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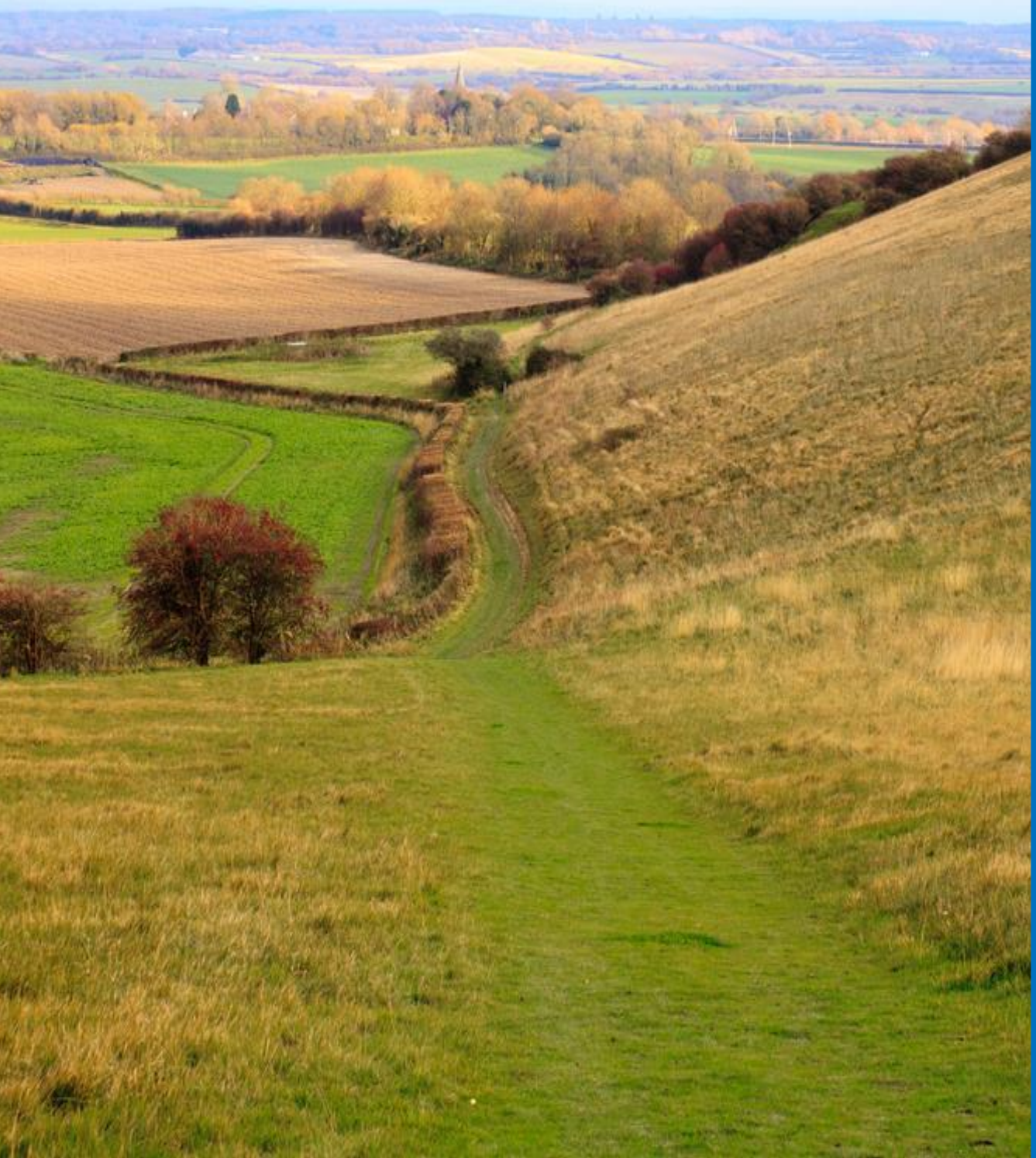
Public Health & Social Research Unit

MAY 2016

Making the next generation tobacco-free

West Sussex Tobacco Control Needs Assessment



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The *Making the next generation tobacco-free: West Sussex Tobacco Control Needs Assessment* was a significant undertaking with many individuals and organisations contributing their time and insight into the production of this report. We would like to thank the steering group members, members of the public, professionals and service providers for their valuable contributions throughout the project.

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1. Executive Summary

Smoking is the single largest cause of premature death and preventable illness. This assessment has been undertaken to gather evidence to guide the commissioning of tobacco control activities in West Sussex. It aims to help partners negotiate and agree local priorities that tackle tobacco use and health inequalities. Tobacco Control is an evidence-based approach to tackling the harm caused by smoking. It includes strategies that reduce the demand for, and supply of, tobacco in communities through;

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second-hand smoke
- Effective communication for tobacco control

Key findings

- Whilst smoking prevalence has declined across the county, every person who smokes or starts smoking is harming their health and that of others through second-hand smoking.
- From 2010 to 2014, the estimated smoking prevalence in West Sussex dropped by 2.63% to the current prevalence of 17.0%. This is not a significant change.
- Although the rate of deaths from smoking has decreased, there is only a slight change in absolute numbers (due to population increase), highlighting that the burden on health and social care and other statutory services remains.
- The national youth survey (WAY) found that the proportion of 15 year olds classing themselves as regular smokers in West Sussex was significantly higher (7.07%) than England (5.45%).
- There are significant variations in the levels of tobacco use across West Sussex, with high levels of smoking within the most deprived areas.
- Between 2012 and 2014, an estimated 3,995 deaths were attributable to smoking in West Sussex. This is lower than England and the South East average.
- Smoking related hospital admissions have increased between 2010/11 and 2014/15. Although West Sussex remains significantly lower than the national rate, in the last three years the rate of smoking related admissions has gone from being significantly lower to significantly higher than the South East region rate.
- It is estimated that smoking in West Sussex currently costs society £207 million each year, which equates to roughly £1,850 per smoker per year.
- Key challenges for tobacco control in West Sussex are: lack of strong leadership and vision on tobacco control; poor communication and engagement with local communities in tobacco control activities; and inadequate partnership working. WSCC, as the home of public health, therefore has a key role to play in setting exemplar policies.
- There is need to raise awareness of tobacco control beyond health and highlight the impact on other social and economic aspects such as smoking related fires, litter and crime.

- Smoking cessation support services and interventions should be well publicised and should address the barriers to accessing services.
- To gain the greatest reduction in tobacco use and tobacco related harm, priority should be given to the five high risk population groups identified as being more at risk of tobacco use and/or exposure. These are; pregnant women, young people, BAME groups, mental health service users and those from a low socio economic groups.

1.1 Introduction

Tobacco use remains one of our most significant public health challenges. Smoking continues to be one of the major causes of death and illness in West Sussex and in the UK. It significantly contributes towards the creation and worsening of health and social inequalities in our society. Although there has been a decline in the number of people smoking, as a result of laws, policies and activities tackling tobacco use, people are still dying prematurely. This means that the burden on health, social care services and society as whole remains.

The effects of smoking on the body are well documented and these include coronary heart disease, cardio-vascular disease, Chronic Obstructive Pulmonary Disease (COPD), Type 2 diabetes, various types of cancers and stroke. Second-hand smoke exposure is also harmful to non-smokers and can have lifelong effects. Smoking in pregnancy, for example, can damage the unborn baby and also negatively affect children's developmental outcomes.

People who smoke are usually those who are already vulnerable. Specific social groups have been identified as being more at risk from and/or being major consumers of tobacco. This is observed at national, regional and local levels. In West Sussex, these high risk groups are: those living in deprived areas, in low income jobs, of a minority ethnic group, with a mental illness, young people and pregnant women. These groups are not mutually exclusive however, the majority of smokers in West Sussex fall into at least one of these groups.

We know that by tackling tobacco use, we tackle health inequalities, which is why tobacco control is central to any strategy which aims to address the public's health. But it is not just the role of public health to tackle tobacco use; tobacco control is everybody's business and so a coordinated approach, across departments, organisations and communities is needed.

1.2 Types of tobacco

The two main types of tobacco products are smoking and smokeless. Although smoking tobacco, particularly cigarettes, is the dominant type of tobacco used in West Sussex and in the UK, other novel products are emerging, for example, waterpipes and chewing tobacco. These novel tobacco products bring with them a new set of challenges for those looking for ways to tackle tobacco use.

1.3 International, national and local context

Tobacco control is a global, national, and local issue and to address this, there are a number of evidence based policies, guidelines and legislation which inform tobacco control activities (Figure 1).

Figure 1 - International, national and local tobacco control policy context

The Smokefree West Sussex Partnership CLeaR self-assessment of tobacco control activities in West Sussex highlighted the following key challenges: lack of clear leadership; poor communication and de-normalisation of tobacco use; and inadequate supra-local and local partnership working.

1.4 West Sussex demographic context

The population of West Sussex is increasing. The largest increases are projected in the older age groups (85+) and decreases projected in working age adults (20-54 years) and young children (<5 years).

West Sussex is less ethnically diverse compared to England (11.2% BAME in West Sussex compared to 20% in England). However, there are over 21 languages being spoken by more than 500 people and a great many more spoken by fewer people. The majority of BAME populations in West Sussex are in the Crawley, Worthing and urban Arun areas.

West Sussex is a relatively affluent county but there are some very deprived neighbourhoods. County level data masks considerable differences within these small areas. The most deprived lower-tier local authority in West Sussex is Adur and the least deprived is Mid Sussex. In relation to neighbourhood level deprivation, West Sussex has four small areas (all within Arun) that are amongst the 10% most deprived areas in England. These four small areas fall within the River, Courtwick with Toddington and Bersted wards in Arun.

1.5 Tobacco, health and wellbeing in West Sussex

Smoking trends in West Sussex are declining, in line with England and the South East region. However, there is great variation in rates of smoking between communities in West Sussex.

Although Crawley has historically had the highest prevalence of smoking in the county, Worthing now has the highest rate with some 20.3% of the adult population recorded as smoking.

Nationally, the younger age groups have the highest smoking prevalence, with prevalence peaking at 23% in the 18-24 and 25-34 year old groups. Smoking prevalence decreases with age to 9.2% in the 65+ age groups.

Ethnicity and smoking

We know that people from ethnic minority groups are more likely to smoke or use tobacco than their white British counterparts. Certain types of tobacco products are more common in some communities, for example, chewing tobacco is common in the South Asian communities.

An estimated 8,500 smokers in West Sussex reported their ethnicity as anything other than 'white'.

Deprivation and smoking

It is a well-known fact that people who smoke are usually concentrated in areas of high deprivation, adding to inequalities between the most deprived and least deprived areas. The Lifestyles and opinions survey showed that those living in the most deprived LSOAs in the country were over 10% more likely to be smokers than those living the least deprived quintile nationally. This is also reflected in West Sussex.

Smoking in pregnancy

We know that smoking in pregnancy causes serious harm to the unborn baby. Stillbirth, growth problems, premature birth and a number of serious developmental diseases in infancy and sudden infant deaths are all associated with smoking in pregnancy.

In the first three quarters of 2015/16, significantly more mothers in Coastal West Sussex CCG (11.5%) were smokers at the time of delivery than in Crawley CCG (6.7%) or Horsham and Mid Sussex CCG (4.3%). Overall for West Sussex, it was estimated that 9.6% of mothers were smoking at delivery in 2014/15; this is significantly lower than estimates for England (11.4%).

Young people

We know that in terms of age, smoking is at its highest level in younger age groups. Learned behaviours, from parents or family members who smoke, influence the early uptake of smoking in young people. A recent WAY survey of 14-15 year olds show that significant numbers of young people in West Sussex are taking up smoking at an early age, compared to England and the South East.

Mental health illness and smoking

Smoking prevalence is substantially higher within this population group (40%), when compared to the general population (21%). According to national estimates 70% of patients in psychiatric units and up to 40% of people with mental illness living in the community are smokers.

Tobacco related illnesses and deaths

In West Sussex alone, it is estimated that between 2012 and 2014, 3,995 people died from smoking related causes. The average in West Sussex remains consistently below that of England and the

South East Region; however the demand on services to support people who are ill and dying from smoking related causes remains high.

Smoking related hospital admissions

Although death rates are declining, admissions to hospital for smoking related illnesses have been increasing in West Sussex, compared to England and the South East. Understanding the cause of this increase requires further investigation.

Deaths from specific smoking related causes

The most recent local data (2011-13) shows that within West Sussex the rate of smoking attributable deaths ranges from 279.89 per 100,000 in Crawley to 200.55 in Mid Sussex. Deaths from lung cancer have remained stable in West Sussex and significantly below the England average.

COPD deaths do not follow any particular pattern and there have been no significant improvements, but rates remain consistently below the England average.

Deaths from smoking related heart disease have fallen over the last eight years, as have deaths from smoking related strokes, following similar trends for England and the South East.

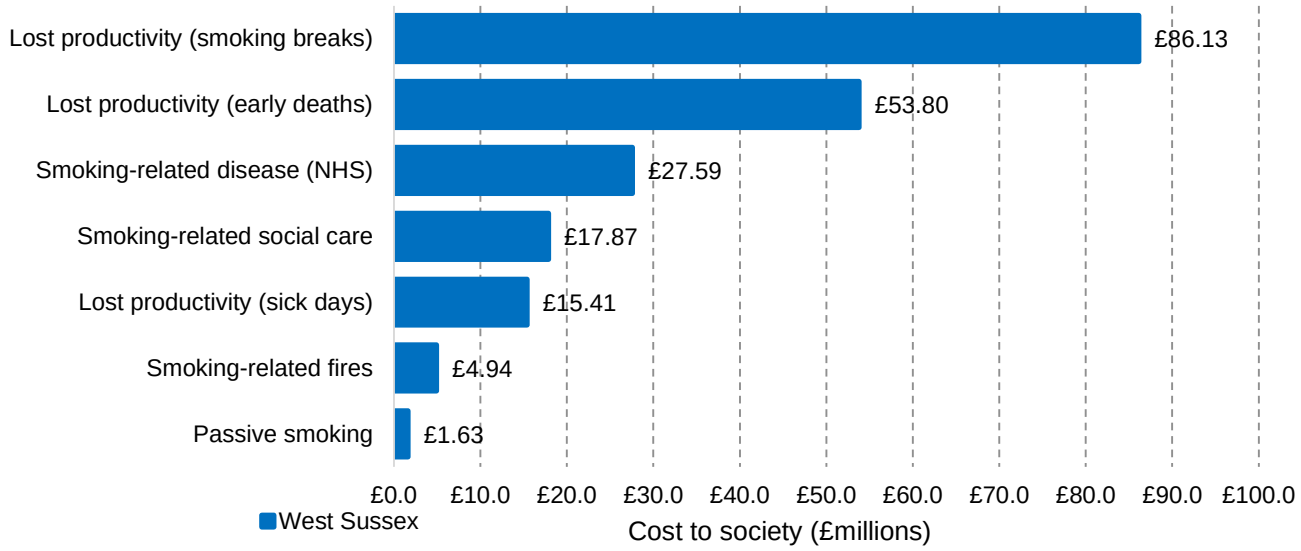
Domestic fires

Over the last six years, 216 fires in West Sussex were caused by smoking materials. Although incidences of these types of fires are declining there have been 11 fatalities and 24 injuries resulting from smoking related fires since 2010 in West Sussex.

The economic impact of tobacco use

The cost to society of smoking in West Sussex is estimated to be £207 million, broken down as shown in Figure 2.

Figure 2 Estimated cost of smoking in West Sussex (£millions)



Smoking related litter

As well as the negative environmental impact of smoking related litter such as cigarette butts, it is also the most frequently found type of litter in England. It costs £342 million per year to clean up

the 200 million cigarette butts thrown away daily by UK smokers. In West Sussex, around 442 million filtered cigarettes are smoked each year, resulting in approximately 75 tonnes of waste annually.

Second-hand smoke exposure/ environmental tobacco smoke

Exposure to second-hand tobacco smoke is associated with an increased risk of conditions such as chest infections, asthma attacks, low birth weight and sudden infant death syndrome. Young children are especially vulnerable to the effects of tobacco smoke due to their rapid physical development. For example, they breathe more rapidly, inhaling more pollutants per pound of body weight (a higher relative ventilation rate) than adults.

Second-hand smoke in the home is a major source of exposure for children. Smokefree homes and public places are critical in reducing second-hand smoke exposure.

Trends in alternative tobacco products

Local data on the use of alternative tobacco products are scarce, but national data can be used to understand trends and patterns of use in the local population.

Waterpipes (also known as shisha, hookah, hubble-bubble, narghile)

National surveys indicated that waterpipe use is prevalent among some adults, particularly of Asian ethnicity and some young people. Surveys conducted in other areas in the UK found that, waterpipe use in young people was more prevalent, compared to cigarette use or drug use.

Smokeless tobacco

Smokeless tobacco, particularly chewing tobacco (Paan/betel nut) is commonly used by the South Asian community. Although there is a lack of robust local and national data on smokeless tobacco, studies in other areas found that as high as 49% of adult Bangladeshi women were chewing Paan.

1.6 Six strands of comprehensive tobacco control

Tobacco control activities in England are guided by the World Health Organisation's (WHO) internationally recognised six strands approach.

1.6.1 Stopping the promotion of tobacco

This strand is aimed at de-normalising smoking and countering the tactics of the tobacco industries in promoting tobacco products. The promotion of tobacco products is particularly appealing to younger people and therefore de-normalising tobacco use remains a crucial part of any tobacco control strategy.

Various legislation and regulations have made a significant impact on the promotion of tobacco. However, to date this does not extend to 'accessories' around tobacco products. Tobacco companies engage in some activities to exploit this gap, such as using desirable and well-known brands to promote some tobacco accessories. Stopping the promotion of tobacco also includes niche products such as shisha and chewing tobacco. West Sussex Trading Standards Service (TSS) enforces these regulations around tobacco promotion and monitor compliance, including point of sale displays. WS TSS also supports businesses to comply with statutory and social responsibilities

around the promotion of tobacco products. At the time of the assessment, there were no reported cases of noncompliance with point of sale displays in West Sussex.

Evidence based interventions

Evidence based guidelines and recommendations to reduce tobacco promotion have been developed by several organisations including NICE, WHO, Department of Health, Trading Standards Institute.

Local authorities have a key role to play in de-normalising tobacco use, including implementing behavioural change and prevention interventions that are easy, attractive, social and timely (EAST), to change social norms. Other interventions include:

- Point of sale interventions
- Provision of information and educating young people about risk behaviours
- Monitoring and evaluating tobacco control activities

The local government declaration on tobacco control and the NHS statement of support for tobacco control signifies the local authority and NHS organisation signatories' responsibilities and commitment to ensure tobacco control is part of their mainstream public health work. At the time of the assessment, none of the West Sussex local authorities, or the CCGs had signed the local government declaration or the NHS statement of support for tobacco control.

1.6.2 Making tobacco less affordable

Making tobacco less affordable is another national work stream which focuses on taxation, as part of tobacco control activities. Increasing the price of tobacco is an effective tobacco control activity. Younger people are sensitive to price increases due to limited income, consequently, increasing the price of tobacco has an impact on the initiation and prevalence of smoking in young people. Illicit tobacco erodes these tobacco control efforts due to the unpaid duty, which makes tobacco affordable and available for young people. We know from research that those most likely to buy illicit tobacco are: young people, those from a deprived background, heavy smokers and those with a higher level of addiction. We also know that these are the areas where the population of smokers is highest and therefore the demand for cheap tobacco is likely to be high. Some niche tobacco products, i.e. shisha and smokeless tobacco, are also smuggled or bootlegged into the UK.

Current West Sussex tobacco control activities

West Sussex TSS is responsible for enforcing legislation banning illicit tobacco sales and possession across the county. They conduct intelligence led visits to premises and investigations including the use of sniffer dogs, where appropriate. TSS will seize any illicit tobacco found and issue a warning, caution or prosecute, depending on the offence.

There were 20 incidents of illicit tobacco seizure between the start of 2014 and end of 2015. Four seizures of illicit tobacco products within the last two years have resulted in three prosecutions (one shop having illicit tobacco seized on two separate occasions).

Although there is a national joint working protocol between Trading Standards and HM Revenue and Customs (HMRC), there are no local arrangements in place.

Evidence based interventions and guidelines in tackling illicit tobacco

Collaborative working with key stakeholders across larger geographical areas is a cost effective way of tackling illicit tobacco. There are some national examples of good practice in partnership working to tackle illicit tobacco.

Understanding the norms associated with illicit tobacco is key to understanding which interventions are effective to tackle this. Data helps us to understand the prevalence of use of illicit tobacco and where offences are occurring. This underlines the importance of data collection, monitoring and evaluating counter-tobacco activity to allow analysis of patterns of incidents and target interventions to tackle illicit tobacco.

Evidence from engagement with local stakeholders

Public consultation findings

The results of the public survey demonstrate that illicit tobacco sales and use is prevalent in West Sussex, with one in ten young people responding to the survey reporting that they had been offered illicit tobacco products within the previous six months.

Seventy percent of the survey respondents (n=416) were unsure or didn't know where or how to report illegal tobacco sales. Encouragingly there is an appetite for action on this with useful suggestions as to how this issue could be tackled in their local communities including; educating people of harms of illegal tobacco sales (not just health harms of smoking, but harms of unpaid duty etc.), greater presence of enforcement (including more trading standards officers and police) and promoting the ease of reporting (including confidential and anonymous reporting).

Professionals survey findings

The survey suggested that most professionals lack awareness around the use of illicit tobacco in their client groups and how to report it.

Effective regulation of tobacco products

Whilst regulation plays a key role in reducing tobacco use and de-normalising smoking, the enforcement of tobacco control legislation and regulations is critical to the effectiveness of tobacco control activities. The availability of novel or niche tobacco products in communities throughout England means that there is also need to ensure that these are also effectively regulated.

Current West Sussex tobacco control activities

The West Sussex TSS is the primary body for the enforcement of legal controls over age-restricted products, including tobacco.

There have been a number of violations of the regulations regarding underage sales and illicit tobacco products in West Sussex, resulting in 28 interventions in 2014/15. These interventions varied from warnings and follow up visits to prosecutions for repeat/serious offences. The data shows that some areas in West Sussex have had more interventions, compared to other areas.

Currently, no data has been collected on violations specifically for niche tobacco products, as these are not considered high risk in West Sussex.

Evidence based interventions and guidelines

Evidence based interventions for local enforcement include;

- Ensuring organisations and businesses comply with regulations, including appropriate no smoking signage in smokefree places and vehicles.
- Providing information and raising awareness about tobacco harms and addressing some misconceptions that using some niche tobacco products is less harmful than cigarettes
- Partnership working between TSS, environmental health, licencing and retailers, police and the wider community
- Intelligence sharing with other partner organisations for a variety of regulatory concerns, i.e. sharing information following visits for other purposes.

Evidence from engagement with local stakeholders

Public consultation findings

Most participants in the public survey and the Black, Asian, Minority ethnic groups (BAME) interviews had a good level of understanding of tobacco regulations in terms of smokefree legislation and age of sale for tobacco products.

Professional survey findings

There was an appetite for partnerships and joint working initiatives to support tobacco control activities. Some of the training needs identified by professionals included regulations and legislation, smoking cessation methods and smoking related harm to young people.

6.3 Helping tobacco users quit

One way of tackling health inequalities is to offer a comprehensive and easily accessible smoking cessation service. Evidence shows us that with appropriate treatment and support, most people will quit successfully. West Sussex has a stop smoking service which has two components; a GP and pharmacy service for any smoker and specialist service for the following target groups:

- Residents in deprived wards
- Routine and manual workers
- Minority ethnic groups
- Young people (<25 years)
- Mental health service users in the community
- Pregnant smokers and their partners
- Smokers with five previously unsuccessful quit attempts
- Adults living in with children under 5 (*recently added* group)

In West Sussex, in 2014-15, a total of 5,224 smokers accessed stop smoking services in a variety of settings, including GPs and pharmacies.

Stop smoking services activity (2014-15)

West Sussex Stop smoking services	Access	Quit	Rate
Pharmacy	610	266	43.6%
GP Practice	3229	1595	49.4%
Prison	101	25	24.8%
Specialist Stop Smoking setting/community	1284	751	58.5%

West Sussex Specialist Stop Smoking Services

West Sussex specialist stop smoking services are delivered to specific target groups in a various locations. The specialist service offers a range of evidence based interventions such as groups, intensive one to one support and pharmacotherapy.

Access to stop smoking services by target groups

A total of 3160 smokers classed as being in a target group accessed stop smoking services commissioned by WSCC. Of these:

- 1074 (34%) were seen by the specialist stop smoking service
- 1739 (55%) were seen by GPs
- 301 (10%) were seen by pharmacies
- 46 (1%) were seen elsewhere

In 2014/15 data shows 1266 smokers who fell into the target groups, accessed the specialist service (i.e. set a quit date). These data show us that the numbers of successful quitters, in all target groups, are falling short of expectation for a specialist service.

The Health Equity Audit shows that access to stop smoking services was varied both geographically and demographically, and was found to be below the 5% performance targets recommended in the NICE guidelines.

Current specialist Stop smoking service pharmacotherapy provision

Pharmacotherapy is a major component of a gold standard stop smoking service. Although the specialist service provides a comprehensive stop smoking service, the lack of a Patient Group Direction (PGD) or in-house clinician limits the stop smoking advisors, as they are unable to prescribe pharmacotherapy. Instead, they require a GP to write the prescription for the service user. This broadly equates to one in three patients having to attend an additional appointment with a GP.

Smokers who do not qualify for free prescriptions must pay for their pharmacotherapy. This is likely to be a barrier to quitting as well as reducing the impact of any messages about a smoker saving money. There are examples of incentivised schemes for smoking cessation. The full report points to a number of other options for commissioners summarised here:

- Use providers to train professionals to be smoking advisors rather than delivering the service themselves.
- Increase the sign up of pharmacies to take on smoking cessation work to support GPs.
- Increase use of nurse prescribers in stop smoking GP surgeries to support GPs.
- Placing specialist advisors in clinics or wards where there are high levels of target groups who would benefit from opportunist approaches and immediate referral/consultation.
- Using demand forecasting models to explore how this might enhance commissioning of these services.

There is a wide range of evidence based interventions and guidelines for the target groups, which can be incorporated as part of tobacco control activities.

Using market segmentation in tobacco control

The top five West Sussex LSOAs with households identified by Experian's Mosaic data as most likely to smoke are; Three Bridges, Courtwick with Toddington; Broadfield South; Bersted, Orchard; Aldwick East, Pevensey.

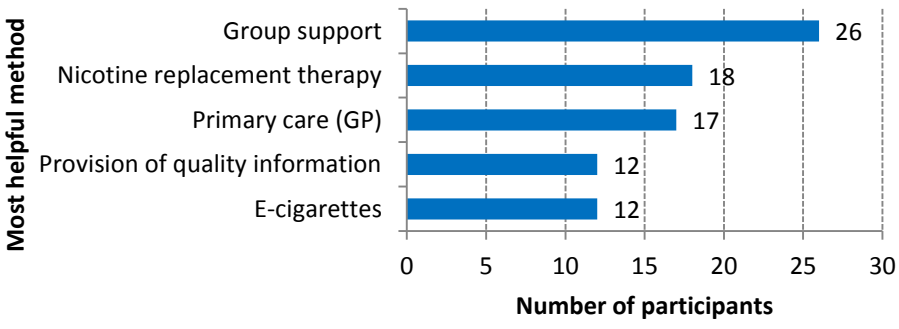
Evidence from engagement with stakeholders

Public consultation findings

Although over half (55.7%) of the survey respondents were aware of services and support available to help people to quit smoking, there was a lack of awareness of services by some respondents.

A small proportion of respondents (10.2%) reported using tobacco products and/or nicotine products, and of these, 54% had attempted to quit or cut down. Just under half (47%) did not have any intentions to quit. Reasons for not quitting included: difficulties to break the habit/addiction, stress, time, willpower, social situations and the belief that their consumption is infrequent and therefore not posing significant risk to health. This highlights that there is willingness to stop smoking among the majority of smokers, however there is need to reach and support those who are ready to stop, as well as those who currently have no intention to quit.

The most common methods used to cut down or quit tobacco use were e-cigarettes, followed by going cold turkey and Nicotine Replacement Therapy (NRT). Self-directed attempts to quit using NRT demonstrate opportunities for pharmacies to play a greater role in smoking cessation. Group support, NRT and GPs are popular choices for those wishing to quit smoking. Accessibility, universality and ease of these services and resources are also key factors in their popularity.



The survey also highlighted that family and friends were the key influences in the decision to smoke or not smoke for those aged under 26. This indicates the importance of working with families and local communities in de-normalising tobacco use. The findings from the public survey were similar to findings from the interviews with BAME groups, who also indicated that GPs were the first port of call for stop smoking advice or services. A key issue for some BAME groups is that there is a lack of culturally appropriate services.

Professional survey findings

The majority of the professionals surveyed indicated that there is an awareness of the Smokefree West Sussex Stop Smoking Services among professionals, however, referrals to the service is very low. More than half of the respondents had never made a referral to the service, indicating the underutilisation of the Making Every Contact Count approach. Furthermore, professional activity around the five As of brief interventions for tobacco use (ask, advise, assess, assist, arrange follow up) differed greatly. The responses demonstrated the need for training and provision of resources for professionals to enable them to tackle this through the MECC approach.

1.6.5 Reducing exposure to second hand smoke

This strand's key focus is on protecting non-smokers from the harms of tobacco smoke, as there is no safe level of exposure to second-hand smoke. Non-smokers, particularly children and young people, are vulnerable to tobacco smoke, and the health of babies born into lower income households is disproportionately affected by second-hand smoke.

Current West Sussex tobacco control activities

In West Sussex, smokefree policies in public services vary across organisations, including NHS Trusts, local authorities, and Clinical Commissioning Groups (CCGs). Our review of local policies found that nearly all (four out of five) NHS Trusts had a 'Smokefree policy' that completely banned smoking on the premises, in line with WHO recommendations.

Whilst WSCC and most of the districts and borough councils all had a policy regulating smoking in the workplace, only Crawley borough council had a 'Smokefree' policy and Arun district council had a 'no smoking' policy. There were variations in the acceptability of smoking on the premises, with three local authorities (WSCC, Horsham, and Arun) permitting smoking outside or in designated areas.

Voluntary smokefree policies

Some district and borough councils, have implemented voluntary smokefree policies in their playgrounds. In addition, some businesses in West Sussex have also implemented smokefree policies, particularly train stations.

Smokefree legislation enforcement

Environmental health departments that sit within the West Sussex districts and borough councils are responsible for enforcing smokefree legislation and ensuring compliance. The full report details the number of infringements reported in the West Sussex district and borough from 2010. These figures show that a high number of complaints/non-compliance are related to taxis/private hire cars drivers, indicating a need to reach this group.

Evidence based interventions to reduce exposure to second hand smoke

There is strong evidence that comprehensive smokefree legislation in all enclosed public places and workplaces, including bars, restaurants, reduces exposure to second-hand smoke and consequently reduce hospital admissions for certain diseases. The enforcement of the national smokefree legislation and supporting families to make their homes and cars smokefree are some of the key tobacco control interventions to reduce second-hand smoke exposure and de-normalise smoking. Indoor smokefree laws greatly reduce but do not completely remove the potential harm caused by second-hand smoke exposure, due to the residual exposure from smoking on premises or around boundaries of venues. Smokefree workplaces can also lead to an increase in smoking cessation among workers. Raising awareness of smokefree policies, ensuring clear and adequate signage as well as support to encourage smokers to quit are important in reducing second-hand smoke exposure. WHO also recommends the enforcement of a complete smokefree environment in healthcare and educational facilities.

Evidence from engagement with stakeholders

Public consultation findings

There was a high level of awareness of regulations banning smoking indoors and in enclosed outdoor spaces, and around smoking in cars with children.

Some respondents also indicated that their local towns are not doing enough to protect non-smokers from second-hand smoke exposure, although some indicated there is some level of activity to protect non-smokers in their city/town.

Support for smokefree public places was high with 87.4% of respondents in the public consultation survey saying that they supported smokefree public places. This was a similar finding from the interviews with some BAME groups, who expressed some support for smokefree areas. In addition, almost a quarter of participants (143 participants (24.4%)) reported that people living in their household or regular visitors to the household were smokers. However, 71.3% of these participants also reported that their homes were completely smokefree. This indicates that smokefree homes are acceptable to the public and there is an opportunity to normalise smokefree homes by supporting the local population.

School survey findings

The majority of the schools who took part in the survey (15 out of 18 participants) had a smokefree policy. However, only three schools had reviewed their policies in the last 12 months.

Professional survey findings

The majority of the professionals who responded reported that their organisation has a smokefree policy.

The main gaps in the provision of services to reduce tobacco use and second-hand smoke identified by professionals in the survey include; parents' lack the understanding of the impact of second-hand smoke on their children, and provisions to protect staff during home visits.

1.6.6 Effective communications for tobacco control

There is strong evidence that effective anti-tobacco communication interventions are powerful tools for preventing the initiation of tobacco use, promoting and facilitating smoking cessation and changing social norms in regards to tobacco use.

Current West Sussex tobacco control activities

Local tobacco control communications are mainly carried out by Smokefree West Sussex Partnership (SWSP). The majority of the communication activities are focused on motivating smokers to quit. However, this creates a gap in communications aimed at reducing initiation, and tackling illicit tobacco. From the CLeaR self-assessment, West Sussex local action on communications and de-normalisation is one of the poor performing areas, particularly in engaging with local communities.

Evidence based interventions

Effective health communication strategies use a wide range of methods and channels to bring the message home, including mass media, social media, public relations and sponsorships.

The use of behavioural insights and evidence based approaches in developing communications and social marketing initiatives, particularly in engaging young people, are key to reducing tobacco use. NICE recommends the use of evidence based strategies in the coordination and delivery of tobacco control communications. There is strong evidence that working with the local communities in producing culturally sensitive resources and delivering and evaluating appropriate services is effective in raising awareness of services and health risk factors of tobacco use.

Evidence from engagement with stakeholders

Public consultation findings

Participants in both the public survey and BAME interviews highlighted a lack of exposure to anti-tobacco communications or adverts, although a majority of them indicated that they had come across e-cigarette adverts. BAME interview participants expressed the need to break down the language barriers through mass communications that are tailored to different groups.

One in five (21%) of those under 26 years old responded that they had not received any information on tobacco use in school/college/university. This highlights the gap in reaching and engaging with the young people to reduce tobacco use.

Professional survey findings

The majority of professionals indicated that they do not receive updates on tobacco control activities. There is a clear need to improve communications with professionals to ensure they align their work with tobacco control strategies, as well as a need to raise awareness of the stop smoking services, including training, and the harms of smoking and second-hand smoking.

National campaigns are a key part of tobacco control activities, which need to be included as part of MECC. However, the survey indicated that just over half of the respondents (52%) reported that they or their organisation supported Stoptober and 23% reported that they didn't support any campaigns.

In addition, the majority of respondents highlighted that the information resource provided by West Sussex Stop smoking services and the NHS are 'partly' adequate to help them engage in tobacco control activities. This indicates that there is a gap in the information resources provided to professionals to enable them to engage in tobacco control activities.

Schools survey findings

Schools play a key role in educating young people about the harms of tobacco use and second-hand smoke to prevent initiation. Half (9) of the participants reported that none of their school staff had received any training to discuss tobacco control/smoking related harm with young people and only two schools reported all their staff had received training. Four of the schools reported that a few staff members had received training, whilst two schools responded "don't know/not sure". A clear need for consistent useful and high impact resources emerged from the schools survey.

1.7 Information and intelligence

Comprehensive surveillance and monitoring of tobacco control activities, including, the prevalence of tobacco use, impact of policies and interventions, and tobacco industry tactics (i.e. marketing, lobbying) are all key elements of tobacco control. Data collection and making the best use of existing and emerging research evidence is important in ensuring the effectiveness of tobacco control activities.

Current West Sussex tobacco control activities

The Smokefree West Sussex operational plan (2014-17) identifies the current activities carried out to meet this strand, including use of international, national, regional and local information and data on tobacco control activities and outcomes.

Evidence based interventions and guidelines

Evidence based interventions for tobacco control information and intelligence are centred on monitoring three key factors;

- tobacco products (i.e. tobacco constituents, nicotine content and additives);
- smokers or potential smokers, as well as unintentional smokers (i.e. monitoring patterns of initiation, susceptibility to tobacco use, quitting patterns, sources of tobacco);
- the tobacco industry (i.e. marketing, packaging, lobbying and other promotional activities).

International and national organisations such as WHO, NICE, PHE, ASH, and HMRC have published guidelines, information and tools for tobacco control activities. Collaborative working and intelligence sharing is critical to tobacco control activities, including establishing and maintaining partnership working between agencies and a protocol for sharing intelligence across the agencies.

Evidence from engagement with stakeholders

Professional survey findings

Professionals who took part in the survey highlighted some missed opportunities in regards collecting data on tobacco control activities, with a number of the them indicating that they could

potentially collect data that they do not collect at the moment such as underage sales or tobacco use, the use of illicit tobacco products, smoking in the home and second-hand smoke exposure.

1.8 Gaps in services/knowledge

There are gaps in:

- our knowledge of the prevalence of niche tobacco products such as shisha, and chewing tobacco;
- services supporting smokers to quit, particularly in reaching high risk target groups;
- local data on secondhand smoke exposure, particularly for children and young people;
- leadership on tobacco control activities, particularly in leading organisations, such as WSCC, in implementing exemplary policies;
- coordination and partnership working with all key stakeholders, locally and regionally;
- our knowledge and understanding of why smoking related hospital admissions in West Sussex are rising compared to the South East region.

1.9 Recommendations

This needs assessment examined the current profile of tobacco control in West Sussex and made recommendations for action to reduce the prevalence of tobacco use and protect non-smokers, thereby reducing health inequalities in the local population (below).

Recommendations - Training and support (including making every contact count (MECC))

Action to be taken by	Recommended action
Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sector organisations and others commissioned to provide public services – in conjunction with trading standard, environmental health and public health teams	Should provide training and information for staff, members of the public and businesses on tobacco control regulations including: • how to report infringements confidentially • penalties for sale and use of illicit tobacco • health harms of unregulated illicit tobacco products • harm to the economy of unpaid duties from illicit tobacco sales
Local authorities, clinical commissioning groups, NHS trusts and voluntary and community sectors.	Provide training and support to empower the workforce to maximise opportunistic approaches with their client groups aligned with the Make Every Contact Count approach; allowing them to feel confident to and raise the subject of tobacco use; even in challenging and complex scenarios.
Local authorities, clinical commissioning groups, NHS trusts and voluntary and community sectors.	In accordance with CLeaR principles; provide training to enable staff to deliver very brief advice (VBA) on stop smoking services, harms of second-hand smoke, and harm in different groups.

Recommendations - Peer support

Action to be taken by	Recommended action
Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sectors,	Co-design and co-commission evidence based peer-led interventions to prevent uptake of smoking by service users and potential service users, particularly adolescents.

schools and colleges	

Recommendations - Data collection and sharing

Action to be taken by	Recommended action
Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sector organisations and others commissioned to provide public services – in conjunction with trading standard, environmental health and public health teams	To maximise on current opportunities and identify new opportunities for: • data collection on tobacco control activity, for example illicit tobacco, second-hand smoke exposure • Ensure the formal evaluation of the range of tobacco control interventions is included in commissioning strategies
Trading standards and environmental health	Improve the collection and sharing of data/intelligence: • Particularly on visits to small businesses to inform and monitor tobacco control activity and feed into the national plan and data set. • To facilitate evaluation of interventions to prevent the sale and use of illicit tobacco. • On other tobacco products rather than smoking tobacco alone
Public health, trading standards and environmental health	Use local data to target activity in geographical areas as well as population groups e.g. using IMD data to target illicit tobacco supply, illegal tobacco sales and high smoking prevalence.

Recommendations - Policy and leadership

Action to be taken by	Recommended action
West Sussex County Council	Provide clear leadership (in line with CLeaR principles) and exemplar policy by reviewing current tobacco use policy to reflect best practice from other leading organisations e.g.: • Changing the title from 'Smoking policy' to 'Smokefree policy' • De-normalise smoking and protect staff from exposure to second-hand smoke by moving away from approved designated smoking areas which facilitate smoking to a

	blanket ban on smoking on all WSCC premises • Promote a range of services and information to support staff to give up smoking
West Sussex County Council, all District and Borough Councils in West Sussex, all Clinical Commissioning Groups (CCGs) in West Sussex	Provide clear leadership and commitment to tobacco control in West Sussex by: • Ensuring smokefree policies protect staff and the public from the harmful effects of smoking in all areas. • Acknowledging responsibilities under Article 5.3 of the WHO FCTC by signing the Local Government declaration and the NHS statement of support for tobacco control
Education commissioners, head teachers and boards of governors	Ensure that all schools have a clear available and accessible smokefree policy, which supports and facilitate healthy choices and encourages smokers to quit.
Local authorities and districts and borough councils, voluntary and community sector organisations	Take the opportunity created by this report to : • Review occupational health policies and risk assessments for staff who may be vulnerable to exposure to second-hand smoke during home visits • capitalise on the momentum from the public survey and consider smokefree policies for more public spaces

Tobacco control messages

Action to be taken by	Recommended action
All	Involving local communities and target groups in encouraging people to stop using tobacco and de-normalise all types of tobacco use in our society.
Public health, trading standards and environmental health	Ensure that messages to the public, professional and organisational groups and local businesses around tobacco control are not solely around smoking but a co-ordinated multi-agency approach to the supply, demand and use of all types of tobacco.
Public Health in local authorities, CCGs and NHS trusts	Increase awareness of the health harms of second-hand smoke – especially in children - through: • Stronger, clearer messages and materials for the workforce to support and facilitate conversations with the public and service users

	• Incorporate this message into patient checklists e.g.: health visitors at developmental checks; midwives on discharge;
Public Health in local authorities, CCGs and NHS trusts	Develop a clear social marketing strategy to address de-normalisation of tobacco use; including greater use of social media to both reach target groups and professionals; using proven social marketing techniques and frameworks such as EAST and implementing NICE recommendations on mass media communications
Public Health in local authorities	Provide clear guidance to professional and public on the use of e-cigarettes including: • Use of e-cigarettes as an approved harm reduction technique • The potential risk of continued nicotine addiction
Public Health in local authorities, NHS Trusts, CCGs, Healthwatch and other voluntary and community sector organisations, (including health and social workforce, pharmacies and GPs)	Ensure that all tobacco control activity are culturally appropriate and information is accessible by BAME groups for whom English is not their first language, by; • carrying forward recommendations from the BAME needs assessment (also found on the JSNA website) • raising awareness and engaging with smokers in culturally and linguistically appropriate ways, to reduce the impact of advertising from unregulated overseas TV channels. • using local data to find out the most commonly spoken languages in their area • providing campaign materials, signage, leaflets, and web based information – in a range of languages. • raising awareness of barriers to some therapies for certain religious groups e.g.: considering alternatives to NRT patches which contain alcohol for religions which prohibit alcohol.

Recommendations - Partnership working

Action to be taken by	Recommended action
All members of the West Sussex Smokefree Partnership and partner organisations	In line with CLeaR recommendations for West Sussex and the national tobacco control plan, increase strategic partnership working by: • increasing membership of and participation in the Smokefree West Sussex Partnership,

	to involve all key stakeholders and agencies, including improving attendance at meetings by key partner representatives • increasing engagement with local business leaders and the business community with the Smokefree West Sussex partnership • incorporating local partnership working with HMRC and other agencies in Trading Standards strategic plans. • Setting up arrangements to facilitate supra-local tobacco control activities and commissioning with regional partners
Commissioners of environmental health and trading standards services	Enhance tobacco control through improved partnership working in licensing areas through increased shared initiatives and visits.

Recommendations - Improving uptake of stop smoking services and products

Action to be taken by	**Recommended action**
Public Health commissioners, CCGs	In addition to the actions set out in the recent Specialist Stop Smoking Service Rapid Needs Analysis (see below) commissioners of tobacco control activity should: • Ensure that smoking cessation support services and interventions address the barriers to successful quit attempts, including; • time to attend appointments at multiple locations by providing a one-stop-shop tailored to the individual including digital media and virtual support • dispelling the myth about 'lack of will power' as a barrier by ensuring behavioural insights are incorporated in service design • ensuring a joined up and complementary approach with metal health services • being clear about what a person can expect from a stop smoking service • include a stronger, more visible and evidence based peer support element to smoking cessation services across all age groups in suitable environments – physical or digital

Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sector organisations and others commissioned to provide public services	Ensure there is high profile and clear guidance, clear and accessible referral and care pathways for people who wish to stop smoking.

Recommendations - Commissioning stop smoking services

Given the stop smoking services data presented in report, commissioners may wish to consider a range of options for this service:

- Whether there is need for a specialist service in its current form – given the efficacy of GPs to successfully treat people in target groups.
- Changing the emphasis of the SSSS providers from support for smokers in target groups to training and supporting other professionals to deliver these interventions to smokers across the population.
- Consider subsidising quit attempts
- Increase the sign up of pharmacies to take on smoking cessation work to support GPs.
- Increase use of nurse prescribers in stop smoking GP surgeries to support GPs.
- Placing specialist stop smoking advisors in Trusts, where there are high levels of target groups who would benefit from opportunist approaches and immediate referral/consultation.
- Engaging with the clinical commissioning groups to request a patient group directive and shared pathways to improve services and enable all frontline staff to make every contact count and in turn make savings.
- Engaging with maternity services and mental health services registered practitioners to agree pathways where midwives and Community Psychiatric Nurses are able to provide NRT or pharmacotherapy through patient group directions (PGD) mechanism to increase the success of opportunistic approaches in the pregnant population and those accessing mental health services.
- Using demand forecasting models to explore how this might enhance commissioning of these services.

2. Introduction

2.1 What we want to do

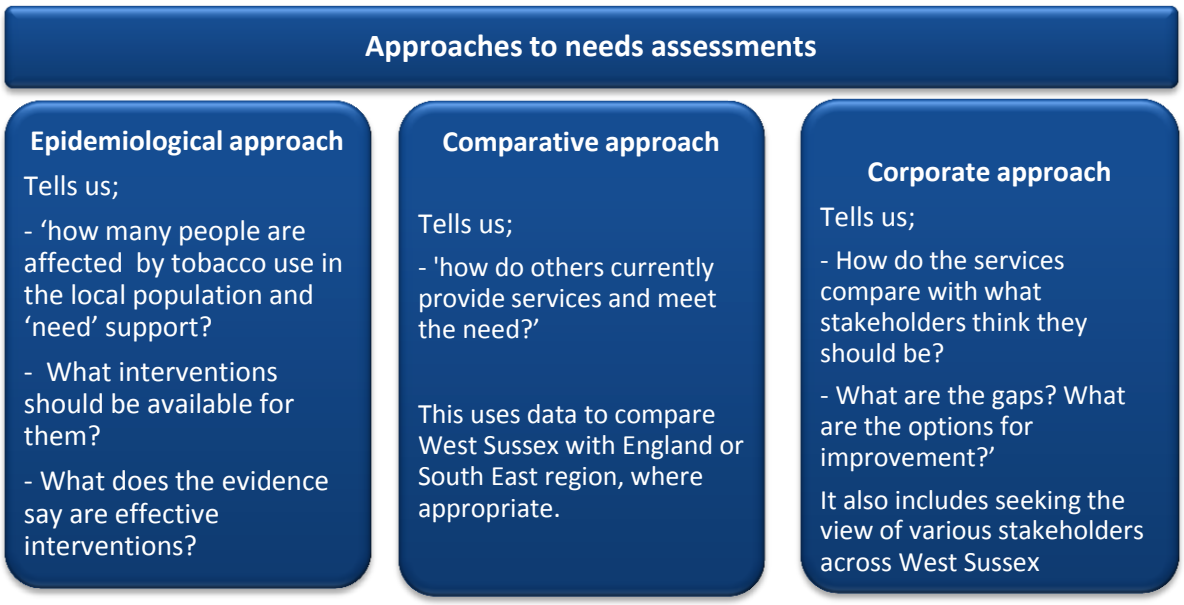
This needs assessment will inform and guide the commissioning of tobacco control activities in West Sussex and also help partners to negotiate and agree local priorities. In this tobacco control needs assessment (TCNA), we aim to find out:

- Why people use tobacco?
- The extent of tobacco use in West Sussex?
- The health, social, and economic cost of using tobacco in West Sussex
- What can be done to reduce tobacco use and protect people from secondhand smoke?
- The tobacco control activities currently in place in West Sussex
- The support available to help tobacco users stop
- The gaps and opportunities to improve tobacco control in West Sussex
- The future needs for health and social care for those who use tobacco
- How WSCC can implement strategies to become a role model in tobacco control?

2.2 Methods

So we can understand current and future tobacco control needs across West Sussex, this TCNA uses a combination of different approaches to assessing needs as shown in Figure 3.

Figure 3 - Approaches used to assess tobacco control needs in West Sussex



Local views were collected through an online survey with members of the public across West Sussex. Qualitative interviews with some Black Asian and Minority Ethnic (BAME) groups were also conducted by a commissioned community researcher to seek the views of some BAME groups in regards to tobacco use, exposure to tobacco and tobacco control activities. Surveys were conducted with professionals who come into contact with tobacco users and schools across West Sussex (stakeholder engagement reports are included in Appendix 1).

In addition, we carried out a literature review to identify current evidence and best practice. We also used a range of statistical and survey data relating to tobacco control and, where appropriate, comparing these with South East region and England. A desk top analysis of departmental/organisational reports, policies and strategies was also undertaken.

2.3 Report structure

The report structure is based on the Tobacco Control Plan for England 2011. The report first provides some background information about tobacco use, and current policies and guidance. It then goes on to describe tobacco, health and wellbeing in West Sussex. We use the internationally recognised and evidence based six key strands for tobacco control:

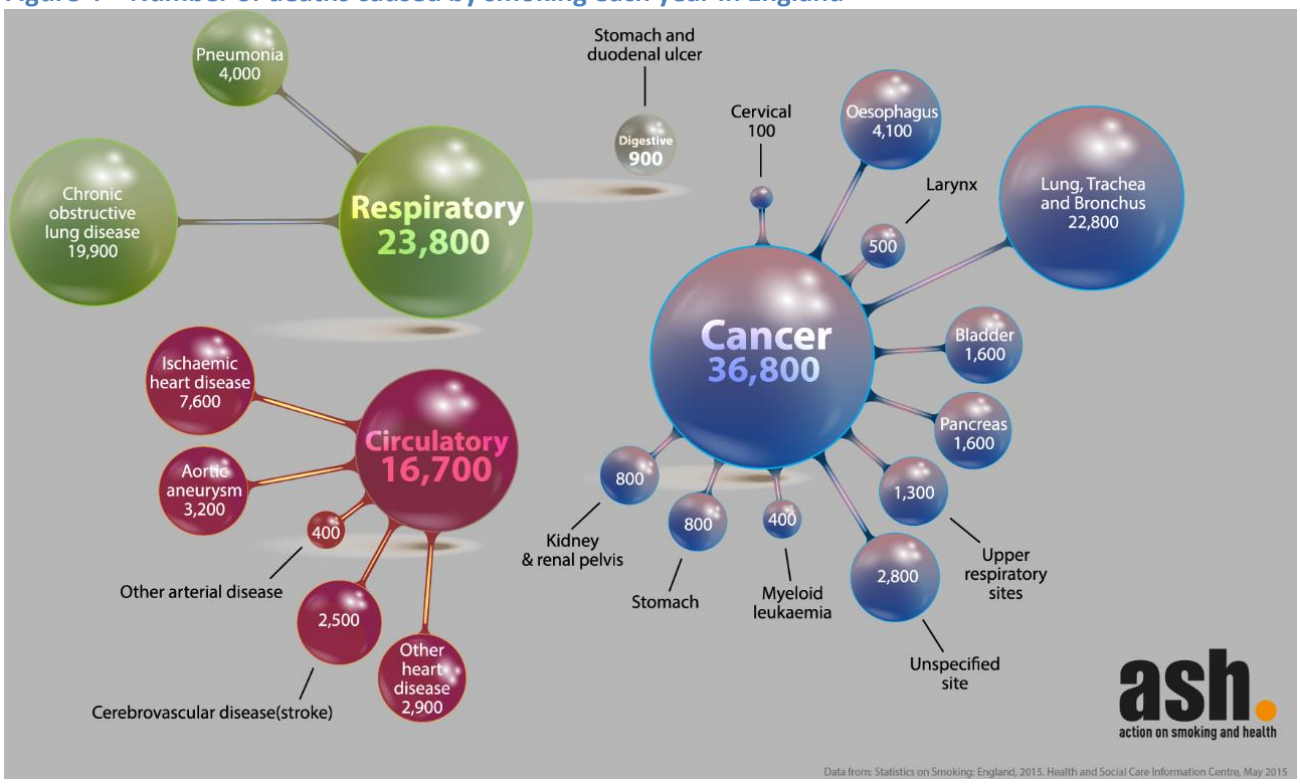
- stopping the promotion of tobacco;
- effective communication for tobacco control;
- helping tobacco users quit;
- making tobacco less affordable; and
- reducing exposure to second-hand smoke
- effective regulation of tobacco products

We used this as a framework for describing current West Sussex tobacco control activities against each strand, along with the current evidence base. Recommendations were made based on our findings.

3. Background information

Stopping tobacco use is very important because people are still dying. Tobacco use is a risk factor for six of the eight leading causes of death in the world (i.e. heart disease, stroke, lung infections, chronic obstructive pulmonary disease (COPD), diarrhoeal diseases, tuberculosis, and lung cancers). In the UK, most deaths and diseases from tobacco use are overwhelmingly the result of smoking cigarettes and other smoked tobacco products. Smoking is the single largest cause of health inequalities and remains a major preventable cause of ill health and premature death [1] (Figure 4)

Figure 4 – Number of deaths caused by smoking each year in England



Source Action on Smoking and Health (ASH) 2015

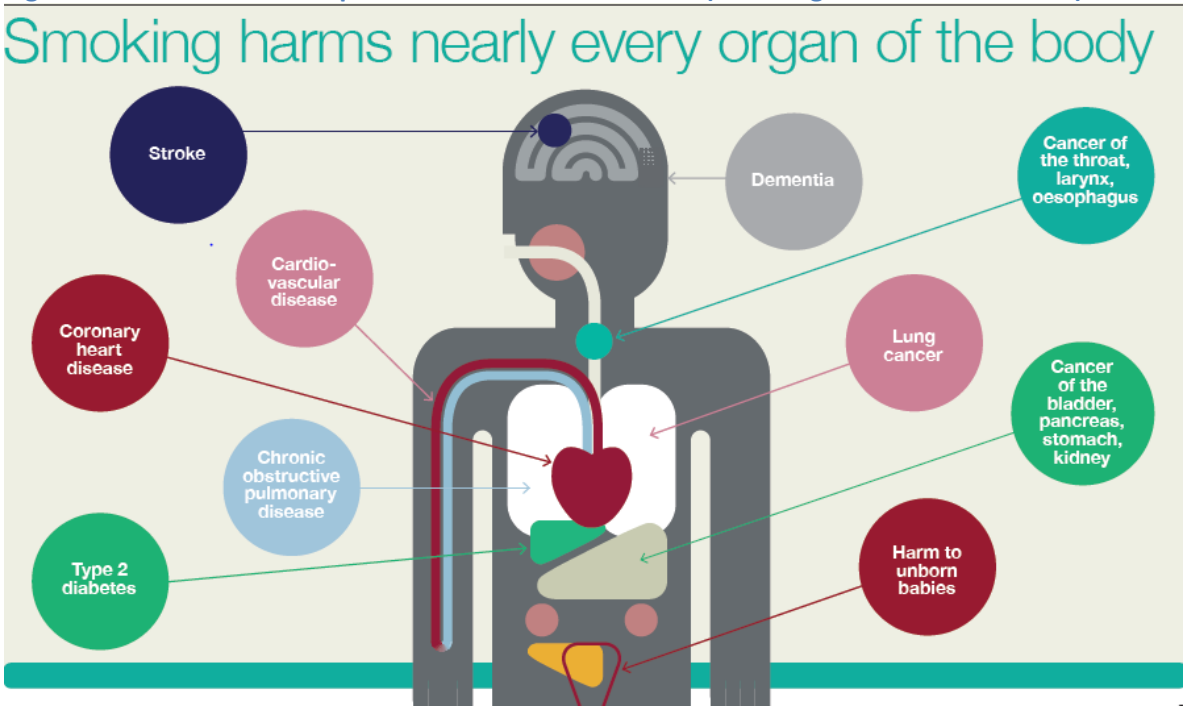
Whilst smokers have an increased risk to their own health, their smoking also impacts on non smokers through secondhand smoke (Figure 5). A telling statement often expressed by tobacco control advocates is that "*tobacco is the only legal consumer product which kills when used as intended by the manufacture*r"[i]. Tobacco smoke contains over 7,000 chemical compounds, including carbon monoxide, arsenic, cyanide and benzene. Many of these compounds are toxic, so it is no surprise that there are significant human, economic and social costs that result from smoking.

Approximately half of regular cigarette smokers will die from diseases related to their addiction. Every year around 100,000 smokers in the UK die from smoking related causes [2]. In addition,

[i]WHO http://www.who.int/features/2013/australia_tobacco_packaging/en/

smokers under the age of 40 have a five times greater risk of a heart attack than non-smokers. Secondhand smoke exposure has also been shown to cause lung cancers, heart disease, and negatively affects those with asthma, as well as having adverse effects in children and unborn babies. There are no safe levels of secondhand smoke exposure. The United States Environmental Protection Agency (EPA) classifies environmental tobacco smoke as a Class A (known human) carcinogen. This means that it is known to cause cancer and is classified alongside other cancer causing substances such as asbestos, arsenic, and radon gas [3].

Figure 5 - The health consequences linked to tobacco use (including second-hand smoke)



Source: PHE

Smoking costs the National Health Service (NHS) in England approximately £2bn a year [4]. This is the medical cost for treating diseases caused by smoking. It does not take into account the cost of social care and the wider cost to society. Although there has been a reduction in smoking related fires due to EU safety standards, smoking materials remain the main cause of fatal accidental fires in the home, accounting for 85 deaths and 673 casualties in Great Britain in 2013/14[4]. Some of these fires happened here in West Sussex.

Smoking is not only a health issue. Its impact is far reaching, across society. The Marmot review identified smoking as a significant contributor to the creation and exacerbation of health inequalities, widening the gap in life expectancy between the rich and poor [5]. Although there has been a general decline in smoking, there are large disparities in tobacco use across groups defined by race and ethnicity, socioeconomic status, and educational level [6]. It is essential to understand that tobacco use is a result of diverse and complex social, cultural, economic and political factors and, therefore requires a comprehensive approach. As the Chairman of the Scientific Committee on Tobacco and Health (UK) aptly puts it "*if we are serious about improving public health then tobacco control warrants priority attention from government. Resources devoted to this area should reap*

substantial benefits for the current generation of smokers and for generations to come"[7].Tobacco control requires strong political commitment as well as the participation of civil society and the local community. The best results are generated by adopting comprehensive, multifaceted, intervention strategies that encompass a variety of regulatory, enforcement, and policy approaches that are location-specific and include the collaboration of a wide range of stakeholders. Expenditure on tobacco control provides good value for money; reduced smoking results in a net annual benefit of £1.7bn [4].

3.1 Types of tobacco products

Different types of tobacco products are on sale. Their use and prevalence vary across regions and social groups. Since this needs assessment aims to focus on all tobacco products, we provide a brief overview of the different types of tobacco products available in the UK. The two main types of tobacco are smoked and smokeless.

3.1.1 Smoked tobacco products

This includes manufactured cigarettes, hand rolled tobacco (HRT or roll your own tobacco (RYO), cigars, pipes and waterpipes (also known as 'Shisha', 'hookah', 'hubble-bubble', 'narghile'). Although other types of tobacco are used across the country, manufactured cigarettes and HRT are the dominant form of smoked tobacco used in England and account for 96% of all tobacco sales worldwide [8]. All smoked tobacco products are subject to regulations on taxation, advertising, point of sale displays, labelling as well as smokefree laws.

Waterpipes; are used to burn charcoal and inhale tobacco, after its smoke has been passed through a water basin. They are often used to smoke tobacco and other substances. Waterpipe tobacco may be flavoured with fruits or sugar syrup and aromatic substances, and the sweetened flavoured waterpipe tobacco is commonly called *maasel [9]*. There are often misconceptions about waterpipes, as accessories are often sold with a claim that they reduce the harm of smoking [9]. However, there is no evidence to support such claims.

Cigars and pipes; cigars are made of tobacco leaves or parts of leaves rolled together and covered with a binder (a firm tobacco leaf which holds the filler together and gives the cigar its shape) and an outer wrapper made of natural or reconstituted tobacco [10]. Pipes are reusable smoking devices that contain a bowl in which tobacco is placed and lit. The smoke is drawn through the stem and inhaled.

3.1.2 Smokeless tobacco

Smokeless tobacco is used across the world in a range of forms either orally or nasally. Used orally, smokeless tobacco can be chewed, sucked, applied to the teeth or gums (e.g. topical toothpaste or powder), dissolved in the mouth, or gargled. Used nasally, smokeless tobacco can be inhaled as a mixture of a small quantity of very fine tobacco powder and other substances, called dry snuff. A range of smokeless tobacco products are often imported from South Asia (India, Pakistan, Bangladesh, and Sri Lanka) and used by communities of South Asian origin in the UK [11]. Tobacco for oral use, specifically tobacco products designed to be sucked or held in the mouth, is prohibited

in England under the Tobacco for Oral Use (Safety) Regulations 1992. However, these regulations do not include chewing tobacco or smoked tobacco.

Like smoked tobacco products, smokeless tobacco products such as snuff and chewing tobacco have been shown to cause cancer. They are also associated with a range of health problems, including [12];

- nicotine addiction;
- mouth and throat cancer;
- dental disease;
- cardiovascular disease;
- problems in pregnancy and following childbirth (including blood problems in the unborn baby, problems with the placenta which can affect the oxygen supply to the baby, stillbirth (where the baby dies in the womb), premature birth , and low birthweight due to growth problems); and
- late diagnosis of dental problems (because the smokeless tobacco product helps mask the pain).

3.1.3 Other nicotine delivery systems products

Whilst tobacco products are the key focus of this needs assessment, the role of nicotine products in smoking cessation and harm reduction warrants discussion. Although nicotine is the major chemical compound responsible for addiction in tobacco products (smoked and smokeless)[6], tobacco smoke inhalation from the burning of known carcinogenic substances is predominantly responsible for all the harm caused by smoking [13]. Tobacco products are by far the most harmful of any of other nicotine sources, such as e-cigarettes and therapeutic nicotine sources, i.e. nicotine gum, and patches. The risk of developing nicotine addiction depends on the dose of nicotine delivered and the way in which it is delivered. The potential for addiction increases with the dose delivery rate, the rate the body absorbs it, and the concentration of nicotine. Nicotine dependence is the main underlying driver of sustained tobacco use.

There has been an increase in the use of electronic nicotine delivery system (ENDS) products, largely marketed by tobacco companies and other manufacturers. However, these have also been identified as helpful in smoking cessation and harm reduction for tobacco users, particularly e-cigarettes. The common types are identified below.

The US Surgeon General report indicated that apart from the proven effectiveness of nicotine replacement therapy for smoking cessation, evidence on the long term use of nicotine exposure is still limited and further research is warranted [6]. The main ENDS are as follows;

3.1.3.1 E-cigarettes (Electronic Cigarettes)

These are also known as nicotine vaporisers or ENDS. In e-cigarettes, a battery-powered heating element heats a solution of nicotine and other products to produce a vapour, which delivers the nicotine to the user. Vapour is released into the air when the user breathes out. These are a contrast to the conventional cigarette as there is no combustion involved, and therefore no smoke.

The use of e-cigarettes is estimated to be around 95% less harmful than smoking. They are therefore, recommended as an option for smokers to reduce harm from smoking, particularly for those who have tried other methods of quitting without success. Public Health England (PHE) recommends that smokers who cannot or do not want to stop smoking can be encouraged to switch to e-cigarettes as a harm reduction strategy [14]. Similarly, the Royal College of Physicians recently (2016) recommended the use of e-cigarettes as a harm reduction method.

3.1.3.2 E-Shisha

The distinction between waterpipes and electronic devices known as “e-hookahs”, “e-shisha” or “hookah pens” is that these devices are types of ENDS. They can be flavoured so that the taste is similar to that of the flavoured waterpipe tobacco, but do not involve charcoal combustion. A sweetened liquid is electrically heated to create an aerosol that is then inhaled. Research is currently being done on the health effects of these devices [9].

4. National and local policy context

4.1 Global/National policies and regulations

Tobacco control is driven and guided by local, national and international policies and regulations aimed at reducing the use of tobacco products and protecting non-smokers. The following section explores the global, national and local policies and regulations in regards to tobacco control.

4.1.1 WHO Framework Convention on Tobacco Control (FCTC)

The WHO FCTC is the first global public health treaty which provides an internationally coordinated response to the tobacco epidemic. The WHO FCTC combines measures to reduce the demand and supply of tobacco products, as well as other key guidance. This includes a requirement that authorities act to protect public health policies from interference by commercial and other vested interests of the tobacco industry. The treaty's scope covers the full chain of tobacco product production, distribution and sale.

The Convention is made up of 38 articles which are divided into different sections (further details can be found in the WHO FCTC). The core statements about **reducing demand** for tobacco in the WHO FCTC are contained in articles 6–14:

- Price and tax measures to reduce the demand for tobacco, and
- Non-price measures to reduce the demand for tobacco, namely:
    - Protection from exposure to tobacco smoke;
    - Regulation of the contents of tobacco products;
    - Regulation of tobacco product disclosures;
    - Packaging and labelling of tobacco products;
    - Education, communication, training and public awareness;
    - Tobacco advertising, promotion and sponsorship; and,
    - Demand reduction measures concerning tobacco dependence and cessation.

The core statements about **reducing supply** in the WHO FCTC are contained in articles 15-17:

- Illicit trade in tobacco products;
- Sales to and by minors; and,
- Provision of support for economically viable alternative activities.

4.1.2 Healthy lives, Healthy People: Tobacco Control Plan for England

This national Tobacco Control Plan was launched in 2011 setting up the government's strategy for tackling tobacco in England and is in line with the WHO FCTC. At the time of this assessment, the Tobacco Control Plan is under review with a new one due later in 2016. The current plan includes clear goals to achieve by 2015:

- Reduce smoking prevalence among adults in England to 18.5% or less
- Reduce smoking prevalence among young people in England to 12% or less
- Reduce smoking during pregnancy in England to 11% or less

These indicators are included in the Public Health Outcomes Framework.

Through the plan, the Government outlines its support for comprehensive tobacco control in England focusing on the WHO's six internationally recognised and evidence-based strands:

- Stopping the promotion of tobacco;
- Making tobacco less affordable;
- Effective regulation of tobacco products;
- Helping tobacco users to quit;
- Reducing exposure to second-hand smoke; and
- Effective communications for tobacco control

4.1.3 Legislative changes

Comprehensive tobacco control requires a multifaceted approach that includes a strong regulatory framework to counter the tobacco industry, as well as educational, clinical, economic and social strategies. A number of legislative changes have been implemented to reduce the prevalence of smoking (more detail about national policy and legislation is available in the ASH Law Guide at www.ash.org.uk/information/law-guide);

- Ban on display of tobacco products in shops (2015)
- Standardised packaging of tobacco products regulations (2015)
- Tobacco advertising and promotion regulations (2011)
- Ban on smoking in cars with children/young people under 18 years of age (2015)
- Smokefree legislation (2007) (Smokefree policies for prisons currently in progress)
- Regulations on the proxy purchasing of tobacco and nicotine products (such as e-cigarettes) 2015
- Age of sale for nicotine products (including e-cigarettes) (2015)

In addition, from May 2016, new regulations under the revised EU Tobacco Products Directive will introduce new standards of quality and safety for unlicensed e-cigarette products. Licenced e-cigarettes, when available, will be regulated by the Medicines and Healthcare Products Regulatory Agency (MHRA).

4.2 West Sussex priorities

4.2.1 West Sussex Joint Health and Wellbeing strategy 2015-2018

This strategy sets out the key priorities for the West Sussex Health and Wellbeing Board (HWB) which all organisations across West Sussex should ultimately support and embed in planning and commissioning of services to ensure an explicit link between evidence of need and service planning. All three priorities are related to tobacco control activities (Table 1).

Table 1 - West Sussex Health and Wellbeing Priorities

Priority	Outcome	Links between HWB priorities and tobacco control
Early years (0-2 olds)	To optimise life opportunities for 0-2 year olds by supporting families	Reducing smoking in pregnancy and in households with young children will contribute towards reducing infant mortality, low birth weight, health inequalities and improving maternal and child health and other conditions associated with second-hand smoke exposure.
Wellbeing and Resilience	A comprehensive system to support wellbeing and resilience for the whole of the West Sussex population, that is locally based and better integrated with treatment services	Reducing the uptake and prevalence of smoking in adults and young people will contribute towards reducing health inequalities, mortality rates from cancer, CVD and respiratory diseases. It will also contribute towards boosting the local economy through reducing lost productive days due to tobacco related sickness absence; smoking related fires; littering and; increase the disposable income of the poorest people in West Sussex, as poorer smokers spend five times as much of their weekly household budget on smoking than richer smokers[ii]
Workforce	A vibrant and motivated workforce with the right training and the right values to support a high quality health and care system.	Reducing smoking in the workforce will help reduce the cost of lost productivity, which includes smoking breaks, sick days, and lost years of productivity due to premature deaths. It will also help protect non-smokers from second-hand smoke. As employers, protecting the workforce's health by developing exemplar policies such as smokefree workplace policies that de-normalise smoking and protect staff and patients from exposure to second-hand smoke whilst supporting staff to quit.

4.2.2 Future West Sussex (WSCC) priorities

West Sussex County Council has set its priorities as shown below (Table 2). Tobacco use has an impact on all the priorities and outcomes.

Table 2- Future West Sussex priorities

Priorities	Outcomes	Links between WSCC priorities and tobacco control
Giving children the best start in life	• Improved physical and emotional wellbeing • Families receive the support they need early • Children are safe and secure • Young people are ready for	• Reducing smoking in pregnancy and in homes with children will help reduce the adverse effects of second-hand smoke exposure on children, including low birth weight, asthma and negative developmental outcomes • Reducing parental smoking also reduces the initiation of children and young people (children whose

[ii] ASH (2015) cited by PHE (2015) Tobacco Control: Joint strategic needs assessment support pack

	school and ready for work	parents/siblings smoke are three times more likely to smoke than children living in non-smoking households)
Championing the West Sussex economy	• Growth of jobs • Growth of enterprise • Skills: ensuring local people of all ages have support to access work • Improving infrastructure that business and local communities need to support economic growth	• Reducing tobacco use will also contribute towards boosting the local economy through reducing lost productive days due to tobacco related sickness absence, smoking related fires, and littering • Reducing smoking in the local communities increases household incomes for the poor and benefits the local economy • Illicit tobacco use undermines the local economy and the measures to encourage smokers to quit.
Supporting independence in later life	• Increased financial security • Adults are safe and secure • Increased independence • Healthy life expectancy	• Tobacco use significantly reduces the healthy life expectancy and can reduce independence due to smoking related long term conditions. Therefore, reducing tobacco use will reduce health inequalities, and improve the healthy life expectancy.

4.2.3 West Sussex NHS Clinical Commissioning Groups' (CCG) priorities

The three West Sussex clinical commissioning groups (CCGs), NHS Coastal West Sussex CCG, NHS Crawley CCG and NHS Horsham and Mid Sussex CCG have indicated that tackling lifestyle factors, including smoking, is a key priority in their commissioning plans (Table 3 and Table 4). Their commissioning strategies set out their commitment to reduce health inequalities and support the local population in making healthy lifestyle decisions, to address these lifestyle risk factors, including smoking.

4.2.3.1 NHS Coastal West Sussex CCG

Table 3 - Coastal CCG commissioning priorities

Priorities	Links between CCG priorities and tobacco control
Urgent and Proactive care	Smoking related illnesses impact on urgent and proactive care, for example, smokers who are asthmatic are more likely to need emergency care than never smokers, therefore the prevention and cessation of smoking would impact on urgent care[15]
Mental health and learning disabilities	People with mental illness have the highest prevalence of smoking. Consequently this result in higher mortality rates for those with mental illness compared to the general public. Reducing smoking in these groups will improve their health outcomes and mortality rates
Planned care	Reducing tobacco use will significantly reduce smoking attributable hospital admissions and helps people stay well and reduce the risk of needing hospital care
Children and young people	Preventing the smoking initiation and protection from second-hand smoke

	exposure for children and young people are some of the most effective ways to reduce smoking prevalence; improve the health of the population; and give children a best start in life.
Medicines management	Provision of recommended, evidence based pharmacotherapy to help smokers quit is another effective way to reduce smoking prevalence, and reduce health inequalities.

4.2.3.2 NHS Crawley CCG and NHS Horsham and Mid Sussex CCG

Similarly, NHS Crawley CCG and Horsham and Mid Sussex CCG priorities are linked to tobacco control activities. Crawley CCG and Horsham and Mid Sussex share similar priorities, however, some priorities differ (were indicated)[iii];

Table 4 - Crawley CCG and Horsham and Mid Sussex CCG priorities

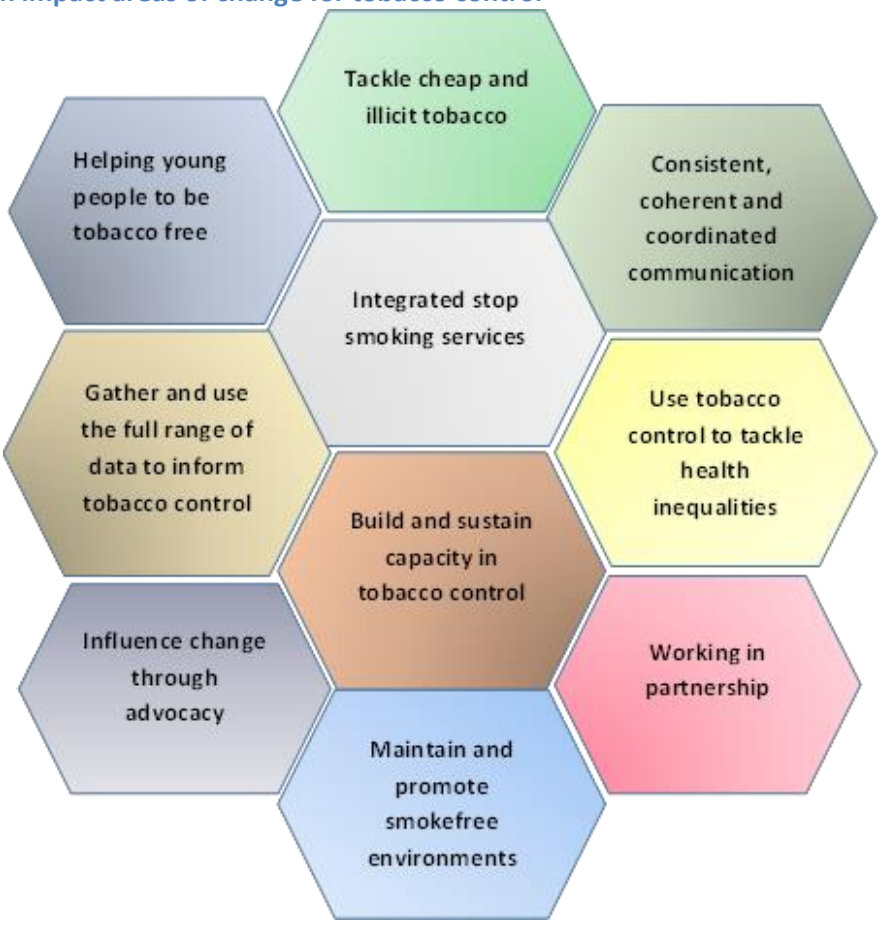
Priority activities	Links between CCG priorities and tobacco control
• **Developing stroke services – prevention, acute care, recovery and rehabilitation** • **Improving cancer care – prevention, awareness, early detection and treatment, holistic care** • **Reviewing and enhancing diabetes care (*Crawley CCG*)**	Smoking is a key risk factor for stroke, cancer and diabetes and therefore preventing the initiation and helping smokers to quit will contribute towards reduce smoking attributable illnesses such as cancer and stroke
• **Improving primary and community care, including long term conditions – primary care access/capacity -**	Smoking cessation interventions included as part of an individual's treatment for their respiratory, cardiovascular, mental health or any other health condition in primary or secondary care would strongly impact on disease progression, clinical outcomes and health care utilisation.
• **Focus on high cost low volume complex patients (*Crawley CCG*)**	Individuals exposed to risk factors such as smoking/tobacco use are likely to face complex physical, psychological and social problems that require complex care, therefore, primary prevention is essential to reduce tobacco use
• **Developing and implementing a social prescribing model (*Crawley CCG*)**	Social prescribing can be used to support health improvement and reduce health inequalities, and this includes activities to support quitting smoking
• **Urgent and emergency care, including out of hours and care for frail older people**	Smoking related illnesses impact on urgent and proactive care, for example, smokers who are asthmatic are more likely to need emergency care than never smokers, therefore the prevention and cessation of smoking would impact on urgent care[15]

[iii] Crawley CCG and Horsham and Mid Sussex CCG 2016/17 operating plan. Final version

4.2.4 Smokefree West Sussex Partnership

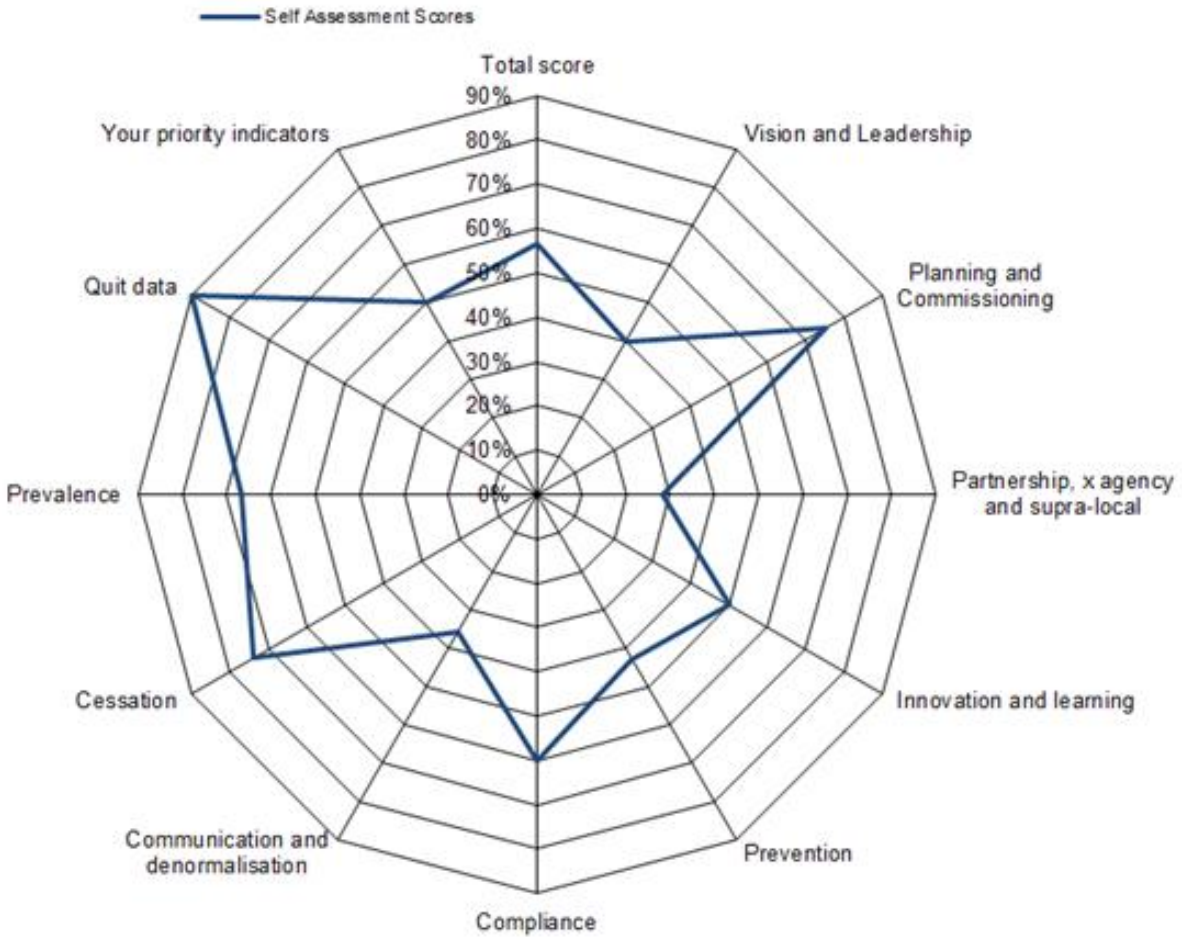
The Smokefree West Sussex Partnership (SWSP) is a non-statutory multi-agency alliance that aims to develop a coordinated strategic approach to reducing the harms caused by smoking in West Sussex. The SWSP works collaboratively to progress the objectives outlined in the Smokefree West Sussex Operational Plan (2014-2017). The plan was established using national guidance outlined in the Tobacco Control Plan for England 2011, and is aligned with the ten high impact changes developed by the Department of Health (Figure 6);

Figure 6 - Ten High impact areas of change for tobacco control



CLeaR is an evidence based improvement model which helps local government and its partners to develop local action to reduce smoking prevalence and the use of tobacco. The model comprises a self-assessment questionnaire aimed at evaluating the effectiveness of local action addressing harm from tobacco. The chart below (Figure 7) shows West Sussex's CLeaR self-assessment scoring, as a percentage of available marks in each section.

Figure 7 - West Sussex CLeaR self-assessment profile



The challenges highlighted by the self-assessment are;

- A lack of strong leadership and vision for comprehensive action on tobacco control
- Despite some evidence of partnership working through the SWSP, national and supranational partnership working is weak and is an area that needs more work
- Tobacco control activities in regards to communication and de-normalisation of tobacco use are lacking, with little evidence of engaging with local communities

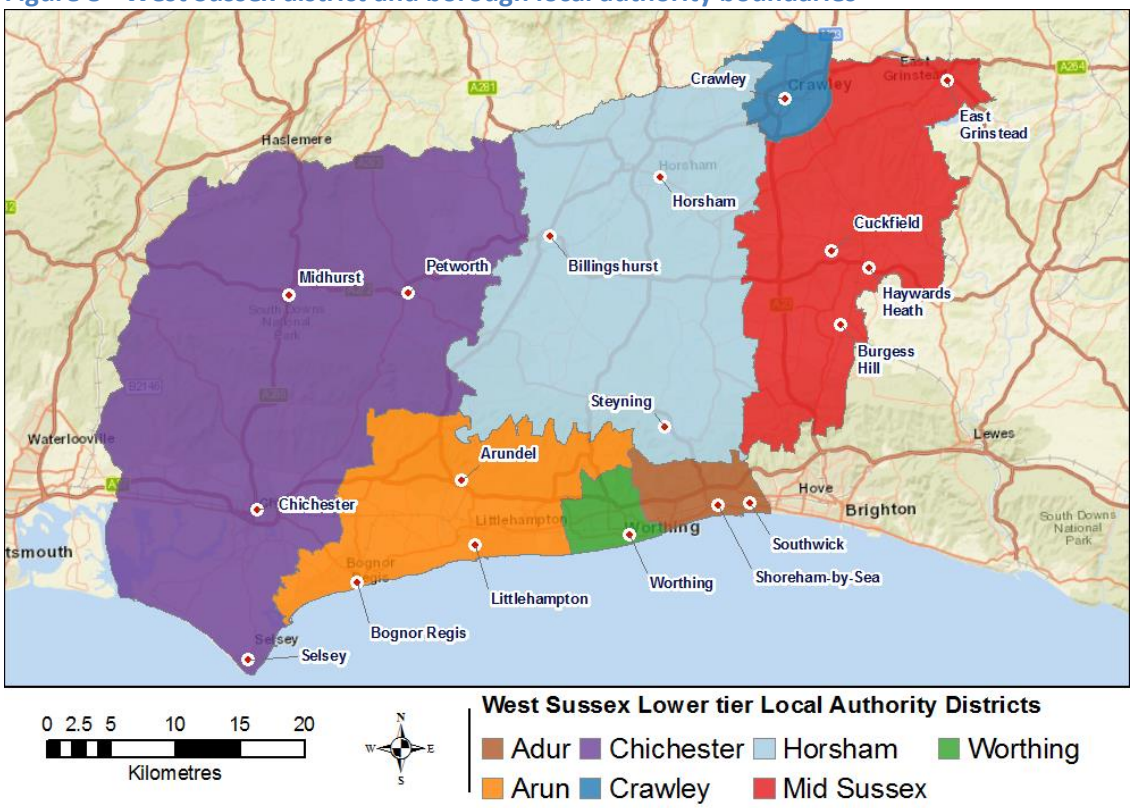
5. West Sussex Demographic context

5.1 About West Sussex

West Sussex covers a large geographical area (769 square miles) and consists of areas which are very rural and contains hundreds of small villages and hamlets particularly in the districts of Chichester, Horsham and Mid Sussex. There are also many market towns across the area including Midhurst, Billingshurst, Storrington, Henfield and Hurstpierpoint. The main towns include Chichester, Horsham, Haywards Heath, Burgess Hill, Crawley, East Grinstead as well as Worthing, Bognor and Littlehampton along the coastal strip. Rural West Sussex covers an area of 165,060 hectares or 83% of the County. It includes the South Downs National Park, which covers around 40% of the County[iv]. The county is bordered by East Sussex to the east, Hampshire to the west and Surrey to the north.

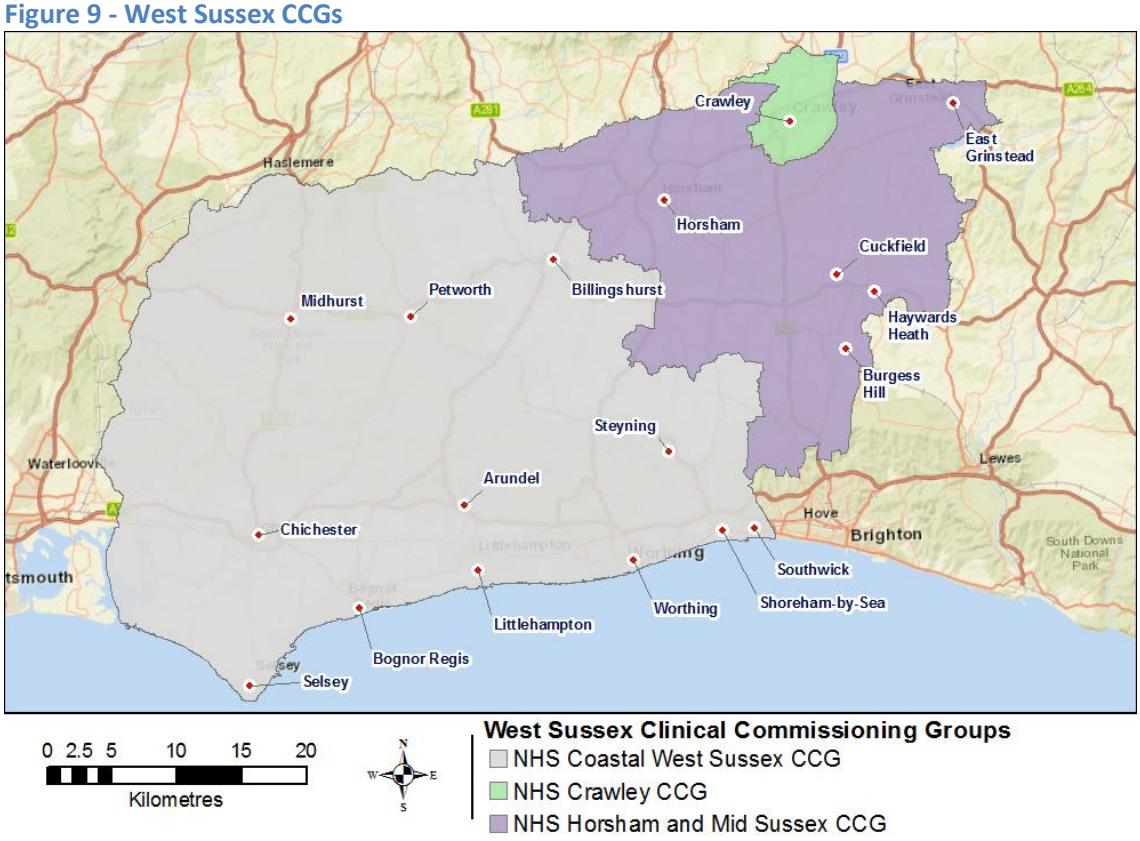
West Sussex consists of seven districts and boroughs (Adur, Arun, Chichester, Horsham, Mid Sussex, Crawley and Worthing) (Figure 8). These are contained within three Clinical Commissioning Groups (CCGs): Coastal West Sussex, Horsham and Mid Sussex and Crawley NHS CCGs (Figure 9).

Figure 8 - West Sussex district and borough local authority boundaries



[iv] WSCC West Sussex Local Economic Assessment. Spatial Area Factsheets - Rural West Sussex.

Figure 9 - West Sussex CCGs

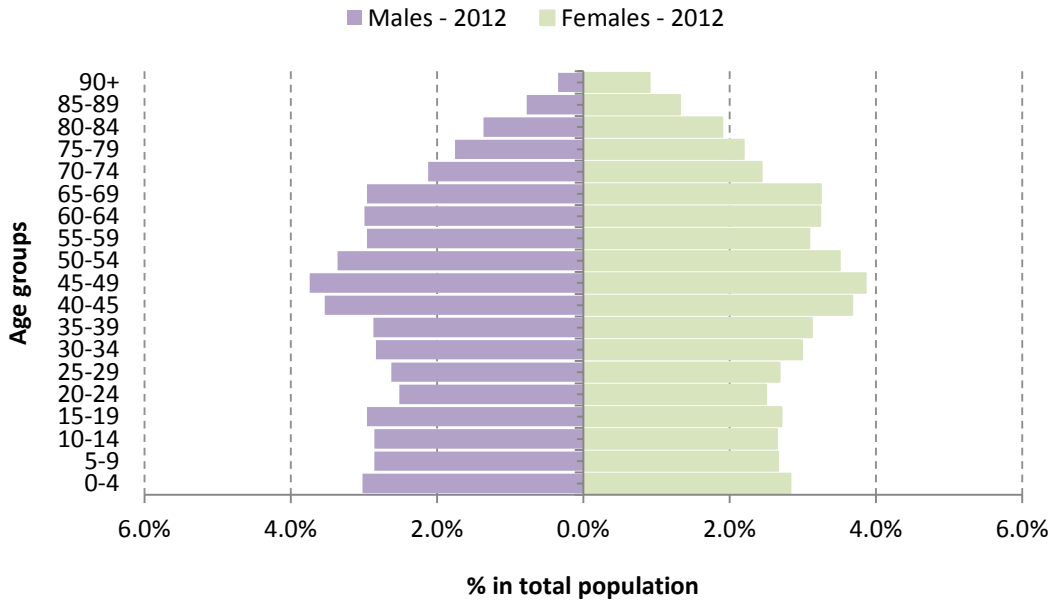


5.2 Population profile, deprivation, employment, ethnicity

5.2.1 Resident Population

West Sussex has a resident population of approximately 828,400 people (Figure 10). Of the local authorities, Arun has the largest population (approximately 154,400 people) and Adur has the smallest population (approximately 63,200 people).

Figure 10 - West Sussex population



Source: ONS – Mid-year population estimates, 2014 (released Jun-2015)

The West Sussex population is projected to increase from 815,000 (2012) to 881,000 (2022) and 971,000 (2037). The structure of the population continues to age, with larger increases projected in older age groups (85+ and 90+ years) and decreases projected in working age adults (20-54 years) and young children (<5 years).

5.2.2 Ethnicity

West Sussex is less ethnically diverse compared to England (11.2% BAME in West Sussex compared to 20% in England[v]). The most numerous ethnic minority groups in West Sussex fall under the census category "White: *Other White*" (31,900 residents in 2011; 4% of total population). This broad category can include people from the EU and wider European continent or Russia, North and South America, Australia/New Zealand and any other region of the world, providing their genealogy is of typically white European ancestry. Simply, the category describes all those of a traditional European ancestry who are not British, Irish or Gypsy/traveller and in this, much detail can be lost.

The next highest groups are Asian/Asian British: Indian, Pakistani and Bangladeshi (9,660, 5,240 and 2,350 residents respectively). In Britain, the "Asian community" is commonly intended to include residents whose ancestry originates from South Asia, and as such does not typically include those from East or South East Asia, Northern/Central Asia, or the Middle East. Full breakdowns are included in Table 5.

Table 5 - Ethnic background of West Sussex population

2011 Census Data	Numbers *(Figures rounded so may not sum)*			Percentage		
	West Sussex	**SOUTH EAST**	**ENG**	**West Sussex**	**SOUTH EAST**	**ENG**
	806,890	8,634,800	53,012,500			
White: **English/Welsh/Scottish/Northern Irish/British**	717,550	7,359,000	42,279,200	88.9%	85.2%	79.8%
White: **Irish**	5,980	73,600	517,000	0.7%	0.9%	1.0%
White: **Gypsy or Irish Traveller**	1,070	14,500	54,900	0.1%	0.2%	0.1%
White: **Other White**	31,900	380,700	2,430,000	4.0%	4.4%	4.6%
Mixed/multiple ethnic group: **White and Black Caribbean**	2,890	46,000	415,600	0.4%	0.5%	0.8%
Mixed/multiple ethnic group: **White and Black African**	2,060	22,800	161,600	0.3%	0.3%	0.3%
Mixed/multiple ethnic group: **White and Asian**	4,270	58,800	332,700	0.5%	0.7%	0.6%
Mixed/multiple ethnic group: **Other Mixed**	2,940	40,200	283,000	0.4%	0.5%	0.5%
Asian/Asian British: **Indian**	9,660	152,100	1,395,700	1.2%	1.8%	2.6%
Asian/Asian British: **Pakistani**	5,240	99,200	1,112,300	0.6%	1.1%	2.1%
Asian/Asian British: **Bangladeshi**	2,350	28,000	436,500	0.3%	0.3%	0.8%
Asian/Asian British: **Chinese**	2,960	53,100	379,500	0.4%	0.6%	0.7%
Asian/Asian British: **Other Asian**	8,130	119,700	819,400	1.0%	1.4%	1.5%

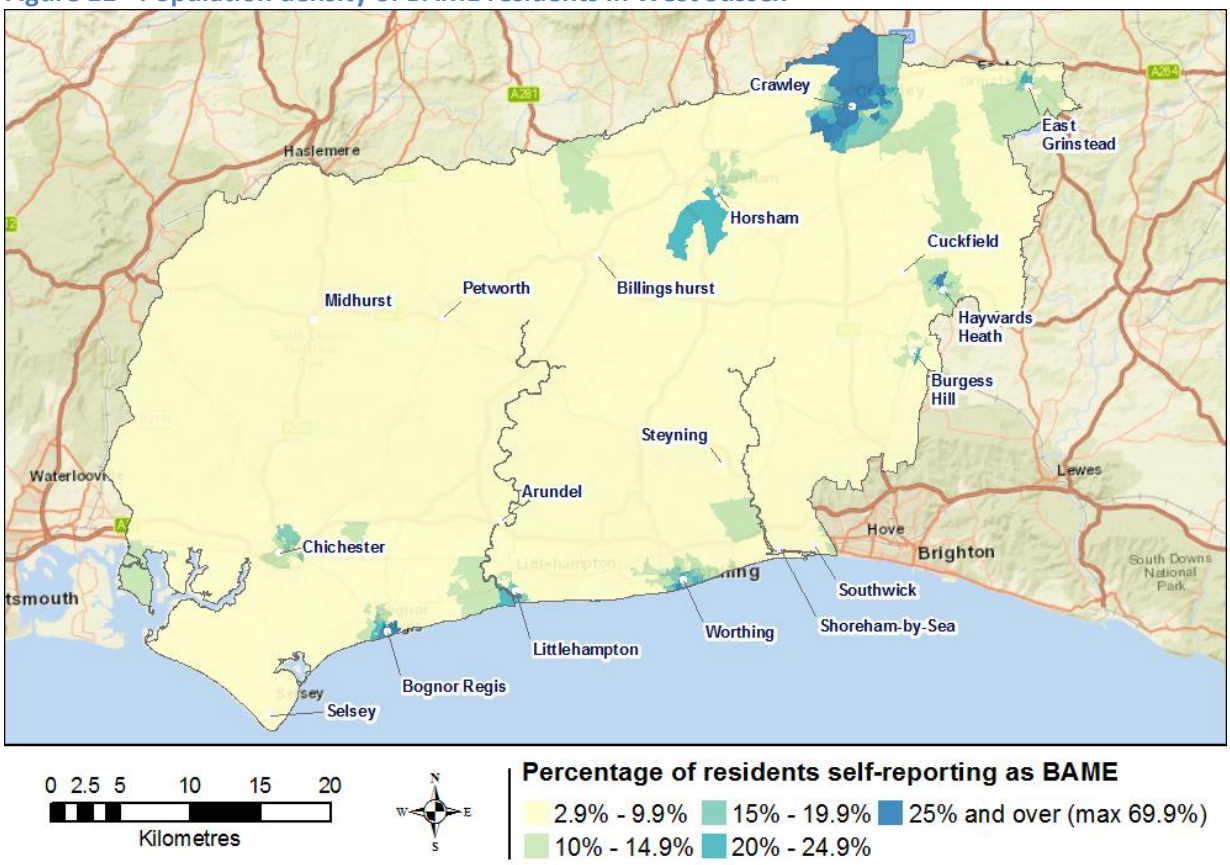
[v] In this assessment, BAME refers to those people who self-identified as other than White British/English/Scottish/Welsh within the UK Census

Black/African/Caribbean/Black British: **African**	4,570	87,300	977,700	0.6%	1.0%	1.8%
Black/African/Caribbean/Black British: **Caribbean**	1,340	34,200	591,000	0.2%	0.4%	1.1%
Black/African/Caribbean/Black British: **Other Black**	1,240	14,400	277,900	0.2%	0.2%	0.5%
Other ethnic group: **Arab**	1,080	19,400	221,000	0.1%	0.2%	0.4%
Other ethnic group: **Any other ethnic group**	1,680	31,700	327,400	0.2%	0.4%	0.6%

Source: ONS Census 2011

Using geographical analysis, we know that in 2011 resident Black Asian Minority Ethnic (BAME) populations are predominantly centred within the Crawley, Worthing and urban Arun areas (Figure 11).

Figure 11 - Population density of BAME residents in West Sussex



Source: ONS Census 2011

*Note – When using Lower Super Output Areas, large geographical boundaries (in rural areas) will contain a similar number of residents to very small geographical boundaries (in urban areas)

5.2.3 Deprivation

Given smoking is strongly associated with deprivation, it is important to highlight levels of deprivation in West Sussex. There are two main sources of information relating to the overall level of deprivation experienced by people within specific areas or neighbourhoods: Department for Communities and Local Government (DCLG) rankings (Indices of Deprivation 2015) and data collated from the decennial census (2011 census).

5.2.3.1 Index of Deprivation 2015 (ID2015)

The Index of Deprivation 2015 (ID2015) is the most commonly reported assessment of local area deprivation.

- According to the ID2015, West Sussex is an affluent county, relative to the England average. In 2015, West Sussex was the 21st least deprived county in England, out of 152[vi]. However, county level data mask considerable differences within small areas, and there are some very deprived neighbourhoods.
- The most deprived lower-tier local authority in West Sussex is Adur (ranked 159th least deprived of the 326 lower-tier local authorities in England)[vii]. The least deprived is Mid Sussex (ranked 321st).
- In relation to neighbourhood level deprivation, West Sussex has four small areas (all within Arun) that are amongst the 10% most deprived areas in England. These four small areas fall within the River, Courtwick with Toddington and Bersted wards in Arun[viii].
- Amongst the CCGs in West Sussex, NHS Crawley CCG was the most deprived (134th of 209 CCGs in England), and NHS Horsham and Mid Sussex CCG was the least deprived (205th). NHS Coastal West Sussex CCG was ranked 160th.

5.2.3.2 2011 Census – Indices of Deprivation

The 2011 census collected a wide variety of information that can identify the characteristics common to deprived households. The census examined four dimensions of deprivation:

- Employment *(deprivation identified where any member of a household not a full-time student is either unemployed or long-term sick).*
- Education *(deprivation identified where no person in the household has at least level 2 education, and no person aged 16-18 is a full-time student)*
- Health and disability *(deprivation identified where any person in the household has general health 'bad or very bad' or has a long term health problem).*
- Household overcrowding *(deprivation identified when the household accommodation is either overcrowded, with an occupancy rating -1 or less, or is in a shared dwelling, or has no central heating.)*

Information is provided where households have none of the above, and where households "score" on one, two, three, or all four dimensions of deprivation.

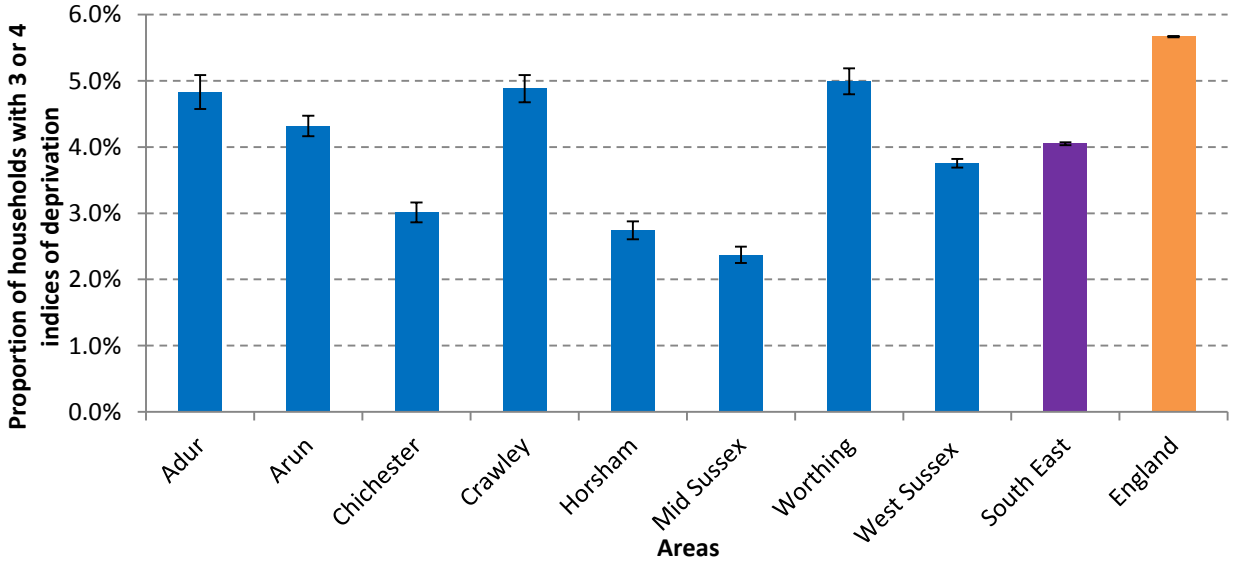
[vi] Rank of average score was used. The average score is a population weighted average of the combined scores for the LSOAs in a larger area. These scores are then ranked (1 most deprived). This gives a measure of the whole are covering both deprived and non-deprived areas. The main difference from the average rank measure is that more deprived LSOAs tend to have more "extreme" scores than ranks. So highly deprived areas will not average out to the same extent as using ranks (highly polarised areas will tend to score higher on average score than average rank measure).

[vii] A rank of 1 = most deprived

[viii] The Courtwick and Toddington and River ward boundaries have changed recently. The ward Ham has now been merged into these two wards.

Nearly 13,000 households in West Sussex were deprived in three or four dimensions in the 2011 census. This is approximately 3.8% of all households in the county and is significantly lower than England (5.7%) and the South East (4.0% - Figure 12). Worthing has the highest proportion of households with three or four indices of deprivation (5.0%), and Mid Sussex has the lowest proportion (2.4%), although all local authorities in West Sussex have significantly fewer deprived households (on three or four domains) than in England.

Figure 12 – Proportion of households with 3 or 4 measures of deprivation in West Sussex, the South East and England (2011 Census)



Source: NOMIS (2011 Census – Households by Deprivation Dimensions)

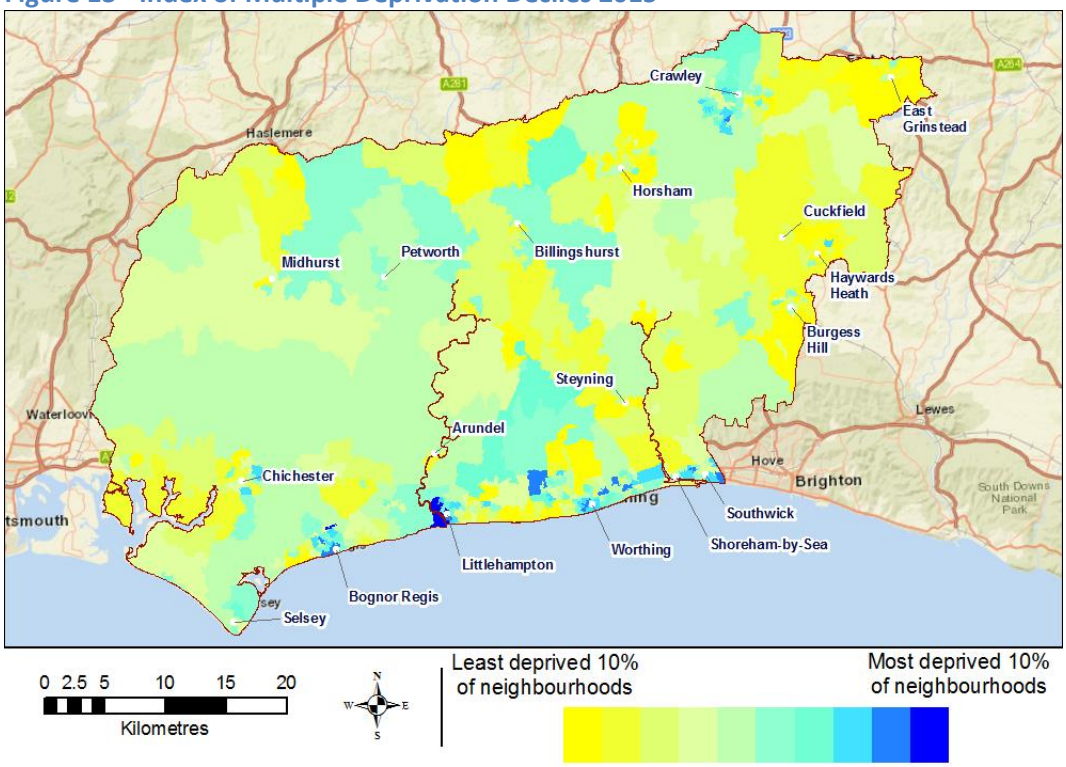
Table 6 reveals the ten LSOAs with the highest proportion of households with three or four measures of deprivation. These areas represent the most deprived locations in the county.

Table 6- Ten most deprived LSOAs in West Sussex (with the greatest proportion of households with 3 or 4 measures of deprivation) – 2011 Census

	LSOA	Ward	District	Proportion of households that have 3 or 4 measures of deprivation
1	E01031404	Bersted	Arun	17.3%
2	E01031427	River/Courtwick and Toddington	Arun	14.1%
3	E01031819	Northbrook	Worthing	13.3%
4	E01031456	River	Arun	13.0%
5	E01031371	Southlands	Adur	12.1%
6	E01031779	Broadwater	Worthing	11.9%
7	E01031808	Heene	Worthing	11.8%
8	E01031432	Hotham	Arun	11.6%
9	E01031436	Marine	Arun	10.8%
10	E01031358	Mash Barn	Adur	10.7%

Source: 2011 Census – Households by deprivation dimensions

Figure 13 - Index of Multiple Deprivation Deciles 2015



The two maps below show LSOAs in West Sussex that have households with at least one measure of deprivation (Figure 14), or three or four measures of deprivation (Figure 15).

Figure 14 - The proportion of households that have 1 or more measure of deprivation

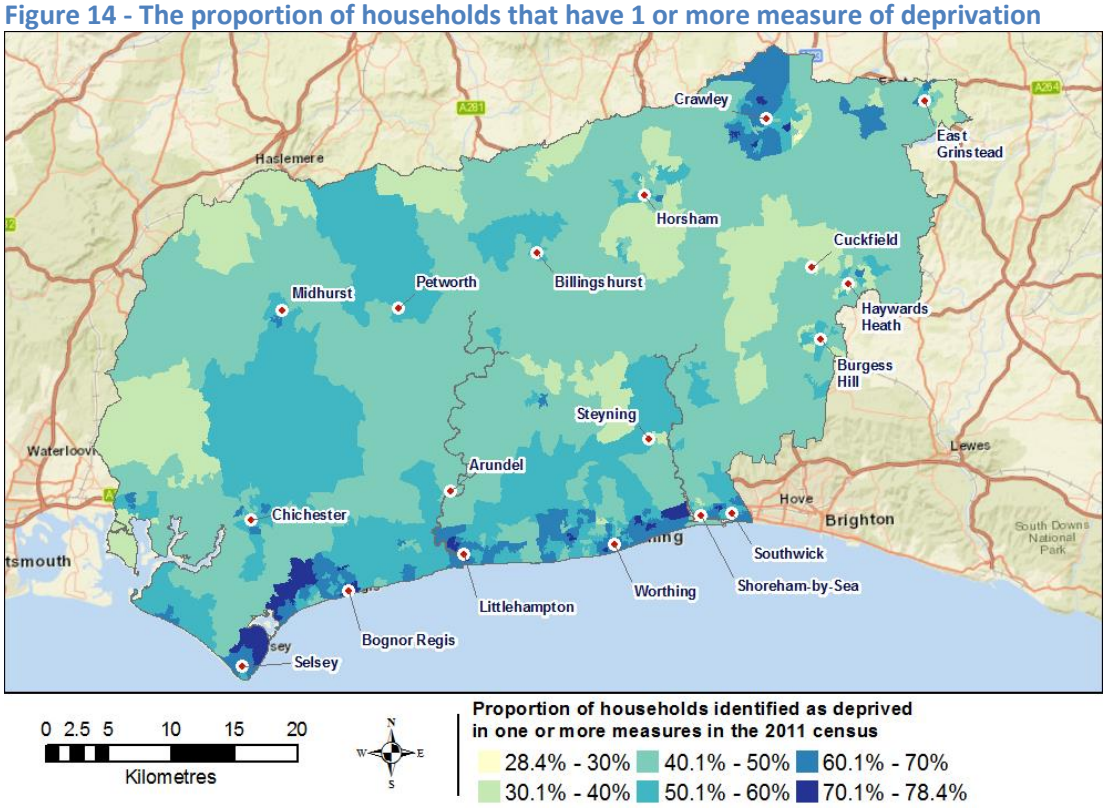
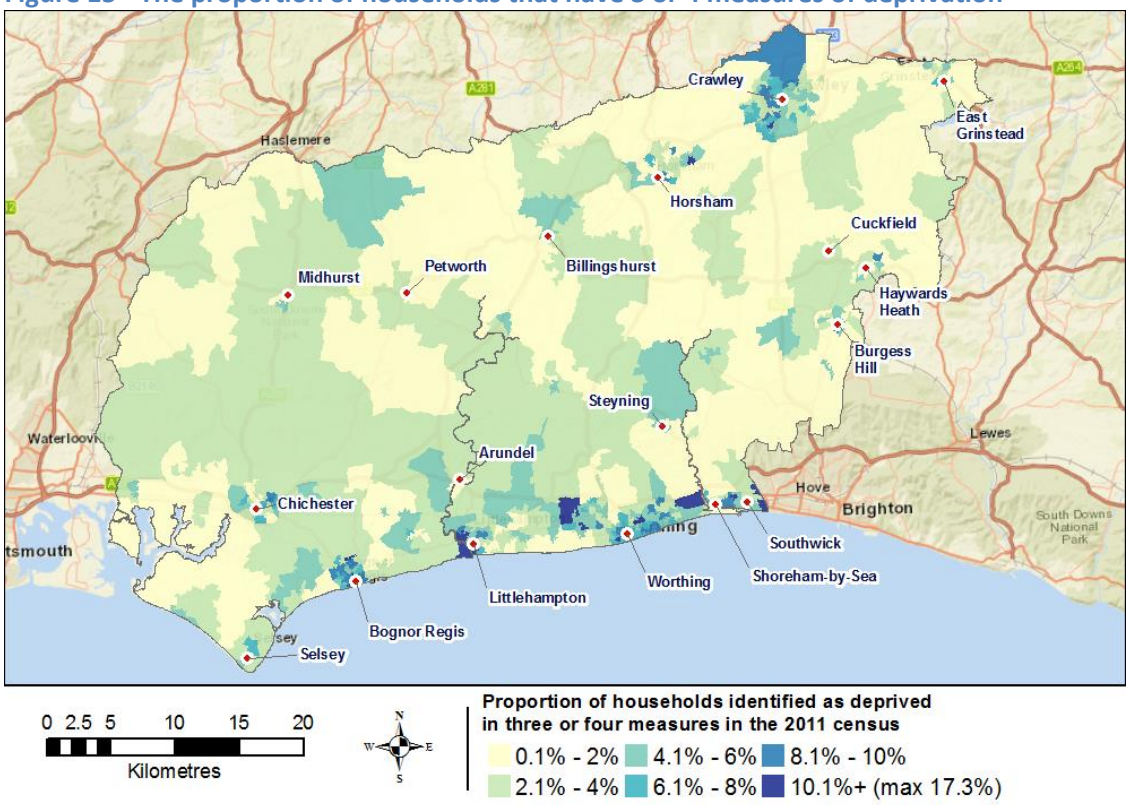


Figure 15 - The proportion of households that have 3 or 4 measures of deprivation



6. Tobacco, health and wellbeing in West Sussex

Although there has been a significant reduction in the number of people who smoke and a reduction in exposure to second-hand smoke across the country, tobacco use remains a significant and complex public health challenge [1]. Despite the preventable nature of this issue, tobacco use continues to lead to devastating disease and disability and harms nearly every organ of the body. Alone, it remains the leading cause of many different types of cancers, heart disease, stroke, lung disease, diabetes and chronic obstructive pulmonary disease (COPD). It also increases the risks of eye conditions, problems with the immune system, and reproductive, foetal and developmental conditions of childhood. Smokeless tobacco products also have harmful effects on health which include cancers and many oral diseases. In addition, smoking also has significant negative impact on health for non-smokers due to second-hand smoke exposure. In short, large numbers of people are dying, from a completely preventable cause.

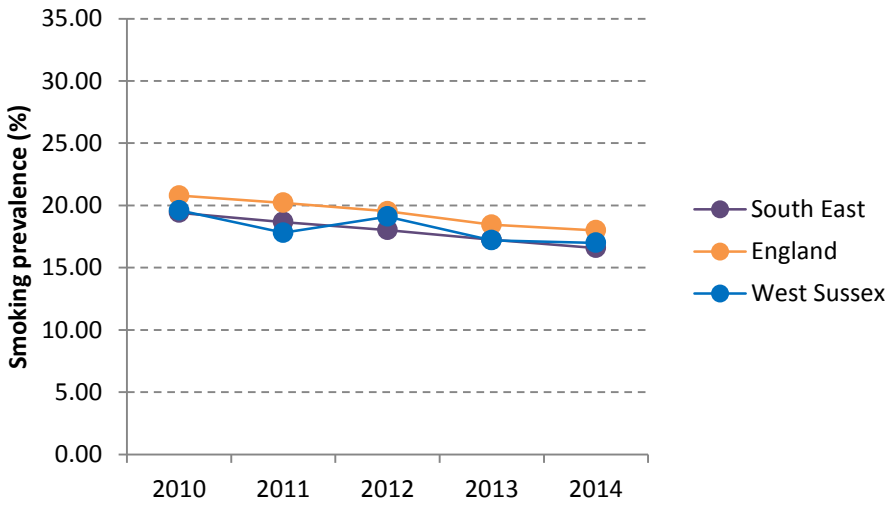
In order to ensure that we put tobacco control into context as part of wider local public health and wellbeing agendas, this chapter examines the prevalence of smoking in the local population. It reviews smoking prevalence in groups that are considered to be high risk for tobacco use (i.e. pregnant women, young people, mental health service users, Black Asian Minority Ethnic (BAME) groups and those of low socioeconomic status (SES). The chapter further describes the burden of disease attributable to tobacco use, including social and economic costs.

6.1 Smoking prevalence in West Sussex

6.1.1 Adult smoking prevalence

Over the five year period, from 2010 to 2014, the estimated smoking prevalence in West Sussex dropped 2.63% percentage points to the current prevalence of 17.0%. This does not represent a significant change. West Sussex prevalence has followed both national and regional trends (Figure 16).

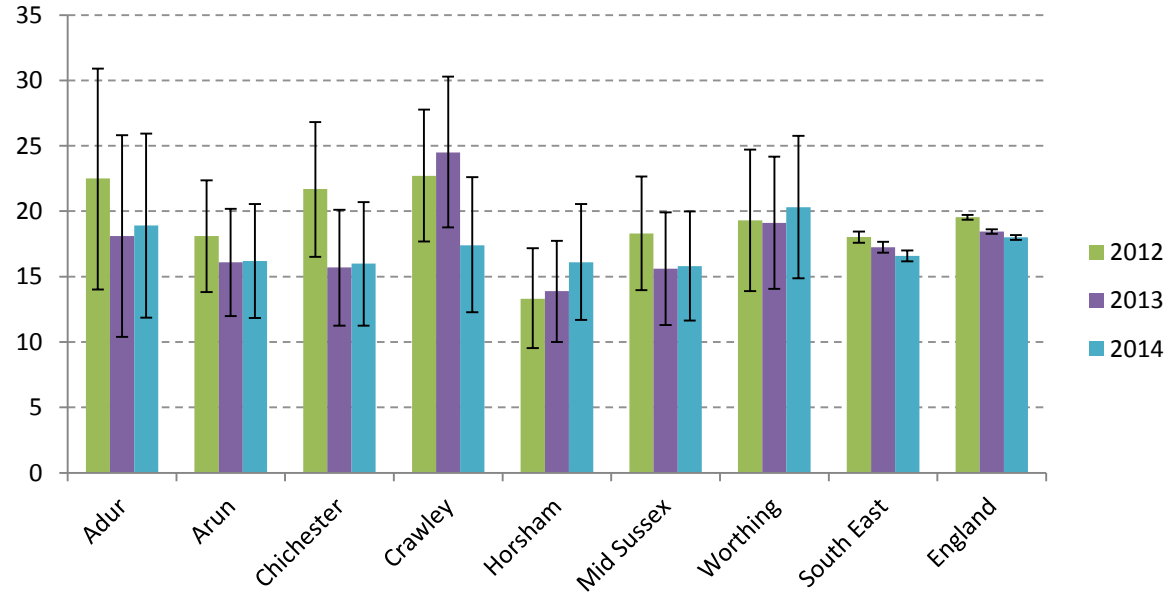
Figure 16 - Estimated smoking prevalence (18+)



Source: IHS

Locally, smoking prevalence in adults varies greatly throughout the districts and boroughs within the county (Figure 17). Over the last three years Crawley has on average had the highest smoking prevalence at 21.5%, though more recent estimates indicate that Worthing now has the highest smoking prevalence at 20.3%. Nationally, smoking prevalence is concentrated in certain groups and areas, therefore these high prevalence estimates could be due to the high proportion of BAME communities, and routine and manual workers in Crawley and relative deprivation in Worthing.

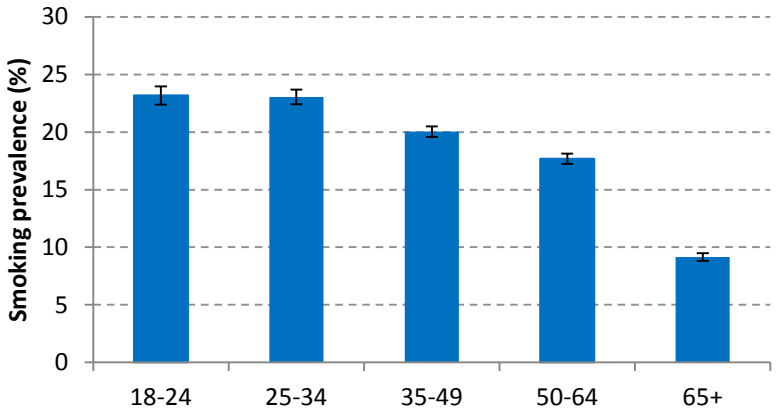
Figure 17 - Smoking prevalence by district (18+)



Source: IHS

Over the past few years, the integrated household survey (IHS) has highlighted the differences in the smoking profile of England by age, sex, and other demographics. These are national level prevalence estimates but we can assume these characteristics are similar at local and regional levels.

Figure 18 - Smoking prevalence in England by Age (2014)



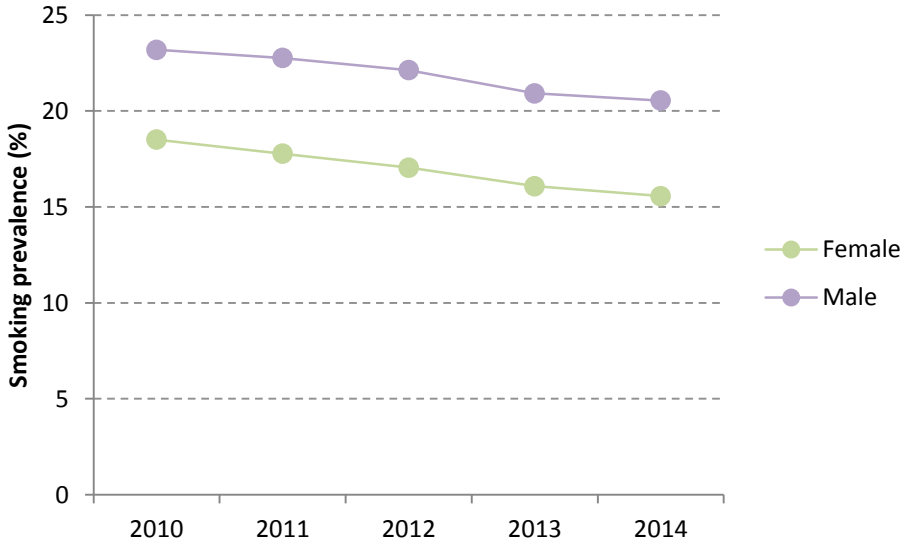
Source: IHS

The most recent release of the IHS (2014) show that the younger age groups have the highest smoking prevalence, with prevalence peaking at 23% in the 18-24 and 25-34 year old groups (Figure

18). From then on, prevalence decreases for each age band to 9.2% in the 65+ age group. Over the past five years all five of the age groupings have seen a decrease in estimated smoking prevalence.

The 2014 data also show a significant difference in smoking prevalence between genders. In 2014 it was estimated that 20.5% of males smoked; this was 4.9% higher than the estimate for females of 15.6% (Figure 19). As with the overall smoking estimates, prevalence in both males and females has fallen year on year since 2010.

Figure 19 - Smoking prevalence in England by gender (2014)



Source: IHS

6.1.2 Ethnicity and smoking

Although smoking rates have declined in the UK, there are large disparities across some ethnic groups. Explanations for the disparities in ethnic minority tobacco use include religious and cultural beliefs, and also lack of awareness about the health risks of tobacco use [16, 17]. The diversity in the types of tobacco products used further exacerbates these disparities as some tobacco products such as waterpipes and smokeless tobacco are more prevalent in certain ethnic communities. For example, the use of smokeless tobacco products is more prevalent in South Asian communities [11]. However, smoking rates among ethnic minority groups are generally lower than those in the general population. In addition, there are variations in smoking prevalence between men and women within different ethnic groups. In men, compared to the general population, rates are particularly high among Black Caribbean and Bangladeshi groups. Although the variation may be explained by socioeconomic differences, the consequences of smoking may vary greatly between the different ethnic groups [18, 19]. Heart disease, for example, is particularly prevalent among some minority groups due to the combination of smoking and the presence of other risk factors [18, 19]. Black, Asian and Minority Ethnic groups are a priority group for tobacco control and one of the target groups for the West Sussex Specialist Stop Smoking Service.

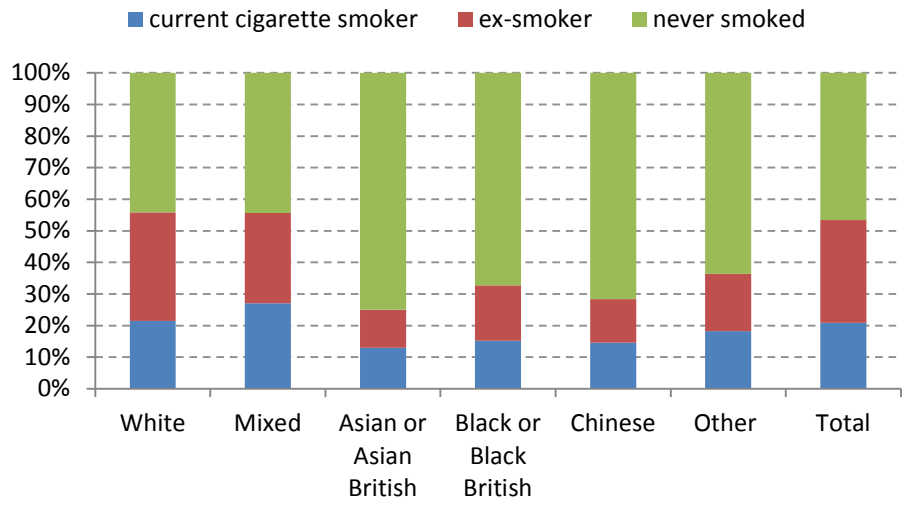
In regard to second-hand smoke exposure, White ethnicity has been associated with more exposure to second-hand smoking by children, as compared to ethnic minorities. However, there are

variations within the groups, which could be attributed to the social patterning of smoking, particularly in low SES groups. [20].

6.1.2.1 Smoking prevalence in different ethnic groups

The IHS reported smoking prevalence by ethnicity up until the April 2010 to March 2011 release, however discontinued this statistic in later editions. These data only cover these six broad ethnic groups; White, Mixed, Asian, Black, Chinese, and Other. This is a specific issue within West Sussex given than there has been a growing population of 'white other' in the last ten years. These ethnic groups are known to have a different smoking prevalence when compared to their white British counterparts. Studies predating this IHS release have shown males of 'white other' ethnicity typically have a higher smoking prevalence compared to their white British counterparts. The broad ethnic groups used in the 2010-11 IHS will disguise these differences (Figure 20).

Figure 20 - Smoking status by ethnicity, UK (2010-11)



Source: IHS

In West Sussex there were estimated to be around 5,000 smokers who report their ethnicity as anything other than 'white' (IHS 2013).

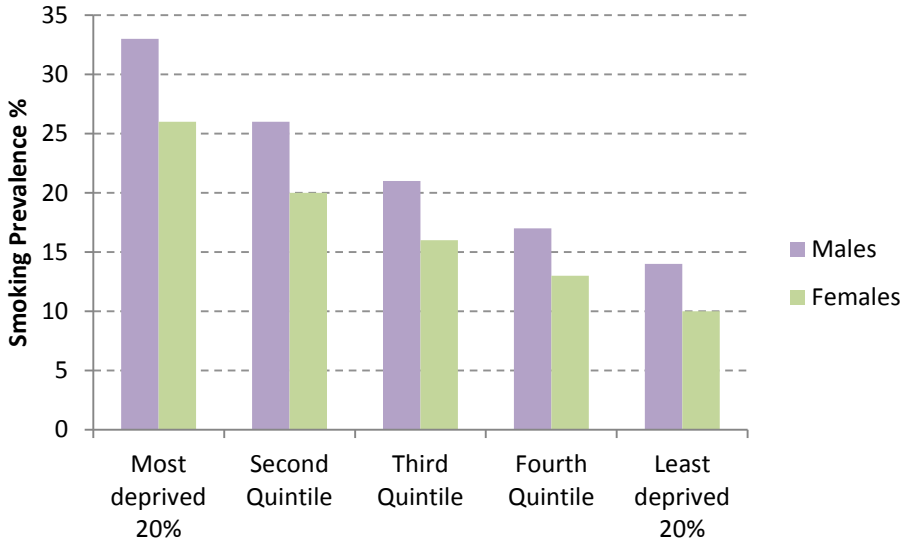
6.1.3 Deprivation and smoking

People living in deprived areas are more likely to smoke, and death rates from tobacco use are two to three times higher among those living in deprived areas than those who are better off [21, 22]. In addition, those most at risk, i.e. long-term smokers, are disproportionately drawn from the most deprived areas and are more likely to start smoking at a younger age. Low socio-economic status (SES) groups are also more likely to suffer the harmful consequences of second-hand smoke [23]. Evidence indicates that there is a significant association between a child's exposure to second-hand smoke and SES. Children from low SES households were found to be three times more likely to be exposed to second-hand smoke [20]. Furthermore, smoking by parents or caregivers is a strong predictor for young people taking up smoking. If both parents smoke, children are three times more likely to start smoking than if neither parent smokes [24].

6.1.3.1 Deprivation and smoking prevalence

In 2012, the findings from the Lifestyles and Opinions survey conducted by the ONS showed that those living in the most deprived LSOAs in the country were over 10% more likely to be smokers than those living the least deprived quintile nationally (Figure 21). This is in line with research findings in this area. The higher levels of smoking within the most deprived areas adds to the already large gap in health inequalities seen between the most deprived and least deprived areas.

Figure 21 - Smoking prevalence by gender and deprivation decile (2012)



Source: ONS

6.1.4 Smoking in pregnancy

Tobacco use during pregnancy has significant influence on the unborn baby and early brain development [25]. There is an association with a number of poor health outcomes in infants and children such as low birth weight; premature birth; Sudden Infant Death Syndrome; stillbirth or foetal death during labour; infant death shortly after birth; and birth defects. Smoking prevalence is higher in areas of deprivation, however, babies from all backgrounds are at risk from problems that arise from a mother smoking during pregnancy [26]. Similarly, the use of smokeless tobacco products has been shown to be toxic to the unborn baby. Research indicates that women who use smokeless tobacco during pregnancy have a higher risk of several adverse outcomes such as premature birth and low birth weight [11].

There is an unequal distribution of smoking in pregnancy across different age and social groups. For example, pregnant teenage mothers are more than three times as likely to smoke as mothers aged 35 or over [27]. Also, those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke throughout pregnancy. These differences further widen the inequality gaps as infants born to smokers are more likely to become smokers. Due to the significant impact of tobacco use in pregnancy, pregnant tobacco users are a key target group for tobacco control activities, including smoking cessation and preventing second-hand smoke exposure. Although there is a reduction in smoking prevalence during pregnancy, relapse after child birth remains high, which significantly increases the risks of smoking related

adverse outcomes for both the mother and the child [28]. A recent systematic review focusing on the rates of re-starting smoking after childbirth found that approximately 43% of women who were abstinent at the end of pregnancy resumed smoking by six months postpartum [29].

6.1.4.1 Maternal smoking prevalence

The Tobacco control plan for England (2011) aims to reduce the rate of smoking in pregnancy to less than 11% by the end of 2015. There has been a steady decline in the percentage of women recorded as smoking at the time of delivery in England, from 15.1% in 2006/07 to 11.4% in 2014/15. The Health and Social Care Information Centre (HSCIC) provides quarterly summaries on maternal smoking rates at the time of delivery for each CCG[ix]. In the first three quarters of 2015/16, significantly more mothers in Coastal West Sussex CCG were smokers at the time of delivery than in Crawley CCG or Horsham and Mid Sussex CCG (Table 7). Of the 50 CCGs in the South of England, 30 had met the national ambition of reducing smoking in pregnancy to 11% by the end of March 2016.

Table 7 - Maternal smoking at time of delivery for West Sussex CCGs (2015/16)

CCG	2015 – 2016			Total 2015-16 (Q1-Q3 only)
	Quarter 1	Quarter 2	Quarter 3	
Coastal West Sussex CCG	11.1 % (9.5 - 13.1)	10.4% (8.8 - 12.3)	12.9% (11.1 - 14.9)	11.5% (10.5 - 12.6)
Crawley CCG	6.7% (4.7 - 9.4)	6.4% (4.4 - 9.2)	7.0% (5.0 - 9.8)	6.7% (5.3 - 8.1)
Horsham and Mid Sussex CCG	3.2% (2.0 - 5.0)	5.5% (3.9 - 7.6)	4.2% (2.8 - 6.2)	4.3% (3.3 - 5.3)
England	10.7% (10.5 - 10.8)	10.5% (10.3 - 10.6)	10.6% (10.5 - 10.8)	10.6% (10.5 - 10.7)

Source: Health and Social Care Information Centre – Maternal Smoking and Delivery

For West Sussex, it was estimated that 8.9% of mothers were smoking at delivery in 2015/16; this is significantly lower than estimates for England (10.6%).

6.1.5 Young people and smoking

Smoking prevention is one of the most effective ways to reduce smoking prevalence in the long term and in turn improve the health outcomes for the population in later life. Among adult smokers, about two-thirds report that they took up smoking before the age of 18 and over 80% before the age of 20 [30]. It is estimated that between one third and one half of children who try smoking are likely to become regular smokers within two to three years [31]. However, the proportion of children who have never smoked is on the decline [32]. Smoking initiation is associated with a wide range of risk factors, which includes parental, caregiver or sibling smoking, and availability of cheap tobacco. Indeed, children who live with parents or siblings who smoke are up to three times more likely to become smokers themselves. Young people are vulnerable to the negative health effects of smoking, both in the short and long term.

[ix] HSCIC – "Statistics on Women's Smoking Status at Time of Delivery: England. Quarter 4 - April 2013 to March 2014" (released Jun-2014).

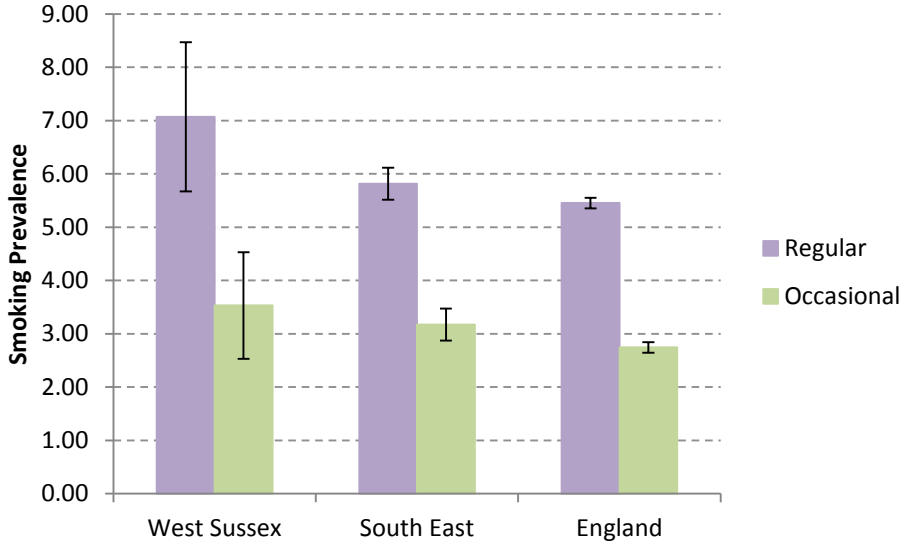
6.1.5.1 Smoking prevalence in young people

In 2014 the West Sussex Public Health and Social Research Unit conducted the third edition of its 14 to 15 year old lifestyle survey. This survey included 3,597 pupils from year ten in 19 Secondary Schools County wide. It should be noted that due to the local nature of this survey, no direct benchmarks can be made against England or other geographies other than within West Sussex. However, the recurrent nature of the reports provides useful insight into ongoing and emerging local trends.

The proportion of regular smokers in 2014 was considerably lower than in previous years with only 5.1% of respondents reporting that they were regular smokers (9% in 2006). Overall more than four in five respondents said they had never smoked. The local survey identified that over the last three periods (2006, 2009, and 2014) girls aged 14-15 were more likely to be regular or occasional smokers than males of the same age. This gap has decreased from 9.5% (29.9% vs. 20.4%) to 3.1% (15.1% vs. 12.0%) between 2006 and 2014. Family structure was linked to smoking behaviour, with those who lived with both birth parents being the least likely to smoke (3%), followed by those with one parent (7%). Furthermore, young people's relationship with their parents was also associated with smoking. For example, three per cent of those who could easily talk to their parents were regular smokers, compared with 14% of those who could not easily talk to their parents

The What About YOUth? (WAY) survey reported on below is a national survey which allows the use for benchmarking against England, the South East and other counties and districts within England. Differences in the way that the 14-15 lifestyle survey (conducted only within West Sussex) and the WAY survey (conducted nationally) were carried out mean that direct comparisons cannot be made between the two different surveys. Recently released findings from the 2014/15 WAY survey have highlighted the relatively higher smoking prevalence in 15 year olds across West Sussex when compared to both the South East and England (Figure 22).

Figure 22 - The prevalence of smokers aged 15 years old, by smoking frequency (2014/15)



Source: WAY

As shown in Figure 22 the proportion of 15 year olds classing themselves as regular smokers[x] in West Sussex (7.07%) was significantly higher than England prevalence of 5.45%. West Sussex was also shown to have a higher prevalence of regular smokers than the South East but that result was not statistically significant. There was a similar trend in the prevalence of 15 year olds identifying as occasional smokers[xi], although there was no significant difference over the geographies of West Sussex, South East, and England.

The WAY survey also asked questions about e-cigarettes and other tobacco products. Of those who answered in West Sussex, 17.7% said they had used an e-cigarette. This was slightly above the South East regional figure of 16.7%, but below the national estimate of 18.4%. When the survey participants were asked the question "Have you ever used/tried other tobacco products (i.e. shisha pipe, hookah, hubble-bubble, waterpipe etc.)?" some 15.1% of those in West Sussex said that they had. This figure mirrored the England proportion of 15.2% but was slightly below the South East estimate of 16.1%.

6.1.6 Mental health illness and smoking

There is a strong link between smoking and mental health. National and international evidence indicates that smoking prevalence is substantially higher within this population group, when compared to the general population [33]. The strength of the association between smoking and mental illness tends to increase with increasing severity of mental illness. As a result, the highest levels of smoking are found in psychiatric inpatients [34]. However, it is not clear whether smoking is the cause or effect of mental illness. Smokers often report that smoking helps to relieve feelings of anxiety and stress, so it may be that these individuals are using smoking as a way to self-medicate and cope with stress [35]. In addition, smoking has an impact on the therapeutic levels of some psychotropic medications.

Although there has been a general downward trend in smoking rates in the general population, smoking among those with mental disorders has changed little, if at all, over the last 20 years. A third of all cigarettes smoked in England are smoked by people with a mental disorder. Unsurprisingly, this high prevalence of smoking results in higher mortality rates in those with mental illness than the general population. It also compounds existing risk factors for premature mortality [36]. Due to high prevalence of smoking in people who use mental health services, they are a target group for the West Sussex Specialist Stop Smoking service.

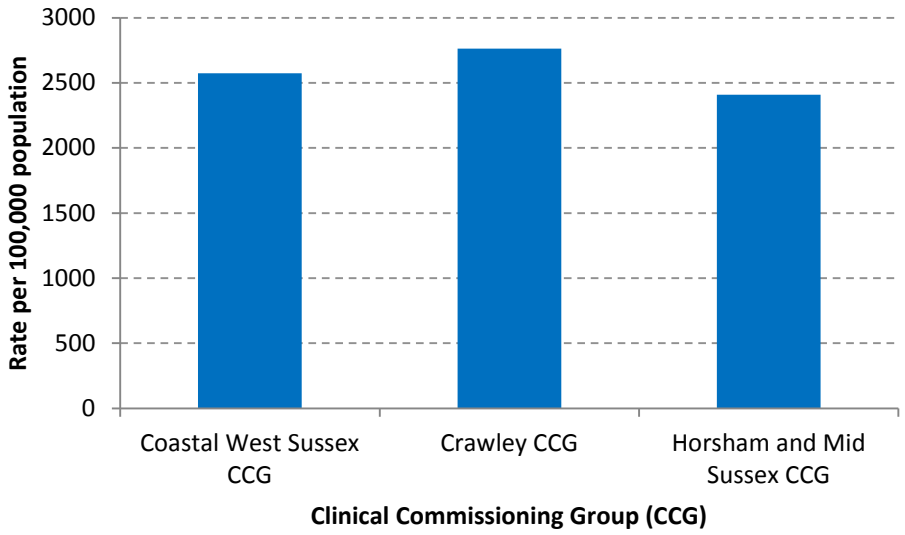
6.1.6.1 Smoking prevalence in mental health service users in West Sussex

West Sussex overall is marginally below England average for people in contact with mental health services. In West Sussex, Horsham and Mid Sussex CCG has a significantly lower number of mental health service users, compared to Crawley and Coastal CCGs (Figure 23).

[x] Regular smokers defined as those smoking one or more cigarettes a week

[xi] Occasional smokers defined as those who answered 'yes' to the question 'I sometimes smoke cigarettes now but I don't smoke as many as one a week'

Figure 23 - People in contact with mental health services per 100,000 population, Q2 2015/16, CCGs in West Sussex



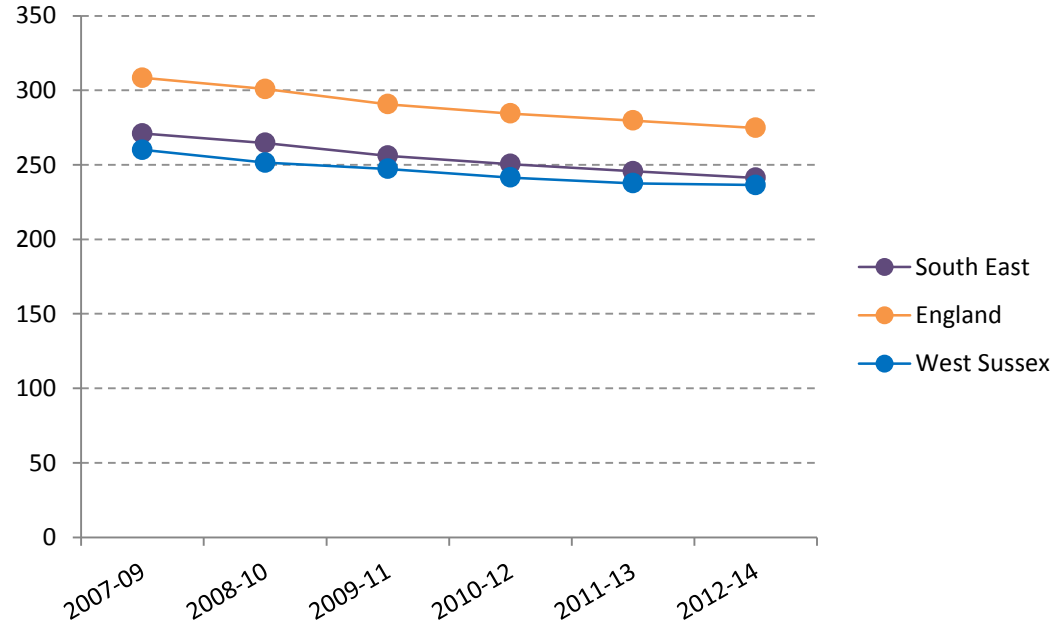
Source: HSCIC

In 2013 the rate of smoking according to the Health Survey for England (HSE) was 21% for the general population and 40% for those with a long standing mental health condition. National data also estimates that 70% of patients in psychiatric units smoke tobacco and up to 40% cent of people with mental illness living in the community are smokers[37, 38]. These are also reflected in West Sussex.

6.2 Tobacco related illnesses and deaths

As stated in the preceding chapters, smoking is the single largest cause of preventable illness and premature death in England.

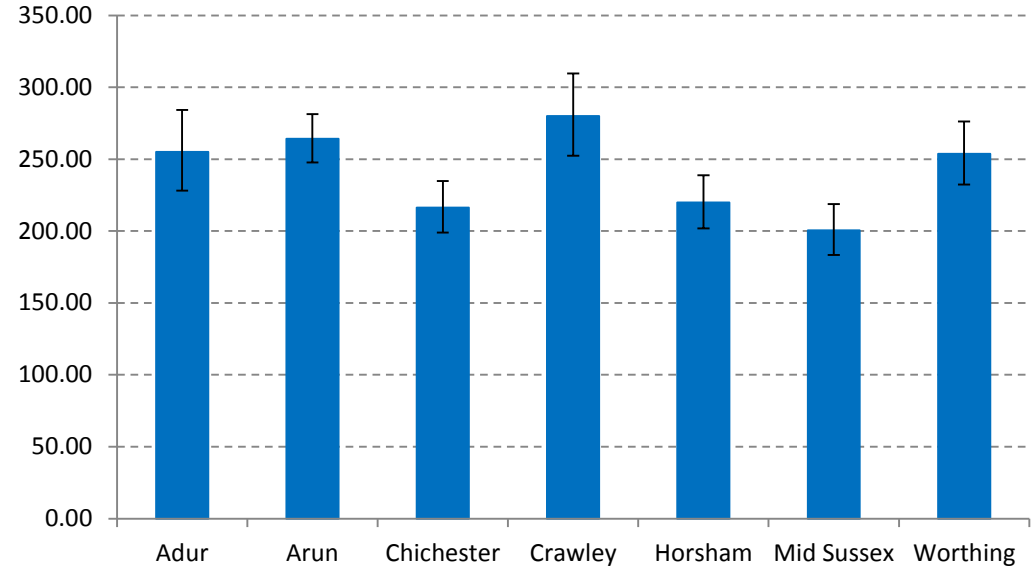
Figure 24 - Smoking attributable mortality standardised rate per 100,000 (35+)



Source: ONS

Locally, it is estimated that between 2012 and 2014, 3,995 deaths were attributable to smoking. This amounts to 236.4 deaths per 100,000 age-sex standardised population, significantly lower than the England estimate of 274.8 deaths per 100, 000. West Sussex remains consistently lower than England and the South East.

Figure 25 - Smoking attributable deaths per 100,000 (35+, 2011-13)



Source: ONS

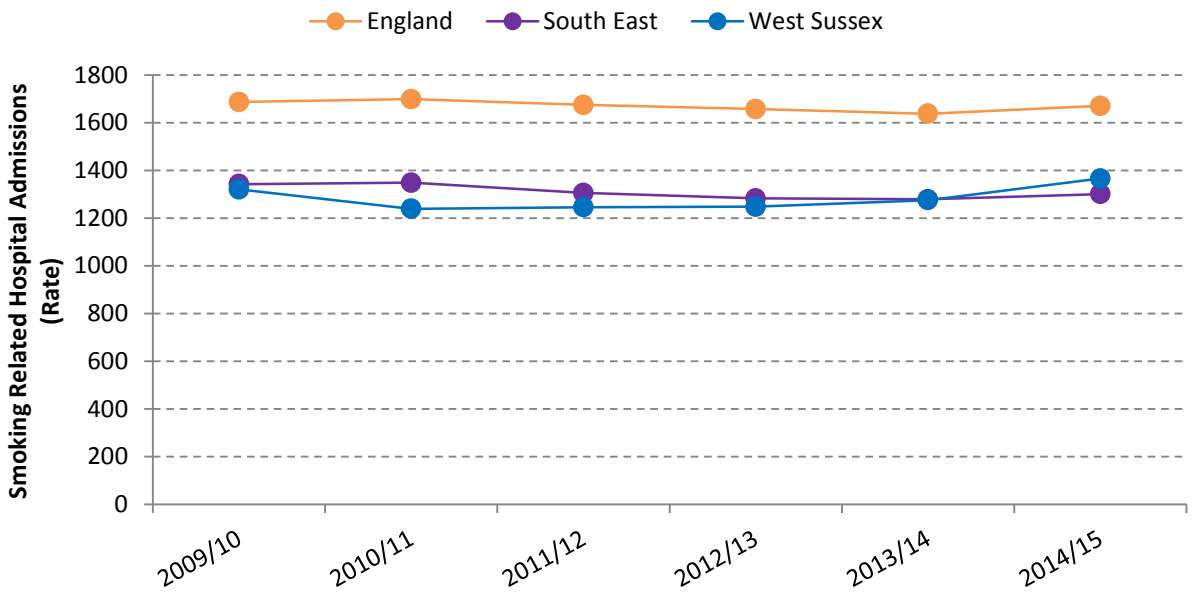
Although the rate of deaths from smoking has shown measurable decrease, the increasing population of West Sussex means that there has been little change in the absolute estimated number of deaths (3,985 between 2008-10 as compared to 3,995 between 2012-14). Although rates are down, the burden on health and social care and other statutory services remains.

As Figure 25 above shows, within West Sussex there is an unequal distribution of smoking related deaths between deprived and least deprived areas. The most recent local data (2011-13) (note this is one year behind the national and West Sussex estimates) shows that within West Sussex the rate of smoking attributable deaths ranges from 279.89 per 100,000 in Crawley to 200.55 in Mid Sussex.

6.2.1 Smoking related hospital admissions

Although death rates from smoking related causes have fallen year on year, smoking related hospital admissions have not. Since a drop after 2009/10, smoking related hospital admissions have increased between 2010/11 to 2014/15. However, West Sussex has consistently remained significantly below the national rate (Figure 26 below). In the last three years the rate of smoking related admissions in West Sussex has gone from being significantly lower to significantly higher than the South East regional rate. Reasons for the increase in smoking related hospital admissions need to be further investigated.

Figure 26 - Smoking attributable hospital admissions (Directly standardised rate - per 100,000)

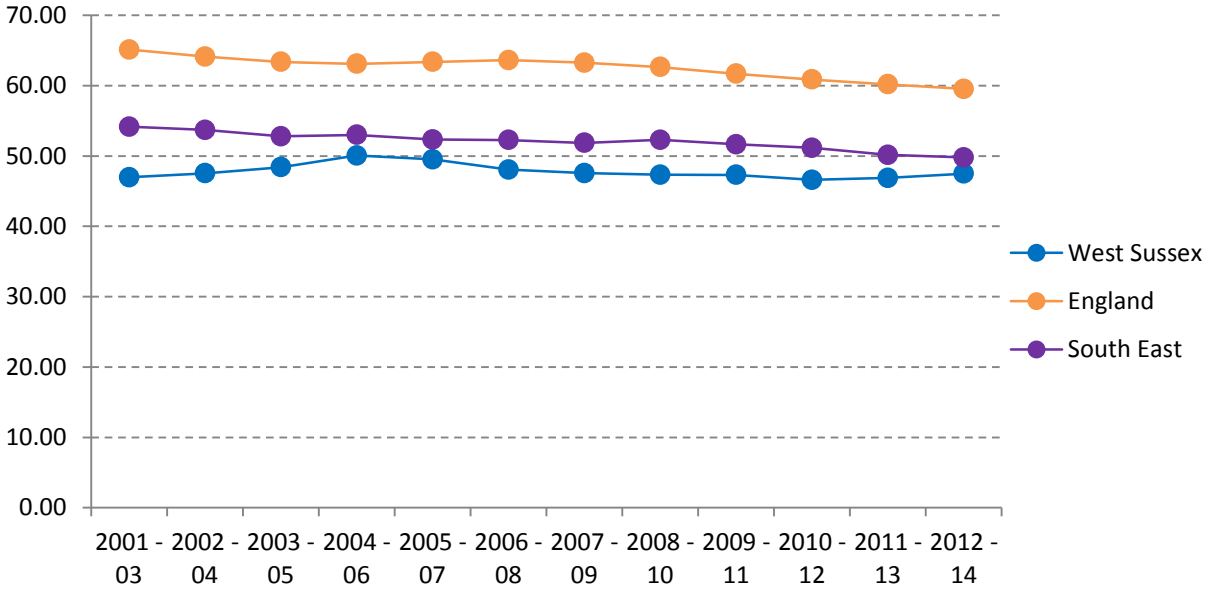


Source: PHE

6.2.2 Cancer mortality

Since a small decrease in lung cancer mortality rates in West Sussex between 2004 and 2008, rates have remained stable and significantly lower than England for the last 15 years (Figure 27).
It should be noted that these are overall mortality rates of lung cancer and therefore will include non-smoking related incidents of lung cancer mortality.

Figure 27 - Age-standardised rate of mortality from lung cancer per 100,000 population (PHE)

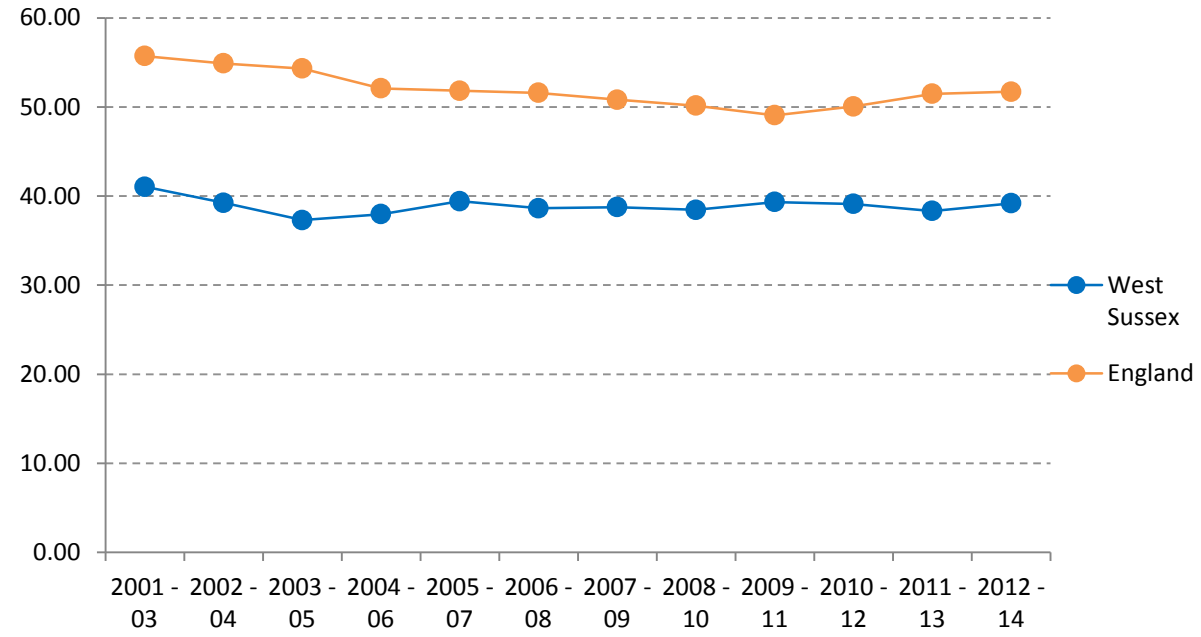


Source: PHE

6.2.3 COPD mortality

Deaths from chronic obstructive pulmonary disease (COPD) in West Sussex have shown no discernible trend in the last 15 years, and although no improvements have been seen, they have remained well below the England rate (Figure 28).

Figure 28 - Age-standardised rate of mortality from COPD per 100,000 population



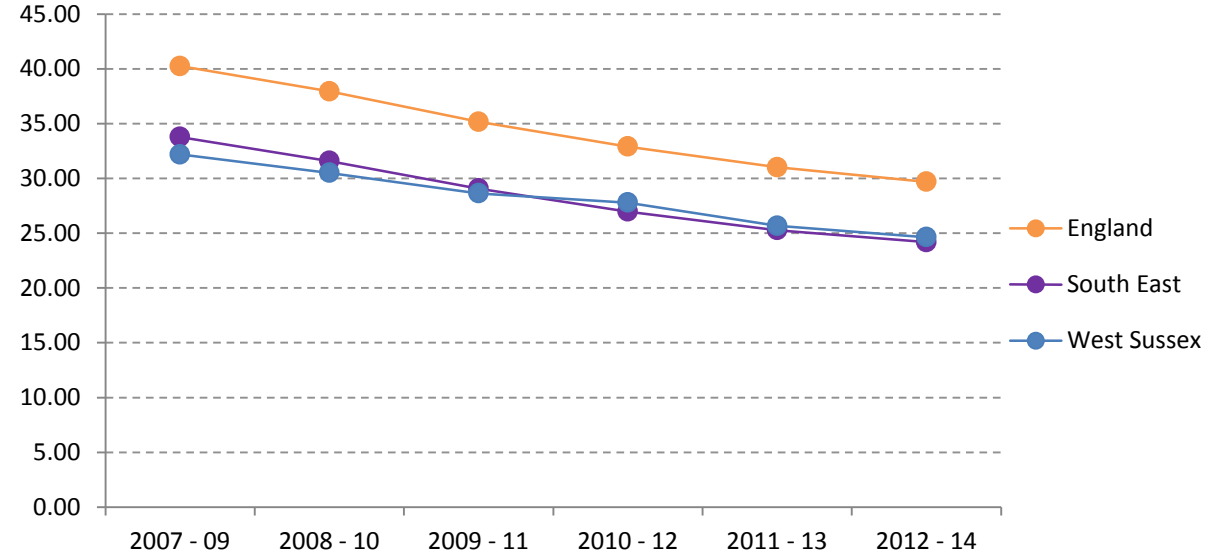
Source: PHE

It should be noted that these are overall mortality rates of lung COPD and therefore will include non-smoking related incidents of COPD mortality.

6.2.4 Cardiovascular (CVD) mortality

In the last eight years, smoking related deaths from heart disease have fallen by 7.56 deaths per 100,000 population, from 32.19 to 24.63. The West Sussex trend is similar to both England and the South East (Figure 29).

Figure 29 - Smoking related deaths from heart disease (Directly standardised rate per 100,000)

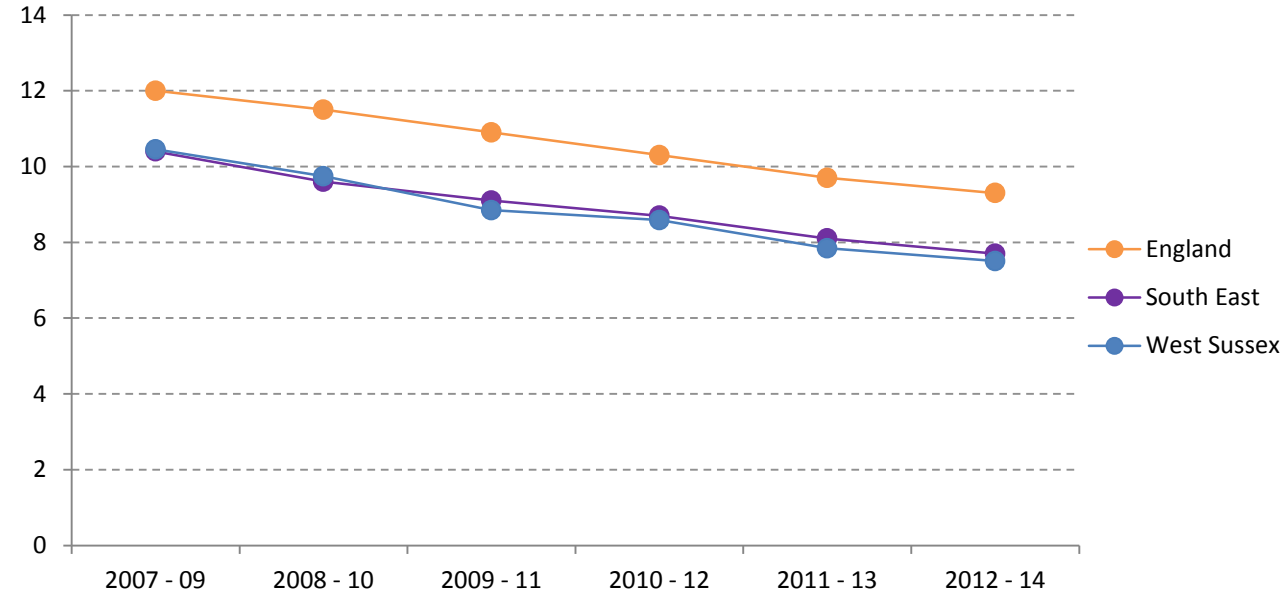


Source: PHE

The rate of smoking related deaths from stroke has fallen by around two per 100,000 population in the last eight years. As with other similar indicators, West Sussex performs better than England, but follows a similar trend to the South East as shown in

Figure 30 below.

Figure 30 - Smoking related deaths from Stroke (Directly standardised rate per 100,000)



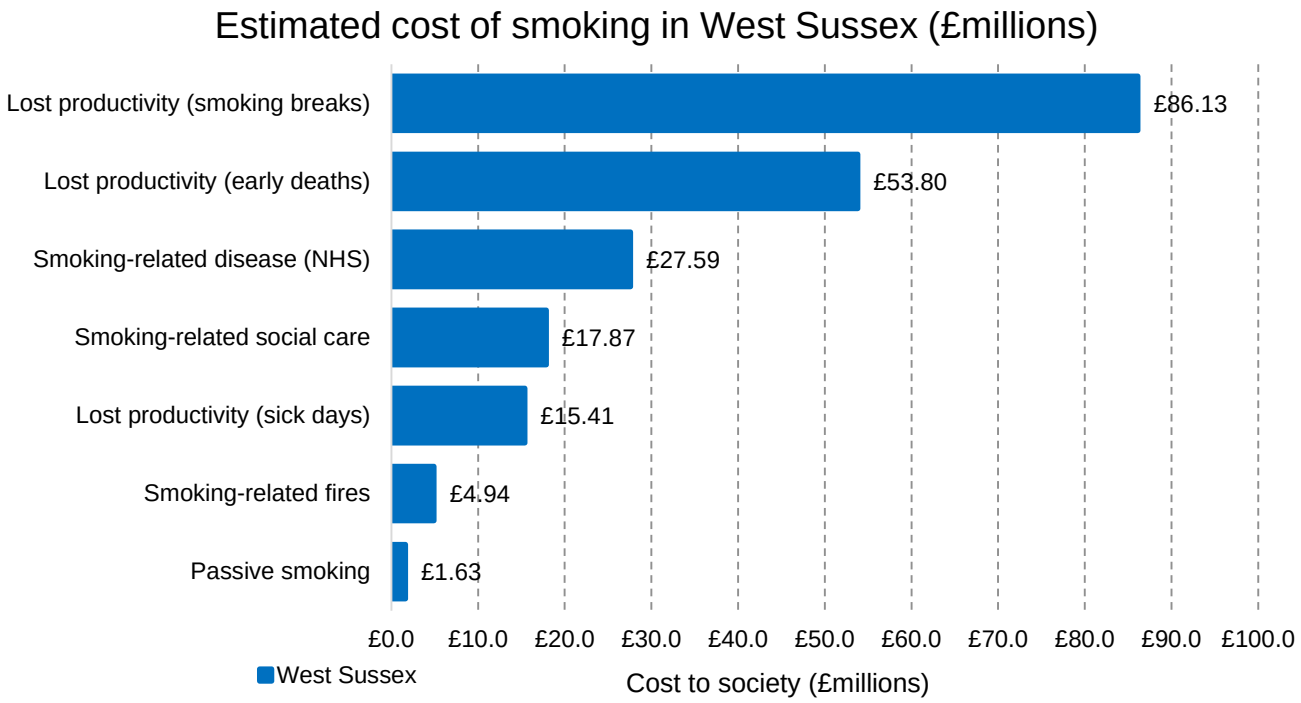
Source: PHE

6.3 Tobacco related costs

It is estimated that smoking in West Sussex currently costs society £207 million each year. This equates to approximately £1,850 per smoker per year [39]. This estimated figure takes into account a number of factors in both the NHS and the wider society. Within these is the cost of lost productivity (to which some £155 million was attributed), including smoking breaks, sick days, and lost years of productivity due to premature deaths.

There is an estimated annual burden on the NHS of £29.2 million, of which £27.6 million is as a direct result of treating smoking related ill-health and £1.6million is due to treating the effects of passive smoking in non-smokers. In addition, there is a £17.9 million annual cost to social care services because current and ex-smokers need care in later life as a direct result of smoking-related illnesses. Of this, £10.3 million comes from local authorities while the remaining £7.6 million is the cost to people who self-fund their care.

Figure 31 - Estimated cost of smoking in West Sussex (2015)



Source: ASH

6.4 Smoking related fires

A high proportion of accidental fires in England are attributed to cigarette and smoking related materials. Nationally, approximately 2,700 fires are caused by cigarettes and smoking related materials, resulting in around 87 deaths. The cost of these fires to the national economy is £259m every year, broken down; £165m is as a result of deaths; £52m resulting from the injuries; £41m resulting from non-human costs such as property damage [40]. However, since 2001-2002, there has been a 41% decline in fires where the source of ignition was smokers' materials (i.e. cigarettes, cigars or pipe tobacco, but not including lighting implements such as matches and lighters) in Great Britain. This reduction could be in part due to the introduction of new EU directive on safety standards for the cigarettes which came into effect in 2011. The regulations require the implementation of reduced ignition propensity (RIP) standards for cigarettes. RIP cigarettes are designed with a mechanism to self-extinguish when left unattended. Illicit cigarettes do not usually comply with the European and UK fire safety regulations, and therefore increase the risk of fires as they continue to burn when they are not actively being smoked.

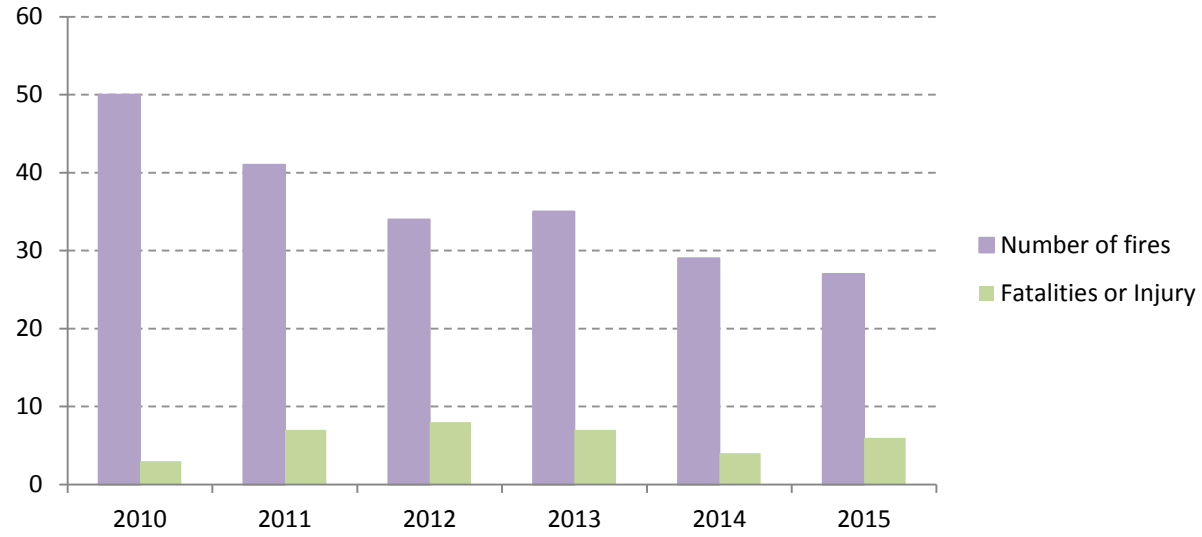
Between April 2013 and March 2014, the largest share of deaths in accidental residential fires (37%) was due to smokers' materials (e.g. cigarettes, cigars or pipe tobacco). Data provided from the West Sussex Fire Service has shown that over the last six years (2010-2015) there have been 216 fires where the source of ignition was recorded as "Smoking materials[xii]". The 26% decline in these fires

[xii] Smoking material as self-reported

over the last six years has been much greater than the 2.6% decline in smoking prevalence over the same period.

Although incidence of fire caused by smoking related materials has fallen over the last six years, the number of victims either injured or killed each year has remained the same. Since 2010 there have been 11 fatalities and 24 injuries caused by smoking related fires in West Sussex, with 45% of these injuries recorded in Arun. This is part explained by the high number of fires from smoking related causes in Arun, although the number of casualties and deaths are still not proportionate.

Figure 32 - The number of reported fires where the source of ignition was smoking materials

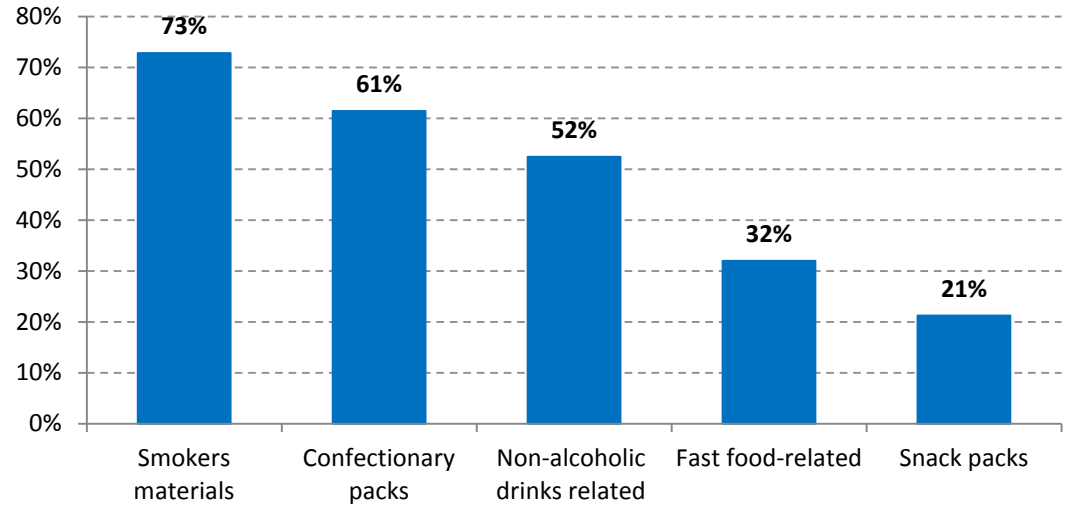


Source: West Sussex, West Sussex Fire Department

6.5 Smoking related litter

Smoking related litter, such as cigarette butts and discarded cigarette packets, is the most frequently found type of litter in England (Figure 33).

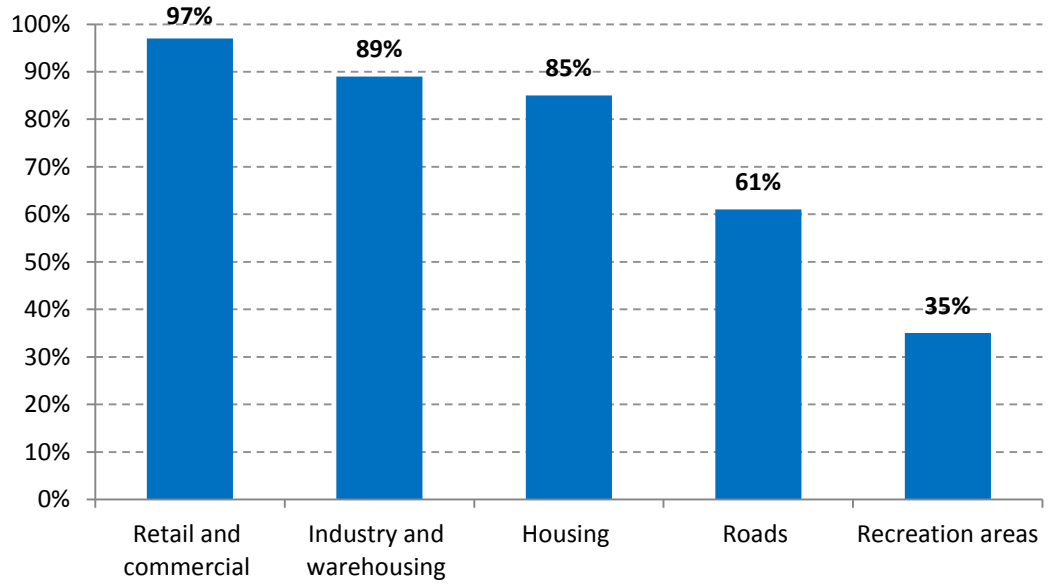
Figure 33 - Percentage of top 5 litter types found on the highest percentage of sites in 2014/15



Source: Keep Britain Tidy

According to Keep Britain Tidy's Local Environmental Quality Survey of England (LEQSE) 2014/15, smoking related litter was found in 73% of all locations surveyed, with retail and commercial areas being the most highly affected (Figure 34).

Figure 34- Percentage of land uses affected by smokers' materials in 2013/2014, LEQSE



Source: Keep Britain Tidy

It costs an estimated £342 million per year to clean up the 200 million cigarette butts thrown away every day by UK smokers[xiii]. In addition, cigarette butts can be dangerous and causes serious environmental problems, taking up to 12 years to biodegrade. Cigarette butts also contain toxic chemicals that harm wildlife and contaminates water supplies [41]. In West Sussex, around 442 million filtered cigarettes are smoked each year, resulting in approximately 75 tonnes of waste annually[xiv].

6.6 Second-hand tobacco smoke exposure

Second-hand smoke exposure, or environmental tobacco smoke (ETS) is associated with an increased risk of chest infections, asthma attacks and sudden infant death syndrome. In addition, children whose parents smoke are likely to become smokers themselves.

6.6.1.1 National profile: attitudes to smoking in people's homes and presence of children

Data on adult smoking behaviour and attitudes are taken from the ONS Omnibus Survey, the latest version of which was "Smoking-related behaviour and attitudes, 2008/09". The survey sampled adults aged 16+ in private households[xv].

[xiii] Mid Sussex local authority: Cigarette littering
[xiv] ASH ready reckoner Dec 2015 update
[xv] HSCIC – Statistics on Smoking 2014. Tables 3.14, 3.16 and 3.17 (http://www.hscic.gov.uk/catalogue/PUB14988/smok-eng-2014-rep.pdf)

In Great Britain, 69% of all adults surveyed said smoking was not allowed inside their homes. Heavy smokers (20+ cigarettes a day) were the least likely to say smoking was not allowed in their homes (21%) compared with 28% of light smokers. In addition, adults living in a household with children were more likely to say that smoking was not allowed anywhere in their home (75% of adults living with children). Of all adults, those who were most aware of the potential harm of second-hand smoke to children and non-smoking adults were more likely to say that smoking was not allowed in their home. For example, 74% of people who were aware of the effect of second-hand smoke on asthma risk in children did not allow smoking in their home, compared to 42% who did not believe that smoking increased the risk. Smokers were also more likely to modify their smoking in front of children than in front of non-smoking adults; 91% of smokers reported modifying their smoking behaviour in front of children. In 2008/09, 77% of smokers reported not smoking at all in the presence of children, which has increased from 54% in 1997.

6.6.1.2 National profile: health impact of second-hand smoke exposure

The Royal College of Physicians estimated that every year in the UK children's exposure to second-hand smoke results in:

- over 20,000 cases of lower respiratory tract infection
- 120,000 cases of middle ear disease
- at least 22,000 new cases of wheeze and asthma
- 200 cases of bacterial meningitis
- 40 sudden infant deaths – one in five of all SIDs

Each year, these cases result in over 300,000 UK GP consultations and around 9,500 hospital admissions, and also cost the NHS about £23.3 million [42]. Furthermore, a national study estimated that exposure to second-hand smoke in the home in the UK causes around 2,700 deaths in people aged 20-63 and a further 8,000 deaths a year among people aged 65 years and older [42].

6.7 Trends in alternative/niche tobacco products

Although manufactured cigarettes are the most common type of smoked tobacco used in England, other types of smoking and smokeless tobacco are also used. The use of alternative tobacco products, particularly waterpipes (shisha), has been increasing over the last few years [9]. However, local data on the use of alternative tobacco is limited and at best available at national level.

6.7.1 Waterpipes (Shisha, hookah, hubble-bubble, narghile)

Although there is no local or national data on the prevalence of waterpipe use, national cross-sectional surveys have found that these are used across the country. According to a national cross-sectional YouGov survey of over 12,000 adults in Great Britain conducted in 2015, the prevalence of adults saying they had ever used a waterpipe was 13% and those who used these frequently was 1% (14% overall). Frequent waterpipe use was more common among adults of Asian (7%), Mixed (5%) and Black (4%) ethnicities than among White adults (0.5%).

A survey of 15 year old's in England - *What about YOUth 2014 (WAY 2014) survey* - found that on a national scale, 15 year olds from a mixed, black or minority ethnic backgrounds were more likely to

have reported ever using alternative tobacco products including shisha than white youngsters (22%, 18% and 14% respectively). Another study conducted among 1,252 secondary school students aged 11 – 16 in Stoke-on-Trent found that there was a higher prevalence of lifetime waterpipe smoking (12%) than drug use (6.5%). Prevalence was less than cigarette (22.2%) and alcohol use (49.2%). These results indicate that shisha use is likely to be more common among older teenagers, males and people of South Asian ethnicity.

A further study conducted among 2,399 secondary school students from years 8, 10, 12 and 13 in northwest London found that current waterpipe use (7.4%) was higher than current cigarette smoking (3.4%). Students were also more likely to have tried waterpipe smoking (24%) compared to cigarette smoking (15.8%). The study also found similarities in the reasons why young people used both waterpipes and cigarettes, which included an increase in age, personal reasons, and family and friends' use of tobacco.

6.7.2 Cigars and pipes

Cigar and pipe smoking has declined in Great Britain, with just 2% of men smoking at least one cigar a month in 2007, as compared with 34% in 1974. Very few women have ever smoked cigars and since 1978 the numbers have been scarcely measurable. In 2007, only one percent of men said they smoked a pipe, and they were almost all aged 50 and over [10].

6.7.3 Smokeless tobacco

Unlike smoking and cigarette use, the data on smokeless tobacco use is scant, although national and international research indicates that the majority of smokeless tobacco users are in ethnic groups from South Asia. Chewing tobacco is most commonly used by the Bangladeshi community with 9% of men and 19% of women reporting that they use chewing tobacco [43]. However, estimates on the prevalence of smokeless tobacco use among South Asian communities varies, as in some localities, the prevalence may be higher. For example, a study, based on saliva analysis and questionnaires, reported that 49% of adult Bangladeshi women in Tower Hamlets, were chewing Paan quid with tobacco (a type of smokeless/chewing tobacco) [44].

7. Six evidence based comprehensive tobacco control interventions

Tobacco control activity in England is guided by the World Health Organisation's (WHO) internationally recognised six strand approach (Figure 35). These are based on international evidence that a co-ordinated and multi-faceted response is required to effectively tackle tobacco use.

Figure 35 - The six strands of comprehensive tobacco control

7.1 Stopping the promotion of tobacco

For years, tobacco companies have normalised smoking by promoting tobacco products in a way that is appealing, particularly to young people. There is strong evidence to conclude that the advertising and promotion of tobacco products by tobacco companies increases the initiation and continuation of smoking among young people. Tobacco was portrayed as the social norm through marketing, so young people exposed to these images and messages are more likely to smoke. Consequently, de-normalising smoking is one of the key tobacco control activities.

Significant strides have been made through legislation to stop the promotion of tobacco products, including the Tobacco Advertising and Promotion (Display) (England) Regulations which prohibit the display of tobacco products at the point of sale. The use of vending machines to sell tobacco products has been prohibited since October 2011. However, tobacco companies' strategies continue to evolve and they seek to influence tobacco use and attitudes by promoting smoking 'accessories' such as waterpipes, cigarette papers and other accessories through fashionable and high profile brands. For example, Porsche Design has introduced a 'Shisha 2' pipe. In its tobacco control plan 2011, the Government highlighted the need to examine the impact of advertising and promotion on smoking accessories and the new tobacco control plan is still to be published.

Waterpipes can be purchased from dedicated supply shops (including Internet vendors) that also sell charcoal, tobacco and accessories. Waterpipes are sometimes marketed as portable, with accessories such as carrying straps or cases. Some accessories are sold with the claim that they reduce the harmfulness of the smoke. These include mouthpieces containing activated charcoal or cotton, chemical additives to the water bowl and plastic mesh fittings to create smaller bubbles. None of these accessories has been tested to verify whether they reduce exposure to harmful substances or reduces the risk of tobacco-related disease and death [9].

7.1.1 Current West Sussex tobacco control activities

West Sussex County Council (WSCC) Trading Standards Service (TSS) monitors compliance with retail point of sale legislation for tobacco. An important part of this is monitoring compliance of retailers to tobacco display regulations. This includes intelligence-led enforcement activities, utilising data from the community, partners and own enforcement interventions. The department also offers advice to help businesses comply with statutory and social responsibilities around the promotion of tobacco products. The WSCC TSS does not routinely conduct follow up visits where non-compliance with the Tobacco Advertising and Promotions (display) regulations 2010 is identified. However, the TSS service uses an intelligence-led approach to assess if a follow up visit is warranted, for example, if there are complaints of non-compliance. At the time of the assessment, there were no reported cases of noncompliance in regard to point of sale (POS) display.

7.1.2 Evidence based interventions and guidelines

Stopping the promotion of tobacco is one of the key national tobacco control activities aimed at de-normalising tobacco use. This is supported by current legislation and is also in line with the WHO FCTC. Through the Tobacco control Plan for England (2011), the Government emphasises the role that local authorities should play in de-normalising smoking and tobacco use, including the use of behavioural insights to change social norms [1]. Behavioural insight specialists recommend that behaviour change interventions should be easy, attractive, social and timely, an approach collectively known as 'EAST'[1]. Given that behaviour is one of the key drivers of tobacco use, the EAST framework can be applied in promoting anti-smoking and anti-tobacco using behaviour and help shape perceptions of tobacco use by young people. Changing norms also requires community action and support; the policies, partnerships, and intervention activities that occur at the local and community level will ultimately lead to changes in behaviour and social norms.

To counter the portrayal of smoking in entertainment (i.e. media which can be seen as promoting tobacco use) the Tobacco Control Plan (2011) also highlights the importance of providing information to young people about risk behaviours, in order to develop their ability to resist pressures to take up smoking. National Institute of Care Excellence (NICE) (PH14) recommends the use of tailored national and local mass media campaigns that using a range of strategies to reduce the attractiveness of tobacco and contribute to a wholesale change in society's attitude towards tobacco use. A systematic review and meta-analysis of 17 randomised controlled trials (RCT) of peer-led interventions to prevent the use of tobacco, alcohol and illicit drugs (of which ten RCTs related to tobacco use) showed that the use of peer-led interventions in public health, particularly with adolescents, may be effective in preventing the initiation of risk behaviours such as smoking [45].

Point of sale interventions recommended by NICE (PH14) include educating local businesses and ensuring that they understand legislation; and carrying out test purchase exercises i.e. test purchases with young volunteers. The Chartered Trading Standards Institute (CTSI) conducted a review of regulatory compliance by small businesses and large business with the Tobacco Advertising and Promotion (Display) (England) Regulations 2010 and found that compliance was

high. However, the review recommended that where non-compliance is identified, a follow up visit to ensure compliance has been achieved should be undertaken. It also recommended data collection, particularly on visits to small businesses, for inclusion in the national tobacco control survey.

Article 5.3 of the WHO FCTC addresses the issue of the protection of public health policies with respect to tobacco control from the commercial and other vested interest of the tobacco industry. In response to this, the local government declaration on Tobacco control was developed. It is a statement of a council's commitment to ensure tobacco control is part of the mainstream public health work, was developed. The NHS statement of support for tobacco control was developed alongside the local government declaration for NHS organisations. The statements, (both the local government and the NHS) commit signatories to take comprehensive action to address the harm from smoking and protect tobacco control work from the commercial and vested interest of the tobacco industry. Similarly, ASH published suggestions that local policies should include some or all of the following, in regards to the WHO FCTC article 5.3;

- Commitment to conform with the requirements of Article 5.3 of the FCTC, and the subsequent guidelines;
- Officer and member engagement with the tobacco industry should only happen where necessary in order to meet regulatory responsibilities to local stakeholders
- Banning of any "socially responsible" activities from the tobacco industry, as this is considered promotion;
- Non acceptance of funding, either monetary or in kind, from the tobacco industry (or their subsidiaries) for any public health or other council work. This does not include government mandated payments from the tobacco industry, such as fines, or planning obligations;
- Banning of any partnership with the tobacco industry, for example around tackling illicit tobacco or under age sale of cigarettes.

At the time of this assessment, neither West Sussex County Council nor any of the seven districts and boroughs in West Sussex had signed the declaration [46] [xvi]. Furthermore, the West Sussex CCGs, NHS Coastal West Sussex CCG, NHS Crawley CCG and NHS Horsham and Mid Sussex CCGs have not yet signed the NHS declaration.

NICE advice (LGB24) provides a few key recommendations for Health and Wellbeing Boards, local authorities and partner organisations, based on the CLeaR framework including:

- Leading by example in smokefree policies and in the support provided to help employees stop smoking.
- Training of people, who are not smoking cessation specialists, but who help prevent or give advice on quitting

[xvi] http://www.smokefreeaction.org.uk/declaration/NHSstatement.html

- Monitoring and evaluating tobacco control activities
- Involving local communities and target groups in encouraging people to stop smoking
- Environmental health and Trading Standards services to prioritise tobacco control

7.1.3 Evidence from engagement with stakeholders

7.1.3.1 Public survey

Just over three quarters of participants in the public survey[xvii] (458 participants, 78%) said they were aware of regulations banning tobacco sponsorship and advertising.

In regard to the promotion of tobacco products, some Black, Asian and Ethnic Minority (BAME)[xviii] participants who took part in the interviews indicated that they have access to international TV stations, notably Asian TV. Some of the interviewees highlighted that they only watch Asian TV, and sometimes see adverts selling cigarettes on Indian TV channels.

7.2 Making tobacco less affordable

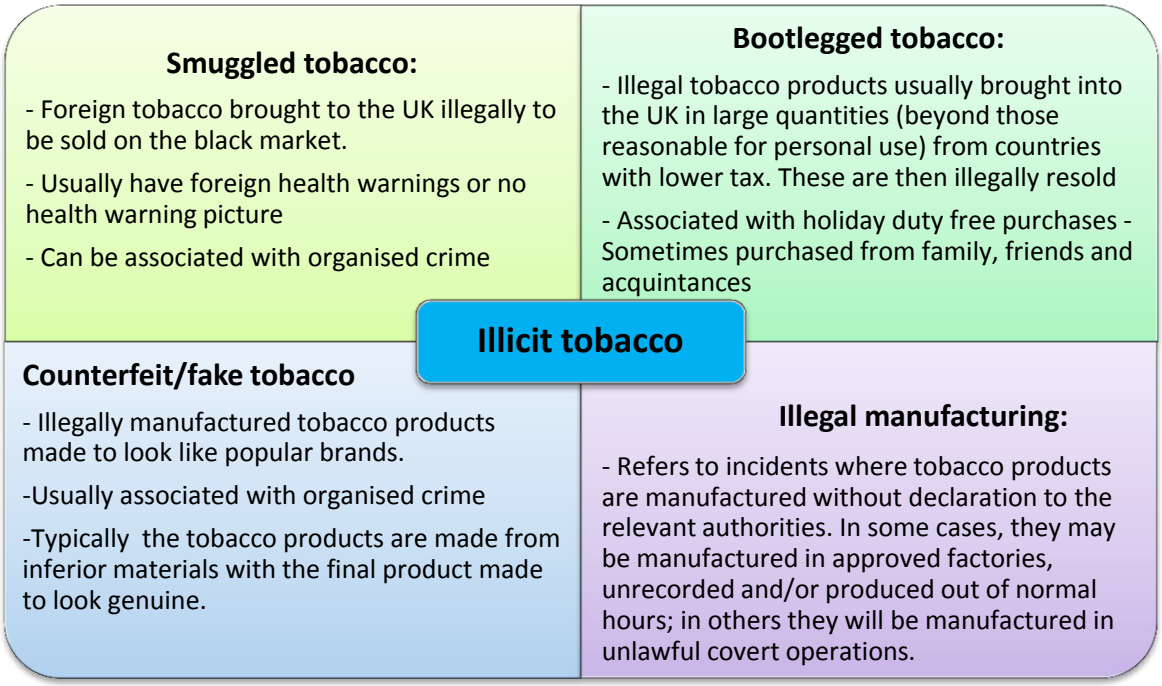
Increasing the price of tobacco has been proven to reduce smoking prevalence. Young people are particularly sensitive to prices as they are more likely to have a low income or low disposable income. Consequently, increasing the price of tobacco has an impact on the initiation and prevalence of smoking in young people. Making tobacco less affordable is another national work stream which focuses on taxation. However, cheap and illicit tobacco has a negative impact on these measures. It not only undermines the impact of pricing and sales controls, but also loses revenue through unpaid UK duty, costing over £2 billion yearly in lost revenue. In addition to this, because it is cheap and accessible to both children and adults it contributes towards the normalisation of smoking, making smoking more socially acceptable [47]. Illicit tobacco also brings crime into the community. There are different sources of illicit tobacco as shown below (Figure 36).

Research indicates that the characteristics of people most likely to purchase illicit tobacco include being young, male, from a deprived background, a heavy smoker and higher level of addiction [47, 48]. Illicit tobacco products, such as counterfeit tobacco, have also been reported to contain high levels of certain harmful substances, and some products contain higher doses of nicotine, leading to higher levels of nicotine addiction [47, 48].

[xvii] A total of 587 responses from the online survey were analysed. Further details available in Appendix 1 – stakeholder engagement reports; Public survey report

[xviii] Qualitative interviews were carried out with ethnic minority groups. Further details available in Appendix 1 – stakeholder engagement reports – Qualitative interviews with BAME groups report

Figure 36 – Illicit tobacco products



As well as cigarettes, other tobacco products such as Shisha, and smokeless tobacco products are known to be smuggled into the UK, particularly from areas where there are high levels of use. Smokeless tobacco products are readily available in shops in areas of England where there are large South Asian communities. Around 85% of the products are sold without any regulatory health warnings and are broadly cheap compared to cigarettes [12]. Shisha is also liable for excise duty is £96.64 per kilo (correct as of March 2013) under its classification in the Integrated UK Tariff. Purely to cover excise duty, correctly declared shisha product must therefore cost a minimum of:

- 50g pack = £4.83
- 100g pack = £9.66
- 150gpack = £14.49
- 175g pack = £16.91
- 250g pack = £24.16
- 500g pack = £48.32
- 1kg pack = £96.64

It is therefore likely that any product available for less than this amount has not been correctly declared, with the appropriate duty being unpaid. The product may be subject to seizure and/or further action by HMRC. HMRC should be notified as per the joint working protocol established between HMRC and Trading Standards Institute) [49].

7.2.1 Current West Sussex tobacco control activities

Data on illicit tobacco seizures is provided in section 7.3.1. The WSCC TSS enforces regulations banning illicit tobacco sales and possession across the county. They carry out visits to certain shops, based on intelligence received and this can be escalated to an investigation if illegal tobacco is found. TSS has an anonymous intelligence-sharing online resource that is available for members of

the public and other agencies to use. In West Sussex, TSS also use sniffer dogs to investigate illicit tobacco and will seize any illicit tobacco found and issue a warning letter, a simple caution or a prosecution in cases of non-compliance. Formal actions against offenders are proportionate and based on the evidence in the investigation. Warning letters will be considered for less serious offences and relatively small quantities of illicit tobacco, however, prosecution will be considered for persistent offenders and larger quantities. In addition, offenders will be asked to sign informal assurances promising not to commit the offence again.

There were 20 incidents of illicit tobacco seizure between the start of 2014 and end of 2015. WSCC Trading standards service seized a total of 1,679 illicit tobacco items (i.e. packs or pouches) between April 2014 and March 2015, and 1399 illicit tobacco items for the period April 2015 – February 2016 (further details in the effective regulation of tobacco products, section 7.3.1). Four seizures of illicit tobacco products within the last two years have resulted in three prosecutions (one shop having illicit tobacco seized on two separate occasions).

7.2.2 Evidence based interventions and guidelines to tackle tobacco use

Although this is a national work stream, tackling illicit tobacco is important at a global, national, regional and local level to cut the supply and reduce the demand for illicit tobacco products. In addition to national strategies, there is need for locally developed strategies to supplement the national efforts. Given increasing financial pressures, the Government's Tobacco Control Plan (2011) highlighted that collaborative working across larger geographical areas is likely to be more cost effective and have greater impact on illicit tobacco. An example of such work is the regional work of the *Tackling illicit tobacco for better health partnership* which is a collaboration of three locally commissioned tobacco control programmes, working with councils, the police and Her Majesty's Revenue and Customs (HMRC) to reduce the supply and demand of illicit tobacco[xix].

To tackle illicit tobacco, there is also need to understand the characteristics of illicit tobacco users/traders and the social norms associated with this. Qualitative research exploring the community norms surrounding illicit tobacco use was conducted using focus groups in a deprived council estate in Nottingham. The research highlighted that the most common source of illicit tobacco was from individuals selling cigarettes from their own homes, and purchasing cigarettes from these individuals was the norm, compared to purchasing them from the shops. Although caution needs to be taken when generalising from these findings, the research highlights that in order to change behaviour, there is need to understand the social norms and drivers for illicit tobacco use. Tobacco control strategies that tackle the demand for cheap tobacco products include interventions that shift the cultural norms and de-normalise tobacco use for example, promotion of

[xix] Tackling illicit tobacco for better health. http://www.illegal-tobacco.co.uk/what-we-do/reducing-supply-intelligence-enforcement/resources/

stop smoking services, enforcement of legislation and raising public awareness of the impact of smoking and illicit tobacco use.

Evidence on interventions to reduce illicit tobacco on a local level is scant, however, a key theme is the need for a collaborative, multiagency approach across Trading standards, HMRC, the police, the health sector (including the NHS), local tobacco alliances, and local communities. This includes the need for a protocol on joint working between HRMC officials and local authority trading standards on tobacco offences [1]. Although there is a national joint working protocol between the Trading Standard institute and the HMRC, there are no separate local arrangements in place between West Sussex TSS and HMRC. In addition, data collection and evaluation of activities to address illicit tobacco sales/use is a key part in the surveillance of illicit tobacco and also to assess the effectiveness of an intervention.

7.2.3 Evidence from engagement with local stakeholders

7.2.3.1 Public consultation

Public survey

A minority of respondents in the public survey (4.1%, *n* = 24 respondents) said they had been offered cigarettes or other tobacco products they believed to be illicit (smuggled, bootlegged or fake). Five respondents said they would prefer not to answer the question.

Focusing on those aged 25 years or under answering the TCNA consultancy survey (*n* = 115), almost one in ten (9.6% *n* = 11) reported that they had been offered illicit tobacco products within the previous six months, and four young people reported making a purchase of illicit tobacco.

Of the 33 current tobacco cigarette users (all ages), three participants (9.1%) reported buying illicit tobacco at least once a week. Of those current hand rolled tobacco users, five (19.2%) participants reported buying illicit tobacco at least once every six months (two participants reported buying it every day/week).

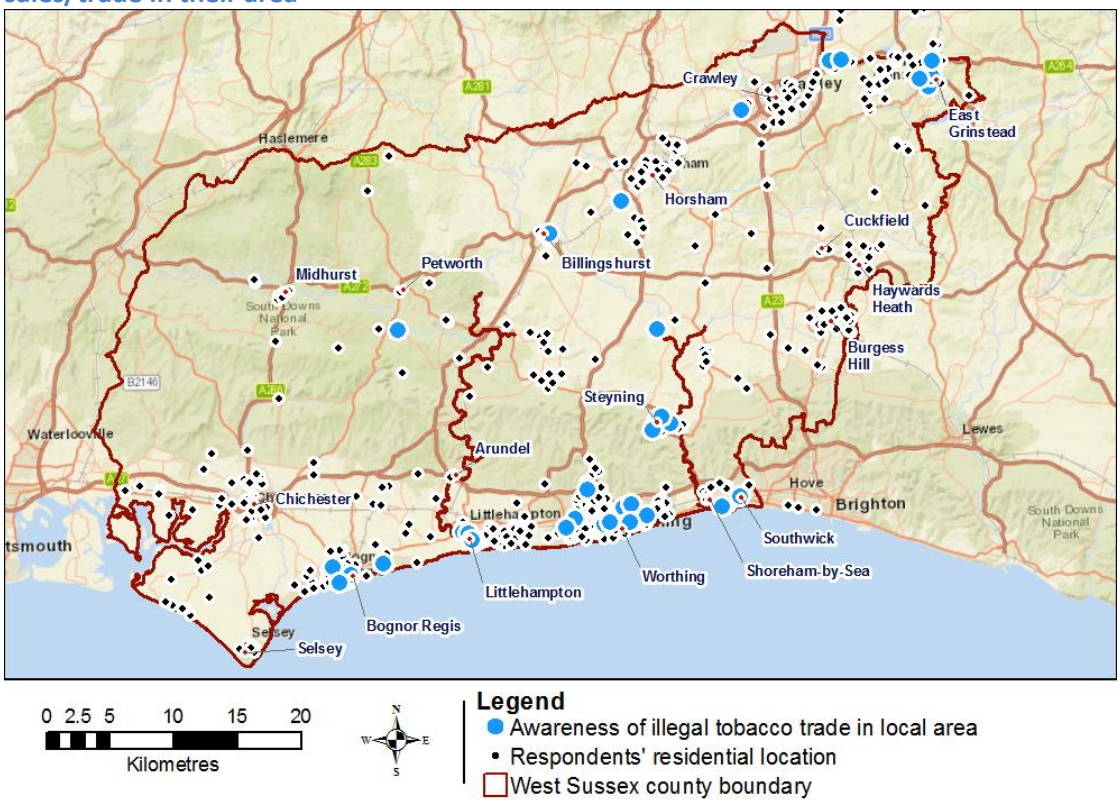
Forty-two participants in the survey (7.2% of all respondents) said they had come across shops or people in the county selling tobacco products where the health harm warnings were written in a language other than English, a further 133 participants (22.7%) said they were not sure. Thirty-nine participants (6.6% of all respondents) said they were aware of illegal tobacco trade in their areas; 11 respondents said they would prefer not to say. Of those under the age of 26, thirteen said they were aware of illicit tobacco trade in their local area, and fifteen young people reported that they came across shops or people in West Sussex selling tobacco with foreign language health warnings.

Just under a quarter of all respondents (24%, 141 people) said they knew how and where to report illegal selling of tobacco (including sales to people under the age of 18 years). A further 28 respondents (4.8% of respondents) said they would not want to report illegal sales of tobacco. Over 70% of respondents (416 people) were either unsure (32%, 188 people) or did not know at all (38.8%, 228 people) where and how to report illegal tobacco sales. Specifically looking at our young respondents, fewer than one in four (n = 27, 23.5%) said they knew how to report illicit tobacco

activity. Just under two thirds of respondents (61.7%, n = 71) said they did not know how to, or were unsure of how to report illicit tobacco activity and a further 16 respondents said they would not want to report illicit tobacco activity.

Thirty-nine respondents (6.6% of all respondents) said they were aware of illegal tobacco trade in their areas; 11 respondents said they would prefer not to say. Figure 37 below shows the residential location, where postcode data were available, of those respondents who reported that they were aware of illegal trade in their area. It should be noted however that the question did not explicitly ask respondents to consider their immediate local residential neighbourhood and so some respondents may have been thinking about a wider geographical area (e.g. their town, or even West Sussex).

Figure 37 - Residential location of respondents reporting that they were aware of illegal tobacco sales/trade in their area



Contains National Statistics data (boundary lines) © Crown copyright and database right (2015)
Basemap (world street map) source: ESRI, © OpenStreetMap contributors (2014)

Participants were asked what could be done in the local community to tackle illicit tobacco sales and use. Responses included educating people of harms of illegal sales (not just health harms of smoking, but harms of unpaid duty etc.), greater fines for those caught breaking the rules, a greater presence of enforcement (including more trading standards officers and police) and promote the ease of reporting (including emphasising confidentiality and anonymity in reporting).

"Raise awareness of the consequences of not paying Duty on the products rather than advertising that smoking is bad for you. There seems to be a lot of 'shock' advertising campaigns to get people

not to smoke but not much information as to why you shouldn't purchase illegal products." – Male, 26-35

"Monitor the selling forums on Facebook etc., they appear every few days in each forum, you can then set up a sting to catch the culprit." – Male, 36-45

"Prominent public campaign and celebrate success stories i.e. prosecutions / seizures." – Male, 46-55

Interviews with BAME groups

Most interviewees, smokers and non-smokers, seemed aware of illicit tobacco. Although there was an awareness, by most, of the availability i.e. sales and use of illicit tobacco, this was not considered a 'problem' or 'big issue' in the local communities, as compared to other issues such as drug use and alcohol. A theme that emerged was the perception that there is nothing wrong with buying or using illicit tobacco, and it was considered more a misdemeanour than a crime, particularly smuggled tobacco. Consequently, some of those who were aware of the use or sale of illicit tobacco didn't feel the need to report it. Those who felt they would report it indicated that they would report it to the police due to their belief that the law is the law and shouldn't be broken, but not necessarily because they worried about the impact of illicit tobacco use and sales.

The main drivers for illicit tobacco were the price and accessibility for young people under the age of 18, and also that it was profitable for those who sold it.

"I'm aware that it is illegal but I'm happy to buy them. Kids like me can't afford to buy tobacco at its current price so smuggled tobacco serves people like me" (smoker 17 years old)

The main sources of illicit tobacco highlighted by the interviewees were friends, car boot sales, shops, other college students and the workplace

*"When I went in a shop and asked for 20 Marlboros, the shop keeper would go to the back and get me foreign illegal Marlboro packet and sell it to me much cheaper and keep all the proceeds and this happens a lot"(*former smoker – 26 years old*)*

"*His (*a student's*) father brings it in (*from Dubai*) and the son sells it to college students… I* (also*) know students that will buy more than they are allowed to buy per person in duty free. They hide it in their clothes and they bring it in to college. They mainly use it for themselves but if someone asks, they will sell it to them"* (non-smoker – 17 years old)

There was some awareness and concerns about the potential harms of illicit tobacco in the form of fake tobacco.

7.2.3.2 Professionals survey[xx]

When asked about the awareness of illicit tobacco use among client/service users that they work with, a majority of the professionals (67% n=63) responded no. Thirteen professionals (14%) responded that they are aware of illicit tobacco use among their clients/service users. However, a total of 70 professionals (75%) highlighted that they didn't know (48 respondents) or were unsure (22 respondents) how to report illicit tobacco use/supply or underage sales if they came across it. Only 22 respondents (22%) reported that they are aware of how to report illicit tobacco.

7.3 Effective regulation of tobacco products

Whilst regulation plays a key role in reducing tobacco use and de-normalising smoking, the enforcement of tobacco control regulations, such as; underage sales, standards for reduced ignition propensity cigarettes, and the labelling and regulation of nicotine containing products, is critical to the effectiveness of the regulations. Children and young people under 18 years of age usually access cigarettes from friends, family and shops, particularly small corner shops, and also from adults who sell them from home. Therefore, enforcement of underage sales regulations will help reduce and stop the availability of tobacco to young people under the age of 18 (NICE PH14). Equally, the enforcement of regulations to stop illicit tobacco has a significant impact on the rates of smoking and smoking uptake.

The availability of novel or niche tobacco products in communities throughout England also means that there is a need to ensure that these are also effectively regulated. Such products include waterpipes (e.g. Shisha) and other smokeless tobacco products. Niche products are subject to the requirements of a range of legislation relating to tobacco products, as previously stated. However, due to its smokeless nature, smokeless tobacco is exempt from Smokefree legislation. Waterpipes are also subject to tobacco control regulations, including packaging and labelling[xxi]. However, they may be available to customers in a non-prepacked form, normally made to the requirements of the user prior to use for example at a shisha lounge, cafe or bar. The various ingredients that make up the shisha are likely to have been removed from their original containers and decanted into other receptacles for example the bowl, which presents a challenge when considering the requirements for warnings to be given to the purchaser.

7.3.1 Current West Sussex tobacco control activities

In West Sussex, the Trading Standards Service (TSS) is the primary body for the enforcement of legal controls over age-restricted products, including tobacco. TSS carries out a range of activities to ensure compliance with regulations. Data provided by West Sussex TSS show that between the start of 2014 to the end of 2015 there have been a total of 28 interventions involving either the seizure

[xx] A total of 94 responses from the professionals across different sectors i.e. health, social care, education, were analysed from the online survey were analysed. Further details are available in Appendix 1

[xxi] The Tobacco Products (Manufacture, Presentation and Sale) (Safety) (Amendment) Regulations 2007

of illicit tobacco products or failed underage sale test purchases; of which eight incidents were in regards to tobacco sales to someone under the age of 18.

Following a seizure or failed underage sales test purchase, an investigation takes place. There are three possible outcomes of these investigations; the offender receives a warning letter, informing the proprietor of the offence and the possible consequences for a repeat offence. The letter may also include advice on how to sell tobacco appropriately and stay within the law. The second is a simple caution; this is a more formal approach where the shop owner will be required to sign a legal document admitting to an offence. The document can be used as evidence in court were the shop owner to breach trading standards again. For repeat offenders, or following the seizure of large hauls of illicit products a prosecution will be brought against the offender. A guilty verdict will often carry a fine or the possibility of a custodial sentence.

Of the 28 recorded interventions, three were still under on-going investigation at the time of this report. Fourteen of the 25 remaining interventions have resulted in a warning letter being sent to the shop owner, while seven resulted in a simple caution. Of the five underage sales breaches that were linked to a location, two occurred each in Crawley and Worthing district and boroughs, while the fifth occurred in Selsey within Chichester district; there were three more recorded breaches of this nature but none of these were mapped to a location. Five failures in the underage sales test purchases (two in Worthing, one in Selsey, one of the two in Crawley, and one unmapped breach) resulted in warning letters being issued. The remaining three test purchases failures were followed up with simple cautions. Given their small size, Worthing borough and Crawley district each had seven and five interventions respectively, while Arun had six. Horsham notably had no breaches, while six of the breaches had no location attached.

There is no data collected on the violations specifically for niche tobacco products such as waterpipes, and chewing tobacco, as these are not considered a high risk in West Sussex.

7.3.2 Evidence based interventions and guidelines

Signs prohibiting smoking are crucial in the implementation and maintenance of compliance with smokefree regulations, and they contribute towards public acceptance of smokefree indoor environments [50]. Organisations and businesses therefore need to ensure compliance with regulations, including appropriate no smoking signage in smokefree places and vehicles. Similarly, in regards to shisha bars, the Chartered Institute of Environmental Health (CIEH) recommends that local authority officers pay attention to signage requirements at every entrance to an enclosed or substantially enclosed part of the premises. It also highlights the need to protect staff/employees from second-hand smoke and environmental health officers could do this by recommending additional signage specifically prohibiting staff from lighting and extinguishing waterpipes in enclosed areas. Given the misconception that smoking shisha is less harmful than cigarettes; the CIEH provided some examples where local authority enforcement strategies include providing information and advice to public on the health hazards associated with smoking shisha. Recommendations for effective communication on tobacco control activities are discussed in the in section 6.6 of this report.

NICE quality standards highlight the importance of intelligence and data collection in identifying non-compliance with regulations, such as under age sales, illicit tobacco sales. Recommendations include working with local retailers and communities to raise awareness and compliance of tobacco legislation and tobacco harms. Ensuring the implementation and maintenance of compliance with tobacco and smokefree regulations also requires partnership working between Trading Standards and retailers, police, and the wider community (NICE QS82). CIEH highlights the need to work with partner organisations for a variety of regulatory concerns, i.e. officers providing information and evidence following their visits for other purposes. In relation to enforcement in shisha bars, partners identified include Trading standards, Environmental Health Service, Building and planning officers, Police, Licencing service, Fire service, HMRC and UKBA, Education Welfare and Child protection.

7.3.3 Evidence from engagement with local stakeholders

7.3.3.1 Public consultations

Public survey

More than 90% of respondents in the public survey (543 people, 92.5%) said they were aware of regulations prohibiting the sale of tobacco to young people under the age of 18 years. Looking at the responses of young people, just under 88% (*n* = 101, 87.8%) reported awareness of legislation prohibiting the sale of tobacco to those under 18.

Only 17 participants (2.9% of all respondents) in the public survey said they were not aware of any smokefree legislation or tobacco control regulations. This includes five young people (4.3% of under 26 year olds).

Interviews with BAME groups

Nearly all interviewees were aware of the ban on indoor smoking; however, awareness of other tobacco related regulations was variable. Some business owners reported that they enforce the regulations on their business premises in order to comply with the law. One restaurant owner reported that in-order to maintain his restaurant smokefree, he asks people caught smoking indoors to leave.

One 17 year old smoker reported that he agreed with the smoking age ban of 16 and that being 18 to buy tobacco products is *"good because it means adult supervision if a child starts to smoke at 16"*. He also reported that he follows restrictions best he can, 'considering that he is 17 and a smoker'.

Violating regulations in regards to tobacco or smoking prompted different responses from the interviewees, with some not interested in raising awareness of the regulations but rather removing the restrictions. Whilst others considered breaking the law, including smokefree law, as a serious issue and would contact the police or 'someone in authority', others took a different approach by simply removing themselves from the situation, and not getting involved.

However, some of the interviewees were the ones violating the law by buying illicit tobacco, or buying tobacco under the age of 18. They reported they would do nothing if someone else is violating the regulations.

*"It's so easy not to get caught (*selling illicit tobacco*) in college and no one likes to snitch at my age, so I don't think the council knows what is going on in colleges" (non-smoker 17 years)*

"I wouldn't care if someone was violating the law; I believe it's a free world as long as it's not hurting me or someone that I know" (smoker – 17 years old)

In some cases, lack of awareness of the regulations resulted in unintentionally breaking the law. One participant from Pakistan who had been in the UK for about four years reported that he wasn't aware of the regulations around the sale of tobacco products but was made aware by a shopkeeper;

"*One day I was outside a restaurant that I work in and two young boys asked me to buy them a packet of cigarettes. I went in to the local newsagent and luckily the shopkeeper knew me and he told me that this was the first and last time that I would say to children that I would buy cigarettes for them. The shopkeeper explained to me that it was against the law and that I could go to prison" (former smoker).*

7.3.3.2 Professional survey

When asked what gaps currently exist in the provision of services to reduce/prevent tobacco use and second-hand smoke exposure, some professionals highlighted the importance of the implementation of regulations and also partnership working "*better liaison could be achieved in licensing areas through increased shared initiatives and visits*"

When asked about training received, nine respondents (10%) indicated that they had received training about regulations relating to tobacco control. 20 respondents (26%) highlighted that they could benefit from training on tobacco control regulations.

Figure 38 - Training needs identified

Training	No. of respondents
Smoking related harm to young people	25 (27%)
Tobacco control regulations and legislation	24 (26%)
Stop smoking/ Smoking cessation methods including pharmacotherapy	23 (24%)
Second-hand smoke exposure	21 (22%)
Smoking related harm in those with mental health conditions	20 (21%)
The impact of smoking on health inequalities	17 (18%)
Brief advice	17 (18%)
Understanding your role in reducing the use of the tobacco	16 (17%)
Smoking related harm to pregnant women	15 (16%)
Smoking related harm	9 (10%)

7.4 Helping tobacco users quit

Smoking is highly concentrated among the most deprived and disadvantaged groups of the population and this significantly impacts on health inequalities. To help address these inequalities, comprehensive stop smoking services should be provided to help smokers quit. Smokers need support to quit and evidence indicates that of the daily smokers who try to quit unaided, 90-95% are likely to relapse. Although smoking cessation is considered the 'gold standard' in the treatment of tobacco dependence and smoking, harm reduction interventions are recommended to support and extend the reach and impact of existing services. E-cigarettes have been recommended by Public Health England as a harm reduction method, particularly for those smokers who have been unsuccessful with other quitting methods [14].

Effective evidence based smoking cessation interventions, as recommended by NICE (PH 10) are

- Brief interventions
- Individual behaviour counselling
- Group behaviour therapy
- Pharmacotherapies
- Self-help materials
- Telephone counselling and quit lines

These are provided on three levels of stop smoking services; brief interventions (level 1), intensive one-to-one support and advice (level 2) and group interventions (level 3).

7.4.1 West Sussex Stop Smoking Services

Across West Sussex, stop smoking services are provided by GPs, Pharmacies and a specialist stop smoking service commissioned by WSCC. The specialist service provides services and support for specific target groups (Box 1) in approximately 38 community venues and 12 mobile clinic sites. Smokers falling into the target groups can access the service through a variety of means, by telephone, website or through other clinicians such as GP, pharmacist, midwife. The specialist services also support other providers, deliver training and undertake some marketing activities to recruit quitters. Approximately 83 GP surgeries and 96 pharmacies have signed an agreement with public health to deliver stop smoking services, however only about half of these report any activity. The GP surgery clinics are available for those registered at that practice and who elected to have an appointment with an advisor. Community pharmacy smoking cessation services are available for any resident of West Sussex on a walk in basis, including those in the target groups. Stop smoking services are also available in Ford prison; however, these are not commissioned by West Sussex County Council.

In West Sussex, in 2014-15, a total of 5,224 smokers accessed stop smoking services in a variety of settings, including GPs and pharmacies (Table 8).

Table 8 – West Sussex stop smoking services

West Sussex	Access	Quit	Rate
Pharmacy	610	266	43.6%

GP Practice	3229	1595	49.4%
Prison	101	25	24.8%
Specialist Stop Smoking setting/community	1284	751	58.5%

West Sussex Specialist Stop Smoking services access by target groups

Box 1– list of target groups for specialist stop smoking services

Specialist smoking cessation service target groups:

- Residents in deprived wards
- Routine and manual workers
- Minority ethnic groups
- Young people (<25 years)
- Mental health service users in the community
- Pregnant smokers and their partners
- Smokers with five previously unsuccessful quit attempts
- Adults living in houses with children under 5[xxii]

It should be noted that smokers accessing non-specialist services may fall into target groups, and there is an overlap between target groups.

7.4.1.1 Deprivation (including routine and manual workers)

The link between smoking and health inequalities are well documented. Illnesses and deaths from smoking in low-income groups are some two to three times higher than those in less deprived groups. Despite showing declining rates of smoking in previous years, recent figures suggest an increase in this group.

As outlined in the previous chapters, although prevalence of smoking in adults in routine and manual occupations fluctuates across the districts of West Sussex, they are not significant enough to indicate a higher level of need in any particular area over another.

Between April 2014 and March 2015 the specialist service reported seeing 458 people in routine and manual occupations. Of these, 287 were recorded as a successful quit. This represents a 63% quit rate, which compares favourably with the national and South East regional averages in this group of 55% and 58% respectively.

7.4.1.2 Black, Asian and minority ethnic smokers – West Sussex

In West Sussex there were estimated to be some 5000 smokers who report their ethnicity as anything other than 'white'.

[xxii] This group has recently been added as a target group for the specialist service. As a result, data was not available at the time of writing and therefore, not included in this report.

Between April 2014 and March 2015, 26 people recorded as being of black, Asian, or minority ethnic origin set a quit date in West Sussex; of these 18 (69%) were successful, with 11 being CO verified. Although the quit rate in this group is significantly higher than in other groups, overall, access rates of stop smoking services are much lower in populations classed as 'non-white' or 'white other'. These data highlight that the access rates remain well below the five percent target set by NICE. However, due to poor data quality in recording of ethnicity, these access rates should be interpreted with caution. The recent Health Equity Audit of the smoking cessation service (Appendix 2) highlights differences in access between the specific ethnic groups. However, small absolute numbers mean that the differences highlighted in the data should be interpreted with caution, and warrant further investigation

7.4.1.3 Young people

Although there is a decrease in the trend of young people smoking regularly; there remain a significant number of young people who smoke. Previous chapters show that there are challenges in establishing the numbers of younger smokers.

Between April 2014 and March 2015, 113 people aged 16 – 24 years accessed the specialist service. Of these, 53 are recorded as four week quits, of which 24 were CO verified and remainder self-reported. This represents a quite rate of 47 per cent.

7.4.1.4 Users of mental health services

We know that West Sussex is below the England average for people in contact with mental health services. Although local data are not available, it is in this particular population that national smoking rates are at their highest. There is a growing body of evidence that shows tackling smoking in this population will reduce the incidence and severity of mental illnesses in this group.

Data from providers shows that 104 people using mental health services in secondary care accessed the specialist stop smoking service in a variety of settings. Given the size of this target group (see Chapter 5) and the estimated prevalence of smokers in the population, it is reasonable to assume that access rates in this group remain below the five percent target figure set out by NICE.

In total, mental health service users in the community account for about eight per cent of the total numbers accessing specialist services. Of these, 19 were in routine and manual occupations and have been accounted for in data for that group. Discounting these, 85 people recorded as having a mental illness and are receiving treatment from a secondary care provider set a quit date through the specialist service; of these 39 (45.9%) were successful, as verified by CO testing, with a total of seven (8.2%) as self-reported quits. There were a significant number (10%) lost to follow up at 12 weeks.

7.4.1.5 Pregnant women and maternity services

Although smoking occurs across the population, the risks are not evenly distributed and there are groups in the population who are at higher risk of taking up smoking and at risk of harm from the effects of smoking. As the previous chapters show, there has been a recent decline in the rate of women recorded as smoking at time of delivery in West Sussex.

Between April 2014 and March 2015, 187 pregnant women set a quit date in West Sussex – this represents a 25% rate of uptake of service in the eligible population, which is in excess of that set out by NICE of five per cent; of these 86 (46%) were successful (self-reported only) and 44 had this confirmed by CO validation. However, 55 (29%) pregnant woman were lost to follow up. In addition, it could also mean that the extent of the problem, i.e. smoking in pregnancy, is underestimated due to under-reporting. The quit rate remains slightly below the average rate reported for 2013/14 in England (47%) and above the 2013/14 average for the South East region (42%).[10]

7.4.1.6 Smokers who have five or more unsuccessful quit attempts

As with all other target groups, there will invariably be cross over with these and other characteristics as people accessing services may fall into one or more target groups.

Local providers collected data showing that in 2014/15, 471 of those accessing the specialist service were classed as having had 5 or more unsuccessful attempts at quitting. Of these 303 (64.3%) were successful, and 232 of these were CO verified.

7.4.1.7 Overview of specialist service use

In 2014/15, a total of 3146 smokers who would be classed as being in a target group accessed smoking services commissioned by WSCC. Of these:

- 1094 (34.8%) were seen by the specialist stop smoking service
- 1736 (55.2%) were seen by GPs
- 301 (10%) were seen by pharmacies

The 2014/15 data also shows that a total of 1280 smokers accessed the specialist stop smoking services, (i.e. set a quit date), of which 186 smokers were not classed as being in the target groups. In addition 36 smokers in the target groups were treated in prison.

These data show us that the numbers of successful quitters, in all target groups, are falling short of expectation for a specialist service. There is also a significant proportion (14%) of specialist service users who do not fall into target groups; with 186 smokers supported who did not belong to any target group. Although the transactional data show who these people are and the settings they were seen in, it is not clear how or why they were referred into the specialist service.

Data also show that a significant number of smokers in the target groups are being seen *outside* of the specialist service. For instance, in the non-specialist setting, GPs saw some 3234 smokers of whom 1736 (54%) were in target groups. This means that more than half of smokers seen by GPs could have had support from the specialist service. It remains unclear as to why this is happening but things that would influence this are:

- GPs are best placed to use opportunistic approaches with their patients;
- GPs are able to prescribe and give advice in a single consultation;
- given that one third of patients are referred back to the GP for prescriptions in any event, it may be the most practical solution approach for the patient.

Although the specialist service provides a comprehensive stop smoking service, including access to prescription only medications, there are limitations. Due to the lack of in-house clinicians in some clinic locations and the absence of a PGD for the smoking advisors, the service cannot provide a 'one stop shop service' where the client leaves with a prescription. Instead, they require a GP to write the prescription for the service user. For example, where Varenicline and Bupropion are chosen as the optimum therapy by the smoker and advisor, smokers are referred back to a GP for the prescription. The customer mapping journey (Appendix 3) shows the pinch points which – regardless of point of access of smoking services - returns the person seeking support to the GP or primary prescribing clinician.

In addition, stakeholder feedback received from maternity services suggests that there are similar barriers to pregnant women accessing nicotine replacement therapy (NRT). Although this population are contra-indicated for Varenicline and Bupropion, midwives are unable to provide any NRT that impacts on their ability to use MECC aligned opportunistic approaches. In this case, and others who use the MECC approach in their work, a PGD would be of significant value as an enabler. Other local authorities have used this approach with good results.

7.4.1.8 Current set up of the specialist stop smoking service

There is no patient group directive and no clinician within the specialist service. This may represent a significant barrier to the success of the service. This can be demonstrated by looking at the data which shows the prevalence of pharmacological therapy use in quit attempts in the specialist service. Of a total of 5177[xxiii] smokers accessing any WSCC stop smoking service, 1932 (37%) required a therapy only available on prescription. Of these, 381 (20%) were seen in the specialist setting. Of the total accessing specialist services, 31% require pharmacological therapy, which is available on prescription only. This broadly equates to one in three patients having to attend an additional appointment. Based on the standard ten minute GP appointment time, this equates to an additional 63.5 hours of GP time over a year.

Benchmark authorities have reported a significant increase in performance where PGDs are available for specialist and other clinical staff. This has many benefits because:

- patients have a seamless service where they can attend a single appointment to commence their therapy;
- this increases accessibility, especially to those unable to travel to or attend multiple appointments and venues;
- this empowers and enables clinicians to deliver a whole service and provide continuity; and
- this will free additional GP consultation time therefore making savings.

[xxiii] This figure differs slightly compared to the HEA figures due to the lag time in the data

This is supported further by feedback from maternity services, who suggest that empowering and equipping midwives with a PGD will enable them to capitalise on opportunistic approaches within the pregnant population, and increase quit rates.

7.4.2 Access to stop smoking services - Health Equity Audit (HEA)

West Sussex County Council Public Health and Social Research Unit were commissioned by the stop smoking service commissioners to undertake an HEA (Appendix 2). The HEA looked at the availability and accessibility of the entire stop smoking service (i.e. both general and specialist), especially to those with protected characteristics under the Equality Act, 2010. This audit concluded that access to stop smoking services was varied both geographically and demographically and was found to be below the performance 5% targets recommended in NICE guidance. HSCIC data suggest that these inequalities remain. The full HEA is appended (Appendix 2).

7.4.2.1 Effectiveness of service

Data show that of the 1266 smokers accessing the specialist service, 751 (59%) were recorded as having successfully quit at four weeks (both self-reported and CO verified). (It should be noted that data for anything over this time period are inconsistent and therefore should be interpreted with caution). This represents a quit rate of 59%, with 14% being lost to follow up. The specialist service quit rate compares favourably with those GPs and pharmacies providing smoking cessation services, whose quit rates are 49% for each setting; with 'lost to follow up' rates of 28% and 30% respectively. However, as GPs and pharmacies provide services across the whole population and a wide health spectrum, this difference in quit rates is to be expected.

7.4.2.2 Conclusions about the specialist stop smoking service

The current specialist service, although having favourable quit rates compared to GPs, does not seem to be attracting the target groups into the service. There are a number of reasons why. However other healthcare providers such as GPs and pharmacies do attract and successfully treat these groups. The survey of professionals highlighted a need for more training; this, in line with supportive mechanisms such as PGDs, will enable them to ensure every contact counts. It is clear from the survey of the general population that smokers and ex-smokers who responded have used or intend to use the most convenient means to stop smoking – regardless of the evidence base. Currently the system in place allows the provider to deliver an incomplete service in terms of pharmacotherapy because they rely on the GP to prescribe for the individual. This acts as a' pinch point' in the system, causing further inconvenience for the smoker; and given the evidence around behaviour change needing to be easy, attractive, social and timely, this is a sub-optimal approach.

Recommendations:

Given the data presented in this chapter, commissioners may wish to consider a range of options for this service:

- Whether there is need for a specialist service in its current form – given the efficacy of GPs to successfully treat people in target groups.
- Changing the emphasis of the SSSS providers from support for smokers in target groups to training and supporting other professionals to deliver these interventions to smokers across the population.

- Consider subsidising quit attempts
- Increase the sign up of pharmacies to take on smoking cessation work to support GPs.
- Increase use of nurse prescribers in stop smoking GP surgeries to support GPs.
- Placing specialist stop smoking advisors in Trusts, where there are high levels of target groups who would benefit from opportunist approaches and immediate referral/consultation.
- Engaging with the clinical commissioning groups to request a patient group directive and shared pathways to improve services and enable all frontline staff to make every contact count and in turn make savings.
- Engaging with maternity services and mental health services registered practitioners to agree pathways where midwives and Community Psychiatric Nurses are able to provide NRT or pharmacotherapy through a PGD mechanism to increase the success of opportunistic approaches in the pregnant population and those accessing mental health services.
- Using demand forecasting models to explore how this might enhance commissioning of these services.

7.4.3 Using market segmentation tools in tobacco control

Having identified high risk groups for tobacco use, we used Experian's market segmentation tool called Mosaic to explore smoking trends in West Sussex. Mosaic uses data from different sources and divides the UK population into 15 Mosaic Groups and 66 more detailed types. It uses over 400 data variables and paints a picture of UK consumers based on their demographic characteristics, lifestyles and behaviour. Using these Mosaic groups helps give commissioners and service providers some insight into consumer trends that impact on smoking activities in West Sussex, and will also help in segmenting the 'market' for stop smoking services and other tobacco control activities. It is worth stressing that as Mosaic is a market segmentation tool, it uses the data to make best guesses. Based on Mosaic groups, we identified the people likely to smoke cigarettes (Figure 39).

Figure 39 - Mosaic types likely to smoke cigarettes in West Sussex

Young people endeavouring to gain employment footholds while renting flats and terraces	**Hard-pressed singles in low cost social flats searching for opportunities**
• **45.4%** of households are likely to have smoked in the last year • **1,790 (0.49%)** households in West Sussex • Likely age: **18-25** • Likely household income: **<£15k** • Council or association homes • Preferred communication channel: **Smartphone** • Found in the largest numbers in **Central Ward (Worthing)**	• **44.9%** of households are likely to have smoked in the last year • **2,465 (0.68%)** households in West Sussex • Likely age: **26-30** • Likely household income: **<£15k** • Council or housing association homes • Preferred communication channel: **Post** • Found in the largest numbers in **Roffey South Ward (Horsham)**
Renters of social flats in high rise blocks where levels of need are significant	
• **42.9%** of households are likely to have smoked in the last year • **618 (0.17%)** households in West Sussex • Likely age: **31-35** • Likely household income: **<£15k** • Council or housing association homes • Preferred communication channel: **E-mail** • Found in the largest numbers in **Three Bridges Ward (Crawley)**	

Source: Experian Mosaic

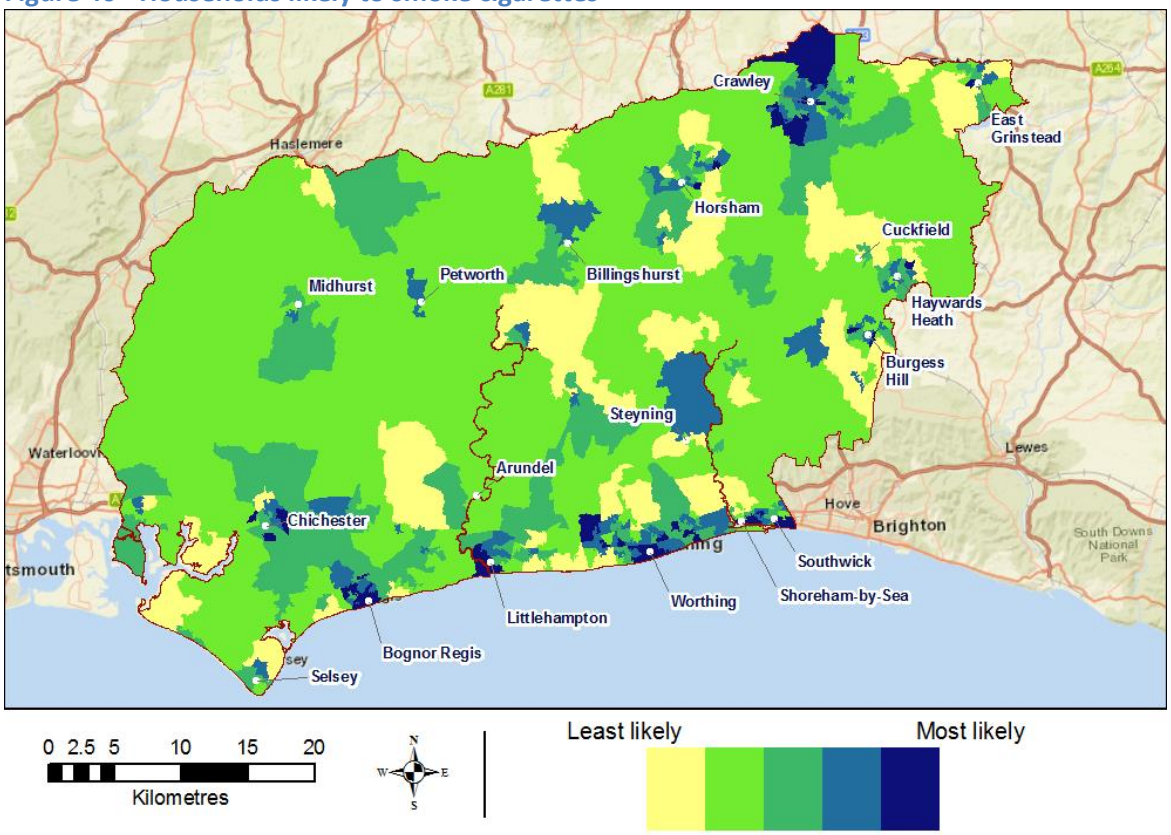
The top five LSOAs with the highest number of household most and least likely to smoke were also identified using Mosaic data (Table 9).

Table 9 - Likelihood of smoking cigarettes by LSOA level as shown below.

Most likely to smoke top 5 LSOAs			Least likely to smoke – top 5 LSOAs		
LSOA	**Ward**	**Average % of households most likely to smoke**	**LSOA**	**Ward**	**Average % of households least likely to smoke**
E01032835	Three Bridges	35.9%	E01031621	Chanctonbury	6.5%
E01031429	Courtwick with Toddington	32.9%	E01031412	East Preston	8.2%
E01031404	Broadfield South	32.6%	E01031803	Goring	8.3%
E01031404	Bersted, Orchard	31.7%	E01031383	Aldwick East, Aldwick West	8.5%
E01031450	Aldwick East[xxiv], Pevensey	31.1%	E01031703	Burgess Hill Franklands	8.6%

Figure 40 below shows the households most likely to smoke cigarettes, using Mosaic data.

Figure 40 - Households likely to smoke cigarettes



[xxiv] Aldwick East appears in both lists, however, they are 2 different LSOAs, though both are within Aldwick East ward

7.4.4 Evidence based interventions and guidelines for target groups

7.4.4.1 BAME groups - evidence based tobacco control interventions and guidelines

Tobacco use is culturally embedded in some minority ethnic groups, where tobacco use is seen as socially acceptable and contributes to group cohesion and identity [51]. Therefore, interventions that are culturally sensitive are the most effective and in addition, smoking cessation methods can be tailored to meet the needs of different communities[43, 51]. Examples of good practice in tailoring smoking cessation and community engagement include the West Sussex Specialist Stop Smoking service work with Asian minorities through Mosques in Crawley. Other examples are the Leicester NHS stop smoking service STOP! and the Bangladeshi Tobacco Cessation project in the London Borough of Tower Hamlets [51, 52].

Lack of awareness about the health risks of tobacco use, particularly smokeless tobacco among some ethnic groups has contributed to the ongoing use of tobacco products. Raising awareness, in combination with other evidence based interventions as highlighted in chapter seven of this report, are all key to reducing tobacco use. NICE published guidelines and recommendation on smokeless tobacco cessation, PH39, which includes the need to assess the scale of smokeless tobacco use locally, provision of brief advice and referral by health professionals, community engagement through working with local South Asian communities to plan, design, implement and publicise activities to reduce and stop the use of tobacco (NICE PH39). A Cochrane review also found that advice delivered by dental professionals is effective in helping tobacco chewers to stop [53]. However, we know that dental registration levels are very low in some ethnic groups.

7.4.4.2 Smoking in pregnancy - evidence based tobacco control activities and guidelines

PHE published an evidence review for the healthy child programme that included evidence on smoking during pregnancy. The review [54] found that:

- financial incentives to promote non-smoking during pregnancy have a potential to reduce smoking rates among pregnant women
- psychosocial interventions during pregnancy can increase the proportion of women who stop smoking in late pregnancy.
- proactive telephone counselling is effective in helping to reduce smoking in pregnant smokers who seek help from quit lines.
- Self-help smoking cessation interventions for pregnant smokers appears to be effective
- Behavioural change components within effective smoking cessation interventions during pregnancy include: the provision of rewards based on smoking cessation; utilising carbon monoxide (CO) measures; facilitating relapse prevention; information on consequences of smoking and cessation; identifying relapse triggers; goal setting; assessing current and past smoking behaviour; assessing readiness to quit; appropriate written materials; and facilitating social support
- The evidence for the efficacy of interventions to establish smoke-free homes in pregnancy and in the neonatal period is still inconclusive.

Women who quit smoking during pregnancy demonstrate high rates of relapse after childbirth, and consequently may need additional support. NICE has also issued guidance with recommendations

on stopping smoking in pregnancy and following childbirth (PH26). The recommendations include training needs for midwives, health visitors and other health professionals, provision of tailored and accessible services as well as the interventions relating to partners and other household members who smoke.

7.4.4.3 Young people - Evidence based tobacco control interventions and guidelines

Education and the enforcement of trading standards are key factors in making sure school age children and teenagers understand the risks and negative health impacts of using tobacco related products. This will support, empower and enable young people to manage peer pressure and informs positive decision making around smoking and other tobacco use. The National Institute for Health and Care Excellence (NICE) recommends that multi component interventions that combine community-based activities, mass media campaigns and systematic tobacco education in schools are effective approaches in reducing smoking uptake in children and young people. NICE has also issued some guidelines and recommendations on interventions to prevent the uptake of smoking amongst children and young people:

- PH14 – Smoking: preventing uptake in children and young people
- PH23 – Smoking prevention in schools

Evidence indicates that schools have a key role to play in preventing tobacco use among children and young people including tobacco education, peer-led interventions, providing very brief advice and smokefree policies. However, it is equally important to focus on programmes that de-normalise smoking in the general population and promote smokefree home environment, given that parental, caregiver or sibling smoking is one of the predictors of a young person smoking.

7.4.4.4 Mental health service users - evidence based interventions and guidelines

People with mental health problems are just as likely to want to quit smoking as the general population and are able to do so if they are supported using evidence based stop smoking interventions [34]. NICE guideline PH 48 sets out some recommendations for smoking cessation in mental health services. The recommendations include: identifying people who smoke and offering them help to stop; providing intensive support for people using acute mental health services; putting in place referral systems for people who smoke and; developing smokefree policies. In addition, the Five year forward view for mental health set out an ambition for all mental health inpatient units and facilities to become smokefree by 2018. The core standards for community-based mental health services, developed by the Royal College of Psychiatrists' College Centre for Quality Improvement (CCQI) and the British Standards Institution (BSI) also recommend a review of the patient's lifestyle factors, including smoking, as an essential part of initial assessment. In addition, smoking cessation advice should also be given [55].

7.4.5 Evidence from engagement with stakeholders

7.4.5.1 Public consultations

Public survey

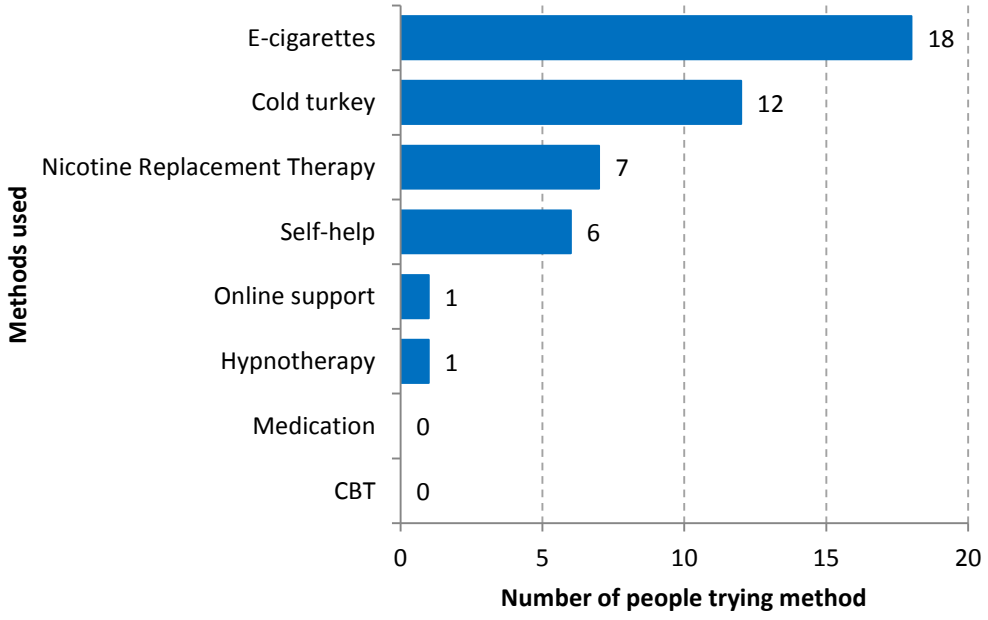
More than a quarter of respondents (156 respondents, 26.6% of all respondents) said that they were aware of activities in their local communities that focus on helping people to quit smoking.

Participants in the public survey consultation were asked if they had ever accessed stop smoking services or other support to stop smoking for themselves or on behalf of someone else. If participants reported that they currently used tobacco or nicotine products elsewhere in the survey, they were also asked if they had attempted to quit or cut down use in the past 12 months.

Sixty participants in the public survey reported currently using some kind of tobacco or related products (including nicotine products such as e-cigarettes, and other 'smokeless' tobacco products). Of these, 18 participants (30.5%) said they had tried to stop smoking in the last 12 months, and a further 14 participants (23.7%) reported trying to cut down tobacco use. Of the 32 respondents who attempted to quit or cut down use, 23 participants reported using just one method of trying to quit/cut down. Six participants used two methods and three participants reported using three methods to quit.

Figure 41 shows the most common methods used to cut down/quit smoking among current tobacco or nicotine users in the public survey. Of the 32 participants who tried to quit or cut down use in the last 12 months, more than half (18 participants, 56.3%) reported using e-cigarettes. The second most common method of trying to cut down/quit was to stop using tobacco without any aid (go cold turkey) with 12 participants reporting this method of cessation. The third most common method to quit tobacco was nicotine replacement therapy (n=7, 21.9% of those who attempted to quit). None said they had tried cognitive behaviours therapy (CBT) or other medication (e.g. Champix) to stop smoking.

Figure 41 – Methods used to attempt to cut down/quit tobacco use



Notes: the same person may be counted more than once if they used multiple methods to attempt to cut down/quit tobacco use.

Whilst more than half of current tobacco or nicotine product users in the survey had attempted to quit or cut down use, 46.7% (28 participants) reported having no intention to quit. Three participants reported using only e-cigarettes (e.g. not using smoked or smokeless tobacco) and had

no intention to quit using e-cigarettes. Four participants reported that the addiction/habit was too difficult to break and four said stress was the reason they did not quit. Social situations were a reason for not quitting for two current tobacco users and another two participants cited external reasons stopped them from quitting.

"I do not think that the small amount of cigars I smoke warrants it." – Male, 56-65

"I only do it when I am on a night out - regard it as a 'treat' rather than a habit." – Female, 19-25

Time, lack of will power, and mental health were cited just once each as reasons for not quitting.

Just over half of the respondents in the public consultation survey (327 respondents, 55.7%) said they were aware of services and support available in West Sussex to help people stop smoking/using tobacco. A further 20.4% said they were unsure and 23.3% (137 respondents) said they were not aware of any smoking cessation services in West Sussex. Forty-eight participants (8.2%) said they had accessed stop smoking services for themselves or for others. Of those who accessed stop smoking services for themselves (*n* = 26), a third (*n* = 9, 34.6%) reported that they were not currently using tobacco products at the time of the survey.

Participants who reported current tobacco or related product use who were aware of stop smoking services but had not accessed them (*n* = 30) were asked what prevented them from using the service. The main reason given was that they had no intention to quit (*n* = 20) or an uncertainty over whether or not to quit (*n* = 7). Two respondents said they were too stressed to consider quitting. Other barriers were: not knowing the service was available (*n* = 1), difficulties getting to the service due to transport issues (*n* = 1); not knowing what to expect (*n* = 1); not having the time to attend sessions (*n* = 1); and not using tobacco (*n* = 1).

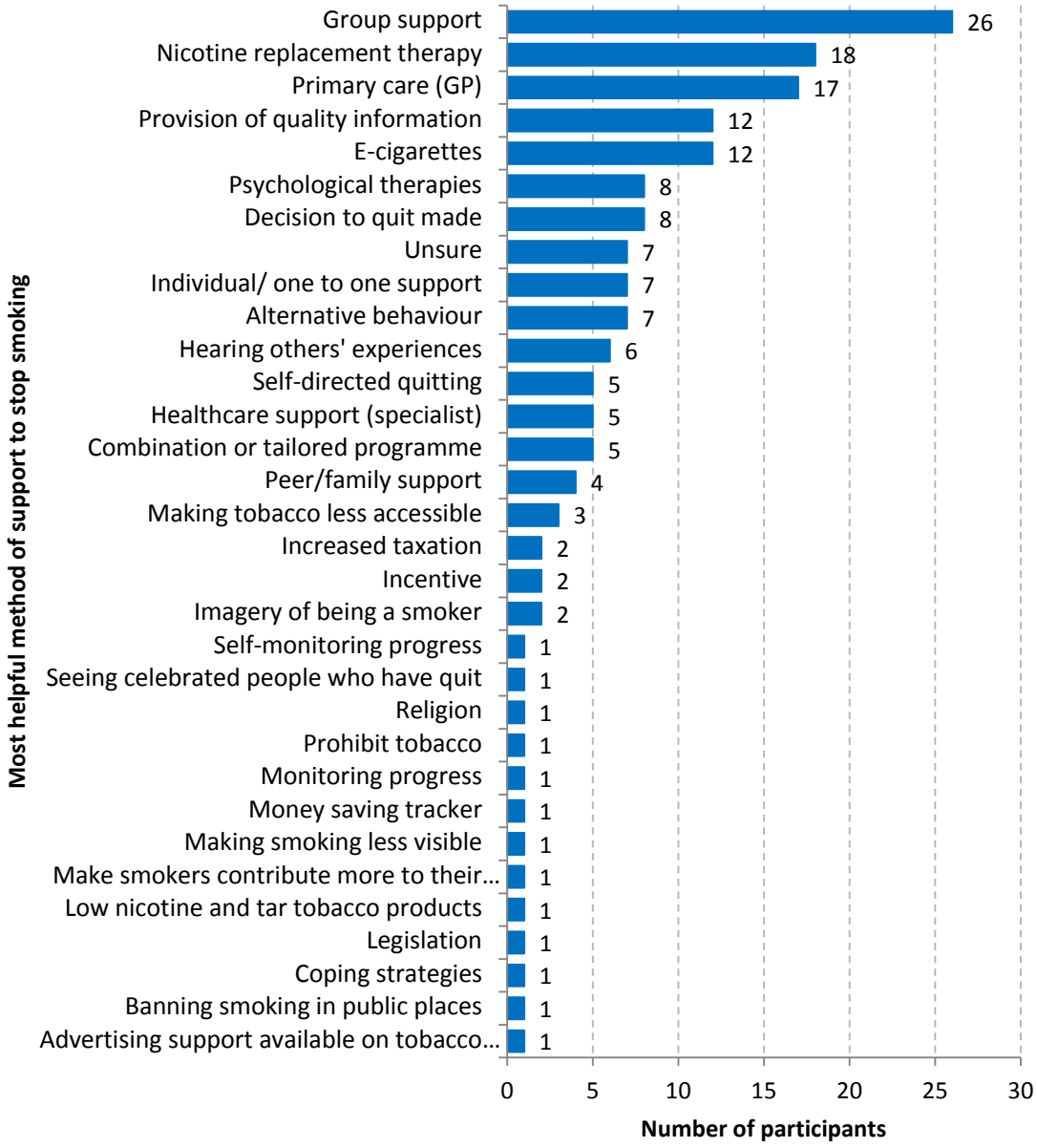
All participants, regardless of whether they used tobacco or nicotine products were asked *'If you wanted to stop smoking/using other tobacco products, what support do you think would be most helpful?'* This was a free text question (rather than a question where the respondent choses one or more options from a list) and a total of 169 responses were collected. These were grouped into themes (Figure 42). The top five themes of support given by respondents were; group support, nicotine replacement therapy, going to a GP or pharmacy, having quality information, and using e-cigarettes.

"Local community group meetings once a week, like 'AA'" – Female, 19-25

"Groups such as Weight Watchers and AA where experiences can be shared with people in the same situation. Providing support and goals which are set by the group to encourage giving up." – Female, 46-55

"Making nicotine replacement products e.g. chewing gum or lozenges as freely available as cigarettes. At present they are only stocked by chemists or a couple of supermarkets, whilst cigarettes are available in every corner shop" – Female, 66-75

Figure 42 – Most helpful support for stopping smoking/other tobacco products

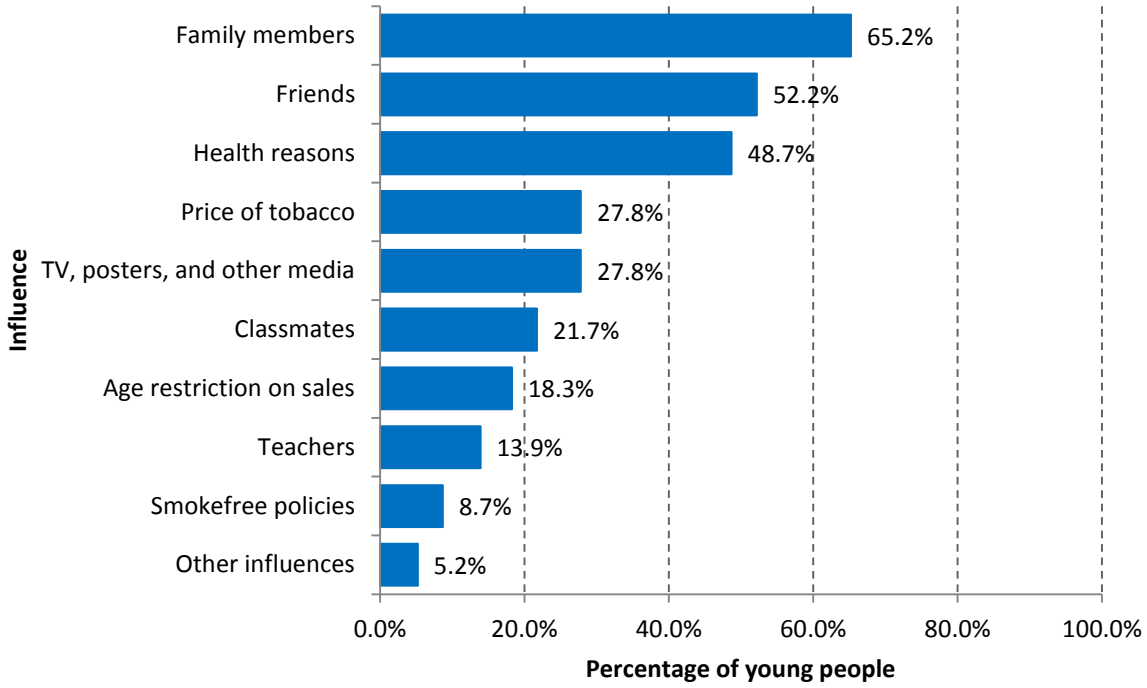


Among those aged 25 and under, 19.1% (*n* = 22) reported current tobacco or related product use (including nicotine products such as e-cigarettes) and three quarters of these participants (*n* = 17, 77.3%) reported trying to cut down or stop using tobacco or related products in the last 12 months. Those young people who reported trying to quit or cut down tobacco use in the past 12 months primarily used e-cigarettes (*n* = 10) to try to quit. Eight participants used just e-cigarettes, one participant used e-cigarettes in conjunction with other nicotine replacement therapy and one participant used e-cigarettes in conjunction with self-help material. Six young people tried to quit or cut down without any support (e.g. cold turkey) and one participant used self-help material alone.

Young people taking part in the survey were asked to think about the reasons behind their decisions to use or not use tobacco. The top three influences on decisions to use or not use tobacco among those aged under 26 years were family members, friends and health reasons. The graph below

indicates the proportion of respondents who reported each source of influence for their decisions around tobacco use (Figure 43).

Figure 43 – Influences on decision to use/not use tobacco among those aged under 26 years



Among the 22 current users of tobacco or related products aged 13-25 years, the most influential source for the decision to use tobacco was friends with around three quarters (77.3%, n = 17) reporting that friends influenced their tobacco use decisions. The second most cited source of influence for current users of tobacco or related products was family members with just under a third (31.8%, n = 7) saying that family members influenced their decisions.

Among current users aged 13-25 years, 17 respondents reported that experimenting was the reason for starting the use of tobacco products. More than half of the current tobacco smokers said that stress was one reason for starting tobacco use. Nine young people said that social/peer pressure was a reason for starting tobacco use and five respondents said that the reason for starting smoking was in order to make it easier to meet new people.

Interviews with BAME groups

GPs were considered as the first port of call for those wishing to stop smoking and most people reported that they would advise a family member or friend to see a GP if they wish to stop smoking. Those who didn't know about any stop smoking services also indicated that they would refer to GP. For those aware of the smoking cessation methods such as nicotine gum and patches, pharmacies were also seen as a place to refer someone who wants to stop smoking. Other than GP and pharmacy services, a few respondents highlighted that there were outreach stop smoking services/clinics carried out in schools and mosques.

Nicotine delivery products such as e-cigarettes, nicotine patches and nicotine gum were known to most interviewees as stop smoking aids. Similarly, others only knew about the medication (i.e. patches and gum) but did not know about behavioural therapies available to help people quit.

In some cases, e-cigarettes were used first as a quitting aid or for cutting down, but this resulted in dual use of both cigarettes and e-cigarettes at times. Dual use of e-cigarettes and cigarettes was also attributed to habit.

The ingredients in the aids used to help people stop smoking also have been highlighted as influencing whether some people use the product, as one participant expressed

*"For Muslim people, the nicotine strips from the GP are not ideal because they contain a small amount of alcohol... that is the problem with the UK that so many medicines have alcohol in them. The GP did not tell me when I was prescribed the nicotine strips that they had alcohol in them, it's only when I read the box that I knew" (*former smoker)

Some of the factors that influence people to smoke were reported and these included: taste, wanting to fit in as smoking was seen as socially acceptable and favourable in some cases; wanting to portray a certain image about self; influenced by friends, and stress and adverse life events. On the other hand, influences not to smoke or to stop smoking included: health reasons (cited by most of the interviewees); early education about harms of tobacco, cigarette price, the smell and taste of cigarettes; and family influence. Friends and family were influential in smoking and also not smoking/quitting decisions as highlighted by some interviewees. Influences from family also included some cultural practices as one young participant reported that he never smokes at home in front of his parents as this is deemed disrespectful in their culture.

Social influences for young people were also both a driver for smoking and a barrier to quitting and there emerged the idea of social smoking, which is seen as part of the socialisation process. Social smokers were referred to as those who only smoke in social situations such as parties or with friends. Self-designated "social smokers" may consider themselves in a different category to other, more regular smokers. This could impact their perception of the harm caused by smoking. In addition, those who manage to avoid 'social smoking' tend to end up being exposed to second-hand smoke as they socialise with smokers.

"I was influenced by my friends and I only smoke socially, it is not something that I started on my own… I don't get addicted to it; I only take a few puffs because my friends pass me the cigarette or the shisha but I have never bought a packet or smoked a whole cigarette. My friends think it's cool so I guess I have a puff with them" (smoker 16 year old)

"A lot of my friends are social smokers so at parties they will smoke. If you go to a party and everyone is socially smoking, what are you going to do? Just stand around by yourself? You end up smoking with them and then this is the slippery slope. (Non-smoker 17 years old)

For most interviewees, the main barrier to accessing services was language. Some people do not speak English as a first language, and a poor grasp of English makes it difficult for them to fully understand or engage with services. A recurrent theme among interviewees was the lack of promotional activity in other languages, which impacted on awareness and use of services.

"language is of course a barrier, if people cannot speak English or understand English then they won't be able to understand or use the service to its full intended extent or to the same advantage as those who speak English" (non-smoker).

Another cultural barrier to accessing services was the different help-seeking behaviours.
"The older generation do not like to go and ask for help, they don't want to tell anyone that they have a problem"

Paan, a type of chewing tobacco, is often used by people from South Asian community, particularly Bangladeshi and it is considered a form of cultural identity. Some Paan chewers lack an awareness of the health risks of Paan. Shisha was also reported to be used, particularly by young people and seen as a social activity by some.

"*It's everywhere, so many kids my age use shisha. Asian boys always go to shisha bars and some girls go too and now some white people have started going in my year group"* (non-smoker)

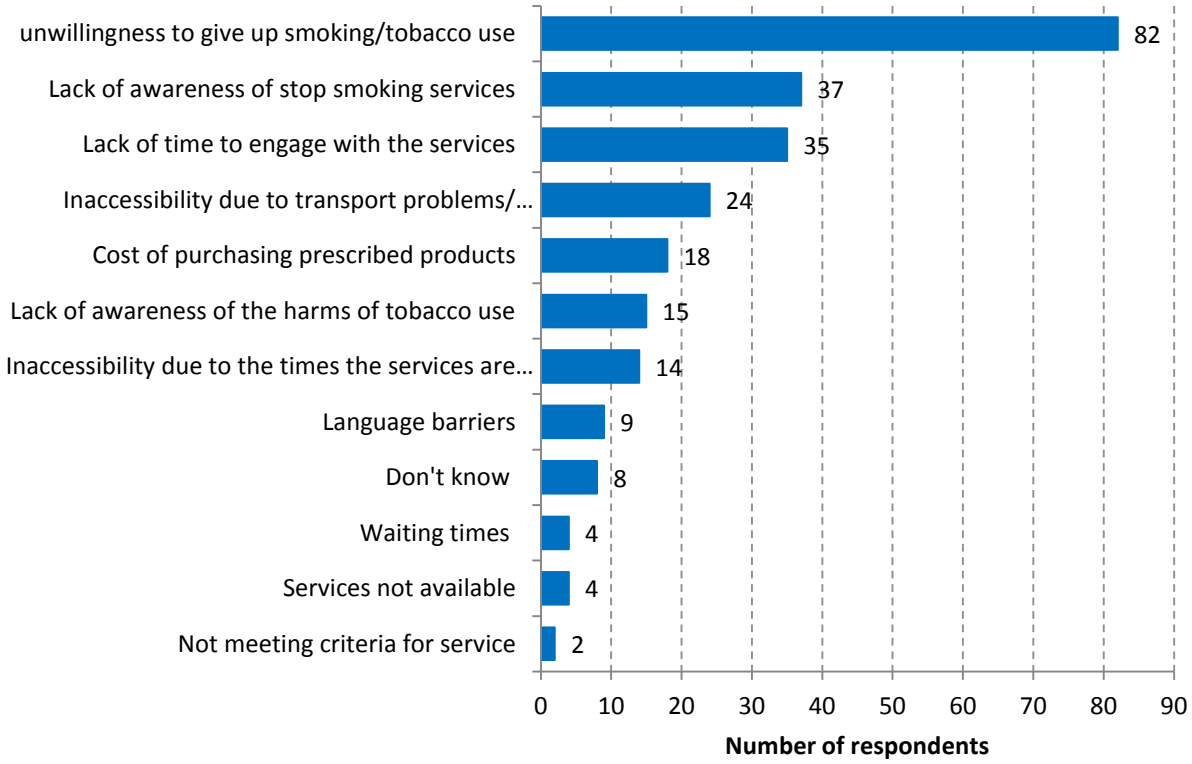
7.4.5.2 Professionals survey

67% (63 respondents) of the professionals were aware of the Smokefree West Sussex Stop Smoking Service, 32% (30 respondents) didn't know about the service. However, more than half of the respondents (55%, 52 respondents) said they had never referred anyone to the service. Only 16% (15 respondents) always referred (n =2) or regularly referred people (n =13) (
Figure 44)

Figure 44 - Frequency of referral to stop smoking services

When asked what they believed where the main barriers to accessing stop smoking services by the people/clients or service users they work with, the majority of respondents (82, 87%) indicated that unwillingness to give up smoking/tobacco use is the main barrier, followed by lack of awareness of Stop smoking services (37 respondents, 39%) and lack of time to engage with services (35 respondents, 37%) (Figure 45)

Figure 45 - Responses to barriers to accessing stop smoking services



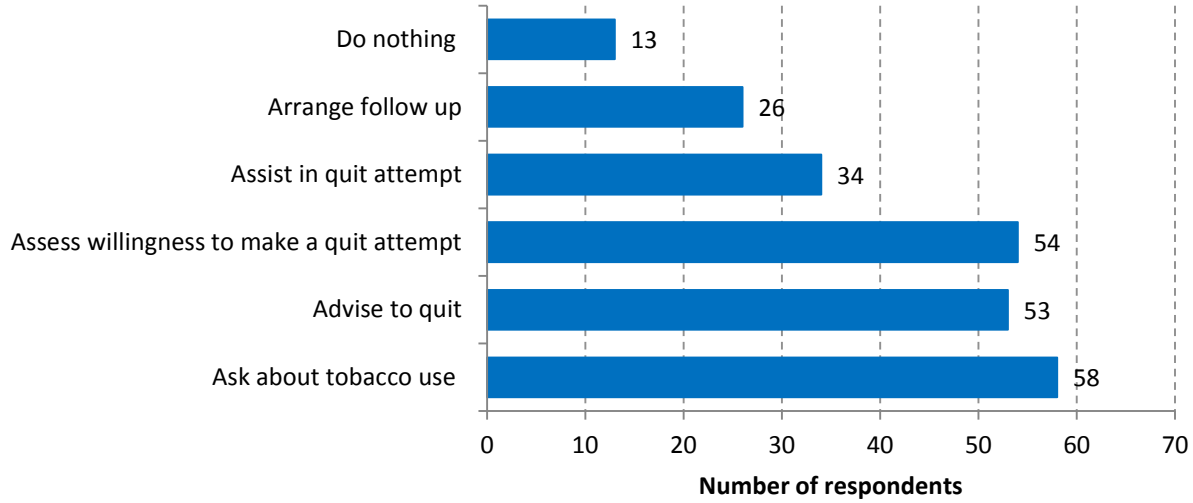
Other barriers identified were inability to access services due to learning disabilities and *"young parents feeling stigmatised*".

The professionals who took part in the survey were asked if they engaged their clients/service users in any of the five As of brief interventions (i.e. Ask about tobacco use, Advise to quit, Assess willingness to make a quit attempt, Assist in quit attempt, Arrange follow-up). Responses are shown in Figure 46.

When asked what gaps exist in the provision of services to reduce/prevent tobacco use and second-hand exposure, some professionals indicated that lack of in-house services for pregnant woman and the referral to the stop smoking service can be an impediment

"Currently pregnant women have to be referred to SSS and this can be another hoop for women to jump through, for vulnerable women and young parents it could be more successful if midwives could provide NRT within the community so that it is much more readily available and gives people more opportunity".

Figure 46 – Responses to engagement with the five As of brief interventions



7.5 Reducing exposure to second-hand smoke

Smoking not only affects the health of the smokers, it also causes significant harm to non-smokers through second-hand smoke. There is conclusive international evidence that smoking affects most organs and that there is no safe level or risk free exposure to second-hand smoke (SHS). Second-hand smoke or exposure to tobacco smoke is known to be cancer causing and can cause long term and severe harm, including death, for children, unborn babies and new-born infants (WHO). Negative health effects associated with exposure to SHS include conditions such as lung cancer, respiratory diseases, cardiovascular diseases, asthma, eye and nasal irritation. It also increases the risk of low birth weight and Sudden Infant Death Syndrome (SIDS) in babies of non-smokers who have been exposed to second-hand smoke. The health of babies born into lower income households is disproportionately affected by second-hand smoke.

Whilst there is conclusive evidence about the harms of second-hand tobacco smoke, evidence on the impact of second-hand exposure to electronic cigarette vapour is still limited. However, as e-cigarettes do not contain tobacco, current evidence indicates that risks from second-hand exposure to e-cigarette vapour are likely to be extremely low and minimal compared to conventional cigarettes [14].

7.5.1 Current West Sussex tobacco control activities

In West Sussex, smokefree policies in public services vary across different organisations, including NHS trusts, local authorities, and clinical commissioning groups (CCGs). We have reviewed the policies around tobacco use relating to staff/visitors, as part of this assessment. There are a total of six policies from the five NHS trusts covering West Sussex, one of which is a separate policy for the forensic mental health services within the Trust. All the NHS Trusts had a smokefree policy, and the majority of them, except one, had a complete ban on smoking on the premises. Only one trust permitted smoking in designated areas.

In regards to training for frontline staff who may identify or refer smokers, two trusts explicitly indicated they provide or offer training, and one of these Trusts provides smoking cessation training

to clinical staff who have been trained as smoking advisors. In the remaining policies, training provision was not clearly specified.

Similarly, policies for all West Sussex local authorities, including WSCC were reviewed. All the organisations had a policy regulating smoking in the workplace. Five local authorities (WSCC, Horsham, Worthing, Adur and Mid Sussex) had a 'smoking' policy, one district council (Arun) had a 'no smoking' policy and one (Chichester) had a policy statement. Only Crawley Borough council had a 'smokefree' policy. Five local authorities had a complete ban on smoking on premises (Mid Sussex, Crawley, Chichester, Adur and Worthing), whilst the other three (WSCC, Horsham, and Arun) permitted smoking outside or in designated areas. All the local authority policies did not explicitly identify training offered or provided for staff about smoking and tobacco use.

7.5.1.1 Voluntary Smokefree policies

Arun Wellbeing previously funded "No Smoking" signage for each playground across the district as a voluntary smokefree initiative. However, there is no legal enforcement of the policy. In 2012, Worthing Borough council proposed smoking bans in outdoor play areas[xxv]; however, at the time of writing, we were not able to clarify whether these have been implemented.

Whilst the smokefree legislation prohibits smoking on trains, it does not include open train platforms. Train service providers in West Sussex (Southern Rail, and Thameslink/Gatwick Express) have smoking bans on their platforms[xxvi]. E-cigarettes are also banned on their train platforms.

7.5.1.2 Smokefree legislation enforcement

Environmental health departments that sit within West Sussex district and borough councils are responsible for enforcing smokefree legislation and ensuring compliance. The environmental health teams provide data on non-compliance with smokefree legislation and also whether there are voluntary smokefree policies in public areas in place.

Crawley: in the past 5 years, there have been a total of 27 complaints regarding non-compliance with the smokefree legislation. Generally, compliance has been achieved without formal notices being issued.

2015 - 5
2014 - 7
2013 - 4
2012 - 5
2011 - 6

[xxv] Joint Strategic Committee 2012 agenda item 9 http://www.adur-worthing.gov.uk/media/media,90318,en.pdf
[xxvi] Source: http://www.thameslinkrailway.com and Southern passenger charter

Adur and Worthing: 2 cases of noncompliance with the smokefree legislation where reported, 1 involving an individual smoking at a football club bar, and the other was a complaint in regards to smoking at the entrance of a coffee shop. Both cases were resolved informally.

Horsham: A total of 12 fixed penalty notice (FPN) were issued in respect of taxi/private hire drivers smoking in their vehicles with the last FPN issued in 2012.

Arun: A total of 20 FPNs were issued for smoking in taxis by taxi/private hire drivers since 2010:
2010 8
2011 3
2012 5
2013 2
2014 2
2015 0
One unpaid FPN resulted in prosecution. Informal actions were also undertaken in the form of 'Word of Advice' on one taxi firm and one pub in regards to smoking on the premises. A few complaints about smoking in smokefree areas were also reported and dealt with by way of advice, verbal or in writing. One gambling premises and three pubs were advised regarding smoking shelters that do not comply with regulations.

Chichester: a total of 60 complaints have been received since 2007, broken down as following;
2007 – 18 Complaints – plus 37 requests for advice/guidance/signage to support the new requirements.
2008 – 10
2009 – 6
2010 – 2
2011 – 7
2012 – 5
2013 – 8
2014 – 0
2015 – 1
2016 – 3 (as of April 2016)
All complaints received were resolved with education and warning, and without formal action such as FPNs. No repeat offences have been reported.

Mid Sussex: At the time of writing, we had not received data from Mid Sussex.

7.5.2 Evidence based interventions and guidelines to reduce second-hand smoke

There is strong evidence that comprehensive smokefree legislation in all enclosed public places and workplaces, including bars, restaurants, reduces exposure to second-hand smoke [1, 6, 56]. Consequently, a reduction in exposure to second hand smoke has also been shown to reduce hospital admissions for acute coronary events, and other smoking related mortality and morbidity, particularly in non-smokers [56]. The enforcement of the national smokefree legislation and

supporting families to make their homes and cars smokefree are some of the key tobacco control interventions to reduce second-hand smoke exposure. As well as reducing environmental tobacco smoke, promoting and encouraging smokefree environments also has the potential to influence social norms, reduce smoking related litter, reduce childhood exposure to smoking behaviours of others and encourage quitting [57]. The Tobacco Control Plan for England recommended the creation of local smokefree ambassadors at a community level, to encourage and support people to make their homes and families smokefree [1]. There is evidence that smokefree workplaces can lead to an increase in smoking cessation among workers.

WHO recommends the enforcement of a complete smoke free environment in healthcare and educational facilities, as well as indoor places [58]. The current national smokefree legislation prohibits smoking in enclosed spaces; however non-enclosed areas such as health care premises, workplace campuses and outside building entrances are not included. Indoor smokefree laws greatly reduce, but do not completely remove the potential harm caused by second-hand smoke exposure due to the residual exposure from smoking on premises or around boundaries of venues [59]. This presents an opportunity for healthcare and educational establishments to implement smoke free policies across their premises/campus to protect people from environmental tobacco smoke. Raising awareness of smokefree policies, by providing clear and adequate signage and supporting smokers to quit are important when it comes to increasing compliance. Evidence suggests that smokefree policies can potentially be extended to other public areas such as parks, playgrounds, high streets and outside building entrances.

Some organisations have smokefree policies that do not allow smoking on their premises and similarly other public places such as train platforms have been designated as smokefree, where smoking is not permitted.

West Sussex has one prison, Ford prison and smoking is currently still permitted in the prison. However, nationally, this is still under review.

7.5.3 Evidence from engagement with stakeholders

7.5.3.1 Public consultations

Public Survey

More than three quarters of respondents in the public consultation survey (450 people, 76.7%) said they were aware of regulations banning smoking indoors and in enclosed outdoor spaces. Just under three quarters of those aged 25 years or under (n = 82, 71.3%) reported that they were aware of tobacco control regulations to restrict the use of tobacco products in enclosed public spaces.

Over 87% (516 respondents) said they were aware of regulations banning smoking in cars with passengers under the age of 18. Slightly fewer young people (those under 26 years old) (n = 89, 77.4%) said they were aware that there was a ban on smoking in cars with children.

Only ten per cent (57 respondents, 9.7% of all respondents) said that they were aware of activities in their local communities focusing on reducing exposure to second-hand tobacco smoke.

When asked how much they thought their town/city did to protect non-smokers from second-hand tobacco smoke, 19.4% (114 respondents) said their town/city did nothing. A third of respondents (204 respondents, 34.8%) said their town/city did 'a bit' to protect non-smokers from second hand smoke and a further 42 respondents (7.2% of all respondents) said their town/city did a lot to protect non-smokers from second hand smoke.

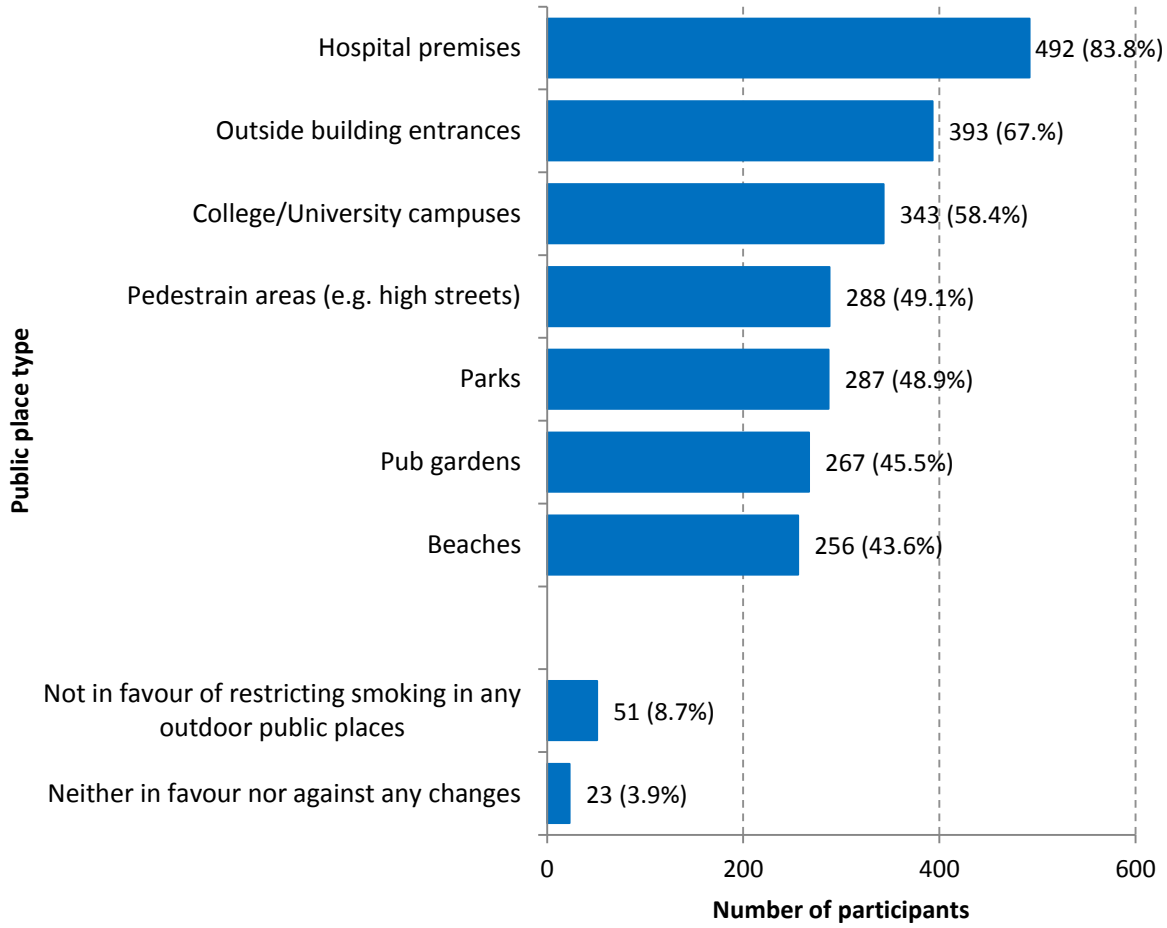
Almost a quarter of respondents (143 respondents, 24.4% of all respondents) reported that people living in their household or regular visitors to the household were smokers. However, 102 (71.3%) of these participants also reported that their homes were completely smokefree (e.g. smoking was not permitted inside the home) and a further 21 respondents (14.7% of those who said members of the household or regular visitors smoked) said that smoking was only allowed in some rooms.

Forty-one participants (7% of all respondents) said that their homes were not smokefree (e.g. anyone could smoke in the house) although less than half of these (*n* = 19) said that members of the household or regular visitors smoked. Of the 115 young people answering the TCNA consultancy, over 90% (*n* = 104) reported that smoking was not permitted, or only permitted in certain areas of their home.

Support for smokefree public places was high with 87.4% of respondents in the public consultation survey (513 respondents) saying that they supported smokefree public places. Figure 47 shows the percentage of respondents who supported restricting smoking in specific public spaces such as parks, beaches, hospital premises and pedestrian areas. The figure shows that more than four in five people (83.8%, *n* = 492) supported making hospital premises smokefree. Over two thirds of respondents (67%, *n* = 393) supported restricting smoking near entrances to buildings and 58.4% (*n* = 343) supported banning smoking on college and university campuses. However, less than half of respondents to the public survey consultation supported banning smoking in pedestrian areas (49.1%, *n* = 288), parks (48.9%, *n* = 287), pub gardens (45.5%, *n* =267) and beaches (43.6%, *n* = 256). Almost one in ten respondents (8.7%, *n* = 51) said they were not in favour of restricting smoking in any outdoor public places.

Almost 90% of young people (*n* = 101, 87.8%) said that they supported smokefree policies in public places with 96 young people (83.5%) supporting a ban on smoking on hospital site. Over two thirds of young people said they would support restricting tobacco use in parks (*n* = 78, 67.8%). Just over half (*n* = 59, 51.3%) of young people said they would support restricting tobacco use on beaches. However, less than half of young people (*n* = 54, 47%) supported a ban on smoking on college campuses, and just two in five (42.6%, *n* = 49) said they supported policies restricting tobacco use in pedestrianised areas. Six young people said they were not in favour of restricting tobacco use.

Figure 47 – Support for smokefree places by type of place among public survey respondents



Notes: percentage of respondents given in brackets

Interviews with BAME groups

Similar to the public survey responses, nearly all those interviewed, including smokers, supported the idea of having some smokefree areas, particularly where children play. However, views about which areas should be smokefree varied between individuals. Responses included smokefree pavements and door entrances, town centres, hospitals, pub gardens, beaches, parks, banning smoking in all outdoor places, bus stops, and places where food is served.

"I don't think outdoor places like parks and beaches should be banned from smoking because its outdoor places and people should be allowed to smoke. But bus stops should be smokefree as they should count as indoor public areas" (smoker)

Non-smokers reported that they were exposed to second-hand smoke on pavements and building entrances, which was a concern for them as it affected their health too. Some felt that second-hand smoke takes away their choice not to smoke

"Smoking affects all the people, smokers and non-smokers, but non-smokers more because they have made a choice not to smoke but we are forced to smoke against our will" (non-smoker)

"I know that in shops it's banned but when you come out of them, you get a wave of smoke in your face and in markets where people are shopping as well" (non-smoker)

To reduce second-hand smoke exposure, the following themes emerged;

- Helping smokers to stop smoking
- Extending the smoking ban to all or more outdoor areas
- Non-smokers taking some responsibility by avoiding smoke
- Helping non-smokers understand how to reduce second-hand exposure
    - *"a person must be responsible for themselves and if they haven't asked the person to stop smoking, and they won't, then the person should get up and walk away"* (non-smoker)
    - *"They should move instead of sitting down next to someone who is smoking but if they are already sat on a bench for example, then another person should not light up a cigarette. This is common sense and should not be regulated"* (smoker)
- Provision of designated smoking areas

Some interviewees felt they had more control over smoking in their homes, compared to public areas. Most of the non-smokers reported that their homes are smokefree and that visitors are only allowed to smoke outside.

7.5.3.2 School survey

When asked if the school had a smokefree policy, 15 respondents (out of 18) reported that their school has a smokefree policy which covered pupils, teachers and other school staff as well as parents and visitors. Two responded that the school did not have a smokefree policy, whilst one respondent responded 'don't know'. Most of the respondents (12) reported that their smokefree policy had not been reviewed in the last 12 months, and two didn't know if they had been reviewed. Only three respondents reported that their school smokefree policy had been reviewed in the last 12 months.

The respondents highlighted that smoking was prohibited in certain areas of their schools as shown below (Table 10).

Table 10- Smokefree areas in schools

Areas where smoking is prohibited	Number of respondents
School playgrounds	16
Car park	16
School gates	12
Outside building entrances	13
Sheltered outdoor areas	16

7.5.3.3 Professionals survey

When asked about their organisation's smokefree policy, the majority of the respondents (70%, n=66) reported that their organisation had a smokefree policy. Three respondents (3%) said their

organisation did not have a smokefree policy and seven (7%) didn't know whether their organisation had a smokefree policy.

Sixty-one percent respondents (n=58) said that their smokefree policy prohibits smoking anywhere on the premises, with 16% reporting that the policy allowed smoking in designated outdoor areas. A small number of respondents (3%, n=3) didn't know if smoking was prohibited or allowed by their organisations. Similarly, most of the respondents (47%, n=44) reported that their organisations prohibited e-cigarettes on the premises, and 11% (n=10) said that e-cigarettes were allowed in designated areas. However, a number of people (23%, n=20) didn't know their organisation's policy on e-cigarettes. Of those who responded (n=76) 34 reported they did not know if their organisation's policy provide guidance for staff who are likely to be exposed to second-hand smoke. Ten respondents said their organisation did not have guidance where staff were likely to be exposed, and nine confirmed that they did.

When asked whether there were any gaps in the provision of services to reduce/prevent tobacco use and second-hand smoke exposure, some professionals felt that parents lack the understanding of the impact of second-hand smoke on their children:

"I *don't think some parents are able to understand the relation to them smoking and the second-hand smoke getting to their children*…"

Another respondent highlighted that there is not enough protection of staff when they visit smokers' homes:

"*Healthcare staff are exposed to second-hand smoke; the only provision seems to be to ask the client to open the window prior to your visit".*

7.6 Effective communications for tobacco control

There is strong evidence that effective anti-tobacco communication interventions are powerful tools for preventing the initiation of tobacco use, promoting and facilitating smoking cessation and changing social norms in regards to tobacco use. The Tobacco control plan (2011) stresses this point and the need for the implementation of effective, coordinated marketing communications and mass media, both locally and nationally [1]. This includes amplifying the national campaigns at local and regional levels. Communications about the harms of smoking are essential in raising awareness and de-normalising smoking. Furthermore, in order to sustain the effects of a communication intervention, there is need to adapt and make changes over time, as what is seen as current and up to date may rapidly change given the ongoing technological and digital innovations [1]. Similarly, there is need to adapt communications to make them culturally relevant so they can reach their intended audiences.

7.6.1 Current West Sussex tobacco control activities

Tobacco control communications are mainly carried out by Smokefree West Sussex Partnership (SWSP). The SWSP's key marketing communications are centred on motivating smokers to quit, providing information on the effectiveness of the service and contact details of the service. This is

done through press releases, SWSP website, leaflets and supporting the following national campaigns; Stoptober, No Smoking Day, Smokefree Homes and Cars and local campaigns; Safer Sleep Week, Breathe Easy Week. However, the focus of communications on motivating smokers to quit leaves a gap in communications aimed at reducing initiation, and tackling illicit tobacco. The West Sussex CLeaR assessment indicated that West Sussex local actions on communications and de-normalisation is one of the poor performing areas, particularly in regards to engaging with communities.

7.6.2 Evidence based interventions and guidelines

Effective health communication strategies use a wide range of methods and channels to bring the message home, including mass media, social media, public relations and sponsorships. Social marketing is an approach used to develop activities aimed at changing or maintaining people's behaviour for the benefit of individuals and society as a whole. The primary aim of social marketing is "social good" and has often been used as a tool for health promotion. It is a "customer-oriented" approach and uses the concepts and tools used by commercial marketers in pursuit of social goals like anti-smoking campaigns. Interventions are more effective when developed with the users; therefore, co-designing is important in social marketing interventions. NICE guidelines PH10 and PH14 give some recommendations on social marketing interventions such as using multifaceted approaches and media campaigns as highlighted below.

The Tobacco control plan 2011 places emphasis on the use of behavioural insights and evidence based approaches in developing communications and social marketing initiatives, particularly in engaging young people and providing them information about risky behaviours that impact on their health. It also stressed the need to work with health and social care professionals to help engage with smokers, including pregnant smokers and their partners. NICE (PH 10) recommends the coordination and delivery of tobacco control communication strategies with key partners, i.e. NHS, Local Authorities and non-governmental organisations as well as regional partners. The strategies should;

- use the best available evidence of effectiveness
- be developed and evaluated using audience research
- use 'why to' and 'how to' quit messages that are non-judgemental, empathetic and respectful.
- involve community pharmacies in local campaigns and maintain links with other professional groups such as dentists, fire services and voluntary groups
- ensure campaigns are sufficiently extensive and sustained to have a reasonable chance of success
- consider targeting and tailoring campaigns towards low income and minority ethnic groups to address inequalities.

The use of digital media in health communication is a potentially powerful tool in targeting and engaging specific audiences through multiple communications such as websites, smartphones and tablet applications. However, these are complements not substitutes of traditional mass media [6]. Furthermore, there is need to evaluate the effectiveness of these different methods to build an evidence base.

Anti-smoking messages should not be looked at in isolation as *"it is not the content that make a difference, but the meaning and social relations it evokes"* [60]. There is strong evidence that working with the local communities in producing culturally sensitive resources and delivering and evaluating appropriate services is effective in raising awareness of services and health risk factors of tobacco use [43, 44, 52].

Box 2 – Case study

Case study - Social marketing in practice

By leveraging social marketing and co-design approaches Bolsover District Council engaged young people in the research, development and implementation of their own tobacco control interventions. Five secondary schools took part in the scheme to engage younger pupils around the dangers of smoking. The interventions generated by the pupils themselves included:

- a video with the pupils as lead characters
- posters and an anti-smoking clinic
- a games board for local junior feeder schools. The board encourages exercise and being smoke-free whilst using activities requiring mental arithmetic skills
- collaboration with a theatre group to deliver the 'no smoking' message through a stage play performed at feeder schools in the area.

7.6.3 Evidence from engagement with local stakeholder

7.6.3.1 Public consultation

Public survey

Just under half of the 115 respondents aged under 26 years in the public consultancy survey reported that they had seen or heard anti-tobacco messages or adverts online, on posters, or on TV in the previous 30 days (48.7%, n = 56). Nearly two thirds of young people (60%, n = 69) said they had seen e-cigarettes advertisements in the previous 30 days.

Of those aged under 26 years who took part in the TCNA consultancy survey, one in five (20.9%, n = 24) said they had not received any information in school/college/university on tobacco use. Among those who received information, 33 respondents (28.7% of young people) said that the information received at school/college/university was helpful in deciding to not start using tobacco and a further 5 respondents said that the information they had received made them think about quitting using tobacco. However, 17.4% of young people (n = 20) said that the information they had received did not help them to make decisions about using tobacco.

Just four respondents (3.5% of those under the age of 26 years) reported that their school/college/university had special groups of classes for students who wanted to quit using

tobacco. However, more than a third of young people (37.4%, n = 43) were not sure if classes were available.

Interviews with BAME groups

Although most of the interviewees could not recall seeing anti-smoking or stop smoking messages recently, most of them, both smokers and non-smokers, recalled seeing adverts for e-cigarettes or quitting products either on posters or on TV.

There were calls to increase awareness of services and harms of tobacco by breaking down the language barriers through mass communications that are tailored to different groups as highlighted by the interviewees.

"I think that adverts in my language should be placed in mosques in Asian shops and especially in the GP surgery."(Non-smoker)

"Advertise in different languages, deliver leaflets home to home and social clubs should have posters in different languages"

Other ideas to reduce tobacco use include providing counselling and others were also about the placement of these promotional activities;

"In every newsagent where there are shutters in front of the cigarettes being sold, they should advertise non-smoking activities…" (Smoker)

7.6.3.2 Schools survey[xxvii]

Schools play a key role in educating young people about the harms of tobacco use and preventing initiation. When asked how the schools incorporate tobacco control/anti-smoking education, 10 of the 18 schools that responded indicated that this was done as part of the national curriculum, 15 responded that it was done as part of PSHE and only 3 schools reported not providing any. However, a number of schools (8) educated their about the harms of tobacco use as part of the national curriculum as well as part of PSHE, and 4 used the national curriculum, PSHE and third sector or independent programme. The majority of respondents (10) indicated that they delivered this once per year for selected year groups and 3 reported that this was done once per year for all pupils.1 school responded that they delivered this once per term for selected year groups.

When asked what support schools need to prevent tobacco use and reduce second-hand exposure, the key themes that emerged from the 18 responding schools were that there is need to raise awareness of the harms of tobacco use and also provision of resources and communication strategies, that are suitable for their target group *"… visits from anti-smoking groups often help reinforce the message with students especially with high impact messages and leaflets etc."*.

[xxvii] A total of 18 schools responded to the online survey. Further details are available in Appendix 1 – Stakeholder engagement reports; schools survey.

"It would be valuable to have resources that teachers could use easily - video clips, PowerPoint presentations etc. as it is the work in planning and preparing that can be a barrier to providing more comprehensive teaching to young children. As a primary school, Years 5 and 6 would be the most appropriate target audience for these resources".

Schools were asked if their staff had received training to discuss tobacco control/smoking related harms with young people or offer very brief advice in regards to tobacco use. Of the 18 schools that responded, half (9) reported that none of their school staff had received any training, and only two schools reported all their staff had received training. Four of the schools reported that a few staff members had received training, whilst two schools responded "don't know/not sure".

When asked about programmes they provided that promote wellbeing and resilience in young people linked to tobacco control activities, five schools didn't provide any programmes, five were "not sure". Seven schools highlighted that they provided the following programs:

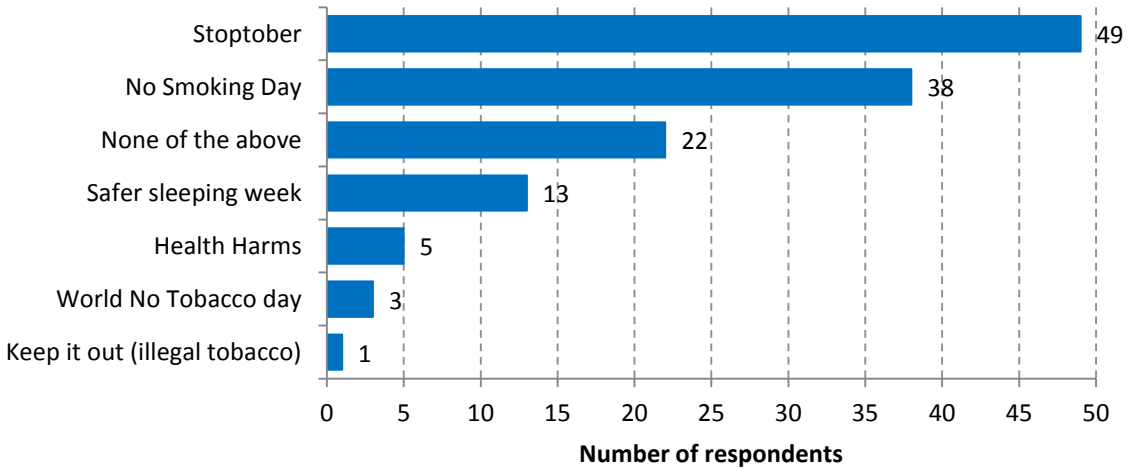
- programme with year 8 with Health Professionals
- Family Fitness session
- School nurse provision
- Life Education Van
- Happy Hearts come in every term for mixed year groups and touch this topic.
- PSHE scheme of work

7.6.3.3 Professionals survey

Thirty six respondents (38%) indicated that they do not receive updates on tobacco control activities. Twenty four respondents (26%) reported that they received updates by email, and the least mentioned method was social media (4% n=4).

National campaigns are a key part of tobacco control activities, and just over half (49 respondents (52%)) reported that they or their organisation supported Stoptober. However, 22 respondents (23%) reported that they didn't support any campaigns (Figure 48). One professional commented *"We know about them but don't necessarily actively do anything to promote them further*".

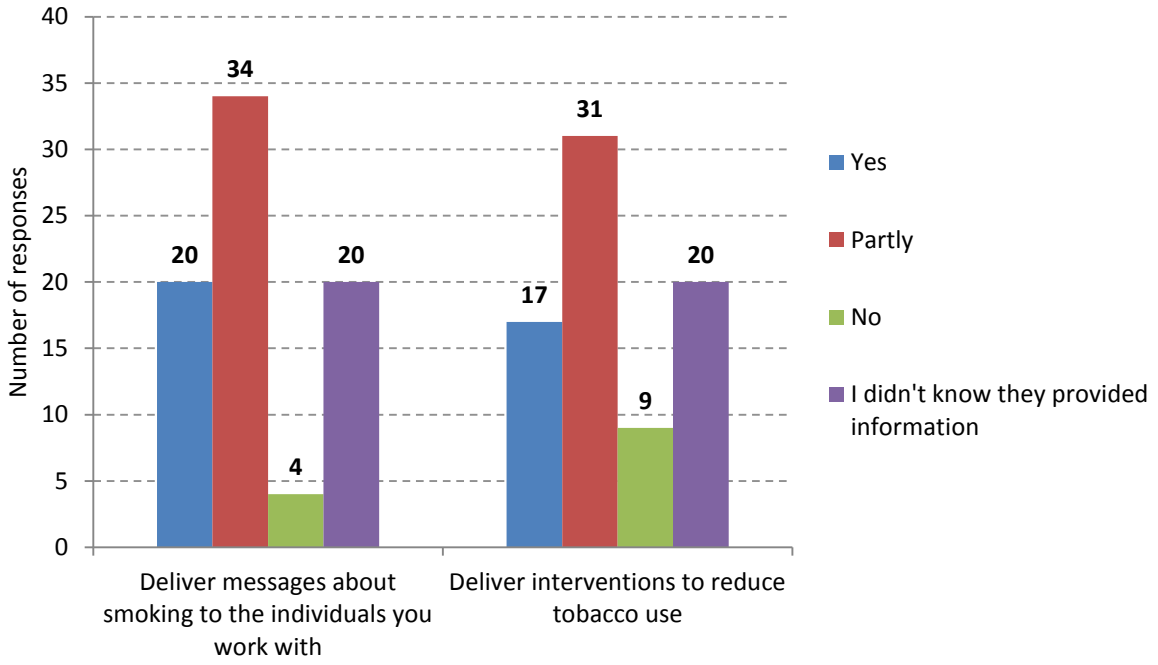
Figure 48 - Supporting anti-smoking campaigns



When professionals were asked if there are any gaps in service provision to reduce or prevent tobacco use and second-hand smoke exposure, it emerged that there is a need to raise awareness of stop smoking services and the harms of smoking and second-hand smoking.

Respondents were asked whether information resources provided by the West Sussex Stop smoking services and the NHS are adequate to enable them to deliver messages and/or interventions to reduce tobacco use. The majority of the respondents indicated “partly”, followed by “I didn’t know they provided information” (Figure 49).

Figure 49- Provision of resources for tobacco control activities



8. Information and Intelligence

In order to effectively plan, implement and evaluate tobacco control strategies, there is need for comprehensive surveillance and monitoring of tobacco control activities, including, the prevalence of tobacco use, impact of policies and interventions, and tobacco industry tactics (i.e. marketing, lobbying). As stressed in the Tobacco control plan for England, good quality information lies at the heart of effective local commissioning for comprehensive tobacco control. Information and intelligence not only includes health and social care, but also tackling illicit tobacco, and underage sales and enforcement activities. Making the best use of existing and emerging research evidence is also important in ensuring the effectiveness of tobacco control activities.

8.1.1 Current West Sussex tobacco control activities

The Smokefree West Sussex operational plan (2014-17) identifies the current activities carried out to meet this objective. Activities include international, national, regional and local information and data on smoking prevalence, health outcomes, smoking behaviours and attitudes. Locally, intelligence is also collected by different organisations and departments i.e. Public Health, Trading Standards, Fire services, CCGs, Environmental health, NHS Trusts and other organisations through routine data collection, surveys (e.g. the lifestyle survey for 14-15 year olds) and other feedback reports. TSS intelligence led enforcement utilises data from partner organisations and the community.

8.1.2 Evidence based interventions and guidelines

The epidemiological model can be used as a framework for comprehensive surveillance and monitoring of tobacco control activities. The epidemiological model is often used in public health to study health problems and focuses on the interaction between three key factors; the agent, host, vector and environment [61]:

Agent: Traditionally defined as a factor that is required for a disease to occur. In the case of tobacco, the agent is tobacco products and the smoke emissions that cause disease and addiction. Therefore surveillance and monitoring includes the monitoring tobacco constituents, pH and additives including the nicotine content.

Host: Refers to the smoker or potential smoker. It also includes unintentional smokers (i.e. second-hand smokers). This includes surveillance and monitoring of patterns of initiation; susceptibility to tobacco use; indicators of dependence/addiction; quitting patterns; mental health indicators; reception of advice from health professionals; sources of tobacco; price paid for tobacco; awareness of tobacco control programs; opinions about tobacco control activities.

Vector: Distributes or transfers the agent to likely individuals. In this case, the tobacco industry is the vector. Surveillance and monitoring of the tobacco industry includes monitoring public relations, marketing, packaging and promotional other activities, and lobbying.

All these operate within certain environments, i.e. economic, political, and socio-cultural, which need to be monitored. Interventions should be tailored to meet local needs. Data and information

on the agent, host and vector is available through national and local data collection, including local tobacco profiles, health outcomes monitoring through Public Health Outcomes Framework and NHS Outcomes frameworks. WHO also recommends using evidence based methods in conducting and implementing surveys, and national surveys include IHS. As the Tobacco Control Plan for England highlights, good quality local information is at the heart of effective commissioning. This also include ensuring completeness of data collected

International and national organisations such as WHO, NICE, PHE, ASH, HMRC and CDC publish guidelines and information on tobacco control activities. Furthermore, a number of tools have been produced to provide information on tobacco control i.e. NICE tobacco control return on investment tool; Local tobacco control profiles; Local tobacco control toolkit; CLeaR tobacco control assessment. As highlighted in previous chapters, collaborative working and intelligence sharing is critical to tobacco control activities. This includes establishing and maintaining partnership working between agencies and a protocol for sharing intelligence across the agencies [62].

8.1.3 Evidence from engagement with stakeholders

8.1.3.1 Professional survey

Participants were asked whether they currently or could potentially collect data for different tobacco control activities and the responses highlighted some missed opportunities in regards collecting data on tobacco control activities. 38 respondents (40%) said that they currently collect data on smoking status and 19 (20%) reported they do not currently collect this but could potentially collect the information (Table 11).

Table 11 - Data collection

Types of data	Currently collect this data	Could potentially collect this data	Unable to collect this data	Not sure/Don't know
Smoking status	38 (40%)	19 (20%)	2 (2%)	13 (14%)
Underage tobacco sales or use	3 (3%)	14 (15%)	24 (26%)	27 (29%)
Use of illegal tobacco products	1 (1%)	13 (14%)	22 (23%)	32 (34%)
Second-hand smoke exposure	10 (11%)	33 (35%)	6 (6%)	19 (20%)
Smoking in the home	17 (18%)	28 (30%)	6 (6%)	16 (17%)
Supply or sales of illegal tobacco	0	10 (15%)	21 (22%)	35 (37%)

9. Conclusions and Recommendations

9.1 What does this tell us?

- Whilst smoking prevalence has declined across the county, every person who smokes or starts smoking is harming their health and that of others through second-hand smoking.
- Although the rate of deaths from smoking has decreased, there is only a slight change in absolute numbers (due to population increase), highlighting that the burden on health and social care and other statutory services remains.
- There are significant variations in the levels of tobacco use across West Sussex, with high levels of smoking within the most deprived areas, adding to the already large gap in health inequalities.
- It is estimated that smoking in West Sussex currently costs society £207 million each year, which equates to roughly £1,850 per smoker per year.
- Evidence based interventions, and guidelines, as well as regulations can be used collaboratively to identify the right approaches to tackle tobacco use.
- To gain the greatest reduction in tobacco use and tobacco related harm, as well are reduce health inequalities, priority should be given to the five high risk population groups identified as being more at risk of tobacco use and/or exposure. These are; pregnant women, young people, BAME groups, mental health service users and those from a low socio economic groups.
- Comprehensive tobacco control action requires strong leadership and vision, and WSCC, as the home of public health, has a key role to play in setting exemplar policies.
- As highlighted by members of the public, in order to protect non-smokers, there is an appetite to further increase smokefree outdoor areas in West Sussex, particularly in areas where children play.
- There is need to raise awareness of tobacco control beyond health and highlight the impact on other social and economic aspects, such as smoking related fires, litter and crime.
- Smoking cessation support services and interventions should be well publicised and address the barriers access to services.

9.2 What are the gaps in services/knowledge

- It is difficult to for us to estimate the prevalence of niche tobacco products such as shisha, and chewing tobacco, and this presents a gap in our knowledge.
- Access to stop smoking services is varied both geographically and demographically, and was found to be below the 5% performance targets recommended for local authorities by NICE, indicating a gap in supporting smokers to quit.
- Services are not maximising on all opportunities they could potentially communicate messages regarding tobacco use.
- Coordination and partnership working with all key stakeholders, i.e. local authorities, public health, trading standards, police, fire services, CCGs, NHS Trusts, housing, environmental

health and HMRC, needs to be improved. This also includes working on a regional level, for example, regional coordination of tobacco control activities

- There is a knowledge gap on local data on secondhand smoke exposure, particularly for children and young people.
- There is a gap in leadership on tobacco control activities, particularly in leading organisations, such as WSCC, in implementing exemplary policies, as the home of public health.
- Smoking related hospital admissions in West Sussex are rising compared to the South East region. Understanding this requires further investigation.

9.3 What we still need to do

Table 12: Recommendations - Training and support

Action to be taken by	Recommended action
Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sector organisations and others commissioned to provide public services – in conjunction with trading standard, environmental health and public health teams	Should provide training and information for staff, members of the public and businesses on tobacco control regulations including: • how to report infringements confidentially • penalties for sale and use of illicit tobacco • health harms of unregulated illicit tobacco products • harm to the economy of unpaid duties from illicit tobacco sales
Local authorities, clinical commissioning groups, NHS trusts and voluntary and community sectors.	Provide training and support to empower the workforce to maximise opportunistic approaches with their client groups aligned with the Make Every Contact Count (MECC) approach; allowing them to feel confident to and raise the subject of tobacco use; even in challenging and complex scenarios.
Local authorities, clinical commissioning groups, NHS trusts and voluntary and community sectors.	In accordance with CLeaR principles; provide training to enable staff to deliver very brief advice (VBA) on stop smoking services, harms of second-hand smoke, and harm in different groups.

Table 13: Recommendations - Peer support

Action to be taken by	Recommended action
Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sectors, schools and colleges	Co-design and co-commission evidence based peer-led interventions to prevent uptake of smoking by service users and potential service users, particularly adolescents.

Table 14: Recommendations - Data collection and sharing

Action to be taken by	Recommended action
Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sector organisations and others commissioned to provide public services – in conjunction with trading standard, environmental health and public health teams	To maximise on current opportunities and identify new opportunities for: • data collection on tobacco control activity, for example illicit tobacco, second-hand smoke exposure • Ensure the formal evaluation of the range of tobacco control interventions is included in commissioning strategies
Trading standards and environmental health	Improve the collection and sharing of data/intelligence: • Particularly on visits to small businesses to inform and monitor tobacco control activity and feed into the national plan and data set. • To facilitate evaluation of interventions to prevent the sale and use of illicit tobacco. • On other tobacco products rather than smoking tobacco alone
Public health, trading standards and environmental health	Use local data to target activity in geographical areas as well as population groups e.g. using IMD data to target illicit tobacco supply, illegal tobacco sales and high smoking prevalence.

Table 15: Recommendations - Policy and leadership

Action to be taken by	Recommended action
West Sussex County Council	Provide clear leadership (in line with CLeaR principles) and exemplar policy by reviewing current tobacco use policy to reflect best practice from other leading organisations e.g.: • Changing the title from 'Smoking policy' to 'Smokefree policy' • De-normalise smoking and protect staff from exposure to second-hand smoke by moving away from approved designated smoking areas which facilitate smoking to a blanket ban on smoking on all WSCC premises • Promote a range of services and information to support staff to give up smoking
West Sussex County Council, all District and Borough Councils in	Provide clear leadership and commitment to tobacco control in West Sussex by:

West Sussex, all Clinical Commissioning Groups (CCGs) in West Sussex	• Ensuring smokefree policies protect staff and the public from the harmful effects of smoking in all areas. • Acknowledging responsibilities under Article 5.3 of the WHO FCTC by signing the Local Government declaration and the NHS statement of support for tobacco control
Education commissioners, head teachers and boards of governors	Ensure that all schools have a clear available and accessible smokefree policy, which supports and facilitate healthy choices and encourages smokers to quit.
Local authorities and districts and borough councils, voluntary and community sector organisations	Take the opportunity created by this report to : • Review occupational health policies and risk assessments for staff who may be vulnerable to exposure to second-hand smoke during home visits • capitalise on the momentum from the public survey and consider smokefree policies for more public spaces

Table 16: Tobacco control messages

Action to be taken by	Recommended action
All	Involving local communities and target groups in encouraging people to stop using tobacco and de-normalise all types of tobacco use in our society.
Public health, trading standards and environmental health	Ensure that messages to the public, professional and organisational groups and local businesses around tobacco control are not solely around smoking but a co-ordinated multi-agency approach to the supply, demand and use of all types of tobacco.
Public Health in local authorities, CCGs and NHS trusts	Increase awareness of the health harms of second-hand smoke – especially in children - through: • Stronger, clearer messages and materials for the workforce to support and facilitate conversations with the public and service users • Incorporate this message into patient checklists e.g.: health visitors at developmental checks; midwives on discharge;
Public Health in local authorities,	Develop a clear social marketing strategy to address de-normalisation of tobacco use; including greater use of social

CCGs and NHS trusts	media to both reach target groups and professionals; using proven social marketing techniques and frameworks such as EAST and implementing NICE recommendations on mass media communications
Public Health in local authorities	Provide clear guidance to professional and public on the use of e-cigarettes including: • Use of e-cigarettes as an approved harm reduction technique • The potential risk of continued nicotine addiction
Public Health in local authorities, NHS Trusts, CCGs, Healthwatch and other voluntary and community sector organisations, (including health and social workforce, pharmacies and GPs)	Ensure that all tobacco control activity are culturally appropriate and information is accessible by BAME groups for whom English is not their first language, by; • carrying forward recommendations from the BAME needs assessment (also found on the JSNA website) • raising awareness and engaging with smokers in culturally and linguistically appropriate ways, to reduce the impact of advertising from unregulated overseas TV channels. • using local data to find out the most commonly spoken languages in their area • providing campaign materials, signage, leaflets, and web based information – in a range of languages. • raising awareness of barriers to some therapies for certain religious groups e.g.: considering alternatives to NRT patches which contain alcohol for religions which prohibit alcohol.

Table 17: Recommendations - Partnership working

Action to be taken by	Recommended action
All members of the West Sussex Smokefree Partnership and partner organisations	In line with CLeaR recommendations for West Sussex and the national tobacco control plan, increase strategic partnership working by: • increasing membership of and participation in the Smokefree West Sussex Partnership, to involve all key stakeholders and agencies, including improving attendance at meetings by key partner representatives • increasing engagement with local business leaders and the business community with the Smokefree West Sussex partnership • incorporating local partnership working with HMRC

	and other agencies in Trading Standards strategic plans. • Setting up arrangements to facilitate supra-local tobacco control activities and commissioning with regional partners
Commissioners of environmental health and trading standards services	Enhance tobacco control through improved partnership working in licensing areas through increased shared initiatives and visits.

Table 18: Recommendations - Improving uptake of stop smoking services and products

Action to be taken by	**Recommended action**
Public Health commissioners, CCGs	In addition to the actions set out in the recent Specialist Stop Smoking Service Rapid Needs Analysis (see below) commissioners of tobacco control activity should: • Ensure that smoking cessation support services and interventions address the barriers to successful quit attempts, including; • time to attend appointments at multiple locations by providing a one-stop-shop tailored to the individual including digital media and virtual support • dispelling the myth about 'lack of will power' as a barrier by ensuring behavioural insights are incorporated in service design • ensuring a joined up and complementary approach with metal health services • being clear about what a person can expect from a stop smoking service • include a stronger, more visible and evidence based peer support element to smoking cessation services across all age groups in suitable environments – physical or digital
Local authorities, clinical commissioning groups, NHS trusts, voluntary and community sector organisations and others commissioned to provide public services	Ensure there is high profile and clear guidance, clear and accessible referral and care pathways for people who wish to stop smoking.

Table 19: Recommendations - Commissioning stop smoking services

Given the stop smoking services data presented in this report, commissioners may wish to consider a range of options for this service:

- Whether there is need for a specialist service in its current form – given the efficacy of GPs to successfully treat people in target groups.
- Changing the emphasis of the SSSS providers from support for smokers in target groups to training and supporting other professionals to deliver these interventions to smokers across the population.
- Consider subsidising quit attempts
- Increase the sign up of pharmacies to take on smoking cessation work to support GPs.
- Increase use of nurse prescribers in stop smoking GP surgeries to support GPs.
- Placing specialist stop smoking advisors in Trusts, where there are high levels of target groups who would benefit from opportunist approaches and immediate referral/consultation.
- Engaging with the clinical commissioning groups to request a patient group directive and shared pathways to improve services and enable all frontline staff to make every contact count and in turn make savings.
- Engaging with maternity services and mental health services registered practitioners to agree pathways where midwives and Community Psychiatric Nurses are able to provide NRT or pharmacotherapy through a PGD mechanism to increase the success of opportunistic approaches in the pregnant population and those accessing mental health services.
- Using demand forecasting models to explore how this might enhance commissioning of these services.

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