Tobacco Control Needs Assessment

Bath and North East Somerset

2019
Executive Summary

Background
Bath and North East Somerset (B&NES) Council’s Tobacco Action Network’s vision is for a smoke free Bath and North East Somerset, where children and young people grow up free from the harms caused by tobacco (1) Local authority budgets have been significantly reduced in recent years meaning there is a context of limited resources and competing pressures to note.

Aims and objectives
The purpose of this needs assessment is to systematically determine and address needs or ‘gaps’ between current conditions of tobacco use in B&NES and the desired conditions for a smoke free B&NES. Need refers to the population’s ability to benefit from health care and services but also to broader dimensions such as benefit from preventative and population level policies. The findings from the needs assessment are intended to guide the future commissioning and delivery of tobacco control services and also to inform the process by which the B&NES Tobacco Control Strategy will be refreshed when the current strategy ends.

Methodology
In the triangulation of incidence and prevalence, effectiveness and existing services this needs assessment follows a primarily epidemiological approach to needs assessment. A focus group for B&NES professionals working in tobacco control was undertaken to support the needs assessment.

Key results
Smoking prevalence in adults in B&NES is 13.4% (around 20,000 people) and has been falling over time. This is lower than the national average but higher than in some similar local authority areas representing room for improvement. B&NES Stop Smoking Service activity is fairly low and it is likely that a significant proportion of smokers in B&NES are self-supporting through quit attempts. E-cigarette use in quit attempts is increasing in prominence.

Gaps
Smoking prevalence in certain priority groups (pregnant women, people with severe mental illness or substance misuse issues, people who are LGBTQ, communities that are more socioeconomically deprived, children and young people and gypsy and traveller communities) is higher than in the general population or than national targets and represents an important source of health inequality to be addressed – services in B&NES were noted to lack either specific resources to assist these groups, available data to assess need and progress in tobacco control or engagement with new avenues and professional groups that may help to better reach these communities.

Recommendations
A number of recommendations have been made to address the gaps identified by this needs assessment
Contents

Executive Summary .............................................................................................................. 3
Abbreviations .......................................................................................................................... 5
Background ............................................................................................................................... 6
Aim and scope .......................................................................................................................... 6
Objectives ................................................................................................................................. 7
Methodology ............................................................................................................................. 7
Local health needs ..................................................................................................................... 8
  Local demographics ................................................................................................................. 8
  Inequalities and deprivation in B&NES ................................................................................... 9
  Prevalence of tobacco use .................................................................................................... 10
Other characteristics of smokers ............................................................................................... 11
Priority groups ......................................................................................................................... 12
  Pregnancy ............................................................................................................................... 12
  Mental health including substance misuse disorders ............................................................ 12
  LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning) .............................. 14
  Deprivation ........................................................................................................................... 14
  Prison ..................................................................................................................................... 16
  Children and young people: in particular excluded children and children in care ................ 16
    Travellers ............................................................................................................................ 17
Other prevalence sources: ........................................................................................................ 18
  E-cigarettes ............................................................................................................................ 18
  Passive smoking ..................................................................................................................... 19
  Illegal Tobacco ....................................................................................................................... 20
  Quit attempt behaviour ......................................................................................................... 20
  Impact of tobacco use ........................................................................................................... 22
What works .............................................................................................................................. 24
  Cost Effectiveness and Return on Investment ...................................................................... 25
Local Demands ....................................................................................................................... 27
  Resident/service users feedback ............................................................................................ 27
  Professional feedback ............................................................................................................ 27
Support currently offered ......................................................................................................... 30
  National policy and support available ................................................................................. 30
  Local policy and support available ....................................................................................... 30
  Service activity ....................................................................................................................... 32
Training .................................................................................................................. 32
B&NES Stop Smoking Services activity ............................................................... 32
Nicotine replacement therapy (NRT) prescription data ................................... 36
Financial Data ..................................................................................................... 37
Activity in Pregnancy Services ........................................................................ 38
Activity in substance misuse services ............................................................ 38
Activity in secondary Care ............................................................................... 39
E-cigarettes/vape shops .................................................................................... 39
Identification of Health Gaps ........................................................................... 40
Horizon Scanning .............................................................................................. 43
Recommendations ............................................................................................. 44
Acknowledgements .......................................................................................... 45
Bibliography ...................................................................................................... 45

Abbreviations

ASH – Action on Smoking and Health
AWP – Avon and Wiltshire Partnership Mental Health Trust
B&NES – Bath and North East Somerset
CCG – Clinical Commissioning Group
CQUIN - Commissioning for Quality and Innovation
GP – General Practice/Practitioner
HMRC – Her Majesty’s Revenue and Customs
LGBTQ – Lesbian, Gay, Bisexual, Transgender, Queer or Questioning
MECC – Making Every Contact Count
NHS – National Health Service
NICE – National Institute for Health and Care Excellence
NRT – Nicotine replacement therapy
PHE – Public Health England
RUH – Royal United Hospital, Bath
SHEU - School Health Education Unit Health Related Behaviour Survey
TAN – Tobacco Action Network
Background

Smoking is the most important cause of preventable ill health and premature mortality in the UK.

Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

The Government’s Tobacco Control Plan (2) published in July 2017 sets out the Government’s strategy to reduce smoking prevalence among adults and young people, and to reduce smoking during pregnancy. Another of the main targets is to "reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population".

The Bath and North East Somerset (B&NES) Tobacco Control Strategy 2013-2018 (1) aims to reduce health inequalities by:

- Preventing young people from starting to smoke
- Encouraging smokers to quit
- Reducing the harm from smoking through
  - exposure to toxins from second hand smoke and
  - harm to existing smokers

Aim and scope

The overall aim of the needs assessment is to systematically determine and address needs or ‘gaps’ between current conditions of tobacco use in B&NES and the desired conditions for a smoke free B&NES. Need refers to the population’s ability to benefit from health care and services but also to broader dimensions such as benefit from preventative and population level policies. The needs assessment aims to clarify the current progress on tobacco control in the B&NES local authority area with particular reference to priority groups and inequality.

In scope are all locally determined activities across health, care and local authority organisations. Out of scope are elements under national or international control such as legislation and taxation.

The needs assessment also aims to map the services offered in B&NES that enable tobacco control and smoking cessation and in doing so identify any gaps between need and provision. Considerations of the relevance of second-hand smoke exposure and illegal tobacco products on B&NES’ position are also included. E-cigarettes have come to prominence since the last tobacco control needs assessment and strategy were written for B&NES and so this needs assessment specifically provides data and insight into the contemporary situation regarding tobacco control.
It is acknowledged that decision making in the context of allocation of scarce resources is of particular relevance in the current climate of budgetary cuts within local authorities. As such, the findings from the needs assessment are intended to guide the future commissioning and delivery of tobacco control services and also to inform the process by which the B&NES Tobacco Control Strategy will be refreshed when the current strategy ends.

**Objectives**

- The assessment of incidence and prevalence of tobacco use and associated harms in B&NES residents
- Summary of the evidence on the effectiveness and cost-effectiveness of services in the context of national guidelines and emerging evidence
- Mapping and activity analysis of current tobacco control and smoking cessation services
- Identification of health gaps and the recommendations agreed upon by the B&NES Tobacco Action Network (TAN) members to address these

**Methodology**

Consideration of the methodology for this needs assessment was informed by documentary guidance by the authors Stevens and Raftery (3). In the triangulation of incidence and prevalence, effectiveness and existing services this needs assessment follows a primarily epidemiological approach to needs assessment (3).

In its use of comparison and contrast with available data for other local authority areas and national epidemiological and service data the methodology also incorporates a comparative approach.

Finally with reference to the input of the members of the B&NES Tobacco Action Network and professionals in B&NES working in smoking cessation services through TAN meetings and a professionals’ focus group this needs assessment demonstrates a corporate approach element.

A note on comparisons made in data: The CIPFA ‘near neighbours’ model (4) identifies 15 local authorities most similar to B&NES based on criteria such as size, demographics and economy. Comparisons made to these local authorities provide insight into how B&NES can reasonably expect to perform or improve that may be more meaningful than through use of national or regional averages.

The development of this needs assessment has been supported by the B&NES public health team and members of the B&NES Tobacco Action Network Group along with colleagues from their organisations.

A focus group for B&NES professionals working in tobacco control was undertaken to support the needs assessment.
Local health needs

Local demographics

Bath and North East Somerset is a unitary authority in the South West with an adult (18+) population of 147,600 and a median salary of £20,338. It falls within the least deprived quintile among upper-tier authorities in the South West (5) however B&NES faces economic issues (6); house prices are 40% higher than the national average while average wages are 10% lower. Long term unemployment, particularly long term youth unemployment is of particular concern.

- The B&NES population in mid-2016 was 187,751.
- B&NES Clinical Commissioning Group’s footprint has an estimated 206,000 registered patients (7).
- The age structure of B&NES is similar to the South West region aside from the higher proportion of 20 to 24 year olds which reflects the region’s university students.
- Bath and North East Somerset is less ethnically diverse than the UK as a whole, 90% of local residents define their ethnicity as White British. This is followed by 3.8% defining as White Other and 1.1% defining as Chinese.
- Taking expected housing growth into account, the overall population is expected to increase to nearly 200,000 by 2024, an increase of 11% from 2014.
- It is expected that the student age population will remain significant and the population is expected to continue to become older. (8)

Figure 1 depicts the most recent population pyramid of Bath and North East Somerset local authority region. (9)

Figure 1: Population pyramid for Bath and North East Somerset local authority region
Inequalities and deprivation in B&NES

Despite being an area with generally good health and low crime, there is significant variation within B&NES.

One area is within the most deprived 10% of the country:
- Twerton West

Four further areas are within the most deprived 20% of the country:
- Whiteway
- Twerton
- Fox Hill North
- Whiteway West

Compared to the most affluent communities in the area, the most deprived communities:
- have 45% higher cancer rates,
- are three times as likely to smoke,
- are 22% more likely to think that anti-social behaviour is a problem in their area
- 16-17 year olds are nearly 4 times as likely to be not in education, training or employment. (8)

Approximately 30,000 B&NES residents are employed in routine or manual work (10).

Figure 2: Map of areas of deprivation in B&NES local authority region

Source (11)
Prevalence of tobacco use

There are **20,755** adult smokers in B&NES (5).

Though the prevalence of smoking amongst adults in B&NES is falling as an overall trend, it is still at **13.4%** (Fig 3). This is statistically similar to the prevalence for England (14.9% of adults) (9). These figures are from the national Annual Population Survey and are considered the most robust available (9).

In the most recent local authority level survey (Voicebox Survey 2018 (12)) with 1,207 respondents, **9%** identified as current smokers. There has been a downward trend in this figure from previous rounds of the same survey: 10% in 2016 and 16% in 2014 - though as the number of respondents is relatively small these figures may not reliably represent the whole B&NES resident population. Just under a third (32%) responded to say they were ex-smokers and the remaining 59% have never smoked.

**In some of the local authority areas identified as ‘similar’ (4) to B&NES the prevalence of smoking is as low as 9-10%**

Figure 3: Smoking prevalence in B&NES adults trend (9)

Smoking prevalence is higher in males than females nationally and in B&NES (Fig 4). (9)

---

1 York, South Gloucestershire, Solihull
Other characteristics of smokers

The Annual Population Survey in 2017 (13) found other patterns in smoking:

- Economic activity: the proportion of current smokers was significantly higher among unemployed persons (29.6%) when compared with those who were employed (15.5%) and economically inactive (13.4%)

- Relationship status: those who were married or in a civil partnership had the lowest proportion of current smokers (9.9%), which was around half the proportion among those who were cohabiting (22.1%), single (21.5%), or widowed, divorced or separated (17.7%)

- Education: those with a degree had the lowest proportion of current smokers (7.6%), which is around a quarter of the proportion among those with no qualifications (29.1%)

- Ethnicity: the proportion of current smokers ranged from 8.8% among Chinese respondents to 20.1% among respondents from the Mixed ethnic group

- Country of birth: those who were born in Poland had the highest proportion of current smokers (27.1%), whereas those born in India had the lowest proportion of current smokers (4.7%)

- Religion (England only): prevalence varies by sex, for example, the proportion of current smokers among Muslim men was 21.4%; among women this was just 3.8%

- Self-perceived health: smokers were less likely to report having very good health and more likely to report having very bad health, when compared with those who have never smoked
Priority groups

Pregnancy
Smoking during pregnancy increases the risk of stillbirth, and babies born to mothers who smoke are more likely to be born with low birthweight, born prematurely with the associated risks, develop asthma, chest infections, glue ear and learning difficulties. Maternal smoking after birth is associated with a threefold increase in the risk of sudden infant death. Smoking prevalence among pregnant women in more disadvantaged groups and those aged under 20 remains considerably higher than in older and more affluent groups. Children who grow up with a smoking parent are also more likely to become smokers themselves, further perpetuating the cycle of inequality and affecting their life chances (2).

11.9% of B&NES women are identified as current smokers at the start of their pregnancy (around 200 women a year) and 7.5% remain so at the time of delivery. This prevalence is decreasing and is lower than the England average (9) (Figure 2). B&NES’ near neighbours have a range in prevalence of smoking at the time of delivery of 6.9% to 14.1%. (9)

The Tobacco Control Plan’s commitment is to reduce the prevalence of smoking in pregnancy to 6% or less. (2)

Figure 5: Smoking prevalence in women at the time of delivery trend (9)

Mental health including substance misuse disorders
The prevalence of smoking is much higher in groups with severe mental illness (schizophrenia, bipolar affective disorder or other psychoses) than the rest of the population and people with a severe mental health condition die on average 10 to 20 years earlier than the general population, mainly due to physical health issues,
making mental illness a major cause of inequality (14). The Tobacco Control Plan notes “People with mental health conditions want to quit smoking as much as other smokers do, yet health professionals can be reluctant to offer them stop smoking support. Some professionals mistakenly believe that stopping smoking could negatively affect their patients’ mental health, when it can actually reduce symptoms of anxiety and depression.” (2)

38.7% of adults with severe mental illness in B&NES are current smokers; this is similar to the England average for this group (Figure 6) and the range in near neighbours is 32.6 to 43.8% (9). Trend data is not available. There were 1,644 people with severe mental illness registered with GPs in B&NES in 2017 (15) meaning there are an estimated 636 smokers in this group.

Figure 6: National figures for smoking rates in adults with severe mental illness

The estimated prevalence of injected drug misuse in B&NES is 3.77 per 1,000 adults (9) giving an estimate of 5,564 adults affected in B&NES in 2017. Clients starting substance misuse treatment in B&NES in 2014/15 had a smoking prevalence of 76% (national figure was 64%), this rose to 82% at the point of treatment outcome review (16).

It has been noted anecdotally in B&NES that there are increasing numbers of pregnant women using cannabis and that cannabis use and tobacco use are correlated. International figures from the USA suggest that rates of cannabis use in pregnancy are increasing with a prevalence of 3.9% in 2014. Low income or socioeconomic disadvantage, being single, psychiatric diagnoses, and tobacco, alcohol, and other illicit drug use were associated with increased past-year cannabis use. Having a partner who uses cannabis is one of the strongest predictors of cannabis use during pregnancy (17)
LGBTQ (Lesbian, Gay, Bisexual, Transgender, Queer or Questioning)

2.1% of the population of the South West region of England identify as gay, lesbian or bisexual (18) meaning there are likely to be approximately 3,000 LGB adults in B&NES.

Data from the Integrated Household Survey shows that lesbian and gay people are much more likely to smoke than heterosexual people (25.3% compared to 18.4%). Whilst there is a lack of research on smoking among bisexual and trans people, surveys do show both bisexual and trans people are more likely to smoke. Young LGB people are also more likely to smoke, to start smoking at a younger age and smoke more heavily. (19)

Deprivation

Differences in prevalence in smoking can be compared by GP practice in B&NES using Quality Outcome Framework (QOF) data (20) It is evident that prevalence is significantly higher in practices in B&NES’ areas of greater deprivation (figure 7).

Figure 7: Estimated smoking prevalence by GP surgery in B&NES CCG 2017-18

Smoking is much more common in people living in certain types of housing (Figure 8). While 18% of all people in England live in social housing, among smokers it is almost a third. One of the reasons for this is that while smokers in social housing are
equally motivated and equally likely to try to quit as smokers living in other types of housing, they are half as likely to succeed. They are also more likely to be heavily addicted to smoking. (21) Data from the 2011 Census shows that in B&NES 66.7% of households are owner occupied, 16.9% are private rented and 14.4% are social rented. (8)

Figure 8: National figures for smoking rates by housing type

Nationally around 1 in 4 people in routine and manual occupations smoke compared with just 1 in 10 people in managerial and professional occupations (13) and this pattern is reflected in B&NES (Figure 8). Two adult smokers with a 20-a-day habit are likely to spend over £6,000 per year on cigarettes. Poorer smokers spend 5 times as much of their weekly household budget on smoking as richer smokers. (22)

There are an estimated 30,000 routine and manual workers in B&NES (10). The prevalence of smoking in in this group is 30% in B&NES which is not significantly different to the England average. B&NES’ near neighbours have a range in prevalence of 16.8% to 35%. (9)

This prevalence indicates that there are around 9,000 smokers in routine and manual work in B&NES i.e. nearly half of B&NES current adult smokers are routine and manual workers. There has been no improvement in smoking prevalence in this group in recent years whereas nationally there have been improvements in all groups (9) (Figure 9).
**Figure 9: Trends in smoking prevalence in adults by socioeconomic group (9)**

**B&NES**

- Managerial and professional
- Intermediate
- Routine and Manual
- Never worked and long term unemployment

**England**

**Prison**

B&NES does not have a prison population.

**Children and young people: in particular excluded children and children in care**

Most people begin smoking when they are still children, and children who start smoking at the youngest ages are more likely to smoke heavily and find it harder to give up. (23)
The most recent (2015) nationally provided figures for the prevalence of regular smoking (one or more cigarettes a week) in B&NES at age 15 is 6.6%, a further 3.8% are occasional smokers. (9). These rates are similar to the England average.

The School Health Education Unit Health Related Behaviour Survey (SHEU) survey undertaken in B&NES in 2017 (24) questioned secondary school pupils about their tobacco use behaviour and indicated that 33% of secondary school pupils had tried smoking though only 4% of Year 10 pupils are regular smokers. A further 10% of girls and 5% of boys in this age group stated they were current smokers but smoke less than one cigarette a week.

Source: SHEU survey 2017 (24)
This figure has been static across these surveys since 2013 with a drop from 5% in 2011 (25).

The Tobacco Control Plan for England aims to bring prevalence of smoking in young people down to 3% by 2020.

Higher rates in vulnerable children
There is higher prevalence of smoking among certain young people, including those from multiply deprived backgrounds, entitled to free school meals or looked after by the local authority (26). In 2017 B&NES had 160 children in care, 2970 children in poverty, 38 first time entrants to the youth justice system and 240 16-17 year-olds not in education, employment or training (9)

Smoking is transmitted across the generations in a cycle underpinned by social norms, familiarisation and addiction. Children who live in a home where parents smoke are 90% more likely to start smoking themselves (21). The SHEU survey found 20% of secondary school pupils said someone smokes regularly around them. (24)

Travellers
The Gypsy/Traveller count in July 2017 recorded 38 total dwellings in Bath and North East Somerset (8). Findings of a health needs assessment (27) suggest that Gypsies and Travellers experience different needs to that of the population as a whole. These needs are often coupled with a reluctance to engage with public services. Smoking was revealed to be key health concern for both service users across the communities as well as their health care providers. Smoking was reported by 53% of respondents to a health survey in this group (27). B&NES also has a large community of Boaters who are considered to be a similarly vulnerable population; local outreach workers estimate that smoking prevalence may be as high as 75% in this group.
Other prevalence sources:

**NHS Health Check**
The NHS Health Check is a health check-up for adults in England aged 40-74. It is designed to detect early signs or risk factors for stroke, kidney disease, heart disease, type 2 diabetes or dementia. Around 6000 checks are undertaken in B&NES each year.

In 2014/15 11% of check attendees of the approximately 6000 checks undertaken in B&NES were current smokers and it was noted that onward referral to smoking cessation services was rarely documented for these individuals.

**Health Optimisation**
Patients requiring referral for non-urgent, elective surgery in B&NES are being considered for health optimisation interventions (weight management and smoking cessation) in a 3 month window before their surgical referral is made. Data from the first phase of the policy rollout shows 4.5% of hip and knee surgery patients were current smokers at the point of referral.

**Secondary care – smokers at admission**
Of patients who stayed 24 hours or more in the Royal United Hospital in quarter 2 of 2018, 10.3% were recorded as current smokers (99.6% of patients had their smoking status recorded). Nationally the estimate for smoking prevalence in inpatients is 25% (28).

**E-cigarettes**
An estimated 2.9 million adults in Britain currently use e-cigarettes (vape) – use of e-cigarettes has remained stable at 5% of adults since 2013 (29). Regular vaping in under-18s remains low at 1.7% (30). Over time, the proportion of vapers who smoke tobacco has fallen and the proportion who are ex-smokers has risen, while regular e-cigarette use among people who have never smoked has remained negligible at 0.3% (31).

The latest data from Action on Smoking and Health (ASH) shows that 1.7 million vapers – over half of the total – have managed to stop smoking completely (31) - and ONS figures suggest that more than 900,000 people have given up both smoking and vaping. This suggests that for many smokers, dual use (vaping while continuing to smoke) may be a stage in their journey to becoming smoke free and, ultimately, nicotine free (22). Specialist vape shops are the most popular source for purchase. A declining minority of current smokers believe e-cigarettes are less harmful than cigarettes or are unsure. An increasing proportion believes they are equally harmful (29). There is no clear social gradient in e-cigarette use (29). Only 4% of quit attempts made through Stop Smoking Services nationally use an e-cigarette, despite this being an effective approach (30).

The B&NES Voicebox Survey 2018 (12) reported that a quarter (24%) of the current or ex-smokers have ever used an e-cigarette; over half (55%) of those who have used an e-cigarette did so to help them quit smoking tobacco products completely and 29% to enable them to reduce their tobacco use.
The SHEU survey undertaken in B&NES in 2017 (24) questioned secondary school pupils about e-cigarettes and indicated that 30% of secondary school pupils had tried e-cigarettes:

![Image](3 out of 10 Year 10 pupils have used an e-cigarette)

Source: SHEU survey 2017 (24)
This figure is similar to that of 2015 (28%) (25).

Passive smoking
Indoor smokefree policies are currently much more widespread than those for outdoor areas and there are inequalities in levels of protection from second-hand smoke exposure afforded to certain groups, particularly children, given the pattern of smokefree outdoors nationwide (32)
The SHEU survey undertaken in B&NES in 2017 (24) questioned secondary school pupils about passive smoking and indicated that 20% of secondary school pupils had regular exposure:

![Image](2 out of 10 boys and 2 out of 10 girls in Year 10 said someone smokes regularly around them)

Source: SHEU survey 2017 (24)
This figure has remained unchanged from 2015 though it was noted then that there was a wide variation between rates of exposure in children eligible for free school meals (35%) and those ineligible (16%) (25).

The Health Survey for England measures ‘self-reported locations of exposure to other people’s smoke’ among those aged 16 years and over. Respondents in the most recent (2015) survey reported that more exposure occurred in the ‘outdoor smoking areas of pubs, restaurants and cafes’ compared with the proportions who said they were exposed in other settings (Table 1). (33)
Table 1: National self-reported exposure to other people’s smoke

<table>
<thead>
<tr>
<th>Location of exposure to other people’s smoke: Self-reported exposure to other people’s smoke</th>
<th>% of respondents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outdoor smoking areas of pubs/restaurants/cafes</td>
<td>16%</td>
</tr>
<tr>
<td>At own home</td>
<td>9%</td>
</tr>
<tr>
<td>In other people’s homes</td>
<td>9%</td>
</tr>
<tr>
<td>At work</td>
<td>8%</td>
</tr>
<tr>
<td>Travelling by car/van</td>
<td>3%</td>
</tr>
<tr>
<td>In other places</td>
<td>6%</td>
</tr>
<tr>
<td>None of these</td>
<td>67%</td>
</tr>
</tbody>
</table>

Source: (33)

**Illegal Tobacco**

Illicit trade covers smuggling, counterfeiting, bootlegging and illegal manufacturing of tobacco. Illicit trade has a role in funding organised crime, and illegal tobacco is a particular danger to children and young people as it can be sold at much lower ‘pocket money’ prices (34). Estimates of the prevalence of illegal tobacco sales and use in B&NES are difficult to make, though the B&NES Trading Standards team report successful detection of illegal tobacco on premises in response to intelligence received (35). Smokers in B&NES spend roughly £43.3m on tobacco products a year – around £2050 per smoker (5). HMRC estimates that in 2015/16 13% of cigarettes in the UK market were illicit, and 32% of hand-rolled tobacco in the UK market was illicit. (36)

The Voicebox Survey 2018 (12) included questions on how much current smokers in B&NES pay for their products; between one and two thirds of respondents indicated that they pay below recommended retail price for their tobacco which may suggest that use of illegal tobacco is high in B&NES.

The 2017 SHEU survey found that 15% of year 8 and 10 pupils had been offered ‘cheap or foreign cigarettes or tobacco’ (24).

**Quit attempt behaviour**

Nationally, 25.5% of adult smokers report having tried to stop smoking within the last year (29). There has been a general decline in this percentage year on year from a maximum of 42.6% in 2007. Local level figures from the Voicebox Survey suggest that one third (34%) of current smokers made a serious attempt to give up smoking during the prior 12 months – this was higher than in 2016 (25%). 43% of current smokers reported that they would like to give up smoking in the next 12 months; this was lower than in 2016 (51%) (12).

Other indications of self-reported attempts in B&NES include the fact that around 600 people used smoking cessation services and 273 nicotine replacement therapy items were prescribed from primary care in the 2016/17 financial year. This indicates that around 4% of B&NES smokers made formal quit attempts in that financial year (though there may be some overlap between prescriptions and service registrations and some people may have had more than one attempt/prescription). Considering
the national figure that 25.5% of smokers made a quit attempt last year this means there may be around 21% (approx. 4,400 people) of smokers in B&NES having made self-supported quit attempts who had little or no interaction with local services. Some of these people may have made quit attempts without use of NRT, using e-cigarettes or with NRT products bought over the counter – data is not available for these elements.

Nationally, 5% of smokers reported that they had stopped smoking in the last year – this was a success rate of 17.4% in smokers who tried to stop, these figures have remained stable over the last 5 years (29).
Impact of tobacco use

Smoking related deaths and diseases in B&NES are lower than the English average; however smoking is still the single biggest cause of premature death and disease locally.

Life expectancy varies in Bath & North East Somerset by up to 7.3 years for men in the most deprived areas and by 3.7 years for women (9). Smoking accounts for approximately half this difference in life expectancy. (1; 51)

Figure 10 summarises deaths attributable to smoking in B&NES. 197 deaths per 100,000 in B&NES are directly attributable to smoking; there has been a consistent trend of reduction in this figure in the last decade and B&NES has the lowest figure amongst its nearest neighbours (9).

**Figure 10: Summary of smoking related mortality in B&NES compared to England (9)**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Period</th>
<th>Bath &amp; NESom</th>
<th>Region England</th>
<th>England</th>
<th>Recent Trend</th>
<th>Count</th>
<th>Value</th>
<th>Value</th>
<th>Value</th>
<th>Value</th>
<th>Range</th>
<th>Best</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking attributable mortality</td>
<td>2015 - 17</td>
<td>655</td>
<td>197.1</td>
<td>229.6</td>
<td>262.6</td>
<td>462.3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking attributable deaths from heart disease</td>
<td>2015 - 17</td>
<td>55</td>
<td>16.9</td>
<td>21.1</td>
<td>24.7</td>
<td>56.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11.9</td>
</tr>
<tr>
<td>Smoking attributable deaths from stroke</td>
<td>2015 - 17</td>
<td>17</td>
<td>5.1</td>
<td>7.2</td>
<td>8.2</td>
<td>15.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3.1</td>
</tr>
<tr>
<td>Deaths from lung cancer</td>
<td>2015 - 17</td>
<td>227</td>
<td>41.9</td>
<td>46.4</td>
<td>56.3</td>
<td>106.6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>33.5</td>
</tr>
<tr>
<td>Deaths from oral cancer</td>
<td>2015 - 17</td>
<td>20</td>
<td>3.8</td>
<td>4.3</td>
<td>4.6</td>
<td>9.0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.2</td>
</tr>
<tr>
<td>Deaths from chronic obstructive pulmonary disease</td>
<td>2015 - 17</td>
<td>199</td>
<td>33.5</td>
<td>43.0</td>
<td>52.7</td>
<td>103.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>27.4</td>
</tr>
<tr>
<td>Potential years of life lost due to smoking related illness</td>
<td>2015 - 17</td>
<td>2,576</td>
<td>906</td>
<td>1196</td>
<td>1365</td>
<td>2,944</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>706</td>
</tr>
<tr>
<td>Stillbirth rate</td>
<td>2014 - 16</td>
<td>18</td>
<td>3.4</td>
<td>3.7</td>
<td>4.5</td>
<td>7.7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2.3</td>
</tr>
<tr>
<td>Neonatal mortality</td>
<td>2014 - 16</td>
<td>11</td>
<td>2.07</td>
<td>2.35</td>
<td>2.74</td>
<td>5.94</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1.12</td>
</tr>
</tbody>
</table>

Figure 11 summarises ill health attributable to smoking in B&NES. Of every 100,000 hospital admissions in B&NES, 1,113 are attributable to smoking; there has been no significant trend in this figure over the last decade and B&NES has the lowest figure amongst its nearest neighbours. (9)
Figure 11: Summary of smoking related ill health in B&NES compared to England (9)

From the Voicebox Survey, only two thirds of current smokers (67%) felt that their present level of smoking is harmful to their health, this is the same as in 2016 (12).
What works

Tobacco control is an area of public health that has a very strong and consistent evidence base. If recommended interventions are delivered, the evidence indicates clearly that they will save lives and reduce chronic ill-health and disability, providing net savings to the local and national economy within a few years. (22)

The main drivers of reduction in smoking prevalence are decreasing uptake and increasing cessation.

In July 2017, the government published its Tobacco Control Plan for England, to pave the way for a smoke free generation. The comprehensive plan sets out national ambitions for achievement by the end of 2022. The associated delivery plan makes it clear that helping smokers to quit is the job of the whole health and care system.

Comprehensive tobacco control interventions, implemented at a local level and part of a strategic partnership approach, reduce smoking prevalence and have been proved effective in reducing social and health inequalities (22).

Public Health England publish the evidence based principles and indicators for tobacco control in Tobacco commissioning support 2019 to 2020: principles and indicators NICE tobacco harm reduction guidance PH45 sets out a series of approaches that support smokers to quit in the longer term. In line with NICE guidance NG92 ‘Stop smoking interventions and services’, service providers should treat at least 5% of their local smoking population. Stop smoking support should be routinely offered, and made easily accessible, to vulnerable populations and those identified as at risk in a needs assessment. (22).

There is also specific NICE guidance on how best to support women to stop smoking in pregnancy, preventing uptake of smoking in children and young people, stopping smoking in the workplace and smoking cessation in secondary care.

The evidence associated with different components and models for providing stop smoking interventions is summarised in the PHE models of delivery guidance.

A 2016 evidence review by the National Centre for Smoking Cessation and Training (NCSCT) suggests that smoking should be targeted in isolation rather than as part of an integrated health behaviour service and that smoking cessation interventions by themselves are more cost-effective than multiple risk behaviour interventions (37)

E-cigarettes can support people to quit smoking. Public Health England recommends that stop smoking services should be open to e-cigarette use in people keen to try them to help them quit (38).

Reducing the visibility of smoking including through compliance with smoke free legislation, can be expected to make smoking less normative, helping to support smokers who are in the process of quitting and motivating other smokers to try to quit. (22)
Cost Effectiveness and Return on Investment

Figure 12: output from NICE Tobacco Control Return on Investment tool for B&NES

NOTE figures are estimates only and not verified values
Using the data collated by this needs assessment on local population size, prevalence and service uptake in local stop smoking services and pregnancy services, the NICE Return on Investment (ROI) tool (39) estimates that the current package of interventions results in 301 additional quitters in B&NES in a year over and above the background quit rate (1.98%) providing 170 additional QALYs (Quality adjusted life years) to B&NES residents. This is indicated in the Figure 12 as the ‘Current Package’. The cost, uptake and effectiveness of the local smoking cessation interventions are pre-loaded by NICE based on the national evidence base and are therefore estimates for B&NES meaning the total cost and effect of the service in B&NES is also an estimate. In particular the figure for GP-led cessation interventions cannot be verified for B&NES patients and is likely to be an overestimate.

When a Sub-national Tobacco Control Programme of non-specialist service interventions is also included as an ‘Alternative Package’ an additional 256 quitters per year are anticipated along with a further 170 QALYS. The Sub-national Tobacco Control Programme includes interventions such as monitoring and enforcement of legislation e.g. indoor smoking bans and preventing illicit tobacco sales, undertaking mass media campaigns and promoting effective provision of support for smoking cessation in the non-specialist setting with the effect of increasing the background quit rate from 1.98% to 5%. The average national cost for an evidence based programme such as this is £0.41 per person and assumes 100% of current smokers are included in the uptake.

The PHE Health Economics Evidence Resource Tool (40) gives information on the cost-effectiveness of individual interventions indicating that there is strong evidence that the current standard content of local stop smoking interventions is cost-effective and often cost-saving.

Recommendations from the NICE summary of systematic reviews (41) on cost-effectiveness of tobacco control interventions note that interventions that increase the quit rate in a population by 1% are cost effective at any cost under £225 per person. They also note that e-cigarettes are more cost-effective than many current nicotine replacement therapies and as they are also cheaper than cigarettes this may be a useful lever in harm-reduction strategies.
Local Demands

Local views are important in highlighting specific tobacco control needs in the B&NES population and local experiences of tobacco control services in place. They indicate where there is most appetite to make progress on tobacco control in B&NES.

Resident/service users feedback

Formal service user feedback from B&NES Stop Smoking Service is not collected routinely. Responses to a public consultation (42) regarding health optimisation including smoking cessation in the setting of preparation for elective surgery in 2018 found that 82% of respondents (141 people) felt that the NHS should actively encourage people to stop smoking for a period of time before they have elective surgery.

Current smokers were asked whether they felt confident that with support from Stop Smoking Services that they could stop smoking for four weeks or more, or stop smoking forever. Only 10 current smokers responded to this question, of which two reported confidence that they could stop smoking for any length of time.

Respondents who gave information on their experiences of using the smoking cessation service mostly gave general statements of having had a positive experience with some specifically commenting that the location and hours of operation were convenient. Negative comments included having felt criticised or reprimanded when attending the service and that the timescales used for smoking cessation plans weren’t bespoke enough to suit all users. There were also comments that services must address the psychological and emotional/stress factors that are involved in smoking.

Interviews are planned shortly to gain feedback from pregnant service users newly offered the use of e-cigarettes in maternity stop smoking services.

Professional feedback

Feedback was sought from professionals working directly in smoking cessation services or related settings such as community pharmacy, secondary health care, school nursing and public health teams. The feedback was collected using a focus group and individual interviews for those unable to attend the focus group. The feedback is summarised in table 2.

Table 2: Summary of topics covered and themes in responses:

| Prevailing attitudes towards smoking cessation | High on the agenda but subject to competing pressures from work on obesity, drugs and alcohol. CQUIN has raised profile in secondary care settings. Financial pressures and staff turnover have had an impact on staff trained and active in offering smoking cessation advice. Making Every Contact Count (MECC) and a move to helping all health professionals feel smoking cessation is their business has been effective. Tobacco dependence should be regarded as a relapsing condition rather than a lifestyle choice – services need to reflect this. |
| E-cigarettes and vaping | Most conversations at the Stop Smoking Service include vaping and it is considered an ‘e-cigarette friendly’ service. Service |
users are very interested in advice on whether they should be trying it. There was a feeling that vaping is ‘the next big thing’ and that recognition of this is important to avoid missed opportunities to reach those it could help. Concern from some that the evidence on possible harms from vaping is not yet robust enough to allow full confidence in recommending e-cigarettes to all. Service users provided with e-cigarettes in maternity services view them as medical devices and often encourage friends and family to join them too. Concerns over product quality when bought privately – a ‘safe to buy’ validation pathway for customer confidence in suppliers would be welcome. Vaping is not supported in all settings, particularly in schools.

| Levels of support and improving success in self-support | Recognition of the large number of smokers in B&NES who want to quit and who attempt to do so through self-support alone. Agreed that work to improve success rates and quality of information and encouragement offered to this group would be a valuable endeavour. It was felt that there is high variation in the quality of advice and attention offered ad hoc in pharmacies dependent on the staff working on the day. There was concern that national investment into campaigns and resources has dwindled and specific gaps were noted in appropriate resources to offer young people and for very brief intervention in MECC. Idea to introduce ‘Have I asked you about smoking?’ badges for staff in contact with service users to prompt conversation. |
| Priority groups | National material is too heteronormative, difficult to obtain in languages other than English, large prints etc. Stop Smoking Services are LGBTQ friendly but mental health and sexual health seem to be prioritised for this group. There have been increases in training uptake for smoking cessation advice in B&NES substance misuse services. Noted that pharmacists often have regular contact and good relationships with service users attending for opioid substitutes and this may be a way to reach this group for smoking cessation input. A brief intervention for cannabis use would be valuable given the rise in concurrent use in maternity service users. Could consider opt out rather than opt in to smoking cessation service referrals for smokers identified in secondary care settings. |
| Smoke free policies | RUH has made strong progress. Maternity service users know ahead of time that they will not be able to smoke on hospital sites and this is proving to be a motivation for considering cessation ahead of delivery. Council support for smoke free is strong, taxi services, leisure services and youth services are the next priorities. Bath College want smoke free but has struggled to maintain this. Interest in a business-driven approach in Bath city centre – working on the incentives businesses face to reduce smoking in outdoor spaces as other customers and therefore business are affected |
| Horizon scanning and emerging issues | Concurrent cannabis use is noted to be a rising issue amongst pregnant women in B&NES. Illegal tobacco agenda in B&NES is going well, support for a repeat of the recent campaign. There is |
a need to do more cross-boundary work/ work at scale to maximise the impact of limited resources in local areas. NHS long-term plan places an importance on smoking cessation which may be reflected in financial support in the future. Legislation changes may seek to raise the legal age for purchasing tobacco and require a license to sell tobacco. Reiterated the shift in focus from few people receiving high intensity support through face to face services to increased support for those interested in quitting through minimal/self-support.
Support currently offered

National policy and support available

Public Health England address smoking cessation nationally through various programmes and campaigns: One You incorporating Stop October, Health Harms and Smokefree NHS. An overarching objective of these campaigns is to trigger significant numbers of quit attempts by normalising quit attempt behaviour, increasing motivation to quit and making quitting easier. The Horizon Scanning section of this document addresses the likely future directions in policy and guidance.

Local policy and support available

The B&NES Tobacco Action Network (TAN) chaired by B&NES public health meets every four months to support workforce development, intelligence gathering, coordination of communications and marketing and the promotion of evidence based practice across the tobacco control community. Its members represent the key stakeholders and service providers in B&NES. The TAN’s Tobacco Control Strategy (1) made a number of recommendations and produced an action plan to address these.

B&NES public health team commission smoking cessation services and dedicate time to promoting wider tobacco control activity.

B&NES Stop Smoking Service is provided by Virgin Care and commissioned by Public Health. It is a free confidential service offering support and advice to smokers aged 12 years and over who live or work in Bath and North East Somerset who either want to stop smoking or to cut down the amount they smoke. Individual, face to face or telephone consultations are provided. The service can be accessed through GP practices or at most pharmacies in B&NES.

Dedicated Stop Smoking Clinics are held in 7 community locations across B&NES on weekdays at a variety of times including early evenings. Some of which are drop in sessions. The clinic list is available here.

Secondary care: RUH, Virgin Care and AWP Mental Health Trust are work towards 'CQUIN 9' for risky behaviours, the intention is that all inpatients and AWP service users have their smoking status recorded and brief interventions offered.

Maternity: pregnant smokers are offered support through the Health in Pregnancy (HIPIs) team. This service is expanding to offer use of e-cigarettes in quit attempts for the first time.

Other:

- NHS Health Checks are operational in B&NES - brief advice on smoking cessation is given. The focus for Health Check delivery is now on council workers and certain other workplaces.
- Health Optimisation – B&NES CCG has introduced a policy to identify and assist smokers to stop smoking before operations in a 3 months window before all non-urgent elective surgical referrals. The policy's future beyond its use in the hip and knee pathway is uncertain. There is an evaluation of the
impact of the first phase of the policy rollout underway which seeks to place particular focus in determining any impact on health inequalities.

- Work is underway to increase the uptake and completeness of annual health checks for patients with severe mental illness in B&NES. The checks include smoking cessation advice and onward referral where appropriate.
- Primary and secondary prevention work – school nurses and health visitors support the smoking cessation agenda and school lesson plans were produced to address tobacco use. Smokefree playgrounds and sports clubs have been a focus of tobacco control work in B&NES.
- Illegal tobacco work – B&NES had a #report it campaign which may be repeated. The Voicebox Survey 2018 showed 13% of respondents had heard or seen a bit/ a lot about the #report it illegal tobacco campaign in recent months (12). Work is undertaken as part of a wider regional network of nine local authorities and Trading Standards teams.
- B&NES teams support PHE’s national campaigns and provide local resource to increase their impact e.g. Stoptober.
Service activity

Training

Virgin Care Services provide smoking cessation training for health and care professionals in B&NES. In the past year from February 2019, 14 new advisors were trained in the settings of primary care, pharmacy, AWP mental health trust and DHI (drug and alcohol services). 13 advisors received refresher training in the settings of primary care, pharmacy, AWP, DHI and Project 28 and school nursing. Specialist smoking cessation provision training was completed for 10 Healthy Choices lifestyle advisors at the Royal United hospital, 6 midwives and 6 nurses in the Family Nurse Partnership.

67 staff at hospital sites in B&NES including healthcare assistants, reception staff and porters received training to help meet the ‘risky behaviour’ CQUIN requiring all inpatients to have their smoking status recorded and brief interventions offered where appropriate.

B&NES Stop Smoking Services activity

In the financial year 2017/18 613 people set a quit date with the service and 407 successfully quit (66%). The number of service users setting a quit date has remained low over the last three years, though the percentage going on to successfully quit is rising each year. Table 3 provides the breakdown for these figures by demographics and setting of the service. More women than men use the service, the median age group is 45-59 years old and 43% of service users are routine and manual workers.

The majority of activity occurred in the primary care setting (60.7%) followed by community (24.6%). Only 5.4% of activity occurred in the pharmacy setting.

NICE suggested performance targets (43) include:

• ‘treating at least 5% of the estimated local population who smoke each year’. B&NES services reached **2.95%** of the population of smokers in B&NES last financial year

• ‘achieving a successful quit rate of at least 35% at 4 weeks, based on everyone who starts treatment and defining success as not having smoked (confirmed by carbon monoxide monitoring of exhaled breath) in the fourth week after the quit date.’ B&NES services achieved a **66%** quit rate.

• ‘Prioritise specific groups who are at high risk of tobacco-related harm’: B&NES service users were 6% BME (while 10% of B&NES residents are BME) and 43% routine and manual occupation workers (while 30% of the economically active B&NES population are in this group).

• Data is not collected/clear on how many service users were travellers/gypsy or LGBTQ
Table 3: B&NES Stop Smoking Service activity in financial year 2017/18 and the prior 2 years* (44)

<table>
<thead>
<tr>
<th></th>
<th>2017/18</th>
<th></th>
<th>2016/17</th>
<th></th>
<th>2015/16</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Set a quit date</td>
<td>Successfully quit (self-report)</td>
<td>Set a quit date</td>
<td>Successfully quit (self-report)</td>
<td>Set a quit date</td>
<td>Successfully quit (self-report)</td>
</tr>
<tr>
<td></td>
<td>n</td>
<td>% of total</td>
<td>n</td>
<td>% of total</td>
<td>n</td>
<td>% of total</td>
</tr>
<tr>
<td>Total</td>
<td>613</td>
<td>66%</td>
<td>407</td>
<td>66%</td>
<td>599</td>
<td>61%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>male</td>
<td>285</td>
<td>47%</td>
<td>181</td>
<td>45%</td>
<td>248</td>
<td>41%</td>
</tr>
<tr>
<td>female</td>
<td>328</td>
<td>54%</td>
<td>226</td>
<td>56%</td>
<td>351</td>
<td>59%</td>
</tr>
<tr>
<td>Ethnicity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>575</td>
<td>94%</td>
<td>382</td>
<td>94%</td>
<td>563</td>
<td>94%</td>
</tr>
<tr>
<td>BME</td>
<td>13</td>
<td>2%</td>
<td>8</td>
<td>2%</td>
<td>18</td>
<td>3%</td>
</tr>
<tr>
<td>Not stated</td>
<td>25</td>
<td>4%</td>
<td>17</td>
<td>4%</td>
<td>18</td>
<td>3%</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>under 18</td>
<td>X</td>
<td>0%</td>
<td>x</td>
<td>0%</td>
<td>x</td>
<td>0%</td>
</tr>
<tr>
<td>18-34</td>
<td>130</td>
<td>22%</td>
<td>100</td>
<td>23%</td>
<td>160</td>
<td>26%</td>
</tr>
<tr>
<td>35-44</td>
<td>130</td>
<td>22%</td>
<td>90</td>
<td>21%</td>
<td>110</td>
<td>19%</td>
</tr>
<tr>
<td>45-59</td>
<td>180</td>
<td>30%</td>
<td>120</td>
<td>29%</td>
<td>190</td>
<td>32%</td>
</tr>
<tr>
<td>60+</td>
<td>160</td>
<td>27%</td>
<td>110</td>
<td>27%</td>
<td>130</td>
<td>22%</td>
</tr>
<tr>
<td>Pregnant</td>
<td>44</td>
<td>42%</td>
<td>46</td>
<td>38%</td>
<td>50</td>
<td>32%</td>
</tr>
<tr>
<td>Free prescriptions</td>
<td>320</td>
<td>52%</td>
<td>213</td>
<td>52%</td>
<td>268</td>
<td>45%</td>
</tr>
<tr>
<td>Socioeconomic</td>
<td>FT student</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FT student</td>
<td>15</td>
<td>2%</td>
<td>12</td>
<td>3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>never worked or unemployed &gt;1yr</td>
<td>54</td>
<td>9%</td>
<td>21</td>
<td>5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>retired</td>
<td>100</td>
<td>16%</td>
<td>68</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>sick/disabled unable to return to work</td>
<td>44</td>
<td>7%</td>
<td>23</td>
<td>6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>unpaid home carers</td>
<td>9</td>
<td>1%</td>
<td>7</td>
<td>2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>managerial or professional occupation</td>
<td>21</td>
<td>3%</td>
<td>15</td>
<td>4%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>intermediate occupation</td>
<td>50</td>
<td>8%</td>
<td>37</td>
<td>9%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>routine and manual occupation</td>
<td>266</td>
<td>43%</td>
<td>193</td>
<td>47%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>prisoners</td>
<td>0</td>
<td>0%</td>
<td>0</td>
<td>0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>uncoded</td>
<td>54</td>
<td>9%</td>
<td>31</td>
<td>8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Setting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>community</td>
<td>151</td>
<td>24.6%</td>
<td>115</td>
<td>28.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>community psychiatric</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>hospital</td>
<td>13</td>
<td>2.1%</td>
<td>6</td>
<td>1.5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>psychiatric hospital</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>pharmacy</td>
<td>33</td>
<td>5.4%</td>
<td>9</td>
<td>2.2%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>dental</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP</td>
<td>372</td>
<td>60.7%</td>
<td>235</td>
<td>57.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>maternity</td>
<td>44</td>
<td>7.2%</td>
<td>42</td>
<td>10.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>other</td>
<td>0</td>
<td>0.0%</td>
<td>0</td>
<td>0.0%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Some numbers in this table have been rounded to protect groups with small numbers.*
Table 4 shows the performance of B&NES stop smoking services against national service figures. B&NES services perform similarly to national stop smoking services on all measures included in the benchmarking data except for numbers of smokers setting a quit date where the rate is significantly lower than average.
Nicotine replacement therapy (NRT) prescription data

Figure 13 gives the available data on NRT prescriptions in the 2016/17 financial year in B&NES. B&NES GP practices prescribe an average of 11 smoking cessation products per 1000 smokers per year (there is a large range by practice: 1 - 51) with a total of 273 products prescribed. NRT provided directly from the stop smoking service or bought over the counter will not be included in this data.

Figure 13: Number of smoking cessation products prescribed per 1000 smokers by CCG

The dark blue bar represents B&NES CCG showing that B&NES prescribes more smoking cessation products per 1,000 smokers than the average across CCGs nationally. There is a downward trend both locally and nationally in these figures over the last 2 years.
Financial Data

The cumulative total spend on smoking cessation services by B&NES local authority in the financial year 2017/18 was £309,728 (of which £266,345 was for delivery and £43,383 was for pharmacotherapies). This is a decrease in spending from the previous financial year where cumulative spend was £362,755, however the Spend and Outcome Tool (SPOT) data from PHE indicates that B&NES is nonetheless at the higher end of spending for stop smoking services per head per annum at a figure of £2.85 (Table 5). (45). This reflects the nature of B&NES services whereby there has been continued investment in specialist smoking cessation service staff provision and in wider work such as illegal tobacco control. Only interventions deemed cost-effective by national guidance are used within B&NES services.

Table 5: Spend and Outcome Tool data for B&NES stop smoking services and interventions

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Bath &amp; North East Somerset UA</th>
<th>Type</th>
<th>LA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Period</td>
<td>2017</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Selected measures for Bath & North East Somerset UA

<table>
<thead>
<tr>
<th>Tobacco Control</th>
<th>Local value</th>
<th>Z score</th>
<th>National</th>
<th>PHE centre</th>
<th>ONS cluster</th>
<th>Deprivation decile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking and tobacco - Stop smoking services and interventions (RO)</td>
<td>£2.85</td>
<td></td>
<td>£2.10</td>
<td>£1.45</td>
<td>£1.68</td>
<td>£1.71</td>
</tr>
</tbody>
</table>
Activity in Pregnancy Services

Table 5 outlines the smoking cessation activity in maternity services. Of 1706 women who had their booking appointment in the financial year 2017/18, 203 (11.9%) were identified as smokers. 10 of these were identified through use of a CO monitor. 192 of these were invited to access smoking cessation services. 130 (68%) accepted at least one contact and 44 (23%) set a quit date of whom 42 (95%) successfully quit for at least four weeks. A pilot programme offering e-cigarettes for smoking cessation in pregnant women is underway in B&NES and will be evaluated in 2019.

Activity in substance misuse services

Table 6 gives the smoking cessation figures for clients starting substance misuse treatment in B&NES in 2014/15 (16) showing that an extremely low proportion of smokers in these services have engaged with smoking cessation.

Table 6: Activity in substance misuse services

<table>
<thead>
<tr>
<th>Smoking cessation interventions provided to clients who smoke tobacco</th>
<th>Local</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n</td>
<td>Proportion of clients identified</td>
</tr>
<tr>
<td>Opiate</td>
<td>596</td>
<td>3%</td>
</tr>
<tr>
<td>Non-opiate</td>
<td>98</td>
<td>2%</td>
</tr>
<tr>
<td>Non-opiate and alcohol</td>
<td>277</td>
<td>4%</td>
</tr>
<tr>
<td>All</td>
<td>961</td>
<td>3%</td>
</tr>
</tbody>
</table>

In young people’s substance misuse treatment services: Reducing smoking rates amongst those in treatment was identified as a key priority. As such, all Project 28 (young people’s drug and alcohol service in B&NES) staff have received support to stop smoking training. 100% of young people were smoking tobacco at the start of treatment in 2016/17, which was reduced to 39% at exit (compared to 90% at exit the previous year). Nationally, 55% of young people continued to smoke at treatment exit. (46)
Activity in secondary Care
The Royal United Hospital (RUH) acute trust, Virgin Care community trust and the Avon and Wiltshire Partnership (AWP) mental health trust have ‘Commissioning for Quality and Innovation’ (CQUIN) outcome targets to achieve attracting financial reward. Table 7 gives data from quarter two of 2018/19: In the latest quarter of data available. The RUH achieved the CQUIN in full with over 99% of inpatients having their smoking status recorded and all smokers being offered advice.

Table 7: 2018/19 RUH Q2 CQUIN Achievement:

| Number of patients stayed 24 hours of more in Q2 | 4510 |
| % screened for smoking status with results recorded (target = 90%) | 99.6% |
| Number of patients who smoke | 463 (10.3%) |
| % of smokers offered advice (target = 90%) | 100% |
| % of smokers referred to healthy choices team (target = 30%) | 81% |

Table 8: 2018/19 Virgin Care Q2 CQUIN Achievement:

| Number of patients admitted to community hospitals | 145 |
| % screened for smoking status with results recorded (target = 90%) | 99% |
| Number of patients who smoke | 4 (2.8%) |
| % of smokers offered advice | 50% |
| % of smokers referred to stop smoking services | 25% |

Table 8 shows that in the same quarter Virgin Care achieved high rates of screening for smoking in the community hospital setting but had very few patients who were smokers, making interpretation of the activity difficult.

AWP mental health trust went completely smokefree in November 2017. Data on the success of screening patients for smoking and offering advice is not available though it is expected to be in a few months once IT changes have been made.

The Royal United, St Martin’s and Paulton Hospitals all went completely smoke free on 1 January 2019.

E-cigarettes/vape shops
As at December 2018 there were 12 ‘vape shops’ listed in B&NES (6 in Bath, 1 each in Keynsham, Peasedown St John, Radstock, Midsomer Norton and Chew Magna). None of these are members of the Independent British Vape Trade Association. Member shops are certified as unassociated with the tobacco industry, the nearest of which are in Bristol or Chippenham (47).
Identification of Health Gaps

Table 9 summarises the main gaps in tobacco control in B&NES identified through the needs assessment process.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Current Situation</th>
<th>Gaps</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence in adults in B&amp;NES</td>
<td>Smoking prevalence is 13.4%</td>
<td>Prevalence could match 'near neighbours' by reviewing their practice and be reduced to 9-10%</td>
</tr>
<tr>
<td>Priority group: Smoking prevalence in pregnant women in B&amp;NES</td>
<td>Smoking prevalence is 7.5% at time of booking</td>
<td>National target is 6% or less</td>
</tr>
<tr>
<td>Priority group: Health inequalities exist in the severe mental illness population in B&amp;NES due to smoking prevalence</td>
<td>Smoking prevalence is 32.6%. Data not currently from AWP mental health trust settings on success in screening service users for smoking and offering interventions</td>
<td>Aim to match near neighbours best rate of 32.6% Data availability from AWP settings</td>
</tr>
<tr>
<td>Priority group: smoking prevalence in people with substance misuse issues in B&amp;NES</td>
<td>Very low engagement of drug and alcohol service user engagement with smoking cessation</td>
<td>Improvement needed in engagement of drug and alcohol service users Potential to make more use of existing related interactions in pharmacies</td>
</tr>
<tr>
<td>Priority group: smoking prevalence in people who are LGBTQ in B&amp;NES</td>
<td>Smoking prevalence is 25.3% No particular resources or targeting of services to this group in B&amp;NES</td>
<td>Prevalence could match the overall adult population of 13.4% Services don’t record this as a demographic. No targeted service</td>
</tr>
<tr>
<td>Priority group: smoking prevalence in greater socioeconomically deprived groups in B&amp;NES</td>
<td>Smoking prevalence is 35% in social rented housing tenants. Smoking prevalence is 30% in routine and manual worker group and the rate is not improving in B&amp;NES</td>
<td>Prevalence could match the overall adult population of 13.4% Services could increase focus on specifically targeting the social rented housing sector and professionals in that field</td>
</tr>
<tr>
<td>Priority group: smoking prevalence in children and young people in B&amp;NES</td>
<td>Smoking prevalence is 6.6% in 15-yr-olds in B&amp;NES Smoking prevalence is higher in vulnerable children than other children</td>
<td>Target is 3% by 2020 to achieve a ‘smokefree’ generation Specific resources suitable for this group are felt to be lacking in availability</td>
</tr>
<tr>
<td>Priority group: smoking prevalence in gypsy, traveller and boater groups in B&amp;NES</td>
<td>Smoking prevalence is estimated to be over 50% in gypsy and traveller groups</td>
<td>Prevalence could match the overall adult population of 13.4% Services don’t record this as a demographic. Some targeted work already undertaken</td>
</tr>
<tr>
<td>NHS Health Checks in B&amp;NES</td>
<td>Very low onward referral rates</td>
<td>Continuing professional</td>
</tr>
</tbody>
</table>
### B&NES referrals to smoking cessation services
- **To smoking cessation for attendees identified as smokers**
- **Development and refresher training for health check delivery team re-emphasising the importance of facilitating smoking cessation**

### E-cigarettes use in stop smoking offer in B&NES
- B&NES services are e-cigarette friendly but there is variation in advice received and service users want advice on where to buy e-cigarettes
- **Verified advice on use and purchase of e-cigarettes to all those who would benefit. Vape shops not formally listed or inspected**

### Passive smoking
- **Affects 20% of children at home in B&NES**
- **Link with potential to target the social housing sector where smoking prevalence is highest**

### Illegal tobacco use in B&NES
- **Survey results and national estimates suggest illegal tobacco use in B&NES is high**
- **Further campaigns, tobacco sales licensing and shop visits by Trading Standards**

### Quit behaviour and support in B&NES
- A quarter to a third of smokers want to quit in the next year 4,400 people are likely to have tried to quit solo.
- **Success rate in self-support quit attempts are 17.4%**
- **All smokers who want to quit should receive optimised help. Self-support offer is weak**
- Data is lacking on who is trying to quit without support/who is interested in quitting

### Stop Smoking Services activity in B&NES
- **Services reach 2.95% of smokers in B&NES**
- **Stop Smoking Services should reach 5% of smokers**

### Perceived risks to health from tobacco use
- A third of smokers in B&NES feel their smoking isn't harmful to their health
- **Education and awareness of the health risks of tobacco use**

### Economic impacts on the local authority of tobacco use in B&NES
- **Cost to local authority from impact of tobacco use is very high due to the effects on social care needs, productivity loss, fires and littering. 6 house fires a year caused by smoking in B&NES**
- **Fire service, social services and employers may be able to increase their input into tobacco control**

### Stop Smoking Services model
- B&NES services are separated in some elements but also integrated into the HLS in some regards
- **Stop smoking services are most effective when operated separately**

### Compliance with Smoke Free legislation in B&NES
- Official complaints of breaches are not recorded systematically but are available
- **No robust data available**

### Pharmacies’ role in smoking cessation
- Feedback has indicated that factors such as high staff turnover, locum staff and variation between locations mean advice on smoking cessation is rarely offered and advice given is not always optimal
- **Advice given in pharmacies needs to be high quality and consistent and offered to a higher number of people.**

### National smoking cessation resources
- Limited resources and products available
- **National smoking cessation resources need to be**
### Settings to address tobacco control

- Acute and community trusts have gone smoke free. Smoke free play areas and sports clubs work undertaken.
- Universities are not specifically targeted for tobacco control efforts and Bath College has not maintained its Smoke Free status.
- Referrals to services are low in general and especially low from some settings e.g. dentistry.

### NRT prescription use in B&NES should be used to improve smoking cessation attempt successes

- There is a downward trend in prescriptions in B&NES.

### Support and incentivisation for tobacco control in schools B&NES

- Director of Public Health award has ceased which used to be a major driver of health improvement work in schools.
- School nurses provide smoking cessation advice.

### Youth services, leisure services, the universities and Bath College should be addressed for tobacco control opportunities.

- Referrals from all settings to Stop Smoking Services could be increased. Adult and children's social services could increase referrals and signposting to services.

- Referrals to services are low in general and especially low from some settings e.g. dentistry.

- Universities are not specifically targeted for tobacco control efforts and Bath College has not maintained its Smoke Free status.

- Referrals to services are low in general and especially low from some settings e.g. dentistry.

NRT prescription use in B&NES should be used to improve smoking cessation attempt successes.

Target is prevalence of 3% in children by 2020 to achieve a 'smokefree' generation.

Specific resources suitable for this group are felt to be lacking in availability.
Horizon Scanning

There are upcoming changes to the organisation of health and care which may impact on tobacco control activity.
The recently published NHS long term plan makes commitments to smoking cessation which may reflect direction of resources in the future. The commitments are summarised in table 10 and already reflect work that is taking place in B&NES.

Table 10: Tobacco related content in the NHS Long-Term Plan

<table>
<thead>
<tr>
<th>Section</th>
<th>Commitment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.9</td>
<td>By 2023/24 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services</td>
</tr>
<tr>
<td>2.10</td>
<td>Adapted model available for expectant mothers and their partners</td>
</tr>
<tr>
<td>2.11</td>
<td>New universal smoking cessation offer be available as part of the specialist mental health services for long-term users of specialist mental health, and learning disability services</td>
</tr>
</tbody>
</table>

The B&NES Swindon and Wiltshire Sustainability and Transformation Partnership (BSW STP) System Operational Plan: 2019/20 recognises smoking as one the key causes of health inequalities in vulnerable communities and identifies the following as one of its ten early ‘must do’s’:

- Build on the Smokefree NHS BSW STP initiative to ensure an equitable and effective approach to Smoking Cessation within Acute and Community settings

Primary Care Networks (48) are mandated to be set up in the next year – these are based around a GP registered list of approximately 30,000 – 50,000 patients, and encompass general practice and other partners in community and social care in local areas to provide more proactive care for the people and communities they serve. There are likely to be 5 such networks in B&NES. These networks will have a remit to address health improvement and prevention providing an opportunity to reach B&NES residents at scale to offer smoking cessation advice, prescriptions and referrals.

Publication of new guidance for local authorities on tobacco control is anticipated from Action on Smoking and Health. Early indications are that this guidance will advocate for a focus on improving the uptake and quality of self-support in smoking cessation in order to far more people than those reached by specialist stop smoking services while still achieving acceptable success rates.
Recommendations

- Set a vision of a smokefree generation (5% smoking prevalence or less) with use of trajectory modelling to set a target date
- Liaise with ‘nearest neighbour’ local authority TANs with lower prevalence rates about their practice to learn from their experiences
- Move to focusing on improving uptake and quality of self-support quit attempts over specialist service referrals in order to reach far more people. E-learning/wider reach training for more staff may facilitate this.
- In order to reduce inequalities, approach professionals and services representing new avenues and enhanced partnership working to better reach priority groups e.g. Social and Early Help Services, Universal Credit workers, fire service frontline staff
- Address settings that have not yet received targeted tobacco control input - Youth services and leisure services, the universities and Bath College
- Continue to promote e-cigarette friendly services and environments. Consider encouraging a relaxation on vaping stance in suitable locations. Address the issue of rising public concern over relative safety compared to tobacco smoking.
- Identify a lead/champion for primary care, pharmacy and dentistry and other settings where offers of brief interventions and referral rates to smoking cessation services are low. Consider inclusion of these leads in the TAN.
- Address data needs – repeat questions in the Voicebox survey to provide trend data, support a continuation of the SHEU survey or equivalent, improve data collection in Stop Smoking Services for priority group characteristics, and improve data availability from health and care settings.
- Reinvigorate pharmacies’ role in smoking cessation advice and take advantage of their regular interactions with certain groups such as opioid substitution prescription users
- Advocate for improvements in national printed and electronic resources for use in smoking cessation advice
- Use MECC training or other means to refresh confidence in staff to increase brief interventions, recording and specialist service referral rates from NHS Health Checks and ensure they are also confident in the essential facts of smoking cessation
- Pursue the suggestion of vape shop formal listings and visits for assessment by trading standards team
- Explore the potential offered by primary care networks for new models of health improvement channels – e.g. there is interest in health optimisation including smoking cessation for all non-urgent surgical patients in a community based clinic.
- Review needs for refresher training to ensure as many smoking cessation advisors are available as possible
Acknowledgements

The development of this needs assessment has been supported by the B&NES public health team and members of the B&NES Tobacco Action Network Group along with colleagues from their organisations.

Bibliography


10. Email communication with Public Health Research and Intelligence Officer. 2018.


35. **team, Email correspondence with B&NES trading standards.** 2019.


44. **Bath and NE Somerset Stop Smoking Service.** SSS_monitoring form 201718 (internal document).


46. Email communication summary of performance on smoking for young people’s treatment services. 2018.


