Smoking Joint Strategic Needs Assessment

According to the Public Health White Paper 'Healthy Lives, Healthy People', smoking is the biggest single preventable cause of ill-health and early death in the United Kingdom. The number of deaths from smoking is greater than the next six biggest causes of preventable death combined.

Contents

1. Why is smoking a priority?

Smoking is common, deadly, unevenly distributed across the population, and expensive.

Approximately 7.2 million adults in England smoke; 31,320 in Cheshire West and Chester. Roughly one in two long-term regular smokers will die from smoking; half in middle age.

Tobacco causes over 80,000 premature deaths in England each year (deaths that occur before a person reaches age 75), and according to Public Health England, smoking is one of the Government's most significant public health challenges.

The health risks from tobacco are well recognised. In 2015/16, nationally around 474,000 people were admitted to hospital with a primary diagnosis of a disease attributable to smoking.

Smoking remains the number one driver of the difference in life expectancy and healthy life expectancy between the most advantaged and disadvantaged communities.

Smoking is associated with a number of cancers as well as cardiovascular disease, chronic obstructive pulmonary disease (COPD) including emphysema and chronic bronchitis, and other respiratory conditions. About a third of all cancer deaths can be attributed to smoking. According to the Department of Health, COPD is one of the most costly diseases in terms of acute hospital care.

In England, smoking is estimated to cost the NHS £2 billion a year, and local authorities £1.4 billion a year for care in later life as a result of smoking related illnesses. In addition, £17 billion a year is spent on wider costs to society including sickness, absenteeism, environmental pollution and smoking related fires. These costs impact on every person in society, whether or not they are smokers themselves. Smoking is expensive and strongly associated with poverty and maintains families in poverty.

Smoking during pregnancy can lead to miscarriage, sudden infant death and low birth weight. It can also increase the risk of a child being born with a learning or physical disability. Children with caregivers who smoke are at increased risk of respiratory problems and likelihood of becoming smokers themselves.

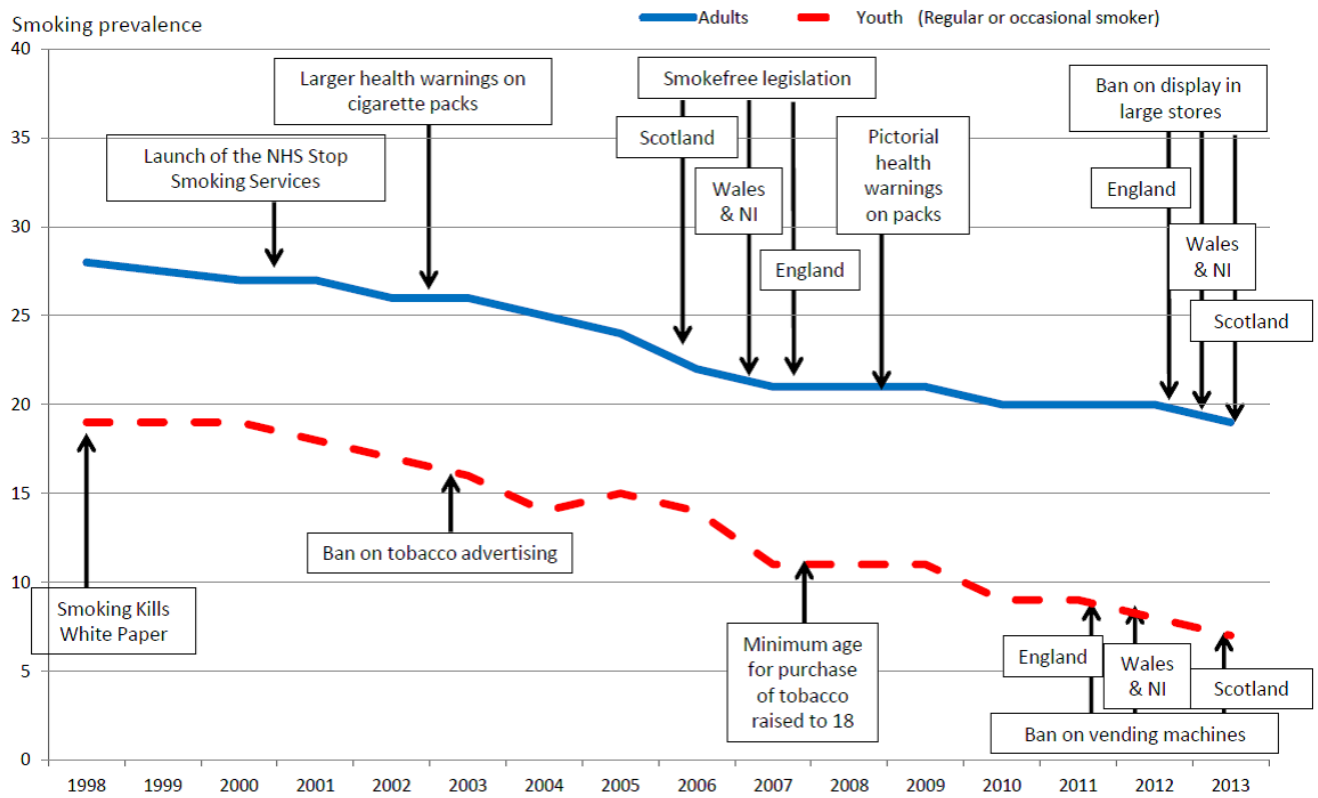
Evidence shows that the younger an individual starts to smoke, the more likely they are to be an adult smoker, due to nicotine being highly addictive. An estimated two thirds of smokers start smoking under the age of 18.

2. Current context

This is an exciting and fast-moving time for tobacco control. This JSNA chapter plays a vital role in describing patterns of local need and the essential evidence resources to ensure that our services and strategies are the best possible response to the challenges and opportunities we face in Cheshire West and Chester.

Globally, many emerging economies continue to see rates of tobacco use increase, with accompanying rises in associated ill-health and premature death (World Health Organisation, 2015). In England, smoking continues to decline, although it is still the number one health behaviour that cause differences in life-expectancy and healthy-life across our communities (Institute of Health Equity, 2010). This is because smoking is a major cause of both cancer and circulatory diseases including heart disease, stroke and dementia ,and many more people in disadvantaged groups smoke compared to those living in less deprived areas.

A number of universal policies and changes in the law have all contributed to the down-turn in smoking (graph below).



It is interesting to note that the impact has been even greater for children than for adults due to the effect of limiting access with a ban on under 18 sales and on cigarette machines. The ban on smoking in cars and spread of initiatives such as smoke-free schools and parks has also had an effect.

There is reduced exposure to the sight of cigarettes and people smoking, with covered displays, an advertising ban, and restrictions on smoking in enclosed public spaces. From May 2017 cigarettes must be sold in plain rather than branded packaging. The unattractive khaki green coloured packs carry explicit health warnings and pictures, with the aim of disrupting habitualised purchasing behaviours and making cigarette use less socially acceptable and aspirational. Retailers are already reporting a drop in sales (Action on Smoking and Health, 2017).

The UK is also signed up to the WHO Framework Convention on Tobacco Control. The Convention is a legally binding treaty which commits Parties to the Convention to:

- develop and implement a series of evidence-based tobacco control measures
- regulate tobacco industry marketing activities and sales reach
- reduce the demand for tobacco
- provide agricultural alternatives for those involved in growing and producing tobacco.

These measures reflect the five accepted key pillars of successful tobacco control policy, MPOWER, which refers to:

- M: Monitoring tobacco use and prevention policies
- P: Protecting people from tobacco smoke
- O: Offering help to quit tobacco use
- W: Warning about the dangers of tobacco
- E: Enforcing bans on tobacco advertising, promotion and sponsorship
- R: Raising taxes on tobacco.

Some countries are willing to go further still to create an environment that is even more hostile to smoking. For example, Australia has more far-reaching restrictions on smoking in public spaces and is set to introduce a prohibitive price increase from 2020. The UK government's updated tobacco control strategy 'Towards a Smokefree Generation: a tobacco control plan for England 2017-22) includes stretching new targets in our bid to see a smokefree generation. Specified targets by the end of 2022 are:

- Reduce the prevalence of 15 year olds who smoke to 3% or less
- Reduce the prevalence of adults who smoke to 12% or less. (The ultimate goal of a smokefree generation is for overall smoking prevalence to be 5% or below)
- Reduce the inequality gap between smoking in people classed as holding routine or manual occupations and the general population
- Reduce the prevalence of smoking in pregnancy to 6% or less

Cheshire West and Chester is already well positioned in relation to these, but the public health burden that smoking represents cannot be underestimated. Smoking is responsible for half the difference in life expectancy that exists between the most and least deprived parts of our borough. Smoking is a prominent risk factor for the top three causes of premature death in Cheshire West and Chester – circulatory disease, cancer and respiratory disease. The cost to human lives, to productivity and health and social care services are immense.

The challenge now is to develop services and a coherent partnership strategy that will be effective in tackling the changing patterns of smoking in our communities. As is made clear elsewhere in this report, smoking, whilst still common (1 in 7 adults), tends to be more common in deprived areas and amongst people who may face other life challenges e.g. unemployment or on a low income, living with a mental health condition, or making the transition to higher education. Looking at smoking from this perspective can help bring attention to the underlying factors that trigger and maintain a potentially lethal and expensive habit in the midst of powerful tobacco control policy measures. As most smokers began smoking in their teenage years, reducing smoking amongst influential adult family members is important to back up the enforcement of legislation preventing purchase and supply to under 18s.

Tobacco control has traditionally been championed by Public Health professionals within the health system, however it has recently become a major focus for hospitals and other healthcare settings too. This has been spurred on by the drive to make the whole health and social care system sustainable and more prevention-focused. In return for additional payments, hospitals and community trusts need to develop systems to identify smokers, giving advice and support to quit in hospital, and refer on to community smoking cessation services. Public Health England (PHE) is also encouraging maternity services to ensure that evidence based recommendations are in place, helping women who smoke during pregnancy to quit.

A final issue to consider within the current social context of smoking is the advent of so-called electronic cigarettes (the term vaping is preferred over e-cigarette or smoking to underline that burning is not involved). Vaping first appeared on our streets 2007. Its popularity has spread quickly and is the number one stop smoking method in England.

As an inhaled nicotine delivery system that arose outside the pharmacy and tobacco industries, vaping has drawn polarised views and has generated controversy amongst Pubic Health researchers, policy-makers and practitioners, including stop smoking services. Drug companies are developing their own vape delivery systems, but none has yet completed the lengthy approval process. Public Health England (PHE) is the body responsible for advising the government and public health professionals on the latest evidence and best practice. The National Institute for Health and Social Care Excellence (NICE) also has a rigorous process to develop and disseminate best practice, but guidance on this issue is not expected until October 2017. PHE's guidance on vaping frames it as a harm reduction method, and this stance has been echoed by many high profile health and campaigning organisations e.g. Cancer Research UK, the Royal College of Physicians and Action on Smoking and Health. Notable exceptions include the World Health Organisation. Vaping is discussed in some more detail in the discussion section.

3. What are the key issues locally?

Cheshire West and Chester has lower smoking prevalence rates than the England and North West average. However, at present the nation is still paying the price of the legacy of smoking and lifelong smoking, but the numbers of smokers are falling.

1. In Cheshire West and Chester, smoking prevalence is higher amongst routine and manual workers (25.6%) than for all adults (11.7%). Routine and manual workers are the single biggest homogenous group of smokers in Cheshire West and Chester with the highest prevalence of smoking (there are other groups with a high prevalence but in smaller numbers).

2. Those most likely to be smokers live in the boroughs more disadvantaged areas and tend to include people receiving benefits, the unemployed, routine and manual workers, and housewives. Smoking is the main driver of the difference in life expectancy and healthy life expectancy between those living in disadvantaged and advantaged areas. In addition, those who smoke often engage in other unhealthy behaviours.

3. Modelled estimates suggest that In Cheshire West and Chester, approximately 630 young people aged 11 to 15 (3.6%) are regular smokers compared to a national average of 3.1%. Cheshire West and Chester wards with the highest estimated prevalence of regular smokers are St Paul's, Garden Quarter and Neston.

4. Admissions to hospital with a primary diagnosis of a disease attributable to smoking have increased in Cheshire West and Chester since 2013/14 and are now the highest seen in the last seven years reflecting long term smoking in communities.

5. There are increasing rates of smoking related disease reflecting patterns of life-long smoking in the population over previous years. For example, deaths from lung cancer (all persons) have been increasing in Cheshire West and Chester since 2010.

6. ASH Action on Smoking and Health (2016) estimated that the total annual cost to the NHS in Cheshire West and Chester as a result of smoking is £12.7 million.

7. Smokers on average require social care four years earlier than non-smokers. It is estimated that the cost to social care for current and ex-smokers who require care in later life as a result of smoking-related illnesses, is an additional £7.7 million a year in Cheshire West and Chester. This represents £4.2 million in costs to the local authority and £3.5 million in costs to individuals who self-fund their care.

4. Who is most at risk – What national research tells us

Socioeconomic status

Those living in the most disadvantaged areas are more likely to be smokers. This includes those receiving benefits, those who are unemployed, those employed in routine and manual occupations and housewives.

Gender

Men are more likely to be smokers than women and smoke a higher number of cigarettes (Health and Social Care Information Centre).

Age

Nationally, smoking prevalence is highest for young adults aged 18-29. Smoking is highest in the 18-24 age group and declines with age. Around two thirds of current and ex-smoker's who smoke/ smoked regularly at some point in their lives, started before they were aged 18. In Cheshire West and Chester, approximately 2,040 young people aged 11-17 smoke.

Smoking in pregnancy

Pregnant women who smoke put the unborn baby in danger as well as themselves. There is a higher risk of miscarriage, complications, infant mortality and sudden infant death. Children born to mothers who smoke are more likely to develop respiratory problems and a disability.

Ethnicity

According to HSCIC, some black and minority ethnic groups (BME) are more likely to smoke than the general population - Bangladeshi and Irish men, and Irish and Black Caribbean women. North West Insight data indicates that some BME groups are more at risk of illicit tobacco including those who are Polish or South Asian.

Sexual orientation and gender identity

Those who identify as lesbian, gay, bisexual or transgender (LGBT) are more likely to smoke than the general population; one in four. According to Action on Smoking and Health, LGBT people are more likely to be depressed, isolated and bullied which can lead to unhealthy behaviours.

Mental health

There are higher rates of smoking among people with mental health conditions than the general population. Nationally, adults with a common mental health disorder are twice as likely to smoke, and adults with schizophrenia or bipolar disorder are three times more likely to smoke (Action on Smoking and Health).

Homeless

Nationally, it is estimated that 78% of homeless people smoke. In recent research with homeless people in Cheshire West and Chester, 59 out of 68 homeless people surveyed were smokers (87%). This is higher than the England average. Of these, 27 indicated they wanted to quit and when asked if they had been offered support to stop smoking 15 (29%) said they had compared to 68% offered help nationally.

Offenders

According to Public Health England, approximately four times as many people in prisons smoke than in the general population. Smoking levels are also higher amongst those in police custody and probation. Those in prisons who are not smokers are exposed to extensive second hand smoke.

Vulnerable children

All children are at higher risk of becoming smokers if they live with a person who smokes, or someone in their peer group smokes. However, vulnerable children are even more at risk. This includes children living in care, children who truant and young offenders.

5. Adult smoking prevalence

Key message
Although smoking rates in Cheshire West and Chester reduced in 2016 and are below the England average, smoking prevalence is higher for people employed in routine and manual occupations. Smoking is a prominent contributor to the health inequalities that exist between those living in the most advantaged and disadvantaged areas of the borough.

Public Health England estimates that 11.7% of adults aged 18 and over residing in Cheshire West and Chester smoke. This equates to approximately 31,320 residents. This is a decrease from 2016 and lower than the England average (15.5%), placing Cheshire West and Chester in the lowest quartile of local authorities. In addition, there are approximately 1,776 smokers aged 16 and 17 in Cheshire West and Chester.

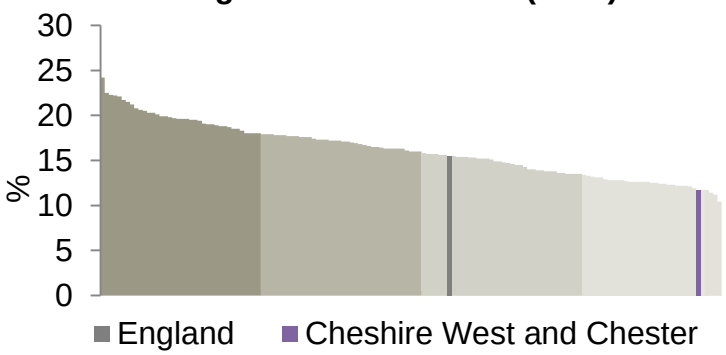
Smoking prevalence is higher for people employed in routine and manual occupations than in the general population. This is a trend reflected both nationally and locally.

Routine and manual workers are more likely to reside in areas of deprivation where smoking prevalence is highest due to it still being a normative behaviour. Targeting smokers in routine and manual occupations can help drive down health inequalities.

In Cheshire West and Chester, around 32% of residents aged 18 to 64 are employed in routine and manual occupations. It is estimated that 25.6% of them are smokers, approximately 16,280 people. This means that people employed in routine and manual occupations make up more than half of the overall Cheshire West and Chester smoking population (52%).

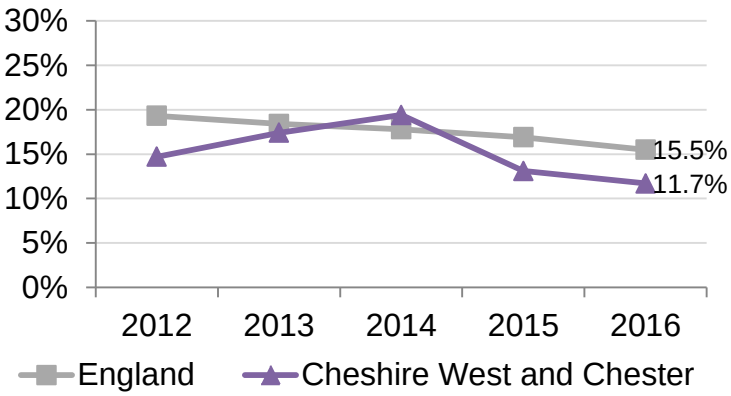
Smoking prevalence for routine and manual workers aged 18 and over was 25.6% in 2016. Over the last five years this has remained below the England average.

Percentage of adult smokers (2016)



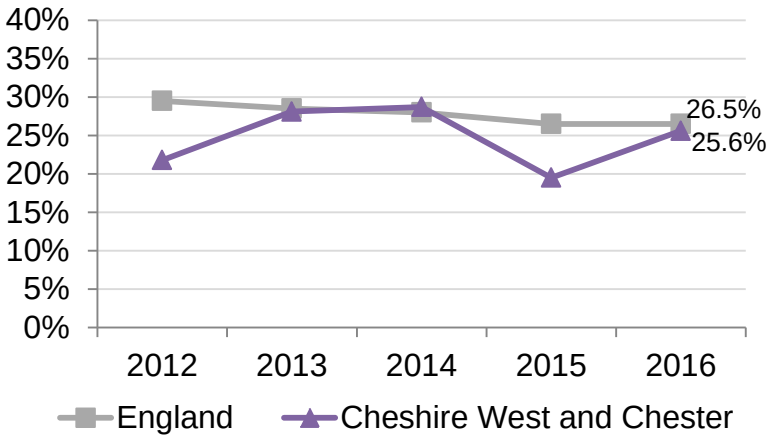
English Local Authorities with local geographical areas
Source: Annual Population Survey (2015)

Smoking prevalence aged 18 and over



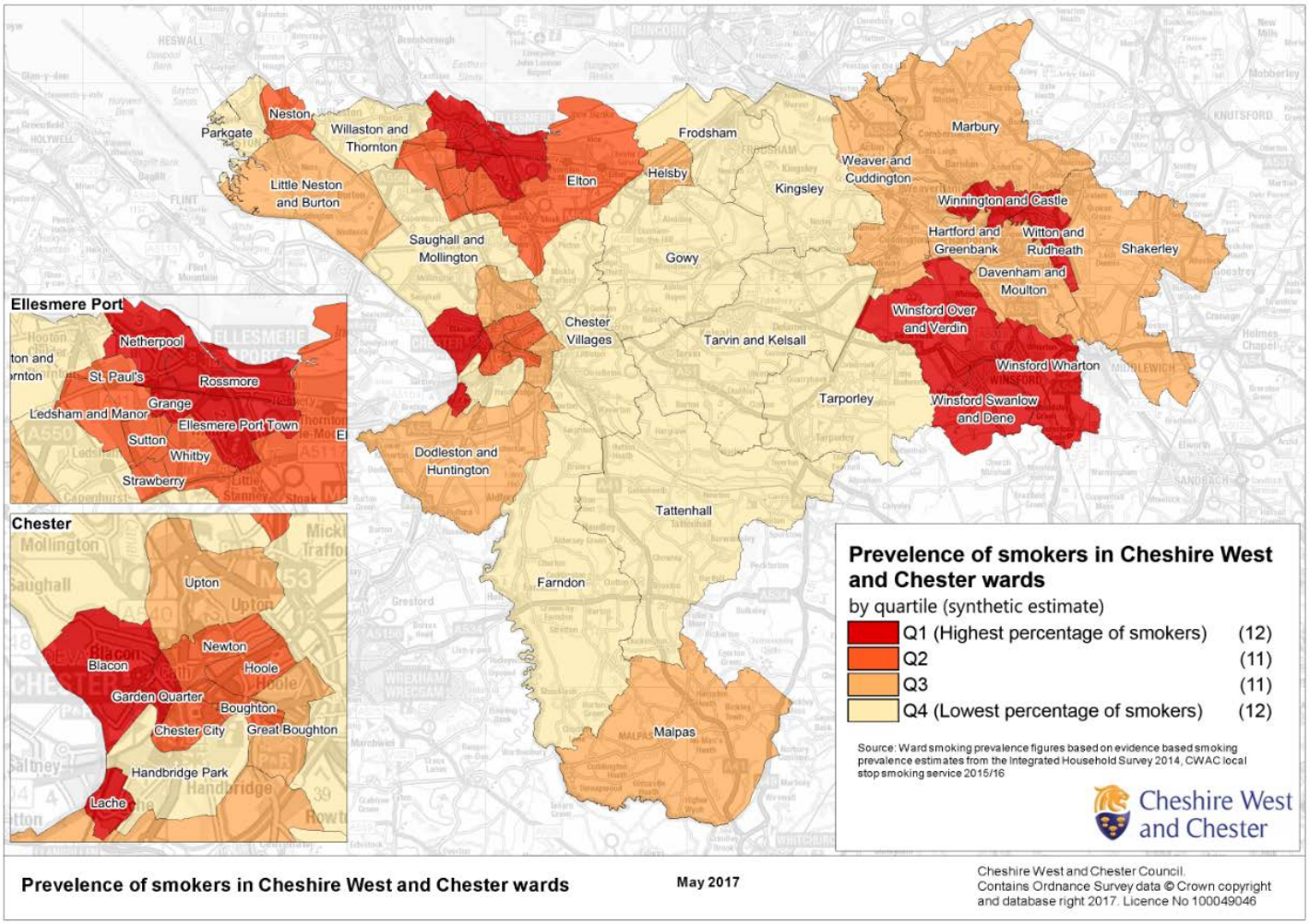
Source: Annual Population Survey (2015)

Smoking prevalence aged 18 and over: routine and manual workers



Source: Annual Population Survey (2015)

Smoking prevalence by ward has been mapped below using evidence based smoking prevalence estimates from the Integrated Household Survey 2014.



The table below shows the wards with the highest percentages of smokers residing there (taken from the map above).

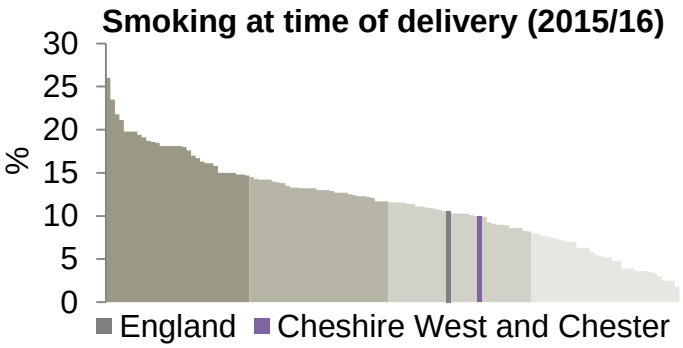
Locality	Ward
Ellesmere Port	Netherpool
	Rossmore
	Grange
	Ellesmere Port Town
Chester	Blacon
	Garden Quarter
	Lache
Northwich and Winsford	Winsford Over and Verdin
	Winsford Wharton
	Winsford Swanlow and Dene
	Winnington and Castle
	Witton and Rudheath

6. Smoking during pregnancy

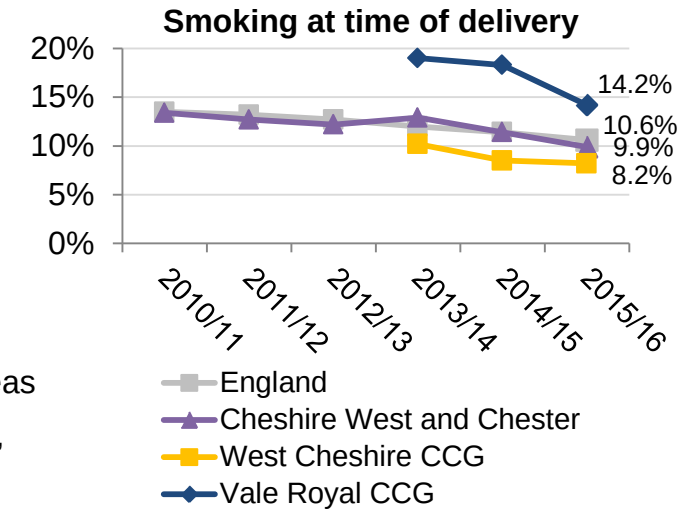
Key message

Although the rate of women smoking during pregnancy in Cheshire West and Chester reduced in 2015/16 and is below the England average, this is not consistent across the borough. In Vale Royal CCG area, rates of women smoking during pregnancy is higher than the England average and in some wards rates are in excess of 25%.

According to Public Health England, smoking during pregnancy can lead to a higher risk of miscarriage, complications during labour, low birth weight and sudden infant death. Children born to mothers who smoke are more likely to suffer from respiratory problems, problems of the ear, nose and throat and may have a physical or learning disability.



English Local Authorities with local geographical areas

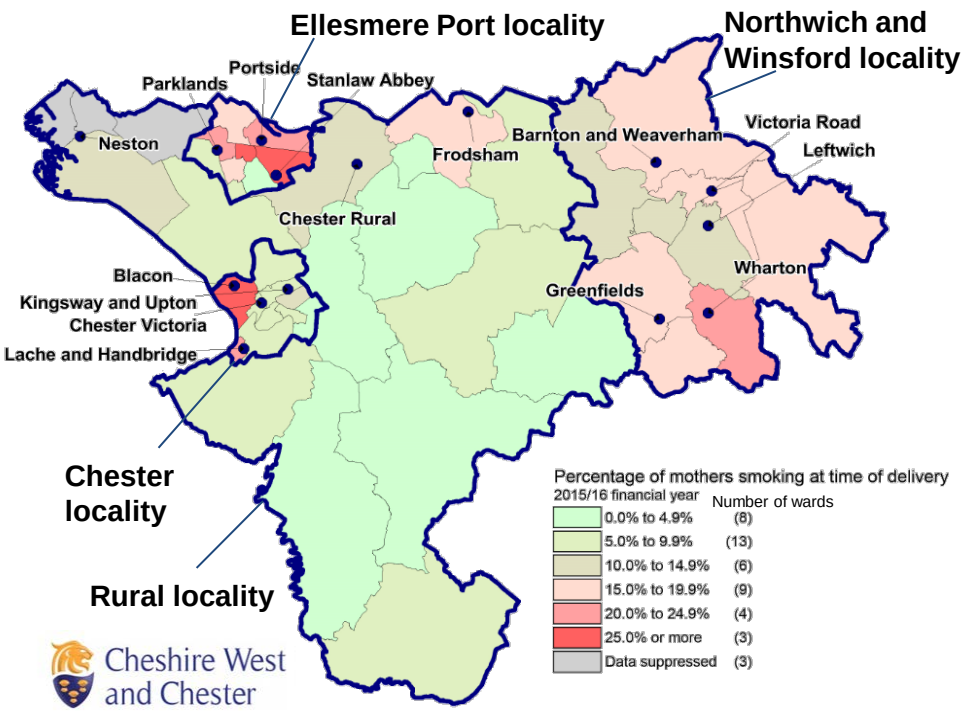


Source: Women smoking at time of delivery Q4 2015.16, Public Health England

Cheshire West and Chester has seen a decrease in the rate of smoking during pregnancy. It is now at its lowest in the last six years. Prevalence of smoking at time of delivery was 9.9% in 2015/16; slightly lower than the national average (10.6%). This equates to approximately 354 mothers. However, there was variation between Clinical Commissioning Groups: prevalence in Vale Royal CCG area was 14.2% and in West Cheshire CCG area it was 8.2%.

Local hospital data shows that in 2015-16, the majority of wards within Northwich and Winsford locality, at least 15% of mothers were smoking at time of delivery.

In the Ellesmere Port locality some wards experience rates in excess of 25%, as do the wards of Blacon and Lache in Chester locality. (Although Wards with low numbers should be treated with caution as mothers may be accessing hospitals outside of the Borough).



Percentage of mothers identified as smoking at time of delivery
Countess of Chester Hospital and Mid Cheshire hospitals
2015/16 financial year, by ward with children's centre locations and locality boundaries

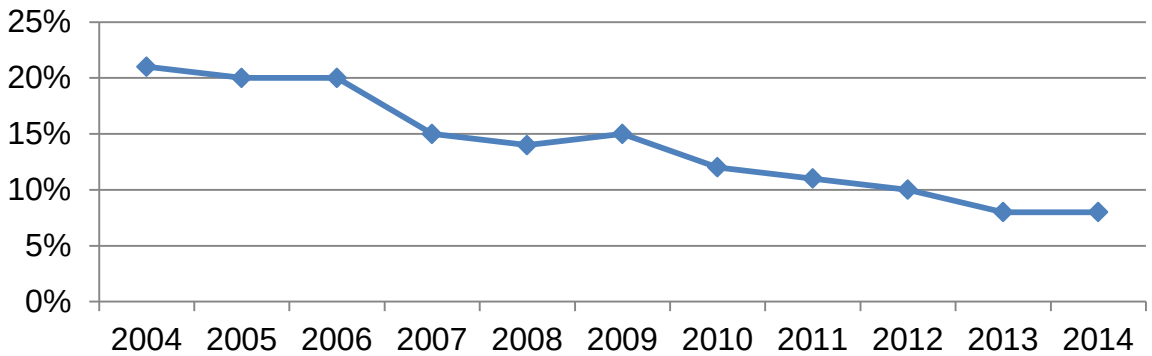
7. Young smokers

Key message

In Cheshire West and Chester an estimated 930 young people aged 11-15 are smokers. Starting smoking in childhood is a pre-determinant of smoking regularly as an adult with around two thirds of adult smokers started smoking at a young age. Young people are more likely to smoke if there is an adult smoker in the household and those living in deprived areas are most at risk.

In England, the number of young smokers has fallen drastically over the last ten years. The SDD Survey (Smoking, drinking and drug use among young people in England) showed a smoking prevalence of regular smokers aged 15 in 2004 of 21%, which had fallen to 8% in 2014.

Smoking prevalence age 15 years - regular smokers, England



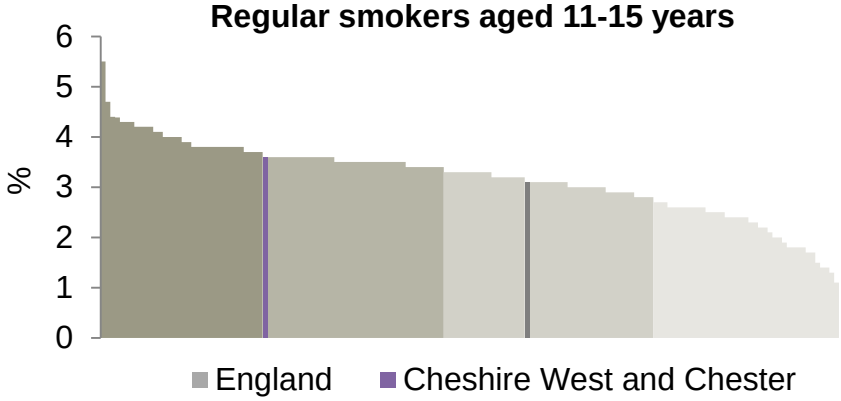
Source: Smoking, drinking and drug use among young people in England (SDD survey)The NHS Information Centre for Health and Social Care

Research indicates that young people with family members who smoke are more likely to become regular smokers themselves. Around 20% of children live in homes where at least one person smokes. In Cheshire West and Chester this equates to approximately 11,700 children aged 0-15 with an increased risk of becoming a smoker. As smokers are more likely to be found in deprived areas, this continues to exacerbate health inequalities.

Those also most vulnerable to uptake include children in care, those who truant or are excluded from school, lesbian, gay, bisexual or transgender+ (LGBT+) children, those with mental health issues and young offenders.

Public Health England has produced model based estimates of smoking prevalence for 11-15 year olds. It was estimated that in Cheshire West and Chester in 2014, 3.6% of 11-15 year olds are regular smokers: approximately 630 young people. This is slightly higher than the England average of 3.1%. A further 300 11-15 years olds in Cheshire West and Chester are estimated to be occasional smokers (1.5%).

Regular smokers aged 11-15 years



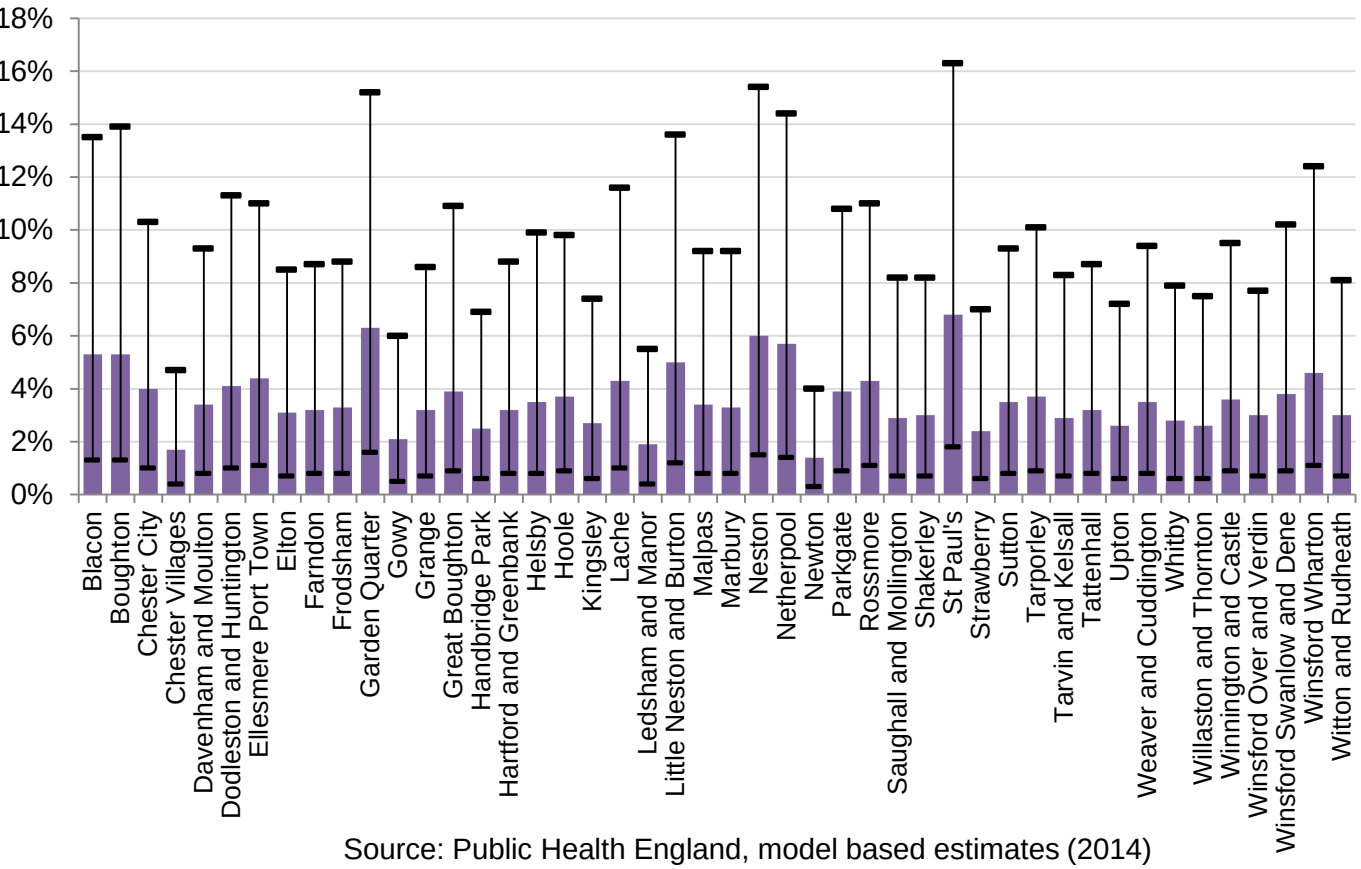
English Local Authorities with local geographical areas

Source: Public Health England, model based estimates (2014)

Model based estimates at ward level suggest variation in prevalence of being a regular smoker across the borough (note: differences are not statistically significant and confidence intervals are wide). Wards with the highest estimated prevalence of young smokers aged 11-15 years are:

- 6.8% in St Paul's (Ellesmere Port locality)
- 6.3% in Neston ward in (Ellesmere Port locality)
- 6% in Garden Quarter (Chester locality)

Model based smoking prevalence by Ward (2009-12) – regular smokers aged 11-15



Source: Public Health England, model based estimates (2014)

Estimates indicate the highest numbers of smokers aged 11-15 in the following wards:

- 38 in Blacon (Chester locality)
- 33 in St Paul's (Ellesmere Port locality)
- 28 in Davenham and Moulton (Northwich and Winsford locality)
- 26 in Winsford and Wharton (Northwich and Winsford locality)
- 25 in Weaver and Cuddington (Northwich and Winsford locality)
- 25 in Winsford Over and Verdin (Northwich and Winsford locality)
- 23 in Ellesmere Port Town (Ellesmere Port locality)
- 20 in Little Neston and Burton (Ellesmere Port locality)

(Note: estimated numbers are based on the estimated prevalence and width of confidence intervals have not been taken into account. This means that the number of young smokers could be considerably lower or higher).

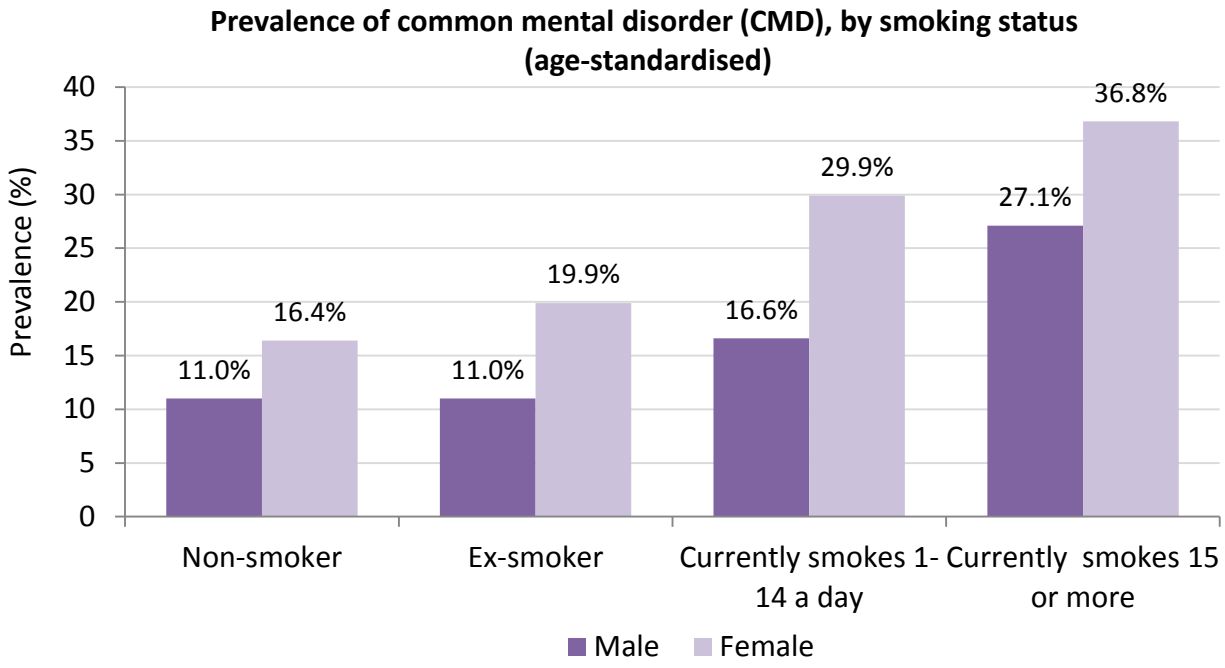
8. Mental health disorders and smoking

Key message
'People with mental health problems are at increased risk of poor physical health and premature mortality. The causes of premature death are mainly chronic physical conditions such as coronary heart disease, type 2 diabetes and respiratory diseases. These are associated with modifiable risk factors such as smoking, obesity and high blood pressure and are seen as preventable with recommended monitoring of physical health together with appropriate interventions and treatment' (Psychosis Data Report, National Mental Health Dementia and Neurology Intelligence Network)

According to Public Health England, high smoking rates among people with mental health problems are the single largest contributor to their 10 to 20 year reduced life expectancy. People with a mental health disorder are more likely to have a medical condition, be overweight, more dependant smokers, and to have smoked longer than smokers in the general population. It is estimated that people with a mental health or substance use problem buy approximately 42% of the tobacco sold in the UK, and the NHS spends approximately £720 million a year treating smoking related diseases in people with mental disorders (National Centre for Smoking Cessation and Training).

Smoking rates amongst people with depression or anxiety are thought to be twice as high as those in the general population, and three times higher in those with schizophrenia and bipolar disorder.

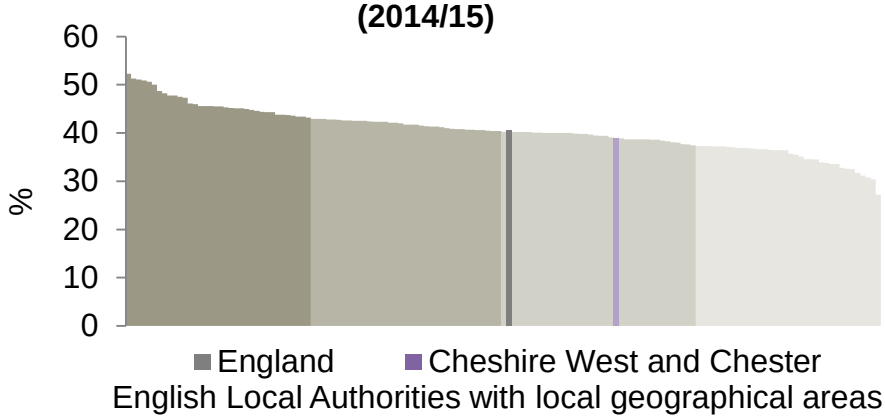
According to the Adult Psychiatric Morbidity Survey 2014, smokers were significantly more likely than non-smokers to have a common mental health disorder. Among smokers, those smoking 15 or more cigarettes a day were more likely to have a common mental disorder than those who smoked fewer than 15 cigarettes a day (age standardised prevalence: 14.1% of those who had never smoked and 15.2% of ex-smokers had a common mental disorder, compared with 23.3% of those smoking fewer than 15 cigarettes a day and 31.3% of those smoking 15 or more).



Source: Adult Psychiatric Morbidity survey 2014

In 2014/15, Cheshire West and Chester GP registers indicated that 38.9% of residents aged 18+ with a severe mental illness were smokers. This is lower than the England average of adults with a severe mental illness who were smokers (40.5%) but almost three times the smoking rate of the general Cheshire West and Chester population (11.7%).

Smoking prevalence in adults with serious mental illness (2014/15)



Source: Public Health England Note: Serious mental illness refers to a diagnosis of schizophrenia, bipolar affective disorder or other psychoses that are not in remission,

Both Vale Royal CCG and West Cheshire CCG have a lower percentage of patients with a severe mental illness on GP registers who smoke than the England average. In Vale Royal CCG 41.9% of GP patients with a severe mental illness received a complete list of primary care physical health checks and in West Cheshire CCG this was lower at 30.2% (2014/15) which is below the England average of 34.8%. Health checks include smoking, BMI, blood pressure, cholesterol, blood glucose and alcohol consumption.

People with severe mental illness aged 18+ identified on GP systems (2014/15)	Vale Royal CCG	West Cheshire CCG	England
Number of patients with severe mental illness	775	2,188	56,817,654
% of patients with severe mental illness who are current smokers	36.7%	39.7%	40.5%
Number of patients with severe mental illness who are current smokers	231	533	146,442
% of patients with severe mental illness who have received a complete list of primary care physical health checks	41.9%	30.2%	34.8%

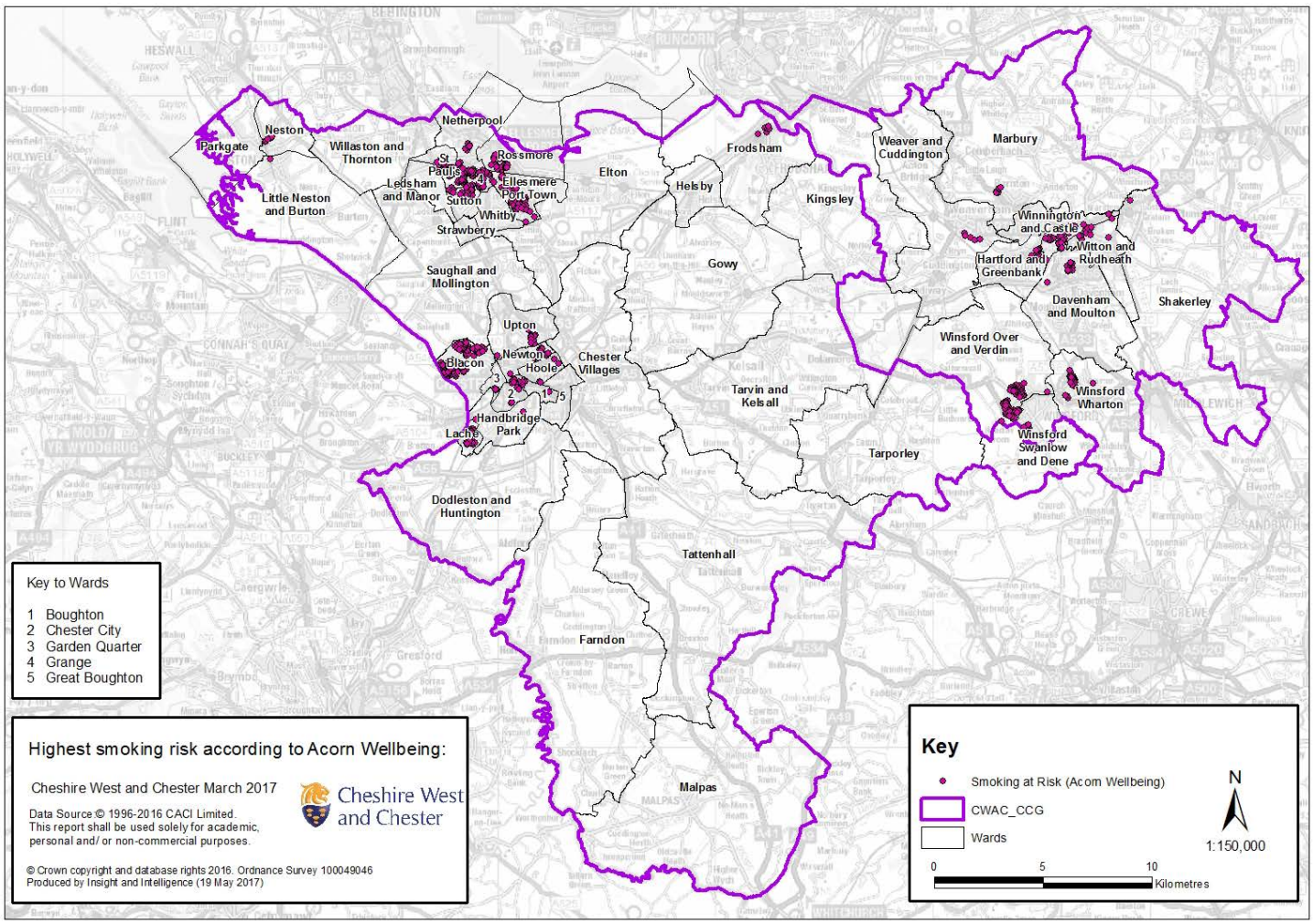
Source: Psychosis Data Report, National Mental Health Dementia and Neurology Intelligence Network

9. Social segmentation

Key message
Those residing in neighbourhoods with the highest estimated number of heavy smokers tend to be on low incomes and experience a wide range of health conditions. However, they appear to be engaged with local health and social services. This presents opportunities to take a holistic approach to stop smoking advice and interventions.

Acorn is a social segmentation tool that analyses demographic data, social factors, population and consumer behaviour to provide information and an understanding of different types of people. Acorn can be used to identify groups of people that are most likely to engage in certain behaviours such as smoking, and where they might reside. This helps to target services in the right areas.

According to Acorn data, those most likely to be current heavy smokers (20+ per day) live in neighbourhoods classed as 'hardship heartlands'. The map below shows the areas in Cheshire West and Chester which are more likely to have heavy smokers residing there.



This section describes the characteristics associated with those areas most likely to have heavy smokers. For the purpose of this report, these areas will be called high risk areas.

Population and household

(Note: in the tables the UK average is 100. Anything above 100 is higher than the UK average, anything under 100 is below the UK average.)

High risk areas are twice as likely as the UK average to have lone parents, aged under 35 with young children aged 0-4 years living there. These neighbourhoods also contain a higher proportion of one person households (non-pensioner). Housing tends to be small socially rented terraces and flats or maisonettes. Those living in high risk areas are more likely to have a disability than the UK average.

Income, occupation and education

Residents living in high risk areas are most likely to have an average household income of £0-£20,000. Compared to the UK average, they are unlikely to have any formal qualifications, or at least nothing higher than GCSE or equivalent.

In these neighbourhoods, more than twice the UK average are unemployed or have never worked. Jobs in routine and semi-routine jobs are most common, and skilled/manual workers and housewives are above the UK average. Benefit uptake is more than twice the UK average.

Health

Residents in areas most at risk are likely to engage in unhealthy behaviours, particularly around eating. They are more likely than the UK average to have been diagnosed with a wide range of health conditions or illnesses, in particular, emphysema, chronic bronchitis, clinical depression and angina. They are also more likely to be obese and to be taking medication for cholesterol.

Engagement with local health services

Residents living in high risk smoking areas are more likely than the UK average to be engaged with local health services including the Acute Trust, the Mental Health Trust and the Community Health Trust.

Acute Trust services more likely to be used than the UK average are (ranked in order of most used):

- Diabetes and endocrinology
- Respiratory
- Kidney/renal
- Carers issues
- Men's health

Acute Trust services

Variable	Index	0	100	200+
Cancer Services	98			
Cardiovascular Care	89			
Carers Issues	129			
Catering, cleaning and environment	115			
Children and Young People's Services	91			
Communication & IT Services	97			
Community Services	75			
Diabetes and Endocrinology	155			
Emergency and Critical Care	96			
Kidney/Renal	137			
Long Term Conditions (Chronic)	80			
Medicine, Treatments and Therapies	54			
Men's Health	120			
Neuro (Brain) services	69			
Older People's Care	90			
Orthopaedics and Rheumatology	83			
Outpatient Care	90			
Respiratory	143			
Surgery	117			
Women's health	94			

Mental Health Trust services more likely to be used than the UK average are (ranked in order of most used):

- Community mental health service
- Social care
- Child and adolescent services
- Specialist services
- Adult mental health

Mental Health Trust services

Variable	Index	0	100	200+
Adult Mental Health	108			
Carer Issues	94			
Child and Adolescent Services	123			
Community Mental Health Service	149			
Learning Disabilities	86			
Mental Health Support	73			
Older People's Mental Health	90			
Secure Care	103			
Social Care	149			
Specialist Services	117			

Community Health Trust services more likely to be used than the UK average include:

- Family services
- Walk-in and urgent care centres
- Social services

As the table shows there are many other services used by those in high risk smoking areas than the UK average.

Residents living in these neighbourhoods are less likely than the UK average to attend and help at health related events, and are less likely to share their views in consultations about plans and services.

Community Health Trust services

Variable	Index
Adult services	179
Children's Services	168
Community Hospitals	40
Dental Services	201
End of Life Care	111
Family Services	252
GP Services	136
Health Promotion and Healthy Living	165
Learning Disabilities Services	166
Long Term Conditions	166
Membership/Governor Activities	195
Mental Health	153
Older People's Services	106
Recovery and Rehabilitation	162
Service Development	204
Social Services	218
Specialist Services	126
Tests, Treatments and Therapies	211
Walk-in and Urgent Care Centres	234

However, there are some living in these areas who are more likely than the UK average to want to learn, contribute and give their time.

Variable	Index
1 – Passive Supporters: Do not want to be informed	132
2 – Armchair Observers: Receive information, rarely delves further	105
3 – Armchair Learners: Health-aware members looking for personal improvement	117
4 – Armchair Contributors: happy to take part in surveys and provide feedback	113
5 – Contributors: Seeking opportunities for additional involvement	126
6 – Influencers: Seek to share views in consultations about plans and services	92
7 – Enthusiasts: Attends and helps at events	80
8 – Time Givers: Willing to volunteer, give additional time and support	113
9 – Champions: Fundraisers and member recruiters	121
10 – Ambassadors: Motivated to stand as Foundation Trust Governor	108

Interests

Those living in high risk smoking areas are more likely than the UK average to be interested in gambling and angling. They are also more likely to be a member of a social group and a football supporter. This helps services target stop smoking campaigns to specific areas.

Technology and communications

Those living in high risk areas are more likely than the UK average to find text message and telephone contact acceptable marketing channels and to respond to these channels. They are less likely to respond using other channels. They are more likely than the UK average to never use the internet or to use it infrequently and less likely to have access to the internet on a mobile phone.

	Acceptable marketing channels	Response by marketing channel
Variable	Index	Index
Leaflets	91	101
Mail - Addressed to 'The Householder' or 'The Occupier'	84	74
Mail - Addressed to you by name	68	52
Newspaper / Magazine Adverts or Customer 'Magazines'	64	55
TV/Radio	91	90
Posters	72	74
Email	58	53
Text message	104	114
Telephone	106	110
Cinema	60	76

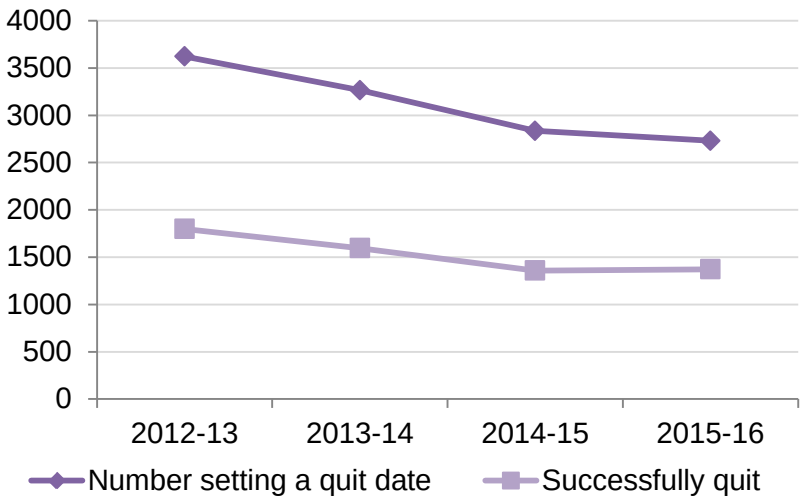
10. Stop smoking services

Key message
In Cheshire West and Chester, there has been a steady decline in the number of smokers accessing Stop Smoking Services. Wards with the highest percentage of smokers accessing the service are located in the west of the borough, particularly Ellesmere Port locality. The successful targeting here needs to be considered in Winsford and Northwich locality.

The number of smokers accessing stop smoking services in Cheshire West and Chester has more than halved since 2010/11, reflecting the national trend. This is most likely due to e-cigarettes becoming the most popular quitting tool in England (Public Health England).

In 2015/16, 2,730 smokers set a quit date with local Stop Smoking Services. At four weeks, 1,373 had successfully quit; 50% of all those who set a quit date. This is similar to the England quit rate of 51%. 34% of those setting a quit date in Cheshire West and Chester were known to have not quit, compared to 26% in England.

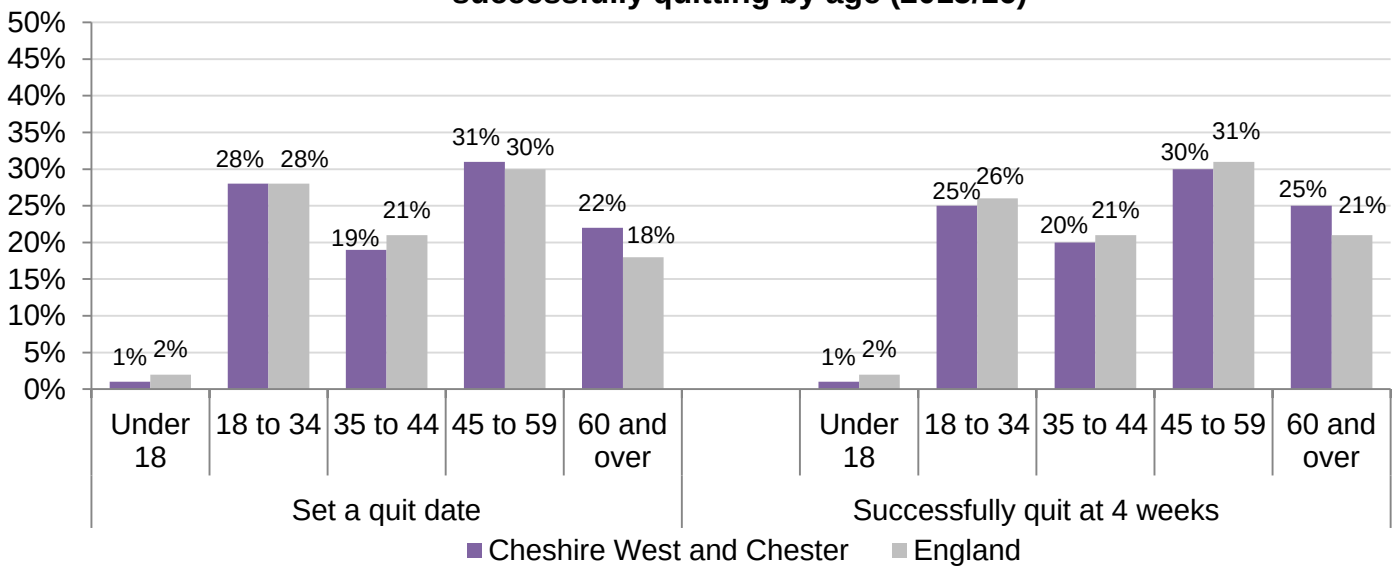
Number setting a quit date and successfully quitting in Cheshire West and Chester by year



Source: Cheshire West and Chester Stop Smoking Services

In Cheshire West and Chester in 2015/16, of those setting a quit date with stop smoking services almost a third were aged 45 to 59 years (31%). More females (57%) than males (43%) set a quit date, reflecting the national trend. For both genders, one in two successfully quit. Around 5% of those setting a quit date were from a black or minority ethnic background (BME) (this includes Irish and any other white background that is not British).

Number of people in Stop Smoking Services setting a quit date and successfully quitting by age (2015/16)

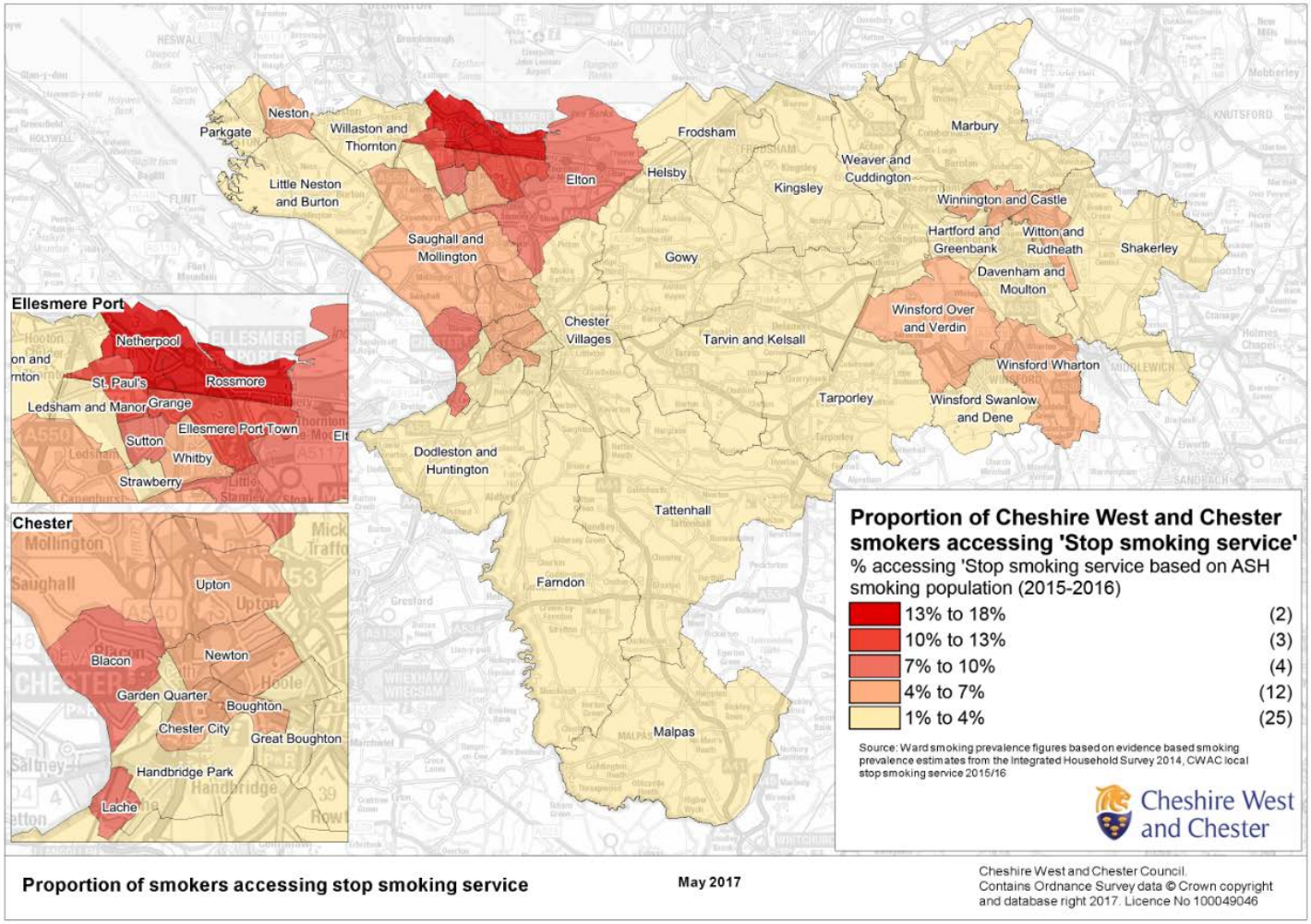


Note: Percentages may not sum to 100 due to rounding
Source: Health and Social Care Information Centre; Cheshire West and Chester Stop Smoking Services

During 2015/16, 97 pregnant women set a quit date. Of these, 48 successfully quit (49%).

In Cheshire West and Chester, clients from a managerial or professional background had the most success in quitting along with those who were retired. Those who have never worked or have been unemployed for over one year had the least success at quitting.

The map below shows the proportion of Cheshire West and Chester smokers accessing Stop Smoking Services by ward. Wards with the highest percentages of clients accessing the service are located in the west of the borough, particularly in Ellesmere Port locality and areas of Chester locality. These wards are those areas that are most deprived and have the highest prevalence of smokers, suggesting the right areas are being targeted. This is not reflected to the same extent in the east of the borough which can be seen in the map below.



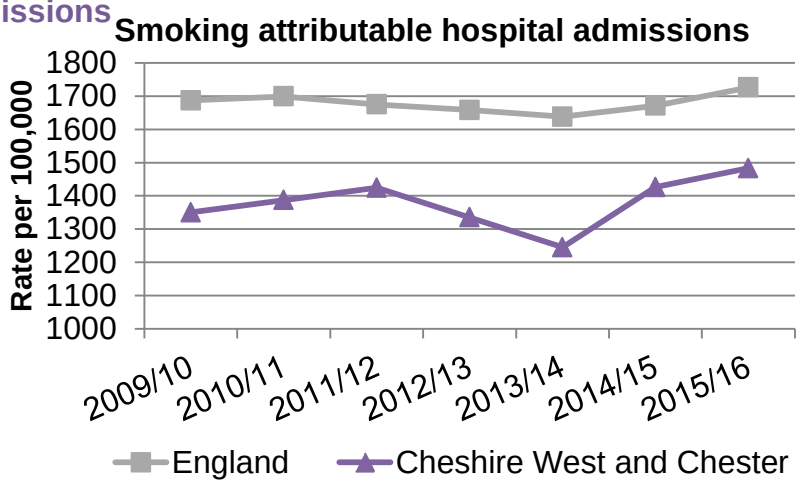
11. Smoking related ill-health

Key message

Smoking is associated with cancer , heart disease and respiratory disease, the three biggest killers in Cheshire West and Chester. Admissions to hospital with a primary diagnosis of a disease attributable to smoking have increased in Cheshire West and Chester and are at the highest level in the last six years. Incidence of lung cancer in females has been steadily increasing, as have oral cancer registrations (all people). This reflects a cohort that began smoking many years ago and a failure to prevent their smoking.

11.1 Smoking attributable hospital admissions

During 2015/16, the rate of smoking-attributable hospital admissions in Cheshire West and Chester was 1,483 per 100,000. This is significantly better than the national rate of 1,726 per 100,000 and equates to approximately 3,085 admissions a year. However, it is an increase from previous years. Cancers which can be caused by smoking have the highest number of smoking-attributable admissions.

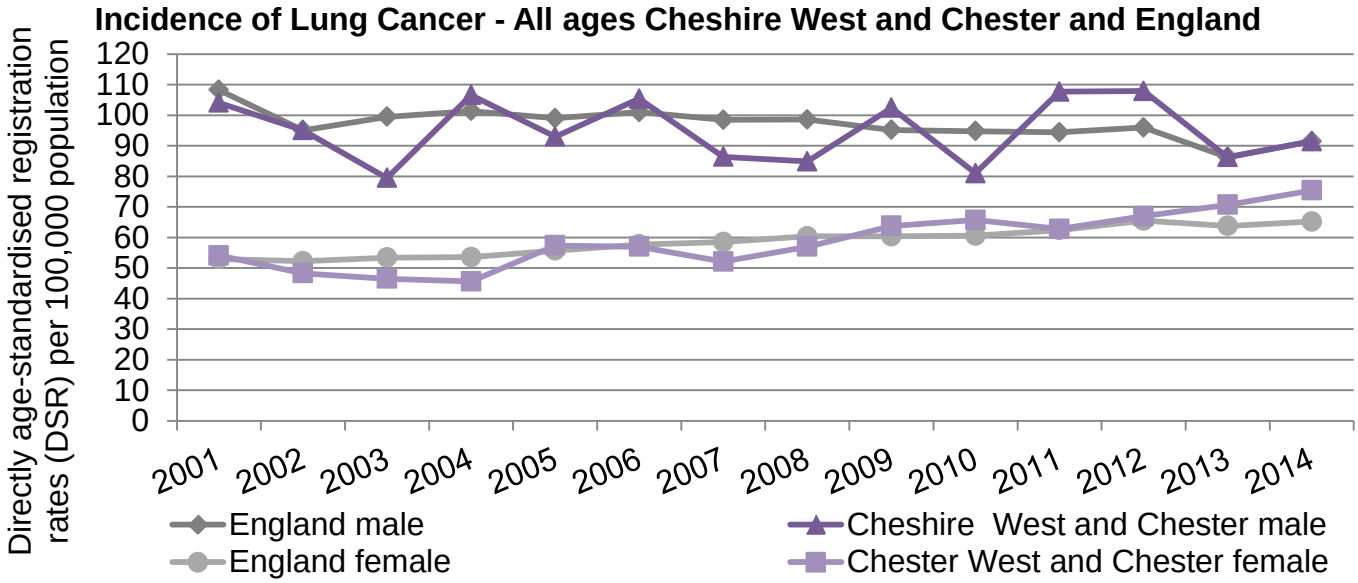


Source: Local Tobacco Control Profiles for England (2016)

11.2 Lung cancer

In Cheshire West and Chester the incidence of lung cancer in females (75.4 per 100,000) has increased over the last 10 years and is higher than England (65.2 per 100,000). In males, the incidence of lung cancer has also increased (91.5 per 100,000) and is similar to the England average (91.3 per 100,000). The gender inequality gap is getting smaller though lung cancer still remains higher for men.

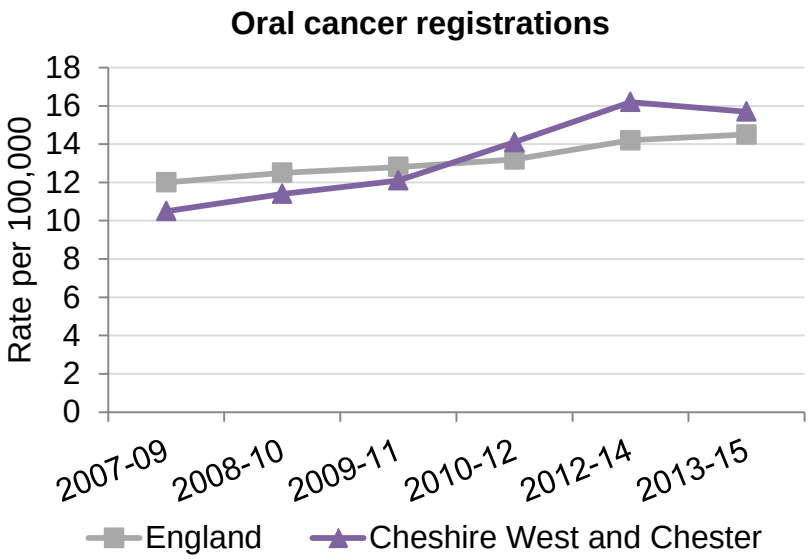
According to Cancer Research UK, more than 8 out of 10 lung cancers are caused by smoking. Risk of lung cancer increases the longer and more heavily a person smokes. Lung cancer is the effect of long term exposure and current rates reflect a generation of smokers who began smoking around 30-40 years ago. Given the patterns of smoking behaviour amongst young people and the changing perceptions of smoking, it can be expected that these rates will come down.



Source: NHS Cancer Registry Tool 2016

11.3 Oral cancer

The International Agency for Research on Cancer estimates that 65% of oral and pharyngeal cancers in the UK are linked to tobacco smoking. Incidence of oral cancer have been increasing each year in Cheshire West and Chester, but 2013-15 shows a decrease from 16.2 per 100,000 in 2012-14, to 15.7 per 100,000 in 2013-15. This remains higher than the national rate of 14.5 per 100,000. This equates to around 158 oral cancer registrations a year locally.



Source: Local Tobacco Control Profiles for England (2016)

11.4 Second hand smoke

According to Cancer Research UK, one in five lung cancers is caused by second hand smoke. Around 20% of children in the UK live in homes where at least one person smokes. Second hand smoke exposure among children in the UK is estimated to cause over 165,000 new episodes of disease, 9,500 hospital admissions, at least 200 cases of bacterial meningitis, and about 40 sudden infant deaths each year (Public Health England).

In Cheshire West and Chester, hospital admissions for asthma in under 19 year olds is 165.1 per 100,000 (2015/16), approximately 116 young people, which is lower than the England average of 202.4 per 100,000. This is a decrease from 2014/15 when the rate was 204 per 100,000. In the 2014 national annual survey of smoking, drinking and drug use amongst young people aged 11 to 15, 64% of young people had been exposed to second hand smoke indoors or in a car in the last year.

12. Mortality

Key message

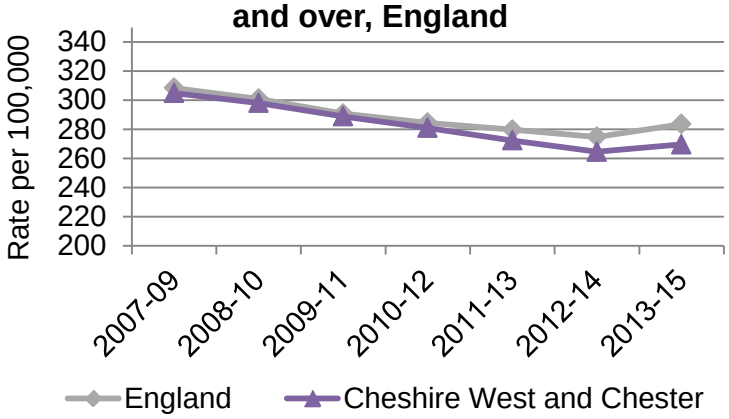
In Cheshire West and Chester, deaths from lung cancer have been increasing since 2010. There are inequalities in smoking related deaths between those who live in the most and least deprived areas. An estimated 6,837 potential years of life were lost between 2013-15 in Cheshire West and Chester due to a smoking related illness, a rate of 1,289 per 100,000 adults aged 35 and over. This means that there is one death caused by smoking every ten hours in Cheshire West and Chester.

In Cheshire West and Chester there were approximately 269.6 smoking-attributable deaths per 100,000 adults aged over 35 in 2013-15.

This equates to approximately 552 deaths per year in Cheshire West and Chester. This is lower than the national rate (283.5 deaths per 100,000 adults aged over 35) but an increase from 2012-14.

The majority of deaths were due to lung cancer, chronic obstructive pulmonary disease, heart disease and stroke.

Smoking attributable mortality - adults aged 35 and over, England



Source: Local Tobacco Control Profile (2015)

Smoking attributable mortality has been decreasing in Cheshire West and Chester since 2007-09. There has been a fall in smoking attributable deaths from heart disease and stroke, and deaths from chronic obstructive pulmonary disease. However, deaths from lung cancer have increased since 2010. Lung cancer more so than the others reflects smoking behaviour in the population; the other diseases are multifactorial.

Indicator	Cheshire West and Chester: per 100,000	Cheshire West and Chester: Number	England: per 100,000	Statistically different from England
Smoking attributable deaths from heart disease (Persons, aged 35+) (2013-15)	25.0	153	29.7	No
Smoking attributable deaths from stroke (Persons, aged 35+) (2013-15)	7.1	43	9.3	No
Deaths from lung cancer (Persons, all ages) (2013-15)	61.3	629	58.7	No
Deaths from chronic obstructive pulmonary disease (Persons, all ages) (2013-15)	46.3	474	52.6	Yes

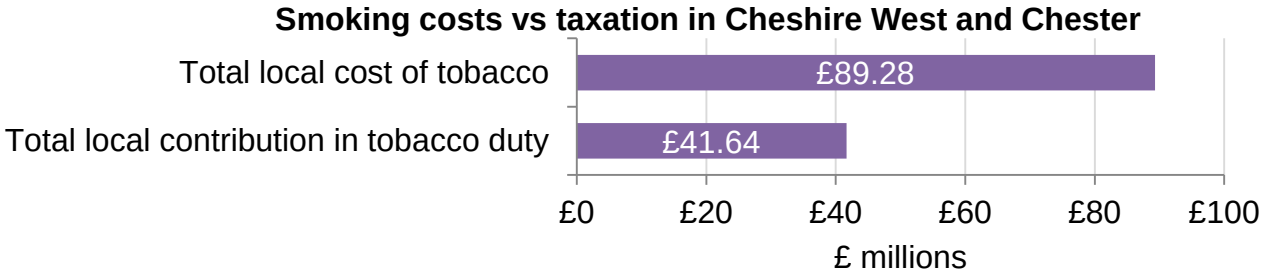
Source: Local Tobacco Control Profile (2015)

Unhealthy behaviours such as smoking have a large impact on life expectancy, particularly in the most deprived areas. In Cheshire West and Chester, life expectancy (2013-15) is slightly higher, but statistically similar, to the England average for women (83.2 years compared to 83.1 years) and for men (79.7 years compared to 79.5 years). However life expectancy is significantly lower in deprived areas, with the internal inequality gap widest for men. Heart disease and cancer are the key diseases that contribute to inequalities for men. Cancer, particularly lung cancer, is prominent for women and has been increasing. In Cheshire West and Chester, 44% of premature deaths for persons aged under 75 years are caused by cancer. Of these premature deaths caused by cancer, lung cancer accounted for a quarter. Lung cancer mortality is higher for those living in the most deprived areas of the borough.

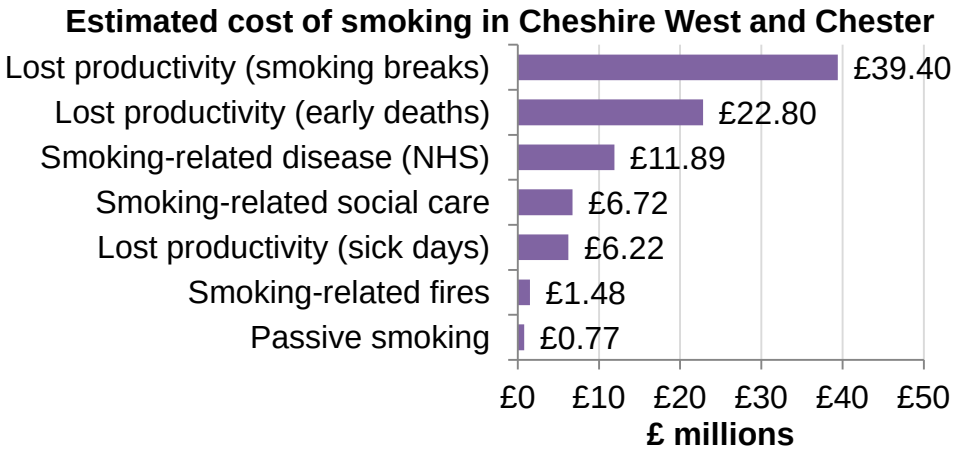
13. Costs of smoking

Key message
'Smoking not only contributes to the social care bill but also has a significant impact on the well-being of smokers who need care on average four years earlier than non-smokers.' Action on smoking and Health

ASH Action on Smoking and Health (2016) estimates that smoking costs Cheshire West and Chester £89.3 million a year, approximately £1,673 per smoker per year.



There is a significant impact on the economy and local business due to: lost productivity; smoking related disease and social care; accidental fires; and the health of non-smokers. Every year in Cheshire West and Chester deaths due to smoking result in 1,230 years of lost productivity, a cost to the local economy of approximately £23 million.



The total annual cost to the NHS in Cheshire West and Chester is approximately £12.7m; £11.9m as a direct result of treating smoking-related ill health and £774,774 due to treating the effects of passive smoking in non-smokers.

Smokers on average require social care 4 years early. Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost society and additional £6.7m each year; £3.9m in costs to the local authority and £2.9m in costs to individuals who self-fund their care

In addition, the majority of cigarette filters are non-biodegradable and an estimated 209 million filtered cigarettes smoked in Cheshire West and Chester results in approximately 36 tonnes of waste annually to be disposed of in landfill site; 8 tonnes of this will be discarded as street litter to be collected by street cleaning services.

14. Evidence of what works

Tobacco control is one of the most well-evidenced areas of public health. Trusted resources for accessing evidence are The National Institute for Health and Care Excellence (NICE), Public Health England (PHE), the National Centre for Smoking Cessation and Training (NSCCT), the Cochrane Collaboration, and Action on Smoking and Health (ASH).

NICE currently hosts eight public health guidance documents, three quality standards, one local government briefing (on prevention, smoking cessation, harm reduction and reducing smokeless tobacco use), and a scope (Smoking Interventions and Services due for publication in October 2017, which will cover brief and very brief advice, behavioural interventions, pharmacotherapy, including all forms of nicotine replacement, use of digital media and advice and referral options for vapers).

The mainstay of NICE's advice about smoking is contained within public health guidance documents, with recommendations that also feature in NICE smoking pathway and related quality standards. The four pieces of guidance given prominence in the national strategy are:

PH5 (2007) Smoking: workplace interventions – advice for employers who want to support staff to stop smoking and reduce risk of exposure to second-hand smoke. Contains advice on 'what works' including brief intervention, allowing employees to attend in-hours support sessions, employers that stop smoking services should target, including those supporting a workforce on low incomes, from disadvantaged backgrounds or where a high proportion smoke

PH45 (2013) Smoking: harm reduction – advice focusing on the needs of people who are highly dependent (including the priority groups identified elsewhere in this report), and who cannot stop smoking completely, or who wish to switch onto licensed, or non-smoked nicotine products, or who want to stop temporarily or to cut down. Recommendations include raising awareness of and promoting nicotine replacement options, providing information and advice for self-help, helping people select the best harm reduction approach, adopting best practice in behavioural support through effective education and training, advising on and supplying nicotine alternatives and arranging follow-up.

PH48 (2013) Smoking: acute, maternity and mental health services - covers both smokefree policies and effective ways for people to stop or abstain from smoking within secondary care services, and to carry on with support in the community. Applies to staff, visitors and patients.

PH26 (2010) Stopping smoking in pregnancy and after childbirth – covers advice for services involved in the antenatal and postnatal care of women up to one year after birth, including recommendations on systematic identification of women who smoke, referral to smoking cessation services, intensive support and additional actions for women from disadvantaged backgrounds.

Others to note are:
PH10 (2008) Stop smoking services
PH 14 (2008) Smoking: Preventing uptake in children and young people
P23 (2010) Smoking prevention in schools
PH1 (2006) Smoking: brief interventions and referrals

Quality standards are sets of measurable, evidence-based quality statements, which are useful to shape local improvements and are presented from an integrated, partnership driven perspective. The quality standards relating to smoking are:

QS92 (2015) **Smoking: harm reduction** – contains advice for people who are heavily dependent and wish to reduce smoking, to stop smoking but continue to use nicotine, or who wish to stop smoking temporarily

QS43 (2013) **Smoking: supporting people to stop** – contains advice for healthcare services about checking smoking status, offering advice and onward referral to evidence-based cessation services, offering behavioural and pharmacotherapeutic support, completion of a complete course of pharmacotherapy and validation of smoking status using a carbon monoxide check at 4 weeks after the quit date

QS82 (2015) **Smoking: reducing and preventing tobacco use** – contains advice on delivering interventions in schools, smokefree schools, trading standards actions on retailers selling to under 18s, enabling employees to access smoking cessation support during work hours without loss of pay, prohibition on smoking in work hours, ban on smoking in the grounds of healthcare settings and removal of designated smoking areas, secondary care services to offer nicotine replacement and stop smoking pharmacy service on site, promotion of national stop smoking campaigns, preventing access, demand and supply to illicit tobacco

15. Local preventative work

Reducing smoking in populations requires a multi-faceted approach and cooperation between organisations.

In Cheshire West and Chester much work has been done to tackle smoking. Examples of local work currently ongoing include:

- Smokefree hospital initiatives at The Countess of Chester, Leighton Hospital and Cheshire and Wirral Partnership, which also link into service developments to deliver the Commissioning for Quality and Innovation (CQUIN)
- Implementation of the recommendations from the BabyCLear evaluation within local maternity services
- Work with the Council fostering service to further strengthen smoking and second-hand smoke policy. Vaping is also being looked at as part of this review
- Smoking cessation and referral are a continuing element of Cheshire Fire Service's Safe and Well check
- Smokefree parks, schools and universities
- Smoking cessation included within the health optimisation pathway for people undergoing non-urgent, elective surgery

The smokefree partnership group has also completed a CLeaR assessment, which evidences these strength areas as well as identifying aspects of tobacco control where there is scope to do more.

The updated information in this JSNA chapter will directly inform commissioning of services to help people quit smoking and a new five year tobacco control strategy for Cheshire West and Chester, which will set out our commitments to:

- support healthcare partners to implement NICE guidance and maximise the opportunities that come from joint pathway development, including links into commissioned stop smoking support
- work with other partner organisations and services to shape and support their preventative work with groups in greatest need, for example, by promoting Making Every Contact Count approaches through the 0-19 service's 'think family' approach or with housing associations staff
- understanding local needs and priority groups at a locality level and making sure individuals members of the public and professionals know how to access the most appropriate advice and support in their area
- develop evidence-led policies in individual settings
- continuing to make the best use of regulatory services
- addressing peoples' need for balanced information about vaping and promoting effective national stop smoking campaigns.

17. Discussion

1. Summary update on e-cigarettes

Since the last update of this JSNA chapter e-cigarettes have grown in prominence in the world of smoking and smoking cessation. A subsidiary JSNA chapter will be developed as new data from the Office of National Statistics (ONS) and Public Health England becomes available.

E-cigarettes belong to a class of devices known as electronic nicotine delivery systems (WHO, 2014). The vapour which is inhaled contains propylene glycol, and may have added glycerol, flavouring and nicotine. The first e-cigarette arrived on the Chinese market in 2004 and appeared in the UK in 2007. Little more than a decade later e-cigarettes are the most popular method of quitting smoking, with ten times as many people opting for this option compared to stop smoking services (PHE, 2015) and vaping is credited with delivering an additional 18 000 quits since 2015 above and beyond those achieved through existing quit methods.

PHE's tobacco profiles currently include a single indicator relating to e-cigarette use at a local level: amongst 15 year olds – 'have you ever used/tried an e-cigarette?' In Cheshire West and Chester the figure from 2014/15 is 23.9%, which is similar to the North West rate, but higher than the all England average (18.4%). It is important to note than in the UK habitual e-cigarette use amongst young people is almost wholly confined to individuals who also smoke cigarettes (PHE, 2015).

E-cigarettes have caused considerable controversy because many people including some health and public health professionals consider them an 'unknown quantity' in terms of short and long-term risk to health and because of the initial lack of regulation of their design, manufacture and sale. In response to the uncertainty in the evidence base in 2014 the World Health Organisation demanded tighter regulation. Public Health England produced its landmark review on e-cigarettes in 2015. This concluded that e-cigarettes are '95% safer than cigarettes' and can help smokers to quit. The report was supportive of encouraging smokers who had failed to quit using other methods to try vaping and for stop smoking services to offer behavioural support. The report also endorsed stricter regulation and encouraged policy-makers to avoid any form of promotion or role-modelling of vaping towards young people. This document was followed up by guidance aimed at organisational policy makers. Based on harm reduction principles and drawing a strong distinction between vaping and smoking, this resource avoids being overly prescriptive and enables organisations to weigh up risks and benefits and arrive at a reasoned position on vaping in line with both evidence and situation specific risks and benefits. A consensus statement from PHE co-signed by a dozen high profile health and public health bodies called for clearer messaging on the knowns and unknowns for the public and a bringing together of the public's most popular quit method, i.e. vaping and the unquestionably most effective quit method, i.e. specialist behavioural support and pharmacotherapy, which is the cornerstone of stop smoking services (PHE, 2015).

May 2017 marked the point by which all e-cigarette retailers and manufacturers were expected to be compliant with new, stricter regulation introduced in May 2016 and overseen by the Medicines and Healthcare Products Regulatory Agency (MHRA). The new regulations cover, minimum standards for the e-cigarette and liquids, bans on certain ingredients, limits the amount and strength of nicotine, requires child tamper-proof design and a written warning on the addictive quality of nicotine. Local trading standards officers have powers of enforcement and existing law already makes it illegal to sell e-cigarettes to or purchase for people under the age of 18.

The advent of the new national tobacco control plan for England in 2017 has further consolidated the government's view on the place of electronic nicotine delivery systems within national tobacco control strategy. 'Towards a smokefree generation' includes as one of its four main national ambitions, 'helping people to quit smoking by permitting innovative technologies that minimise the risk of harm'; it later provides instruction to MHRA to support development of e-cigarette type products licensed for medical use, i.e. a prescribable e-cigarette.

Data published in 2016 by the (ONS) shows the extent to which e-cigarettes are being adopted as an alternative to smoked tobacco as a means of nicotine delivery, and also the misalignment between public and widely accepted professional belief about the relative harm from vaping and smoking. Key statistics include:

- In 2014 there were 2.2 million vapers; 59% of these still smoked as well. Although in the light of the current evidence base displacing smoked tobacco with vaping can be considered harm reducing, 'dual use' is a problem because the full health benefits are not realised and returning to past smoking levels is more of a risk
- In 2014 53% of 'vapers' were using e-cigarettes in order to quit smoking
- Only 22% of vapers said they thought e-cigarettes were less harmful than smoking, and 76% felt that they caused no harm to bystanders
- 41% of non-vapers feel exposure to vapour is harmful to others (this is not substantiated by current evidence)
- 27% of people surveyed did not think e-cigarettes are less harmful than smoking (this is at odds with PHE's assessment of their being 95% less harmful)

2. What needs might be unmet?

Areas where the evidence presented here suggests that we need to focus attention or do things differently include:

- **Priority groups**. As listed above, these are parts of the population which have not seen the same fall in smoking as the general population and in which smoking rates have been higher over time. The single biggest group is people in routine and manual occupations (raising the possibility of workplace-based advice and interventions) and those living in areas of higher deprivation. Another key and overlapping group is people living with diagnosed or undiagnosed mental health conditions

- **Smoking in pregnancy** is falling, but the overall one in ten women who smoke through pregnancy, a rate that is almost twice as high in the Vale Royal CCG area compared to West Cheshire and isolated, small areas where up to one in four women smoke in pregnancy show there is unmet need

- **Young people.** Young people continue to obtain and try tobacco and e-cigarettes and a small proportion (typically those with other vulnerabilities in their lives) take up the habit regularly. These are the smokers of tomorrow. Tailored, evidence-based advice and support needs to be embedded within services for young people, coupled with continuing enforcement of relevant laws aimed to prevent young people's exposure to smoke, cigarettes and e-cigarettes

- **Access to support.** Uptake of smoking services is better in areas of deprivation around Ellesmere Port and Chester compared to prevalence 'hotspots' on the eastern side e.g. Winsford. The underlying causes of this pattern needs to be understood and addressed. There is also a case to be made for more embedded specialist advice within services and community settings so people can find the help they want in a timely and more convenient way

- **Health and care services.** As the segmentation tool shows, smokers in our area will tend to be engaged with physical and mental health services. Given the emphasis in current national policy on building up prevention activity in these organisations it is clear that more partnership work and possibly co-commissioning is needed to develop pathways and implement NICE guidance. A key area to focus on is how the smoking cessation offer can be further strengthened in primary care and community services, particularly for people with a mental health condition who may have relatively little contact with secondary care services.

- **Clear advice and communications about new technologies.** There is a need to work closely with PHE and communications colleagues to improve the quality and consistency of information available to the public on new nicotine delivery systems including e-cigarettes, especially whilst these are not licensed for medical use, i.e. prescribable. Messaging needs to include practical advice about safety, how to buy a safe (not illicit) product, other sources of support and advice to stop smoking, risks of continuing to smoke and honest information about areas where the evidence is less certain, e.g. continued use over many years. Implications of the growing evidence base and guidance for smokefree policy-makers needs to remain an active topic for discussion and review.

3. What are the challenges of meeting these needs?

- **Cost** As commissioners need to 'do more with less' there is merit in directing 'gold standard' smoking cessation services to groups in greatest need with a range of less intensive advice and support on offer including a universal information service. Running a more targeted service has implications for health service providers who are being asked to systematically assess advise and assist smokers, including arranging access to support once they leave hospital.

- **Tackling maintenance factors** Many very dependent smokers may see smoking as a low priority or smoking-related poor health as given. Many may live in families and communities with high rates of smoking, which normalises smoking behaviour. Effective interventions need to tackle not just addiction but also build resilience, coping and harm reduction strategies to sustain a quit long-term. This is why offering linked support around other stressors as part of a holistic offer should be considered.

- **Consensus** Vaping remains an emotive and controversial subject. The public need a balanced, evidence-based message to help them make informed choices, but many organisations feel they cannot yet take on national guidance and treat vaping differently from smoking, which may leave people feeling confused about the potential risks and benefits of vaping compared to smoking.

16. Recommendations

Currently, anyone can access specialist stop smoking support from the local stop-smoking service. Smokers can also be prescribed medications to help with nicotine craving and various forms of licensed nicotine replacement therapy (NRT) by the GP, and can visit the local chemist to receive advice and purchase over the counter NRT.

The National Centre for Smoking Cessation and Training (NCSCT) recommend that a smoking cessation service is developed that is based on the most effective, evidence-based components, i.e. face-to-face individual or group support with pharmacotherapy over 6-12 weeks. This should be delivered by staff with specialist skills trained to NCSCT standards and should not be included in a wider-ranging lifestyle change intervention. Telephone and text message support can add value.

This 'gold standard' support should be made available to as many people in priority groups as possible, i.e. to those who are least likely to quit successfully and where cues to continue smoking are stronger because smoking is more commonplace within social networks. Initial and ongoing development of the service should aim to engage with service user groups outlined in this JSNA and local people at locality level.

Additional provision can make use of a supported pharmacotherapy offer, consisting of brief advice and medication at an initial appointment with one other follow-up appointment. This option need not be delivered by specialists but professionals should have undertaken basic NCSCT training . A visible, well maintained and informative web offer can signpost support in the wider population.

More widely, commissioners can consider building in a 'making every contact count' and campaign promotion arm to their service, which can deliver training to build local capacity around brief intervention training in frontline services both within and beyond the council. If this is part of an integrated service this can address a range of health behaviours.

Smoking status should be routinely assessed within other public health services e.g. substance misuse, sexual health and other integrated lifestyle services, as an initial step towards planning a quit attempt or adopting harm reduction advice.

With the upturn in smoking cessation activity in healthcare settings, it is essential that commissioners, public health and clinical colleagues work together to ensure that the different parts of the system link up and work well for individuals as they move across organisational boundaries, e.g. discharge from hospital. Consideration of opportunities to co-commission with CCGs where there is a clinical aspect to need, e.g. in pregnancy, should be sought.

The advantages of commissioning an e-cigarette friendly service should be considered. Collaboration at a regional level and with PHE is important to bring balanced, accurate information to the public about e-cigarettes. This should set out what we know and do not know about short and long-term risks of vaping compared to smoking, other forms of nicotine replacement and not smoking.

Stop smoking services should be situated within a whole-person approach that recognises that smoking is often cued and maintained by social norms and life stressors. Enabling easy access to support to help individuals with underlying issues may enhance the chances of a sustained quit attempt. Accessibility concerns both the location of stop smoking services and advice in places that are convenient, as well as commissioning a service that can flex and respond to concerns in addition to the primary need. Providing specialist smoking cessation staff with additional knowledge and skills to support people with diagnosed or undiagnosed mental health conditions would be a relevant service improvement to consider. Recognising the need to build in resilience and harm reduction strategies in the face of strong environmental cues to relapse is also important.