

# Berkshire West

# Stop Smoking Service

# Needs Assessment

SEPTEMBER 2020

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## Contents

Executive Summary - Key Points .....	3
Reducing inequalities .....	6
Model of service delivery .....	8
Aims of need assessment .....	10
Objectives of Berkshire West need assessment .....	11
Policy context .....	11
National policy context .....	11
Local .....	13
Berkshire West Population .....	15
Adult smoking prevalence .....	17
Adult smoking prevalence trends.....	19
Smoking prevalence by socioeconomic group.....	20
Routine and manual occupation.....	20
Socioeconomic deprivation .....	22
Wards with high prevalence .....	22
GP populations with high smoking prevalence.....	24
Smoking in those living in social housing.....	26
Smoking prevalence amongst people with mental health conditions.....	27
Smoking in individuals receiving treatment from substance misuse services .....	28
Smoking prevalence in pregnant women.....	29
Smoking prevalence by age .....	32
Children and young people.....	32
Smoking prevalence by ethnicity .....	35
Individuals with long-term physical health conditions.....	36
Smoking in Learning Disability.....	36
Smoking prevalence in people experiencing homelessness.....	37
Smoking prevalence by sexual orientation or identity in LGBT .....	37
Smoking-related harm .....	37
Smoking attributable mortality .....	37
Smoking related ill health.....	38
E-cigarette use .....	38
Impacts of Covid-19 on smoking .....	39
Adult smoking cessation and quit rates .....	40
Berkshire West Local Stop Smoking Service provision .....	40
Smoking Cessation in Secondary Care.....	41

Mental health trust.....	41
Maternity services .....	42
Secondary care trust.....	42
Stop Smoking Activity .....	43
Numbers setting a quit date and rates for successful quitters .....	43
Cost per quitter .....	45
Local Stop Smoking Service Activity Data (Smokefreelife Berkshire, Solutions4Health Ltd.) .....	45
Quit success rates.....	46
Successful quits by gender .....	46
Successful quits by age group .....	47
Successful quits by target group .....	47
Quit rate inequalities .....	48
Tobacco related costs .....	52
Estimated costs to society .....	52
Estimated costs to social housing providers .....	54
Costs to individual.....	54
Return on investment.....	55
Engagement.....	56
Public Engagement.....	56
Methods .....	56
Survey Response.....	56
Findings .....	60
Stakeholder engagement.....	67
Survey Response.....	67
References .....	74

## Executive Summary - Key Points

### Smoking prevalence in Berkshire West

- In 2019, smoking prevalence in adults (18+ years) was estimated to be 10.9%. This means an estimated 41,118 smokers in Berkshire West<sup>1</sup>. Estimated smoking prevalence varies between the three local authorities; Reading 13.9% (17,593), West Berkshire 10.3% (12,717) and Wokingham 8.4% (10,808).
- The adult smoking prevalence in Berkshire West is lower than both the regional (South East) and national (England) average.
- Smoking prevalence in adults continued to fall between 2011 and 2018, but a slight (not statistically significant) increase was seen between 2018 and 2019. Decline has been slower in Wokingham.

Smoking is a major contributor to health inequalities in Berkshire West

### *Routine and manual workers*

- Smoking prevalence amongst those in routine and manual occupations is much higher than those working in managerial and professional occupations. In Reading smoking prevalence amongst routine and manual occupations was 29.3% (West Berkshire 23.8% and Wokingham 23.4%), this is higher than the regional and national average (although not statistically significant).
- Whilst there has been a decline in smoking prevalence since 2011, there has been little decline amongst routine and manual workers. The inequality gap is wide with the odds of smoking if work in a routine and manual worker being 3.79 times that of other employed groups in West Berkshire in 2019 (compared to 2.4 times nationally)

### *Deprivation*

- Smoking rates are much higher within deprived communities. There is a clear relationship between increasing deprivation and increasing smoking prevalence.
- Smoking prevalence estimates by ward have been modelled by Action on Smoking Health (ASH).
- A substantial number of GP Practices that have a smoking prevalence in their practice population higher than the average for NHS Berkshire West CCG, do not have a smoking cessation advisor located at the practice. Housing tenure appears to be the strongest independent predictor of smoking in England.
- An estimated 22.2% of social housing units in Reading are thought to be smoking households, 18.5% in West Berkshire and 15.7% in Wokingham.
- Smoking prevalence in residents who rent from local authority or housing association is much higher than in those who privately rent, or own outright or with a mortgage. In Reading, 25.1% of residents who rent from local authority or housing association are estimated to be smokers, this is 32.7% in West Berkshire and 28.1% in Wokingham.

### *Individuals diagnosed with mental health condition(s)*

- The smoking prevalence in adults with diagnosed long-term mental health conditions is more than twice that of the general population in Berkshire West (25.2% versus 10.9% respectively), this varies by LA with prevalence; 28.9% in Reading and 17.6% in Wokingham.

- 1 in 3 adults with a serious mental illness are smokers in Berkshire West, three times the general population.

### ***Individuals receiving treatment from substance misuse services***

- People receiving treatment in substance misuse services are far more likely to be smokers. Across all substance groups' prevalence is high, as high as 77% in those who misuse opiates.

### ***Pregnant women***

- In 2019/20 5.8% of pregnant women were recorded as smoking at the time of delivery (SATOD) in Berkshire West, an estimated 306 women (10.5% in England).
- The rate of decline in SATOD has been slow and stagnant in the last few years with a slight (non-significant) increase in the last year.
- Prevalence of smoking is much higher in teenage mothers, those in routine and manual occupations and those living in the most deprived LSOAs.

### ***Children and Young People***

- There has been a general decline in smoking prevalence amongst young people over the last 10 years. Lack of recent national data means we rely on estimates from the local Schools Attitudinal Survey. This estimates between 0.6% and 1.5% of 15 year olds are regular smokers in Berkshire West, meeting the national Tobacco Control Plan target of less than 3% of 15 year olds as regular smokers by the end of 2022.
- Continuing to encourage adult smokers to quit is the most important part of reducing prevalence amongst children and young people as children with parents who smoke are significantly more likely to take up smoking themselves.
- The Schools Attitudinal Survey found 3.7% of pupils smoked e-cigarettes. This survey found that young people who have never smoked tobacco cigarettes are trying e-cigarettes and e-shisha.

### ***Black Asian and Minority Ethnic (BAME) groups***

- The number of people from a Black Asian and Minority Ethnic (BAME) group living in Berkshire West is likely very different to the 2011 Census, as suggested by school profiles for the area.
- Based on national data of smoking prevalence by ethnic groups and the 2011 Census population estimates, after 'White' smokers (n=36,134), the largest number of smokers in Berkshire West are 'Asian' (n=1768) or 'Mixed' (n=1477) ethnicity. National figures show smoking prevalence is high in 'mixed' ethnic minority groups – 19.5% (2019).

### ***Individuals with long-term physical health conditions***

- Adults with a long-term condition are more likely than their peers to smoke. People in low-income groups are more likely to smoke and to suffer multiple comorbidities, further deepening health inequalities that those with long-term conditions face.

## Smoking related harm in Berkshire West

- There were 1,407 smoking-attributable deaths in Berkshire West between 2017 and 2019
- Reading has a 73% higher rate of smoking attributable mortality and 72% higher rate of smoking attributable hospital admissions than Wokingham.
- In 2018/19 in Berkshire West, it is estimated there were a total count of 2,562 smoking attributable hospital admissions. The rate of hospital admissions attributable to smoking is significantly lower than the national average in all three local authorities.

## E-cigarettes

- E-cigarettes have become a popular stop smoking aid and there has been a decline in use of over the counter nicotine replacement therapy (NRT) with e-cigarettes increasing in popularity since 2013.
- Use by long-term ex-smokers has grown. Use in smokers and recent ex-smokers has more recently plateaued.

## Impact of Covid-19 on smoking prevalence

- YouGov polls suggest 18-34 year age group were more likely to quit now than before, although for the majority lockdown made no difference.
- For those people with mental health conditions, a greater proportion than the general smoking population reported smoking more during lockdown and being less likely to quit as a result of Covid-19.
- There is a strong relationship between job loss and prevalence of smoking which is a concern and highlights the importance of smoking cessation during the recovery from Covid-19.

## Local Stop Smoking Services in Berkshire West

- Until 2018/19 the Stop Smoking Service was treating at least 5% of the estimated local population who smoke each year, with 2,262 people setting a quit date in Berkshire West in 2018/19 (approximately 5.7% of smoking population). However, since budget reductions, in 2019/20 this fell to 1,191 smokers setting a quit date, just 2.9% of the smoking population. The rates of people setting a quit date per 100,000 smokers has since fallen below the South East average across all three local authorities.
- The rate of smokers that have successfully quit at 4 weeks per 100,000 smokers exceeded regional and national rates in Berkshire West in 2018/19.
- 67% of those who SAQD went on to be successfully quit (self-reported) at 4 weeks (compared to 52% on average in England).
- Quit success rates in Berkshire West were 63% in 2019/20 (64% in Reading, 63% in Wokingham and 62% in West Berkshire), this favours comparably to South East average (53%).
- In 2018/19 76% of 4 week quits were CO-validated, exceeding the current contract target of >70% but not the national recommended target >85%.
- Approximately half of 4 week self-reported quits were from target groups in 2019/20 (Reading 54.6%, West Berkshire 48.8% and Wokingham 52%). Just less than half of 12 week self-reported quits are from target groups in 2019/20 (Reading 49.1%, West Berkshire 44.5% and Wokingham 47.9%).

- The proportion of all successful 4 week self-reported quits from specified target groups in 2019/20 tends to fall below the England average. With exception, in 2019/20:
  - Successful 4 week quits in Routine and Manual Workers as a proportion of total successful 4 week quits was less than the 40% KPI target in all three local authorities, however, it exceeded England's average 29.7% (Reading 35.8%, West Berkshire 38.0%, and Wokingham 39.3%).
  - Successful 4 week quits in BAME groups as a proportion of total successful 4 week quits was higher in Reading than the expected KPI target 15% and England average 12.9% (Reading 15.5%, West Berkshire 4.5% and Wokingham 8.4%)
  - The successful 4 week quits in Young People (<18) as a proportion of total successful 4 week quits was similar to the England average (1.2%)
  - The successful 4 week quits in pregnant women as a proportion of total successful 4 week quits did not meet the national average 5.5% (Reading 3.7%, West Berkshire 1.6%, Wokingham 0.8%)
- For 4 week success rates in target groups, amongst those who set a quit date from a routine and manual occupation, 46% were successful 4 week quits, compared to 95% of those working in managerial and professional occupations in Wokingham (49% vs 79% in Reading, 47% vs 92% in West Berkshire, 54% vs 57% in England).
- Quit success rates was 72% in pregnant women in Berkshire West, however very small numbers of pregnant women had set a quit date in 2019/20, therefore not allowing comparison with other areas in the South East.
- Quit success rates were lowest in those aged under 18 for the service (30%) and highest, 71.6% in those aged 45-59.
- The pharmacotherapy most frequently used by clients was mono-NRT in 2018/19 accounting for 83.7% of those who SAQD, combination NRT was not used by any client, and varenicline by 9.6%. The 4 week quit success rate was 68% amongst those using mono-NRT and 84% amongst those using varenicline.

Whilst in Berkshire West many of the 2022 targets set out by the national Department of Health *Towards a smoke-free generation: tobacco control plan for England* (DH, 2017) have already been met, progress has become stagnant and there remains a number of significant inequality gaps that are widening.

### **Reducing inequalities**

The following recommendations for both Local Authority Commissioners and the future Provider of stop smoking services are made to support a reduction in inequalities:

- Specific focus should be given to increasing accessibility of the stop smoking service to Routine and Manual Workers and achieving higher quit success rates in this priority group. To achieve this, the service should draw on the evidence-base and consumer insight to ensure tailored service provision that meets the needs of Routine and Manual Workers.
- The location of face-to-face stop smoking services must increase accessibility in the most deprived areas of each local authority. Underlined in the public engagement results was strong support for delivery of Stop Smoking Services at GP practices, establishing delivery of services within these practices should be driven by local smoking prevalence and level of deprivation. Other high footfall community venues such as pharmacy should be considered.



- Consideration should be given to both public and stakeholder engagement feedback in determining the most appropriate settings for delivery of any face-to-face stop smoking clinics. Delivery should be flexible and encompass other methods besides face-to-face including use of technology such as videoconferencing and telephone.
- Local Authority and NHS Commissioners, acute, maternity and mental health services, and the local stop smoking service Provider should work closely together to deliver the objectives set out in the NHS Long Term Plan and ensure coordination of future community and secondary care tobacco dependency services.
- Helping those individuals who are receiving treatment from substance misuse services should be an important focus for stop smoking services given the high prevalence of smoking and knowledge that smoking risks worsening diseases associated with substance misuse and increases relapse for those in recovery. The Provider should work alongside public health teams, substance misuse services and other relevant services such as homelessness support to consider novel referral routes and outreach initiatives where appropriate.
- Robust referral pathways from key partners such as acute trust, GPs, maternity services, mental health and substance misuse services should be established and strengthened. Use of embedded referral forms within clinical systems and strong feedback mechanisms from service provider to referrer, or referring organisation, following receipt of referral, should include information such as; set a quit date and outcomes of intervention.
- There should be a minimum provision of a lead acute coordinator working within acute, maternity and mental health settings that is able to promote awareness of the stop smoking service amongst staff, encourage and support very brief advice (VBA) and referrals to service, and who is trained to an appropriate NCSCT accredited level.
- Targeted, intensive support is required to reach the relatively small cohort of pregnant women who smoke to tackle inequalities. National data highlights a higher prevalence of smoking in teenage mothers, those in routine and manual occupations and those living in the most deprived lower supra output areas (LSOAs). Intelligence used by maternity services to target their 'continuity of care' service could be used to target stop smoking service delivery too. The stop smoking service should collaborate with other initiatives and outreach schemes to identify opportunities for intensive ongoing support with women who have complex social and emotional needs.
- Service Provider should work closely with partners of the Local Maternity System to implement changes recommended following the Maternity CLeaR assessment in Berkshire West.
- Prevention of uptake of smoking in children and young people is important as well as ensuring that stop smoking services are tailored to the needs of this group. The Local Schools Attitudinal Survey results should be used by both the Tobacco Control Alliance and stop smoking service provider to promote awareness and tailor prevention of smoking work and service provision to young people. Support for pathways for referral to the stop smoking service should be considered for young people with high prevalence of smoking e.g., Youth Offending Teams.



- The stop smoking service should be accessible and provide information in easy-read format for those with learning disabilities to cut down or quit smoking should they wish to do so.
- Ensure health impact assessments of the Stop Smoking Service are conducted, ideally within the first 15 months of set-up to ensure BAME communities and other priority groups have good access, experience and outcomes of the commissioned service.
- Smoking prevalence data (including smokeless tobacco, shisha etc.) is poor and the engagement survey underrepresents the 'voice' of the BAME population. Ethnicity profiles of each local authority should be renewed and local community intelligence to determine where services should be targeted to reach this population.
- Work with partners of the Tobacco Control Alliance and wider relevant stakeholders should continue, for example smoke-free policies such as smoke-free homes given recently published data on higher smoking prevalence in residents who rent from local authority or housing association compared to private rental or property owners (outright or with a mortgage).

### **Model of service delivery**

There is strong support within engagement results to ensure that intensive specialist stop smoking support is available to those that need it. Evidence maintains that these traditional smoking cessation services continue to offer the best chance of successful quits. The overall quit success rate in Berkshire is higher than south east regional average.

However, given the reducing public health and Council budgets, the current universal specialist service model has approximately 2.9% of the smoking population setting a quit date, of which approximately 1.8% successfully quit. This is less than the expected 5% target which NICE guidelines recommend. As numbers of smokers in general reduce, so have the numbers accessing services but the reduction also reflects the reduced service capacity. An estimated two-thirds of smokers report a desire to quit which highlights the opportunity to broaden support services to appeal to a wider smoking audience. As a result, future commissioning of the stop smoking service should:

- Explore options for smokers not in priority groups who would like to quit alone, increasing online and digital support.
- Deliver a service that focuses resource with the most intensive support offered for those smokers in priority groups (to address local inequalities) and/or highest tobacco dependency. There is backing from local stakeholders for a model of service delivery that enables informed choice, matching support to level of need (dependence, priority group status) and motivation and willingness to quit.
- Offer a 'lighter touch' support of brief advice and pharmacotherapy for those smokers who are not willing to commit to a full intensive specialist course. Suggested delivery settings by professional stakeholders were; pharmacies, community venues and videoconferencing.
- Ensure that the service is an e-cigarette friendly service which is supported by the evidence and broadly by public and stakeholders. However, concerns amongst local professional stakeholders and public around e-cigarettes should be addressed with

education and information widely made available about the benefits, risks and safety profile of e-cigarettes and other unlicensed nicotine containing products.

- Take account of the insight gleaned from public and professional stakeholders and local data within this needs assessment.
- Need for a comprehensive marketing and communications plan that increases the visibility of the service and promotes awareness amongst the public, smoking population and key professional stakeholders.

## Introduction and Background

Whilst the proportion of the population who smoke tobacco has fallen, tobacco smoking still remains the leading cause of premature death, killing 77,800 people in England in 2017 (NHS Digital, 2019). In 2017/18 there were estimated to be 489,300 hospital admissions attributable to smoking in adults aged 35 in England, accounting for 4% of all hospital admissions in this age group (NHS Digital, 2019). The annual cost of smoking to the National Health Service [NHS] in England is estimated to be £2.5 billion (Action on Smoking Health [ASH], 2018a) and this does not account for the wider societal and personal cost that smoking has.

Smoking contributes substantially to existing health inequalities, accounting for approximately half of the difference in life expectancy between the lowest and highest income groups. Harm from smoking is concentrated in our most disadvantaged communities (Department of Health [DH], 2011; Public Health England [PHE], 2019a).

Stop smoking services can contribute to reducing these health inequalities (National Centre for Smoking Cessation Training [NCSCT], 2013). Stopping smoking at aged 30 years leads to a gain of almost 10 years of life expectancy. Stopping at age 60 still yields a 3-year gain in life expectancy. Following a heart attack, if a smoker quits, they reduce their chances of having another heart attack by 50% (World Health Organization [WHO], 2020).

Of those adults who currently smoke seven out of ten want to quit and 75% regret starting (ASH, 2019a). There is a strong evidence base that smokers are three times as likely to succeed with a combination of pharmacotherapy and specialist skilled behavioural support compared to an unaided quit (Bauld *et al.*, 2016; Hughes *et al.*, 2004; Lancaster & Stead, 2017; Stead, 2016). The combination of pharmacotherapy and behavioural interventions has also been found to be highly cost-effective (Flack *et al.*, 2007). Just 10 people need to be treated with medication (varenicline) and behavioural support to achieve a long-term quit (6-month abstinence) and 20 to prevent one premature death (Van Schayck *et al.*, 2017).

Children growing up in smoking households are 90% more likely to become smokers themselves. Given smoking cessation has a far bigger and more immediate impact than smoking prevention, helping adult smokers quit reduces uptake amongst children (Laverly *et al.* 2019; Shahab, 2011).

The national tobacco control plan for England '*Towards a smoke-free generation*' (DH, 2017) has clearly set out the Government's ambition for England to be 'smokefree' by 2030 with smoking rates at 5% or less (DH, 2017). Despite Berkshire West (Reading Borough Council, West Berkshire District Council and Wokingham Borough Council) having a lower prevalence of smoking than the England average, there are significant inequalities amongst different population groups.

A health needs assessment is being carried out at this time to assess the current picture of tobacco use in Berkshire West and any gaps in provision. This will inform decision making on future provision of Local Stop Smoking Services.

### Aims of need assessment

- Collate data and intelligence to understand the smoking population and the inequalities that exist across Berkshire West and for each local authority
- Prioritise resource allocation for smoking cessation to ensure maximise outcomes in populations most at need

- Use the resulting needs assessment to inform and guide future commissioning and provision of Stop Smoking Service in Berkshire West

### **Objectives of Berkshire West need assessment**

- Outline an overview of national and local policy and the needs of smokers in Berkshire West using national and local data sources to describe smoking and compare with local comparators and national figures
- Outline current service provision and identify any gaps or unmet need
- Consultation with key stakeholders to understand the strengths and weaknesses of current services, and gaps in service provision or referral pathways. Local population consultation survey to understand smoking habits and opinions.
- Make recommendations with respect to service provision, expected performance and cost

### **Policy context**

#### **National policy context**

*Department of Health 'Towards a smoke-free generation: tobacco control plan for England' (July 2017) (DH, 2017)*

The Government set an ambition for England to be 'smokefree' by 2030 (smoking prevalence less than or equal to 5%). To achieve this, universal access to support for smokers to quit, in healthcare and through the community is required to meet the four ambitions by the end of 2022:

- Smoke-free generation (reduce smoking prevalence amongst 15 year olds who regularly smoke to 3% or less, reduce adult smoking prevalence to 12% or less) and reduce the inequality gap between routine and manual occupations and the general population
- Smoke-free pregnancy (reducing prevalence to 6% or less)
- Parity of esteem for those with mental health conditions, including improved data collected and making all mental health inpatient services sites Smokefree by 2018
- Backing evidence based innovations to support quitting (using innovative technology and maximising availability of safer alternatives e.g. electronic cigarettes)

To achieve this the Tobacco Control Plan for England is targeted around four themes: 1) prevention first, 2) supporting smokers to quit, 3) eliminating variation in smoking rates, and 4) effective enforcement. A range of actions to achieve these ambitions include; ensuring effective operation of legislation to reduce the uptake of smoking by young people, supporting pregnant smokers to quit, providing access to training for all health professionals on how to help patients to quit smoking, especially in mental health services and creating a Smokefree NHS by 2020. Eliminating variation in smoking rates by promoting links to stop smoking services across the health and care system and full implementation of National Institute of Clinical Excellence (NICE) guidelines by 2022. Finally maintaining high duty rates for tobacco products and using lessons from HMRC work on sanctions to stop illicit tobacco.

#### *Recent legislation*

Recent legislation in relation to tobacco include:

- Children and Families Act (2014)  
Regulations to prohibit; smoking in vehicles when children are present, proxy purchasing of tobacco by adults for children, and sale of nicotine products (e-cigarettes) to persons under the age of 18

- Standardised Packaging of Tobacco Products Regulations (2015)

#### *The NHS Long Term Plan, January 2019*

The NHS Long Term Plan published January 2019 sets out new, funded, action the NHS will take to strengthen its contribution to prevention and health inequalities, specific action includes to cut smoking. By 2023/24 all people admitted to hospital who smoke will be offered NHS funded tobacco treatment services. The Ottawa Model (Reid *et al.*, 2010) for Smoking Cessation will be adapted for expectant mothers and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments. A new universal tobacco treatment service available as part of a specialist mental health services for long-term users of specialist mental health, and in learning disability services. This will include the option to switch to e-cigarettes while an inpatient.

#### *Health Matters: Tobacco and Alcohol CQUIN (March 2019) NHS England, Public Health England*

Commissioning for Quality and Innovations (CQUINs) provide targets to trusts in specific areas with financial incentive to achieve those aims. The Tobacco and Alcohol CQUIN focuses on identification of smokers and, where required, provision of very brief advice and referral to specialist services for all inpatients in community and mental health trusts (2017-19) and all acute trusts (2018-19). Approximately 25% of patients are likely to screen positive for smoking (British Thoracic Society [BTS], 2016) and up to 70% in psychiatric units (Jochelson & Majrowski, 2006). Giving very brief advice (VBA) and referring to stop smoking services makes those who want to quit between 15-20% successful compared with a 3-4% among those without a referral.

#### *Saving Babies Lives Care Bundle, NHS England, March 2019*

This aims to provide detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality. It focuses on five elements of care that are widely recognised as evidence based and/or best practice, the first being 'reducing smoking in pregnancy'. This follows NICE guidance, offering carbon monoxide (CO) testing for all women at antenatal booking, and as appropriate throughout, to identify smokers (or those exposed to tobacco smoke) and offer them a referral for support from a trained stop smoking advisor.

#### *Smoking in Pregnancy Challenge Group: Local Maternity Systems (LMS) Smokefree Pregnancy Pathway*

Saving Babies' Lives found inconsistent practice in relation to implementing components of NICE guidance, including carbon monoxide (CO) monitoring of all women and referral of smokers to stop smoking services. This advises CO monitoring for all women at their booking and 36 week appointment, and at time of delivery. Women who smoke should also have additional CO monitoring at each appointment with offer of support always made available to them.

#### *National Guidelines*

This needs assessment has been informed by the following National Institute for Health and Care Excellence (NICE) guidelines:

- NICE (2018) *Stop smoking interventions and services* [NICE Guideline No. 92] <https://www.nice.org.uk/guidance/ng92>

Highlights specific groups at risk of tobacco-related harm: people with mental health problems, misuse substances, health conditions caused, made worse, or related to smoking, pregnant women, other high prevalence communities (manual workers, travellers, LGBT community)

- NICE (2013) *Smoking: Supporting smokers to stop* [NICE Quality Standard No. 43] <https://www.nice.org.uk/guidance/qs43>
- NICE (2013) *Smoking: acute, maternity and mental health services* [NICE Guideline No. 48] <https://www.nice.org.uk/guidance/ph48>
- NICE (2010) *Smoking: Stopping in Pregnancy and after childbirth* [NICE Guideline No. 26] <https://www.nice.org.uk/guidance/ph26>
- NICE (2007) *Varenicline for smoking cessation* [NICE Technology appraisal guidance No. 123] <https://www.nice.org.uk/guidance/ta123>
- NICE (2015) *Smoking: reducing tobacco use* [NICE Quality Standard No. 82] <https://www.nice.org.uk/guidance/qs82>
- NICE (2013) *Smoking: harm reduction* [NICE Guideline No.45] <https://www.nice.org.uk/guidance/ph45>
- NICE (2015) *Smoking Harm Reduction* [NICE Quality Standard No. 92] <https://www.nice.org.uk/guidance/qs92>
- NICE (2010) *Smoking prevention in schools* [NICE Guideline No. 23] <https://www.nice.org.uk/guidance/ph23>
- NICE (2008) *Smoking: preventing uptake in children and young people* [NICE Guideline No. 14] <https://www.nice.org.uk/guidance/ph14>
- NICE (2014) *Behaviour change: individual approaches* [NICE Guideline No. 49] <https://www.nice.org.uk/guidance/ph49>
- NICE (2007) *Behaviour change: general approaches* [NICE Guideline No. 6] <https://www.nice.org.uk/Guidance/PH6>

Other guidelines:

- National Centre for Smoking Cessation and Training (NCSCT) (2014) *Local Stop Smoking Services: Service and delivery guidance 2014* [https://www.ncsct.co.uk/usr/pub/LSSS\\_service\\_delivery\\_guidance.pdf](https://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf)
- Royal College of Physicians (RCP) (2018) *Hiding in Plain Sight: Treating Tobacco Dependency in the NHS* <https://www.rcplondon.ac.uk/projects/outputs/hiding-plain-sight-treating-tobacco-dependency-nhs>

## Local

*Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) Strategic Delivery Plan*

The Strategic Delivery Plan outlines the challenges in reducing smoking rates within certain socioeconomic groups, particularly routine and manual workers, highlighting that in Berkshire West this is worse than the England average.

*Berkshire West Integrated Care Partnership (ICP) Prevention Plan*

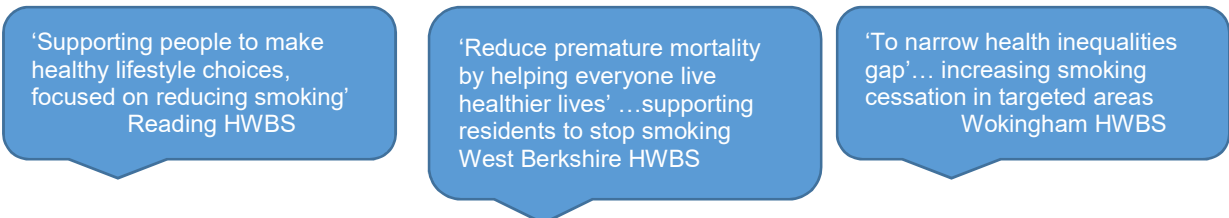
The Berkshire West ICP Prevention Plan focuses on four priority areas, including ‘Embedding prevention and reducing variation across all pathways’. Tobacco dependency is a priority area in this with actions to:

1. complete a CLEAR maternity smoking assessment and provide support to pregnant women who smoke.
2. ensure funding drawn down through the NHS LTP aligns with existing commissioned services and targets vulnerable and at-risk population groups



## Health and Wellbeing Strategy

Reducing smoking prevalence is an important component of helping Berkshire West Local Authorities reduce the inequalities gap caused by smoking. All three Health and Wellbeing Board's Strategies include a strategic aim to reduce smoking prevalence. Berkshire West (Reading, West Berkshire & Wokingham) are also currently developing a joint health and wellbeing strategy and it is expected that smoking will feature within the priorities.



## Berkshire West Tobacco Control Plan 2019-22

The Berkshire West Tobacco Control Alliance supports the provision of an integrated stop smoking approach to support local need. The Tobacco Control Alliance set out a delivery plan to reduce tobacco harm across Berkshire West, available [here](#). The delivery plan has been developed in line with the national delivery plan and sets out six areas for action. These include: 1) Prevention first, a smoke free generation, 2) stamping out inequality and eliminating variance in smoking rates, 3) Supporting all smokers to quit, 4) Evidence based innovation, 5) A smoke free NHS and public places, 6) Effective enforcement.

The Alliance seeks to focus resource and work on target groups, including: 1) those with a mental health condition, 2) pregnant women, 3) routine and manual workers, 4) Black, Asian and minority ethnic communities.

## Berkshire West Smoking in Pregnancy [SiP] CLear Assessment

CLear is an evidence-based approach to tobacco control that has three focuses:

1. **Challenge** for the existing tobacco control services
2. **Leadership** for comprehensive action on tobacco control
3. **Results** demonstrated by outcomes achieved measured against national and local priorities.

In 2020 a SiP CLear assessment was undertaken by Berkshire West, Oxfordshire and Buckinghamshire. The assessment involved local maternity system partners for each area and representatives from local Public Health teams. The results for Berkshire West showed that whilst SiP featured in local plans and strategies, there was no specific group addressing or focussing on SiP.

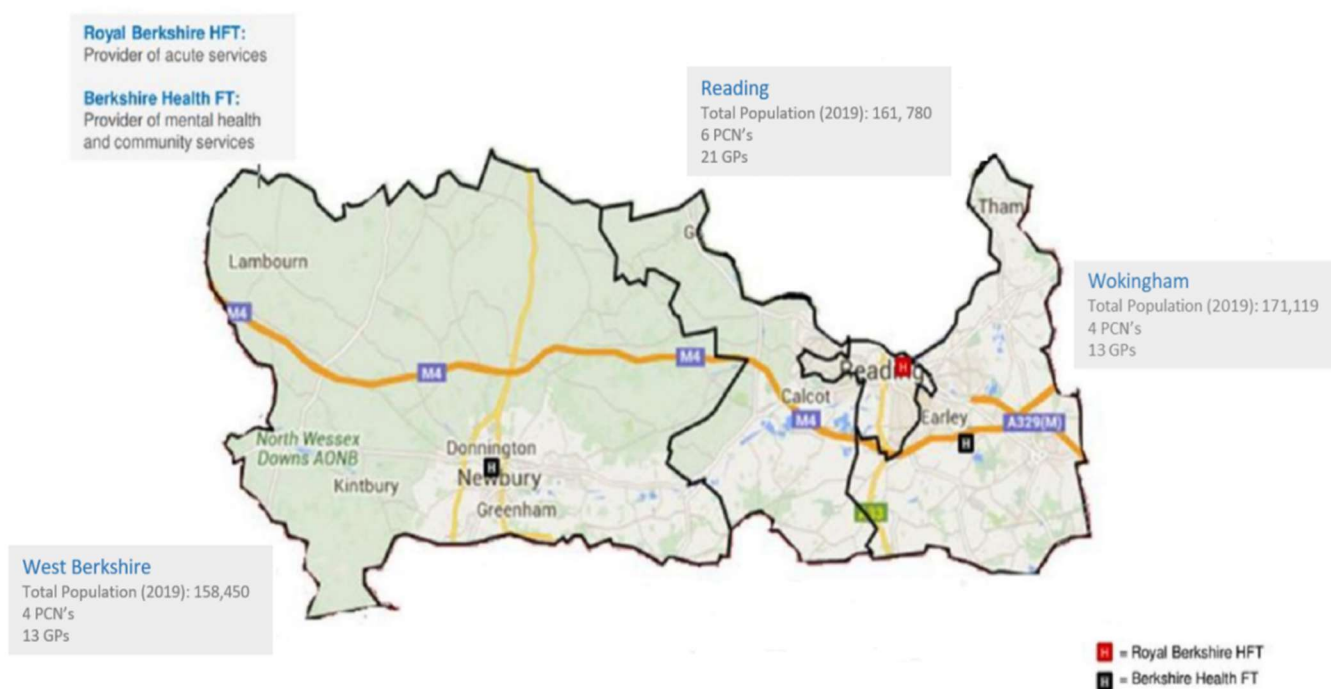
Local maternity services were undertaking a gap analysis against PH26 and PH48. CO monitors are available within local Berkshire West maternity services and training on their use is expected to happen early 2021 – the delay occurred because of the coronavirus pandemic. All staff within the local stop smoking service provision are trained to the relevant standards. One of the key findings was the need to explore better data capture, recording and reporting processes for feeding back outcomes of women undertaking a quit whilst pregnant to maternity services. Further opportunities to support and maintain a successful quit through health visitor's post-partum support was also identified.



## Berkshire West Population

Berkshire West is a geographical region based within the Thames Valley in the South East of England. There are three Local Authorities which form this geographical area; Reading Borough Council, West Berkshire District Council and Wokingham Borough Council. There is now one joint Clinical Commissioning Group (CCG), Berkshire West CCG which operates across four localities: Newbury & District, North & West Reading, South Reading and Wokingham. The mid-year estimated combined total population in 2019 was 491,679<sup>2</sup>.

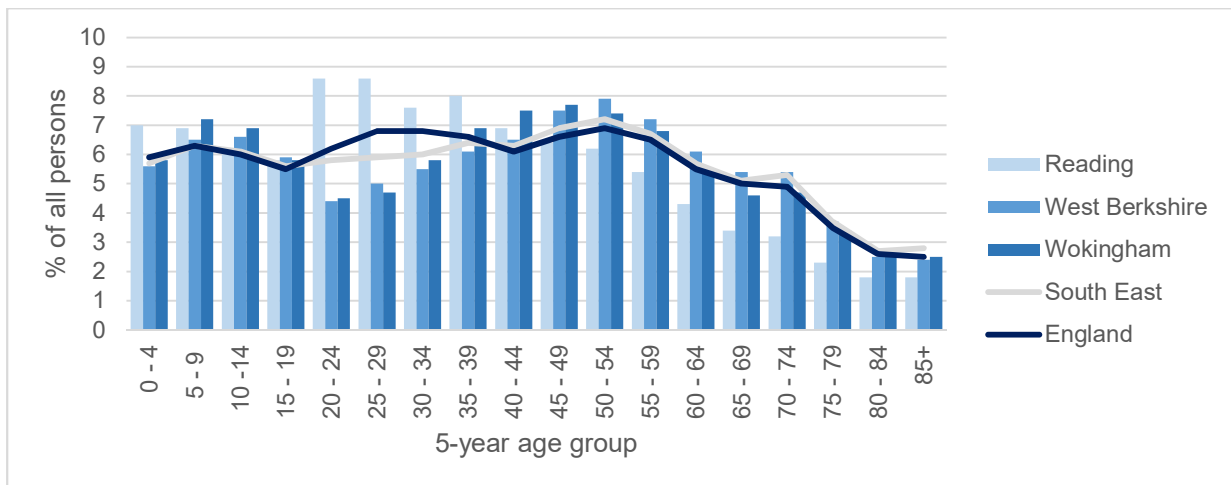
**Figure 1. Map of Berkshire West**



The age profile differs across the three local authorities in Berkshire West. Reading has a greater proportion of young children (aged 0 to 9 years) and younger adults (aged 20 to 44 years), in comparison to the South East and national averages. In contrast, there is a smaller proportion of adults aged 50 and over in comparison to South East and England. West Berkshire and Wokingham have a greater proportion of children aged 5 to 14 years and adults aged 35 to 59 years in comparison to the South East and national averages, but lower proportions of younger adults (aged 20 to 34 years).

<sup>2</sup> Sum of Reading, West Berkshire and Wokingham population estimates from Berkshire Observatory data available at <https://berkshireobservatory.co.uk/>

**Figure 2. Population estimates for all persons by 5-year age group for 2019, Berkshire West**



Source data: Berkshire Observatory available at <https://berkshireobservatory.co.uk/>

Ethnicity data for the region is based on the last census in 2011, this counted 79.7% of the population as White British, similar to the national average (79.8%), but less than the South East average (85.2%). The last Census counted a total of 94,012 people from ethnic minority groups, this was highest in Reading (53,973, 34.7%), then Wokingham (25,261, 16.4%) and the smallest proportion in West Berkshire 14,778 (9.6%)<sup>3</sup>. The spatial variation percentage of non-White population across Berkshire West CCG, by Wards (2011) is shown in Figure 3 below.

**Figure 3. Spatial variation percentage of non-White population in Berkshire West CCG, by Wards (2011)**



Adapted from source: Public Health England Epidemiology and Surveillance Team  
 Definition: The number of people stating their ethnicity as 'not White' in the 2011 Census

The more recent school profiles (2019)<sup>4</sup> indicate that the ethnic minority population has continued to increase since 2011. In Reading, 58.5% of Primary school pupils and 57.6% of Reading Secondary school pupils are from a minority ethnic group. Increases in the proportion of ethnic minority populations has also increased in the other two Local Authorities, with 18.2%

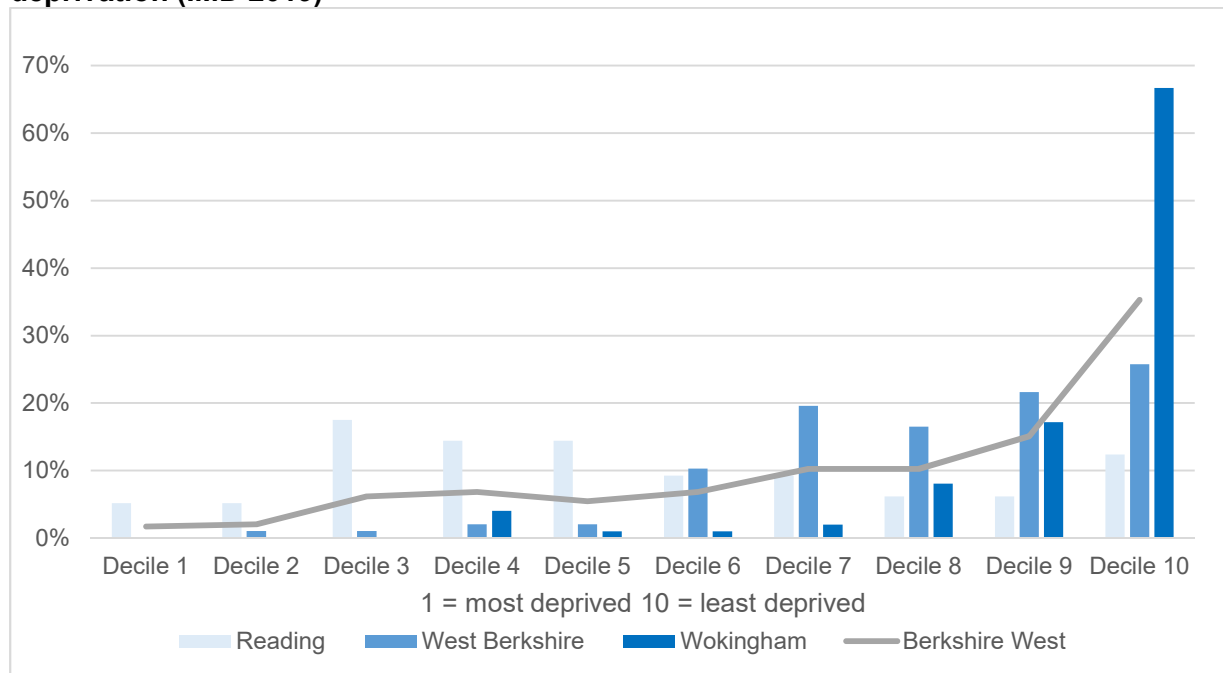
<sup>3</sup> Based on data from Berkshire Observatory, detailed ethnicity groups, total excluding White English/Welsh/Scottish/Northern Irish/British <https://reading.berkshireobservatory.co.uk/population/>

<sup>4</sup> Data from School Wellbeing Profiles, 2019

of West Berkshire Primary school pupils from a minority ethnic group, and 35.2% of Wokingham Primary and 31.1% Wokingham Secondary school pupils.

Berkshire West is relatively affluent compared to many geographical regions in England. Figure 4 shows the proportion of Lower Super Output Areas (LSOAs) in Berkshire West that fall within each decile. Decile 1 represents the most deprived 10% of LSOAs in England while decile 10 shows the least deprived 10% of LSOAs. The majority of LSOAs in Berkshire West (35.3%) are in the least deprived 10% of LSOAs in England. This is skewed by the more affluent areas in West Berkshire and Wokingham, whilst a much higher proportion of LSOAs in Reading fall in the more deprived centiles.

**Figure 4 Proportion of LSOAs in each Local Authority that fall within each decile of deprivation (IMD 2019)**



Source data: Berkshire Observatory (IMD 2019, MCHLG)

Healthy life expectancy is significantly higher than the national and regional averages for both males and females in Wokingham, and in West Berkshire higher than national averages. However, Reading has similar life expectancy for both males and females as the national average, but lower female healthy life expectancy compared to the regional average. Cancer is the highest cause of preventable death in people aged under 75 years old.

### Adult smoking prevalence

Figure 5 shows the estimated adult smoking prevalence in Berkshire West to be between 9.1 and 13.9%<sup>5</sup>.

<sup>5</sup> Measuring smoking prevalence can be challenging as estimates are dependent on self-reported smoking status. There are several sources that can be used; Annual Population Survey (APS), Quality and Outcomes Framework (QOF) and GP Patient Survey (GPPS). It should be noted that the QOF estimate is higher as this includes those aged 15+ whereas APS and GPPS is 18+.

**Figure 5. Estimated adult smoking prevalence in Berkshire West, 2018**



Public Health England (PHE) derive smoking prevalence estimates from the Annual Population Survey (APS), data presented below is consistent with this source. In 2019, smoking prevalence in adults (18+ years) was estimated to be 10.9%. This means an estimated 41,118 smokers in Berkshire West<sup>6</sup>. Estimated smoking prevalence varies between the three local authorities (table 1).

**Table 1. Smoking prevalence in adults, 18+ (APS), by Local Authority, 2019**

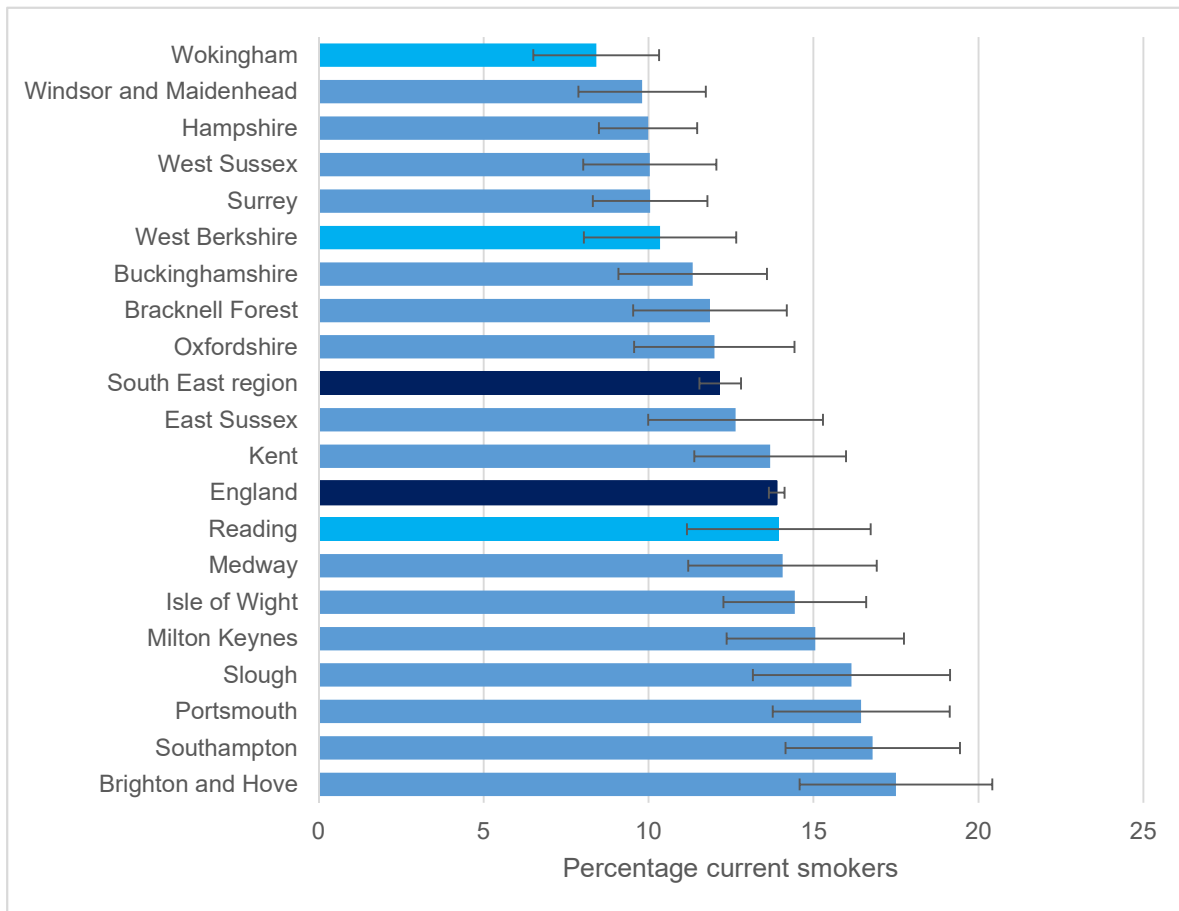
Smoking prevalence in adults, 18+ (APS), 2019, % (estimated count)		
Reading	West Berkshire	Wokingham
13.9% (17,593)	10.3% (12,717)	8.4 (10,808)

Source data: Public Health England (2019) Local Tobacco Control Profiles

There is variation amongst the three local authorities in Berkshire West. Wokingham has one of the lowest smoking prevalence (8.4%) in the country, second only to Richmond upon Thames. Wokingham adult smoking prevalence is statistically significantly lower than the regional and national average, and West Berkshire is lower than the national average. Reading is not statistically significantly different to either national or regional average (13%; 95% CI 10.2 – 15.8) Figure 6.

<sup>6</sup> Based on counts from smoking prevalence in adults (18+) – current smokers (APS). 2019 available at PHE Local Tobacco Control Profiles

**Figure 6. Comparison of smoking prevalence in adults (18+) – Current smokers (APS), 2019 in local authorities in South East**



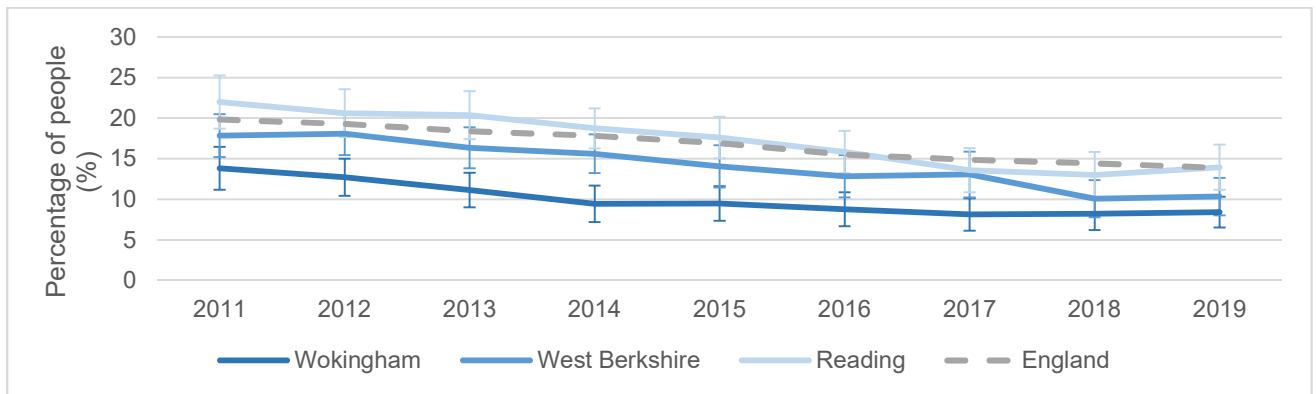
Source data: Annual Population Survey

### **Adult smoking prevalence trends**

The trend both nationally and locally has been a terminal decline in smoking prevalence. However, in Berkshire West there was a small increase in smoking prevalence in adults 18+ between 2018 and 2019 from 10.5% (95% CI 9.1% to 11.9%) to 10.9% (95% CI 9.5% to 12.3%), although this was not statistically significant (figure 7).

In line with national trends, there has been a terminal decline in smoking prevalence across all three local authorities, however between 2018 and 2019 there was a slight increase in prevalence but this is not a statistically significantly increase. There has been a decline of 8% in Reading, compared to 7.5% in West Berkshire, 5.4% in Wokingham and 5.96% in England.

**Figure 7. Smoking prevalence in adults (18+) Trend: 2011 to 2019**



Source: Annual Population Survey (APS), Public Health England

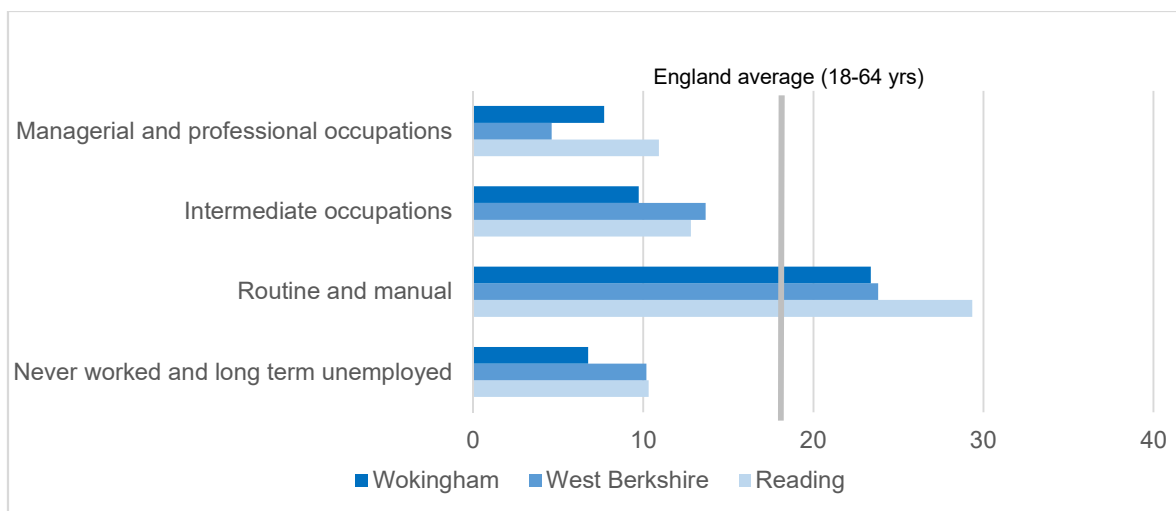
15.9% of men smoked compared with 12.5% of women in the UK. Those aged 25 to 34 years had the highest proportion of current smokers (19.0%) (Office for National Statistics [ONS], 2019).

**Smoking prevalence by socioeconomic group**

**Routine and manual occupation**

Approximately half of all smokers in England work in routine and manual occupations. Smoking prevalence is highest in routine and manual workers<sup>7</sup>. In Reading, in 2019 more than one in four people (29.3%) in routine and manual occupations are a smoker, compared to one in ten in managerial and professional occupations. Smoking prevalence in adults in routine and manual occupations in 2019 was 23.8% in West Berkshire and 23.4% in Wokingham.

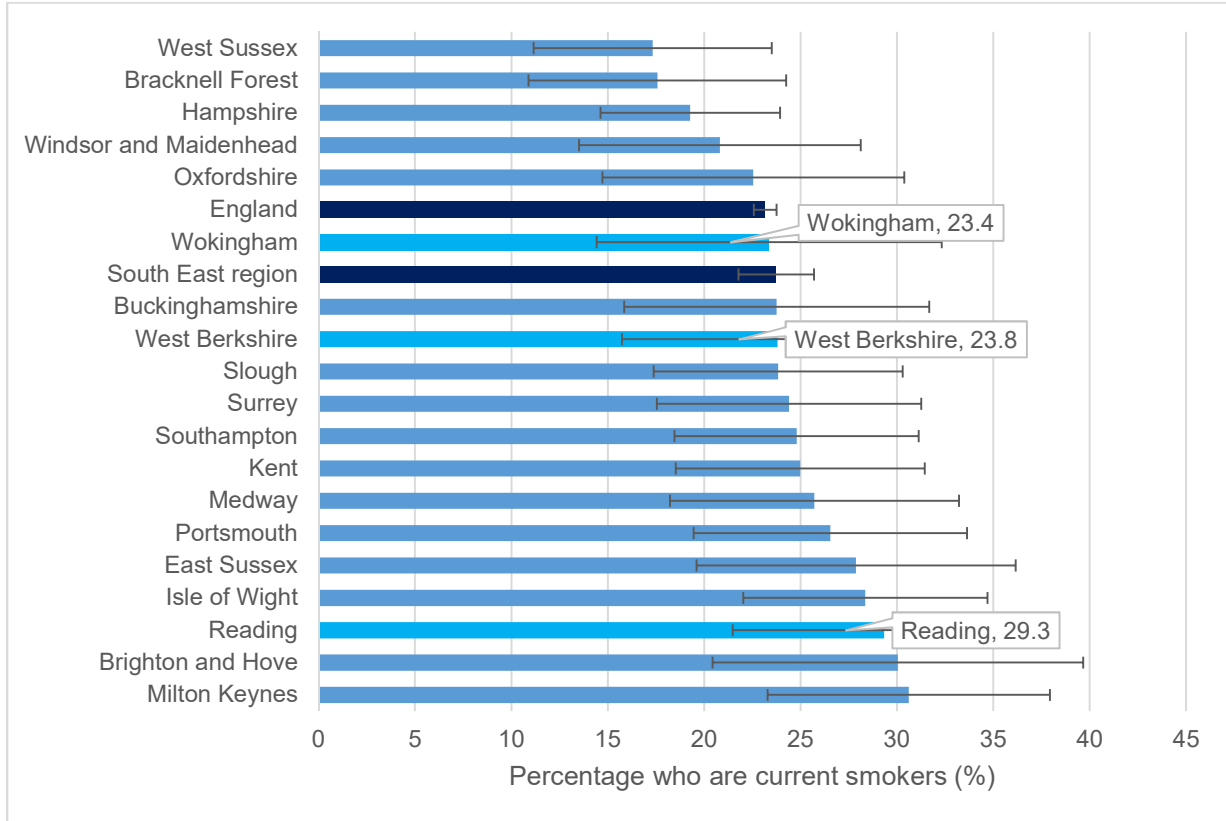
**Figure 8. Smoking prevalence in adults (18+) - current smokers in Berkshire West, by Local Authority, by socioeconomic status, 2019**



<sup>7</sup> For example: labourers, bar staff, lorry drivers, receptionists, care workers

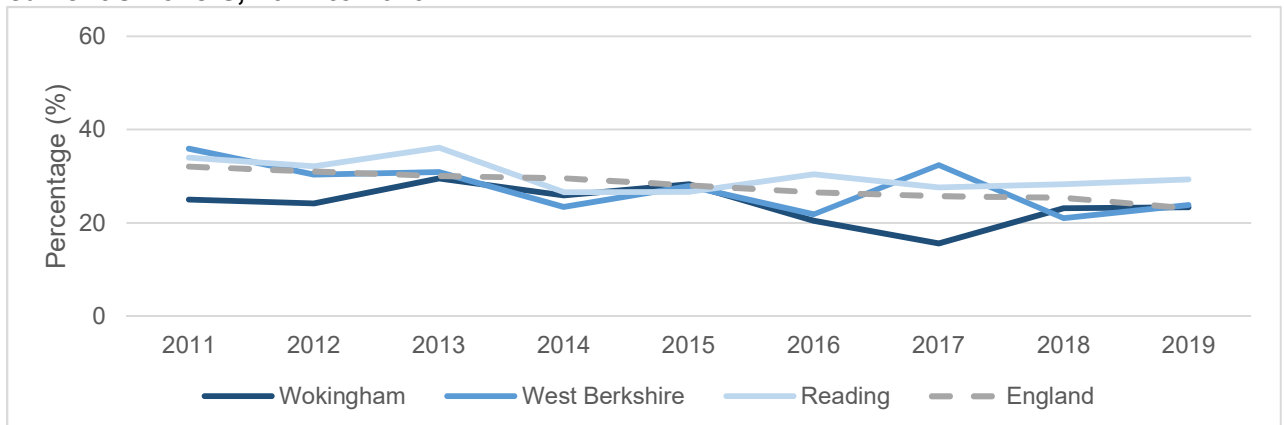
The smoking prevalence in routine and manual workers is higher than the national average in Reading, West Berkshire and Wokingham but this is not statistically significant (Figure 9).

**Figure 9. Smoking prevalence in adults (18-64) in routine and manual occupations - current smokers, %, 2019**



The decline in smoking rates amongst higher-income groups has been greater than amongst lower-income groups. Since 2011 there has been very little change in smoking prevalence amongst those in routine and manual work. Due to smaller numbers, confidence around these estimates is wide so variation year by year is not always statistically significant.

**Figure 10. Smoking prevalence in adults (18-64) in routine and manual occupations - current smokers, 2011 to 2019**

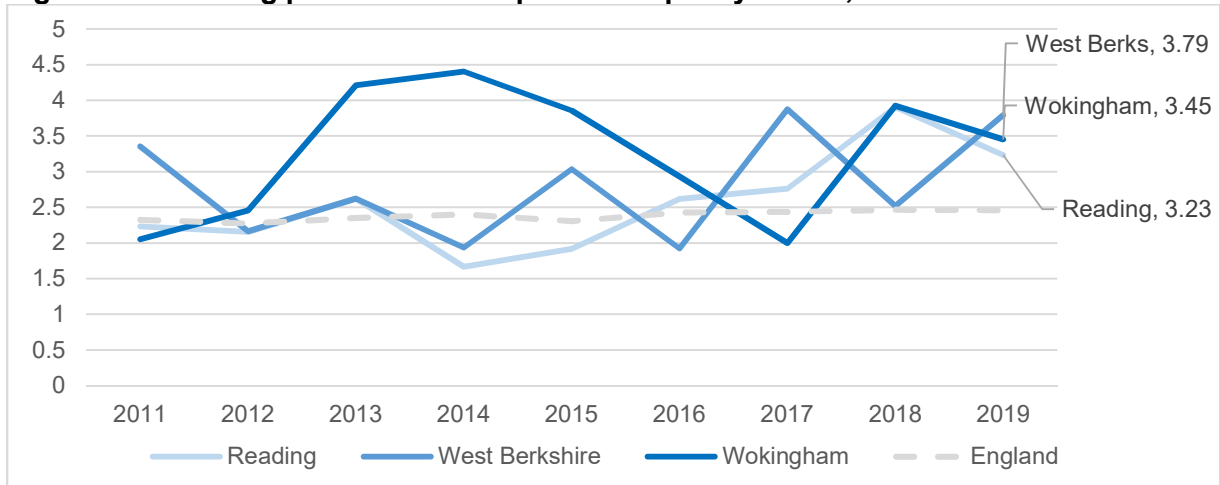


Whilst Wokingham has one of the lowest smoking prevalence in the UK, it is one of the worst local authorities outside of London for inequalities in smoking prevalence. The odds of being



a smoker if a routine and manual worker in Wokingham is three and a half times that of those in other employed groups (Wokingham ratio 3.45; 95% CI 2.03 to 5.87), 2019. This gap is largest in West Berkshire (ratio 3.79, 95% CI: 2.2 to 6.47) The burden of tobacco dependence disproportionately affects the poorest people living in Berkshire West, and the gap between the poorest and richest of our residents appears to be widening in Berkshire West.

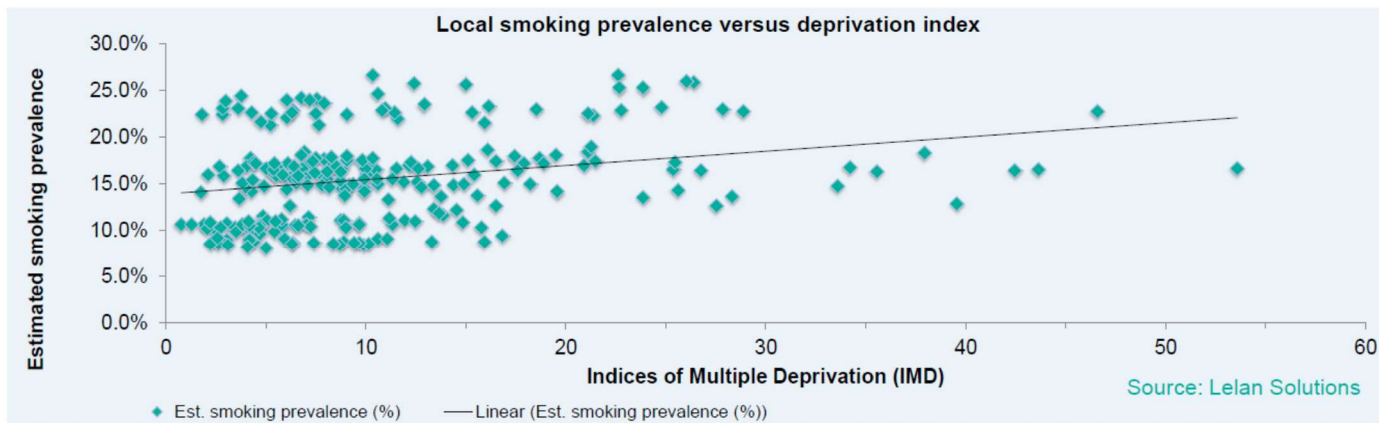
**Figure 11. Smoking prevalence occupation inequality – ratio, 2011 to 2019**



### Socioeconomic deprivation

Smoking rates are much higher within certain groups and deprived communities. The graph below shows the clear relationship between increasing deprivation and increasing smoking prevalence.

**Figure 12. Local smoking prevalence versus deprivation index**



See also:

Smoking: Health Inequalities (Councillor Briefings) <http://ash.org.uk/localtoolkit/docs/cllr-briefings/HealthInequalities.pdf>

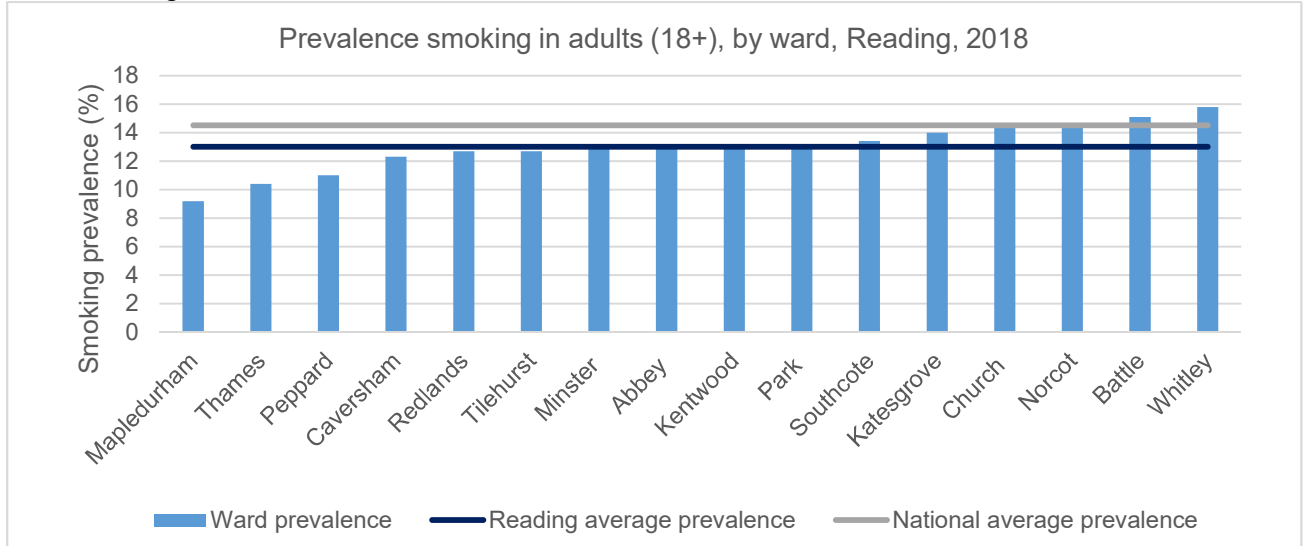
Data for smoking prevalence at sub local authority level is not accessible from the Annual Population Survey. However, ASH modelled estimates for smoking prevalence by ward and Quality Outcomes Framework (QOF) data collated at GP practice level is provided below.

### Wards with high prevalence

ASH modelled estimates for smoking prevalence by ward, which supports the specialist service in targeting areas with high prevalence.

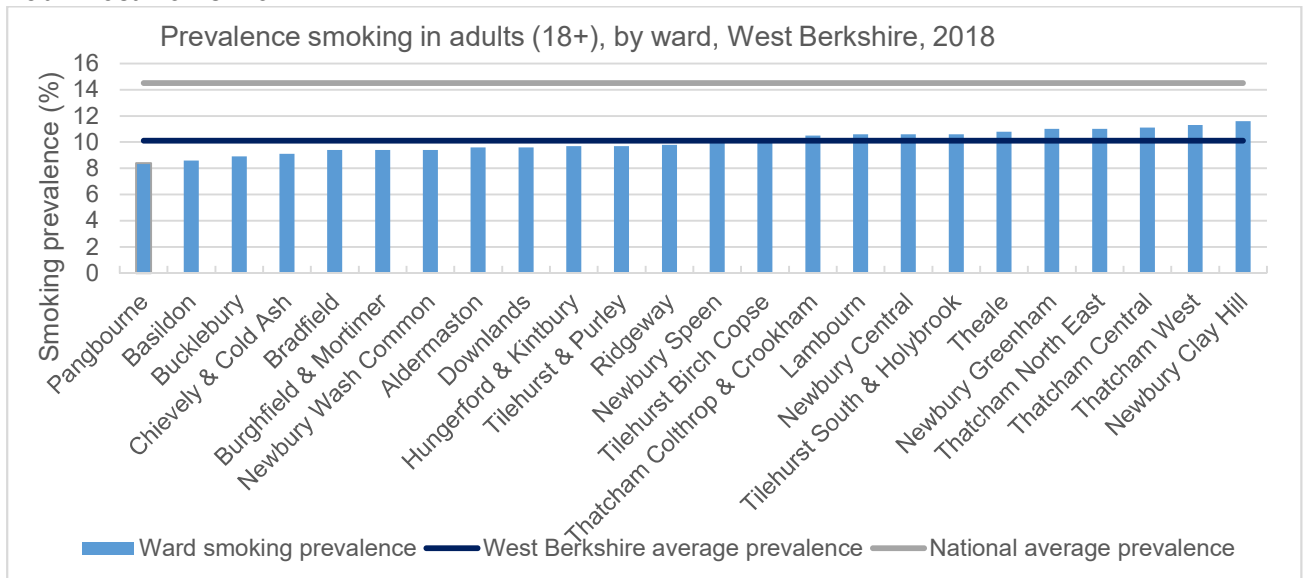
**Figure 13. Prevalence smoking in adults (18+), by ward, each Local Authority in Berkshire West, 2018**

**13a. Reading**



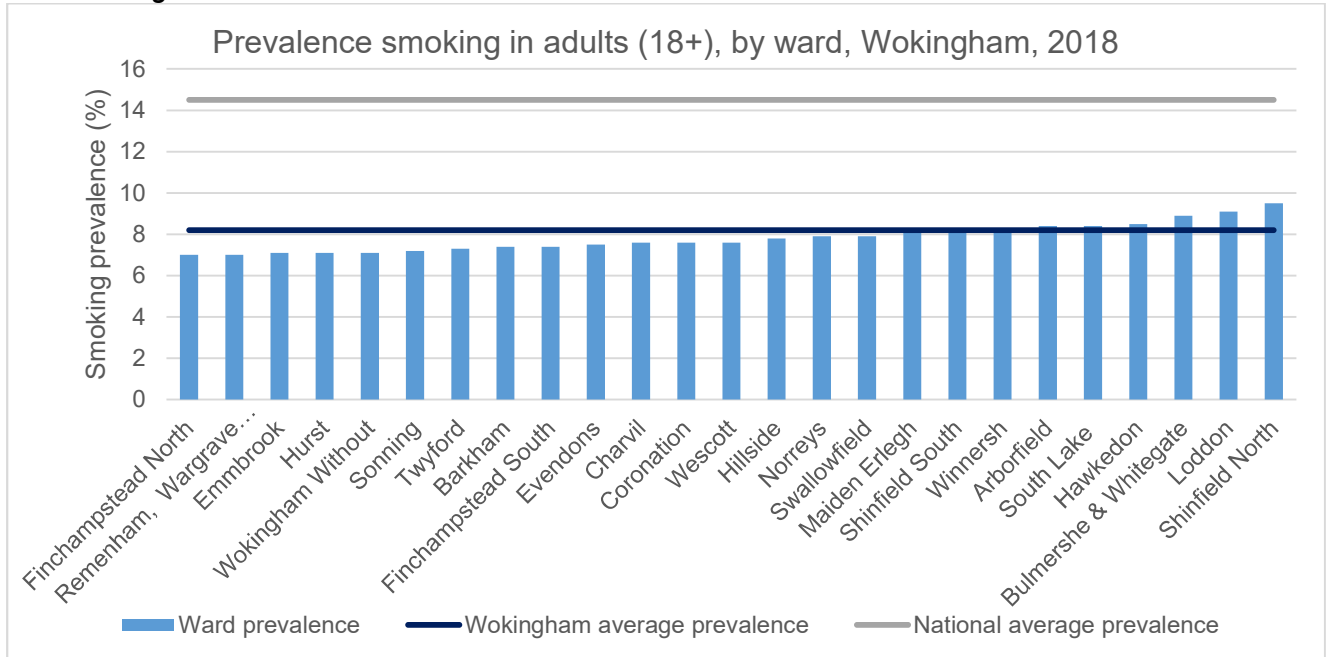
Source: ASH local modelled estimates by ward ASH Ready Reckoner

**13b. West Berkshire**



Source: ASH local modelled estimates by ward ASH Ready Reckoner

### 13c. Wokingham



Source: ASH local modelled estimates by ward ASH Ready Reckoner

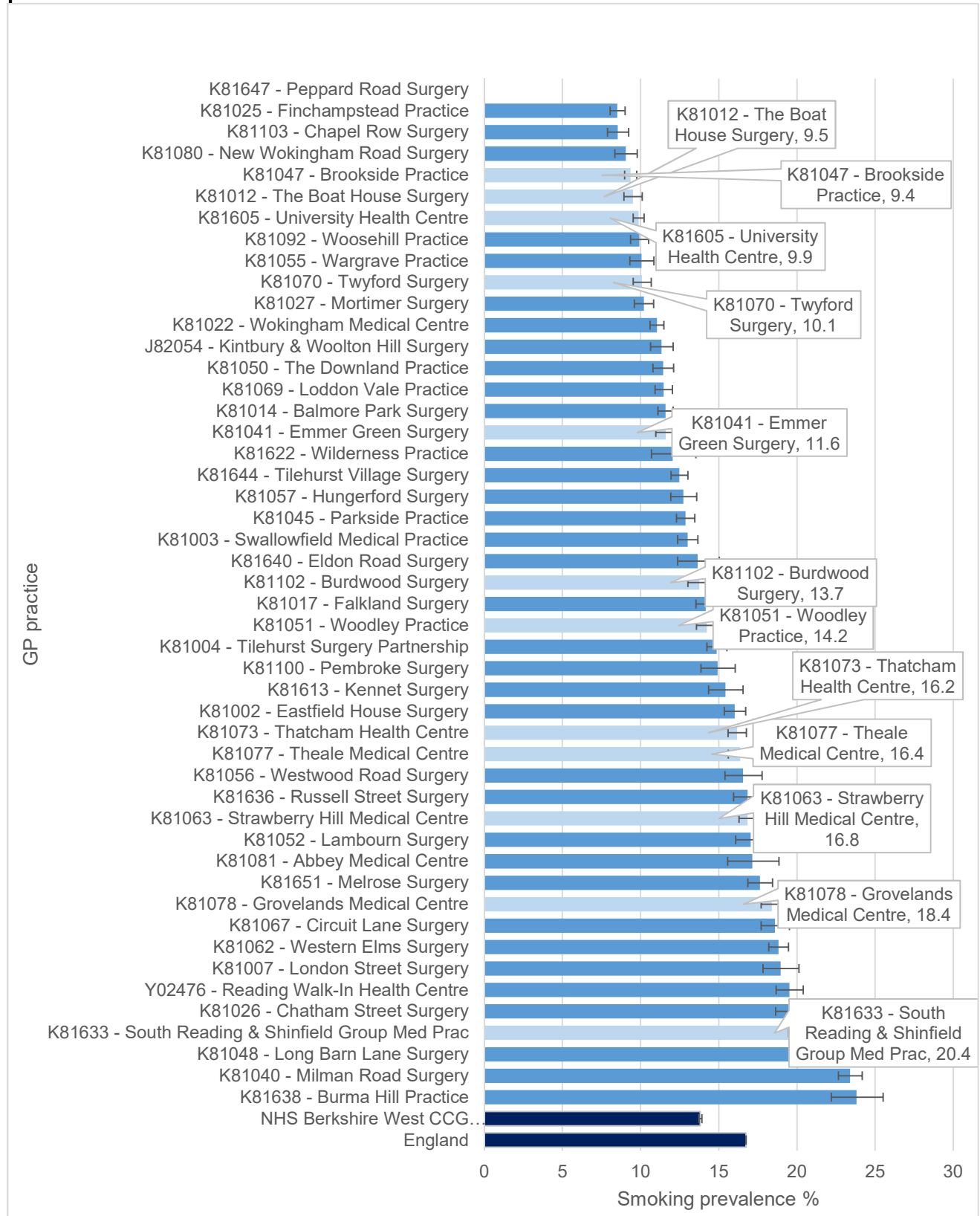
### GP populations with high smoking prevalence

In 2018/19 the prevalence of registered patients recorded as current smokers ranged from 8.5% in Finchampstead Practice (Wokingham) to 23.4% in Milman Road Surgery (Reading). It should be noted this includes patients aged 15+ rather than Annual Population Survey estimates 18+.

There is currently a large geographical variation in referrals from GP's to specialist stop smoking support services. Primary care is a crucial part of the prevention pathway, with smokers attending their GP 35% more than non-smokers. If smokers are offered a referral to stop smoking services by their GP rather than advice alone, they are twice as likely to make a quit attempt.

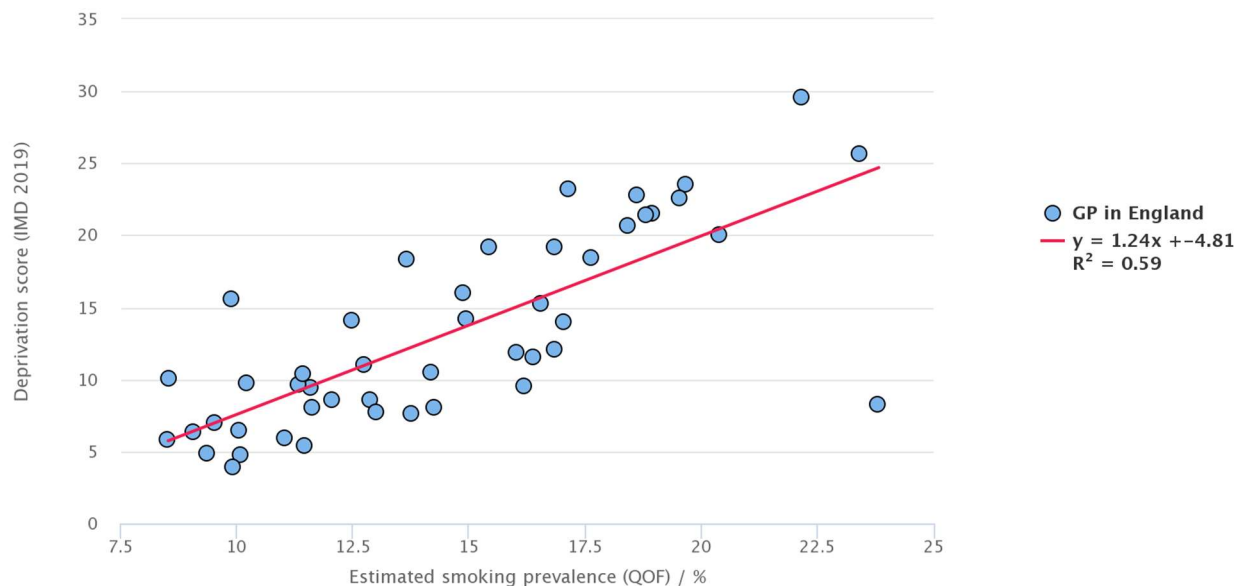
The Quality Outcomes Framework (QOF) data is collected at the practice level. Figure 14 below shows the QOF estimated prevalence (%) of patients aged 15+ years for GPs in the Berkshire West CCG (noting the different age population). 12 local GPs have arrangements to offer the service to their patients 'in-house', these are highlighted on the right of Figure 14. Many others have established relationship with the local community provision and proactively refer patients into services, although there are opportunities strengthen partnership working where there is high prevalence.

**Figure 14. QOF estimated smoking prevalence (%), 15+ years, 2018/19 for GP practices in Berkshire West CCG**



The proportion of patients recorded as smokers correlates well with Integrated Household Survey (IHS) smoking prevalence and is a good estimate of the actual smoking prevalence (Honeyford *et al.* 2014). The graph below also demonstrates the clear relationship between smoking prevalence and deprivation score (Index of Multiple Deprivation score 2019) for that GP practice.

**Figure 15. Berkshire West GP practice, level of deprivation and estimated smoking prevalence (QOF), 2018/19**



Source data: Public Health England Fingertips National General Practice Profiles

### **Smoking in those living in social housing**

Of all the socioeconomic measures, housing tenure appears to be the strongest independent predictor of smoking in England. Nearly one in three (28.6%) people renting from a local authority or housing association, twice as many as in the population as a whole (and compared to 22% of private tenants, 7.6% of those who own their home outright and 10.1% of people who own with a mortgage) (PHE, 2020a).

Across Berkshire West, in Reading, 25.1% of residents who rent from local authority or a housing association are estimated to be current smokers, this is 32.7% in West Berkshire, and 28.1% in Wokingham. A lower prevalence is seen in those who privately rent (19.7% in Reading, 16.9% in West Berkshire, and 20.3% in Wokingham) and even lower in those who own their home outright or with a mortgage reflecting the national picture (PHE, 2020a).

Higher rates of smoking among social housing residents also translates into higher rates of second hand smoke (SHS) exposure. Children living in social housing are more than twice as likely to be exposed to SHS in the home compared to children living in owner occupied housing (26.5% vs 10.3% respectively). However, social tenants are more likely to have tried to quit than those who live in other housing types, but are less likely to succeed (Jackson *et al.*, 2019). This is thought to be due to a lack of social support, higher nicotine dependency and more challenging life circumstances (ASH, 2019b).

Table 2 shows the estimated number and proportion of social housing units that have at least one smoker residing within them. Across Berkshire West this is an estimated 2,983 households that if successfully targeted could reduce inequalities.

Social tenants spend a higher proportion of their disposable income on smoking (12.4%) compared to private renters (8.8%) and homeowners (8.4%). As such social tenants are more likely to be in poverty because of smoking. Financial benefits of supporting social tenants to stop smoking are outlined in ‘Tobacco related costs’.

**Table 2. Estimated social housing units in Berkshire West**

	Reading	West Berkshire	Wokingham
Social housing units managed	4,471	8,986	2,092
Social housing units estimated to be smoking households	991 (22.2%)	1,663 (18.5%)	329 (15.7%)

Source: Data from ASH *Social Housing Calculator* available online <https://ash.org.uk/social-calc/>

### **Smoking prevalence amongst people with mental health conditions**

Smoking is twice as common in people with depression or anxiety and three times as common in those with a serious mental illness (SMI) (Royal College of Physicians [RCP], 2013). It is estimated a third of all cigarettes smoked in England are smoked by people with a mental disorder, highlighting the strong dependency in this group of people (PHE, 2016).

The decline in smoking prevalence has largely been seen in the general population, smoking prevalence in people with mental health conditions has unfortunately changed little in 20 years. People with a mental health condition are just as likely to want to stop, but are more heavily addicted to smoking, more likely to anticipate difficulty stopping smoking and historically less likely to succeed (ASH, 2013).

In Berkshire West the smoking prevalence in adults with a long-term mental health condition is 25.2%, over twice that in the general population (10.9%). In Reading it is 28.9%, compared to 25.1% in West Berkshire, 17.6% in Wokingham, 25.0% regional average and a national average of 26.8% (Public Health England, 2019)<sup>8</sup>.

In 2016/17, the smoking prevalence in adults (18+) with anxiety or depression was 33.9% in Reading, 24.4% in West Berkshire, 21.3% in Wokingham. Reading was statistically significantly higher compared with the regional (24.3%) and national average (25.8%) (PHE, 2019b).

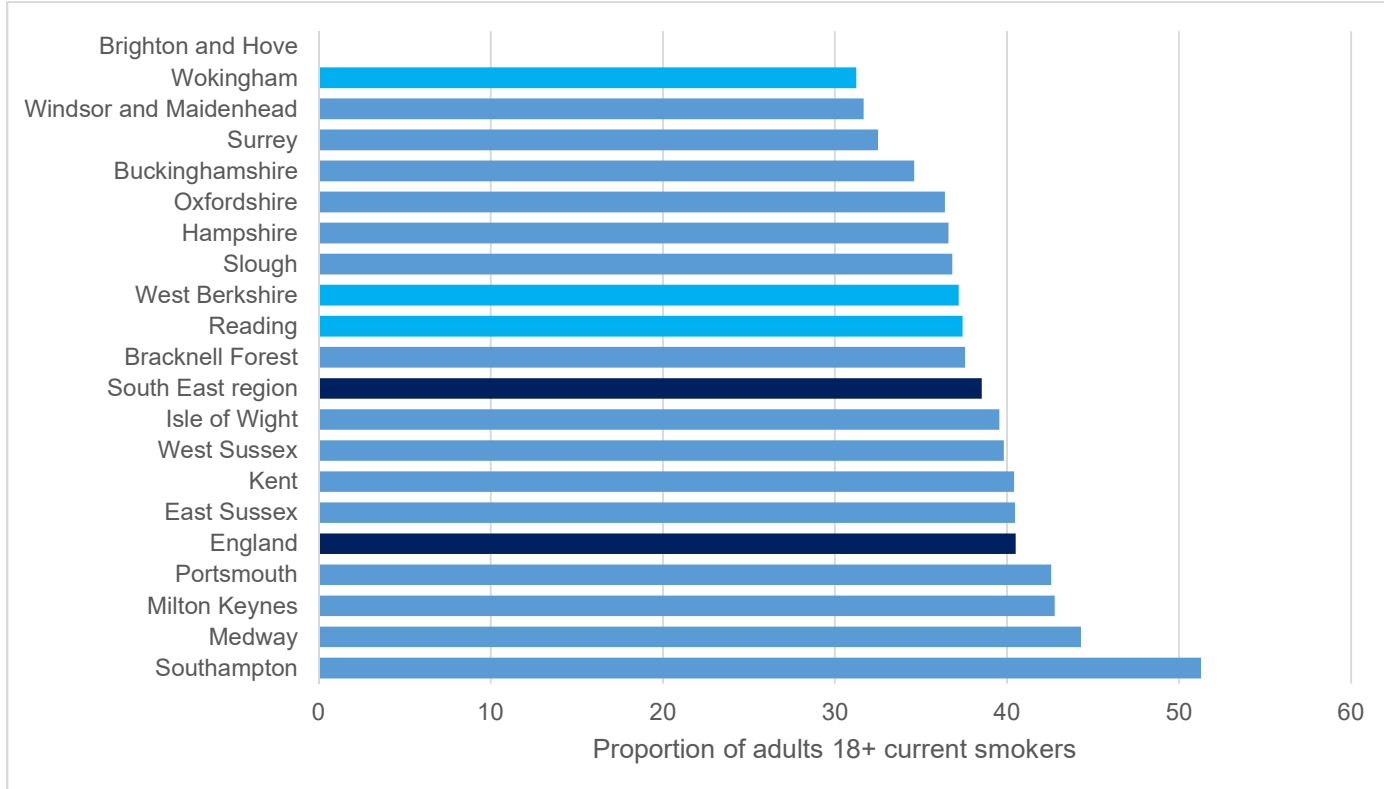
The prevalence of smoking in adults with a diagnosis of serious mental illness (SMI) is even higher. Data from 2014/15 found 37% of those with SMI were current smokers in both Reading and West Berkshire. Wokingham had a statistically significantly lower proportion (31.24%, 95% CI 27.8 to 34.9) than the England average (40.5; 95% CI 40.4 to 40.7). Still, 1 in 3 adults with SMI are smokers and more than half will die prematurely and are more likely to experience poor mental health outcomes (Robson, 2020).

The NHS Long Term Plan ambition for 20/21 was that at least 60% of people on SMI registers should receive a comprehensive physical health check, this includes advice and facilitation of referral for smoking cessation. In 2019/20, 5% in Q1, 6.8% in Q2, 10.9% in Q3 and 0% in Q4, of people on SMI registers received a comprehensive physical health check in NHS Berkshire

<sup>8</sup> Source data: GP patient survey data 2018/19, accessed at PHE Local Tobacco Control Profile

West CCG. This is a significantly lower proportion than the BOB STP partners, South East and national average.

**Figure 16. Smoking prevalence in adults (18+) with serious mental illness (SMI), 2014/15**



Source: Health & Social Care Information Centre. CCG Outcomes Indicator Set

**Smoking in individuals receiving treatment from substance misuse services**

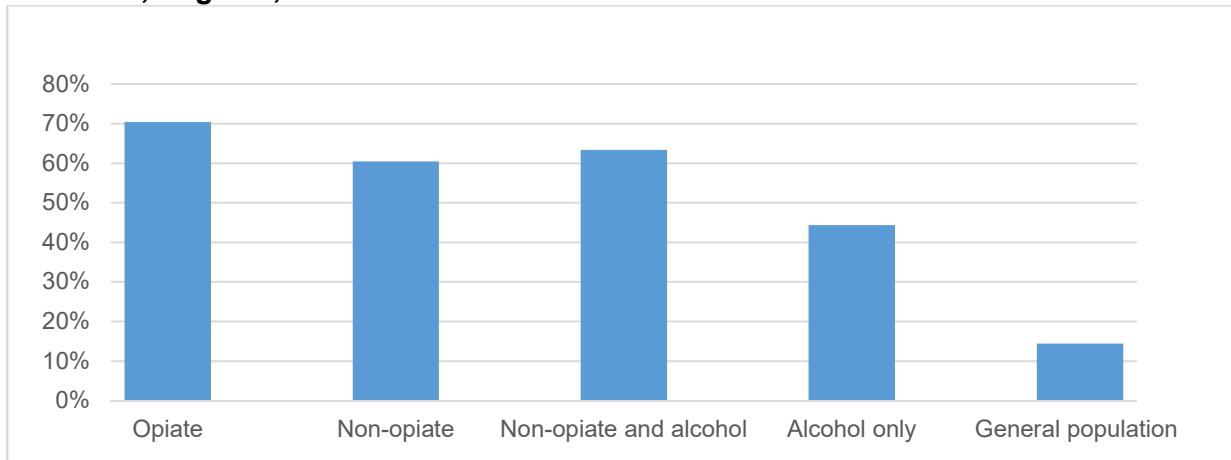
Smoking worsens diseases associated with alcohol misuse, for example liver, lung and coronary heart disease, oral cancers, and increases risk of dementia (Bobo & Husten, 2000). Cigarette smoking increases the likelihood of relapse amongst individuals in recovery from substance misuse disorders (Weinberger *et al.*, 2017). A national audit across addiction services found among drug service users 88% were smokers (Ward, 2020).

The National Drug Treatment Monitoring Service (NDTMS) reports the number and proportion of people using substance misuse services who said they have smoked tobacco in the 28 days before starting treatment. Across all substance groups, males and females reported smoking at similar levels in 2018/19. In all substance groups, the level of smoking was substantially higher than the smoking rate of the general population; 44.4% in those using alcohol only to 70% in those using opiates. This is between 2.5 to almost 5 times respectively than amongst the general population average (14.4%).

People in alcohol and drug treatment appear willing to quit but may not be offered the support to do so (Nahvi *et al.*, 2006). Data from the NDTMS in 2018/19 found that only 3% of people reporting smoking at the start of treatment were recorded as having been offered referrals for smoking cessation services (PHE, 2019c).



**Figure 17. National Drug Treatment Monitoring System – Proportion of people using substance misuse services who have smoked tobacco in the 28 days before starting treatment, England, 2018-19**



Source data: PHE Adult substance misuse treatment statistics 2018 to 2019

<https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2018-to-2019>

Local data from Young People’s Drug and Alcohol Services report a higher prevalence of nicotine dependence than the local attitudinal surveys of the general younger 11-17 year old population.

### **Smoking prevalence in pregnant women**

Smoking when pregnant has detrimental impact on both mother and baby. Complications in pregnancy and birth include placenta praevia, deep vein thrombosis, miscarriages, still birth, prematurity, low birth weight (with consequences for health during the life course) and sudden infant death syndrome (Riaz *et al.*, 2018). Smoking during pregnancy has been estimated to increase the risk of infant mortality by 40% (NHS England, 2014).

Given the substantial evidence that smoking during pregnancy and exposure to second-hand smoke can lead to premature birth and low-birth weight at full-term (Been *et al.*, 2014), monitoring these indicators helps determine whether reduction in smoking prevalence and smoking prevalence during pregnancy are having an effect on related health issues. In 2016-18 the rate of premature birth was 79.2 per 1,000 in Reading, 74.3 per 1,000 in West Berkshire and 73.5 per 1,000 in Wokingham, similar to national average. In 2018, 2.8% babies born at term were low birth weight in Reading, 1.52% in West Berkshire and 1.97% in Wokingham, only West Berkshire and Wokingham having significantly lower proportion than national average.

Smoking is also an important risk factor for still birth (which has declined little over the last 20 years, the UK remains amongst the highest in high income countries). Between 2016 and 2018 there were 63 still births in Berkshire West, rates in all three local authorities were similar to the national average. Smoking is also a major factor in neonatal mortality (deaths in the first 28 days of an infant’s life). Between 2017 and 2019 there were 48 neonatal deaths in Berkshire West, rates in all three local authorities were similar to the national average.

Smoking cessation during pregnancy will reduce infant’s exposure to second-hand smoke. It also provides an opportunity for those cohabiting to stop smoking and is vital to prevent future smokers given it is known that children from a smoking household are 90% more likely to become smokers than those who are not (Laverty *et al.*, 2019).

**Figure 18. Smoking in pregnancy risks**



Source: Public Health England *Health Matters: Stopping Smoking – what works?* Available at <https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works>

Smoking status at the time of delivery (SATOD) was 5.8% (95% CI, 5.2-6.4%) in Berkshire West CCG<sup>9</sup> in 2019/20, equating to 306 women. This compares to a regional average of 9.6% and a national average of 10.4% and meets the national target to reduce SATOD to 6.0% by 2022 as set out by the Tobacco Control Plan for England (DH, 2017).

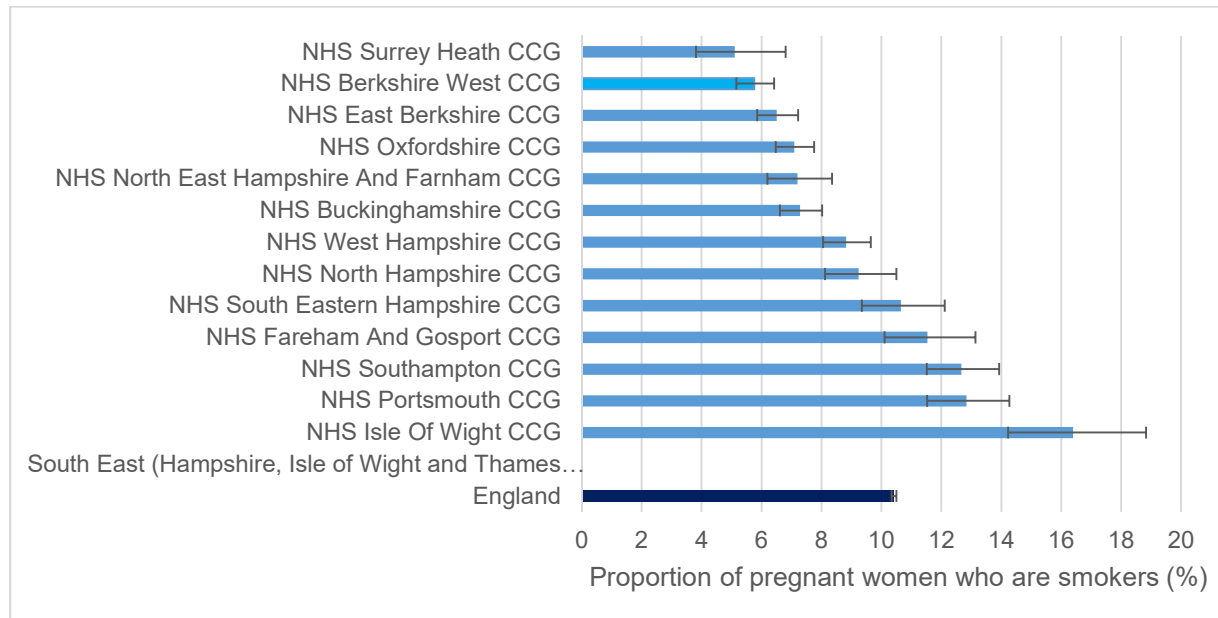
There has been a slow reduction in prevalence of SATOD, with a 0.18 percentage point per annum (ppt pa) in Berkshire West, compared to 0.39 ppt pa in England. If we maintain this decrease per annum we should achieve the 2030 target of below 5% by 2022/23. However, the decline in prevalence has been stagnant in the last couple of years and between 2018/19 and 2019/20 there has been a slight increase (not statistically significant). It is likely that the remaining smokers in pregnancy are complex cases.

Pregnant mothers under the age of 20 are six times as likely to smoke as mothers aged 35 or over (NHS Digital, 2018). Whilst the rate of under 18s conception rate is significantly lower in Wokingham (7.5 per 1,000) and West Berkshire (10.2 per 1,000) compared to the regional (13.5 per 1,000) and national average (16.7 per 1,000), in Reading the rate (20.2 per 1,000) is higher than South East average and similar to England average. Those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke throughout pregnancy (29% and 7% respectively). Nationally, prevalence of smoking in early pregnancy is as high as 24% amongst those living in the most

<sup>9</sup> This is presented for Berkshire West CCG as opposed to local authority as numerator counts for local authorities are estimated from counts for CCGs

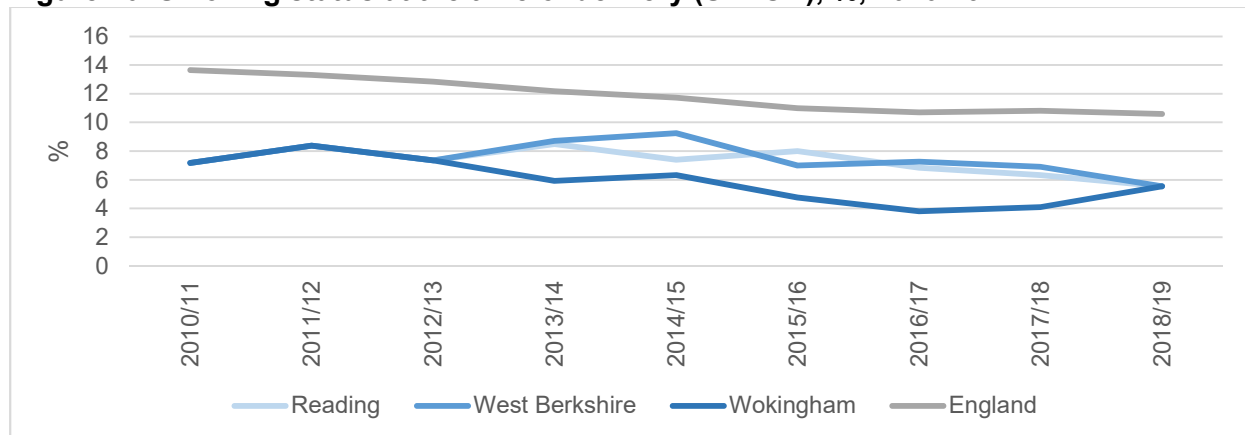
deprived LSOA, and 31.8% in those mothers aged <18 years old. Infants born to mothers who smoke are much more likely to become smokers themselves, further perpetuating health inequalities.

**Figure 19. Smoking status at time of delivery (SATOD), %, 2018/19**



Source data: PHE Local Tobacco Control Profile (PHE, 2019b)

**Figure 20. Smoking status at the time of delivery (SATOD), %, 2010-19**



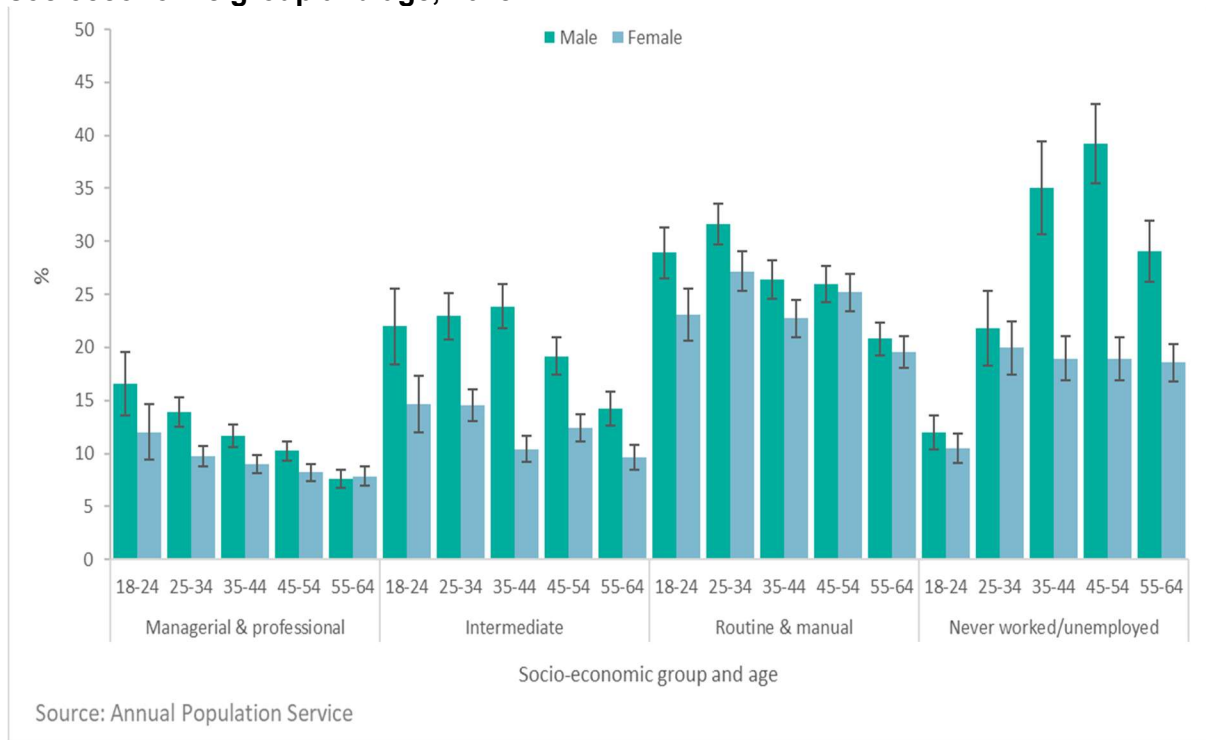
Source data: PHE Local Tobacco Control Profiles (PHE, 2019b)  
SATOD by local authority until 2018/19 reported as count for CCG.

The Maternity Services Dataset captures the number of women currently smoking at the time of their booking appointment as a measure of smoking in early pregnancy. In Berkshire West CCG, 8.8% (95%CI; 8.0% to 9.5%) of pregnant women identified as smoking in 2018/19, lower than the national average. This was highest in West Berkshire where 11.7% (95% CI 10 to 14.3%) women identified as smoking at the time of booking. It is not possible to directly compare rates of smoking at booking to delivery as different data sets are used and different cohorts in each data set. The greater proportion in West Berkshire may reflect a greater number attending the booking appointment or of midwives recording smoking status at booking.

### Smoking prevalence by age

Nationally, smoking rates are lowest in the 65+ age group and highest in 25-34 year age group (7.2% and 19.2% respectively in 2018) (ONS, 2019). Interestingly, when looking at this national data by socio-economic group, this trend is reversed in the 'never worked/unemployed' group with higher prevalence in older age groups (figure 21).

**Figure 21. Smoking prevalence in adults – current smokers (age 18-64), socioeconomic group and age, 2018**



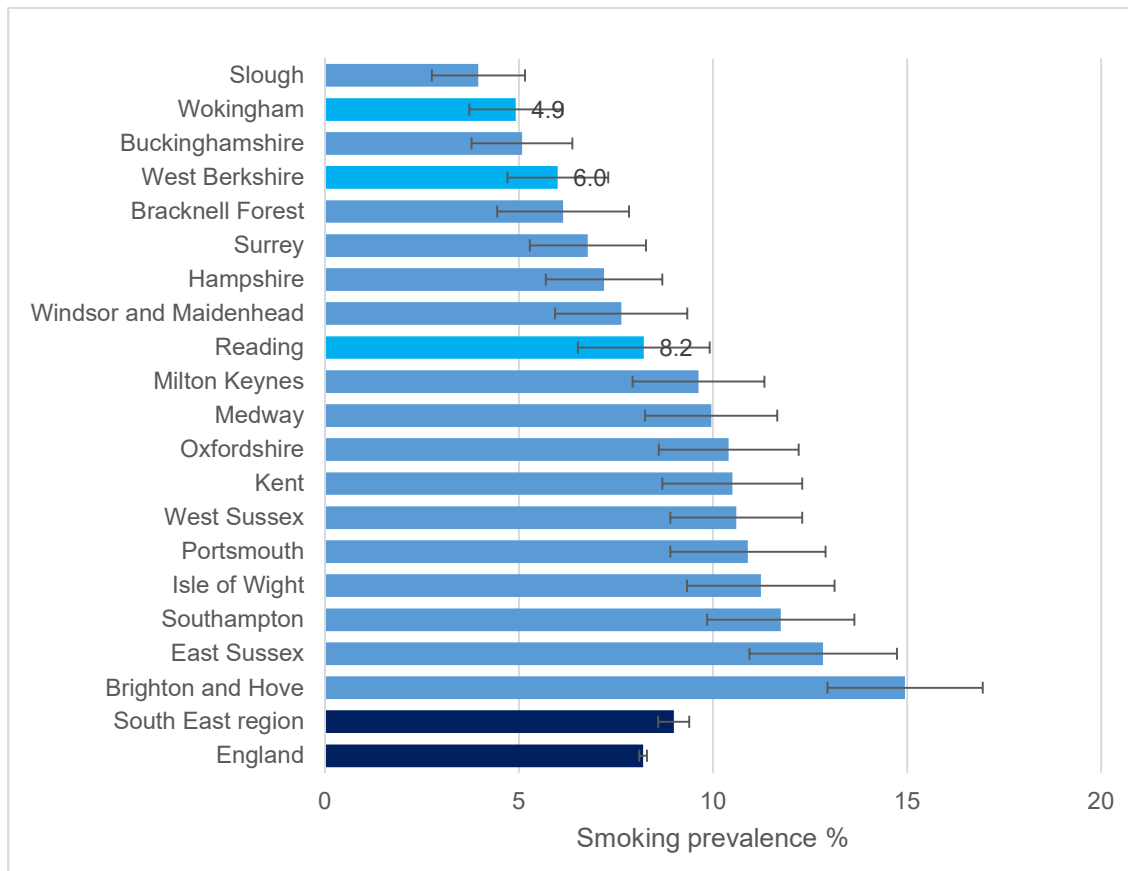
### Children and young people

Higher odds of youth smoking are associated with exposure to parent, carer, sibling and peer smoking, lower socioeconomic status and higher levels of truancy and substance misuse.

The Smoking, Drinking and Drug Use Among Young People in England Survey (SDD), carried out every 2 years (NHS Digital, 2017) found 5% (95% CI, 4-6%) of 11-15 year olds were classified as 'current smokers' in 2018. This has been a general decline since 1996 when 22% of pupils were current smokers. Current smokers are defined as both regular smokers (at least one cigarette per week) and occasional smokers (less than one cigarette per week).

The What About Youth (WAY) survey conducted in 2014/15 allows us to benchmark ourselves amongst other areas in the South East (figure 19). Between 4.9% of Wokingham 15 year olds self-reported as a regular smoker, compared to 8.2% in Reading.

**Figure 22. Smoking prevalence at age 15, current smokers (WAY survey), 2014/15**



The local schools attitudinal survey is conducted each year amongst secondary school-aged children (11-18 years) to look at consumption of cigarettes and alcohol amongst young people, in Reading, West Berkshire and Wokingham. In 2018/19<sup>10</sup>, 5.3% (95% CI 4.3 to 6.3) of all pupils who responded to the survey aged 11-17 were classified as ‘current smokers’<sup>14</sup>. The local attitudinal survey in 2018/19 found 3.1% (95% CI 2.4 to 3.9) of 11-17 year olds were regular smokers, this fell to 2.1% (95% CI 1.4 to 2.7) in 2019/20.

When considering the national target to reduce regular<sup>15</sup> smoking in 15 year olds to less than 3% by 2022, this local survey data suggests this target has been reached in Berkshire West. In 2018/19 1.1% of 15 year olds were regular smokers (95% CI 0.6 to 1.5) and in 2019/20 this fell to 0.9% (95% CI 0.5 to 1.4%). Although this reduction between 2018/19 and 2019/20 was not statistically significant and it should be noted that in 2019/20 there were insufficient numbers of pupils who completed the survey in Reading so this is not representative of all of Berkshire West.

In 2018/19 10 schools participated in the survey (Reading 3, West Berkshire 5, Wokingham 2). In 2019/20 only five schools participated (West Berkshire 2, Wokingham 3). The representativeness of the sample to all pupils aged 11-15 in Berkshire West is not clear and given no Reading schools were represented in 2019/20, comparison of these results with the previous year should be considered flawed.

<sup>10</sup> Schools Attitudinal survey conducted 29 October 2018 to 31 January 2019, 10 schools participated with 1,938 responses.

**Table 3. Results of Schools Attitudinal Survey (Berkshire West)**

All pupils (11-17 years old)	2018//19		2019/20*	
	Usually smoke 'Every day / almost every day'	2.2%	95% CI (1.6 to 2.9)	1.5%
'Current smoker' <sup>11</sup>	5.3%	95% CI (4.3 to 6.3)	3.3%	95% CI (2.4% to 4.1%)
'Regular smoker' <sup>12</sup>	3.1%	95% CI (2.4% to 3.9%)	2.1%	95% CI (1.4% to 2.7%)
Ever smoked in the last month	5.5%	95% CI (4.5 to 6.5)	3.6%	95% CI (2.7 to 4.5)
Smoked in the last 7 days	3.4%	95% CI (2.6 to 4.3)	2.2%	95% CI (1.5 to 2.9)
Aged 15 years	2018//19		2019/20*	
'Current smoker'	1.9%	95% CI (1.3 to 2.5)	1.4%	95% CI (0.8 to 1.9)
'Regular smoker'	1.1%	95% CI (0.6 to 1.5)	0.9%	95% CI (0.5 to 1.4)

\*does not include Reading schools

This Schools Attitudinal Survey found that the majority of young people who smoke did not deem themselves to smoke enough to need to quit. Those that smoked and did want to quit stated they would prefer to seek help from a family member or friend, with just 12.4% preferring to seek support from a local stop smoking service.

### *E-cigarette use*

In 2018/19 local schools attitudinal survey, 4.1% of all pupils (aged 11-17) reported using e-cigarettes or e-shisha. In 2019/20 this fell to 3.7%, but care should be taken when interpreting this for the reasons given above.

60% of those pupils who reported using an e-cigarette or e-shisha also used cigarettes in 2018/19. This was just 33% in 2019/20. This suggests young people who have never smoked tobacco cigarettes are trying e-cigarettes and e-shisha. This is contrary to findings from national research that only young people who smoke tobacco cigarettes are using e-cigarettes and e-shisha.<sup>13</sup>

<sup>11</sup> Current smoker includes responses to 'how often do you usually smoke?' 1) every day/almost every day, 2) about twice a week and 3) about once a week, 4) about once a fortnight, 5) about once a month, 6) only a few times a year <https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2018/part-1-smoking-prevalence-and-consumption>

<sup>12</sup> Regular smoker is defined in SDD survey as those 11-15 year olds who smoke at least 1 cigarette per week. Therefore for local attitudinal survey, this included those who responded to 'how often do you usually smoke?' 1) every day/almost every day, 2) about twice a week and 3) about once a week

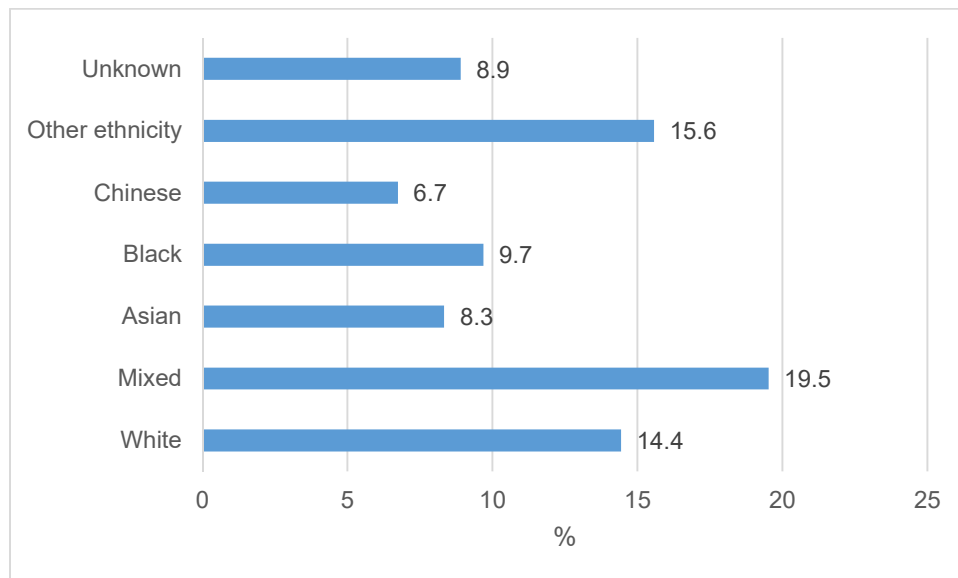
<sup>13</sup> McNeill, A., Brose, L.S., Calder, R., Bauld, L., Robson, D., (2018) *Evidence review of e-cigarettes and heated tobacco products 2018*. A report commissioned by Public Health England Accessed online: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/684963/Evidence\\_review\\_of\\_e-cigarettes\\_and\\_heated\\_tobacco\\_products\\_2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/684963/Evidence_review_of_e-cigarettes_and_heated_tobacco_products_2018.pdf)



### Smoking prevalence by ethnicity

There is no local data available specifically for smoking prevalence by ethnic group for Berkshire West. However, data at a national level in 2019 shows that smoking prevalence is highest in the 'mixed' ethnic group, 19.5%, compared to the lowest in 'Chinese' ethnic group, 6.7%.

**Figure 23. Smoking prevalence in adults (18+) – current smokers (APS), England, by broad ethnic group, 2019**



Source data: PHE *Smoking prevalence in adults (18+) – current smokers (APS)* partition data by ethnic group (PHE, 2019b)

Aspinall & Mitton (2014) found that self-reported cigarette smoking prevalence was highest among the 'White Other' ethnic group, with reported rates as high as 40-50% and as high as 49% in Gypsy/Irish Traveller communities compared to White British participants. 2011 Census data suggests just 0.13% of the Berkshire West population identified their ethnicity as Gypsy/Irish Traveller.

Table 4 outlines the estimated number of adults who are smokers in each broad ethnic group in Berkshire West and by local authority. It should be noted that this is based on Census 2011 figures. In Reading and Wokingham the largest number of smokers are in 'Asian' ethnic minority group, in West Berkshire this is 'Mixed' ethnic minority group.

Reading is the most ethnically diverse of the three local authorities, with the largest Asian population. The Bangladeshi population makes up just 0.4% of Reading population. There has been varying and contradictory estimates of the prevalence of smokeless tobacco use in English South Asian communities. Studies focus on Bangladeshi women and show women are more likely to chew tobacco (McNeill *et al.*, 2010).

Amongst minority ethnic groups in Berkshire West expect the highest number of smokers to belong to 'Asian' or 'Mixed' ethnic group. It should be noted there are significant limitations to this data as it is based on the proportion of the population belonging to broad ethnic groups from ONS Census 2011 data.



National data suggests smoking rates vary significantly according to country of birth, with rates as high as 24.8% amongst those born in Poland, compared with 5.2% amongst those born in India (PHE, 2019d).

**Table 4. Estimated number of adults (18+) smoking in each broad ethnic group, by local authority**

Broad ethnic group	Smoking prevalence in adults (18+), England, 2019 (APS)	Estimated number of adults (18+) smoking			
		Reading	West Berkshire	Wokingham	Total Berkshire West
Asian	8.3	1088	160	521	<b>1768</b>
Black	9.7	680	82	124	<b>887</b>
Chinese	6.7	72	27	49	<b>148</b>
Mixed	19.5	807	289	380	<b>1477</b>
White	14.4	11229	12854	12051	<b>36134</b>
Other	15.6	157	35	109	<b>301</b>
<b>Minority ethnic group total</b>		2804	592	1184	<b>4581</b>
<b>Total (broad ethnic groups)</b>					<b>40,715</b>

Estimated smoking numbers in each ethnic group calculated by applying smoking prevalence by broad ethnic group (APS) to estimated population numbers aged 16-64 by broad ethnic group using ONS Census 2011 count (Source data: Berkshire Observatory)

### ***Individuals with long-term physical health conditions***

Among those who are heavily addicted to tobacco, 44% self-report a long-term illness or disability compared with 32% of never smokers (ONS, 2015). In Reading, 12.9% of the population are classified as having a long-term health problem or disability, compared to 13.2% in West Berkshire, 11.9% in Wokingham, 15.3% South East England and the national average of 17.6% (PHE, 2011). Adults with long-term physical conditions are more likely than their peers to smoke. These differences are evident across both men and women, and across age groups (Emerson, 2018), thus suggesting the need for these individuals to receive targeted support to support them to quit.

People in low-income groups are more likely to suffer one or more long-term conditions. Smoking rates are higher amongst low-income groups further deepening health inequalities that those with long-term conditions face.

The proportion of deaths attributable to smoking are highest amongst those who die from; lung cancer and other malignant neoplasms (cancer), Chronic Obstructive Pulmonary Disease (COPD), Stroke and Ischaemic Heart Disease (Ezzati, undated).

### ***Smoking in Learning Disability***

People living with a diagnosed learning disability have a higher chance of experiencing significant health inequalities when compared to the general population. On average, people

with learning disabilities die 16 years earlier than the general population – 13 years for men and 20 years for women (Heslop *et al.*, 2013).

There were 2,310 patients with learning disabilities, as recorded on practice disease registers in Berkshire West in 2018/19 (PHE, 2019e). The Buckinghamshire Oxfordshire Berkshire (BOB) Integrated Care System (ICS) 5-year plan<sup>14</sup> set out a clear aim for more than 75% of young people aged 14+ and adults with a learning disability to take up an annual health check and to ensure results of these are converted to a Health Action Plan including access to smoking cessation. The proportion of eligible adults with a learning disability having a GP annual health check in 2018/19 was 56.5% in Berkshire West (Reading 49.2%, West Berkshire 60.8%, and Wokingham 63.4%). It is not known how many of these identified the need for access to smoking cessation support. National evidence suggests the smoking prevalence in people with learning disabilities is comparable to the general population (Kerr *et al.*, 2009). Smoking rates have been found to be higher among people with an intellectual disability who do not access specialist intellectual disability services compared to those who do access these specialist services (Emerson, 2011).

### ***Smoking prevalence in people experiencing homelessness***

People experiencing homelessness face greater health inequalities and have higher smoking rates than the general population. Whilst we do not have local data on smoking and homelessness, national data demonstrated in 2014 that 77% of people experiencing homelessness smoked compared to 17% in the general population (Homeless Link, 2014). People experiencing homelessness were more likely to smoke heavily (more than 20 cigarettes a day compared to an average of 11 per day in the general population (ASH, 2019c). In 2017/18 246 per 1,000 households were homeless and in priority need (3.7%) in Reading. This rate was higher than South East (2%) and England (2.4%).

### ***Smoking prevalence by sexual orientation or identity in LGBT***

Lesbian, gay and bisexual people are more likely to smoke than heterosexual people. Smoking prevalence amongst those people identifying as heterosexual in 2017 was 15.9%, but 1.5 times higher at 23% for lesbian, gay and bisexual individuals (ONS, 2018). Lesbian, Gay, Bisexual and Transgender (LGBT) are at higher risk of smoking-related illness (Lunn *et al.*, 2017). Members of the LGBT community are also more likely to experience homelessness (Albert Kennedy Trust [AKT], 2018), experience poor mental ill health and use illegal drugs, all of which increases risk of smoking initiation and dependence (ASH, 2019d).

### **Smoking-related harm**

Smoking is the most important cause of preventable ill health and premature mortality. Smoking is a major risk factor for many diseases; lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease and is associated with a number of cancers (for example oral and oesophageal cancers).

### ***Smoking attributable mortality***

Between 2016 and 2018 there were 1,407 deaths attributable to smoking in Berkshire West. West Berkshire and Wokingham benchmarks statistically significantly lower than expected

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<sup>14</sup> Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care System (ICS) System Plan submission – 27 September 2019 DRAFT Strategic Delivery Plan (System narrative)  
<https://www.bobstp.org.uk/media/1752/ics-ltp-1st-draft-submission-v10-2.pdf>

mortality attributable to smoking compared to national and regional averages. Reading smoking attributable mortality (DSR 253.5 per 100,000; 95% CI 231.5 to 277.1) is similar to South East (DSR 250.2; 95% CI 249.2 to 251.2). There is variance between the three Local Authorities, Reading has a 73% higher rate of smoking attributable mortality than Wokingham (Wokingham DSR 146.5 per 100,000), after taking account of the confounding factor of age.

Around 86% of deaths from COPD are caused by smoking and hence preventable (PHE, 2020). The mortality rate from COPD (2017-19) was 46.4 per 100,000 in Reading, 39.7 per 100,000 in West Berkshire and 30 per 100,000 in Wokingham (PHE, 2020b). In the same period, the rate of deaths from lung cancer was 51.3 per 100,000 individuals in Reading, compared to 35.4 in West Berkshire, 35.2 in Wokingham 45.0 average in South East England and national average of 53.0 (PHE, 2020c).

The potential years of life lost (PYLL) due to smoking related illness provides a measure of the potential impact that smoking has in reducing people's lifespan. This rate was highest in Reading meaning a greater burden of premature mortality than in either West Berkshire or Wokingham (PYLL is 1,371 per 100,000 in Reading, 989 per 100,000 in West Berkshire, 619 per 100,000 in Wokingham, 1,078 per 100,000 South East England average and 1,313 per 100,000 as the national average) (PHE, 2020d). We know that smoking accounts for approximately half the difference in life expectancy between the richest and poorest groups in society (Marmot, 2010).

### ***Smoking related ill health***

In 2018/19 in Berkshire West, it is estimated there were a total count of 2,562 smoking attributable hospital admissions. The rate of hospital admissions attributable to smoking is significantly lower than the national average in all three local authorities.

There is variance between the three Local Authorities in the area, with the rate of smoking attributable hospital admissions being 72% higher in Reading than Wokingham (after controlling for the confounding effects of age). There were 1,221 per 100,000 population smoking attributable hospital admissions in Reading in 2018/19, compared to 912 for West Berkshire, 710 for Wokingham and 1,156 regionally and 1,612 nationally (Public Health England, 2019b).

The rate of emergency hospital admissions for COPD (chronic obstructive pulmonary disease, for which smoking is the biggest preventable risk factor) is significantly higher in Reading (475 per 100,000; 95% CI 423 to 531) compared to the national average (414 per 100,000; 95% CI 412 to 417). Whilst West Berkshire and Wokingham had significantly lower rates compared to the national average (263 per 100,000 and 213 per 100,000 respectively). This means the rate of emergency hospital admissions for COPD in Reading is 2.23 times that in Wokingham (after controlling for the confounding effects of age).

Oral cancer and oesophageal cancer registrations were similar to national averages across all three local authorities in Berkshire West (except oral cancer registrations in Wokingham which were lower than the national average).

### ***E-cigarette use***

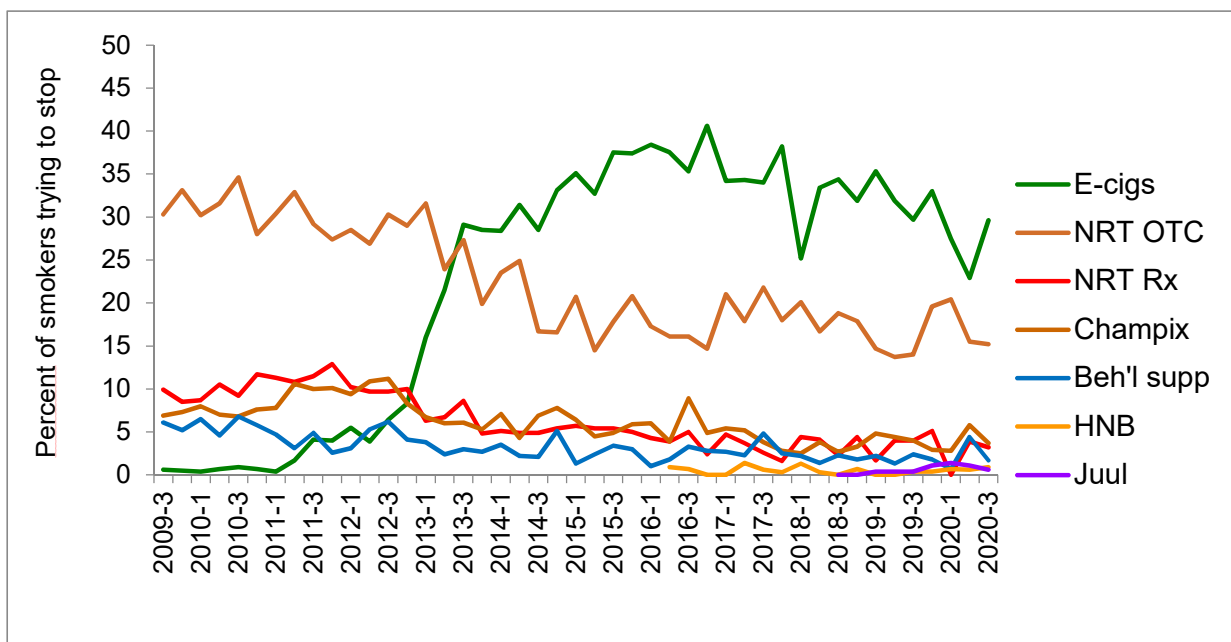
It is estimated over 3.2 million (6.2%) adults in UK use e-cigarettes. Of these, 52% are ex-smokers, 44% are smokers and 4% are people who report never being smokers. E-cigarettes have become the most popular stop smoking aid and there is growing evidence that they can be effective in helping smokers to quit, particularly when combined with behavioural support

from local stop smoking services (PHE, 2015). Currently there are no MHRA medicinally licensed e-cigarettes available on UK market so they cannot be prescribed by local stop smoking services. However, current stop smoking services in Berkshire West are supportive of smokers who want to use e-cigarettes in their quit attempt and provide behaviour support alongside if they decide to use e-cigarettes.

Beard *et al.* (2016) found that whilst no change in overall self-reported quit attempts, with around 30-40% of smokers continuing to report a quit attempt, increased use of e-cigarettes was associated with a decline in use of prescribed nicotine replacement therapy (NRT). Authors found that for each percentage point increase in e-cigarette use during a quit attempt, the success rate increased by 0.06%. It seems plausible that smokers are turning to e-cigarettes to help them quit conventional cigarettes without receiving formal cessation support. The English Smoking Toolkit Study (West *et al.* 2020) suggests smokers from disadvantaged social groups are just as likely to use e-cigarettes in quit attempts as those from more privileged social groups. However, there is a lack of academic literature to evaluate the impact on socioeconomic inequalities in cessation and smoking prevalence (Smith *et al.*, 2018).

The Smoking Toolkit Study (West *et al.*, 2020) found that the use of e-cigarettes in the adult population has remained relatively stable since 2013, however their use by long-term ex-smokers has grown and use in smokers and recent ex-smokers has increased and more recently plateaued.

**Figure 24. Aids used in most recent quit attempt**



Source: West *et al.*, (2020)

### Impacts of Covid-19 on smoking

Smoking status from a YouGov poll collected weekly from April 2020 found that for all age groups, the majority of adults (18+) are smoking about the same. Although lockdown appeared to have had more impact on the 18-34 age group which was split between those who appear to be more likely than other groups to be smoking more, but also slightly more likely to be smoking less (PHE, 2020e).

All those aged 18+ reported they were less likely to experience second-hand smoke during lockdown, although for the majority it has made no difference. This may be a different picture for those children and young people who are living with smokers, particularly if smoking habits increased in many.

The YouGov survey also suggested that adults 18+ appear more likely to quit now than before (particularly for the 18-34 age group), although for the majority lockdown made no difference. This was the same for responses to likelihood to stay quit.

Whilst 26% of smokers reported smoking more during lockdown, this was higher in those with mental health conditions, with 40% reported smoking more. A greater proportion of smokers with mental health conditions reported being less likely to quit as a result of Covid-19 (20% vs. 13% in general smokers). However, smokers with mental health conditions reported being more likely to successfully quit during Covid-19 and also more likely to use an e-cigarette.

We are expecting to enter into an economic recession due to Covid-19. Evidence on the relationship between the recession and smoking is mixed (Catalano *et al.*, 2011; Margerison-Zilko *et al.*, 2016), but there are studies showing that individuals experiencing economic strain due to the Recession in 2008 were more likely to smoke, and that there was a stronger relationship between smoking and job loss among those with less education.

## **Adult smoking cessation and quit rates**

### ***Berkshire West Local Stop Smoking Service provision***

\*Currently, local Stop Smoking Services in Berkshire West are commissioned separately by Reading Borough Council, West Berkshire District Council and Wokingham Borough Council. The current provider for all is Solutions4HealthLtd, trading as Smokefreelife Berkshire. The current contracts are managed on behalf of each Local Authority by the Shared Public Health Team at Bracknell Forest Council. These have been in place since 1<sup>st</sup> April 2016 and the end of the contract has been extended six-months to 30<sup>th</sup> September 2021.

Specialist smoking cessation advisors provide a 12-week treatment plan to smokers who live, or work in, Reading, Wokingham and West Berkshire. This combines specialist and intensive behavioural support with pharmacotherapy.

If a referral is made from a health professional or if an individual self-refers via telephone, text, Smokefreelife Berkshire website or social media, then an assessment of readiness to quit and confidence to change is completed with the client via telephone. Drop-in and mobile clinics are available too, so clients can also be triaged face-to-face.

Behavioural support is provided predominantly via one-to-one face-to-face sessions, and support is also available via Quitline, text or face-to-face video chat. There are very limited home visits offered to pregnant women, or those with mobility issues. Group sessions use to be offered but have ceased over the course of the contract. Group sessions were previously run through targeted workplaces.

In addition, at least 8 weeks of Nicotine Replacement Therapy (NRT) and other pharmacotherapies in accordance with NICE guidelines (NICE, 2018) –Varenicline (Champix) and Bupropion (Zyban) – are offered.

\*Support is offered in a variety of settings including GP's and pharmacies. Solutions4Health Ltd have subcontracts with several local GP's and pharmacies. The majority of GP's have clinics specifically run by a Solutions4Health Ltd smoking cessation specialist advisors.



Clinics at pharmacies are generally run by trained pharmacists. Drop-in and/or mobile clinics are also offered in local community settings including libraries, supermarkets, shopping centres and other venues using the mobile van. A selection of clinics operate as appointment only. Although not offered currently, in the past the service has also been offered with the local acute, maternity and mental health settings.

In Reading, there are 4 GP's with clinics and appointments available for registered patients, 4 pharmacies also have appointments (details for a further three are not provided), drop-in clinics are available on different days at Reading Council and two supermarkets (using the mobile van in car parks).

In West Berkshire, there are 2 GP's with appointments available for registered patients only and a further 3 with appointments available to all. At the time of publication, one pharmacy was available for appointments only and drop-in clinics are available at one supermarket and at Newbury market using the mobile van. A further clinic is offered on one morning a week to students at Newbury College.

In Wokingham, there are 4 GP's with appointments available (one of which is only for clients registered at the practice). There are 4 pharmacies providing appointments via the pharmacy. There are also drop-in clinics available at two supermarkets, the Wokingham market and Woodley Library.

Opening times of the clinics vary, with most clinics available one day a week. The majority of operating hours are between 09:00 – 17:00 with a few places extended until 18:30.

A telephone quit line is also available with specialist advisors available 08:00 – 20:00 seven days a week. Since Covid-19, Solutions4Health Ltd have also offered a phone App, 'Quit with Bella' which provides support to stop smoking and a live chat function 24/7.

Smokefreelife Berkshire offers some smoking cessation training to external partners. This is online NCSCT Very Brief Advice (VBA) training.

*\*Since Covid-19, national guidance recommends that all face-to-face clinics cease and now support is provided by telephone or videoconferencing. More information on clinic locations priori to COVID-19 are available online at <https://www.smokefreelifeberkshire.com/how-to-quit/>*

## **Smoking Cessation in Secondary Care**

### **Mental health trust**

Berkshire Healthcare NHS Foundation Trust has been a smoke free organisation since 2015. Prior to January 2020, people who smoke who were admitted to in-patient services at Prospect Park Hospital (Reading) were offered nicotine replacement therapy (NRT) during their admission. In January 2020, patients identified as smokers by screening on admission to Prospect Park Hospital were advised about Smoke Free Policy and nicotine withdrawal management discussed. Patients are offered NRT and if they decline, they are given the option of trying an eburn e-cigarette free of charge for the duration of their stay. They are given information on e-cigarettes and the benefits of switching/ stopping tobacco smoking. Subsequent eburn are sold at the vending machine on site.

There is ongoing smoking cessation, very brief advice essential training for all inpatient staff to develop confidence of staff in supporting smoking cessation. All clinical development leads are expected to complete the NCSCT training and training is offered to Band 4 staff to become

smoking cessation champions. The Trust is currently in discussion with local smoking cessation services to support in-house smoking cessation support groups. A dedicated specialist smoking cessation advisor previously covered Prospect Park Hospital but has not been in post since cuts were made to the smoking cessation budget.

### **Maternity services**

Historically, a Solutions4Health Ltd dedicated specialist smoking cessation advisor would attend the maternity wards at Royal Berkshire Hospital to receive referrals, calibrate carbon monoxide (CO) monitors and provide a physical presence and reminder to staff of the stop smoking service. Over the course of the contract these arrangements have ceased for a number of reasons.

Smoking remains a priority in maternity services as a key agenda in the Saving Babies Lives Care Bundle. Compliance with carbon monoxide (CO) screening is reportedly improving as sufficient CO monitors are supplied to community teams, work is underway to improve training in use of these to support troubleshooting common equipment faults.

At present, midwives identify pregnant women who smoke, by asking and testing carbon monoxide levels of all women (noting feedback from the SiP CLear assessment). Brief advice is used, and referrals made to Solutions for Health (S4H), the current provider. S4H attempt to contact all women referred to them. Women are supported with psychosocial support and nicotine replacement therapy (NRT). Home visits now have strict eligibility criteria, pregnant women are a priority but offered 1:1 session in the first instance.

### **Secondary care trust**

The NHS Smokefree Survey includes all trusts and took place between October 2019 and March 2020. The Royal Berkshire NHS Foundation Trust scored 3 out of 7. This identified challenges with recording smoking status in electronic patient records (introduced for 'Risky behaviour CQUIN') with reports that are not populated in the correct fields and rather as free text in clinical notes. The British Thoracic Society audit (2019) found just over half of patients were screened for smoking. Very brief advice training has been given to all ward-based staff. The respiratory outpatient clinics are currently investigating development of EPR to include recording of smoking status and cessation advice. Pharmacotherapy, whilst available through electronic prescribing has low uptake (just 315 patients prescribed in 2019, nicotine patches only available).

There is a direct e-referral system to Smokefreelife Berkshire, 177 referrals were made using this system between 1<sup>st</sup> April 2019 and 5<sup>th</sup> December 2020. There is currently no permanent in-reach or bedside support being provided. Historically local Trusts were supported by the local community commissioned service and a smoking cessation advisor was available to support outpatients, ward rounds and occupational health in the Trust.

Reduction in service capacity due to budget cuts had a direct impact on changes. In addition to this, one of the challenges of providing local commissioned support within large secondary care trust settings has to do with eligibility as to access local stop smoking service provision, the patients must be a local Reading, West Berkshire or Wokingham residents.



## Stop Smoking Activity

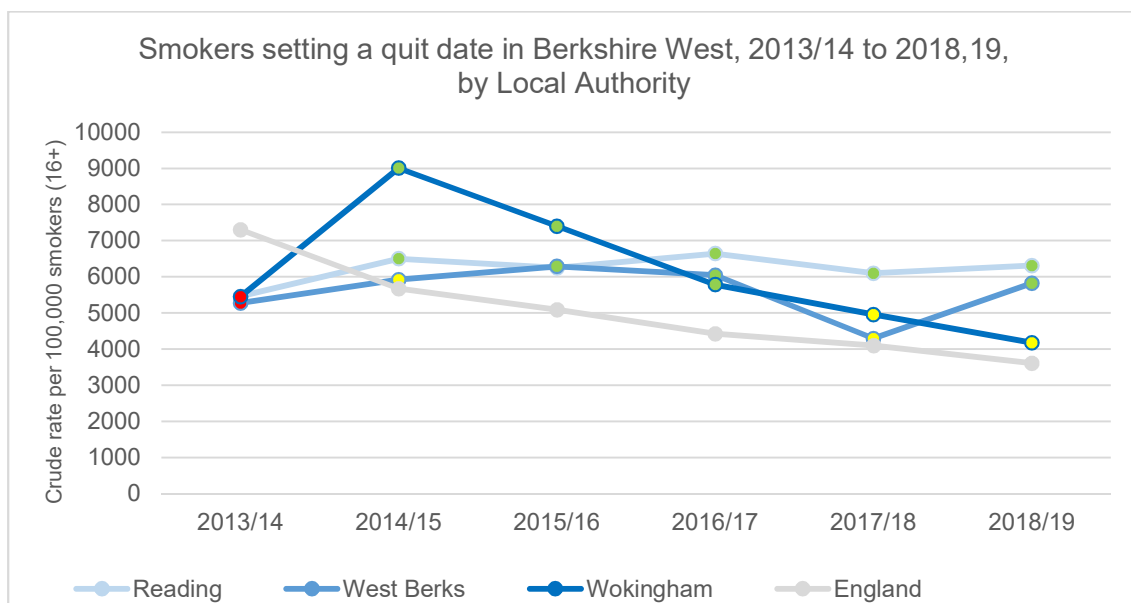
In England, over the last 10 years, between 30 to 40% of smokers have attempted to stop smoking in the past year, every year. The success rate for those who tried has been anything between 13.4 to 19.1% (ASH, 2019e). August 2020 saw an increase in the number of attempts with 35.4% attempting to quit smoking, and record success rates for those who tried of 23.2%.

Of these successful quitters, 2% quit through stop smoking services, 8% get some professional advice and use medication, 14% use over the counter nicotine replacement therapy 35% succeed on their own without any help, and 41% use an e-cigarette. This reflects just the volume of people who try these approaches, not the effectiveness of these methods. Specialist stop smoking services are easily the most effective approach to quitting smoking. Stop smoking services are an essential service for the disadvantaged and highly addicted smokers and are also highly cost effective. However, 98% of smokers do not use them and we should consider the needs of this smoking population too.

### Numbers setting a quit date and rates for successful quitters

Nationally, the number of people accessing local stop smoking services and setting a quit date has gradually been decreasing (figure 25). In Berkshire West, there has been a similar trend in Wokingham and West Berkshire between 2014/15 and 2018/19. NICE (2018) CG92 recommends that stop smoking services should be attempting to treat at least 5% of the estimated local population who smoke each year. In 2018/19, 2,262 people set a quit date in Berkshire West with stop smoking services, approximately 5.7% of the smoking population<sup>15</sup> (Reading 6.5%, West Berkshire 6% and Wokingham 4.3%). Generally, Berkshire West performs well in terms of number of smokers setting a quit date compared to the England figures, however this was before the reduction in funding in 2018/19 (see Local Stop Smoking Service Activity Data for most recent 2019/20 data).

**Figure 25. Smokers setting a quit date per 100,000 smokers (16+), 2013/14 to 2018/19**



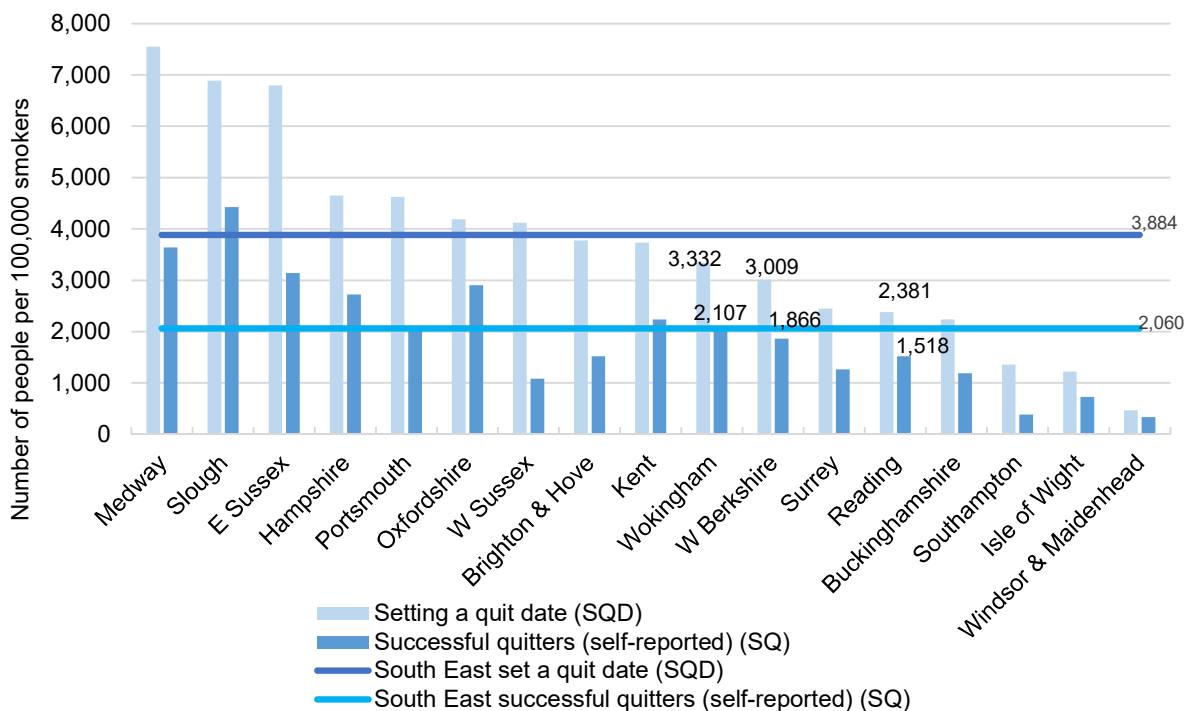
<sup>15</sup> Based on a proportion of number of smokers in 2018 across Berkshire West, 39,371

Data is available from NHS Digital for the rate of self-reported successful quitters at 4 weeks<sup>16</sup>. In Berkshire West quit rates at four-weeks have been significantly higher than the national and regional average over the last 5 years.

Across Berkshire West in 2018/19 there were 1,525 self-reported 4-week quitters (Reading 696, West Berkshire 503, Wokingham 326). This represents 67% of those who set a quit date (SAQD) with the stop smoking services in the same year. In comparison, in England, only 52% of those who SAQD self-report successfully quit. Furthermore, this represents 3.9% of the local population who smoke having successfully quit at 4 weeks (self-reported), which is higher than the national figures (2%).

During 2019/20, the rates of people setting a quit date and successfully quitting per 100,000 (figure 26) smokers has fallen below the South East average across Berkshire West. This is likely to be due to the fact that the local provision has had to reduce service capacity to be in line with local financial envelopes.

**Figure 26. People setting a quit date and successfully quitting (self-reported) per 100,000 smokers attending stop smoking services in the South East, 2019/20**

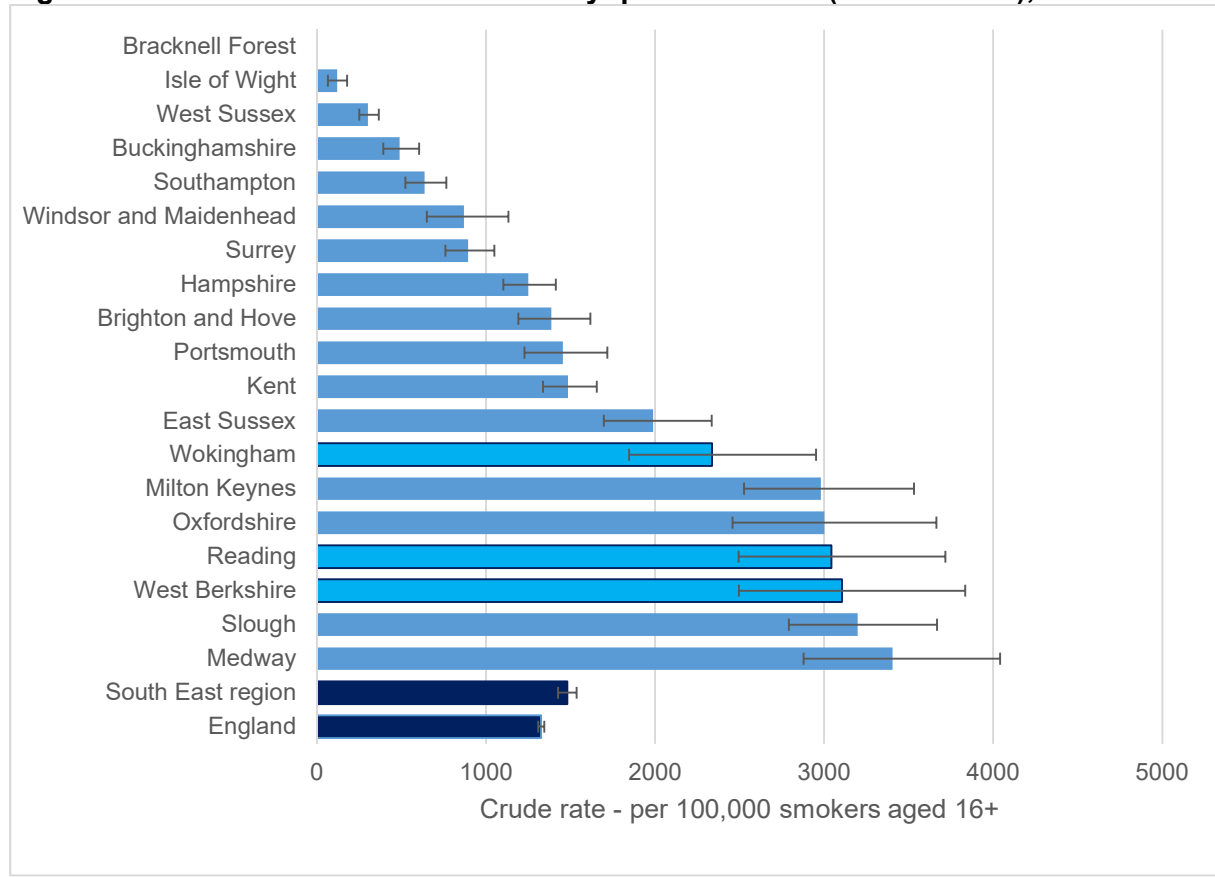


Source: NHS Digital Statistics Stop Smoking Services, 2019/20

In 2018/19 there were 1,164 CO validated 4-week quitters in Berkshire West. This is 51.5% of those who SAQD (Reading 48%, West Berks 53.4% and Wokingham 56% - figure 27)). This exceeds the target from NICE guidance NG92 of at least 35% successful quit rate at 4 weeks (CO validated). Berkshire West compares favourably to England and South East (figure 27). NCSCT (2014) states at least 85% of 4-week quits should be CO validated. In Berkshire West in 2018/19 76% of the total 4 week quits were CO-validated, whilst this does not meet the national guidance target, it exceeds the current local contract target >70%.

<sup>16</sup> Successful quitters are those smokers who successfully quit at the four-week follow-up (report not to have smoked in the past two weeks).

**Figure 27. Smokers that have successfully quit at 4 weeks (CO validated), 2018/19**



All three local authorities compared favourably ranking highest or one of the highest when compared with Chartered Institute of Public Finance and Accountancy (CIPFA) nearest neighbours for 2018/19 for the number of smokers per 100,000 of the smoking population aged 16+ that have successfully quit at 4 weeks and confirmed with CO validation.

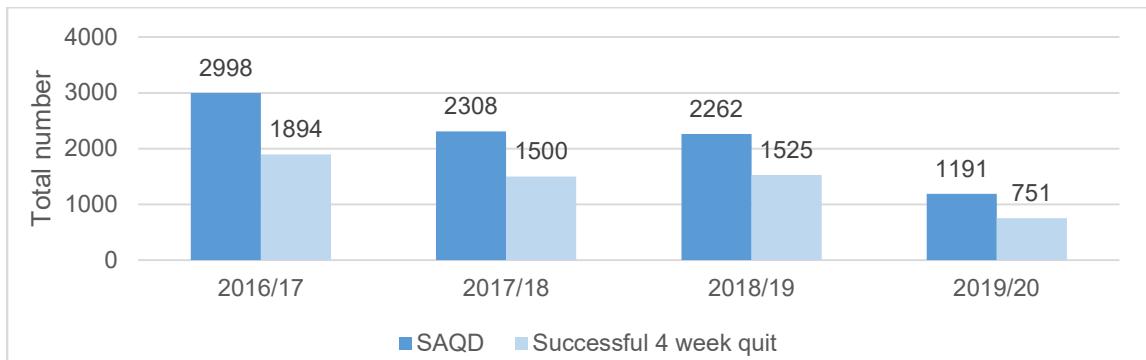
**Cost per quitter**

All three Local Authority contracts are currently wholly payment by results. There are agreed tariffs for payment on successful quits at 4 weeks and 12 weeks. Successful quitters from target groups attract a higher tariff. The payments inclusive of pharmacotherapy costs.

**Local Stop Smoking Service Activity Data (Smokefreelife Berkshire, Solutions4Health Ltd.)**

As noted, there have been reduction in funding by all three Local Authorities in the last couple of years. The final 2019/20 data from Solutions4Health Smokefreelife Berkshire shows a total of 1,191 smokers in Berkshire West SAQD, this equated to 2.9% of the smoking population (41,118 in 2019). There has been a reduction in the number of smokers setting a quit date and successfully quitting at 4 weeks over the past 4 financial years (see figure 28) as a result of these reductions.

**Figure 28. Total number of people setting a quit date by financial year and the number of successful quits, Berkshire West, 2016/17 to 2019/20**

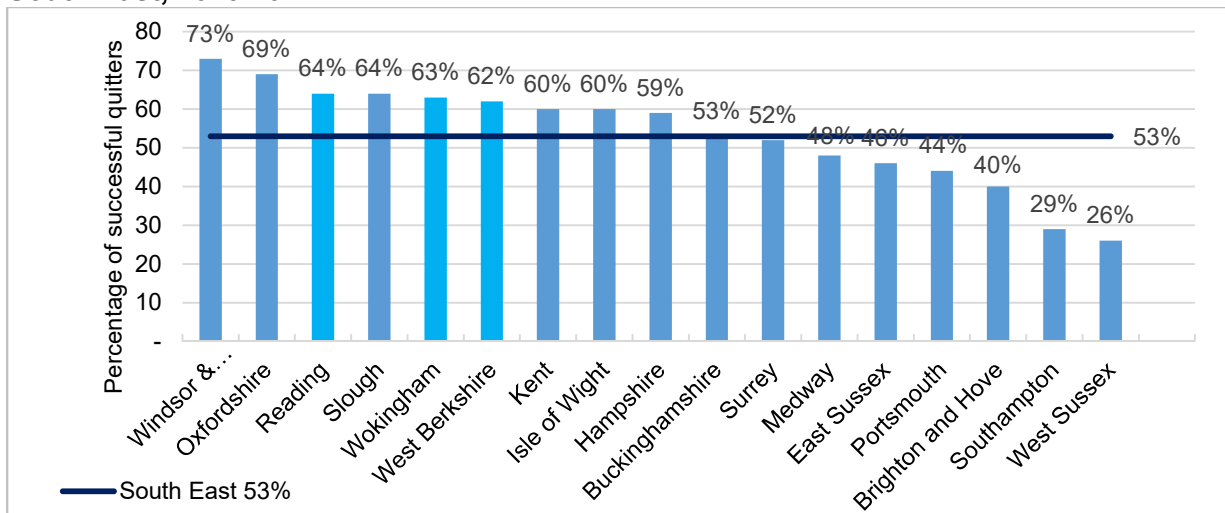


Data source: NHS Digital Statistics Stop Smoking Services and service data for 2019/20

### Quit success rates

In 2019/20 in Berkshire West, a total of 751 reported successful 4 week quits, meaning a quit success rate of 63% (a similar quit conversion rate to previous years), which compared favourably to other areas in the South East (Figure 29).

**Figure 29. Percentage of successful quitters through stop smoking services in the South East, 2019/20**



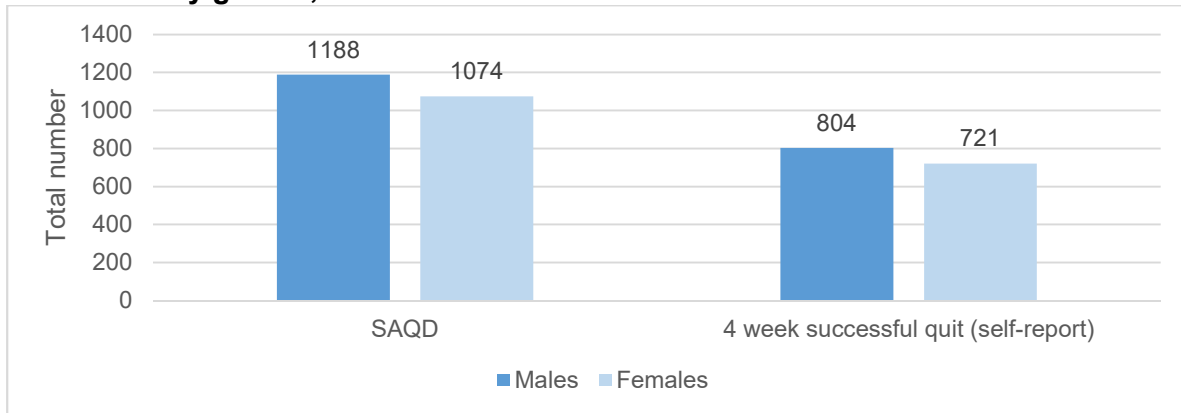
Source data: NHS Digital Statistics Stop Smoking Services, 2019/20

However, since the reduction in smoking cessation budget for all three Local Authorities in 2019, the number of smokers setting a quit date has reduced and thus the number of 4 week successful quits has reduced, meaning 1.8% of the local smoking population have successfully quit in the year.

### Successful quits by gender

Given nationally, in 2019 the proportion of male adults who smoke was 15.8% compared to 12.1% in women, there is a larger proportion of female smokers accessing local stop smoking services. Similar successful quit rates were seen in both men (67.7%) and women (67.1%) accessing the service.

**Figure 30. Number of people in 208/19 setting a quit date and successfully quitting at four-weeks by gender, Berkshire West**



Source data: 2018/19 NHS Digital Statistics Stop Smoking Services

### Successful quits by age group

As shown in table 5 below, the greatest number of people setting a quit date and successfully quitting at 4 weeks were aged 45-59. Similar quit success rates were seen across all ages, except under 18 year olds where the average quit success was low (30%), although this is based on small numbers. Nationally, the age group with the highest proportion of smokers is currently 25-34 year olds, and this should be taken into consideration for future service planning. Only a small proportion of those setting a quit date were aged under 18 years old and the quit success rates were more than half that of other age groups.

**Table 5. Total number of people setting a quit date and number/percentage of successful quits at 4 weeks in Berkshire West, by age group, 2018/19**

	Under 18	18-34	35-44	45-59	60+
Total number setting a quit date	30	582	528	732	390
Number who successfully quit at 4 weeks (self-reported)	9	369	342	524	281
% successful quits at 4 weeks	30%	63.4%	64.8%	71.6%	72.1%

Source data: NHS Digital Statistics Stop Smoking Service, 2018/19

### Successful quits by target group

In 2019/20, 54.6% of 4 week self-reported quits were from target groups in Reading, 48.8% in West Berkshire and 52% in Wokingham.

In 2019/20, 49.1% of 12 week self-reported quits were from target groups in Reading, 44.5% in West Berkshire and 47.9% in Wokingham.

In an attempt to reduce inequalities the three local authorities have focused on increasing the proportion of 4 and 12 week quits amongst target group (table 6)<sup>17</sup>.

**Table 6. Proportion of total successful 4 week quits, by target group, 2019/20**

Target group	Proportion of total successful (self-reported) 4 week quits 2019/20			
	England*	Reading	West Berkshire	Wokingham
<b>Routine and manual workers</b>	29.7%	35.8%	38.0%	39.3%
<b>BAME</b>	12.9%	15.5%	4.5%	8.4%
<b>Young People (&lt;18)</b>	1.2%	0.7%	1.2%	1.3%
<b>Pregnant women</b>	5.5%	3.7%	1.6%	0.8%
<b>Diagnosed mental health condition*</b>	Not available	21%	21.8%	14.4%
<b>Never worked/unemployed</b>	12.3%	5.2%	2.2%	2.5%
<b>Diagnosed long term condition*</b>	Not available	52%	48.4%	33.2%

Source data: NHS Digital Statistics 2019/20 (NHS Digital, 2020)

\*Data from local stop smoking service monitoring data

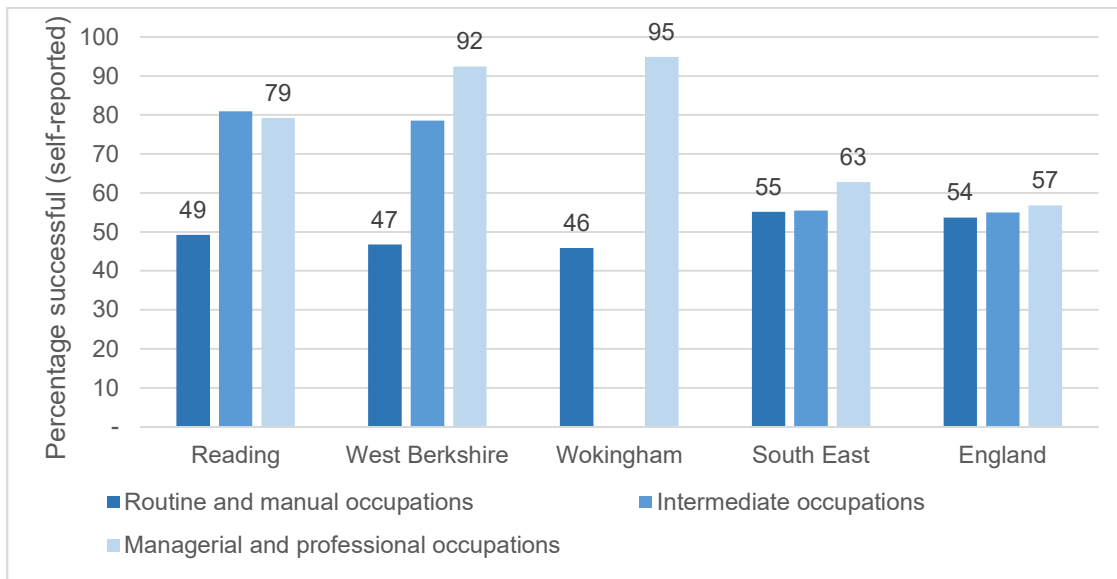
### Quit rate inequalities

The following quit rate inequalities are based on NHS Digital Statistics Stop Smoking Service data in 2018/19.

#### ***Routine and manual workers***

Less affluent groups have less chance of success following setting of a quit date. In England, 2019/20, 57% of managerial and professional occupations were successful (self-reported), compared to 54% routine and manual occupations. However, locally this disparity is wider with 95% of those who have set a quit date from managerial and professional occupations successful compared with 46% in routine and manual worker occupations in Wokingham (figure 31).

**Figure 31. 4-week quit (self-reported) success rates, by socioeconomic group, 2019/20**



Source data: NHS Digital Statistics Stop Smoking Services 2019/20 (NHS Digital, 2020)

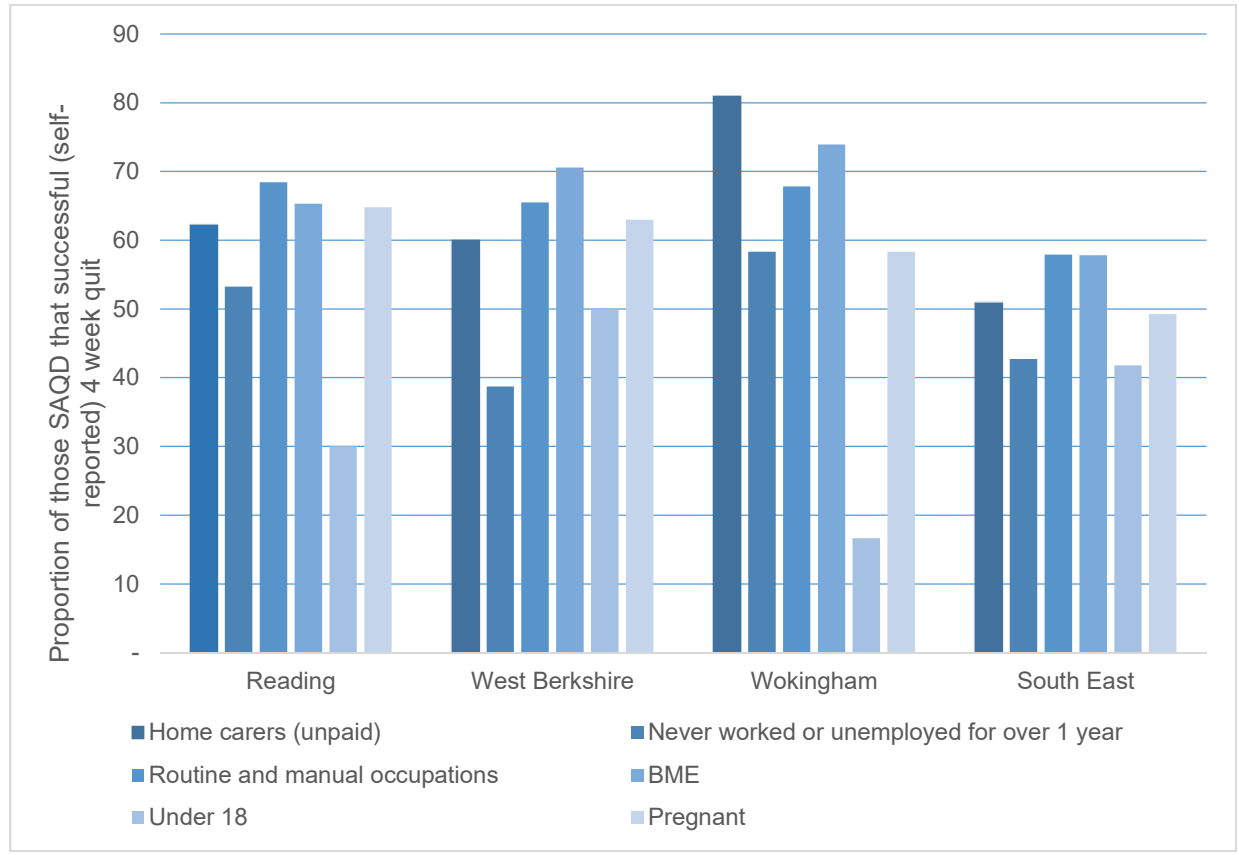
### ***Quit rate in pregnant women***

Across Berkshire West, in 2018/19 there were 93 pregnant women who set a quit date. 63% (n=59) of these pregnant women who set a quit date went on to successfully quit at 4 weeks (self-report). Wokingham had a lower quit success rate amongst pregnant women (figure 32). 34 of these were CO validated, that is just a 58% validated rate (less than the contract target 70% and national target 85%). Pregnant women made up 3.9% of the total successful 4-week quits reported in 2018/19.

In 2019/20, 22 pregnant women set a quit date, 72% (n=16) of the pregnant women went on to successfully quit at 4 weeks (self-report). However, given the low number of women setting a quit date, these are not included in comparisons in NHS Digital Statistics.



**Figure 32. 4-week quit (self-reported) success rates, target groups, 2018-19**

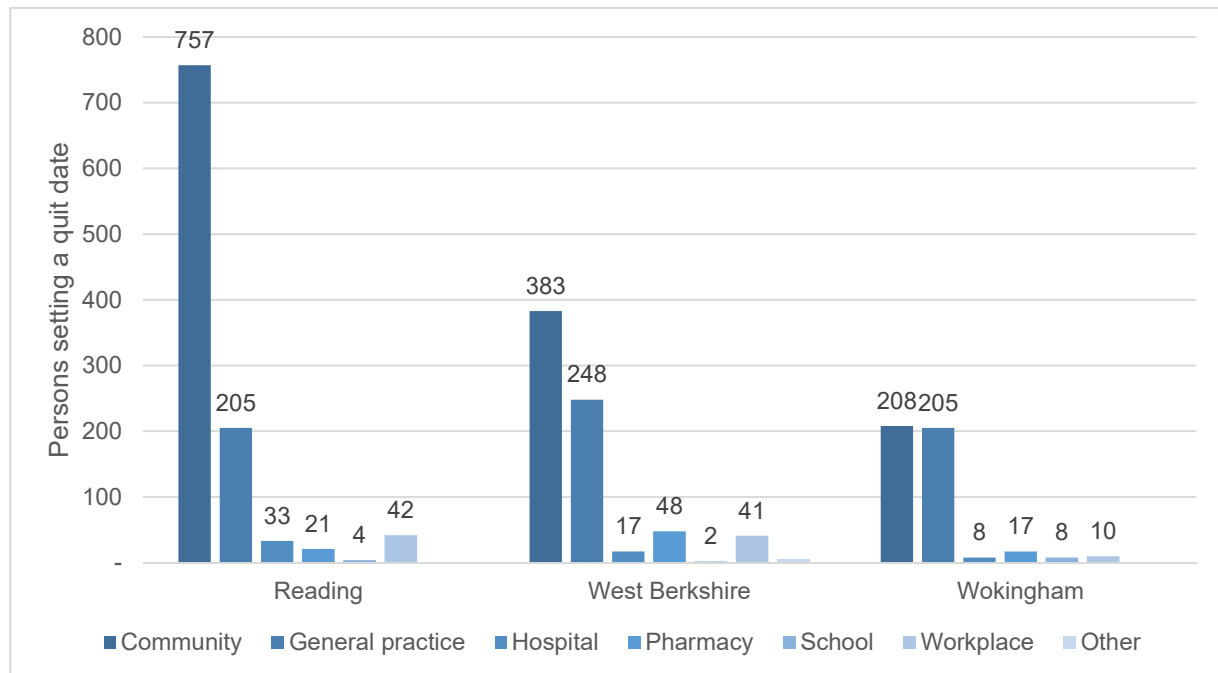


Source: NHS Digital Statistics on Smoking Cessation Services.  
 \*Data suppressed in NHS Digital as denominator greater than 0 and less than 20, the resulting percentage output is not robust enough for comparative purposes. This is the case for 'Carers' in West Berkshire, 'Never worked or unemployed for over 1 year' in Wokingham and all under 18 data

**Intervention setting**

In Berkshire West, the largest proportion of settings for smoking cessation intervention are in the community (60%), followed by General Practice (30%). Similar proportions are seen in General Practice across England, but only 4% are seen in pharmacies compared to 16% in England.

**Figure 33. Setting a quit date (SAQD) by intervention setting, 2018/19**



Source: NHS Digital 2020, [Statistics on NHS Stop Smoking Services: England, April 2018 to March 2019: Tables.](#)

### Pharmacotherapy

In addition to behavioural support, some stop smoking attempts may be supported by medication such as nicotine replacement therapy (NRT), Champix (Varenicline) or Zyban (bupropion).

A Cochrane systematic review compared combination NRT versus single form NRT and found a clear advantage of combination NRT, 35% increase in cessation rate (Rate ratio 95% CI 1.1 to 1.63) (Stead *et al.*, 2012). The incremental benefit of combination NRT over single form NRT is roughly in proportion to the incremental cost (Aveyard, 2012).

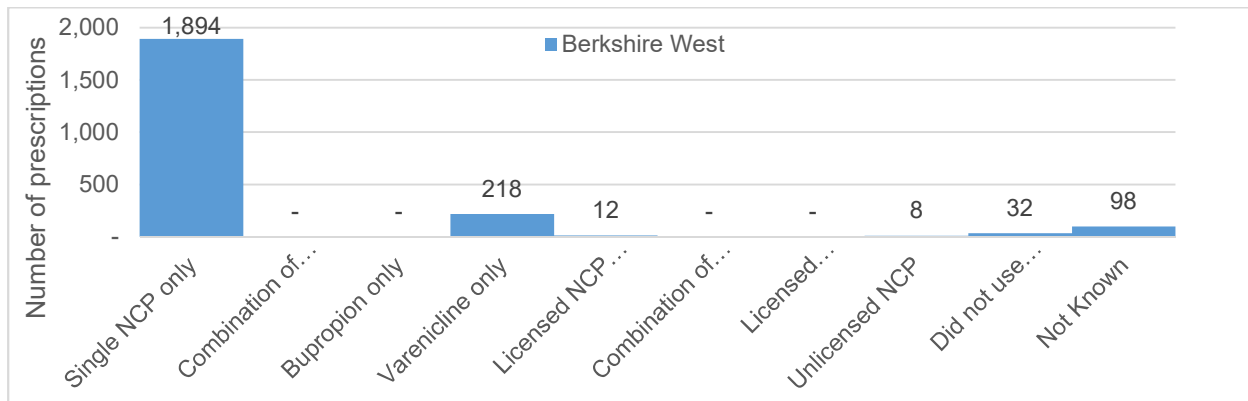
**Table 7. Effectiveness of pharmacotherapy and support options**

Four-week quit rates	No medication	Mono NRT	Combination NRT	Bupropion	Varenicline
No support	16%	25%	36%	28%	37%
Individual behavioural support	22%	37%	50%	39%	52%
Close group behavioural support	32%	50%	71%	55%	74%

Source data: NCSCT (2014) LSSS Service Delivery Guidance, 2014 pg.32

In 2018/19, across Berkshire West, of all pharmacotherapies used to help people quit smoking, 'Single NCP (nicotine containing product) was used most frequently by the service, with the highest number setting a quit date (n=1,894) using mono NRT, and highest number of successful quitters (n=1,279), 68% of those using mono-NRT were successful. Varenicline (Champix) was prescribed for 218 people setting a quit date and 184 successful quitters, with the highest quit rate 84%. Just 32 people setting a quit date did not use any licensed medication or unlicensed NCP, 50% of these successfully quit.

**Figure 34. Pharmacotherapy use amongst those who set a quit date in Berkshire West, 2018/19**



Source: NHS Digital 2020, [Statistics on NHS Stop Smoking Services: England, April 2018 to March 2019: Tables.](#)

## Tobacco related costs

### *Estimated costs to society*

Action on Smoking and Health (ASH) provide a tool for calculating the estimated cost of tobacco to society. The net annual cost of tobacco to society in Berkshire West is approximately £54.6 million. This can be broken down into the costs shown in table 8, the largest cost being loss of productivity. Smokers in Berkshire West spend roughly £42.3 million on tobacco products each year, around £1,029 per smoker.

**Table 8. Breakdown of costs to society of smoking in Berkshire West, using data from the ASH ready reckoner tool (2019)**

	£ (million)		
	Reading	Wokingham	West Berks
Lost productivity (smoking breaks)	10.5	7.6	8.1
Lost productivity (early deaths)	10.3	9.4	10.6
Lost productivity (economically inactive due to smoking-related illness)	2.9	1.1	2
Lost productivity (sick days)	4.5	3.3	3.6
Hospital admissions for smoking-related conditions	1.8	1.6	2.2
Treating smoking-related illness via primary and ambulatory care services	3.5	3.3	4
Smoking related social care	1.7	1.5	1.9
Smoking related fire	0.621	0.401	0.469
Total cost to society	35.8	28.2	32.9
Tobacco expenditure	17.6	11.4	13.3
Net annual cost to society	18.2	16.8	19.6
<b>Net annual cost to society in Berkshire West</b>	<b>£54.6 million</b>		

Source: ASH Ready Reckoner <https://ash.org.uk/ash-ready-reckoner/,v7.0> 2019

The total cost to society in Berkshire West can be broken down into 5 key areas:

### 1. Healthcare

The total annual cost to the NHS across Berkshire West is about £16.4 million (Reading £5.3m a year, West Berkshire £6.2m and Wokingham £4.9m). This includes smoking-related hospital admissions and the wider cost of treating patients via primary and ambulatory care services (Action on Smoking Health, 2019). ‘

- 2,440 hospital admissions due to smoking-related conditions (820 in Reading, 920 in West Berkshire and 700 in Wokingham)
- 171,590 GP consultations, 56,120 practice nurse consultations, 95,280 GP prescriptions and 32,610 outpatient visits

### 2. Social Care

Current and former smokers often require social care in later life as a result of smoking-related illnesses. Each year, this costs society in Berkshire West an additional £3.6 million.

- Of this £3.6 million, £2.9 million is funded by the Local Authorities social care budget (£1.3m in Reading, £1.6m in West Berks and £1.2m in Wokingham)
- £940,920 is paid by individuals or families who self-fund private care.

### 3. Productivity and workforce

Smokers take more sick-leave from work than non-smokers and smoking increases the risk of disability and early death. It is estimated that each year, £73.9 million of potential wealth is lost from the local economy in Berkshire West as a result of lost productivity due to smoking. Across Berkshire West:

- There are 596 early deaths due to smoking which result in 892 years of lost economic activity, costing businesses about £30.3 million
- 96 employees in Berkshire West are economically inactive and unable to work due to smoking-related illness, resulting in an annual cost to business of £6 million
- Absenteeism due to smoking related illness results in about 76,320 days of lost productivity costing a further £11.4 million
- The estimated cost to business of smoking breaks for smokers in Berkshire West is £26.2 million

### 4. Littering and smoking

There is also a cost to the environment due to littering. Most cigarette filters are non-biodegradable and must be collected and disposed of in landfill sites. 62% of people drop litter and smoking materials constitute 35% of all street litter. Smokers in Berkshire West consume about 316,010 cigarettes a day, that's 46kg of waste daily and 16 tonnes of annual waste. 7 tonnes of this has to be collected by the Local Authorities.

### 5. House fires

Smoking materials are a major contributor to accidental fires in England with around 7% being smoking related. Fatalities are disproportionately high in smoking related fires, representing 49% of all house fire deaths. It is estimated that Berkshire Fire and Rescue Service will attend about 15 smoking related house fires in Berkshire West each year. This costs £1.49 million annually to Berkshire West.

## Estimated costs to social housing providers

The ASH calculator allows housing providers to estimate the number of households in their local area or housing stock who would need to be supported to quit in order to balance their total rental arrears<sup>18</sup>.

**Table 9. Estimated costs to social housing providers, by Local Authority**

	Reading	West Berkshire	Wokingham
Expected earnings in rental receipt of dwelling stock each week	£503,967	£1,057,524	£254,828
Amount unpaid in rental arrears each week	-£11,087 (2.2%)	-£46,786 (4.4%)	-£11,467 (4.5%)
Cost to tenants (cigarettes and tobacco) per week (average)	-£55	-£56.71	£66.13
Additional social renters living in poverty	22.6%	8.3%	27.5%
Potential return of disposable income to community each week if social renters quit	£54,482	£94,328	£21,784
Smoking households required to quit (if savings paid to rent instead of tobacco social tenant arrears)	202 (20%)	825 (50%)	173 (53%)

For example, if just 20% social tenant smokers in Reading quit, their savings would cover all of the expected rent arrears in the local authority.

Each week Reading local authority is expected to earn £503,967 in rental receipts for this dwelling stock, however around £11,087 (2.2%) will be left unpaid each week in rental arrears. Helping social renters in Reading to quit smoking could return around £54,482 of disposable income to the community each week. If these savings were paid towards rent instead of tobacco, social tenant arrears could be wiped-out if 202 smoking households (20%) were to quit.

### Costs to individual

In England, there are 1.4 m households with a smoker that fall below the poverty line, a third will be lifted out of poverty if that smoker were to quit (Taylor *et al.*, 2014). When expenditure

<sup>18</sup> Data from the ASH Costs of smoking in social housing local authority calculator Accessed online 25 October 2020 <https://ash.org.uk/social-calc/>

on tobacco is taken into account, around 500,000 extra households (comprising over 850,000 adults and almost 400,000 children) are classified as in poverty in the UK compared to the official Households Below Average Income figures. This demonstrates that tobacco imposes a real and substantial cost on many low-income households.

For example, in Reading, reviewing the data from the ASH calculator in table 9. demonstrates that for each smoking household in Reading, cigarettes and tobacco will cost tenants £55.00 per week on average. As a result, an additional 22.6% of social renters in Reading will be living in poverty. The average rent arrears of social tenants in 2016/17 was just over £400 (ASH, 2019b) meaning that for those who smoke, their entire rent arrears could be wiped out within 9 weeks of quitting smoking.

### **Return on investment**

Behavioural support and pharmacotherapy cost less than £6,000 per QALY (Quality Adjusted Life Years), well below the NICE 'cost-effective' threshold £20,000 - £30,000 per QALY (Shahab, 2014). Smoking cessation services remain a highly cost-effective preventative measure to reduce premature mortality and morbidity and reduce inequalities.

National Institute of Clinical Excellence (NICE) Tobacco Return on Investment (ROI) tool has been developed to help decision making in tobacco control at local and subnational levels. The tool evaluates a portfolio of tobacco control interventions and models the economic returns that can be expected across different payback timescales. Different interventions, including pharmacotherapies and support and advice, can be mixed and matched to see which intervention portfolio and package provides the best 'value for money', compared with 'no-services'.

The following is an example analysis for Berkshire West, based on 2018/19 data. It assumes that Berkshire West commissions NICE-approved services and that the provision matches the expected NICE-recognised levels of effectiveness.

#### Inputs

- Costs provided by NICE ROI tool for each individual intervention
- NICE-recognised levels of effectiveness for each individual intervention
- Uptake based on LSSS data returns (on basis that 4.3% of smokers uptake of LSSS)

Total cost of ALL interventions - £399,904, in 2018/19 the contract across Berkshire West was worth £679,000

Calculated that 5 additional quitters per 1,000 smokers as a result of local SSS interventions and a total of 241 additional quitters in Berkshire West.

With the current local stop smoking service interventions in place at present, compared to no intervention/service being in place:

Short term savings (2 years)

- £400,000 NHS savings
  - o £50,000 saved in admissions
  - o £25,000 in GP consultations
- £200,000 Productivity gains

Overview of the investment cost and short-term net present value savings is £90,369

The provision of effective comprehensive NHS Stop Smoking Services delivers clinically effective interventions and is cost-saving. This can be thought of in terms of providing a return on investment of £9.37 per smoker over the course of a lifetime for every £1 spent on

implementing the current package, if both quasi-societal savings and value of health gains are considered.

In Berkshire West, 22.6% of the investment in the Current Package will be paid back by the savings generated in the local economy in the first 2 years of investment

## **Engagement**

### ***Public Engagement***

Consultations on the annual funding for public health and/or smoking cessation services in West Berkshire and Reading found that respondents were in favour of more targeted services that worked with those at greater risk of ill health e.g. pregnant women, manual workers and those from less affluent areas. There was a suggestion to develop a digital offer to provide ongoing assistance at a lower cost. Many observed the under-use of the service and had not understood how much more likely people are to quit with support.

As part of the joint re-tendering of the stop smoking services across Berkshire West, a public stop smoking survey was conducted to gain an increased understanding of people's views on tobacco and Local Stop Smoking Services available in Reading, West Berkshire and Wokingham.

### **Methods**

The questionnaire was developed with input from members of Reading, West Berkshire and Wokingham Public Health Teams. It was hosted on the West Berkshire Consultation website. The design of the questionnaire had a range of questions, using box checking and free-text options. The survey was also advertised on social media sites using a targeted advertising campaign to boost responses from younger residents. Current smokers, ex-smokers and those who have never smoked were all encouraged to respond. Links to the survey were circulated amongst relevant stakeholders across the three Local Authorities including; Royal Berkshire NHS Foundation Trust (including cancer steering group, respiratory, maternity services); Berkshire Healthcare Foundation Trust (including school nursing team, sexual Health, acute mental health trust and community mental health teams); Primary care (including GP newsletter, Berkshire West CCG, Pharmacy newsletter); Education (including personal, social, health and economic (PSHE) leads in schools, Newbury college, and Reading University); community and voluntary sector leads (including Healthwatch, local authority community engagement teams, Black and Minority Ethnic forums); substance misuse services and youth offending services, housing teams, sports & leisure teams, and the Economic Development Manager for dissemination to workplaces. These stakeholders were asked to share with wider circles as appropriate.

The survey was live for just over a 7-week period from 25<sup>th</sup> August to 18<sup>th</sup> October 2020.

### **Survey Response**

A total 406 people responded to the survey, however 33 only answered the first or second questions and two were duplicate responses. 371 responses were used in the final dataset.

18.6% of respondents were from Reading, 50.4% from West Berkshire and 27.5% from Wokingham (3.5% were from other surrounding areas).

231 of 371 respondents consented to giving special category data. From this, data on characteristics of respondents consenting are given below. This is broken down by each Local

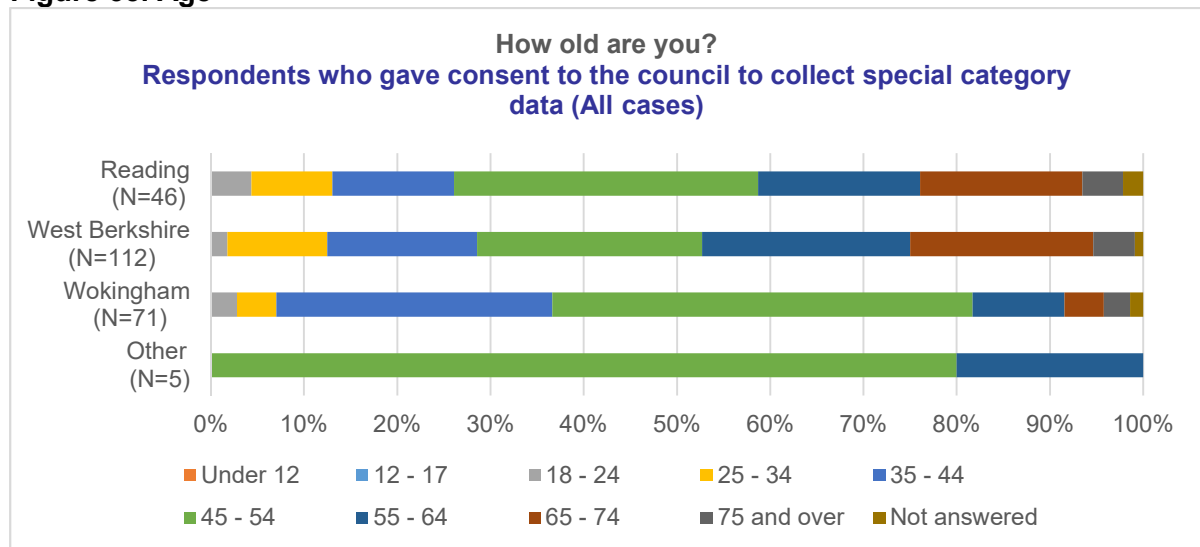


Authority, 'Other' being a respondent not resident in one of the three Berkshire West Local Authorities.

**Age**

Unfortunately there were no responses from those aged under 12 or 12-17 years old despite promotion via schools and colleges. This is likely due to the competing demands of returning to school during the pandemic.

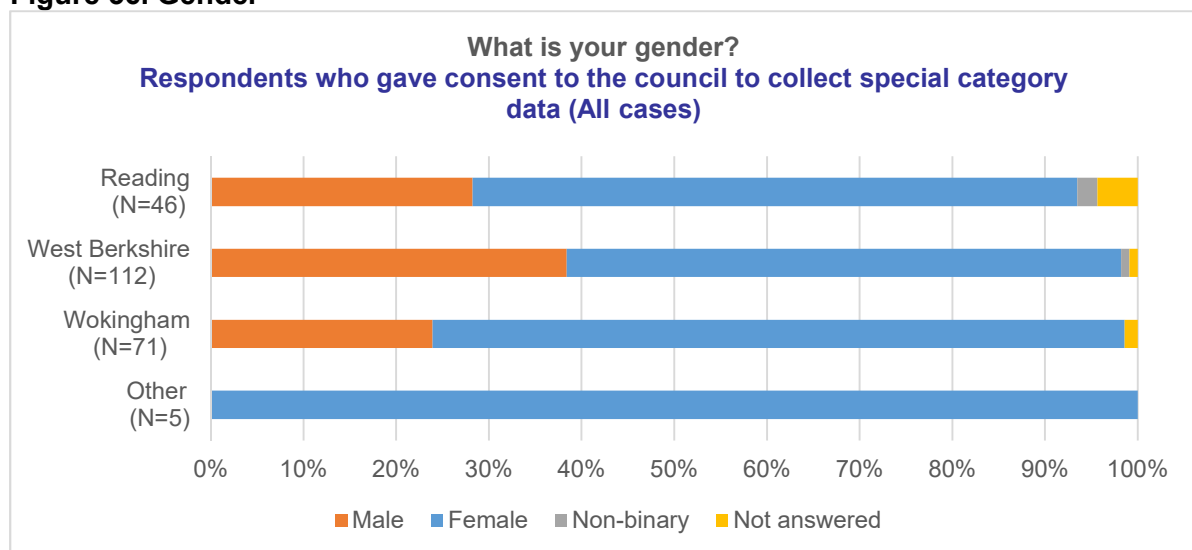
**Figure 35. Age**



**Gender**

The majority of respondents were female. This suggests males were underrepresented in the survey, which is important as smoking prevalence is higher amongst males.

**Figure 36. Gender**

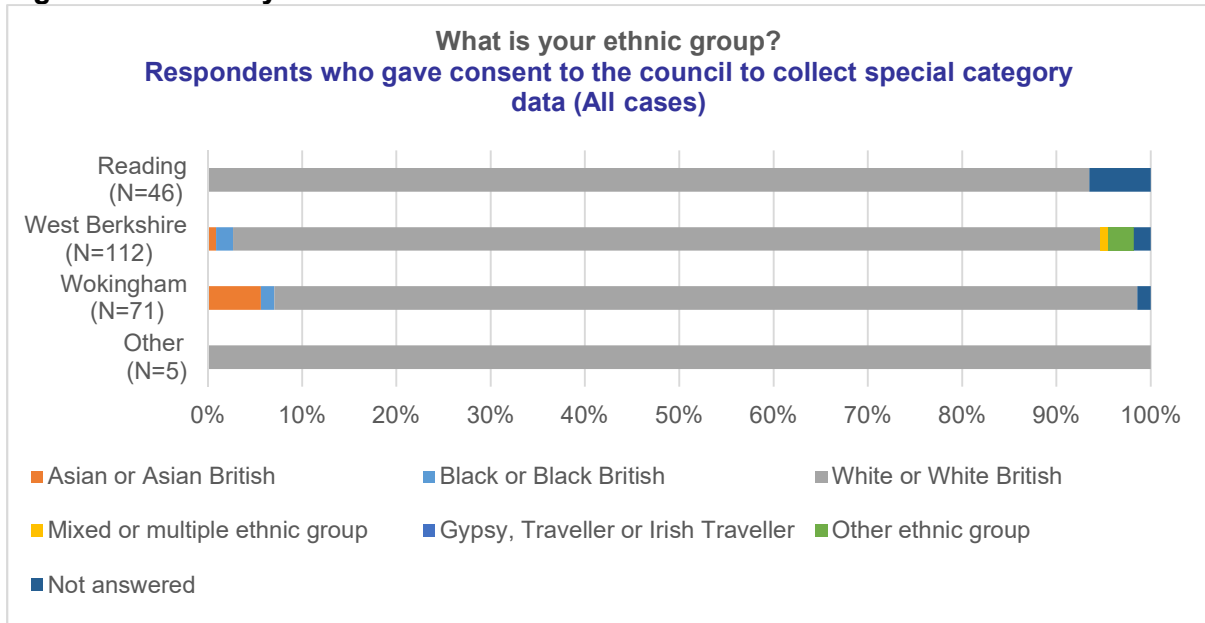


**Ethnicity**

96.6% of people across Berkshire West responded as being 'White or White British'. Whilst this is the largest population group in each Local Authority (based on Census 2011), the

proportions of all other ethnic groups responding to the survey were smaller than the estimated average populations, so it is likely that views of individuals from a Black and Minority Ethnic (BAME) background are underrepresented.

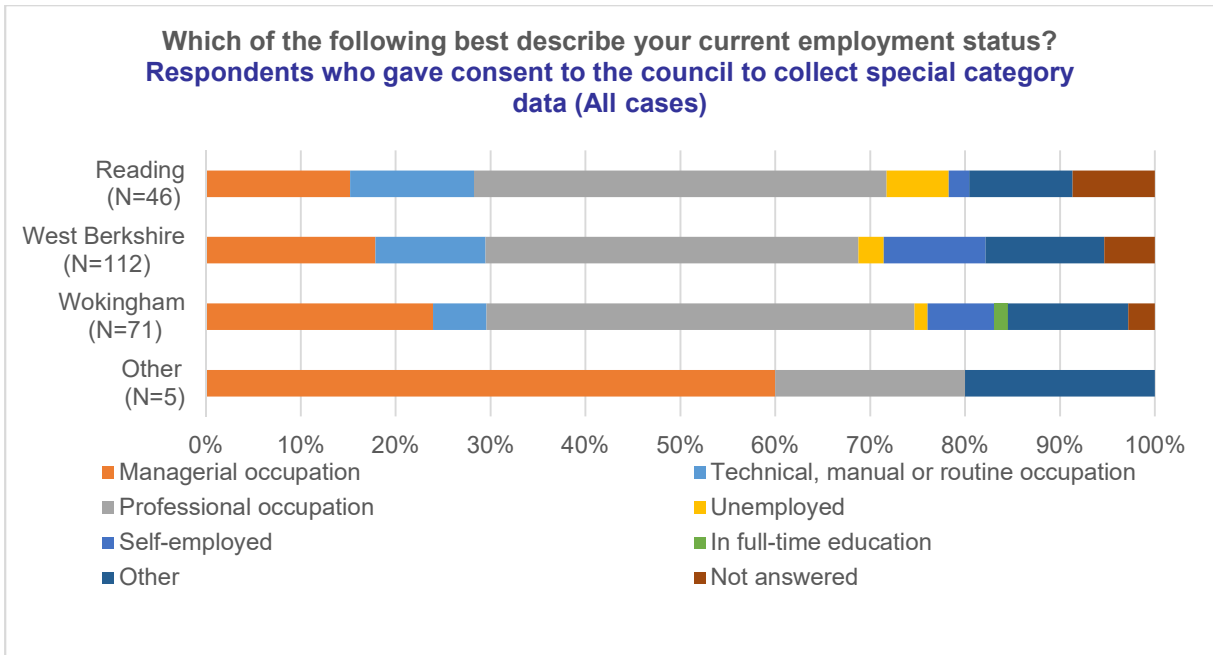
**Figure 37. Ethnicity**



**Socioeconomic status**

The majority of respondents were from managerial or professional occupations which reflects the higher proportion of Berkshire West population working at this employment status. However, given the relatively small proportion of respondents in technical, manual or routine occupation, the views of routine and manual workers (in whom smoking prevalence is high) are likely underrepresented.

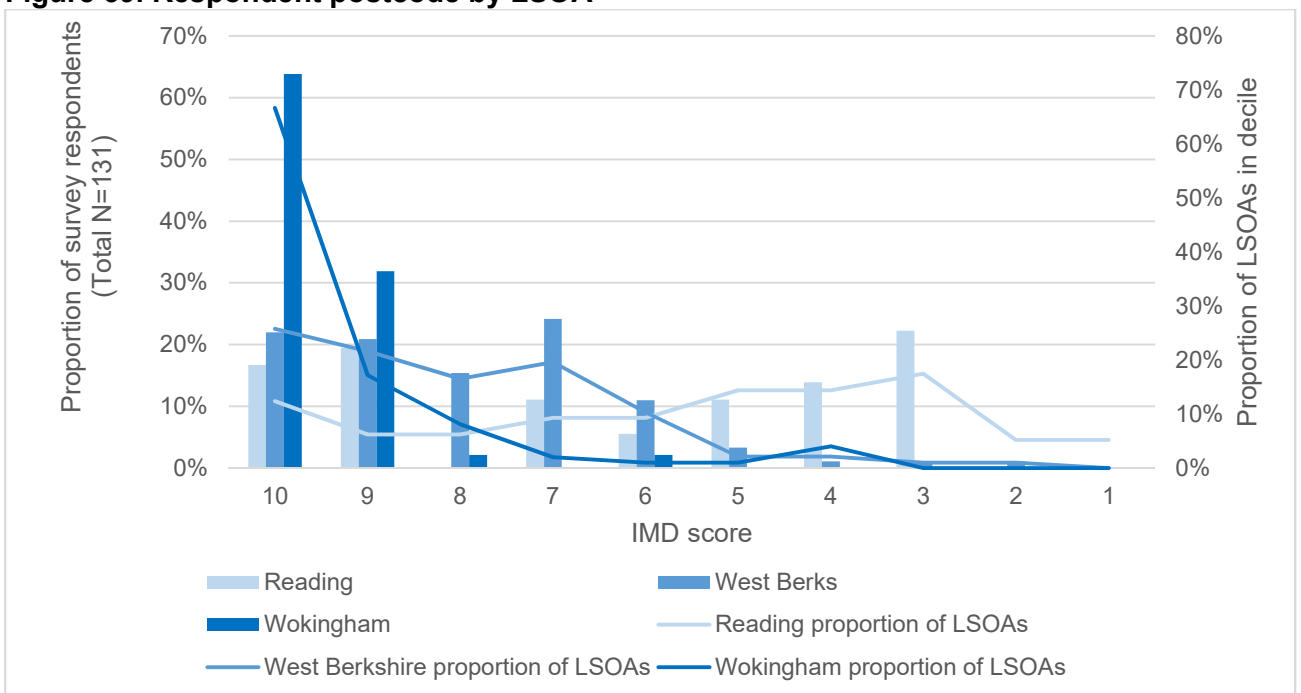
**Figure 38. Employment status**



### Deprivation

Postcodes were given by N=181 respondents, this allowed for determination of which IMD score decile (2019) the respondent lived in. Figure 39. outlines the proportion of survey respondents in each IMD decile (10 is least deprived). This is compared against the proportion of LSOAs in each decile for each Local Authority. This demonstrates that whilst the majority of respondents were from least deprived areas, the survey respondents represented the Local Authority populations well in terms of level of deprivation.

**Figure 39. Respondent postcode by LSOA**

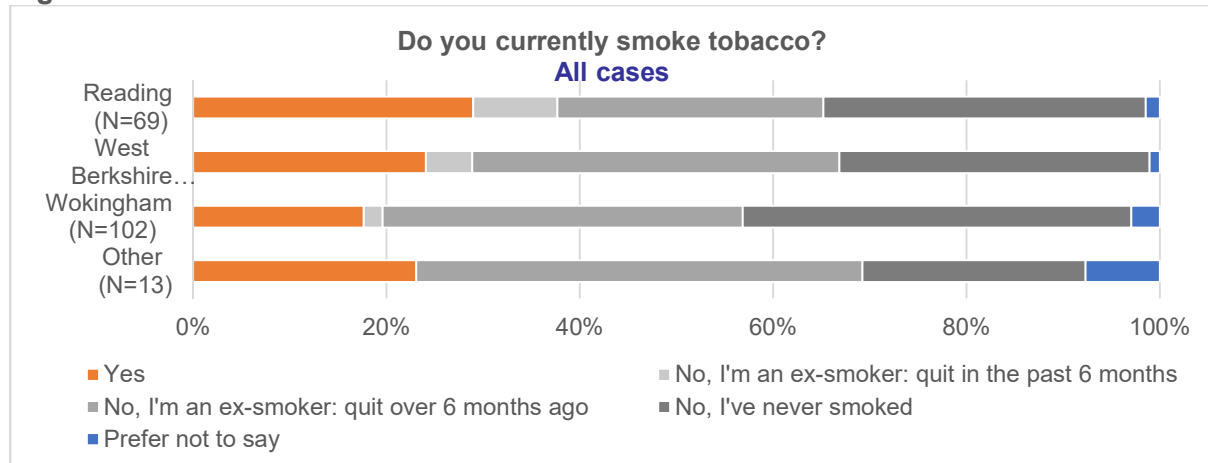


## Findings

### Smoking status

From the 371 respondents, 86 (23.2%) reported they were current smokers, this is higher than the regional adult smoking prevalence (10.9%). 151 respondents reported being an ex-smoker, 4.6% (n=17) were ex-smokers who quit in the last 6 months, 36.1% (n=134) were ex-smokers who had quit over 6 months ago. 34% (n=127) respondents had 'never smoked' and just 7 respondents chose 'prefer not to say'.

Figure 40.

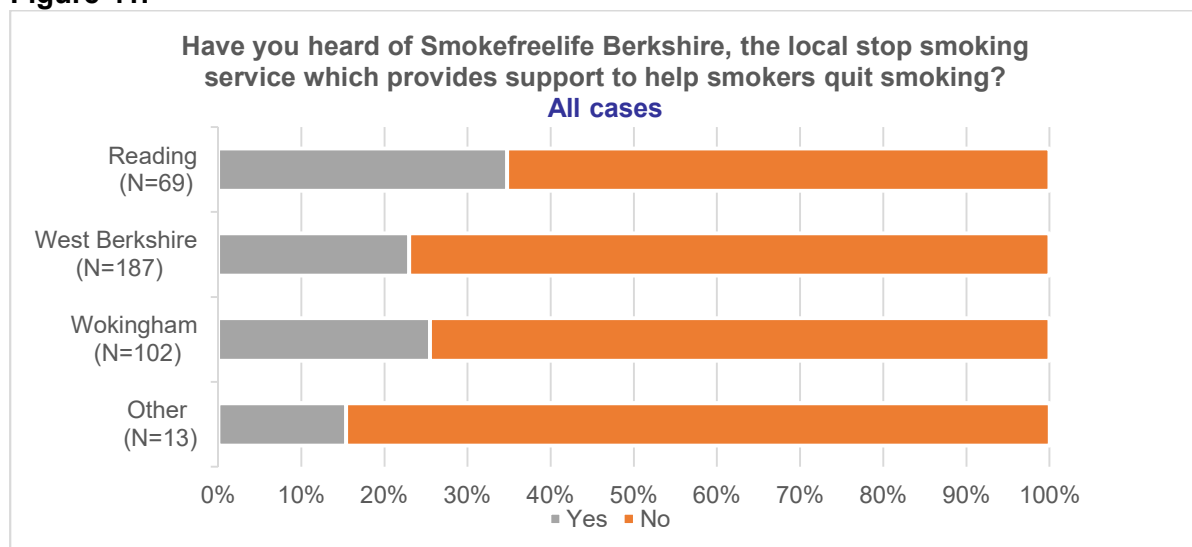


Local Stop Smoking Services (Smokefreelife Berkshire)

### Awareness of the service

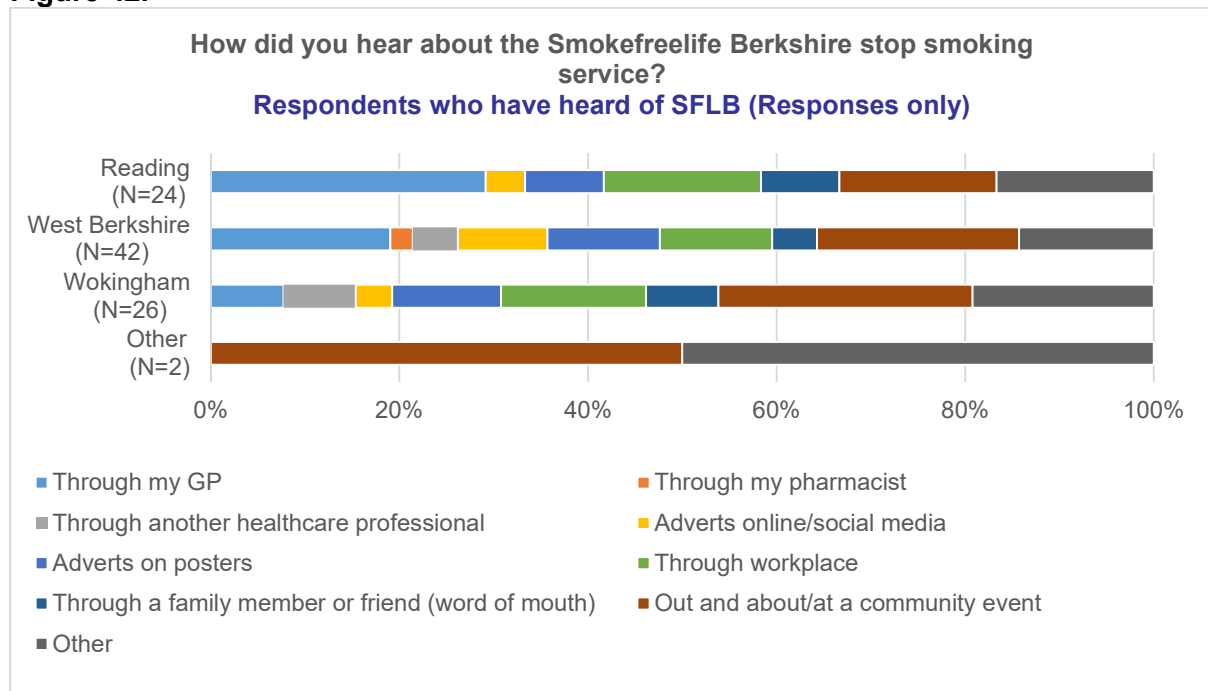
The majority of respondents had not heard of Smokefreelife Berkshire, just 25% reported they had heard of the service. When looking at current or ex-smokers (n=141), 32% had heard of Smokefreelife Berkshire (n=45). Current smokers (n=45) are the group that might potentially access the service, a third (n=15) had heard of Smokefreelife Berkshire.

Figure 41.



Of those respondents who had heard of Smokefreelife Berkshire, the majority had heard of the service whilst out and about or at a community event or through their GP. Those respondents that put 'other' reported knowing the service as part of their work role or seeing the mobile vans at various community venues. A few reported doing a 'Google' search to find it.

**Figure 42.**

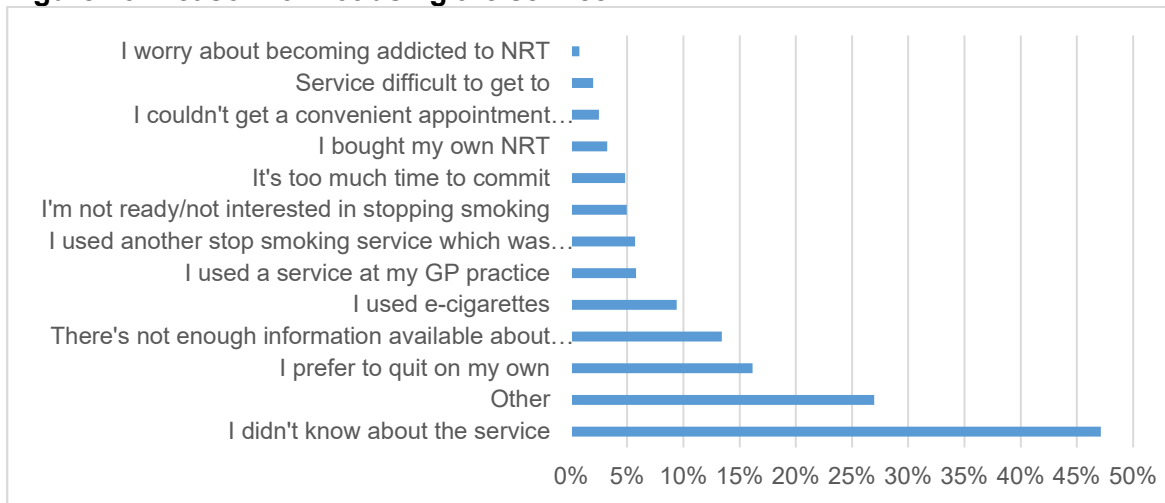


**Service use**

Of those respondents who were current or ex-smokers (n=237), only 11.1% (n=28) had used Smokefreelife Berkshire stop smoking service. The majority (88.1%) reported not having used the Smokefreelife Berkshire service. 15.5% (n=36) had used a different stop smoking service; 3 were out of area, others had used the 'Alan Carr' course (n=2), their GP (n=6), pharmacist (n=2), at least 4 reported using a mobile van, which may have been the service.

For those who had not used the service, the main reason given most frequently was not being aware of the service (47.1%). 'Other' reasons given were most frequently that they had stopped smoking unaided, a few suggested the time commitment was an issue due to working out of area. Preference to quit alone seemed to be the next main reason for not using the service.

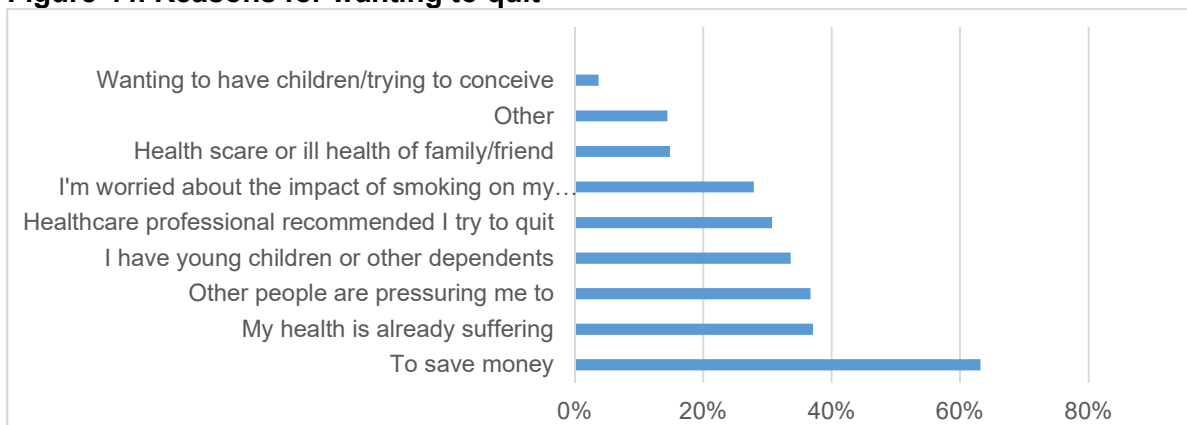
**Figure 43. Reason for not using the service**



**Motivation**

Of those respondents who received support from Smokefreelife Berkshire (n=31), the majority reported concerns about their future health as the main reason for wanting to quit (75.8%), saving money was another popular reason for wanting to quit (63.2%). 28% stated they were worried about the impact of smoking on their risk of Covid-19.

**Figure 44. Reasons for wanting to quit**



**Satisfaction**

Of the 32 respondents who reported using Smokefreelife Berkshire, the majority reported being very satisfied (47.1%, n=14), a third (n=10) reported being neither satisfied nor dissatisfied and 9.8% (n=3) were very dissatisfied.

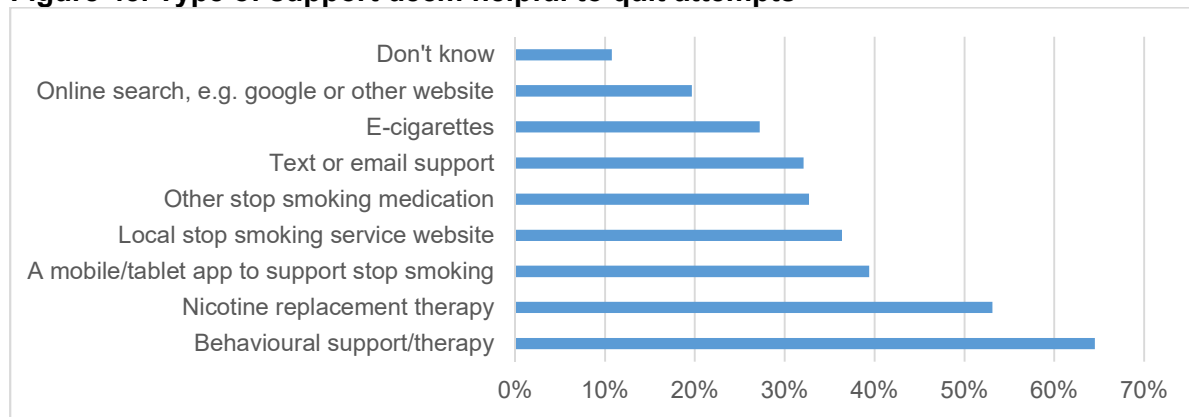
Those that reported high satisfaction made comments that advisors were friendly and motivating, a couple of respondents reported the value of carbon monoxide testing 'as not cheating possible'.

One respondent reported not following it up as it was offered in a public shopping centre. Few comments were provided for those who were very dissatisfied, one respondent felt that there was no flexibility in the programme that encouraged the client to first set a quit date.

*Views on helping someone to quit smoking*

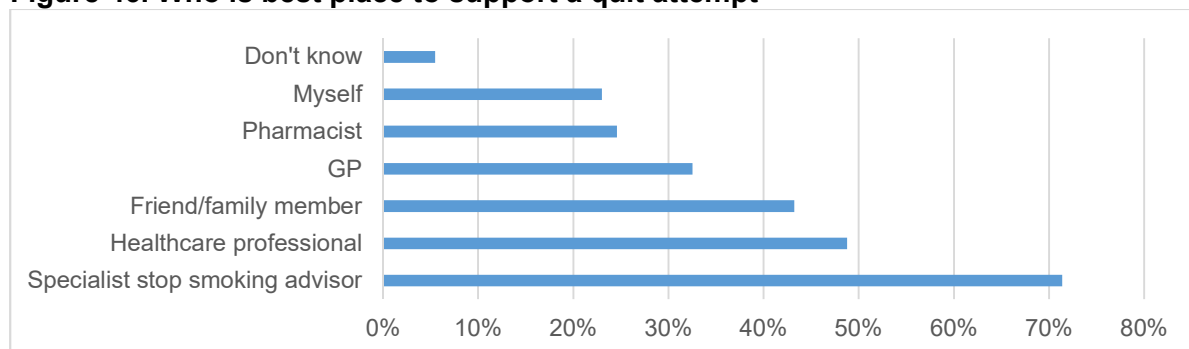
Respondents were asked their views on what type of support they would deem most helpful for someone attempting to quit smoking (n=348). The majority reported behavioural support/therapy (64.5%, n= 224) and nicotine replacement therapy (53.1%, n=185). Almost 40% supported use of a mobile/tablet application to support stop smoking too (n=137).

**Figure 45. Type of support deem helpful to quit attempts**



The majority of respondents (n=246) viewed a specialist stop smoking advisor as most helpful to support someone to quit smoking, 48.8% (n=168) felt a healthcare professional would be helpful too.

**Figure 46. Who is best place to support a quit attempt**

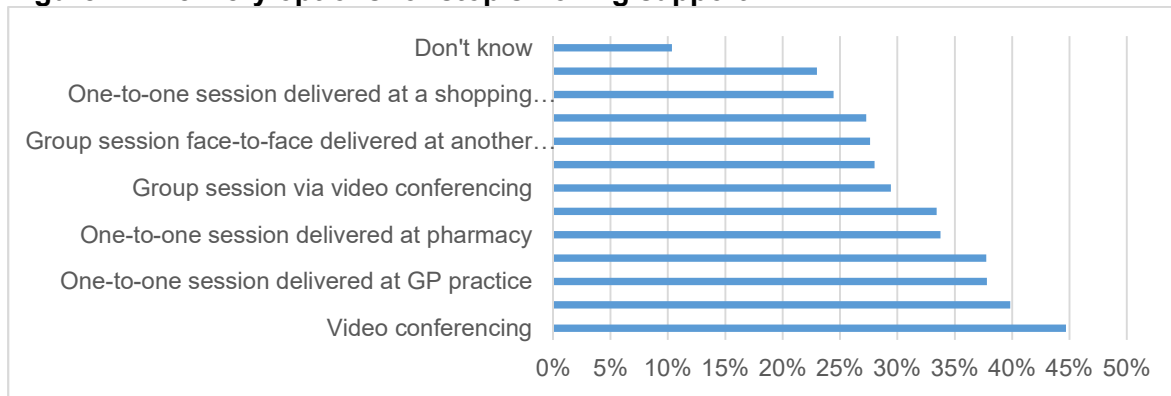


Greatest support was given for delivery of stop smoking support via videoconferencing (44.7%, n=134), this was followed by 1:1 support at a community venue e.g. café, pub, day centre, library (39.8%, n=120), GP practice (37.8%, n=113) or home (37.8%, n=113). Group sessions appeared less popular, in free-text comments the 1:1 option was seen as more personalised, but others recognised the value of a group setting.

In free-text comments suggestions were made for community venues such as function rooms in pubs, coffee shops, community centres, village or church hall. A couple of respondents made comments that the stalls in shopping centres and supermarkets were 'a waste of time'. Comments suggested home visits would be most helpful for those with mobility issues or mental health conditions.



**Figure 47. Delivery options for stop smoking support**

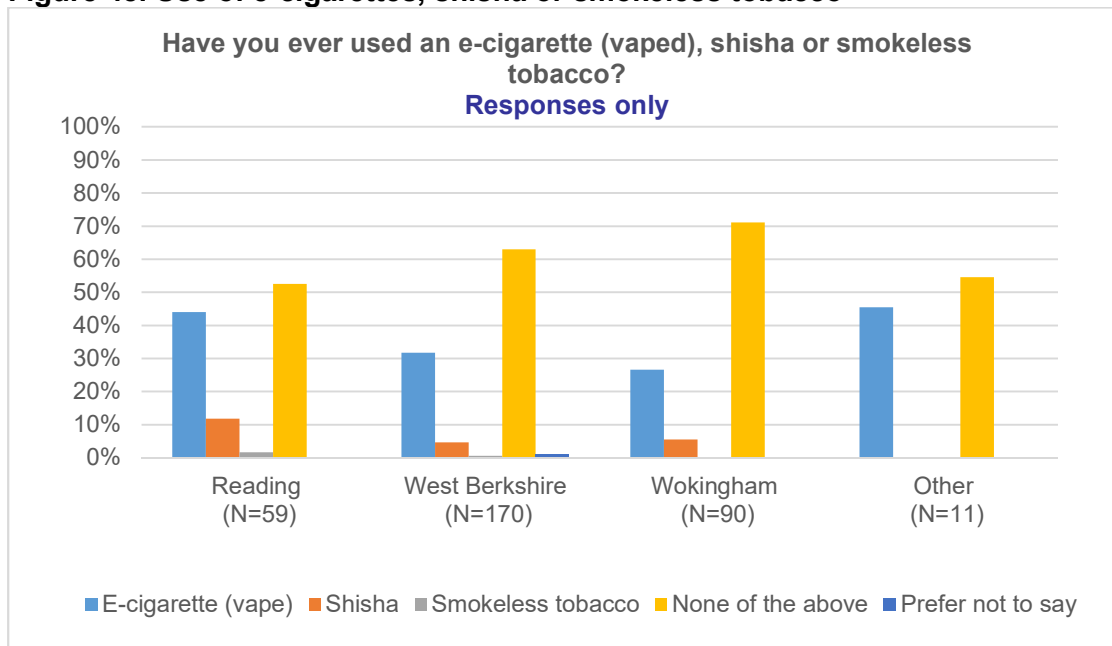


*E-cigarettes*

A significant proportion of respondents (n=109) reported having used an e-cigarette. Across all three local authorities, only 20 (6.3%) of respondents reported having ever used Shisha and just 2 using smokeless tobacco (0.6%).

Of those that reported ever using an e-cigarette, over a third (n=39) reported using them in the past but no longer using them. 17% (n=20) used them to quit smoking and no longer used them. 11% (n=13) had only tried them once. One fifth of respondents reported using them daily (17 instead of smoking and 7 in addition to smoking cigarettes). 15% (n=18) report using them occasionally and 6 use alongside nicotine replacement therapy.

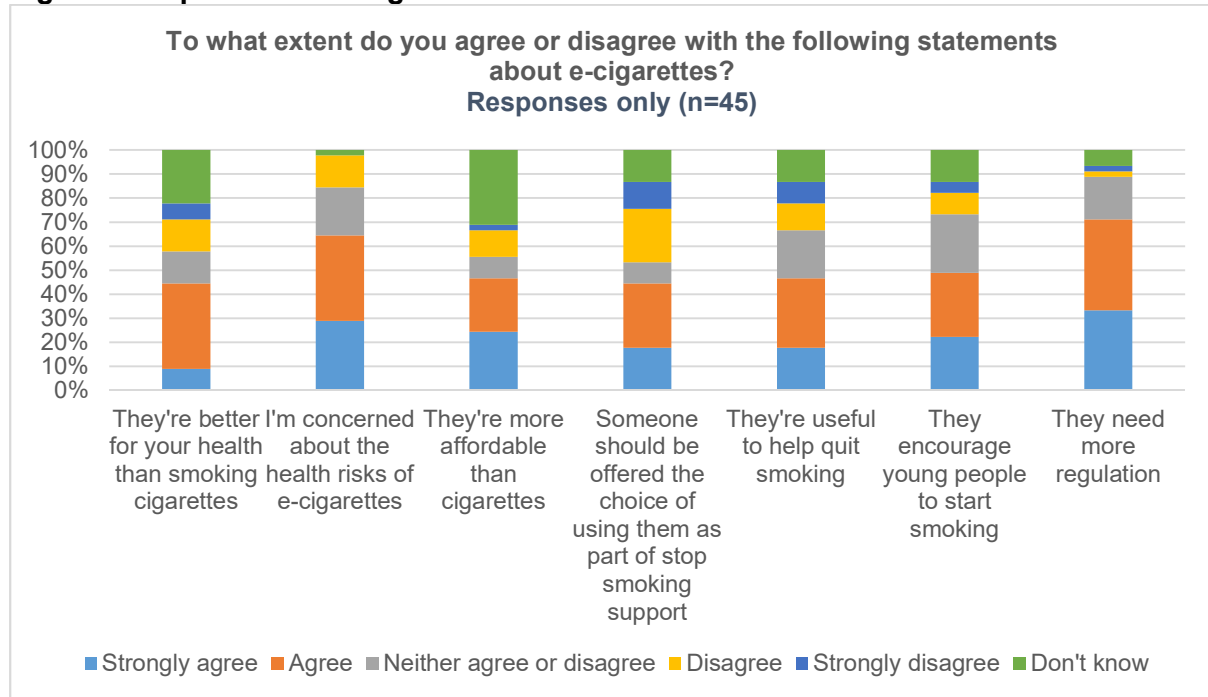
**Figure 48. Use of e-cigarettes, shisha or smokeless tobacco**



*Opinions about e-cigarettes*

Almost half of respondents agreed that e-cigarettes were better for your health than smoking cigarettes but more than 60% of respondents still had concerns about the health risks of e-cigarettes and almost three quarters felt they needed more regulation. Broadly, there was support for the fact that they may be useful to help quit smoking and almost half (47%) agreed that someone should be offered the choice of using them as part of stop smoking support.

**Figure 49. Opinions on e-cigarettes**



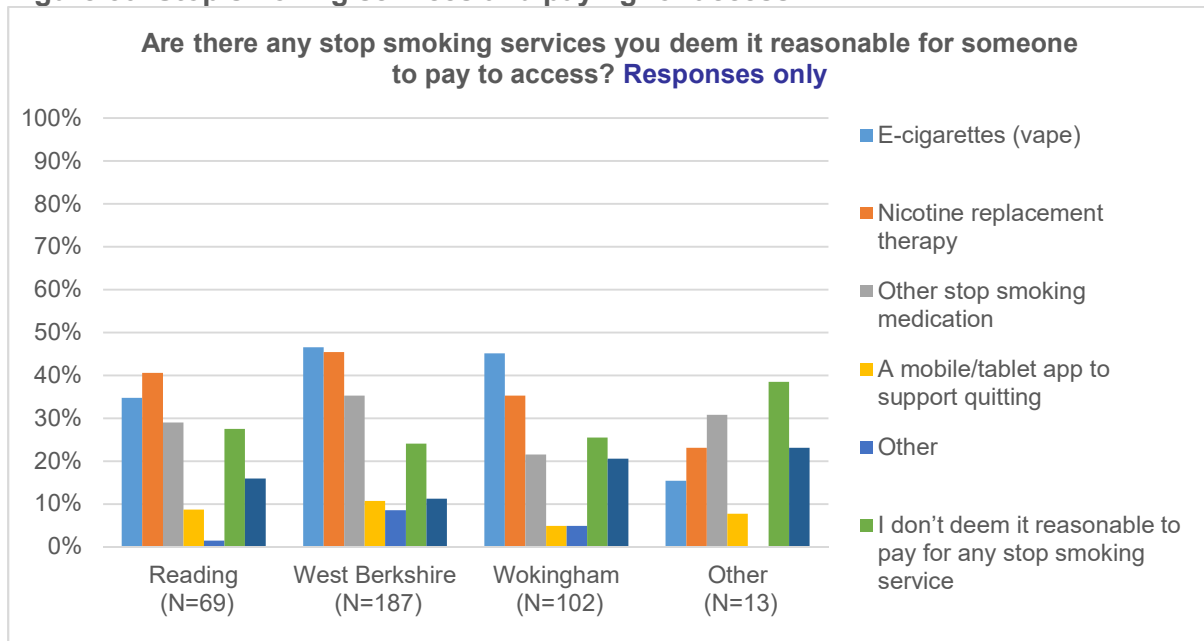
There were over 100 free-text comments when asked if it was deemed reasonable for someone to pay to access any of the stop smoking services listed. Whilst there appeared to be some support in paying to access e-cigarettes, NRT and other pharmacotherapy, a quarter (25.7%, n=92) did not deem it reasonable to pay for any stop smoking service.

The vast majority of free-text comments stated that they felt paying to access services would be a barrier to engaging with a stop smoking service and given the costs saved to the NHS, stop smoking support should be free.

There were no responses from residents in Wokingham supporting payment, other than a few suggestions it could be subsidised. Less than half of the free text comments from West Berkshire residents argued that insufficient funds in NHS should not be spent on smoking and that it might help to focus commitment. A minority of responses in Reading residents agreed with this. However, in all three local authorities the majority of free text responses deemed that support should be free to avoid cost being a barrier, recognition that it was an addiction and other addictions are paid for on the NHS and that as an evidence-based intervention it saved the NHS in the long-term.

A few comments suggested that e-cigarettes were a direct replacement for a cigarette and as such should be self-funded.

**Figure 50. Stop smoking services and paying for access**



*Opinions about smoking in their local area*

When asked if smoking is a problem, 69% of respondents living in Reading reported they 'strongly agree' or 'agree'. 64.2% reported the same in West Berkshire and 62.2% in Wokingham.

Many free text responses acknowledged the health benefits from stopping smoking and the subsequent impact of this on the NHS. Many outlined the cost savings that could be achieved through supporting smokers to quit, to the NHS, society and the individual, with a number of respondents recognising the personal cost to the individual smoker. A few respondents felt that it should not be the responsibility of the local authorities to pay for smoking cessation.

The proportion responding 'strongly agree' or 'agree' when asked if helping people to quit should be a priority was 80.7% in Reading, 76.6% in West Berkshire, 82.9% in Wokingham. Similar proportions of respondents reported smoking as an addiction, whilst others described it as a personal 'choice'. Several recognised that informed choice was important in supporting people to stop smoking and that smokers should be ready to quit. A number of respondents felt that prevention of smoking should be prioritised. Whilst there was a recognition that smoking prevalence had reduced over the years, some still acknowledged that there are people who require support.

Cigarette waste was thought to pose an environmental issue by respondents in all three Local Authorities with 86.2% of respondents in Reading, 79.8% in West Berkshire, 73.1% in Wokingham either 'strongly agree' or 'agree'. Several respondents highlighted second-hand smoke as an issue in some places, cigarette butts as littering and the environmental issues caused by this.

There was strong support for banning smoking across a number of different environments, including; children's playground, outside schools, on NHS hospital sites, within shopping precincts, inside homes with young children. Less support was given to banning it inside cars (42.5%) or any social housing rented (41%).

Many final free-text responses commented that they were not aware of stop smoking services available and had sought help from their GP practice with little result.

### Stakeholder engagement

The questionnaire was developed with input from members of Reading, West Berkshire and Wokingham Public Health Teams. It was hosted on the West Berkshire Consultation website. The design of the questionnaire had a range of questions, using box checking and free-text options. Links to the survey were circulated amongst relevant stakeholders across the three Local Authorities and wider partners including those outlined above in 'methods' of public engagement; These stakeholders were asked to share with wider circles as appropriate.

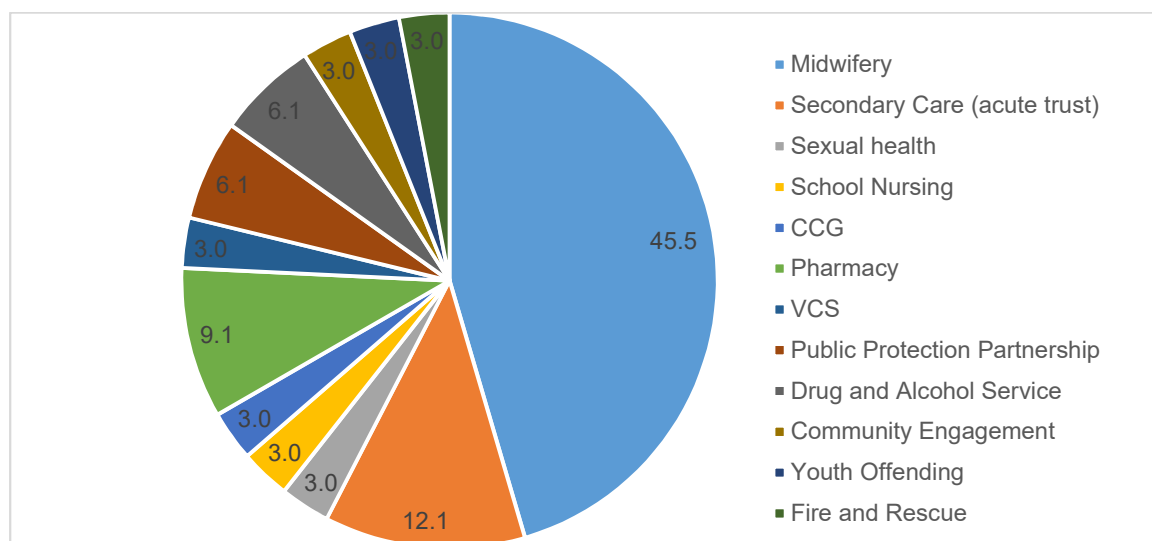
The survey was live for a 7-week period from 10<sup>th</sup> September to 28<sup>th</sup> October 2020.

### Survey Response

A total 33 stakeholders responded to the survey.

The majority of these stakeholders with from midwifery services. N=5 health professionals working in secondary care/acute trust included two professionals working in cancer services, one in Respiratory, one unidentified role.

**Figure 51. Survey respondents by profession**



### Awareness of Smokefreelife

81.8% had heard of Smokefreelife Berkshire. For those stakeholders who had not, suggestions to better promote awareness of the service included; inclusion in mandatory training/professional days, promotional material such as business cards in clinics/surgeries, leaflets included in pregnant women's 'Bounty' packs, posters in ward areas and through newsletters.

### Experience of Smokefreelife

Just over half (51.9%, n=14) of the respondents who had heard of Smokefreelife Berkshire had previously referred someone to the service. Of those who had previously referred, no one reported a negative experience and instead it was positive for the majority (n=5 excellent, n=5 very good) and n=4 satisfactory. Those that reported satisfactory stated they had only been given a phone number or completed an online referral form but had not received feedback or confirmation of the referral.

One stakeholder in the acute trust reported that they were previously able to raise an order for 'referral to Smokefreelife Berkshire' on the electronic patient record (EPR) but thought this was no longer collected or reviewed. Now, referral was made on the website, but the time taken to complete was deemed a barrier and instead an EPR referral allowed patient details to be populated making it quick and easy.

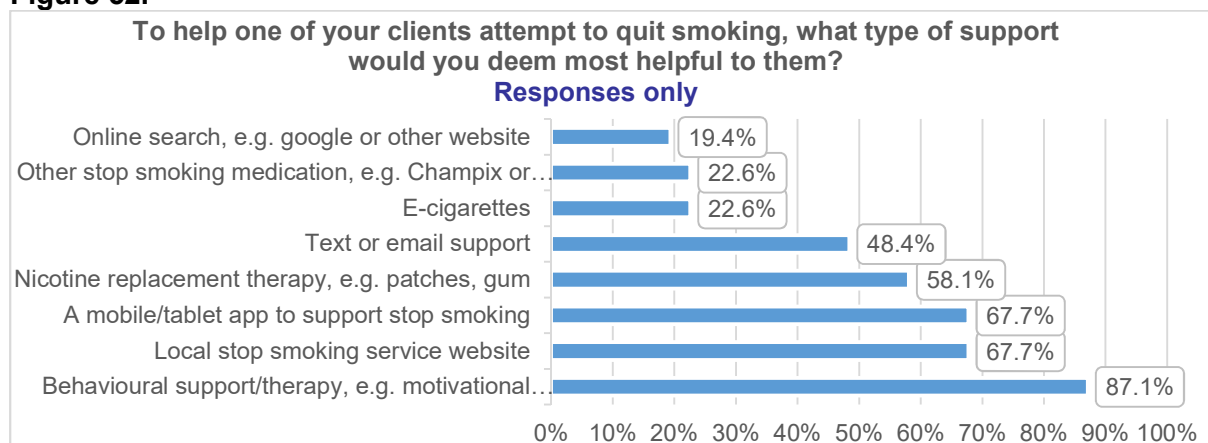
Respondents from drug and alcohol teams reported not having referred previously and one stated that they felt service users were not ready to quit.

N=7 respondents rated the effectiveness of the services provided by Smokefreelife Berkshire in helping smokers to quit positively (1= extremely effective, 6 = very effective). A further n=3 reported as somewhat effective and the remainder (n=4) reported 'don't know'. It was reported by a midwife that often patients are not contacted or only contacted once so do not take up the service. Another midwife requested an acknowledgement of referral and follow-up on actions taken. A pharmacist reported that clients are not always informed they need to make an appointment so are disappointed if a trained pharmacist/stock is not available.

### Views on helping someone to quit smoking

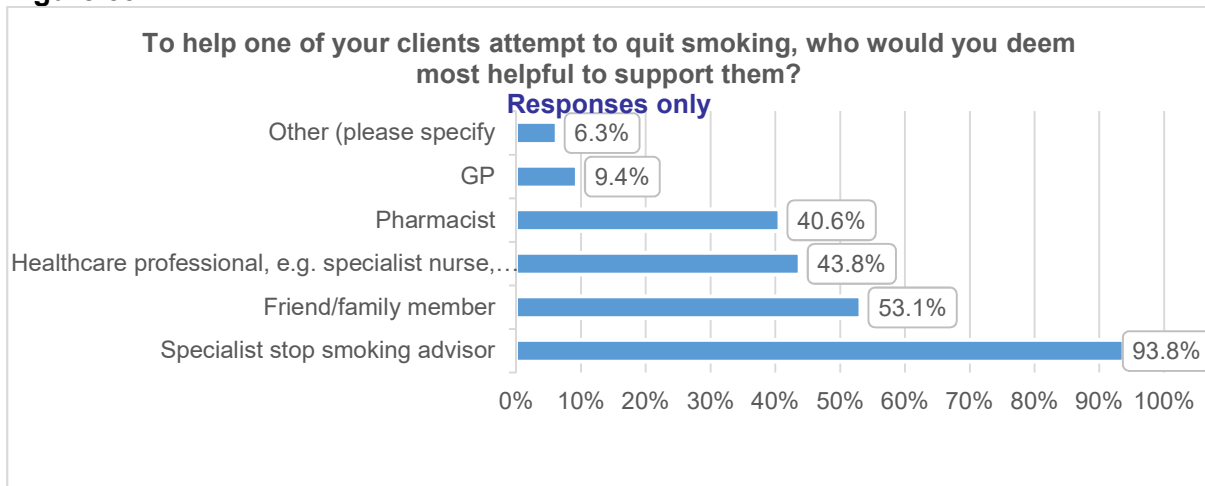
Support for digital services to support clients to attempt to quit smoking were ranked 2<sup>nd</sup> and 3<sup>rd</sup> after behavioural support/therapy, above pharmacotherapy by stakeholders.

**Figure 52.**



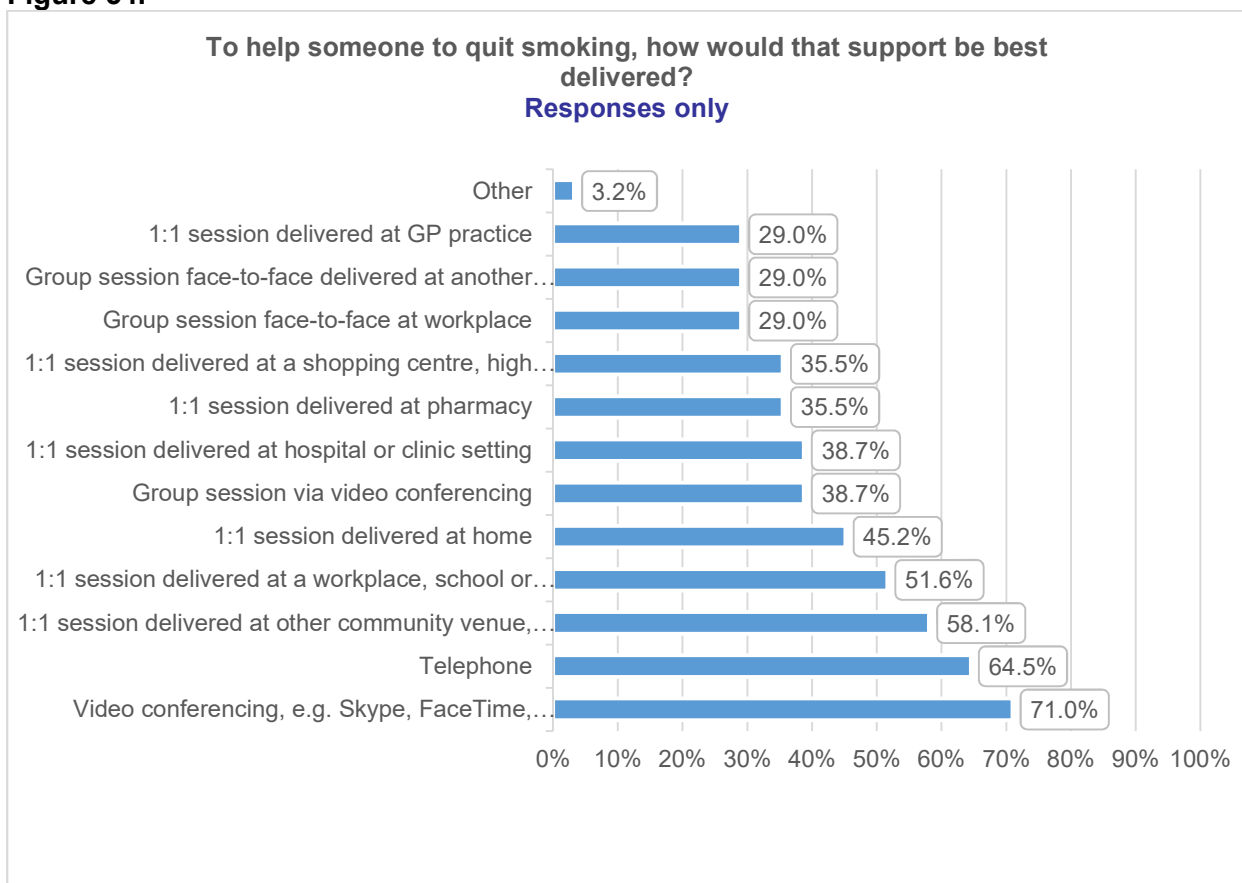
There was strongest support for specialist stop smoking advisors as the most helpful to support their clients to stop smoking (93.8% of responses). Only 9.4% suggested GP, and 40.6% pharmacist.

**Figure 53.**



Responses as to where support to stop smoking is best delivered was broadly the same as the public, however telephone support was more highly rated by professional stakeholders than the public and delivery at a GP practice much lower.

**Figure 54.**



*Views on local provision of support to stop smoking*

Stakeholders were asked what has worked well and what has not worked well in the local provision of support to stop smoking. Themes from free-text responses are given below.

What has worked well:

- Midwives valued the use of CO monitoring and availability of home visits
- The offer of regular face-to-face sessions within GP setting or via Skype
- Strengthened relationships between Pharmacy and local stop smoking service during Covid-19 pandemic as NHSmail used more frequently by specialist stop smoking advisors to access varenicline (Champix)
- A few stakeholders reported the value of presence in shopping centres

What has not worked well:

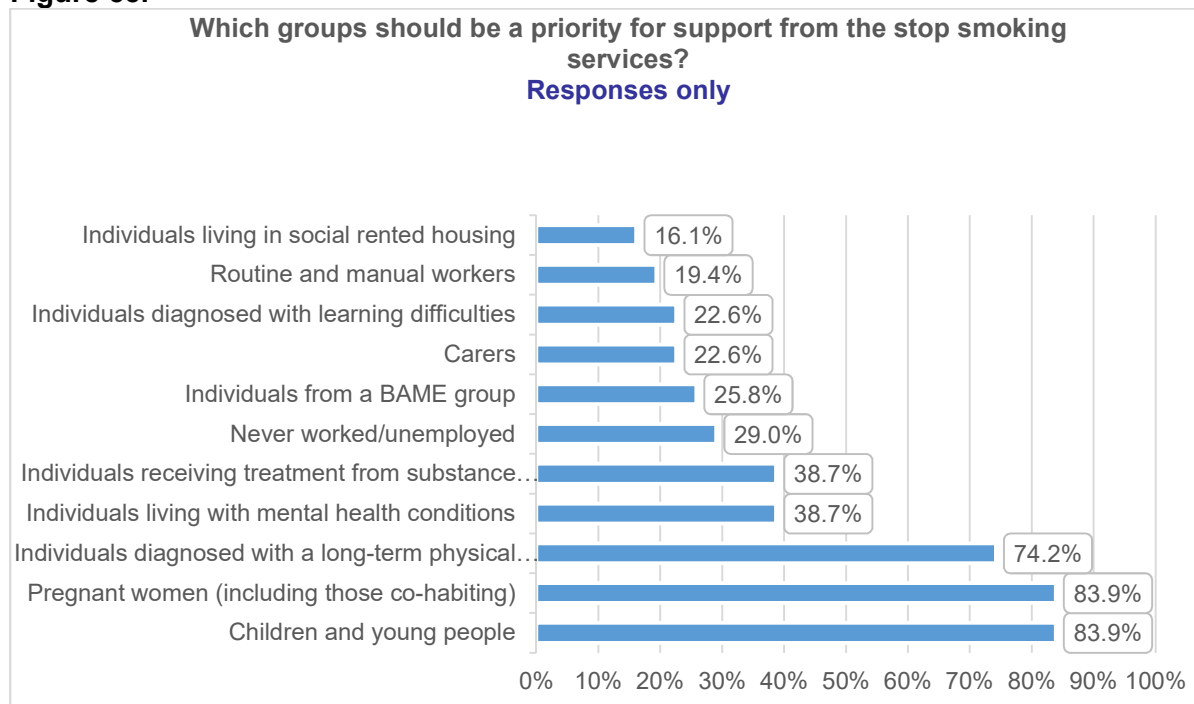
- Lack of feedback on referrals made (at least acknowledgement of receipt)
- Promoting resource (smoking cessation nurse in antenatal clinic) that are later withdrawn.
- There could have been improved connections between local smoking cessation advisors and local pharmacies? Need for ongoing support to certain groups
- Limited applicability and relevance to young people who smoke

Suggestions included mixed provision of face-to-face and digital. A stakeholder from the Community Engagement Team suggested in deprived areas, regular group sessions should be delivered to enable peer encouragement without it being 'time driven'.

*Priority groups*

When asked which groups should be a priority for support from the stop smoking services, the majority (83.9%) stated children and young people, pregnant women and those with a long-term physical condition were also deemed important (and probably a reflection of the responding stakeholder's clients/patients).

**Figure 55.**





When asked what could be done to increase the number of smokers that the local community stop smoking service support, the majority stated increased visibility of the service (89.7%). Other suggestions included better integration with services and agencies that have a reach into hard-to-reach groups and children and young people (Youth Offending Team), easier access located at pharmacies (drug and alcohol), local campaigns and social media influence.

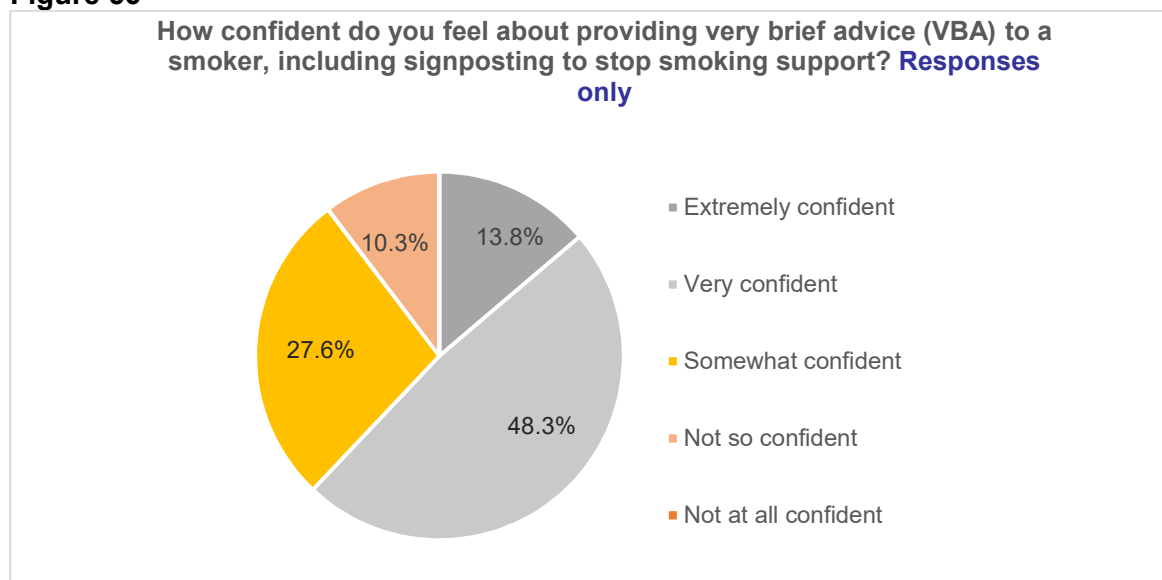
One acute trust health professional reported the value in the previous inpatient service that allowed ward patients to be referred and the use of EPR for outpatient referrals to the service.

69% of respondents felt that providing a digital offer would increase the number of smokers that the local community stop smoking service support.

### Very Brief Advice

The majority of respondents were confident in providing very brief advice, including signposting to stop smoking support. For those that were not confident, free-text comments in response to what would help them feel more confident reiterated the need for a responsive service to signpost smokers to and feedback from the referral e.g., timeline of action and how support is delivered.

**Figure 56**



Just over half of respondents reported working with smokers under the age of 18 (51.7%, n=15), however over a quarter (26.6%) felt 'not so confident' or 'not at all confident' in signposting young people to quit smoking. The only comments were one stakeholder that reported they felt unsure of the motivations for young people to stop and another who was unsure whether there is a referral service in local surgeries or schools.

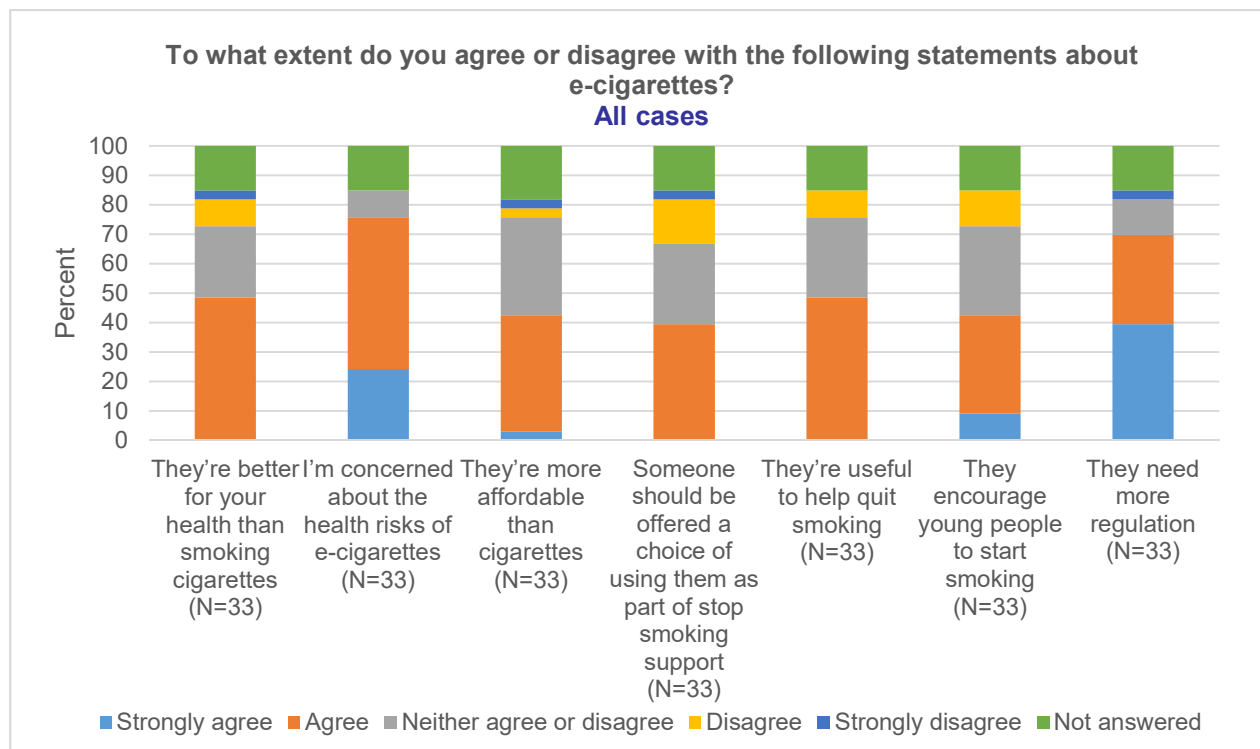
### E-cigarettes

A number of midwives disagreed that e-cigarettes were better for your health than cigarettes. Three-quarters of respondents expressed concerns over the health risks of e-cigarettes. Over 60% reported that someone should be offered a choice of using them as part of stop smoking support.

One individual commented that patients should have trialed other options that have a more substantial evidence base and safety data, before using e-cigarettes as a last option.

Some stakeholders felt there was an individual responsibility and people should pay for support, however, most reported the cost-effectiveness of stop smoking support and expressed concern that it would be a barrier to accessing support, particularly for those most vulnerable. One individual stated smokers who have free prescriptions should be able to access it free, and other should access it for the cost of the prescription, similar to many of the public responses.

**Figure 57.**



*Proposed future service delivery model*

Stakeholders were provided a link to a PowerPoint presentation and a brief summary of the proposed future service delivery model. This was based on the Professor Robert West (UCL) Stop Smoking + model. Stakeholders were invited to respond to three questions:

1. Which level of support do you think would be most effective for who, and why?

Perception that self-support, phone or Skype would be more appealing to the younger smokers, one stakeholder recognised rather than age, based on digital ability. In general, felt that specialist stop smoking support would be most appropriate for priority groups (particular reference given to those with mental health issues, young people supported by youth offending services, learning disabilities, diagnosed COPD, cancer with curative treatment intent, IHD). The need for specialist support to be given in a 'young person centred manner' was stated.

Respondents acknowledged that the level of support and its effectiveness would be dependent on level of motivation of smoker, level of nicotine dependence and their confidence in stopping smoking. Those with highest motivation would benefit from self- or brief-support, those 'long-term entrenched smokers' benefit from specialist support.

The brief support at Level 2 was deemed by some to be preferable to those who can't commit.

2. How and where do you think each level would be best delivered?

Suggestions for where level 1 support could be provided included; apps (via iPhone/android), social media (Facebook and Instagram), schools or from home via websites. The use of apps was felt to be more relevant during the pandemic.

Level 2 brief support was deemed best delivered in pharmacies, shopping centres or supermarkets, and video-links by stakeholders. Specialist support suggested delivery was in GP surgeries or specialist clinics and face-to-face. It was suggested to avoid clinical settings for hard-to-reach young people.

3. Please provide any comments on which aspects of the model may not work and why

One stakeholder expressed concern that those accessing self-support may 'hide' those least committed and they require more information. Concern that reliance on a digital service could increase health inequalities and would depend on balance of resource put into each level. Recognition that wide availability of places to deliver sessions to ensure rural access too. It was felt that all options should be interchangeable so appropriate level of support at different times.

One stakeholder suggested that for those hard-to-reach individuals, a service that allows for relapses and mistakes would be most helpful.

*Other comments*

A pharmacist who provides the Varenicline (Champix) Patient Group Directive (PGD) service, felt it would be beneficial to understand what behavioural support is provided and how pharmacy can provide support.

Deemed important in rural West Berkshire to have mobile and accessible services. One stakeholder from the substance misuse service expressed a wish to have their staff trained in smoking cessation to deliver services in house.

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