continue to listen to people's experiences as we assess whether changes are making support easier to access, more consistent and more responsive.
Thank you again for this constructive and important contribution. We value our relationship with Healthwatch Norfolk and look forward to continuing to work together as we take this work forward.
Yours sincerely

Professor Derek Ward
Director of Public Health

Acknowledgement

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References

Allen Carr's Easyway. (n.d.). *Stop smoking in Norfolk for FREE*. Retrieved from Allen Carr's Easyway: https://www.allencarr.com/location/norfolk-council/

ASH. (2025, November). *Smoking Statistics*. Retrieved from ASH.: https://ash.org.uk/resources/view/smoking-statistics

ASH. (2025). *Use of vapes among adults in Great Britain.* ASH.

ASH. (2025, March). *Young people and smoking*. Retrieved from ASH: https://ash.org.uk/resources/view/young-people-and-smoking

ASH Scotland. (2023). *Cost of living, cost of smoking: The effect of smoking on personal finances and poverty in Scotland.*

Ashour, A. M. (2023). Use of Vaping as a Smoking Cessation Aid: A Review of Clinical Trials. *Journal of Multidisciplinary Healthcare*.

Asthma + Lung UK. (2024, March 31). *Why is smoking bad for you? The effects of smoking*. Retrieved from Asthma + Lung UK: https://www.asthmaandlung.org.uk/living-with/stop-smoking/why-is-it-bad

Asthma + Lung UK. (2025, October 2). *How passive smoking affects your child's lungs*. Retrieved from Asthma + Lung UK: https://www.asthmaandlung.org.uk/support-parents-carers/how-can-passive-smoking-affect-your-childs-lungs

Better Health. (n.d.). *Quit smoking with nicotine replacement therapies (NRTs)*. Retrieved from Better Health: https://www.nhs.uk/better-health/quit-smoking/ready-to-quit-smoking/quit-with-nicotine-replacement-therapies-nrt/

Better Health. (n.d.). *Quit smoking with nicotine-free medicines*. Retrieved from Better Health: https://www.nhs.uk/better-health/quit-smoking/ready-to-quit-smoking/quit-with-nicotine-free-medicines/

Britton, J., & Bogdanovica, I. (2014). *Electronic Cigarettes: A report clomissioned by Public Health England.* London: Public Health England.

CDC. (2025, January 31). *Health Problems Caused by Secondhand Smoke*. Retrieved from CDC: https://www.cdc.gov/tobacco/secondhand-smoke/health.html

Department of Health & Social Care. (n.d.). *Smoking profile*. Retrieved from Fingertips | Public health profiles: https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132900/ati/15/iid/92536/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

Department of Health & Social Care. (n.d.). *Smoking Profile*. Retrieved from Fingertips | Public Health Profiles: https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132885/ati/502/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Department of Health and Social Care. (2026, April 29). *Tobacco and Vapes Bill becomes law*. Retrieved from Gov.UK: https://www.gov.uk/government/news/tobacco-and-vapes-bill-becomes-law

Jackson, S. E., Brown, J., Kock, L., & Shahab, L. (2024). Prevalence and uptake of vaping among people who have quit smoking: a population study in England, 2013-2024. *BMC Medicine*, 503.

Jackson, S. E., Shahab, L., Tattan-Birch, H., & Brown, J. (2024). Vaping among adults in England who have never regularly smoked: a population-based study, 2016-24. *Lancet Public Health*, 755 - 765.

Machado, N. M., Feldman, K., Menezes do Anaral, L., Ronzani, T. M., & Richter, K. P. (2022). Vaping, Perceptions of Vaping, and Plans to Quit Among E-cigarette Users in the United States and the United Kingdom. *Nicotine & Tobacco Research*, 1504-1508.

NHS. (2022, October 10). *Using e-cigarettes to stop smoking*. Retrieved from NHS: https://www.nhs.uk/live-well/quit-smoking/using-e-cigarettes-to-stop-smoking/

NHS Better Health. (n.d.). *Understanding the true impact of smoking*. Retrieved from Better Health: https://www.nhs.uk/better-health/quit-smoking/why-quit-smoking/understanding-the-true-impact-of-smoking/

NHS England. (2024, October 17). *Smoking, Drinking and Drug Use among Young People in England, 2023*. Retrieved from NHS England: https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2023

NHS England. (2025, October 23). *Statistics on Local Stop Smoking Services in England - April 2025 to June 2025 (Q1)*. Retrieved from NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2025-to-june-2025-q1

NICE. (2026, January). *What are the harms caused by smoking?* Retrieved from National Institute for Health and Care Excellence: https://cks.nice.org.uk/topics/smoking-cessation/background-information/harms-caused-by-smoking/

NICE. (2026, January). *What is the prevalence of smoking*. Retrieved from NICE CKS: https://cks.nice.org.uk/topics/smoking-cessation/background-information/prevalence/

NICE. (n.d.). *Smoking cessation*. Retrieved from NICE: https://bnf.nice.org.uk/treatment-summaries/smoking-cessation/

Norfolk County Council. (2026). *Support with stopping smoking*. Retrieved from Ready to change: https://www.norfolk.gov.uk/42355

Norfolk County Council Public Health. (2024). *Norfolk JSNA Health Needs Assessment Smoking and Tobacco Control.*

Norfolk County Council Public Health. (2025). *Norfolk Flourish Survey 2024 - Smoking and Vaping.*

Norfolk County Council. (n.d.). *What to expect when you quit smoking*. Retrieved from Ready to Change: https://www.norfolk.gov.uk/article/42334/What-to-expect-when-you-quit-smoking

Office for Health Improvement & Disparities. (2025, July 4). *Smoking and tobacco: applying All Our Health*. Retrieved from Gov.UK: https://www.gov.uk/government/publications/smoking-and-tobacco-applying-all-our-health/smoking-and-tobacco-applying-all-our-health

Office for Health Improvement & Disparities. (2025, November 4). *Smoking profile: statistical commentary, November 2025*. Retrieved from Gov.uk: https://www.gov.uk/government/statistics/smoking-profile-november-2025-update/smoking-profile-statistical-commentary-november-2025

Office for National Statistics. (2025, November 4). *Adult smoking habits in the UK: 2024*. Retrieved from Office for National Statistics: https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2024

Public Health England. (2019, December 17). *Health matters: stopping smoking - what works*. Retrieved from Gov.Uk: https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works

SmokeFree Norfolk. (n.d.). *Smokefree Norfolk*. Retrieved from Smokefree Norfolk: https://smokefreenorfolk.co.uk/

Appendix

Appendix A - Full Survey:

NCC smoking survey

1.

Who is Healthwatch Norfolk?

Healthwatch Norfolk is the independent voice for patients, service users and carers in the county. We use feedback from people to shape the future of local health and care services.

What is this survey about?

This survey forms part of an independent evaluation of smoking cessation services in Norfolk commissioned by commissioned by Norfolk County Council Public Health, by gathering data from current smokers and those who have stopped smoking in the past 10 years. We are exploring people's views, experiences and barriers to quitting smoking.

The survey will take approximately 10 minutes to complete. Some questions are optional.

If you would prefer to do this survey with us over the phone, please call Healthwatch Norfolk on 01953 856029 and we will arrange a time to ring you back to complete the survey. Alternatively, please email: enquiries@healthwatchnorfolk.co.uk to receive the survey in alternative formats, including Easy Read, large print or in different languages.

How the survey results will be used

Survey responses are being collected and analysed by Healthwatch Norfolk. You can read our privacy policy at: www.healthwatchnorfolk.co.uk/about-us/privacy-statement.

All responses will be anonymous. The survey findings will be used as part of an independent evaluation for Norfolk County Council. The report will be publicly available on our website and may be used in other Healthwatch Norfolk communications.

Survey closing date: 28/02/2026

Please note that questions marked with an asterisk (*) require responses.

1. Please tick to confirm

- [ ] I have read and understood the above statement

2. Smoking

2. Are you currently a smoker of cigarettes and/or cigars, have attempted to stop smoking and relapsed or have stopped smoking in the past 10 years?

- [ ] I am currently a smoker of cigarettes and/or cigars
- [ ] I am a smoker who has attempted to stop smoking and relapsed
- [ ] I have stopped smoking within the last 10 years
- [ ] I have not smoked in the last 10 years
- [ ] I have never smoked

3. Smoking - continued

3. How old are you?

- [ ] Under 12
- [ ] 12-17
- [ ] 18-34
- [ ] 35-44
- [ ] 45-59
- [ ] 60 or over

4. What is the first half of your postcode? (E.g. NR1)

5. How long have you been a smoking?

- [ ] Less than 1 month
- [ ] 1-6 months
- [ ] 6-12 months
- [ ] 1-5 years
- [ ] 5-10 years
- [ ] 10-20 years
- [ ] More than 20 years

6. If you have stopped smoking, how long ago did you quit?

- [ ] Less than 1 month ago
- [ ] 1-6 months ago
- [ ] 6-12 months
- [ ] 1-5 years ago
- [ ] 6-10 years ago
- [ ] More than 10 years ago

7. Have you ever sought help from any smoking cessation (stopping smoking) services?

- [ ] Yes

- [ ] No
- [ ] I don't know
- [ ] Prefer not to say

If yes, please explain what services you used and how you found these:

8. Are or were there any barriers preventing you from accessing smoking cessation support? You can select more than one answer

- [ ] Don't know where to get help
- [ ] Lack of support to stop smoking from family or friends
- [ ] Stress/Anxiety/fear of stopping smoking
- [ ] Don't want to stop smoking
- [ ] Not able to get time off work
- [ ] Location
- [ ] Availability of appointments
- [ ] Waiting lists
- [ ] Concerns over cost
- [ ] No access or unable to use the internet
- [ ] Family or caring commitments
- [ ] Other (please specify):

9. Please tick all the smoking cessation support services you have heard of. You may choose multiple responses.

- [ ] Ready to Change
- [ ] Smokefree Norfolk
- [ ] Allen Carr's Easyway (ACE)
- [ ] GP services
- [ ] Pharmacy services

- [ ] NHS Quit Smoking app
- [ ] Better Health
- [ ] Stoptober
- [ ] Private therapies (e.g. CBT and Hypnotherapy)
- [ ] Prefer not to say
- [ ] Other (please specify):

10. What format would you prefer for support to stop smoking? You can select more than one option.

- [ ] In-person appointment
- [ ] Online
- [ ] Telephone calls
- [ ] Group support
- [ ] Other (please specify):

11. Please tick to indicate which of these harm reduction approaches to stopping smoking you have used in the past.

- [ ] Vaping/E-cigarettes
- [ ] Nicotine gum
- [ ] Nicotine patches
- [ ] Nicotine mouth spray
- [ ] Nicotine Lozenges
- [ ] Nicotine inhalator
- [ ] Nicotine nasal spray
- [ ] Nicotine tablets
- [ ] Prescription medication-Varenicline and Cytisine
- [ ] Psychological support
- [ ] Stopping with no support/medication
- [ ] Other (please specify):

12. Please tick the boxes below to show which of these harm reduction approaches to stopping smoking you would consider using and which ones you would not use.

	Would be open to using	Would not use
Vapes/E-cigarettes	☐	☐
Nicotine gum	☐	☐
Nicotine patches	☐	☐
Nicotine Mouth Spray	☐	☐
Nicotine Lozenges	☐	☐
Nicotine Inhalator	☐	☐
Nicotine nasal spray	☐	☐
Nicotine tablets	☐	☐
Prescription medication	☐	☐

13. If you have either tried to quit smoking in the past, or successfully quit smoking, what approach helped you to quit?

14. If you have any other comments regarding smoking cessation services and support for stopping smoking please share them here:

15. If you would be interested in taking part in a focus group about stopping smoking please provide us with your name and contact details.

4. Demographics

About you

In this next section we will be asking you some questions about yourself and your life. All these questions are optional. Your answers help us make sure that we hear from people from different backgrounds and that we understand the needs of different groups in our community. Remember: all your answers are strictly confidential and the survey is anonymous.

16. How old are you?

17. What is your gender?

- [ ] Male
- [ ] Female
- [ ] Non-binary
- [ ] Genderfluid
- [ ] Genderqueer
- [ ] Intersex
- [ ] Prefer not to say
- [ ] Prefer to self describe:

18. What is your sexuality?

- [ ] Bisexual
- [ ] Homosexual (Gay or Lesbian)
- [ ] Heterosexual (Straight)
- [ ] Pansexual
- [ ] Prefer not to say
- [ ] If you feel the choices do not provide a suitable option, please write how you would describe your sexual orientation:

19. What is your ethnic group

- [ ] Arab

Asian/Asian British:

- [ ] Bangladeshi
- [ ] Chinese
- [ ] Indian
- [ ] Pakistani
- [ ] Any other Asian/Asian British background

Black/Black British:

- [ ] African
- [ ] Caribbean
- [ ] Any other Black/Black British background

Mixed/ Multiple ethnic groups:

- [ ] Asian and White
- [ ] Black African and White
- [ ] Black Caribbean and White
- [ ] Any other Mixed/ Multiple ethnic groups background

White

- [ ] British / English / Northern Irish / Scottish / Welsh
- [ ] Irish
- [ ] Gypsy, Traveller or Irish Traveller
- [ ] Roma
- [ ] Any other White background please specify below

Other

- [ ] Any other Ethnic Group
- [ ] Prefer not to say
- [ ] If other, please specify:

20. Please select any of the following that apply to you:

- [ ] I have a disability
- [ ] I have a long term condition
- [ ] I am a carer
- [ ] None of the above
- [ ] I prefer not to say

21. Where did you hear about this survey?

- [ ] GP website
- [ ] Healthwatch Norfolk Event
- [ ] Healthwatch Norfolk Newsletter
- [ ] Healthwatch Norfolk Website
- [ ] News (Website / Radio / Local Newspaper)
- [ ] Podcast
- [ ] Search Engine (e.g. Google)
- [ ] Social Media (e.g. Facebook / Instagram / Twitter)
- [ ] Through a friend or co-worker
- [ ] Youtube
- [ ] Other (please specify):

22. Healthwatch Norfolk produce fortnightly newsletters about health and social care in Norfolk. If you would like to receive this newsletter please leave your email here:

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