Executive Summary

Introduction

This needs assessment was completed in May 2017 by the Public Health Principal for Tobacco Control (with support from Magda Szapiel and Jackie Beavington), within the Adults and Older People’s Strategic Public Health Team in Bristol City Council (BCC). Identifying the gaps between what is needed and what is available, and planning how these gaps will be addressed within available resources is at the heart of this document. The key driver in developing this document is to inform the re-procurement of smoking cessation services.

Smoking cessation services are part of a wider programme of local authority commissioned services. In the future these services will be included within the proposed behaviour change procurement programme, due to be completed by April 2018. Consequently, this assessment should be seen as part of a wider commissioning programme of Behaviour Change, emphasising early intervention and prevention work across the life course and reducing future smoking related health inequalities and health and social care needs within the adult population.

This document looks at smoking and tobacco control in the context of current national and local policy and identifies populations groups who have high smoking and smoking attributable mortality prevalence rates. Although many of the measures, such as the advertising ban, smoke-free laws, taxation and standardised packaging, are self-sustaining, other measures, including mass media campaigns, smoking cessation services and enforcement measures,
such as tackling tobacco smuggling, require ongoing funding. The inequalities created by smoking will only be eliminated if these measures are sustained.

The needs assessment found evidence of current highly valued targeted and specialist services; however several gaps were identified, including poor local intelligence and uptake of commissioned services for specific population groups who are nationally known to have high smoking prevalence. There was also evidence of low numbers of referrals into smoking cessation services for those with high levels of smoking prevalence, an example being referrals from Mental Health Services. Our current commissioned services are not always meeting the needs of those who will benefit most. Recent changes within Bristol City Council’s in-house smoking cessation delivery function opens up the opportunity to review the current service model and to target population groups with high smoking prevalence.

Key issues and gaps

Smoking in Pregnancy and after Childbirth

- Smoking in pregnancy in some parts of the city is significantly higher in the city (30%) than the England average (10.6%)
- Older girls (in year 8) are more likely to smoke than boys in Bristol

Smoke Free Environments and Homes

- Other than the information provided through the Healthy Child Programme 0-5 (delivered by Midwifery, Health Visiting and Family Nurse Partnerships), it appears that Early Help Services and Early Years providers do not focus on reducing smoking in the home or exposure to second hand smoke amongst children.
- Approximately 5% of households in the city allow smoking in the home increasing risk of exposure to second-hand smoke and initiation of smoking in children and young people.
- In the 2015 Quality of Life Survey it was found that 4.7 % of smokers and non-smokers allowed smoking in the home. This increases to 12.3 % amongst people living in deprived areas and 10.4 % of households of disabled people.
- National campaigns are not targeted to high smoking prevalence populations and there are limited evaluations carried out to understand how national campaigns encourage behaviour change amongst population groups with high smoking prevalence.

Smoking in Children and Young People

- Although various services seek to reduce smoking initiation amongst children and young people as part of their overall offer, this is not the primary aim of any one service and there is a lack of a coordinated approach across the City.
- Approximately 87% of schools in Bristol City do not currently have Healthy Schools Status. These schools may need additional support in encouraging and supporting to develop smoke-free policies and practices in line with the relevant Healthy Schools criteria on smoking.
- Current smoking cessation services do not meet the needs of young people who smoke.
- There is evidence that the prevalence of smoking amongst 16 & 17 year olds in the city is higher than the England average and model based estimate.
• Although we have some information on smoking prevalence amongst young people it is not precise. Further work is needed to improve the quality of this data, especially for vulnerable groups such as children in care, youth offending, NEET's, Pupil Referral Units etc.

Smoking and Inequalities
• There continues to be significantly higher rates of smoking in routine and manual groups and in certain areas of the city for example in Hartcliffe & Withywood, and Lawrence Hill, there is a risk that this inequity may increase as the overall smoking prevalence decreases.
• Although we know that some population groups have higher prevalence rates of smoking nationally, little is known about these population groups at a local level due to poor equality monitoring.
• Health equity audits and ACORN modelling (market segmentation tool) is required to help us understand which population groups and geographical areas with high smoking prevalence are accessing our services and if there is an inequity amongst outcomes.
• Smoking rates continue to be particularly high amongst routine and manual, unemployed and long term sick and disabled in the city.
• National data highlights particularly higher smoking prevalence in adults from dual heritage, South Asian, Black Caribbean and Eastern Europe backgrounds who have settled in the UK including Bristol City. Uptake of service provision with positive outcomes are limited for such populations in Bristol
• There is limited research on smoking prevalence on new migrants that have settled in the UK from outside of the EU
• Available national and local evidence suggests that smoking prevalence is higher amongst lesbian, gay, bisexual and trans gay adults.
• Available national and local evidence suggests that smoking prevalence is higher amongst lone parents and ex-offenders than other groups.
• Smoking prevalence is significantly higher amongst adults with poor mental wellbeing and amongst adults with mental health problems.
• Adults who drink at levels which harm their health and adults with substance misuse problems have very high rates of smoking.

Illicit Tobacco
• Illicit and counterfeit tobacco is a significant source of the tobacco smoked in the city, making tobacco more readily available and contributing to crime in communities.

Service Performance
• Activity and quit conversion rates are low amongst our current providers, especially in area of high deprivation and amongst population groups who are nationally known to have high smoking prevalence.
• Poor equality monitoring as part of the death registry, and in primary and secondary care undermines the ability to understand which groups should be prioritised and how our local efforts and resources should be arranged to address health inequalities in the city.
• Low and poor quality referrals from local Trusts, impacts on the outcomes achieved once individuals are refereed on to smoking cessation services.
- Low referrals from agencies such as Health Visitor and Mental Health Services.
- Efforts to reduce smoking prevalence in local population groups need to include a place based approach and to address the wider determinates of health inequalities (e.g. debt management, employment etc).

**Alternative Models**
- Harm reduction options (with the use of e-cigs) need to be more readily available to high smoking prevalence groups who are not able to achieve an abrupt four week quit, this should be funded from the Local Authority nicotine replacement therapy budget.
- Various alternative models of delivery need to be developed to meet the needs of population groups with high smoking prevalence

**Recommendations**

**Smoking in Pregnancy and after Childbirth**
- Develop a multi-agency smoking in pregnancy pathway and enhance interventions to reduce smoking in pregnancy and support women who want to quit based on the latest evidence in the Healthy Child Programme Rapid Review.
- Implement the Smoking in Pregnancy and Childbirth NICE recommendations which aim to help areas to reduce smoking rates in pregnancy using a whole systems approach. The indicators bring together existing resources to help support areas to identify situations where they could positively impact rates of smoking in pregnancy.
- Develop interventions to reduce the exposure of children to second-hand smoke in different settings, including in the home and outdoor areas, and assist with reducing the number of children that start smoking as a result of living in a smoking home and family.
- Ensure that providing information around smoking (including risks of exposure to second hand smoke amongst babies and children), brief intervention and referral to smoking cessation services is prioritised in the service specifications for all maternal, health visiting and early years services.

**Smoking in Children and Young People**
- Targeted and early intervention in young adulthood could positively impact on the prevalence of smoking related mortality in the city over the next thirty to fifty years.
- Provide a coordinated approach across the city to reducing smoking initiation and smoking prevalence amongst children and young people across agencies/services.
- Ensure services who work with young people provide evidenced based support/brief intervention around smoking and particularly target those at greatest risk; including pupils who have truanted or been excluded from school and pupils who receive free school meals.

**Smoke Free Homes and Environments**
• Target local campaigns at population groups who have the highest smoking prevalence, by working with communities to develop insights and shared ownership.

Smoking and Inequalities
• Develop specific pathways and service models for people with different levels of mental health problems.
• Work alongside the local Sustainability Transformation Footprint to fully implement NICE guidance PH45 (Smoking cessation in secondary care: acute, maternity and mental health services) via the Preventing ill health by risky behaviours – alcohol and tobacco Commissioning for Quality and Innovation (CQUIN).
• Ensure services are targeting and impacting upon smoking rates in more deprived areas and amongst population groups with high smoking prevalence (highlighted in this paper).
• Ensure pathways and appropriate service models exist for people with drug and alcohol problems who wish to stop smoking or reduce the harm from tobacco (including ex-offenders).
• Ensure new providers are collating and reporting on equality data.
• Carry out a Health Equity audit to determine which groups (to include deprived areas, lone parents and those with protected characteristics) are not accessing smoking cessation services, which are least likely to stop smoking and to determine effective interventions, that include harm reduction approaches.
• Ensure there are simple pathways in place to signpost people on to community based support e.g. employment, debt management etc.

Illicit Tobacco and Smoke Free Environments
• Allocate resources to tackling illicit and counterfeit tobacco.
• Develop and promote smoke free environments, and support new tobacco control legislation with communication in the city.

Service Performance
• Work with local agencies to improve the quantity and quality of referrals.
• Explore alternative delivery options to improve uptake and successful outcomes.

Alternative models
• Local intelligence about tobacco use among Black, Asian and Minority Ethnic and other population groups, some of which have other protected characteristics has important implications when planning local health services, tackling health inequalities and reducing the burden of ill health from lifestyle-related disease.
• Monitor the evidence and guidance relating to the use of e-cigarettes in harm reduction and smoking cessation and evaluate the harm reduction approach used across the city with a view to roll out amongst priority population groups.
• Re-commission the smoking cessation /harm reduction services targeting population groups with high smoking prevalence, offering flexible services that meet their needs.
Identify how smoking cessation and tobacco control initiatives can be integrated into the Local Authority Policy and commissioning arrangements.

**JSNA Chapter Report**
**What do we know: The National Context**

1. **Who is at risk and why?**

**Health and Social Impact**
Tobacco use remains one of the most significant Public Health challenges and is the primary cause of preventable illness and death. About half of all life-long smokers will die prematurely and on average, cigarette smokers die 10 years younger than non-smokers.

Every year smoking causes around 80,000 deaths in England. Smoking causes 80% of deaths from lung cancer, bronchitis and emphysema, and 14% of deaths from heart disease (Action on Smoking and Health (ASH), 2016).

Stopping smoking reduces the risk of developing many fatal diseases. One year after stopping, the risk of a heart attack falls to about half that of a smoker. Within 15 years the risk falls to a level similar to that of a person who has never smoked. If smokers quit before the age of 30 they can avoid almost all of the risk of lung cancer attributable to smoking. The earlier an individual stops smoking the longer their life expectancy is likely to be.

**Figure 1: Smoking and Disease (ASH, 2016)**

<table>
<thead>
<tr>
<th>Smoking causes:</th>
<th>Secondhand smoke causes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 14% of deaths from heart disease</td>
<td>• An increased risk of coronary heart disease by 25-35%</td>
</tr>
<tr>
<td>• Smokers under the age of 40 have a</td>
<td>• Children to be born underweight,</td>
</tr>
<tr>
<td>five times greater risk of a heart</td>
<td>• Harm to babies and children, with an increased risk of</td>
</tr>
<tr>
<td>attack than non-smokers</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Increased risk of cot death and glue ear.</td>
</tr>
<tr>
<td>Teenagers to have;</td>
<td>• 80% of deaths from lung cancer</td>
</tr>
<tr>
<td>• more asthma and respiratory</td>
<td>• An increased risk of lung cancer in non-smokers by 20-30%</td>
</tr>
<tr>
<td>symptoms</td>
<td></td>
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<tr>
<td>• poorer health,</td>
<td></td>
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<tr>
<td>• more school absences</td>
<td></td>
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<tr>
<td>• lower fitness levels</td>
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<td></td>
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<tr>
<td>• 80% of deaths from bronchitis</td>
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There are multiple negative effects of smoking, including:

- Increased sensitivity and reduced lung function in people with asthma;
- Irritation of the eye, nose and throat;
- Reduced lung function in adults with no chronic chest problems.

- More than one quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, pancreas, stomach, liver and cervix.
- It is estimated that globally 600,000 deaths a year are caused by secondhand smoke.
- Most of these deaths are among women and children.

The total smoking cost to society amounts to approximately £12.9bn compared with £9.5bn of income from taxation on tobacco products (Action on Smoking and Health (ASH), 2017). This includes significant costs to the NHS and Local Authorities. Smokers take more sick leave than non-smokers and more breaks during the day. Cutting the level of smoking can improve productivity for small businesses (Featherstone, 2014). Cigarettes and other smoking materials are the primary cause of fatal accidental fires in the home. In 2014/15, smokers’ materials accounted for 59 deaths and 456 causalities in England - over a third of all accidental dwelling fire deaths (Action on Smoking and Health (ASH), 2017).

In 2015, the total UK household expenditure on tobacco was estimated to be £19.3bn. A 20-a-day smoker of a premium brand will spend about £3600 a year on cigarettes. This could increase to over £7,000 a year for a family with two parents smoking (Action on Smoking and Health (ASH), 2017). This can be a significant proportion of the income of a family earning for example £21,000 a year. As a result they are more likely to require services like food banks (All-Party Parliamentary Inquiry into Hunger in the United Kingdom, 2014). Stopping smoking can make a significant difference to household incomes, supporting people to budget in difficult times. There is also evidence to show that money saved when people quit is spent locally thus supporting the local economy (Public Health England, 2014).

Other short-term benefits of stopping smoking include an improvement in appearance, mental wellbeing and mental health symptoms (Shahan, 2013).

**Trend and prevalence in adult smoking**

Less than 1 in 5 of adults now smokes: 19% of men and 15% of women. This means there are about 9.1 million adult smokers in the UK. Smoking rates have more than halved since 1974 when 51% of men and 41% of women smoked. Smoking prevalence is highest in the 25-34 age groups (24%) and lowest amongst those aged 60 and over (10%). Smoking rates are much higher among poorer people. In 2015, 12% of adults in managerial and professional occupations smoked compared with 28% in routine and manual occupations.
This has reduced from over 50% of men and 40% of women to 22% of men and 17% of women in 2013 to an overall prevalence of 19% of adults smoking (figure 2).

Figure 2: Trend in smoking in England 1974 to 2013 Health & Social Care Information Centre (2014)

Exposure to second-hand smoke in adults
Exposure to second-hand smoke can increase the risk of lung cancer in non-smokers by 20-30% and increase the risk of coronary heart disease by 25-35% (Action on Smoking and Health (ASH), 2016). The Health Survey for England has found that amongst adults, exposure to second-hand smoke was highest amongst men and 16 to 24 year olds and decreased with age (Royal College of Physicians, 2010). The most reported areas for exposure were outdoor areas outside pubs/restaurants and cafes, followed by other people’s homes and people’s own homes.

Usage of manufactured and hand rolled cigarettes
Releases of cigarettes for home consumption have fallen since the mid 1990’s. Around 31.6 billion sticks were released in 2015; 62% less than in 1996. Between 2004 and 2013, releases of hand-rolling tobacco more than doubled, reflecting the increase in the proportion of adults who smoked hand-rolled cigarettes. Releases have fallen by 2% since 2013, (Health and Social Care Information Centre, 2016).

Illicit and counterfeit tobacco
Illicit and counterfeit tobacco products are cigarettes, hand-rolling tobacco or niche products (such as bidis and shisha) that have been smuggled or are counterfeit or illicit. A high proportion of illicit and counterfeit cigarettes coming into England are mass produced and factory-made at known locations, mainly outside the EU (Tackling Illicit Tobacco for Better Health partnership, 2014). HMRC ‘tax gap’ estimates published in 2015-16 give an indicative market share of 13% for cigarettes.
and a tax gap of £1.6 billion and 32% for hand rolling tobacco with a tax gap of £0.8 billion (HM Revenue & Customs, 2016).

There is no evidence that smoking illicit and counterfeit tobacco is any more harmful to health than smoking legal, duty-paid tobacco. Smoking kills at least half of all life-long users, whether it is illicit and counterfeit or duty-paid tobacco. However, illicit and counterfeit tobacco particularly impacts on our communities in the following ways:

- Funds and supports serious and organised crime - there is evidence that illicit and counterfeit tobacco funds organisations such as the international criminal and terrorist organisations (Wilson, 2009), (Chen, 2009) and (Sharrock, 2006).
- At significantly less than half the price of legitimate tobacco, it makes tobacco affordable and accessible to everyone including children and young people, ensuring people start young and continue the habit into adulthood.
- Impacts legitimate traders who cannot complete with illicit prices.
- Creates a huge loss of revenue for the Government
- More likely to cause fires as often illicit and counterfeit cigarettes are not self-extinguishing (under UK and EU law, cigarettes must have a reduced ignition propensity (RIP) i.e. self-extinguishing).

In recent years a lot of progress has been made nationally to reduce the high levels of illicit and counterfeit tobacco. Action by HM Revenue & Customs (formerly Customs & Excise) since 2000 has resulted in a reduction of the illicit cigarette market by half and a reduction of the illicit tobacco market by a third (HM Customs and Excise – tackling illicit tobacco from leaf to light, 2015). Public opinion is largely in favour of increased taxation, according to various opinion polls (Action on Smoking and Health (ASH), 2013). High levels of illicit and counterfeit tobacco means there is a significant loss of revenue to the government, estimated at 2.4 billion in 2015-16.

**Waterpipes and Shisha**

Waterpipes are also known as shisha, hookahs, narghiles, or hubble-bubble pipes. Research has found that waterpipe smoke contains many of the similar toxins and carcinogens to cigarette smoke and those smokers have more than double the risk of lung cancer, respiratory illness, low birthweight and periodontal disease (Action on Smoking and Health (ASH), 2013). However shisha users can inhale significantly more smoke in a session (e.g. 45 minutes) with significant increased carbon monoxide blood levels. A UK cross sectional study in 2012/13 found that 1% of the adult population used shisha regularly (at least once or twice a month) and that use was more common amongst adults of Asian (7%), Mixed (5%), and Black (4%) ethnicity than amongst white adults (0.5%) (Grant, 2014). Factors which increased usage were being male, being from a higher social grade and being younger.
Smokeless tobacco
Smokeless tobacco increases the risk of oral, oesophageal and other cancers and cardiovascular disease (Action on Smoking and Health, (ASH), 2012). In England, smokeless tobacco is combined with other ingredients in traditional South Asian products including Betel quid or paan, gutkha and zarda. Although products should contain health warnings, many chewing tobacco products on sale in the UK do not (Action on Smoking and Health (ASH), 2011). Data from the 2004 Health Survey for England indicated that prevalence of smokeless tobacco use were highest in Bangladeshi women (19%), followed by Bangladeshi men (9%), Indian men (4%) and Pakistani men (2%) (Millward & Karlsen, 2011). Research in the UK has particularly (but not exclusively) focused on the Bangladeshi community. Research has found that people use the products for reasons relating to tradition and cultural heritage, as well as using smokeless tobacco as part of a habitual practice that has a deeply rooted social component. It is used to relieve stress, boredom or relax, and there are some beliefs about negative and positive health effects (Messina, et al., 2012).

Electronic cigarettes
As of May 2016, e-cigarettes were regulated as medicinal products, similar to other nicotine delivery products, following the EU Tobacco Products Directive passed by the European Parliament in February 2014.

The Health and Social Care Information Centre (Health and Social Care Information Centre, 2016) found that there were an estimated 2.3 million current e-cigarette users in England in 2015. This represents 4% of adults in Great Britain although usage varied by age and gender. In relation to reasons for using e-cigarettes, 53% of e-cigarette users gave the main reason for use “as an aid to stop smoking”. The next most common reason was “they are perceived to be less harmful than cigarettes” (22%).

More recent and in depth analysis through the Smoking Tool kit study (West, 2015) has found that use amongst never smokers is extremely rare, that 85% of e-cigarette users also smoke, that 22.9% of smokers and recent ex-smokers use e-cigarettes and 14.9% use them daily. The prevalence of usage has plateaued since 2014. Usage is higher than nicotine replacement therapy. The study has estimated that 20,000 smokers stopped smoking last year who would not have stopped smoking otherwise. There is an emerging body of research linked to e-cigarette use amongst deprived populations, currently little is known about which population groups are more or less likely to use e-cigarettes.

Smoking, age and gender in adults
During 2015, a higher proportion of men (20%) smoked cigarettes than women (17%), particularly in the younger age groups (figure 3). Smoking prevalence peaks in the 25-34 years age group (30% of men and 20% of women) and decreases with age.
Smoking and socio-economic classification
Smoking prevalence differs by occupation as a marker of socioeconomic group. Nearly 30% of adults in ‘routine and manual’ occupations are smokers. Routine and Manual (R&M) smokers are defined by their occupation (according to the Standard Occupational Classification, or SOC, codes). The SOC codes in terms of R&M groups include occupations such as lower supervisory and technical or routine and semi-routine occupations. This compares to 14% of adults in ‘managerial and professional’ occupations (Figure 4) (Health & Social Care Information Centre, 2014). Prevalence of smoking in routine and manual groups has been steadily declining from 33% in 1998.
When looking at smoking status by economic activity, across time those who are employed are less likely to be smokers than those who are unemployed and looking for work. In 2015, of all employed persons 18.8% were current smokers whereas 29.3% of those unemployed or looking for work were current smokers. Since 1990, smokers who are unemployed or currently looking for work tend to smoke more cigarettes each day relative to smokers who are currently employed. However, in 2015 the gap in cigarette consumption between smokers who are employed versus smokers who are looking for work was minimal.

**Figure 5: Adult Smoking trend in England by Deprivation quintile**

Whilst smoking has decreased across the deprivation gradient, higher rates of smoking continue to be correlated with increasing deprivation as they were in 1973. Smoking relates in the most deprived fifth of England are the same as the England average in 1990 (figure 5).

**Smoking and ethnicity**

Analysis of smoking prevalence by ethnicity published by the Race Equality Foundation (Millward & Karlsen, 2011), highlights variation across ethnic groups in the levels of smoking by sex (figure 6). Amongst men, over a third of Black Caribbean and Bangladeshi men smoked, which was much higher than the general population at the period (no statistical comparison is published). Smoking rates are highest amongst women from Black Caribbean and White Groups, which are similar to the average level of smoking amongst women. Little is known about smoking prevalence for migrants from outside of the EU. Local intelligence about tobacco use amongst these groups has important implications when planning health services, tackling health inequalities and reducing the burden of ill health from lifestyle-related disease.

**Figure 6: Prevalence of smoking by ethnic group and sex, (2006-2008)**
Aspinal and Mitton analysed adult smoking rates from the 2009/10–2011/12 (Integrated Household Survey, 2014) by country of birth and found that smoking prevalence was substantially higher amongst migrants from East European countries (figure 7) and from Turkey and Greece.

**Figure 7: Smoking prevalence (2009/10- to 2011/12) amongst migrants from EU Accession countries which were the greatest source of immigration in Bristol (2013/14)**

<table>
<thead>
<tr>
<th>Country of birth</th>
<th>Smoking prevalence (males)</th>
<th>Smoking prevalence (females)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poland</td>
<td>39.4%</td>
<td>30.0%</td>
</tr>
<tr>
<td>Romania</td>
<td>36.1%</td>
<td>22.9%</td>
</tr>
<tr>
<td>Hungary</td>
<td>32.6%</td>
<td>17.8%</td>
</tr>
<tr>
<td>Lithuania</td>
<td>53.5%</td>
<td>33.2%</td>
</tr>
<tr>
<td>Slovak Republic</td>
<td>50.7%</td>
<td>35.9%</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>37.6%</td>
<td>29.6%</td>
</tr>
</tbody>
</table>

Source: Nino National Insurance Registrations

**Smoking and sexual orientation**

There is some evidence that people from lesbian, gay, bisexual and trans (LGBT) groups smoke at higher rates than the general population (National Centre for Smoking Cessation and Training, 2014). Analysis of data from the 2014 Integrated Household survey supports this, in particular in relation to gay and lesbian people (figure 8). The reasons behind this are not well known, but there are suggestions from U.S. research that gay and lesbian social spaces (such as bars), violence,
stress, and discrimination, as well as barriers to healthcare access and treatment services, contribute to the higher rates of smoking (Lee, 2009).

**Figure 8: Smoking and sexual orientation in England 2013 (Public Health England, unpublished analysis)**

**Smoking and mental health and substance misuse**
Smoking rates amongst people with a mental health condition are significantly higher than in the general population and there is a strong relationship between smoking and mental health conditions, (Royal College of Physicians and Psychiatrists, 2016). This association becomes stronger relative to the severity of the mental condition, with the highest levels of smoking found in psychiatric in-patients (Jochelson et al., 2006) and (Royal College of Physicians and Psychiatrists, 2016). It is estimated that of the 10 million smokers in the UK about 3 million have a mental health condition (Royal College of Physicians and Psychiatrists, 2016). It is not clear whether smoking is the cause or effect of mental conditions. However, some researchers believe that smoking may act as a trigger for mental ill-health (West, 2005).

As a result of high smoking rates, people with a mental health condition also have high mortality rates compared to the general population. Quitting smoking is particularly important for this group since smoking is the single largest contributor to their 10-20 year reduced life expectancy (Primary Care Mental Health Forum, 2014).

A systematic review by Taylor (Taylor, 2014) found significant improvements in anxiety, depression, and stress following smoking cessation. The size of the effect was as large amongst patients with mental health problems as with those without, and similar or larger than those of antidepressant treatment for mood and anxiety disorders. This supports the view that smoking cessation is positive for mental health, and that it is the withdrawal symptoms from smoking that cause worsening of mental health symptoms rather than smoking improving them.
Although there are no official national statistics on concurrent smoking and substance misuse for adults, high prevalence figures have been reported in multiple studies. A recent unpublished pilot found that 89% of opiate users and 77% of alcohol users in substance misuse treatment smoked (compared to 17% nationally). The same pilot found that 45% of substance misuse workers smoked.

The recent Public Health England (Public Health England, 2016) report linked to the increase in drug related deaths, found evidence that heroin users with chronic obstructive pulmonary disease (COPD) due to long-term smoking are at higher risk of overdose death.

**Smoking and pregnancy**
ASH report that smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK (Action on Smoking and Health (ASH), 2013).

Given the damage that tobacco smoke can have on an unborn child, it is paramount that rates of smoking in pregnancy are reduced. Although rates are lower than in the past, over 12% of women in England are recorded as smoking at the time of delivery, which translates into over 83,000 infants born to smoking mothers each year (Action on Smoking and Health (ASH), 2013). Smoking rates not only vary by region but also by age and social group: Pregnant women from unskilled occupation groups are five times more likely to smoke than professionals, and teenagers in England are six times more likely to smoke than older mothers. Infants born to smokers are much more likely to become smokers themselves (Action on Smoking and Health (ASH, 2013), which perpetuates cycles of health inequalities. The government’s two priorities for public health are increasing healthy life expectancy and reducing inequalities, (Department of Health, 2012). In order to achieve this, giving every child the best start in life must be made a priority and this has to include protecting babies from the damage of tobacco smoke, both before and after birth.

Smoking prevalence is measured by Smoking at Time of Delivery (SATOD) rates recorded at the time of giving birth. In England, SATOD rates have steadily been declining from 17% in 2005 to 10.6 % in 2016(Health & Social Care Information Centre, 2016). However, this still equates to just over 67,000 infants born to smoking mothers in England, Action on Smoking and Health (ASH), 2016).

SATOD rates vary amongst certain groups. Women who smoke in pregnancy are more likely to be under 20 years old (57%) and from the routine and manual occupational group (40%). Mothers aged under 20 are the least likely to give up smoking at some point before or during pregnancy.

**Smoking and second-hand exposure in children**
It is important to recognise that it is children who start smoking, not adults. Almost two thirds (65%) of smokers start before they are aged 18(Health & Social Care Information Centre, 2014).
Children who grow up in households where those around them smoke are 3 times more likely to become an adult smoker. Exposure to household smoking (role models) generates about 20,000 new smokers by the age of 16 each year, (Leonardi-Bee, 2011).

Children and adolescents with behavioural disorders are at significant increased risk of initiating smoking compared with those without, (Royal College of Physicians, 2013).

In 2013, 22% of young people in England aged 11 to 15 years said they had tried smoking at least once—the lowest level recorded since the smoking Drinking and Drug Use Survey began in 1982. 3% were regular smokers (9% in 2003). Older pupils were more likely to be regular smokers than younger pupils (8% of 15 year olds compared to less than 0.5% of 11 and 12 year olds).

The 2010-2015 Government’s Tobacco Plan (Department of Health, 2011) set an ambition to reduce the proportion of 15 year olds who smoke regularly to 12% or less by 2015. This target has been achieved (figure 9). Public Health England is seeking to build upon this strategy with their ambition for England to have a tobacco-free generation by 2025, (Fenton, 2015). This is defined as a smoking prevalence of 5% amongst 15 year olds.

Figure 9: Percentage of 15 year olds who smoke regularly (1998-2013) Health & Social Care Information Centre (2014)

The Royal College of Physicians identified that exposure to second-hand smoke is a significant cause of morbidity and mortality to babies and children in the UK, (Royal College of Physicians, 2010). In the report, following multivariate analysis on the impacts of passive smoking, the authors conclude that children from poorer backgrounds have higher exposure to second-hand smoke even allowing for higher parental smoking rates. Also those modifiable risk factors have the greatest impact on exposure to second-hand smoke (whether the child lives in a home where smoking occurs regularly, whether the parents smoke, and whether the child is looked after by carers). Other similar predictors for smoking in adolescents were found in a longitudinal study, including spending time in smoky places, IMD school score, and household smoking rules (Smith et al. 2009).
Cigarettes are also used as a currency in child grooming and sexual exploitation where young people receive something such as cigarettes as a result of performing, and/or others performing on them, sexual activities (Local Government Association, 2013).

There are concerns that marketing of e-cigarettes could be particularly appealing to children and young people resulting in increased use of these products in this age range (Bauld et al., 2014). There are also potential poisoning risks with children experimenting with e-cigarette liquids (Child Accident Prevention Trust, 2014). However the proportion of children who have tried these products has been found by one survey to be low. There is a debate as to how this potential risk of exposure should be considered in relation to the potential for e-cigarettes to reduce tobacco related harm in the population, (Britton, 2014). It is proposed that the marketing of e-cigarettes in the UK should be more controlled in relation to under 18’s, (Bauld et al. 2014).
2. What is the size of the issue in Bristol?

**Smoking and associated costs to the local NHS and Local Authority agencies**

Bristol has higher rates of smoking attributable hospital admissions, smoking attributable mortality and deaths from COPD compared to the England average (Public Health England, 2015). The total annual costs to the local NHS in Bristol due to smoking related ill health is approximately £16.7m (Action on Smoking and Health, (ASH) 2015) (see figure 10).

It is estimated that the cost per capita of smoking attributable hospital admissions in people aged 35 years and over (2011/2012) is lower at £27.5 in the city than the England average of £38.0 (Public Health England, 2015). It is estimated that each year smoking costs ‘society’ in Bristol approximately £114.0m (Action on Smoking and Health (ASH), 2015). Although the costs of smoking to the NHS and to the economy in general are well understood, there are also costs to the social care system, which are less well known.

Current and ex-smokers who require social care in later life as a result of smoking – related illnesses cost Bristol City Council an additional estimated £5.2m each year. As a result of smoking, nationally 52,000 more people are receiving care provided by a local authority or private provider. A further 98,000 are receiving care from a relative or friend. If ex-smokers are included in the number of additional people being cared for by friends and relatives this goes up to 234,000 people. Smoking-related illnesses place a burden not only on services but on individuals and their family life, (Action on Smoking and Health (ASH), 2017).

**Figure 10: Estimated costs of smoking (£millions) in Bristol City**

<table>
<thead>
<tr>
<th>Category</th>
<th>Cost in millions £s per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost to the local economy</td>
<td>£28.9</td>
</tr>
<tr>
<td>Smoking breaks</td>
<td>£47.7</td>
</tr>
<tr>
<td>Smoking-related sick days</td>
<td>£9.0</td>
</tr>
<tr>
<td>Total annual cost to NHS</td>
<td>£16.7</td>
</tr>
<tr>
<td>Current and ex-smokers care in later life as a result of smoking-related illnesses:</td>
<td></td>
</tr>
<tr>
<td>Cost to Bristol City Council</td>
<td>£5.2</td>
</tr>
<tr>
<td>Cost of self-funded care</td>
<td>£4.3</td>
</tr>
<tr>
<td>Impact of accidental fires</td>
<td>£2.1</td>
</tr>
<tr>
<td><strong>Smoking cost to society total</strong></td>
<td><strong>£114.0</strong></td>
</tr>
</tbody>
</table>

Source: Action on Smoking and Health, The Local Cost of Tobacco (2015)

The Care Act (2014) placed a duty on local authorities to enable access to services that reduce the need for support among people and their carers in the local area, and contribute towards preventing or delaying the development of such needs. Since smoking doubles the risk of developing care needs, it is highly relevant when considering the provision of preventive services. The cost to self-funders (individuals who do not meet the local authority means test) in Bristol is approximately £4.3 m (Action on Smoking and Health (ASH), 2017).
However, for the reasons above, and because self-funders may well opt for more expensive services, this estimate is expected to be low.

**Smoking breaks and sick leave costs**

With the average cigarette taking about seven minutes to smoke, and smokers taking an average of four cigarette breaks a day, this equates to a vast amount of time lost smoking breaks. Local calculations show that smoking employees cost Bristol business’s approximately £47.7 m per year.

Figures from the Office for National Statistics looking at the smoking and working habits of 300,000 Britons, also found smokers take more sick days than the average employees. These sick days alone are estimated to cost the local economy £9 m each year.

**Return on Investment**

It is estimated that in Bristol investing an additional £2,061,916 in the interventions we currently commission would save £1,062,584 in the short term (two years) and would give more returns over time. After five years for every £1 invested, the local economy would see a return of £1.93 (if 30% of all adult smokers were offered smoking cessation interventions). More work is required to understand the return on investment at a local level for each part of the local economy. All the key tobacco control measures set out in the WHO Framework Convention on Tobacco Control have now been implemented in England. Many of these measures, such as the advertising ban, smoke-free laws, taxation and standardised packaging, are self-sustaining. However other measures, including mass media campaigns, smoking cessation services and enforcement measures such as tackling tobacco smuggling require ongoing funding. The inequalities created by smoking will only be eliminated if these measures are sustained.

Given that local spending will be tightly controlled for some years to come, it may be necessary to find new ways of raising funds to pay for tobacco control measures. The tobacco manufacturers, whose products cause so much health, social and economic damage, should make a greater contribution to mitigating that harm. The four major tobacco manufacturers remain among the most profitable corporations on earth, so they could certainly afford to do this.

**Social Value and Return on Investment**

Investing in such prevention interventions would not only pay health dividends for current and future generations, but fewer people living with serious conditions would also reduce costs to public services, families and carers as well as enabling people to be able to return to work or volunteering and to be actively engaged in community life.
Impact of smoking in Bristol

Smoking attributable Mortality and Hospital Admissions

Bristol has significantly higher rates of smoking attributable admissions to hospital and deaths from COPD and smoking attributable mortality than England (Public Health England, 2015). When rates are compared with Bristol's nearest statistical neighbours, Bristol has the third lowest rates of smoking attributable mortality, second lowest rates of smoking attributable deaths from heart disease and the second lowest rates of deaths from lung cancer (figure 11). However, the rate of smoking attributable admissions is the second highest among the statistical neighbours. Although the statistical comparators are useful to help us to understand how we compare with similar cities, it is more helpful to compare the above indicators at a local level in order to identify where smoking related health inequalities exist across the city.

Figure 11: Smoking related health outcomes in Bristol and CIPFA nearest statistical neighbours and England (Source: Local Tobacco Control profiles, 2015)

<table>
<thead>
<tr>
<th>Area</th>
<th>Smoking attributable hospital admissions (1)</th>
<th>Smoking attributable mortality (2)</th>
<th>Smoking attributable deaths from heart disease (3)</th>
<th>Deaths from lung cancer (4)</th>
<th>Deaths from COPD (5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1,671</td>
<td>274.8</td>
<td>29.7</td>
<td>58.7</td>
<td>52.6</td>
</tr>
<tr>
<td>Bristol</td>
<td><strong>1957</strong></td>
<td><strong>290.6</strong></td>
<td><strong>27.0</strong></td>
<td><strong>61.8</strong></td>
<td><strong>59.9</strong></td>
</tr>
<tr>
<td>Southampton</td>
<td>1598</td>
<td>321.1</td>
<td>33.3</td>
<td>69.2</td>
<td>74.9</td>
</tr>
<tr>
<td>Plymouth</td>
<td>1953</td>
<td>310.8</td>
<td>35.2</td>
<td>64.0</td>
<td>56.8</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>1430</td>
<td>332.9</td>
<td>34.9</td>
<td>69.3</td>
<td>73.4</td>
</tr>
<tr>
<td>Sheffield</td>
<td>1944</td>
<td>291.4</td>
<td>34.4</td>
<td>70.7</td>
<td>53.6</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>1379</td>
<td>305.0</td>
<td>26.6</td>
<td>60.6</td>
<td>51.6</td>
</tr>
<tr>
<td>Coventry</td>
<td>1607</td>
<td>285.4</td>
<td>27.6</td>
<td>67.9</td>
<td>58.4</td>
</tr>
<tr>
<td>Leeds</td>
<td>1698</td>
<td>340.2</td>
<td>39.8</td>
<td>77.6</td>
<td>61.9</td>
</tr>
<tr>
<td>Swindon</td>
<td>1729</td>
<td>284.4</td>
<td>29.9</td>
<td>61.8</td>
<td>54.7</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>2663</td>
<td>361.8</td>
<td>36.0</td>
<td>96.4</td>
<td>76.0</td>
</tr>
</tbody>
</table>

- Rate in the area is statistically better than the England average
- Rate in the area is statistically similar to the England average
- Rate in the area is statistically significantly worse than the England average

(1) Directly standardised rate of smoking attributable admissions to hospital per 100,000 population aged 35 and over (2014/15)
(2) Deaths attributable to smoking, directly age-sex standardised rate for persons aged 35 years + per 100,000, 2013-2015
(3) Directly age-standardised rate of smoking attributable deaths from heart disease per 100,000 population aged 35 years and over, 2012-2014
(4) Age-standardised rate of mortality from lung cancer in persons of all ages per 100,000 population, 2013-15
(5) Age-standardised rate of mortality from chronic obstructive pulmonary disease in persons of all ages per 100,000 population, 2013-15
Adult smoking prevalence
Prevalence of adult smoking has been measured locally through the annual Bristol City Residents/Quality of Life Survey since 2006 (Bristol City Council, 2015). The survey has shown an overall downward trend in smoking prevalence for citizens aged 18 years and over during this time period to the current 2015 level, where 10.5% of survey respondents were found to smoke (figure 12).

Figure 12: Bristol Quality of Life Survey 2015: Percentage of residents who smoke

Local smoking prevalence is also measured through the Annual Population Survey (APS) and reported in the Public Health Outcomes Framework. This survey uses a different methodology to the local Quality of Life Survey, both in terms of the size of the survey and how it is conducted, as well as how participants are asked about their smoking behaviour. Through this survey the city’s smoking prevalence was found to be 18.1% in 2015, higher than the APS England prevalence of 16.9%.

Using the results from the 2013 Integrated Household Survey, the 2015 Quality of Life Survey and the latest population estimates, it is estimated that there are around 60 – 70,000 smokers aged over 18 years in the city.

Figure 13: Trend in smoking in adults (aged 18 years and over) in Bristol City (2012-2015) – Annual Population Survey

Smoking Prevalence and Gender
In the 2014 Quality of Life Survey, smoking was higher amongst females aged 16 years and over than males (10.7% and 10.3%, respectively), but the results are not statistically significant. This is not consistent with the higher prevalence of smoking amongst men than women from the national data. There has been a greater decrease in smoking prevalence amongst women than men between 2008 and 2014, although the gap in the linear trend remains similar (figure 14).

Figure 14: Trend in smoking prevalence between males and females in Bristol City 2005 and 2015 (Quality of Life Survey)

According to the Annual Population Survey the adult smoking prevalence in Bristol (18.1%) is higher than the England average (16.9%) but one of the lowest in the statistical neighbours group. However, the smoking prevalence among adults in routine and manual occupations is much higher at 31.1% (still at the level of England average though). The smoking prevalence in adults with serious mental illness in Bristol is one of the highest among its statistical neighbours.

Figure 15: Smoking prevalence in Bristol and its nearest statistical neighbours vs England (2015)
Smoking prevalence in adults - current smokers (APS) - prevalence of smoking among persons aged 18 years or over who are self-reported smokers in the Annual Population Survey 2015.

Smoking prevalence in adults in routine and manual occupations - current smokers (APS) - prevalence of smoking among persons aged 18 years or over in the routine and manual group who are self-reported smokers in the Annual Population Survey 2015.

Smoking prevalence in adults with serious mental illness (SMI) 2014/15 - smoking status of people diagnosed with a Serious Mental Illness (SMI), schizophrenia, bipolar affective disorder and other psychoses, on GP lists (i.e., not living in an institution).

Smoking status at time of delivery 2015/16 - % of women who smoke at time of delivery.

* Data quality issues

Source: Local Tobacco Control Profiles, PHE

Figure 16: Distribution of smoking across age bands in England

Local data on the distribution of smoking across age bands is not available. As Bristol has a particularly young population and an increasing number of children it is important to increase work around early intervention and prevention, to reduce the uptake of smoking in young people. Early intervention in young adulthood could
positively impact on the prevalence of smoking related mortality in the city over the next thirty to fifty years.

**Smoking and Health Inequalities**
Amos (Amos, 2016) emphasises that most national surveys focus on socio-economic status and highlights that all forms of disadvantage are associated with higher smoking rates; she concludes that apart from socio-economic status, smoking prevalence is highly influenced by the following characteristics.

- Gender
- Ethnicity
- Lone parenthood
- Mental health problems
- Youth offenders, prisoners
- Sexual orientation-lesbian, gay, bisexual
- Other excluded groups e.g. travellers, homeless

Further local modelling will be required using ACORN segmentation tools cross referenced against Local Authority owned activity data, to identify access and outcome data locally by BME Group, other protected characteristic or population group’s e.g. lone parents who are nationally known to have high smoking prevalence rates. This will enable commissioners to understand how we are meeting the needs of local priority population groups. Historically, poor equality monitoring and recording in primary and secondary care (often under specified or performance managed by commissioners) inhibited our ability to understand which population groups are at risk of modifiable lifestyle related poor health and related health inequalities and which of these population groups are /are not accessing our commissioned services. If we are to address health inequalities in the future, an understanding of which lifestyle behaviours and associated premature deaths are associated with each population group is crucial to targeting and allocating resource. In the following section, an analysis of population groups and their relationship to smoking is discussed.

**The social determinates of health and the Local Authority**
The WHO Commission (WHO Commission, 2010) argues that for reasons of social justice, action to achieve health equity is imperative. It says that attempts to reduce health inequity must be predicated on addressing the wider social and economic determinants, such as levels of education, economic status, and power relations. In order to address health inequalities it is necessary to address inequities in the way society is organised. At a local level, Public Health commissioned services require better integration into local authority led services to achieve the above. Efforts to ensure that Public Health Services are place based and health equity is embedded within all Local Government policies and commissioning intentions is central to addressing the social determinates of health inequalities.

**Smoking and Deprivation**
Adult smoking prevalence has decreased in the city over the last decade. But according to the Bristol Quality of Life Survey (2015/16) 18% of Bristol residents smoked in 2015, which is significantly higher than the current national prevalence of 16.9%. This represents a significant health inequality which is indicative of the positive correlation between smoking prevalence and deprivation. There is also a
positive association between smoking prevalence and deprivation within the city. Bristol wards such as Hartcliffe & Withywood and Lawrence Hill have significantly higher smoking prevalence than the city average and almost double the England average.

In some parts of the city (Filwood, Whitchurch Park, Hartcliffe) smoking rates were as high as 30% at the time of delivery, Maternity data from Bristol-located NHS maternity providers (2012), compared to England 10.6% (Public Health England, 2015). Smoking in pregnancy increases risk of complications, which affect mothers and babies’ health, and increases risk of miscarriage and maternal death. Children who grow up in families and communities with a high proportion of smokers are more likely to become smokers themselves. Over two thirds of adult smokers took up the habit before the age of 18 (Department of Health, 2011). Second-hand smoke continues to be a significant cause of morbidity and mortality in children and approximately 5% of households in the city have a smoker (Bristol Quality of Life Survey, 2015/16). Smoking prevalence amongst young people in England has decreased significantly over the last decade with only 8.2% of 15 year olds who classify themselves as current smokers. Among 15 year olds in Bristol it is much higher at 11.3%. Model based estimates, local survey data, and the strong correlation between child and adult smoking, suggests that smoking prevalence amongst young people in Bristol, particularly in the most deprived areas, is likely to be higher than the national average.

**Geographical and socioeconomic differences in smoking**

Maps showing prevalence of smoking by local ward are published as part of the Joint Strategic Needs Assessment. The map below (figure 17) shows that some parts of the city have a smoking prevalence much higher than the England prevalence of 16.9%
Figure 17: Differences in smoking prevalence across Bristol: Bristol Quality of Life survey 2015: Percentage of respondents who smoke

Due to the Quality of Life sample size, the smoking prevalence figures are underestimated both on the city and ward level. However, the figures clearly show the differences in smoking habits in Bristol wards. The smoking prevalence in Hartcliffe & Withywood and Lawrence Hill wards is significantly higher than the city average (figure 18).

Figure 18 Prevalence of smoking in Bristol City ward (Bristol Quality of Life Survey 2015: % of respondents who smoke by ward)

<table>
<thead>
<tr>
<th>Ward</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ashley</td>
<td>13</td>
</tr>
<tr>
<td>Avonmouth &amp; Lawrence Weston</td>
<td>14</td>
</tr>
<tr>
<td>Bedminster</td>
<td>15</td>
</tr>
<tr>
<td>Bishopston &amp; Ashley Down</td>
<td>10</td>
</tr>
<tr>
<td>Bishopsworth</td>
<td>4</td>
</tr>
<tr>
<td>Brislington East</td>
<td>10</td>
</tr>
</tbody>
</table>
Prevalence of smoking in the most deprived areas of the city is significantly higher than the city average.

Spatial analysis indicated far more smokers lived in deprived parts of the city, where 29% of households had a smoker. Hartcliffe & Withywood is the ward with the highest smoking prevalence (34% of households have a smoker). This is significantly higher than the prevalence of smoking in the most deprived deciles in England.

Figure 20: Smoking prevalence in adults – current smokers, England 2015, by IMD 2015 deprivation decile
Smoking and routine and manual workers
Smoking rates amongst the routine and manual group in the city (31.1 %) are also significantly higher than the city prevalence using the Annual Population Survey results (18.1%). The prevalence in the routine and manual group in the city is also higher than the national prevalence (26.5%) for this group, (Public Health England, 2015) which suggests that other local factors contribute to higher smoking rates in this group. More local data analysis is required to understand other population groups such as long term unemployed. National data suggests that those seeking work or unemployed are twice as likely to smoke.

Figure 21: Smoking prevalence in adults, Bristol and England 2015

Smoking and Mental Health
High rates of smoking are a significant cause of people with mental health problems dying younger than the general population. Smoking rates are reported to be as high as 70% amongst mental health inpatients (Jochelson et al. 2006) and 47.3%.
amongst patients with enduring serious mental illness smoke. In Bristol this equates to 1,456 patients, (HSCIC Indicator, 2014/15). This is statistically significantly higher than the national rate of 40.5%. Research suggests that smoking may contribute to stress and anxiety and stopping smoking is associated with an improvement in symptoms.

The mental wellbeing of citizens is collected through the annual Quality of Life Survey. In 2015, 16.3% of the population had above average mental wellbeing (increase from 13% in 2013), 56.7% average wellbeing and 13.5% below average wellbeing (decrease from 17.5% in 2013) (Bristol City Council, 2015). Analysis of the pooled 2012-2014 data shows that the proportion of adults who smoke who have poor mental wellbeing is significantly higher than amongst those with average and above average mental wellbeing.

It is estimated that over 92,000 adults in the city experience mental health problems. It is estimated that there could be at least 30,000 adults with mental health problems who smoke in the city (Adult Psychiatric Morbidity Survey, Health and Social Care Information Centre, 2007 and 2014) which suggests almost half of adult smokers in the city could have a mental health problem (figure 22). This proportion could be higher if adjusted for deprivation.

**Figure 22: Estimated number of adults with a Mental Health problem who smoke in Bristol City- update for Bristol**

<table>
<thead>
<tr>
<th>Mental Health problem</th>
<th>Number of adults with mental health problem</th>
<th>Percentage who smoke</th>
<th>Number who smoke</th>
</tr>
</thead>
<tbody>
<tr>
<td>Common mental health problem (depression or anxiety)*</td>
<td>74,528</td>
<td>31.3%</td>
<td>23,327</td>
</tr>
<tr>
<td>Post-traumatic stress disorder (APMS 2007)**</td>
<td>14,928</td>
<td>40.4%</td>
<td>6,031</td>
</tr>
<tr>
<td>Severe mental health problem (psychosis, personality disorder)***</td>
<td>3,076</td>
<td>47.3%</td>
<td>1,455</td>
</tr>
</tbody>
</table>

Notes to the Table 5 above:
*Common mental health problem prevalence figures have been taken from the Adult Psychiatric Morbidity Survey (2014), and applied to the Bristol population.
**Post traumatic stress disorder (APMS 2007) - Source: Smoking and mental health. A joint report by the Royal College of Physicians and the Royal College of Psychiatrists (https://www.rcplondon.ac.uk/file/3583/download?token=66s1PE7c)
***Severe mental health problem (psychosis, personality disorder) - Source: Health and Social Care Information Centre: CCG OIS 1.23 - Smoking rates in people with serious mental illness (SMI) 2014/15. Data identified on GP systems.

The Five Year Forward View for Mental Health (NHS England, 2016) states that local systems should prioritise ensuring that people with mental health problems, who are at greater risk of poor physical health, get access to prevention and screening programmes. This includes primary and secondary prevention through screening and NHS Health Checks, as well as interventions for physical activity, obesity, diabetes, heart disease, cancer and access to ‘stop smoking’ services.
As part of this, NHS England and Public Health England should support all mental health inpatient units and facilities (for adults, children and young people) to be smoke-free by 2018.

Local drivers to ensure better physical health for people with mental health problems include the commissioning for quality and innovation prevention incentive for local mental health services. Current developments are underway to help us to co-develop local outcomes across the system to ensure that this population group is prioritised. There are plans for the local mental health trusts to be smoke free by June 2017.

**Smoking and Substance Misuse**
Smoking is estimated to be high amongst dependent drinkers (46%) and illicit drug users (69%) (McManus, 2010). Using population estimates for these groups in the city, it is estimated that there are around 3,870 and 3,860 smokers in these groups, respectively. (APMS 2014, NHS Digital, 2014). A local arrangement is in place to support Substance Misuse Services to offer a harm reduction service to clients using the services. Outcomes are associated with a reduction in tobacco use and embedded within the whole substance misuse pathway; this includes both the treatment and rehabilitation aspect of the service offer. Work is currently underway to work alongside Local Authority commissioners to integrate tobacco harm reduction in to the current re-procurement process. This is expected to be completed by October 2017.

**Smoking and Learning Disabilities**
People with learning disabilities (LD) are reported to have lower levels of smoking than the general population (Emerson & Baines, 2010); however this is believed to be variable depending on level of LD. In Bristol, local analysis of an audit of primary care data in 2014 showed that people with LD were more likely to have smoking status recorded in the previous year than the general population. The proportion of smokers was similar to the general population, but the proportion of ex-smokers was significantly less. All services, including lifestyle services and smoking cessation services are required to make reasonable adjustments to their services for people with LD so that they are accessible.

**Smoking and Ex-Offenders**
People in contact with the criminal justice system face significant health inequalities: Mortality rates for prisoners are 50% higher than the rest of the population and people in and out of the criminal justice system are four times more likely to be smokers (Public Health England, 2017). In the South West, the roll out of smoke free prisons is underway. We are currently in phase 1 since the implementation of the early adopters April 2016-May 2017. Although we do not currently have information about if and who is remaining smoke free on release at this point, the work between Public Health England and the Local Authorities will focus on supporting prisoners to remain smoke-free on release.

**Smoking and Ethnicity**
PHOF data shows that citizens of mixed heritage, White (not British) and White British have the highest smoking prevalence, with the latter two groups having a
smoking prevalence statistically higher than the city average (figure 23). It is not clear how this data reflects smoking prevalence at a local level, as little is known locally about the high national rates of smoking amongst Bangladesh and Black British communities. Furthermore it is difficult to link smoking related premature mortality or smoking related admissions to ethnicity as death registry data does not include ethnicity monitoring and in general, hospital trusts are poor at recording equality data, and this includes ethnicity.

**Figure 23: Percentage of smokers by ethnic group**

![Percentage of smokers by ethnic group](image)

Source: Local Tobacco Control Profiles 2015, PHE

**Figure 24: Bristol Quality of Life Survey 2015: Percentage of respondents who smoke**
Whilst the Quality of Life data (figure 24) gives a snapshot of the population groups who smoke in Bristol it is a fairly small sample, and it is unlikely to reflect the views or experiences of groups who do not respond to local surveys or engage in mainstream services. Further analysis would need to break down the disabled category further in to disabled people who have poor mental health and take into consideration those with protected characteristics. National and Local data rarely describes the intersections between population groups and the increased exposure to health inequalities.

Although the national data for smokers by ethnic groups (figure 23) is helpful, it estimates that 35.5% of smoking prevalence is amongst groups reported as other and unknown. It is not clear who is included within these population groups, but it is anticipated that other refers to white non British communities. Little is known about the smoking prevalence of population groups that have migrated from outside of the EU, including African or Arab.

Although national data suggests high smoking prevalence amongst Eastern Europeans (figure 7) and those from Turkey and Greece, locally we know very little about the smoking prevalence of Eastern European communities (and others stated) in Bristol. Further work will need to be carried out to understand which population groups are most affected and how we commission services to meet the needs of such communities. Romanians are the main significant group living in Bristol followed by Polish population groups (figure 25).

**Figure 25: National Insurance registrations in Bristol from Eastern European Countries in 2015/16**

<table>
<thead>
<tr>
<th>Nationality</th>
<th>NINo registrations</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Romania</td>
<td>1,356</td>
<td>38.7%</td>
</tr>
<tr>
<td>Poland</td>
<td>1,172</td>
<td>33.4%</td>
</tr>
<tr>
<td>Bulgaria</td>
<td>301</td>
<td>8.6%</td>
</tr>
<tr>
<td>Country</td>
<td>Registrations</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------------</td>
<td>---------------</td>
<td>------------</td>
</tr>
<tr>
<td>Hungary</td>
<td>271</td>
<td>7.7%</td>
</tr>
<tr>
<td>Czech Republic</td>
<td>124</td>
<td>3.5%</td>
</tr>
<tr>
<td>Lithuania</td>
<td>119</td>
<td>3.4%</td>
</tr>
<tr>
<td>Slovakia</td>
<td>80</td>
<td>2.3%</td>
</tr>
<tr>
<td>Latvia</td>
<td>62</td>
<td>1.8%</td>
</tr>
<tr>
<td>Estonia</td>
<td>10</td>
<td>0.3%</td>
</tr>
<tr>
<td>Slovenia</td>
<td>5</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,507</strong></td>
<td></td>
</tr>
</tbody>
</table>

Source: Department for Work & Pensions Stat-Xplore Dataset: NINO Registrations To Adult Overseas Nationals Entering The UK

**Smoking and sexual orientation**

Analysis of smoking by sexual identity follows a similar pattern to the national data with smoking prevalence being significantly higher amongst gay and lesbian groups than the heterosexual group and the city average (figure 26).

From the 'Analysis by equalities groups (Quality of Life in Bristol, 2015-16)indicated more lesbian, gay, and bisexual or transgender people lived in households with a smoker, compared to the city average, at 31%. This would support the work by Amos (Amos, 2016) who suggests that smoking prevalence is highest amongst those who experience the greatest disadvantage.

**Figure 26: Smoking prevalence by sexual orientation**

![Smoking Prevalence by Sexual Orientation](figure26.png)

**Smoking and Disability**

Disabled people, at 23%, were also more likely to live in a household with a smoker, compared with non-disabled people, at 16%.

Responses to additional smoking questions ‘Do you smoke?’ and ‘Does someone smoke regularly indoors?’ confirm the same trend. In 2015 approximately 11% said they smoked themselves (18% in 2006) and 5% of households had someone regularly smoking indoors (16% in 2006).

**Smoking and Pregnancy**
Smoking rates during pregnancy in Bristol are at the same level as the England average and have been falling since 2013/14 (figure 20). 10.1% (637) of women smoked during pregnancy in 2015/16.

**Figure 27: Smoking status at time of delivery in Bristol, South West and England**

<table>
<thead>
<tr>
<th>Year</th>
<th>Bristol</th>
<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010/11</td>
<td>10.3</td>
<td>13.5</td>
<td>13.5</td>
</tr>
<tr>
<td>2011/12</td>
<td>10.6</td>
<td>13.1</td>
<td>13.2</td>
</tr>
<tr>
<td>2012/13</td>
<td>12.3</td>
<td>13.3</td>
<td>12.7</td>
</tr>
<tr>
<td>2013/14</td>
<td>12.7</td>
<td>13.0</td>
<td>12.0</td>
</tr>
<tr>
<td>2014/15</td>
<td>11.1</td>
<td>11.9</td>
<td>11.4</td>
</tr>
<tr>
<td>2015/16</td>
<td>10.1</td>
<td>11.2</td>
<td>10.6</td>
</tr>
</tbody>
</table>

Source: Local Tobacco Control Profiles 2015, PHE

The percentage of women who smoke at the time of delivery is significantly lower than the majority of statistical neighbours with the exception of Brighton and Hove (figure 28). In some parts of the city (Filwood, Whitchurch Park, Hartcliffe) smoking rates were as high as 30% at the time of delivery (Maternity data from Bristol-located NHS maternity providers, 2012), compared to England 10.6% (Public Health England, 2015).

**Figure 28: Smoking at the time of delivery in Bristol and Comparator areas (CIPFA nearest statistical neighbours) and England, 2015/16**

<table>
<thead>
<tr>
<th>Area</th>
<th>Number of women smoking at time of delivery</th>
<th>% of women smoking at time of delivery</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>67,195</td>
<td>10.6</td>
</tr>
<tr>
<td>Bristol</td>
<td>637</td>
<td>10.1</td>
</tr>
<tr>
<td>Southampton</td>
<td>474</td>
<td>14.3</td>
</tr>
<tr>
<td>Plymouth</td>
<td>329</td>
<td>10.8</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>341</td>
<td>12.7</td>
</tr>
<tr>
<td>Sheffield</td>
<td>789</td>
<td>12.7</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>185</td>
<td>6.3</td>
</tr>
<tr>
<td>Coventry</td>
<td>546</td>
<td>12.2</td>
</tr>
<tr>
<td>Leeds</td>
<td>1,097</td>
<td>11.0</td>
</tr>
<tr>
<td>Swindon</td>
<td>309</td>
<td>11.4</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>440</td>
<td>13.2</td>
</tr>
</tbody>
</table>

Rate in the area is statistically better than the England average
Rate in the area is statistically similar to the England average
Rate in the area is statistically significantly worse than England average

Source: Local Tobacco Control Profiles 2015, PHE
**Referrals in to local smoking cessation services** In 2011 a Commissioning for Quality and Innovation (CQUIN) incentive was set up to encourage Acute trusts to identity smokers, offer immediate access to stop smoking medications, brief intervention and refer smokers to smoking cessation services for which they were paid. However, whilst this resulted in large numbers of referrals, they were of poor quality and did not result in smokers accessing smoking cessation services. Since then, there is a facility for staff to refer smokers to the Bristol smoking cessation services electronically (and unpaid). Poor quality referrals, result in low quit rates, with a high % of the current referrals received, either not being contactable or resulting in outcomes (see figure).

The implementation of the national NHS CQUIN requirements on risky behaviours (alcohol and tobacco) is currently being developed locally. It is not yet known if the hospital Trusts in Bristol have signed up to achieving this in the next 2 years. CO monitoring and a care plan on discharge are not specifically part of the national CQUIN but Trusts will be required to offer referral (not signposting) to specialist behavioural support for all smokers. Information for staff on harm reduction should be provided as part of the training of staff to implement the CQUIN. Local modelling is required to help us to identify how many referrals each Trust should be making against actual and an analysis of how many referrals convert to actual outcomes. A snapshot of referrals made into smoking cessation by organisation and associated outcomes in 2016-17 (see figures 29 and 30 below) show an unacceptably low conversion rate of referrals to outcomes. More work is required with the referrers to improve the quality of referral.

Health Visitor and Mental Health Trust referrals (including IAPT) are consistently low and more work is required to understand the reason for this. As part of the Tobacco and Alcohol CQUIN, work is currently underway to work in collaboration with Mental Health Commissioners (within the Clinical Commissioners Group) to implement the programme at a local level. Work is also underway with Local Authority Health Visitor commissioners to embed brief intervention, referral and smoke free homes in to the developing service specifications.

**Figure 29: Referral into smoking cessation services by organisation 2016-17**
In the 2015 Quality of Life Survey it was found that 4.7% of smokers and non-smokers allowed smoking in the home. This increases to 12.3% amongst people living in deprived areas and 10.4% of households of disabled people.

Figure 30: UBH and NBT: Referrals to LiveWell Bristol and Stop Smoking Service Outcomes 2016-17

<table>
<thead>
<tr>
<th>Referrer Type</th>
<th>Total Referrals</th>
<th>Declined Service</th>
<th>Unable to Contact</th>
<th>Closed - No outcome</th>
<th>Access Service</th>
<th>Quit Date Not Set</th>
<th>Quit Date Set</th>
<th>4 Week Quit</th>
<th>4 Week Quit %</th>
<th>CO Verified</th>
<th>CO Verified %</th>
<th>4 Week Not Quit</th>
<th>4 Week Not Quit %</th>
<th>4 Week LTFU</th>
<th>4 Week LTFU %</th>
<th>Not Reported</th>
</tr>
</thead>
<tbody>
<tr>
<td>Secondary Care- NBT</td>
<td>33</td>
<td>7</td>
<td>14</td>
<td>66</td>
<td>1</td>
<td>96</td>
<td>89</td>
<td>6</td>
<td>2</td>
<td>33.33%</td>
<td>1</td>
<td>50%</td>
<td>1</td>
<td>16.67%</td>
<td>2</td>
<td>33.33%</td>
</tr>
<tr>
<td>Secondary Care- UHB</td>
<td>28</td>
<td>5</td>
<td>12</td>
<td>54</td>
<td>5</td>
<td>3</td>
<td>86</td>
<td>5</td>
<td>3</td>
<td>20%</td>
<td>3</td>
<td>100%</td>
<td>2</td>
<td>13.33%</td>
<td>7</td>
<td>46.67%</td>
</tr>
</tbody>
</table>

Figure 31: Percentage of respondents who live in households with someone who smokes regularly within the home

Percentage of respondents who live in households with someone who smokes regularly within the home

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Bristol average</td>
<td>4.7</td>
<td></td>
</tr>
<tr>
<td>Deprived Areas</td>
<td>12.3</td>
<td></td>
</tr>
<tr>
<td>Older people</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>Disabled people</td>
<td>10.4</td>
<td></td>
</tr>
<tr>
<td>BME</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>Carer</td>
<td>6.8</td>
<td></td>
</tr>
<tr>
<td>LGBT</td>
<td>7.5</td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>4.9</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>4.4</td>
<td></td>
</tr>
<tr>
<td>Christian</td>
<td>4.6</td>
<td></td>
</tr>
<tr>
<td>Muslim</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>No faith</td>
<td>5.2</td>
<td></td>
</tr>
</tbody>
</table>

Source: Quality of Life Survey 2015, Bristol

Smoking amongst Children and Young People

Figure 32: Smoking prevalence at age 15
The local What about You (WAY) survey includes a number of questions related to smoking tobacco. The local results can be seen in the table below (figure 31).

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Bristol</th>
<th>South West</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence at age 15 - current smokers (WAY survey)</td>
<td>11.3</td>
<td>9.80</td>
<td>8.2</td>
</tr>
<tr>
<td>Smoking prevalence at age 15 - regular smokers (WAY survey)</td>
<td>7.8</td>
<td>6.33</td>
<td>5.5</td>
</tr>
<tr>
<td>Smoking prevalence at age 15 - occasional smokers (WAY survey)</td>
<td>3.5</td>
<td>3.48</td>
<td>2.7</td>
</tr>
<tr>
<td>Use of e-cigarettes at age 15 years (WAY survey)</td>
<td>18.0</td>
<td>19.20</td>
<td>18.4</td>
</tr>
<tr>
<td>Use of other tobacco products at age 15 years (WAY survey)</td>
<td>19.1</td>
<td>15.00</td>
<td>15.2</td>
</tr>
</tbody>
</table>

Rate in the area is statistically similar to the England average
Rate in the area is statistically significantly worse than the England average

However, Public Health England has produced local area model based estimates of occasional and regular smokers aged 11-15, 15 and 16-17 years (figure 32). These estimates should be used with caution as they have very large margins of error (confidence intervals) and therefore are not able to demonstrate statistical differences.

Figure 33: Model based estimates of smoking in children and young people in Bristol

<table>
<thead>
<tr>
<th>Age group</th>
<th>Occasional smokers</th>
<th>Regular smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-15 years</td>
<td>1.5%</td>
<td>3.5%</td>
</tr>
<tr>
<td>15 years</td>
<td>4.1%</td>
<td>9.7%</td>
</tr>
<tr>
<td>16-17 years</td>
<td>6.1%</td>
<td>16.3%</td>
</tr>
</tbody>
</table>


Bristol schools carry out a health based survey with pupils in years 4 (8-9 year olds), 6 (10-11 year olds), 8 (12-13 year olds) and 10 (14-15 year olds). The survey is known as Pupil Voice. Data showing smoking habits among pupils is recorded below. Schools volunteer for this survey and not all schools choose to take part. The data shows an increase from 10% of boys and 7% of girls saying they have tried smoking in year 8 up to 25% of boys and 28% of girls in year 10. This shows that older girls are more likely to smoke than boys. Most smokers in yr 8 or yr 10 reported first trying a cigarette by their 12th birthday.

Figure 34: Pupil Voice (2015) Bristol City Council
School Based Programmes
Currently schools are expected to deliver a session on smoking as part of their Personal Social Health and Economic Education (PHSE) programme in each school year, but it is doubtful whether this happens in every year group. Although various services seek to reduce smoking initiation amongst children and young people as part of their overall offer, this is not the primary aim of any one service and there is a lack of a coordinated approach across the City. Approximately 87% of schools in Bristol City do not currently have Healthy Schools Status, and most of those that do are primary schools. All schools may need additional support in encouraging and supporting to develop smoke-free policies and practices in line with the relevant Healthy Schools criteria on smoking.

In 2017-18 The Bristol Local Authorities Children and Young People’s Public Health Team are making some changes to the Healthy Schools programme in Bristol and developing a series of health related awards (badges) that schools can complete as a step towards achieving the Mayors Award. One of these will support schools to develop healthy policies and good quality evidenced based teaching on substance misuse including tobacco.

In addition, the 4YP training programme is being adapted to ensure that tobacco is part of the substance misuse training that is delivered across Bristol to anyone working with children and young people, especially those who work with vulnerable groups.

As Bristol has a particularly young population and an increasing number of children it is important to increase work particularly in wards and population groups with high smoking prevalence to prevent the uptake of smoking in young people. Our current services are not set up to support children and young people, who smoke, and as part of the re-procurement of the behaviour change programme, we will look to our
Children and Young People’s commissioning leads to ensure that the specifications are based on evidence and that they target vulnerable children or population groups who are more likely to smoke.

**Smoking and Illicit Tobacco in Bristol**

Illicit tobacco causes harm to our most vulnerable populations by increasing the availability of tobacco to the most deprived socio-economic groups leading to widening the health inequalities gap. In areas of high deprivation parents are more likely to smoke. This has an impact not only on them but on their children who are both exposed to second hand smoke and more likely to smoke as they grow up.

Research commissioned by Action on Smoking and Health (ASH), 2015) found that one in four of the poorest smokers buy smuggled tobacco compared to one in eight of the most affluent. The availability of cheaper illicit tobacco may exacerbate health inequalities. Easily available and cheap tobacco in these areas undermines Public Health Policies to reduce smoking. Regional tobacco control strategies led by the Directors of Public Health, sharing of supply and demand chain intelligence and targeting hotspots will enable the South West Local Authorities to collectively disrupt the availability of illicit tobacco in groups where smoking related mortality and morbidity are most prevalent.

SWERCOTS is a collective organisation representing the fifteen local trading standards service across the South West of England. Trading Standards plays a key role enforcing provisions relating to the illicit supply of tobacco which has been identified as a key priority for the region in supporting public health objectives.

Between 01/01/2014 and 01/01/2016 SWERCOTS received 1935 intelligence reports (IR) pertaining to Illicit Tobacco and Cigarettes. Of these reports, 219 (11%) referred to locations within the Bristol City Council area of responsibility. Annotated on the map below are the number of IRs set against Bristol wards, and the ward (Easton) which received the highest volume of IR in the reporting period.

**Figure 35: The full breakdown of intelligence reports per ward are detailed in the table below:**

<table>
<thead>
<tr>
<th>Ward</th>
<th>No of IR</th>
<th>Ward</th>
<th>No of IR</th>
<th>Ward</th>
<th>No of IR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Easton</td>
<td>79</td>
<td>Knowle</td>
<td>5</td>
<td>Kingsweston</td>
<td>2</td>
</tr>
<tr>
<td>Bristol area in</td>
<td>34</td>
<td>Lawrence Hill</td>
<td>4</td>
<td>Whitchurch Park</td>
<td>2</td>
</tr>
<tr>
<td>general</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastville</td>
<td>17</td>
<td>Filton</td>
<td>3</td>
<td>Ashton</td>
<td>1</td>
</tr>
<tr>
<td>Bedminster</td>
<td>14</td>
<td>Horfield</td>
<td>3</td>
<td>Bishopworth</td>
<td>1</td>
</tr>
<tr>
<td>Redland</td>
<td>12</td>
<td>Southmead</td>
<td>3</td>
<td>Henbury</td>
<td>1</td>
</tr>
<tr>
<td>Frome Vale</td>
<td>8</td>
<td>Southville</td>
<td>3</td>
<td>Hengrove</td>
<td>1</td>
</tr>
<tr>
<td>Hartcliffe</td>
<td>8</td>
<td>Brislington</td>
<td>2</td>
<td>St George’s East</td>
<td>1</td>
</tr>
<tr>
<td>Ashley</td>
<td>7</td>
<td>Cabot</td>
<td>2</td>
<td>St George’s West</td>
<td>1</td>
</tr>
<tr>
<td>Clifton</td>
<td>6</td>
<td>Emerson Green</td>
<td>2</td>
<td>Stokes Croft</td>
<td>1</td>
</tr>
</tbody>
</table>

**E-Cigarettes**

There is limited data available on the uptake of E-Cigs in Bristol, or on the numbers of smokers who smoke tobacco and vape. Emerging research focuses on the uptake
of E-Cigs in deprived areas and current initiatives include commissioning local Voluntary and Community based organisations to target population groups with high smoking prevalence offering a harm reduction approach through the use of free e-cig vouchers. The pilot is being evaluated by the University of Bristol and is due to be completed by October 2017. As smoking prevalence reduces, the remaining smokers are more likely to be long term, heavy smokers and less successful with quit attempts. The approach needed to reach these smokers will be different to existing approaches and will need to include a focus on harm reduction in advance of quitting.

The current contracts do not take this into account which reflects the reticence of stop smoking advisors to fully embrace this approach. Plans are in place to extend the harm reduction offer across all commissioned services; although this will not include free- e-cig vouchers.

**Nicotine replacement therapy (NRT) and Varenicline**

The NRT budget is held within the Local Authority, and current arrangements are in place to reimburse Primary Care Providers (via the Clinical Commissioning Group Medicines Management Team) who prescribe NRT. Whilst we have access to the activity and spend for NRT in Bristol, more work is required to understand how the prescribing activity links to Public Health related outcomes (i.e. quits).

Varenicline is used for helping people to quit smoking cigarettes. Varenicline is a smoking cessation agent. It works in the brain by blocking the pleasurable effects of smoking. Whilst we are aware of the evidence base around the positive effects of quitting and Verenicline use, it is currently under prescribed in primary care. Local arrangements are in place for Pharmacy and Community Providers to refer to independent prescribers. Recent efforts have included feedback to providers on their prescribing (for GP Practices) and referral activity to the Independent prescribers to increase the prescribing of Varenicline.

**Waterpipes and Shisha usage**

The prevalence of shisha smoking and usage in the city is not known. However, the number of public establishments where people can smoke shisha is monitored through City Council Environmental Health. In 2014, 8 establishments were known to offer shisha smoking, these which were located mainly in the city centre areas. However, this is unlikely to be the complete picture and it is known that shisha is also smoked in homes and there are businesses which can provide home delivery of shisha tobacco and pipes.

**Smokeless tobacco**

Intelligence from other Local Authorities indicates that smokeless tobacco products are sold in Asian supermarkets and shops. Whilst these products are used within the Pakistani community which is the largest Asian community in the city, their use is more prevalent within the Bangladeshi community (Millward & Karlsen, 2011). There are around 2,200 Bangladeshi adults living in Bristol which suggests there are around 310 people using these products in the city assuming a prevalence of 14%.

### 3. Targets and Performance

**Local Policy**
In Bristol there is a Tobacco Alliance Steering Group– which includes membership from councillors, acute trusts, clinical commissioning group, trading standards, licensing, environmental health and a range of voluntary and community provider organisations. Previously, the Alliance adopted the national policy, Healthy Lives, and Healthy People with the stated targets and developed an action plan to work towards achieving those targets.

Smokefree Public Places
One of the work streams for the Alliance was to increase the number of smokefree public places across Bristol. Over the past couple of years the City Council have made all their buildings smokefree; all play areas in Bristol parks were made smokefree; all Children’s Centres have smokefree outside spaces; the Acute Trusts are progressing towards smokefree sites; and Millennium and Anchor Squares in Bristol were made smokefree. All these are voluntary smokefree outside areas, but it is recognised that making it harder for smokers to smoke will encourage them to make a quit attempt. Also removing smoking from public area starts to de-normalise it which helps to prevent the uptake of smoking by children and young people. We are aware of the good work the NHS has done in recent years to create smokefree sites. However we know that some trusts have found it difficult to enforce the policy and reverted to smoking shelters on sites due to pressure from local residents and staff. Many trusts are still struggling with the litter, fires on site and the poor image projected by patients, visitors and staff smoking at the entrances and within the grounds of their estate. Duncan Selbie, Chief Executive of Public Health England recently wrote to NHS Trust CEO’s asking for ‘a step change to achieve a tobacco free NHS’ and he specifically asked for NHS trusts to implement completely smokefree estates, accompanied by access to quitting support for staff and patients.

Through implementing the CQUIN (discussed earlier in this document) Hospital Trusts will already be investing considerable time and resource in the planning and delivery of smoking cessation interventions including looking at formulary provision of medications and training for frontline staff in very brief advice. Therefore it makes sense to include cessation support provision for staff who smoke as well in this package and to provide a conducive smoke free environment which supports them in their attempts to quit, and supporting patients to quit. Without a smoke free estate staff efforts to implement policy will be undermined. There will be strength in all STP area Trusts implementing this policy at the same time in terms of consistency of message to patients and public and the learning and support that can be shared across organisations to help with implementation.

The Bristol Plan (Bristol City Council, 2015) set targets to reduce smoking prevalence amongst citizens aged 18 years and over to 20% by the year 2020. The smoking prevalence in England was 20.8% in 2010 when the target was set and 23.5 % in the city as measured by the Integrated Household Survey. Trajectory from the Integrated Household Survey suggests that if smoking prevalence continues to reduce at the current rate, the 2020 target have already been achieved (figure 21), at a Bristol level.

Figure 36: Bristol Smoking Prevalence trajectory
Smoking prevalence in adults - current smokers

<table>
<thead>
<tr>
<th>Period</th>
<th>Bristol</th>
<th>South</th>
<th>England</th>
</tr>
</thead>
</table>
Rate in the area is statistically better than the England average
Rate in the area is statistically similar to the England average
Rate in the area is statistically significantly worse than the England average

**Figure 37: Bristol Smoking Prevalence trajectory**

![Smoking prevalence in adults - current smokers (APS)](image)

Source: Annual Population Survey 2012-2015

**Bristol Children’s and Young People’s Plan (CYPP) (2015-16)**
Promoting the health and wellbeing of babies, children and young people is one of the priorities of the CYPP. The following indicator is included % of women reporting smoking at the time of delivery.

**Public Health Outcomes Framework 2013-2016**
The Public Health Outcomes Framework (PHOF) had 5 indicators in the health improvement domain

- 2.03 – Smoking Status at the time of delivery similar to England average
- 2.14 Smoking prevalence – routine and manual groups similar to England average
- 2.14 Smoking Prevalence (adults) similar to England average
- 2.09i Smoking prevalence at age 15 - current smokers (WAY survey) – worse than England average
- 2.09ii Smoking prevalence at age 15 - regular smokers (WAY survey) – worse than England average

It also contains indicators relating to reducing premature mortality from smoking related diseases including cardiovascular disease, respiratory disease and cancer.

**Tobacco Control Profiles (2015)**
• Smoking attributable mortality
• Smoking attributable hospital admissions

NHS Outcomes Framework 2015/16
The NHS Outcomes does not contain any indicators relating to smoking. It does contain indicators relating to reducing premature mortality from smoking related diseases including cardiovascular disease, respiratory disease and cancer Department of Health (2015).

CCG Outcomes Framework 2014/15
The outcomes framework for CCGs had 2 indicators relating to smoking in 2014/15 NHS England (2015)
  o Reducing premature death in people with severe mental illness - severe mental illness: smoking rates.
  o Reducing deaths in babies and young children – Maternal smoking at delivery

Social Care Outcomes Framework
The social care outcomes framework does not contain any indicators relating to smoking Department of Health (2015).
4. What is the evidence of what works (including cost effectiveness)?

There is a wealth of evidence supporting tobacco control interventions. The National Institute for Health and Care Excellence (NICE) guidance predominantly focuses on smoking cessation interventions. Other government guidance and research addresses both smoking cessation and wider tobacco control. Healthy Lives, Healthy People; A Tobacco Control Plan for England set out six internationally recognised strands for comprehensive tobacco control (figure 37). The revised Tobacco Control Plan is expected to be published in February 2017. The local plan will be revised to align with this.

Tobacco control is an evidence-based approach to tackling the harm caused by tobacco use and smoking. The hexagon diagram below highlights the holistic model of tobacco control with multi-agency partnership working at its heart. Even though there are several elements to tobacco control the majority of interventions are achieved through partnership working and are reliant on national policy legislation.

Figure 38: Elements of tobacco control

Source: Excellence in Tobacco Control: 10 high impact changes to achieve tobacco control, 2008

Stopping the promotion of tobacco
Helping shape perceptions of tobacco use by adults and young people, by ensuring that non-price measures are in place, such as:

- Advertising restrictions (point of sale display (POS)) in large shops
- Smokefree laws (the proposed ban on smoking in cars whilst children are present and smokefree review)
- Helping shape perceptions of tobacco use by young people
- Change social norms around smoking
- Peer lead interventions - Public Health guidance 23. (National Institute for Clinical Excellence, (NICE, 2010)).

**Making tobacco less affordable**
- Price is the single most effective lever helping people to stop smoking. The health gain from high-priced tobacco, however, can be undermined if the illicit market in tobacco products is allowed to thrive at the expense of legal, duty-paid products.
- Ensuring duty is paid on all tobacco products and the price mechanism is effective – HM Revenue & Customs, Tobacco Tax Gap
- Controlling and de-normalising illicit and counterfeit tobacco sales (All Party Parliamentary Group on Smoking and Health - Inquiry into the illicit trade in tobacco products) and Tackling tobacco smuggling.

**Effectively regulate tobacco products**
- Enforcing tobacco sales legislation (minimum age) Smoking Drinking and Drug use survey.
- Reducing the availability of tobacco to young people through educating tobacco retailers - proxy sales through the Children and Families Act 2014.
- Regulation of nicotine-containing products – Revision of EU Tobacco Products Directive.

**Effectively communicate for tobacco control**
- Educating the public & colleagues about the risks of smoking
- Motivating smokers to quit, including pregnant smokers
- De-normalising smoking amongst our communities – Be there tomorrow
- Encouraging children & young people not to take up smoking – Public Health England Marketing Strategy

**Help tobacco users to quit**
Provision of smoking cessation services that are tailored to the needs of our communities & are;
- Targeted at high prevalence groups – Reducing Health Inequalities through tobacco control
- Provide value for money - All Party Parliamentary Group on Smoking and Health (2010)
- Recognise diverse needs of our communities
- Increase access to & uptake of smoking cessation services – Evaluation of Stoptober campaign
- New approaches to help tobacco users who cannot quit to instead use safer sources of nicotine – Harm Reduction
- Widen professional & community involvement in providing basic stop smoking advice & referral pathways to smoking cessation services – Making Every Contact Count and Brief Intervention
- Healthy Child Programme Rapid Review - The aim of this Rapid review of the evidence was to synthesise relevant systematic review level evidence
about ‘what works’ in key areas of public health for 0-5s, including smoking.

**Reduce exposure to secondhand smoke**
Exposure to secondhand smoke is hazardous to health especially vulnerable adults & children. We can minimise this burden by:
- Encouraging smokers to quit – National campaigns
- Encouraging people to recognise the effects their smoking has on others – Smokefree
- Extending smokefree areas – The impact of the smokefree legislation

**Effectiveness and cost effectiveness**
The All Party Parliamentary Group on Smoking and Health (All Party Parliamentary Group on Smoking and Health, 2010) reported on the effectiveness and cost-effectiveness of tobacco control and found that there is a very strong evidence base for tobacco control interventions and that comprehensive tobacco control provides economic value and a positive return on investment. For example, there is strong evidence which demonstrates that Smoking cessation services are highly effective both clinically and in terms of cost. Department of Health (Department of Health, 2011) guidance recommends that all smokers should be routinely offered advice to quit and a referral to the Stop Smoking Service.
5. What services / assets do we have to prevent and meet this need?

**Strategic Leadership**

**Tobacco Control Strategic Group**
Bristol City has a Tobacco Control Strategic Group. The group is comprised of representatives from:
- Health and Wellbeing Board Representative and Councillor Portfolio Holder for Public Health
- Bristol City Council (Environmental Health & Trading Standards)
- Bristol Healthcare Trusts including Acute and Mental Health
- The University of Bristol
- Bristol Clinical Commissioning Group
- Smoking cessation Community Providers
- Avon Local Medical Committee Representative
- Avon Local Pharmacy Committee Representative

The Groups Strategic Priorities are:
1. Protecting children from the harmful effects of smoking and promotion of the prevention agenda amongst targeted population groups
2. Target population groups (pregnant women, mental health, ex-offenders, substance misuse and those living in deprived areas etc) motivate and assist smokers to quit or to reduce harm from tobacco
3. Strategic leadership
4. Protecting communities from tobacco related harm

The group is refreshing the city’s tobacco control strategy which will be published in 2017. The group also coordinates the city’s strategic action plan which includes actions across the partnership.

**CLeaR Assessment**
CLeaR is an evidence based improvement model designed to help local areas develop local action to reduce smoking prevalence and the use of tobacco. It was developed by Action on Smoking and Health (ASH) and partners and is now led by Public Health England (Public Health England, 2014). The Bristol City Tobacco Control Strategic Group undertook the self-assessment aspect of the tool with partners in 2014. The self-assessment scored highly on many of the domains and found that areas that scored lower were longer term vision and results. It was highlighted that clear lines of regular reporting to the Health and Wellbeing Board (HWB) and key performance indicators for each element of tobacco control could help to take the agenda forward in a holistic way.

**Smoking in Pregnancy Sub Group**
Bristol, North Somerset and South Gloucestershire CCG and Public Health colleagues have established a multi-agency sub group aimed at reducing the prevalence of smoking in pregnancy across Bristol, North Somerset and South Gloucestershire. Members of the steering group will be responsible for driving
implementation of a range of actions aimed at reducing smoking in pregnancy and after childbirth.

**Children and Young People Sub Group**
The Public Health Children and Young People’s sub group are working in partnership with schools and early years settings to prevent smoking in early years and to reduce the number of smoky households after childbirth. Part of the work of this group will be to advise tobacco control commissioning leads of child friendly services for those groups who already smoke e.g. children in care, youth offending etc.

**Population Groups with High Smoking Prevalence Sub Group**
This sub group consists of CCG Mental Health and Local Authority Substance Misuse Commissioners (and provider leads), and Public Health England South West Smokefree Prison Leads. A Community Provider lead represents all community providers who offer a harm reduction service to deprived communities and population groups where smoking prevalence is high. The aim of the group is to work across agencies to reduce the number of smokers in the specified population groups and to identify opportunities to include key performance indicators within current and new contracts to reduce the harm from tobacco. The sub group will also develop an implementation plan for the delivery of the mental health tobacco and alcohol CQUIN.

**Illicit Tobacco**
Trading Standards works to reduce the supply of counterfeit and illicit tobacco across the City. The service works in partnership with Bristol Police, to stop the sale and distribution of these goods by seizing any illicit and counterfeit product sold from any premises, including retail shops and private addresses. Almost all of the South West Local Authorities have signed up to a 2 year agreement with The South West Trading Standards Agency. The outcomes include targeting deprived communities where illicit tobacco is known to be more available and to coordinate a campaign raising the awareness of illicit tobacco within these local communities.

**Smokefree Environments**
The Smokefree Environment work stream will build on the successful prohibition of smoking at playgrounds and other high traffic venues. This year we will scope out what has already been achieved to date and work alongside local neighbourhood partnerships to identify further smoke free areas that are local to communities with high smoking prevalence.

**Environmental Health**
Environmental Health Officers lead on the monitoring and enforcement of the smokefree public spaces legislation. This includes visiting new establishments reported to the service, establishments where changes to their licence or planning permission may indicate change of usage with regard to smoking practice, or where other council officers or other citizens have raised an issue with premises.

**Bristol Clinical Commissioning Group**
Prevention of cancer and long term conditions (including COPD, Diabetes, and CHD) is a priority for the Bristol, South Gloucestershire and North Somerset Sustainable
Transformation Plan (STP) Cluster. Many of the above long term conditions are currently overseen by the STP Respiratory Steering Group and the early intervention and prevention sub group. There is further work to do around ensuring that the work being developed within the STP links in to the overarching Bristol Tobacco Alliance Group Plan. To support the Trust’s Alcohol and Tobacco CQUIN (to be launched April 2017) and in line with the NICE guidance on smoking cessation in secondary care (PH48) the STP cluster plan will need to include supporting the implementation of the Smoke Free Trusts (which include Acute and Mental Health Trusts) to assist the recent CQUINS linked to the secondary care contracts. The key aims of the CQUIN will be to increase the identification of smokers who are admitted to hospital and to refer on to smoking cessation services on discharge.

The CCG is proactively participating in partnership working to reduce smoking in pregnancy through its responsibility for commissioning maternity services. The CCG coordinates the Smoking in Pregnancy sub group.

Mental Health commissioners within the CCG work in partnership with the Healthcare Trust and Public Health to reduce smoking in patients with poor mental health. The newly introduced Alcohol and Tobacco CQUINS will increase the referrals made to Public Health commissioned Smoke Free Services and there will need to be processes put in place to make and receive the expected volume of new referrals.

The University of Bristol MRC Integrative Epidemiology Unit, UK Centre for Tobacco and Alcohol Studies
The Universities’ Division is a leading centre for research on tobacco control and is part of the UK Centre for Tobacco and Alcohol Studies (UKCTCS), one of five Centres of Excellence in Public Health Research funded through the UK Clinical Research Collaboration (UKCRC). The Centre does clinical trials of methods to support smoking cessation in a range of clinical and domestic settings, and has played leading roles in the development of policy on electronic cigarettes and NICE smoking cessation guideline development. The Division is represented on the Tobacco Control Strategic group and collaborates to conduct primary research in the local area.

School Nursing service and Health Improvement Facilitators
Specialist Public Health Nurses (school nurses) deliver public health interventions to school-aged children and young people. Together they work with Public Health Children and Young People’s Teams to deliver the Healthy Child Programme (5-19).

As such, the service plays a crucial role in ensuring that children, young people and families get joined-up support and access to available services at the earliest point, from a child’s transition into school and continuing through their school-aged years.

The school nursing service provides advice and information to children and young people regarding smoking, brief intervention and signposting to smoking cessation services, although referral activity is minimal. A health improvement facilitator within school nursing coordinates health promotion activity for school aged children and this includes smoking. The service distributes campaign material and resources for schools to use during No Smoking Day.
Health Visiting
Health visitors discuss smoking with all new mothers including the risks of second hand smoke exposure and sudden infant death syndrome. Public Health referral data indicates that referrals from Health Visitors are low.

Family Nurse Partnership (FNP)
Evidence shows that FNP’s can reduce smoking prevalence among teenage mothers. Smoking is prioritised in the local FNP service delivery model in terms of offering targeted information, brief intervention and referral to smoking cessation services. Whilst this initiative is at an early stage, referrals are low.

Commissioned Services
Bristol City Council currently commissions a number of providers to deliver smoking cessation and harm reduction services. This includes pharmacy, general practice and various voluntary and community groups. The services offer a comprehensive package of support including behaviour change support delivered by advisors. It provides both direct and indirect supplies of Nicotine Replacement Therapy and facilitation of Varenicline/Zyban. The Community Providers offer free e-cigs to high prevalent smoking populations via a voucher scheme. Whilst GP Practices and Pharmacies do not offer vouchers for e-cigs they are encouraged to offer a harm reduction approach and to signpost clients on to e-cig outlets if required. Although they do not directly provide e-cigarettes they can support clients if they choose to continue using e-cigarettes as part of the quit attempt to help stop smoking tobacco.

During 2016/17 the services and commissioners agreed targets to build on existing work prioritising, people with mental health problems, those living in deprived areas, substance misuse, pregnant women, routine and manual groups and unemployed and long term sick groups (amongst others identified as population groups with high smoking prevalence). Pharmacies were targeted with reaching population groups with specific long term conditions.

Current Service Providers and Activity
From 2015- 2017 (Q3) in total the various providers supported 3,227 (numbers setting a 4 week quit date) with 985 successful quitters (CO validated). Numbers accessing and setting a quit date through NHS Smoking cessation services has declined nationally by 19%. Locally over the last two years, we have seen a reduction in the number of people accessing the service in 2016/17 (compared to Q1-Q3 of 2015/16) (figure 38). Reasons for this may be a reduced number of smokers overall, increased use of electronic cigarettes to support a quit attempt and to reduce the amount smoked. Of the total of those setting a quit date in 15/16 and 16/17 (up to quarter 3) across Bristol City, 437 (13.5%) in 2015/16 were unemployed for over a year, 312 (9.7%) were unable to work through illness, 157 (5%) were a home carer (unpaid) and 745 (23.1%) were in a routine and manual occupation. Although we have limited data on other high smoking prevalence populations, we know that our current services are not always being accessed by those who need them most (see page 24). Activity is low amongst providers in areas of high deprivation and generally across the city. Future health equity audits are required to help understand who is currently accessing/not accessing services and how it can be more equitable for men and women, all broad ethnic groups, targeted population
groups, and the most deprived deprivation quintiles. A separate analysis of geographical equity of access using acorn groups as the measure of need is required to understand access to the service and quit success across the city with areas of lower access.

**Figure 39: Stop Smoking Service Indicators in Bristol and Comparator areas (CIPFA nearest statistical neighbours) and England, 2015/16) compared with England (2015/16) Health and Social Care Information Centre**

<table>
<thead>
<tr>
<th>Area</th>
<th>Setting quit date (rate per 100,000 smokers 16+)</th>
<th>Successful quitters at 4 weeks (rate per 100,000 smokers 16+)</th>
<th>% of successful quitters (self-reported) in routine and manual occupation</th>
<th>% of pregnant women who quit (self-reported)</th>
<th>% of people who quit by all types of pharmacotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coventry</td>
<td>8,892</td>
<td>4,493</td>
<td>51.0</td>
<td>48.8</td>
<td>50.5</td>
</tr>
<tr>
<td>England</td>
<td>5,092</td>
<td>2,598</td>
<td>54.3</td>
<td>45.4</td>
<td>51.0</td>
</tr>
<tr>
<td>Portsmouth</td>
<td>5,003</td>
<td>2,551</td>
<td>53.0</td>
<td>43.3</td>
<td>51.0</td>
</tr>
<tr>
<td>Bristol</td>
<td><strong>4,873</strong></td>
<td><strong>1,814</strong></td>
<td><strong>42.7</strong></td>
<td><strong>30.4</strong></td>
<td><strong>37.2</strong></td>
</tr>
<tr>
<td>Plymouth</td>
<td>4,798</td>
<td>2,379</td>
<td>57.9</td>
<td>37.6</td>
<td>49.6</td>
</tr>
<tr>
<td>Southampton</td>
<td>4,724</td>
<td>2,273</td>
<td>53.0</td>
<td>40.6</td>
<td>48.1</td>
</tr>
<tr>
<td>Newcastle upon Tyne</td>
<td>4,532</td>
<td>1,728</td>
<td>40.8</td>
<td>26.8</td>
<td>38.1</td>
</tr>
<tr>
<td>Brighton and Hove</td>
<td>4,216</td>
<td>2,715</td>
<td>61.5</td>
<td>88.8</td>
<td>64.4</td>
</tr>
<tr>
<td>Swindon</td>
<td>3,559</td>
<td>1,869</td>
<td>55.7</td>
<td>69.3</td>
<td>52.5</td>
</tr>
<tr>
<td>Sheffield</td>
<td>3,410</td>
<td>1,779</td>
<td>57.6</td>
<td>90.7</td>
<td>52.2</td>
</tr>
<tr>
<td>Leeds</td>
<td>2,516</td>
<td>1,624</td>
<td>67.8</td>
<td>57.8</td>
<td>64.6</td>
</tr>
</tbody>
</table>

**Figure 40: Rates of people setting a quit date and successful quitters by 100,000 smokers in Bristol, Local Tobacco Control Profiles 2015/16, Public Health England**

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate of people setting a quit date per 100,000 smokers</th>
<th>Rate of successful quitters (CO validated) at 4-weeks per 100,000 smokers</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013/14</td>
<td>7,888.7</td>
<td>2,548.6</td>
</tr>
<tr>
<td>2014/15</td>
<td>5,306.4</td>
<td>1,777.9</td>
</tr>
<tr>
<td>2015/16</td>
<td>4,872.8</td>
<td>1,487.3</td>
</tr>
</tbody>
</table>
6. What is on the horizon?

Projected service use and outcomes in 3-5 years and 5-10 years

**Adult smoking prevalence**
Adult smoking prevalence in the city is decreasing as indicated by the Quality of Life Survey data. However, prevalence in some parts of the city continues to be at a higher rate than the England average. Extrapolation of the Annual Population Survey trend to 2025 indicates that theoretically the city prevalence could decrease to below 15% after 2020 and further in the following years with a narrowing of the gap in prevalence between the city and England. However, the rate of decrease may be more realistically represented by the extrapolation of the Bristol City Integrated survey results.

National policy decisions such as the introduction of standard packaging and the licensing of electronic cigarettes may alter this scenario further as well as local policy decisions.

**Figure 41: Extrapolation of adult smoking prevalence trends In Bristol City and England to 2025**

![Smoking prevalence (APS) Bristol vs England](image)

Source: APS 2014

**Young People’s smoking prevalence**
Extrapolation of the proportion of regular smokers aged 15 years in England indicates that there is potential for the prevalence to fall below 5% before the year 2020. No local prevalence data is available to model this trend locally, however the model based estimates indicate that the city’s prevalence may be in the region of the national data and be following the national decrease (figure 40). We are aware that in some parts of the city, young people are more likely to start smoking, and future efforts will need to target such populations groups to decrease the trend locally.

**Smoking cessation services**
It is difficult to estimate how the uptake of the city’s smoking cessation services will change in the future. As described above, the uptake of the commissioned services has decreased over recent years in line with the national trend but the quit rates
have not improved. It is likely that prevalence will not drop as quick in groups such as people living in more deprived areas, routine and manual workers, people with mental health problems and other high prevalence groups as in the general population. As these groups become a greater proportion of the smoking population in the city there will be a need for a service to understand more about and adapt to the needs of these groups, this should include an alternative approach [to four week quits] of a stepped harm reduction. The tables below show the estimated Quality and Outcome Framework (QoF) smoking prevalence and numbers of current smokers by GP Practice in Bristol (arranged by each clinical commissioning group locality) against the number of quits achieved. The maps in the appendices highlight the smoking attributed mortality and hospital admissions by Bristol ward. Future provision will need to target population groups within each ward more effectively than current providers.

Figure 42 Numbers of Quit dates set, 4 week Quits CO verified, Current smokers and QOF smoking prevalence in 2015/16 – by GP Practice: Inner City and East locality 2015/16

<table>
<thead>
<tr>
<th>Practice</th>
<th>Quit Dates Set</th>
<th>Number 4 Week Quit Co Verified</th>
<th>Number of current smokers in aged 15+ on practice register</th>
<th>Smoking prevalence QOF 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Broadmead Medical Centre</td>
<td>5</td>
<td>3</td>
<td>2404</td>
<td>31.2%</td>
</tr>
<tr>
<td>Montpelier Health Centre</td>
<td>64</td>
<td>14</td>
<td>4824</td>
<td>30.6%</td>
</tr>
<tr>
<td>The Wellspring Surgery</td>
<td>59</td>
<td>42</td>
<td>1911</td>
<td>29.4%</td>
</tr>
<tr>
<td>Charlotte Keel Medical Practice</td>
<td>59</td>
<td>17</td>
<td>3645</td>
<td>26.5%</td>
</tr>
<tr>
<td>Lawrence Hill Health Centre</td>
<td>52</td>
<td>19</td>
<td>1999</td>
<td>26.5%</td>
</tr>
<tr>
<td>Eastville Medical Practice</td>
<td>85</td>
<td>32</td>
<td>1789</td>
<td>24.7%</td>
</tr>
<tr>
<td>The Maytrees Practice</td>
<td>38</td>
<td>8</td>
<td>838</td>
<td>24.6%</td>
</tr>
<tr>
<td>St George Health Centre</td>
<td>52</td>
<td>17</td>
<td>2075</td>
<td>23.8%</td>
</tr>
<tr>
<td>Beechwood Medical Practice</td>
<td>38</td>
<td>14</td>
<td>1978</td>
<td>22.8%</td>
</tr>
<tr>
<td>Air Balloon Surgery</td>
<td>24</td>
<td>13</td>
<td>2375</td>
<td>21.2%</td>
</tr>
<tr>
<td>Lodgeside Surgery</td>
<td>22</td>
<td>13</td>
<td>1684</td>
<td>20.3%</td>
</tr>
<tr>
<td>Fishponds Family Practice</td>
<td>5</td>
<td>1</td>
<td>1887</td>
<td>18.0%</td>
</tr>
<tr>
<td>The Old School Surgery</td>
<td>1</td>
<td></td>
<td>2455</td>
<td>16.1%</td>
</tr>
</tbody>
</table>

Figure 43: Numbers of Quit dates set, 4 week Quits CO verified, Current smokers and QOF smoking prevalence in 2015/16 – by GP Practice: North and West locality 2015/16

<table>
<thead>
<tr>
<th>Practice</th>
<th>Quit Dates Set</th>
<th>Number 4 Week Quit Co Verified</th>
<th>Number of current smokers in aged 15+ on</th>
<th>Smoking prevalence QOF 2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice</td>
<td>Quit Dates Set</td>
<td>Number 4 Week Quit Co Verified</td>
<td>Number of current smokers in aged 15+ on practice register</td>
<td>Smoking prevalence QOF 2015/16</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>----------------</td>
<td>-------------------------------</td>
<td>-----------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>Hartwood Healthcare</td>
<td>35</td>
<td>17</td>
<td>2107</td>
<td>36.0%</td>
</tr>
<tr>
<td>Hillview Family Practice</td>
<td>26</td>
<td>16</td>
<td>1667</td>
<td>35.1%</td>
</tr>
<tr>
<td>The Merrywood Practice</td>
<td>14</td>
<td>4</td>
<td>1636</td>
<td>32.9%</td>
</tr>
<tr>
<td>The Crest Family Practice</td>
<td>2</td>
<td></td>
<td>1395</td>
<td>31.3%</td>
</tr>
<tr>
<td>Grange Road Surgery</td>
<td>71</td>
<td>25</td>
<td>2390</td>
<td>28.7%</td>
</tr>
<tr>
<td>The Wedmore Practice</td>
<td>49</td>
<td>16</td>
<td>1483</td>
<td>25.1%</td>
</tr>
<tr>
<td>The Malago Surgery</td>
<td>40</td>
<td>14</td>
<td>1905</td>
<td>23.6%</td>
</tr>
<tr>
<td>Bedminster Family Practice</td>
<td>24</td>
<td>11</td>
<td>2033</td>
<td>22.3%</td>
</tr>
<tr>
<td>Stockwood Medical Centre</td>
<td>48</td>
<td>20</td>
<td>1713</td>
<td>22.0%</td>
</tr>
<tr>
<td>Gaywood House Surgery</td>
<td>39</td>
<td>17</td>
<td>1462</td>
<td>21.0%</td>
</tr>
<tr>
<td>Birchwood Medical Practice</td>
<td>2</td>
<td>1</td>
<td>1105</td>
<td>20.7%</td>
</tr>
<tr>
<td>Nightingale Valley Practice</td>
<td>59</td>
<td>10</td>
<td>2507</td>
<td>19.6%</td>
</tr>
<tr>
<td>The Lennard Surgery</td>
<td>16</td>
<td>5</td>
<td>1289</td>
<td>19.3%</td>
</tr>
<tr>
<td>St Martins Surgery</td>
<td>4</td>
<td>3</td>
<td>836</td>
<td>19.3%</td>
</tr>
</tbody>
</table>
Wells Road Surgery        |  1  |  1  | 1128 | 19.2%
The Green Practice At Whitchurch H C | 27  | 10  | 604  | 18.7%
Priory Surgery             | 38  | 12  | 1255 | 18.0%
The Southville Surgery      | 39  | 17  | 1317 | 17.6%
The Armada Family Practice | 72  | 18  | 1853 | 16.4%

Source: Quit Manager, QOF 2015/16

Figure 45 Numbers of Quit dates set, 4 week Quits CO verified, 1/7/2015-31/12/2016 – by Pharmacy/postcode district

<table>
<thead>
<tr>
<th>Postcode District</th>
<th>Quit Date Set</th>
<th>Outcome LTFU</th>
<th>Week 4 Quit</th>
<th>Week 4 Quit - CO Verified</th>
<th>Week 4 Quit Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>BS1</td>
<td>29</td>
<td>24</td>
<td>3</td>
<td>100 %</td>
<td>10 %</td>
</tr>
<tr>
<td>BS10</td>
<td>32</td>
<td>27</td>
<td>5</td>
<td>60 %</td>
<td>16 %</td>
</tr>
<tr>
<td>BS11</td>
<td>34</td>
<td>17</td>
<td>12</td>
<td>92 %</td>
<td>35 %</td>
</tr>
<tr>
<td>BS13</td>
<td>231</td>
<td>167</td>
<td>55</td>
<td>93 %</td>
<td>24 %</td>
</tr>
<tr>
<td>BS14</td>
<td>147</td>
<td>98</td>
<td>31</td>
<td>87 %</td>
<td>21 %</td>
</tr>
<tr>
<td>BS15</td>
<td>29</td>
<td>18</td>
<td>8</td>
<td>100 %</td>
<td>28 %</td>
</tr>
<tr>
<td>BS16</td>
<td>143</td>
<td>51</td>
<td>56</td>
<td>86 %</td>
<td>39 %</td>
</tr>
<tr>
<td>BS2</td>
<td>30</td>
<td>24</td>
<td>5</td>
<td>100 %</td>
<td>17 %</td>
</tr>
<tr>
<td>BS20</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BS24</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BS3</td>
<td>77</td>
<td>57</td>
<td>16</td>
<td>81 %</td>
<td>21 %</td>
</tr>
<tr>
<td>BS30</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>100 %</td>
<td>33 %</td>
</tr>
<tr>
<td>BS31</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BS34</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BS37</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BS39</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>100 %</td>
<td>100 %</td>
</tr>
<tr>
<td>BS4</td>
<td>145</td>
<td>100</td>
<td>33</td>
<td>85 %</td>
<td>23 %</td>
</tr>
<tr>
<td>BS40</td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>50 %</td>
<td>40 %</td>
</tr>
<tr>
<td>BS41</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>BS5</td>
<td>103</td>
<td>73</td>
<td>24</td>
<td>96 %</td>
<td>23 %</td>
</tr>
<tr>
<td>BS6</td>
<td>22</td>
<td>18</td>
<td>1</td>
<td>0</td>
<td>5 %</td>
</tr>
<tr>
<td>BS7</td>
<td>26</td>
<td>14</td>
<td>11</td>
<td>82 %</td>
<td>42 %</td>
</tr>
<tr>
<td>BS8</td>
<td>16</td>
<td>9</td>
<td>4</td>
<td>75 %</td>
<td>25 %</td>
</tr>
<tr>
<td>BS9</td>
<td>8</td>
<td>5</td>
<td>3</td>
<td>100 %</td>
<td>38 %</td>
</tr>
<tr>
<td>Grand Total</td>
<td>1093</td>
<td>716</td>
<td>273</td>
<td>88 %</td>
<td>25 %</td>
</tr>
</tbody>
</table>

Note: 104 clients had no outcome or were not recorded as lost to follow up.

It is difficult to estimate the expected number of smokers by Pharmacy, as unlike General Practice they do not have a registered population. It is possible to look at smoking prevalence rates (see page 26), mortality and hospital admissions by ward (see appendices) and to correlate this to expected and actual uptake by Pharmacy

In summary, low uptake rates can be seen across Pharmacy and GP Practices, and even lower rates are associated with successful quits.
Figure 46 below compares the Bristol population by ethnic groups in Bristol against the estimated smoking prevalence (Office of National statistics) and actual uptake of local smoking cessation services. The data shows quit dates set against verified quits for adults only. It does not break down the ethnic groups by gender or age or the various ethnicities within the Black or white population (e.g. Polish, Romanian etc).

Local smoking cessation services are expected to aim to treat 5% of the estimated population of people who smoke each year. Success rates are expected to be at least 35% at 4 weeks, validated by carbon monoxide monitoring (NICE, 2013).

Local population groups accessing local smoking cessation services varies with an overall uptake rate of 3.9% setting a quit date. There is evidence of some ethnic groups accessing local services and others proportionately underrepresented. Conversion of quit dates set to actual quits (CO verified) vary across the various ethnic groups. More work will be required to understand the actual smoking prevalence amongst local ethnic groups and how they access (or do not access) local smoking cessation services.

Figure 46: Estimated smoking prevalence in adult (18+) BME population in Bristol

Sources:
Smoking prevalence by Sex and Ethnicity 2014: ONS Integrated Household Survey 2014 (population aged 18+)
Quit Manager data extract 2015/16
Smoking habits in the UK and its constituent countries, 2010 to 2015. ONS
Mid-year population estimates 2015, ONS
2011 Census: Bristol population by ethnic group

Smoking prevalence estimates are based on small sample sizes and are therefore subject to a margin of uncertainty. They should therefore be treated with caution.

Population aged 18 years and over

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Population 18+</th>
<th>Smoking prevalence 18+</th>
<th>Estimated number of smokers</th>
<th>% population setting quit date</th>
<th>% population CO verified quitters</th>
<th>Number of quit dates set</th>
<th>Number of CO verified quit</th>
</tr>
</thead>
<tbody>
<tr>
<td>WHITE total</td>
<td>309,806</td>
<td>18.6%</td>
<td>57,694</td>
<td>3.7%</td>
<td>1.3%</td>
<td>2,110</td>
<td>748</td>
</tr>
<tr>
<td>MIXED total</td>
<td>8,737</td>
<td>24.5%</td>
<td>2,142</td>
<td>3.8%</td>
<td>1.3%</td>
<td>82</td>
<td>27</td>
</tr>
<tr>
<td>Asian/Asian British Indian</td>
<td>5,232</td>
<td>8.1%</td>
<td>423</td>
<td>3.5%</td>
<td>0.7%</td>
<td>15</td>
<td>3</td>
</tr>
<tr>
<td>Asian/Asian British Pakistani</td>
<td>4,503</td>
<td>14.0%</td>
<td>629</td>
<td>2.2%</td>
<td>0.6%</td>
<td>14</td>
<td>4</td>
</tr>
<tr>
<td>Asian/Asian British Bangladeshi</td>
<td>1,371</td>
<td>16.1%</td>
<td>221</td>
<td>10.0%</td>
<td>2.3%</td>
<td>22</td>
<td>5</td>
</tr>
<tr>
<td>Asian/Asian British Other Background</td>
<td>3,403</td>
<td>10.8%</td>
<td>366</td>
<td>1.4%</td>
<td>0.8%</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>ASIAN total*</td>
<td>14,509</td>
<td>12.2%</td>
<td>1,775</td>
<td>3.2%</td>
<td>0.8%</td>
<td>56</td>
<td>15</td>
</tr>
<tr>
<td>BLACK total</td>
<td>17,064</td>
<td>13.6%</td>
<td>2,324</td>
<td>5.8%</td>
<td>1.7%</td>
<td>134</td>
<td>39</td>
</tr>
<tr>
<td>Other Ethnic Groups - Chinese</td>
<td>3,528</td>
<td>13.7%</td>
<td>483</td>
<td>0.8%</td>
<td>0.4%</td>
<td>4</td>
<td>2</td>
</tr>
<tr>
<td>Any Other Ethnic Group</td>
<td>2,950</td>
<td>17.1%</td>
<td>504</td>
<td>10.1%</td>
<td>2.2%</td>
<td>51</td>
<td>11</td>
</tr>
<tr>
<td>Total</td>
<td>356,594</td>
<td>18.1%</td>
<td>64,650</td>
<td>3.9%</td>
<td>1.3%</td>
<td>2,493</td>
<td>857</td>
</tr>
</tbody>
</table>
Smoking prevalence for the 'ASIAN total' ethnic group calculated as an average of smoking prevalence of: Asian/Asian British Indian, Asian/Asian British Pakistani, Asian/Asian British Bangladeshi and Asian/Asian British Other Background.
7. Local views

Children and Young People
The Bristol Children and Young People’s Health and Wellbeing Survey 2015 – A report for Bristol Secondary Schools (The Schools Health Education Unit, 2015) presents detailed information about the health beliefs and behaviour pupils. The data below presents responses relating to questions about smoking.

- 16% of pupils responded that they have smoked in the past or smoke now.
- 2% of pupils responded that they usually smoke at least 1 cigarette a week.
- Of the 359 pupils who have smoked, they were on average 11 years old when they first tried smoking a cigarette.
- 4% of pupils responded that they smoked at least one cigarette in the 7 days before the survey.
- 37% of pupils responded that their parents/carers smoke.
- 13% of pupils responded that someone smokes indoors at home in rooms that they use.
- 10% of pupils responded that someone smokes in a car when they are in it too.
- 16% of pupils responded that they have tried e-cigarettes in the past or use one currently (14% never heard of them, 70% never used them).

Behaviour Change – Healthy Lifestyle Service Pre Market Engagement Event
In September 2016, a full Council debate was held on Behaviour Change for Healthy Lifestyles which included; smoking, with various stakeholder workshops attended by local and national providers. Although the feedback was specific to Public Health Lifestyle Services in general, many of the themes can be applied to smoking cessation services. There were a wide range of issues raised; the key points and proposed actions from each of the areas are detailed below:

Feedback from the stakeholder day included the following themes:

- Organisational culture – customer centred service; diversity of workforce; client led services; partnership working; better use of digital technology; greater flexibility and accessibility of workforce; locally based; reduce inequalities
- Service development – flexibility and accessibility of services for service user; variety of pathways of access e.g. use of social media; cater for diversity; single/mix gender services; intergenerational training; community hub
- Behaviour change – incentivisation through loyalty cards, food vouchers; identify root causes of unhealthy lifestyles; use of life skills training, apps, fit bits; less emphasis on medical conditions
- Communication – use of all forms of communication including social media, digital, word of mouth; integrate health messages with other messages; peer review; consistency of messaging; promote talking about issues; marketing/branding
- Holistic approach – emotional health and wellbeing through all services; family dynamics; population groups; use of environments; link to wider determinants; intergenerational; arts and cultural involvement; use of mindfulness, self-
esteem and self-worth approaches; more focus on talking therapies and less focus on medical issues.

**Behaviour Change –Healthy Lifestyle Service Focus Groups**

A series of focus groups and a survey across Bristol have sought to understand how people respond to current lifestyle services and what they would like to see as part of the Bristol commissioning process. The key themes are as follows:

**Frequent Themes**

![Frequent Themes Diagram](image)

**Bristol City Council Online Survey**

A survey was hosted on the Bristol City Council consultation site in 2016 to identify who and how people use our current services and what it means to be healthy. Examples of the questions asked and the feedback can be seen below. A small percentage had accessed smoking cessation services and the main route for accessing this was via their GP. The vast majority of the respondents highlighted that access to web based information and signposting to local services would be an enabler to improve their current health and wellbeing.
Which of our current lifestyle services have you tried?

How can we best enable you to help yourself in becoming healthier?
8. What does this tell us? Unmet needs and service gaps

Key issues and gaps

Smoking in Pregnancy and after Childbirth
  - Smoking in pregnancy in some parts of the city is significantly higher in the city (30%) than the England average (10.6%)
  - Older girls (in year 8) are more likely to smoke than boys in Bristol

Smoke Free Environments and Homes
  - Other than the information provided through the Healthy Child Programme 0-5 (delivered by Midwifery, Health Visiting and Family Nurse Partnerships), it appears that Early Help Services and Early Years providers do not focus on reducing smoking in the home or exposure to second hand smoke amongst children.
  - Approximately 5% of households in the city allow smoking in the home increasing risk of exposure to second-hand smoke and initiation of smoking in children and young people.
  - In the 2015 Quality of Life Survey it was found that 4.7% of smokers and non-smokers allowed smoking in the home. This increases to 12.3% amongst people living in deprived areas and 10.4% of households of disabled people.
  - National campaigns are not targeted to high smoking prevalence populations and there are limited evaluations carried out to understand how national campaigns encourage behaviour change amongst population groups with high smoking prevalence.

Smoking in Children and Young People
  - Although various services seek to reduce smoking initiation amongst children and young people as part of their overall offer, this is not the primary aim of any one service and there is a lack of a coordinated approach across the City.
  - Approximately 87% of schools in Bristol City do not currently have Healthy Schools Status. These schools may need additional support in encouraging and supporting to develop smoke-free policies and practices in line with the relevant Healthy Schools criteria on smoking.
  - Current smoking cessation services do not meet the needs of young people who smoke.
  - There is evidence that the prevalence of smoking amongst 16 & 17 year olds in the city is higher than the England average and model based estimate.
  - Although we have some information on smoking prevalence amongst young people it is not precise. Further work is needed to improve the quality of this data, especially for vulnerable groups such as children in care, youth offending, NEET’s, Pupil Referral Units etc.

Smoking and Inequalities
  - There continues to be significantly higher rates of smoking in routine and manual groups and in certain areas of the city for example in Hartcliffe & Withywood, and Lawrence Hill, there is a risk that this inequity may increase as the overall smoking prevalence decreases.
• Although we know that some population groups have higher prevalence rates of smoking nationally, little is known about these population groups at a local level due to poor equality monitoring.
• Health equity audits and ACORN modelling (market segmentation tool) is required to help us understand which population groups and geographical areas with high smoking prevalence are accessing our services and if there is an inequity amongst outcomes.
• Smoking rates continue to be particularly high amongst routine and manual, unemployed and long term sick and disabled in the city.
• National data highlights particularly higher smoking prevalence in adults from dual heritage, South Asian, Black Caribbean and Eastern Europe backgrounds who have settled in the UK including Bristol City. Uptake of service provision with positive outcomes are limited for such populations in Bristol.
• There is limited research on smoking prevalence on new migrants that have settled in the UK from outside of the EU.
• Available national and local evidence suggests that smoking prevalence is higher amongst lesbian, gay, bisexual and trans gay adults.
• Available national and local evidence suggests that smoking prevalence is higher amongst lone parents and ex-offenders than other groups.
• Smoking prevalence is significantly higher amongst adults with poor mental wellbeing and amongst adults with mental health problems.
• Adults who drink at levels which harm their health and adults with substance misuse problems have very high rates of smoking.

Illicit Tobacco
• Illicit and counterfeit tobacco is a significant source of the tobacco smoked in the city, making tobacco more readily available and contributing to crime in communities.

Service Performance
• Activity and quit conversion rates are low amongst our current providers, especially in area of high deprivation and amongst population groups who are nationally known to have high smoking prevalence.
• Poor equality monitoring as part of the death registry, and in primary and secondary care undermines the ability to understand which groups should be prioritised and how our local efforts and resources should be arranged to address health inequalities in the city.
• Low and poor quality referrals from local Trusts, impacts on the outcomes achieved once individuals are referred on to smoking cessation services.
• Low referrals from agencies such as Health Visitor and Mental Health Services.
• Efforts to reduce smoking prevalence in local population groups need to include a place based approach and to address the wider determinates of health inequalities (e.g. debt management, employment etc).

Alternative Models
• Harm reduction options (with the use of e-cigs) need to be more readily available to high smoking prevalence groups who are not able to achieve an
abrupt four week quit, this should be funded from the Local Authority nicotine replacement therapy budget.

- Various alternative models of delivery need to be developed to meet the needs of population groups with high smoking prevalence

**Recommendations**

**Smoking in Pregnancy and after Childbirth**

- Develop a multi-agency smoking in pregnancy pathway and enhance interventions to reduce smoking in pregnancy and support women who want to quit based on the latest evidence in the Healthy Child Programme Rapid Review.
- Implement the Smoking in Pregnancy and Childbirth NICE recommendations which aim to help areas to reduce smoking rates in pregnancy using a whole systems approach. The indicators bring together existing resources to help support areas to identify situations where they could positively impact rates of smoking in pregnancy.
- Develop interventions to reduce the exposure of children to second-hand smoke in different settings, including in the home and outdoor areas, and assist with reducing the number of children that start smoking as a result of living in a smoking home and family.
- Ensure that providing information around smoking (including risks of exposure to second hand smoke amongst babies and children), brief intervention and referral to smoking cessation services is prioritised in the service specifications for all maternal, health visiting and early years services.

**Smoking in Children and Young People**

- Targeted and early intervention in young adulthood could positively impact on the prevalence of smoking related mortality in the city over the next thirty to fifty years.
- Provide a coordinated approach across the city to reducing smoking initiation and smoking prevalence amongst children and young people across agencies/services.
- Ensure services who work with young people provide evidenced based support/brief intervention around smoking and particularly target those at greatest risk; including pupils who have truanted or been excluded from school and pupils who receive free school meals.

**Smoke Free Homes and Environments**

- Target local campaigns at population groups who have the highest smoking prevalence, by working with communities to develop insights and shared ownership.

**Smoking and Inequalities**

- Develop specific pathways and service models for people with different levels of mental health problems.
- Work alongside the local Sustainability Transformation Footprint to fully implement NICE guidance PH45 (Smoking cessation in secondary care: acute, maternity and mental health services) via the Preventing ill health by
risky behaviours – alcohol and tobacco Commissioning for Quality and Innovation (CQUIN).

- Ensure services are targeting and impacting upon smoking rates in more deprived areas and amongst population groups with high smoking prevalence (highlighted in this paper).
- Ensure pathways and appropriate service models exist for people with drug and alcohol problems who wish to stop smoking or reduce the harm from tobacco (including ex-offenders).
- Ensure new providers are collating and reporting on equality data.
- Carry out a Health Equity audit to determine which groups (to include deprived areas, lone parents and those with protected characteristics) are not accessing smoking cessation services, which are least likely to stop smoking and to determine effective interventions, that include harm reduction approaches.
- Ensure there are simple pathways in place to signpost people on to community based support e.g. employment, debt management etc.

Illicit Tobacco and Smoke Free Environments

- Allocate resources to tackling illicit and counterfeit tobacco.
- Develop and promote smoke free environments, and support new tobacco control legislation with communication in the city.

Service Performance

- Work with local agencies to improve the quantity and quality of referrals.
- Explore alternative delivery options to improve uptake and successful outcomes.

Alternative models

- Local intelligence about tobacco use among Black, Asian and Minority Ethnic and other population groups, some of which have other protected characteristics, has important implications when planning local health services, tackling health inequalities and reducing the burden of ill health from lifestyle-related disease.
- Monitor the evidence and guidance relating to the use of e-cigarettes in harm reduction and smoking cessation and evaluate the harm reduction approach used across the city with a view to roll out amongst priority population groups.
- Re-commission the smoking cessation/harm reduction services targeting population groups with high smoking prevalence, offering flexible services that meet their needs.
- Identify how smoking cessation and tobacco control initiatives can be integrated into the Local Authority Policy and commissioning arrangements.

10. Key Contact
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Appendix 1 Crude rate of hospital admissions for diseases wholly or partially attributed smoking by ward 2013/14-2015/16
Appendix 2 Mortality from diseases that are wholly or partially attributed to smoking by ward 2013-15
Appendix 3 Mortality from Lung Cancer by ward 2011-2015
Appendix 4 Mortality from COPD by ward 2011-2015
References
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8. Action on Smoking and Health (2016). Fact sheet on Smoking and Disease
10. Action on Smoking in Health (2016). Health inequalities and smoking
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17. Maternity data from Bristol-located NHS maternity providers, (2012)


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53. Primary Care Mental Health Forum (2014). Primary care guidance on smoking and mental disorders. [http://www.rcpsych.ac.uk/pdf/PrimaryCareGuidanceonSmokingandMentalDisorders2014update.pdf](http://www.rcpsych.ac.uk/pdf/PrimaryCareGuidanceonSmokingandMentalDisorders2014update.pdf)


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