Making the next generation tobacco-free

West Sussex Tobacco Control Needs Assessment: Appendices

May 2016

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1.Stakeholder Engagement Reports

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1.1 Introduction

The purpose of this West Sussex Tobacco Control Needs Assessment (TCNA) is to gather evidence to guide the commissioning of tobacco control activities in West Sussex and help partners in negotiating local priorities. It aims to find out the extent of tobacco use in West Sussex, its impact and understand what gaps and opportunities exist to promote tobacco free living.

The TCNA is part of the Joint Strategic Needs Assessment (JSNA) which examines the health and wellbeing of the local population. Without talking to and understanding the needs and preferences of those most affected by tobacco use in West Sussex, it is not possible to design commission and provide appropriate services. As such, the stakeholder consultation with communities across West Sussex allows us to understand some to the following research questions:

Are the workforce and community equipped and empowered to address tobacco use?	What stop smoking/anti-tobacco services are currenlty available?	Are the services adequate for current and future needs?
What assets exist in the West Sussex community that can be used to address the needs of people who use tobacco?	Are there any gaps in the services provided?	What programmes are available to promote anti-tobacco/smoking messages to young people and children?
Are the workforce and community equipped and empowered to address tobacco use?	What can be done to reduce tobacco use and secondhand smoke exposure?	What specific cultural influences need to be understood to address tobacco use in parts of the West Sussex population?

Report structure

The stakeholder engagement report is divided into different sections, as follows;

- Public survey report
- Qualitative report on the interviews with BAME groups
- Professional survey report
- Schools survey report

These reports are structured to mirror the six strands for tobacco control (Figure 1) as these were used as a framework in analysing the findings.

Figure 1: Evidence based tobacco control

Methods used to conduct the research

The public engagement for the TCNA took the form of an online survey with residents of, and users of services in West Sussex (for example, those who live outside of the county but attend school/college or university in West Sussex) as well as qualitative interviews with some Black, Asian and Minority Ethnic (BAME) groups. In addition, surveys were conducted with schools and professionals who come into contact with tobacco users or those affected by tobacco use. Each of these studies will be outlined in turn in the following chapters. Figure 2 pulls together all the consultations that were carried out to inform the TCNA.

Figure 2: Tobacco control needs assessment stakeholder engagement
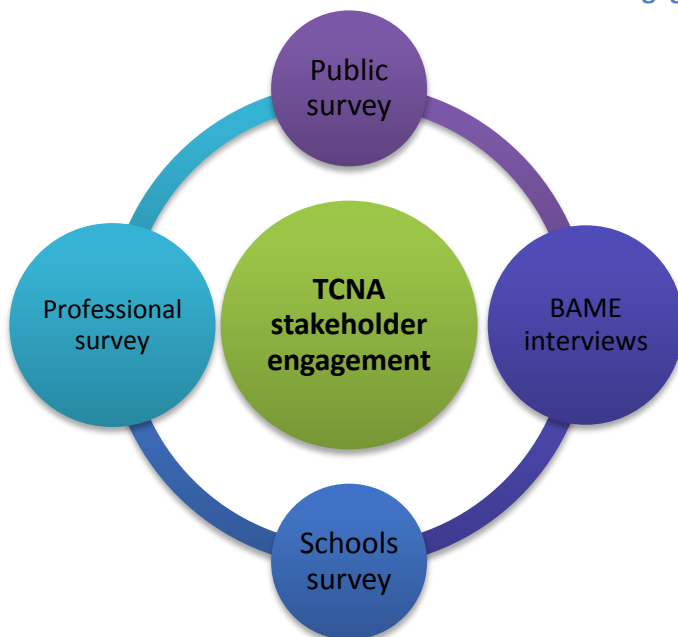
Summary of findings from the public consultations

The following provide a summary of the findings from the survey and interviews with the public and some BAME groups.

- Cigarettes or hand rolled tobacco were the most used tobacco products. However, however cigars, shisha and chewing tobacco (Paan) were also reported to be used.
- E-cigarettes are also in use by smokers who wish or are trying to cut down or quit. However, some smokers end up using both e-cigarettes and manufactured cigarettes.
- Although e-cigarettes have been recommended as a method to help tobacco users quit, there is some uncertainty among members of the public, about their use. This highlights the need for more information for the public and professionals.
- Both public consultations indicated that there is an awareness of what constitutes illicit tobacco; however there is a lack of awareness of how to report it and the wider consequences of illicit tobacco use.
- Various sources for illicit tobacco were highlighted, such as individual sellers/friends, shops, via social media and car boot sales.
- The majority of people supported smokefree places, particularly in areas designated for children. Other suggestions for smokefree places included high streets, pavements, beaches, parks and entrances/doorways; however, there were some disagreements with some of these.
- Both consultations indicated that non-smokers are still exposed to second-hand smoke in public outdoor areas, and suggestions to counter this included making most or all public areas smokefree and providing designated outdoor areas for smokers.
- Some people, particularly young people, reported smoking only in certain social situations and regarded their smoking as infrequent, therefore not constituting a habit and not posing a significant risk to health.
- Some participants highlighted that they only smoke in social situations or occasionally, and so they didn't consider themselves smokers. However, there is a danger, particularly in young people, of getting addicted to nicotine and transitioning to become regular smokers.
- A number of the smokers consulted indicated that they had cut down or were trying to stop smoking. This gives an indication of the need to raise awareness of support and options available for smokers to help them quit
- Most of those who took part in public consultations highlighted that there is a need to promote and publicise stop smoking services and anti-tobacco messages. The professional survey participants also highlighted that lack of awareness of services was a barrier for some people.
- Participants also stressed on the need to raise awareness and educate people about the health, social, and economic risks and harms of tobacco use. This was also reported by the professionals and schools that took part in their respective surveys.

- Issues specific to BAME groups were;
  - there are language barriers in accessing services;
  - niche tobacco products such as Paan are used by some groups and there is a lack of awareness of the harms and risks it causes;
  - some health seeking behaviours are culturally embedded, resulting in some people being reluctant to seek help relating to tobacco use;
  - Some stop smoking products were reported to contain ingredients that are not culturally appropriate, i.e. alcohol in nicotine strips not suitable for Muslims.
  - Those who watch foreign TV, particularly Asian channels may be exposed to promotion of tobacco and are less exposed to national anti-tobacco campaigns

1.2   Public survey report

The West Sussex Tobacco Control Needs Assessment (TCNA) public survey was conducted online using the West Sussex County Council (WSCC) platform 'Have your say' consultation hub. The survey was open to all members of the public, including smokers and non-smokers, although views of young people were particularly sought.

The public survey asked questions on five topics including:

1. Current tobacco use (including types of tobacco or related products used)
2. Considering and attempting to quit
3. Awareness and access to services and support
4. Support for smokefree environments
5. Illicit tobacco product

The survey also included a sub-set of questions specifically for participants aged under 26 years. This subset of questions included sources of information for making decisions to use tobacco as well as awareness of anti-smoking messaging and support, awareness of e-cigarette promotions.

Recruitment and engagement methods

An online design was chosen to enable as many people to take part across West Sussex as possible and to make survey completion as convenient as possible for participants, as responses could be collected at any time of day and easily submitted (compared to paper based surveys which need to be physically returned to researchers once completed). A participant could complete the survey on any internet enabled computer or hand-held device by searching the 'Have your say' consultation website, or by clicking on the survey website link. Whilst online and digital methods of data collection have the advantage of reaching many people from a range of locations in a short space of time, it is important to note that not all West Sussex residents and service users have access to digital media and so the views of those who are digitally excluded may not be represented. However, given the short timeframe to conduct the needs assessment, it was not possible to include a printed version of the survey.

Recruitment of participants included sending electronic mail messages to stakeholders (e.g. local colleges, youth groups, Smokefree West Sussex, GP surgeries, West Sussex Wellbeing hubs and Healthwatch, West Sussex NHS Trust and CCG communication teams, West Sussex libraries, carer support and other organisations who work with carers) asking them to promote the survey to their networks and service users through displaying posters, or sharing the link to the survey on their websites. The survey was also sent to members of the West Sussex Resident's e-Panel; a community of over 7,000 people who volunteer to be consulted regularly regarding local issues. To incentivise participation, participants were invited to take part in a prize draw to win prizes, as a thank you for taking part.

Respondent demographic information

To ensure the TCNA was completed in a timely fashion to support commissioning, the survey was available for 24 days between 22/02/2016 and 17/03/2016. A total of 587[1] responses were collected during this time period. Just under half of participants identified themselves as female (49.2%, *n* = 290), and 47% identified themselves as male (*n* = 277), with the remainder preferring not to state their sex. The age and sex of participants is given in Table 1.

Table 1: Age and sex of participants in the public survey

Age	Sex			Total
	Male	Female	Prefer not to say	
Under 12	0	3	2	5
13-15	25	23	1	49
16-18	32	24	1	57
19-25	1	3	0	4
26-35	7	11	0	18
36-45	8	35	0	43
46-55	25	51	1	77
56-65	46	56	2	104
66-75	94	71	0	165
76-85	28	8	0	36
Over 85	9	2	0	11
Prefer not to say	2	3	3	8
Total	277	290	10	577

Of 587 participants, 115 were aged 25 years or under. This represents 19.6% of the sample completing the TCNA public survey. Among those under the age of 26, five participants were under the age of 12 (representing 4.3% of under 26's and 0.9% of all participants), 49 participants were aged 13-15 years (42.6% of under 26's, 8.3% of the total sample), 57 were aged 16-18 years (49.5% of under 26's, 9.7% of the total sample) and 4 participants reported their age as 19-25 (3.5% of under 26's, 0.7% of all participants). In the sample achieved, 61 participants (10.4%) were aged 46-65 years. Just under a third of participants (*n* = 181, 30.8%) were aged 46-65 and a similar proportion were aged 66-75 (*n* = 201, 34.2%). Less than 2% (*n* = 11) reported their age as over 86 years.

Ethnicity

Table 2 shows the self-reported ethnicity groups taking part in the public survey.

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[1] A total of 589 responses were collected, two participants were identified as outliers as they appeared to deface the surveys (tick every option available). As such, these responses were removed from the dataset leaving a total of 587 responses used in the analyses.

Table 2: Self-reported ethnicity in the public survey

Ethnicity	Number	Percentage
White British	547	93.2%
White Irish	3	0.5%
White Other	8	1.4%
Indian	1	0.2%
Pakistan	-	-
Bangladeshi	-	-
Other Asian	2	0.3%
Black Caribbean	2	0.3%
Black African	2	0.3%
Black Other	-	-
Mixed Black Caribbean and White	-	-
Mixed White and Black African	1	0.2%
Mixed Asian and White	2	0.3%
Other Mixed	2	0.3%
Chinese	-	-
Other	1	0.2%
prefer not to say	13	2.2%
Not answered	3	0.5%
Total	587	-

Over 93% of the participants in the public survey reported their ethnicity as White British, with a further 14 participants (2.4%) reporting their ethnicity as White other or White Mixed.

Disability and long term condition

Almost one in five participants reported a disability or long-term illness (n = 107, 18.2%). Table 3 shows the type of self-reported disability or long-term illnesses among the public survey sample.

Table 3: Disability or long term condition type among participants in the public survey

Disability or long term condition	Number	Percentage*
Physical impairment	46	43.0%
Sensory impairment	13	12.1%
Mental health issue	16	15.0%
Learning disability	2	1.9%
Long-term illness	51	47.7%
Other	9	8.4%
Prefer not to say	15	14.0%
* This is the percentage of participants who reported having a disability or long term condition (n = 107).		

Employment status

Just over one third of participants were in part time, full time or self-employment (*n* = 214, 36.5%). Table 4 shows the self-reported employment status of participants in the public survey. Another third of participants were retired (*n* = 234, 39.9%) and 16.2% were students (*n* = 95).

Table 4: Self-reported employment status of participants in the public survey

Employment status	Number	Percentage
Part time employment	71	12.1%
Fulltime employment	104	17.7%
Self-employment	39	6.6%
Unemployed	6	1.0%
Looking after home	9	1.5%
Student	95	16.2%
In training or apprenticeship	-	-
Volunteer	10	1.7%
Carer	4	0.7%
Retired	234	39.9%
Not Applicable	4	0.7%
Prefer not to say	11	1.9%
Total	587	-

In the remainder of the report, results are analysed across the whole sample of participants. In addition, results are presented for those aged under 26 years of age, as this represents a specific target group for tobacco control activities. Although, BAME groups and mental health service users are also specific target groups for tobacco control, due to the small number of participants in the BAME groups, the results of the survey were not compared across ethnicity. However, BAME groups were the specific focus for the qualitative interviews undertaken as part of the TCNA.

Key Findings on current tobacco use

10.2%
Reported using tobacco or nicotine products

19%
Under 26s reported using tobacco or nicotine products
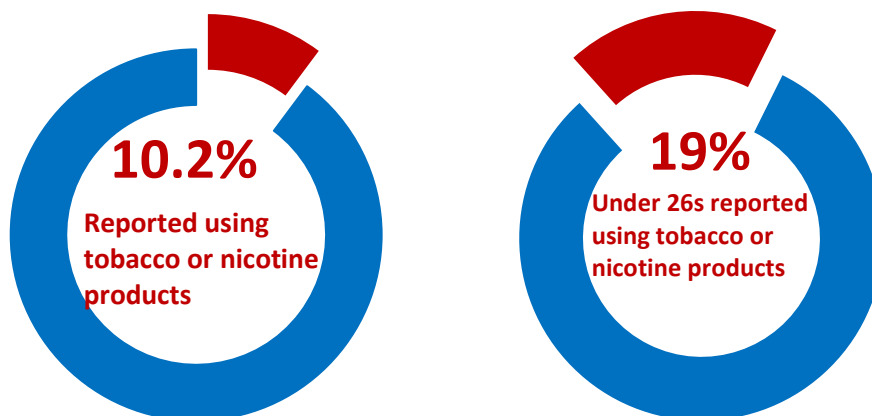
Whilst tobacco control activities include smokers and non-smokers, it is important to understand tobacco (and other related product) use among participants of the public survey to contextualise responses.

In the public survey, one in ten participants reported currently (in the last 30 days) using some form of tobacco or nicotine product (10.2%, *n* = 60). Among those aged 25 and under, 19.1% (*n* = 22) reported current tobacco or related product use (including nicotine products such as e-cigarettes). Current tobacco or related product use was reported by 14.3% (*n* = 7) of 13-15 year olds, and this rose to 22.8% (*n* = 13) among 16-18 year olds. Two of the four 19-25 year olds reported currently using tobacco.

Table 5 shows the specific products used by participants (all ages) in the public survey.

Table 5: Tobacco or nicotine products used by participants (all ages)
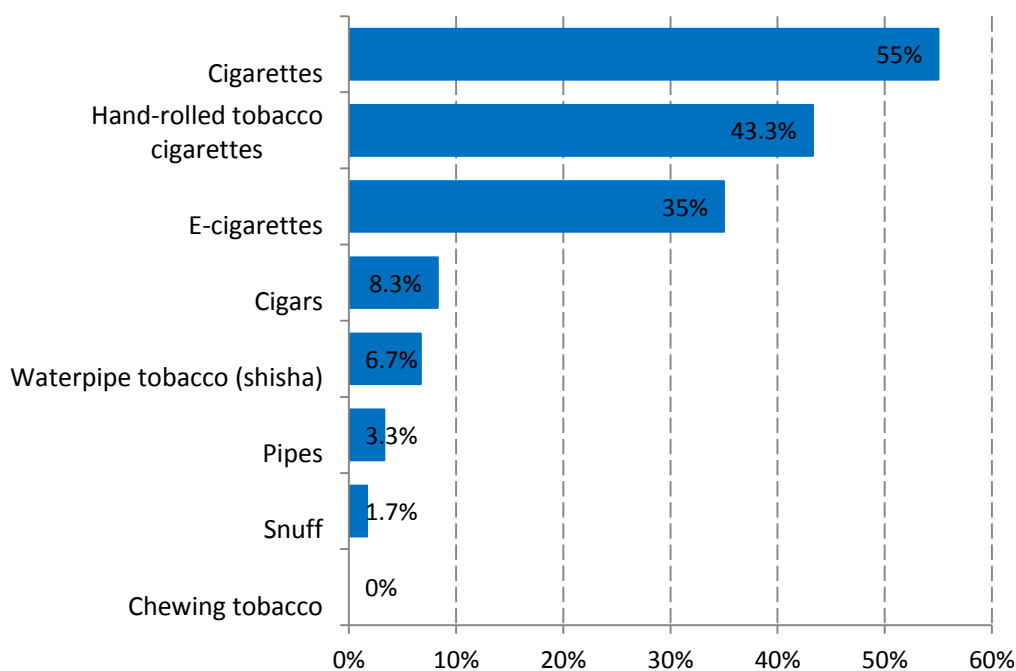
More than three quarters of those who reported currently using tobacco or related products (78.3%, *n* = 46) indicated they use either hand rolled or prepared cigarettes. Among these cigarette users, 14 participants (29.8% of current cigarette or hand rolled tobacco users) also used e-cigarettes. Twenty-one participants reported currently using e-cigarettes. Of these, eight participants reported smoking e-cigarettes but not prepared or hand-rolled tobacco, although one respondent reported using e-cigarettes as well as shisha/waterpipe tobacco.

Among current tobacco users aged 25 and under, 90.9% (n = 20) reported currently using either tobacco cigarettes or hand rolled tobacco and a third of these (36.4% of current tobacco users under 26 years, n = 8) reported using both hand-rolled tobacco and tobacco cigarettes. Among those young people who currently used hand-rolled or prepared tobacco cigarettes, 80% (n = 16) reported that they had considered stopping smoking at some point

in the past. Just one respondent reported currently using cigars and no participants reported currently using pipe tobacco products. Just under a third of young tobacco users reported currently using e-cigarettes (31.8% of current tobacco users under 26 years, n = 7).

Among the seven e-cigarette users under 26 years of age, four were aged 13-15 years and three were aged 16-18 years. Six of the seven young e-cigarette users also reported currently using either hand rolled tobacco or tobacco cigarettes. None of the participants aged 25 years and under reported using chewing tobacco. Four of the under 26 year olds reported using shisha, and one participant reported using snuff.

Findings using the six tobacco control strategies

Stopping the promotion of tobacco

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

Making tobacco less affordable

Key points

9.6%
Of those aged under 26 reported being offered illicit tobacco

70%
Didn't know or were unsure how to report illicit tobacco
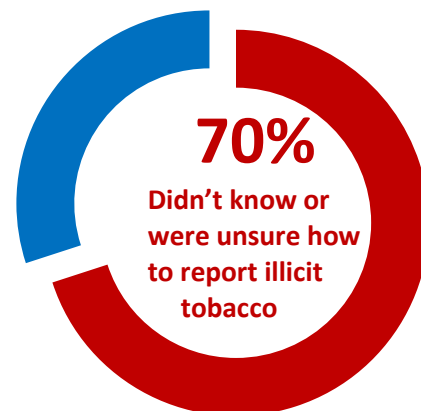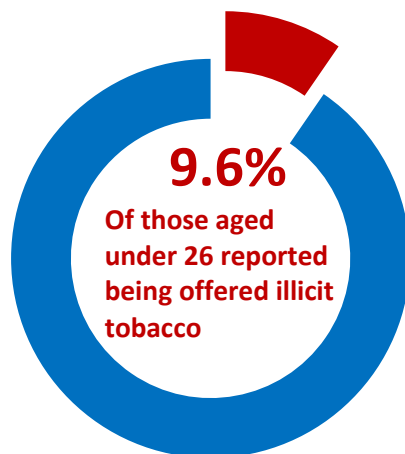
- Over four per cent of participants in the public survey (*n* = 24 participants) said they had been offered cigarettes or other tobacco products they believed to be illicit (smuggled, bootlegged or fake).
- However, almost one in ten (9.6% *n* = 11) of those aged 25 years and under reported that they 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 participants (19.2%) 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 participants) 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.
- Thirty-nine participants (6.6% of all participants) said they were aware of illegal tobacco trade in their areas; 11 participants 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.
- Over 70% of participants (416 people) were either unsure or did not know at all where and how to report illegal tobacco sales; this falls to 61.7% (71 people) for under 26s.

Participants were asked what could be done in the local community to tackle illegal tobacco sales and use. Alongside higher police and trading standards visibility in raiding local premises, 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, and promoting the ease of reporting (including emphasising confidentiality and anonymity in reporting).

Importantly, a small number of participants identified that trading locally did not necessarily mean in shops, but also online:

"I have seen tobacco for sale on Facebook" – Sex unknown, 66-75

"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

Many participants described that it was important to emphasise local seizures:

"Confidential reporting methods e.g. phone lines, good marketing of high penalties for those found guilty" – Female, 56-65

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

There was also a perception that people did not know the wider consequences of purchasing and using illicit tobacco;

"There needs to be much greater awareness of the risks of using unregulated tobacco products. Control needs to move up the police and customs priority list as I understand it is not uncommon for criminals dealing in illegal tobacco to be linked or migrate to illegal drugs." – Male, 46-55

"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

"Public perception/opinion needs to be changed. There needs to be a campaign that shifts opinion, (and not just public interest broadcasts, but, for example, plot lines in soap operas that show these smugglers and the smokers who collude with them as pariahs - depriving the Exchequer of funds that could be used to treat children with cancer etc.) so that buying illegal tobacco isn't seen as getting one over on the authorities but completely socially unacceptable. Smoking itself has become progressively less 'cool'. Smoking in public places is now seen as inconsiderate and unacceptable. Drinking and driving was once considered reasonable and is now (mostly) regarded as completely irresponsible. Illegal tobacco sales and use can achieve the same." – Female, 56-65

Finally, participants described a lack of a clear process for reporting illicit tobacco, anonymously;

"Promote the reporting of such actions via CRIMESTOPPERS, reminding users that they don`t have to leave their names, addresses or contact information." – Male, 66-75

"Phone line where concerned members of the public can leave anonymous information" – Female, 46-55

"The kind of enforcement that is necessary would be clear notices or adverts that tell people who to contact if they see someone selling tobacco illegally." – Sex unknown, 56-65

"Public Information campaign in publications or information leaflets that are distributed throughout the community. Could take space in local press if cost effective to promote the same message informing the public who to phone/inform if they come across this problem." – Male, 56-65

Effective regulation of tobacco products
Key points

92.5% were aware of regulations prohibiting under age tobacco sales

- More than 90% of participants in the public consultation 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.
- Similarly, just under 88% (*n* = 101, 87.8%) of young people (aged 25 years or under) reported an awareness of legislation prohibiting the sale of tobacco to those under 18.
- Only 17 participants (2.9% of all participants) in the public consultation 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).

Helping tobacco users quit
Key points

Current smokers who reported that they have tried to cut down or stop smoking

54.2%

46.7% **Current smokers who reported no intention to quit**
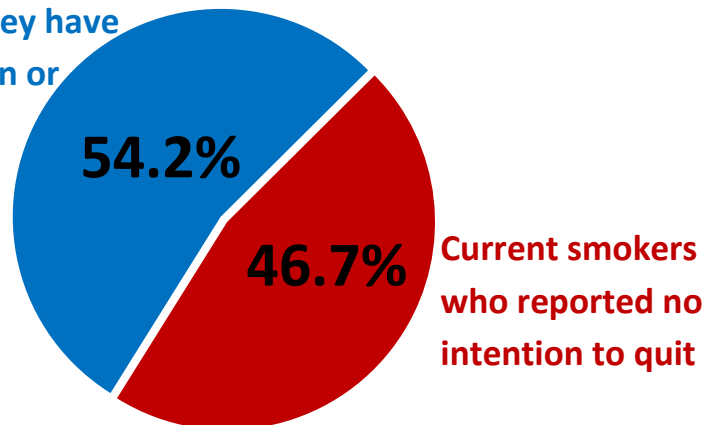
- More than a quarter of participants (156 participants, 26.6% of all participants) said that they were aware of activities in their local communities focusing on helping people to quit smoking.
- More than half of participants who reported currently using some kind of tobacco or nicotine product (*n* = 32) said they had tried to stop or cut down smoking in the last 12 months.
- The most common method of trying to quit or cut down tobacco use was to use an e-cigarette (18 participants, 56.3%). Three participants reported using only e-cigarettes (e.g. not using smoked or smokeless tobacco) and had no intention to quit 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 try to quit tobacco use was with nicotine replacement therapy (seven participants, 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.
- 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, representing a challenging barrier for tobacco control activities to address.
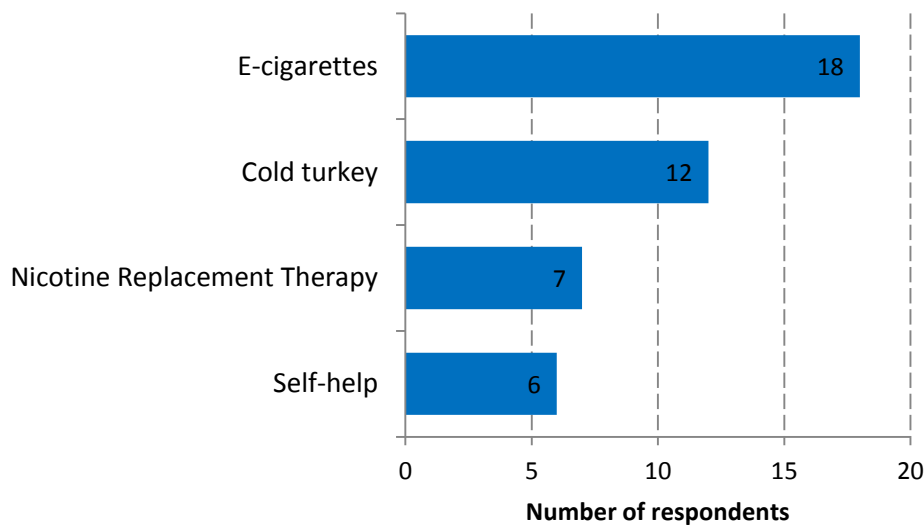
Of those who reported not trying to stop or cut down tobacco use, many suggested that they regarded their consumption as infrequent, not constituting a habit, and not posing a significant risk to health:

> *"I do not think that the small amount of cigars I smoke warrants it."* – Male, 56-65
>
> *"I smoke very rarely - one or two cigars per month perhaps when I wish, sometime less - it depends."* – Male, age unknown
>
> *"I only do it when I am on a night out - regard it as a 'treat' rather than a habit."* – Female, 19-25

- Just over half of participants in the public consultation survey (327 participants, 55.7%) said they were aware of services and support available in West Sussex to help people stop smoking/using tobacco.

55.7% were aware of services to help people quit smoking

- Forty-eight participants (8.2% of all participants) 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.
- The main reason for not accessing support among current users of tobacco or nicotine products was a lack of intention to quit (*n* = 20) or an uncertainty around whether or not to quit (*n* = 7).
- Two participants said they were too stressed to consider quitting. Other barriers indicated by participants 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?*

The most common type of support reported as the most helpful was group support:

> *"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*
>
> *"Nicotine is as addictive as alcohol and tobacco products equally dangerous to health. We have many support groups for alcoholism why not for tobacco addiction? Support groups would be a good way to help those who 'want' to give up." – Male, 56-65*

Nicotine replacement therapy (excluding e-cigarettes) was the second most commonly identify source of support to stop using tobacco products, although these also included an element of social and professional support:

> *"There are plenty of products and what-not to help people get off smoking, offering these products and holding regular seminars of sorts would probably help me, if I were smoking. I mean, peer-pressure is a huge reason as to why people start smoking and I think maybe people then feel too pressured to stop." – Male, 16-18*
>
> *"Nicotine replacements plus support groups and regular checks from health care professionals" – Female, 66-75*

Some participants noted that nicotine replacement therapy products should be made as accessible as tobacco products themselves:

> *"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*

Going to a GP or pharmacy were the next most helpful sources for stopping the use of tobacco products as well as having quality information, and using e-cigarettes.

- 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.
- All those under the age of 26 who said they had tried to cut down or stop smoking in the past 12 months (*n* = 17, 14.8% of under 26s) were still currently using some form of tobacco product at the time of the survey.
- Two thirds of those aged under 26 years (*n* = 75) said their decisions around tobacco use were influenced by family members. Just over half of young people said their friends influenced their tobacco use decisions (52.2%, *n* = 60) and just under half (48.7%, *n* = 56) said that health reasons influenced their decision to use tobacco.

Figure 3: Influences in tobacco use decisions (e.g. to smoke or not to smoke) among those aged under 26 years
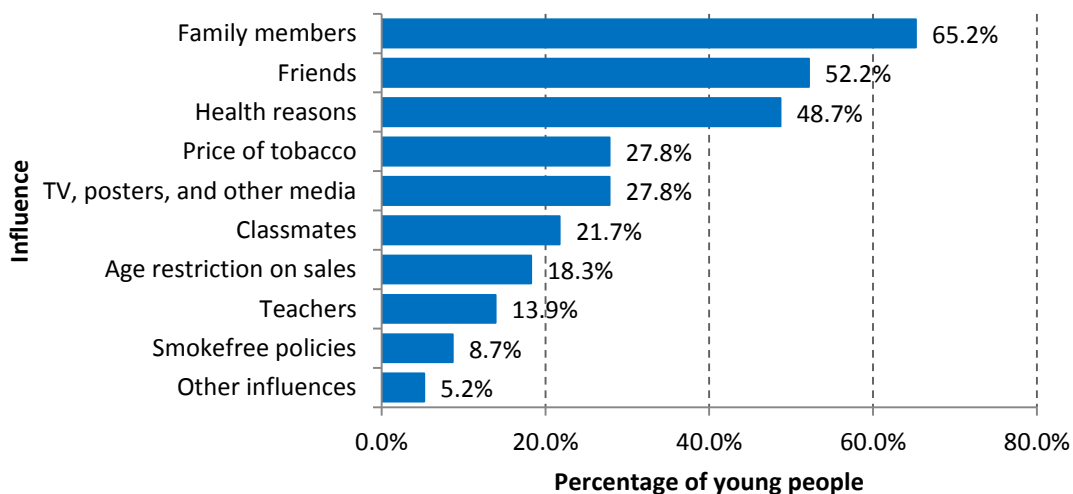
Reducing exposure to second-hand smoke

Key points

87.4% supported smokefree public places

71% Of households with a regular smoker have smokefree homes
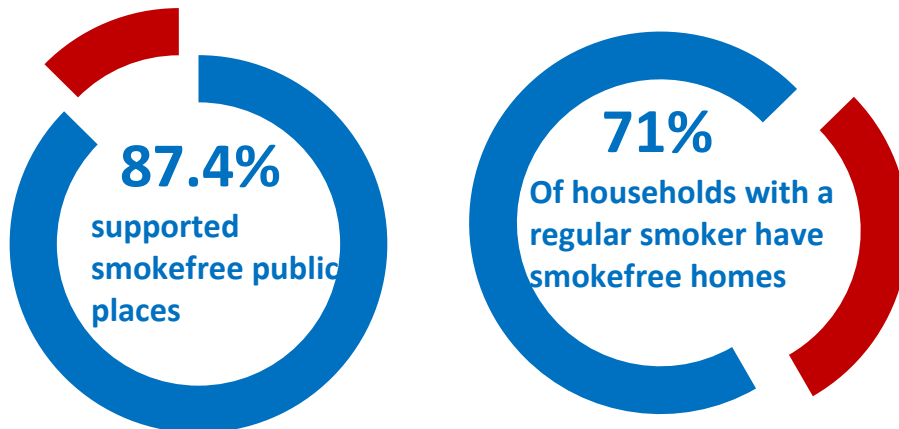
- More than three quarters of participants in the public consultation survey (450 people, 76.7%) said they were aware of regulations banning smoking indoors and in enclosed outdoor spaces. Just under three quarters of those aged 25 years or under (n = 82, 71.3%) reported that they were aware of tobacco control regulations to restrict the use of tobacco products in enclosed public spaces.

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

- Less than one in ten participants (*n* = 57) said that they were aware of activities in their local communities focusing on reducing exposure to second-hand tobacco smoke.

- Almost one in five (*n* = 114) said that their town/city did nothing to protect non-smokers from second-hand tobacco smoke. A third of participants (204 participants, 34.8%) said their town/city did 'a bit' to protect non-smokers from second hand smoke and a further 42 participants (7.2% of all participants) said their town/city did a lot to protect non-smokers from second hand smoke.

- Forty-one participants (7% of all participants) 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 public survey, 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 participants in the public consultation survey (513 participants) saying that they supported smokefree public places.

- Four in five people (83.8%, *n* = 492) supported making hospital premises smokefree. Over two thirds of participants (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 participants to the public survey 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 participants (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 sites. 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.

Effective communication for tobacco control

Key points

48.7% of those aged under 26 had seen or heard anti-tobacco messages
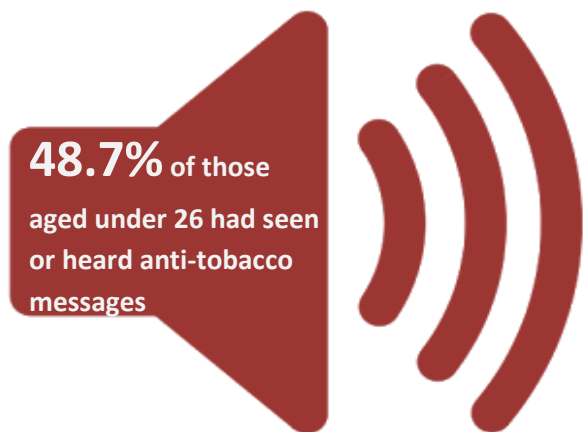
- Just under half of the 115 participants aged under 26 years in the public survey consultancy reported that they had seen or heard anti-tobacco messages or adverts online, on posters, or on TV in the previous 30 days (48.7%, n = 56).

- Nearly two thirds of young people (60%, n = 69) said they had seen e-cigarettes advertisements in the previous 30 days.

- **One** in **five** young people (20.9%, n = 24) **said they had not received any information in school/college/university on tobacco use**.
- Among those who received information, 33 participants (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 participants 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 participants (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.

Overall - What can be improved?

Participants in the public survey were asked '*what can be improved or provided to help you or others to reduce tobacco use and/or second hand smoke?*' Responses largely included activities to strengthen existing regulations around underage sales and making more public places 'smokefree'. However, some participants discussed creating specific spaces for smokers to use that were not encroaching public spaces for non-smokers:

> "*Have/build more closed off or secluded smoking areas around in order to stop people from smoking out in the open. Raise awareness by coming into schools or putting up posters which show the dangers and problems that come with tobacco.*" – Female, 13-15

> "*Banning smoking in high streets, parks and leisure areas such as places of interest etc., so that we can enjoy the fresh air*" – Female, 46-55

> "*Don't make it so easy for people to smoke outside work places and public buildings.*" – Female, 36-45

Others suggested that increasing the stigma of smoking to make smoking even less socially acceptable:

> "*Wider ban in public places. Spent some time in Canada last year areas where you can smoke are very restricted I think it would be easier to give up there as it is really seen as socially unacceptable*" – Female, 26-35

Participants appeared to suggest that e-cigarettes could be made more accessible and promoted as a vehicle to stop tobacco use:

> "*Encourage vaping and nicotine patches. The scientific evidence for there being any significant danger from second-hand smoke in the open air is negligible.*" – Sex unknown, 56-76

> "*E cigarettes could be made cheaper and more accessible if the nicotine content in them is decreased.*" – Male, 16-18

However, it was clear that there were mixed attitudes towards e-cigarette use in public, with some participants calling for a total ban on their use:

"Make it a crime to smoke near other people including parks, town centres and all public places. E cigarettes should be banned too." – Female, 46-55

"Increased restrictions on where people can smoke, e.g. outside workplaces, areas near where children play, etc. Also same restrictions for electronic cigarettes, whether they are harmful or not it's just weird and a bit uncomfortable standing/sitting next to someone smoking one inside e.g. concerts, pubs, etc." – Female, 46-55

"Greatly Increase the cost of smoking related products and ban electronic cigarettes from any public place" – Female, 56-65

These responses highlight an uncertainty around the safety of e-cigarette use, as well as the social acceptability of using e-cigarettes in public, which may dissuade some users of tobacco from trying e-cigarettes as a vehicle to stop smoking. Importantly, some participants described that current messages around health harms of tobacco use were not effective, even though information was readily available, and moreover that harms of tobacco use were ignored if they did not reflect specific methods of consumption (e.g. smoking tobacco in a pipe), applicable to the user;

"Stop the hectoring, it is boring to recipients. And do some genuine research on the health risks and effects of the chemicals added to cigarettes that keep them alight even when put down - and are NOT present in pipe tobacco. Some more research into e-cigarettes would be useful too and that there were still unknowns" – Male, 66-75

"Local newspapers could be persuaded or paid to feature a short article each week by a Doctor or other legitimate authority giving one piece of factual information about diseases or death statistics or other potent arguments for quitting smoking. A serious examination of the whole issue ought to feature from time to time on TV and social media might be used by victims prepared to bear witness to the perils of nicotine." – Male, over 85

Finally, participants reported that existing services could be promoted more effectively, and not just during national campaigns:

"Services are present but there is no proactive promotion of these services (apart from nationally on stop smoking day)" – Male, 36-45

"Stop smoking services should be widely advertised and promoted all year round to make smoke-free environments the norm. Can e-cigarette shops be the place to [R]each out to smokers who use tobacco and e-cigs to encourage them to ditch tobacco completely and make a plan for how to wean themselves off e-cigs over a set time plan?" – Female, 36-45

"More advertising of where to get support not just now and again" – Female, 66-75

1.3   Qualitative report - Interviews with BAME groups

Methods

This second part of stakeholder engagement reports the findings from interviews conducted with people from some of the Black, Asian and Minority Ethnic (BAME) groups, in addition to the online survey. This research was conducted to obtain views and experiences of people from some BAME groups in relation to tobacco use and exposure to second-hand smoke. A total of 14 interviews were carried out with individuals from BAME groups (Table 6). Participants were recruited through various methods such as contacts obtained from religious centres, interpreting services as well as randomly approaching some members of the public. A multi-lingual community researcher was commissioned to carry out the research and she conducted the interviews with some individuals in their native language, due to language barriers. The purpose of the research and details about the needs assessment were given to the participants and informed consent was sought before the interview. In addition, participants were given some vouchers, thanking them for their time. Where consent was given, interviews were recorded and later transcribed by the community researcher. The community researcher conducted the interviews with an interview guide that covered questions similar to those in the online survey, as previously discussed.

Table 6: BAME groups interviews - respondent profile

ID	Age group	Gender	Disability/ long term-illness?	Area	Ethnicity	Employment status?	Currently uses smokes/uses tobacco (Y/N)
1	25-64	Female	NO	Worthing	Bangladeshi	Part time employed	No
2	17	Female	NO	Worthing	Bangladeshi	Student/ Part time employed	No
3	25-64	Male	NO	Worthing	Bangladeshi	Full time employed	No (stopped smoking 30 years ago
4	25-64	Male	NO	Worthing	Bangladeshi	Full time employed	No
5	25-64	Female	NO	Crawley	Pakistani	Looking after home	No
6	16	Male	NO	Crawley	Pakistani	Student/ Part time employed	Yes
7	24-64	Male	NO	Crawley	Pakistani	Part time employed	No
8	26	Male	NO	Worthing	Pakistani	Full time employed	No (stopped smoking 3-4 months ago
9	25-64	Female	NO	Worthing	Pakistani	Looking after home	No
10	17	Male	NO	Arun	White/ Pakistani	Student	Yes
11	52	Male	NO	Arun	Norwegian	Self employed	Yes

12	21	Male	NO	Arun	White/ Pakistani	Student/ Part time employed	No
13	75+	Female	"Ailments of an elderly"	Adur	Indian	Retired	No
14	25-34	Female	NO	Adur	Indian	Full time employed	No

Findings using the six tobacco control strategies

Stopping the promotion of tobacco

Some participants reported watching Indian/Asian TV; however one participant reported that adverts selling cigarettes are common on Indian TV channels. Access to international TV stations, particularly those without restrictions on tobacco products advertising, potentially exposes UK viewers to tobacco advertisements and promotions.

Making tobacco less affordable

Most participants, smokers and non-smokers, seemed aware of illicit tobacco and that it is illegal. Although some participants were aware of the availability of illicit tobacco, they did not consider this a 'problem' or 'big issue' in their local communities, compared to other issues such as drug use and alcohol. The perception among some participants was that there was nothing wrong with buying or using illicit tobacco. Most considered selling or buying smuggled and/or bootlegged tobacco a misdemeanour and not a serious crime. Consequently, some of those who were aware of the use or sale of illicit tobacco didn't feel the need to report it. A few of those who felt they would report it indicated that they would probably do so to the police due to their belief that the law is the law and shouldn't be broken, and most were not aware how and where else to report. There was also a lack of awareness of the consequences of illicit tobacco.

"I would not do anything about it.... (it is) not my problem… the person who buys or sells illegal cigarettes should assume full responsibility of the risks they are taking" (non-smoker)

"I do think illegal tobacco is wrong because people who sell them must be dodgy so I stay away from that…. (if encounters illicit tobacco, would) do nothing really, it's their business". (Smoker)

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)

Different types of illicit tobacco where highlighted, i.e. fake tobacco and smuggled/bootlegged tobacco (smuggled and bootlegged tobacco was used interchangeably in this case). The main reason for the purchase of illicit tobacco was the price and because it is easily accessible to young people under 18 years old. The main reason given for selling illicit tobacco was to make some profit and people found it easy to recover their expenses.

> *"My brother-in-law sold illegal cigarettes and was able to recover the cost of his holiday by selling these cigarettes (brought in from Pakistani)" (non-smoker)*
>
> *"a ticket to Poland cost £40.00 approximately, even with a ticket price, bringing in tobacco from duty free and selling it still is very much cheaper and makes a lot of money" (former smoker)*
>
> *"At present, someone like me has no choice but to buy it this way (illegally) (17 year old smoker)*

However, there were some concerns regarding the potential harm from fake tobacco

> *"fake tobacco products are not nice, I don't trust them but smuggled in is okay, it's usually Pall mall and there is no difference between these and UK shop bought, just the price is cheaper" (smoker)*
>
> *"Fake tobacco I have issues with because a person can put anything in them, but smuggled tobacco, I do not have an issue with. People who smuggle in tobacco are not really causing a big dent in the country's income and they are trying to make some money so good luck to them" (smoker)*

One participant highlighted the dangers of fake tobacco, giving an example

> *"there are different kinds of fake tobacco…. a scam at present is where rolling tobacco is filled partly with sawdust and the buyer is completely unaware until they get home and open it and the other fake product is where they might get Pall Malls or cheaper cigarettes and put it in a Benson and Hedges packet, which I suppose is not so bad". (Smoker)*

Sources of illicit tobacco
Various sources of illicit tobacco that were highlighted by the participants were friends, car boot sales, shops, other college students and workplace. Illicit tobacco from friends was either bought from them or given by them for free.

> *"I often get given smuggled/bootlegged cigarettes by a friend but I also buy it"*
>
> *"When I went in a shop and asked for 20 Marlboro, 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"*

One participant reported this also takes place in the workplace.

> *"It happens a lot, especially from Hungary and Poland. I used to buy it from a Hungarian guy who worked with me…."*
>
> *"At car boots you can buy them as well"*

Other types of 'cheap' tobacco reported include Paan, which one participant commented *"I don't think Paan is taxed correctly"* due to its low price.

Another source of illicit tobacco for students was from other students at college, although the sales were often opportunistic. One participant reported that a student in her class sells illegal tobacco.

> "*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)

Key points

- Tackling illicit tobacco and underage sales requires intelligence from the local communities; however, most participants who were aware of illicit tobacco sales were reluctant to report it or were not aware how to report it
- Although aware of its availability in their community, most participants did not consider illicit tobacco to be a problem in their local community
- Sources of illicit tobacco include friends, shops, workplaces, colleges and car boots.
- Main reasons for buying illicit tobacco was due to the cheap prices and its accessibility for young people

Effective regulation of tobacco products

Nearly all participants 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.

> "*In my business, people are caught smoking in the toilet, I tell them to leave straight away*" (ID non-smoker)

Most of the participants were aware of the ban on smoking in cars with children under 18 but not all smokers were aware of this.

Interestingly, a 17 year old smoker said 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"* and that he follows restrictions best he can, considering that he is a 17 and a smoker.

Reporting violations

The violation of regulations relating to tobacco control, such as smokefree regulations, prompted different responses from participants. Some participants expressed that they did not have any interest in raising awareness of the regulations, and some indicating they would report it. Most participants didn't feel they could intervene or they were not sure how to respond to someone breaking tobacco control regulations. Others indicated they simply remove themselves from the situation and not get involved, whilst others felt they

would point it out to the perpetrator. Confidence to report or express concerns about someone violating smokefree bans (i.e. smoking indoors, smoking in cars with children under 18) also appeared to depend on the individual's assertiveness. However, there were some concerns about repercussions if one intervenes in some cases.

> *"It doesn't bother me (if someone is smoking in non-smoking area)… would just mind my own business" (ID12)*
>
> *"I'm sure there would be more people that would report them (people violating smokefree laws)… you have to be a strong outspoken person to do something"* (ID 1 non-smoker)
>
> *"I am too old, all I can do is call the police, but maybe that is too much. I don't really know what I would do." (ID 13 non-smoker)*
>
> *"I'm quite mouthy; I would ask what are you doing? Obviously, if it's a big scary man I would not pick a fight with him" (ID 2)*

Other participants felt they wouldn't report it but would advise the perpetrator against it

> *"All I can do really is to tell the person not to do what they are doing. Other than that, I don't know what I can do" (ID 7)*

However, other than reporting others, some of the participants were the ones violating the law by buying illicit tobacco, or buying tobacco under the age of 18. Consequently, they would do nothing if someone else is violating the regulations.

> *"I'm underage but tall for my age so my friends will send me to buy cigarettes in the shop" (ID 6)*
>
> *"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" (ID10)*

The likelihood of being caught by the authorities also plays a part in compliance with 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" (ID 2)*

Selling illicit tobacco to an underage person (in this case underage was considered to be under 16 years by some) was frowned upon by some participants. One current smoker indicated that he would speak to the person selling tobacco to an underage person, but thought it was not necessary to report to the authorities. *"I will have a go at them (anyone selling tobacco to a child under 16)…. I would never report anything ever"*

Lack of awareness of the regulations has in some cases led to unintentional non-compliance.

> *"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" (ID 8 former smoker)*

One participant, (who had been in the UK for about 4 years, from Pakistani) reported that he wasn't aware of the underage tobacco sales regulations and was made aware by a shopkeeper.

Helping tobacco users quit

The provision of stop smoking services is a key element of effective and comprehensive tobacco control activities, therefore, the awareness of such services crucial. In regards to service awareness, the participants indicated that 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, as they didn't know anywhere else to refer. Pharmacies were also recognised as a provider of stop smoking services, particularly by those who were aware of stop smoking pharmacotherapy support such as nicotine gum and patches. Other than GP and pharmacy services, a few participants highlighted that there were outreach stop smoking services/clinics carried out in schools and mosques.

> *"On Fridays, twice, I have seen a stall (*at a local mosque in Crawley*) set up to advice people on ways to stop smoking. I don't know what they were offering but I saw NHS logos on their leaflets" (ID 7 non-smoker)*
>
> *"At school I was offered advice and support but I felt it was a lot of nonsense. They had a meeting which offered students a nicotine taster which they placed on our tongues. The organisation came to my school, it was called Stop Smoking for Children, but it did not work for me" (ID 10 smoke).*

Where and how services were provided also influenced people's access to them, as one participant went on to say *"there is a medical room that you can go to get support if you want it. It's embarrassing if you are at school but not at college" (ID 10).*

Another participant, a taxi driver, reported that he became aware of stop smoking support service when he passed his taxi licence

> *"The lady that passed me offered me a stop smoking course that Brighton Council was hosting. She gave me leaflets but I didn't follow up on it" (ID 8 former smoker).*

Barriers to accessing services

However, acceptance and uptake of these services for those wishing to stop smoking varies. Awareness of services available however, didn't always mean participants who smoked wanted to access them due to their readiness to change, barriers and perceptions about the services as discussed in the preceding sections.

For most participants, the main barrier to accessing services was language. A recurrent theme was that those who do not speak English as a first language and have a poor grasp of English have difficulties understanding or fully engaging with services. This was a key barrier that was highlighted by a number of participants who reported that there is a lack of promotional activities in other languages. This in turn impacted on their awareness and use of services.

" I feel that for people like me who's English is not great that these services need to try and have a voice for us to speak to us in our language" (ID. 3 non-smoker)

"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" (ID 1 non-smoker)

"The problem is for someone like me if I smoked, how could I get support when I cannot speak or understand English?" (ID 7 non-smoker)

Financial cost was also seen as a barrier to people accessing stop smoking services.

Another cultural barrier that emerged was that some of the health-seeking behaviours are culturally embedded, resulting in some people not accessing services. Participants pointed out:

"The older generation do not like to go and ask for help, they don't want to tell anyone that they have a problem" (referring to his elderly mother who chewed paan).

The participant went on to say that the family sought help from the GP only after she got ill and was diagnosed with cancer. Another participant expressed that Asian people mostly deal with things at home, rather than outside help, but also indicated that there is need to raise awareness of harms of Paan.

Influences for using tobacco products

Some of the factors that influence people to smoke were reported and these included; taste of tobacco, wanting to fit in, smoking was seen as socially acceptable and

"The older Asian people need support to understand the effects of paan" (former smoker)

favourable in some cases, wanting to portray a certain image about self, 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 participants), early education about harms of tobacco, cigarette prices, the smell and taste of cigarettes, and also family influence. Friends and family were influential in smoking and also not smoking or quitting decisions as highlighted by some participants.

> *"both my parents smoked and growing up that put me off but when I tried it, I was about 14, with a friend and it was the taste that I enjoyed…..the reasons why I decided to cut down were that I was lacking energy to do things and also it was too expensive, but I suppose my health was another reason"* (ID 10 smoker)
>
> *"It (smoking) was trendy, tough, bad and fashionable… I remember standing around the streets in Pakistan openly smoking and I thought I was big and bad and I liked that people were shocked when they saw me smoking."*(ID 8 former smoker*).*
>
> *"I began to realise from my family that what I was doing was not good, that it was damaging my body, my lungs and that I had to stop… my family and my sister, especially, would not let up and she made me quit and supported me all the way until eventually I did (ID 8 former smoker).*
>
> *"It never appealed to me. I tried it just because I was with friends and they gave me a cigarette but I hated the taste, it made me cough… I think there was so much smoke around me, kids from year 7/8 started smoking, there was so much that it just did not appeal to me" (ID 12 non-smoker)*

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

> *"It's considered disrespectful if you smoked when children are around, or if children smoked when adults are around" (ID 2 non-smoker)*
>
> *"Asian culture is quite strict. The younger people do not smoke in front of the elders as it is deemed the height of disrespect" (ID 4 former smoker)*

For young people, social influences were identified as both a driver for smoking and a barrier to quitting. The issue of 'social smoking' emerged, which was seen as part of the socialising process. Social smokers were referred to as those who only smoke in social situations such as parties or with friends. By calling them/themselves social smokers, these smokers were not considered to be in the same category as other smokers, which could impact on their perceptions of the harms of smoking. In addition, those who managed to avoid 'social smoking' reported that they 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" (ID 6 smoker)

"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". (ID 2 non-smoker)

"I do feel that interaction is affected in the wider community. A lot of my friends smoke, they go out to smoke so you separate or you have to stay with them in a smoking area and so it affects interaction." (ID 12 non-smoker)

Stopping smoking

Stop smoking journeys differed for the individuals ready to stop or those who managed to stop smoking, and even those not willing to stop. Methods of quitting depended on personal preference and perceptions. One of the participants who recently stopped smoking (3-4 months ago) reported that he tried nicotine products to help him quit:

"I first used patches to try and stop…. Patches didn't work because I needed something to help with the habit of putting something to my mouth; patches just go on your arm. So that's why I decided to try e-cigarettes. I then went to the GP and he showed me all the products that were available. I told him that I was happy to use the patches but I had a bad habit that after I ate something I smoked, so my doctor gave me nicotine strips which were mint flavoured I placed under my tongue after about 2mins. The strip gave me a high nicotine blast and then I didn't have the craving for a cigarette. This helped me to stop"

Going cold turkey, i.e. stopping smoking without any help, was another way to quit that was reported by the participants. There was a belief that ta smoker can successfully quit without support if and when they wish to stop. However, some current smokers highlighted that their belief that they could 'just stop' was based on hearsay, although there was an element of acknowledging personal differences in accepting and applying such evidence.

"I knew a 50 year old man that after smoking for almost all his life, he placed a cigarette on a top pocket at all times but never smoked it once he decided to stop. However, not all people can do that so I suppose it depends on the person and what works for them… I heard that if you want to stop smoking people should go on holiday… if I ever wanted to stop smoking, I would go to Alaska"(smoker)

Cutting down the amount of tobacco used was identified as an alternative to completely stopping.

Preference to access professional support also varied with individuals and their stop smoking journey, as one participant indicated that he is trying to stop but has not accessed

professional support as he prefers to try e-cigarettes.

> *"I'm happy using e-cigarettes but other than that; I would not use any other service" (smoker)*

Awareness of the stop smoking services offered or available included talking therapies and pharmacotherapy. However, this also became a barrier for some as one participant expressed that he did not believe in other people telling him what to do and that a person can stop on their own.

Relapse after a stop smoking attempt was also reported, as one participant noted

> *"I had surgery… and then I tried to quit after that. For 20 days I did not smoke but one day I thought I can have one cigarette, I just started smoking again"* (ID 8 former smoker)

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

"My GP did not offer me any talking therapies and I didn't even know there were any" (smoker)

The ingredients in the aids used to help people stop smoking also were reported to have a bearing on 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" (*ID8 former smoker)

E-cigarettes

Most of the smokers or former smokers had tried e-cigarettes, either as a stop smoking aid or experimenting. Non-smokers who were interviewed did not report using e-cigarettes. Whilst they are used as a stop smoking method, e-cigarettes were also perceived by some as dangerous as they maintain a habit.

> *"I will say that in my opinion e-cigarettes do not help people to quit smoking, they just move from cigarettes to e-cigarettes because both still give nicotine which is the addiction."*

E-cigarettes were not always favoured by some who tried it due to personal choice or due to some unwanted effects

> *"I tried e-cigarettes but I did not like it. I did not get enough nicotine from them. I always had to puff hard but still it was not enough. So I went back to the shop and asked for stronger nicotine e-cigarettes to satisfy my needs. But what happened with these stronger e-cigarettes was that it burnt my mouth so much so that I could not taste sugar or salt. I stopped using e-cigarettes and started smoking regular cigarettes again"* (ID 8 former smoker).

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

Types of tobacco, culture and tobacco use
Cultural differences have an impact on tobacco use. Paan, a type of chewing tobacco, often used by people from South Asian community, particularly Bangladeshi, was considered a form of cultural identity. However some paan chewers lack awareness of the health risks of paan

> *"People who chew paan have been doing it almost all their lives and they don't equate paan to smoking or other tobacco products. It's almost a cultural thing and both men and women use it, mainly in the elderly community… I also don't think that the harmful effects of tobacco and its products have to through to the older generation in the Asian community"* (non-smokers ID4)
>
> *"Paan makes people's mouths go orange, including their teeth. Old people chew it and it smells…it's a cultural pastime and it would be unfair (to ban it). Bans should be placed on smoke that affects non users"* (non-smoker ID2)

Other than the use 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"* (ID2 non-smoker)

Key points

- Misconceptions about stopping smoking and stop smoking services have an impact on access to services and quitting methods.
- Main barriers in accessing stop smoking services identified are; language, lack of awareness of services, cultural appropriateness of services, social networks and financial costs
- There is a lack of awareness in regards to the harms of some tobacco products such as Paan
- E-cigarettes are used by some to help stop smoking or cut down; however, there are some concerns about it.

Reducing exposure to second-hand smoke

Although most of the participants who took part in the research were non-smokers, all participants supported the idea of having smokefree areas, particularly in children's play areas. This is a positive sign, potentially indicating the de-normalisation of smoking. However, views about which areas should be smokefree varied between individuals and the 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 they are outdoor places and people should be allowed to smoke. But bus stops should be smokefree as they should count as indoor public areas"* (ID 6 smoker)
>
> *"In some places, I am all for it (*banning smoking*) but adults should have more freedom to smoke in pubs, there should be smoking rooms. Playparks are fine because there are children there but not beaches because there is a lot of air and a breeze"* (smoker ID10)
>
> *"I suppose public places like where children play perhaps could be restricted but outdoors should generally be free for everyone, smokers and non-smokers. If you restrict too much, then you are being unfair to people that smoke"* (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"* (ID 5 non-smoker)

Smokefree laws have reduced exposure to second-hand smoke, however, as the participants highlighted, non-smokers are still exposed to second-hand smoke in outdoor public areas, such as pavements and building entrances. This was a concern for non-smokers due to the effect on their health and some felt that second-hand smoke takes away their choice not to smoke:

> *"It's not right that smokers take away the freedom of choice of those people who chose not to smoke"* (non-smoker)
>
> *"Smoking affects all the people, smokers and non-smokers, but non-smokers more because they have not made a choice to smoke but we are forced to smoke against our will"* (non-smoker)
>
> *"When people smoke, they are messy with it, when they breathe out their smoke, it goes into my face"* (non-smoker)
>
> *"I know that in shops it's (*smoking*) banned but when you come out of them, you get a wave of smoke in your face"* (non-smoker)

Smokefree homes

Some participants felt they had more control in regards to creating and enforcing smokefree environments in their homes, as compared to public areas. Most of the non-smokers reported that their homes are smokefree and that

> *"I think it's fair if a person wants to smoke, rather than harm everyone they can exercise their freedom of choice by smoking outside"* (non-smoker ID12)

visitors are only allowed to smoke outside.

Those from non-smoking households tended to have smokefree homes. However, some smokers also had smokefree homes, as one 'social smoker' (ID 6) reported that he is the only smoker in his household and wanted his home to remain smokefree. He also reported that smoking visitors were asked to smoke outside.

What can be done to reduce second-hand smoke?
Participants were asked to give views of what can be done to reduce second-hand smoke exposure and the key themes that emerged were;

- Helping smokers to stop smoking
- Extending the smoking ban to all or more outdoor areas
- Non-smokers taking some responsibility by avoiding smoke and 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 for smokers
  - *"there should be designated outdoor smoking areas for smokers" (non-smoker)*

Some of the participants felt that second-hand smoke exposure was not an issue for them, even though they are exposed to it sometimes. This could be due to lack of awareness of the harm caused by second-hand exposure or an acceptance of the risks.

> *"I know people that are really fussed about it (*second-hand smoke*) but I am not. I grew up in a smoking household so it has never bothered me"* (ID 12 non-smoker)

Key points
- There is a positive acceptance and support for smokefree public areas, particularly children's play areas, by both smokers and non-smokers. However, there are variations in regards to which areas should be made smokefree.
- Smokefree regulations have reduced exposure to second-hand smoke and have contributed towards de-normalising smoking.
- Non-smokers are still exposed to second-hand smoke in public areas such as building entrances and pavements.
- Participants indicated they have more control in making their homes smokefree. This indicates that there is potential to reduce exposure to smoke in the home by encouraging people to create smokefree home environments.

Effective communication for tobacco control

Although most of the participants 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. One participant recalled the advert.

> *"Yes I have seen a lot of adverts for e-cigarettes. The adverts on TV start with a person smoking, their skin is very bad, then something bad happens to their health and then the advert end with them holding an e-cigarette and their skin all cleared up. The adverts are a bit dramatic…"* (Non-smoker ID 2).
>
> *"I see e-cigarette adverts everywhere, they make e-cigarettes look trendy so even kids who didn't smoke are smoking them"* (ID 12)
>
> *"I did see an advert with an old lady and it was about chewing nicotine gum, instead of smoking"* (non-smoker ID 6)

A few participants recalled seeing anti-smoking messages/stop smoking posters in pharmacies, GP surgeries or shops. Comments from some participants highlighted what appears to be a reduction in anti-smoking/stop smoking adverts, compared to previous periods.

> *"Before ages ago there was a big drive to help people and I used to see lots of adverts and posters but now I don't see any adverts anywhere"* (former smoker ID 9)

A number of participants indicated that they watch international TV channels, particularly Asian TV channels, all or most of the time. Given that national anti-smoking/stop smoking adverts on TV are mostly on UK TV broadcasting stations, this could explain why some participants have not seen some of the national campaigns.

> *"It's on all the time (Indian TV)…. I can't speak good English or understand it so well so English TV is no use to me. I don't have a computer and I don't go out so I haven't seen any (*anti-smoking*) posters either"*
>
> *"At the GP I have seen some posters but not really anywhere else. Also at home I watch Asian TV so we don't see (anti-smoking/stop smoking) adverts at home"*

In order to reduce tobacco use, there was a call 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 participants.

> *"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 were also about the placement of stop smoking/anti-tobacco promotional activities;

> *"In every newsagent where there are shutters in front of the cigarettes being sold, they should advertise non-smoking activities" (smoker)*
>
> *"There should be more advertising of anti-smoking services with the GP and the products that help people to stop using tobacco products" (former smoker)"*
>
> *"It seems these services that you speak about need to be advertised more because it seems the help is there but do people know?" (Non-smoker)*

Key points

- There is need to advertise and promote services by tailoring communications to different groups.
- Suggested ways to reduce tobacco use and second-hand smoking include; home delivery of (stop smoking/anti-tobacco) leaflets; posters in different languages; particularly in GPs and social clubs; and taking advantage of the tobacco display ban to advertise anti-smoking activities on the shutters.
- National or local adverts and campaigns may not reach some people, due to language barriers and viewing foreign TV broadcasts.

1.4   Professional survey report

Methods

This part of the TCNA consultation was conducted with professionals across the health, social care, early years, education, voluntary and other sectors, particularly those who are likely to have contact with tobacco users or those affected by tobacco use. The consultation was in the form of an online survey that was conducted using Survey Monkey. There were a total of 94 participants who completed the survey. Professionals were invited to take part in the online survey through various channels including CCGs engagement officers, MIND, early years service bulletin, GP surgeries, pharmacies and other voluntary and community groups across West Sussex. In addition, emails were sent to the communications teams in acute NHS trust across West Sussex, Wellbeing Hubs, WSCC staff working in various settings such as housing, adult and child social care, fire services and communities' teams to inform them of the survey and encourage them to participate.

Respondent profile

Of the 94 participants, 67 answered the question indicating the service they work in. The highest number of participants were from GP services (24%, 16 participants), followed by Teaching staff (15%, 10 participants) and Health Visiting services (13%, 9 participants). The rest of the responses, with five participants or less, were from; Children and family centres, adult social care, children's social care, mental health services, childcare services, pharmacies, voluntary services, public health, Think family, drug and alcohol services, youth workers, admiral nursing services, acute NHS Trust and environmental health services.

The participants cover different areas across West Sussex. Table 7 shows the responses to the question; *"Which areas of West Sussex do you cover*?"

Table 7: West Sussex areas covered

Areas covered	Number and percentage
Adur	8 (9%)
Arun	15 (16%)
Chichester	14 (15%)
Crawley	11 (12%)
Horsham	13 (14%)
Mid Sussex	10 (11%)
Worthing	16 (17%)
The whole of West Sussex	6 (6%)
Total	94
No response	1

When asked if they currently use any tobacco or nicotine products, the majority of the participants (68%, 64 participants) indicated that they did not smoke and five participants (5%) reported that they currently smoke cigarettes. Twenty five people did not respond to the question.

 Findings using the six strands of tobacco control

Making tobacco less affordable

When asked about their awareness of illicit tobacco use among clients/service users that they work with, the majority of the professionals (63 participants (67%) responded that they were not aware of any illicit tobacco use. Thirteen professionals (14%) responded that they are aware of illicit tobacco use among their clients/service users. Seventy professionals (75%) reported that they did not know (48 participants) or were unsure (22 participants) how to report illicit tobacco use/sales or underage sales if they came across it. Only 22 participants (22%) reported that they are aware of how to report illicit tobacco.

Effective regulation of tobacco products

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 and enforcement 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 in regards to regulations relating to tobacco control, nine participants (10%) reported that they had received some training. Twenty participants (26%) indicated that that they could benefit from training on tobacco control regulations.

> Only **10%** of professionals had received training on tobacco control regulations. **26%** could benefit from training on tobacco control regulation.

In terms of data collection for tobacco control activities, participants were asked what data they currently or could potentially collect. Only one participant reported currently collecting data on illicit tobacco products and 13 participants (14%) indicated they could potentially collect this data (Table 8).

Table 8 - Tobacco control 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%)

Helping tobacco users quit

When asked about their awareness of stop smoking services, the majority of participants (67%, 63 participants) were aware of the Smokefree West Sussex Stop Smoking Service, 32% (30 participants) did not know about the service. When considering awareness among those professionals who smoke (five participants), one respondent highlighted awareness of the Smokefree West Sussex Stop Smoking services, four responded that they were not aware of the service.

32%
Weren't aware of stop smoking services

67%
Were aware of stop smoking services
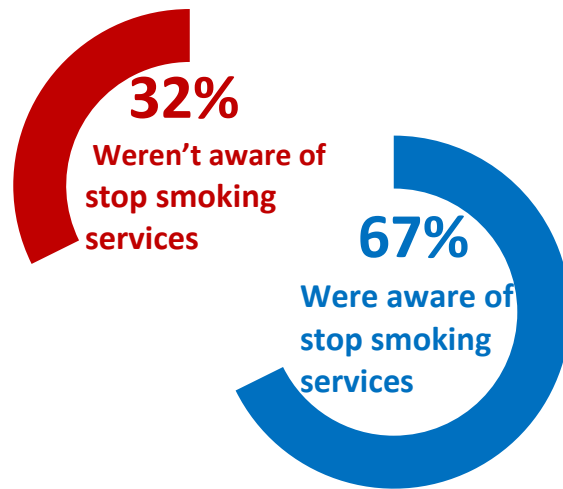
Although the majority indicated awareness of West Sussex Stop Smoking service, more than half of the participants (55%, 52 participants) said they had never referred anyone to the service. Only 16% (15 participants) always referred (2) or regularly referred people (13) (Figure 4)

Figure 4 - Frequency of referral to stop smoking services

Referrals to SSS

Never referred anyone

Regularly

I'm a stop smoking advisor

Sometimes

Always

- Never referred anyone (n = 52, 55%)
- Sometimes (n = 15, 16%)
- Regularly (n = 13, 14%)
- I'm a stop smoking advisor (n = 11, 12%)
- Always (n = 2, 2%)
- No response (n = 1, 1%)
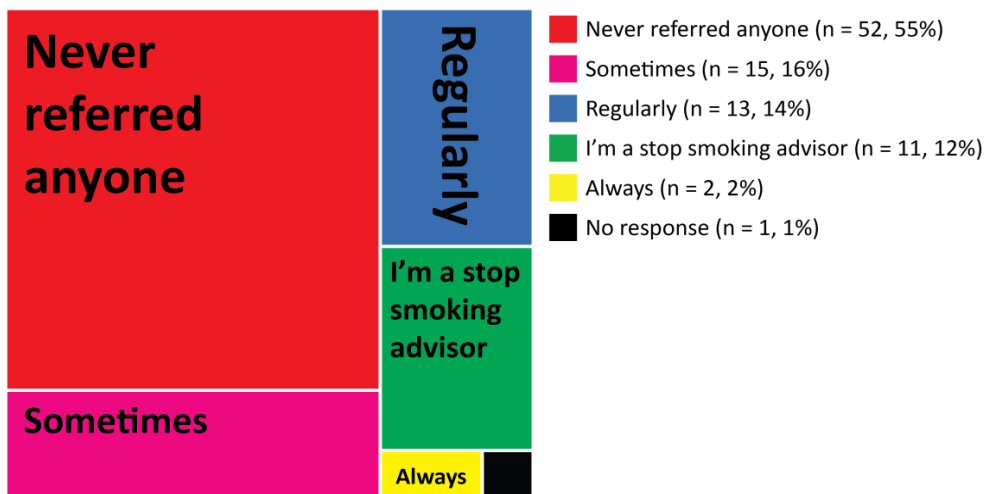
When making referrals to the stop smoking service, the participants indicated preferences for different methods of referring clients/service users. Seventeen (18%) of those who

responded preferred making a referral by phoning the Smokefree West Sussex hotline and the least preferred method was by fax, as indicated below (Figure 5)

Figure 5 - Preferred referral methods
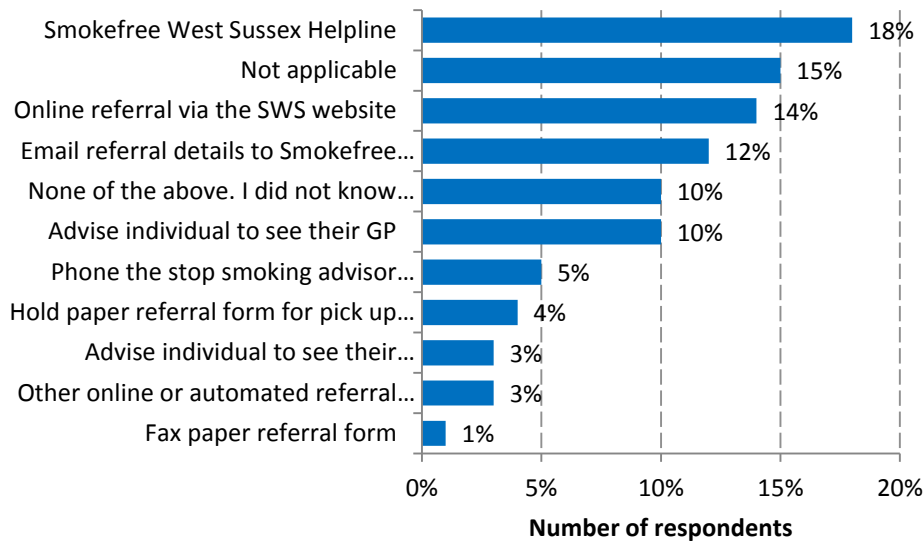
Accessing stop smoking services

When asked what they believed were the main barriers to accessing Stop smoking services by their clients or service users, the majority of participants (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 participants, 39%) and lack of time to engage with services (35 participants, 37%) (Figure 6)

Figure 6 - Responses to barriers to accessing stop smoking services
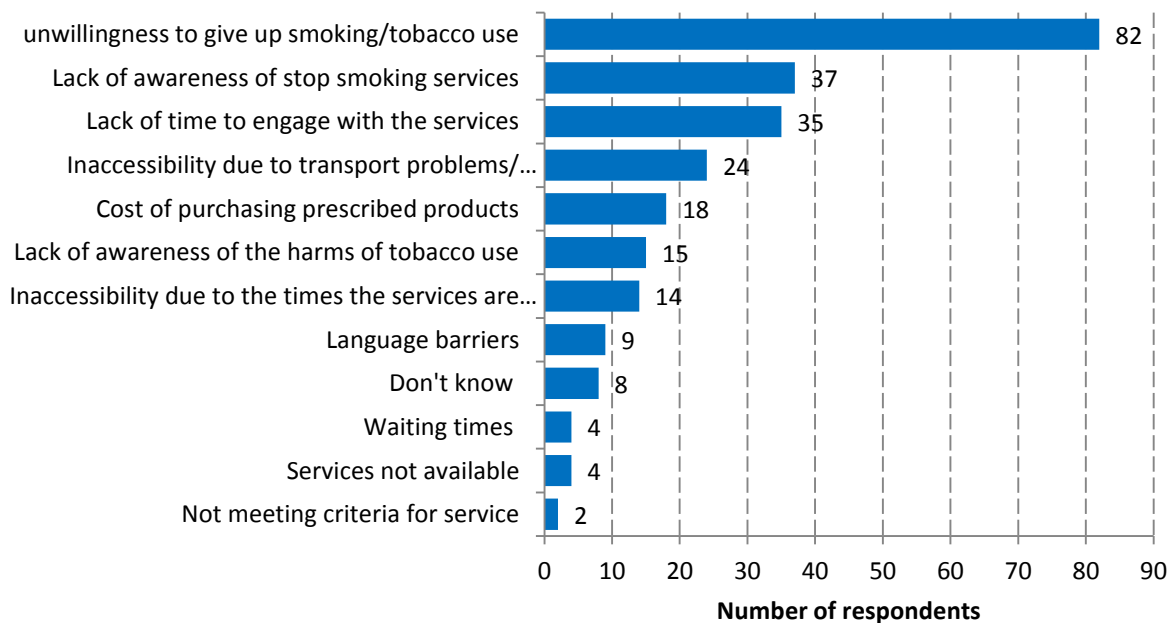
Other barriers identified included the inability to access services due to learning disabilities and *"young parents feeling stigmatised"*.

The professionals who took part in the survey were asked if they engaged their clients/service users in any of the '5 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). The majority of participants (62%) reported that they ask about tobacco use, whilst 14% reported that they did not engage in any of the 5As. Responses were as below, Figure 7.

Figure 7 - Engagement with the 5 As of brief interventions
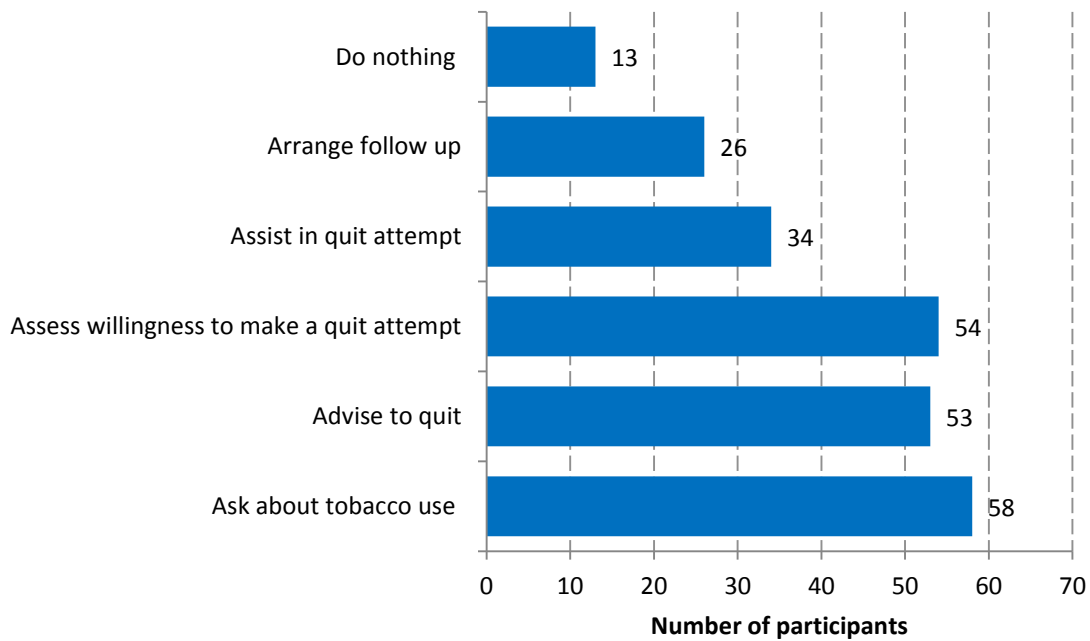
Some participants expressed that although they were in contact with people who smoke in their roles, asking or providing an intervention to support a person to stop smoking is not relevant to them as this could "further complicate" the difficult situations that they deal with already.

Information resources were the most cited resource needed by professionals to reduce tobacco use and second-hand exposure, followed by the provision of in-house and onsite stop smoking services (Figure 8).

Figure 8 - Resources needed to reduce tobacco use and exposure to second-hand smoke
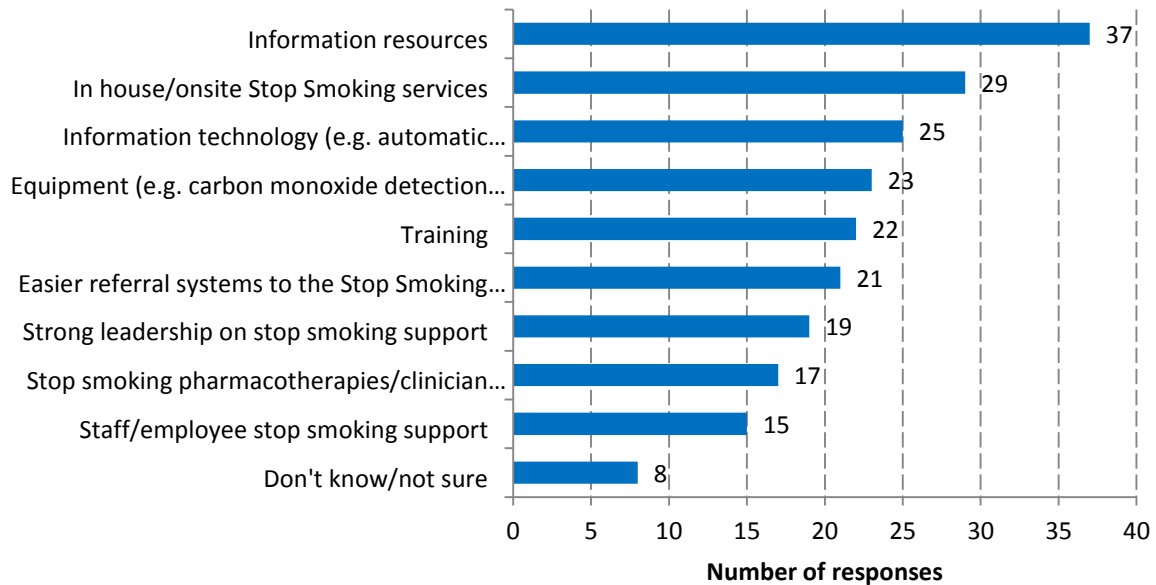
Participants were also asked "**If West Sussex could provide one thing to help you or your organisation/department to reduce tobacco use and second-hand smoke exposure, what would that be?**" The responses covered a wide range of issues. The main issues identified were; the need for equipment, particularly carbon monoxide detection equipment; 'no smoking' signs; information and technology resources i.e. posters, videos and mobile phone apps; raising awareness of the harms of tobacco and second-hand smoke; and training. Other responses included providing designated smoking areas. A number of participants also suggested inviting professionals to visit places such as youth clubs, and childcare setting as well as other targeted groups, to educate and raise awareness relating to tobacco harms.

"Stronger message on second-hand smoke exposure and a way of tackling this with children's parents in a non-confrontational way. Maybe through part of a child's 2 year check. Having a question on the check that we can ask...'Are they exposed to second hand smoke?' Then if this was asked, it would provide an 'in' into talking about it, and then hopefully referrals."

"Intervention programmes should be advertised and run within college"

Increasing the presence of tobacco control activities in hospitals and the provision of free Nicotine Replacement Therapies (NRT) patches were other interventions suggested by the participants. One participant suggested improving the service by improving the flexibility in providing and accessing services for both stop smoking service providers and the client:

"I am a stop smoking service provider … It would be good to split the consultations, for example if a patient had the first consultation to me, then we could get paid for that consultation then they could take that form with them and go for next one to someone else. This would give better flexibility to the customer. Perhaps there could be an online method, where the advisor could find the user online, and then carry on where the last advisor left off."

Gaps in services

When asked what gaps existed in the provision of services to reduce/prevent tobacco use and second-hand exposure, some professionals indicated that lack of in-house services, for example, for pregnant woman, requiring a 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".*

Another gap identified was the need for stop smoking services to engage in home visits, rather than people going to clinics to access them.

Once again, another recurrent gap that emerged was that that there is need to raise awareness the Stop smoking services and the harms of smoking and second-hand smoking.

Training needs identified

Thirty six percent of the participants highlighted that they had not received any training on tobacco control issues such as giving brief advice, stop smoking methods, harms of second-hand smoke, and tobacco and health inequalities. Only nine (10%) reported having received training in tobacco related regulations. One respondent reported receiving training on impact of smoking on Sudden Infant Death Syndrome.

Table 9 – Training needs identified by participants Error! Not a valid link.

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%)

Some of the professionals who responded to the survey 18% (17 participants) indicated that they could benefit from training on the impact of smoking on health inequalities. Furthermore, 16 participants (17%) highlighted they could benefit from training to understand their role in reducing the use of tobacco products. A number of participants indicated that they could benefit in training on smoking related harms in different high risk

groups such as pregnant women, young people, and mental health service users as shown below (Table 9). The responses indicate a general awareness of smoking related harm, as only nine participants (10%) felt they could benefit from training in smoking related harm, compared to the 25 participants (27%) who thought they could benefit from training smoking related harm to young people. Some participants indicated that there is a gap in training such as effects of smoking on mental health and others were not clear about the regulations and others highlighted the need for training updates for staff. *"The ability to assess people effectively"* was another respondent's view of the gaps in tobacco control activities, which could indicate a need for training to enable professionals to assess people effectively.

Reducing exposure to second-hand smoke

Figure 9 – Participant organisations' smokefree policies
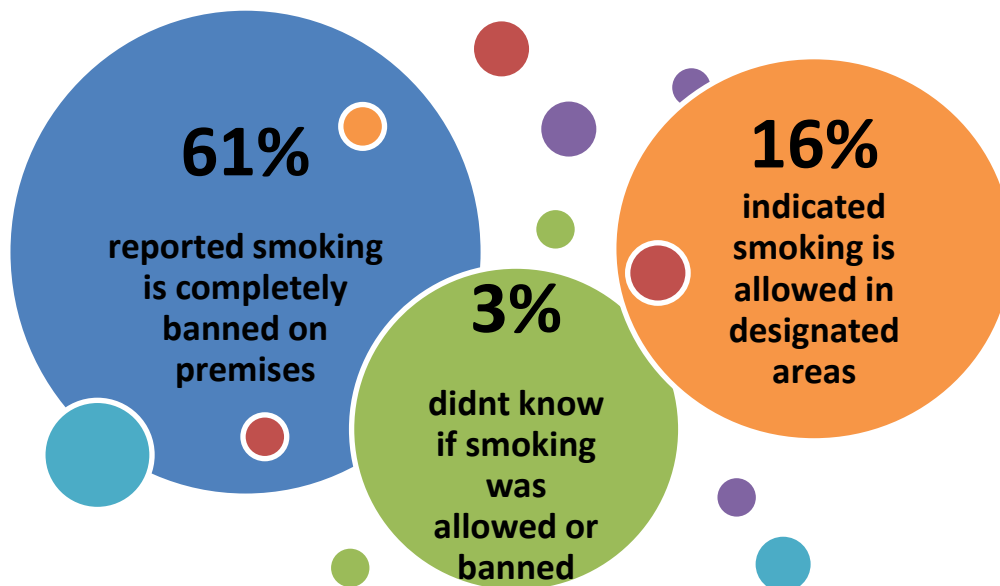
When asked about their organisation's smokefree policy, the majority of the participants (70%, 66 participants) reported that their organisation had a Smokefree policy. Three participants (3%) said their organisation did not have a Smokefree policy and 7 (7%) did not know whether their organisation had a smokefree policy.

Sixty-one percent (58 participants) 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 participants (3%, three participants) didn't know if smoking was prohibited or allowed by their organisations. Similarly, most of the participants (47%, 44 participants) reported that their organisations prohibited e-cigarettes on the premises, and 11% (ten participants) said that e-cigarettes were allowed in designated areas. However, a number of people (23%, 20 participants) didn't know their organisation's policy on e-cigarettes.

When asked if their organisation's smokefree policy provided guidance for staff who do home visits where they are likely to be exposed to second-hand smoke, only nine participants reported that there is guidance in their smokefree policy. Eighteen did not respond and ten professionals responded that their organisation's smokefree policy did not offer guidance for staff who do home visits. One respondent commented on the provisions to protect 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*".

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 there is a gap as some 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…*"

Effective communication for tobacco control

The majority of professionals (36 participants (38%)) who responded to the survey indicated that they do not receive updates on tobacco control activities. Twenty-four participants (26%) reported that they received updates by email, and the least mentioned method was social media (four participants (4%)).

National campaigns are a key part of tobacco control activities, and just over half (49 participants (52%)) reported that they or their organisation supported Stoptober. However, 22 participants (23%) reported that they did not support any campaigns (Figure 10). One professional commented

"*We know about them but don't necessarily actively do anything to promote them further*".

Figure 10 - Supporting antismoking campaigns
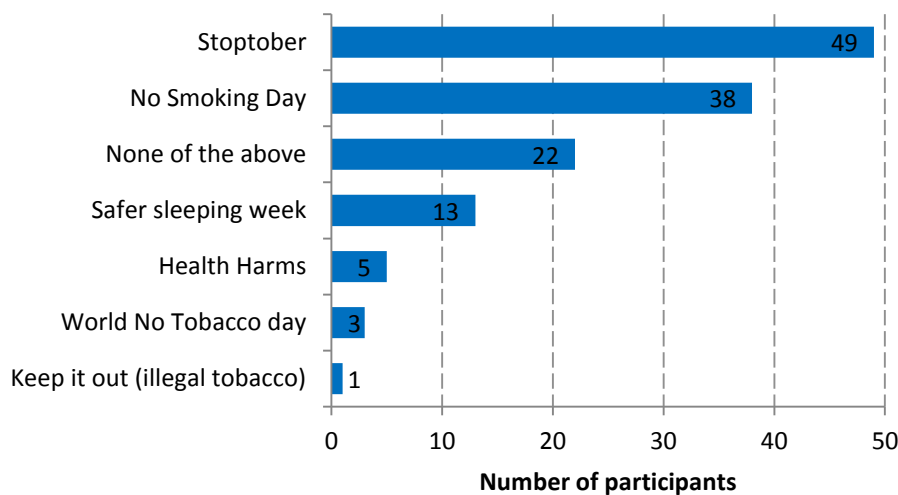
When asked whether information resources provided by the West Sussex Stop smoking services and the NHS are adequate, the majority of participants indicated that the resources were "partly" adequate. In addition, information resources were the most cited as needed by professionals to reduce tobacco use.

Professionals who come into contact with tobacco users have an important role to play in raising awareness of tobacco issues. The professionals who took part in the survey were asked if they had opportunities to raise awareness about tobacco use issues in certain 'high risk' groups. The majority of them (61%, 57 participants) indicated that they had opportunities to raise awareness about tobacco issues in young people under the age of 25 years and, 43% (40 participants) reported opportunities to do the same for pregnant women. Thirty two percent (30 participants) highlighted that they had opportunities to raise awareness in mental health service users and ethnic minority groups. The opportunities were less for those in routine and manual workers, where only 27% (25 participants) responded that they had the opportunity to raise awareness in this group, and 31% (29 participants) could do so for residents in deprived areas. Other responses included maternity services, teenage parents, and people with learning disabilities. These responses give an indication that opportunities exist to reach the target groups and could be used to reduce tobacco use in these groups and other tobacco users.

The question "**what opportunities do you have to raise awareness about tobacco use issues?**" was asked and free text responses were given. The themes that emerged from the responses indicating current opportunities were;

- Outreach work and having stands in different areas and venues and for different groups. Opportunities identified were; stands at colleges "*Fresher's fair in September*", "*maternity unit during Stoptober and safer sleeping week*", supermarkets, health events in schools and colleges and workplace events.

"*We could hold awareness/information meetings/coffee mornings at the sheltered schemes we work within*"

- Communications through posters, emails, leaflets, social media, weekly youth clubs and mentoring
- As part of PSHE in schools
- During home visits

However, some participants felt that this is not within their role and therefore they felt they did not have any opportunities to raise awareness.

Education about tobacco harms and raising awareness was not only limited to the professionals but also that this needs to be extended to service users, schools and school children and parents and other members of the public. Although the highest percentage of participants responded that they have opportunities to raise awareness of tobacco harms in

young people, some participants reported a gap in "*the ability to reach young people effectively*".

Some participants highlighted the need to change the tactics and messages when communicating tobacco risks factors to smokers and non-smokers as people become desensitised to some health messages.

> "*People are often aware of the risk of cancer and have become blasé about it. I used to smoke. I smoked and had 7 chest infections in a row. I finally contracted pneumonia and was too weak to fight it properly. I ended up with asthma, M.E. I lost my income because I could not work in a physical job anymore and lost over the years a great deal more health. Smoking ruined my life. I feel other affects ought to be highlighted as people are almost bored of hearing about cancer. If they think they won't be able to work over years, not be able to go on holiday, lose their home etc... it might make them think. I triggered autoimmune illnesses and have been suffering now for over 26 years in pain because I started the domino with cigarettes.*"
>
> "*Of those that smoke generally, (there is) ambivalence to give up, health does not seem to be the major concern, perhaps anticipating what will be said, or not currently experiencing significant enough (relative to their lifestyle) to think a change is necessary*".

Overall - What can be done to reduce tobacco use and second-hand smoke exposure?

When asked what could be improved in terms of resources to reduce tobacco use, the key themes that emerged were;

- Providing resources in other languages
- Information technology and resources such as mobile app, social media, tailored leaflets and "*online prompts to front line workers facing clients*"
- Communication resources such as information leaflets about e-cigarettes, leaflets tailored for young people, those with learning disabilities and giving more information about all the effects of smoking, not just physical effects. In addition there should be "*half yearly information broadcast through the Early Years Service*"
- Increasing capacity through training and providing more staff
- Partnership working

Summary of key findings

Inadequate training on tobacco control issues which impacts on professionals ability/motivation to work with and engage target groups to reduce tobacco use

Information resources were identified as key resources required by professionals to reduce tobacco use followed by the availability of in-house/onsite stop smoking services.

- Engagement in anti-tobacco campaigns is poor among professionals.

- There is need to awareness about how to report illicit tobacco and underage tobacco sales

Barriers to stop smoking for service users include; lack of willpower; lack of awareness of services; inaccessibility of services; and the cost of purchasing prescribed products.

Low levels of referrals to services by professionals

Although they were in contact with tobacco users, some professionals did not engage their clients/service users in any of the 5As of brief interventions, which indicates missed opportunities.

There are missed opportunities for collecting tobacco control data by professionals as part of the normal routine engagement with service users

There is an increased drive to de-normalise smoking through adaptation of smokefree policies by organisations.

However, there protection of staff who do home visits against secondhand smoke is minimal

1.5   Schools survey report

Methods

In addition to the public consultations and the professional survey, we also conducted online surveys with schools to get a view of their current practices and gaps in services. All School Head teachers in West Sussex were contacted via STAR Chamber, informing them of the TCNA and asking them to take part in the online survey. The survey ran from 29th February until the 16th of March 2016.

Respondent profile

A total of 18 schools responded to the survey and these included; primary, secondary and all through schools. The majority of the schools that responded where primary schools (11), followed by secondary schools (5), one All through school and one First school. Schools in various categories responded to the survey as shown below (Figure 11), however, none of the private or independent schools responded to the survey.

Figure 11 - Categories of schools that responded to survey
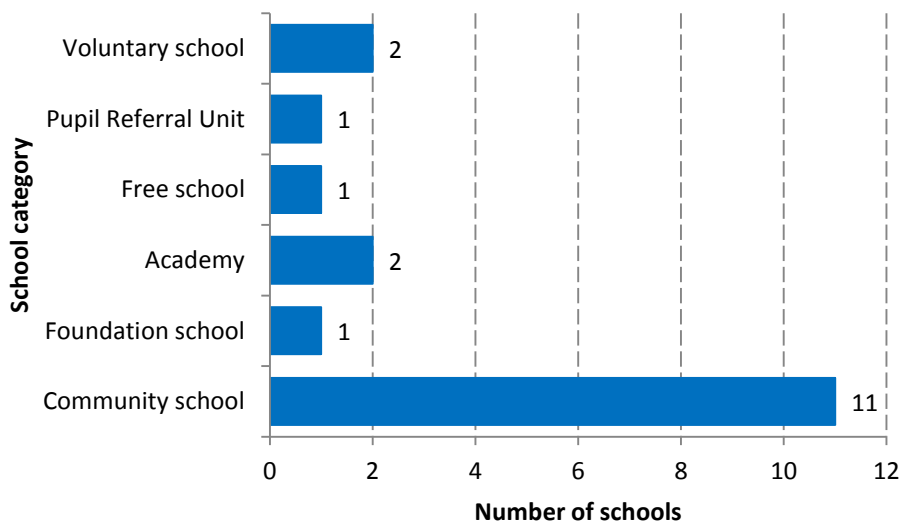
Findings using the six strands

Reducing exposure to second-hand smoke

Smokefree policies

Schools were asked if they had a smokefree policy, in addition to the statutory legislation prohibiting smoking in enclosed public places. The majority of schools (15) responded that they had a Smokefree policy which covered pupils, teachers and other school staff, as well as parents and visitors. Two reported they did not have a smokefree policy, whilst one school responded "don't know".

When asked "**Does your Smokefree policy prohibit smoking in any of the following area?**" the majority of the schools indicated that their smokefree policies covered a range of areas including school gates and outside building entrances (Figure 12).

Figure 12 - Smokefree policies
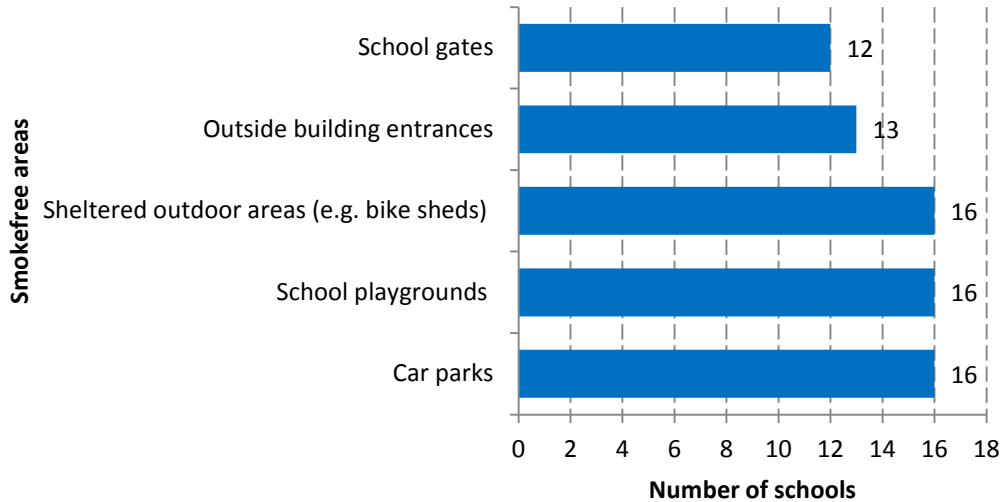
When asked if the school's smokefree policies have been reviewed in the last 12 months, the majority of participants either said no (10) or didn't know (2), no response (1). Of the 16 schools that reported having a smokefree policy, only three had reviewed their policies in the last 12 months Figure 13.

Figure 13 - Responses to the question "have your smokefree policies been reviewed in the last 12 months?"
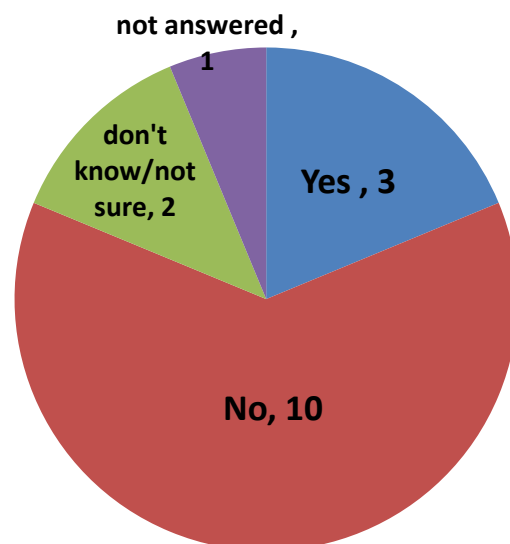
Helping tobacco users quit

Enforcement of smokefree policies

Schools indicated that they take different approaches in enforcing their smokefree policies for pupils as well as for teachers. Of the 16 schools with smokefree policies, 13 responded to the question regarding the enforcement of their policies for pupils. Five primary schools and one first school reported that enforcing the policy on their pupils was not an issue for them, as the children were young and so did not apply. One responded "don't know".

> *"N/A as only primary and has not been an issue, thankfully".*
>
> *"It has never been necessary, small school, everyone complies".*

Given the different age groups, the responses from secondary schools were varied to those of primary schools. The five secondary schools that responded to the question all indicated that they do enforce their policies, although enforcement is mostly sanction based. None of the schools indicated making a referral to stop smoking services or having a class to support the pupils who do not comply with the smokefree policies.

> *"Internal sanctions and contact with parent/carers".*
>
> *"As a school we have a very clear policy and the expectations and sanctions are very clearly explained to the students. In the event of anyone breaking the rule, a consistent sanction is imposed and parents are contacted and invited in to school for a meeting following the internal exclusion".*
>
> *"The message is reinforced, any pupils caught smoking on the school premises are given a suitable punishment".*

E-Cigarettes

The majority of the schools that responded to the survey (12) indicated that e-cigarettes are included in their smokefree policies and are treated same as cigarettes. However, one of the schools indicated that this has not been explicitly stated in the policy but is an "*unstated expectation*". One school reported that e-cigarettes are allowed on the premises as part of the smokefree policy. Of the 18 schools that responded to the survey, three reported that they did not include e-cigarettes in their smokefree policies. Two schools responded 'don't know', and one of these highlighted that this is currently under review

> *"This is something we are updating as informally e-cigarettes are treated the same however this needs to be put in writing in our policy. We adopt the WSCC policies on such matters"*

Training for school staff

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 of them (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 school reported that a few staff members had received training, whilst two schools responded "don't know/not sure".

Effective communication for tobacco control

Tobacco control activities/smoking related harm education

When asked how the schools incorporate tobacco control/anti-smoking education, 10 of the 18 schools indicated that this was done as part of the national curriculum, 15 responded that it was done as part of PSHE and only three schools reported they did not provide any. However, some schools (8) reported that they educated their pupils about the harms of tobacco use as part of both the national curriculum and PSHE; and four used various methods as part of the national curriculum, PSHE and third sector or independent program. The majority of participants (10) indicated that they delivered this once per year for selected year groups and three reported that this was done once per year for all pupils. One school responded that it 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 were;

- the need to raise awareness of the harms of tobacco use;
- legislation to ban smoking in all public places
- provision of resources "*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*".
- communication strategies, that are suitable for their target group "*…We have used the Assist project previously with some impact but visits from Anti-smoking groups often help reinforce the message with students especially with high impact messages and leaflets etc.*"
- training for the teachers "*Training for staff. It is not something we have heavily discussed or had a whole-school input on*".
- Using external agencies to educate children and parents on the harms of tobacco and second-hand smoke exposure was another suggestion.

"I think that having an outside agency in to discuss tobacco and second hand smoke exposure would have more impact on the children. I feel that there should also be workshops within the school for parents to heighten the awareness and then children could also encourage/pressure their parents to attend".

Opportunities to incorporate tobacco control messages in schools

Schools were asked what programmes they provided, independently or in collaboration with other organisations, that promote wellbeing and resilience in young people that may

provide opportunities to incorporate messages about tobacco. Of the 17 schools that responded to this question, five schools responded "no" and five schools responded "don't know/not sure". Seven responded yes, highlighting that they have programs in place. The programmes identified were:

- programme for 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

Summary of findings

Respondents indicated that there is need to work with schools to educate young people about tobacco harms, through providing resources and supporting the delivery of some school programmes

The majority of respoindents highlighted their efforts to de-normalise smoking and protect against secondhand smoke through their smokefree policies. However, a small number had reviewed their policies in the last year and some didn't have a smokefree policy

Respondents highlighted the need for co-designing and tailoring tobacco control programs for their pupils

There is a lack of support, by schools, of the pupils caught in breach of smokefree policies, and the enforcement of smokefree policies is sanction based.

Some schools did not have a comprehensive ban on smoking on or near school premises, such as school gates

2. West Sussex smoking cessation Health Equity Audit 2014/15

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2.1 Aims of the Health Equity Audit (HEA)

The purpose of this report is to provide local stop smoking services, commissioners and decision makers with information about how equitable the distributions of resources provide for stop smoking services were delivered relative to the health needs of the population. The Health Development Agency (2005) defines a Health Equity Audit (HEA) as follows:

> *"HEA is a process for identifying how fairly services or other resources are distributed in relation to the health needs of different groups and areas, and the priority action to provide services relative to need. The overall aim is not to distribute resources equally but, rather, relative to health need. This process assists the planning and decision-making processes of organisations. It determines whether the distribution of health outcomes, healthcare or the determinants of health are inequitable or unrelated to need, and action is then taken to remedy and monitor progress. The purpose is for health and other services to help narrow health inequalities by taking positive decisions on investment, service planning, commissioning and delivery that narrow inequalities."*

The HEA for smoking cessation services will specifically undertake to identify trends in numbers of people who accessed the service by district, age, gender, ethnicity and occupation against the smoking prevalence as we understand it to be in West Sussex. The audit will also highlight the outcomes of the service to determine trends in service delivery methods, accessibility and support provided against age, occupation, area of deprivation and ethnicity.

Data considerations

Availability and access to a central database that provides anonymised low level data for service users accessing smoking cessation services across all providers has greatly improved our ability to analyse data this year.

Although access to data has improved, data collection is still not of the highest standard. Data collection of ethnicity is particularly poor with 94% of service users (n=4879) not having a recorded ethnicity. There were also around 14% (n=726) to 15.5% (n=804) of records with missing data recorded against user's home district and occupation respectively (778 had occupations stated as 'Unable to code' while 26 had no recorded occupation at all).

As with previous smoking profile estimates caution must be taken with the numbers. A combination of both local prevalence for each area are combined with national prevalence for demographic groups to produce the profiles, this allows for a large margin of error especially within demographics made up of small numbers, for example, in West Sussex's

case black, Asian, and minority ethnic (BAME) residents. Taking this into consideration rounding has taken place and therefore not all tables of estimates may sum correctly.

Summary of access to West Sussex stop smoking services

- 5191 persons accessed smoking cessation services across West Sussex.
- more females accessed the service than males; 51.3% female (2663) and 48.7% male (2528)
- access rate of the smoking population is 4.63% broken down to; female – 5.18%, male – 4.17% (see Table 10)
- access rates by gender and age groups ranged between 1.79% for males aged 18-24 and 5.44% for females aged 35-49 (see Table 11)
- 2624 cases recorded as successful quitters; 1336 males and 1288 females
- overall quit rate was 50.5%; male quit rate (52.8%) was higher than for females (48.4%)
- the range of quit rates by gender and age groups was within 15% of the gender averages.
- Quit rates for pregnant women was lower than the overall county average (45.7%)

The West Sussex profile

In 2014, West Sussex had an adult population (18+) of around 659,550. The population is predominantly white (94.7%); Asians hold the second largest share with 3.3% of people. The north of the county is more culturally diverse with the borough of Crawley having the largest percentage of Asian ethnicity (12.3% of its population)[2]. As a whole West Sussex has a relatively old population in comparison to England, especially around the rural areas. While West Sussex is a reasonably affluent county there are pockets of deprivation. Adur was ranked 159th most deprived (from 326) lower-tier authority across England and River, Courtwick with Toddington and Bersted wards in Arun ranged in the 10% most deprived neighbourhoods.

Local smoking profile

Smoking is the leading cause of premature morbidity and mortality accounting for more than 80,000 deaths every year in England[3]. This is higher than all other causes of preventable deaths combined. In West Sussex approximately 4,000 people in the last two years have died from smoking attributable illness[4].

In 2014, the smoking rate in West Sussex in those aged over 18 years is 17.0%, slightly below the national average of 18.0%[5]. The West Sussex average hides the considerable variation between areas across the county, with rates in some districts and boroughs as high as 20.3%

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[2] Census 2011 (ONS)

[3] http://www.ash.org.uk/files/documents/ASH_962.pdf

[4] PHE Tobacco profiles 2012-14

[5] Integrated house survey (ONS)

and as low as 15.8%[6]. In West Sussex smoking prevalence in routine and manual workers stands at 29.2% slightly above the national average (28%)[7].

In 2014/15, the estimated cost of smoking to society in West Sussex was £207.4 million per annum[8]. This includes lost output from early death, time lost in smoking breaks, NHS care, sick days, passive smoking, domestic fires, and smoking related litter.

The impact on health inequalities from smoking is also significant. Over 73,000 households in West Sussex have at least one smoker[9]. When net income and smoking expenditure is taken into account, 17,336 or 24% of households with a smoker fall below the poverty line. If these smokers were to quit, 5632 households in West Sussex would be elevated out of poverty. By stopping smoking roughly 14, 500 people from these households would not be below the poverty line because the cost of smoking would be returned to the household.

Using modelled prevalence estimates for the whole population, age, sex and ethnicity, the number of smokers in the adult population of West Sussex is estimated to be about 112,125[1,10]. Tables 10, 11, 12 and 13 below show prevalence analysis by gender, age, ethnicity and occupation. It should be noted that the 2013/14 heath equity audit based its estimated number of smokers on the estimated GP population (18+). The decision was made that this year's estimate will use the 2014 mid-year population estimates as these provide greater accuracy and detail.

Using 2014-15 Smoking At Time Of Delivery (SATOD) data, the Health and Social Care Information Centre (HSCIC) estimated West Sussex prevalence of smoking during pregnancy to be 9.6%, slightly below the national average (11.4%). This equates to 807 smokers in 8434 maternities, 113 recorded as unknown.

Local smoking cessation services up to March 2015

Stop smoking services are well established in the UK and have a significant impact on helping smokers to stop. The primary role of stop smoking services is to deliver a high quality evidence based stop smoking intervention to the local population[11].

Until the end of March 2014 the specialist stop smoking service was delivered by the NHS, supplemented by a number of local primary cares and Pharmacies to deliver services. A private sector company was awarded the specialist smoking service contract following a competitive procurement process. This contract started in April 2014. The specialist service is responsible for supporting smokers that are considered hard to reach groups in the community and where smoking prevalence is highest. These groups are – BAME, Under 25s, routine and manual workers, mental health service users in the community, pregnant

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[6] West Sussex smoking prevalence brief; March 2015

[7] http://www.tobaccoprofiles.info/

[8] http://www.ash.org.uk

[9] ASH Local poverty calculator 2015 www.ash.org.uk

[10] Based on the 2014 Mid-Year Estimates (ONS)

[11] NCSCT Service and delivery guidance 2014

women and their partners, residents of areas of deprivation and those who have five or more unsuccessful quit attempts.

The specialist service also supports the primary care and pharmacy providers to deliver smoking cessation services through training, equipment and data collection.

The specialist service is also tasked with communicating and marketing local stop smoking services and supporting national campaigns such as Stoptober locally.

In 2014/15 residents could access stop smoking clinics in approximately 28 community clinics, 93 GP surgeries and 98 pharmacies. The GP surgery clinics were available for those registered at that practice and who elected to have an appointment with an advisor. Community pharmacy smoking cessation services were available for any resident of West Sussex on a walk in basis. The specialist service offered group sessions, individual drop in sessions as well as clinics that provide timed appointments.

The model commissioned in West Sussex is an abrupt cessation model after which a person will smoke 'not one puff' on a cigarette. The support offered involves a combination of behavioural support and licenced pharmacotherapy. Residents that receive treatment with the support of a stop smoking service are four times more likely to stop smoking than trying to stop on their own.

2.2   Access to smoking cessation services

In 2014/15, 5,191 smokers in West Sussex accessed the smoking cessation service and set an agreed 4 week quit date. Accessing services means residents had an assessment appointment and set a quit date. Across the county access ranged from 399 smokers in Horsham to 1127 in Arun. Please note 734 (14%.1) users could not be assigned a district. In total an estimated 4.63% of the smoking population in West Sussex accessed stop smoking services. The West Sussex access rate is slightly lower than the performance targets set in the NICE guidance[12], which considers, in a given year, local authorities should aim to treat at least 5% of the local population of smokers. For West Sussex this would mean 5,606 smokers would have needed to access the service, an additional 415 smokers.

When smoking prevalence is taken into consideration at the district level, Horsham had the lowest number of their smoking population access the service (2.34%) and Arun the highest (5.48%) (Table 10). Generally, across all districts, the age ranges of 18-24 had the lowest access rates followed by the 65+ age group, similar to the previous year.

Overall the access rate are up in West Sussex by 0.19% in 2014/15, notable differences in access rates across the districts, compared to last year, is a 1.78% drop in Chichester and 1.07% drop in Adur.

Public Health England released national figures for April 2014 to March 2015 and reported a decline in people setting a quit date, for the third consecutive year, down by 23% on 2013/14 across England's stop smoking service[13]. Public Health England states the following reason for the possible decline:

> "Anecdotal evidence suggests this may be due to an increase in people using e-cigarettes to help them stop smoking rather than making use of these services. It is possible that the fall in smoking prevalence may also be a factor but the decrease in smoking prevalence is a long established trend which covers the earlier period of increasing use of Stop Smoking Services as well as the recent decline."

In West Sussex there was an 18.8% decline in persons accessing the service compared to 2013/14.

Access to Stop Smoking Services by gender

As shown in table 1 below it is estimated that there are more male smokers within West Sussex than female smokers, at a ratio of around 54:46 male to female. Although the estimated male smoking population is larger than the female smoking population in West Sussex, 138 more females than males accessed the smoking cessation service in 2014/15. Nationally, this picture was similar as more women (52%) than men accessed services[13].

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[12] https://www.nice.org.uk/guidance/ph10
[13] http://www.hscic.gov.uk/catalogue/PUB18002

Access rates for women (5.18%) were around one per cent higher than the male access rate (4.17%) within West Sussex. Arun had the highest overall access rate (5.48%) while Horsham and Mid Sussex both had the lowest access rates (2.34% and 2.86% respectively).

Female access rates were higher in all seven districts and boroughs with Adur, Arun and Crawley's female access rates being above the NICE recommended 5%. The male access rate only exceeded 5% in Arun.

Table 10: Estimated smokers and recorded access by gender and district

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Person								
Smokers	112,125	9,555	20,575	15,085	14,625	17,080	17,825	17,385
Access	5,192	392	1,127	529	748	399	509	754
Access %	4.63%	4.10%	5.48%	3.51%	5.11%	2.34%	2.86%	4.34%
Male								
Smokers	60,650	5,155	11,005	8,060	8,100	9,275	9,725	9,330
Access	2,528	171	567	269	363	182	252	367
Access %	4.17%	3.32%	5.15%	3.34%	4.48%	1.96%	2.59%	3.93%
Female								
Smokers	51,475	4,405	9,570	7,025	6,525	7,800	8,100	8,055
Access	2,664	221	560	260	385	217	257	387
Access %	5.18%	5.02%	5.85%	3.70%	5.90%	2.78%	3.17%	4.80%

Estimated smoking population figures have been rounded and therefore aggregating by either gender or district may yield small inaccuracies. Also note that there were 734 persons accessing the service that could not be assigned a district and therefore district access rates are likely to be an underestimate.

Access to Stop Smoking Services by age

Table 11 shows the age break down of estimated smokers and the recorded number of people accessing the smoking cessation service in West Sussex, by age. It is predicted nationally that the age groups 18-24 and 25-34 have the highest smoking prevalence (23.3% and 23.0% respectively); prevalence then drops by each age group to 9.2% for the 65+ band.

The age group 35-49 had the highest access rate in West Sussex, and was also the only age range to have an access rate over 5% (5.33%). All other age ranges with the exception of 18-24 (2.59%) had access rates above 4%.

At district level access rates ranged from 6.65% for 35-49 year olds in Arun to a low of 1.40% for 18-34 year olds in Chichester.

A very small number of under 18 year olds accessed the service (n=33), eight of these were successful 4 week quitters, seven being CO verified. Seventeen of the 33 were lost to follow up (52%), almost double that of the average and the highest across all age groups.

Table 11: Estimated smoking population and recorded services users by age and district

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
18-24								
Smokers	13,265	1,105	2,455	2,070	1,820	1,870	1,950	2,005
Access	343	21	77	29	66	26	36	45
Access %	2.59%	1.90%	3.14%	1.40%	3.63%	1.39%	1.85%	2.24%
25-34								
Smokers	20,765	1,725	3,445	2,245	3,970	2,745	3,295	3,335
Access	942	56	201	78	190	79	90	126
Access %	4.54%	3.25%	5.83%	3.47%	4.79%	2.88%	2.73%	3.78%
35-49								
Smokers	33,215	2,885	5,500	3,985	4,575	5,260	5,715	5,305
Access	1,770	145	366	181	254	130	175	256
Access %	5.33%	5.03%	6.65%	4.54%	5.55%	2.47%	3.06%	4.83%
50-64								
Smokers	28,080	2,355	5,255	4,075	3,025	4,705	4,495	4,175
Access	1,376	93	309	151	162	103	142	222
Access %	4.90%	3.95%	5.88%	3.71%	5.36%	2.19%	3.16%	5.32%
65+								
Smokers	16,800	1,490	3,925	2,710	1,235	2,500	2,375	2,565
Access	679	67	164	84	63	56	57	91
Access %	4.04%	4.50%	4.18%	3.10%	5.10%	2.24%	2.40%	3.55%
Total								
Smokers	112,125	9,555	20,575	15,085	14,625	17,080	17,825	17,385
Access	5,192	392	1,127	529	748	399	509	754
Access %	4.63%	4.10%	5.48%	3.51%	5.11%	2.34%	2.86%	4.34%

Caution should be taken as figures have been rounded at both age and district and therefore may not correctly aggregate. Also due to data collection quality there were 82 users that did not have a recorded age, and 734 users that were not assigned to a district. This would suggest that most access rates at district level are underestimates.

Access to Stop Smoking Services by ethnicity

Due to poor data collection access rates by ethnicity are effectively impossible to calculate. Only 301 users had a recorded ethnicity (out of the total 5191 users) a further 19 of those were recorded as 'not stated' or unknown.

Table 12 shows the estimated number of smokers by ethnicity and district however due to West Sussex's large white population the estimated number of smokers by ethnicity are crude estimates. When estimates are broken down further by district they produce very small numbers, this means when looking at access rates by ethnicity, district, and age band they can fluctuate greatly.

Table 12: Estimated number of smokers by ethnicity and district

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Asian	2,735	110	195	155	1,345	225	335	375
Black	780	35	65	55	370	50	80	115
Mixed	875	80	115	75	225	105	125	150
Other	585	60	50	50	205	45	65	105
White	107,140	9,275	20,150	14,750	12,480	16,650	17,210	16,630
Total	**112,125**	**9,555**	**20,575**	**15,085**	**14,625**	**17,080**	**17,825**	**17,385**

Access to Stop Smoking Services by occupation

When analysing access rates by occupation, data quality must be taken into consideration. Of the 5,191 users 778 had occupations stated as 'Unable to code' while 26 had no recorded occupation at all. Comparing the predicted access rates by occupation with access rates in previous sections, the definitions for occupation used in this document[14] and the definitions used by the specialist service may differ although this cannot be confirmed.

Table 13: Estimated number of smokers and users accessing by occupation and district

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Managerial/ Professional								
Smokers	26,225	1,845	4,140	3,740	3,925	4,055	4,850	3,665
Access	793	39	100	85	125	101	125	113
Access %	3.02%	2.11%	2.42%	2.27%	3.18%	2.49%	2.58%	3.08%
Intermediate								
Smokers	29,450	2,470	5,370	3,805	4,965	3,865	4,580	4,395
Access	179	25	22	11	49	5	20	22
Access %	0.61%	1.01%	0.41%	0.29%	0.99%	0.13%	0.44%	0.50%
Routine and Manual								
Smokers	51,885	4,685	10,375	6,030	11,350	5,525	6,475	7,450
Access	1,644	131	443	160	203	122	152	234
Access %	3.17%	2.80%	4.27%	2.65%	1.79%	2.21%	2.35%	3.14%

Routine and manual workers had the highest access rate within West Sussex (3.17%) although to reach the NICE guidance of 5% access rates, an extra 950 routine and manual workers would have needed to access the service. Managerial and professional workers had similar but marginally lower access rates to routine and manual. Nationally routine and manual and managerial and professional workers made up for 24% and 11% respectively of people accessing services. While in West Sussex they accounted for 31.7% and 15.2% respectively, which is better than the national average.

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[14] http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html#7

Access by intermediate had a strikingly low access rate of 0.61% county wide, with only 179 smokers of an estimated 29,450 accessing the service. Nationally 7.7% of those accessing services came from the intermediate occupation category compared to 3.5% in West Sussex, just over double.

Access to Stop Smoking Services by pregnant women

National prevalence of smoking during pregnancy is 11.4% compared to 9.6% in West Sussex (8434 maternities, 807 smokers, 113 unknown).
In 2014/15, 188 pregnant smokers accessed the service, equating to an access rate for pregnant women of 2.3%. This represents a 21.3% rise in the number of pregnant women accessing the services in comparison to last year. This was contrary to the national trend which saw a 4.8% decrease in the number of pregnant women accessing.

Key points

- West Sussex access rates are down 18.8% compared to 2013/14
- Lowest access rate was in the Horsham district with the highest in Arun
- Lowest rates of access are from the 18-24 and 65+ age group
- More female smokers access the service more than male smokers in all seven districts
- Access by routine and manual workers is highest with intermediate workers accessing the service the least
- Chichester and Adur experienced a significant drop in access rates compared to last year
- Due to unrecorded ethnicity it is impossible to calculate access rates by ethnicity
- 734 users (accounting for .65% access rate) could not be assigned a district due to missing data

2.3 Quit outcomes

Quit rates

- Quit rate at four weeks is 50.5%, similar to the national average
- 76.8% of quitters were CO verified, below the recommended rate of 85%
- The age group 18-24 had the lowest quit rates for both adult genders
- 24% quit rate in under 18 years of age
- The most deprived areas had marginally higher quit rates than the rest of the county
- Of the recorded occupation status students remain to have low quit rates
- Quit rates in pregnancy are lower than the West Sussex average of all smokers and the national average

The four week quit rate is the national measure of success for local stop smoking services. The Russell Standard[15] recommends a quit rate over 50% for self-reported four week quits and commissioning guidelines[16] suggest that self-reported quit rates that fall outside of the 35% - 70% range should be investigated.

The overall self-reported four week quit rate for users of the stop smoking service in West Sussex was 50.5% (2624 quitters of 5191 users), similar to the national quit rate of 52%. The West Sussex quit rate showed a 3% improvement on last year. Quit rates throughout the districts range from 47.3% in Crawley to 56.1% in Horsham (Table 14).

Despite more women than men accessing smoking cessation service in West Sussex males were more likely to quit after four weeks than females, with 52.8% of males quitting and 48.4% of females quitting. This is a similar trend to the national picture. Quit rate by gender in individual districts varied from 41.6% (Crawley females) to 58.7% (Mid Sussex males).

Table 14: Smokers quitting by gender and district

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Quitters								
Male	1,336	88	323	133	194	105	148	188
Female	1,288	105	307	119	160	119	131	185
Persons	2,624	193	630	252	354	224	279	373
Quit rate								
Male	52.8%	51.5%	57.0%	49.4%	53.4%	57.7%	58.7%	51.2%
Female	48.4%	47.5%	54.8%	45.8%	41.6%	54.8%	51.0%	47.9%
Persons	50.5%	49.2%	55.9%	47.6%	47.3%	56.1%	54.8%	49.5%

As with the 2013/14 health equity audit West Sussex age-band analysis shows that the younger age groups of 18-24s and 25-34 year olds have the lowest quit rates in the county

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[15] http://www.ncsct.co.uk/usr/pub/assessing-smoking-cessation-performance-in-nhs-stop-smoking-services-the-russell-standard-clinical.pdf

[16] http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf

(40.2% and 47.2% respectively), this is a trend that is also seen nationally. Females in the 18-24 year age band had the lowest quit rate (36.4%) in West Sussex, which was 12% below the average quit rate of all females and almost 10% below males from the same age range. Although the quit rates were higher in aged 65+ than in 18-24 age group this age group also showed the greatest difference in quit rates between males and females.

Table 15: Quit rates by gender and age in West Sussex

West Sussex	18-24	25-34	35-49	50-64	65+
Male					
Quitters	66	201	477	373	207
Quit rate	45.5%	48.7%	53.2%	54.0%	61.1%
Female					
Quitters	72	244	437	343	183
Quit rate	36.4%	46.1%	50.1%	50.1%	53.8%
Persons					
Quitters	138	445	914	716	390
Quit rate	40.2%	47.2%	51.6%	52.0%	57.4%

The service level data in West Sussex shows that quit rates are directly correlated to age, and that older age groups are more likely to quit at four weeks than younger smokers. There has been a significant increase in the quit rate of the over 65 females since the 2013/14 equity audit although as noted in the previous audit data quality and the relatively small counts may be the cause. This compares to the national trend where the success rate of quitting smoking increases with age.

Contrary to the 2013/14 health equity audit, the average of 4 week quit rates across the three most deprived[17] areas in West Sussex are marginally higher than quit rates for the average across the rest of West Sussex (52% vs. 51.6%). This said service users living within the least deprived decile had the highest quit rate of any of the nine other deciles (58.6%).

Figure 14: Percentage of users that quit (y-axis) by deprivation decile (x-axis)*
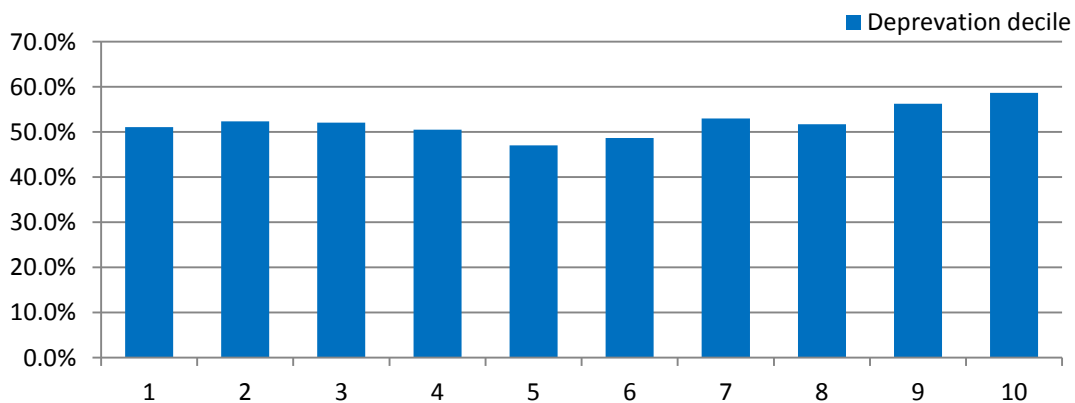
*Deprivation decile where 1 is most deprived and 10 is the least deprived)

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[17] Bottom 3 IMD 2015 national deciles (DCLG)

All four week quit rates fall within the suggested 35% - 70% range[16], however, students and sick/disabled and unable to work categories were at the lowest end of the range at 35.3% and 38.6% respectively. Retired users had the highest quit rate (57.3%) which correlates with the higher success quit rate of the 65+ age band. Routine and manual workers, where there is an estimated high smoking prevalence within this group, had a four week quit rate above 50%.

Table 16: Number of quitters and quit rates by occupation

West Sussex	Retired	Full-time student	Managerial / Professio-nal	Home carer	Routine & manual	Sick/ disabled and unable to work	Never worked/ long-term unemployed	Interme-diate
Quitters	451	36	449	110	879	130	135	100
Quit rate	57.3%	35.3%	56.6%	46.4%	53.5%	38.6%	43.8%	55.9%

In 2014/15, 45.7% (86 of 188) of pregnant women who accessed the smoking cessation service successfully quit. This is slightly below the national average of 46.7%[9]. Fifty- five (29%) of pregnant women were lost to a follow up, nationally 23% of pregnant women accessing smoking cessation services were lost to follow up . This number is higher than those reported as not quit (25%).

CO verification of self-reported quits

While some users of the cessation service may not be able to attend a follow up appointment it is considered best practise to confirm that a user has quit using a carbon monoxide breathe test opposed to a self-reported quit. Commissioning guidelines produced by national centre of smoking cessation and training (NCSCT) advise that 85% of self-reported four week quits are CO verified to validate success rate is good practice[13]. In West Sussex the CO- verified quit rate was 76.8%, around 9% lower than the guidelines but 7.8% higher than the national average. Adur and Worthing had the highest CO conversion rate (80.3% and 80.7% respectively) while Horsham had the lowest at 71.9%.

Males in West Sussex had higher CO verification rates than females (78.3% vs. 75.3%); district to district there were no notable gender inequalities in terms of CO-verification rates. Worthing had the highest gender difference (84.0% vs. 77.3%, male vs. female).

When taking age into consideration the 18-24 age band had the lowest CO verification rate of 58.37%, while 84.9% of those that quit and were aged 65+ were CO-verified. The largest age/gender inequality was with the age band 25-34 which had an 11% gender difference in CO-verification.

Table 17: CO-verification ate by gender and age

CO-verification	18-24	25-34	35-49	50-64	65+	Total

Persons	58.7%	71.2%	74.7%	82.0%	84.9%	76.8%
Male	60.6%	77.1%	74.6%	82.8%	85.5%	78.3%
Female	56.9%	66.4%	74.8%	81.0%	84.2%	75.3%

When comparing the CO-verification rates by setting the specialist service had the lowest rate (71.0%) while GP practices had the highest (79.8%); this was statistically significant differences.

Lost to follow up (LTFU) rate

Neither the Russell standard, commissioning guidelines or NICE guidelines give specific recommendations or bench marks on lost to follow up (LTFU) rates. Nationally 23.1% of users accessing smoking cessations services were lost to follow up. In West Sussex the lost to follow up rate was higher than the national average (26.6%).

Table 18: Lost to follow up rate by gender and district

	West Sussex	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing
Persons	26.6%	18.1%	20.6%	28.5%	34.0%	21.6%	29.5%	25.2%
Male	25.3%	17.0%	21.0%	27.5%	26.2%	19.2%	30.2%	24.5%
Female	27.9%	19.0%	20.2%	29.6%	41.3%	23.5%	28.8%	25.8%

Females had a higher LTFU rate than men in West Sussex (27.9% vs. 25.3%, female vs. male). Crawley was a particular area for concern as 41.3% of females were lost to follow up.

Again the 18-24 age group should be highlighted, having the worst LTFU across the age groups, while 25-34 age group also had a worse than average lost to follow up rate (35.9% and 32.3% respectively). LTFU in females in both these age groups were worse than males. However, the under 18 age group is showing a 52% lost to follow up and a reason for concern.

Table 19: Lost to follow up rate by gender and age

West Sussex	18-24	25-34	35-49	50-64	65+
Persons	35.9%	32.3%	26.2%	24.6%	16.9%
Male	29.7%	31.5%	25.9%	24.0%	14.5%
Female	40.4%	32.9%	26.5%	25.1%	19.4%

Lost to follow up in areas of deprivation

Figure 15 below shows that in general those either living with in the least and those living the most deprived areas had the lowest lost to follow up rates. Those in the most deprived areas may have lower than average lost to follow up rates as they may be more likely to fall into the targeted population.

Figure 15: Percentage of users lost to follow up (y-axis) by depravation decile (x-axis)*
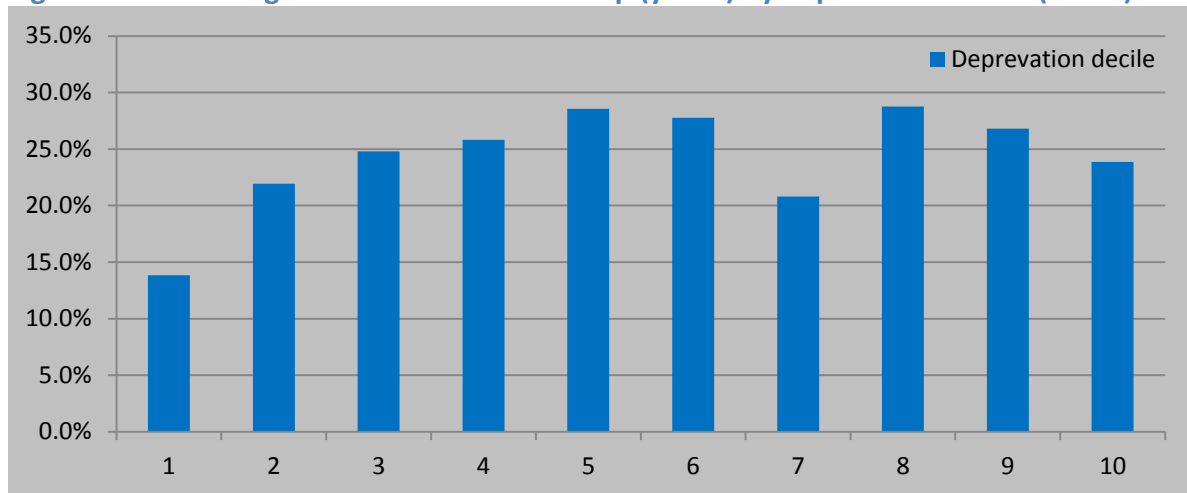
*(deprivation decile where 1 is most deprived and 10 is least deprived)

Intervention & Setting

Pharmacological support

When attempting to stop smoking there are a number of methods that smokers commonly use including:

- Unassisted
- Using nicotine replacement therapy (NRT) bought over the counter
- Using stop smoking medicine provided via prescription
- Using a stop smoking service (behavioural support plus access to stop smoking medicines)
- Unlicensed nicotine products such as nicotine vaporisers (e-cigarettes).

Figure 16 Uptake rates for pharmacological support by district
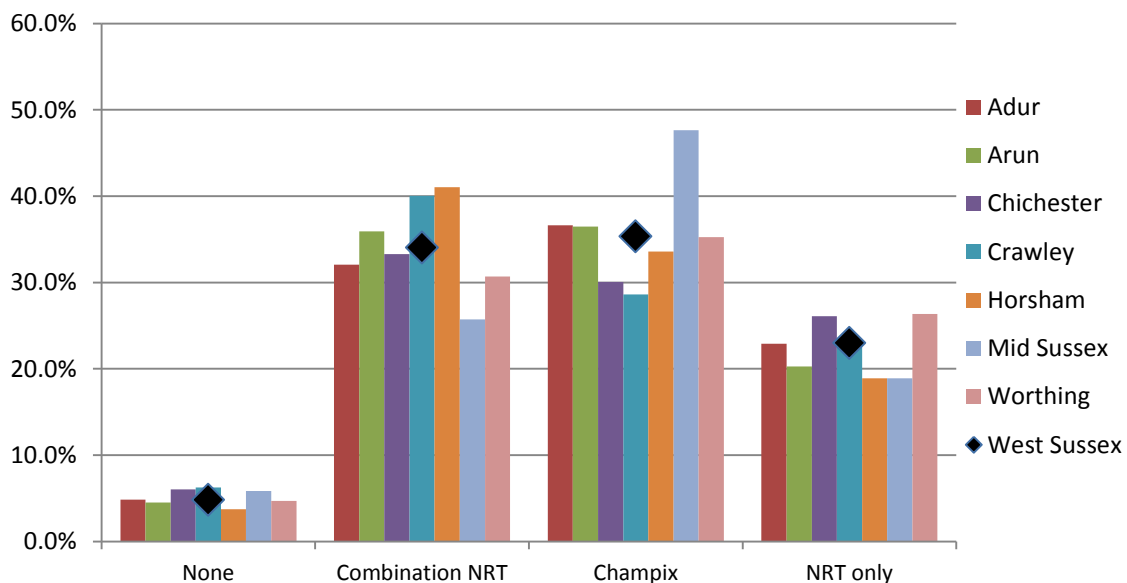
All users of the West Sussex stop smoking service receive behavioural support. When referring to treatments in this section "none" means that the user receives behavioural support but is not using any licensed (NRT, Champix, Bupropion, Champix (Varenicline) or unlicensed nicotine products such as e-cigarettes was the most used stop smoking method with 35.5% of users being prescribed the drug. Combination NRT had similar uptake rates of 34.1%. Only a small number of people (245, 4.7%) did not take up either NRT, or stop smoking medicines or unlicensed products. Not included on the graph in figure 3 but worth noting is the one-hundred-and-twelve people were known to have used unlicensed products; most of these were using it in combination with other methods.

Champix was the most effective smoking cessation method with a quit rate in West Sussex of 59.8% compared to the NRT only and combination NRT having quit rates of 47.2% and 44.3% respectively. Users quitting without NRT or prescriptions had the lowest quit rate of 43.7%.

Figure 17: quit rate by pharmacological support by district
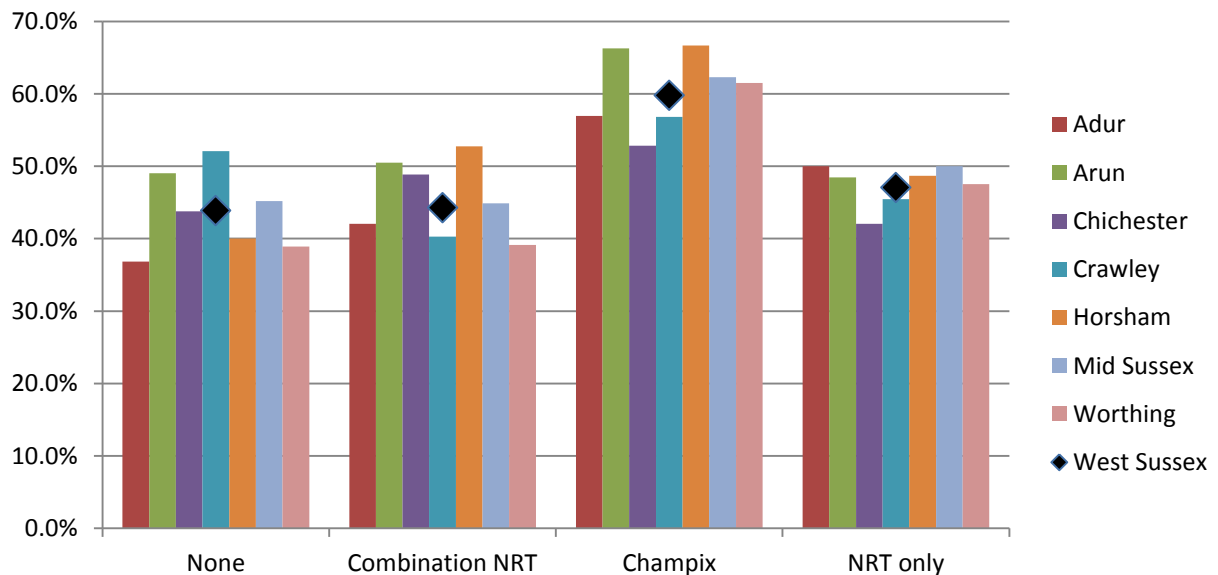
Service setting

The main setting where most interventions took place was in primary care. Sixty-two point eight percent of users accessed the stop smoking service through a GP practice while 24.5% accessed through an SSS setting (specialist service). The only other notable setting was pharmacies (11.2%).

Figure 18: Percentage breakdown of user setting by district
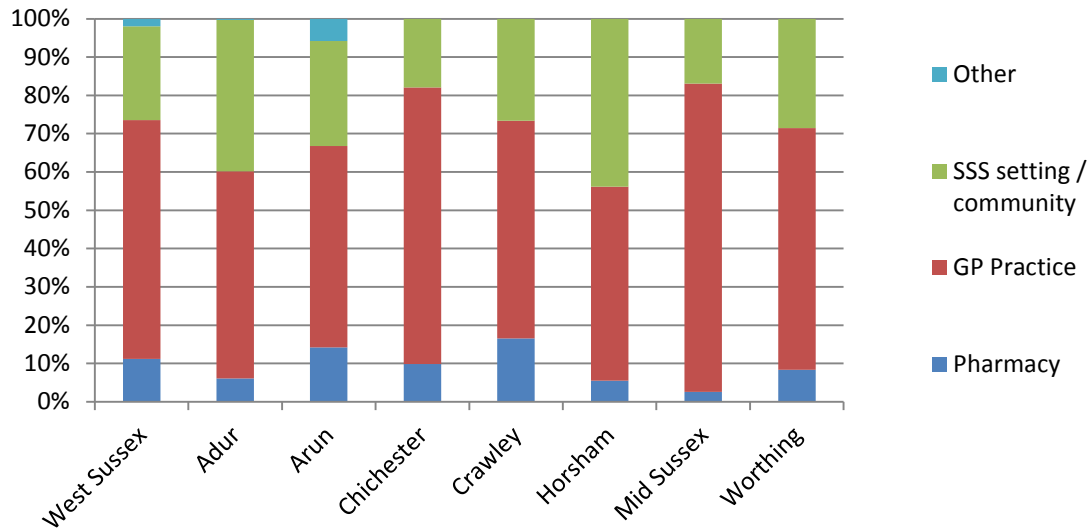
Quit rates in SSS settings (specialist service) were typically higher than any other setting in West Sussex as a whole (59.0% vs. 49.2 in GP practice and 44.2% at pharmacies). Crawley was the only district where SSS settings (specialist service) had a lower quit rate than either GP practices or pharmacies.

Lost to follow up rates within a pharmacy setting is one area for concern, the West Sussex LTFU rate in pharmacies was 38.8%. At district level the lowest LTFU rate was 31.7% in Worthing pharmacies, well above the overall West Sussex and Worthing averages of 26.6% and 25.2% respectively. Conversely LTFU rates in SSS settings (specialist service) were 14.5%, with all districts having rates below 15% with the exception of Crawley (26.6%).

Figure 19: Lost to follow up rates by setting
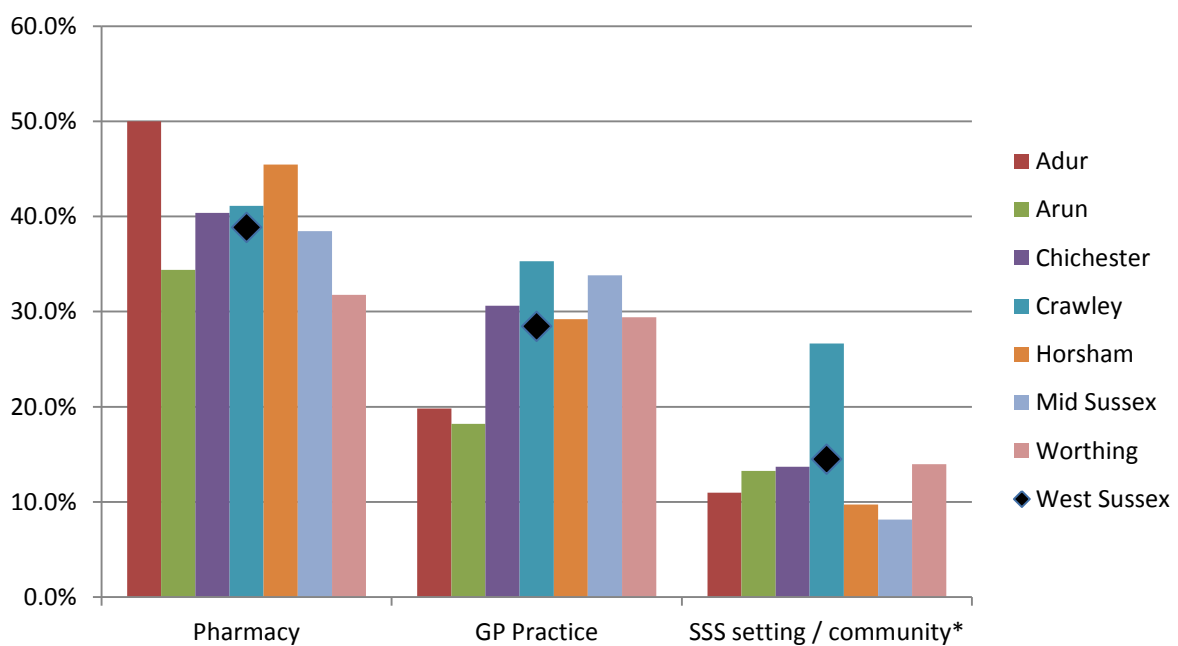
Twelve and fifty-two week smoking status

There are no recommendations from NICE on smoking status at 12 and 52 week follow up. The Russell standard states that a successful service should aim for at least a 15% quit rate on the 52 week follow up (either self-reported or CO-verified).

In West Sussex only the specialist service is expected to follow up service users and record their smoking status at 12 and 52 weeks. There had been 893 recorded 12 week follow ups, these account for 70.9% of the total users of the specialist stop smoking service in 2014/15. Of the 893 that were recorded 455 (51.0%) were either self-reported or CO verified quitters.

Although not a requirement from other providers there were a large number of 12 week follow ups in service users who were seen in a GP setting. However, this data would not be complete as it is not a requirement for GP practices to provide patient identifiable data. There were 945, 12 week follow up records, with the majority of them being lost to follow up (733, 77.6%). Only 17.5% of the 945 were recorded as quitter (2.4% CO-verified, 15.1% self-reported).

To date there has been 158 recorded 52 week follow ups, of those recorded 28.5% (45 of 158) were self-reported quitters (there were no CO verified quitters) [18]. It should be noted that not all 52 week follow up attempts will have been completed yet due to the fact this report has been written midway into the 2015/16 year. Table 11 shows the progress of smoking status at 12 and 52 weeks.

Table 20: Smoking status by week

West Sussex	4 Week Status	12 Week Status	52 Week Status
CO verified quit	2,016	193	0
Lost to follow up	1,381	1,045	82
Not quit	1,186	289	47
Quit self-report	608	467	48

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[18] Data last updated on 12/01/2016
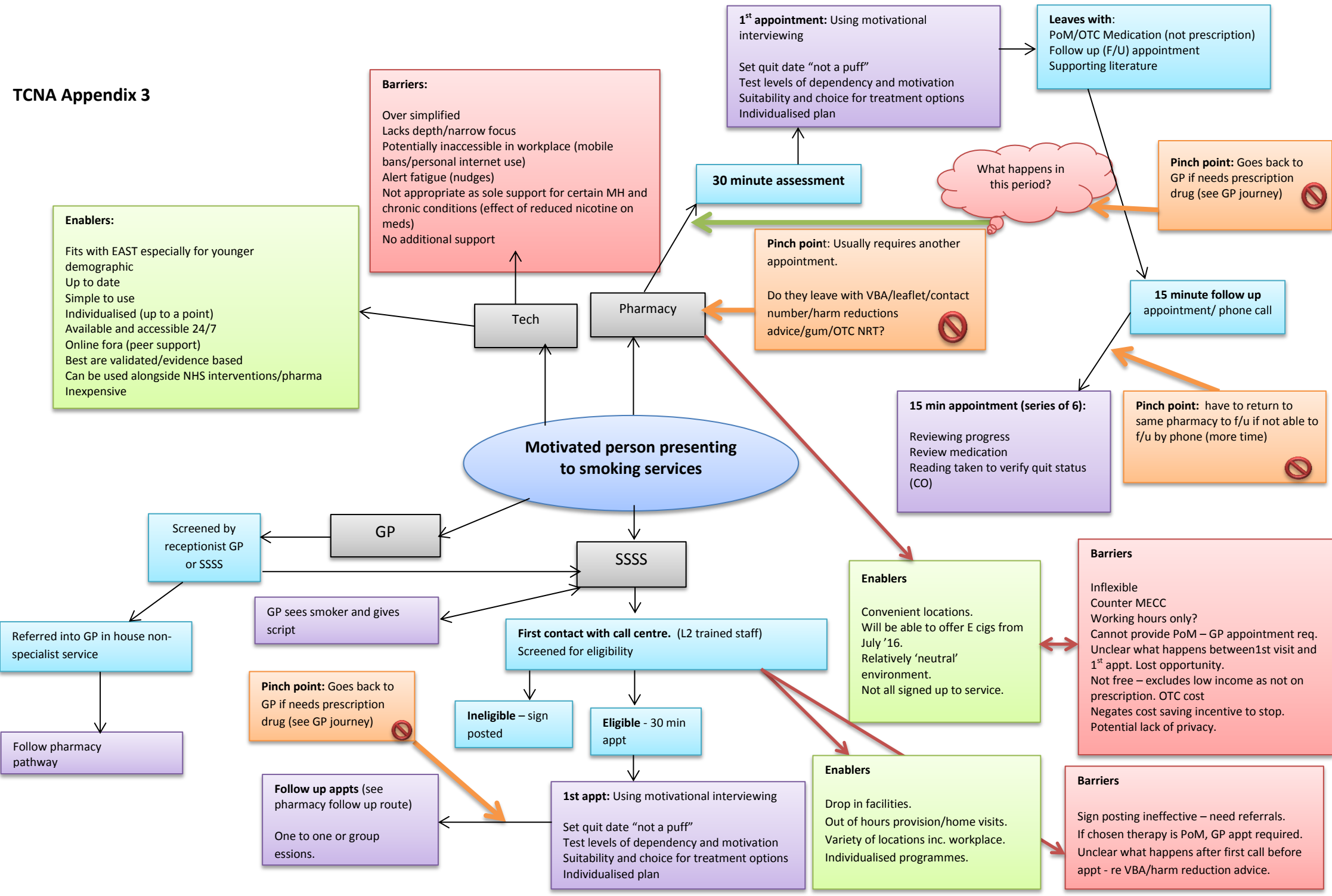
2.4   Recommendations

- Arun and Crawley districts have achieved highest access rates across both males and females. What can we learn from these areas in attracting men and women into services? E.g. locality of clinics, number of clinics, accessibility, promotion, referrals.

- Access rate of under 18 years age group is lower than for any other age group. Very few go on to quit with a quit rate of 24%, half of the average for over 18 year groups. The lost to follow up rate is double that of the average of all age groups and highest across all age groups (52%).

- Communicate to smoking cessation advisors the importance of completing data collection forms for the completeness of health equity audits and information to be able to support smokers in this group with the most appropriate interventions. Areas for particular concern are the data collection of ethnicity and occupation.

- Arun demonstrated good access rates by routine and manual workers at 4.27% followed by Worthing at 3.14%. What can we learn from partners in these localities to apply and attract routine and manual workers in other localities? For example, workplace initiatives, promotion to workplaces, mobile clinic locality, referrals etc.…

- Access by the intermediate occupation is more than half of the national average. Identify the common characteristics of this group (e.g. age, females, males) and advisor knowledge and practice in coding of occupations. Identify ways to engage this group in smoking cessation services.

- Access rate of pregnant women is low (2.3%) when compared to any other access rate by age, gender, occupation. We saw an increase in pregnant women to the service this year and we need to keep building on the good work finding good case studies to share across the county. Additionally how can we improve the quit rate and lost to follow up rates which is currently below national average.

- Access rates in the 18-24 year age group were lower than access by other age groups. Clearly indicating service provision does not meet the needs of this group. Need to explore what will attract them to quit smoking and how can we support that through traditional services or digital self-help support.

- Investigate and trial use of e-cigarettes as a viable aid to quitting for 18-24 and 25-34 year age groups and the sick/disabled and unable to work to increase quit rates.

- What can we learn from general practices in Adur and Worthing localities, who have high CO validation rates, around getting people back to validate their quit through a carbon monoxide breath test?

- Investigate high lost to follow up rate in pharmacy (38.8%) across all districts. How can we better support these service users and service providers?

- Investigate Crawley specialist services quit rate as it is lower than other specialist settings and has the highest lost to follow up rates. How can we support service users and service providers?

2.5   Glossary

4 week quit	Smokers would normally be expected to attend a session 4 weeks after the quit date and if the smoker responds to the question 'Have you smoked at all in the past 2 weeks' with 'No not a puff' they would be considered a quitter.
CO-verified	If a 4 week quitter agrees to a Carbon Monoxide (CO) breath test and has a CO of less than 10ppm (parts per million) they are considered CO-verified
CO-verification rate	The number of CO-verified quitters divided by 4 week quitters
Deprived areas	Local Neighbourhood Improvement Areas which fall within the most deprived 3 deciles of the national Index of Multiple Deprivation (IMD) table
Access rates	The number of smokers accessing the service and setting a quit date as a percentage of the total number of smokers.
Lost to Follow Up rate	The number of people who cannot be contacted to confirm the outcome of their attempt to stop smoking as a percentage of the total number of smokers who accessed the service and set a quit date.

3. Stop smoking services customer journey pinch points

TCNA Appendix 3

Motivated person presenting to smoking services

Tech

Enablers:

Fits with EAST especially for younger demographic
Up to date
Simple to use
Individualised (up to a point)
Available and accessible 24/7
Online fora (peer support)
Best are validated/evidence based
Can be used alongside NHS interventions/pharma
Inexpensive

Barriers:

Over simplified
Lacks depth/narrow focus
Potentially inaccessible in workplace (mobile bans/personal internet use)
Alert fatigue (nudges)
Not appropriate as sole support for certain MH and chronic conditions (effect of reduced nicotine on meds)
No additional support

Pharmacy

30 minute assessment

1st appointment: Using motivational interviewing

Set quit date "not a puff"
Test levels of dependency and motivation
Suitability and choice for treatment options
Individualised plan

Leaves with:
PoM/OTC Medication (not prescription)
Follow up (F/U) appointment
Supporting literature

Pinch point: Goes back to GP if needs prescription drug (see GP journey) 🚫

What happens in this period?

Pinch point: Usually requires another appointment.

Do they leave with VBA/leaflet/contact number/harm reductions advice/gum/OTC NRT? 🚫

15 minute follow up appointment/ phone call

Pinch point: have to return to same pharmacy to f/u if not able to f/u by phone (more time) 🚫

15 min appointment (series of 6):

Reviewing progress
Review medication
Reading taken to verify quit status (CO)

GP

Screened by receptionist GP or SSSS

Referred into GP in house non-specialist service

Follow pharmacy pathway

GP sees smoker and gives script

SSSS

First contact with call centre. (L2 trained staff)
Screened for eligibility

Ineligible – sign posted

Eligible - 30 min appt

Pinch point: Goes back to GP if needs prescription drug (see GP journey) 🚫

Follow up appts (see pharmacy follow up route)

One to one or group sessions.

1st appt: Using motivational interviewing

Set quit date "not a puff"
Test levels of dependency and motivation
Suitability and choice for treatment options
Individualised plan

Enablers

Convenient locations.
Will be able to offer E cigs from July '16.
Relatively 'neutral' environment.
Not all signed up to service.

Enablers

Drop in facilities.
Out of hours provision/home visits.
Variety of locations inc. workplace.
Individualised programmes.

Barriers

Inflexible
Counter MECC
Working hours only?
Cannot provide PoM – GP appointment req.
Unclear what happens between1st visit and 1st appt. Lost opportunity.
Not free – excludes low income as not on prescription. OTC cost
Negates cost saving incentive to stop.
Potential lack of privacy.

Barriers

Sign posting ineffective – need referrals.
If chosen therapy is PoM, GP appt required.
Unclear what happens after first call before appt - re VBA/harm reduction advice.

Motivated person finding out how to quit

Tech (internet/apps)

Enablers:

24/7 availability
Timely (don't need time to go to apt)
Flexible
Appealing to younger demo (pop of interest)
Personalised (up to a point)
Confidential (people don't need to know you're doing it)
Cheap

Barriers:

No internet access – rurality/income
No smart phone – income/not tech savvy
Not tech savvy
Needs not met by app/website (more intensive Rx req)
Possible language barrier
Not all apps and websites validated

Asking peers/family

Barriers:

Not evidence based
Based on another's experience (good/bad/irrelevant)
Potentially unsupportive

Entirely dependent on the person asked (enablers and barriers interchangeable)

Enablers:

Normalises quitting
Peers/family understand persons circumstances
Supportive

Entirely dependent on the person asked (enablers and barriers interchangeable)

Self-referral into smoking services

Enablers:

Direct and timely

Barriers:

If calling helpline and not in target group, will be redirected
Restricted access – not 24 hours or weekends
Depending on service called, may not be optimum care package

Return to where they have seen services advertised

Enablers:

Potentially convenient (ie: supermarket/pharmacy/library)
Accessible/ already accessing area

Barriers:

Info could be out of date
People in locality may not have any additional information or referral processes
Lack of privacy to discuss quitting

Response to a campaign

Enablers:

Normalises quitting (everyone is doing it)
Increased support and capacity
Range of quitting methods offered

Barriers:

Different types of campaign (positive and negative [Stoptober vs Health Harms])

Asking HCP (when using existing services – ie: opportunist)

Enablers:

More likely to get up to date advice
Can refer directly into right services
Positive response to quitting
Aware of/can discuss health benefits
On-going support

Barriers:

Lack of time to discuss or refer
Lack of awareness in some health settings
Lack of resources to provide patient