

HEALTH SYSTEM IMPROVEMENT GUIDE

# Smokefree Buffet





The Smokefree Buffet project is an excellent example of the change we can achieve with collaborative improvement methodology.

The project brought together project manager and improvement advisor expertise from Ko Awatea with the clinical expertise of frontline healthcare staff. Together, they created a new model of self-management support to help clients with long-term conditions quit smoking.

Smokefree Buffet formed part of the wider Manaaki Hauora – Supporting Wellness campaign, which was structured according to the Breakthrough Series Collaborative Model for Achieving Breakthrough Improvement. A collaborative brings together groups of practitioners to work in a structured way to improve aspects of the quality of their service. It involves meetings to learn about best practice in the chosen area, quality improvement methods and change ideas, and to share experiences of making change in local settings.<sup>1</sup> This structure enabled Ko Awatea to engage clinical staff in project teams and build their capability to deliver improvement.

The Breakthrough Series approach incorporated learning sessions where project teams learned how to use quality improvement tools, such as driver diagrams and the Model for Improvement. These tools enabled project teams to understand the factors that drive success in clinical systems and to develop and test change ideas to learn what works in practice to create improvement.

Throughout the Manaaki Hauora – Supporting Wellness campaign, healthcare staff and members of our community have been excited about getting the chance to try things they think will improve care and being given the time, skills and resources they need to do it. Clients and their families are telling a different story about their quality of life now. We are proud to have made a difference for people living with long-term conditions in Counties Manukau.

**Diana Dowdle**  
Delivery Manager

The Smokefree Buffet project team would like to thank our Ko Awatea improvement advisor, Sneha Shetty, and project manager, Danielle Farrell. They have consistently supported us to develop our knowledge in the implementation of improvement methodology. Through their drive Smokefree Buffet has remained a significant part of the Living Smokefree Service team's ongoing determination to improve service delivery.

We would like to acknowledge Summer Hawke (Portfolio Manager), Rikki Nia Nia (Māori Health General Manager) and Margie Apa (Director), who have provided us with the permission to trial innovations and, if these aren't effective, to adapt and try again. The guidance they provide has been extremely helpful in bringing this project to fruition.

We would also like to acknowledge our primary care, secondary care, maternity care and mental health partners, the wider Living Smokefree Service team and our community for their contribution to this project.

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Smoking is a cause or contributor to many long-term conditions.

Smokefree Buffet is a project that supports clients with long-term conditions to engage with stop-smoking services and quit smoking. It also enables healthcare professionals to provide stop-smoking advice and referrals with confidence.

The project was developed by the Living Smokefree Service, the smoking cessation service at Counties Manukau Health, as part of the Manaaki Hauora – Supporting Wellness campaign. Led by Ko Awatea, the centre for healthcare improvement, education and innovation at Counties Manukau Health, this campaign was launched in 2015 to provide self-management support for people living with long-term conditions.

The campaign included 16 project teams, each with a unique aim that related to the overall campaign. It was structured according to Institute for Healthcare Improvement Breakthrough Series methodology.<sup>2</sup> Project teams used the Model for Improvement to develop and test change ideas.<sup>3</sup>

The aim of Smokefree Buffet was to increase the number of people engaged and supported to become smokefree with the Living Smokefree Service by 50 per cent by June 2016 and double the number of people smokefree at four weeks, by:

- strengthening the ‘cessation’ component of the smokefree ABC (Ask, Brief advice, Cessation) in secondary care, primary care, mental health and maternity care

- providing a range of smokefree options to clients with long-term conditions from secondary care, primary care, mental health and maternity care supported by the Living Smokefree Service.

To achieve this aim, the Smokefree Buffet team developed a change package that focused on two primary drivers:

- Client engagement and activation
- Service delivery (healthcare professional/provider engagement)

We identified change concepts and developed and tested specific change ideas that supported these primary drivers to create a change package.

To improve client engagement and activation, we use Cooldrops and Quickmist. We also created a ‘smokefree menu’, a customised smokefree package for mental health, and after-hours drop-in clinics to increase access to treatment options.

Smokefree Buffet improved engagement with healthcare professionals and providers by fostering close links within the healthcare system. We introduced targeted roles to build relationships with each of the four sectors closely aligned with Smokefree Buffet: secondary care, primary care, mental health and maternity care. In addition, we introduced direct antenatal referrals from primary care, group-based therapy training for primary health organisation staff, and training for mental health staff in ABC documentation.

## OUTCOMES

The outcome measure for the project was the number of people who remained smokefree four weeks after their quit date. Process measures included the referral rate, the number of people assessed and the number of people who set a quit date.

Smokefree Buffet achieved substantial increases in all of these measures (Table 1).

**Table 1: Pre- and post-project performance against key measures**

	Oct 2013 - Dec 2014	Jan 2015 - Mar 2016	Percentage increase
Overall referrals	2886	4553	58%
Internal assessments	415	938	126%
Number of quit dates	249	543	118%
Number of quitters	154	318	107%

Overall, Smokefree Buffet has shown benefits in improved reach and smoking cessation outcomes among smokers with long-term conditions, better collaboration between the Living Smokefree Service and other services, better service delivery and addressing the equity gap.

Going forward, we will focus on embedding the Smokefree Buffet change package into business as usual to ensure sustainability. The goal is for all smokefree providers in Counties Manukau to deliver the same package of smoking cessation support to ensure that all people with long-term conditions are better supported to stop smoking.

This work will contribute to achieving the Smokefree Aotearoa 2025 vision that fewer than five per cent of New Zealanders will smoke by 2025.

*"I had a slip up along the way and I wasn't happy that I had let myself down. To me it was the end of the world, but the Living Smokefree team encouraged me that it was only a slip up. I realised the speed bump was okay and I could get myself back up and go for it again. I thought: I can do this!"*

Faye, client, Smokefree Buffet

Smokefree Buffet is an innovative project to give clients with long-term conditions in secondary care, primary care, mental health and maternity care services in Counties Manukau access to a full range of evidence-based support options to stop smoking, encourage clients to engage with stop-smoking services, and to enable healthcare professionals to advise and refer clients confidently for ongoing support.

Counties Manukau has an estimated 62,000 smokers, with particularly high prevalence in the socioeconomically vulnerable areas of Manurewa, Mangere/Otara and Papakura. Approximately one third of people who smoke in Counties Manukau are Māori, one third are Pacific Islanders, and the remainder are New Zealand Europeans or other ethnicities. Smoking disproportionately affects people with long-term conditions, Māori, Pacific Islanders, pregnant women and their whānau (family), people with mental illness and/or addictions, and youths. These groups are the priority for smoking cessation services.

In 2013, Counties Manukau Health (CM Health) launched a five-year Smokefree 2025 initiative to reduce the prevalence of smoking from 15.9 per cent to an interim target of 12 per cent by 2018, with the eventual goal of achieving a smokefree district by 2025.<sup>4</sup> Achieving the initiative's interim target requires an additional 4,200 people per year to quit smoking and stay smokefree. This requires a shift in smokefree activities and effective new approaches to reduce smoking prevalence among our priority communities on a larger scale.

The Living Smokefree Service, the smoking cessation service at Counties Manukau Health, developed Smokefree Buffet in collaboration with primary care, secondary care, maternity care and mental health services. The project is a new approach to providing stop-smoking services which aligns with the CM Health Smokefree 2025 strategy.

The project was developed, funded and supported as part of the Manaaki Hauora – Supporting Wellness campaign led by Ko Awatea, the centre for healthcare improvement, education and innovation at Counties Manukau Health. Manaaki Hauora – Supporting Wellness was an umbrella campaign that supported a range of projects by providing funding, as well as training and expertise in improvement methodology. The campaign had a unifying goal to provide self-management support for 50,000 people living with long-term conditions in Counties Manukau, which all of the collaborative project teams shared. In addition, each collaborative team had a unique aim and change ideas, which ultimately contributed to the overall campaign goal.

The Manaaki Hauora – Supporting Wellness campaign used the Institute for Healthcare Improvement Breakthrough Series (BTS) approach to train and support participating teams in improvement methodology and collaborative working.<sup>2</sup> The BTS was structured as five learning sessions interspersed with action periods.

During learning sessions, collaborative teams learned how to use Model for Improvement quality improvement methodology.<sup>3</sup> The Model for Improvement asks three questions:

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

During action periods, teams tested their theory of change using plan, do, study, act (PDSA) cycles.

This guide describes the development, implementation and outcomes of the Smokefree Buffet project.



*Smokefree Buffet client, Tony Ormsby, using a nicotine patch*

Before Smokefree Buffet, the Living Smokefree Service received referrals for just under half the smoking population from across the healthcare system, which left the remaining people who smoke unsupported to stop smoking. Of those referred, less than half engaged and less than half again set a quit date. This resulted in lower smokefree outcomes and little impact to prevent hospital readmissions.

Smokers with long-term conditions were generally offered smokefree assistance either at the hospital or in the community, but they were given little information about the stop-smoking options and types of support available. This inhibited initial buy-in and engagement with the Living Smokefree Service team and contributed to lower smokefree outcomes.

*"Having smoked for many years, I felt that if I didn't give up soon it may lead to cancer or worse things. My friend passing away in her fifties through smoking-related disease and a neighbour with the worst cough I have ever heard had a big impact on me. I didn't want to sound like that. I wanted to stop the damage where it was. I wanted better for myself; a better future and a better now."*

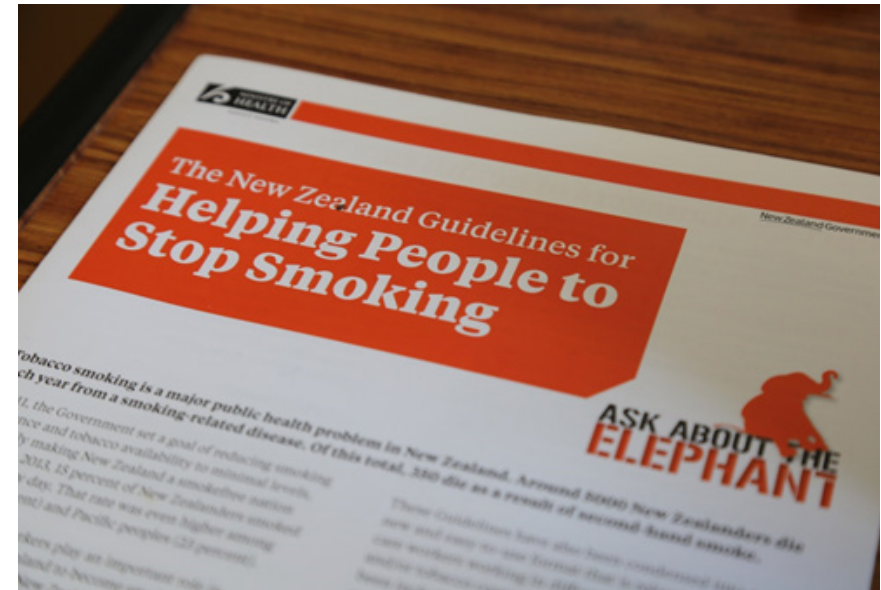
Melanie, client, Smokefree Buffet



*The Smokefree Buffet team at a Manaaki Hauora – Supporting Wellness campaign learning session*

The aim of Smokefree Buffet was to increase the number of people engaged and supported to become smokefree with the Living Smokefree Service by 50 per cent by June 2016 and double the number of people smokefree at four weeks, by:

- strengthening the 'cessation' component of the Smokefree ABC (Ask, Brief advice, Cessation) in secondary care, primary care, mental health and maternity care
- providing a range of smokefree options to clients with long-term conditions from secondary care, primary care, mental health and maternity care supported by the Living Smokefree Service.



*"The hardest thing about giving up smoking was that I felt like I had lost a friend. I missed having a smoke after eating or when I felt stressed. I couldn't depend on my crutch anymore and I had to learn to handle it differently. Having weekly support from the Living Smokefree Service made me want to go for it."*

Faye, client, Smokefree Buffet

## OUTCOME MEASURES

- Number of people who remained smokefree at four weeks post quit date.

## PROCESS MEASURES

### Referral rate

- Increase in the number of referrals for smokefree support.

### Engagement

- Number of people assessed.
- Number of people who set a quit date.
- Number of people who remained smokefree at four weeks post quit date.

The Living Smokefree Service database was used to collect baseline measures in line with the Ministry of Health Stop Smoking Service Tier 1 service specifications.<sup>5</sup>



*Georgina McKenzie, Smokefree Advisor – Primary Care, Smokefree Buffet (left) and Michelle Lee, Smokefree Advisor – Maternity, Smokefree Buffet (right) at a Manaaki Hauora – Supporting Wellness campaign learning session*

Smokefree Buffet developed a change package based on evidence from a literature review and the application of quality improvement tools, such as process mapping, driver diagrams and PDSA cycles.

## LITERATURE REVIEW

Evidence suggests that an approach combining face-to-face support, group-based treatment (GBT) and self-management strategies can effectively help people to stop smoking.

The 2014 New Zealand smoking cessation guidelines cite strong evidence for face-to-face support and GBT in smoking cessation.<sup>6</sup> A 2005 Cochrane review of 53 randomised control trials showed that GBT is more effective than self-help for remaining smokefree six months post quit date.<sup>7</sup> Evidence for self-help materials alone is poor.<sup>8</sup>

The Heart Guide Aotearoa Programme successfully trialled a self-management intervention which included client contact and a resource package. This programme, which was aimed at clients with chronic cardiac conditions and included a smokefree component, has demonstrated improved outcomes for participants and good uptake by Māori and people in rural areas.<sup>9,10,11</sup>

A 2015 study by Martin Cantera et al. in primary care found that multicomponent interventions achieved long-term continuous abstinence rates of between seven and 40 per cent,<sup>12</sup> compared to a 2.5 per cent success rate without support.<sup>7</sup> These multicomponent interventions included a combination of individual or group counselling, printed material, telephone calls, subsidised medications and financial incentives.

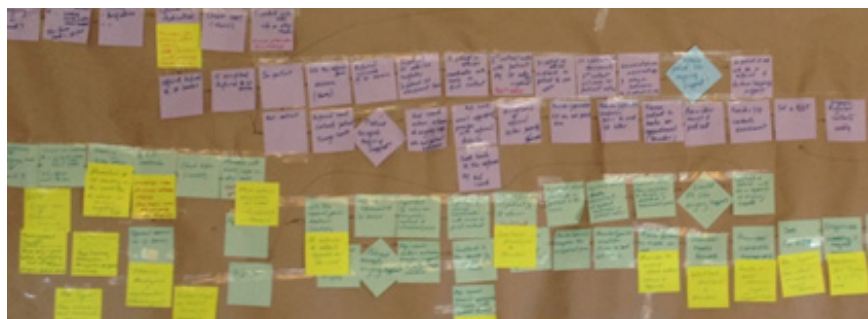
Smokefree Buffet explored this multicomponent approach in our target population groups.

*"There have been so many benefits and so many changes for me. I introduced things into my life that I have always loved: running, walking, physical things. I'm really feeling the benefits of those things, my breathing is fantastic and running is so much easier. I have noticed my skin is getting clearer, it glows like it didn't use to. My teeth have got whiter. I have more money. Nothing smells; my hair, house and breath smell nice, that's a massive change that no one can deny. By having that I have freedom because you can't get rid of cigarettes with a squirt of perfume or a mint. It has given me the freedom to be really spontaneous. There's less cleaning up to do; there are no butts around the house, no ash in the car. I see people that I have always cared about and stay with them for long periods of time without having to run away to have a cigarette. I've always hidden my smoking from people and now there is no hiding."*

Patricia, client, Smokefree Buffet

## PROCESS MAPPING

The Smokefree Buffet team began the quality improvement process by developing a process map. This allowed the team to identify initial points of contact for clients and track the client journey. Creating a visual process roadmap allowed us to understand the current state, potential barriers and areas where intervention could bring value to clients. We reflected on the current state to identify opportunities for change and incorporated these into the documented client journey. This allowed a visual representation of a potential future state to run in parallel with current activity.



*Smokefree Buffet process map*

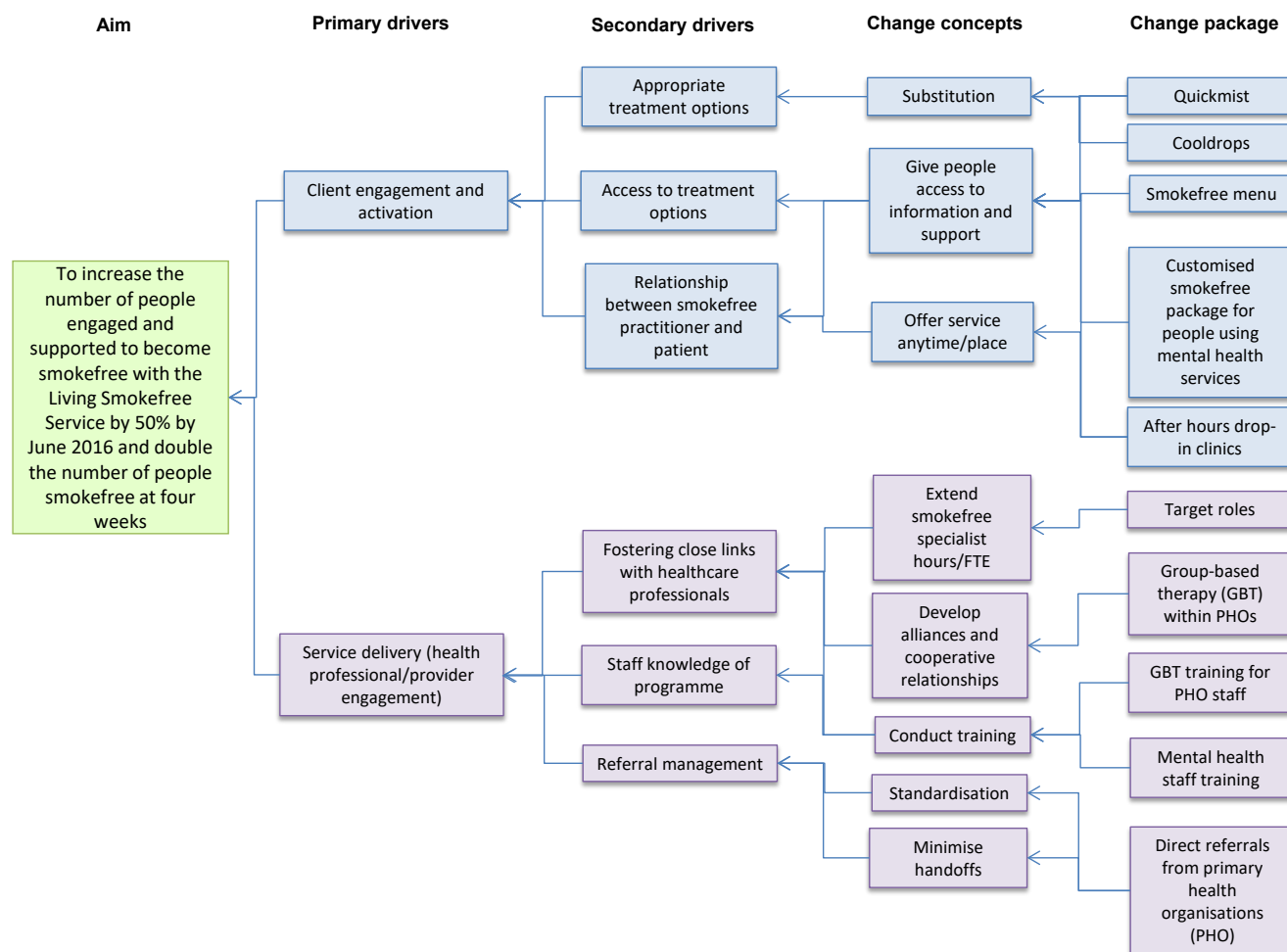
## THE DRIVERS OF CHANGE

Opportunities for change aligned with two primary drivers (Figure 1, p. 14):

- Client engagement and activation
- Service delivery (healthcare professional/provider engagement)

We identified change concepts and developed and tested specific change ideas that supported these primary drivers to create a change package (Figure 1, p. 14).

**Figure 1: Smokefree Buffet driver diagram**



## APPROPRIATE TREATMENT OPTIONS



*A 'buffet' of smoking cessation options*

### Change idea: Cooldrops

Smoking cessation services routinely offer subsidised nicotine replacement therapy (NRT) products in the form of patches, gum and lozenges as an evidence-based treatment component to support a quit attempt. Using nicotine replacement therapy doubles someone's chance of successfully quitting.<sup>6</sup> However, for a variety of reasons, not everybody opts to use NRT, decreasing their likelihood of success.

Cooldrops are a new NRT product which was launched in New Zealand in 2014. They are essentially a small version of the nicotine lozenge and have the same efficacy. This product is not currently subsidised in New Zealand but is available in various retail shops for approximately \$40 for 80 pieces.

The Smokefree Buffet team tested the acceptability and attractiveness of Cooldrops to people engaging with Living Smokefree Service support who did not want regular NRT products. We provided Cooldrops (full 80 pieces) to 33 clients who either had declined the regular products or were deemed as potentially benefiting from additional NRT. These were provided on top of usual care.

Qualitative feedback suggested that Cooldrops reduced cravings and people liked its taste and convenience. Of the 33 clients, 20 set a quit date and 14 were successfully smokefree at four weeks, a 70 per cent quit rate. Of those setting a quit date, five used only Cooldrops, with four people successfully smokefree at four weeks.

To assess whether Cooldrops are an attractive option for Māori and Pacific Islander clients, we looked at the ethnicity breakdown. Of the 33 clients, 17 were Māori, six were Pacific Islanders and 10 were of other ethnicities. Pregnant women accounted for 19 of the clients using Cooldrops. The overall quit rate was 70 per cent, as mentioned above, which comprised a 63 per cent quit rate for Māori, a 100 per cent quit rate for Pacific Islanders and a 50 per cent quit rate for other ethnicities. The pregnant women achieved an 84 per cent quit rate.

Cooldrops appear to be an attractive option for Māori and Pacific Islander clients, easy to use and appropriate to incorporate into the usual platter of treatment options. As this product is not subsidised, Smokefree Buffet is enhancing access by making Coolsdrops available.

### **Change idea: Quickmist**

Nicorette Quickmist is an NRT product that delivers nicotine in a mouthspray formula. It was launched in New Zealand in 2012 and was marketed as taking away cravings within 60 seconds, potentially making it a better tool for people with a higher nicotine addiction who seek faster craving relief. It is also designed to relieve cravings reactively, as opposed to the nicotine patch, gum and lozenge, which require proactive use.

Trials of the efficacy and attractiveness of Quickmist to Living Smokefree Service clients conducted before the Manaaki Hauora – Supporting Wellness campaign demonstrated that people found it effective and convenient, and many preferred it to the subsidised products. Disadvantages were that not everyone could tolerate the strong taste or could afford to continue to buy it, as it costs \$45 in grocery shops and up to \$65 at some pharmacies.

Trials under the Manaaki Hauora – Supporting Wellness campaign explored whether Quickmist could improve engagement and success rates in people with long-term conditions. The mouthspray was used as an enticement to engage with behavioural support, which could be acceptance of a home visit, drop-in clinic appointment or attendance at a group-based programme.

To increase referrals and engagement with a support option, Smokefree Buffet offered Quickmist to secondary care respiratory clients through the inpatient smokefree advisor, to primary care practice clients through participating doctors, and to pregnant women through participating midwives.

In secondary care, initial PDSA cycles showed no significant increase in people accepting a referral from the respiratory ward. However, there was an impact on engagement, with more people attending their appointment to receive the Quickmist. Two out of three clients attending appointments successfully quit. In primary care, three practices agreed to offer the Quickmist on the basis of a referral being sent through. The first practice increased its referrals by seven in a month; the second saw seven out of 18 referrals book for an appointment; and the third saw an increase to five referrals, with four of these booking an appointment. In maternity, there was a slight increase in pregnant women referrals; Quickmist appears to be an effective tool for this population, as pregnant women tend to experience stronger cravings.

The positive engagement results in the respiratory ward and the results observed in primary and maternity care show that Quickmist is a viable tool for increasing engagement. Further work will continue to explore its longer-term impact on quit rates.



*Client learning how to use Quickmist*

*"I had face-to-face support from the Living Smokefree Service, and the lozenges and Quickmist they provided helped with my cravings."*

Melanie, client, Smokefree Buffet

## ACCESS TO TREATMENT OPTIONS

### Change idea: Smokefree menu

Smokefree Buffet organised a feedback session with a respiratory ward to understand the low uptake of referrals and rate of engagement. It became apparent that ward staff were not equipped with the appropriate resources to fully describe all smokefree options available to the client.

As previously discussed, our literature review indicated that providing self-help material to clients without additional support was not sufficient to create lasting change. In line with behavioural change theory, we aimed to create a resource to give people a platter of options they could visualise and understand, which would enable them to make an empowered and informed decision around their smokefree journey.

Health literacy is a critical consideration when developing any written materials for the local community. We aimed to develop a resource that was simple to understand and appealing to use. The first trials involved small numbers of clients using the menu and providing feedback on its ability to convey all the treatment options available and to increase comfort in using the service. After two adjustments the smokefree menu was developed, providing clients with tick box options for all treatments they would like to sample.

The menu was most effective when it was provided to clients with an initial Living Smokefree Service assessment. When we sent the menu out to clients referred to us whom we could not contact by telephone, the acceptance rate was low.

### Change idea: After-hours drop-in clinic

A CM Health needs analysis indicated that stop-smoking services need to support significantly more people to stop smoking than current service targets allow. The Smokefree Buffet drop-in clinic initiative enabled a greater number of people to access convenient (after-hours, hospital-based) stop-smoking support. Referral coordinators offered this form of one-on-one support at Middlemore Hospital and Manukau Super Clinic as an alternative to home-based visits. This resulted in practitioners working more efficiently and being able to support more people. It also created flexibility for clients to drop in at a convenient time and location.

## **Change idea: Customised smokefree package (mental health)**

A strong historical culture of acceptance and tolerance of tobacco use across the mental health and addiction (MH&A) sector has led to poor quit support for service users. Smoking prevalence among MH&A service users is more than twice that of the general population.<sup>13</sup>

The aim of the customised smokefree package (mental health) is to provide a designated mental health smokefree advisor as a point of contact for mental health staff, offer staff training to improve the provision of quit smoking support by mental health professionals, and increase consistent smokefree messages and support to staff and service users to decrease smoking prevalence.

The customised smokefree package (mental health) has resulted in a 196 per cent increase in referrals to the Living Smokefree Service (74 referrals in 2015/16 compared with 25 referrals in 2014/15).

*"Regular contact with the Living Smokefree Service was fantastic for me – the support was amazing. I was able to address my concerns with the smokefree advisor at Te Rawhiti one-on-one. I appreciated the acknowledgement of my hard work and felt she understood my journey. I would not smoke from day to day knowing that I would have time to talk to my smokefree advisor each week. At the beginning this is what got me through. The support I received felt personalised and compassionate. There were no rigid rules or judgement. I felt she was really listening to what I was worried about. There were so many helpful ways for me to explore my smoking fears."*

Patricia, client, Smokefree Buffet

Overall, test cycles led to 119 accepted appointments at the drop-in clinic between November 2015 and March 2016. This was an additional 11 per cent acceptance on top of usual care. Thirty-three people attended for ongoing support, 18 set a quit date, and 11 were smokefree at four weeks. Of the 33 people attending, 13 (39 per cent) were Māori, 10 (30 per cent) were Pacific Islander, and 10 (30 per cent) were of other ethnicities. The drop-in clinics seemed to be most effective for Māori. Māori clients achieved an 83 per cent quit rate, compared with the overall quit rate of 61 per cent. Pacific Islander clients and clients of other ethnicities achieved a 50 per cent quit rate.

This initiative resulted in an increase of referral volumes and reach to an audience we were unable to engage with before. Anecdotal evidence suggests that drop-in clinics suit clients who wish to attend after work without travelling a long distance for an appointment. We also noticed an increased uptake with the CM Health Living Smokefree Service compared to people opting for the National Quitline provider telephone-only support, which has lower efficacy.



*Smokefree Buffet drop-in clinic*

## FOSTERING CLOSE LINKS WITH HEALTH PROFESSIONALS/ PROVIDERS

### Change idea: Target roles

Smokefree Buffet realigned core team roles in the Living Smokefree Service to better meet Ministry of Health and CM Health smoking-related targets.

Ministry of Health smoking-related targets are:

- 90 percent of enrolled clients who smoke, and are seen in general practice, will be provided with advice and help to quit over 15 months
- 90 percent of pregnant women who identify as smokers at the time of booking with a lead maternity carer are offered advice and support to quit.<sup>14</sup>

Although a national target for mental health service users who smoke has not been set by the Ministry of Health, an internal CM Health needs analysis identified this group as a priority population and an internal target has been set.

The realignment allocated a dedicated smokefree advisor for each of the relevant sectors: mental health, primary care, maternity care.

The responsibilities of these roles include strategic support of the sectors to achieve the designated targets, and to promote and encourage the sectors to have their clients access evidence-based ongoing support. The roles build relationships with their aligned sector to create awareness of the services the Living Smokefree Service team can offer their clients.

Since the new roles were put in place, the Living Smokefree Service has seen over an 800 per cent increase in referrals from the primary care sector, with over 85 new referrers sending their clients to the Living Smokefree Service to receive support. The role has promoted the use of the online e-referral system and we continue to see increased use of the programme.

There was also a noticeable increase in referrals and referrers from the maternity sector. The average number of referrals in the three quarters leading up to role realignment was 77, compared to 124 in the following three quarters – a 124 per cent increase. The number of referrers increased from 48 to 69, a 43 per cent increase, with the number of self-employed midwives making referrals increasing from 40 per cent to 70 per cent. This contributes to a wider coverage of pregnant women, one of the priority populations.

There has been a 196 per cent increase in referrals from staff in Mental Health Community Services to the Living Smokefree Service. The smokefree advisor role has initiated a smokefree culture change within this sector and continues to work on a smokefree focus to effect change in this target population.

### **Change idea: Group-based therapy within primary health organisations**

The Living Smokefree Service continually faces challenges with client recruitment. We developed a change idea focused on group-based therapy (GBT) to understand whether recruiting clients and embedding treatment delivery in primary care would increase engagement with our priority populations.

GBT is the most effective form of ongoing behavioural support.<sup>6</sup> After supporting the training of healthcare professionals from the primary care sector (see: Change idea: GBT training for PHO staff) the smokefree advisor (primary care) helped practices run their own GBT sessions by assisting with client recruitment and session facilitation.

The Smokefree Buffet GBT provides an opportunity to support multiple people in one hour a week over seven weeks of the programme. We expected that the community would respond well to these sessions being based in their primary care home; run by professionals they have an existing relationship with in familiar surroundings. Four GBT courses have been run in one local and one rural practice.

Sixteen clients attended the GBTs. Of these, eight were Māori, seven were Pacific Islanders and one was NZ European, showing that GBT is an option that appeals to our priority populations. The delivery of GBT resonated with tikanga Māori values such as opening and closing with karakia (prayers) and whakawhanaungatanga (valuing everyone). Manaakitanga (kindness) and whakamana (recognising the value of each individual) were demonstrated throughout.

The most successful forms of recruitment for the GBT included text outreach, newspaper adverts and inviting other members of the community who may not attend the specified practice. However, recruiting large enough numbers to keep the group dynamics stable after anticipated drop off is an ongoing challenge. Anecdotal evidence from within our service shows only one third of those who enrol for the programme attend, with further drop off expected by the quit date session in the third week.

Going forward, the Smokefree Buffet team hope to work with another Manaaki Hauora – Supporting Wellness collaborative team to train primary care peer specialists to trial language-specific GBT courses. We would also like to trial a social media-promoted GBT campaign to assess whether digital promotion can assist in recruiting high numbers for the sessions.

## STAFF KNOWLEDGE OF PROGRAMME

### Change idea: GBT training for primary health organisation staff

To increase the availability of smokefree support and offer primary care a time-effective, successful treatment model, the Living Smokefree Service offered funded places in group-based therapy training. Offered through primary health organisations (PHO) and directly to engaged primary care practices, the training gave healthcare professionals the opportunity to learn the group-based model of cessation. Participants in the training run at least two of their own GBT sessions at their practices in the year following the training.

Three healthcare professionals attended the training, which was run by Inspiring Ltd. All three provided positive feedback on its usefulness.

### Change idea: Mental health staff training

#### *Mental health smokefree best practice*

We used smokefree best practice (SFPB) training to increase the capability and confidence of Mental Health Services staff at CM Health to provide consistent smokefree assessment, brief advice and cessation support to mental health service users.

Three learning and development courses have been held for staff:

- Smokefree Best Practice – face-to-face training delivered through CM Health Learning and Development
- Helping People to Stop Smoking – a Ministry of Health e-learning module
- Smokefree Training for the Mental Health & Addiction Workforce – an e-learning module available through Ko Awatea's online learning and development platform, KA Learn.

Of the 214 staff in Mental Health Services, 63 per cent were trained in Smokefree Best Practice as at the first quarter of 2016/17, compared with 38 per cent in May 2015. Leadership from managers is the main driver of increased staff training, which continues to be available on a regular basis.

#### *Mental health ABC (Assessment, Brief advice and Cessation support) documentation*

To establish smoking prevalence within CM Health mental health and addiction services, accurate data is required. We adapted refresher training to highlight the importance of recording smokefree assessment details in a client documentation system. Documentation of smokefree assessments has increased from 48 per cent in the third quarter of 2015/16 to 58 per cent in the fourth quarter. Gaining an accurate picture of the current state through improved documentation allows for accurate future service planning and measurement of the impact of interventions.

## REFERRAL MANAGEMENT

### Change idea: Direct referrals from PHOs

Many women in Counties Manukau do not access maternity care early on in their pregnancy. Women commonly first confirm their pregnancy with their primary care provider.

Evidence indicates that quitting smoking within the first 15 weeks of gestation can reverse distress caused to the foetus.<sup>15</sup> It is therefore extremely important to have women who are smoking at their beginning of their pregnancy access support as soon as possible.

Although primary care health professionals work hard to ensure clients are offered the ABC smoking cessation intervention, some people are missed. The Smokefree Buffet team worked with a PHO to find pregnant smokers and refer them to the Counties Manukau Pregnancy Incentives Programme (CMPPI), which provides ongoing behavioural support for smoking cessation, access to quitting medications and the opportunity to earn vouchers for every week a pregnant smoker stays smoke-free. To find the women, the PHO used dashboard tools to identify missed interventions and apply filters to target pregnant women who were currently smoking. PHO tools further filtered these women by residence, weeks of pregnancy, ethnicity and quintile.

Using these tools, the PHO compiled a list of 400 women for Smokefree Buffet to contact. After removing duplicates and out-of-area clients, we contacted 83 women by telephone. Of these, 50 were ineligible for the programme because they had already stopped smoking, were no longer pregnant or had already enrolled in support. Of the 33 eligible women, 17 (52 per cent) accepted support. This compares favourably with the two referrals and one acceptance of support the CMPPI was receiving previously from the PHO each month.

This strategy of reaching out to women who had missed out on a referral by a midwife worked successfully with 17 women who would not have otherwise accepted support. Of the 17 women who accepted CMPPI support, eight set a quit date and five stopped smoking within four weeks.

This outreach strategy will be continually offered as well as offered to other PHOs as long as capacity within the Living Smokefree Service team permits.

The key achievements of Smokefree Buffet are:

- **improved outcome and reach.** There has been a significant increase in engagement and support provision resulting in better quit rates for Māori and Pacific people who smoke. The project achieved a 58 per cent increase in the number of referrals and doubled the number of people who quit at four weeks.
- **closer collaboration.** Smokefree Buffet has improved collaboration with secondary care, primary care, mental health and maternity care. We also worked with other Manaaki Hauora –Supporting Wellness teams to test change ideas together.
- **improved service delivery.** Smokefree Buffet is taking cessation support to the community and expanding access to a wider range of treatment options to ensure those who are frequent users of the healthcare system are supported to reduce the risks of smoking-related harm.
- **addressing the equity gap.** Smokefree Buffet supports those with long-term conditions with additional resources and tailors culturally appropriate support to meet the needs of the individual.
- **embracing quality improvement methodology.** Throughout the Manaaki Hauora – Supporting Wellness campaign, the Smokefree Buffet team developed an exceedingly high number of changes packages and PDSA cycles. We were acknowledged as joint winners of the highest number of PDSAs during the campaign workshops. The wider Living Smokefree Service team continues to apply the methodology in all areas of their work.

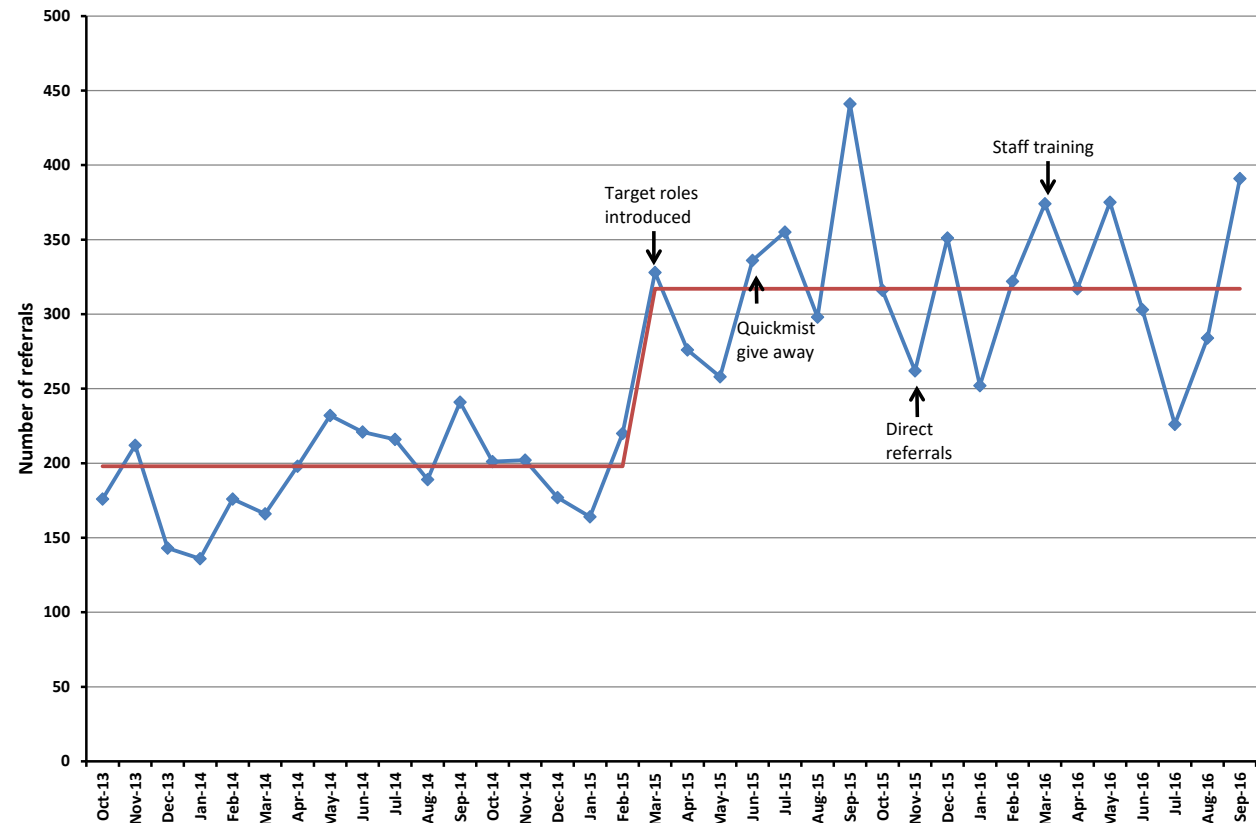


*Smokefree Buffet drop-in clinic*

## INCREASED REFERRALS FOR SMOKEFREE SUPPORT

The Living Smokefree service experienced an overall increase of 58 per cent in the referrals received. The number of referrals increased from a monthly average of 198 (October 2013 to February 2015) to 317 (March 2015 to September 2016). The introduction of the target roles established and enhanced the partnerships between the Living Smokefree team and the healthcare services that helped achieve the first phase of increase in referrals. The improvement idea of direct referrals from PHOs helped sustain the increase in referrals and enabled clients to potentially receive timely access to smokefree services (Figure 2).

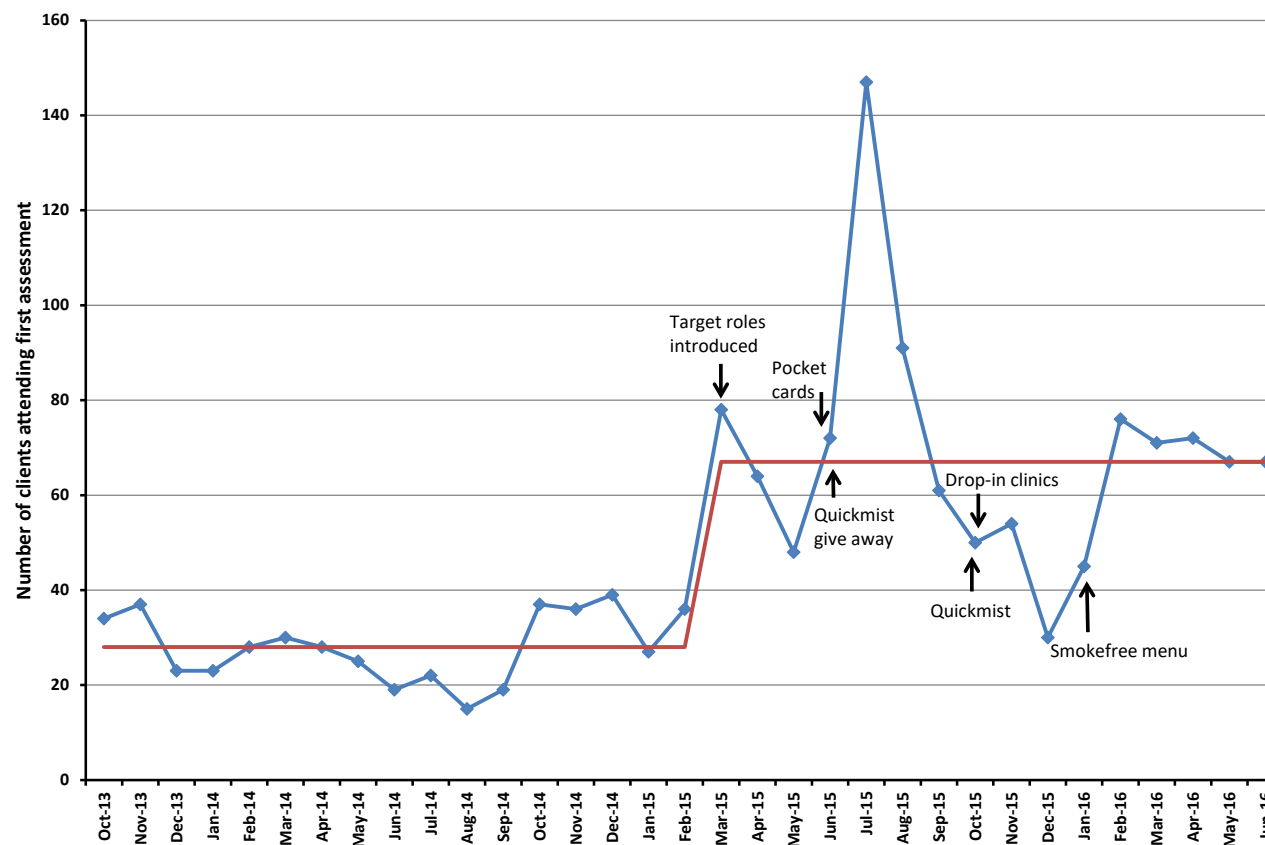
Figure 2: Number of referrals received



### INCREASED NUMBER OF PEOPLE ASSESSED

The increase in the number of referrals was further supported by tailored options like the drop-in clinics and the smokefree menu. These provided clients with a range of options to choose from, enabling the service to offer a customised smokefree package. This resulted in an increase in the number of clients willing to engage, i.e. attend the first assessment appointment with the Living Smokefree team. The overall engagement rate increased by 126 per cent, and the number of clients engaging with the service increased from a monthly average of 28 (October 2013 to February 2015) to 67 (March 2015 to September 2016) (Figure 3).

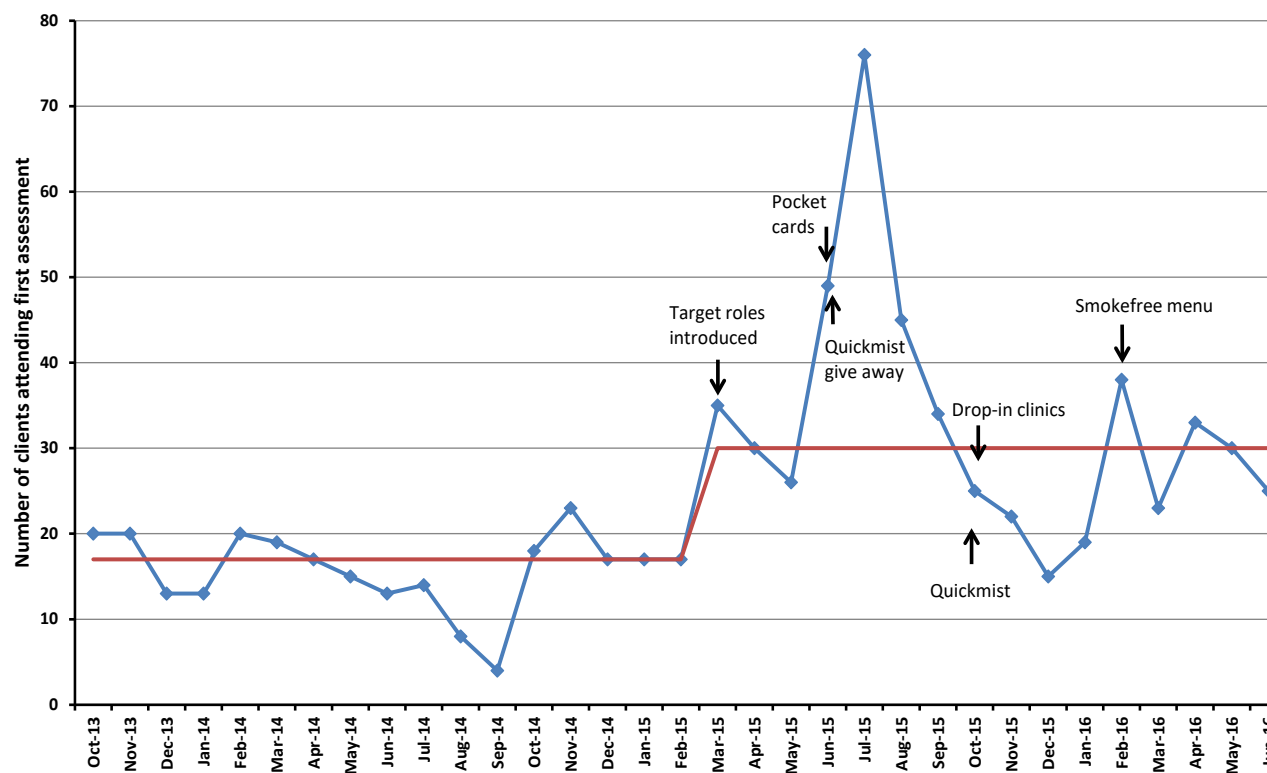
Figure 3: Number of clients attending first assessment



The tailored options supported by the customised smokefree package also had a positive impact on the engagement outcomes for our priority Māori and Pacific Islander client population.

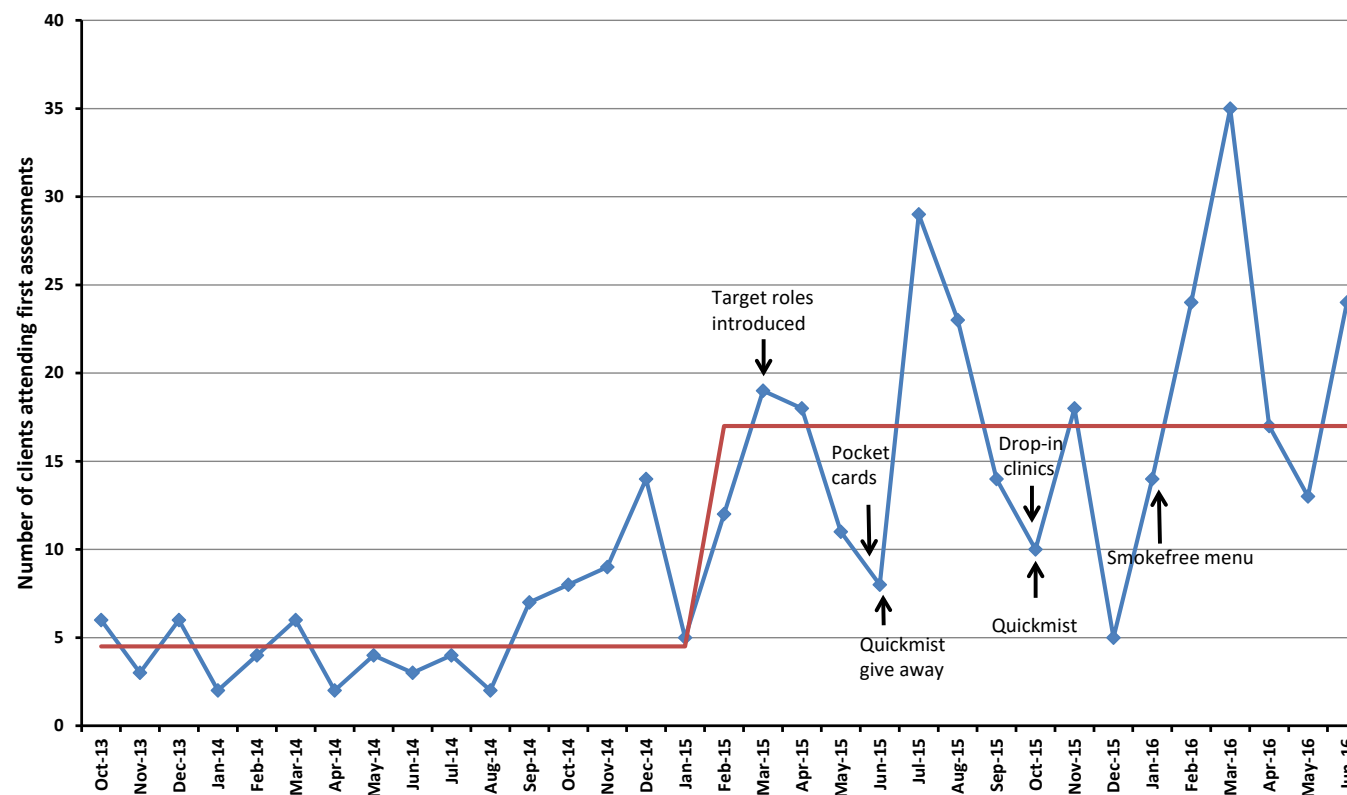
The number of Māori clients engaging with the service increased from a monthly average of 17 (October 2013 to February 2015) to 30 (March 2015 to June 2016) (Figure 4).

**Figure 4: Number of Māori clients attending first assessment**



The number of Pacific Islander clients engaging with the service increased from a monthly average of 5 (October 2013 to February 2015) to 17 (March 2015 to June 2016) (Figure 5).

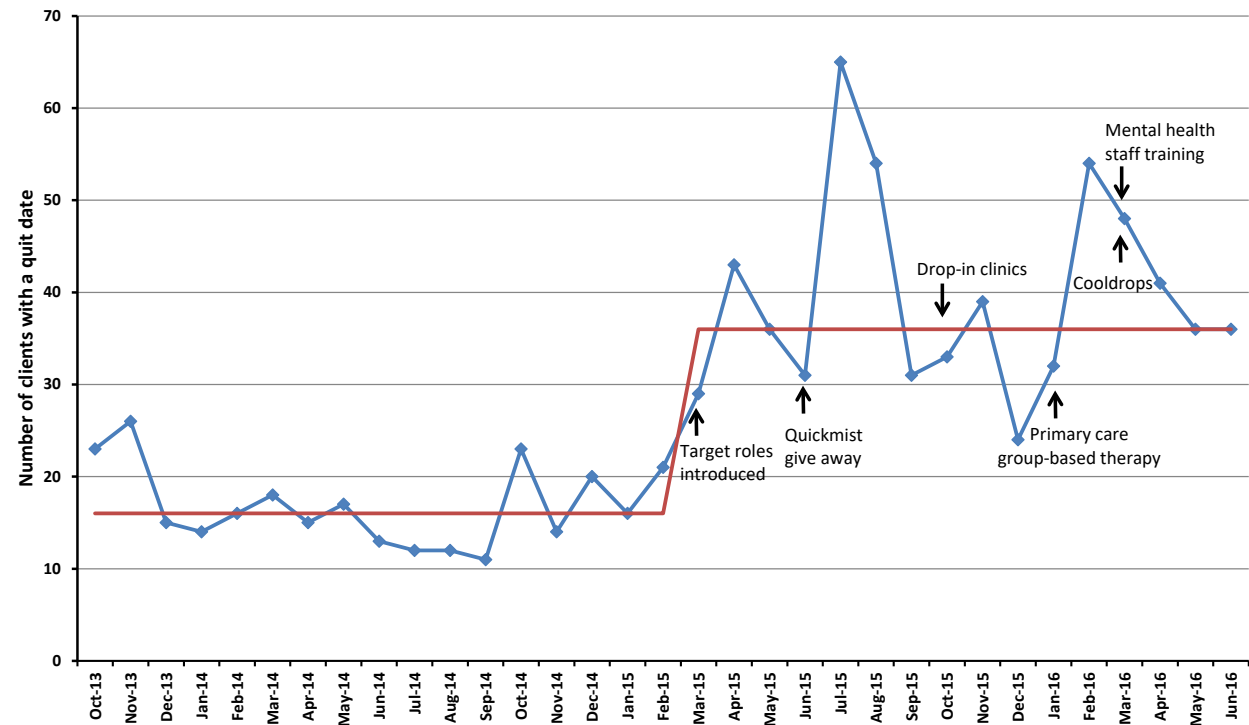
**Figure 5: Number of Pacific Islander clients attending first assessment**



## INCREASED NUMBER OF PEOPLE SETTING A QUIT DATE

The customised smokefree options, access to non-subsidised products, such as Cooldrops, and the seamless support offered to clients through enhanced partnerships with healthcare services resulted in a 118 per cent increase in the number of clients setting a quit date. The monthly average increased significantly from 16 (October 2013 to February 2015) to 36 (March 2015 to September 2016) (Figure 6).

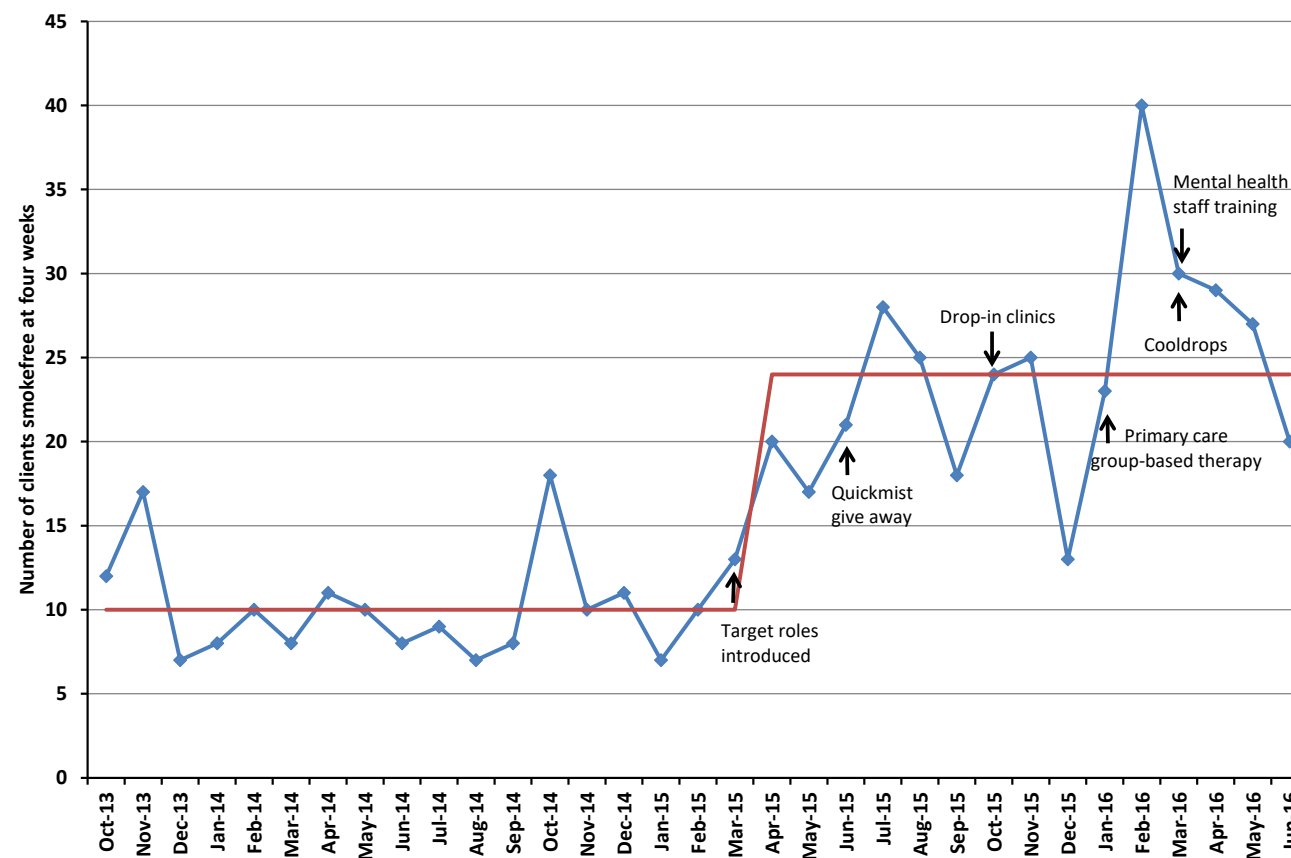
Figure 6: Number of clients assessed who set a quit date



## INCREASED NUMBER OF PEOPLE REMAINING SMOKEFREE

The ability of the Living Smokefree team to support clients setting a quit date improved significantly as a result of their customised smokefree packages and the tailored services enabled by the enhanced partnerships with healthcare services. The number of clients remaining smokefree for four weeks after setting a quit date more than doubled and the monthly average increased from 10 (October 2013 to February 2015) to 24 (March 2015 to September 2016) (Figure 7).

Figure 7: Clients remaining smokefree for four weeks after setting a quit date

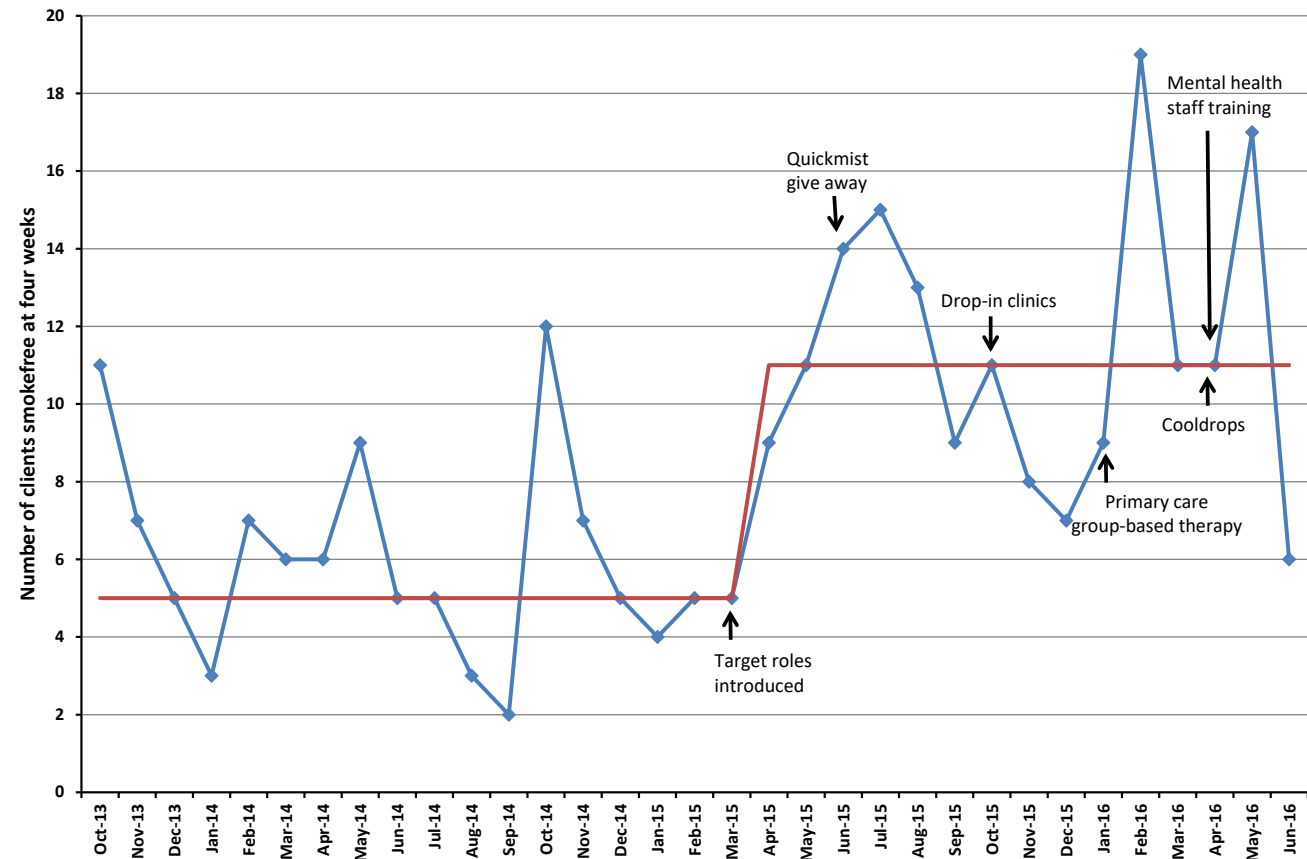


The number of Māori clients remaining smokefree for four weeks after setting a quit date more than doubled and increased from a monthly average of 5 (October 2013 to February 2015) to 11 (March 2015 to September 2016) (Figure 8).

*"My mouth doesn't taste yuck; I'm really aware of that. My fingers are not yellow and I don't smell of smoke. I feel better for being smokefree .... I have been smokefree now for 10 months. I am winning and I feel great."*

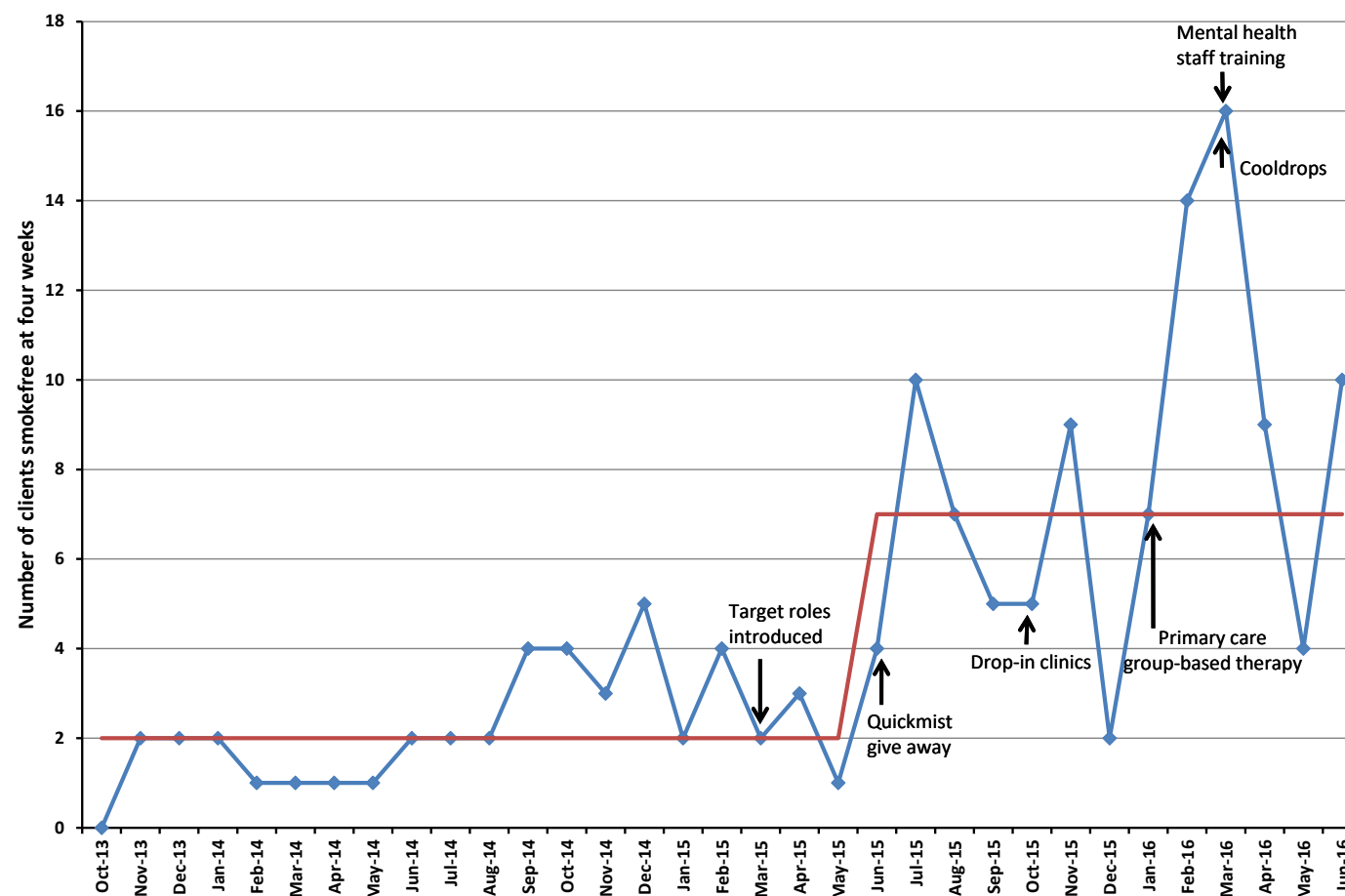
Melanie, client, Smokefree Buffet

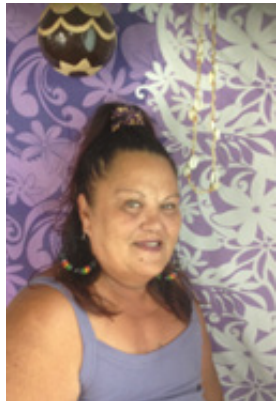
**Figure 8: Māori clients remaining smokefree for four weeks after setting a quit date**



The number of Pacific Islander clients remaining smokefree for four weeks after setting a quit date more than tripled, increasing from a monthly average of 2 (October 2013 to February 2015) to 7 (March 2015 to September 2016) (Figure 9).

**Figure 9: Pacific Islander clients remaining smokefree for four weeks after setting a quit date**





## ANNE'S SMOKEFREE STORY

*"My brother came to live with us and he became really, really sick. He was diagnosed with COPD (chronic obstructive pulmonary disease). Seeing what he went through was horrible. I did not want to smoke in front of him. He was so sick. That was my driving force to stop smoking.*

*Although I was a chain smoker, I was determined to give up. I went to a drop-in clinic at The Cottage and met a smokefree advisor from the Living Smokefree team. I felt I could trust her. There was a connection, a care that I hadn't experienced before. Knowing I had one-on-one, face-to-face support and being with someone who understood made a big difference to me. I would look forward to my weekly visit.*

*Using Quickmist helped me through. At first I stayed away from friends who smoked, but then I started going to the club I belong to. All my friends were smokers. I ended up sitting inside, knowing they were outside together having a smoke. I wasn't aware of how many people smoked. Luckily I had my Quickmist and I would use it to get me through those moments.*

*For the first few weeks, I had different ways to get through my cravings. Slowly, I began to feel okay being around smokers. I turned my smoking room into my sanctuary. As I started to save money I bought myself some frangipani oil, which reminded me of home in the Cook Islands. I noticed I wasn't sitting at the table for hours and hours; instead, I was doing things for myself, building my sanctuary up. My tastebuds changed, my coffee was so sweet and now I do not have sugar in my drinks. I am really proud of myself to know that I achieved something that was hard. I knew I could do it. This is my journey; I want to share my story and what worked for me. Keep at it and you will find what works for you."*

Going forward, the Smokefree Buffet team will focus on embedding the change package into business as usual to ensure sustainability. The goal is for all smokefree providers in Counties Manukau to deliver the same package of smoking cessation support to ensure that all people with long-term conditions are better supported to stop smoking.

We will continue to offer a broad range of evidence-based treatment options that includes group-based therapy, drop-in clinics and access to non-subsidised products.

In addition, the use of PDSA cycles to support change and assess whether adaptations to services benefit the community has spread from the Smokefree Buffet team to the wider Living Smokefree Service team and our community providers. If the teams suspect a potential gap in service they can now implement a process map to better understand the client journey.

Although change packages have been developed the team will continue to test these packages to address the changing needs of clients and services over time and to assess whether ongoing developments could improve outcomes.

Smokefree Buffet was adopted as a standard method of operation by Counties Manukau Health in November 2016. Following this, we submitted a proposal for the upcoming 2017 Ko Awatea campaign addressing health equity. Through this project new members of the team can upskill in improvement methodology, as well as having an opportunity to identify and address culturally appropriate and appealing service delivery.

This work will contribute to achieving the Smokefree Aotearoa 2025 vision that fewer than five per cent of New Zealanders will smoke by 2025.



Left to right: Vivian De la Rama (Smokefree Advisor – Mental Health, Smokefree Buffet); Kirimoana Willoughby (Smokefree Advisor & Referrals Coordinator, Smokefree Buffet); Gloria Onelino (Lead Smokefree Advisor, Quit Bus, Living Smokefree Service); Merenaite Faitala-Mariner (Smokefree Advisor, Living Smokefree Service); Raewyn Neale (Smokefree Advisor – Mental Health, Smokefree Buffet); Priyanka Sharma (Smokefree Advisor – Inpatients, Smokefree Buffet); Georgina McKenzie (Smokefree Advisor – Primary Care, Smokefree Buffet); Michelle Lee (Smokefree Advisor – Maternity, Smokefree Buffet); Basil Fernandes (Team Leader – Smokefree, Smokefree Buffet).

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Ko Awatea is a centre for health and social systems improvement, innovation and education embedded in Counties Manukau Health, the district health board that serves East and South Auckland.

Ko Awatea and Counties Manukau Health are committed to the Triple Aim:

- Improved health and equity for all populations.
- Improved quality, safety and patient experience of care.
- Best value for public health system resources.

To achieve the Triple Aim, Ko Awatea leads practical system transformation projects underpinned by proven methodological approaches.

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