Tobacco Control
Health Needs Assessment 2023

SERVICE USER INSIGHT

There's literally nothing I like about smoking.
I'm so glad to get rid of it from my life.

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SERVICE USER INSIGHT

Now I am quit, my health continues to improve.
My Grandson says I smell of flowers instead of cigarette smoke.
I quit so I can live longer and to help other people I care about to quit long term.

Executive Summary

Bristol is a city with a long and complicated history with tobacco. Rumours implicate Bristol docks as the location where smoking was first observed in England – a sailor was observed 'emitting smoke from his nostrils' here in 1556.

In 1786 the first tobacco factory in Bristol was established on Castle Street. By the 1970s, Europe's largest cigarette manufacturing plant was opened in Hartcliffe and local workers were paid with cigarettes. Indeed, there is a case study in Appendix 1 which provides a brief account of the quit attempt of a woman who worked most of her life at a tobacco factory in Bristol. She was given 200 cigarettes a week for free as part of her employment. Thus commenced a nicotine addiction which lasted for 60 years.

Despite the Hartcliffe factory having closed by 1990; the lingering effects of Bristol's long history tobacco remains evident today in our smoking prevalence, our contrasting patterns of smoking between population groups, and the lasting detrimental impact upon the health and wellbeing of local people.

Today, smoking is the number one contributor towards health inequalities out of all domains of public health.

Smoking prevalence has been declining nationally and locally since at least 1974 when government records began. The introduction of electronic cigarettes (e-cigs) has further boosted this decline, with e-cigs now representing the most popular and the most effective method available to stop smoking.

Adult use of e-cigs must be thought of as distinct from youth experimentation with disposable vaping devices ('vapes'). The use of vapes is not typically associated with smoking cessation and must be addressed through strong national tobacco control legislation as well as local efforts to inform and support young people, their families, and professionals working with them.

Despite the decline in smoking prevalence, there are pockets of persistently high smoking amongst some of Bristol's most vulnerable residents. Smoking is strongly associated with deprivation, with routine and manual employment, with particular ethnic groups and with serious mental illness. The long-term harms from smoking are evident in the numbers of Bristol residents with long term conditions exacerbated or caused by smoking.

A strong argument exists for focussing smoking interventions on primary prevention – focussing on intervening early and at key life stages to reduce health inequalities across the life course[1]. Targeting interventions towards pregnant women, who stand to benefit their

[1] Health matters: Prevention - a life course approach - GOV.UK (www.gov.uk)

own health and that of their unborn child confers benefits to the whole family, the entire lifespan of the unborn child and potentially that child's future children also. Indeed, tackling adult smoking is one of the biggest modifiable factors when considering how to reduce the likelihood of smoking initiation amongst children.

These clusters of persistently high smoking prevalence, hidden in plain sight within Bristol's wards and communities, are the reason for the commissioning of targeted smoking cessation services. Taking a proportionate universalism approach[2], Bristol's targeted smoking cessation service offers an intervention to those at highest risk of harm from smoking, and who are least likely to stop smoking alone.

Tobacco control activities and interventions can be amplified across our ICS footprint by building further upon the strong relationships already established with North Somerset and South Gloucestershire tobacco control colleagues.

Local authority smoking cessation services and the relationships available to local authority tobacco control commissioners represent a unique opportunity to support the NHS in upskilling its activities around smoking cessation and to offer a link with the wider determinants of health. The Treating Tobacco Dependency workstream within hospital Trusts locally and nationally, and the new NHS Targeted Lung Health Checks screening programme are both excellent examples of valuable work targeting smoking cessation efforts to those most affected by the harms of smoking. At the same time, this additional activity has the potential to strongly impact the capacity available to local authority services and potentially detract from their ability to effectively work with local communities on primary prevention. This is felt at both a national and local level.

To support this health needs assessment, engagement was undertaken with some of Bristol's priority communities as well as professionals, volunteers, third sector organisations and other stakeholders. This activity identified strong themes around effective collaborative working and targeted, efficient promotion of the service to priority groups.

After careful review of the evidence available, 17 recommendations for future tobacco control and commissioning priorities have been made:

1. Smoking cessation efforts in Bristol would continue to benefit from taking a targeted approach given both the ongoing popularity of self-quit attempts utilising electronic cigarettes and the very entrenched and localised nature of the remaining smoking population. This service must target those at the highest risk of harms from smoking who are least likely to successfully quit through a self-quit attempt.
2. Any smoking cessation efforts in Bristol would reasonably take a place-based approach. Those residents who are at highest risk of harm from smoking tend to be

[2] Proportionate Universalism Briefing (healthscotland.com)

resident within the same (or very similar) wards – notably Hartcliffe and Withywood, Southmead and Lawrence Hill (possibly including close surrounds).

3. Primary prevention is effective. Interventions which target or prioritise pregnant women, young families, children and young people are likely to reduce or avoid substantial and lifelong health risks as well as positively impact broader smoking prevalence.
4. Continue to support the emerging BNSSG Smoke Free Alliance and tobacco control strategy, advocating for the needs of Bristol residents as appropriate, as well as collaborating on regional interventions.
5. The impact of smoking cessation interventions within the NHS upon local authority commissioned smoking cessation services has potential to be significant and must be monitored closely. Learning must be considered from other ICSs across the South West and nationally. Opportunities to jointly support the Bristol residents impacted by these interventions must be explored, in order to effectively manage demand for smoking cessation support in the community and avoid overloading the capacity of community services.
6. In collaboration with local Trusts and other partners, explore methods to effectively support Bristol residents with serious mental illness to stop smoking.
7. Continue to support NHS England roll-out of Targeted Lung Health Checks, jointly ensuring pathways are in place to support a quit attempt for residents and working to avoid overloading the capacity of community services.
8. Establish a task-and-finish group to identify methods for reliable access to NRT for those Bristol residents who are unable to access this from their GPs.
9. Ensure that the needs of black, Asian and minority ethnic backgrounds – and in particular people from mixed ethnic backgrounds – are identified and addressed within smoking cessation services. This may include community engagement and targeted work with this population at Bristol or BNSSG level.
10. Commissioners to maintain an awareness of environmental issues relating to incorrect disposal of e-cigarettes and vaping devices; linking with local and regional Trading Standards and waste/refuse companies to address unsafe disposal and related concerns.
11. Tobacco control commissioners and smoking cessation services must maintain an awareness of developing technology around electronic nicotine delivery devices as well as the re-branding of existing nicotine containing products from the Tobacco Industry.
12. As services begin to fully recover from the impact of the Covid-19 pandemic, consider opportunities to better engage eligible service users in smoking cessation treatment i.e., NHS Health Checks.
13. Sustain an understanding of local and national movement and opportunities pertaining to supporting smokers to quit using electronic cigarettes.

14. Maintain an awareness of the health needs of Bristol's 'Inclusion Health' population groups and work collaboratively with colleagues to explore opportunities to offer support.
15. Continue to work closely with BNSSG tobacco control commissioners to ensure local authority services are as easy as possible for BNSSG-wide partners to navigate. Explore opportunities for future joint commissioning.
16. Commissioners to explore options to work collaboratively with local communities to design and implement tobacco control interventions.
17. Commissioners and providers to jointly consider targeted promotional activities to specifically engage those communities currently under-represented within the service. Consideration could also be given towards effective promotion of the service with key partners and stakeholders.

It is noted by the authors that the gaps and recommendations identified within this health needs assessment process are unlikely to capture the entire breadth of necessary tobacco control activity nor opportunities which may arise to deliver robust interventions. These recommendations do not represent the full extent of tobacco control activity required to impact upon smoking prevalence and harms.

Introduction

Around half of all regular cigarette smokers will eventually be killed by their addiction[3]. This equates to approximately 38,000 Bristol residents who will die as a direct consequence of their nicotine addiction (based upon 2021 figures).

On average, people who are addicted to nicotine will lose 10 years of life compared to those who do not smoke. They will spend a significant period of time disabled or living with a long-term condition such as cancer (notably lung cancer – with smoking causing 7 out of 10 lung cancer cases) coronary heart disease, heart attack, stroke, and/or chronic obstructive pulmonary disease in the years immediately prior.

Research has also demonstrated an association between smoking and poor mental health, with current smokers scoring worse than non-smokers on every mental wellbeing indicator[4].

The infographic in Figure 1 summarises health harms caused by smoking[5].

[3] 10-High-Impact-Actions.pdf (ash.org.uk)
[4] Smoking and tobacco: applying All Our Health - GOV.UK (www.gov.uk)

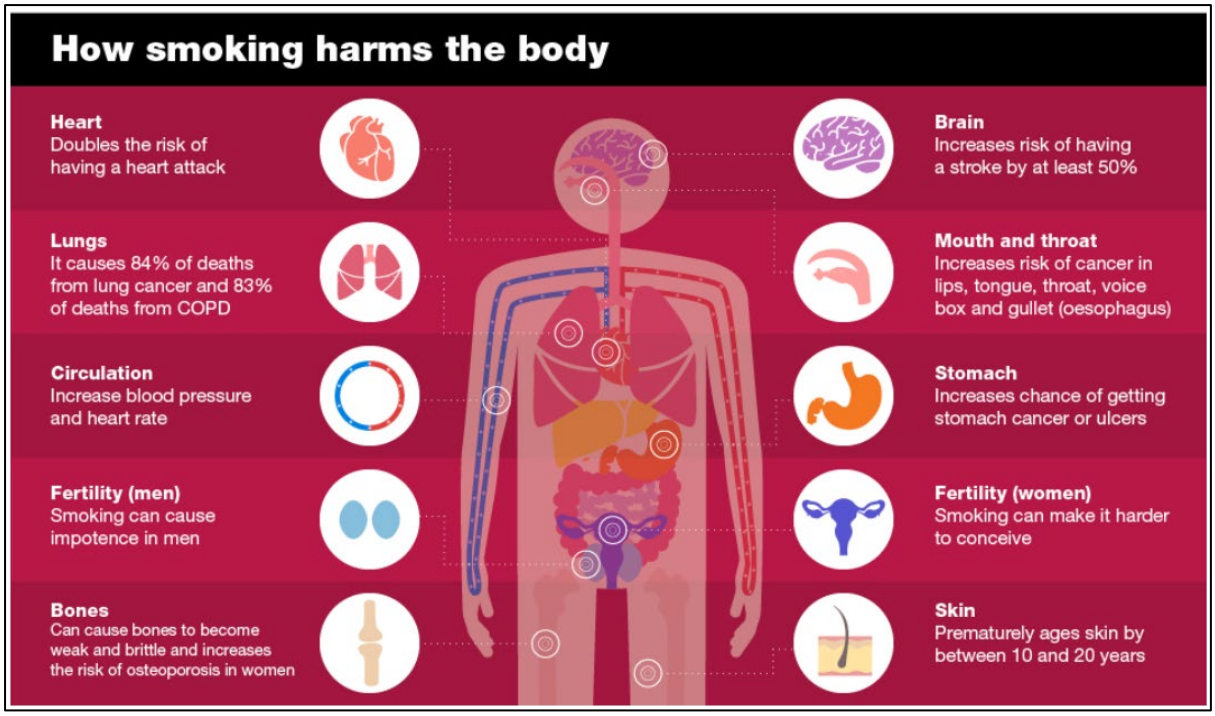

Figure 1: How smoking harms the body

Around 60% of people currently smoking cigarettes want to quit[5], but sadly will have to try upwards of 30 times before they are likely to become and remain abstinent[6].

For the circa 66,000 Bristol residents who remained addicted to cigarette smoking in 2022[7], their future health prospects are considerably negatively impacted compared to their non-smoking counterparts.

Although there has been a general downwards trend in the prevalence of smoking both nationally and in Bristol there remains small but important pockets of the population for whom smoking continues to be rife.

Age-cohort analyses have suggested that the overarching reduction in smoking prevalence is primarily due to the prevention of younger people starting smoking, as opposed to existing smokers quitting[8].

At population level, the largest reduction in smoking prevalence since 2011 has been amongst those aged 18-24[9], which further supports this view.

[5] Health matters: stopping smoking – what works? - GOV.UK (www.gov.uk)
[6] Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers | BMJ Open
[7] ASH Ready Reckoner - ASH
[8] Understanding long-term trends in smoking in England, 1972–2019: an age–period–cohort approach - Opazo Breton - 2022 - Addiction - Wiley Online Library
[9] Adult smoking habits in the UK - Office for National Statistics (ons.gov.uk)

Smoking prevalence remains consistently high amongst people living in deprived areas and people with routine and manual occupations (1 in 4 smoke) as compared to people living in affluent areas with professional or managerial level roles (1 in 10 smoke).

The negative impact of smoking is the single largest contributor towards health inequalities in our modern-day societies – consistently outranking obesity, alcohol, drug poisoning, road accidents, and HIV combined[10].

One of the groups of people for whom smoking has a particularly devastating impact is pregnant women. Pregnant women who smoke are at increased risk of developing smoking related illness themselves, but there is very real and impactful risk of harm to the growing foetus. Risks associated with smoking in pregnancy include miscarriage, stillbirth, premature birth, and low birth weight. For the mother and family, the emotional impact of pregnancy loss and still birth is devastating and is associated with increases in the risk of anxiety, depression, post-traumatic stress disorder, and suicide[11].

Who Smokes in 2023?

Most adult smokers first experimented with smoking as children and were likely already addicted by age 18. Only a very small proportion of smokers begin smoking after the age of 20[12]. This early advent of smoking behaviours is strongly associated with parental and sibling smoking, ease of access to cigarettes, exposure to peers who smoke, socio-economic status, and depictions of smoking in the media[13].

The association between primary carer/familial smoking and children smoking is strong enough that helping parents to stop smoking and establish a smoke free household[14] is considered to be the most effective way of preventing children from taking up smoking[14].

Furthermore, smoking remains entrenched within specific population groups; suggesting the existence of a strong localised cultural impact upon smoking that could reasonably influence both young people starting to smoke and dissuade current smokers from quitting.

Costs of Smoking

The costs of smoking addiction to society are dramatic. In Bristol alone, it is estimated[8] that the negative impact of smoking on productivity, healthcare and social care costs equates to £207.4 million annually. This figure is comprised of:

- £179.28 million in lost productivity
- £18.81 million in healthcare costs

[10] Making-the-case-update-July-2022.pdf (ash.org.uk)
[11] Miscarriage matters: the epidemiological, physical, psychological, and economic costs of early pregnancy loss - The Lancet
[12] Smoking in young people – RCPCH – State of Child Health
[13] 190913-ASH-Factsheet_Youth-Smoking.pdf
[14] Smokefree homes factsheet - general public (who.int)

- £6.44 million in social care costs
- £2.88 million in fire costs

The cost to healthcare is accrued from both the management of smoking related ill health within primary care (£12.79 million) and hospital admissions (£6.02 million).

Many current and/or former smokers require social care support in later life as a result of smoking related illness. The estimated cost of providing this care is £6.4 million per annum, split between domiciliary and residential care. However, the vast majority of current and/or former smokers who require care in later life have their care provided informally by friends and family. If this were to be replaced with formal paid care by local authorities, the estimated impact would total an additional £76.11 million.

Not to be overlooked is the impact on Bristol City Council of having to clean up waste generated by cigarette smoking. An estimated 32 tonnes of cigarette waste is generated annually, 13 tonnes of which are discarded as street litter.

Cost Effectiveness of Smoking Cessation Interventions

Tobacco control and cessation services are among the most cost-effective of all interventions, with the potential to make cashable savings to the NHS, LA's and social care. Health economic analysis shows a cashable ROI of £2.12 for every £1 invested, the public value ROI ratio was £30.49 for every £1 invested. A cost per QALY of £487 was also realised[15].

What is Tobacco Control?

The UK is a world leader in Tobacco Control, but there is still more that needs to be done to eliminate cigarette smoking and achieve the ambition of the first 'smoke free generation' (defined as a population level smoking prevalence of less than 5%) identified in the UK's 2017 - 2022 Tobacco Control Plan for England[16].

For this goal to be achievable, a whole systems approach must be utilised across a multi-disciplinary workforce, including acute health, mental health, public health, regulatory services, employment, social care, children's services, fire and rescue service and criminal justice.

[15] https://bmjopenrespres.bmj.com/
[16] tobacco-control-delivery-plan-2017-to-2022.pdf (publishing.service.gov.uk)

In the 2017 Tobacco Control Plan the UK Government identified four national ambitions for Tobacco Control:

1. The first smoke free generation.
2. A smoke free pregnancy for all.
3. Parity of esteem for those with mental health conditions.
4. Backing evidence-based innovations to support quitting.

These are achieved through four main themes for action:

A. Prevention first
    a. Effective legislation to tackle illegal supply, particularly illegal supply to young people.
    b. Support pregnant women to quit.
B. Supporting smokers to quit
    a. Provide access to training in brief interventions and referrals to all health professionals.
    b. Collaborative action with NHS Trusts.
C. Eliminating variations in smoking rates
    a. Targeted local action to priority groups.
    b. Health and social care partners to support system wide actions on smoking.
D. Effective enforcement
    a. Reduce demand i.e., high duty rates and implementation of relevant sanctions.

Developments post-2017

In 2019 the UK Government built upon these ambitions within the Tobacco Control Plan by announcing a new ambition – that of a smoke free 2030, meaning that fewer than 5% of the population would be smoking in 2030[17].

In 2022 an independent review of the Governments tobacco control activity, led by Dr Javed Khan OBE[18] identified that without significant additional action, the UK was likely to miss this target by at least 7 years. The report made specific recommendations to support this ambition and argued that without the implementation of these recommendations, particularly the four recommendations identified as 'critical', smoke free 2030 would not be met. The four critical recommendations included additional investment to fund smoke free

[17] Advancing our health: prevention in the 2020s – consultation document - GOV.UK (www.gov.uk)
[18] Making smoking obsolete: summary - GOV.UK (www.gov.uk)

interventions, increasing the age of sale for all tobacco products, embracing the promotion of vaping as the most effective tool for helping smokers to quit, and embedding prevention within the NHS.

In April 2022 a ministerial announcement[19] identified new activity to support the ambition of the 2030 smoke free target. This includes the following eight 'steps':

1. Youth vaping: A call for evidence
2. Swap to stop: 1 million smokers.
3. Illicit products: A new national "flying squad".
4. Smoking in pregnancy: A national incentive scheme
5. Smoking in mental health: Quit support in MH services.
6. Licensed medicines: Unblocking supplies
7. Tobacco packaging: Mandatory pack inserts.
8. The Major conditions Strategy: Smokefree at the core

In the spirit of the 2017 – 2022 Tobacco Control Plan, the emphasis remains upon preventing young people from smoking, tackling inequalities, and supporting preventative action from within the NHS.

In 2003 the UK signed up to the World Health Organisations Framework Convention on Tobacco Control[20]. This treaty was developed in response to the globalisation of the tobacco epidemic and is an evidence-based treaty that reaffirms the right of all people to the highest standard of health. The treaty commits members to specific measures to reduce demand for tobacco, regulate the supply of tobacco, and to protect the environment from the harms of the tobacco industry. There are clear guidelines around how local authorities may and may not interact with the tobacco industry. The UK Department for Health and Social Care[21] has expanded upon the treaty for practical application in the UK.

Local Commitments

Bristol City Council has been proactive in supporting the delivery of the 2017 national tobacco control plan ambitions, implementing a range of universal and targeted interventions and building strong collaborations with regional and local partners across local authorities and the NHS.

[19] Minister Neil O'Brien speech on achieving a smokefree 2030: cutting smoking and stopping kids vaping - GOV.UK (www.gov.uk)
[20] WHO Framework Convention on Tobacco Control overview
[21] Guidance for government engagement with the tobacco industry - GOV.UK (www.gov.uk)

Local Authority Declaration on Tobacco Control

In 2013 Bristol signed the Local Authority Declaration on Tobacco Control, joining 120 other local authorities across the UK in doing so[22]. The Declaration is a statement of Bristol's commitment to ensure tobacco control is part of mainstream public health work. The Declaration includes several specific commitments to enable local authorities to take leadership on tobacco:

- Reduce smoking prevalence and health inequalities.
- Support delivery of the national smokefree 2030 ambition.
- Develop plans with partners and local communities.
- Participate in local and regional networks.
- Support Government action at national level.
- Protect tobacco control work from the commercial and vested interests of the tobacco industry.
- Monitor the progress of our plans.
- Join the Smokefree Action Coalition.

One City Plan

Bristol's One City Plan[23] draws together a range of local statutory and non-statutory partners to commit to collaborative action across a range of measures designed to improve quality of life for Bristol residents. The One City Plan Health and Wellbeing Vision for 2050[24] has a vision 'for citizens to thrive in a city that supports their mental and physical health and wellbeing equally, with children growing up free of Adverse Childhood Experiences having had the best start in life and support through their life', and a vision for the gaps in life expectancy between the most economically deprived areas and the most affluent areas of Bristol to be significantly reduced. Smoking cessation is a major contributor towards both goals. This work includes strong commitment to reduce the prevalence of smoking amongst pregnant women.

Bristol City Council Corporate Strategy

The Bristol City Council Corporate Strategy 2022-2027[25] identifies seven strategic themes, identified as being of particular priority for achieving the Councils vision – that of playing a leading role in 'driving an inclusive, sustainable and healthy city of hope and aspiration, one where everyone can share in its success'. One of these themes is Health and Wellbeing, with the identified priority tackling 'health inequalities to help people stay healthier and happier throughout their lives'. Within this theme Bristol will contribute towards the development of the Integrated Care System and its goals of co-production with communities and prevention of ill health.

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[22] The Local Government Declaration on Tobacco Control - ASH
[23] The One City Approach - Bristol One City
[24] Health and Wellbeing Board - Bristol One City
[25] Corporate Strategy 2022-27 (bristol.gov.uk)

Bristol, North Somerset and South Gloucestershire Integrated Care System

The BNSSG ICS Strategy has identified a vision – that of 'Healthier together by working together: people enjoying healthy and productive lives, supported by a fully integrated health and care system – providing personalised support close to home for everyone who needs it'. The strategy identified five areas to intervene across the ICS, which are:

- Tackling inequalities
- Strengthening building blocks
- Prevention and early intervention
- Healthy behaviours
- Strategic prioritisation of key conditions.

Smoking has been identified as one of the main priority areas for ICS activity in addressing healthy behaviours and tackling a priority driver of poor health and health inequalities across BNSSG. The ICS had further committed to agreeing on a financial commitment to deliver preventative work, focus on health and wellbeing support for volunteers and health and social care workforce across the partnership, and in developing a whole-system programmes for stopping smoking.

Tobacco Control in Bristol

Over half of all smokers will eventually quit by themselves, using willpower, and without needing support from a smoking cessation service[6]. Electronic cigarettes are now the most popular way to stop smoking and there is growing evidence to suggest that they are the most effective method of stopping smoking[26].

The numbers of smokers accessing commissioned support to stop services was first identified as declining in 2011/12, with those accessing these services representing a small minority of smokers. Nationally, the number of people accessing smoking cessation services reduced by 74% between 2001/2 and 2016/17.

Office for National Statistics data has identified that this reducing demand for smoking cessation services has continued to date (2021/22). Figure 2, reproduced from a Nuffield Health analysis[27], shows this decrease in demand for services against the increasing popularity of electronic cigarettes.

[26] Stopping Smoking - ASH
[27] Smoking | Nuffield Trust

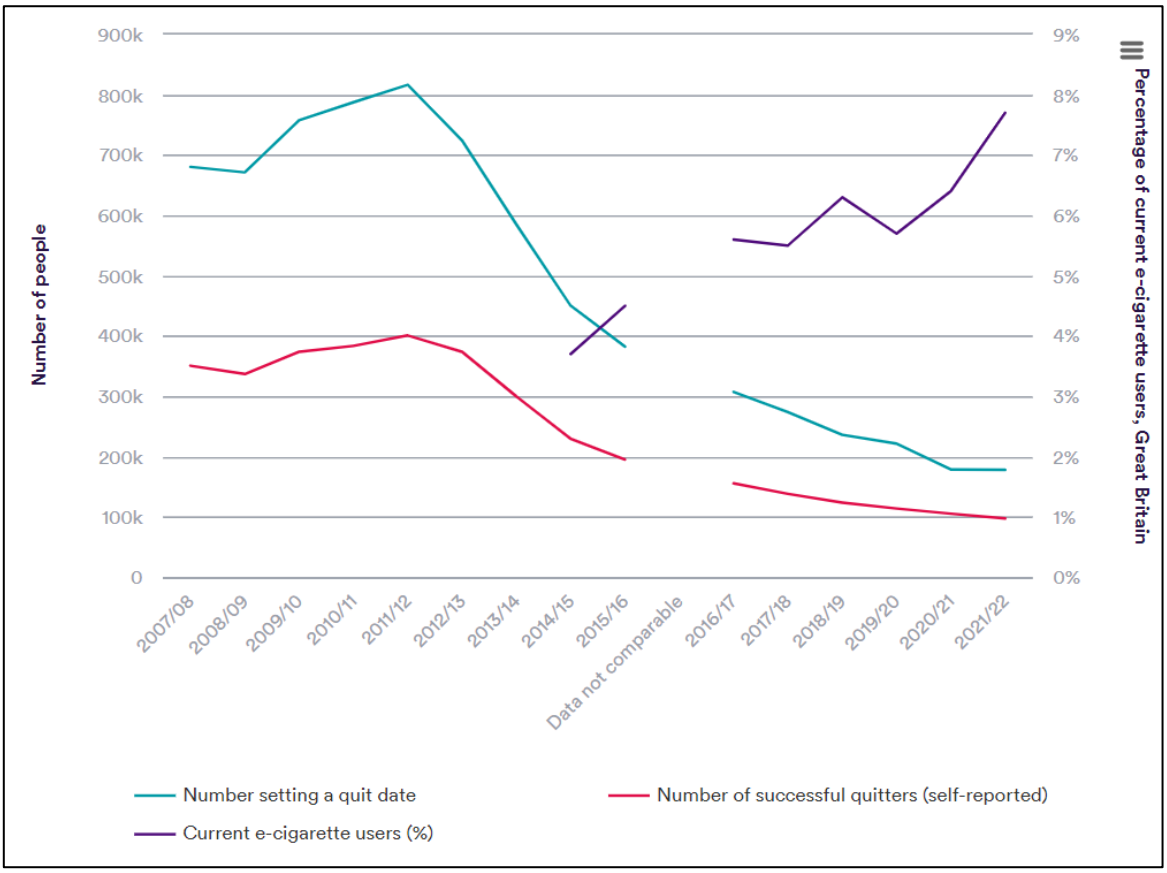


Figure 2: numbers of people setting a quit date with a stop smoking service, numbers of successful quitters, and proportion of current electronic cigarette users, over time.

Targeted Provision

In light of the reducing overall prevalence of smoking, the increasing popularity of e-cigarettes for self-quits, and the reducing demand for smoking cessation services, Bristol City Council Public Health has commissioned a targeted smoking cessation service to target the areas of greatest remaining need.

The targeted service is designed to work proactively and flexibly with the communities of people who are at the highest risk of harm from smoking, who are most likely to need help from a smoking cessation service and least likely to quit by themselves given the persistent high smoking prevalence within their communities.

Bristol's targeted smoking cessation service is to be recommissioned for April 2024. The new smoking cessation service will be required to be more flexible and increasingly adaptive, working collaboratively with commissioners to effectively prioritise resources as the wider tobacco control landscape evolves. This will enable people from Bristol's most vulnerable and deprived communities to receive a high-quality robust smoking cessation intervention, which links efficiently with wider smoking cessation and other lifestyle support.

A new Tobacco Control Plan for Bristol will be developed in 2023/24, which will be adjunctive to a collaborative BNSSG-wide Tobacco Control Plan. This will be supported by a BNSSG Tobacco Control Alliance, which is currently being mobilised.

Both the new targeted smoking cessation service and local Tobacco Control Plan will be informed by engagement with community groups most affected by harms from smoking and who are most likely to require support from smoking cessation services.

SERVICE USER INSIGHT

What made me want to quit and why was now the right time for me?
Because last year I was diagnosed with Cancer.
Meeting people with terminal Cancer made me realize I had a chance to change.

Overview of Bristol's Targeted Smoking Cessation Service

In Bristol, a targeted smoking cessation service has been commissioned since 1st April 2020. Service characteristics are summarised in Table 1 below.

Table 1: An overview of Bristol's targeted smoking cessation service

Eligibility	Targeted service for Bristol residents who are high risk smokers, people who are: • pregnant (or up to 1000 days post-partum) • co-resident family of pregnant/1000 days post-partum person • living with long term conditions exacerbated by smoking • referred via NHS Health Check or SMI Physical Health Check • living in areas of high smoking prevalence	**Length of commission**	1 April 2020 – 31 March 2023 with option for two 1-year extensions.
Access and referral	Self-referral via service-specific phone, email, website or text. Can also be referred by a professional via referral form or phone call. Referral from professional via Quit Manager software.	**Activity levels**	In 2021/22 • Smokers setting a quit date: 1034 • Smokers achieving 4 week quit = 630 (61%)
Service format	1:1 face to face and/or digital support for 12 weeks. Free pharmacotherapy is provided by service for 2 weeks. Pregnant women receive free pharmacotherapy for the duration of their quit attempt.	**Waiting times**	Currently, 99% referrals to the service are contacted within two working days. No waiting list. Service is close to capacity
Who provides the service?	Everyone Health	**GP & Pharmacy provision**	N/A GPs refer eligible patients to Everyone Health. All other patients are encouraged to self-care. Online and digital support available from NHS Smokefree

During the initial 3-year term of the contract, mobilisation of which was significantly negatively impacted by the Covid pandemic, 2031 high priority Bristol residents have engaged with the service and set a quit date. Of these, 1086 have achieved a successful 4 week quit. This equates to a cost per quit of £552 – higher than the England average and the South West average cost-per-quit, yet similar to the south west median cost per quit. This marginal increase in cost-per-quit is arguably to be expected when it is considered that Bristol's targeted approach means the service exclusively works with those smokers who are hardest to engage and retain in treatment. This is unlike many other services in the South West who continue to operate with universal-access services.

Local analysis suggests that Bristol's community smoking cessation services as delivered by Everyone Health significantly exceed the NICE target of engaging 5% of those smokers eligible for a service in Bristol.

Included in Appendix 1 is a series of case studies, with permission to be reproduced, provided by service users from Bristol's smoking cessation service.

SERVICE USER INSIGHT

> Without my advisor I would not be here- smoke free. It would not have been possible for me. She is professional and clearly loves her job. She was so good at mentoring and leading me through the process. She really has been fantastic.

Working in Partnership

Efforts to encourage smoking cessation and prevent smoking uptake must be delivered collaboratively across a broad range of partners. Bristols smoking cessation service works closely with the following partners to deliver training, promote awareness and utilise existing relationships to support residents to access the service via self or professional referral:

- General practise
- Community midwives
- Hospitals
- Health Visitors
- Third sector community organisations
- Community assets
- Workplaces

Many more community partners have a role to play in supporting smoking cessation through delivering brief interventions in smoking, and/or through having brief conversations i.e. Making Every Contact Count interventions.

Bristol, North Somerset and South Gloucestershire (BNSSG) Partnership Working

Preventing uptake of smoking, promoting quitting, and treating tobacco dependence requires a whole system approach[1] [2]. The development of Integrated Care Systems with a focus on improving the health and wellbeing of the population and reducing health inequalities has engendered an opportunity to refresh BNSSG tobacco control activities and bring a diverse range of partners together to coordinate tobacco control interventions across BNSSG.

The BNSSG Integrated Care System strategy[3] makes a commitment to developing a system-wide approach to tobacco. To support this, a new BNSSG Smoke Free Alliance has been created. The Alliance brings together a wide range of partners committed to collaboratively taking action to address nicotine addiction and reducing harms caused by smoking across BNSSG. The initial focus of the Alliance will be developing a system-wide plan for tobacco control[4]. This will be closely linked to local authority tobacco control plans which address localised areas of need.

A BNSSG Smoke Free plan will allow commissioners and healthcare professionals to draw upon combined expertise and identify shared opportunities to improve tobacco outcomes. An overview of the BNSSG whole systems approach to addressing tobacco addiction is modelled in Figure 3, including example tobacco control activities.

System partners have set a vision for a Smokefree BNSSG[5] where less than 5% of the BNSSG population smoke by 2030. Working towards this vision gives partners an opportunity to reduce the impact of tobacco on our population through:

- Preventing initiation of smoking, supporting people to quit, and reducing use and harm.
- Protecting non-smokers.
- Building community capacity.
- Improving outcomes and reducing inequalities.

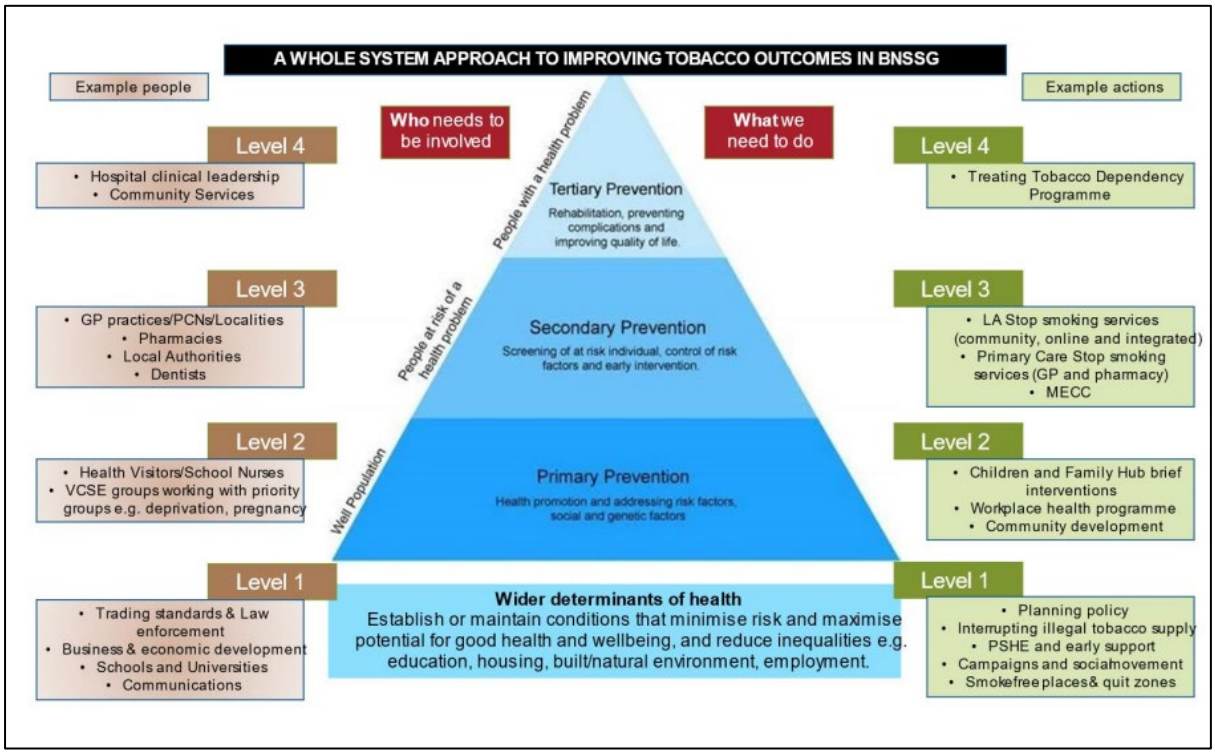


Figure 3: A whole system approach to improving tobacco outcomes in BNSSG

It is understood by BNSSG local authority tobacco control commissioners that one of the barriers to working effectively with BNSSG-wide organisations, such as the NHS or Health Visitors and School Nurses, is around navigating the existence of three separate local authority commissioned smoking cessation servies. Each service (North Somerset, South Glouestershire and Bristol) operates independently and with different service delivery models, access points and eligibility criteria. This can represent a challenge for professionals needing to refer a patient to a smoking cessation service as they must maintain an operational awareness of three separate services.

Tobacco Addiction and Smoking Harms in Bristol

Bristol is the largest city in the South West and one of the 11 ‘Core Cities’ in the United Kingdom. With a population of 472,400 in 2021, Bristol was the fastest growing of all the Core Cities in England and Wales over the last decade.

Bristol has a relatively young age profile with more children aged 0-15 than people aged 65 and over. The median age of people living in Bristol is 32.4 years compared to 40.3 years in England and Wales[28]

The population of Bristol has become increasingly diverse and some local communities have changed significantly. There are at least 45 religions, 187 countries of birth and 91 main languages spoken. The proportion of the population who are not ‘White British’ increased from 12% (2001) to 22% (2011), with 6% White Minority Ethnic, 6% Black, 6% Asian, 4% Mixed and 1% Other (all rounded to nearest 1%).

Bristol has a thriving LGBTQ+ scene. Just over 6% of the Bristol population (aged 16+) identify as Lesbian, Gay, Bi-sexual or Other sexual orientation (LGB+) according to the 2021 Census. 0.8% of the Bristol population (aged 16+) identify as Trans, higher than England and Wales average (0.5%). The percentage of the population who identified as LGB+ in Bristol was nearly twice as high as the England and Wales average (3.2%)[29]

Bristol continues to have deprivation ‘hot spots’ that are amongst some of the most deprived areas in the country yet are adjacent to some of the least deprived areas in the country[30].

SERVICE USER INSIGHT

I gave up on the 11th April.
Since then I feel 100% better.
I have more energy, I don’t have a terrible cough,
and my blood pressure is lower.

[28] Bristol Key Facts 2022 - July 2022 update
[29] JSNA 2022.23 - LGBT (bristol.gov.uk)

[30] Deprivation (bristol.gov.uk)

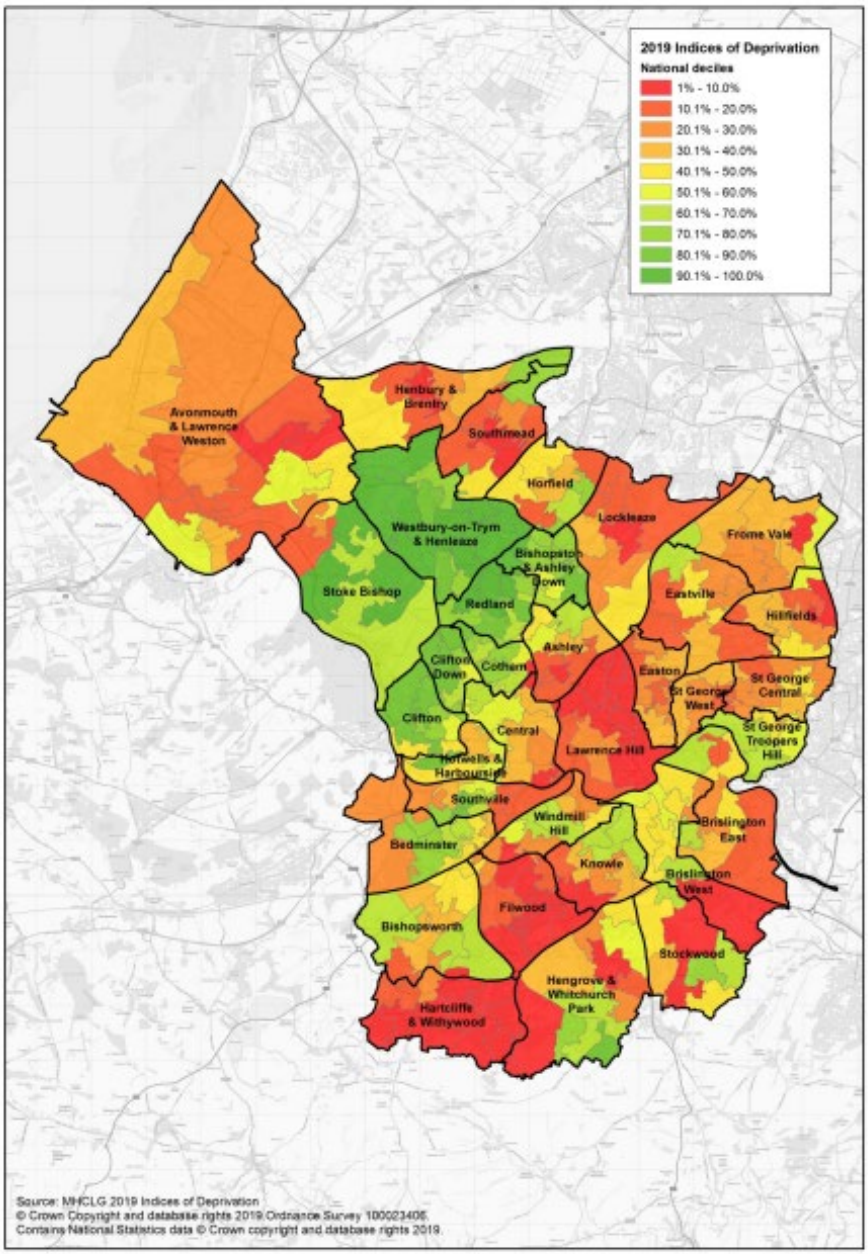


Figure 4: A map of bristol reflecting the 2019 indices of deprivation by ward

Bristol has 41 areas in the most deprived 10% in England, including 3 in the most deprived 1%. The greatest levels of deprivation are in Hartcliffe & Withywood, Filwood and Lawrence Hill. In Bristol 15% of residents - 70,800 people - live in the 10% most deprived areas in England, including 19,000 children and 7,800 older people.

The average life expectancy in Bristol is 82.7 for women, and 78.5 for men (2018-2020) both of which are lower than the England average. Healthy life expectancy is 61.5 and 59.8 for women and men, significantly lower than the national average of 63.9 and 63.1 years respectively.

The smoking rate is 18.0% (2019), significantly higher than the national average (13.9%). 9.3% of women smoke during pregnancy (2020/21), similar to the national average (9.6%)

Overview of Smoking in Bristol

Overall smoking prevalence, measured as the proportion of adults aged 18+ who are currently smoking, has been consistently declining over time in Bristol. Following an apparent drop in prevalence between 2016 and 2017, there are signs of a subsequent uptick again in 2019 and 2020 which brought smoking prevalence back to a level not seen since 2015 – 18%. 2021 data demonstrates a reduction to 16.4%- a tentative improvement, but still higher than the national average of 13%

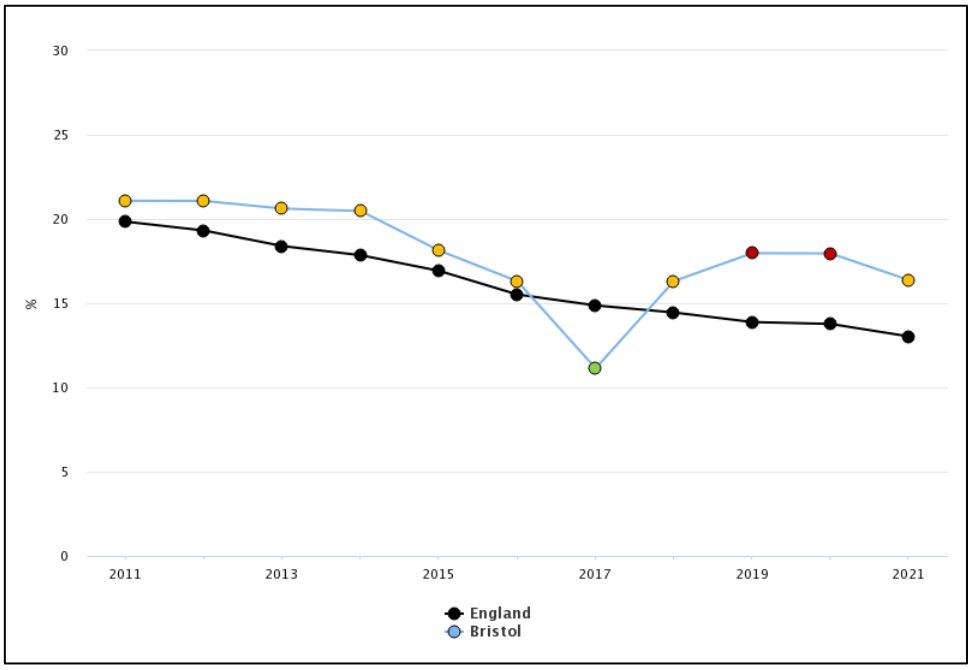


Figure 5: Current adult (18+) smoking prevalence for Bristol and England, since 2011

Higher smoking rates are associated with higher rates of deprivation. As discussed, the greatest levels of deprivation are in Hartcliffe & Withywood, Filwood and Lawrence Hill; and this is where the highest smoking prevalence is seen. Figure 6 shows where the propoprtion of Bristol households with a smoker are highest in 2022/2023. Strong parallels are observed between ward-level deprivation and the percentage of households with a smoker, aggregated by ward. Hartcliffe and Withywood and Lawrence Hill are the wards with the highest proprtion of households with a smoker at 24 – 31%.

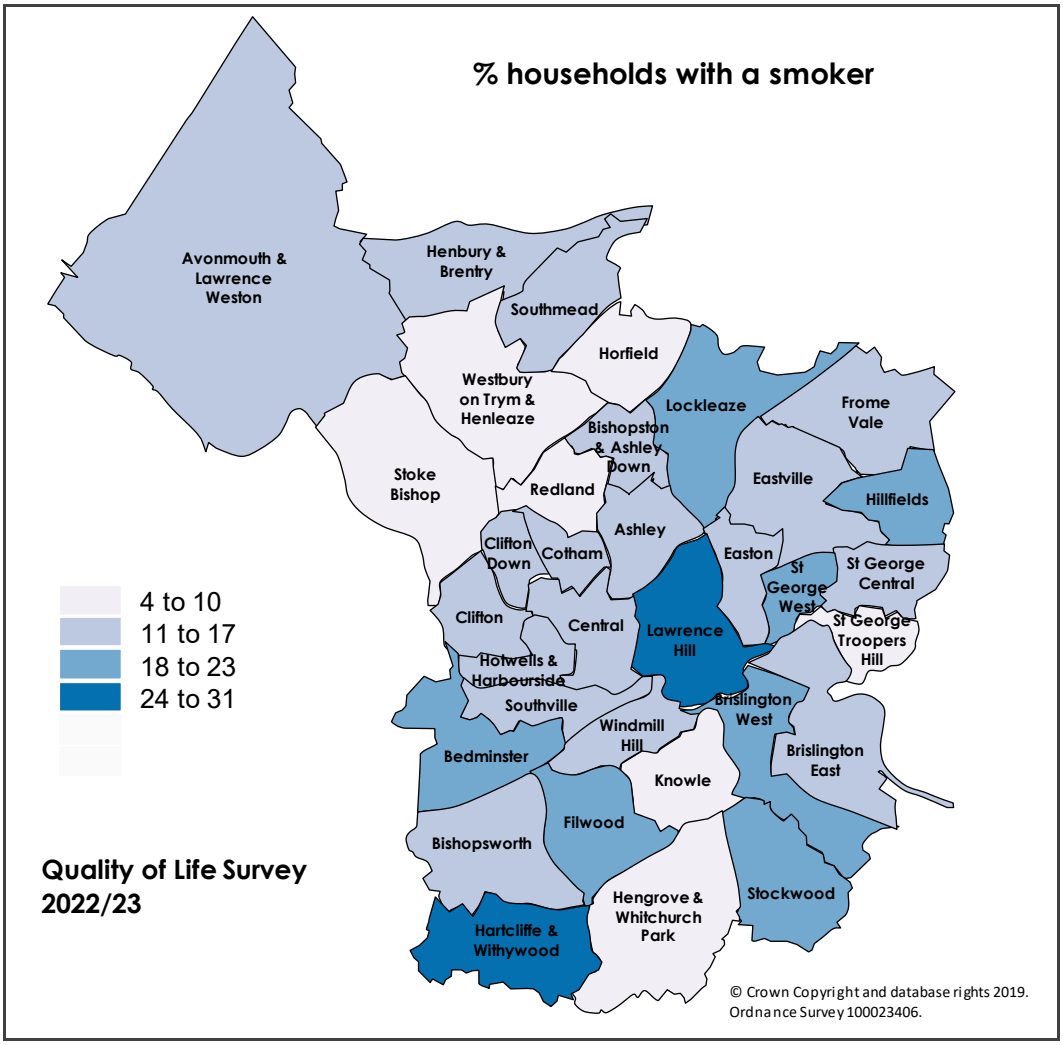


Figure 6: Percentage of Bristol households with a smoker (Bristol Quality of Life Survey 2022/23)

Men remain more likely to smoke than women, and so are disproportionately affected by the health risks associated with smoking. In 2021, 15.1% of men smoked compared with 11.5% of women in the UK; this trend has been consistent since 2011.

It is also understood that smoking prevalence is generally higher amongst people who identify as LGBTQ+ compared to cisgender heterosexual population groups[31]. A recent analysis suggested a prevalence of 27% amongst all lesbian gay or bisexual adults compared to 18% amongst heterosexual adults, and the highest prevalence was identified as being within LGB women at 31%[32].

[31] ASH-Briefing_Health-Inequalities.pdf

[32] National representative data on the health of lesbian, gay and bisexual adults in England published for the first time - NDRS (digital.nhs.uk)

Young People and Smoking

Among adult smokers, about two-thirds report that they took up smoking before the age of 18 and over 80% before the age of 20[33].

Smoking initiation is associated with a wide range of risk factors including parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members, socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media.

The younger the age of uptake of smoking, the greater the harm is likely to be, because early uptake is associated with subsequent heavier smoking, higher levels of dependency, a lower chance of quitting, and higher mortality.

However, the proportion of children who have ever smoked continues to decline. In 2018, 16% of 11–15-year-olds in England (23% in 2012) had smoked at least once; the lowest proportion since the survey began in 1982, when 53% had tried smoking.

The introduction of electronic cigarettes, and especially disposable vape devices which are commonly marketed towards children and young people via social media 'influencers', represents a new challenge from the tobacco industry. Concerns have also been raised about increasing tobacco industry activity to promote novel nicotine delivery systems to young people, such as nicotine pouches as well as disposable vapes[34].

SERVICE USER INSIGHT

I sometimes would smoke up to 20 a day, its hard to know the exact number. I started when was a teenager at 13 or 14.
I have asthma but I never linked the two because smoking became such a normal part of my life.

[33] Young people and smoking - ASH
[34] Tobacco: Industry tactics to attract younger generations (who.int)

Young People - Local Picture

The Pupil Voice Survey is a wide-ranging survey responded to by pupils in Bristol schools, mainly those in years 4, 6, 8 and 10. The latest survey was in the school year 2021/22, and 31 schools participated (around 20% of all schools in the city). Questions about the prevalence and motivations for the use of e-cigarettes / vaping are asked of year 8 and 10 pupils.

20% of year 8 &10 pupils reported having ever vaped in the 2021/22 survey. 7% of pupils were still vaping at the time of the survey, the remainder of that 20% had tried or vaped in the past but given up.

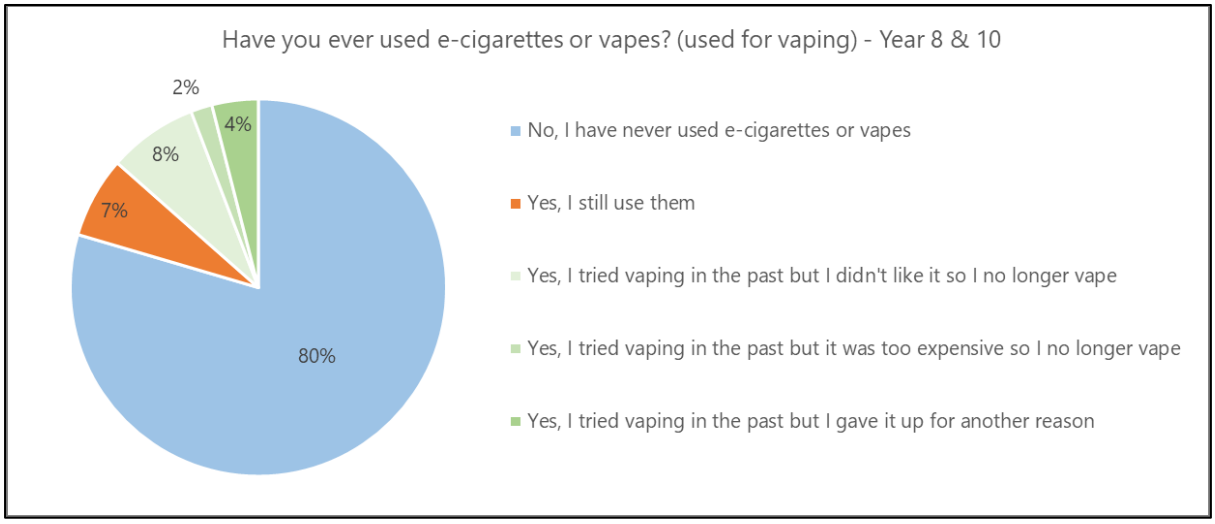


Figure 7: 2021/22 Pupil Voice survey responses to the question 'Have you ever used E-cigarettes or Vapes'.

Vaping was much more prevalent in year 10 than year 8, and much more commonly reported by female pupils than male pupils in both year groups.

The Pupil Voice survey asks respondents about their tobacco smoking habits and smoking in the home. It is possible to analyse the vaping statistics in relation to these other responses as below. There was a very strong association between smoking tobacco and vaping found in the year 8 and 10 responses. Of pupils that reported never smoking tobacco, just 2% reported vaping. Of those that reported smoking at least one tobacco cigarette weekly 85% reported also vaping. There appeared to be a steady increase in the prevalence of vaping as the exposure to tobacco smoking increased, e.g., those that reported having tried smoking or smoked in the past but not smoking tobacco now were more than 10 times more likely to vape than those that had never smoked tobacco at all. Pupils reporting that their parents

smoked were more likely to vape than pupils that reported their parents did not, and this association is seem for pupil tobacco smoking also.

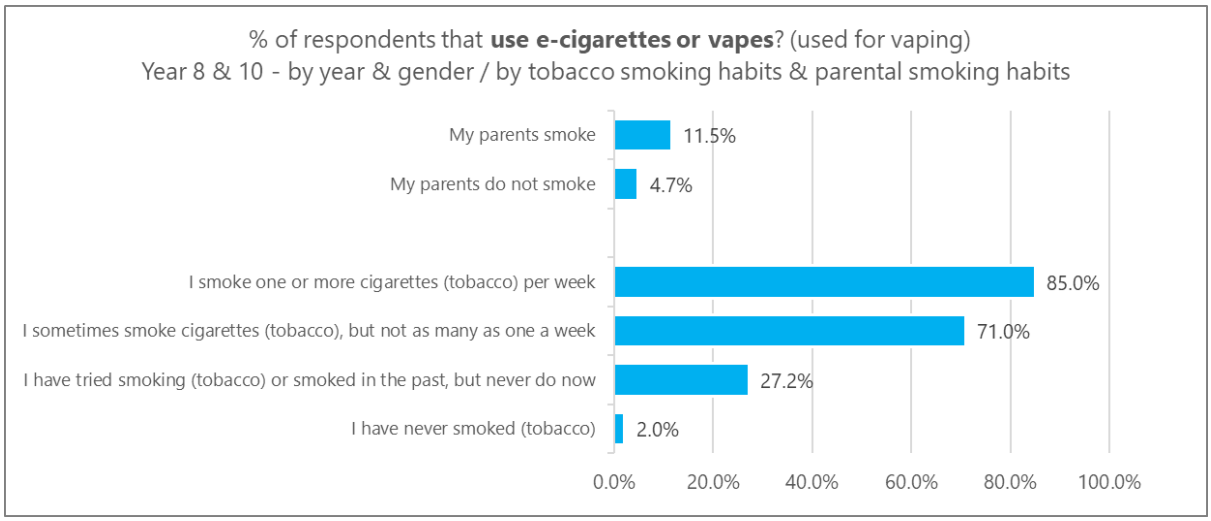


Figure 8: the proportion of year 8 and year 10 Pupil Voice survey (2021/22) respondents who use e-cigarettes or vapes by tobacco smoking and parental smoking habits.

Young People - Current Provision

The most effective intervention in youth smoking is that of prevention. In Bristol smoking cessation interventions are targeted towards pregnant women and co-resident family or partners, and to families with preschool age children, to maximise the opportunity to help families establish a home free from smoking and free from cigatrette smoke.

Bristol also has an established Healthy Schools programme, which takes a whole-school, evidence-based approach to teaching and promoting health and wellbeing. Schools can focus on preventing substance use (including smoking and vaping) among children and young people. The whole school approach involves engaging senior leadership teams to support school policies; taking a cross-curricular approach; empowering pupil voice to drive changes; collaborating with families and carers; supporting staff health and providing them with appropriate resources and training; offering targeted support as required; identifying needs and monitoring impact; and fostering an ethos and environment that prioritises pupil health and wellbeing.

High prices of cigarettes and clamping down upon illegal tobacco trade is also a meaningful intervention in tackling children and young peoples smoking. Bristol City Council Public Health continues to invest in local and regional Trading Standards activity to support this objective.

Pregnant Women, Young Families, and Smoking

Smoking is the number one contributor to poor pregnancy outcomes. The main risks are summarised below, but the full list of harms caused by smoking extend beyond these to also include ectopic pregnancy, physical abnormalities ie. Cleft palate, interuterine growth restriction, placental abruption, asthma, chest and ear infections, pneumonia and behavioural issues i.e. ADHD[35]. This list is not exhaustive.

Table 2: A summary of the harms to a pregnancy of maternal smoking and second-hand smoke exposure

	Maternal Smoking	Secondhand smoke exposure
Low Birth Weight	2 times more likely	Average 30-40g lighter
Heart Defects	25% more likely	Increased risk
Stillbirth	47% more likely	Possible increase
Preterm birth	27% more likely	Possible increase
Miscarriage	32% more likely	Increased risk
Sudden Infant Death	3 times more likely	45% more likely

Local data sharing agreements mean that Bristol City Council has access to both 'smoking at time of delivery/SATOD' and 'smoking at time of booking appointment/SATOB' data). SATOD is the accepted measure of smoking in pregnancy in England.

Nationally, smoking in pregnancy has been reducing in line with a decreasing smoking prevalence in the population overall.

[35] Smoking and pregnancy patient information leaflet | RCOG

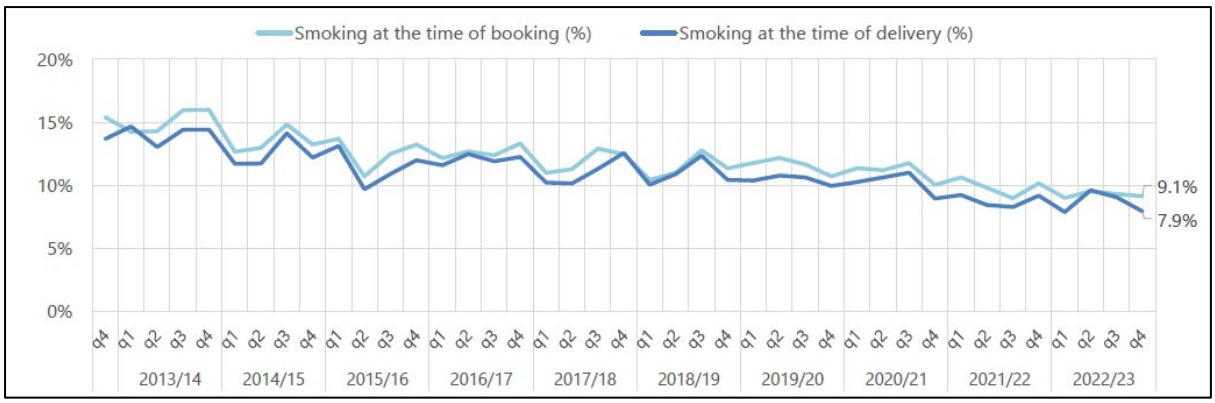


Figure 9: national levels of SATOD and SATOB since 2013/14

Ward-level statistics show just how much SATOD is a highly localised issue, with only a few standout wards way above the city average; Hartcliffe & Withywood (29.2%), Avonmouth & Lawrence Weston (18.8%), Filwood (19.5%) and Southmead (15.6%).

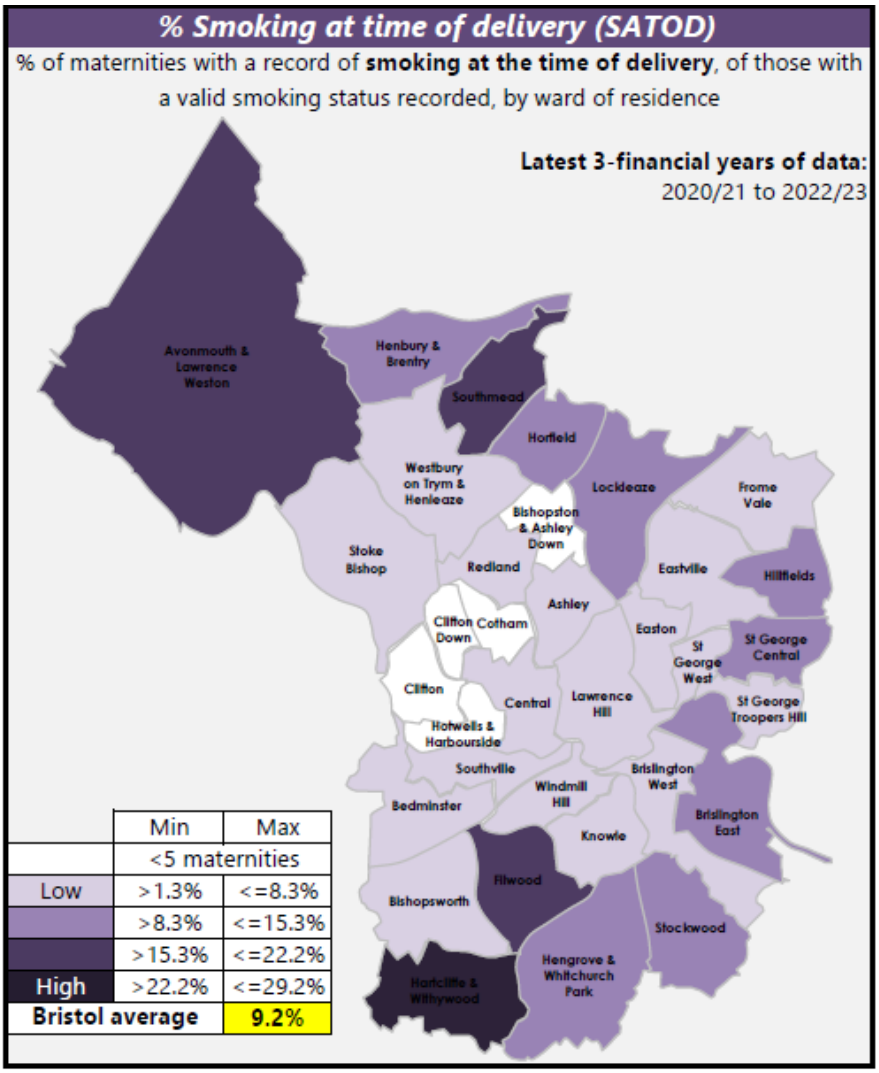
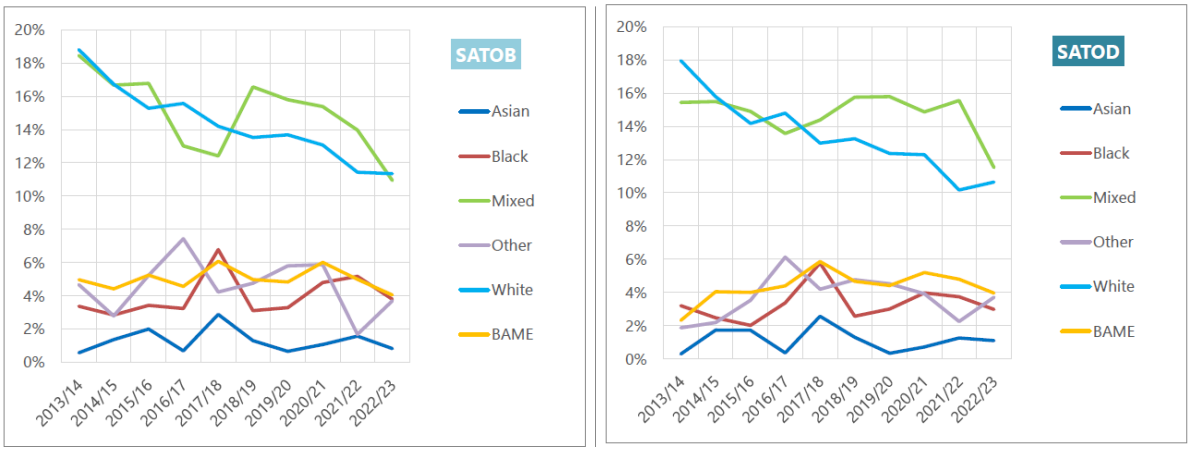


Figure 10: An overview of the proportion of maternities where the mother is smoking at time of delivery, by ward of residence (2020/21 – 2022/23).

A targeted whole-systems approach to working with and supporting pregnant women to stop smoking in Bristol has resulted in a significant reduction in prevalence within areas of Bristol with high SATOD rates. Since 2013/14, it has been residents in the most deprived parts of the city that have experienced the greatest reduction in smoking rates during pregnancy, reducing the 'deprivation gap' (rates in the most deprived vs least deprived quintiles) from around 25% to 15% over nine years[36].

Women from mixed ethnic background have historically demonstrated a higher smoking prevalence compared to other ethnic groups both at booking and at time of delivery. SATOB has been slowly declining since 2018/19, to become more similar to the prevalence seen amongst white women, and a more drastic decline in SATOD can be observed from 2021/22.

There are possible signs of an increase amongst women of 'other' ethnic backround, although numbers from 'other' ethnic backgrounds are very small and are likely to fluctuate more overall compared to other ethnic groups. Other ethnicities have demonstrated a signifiant reduction in SATOD (see figures 11 and 12, below).



Figures 11 & 12: SATOB and SATOD by different maternal ethnicity, since 2013/14.

Women from mixed ethnic backgrounds and women from white ethnic backgrounds remain the most likely overall to be smoking both at booking and at delivery.

It is understood that pregnant women who smoke are likely subject to a great deal of stigma from the wider general public and potentially also from healthcare professionals. This is likely to result in women smoking secretively and may impact negatively upon their subsequent access to interventions and/or retention in services[37]. Pregnancy is an

[36] JSNA 2023.24 - Smoking during Pregnancy (bristol.gov.uk)
[37] Smoking during pregnancy, stigma and secrets: Visual methods exploration in the UK - PubMed (nih.gov)

opportune time to offer an intervention in smoking, given that women are more likely to quit when smoking than at any other time in their lives[38].

Bristol's smoking cessation service is specifically designed to support pregnant women and their immediate families in a sensitive and non-judgmental manner. The service is embedded within community maternity pathways, and referrals are made from maternity to the smoking cessation service on an opt-out basis following a carbon monoxide (CO) monitor reading indicative of smoking. The service delivers a 12-week intervention to the pregnant woman and her co-resident partner or family, consisting of behavioural support and free licenced nicotine replacement medication for the duration of the quit attempt.

People with Long Term Conditions Exacerbated by Smoking

Long term conditions are generally defined as any illness which can be controlled but not cured such as cardiovascular disease or diabetes. Within this category, cancer, coronary heart disease, heart attack, stroke, and/or chronic obstructive pulmonary disease are frequently attributed to and/or significantly worsened by smoking.

Among those who are heavily addicted to tobacco, 44% self-report a long-term illness or disability compared with 32% of never smokers. People with a long-term condition account for 50% of GP appointments, 64% of outpatient appointments and 70% of all inpatient bed days; representing a significant impact upon NHS services[39].

Smoking is responsible for half the difference in life expectancy between the richest and poorest in society and, later in life, people who smoke are almost twice as likely to need some form of social care than never smokers. The provision of this care currently costs Bristol City Council £6.44 million per annum between domiciliary and residential care.

People who smoke are admitted to hospital for related chronic conditions on average 12 years earlier than non-smokers[38].

Bristol has a consistently high rate of hospital admissions attributable to smoking amongst adults aged 35 or over, compared to the England average.

[38] Smoking, Pregnancy and Fertility - ASH

[39] Smoking: Long term conditions (ash.org.uk)

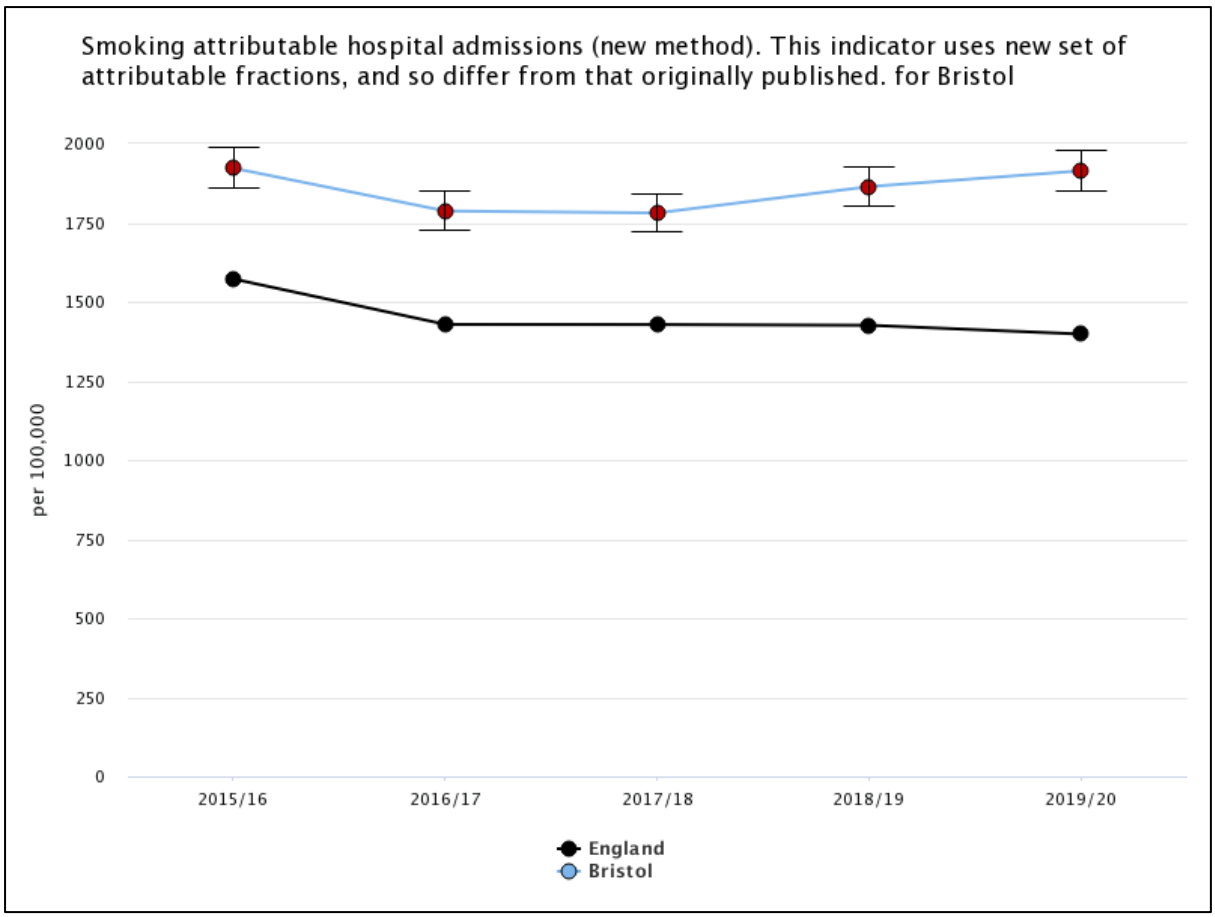


Figure 13: Smoking attributable hospital admissions for Bristol and England since 2015/16

Figure 14 demonstrates an overview of where most people in Bristol identify as having their day-to-day activities limited by long-term physical or mental health conditions or illnesses, as of 2021. If taken as a proxy measure for disability, from this map it is possible to identify areas of high prevalence being clustered around the far south and north of the city – notably Hartcliffe and Withywood, Stockwood and Filwood in the south; and Southmead and Kingsweston in the north.

SERVICE USER INSIGHT

I was diagnosed as asthmatic around the age I started smoking and went on to suffer with regular chest infections. I was hospitalised with Pneumonia twice. I continued smoking, at 45 was diagnosed with COPD. I lost both my mum and dad to smoking related illness but this still didn't deter me from the habit.

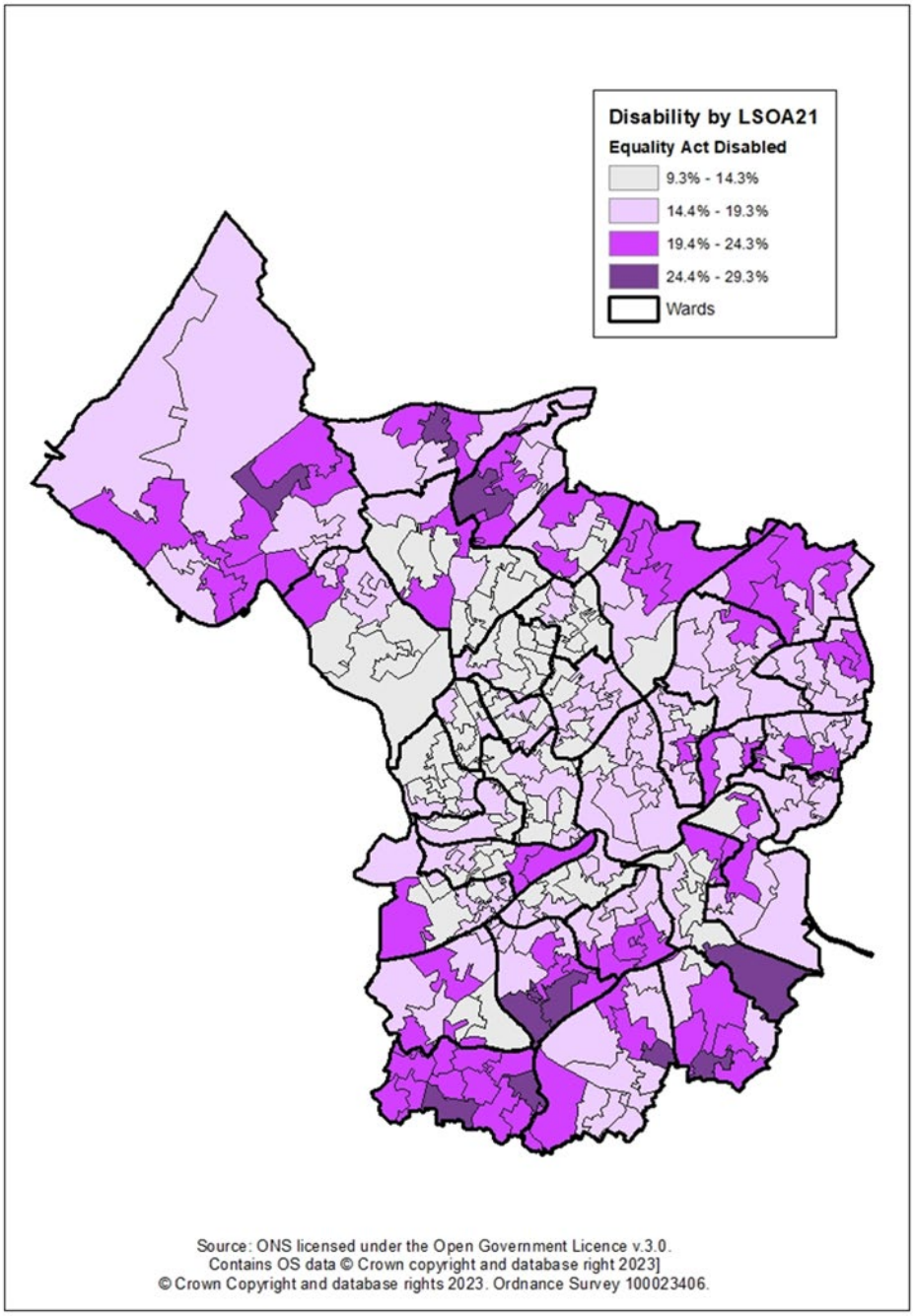


Figure 14: Office of National Statistics data demonstrating the proportion of Bristol residents who identify as having their day-to-day activities limited by long-term physical or mental health conditions or illnesses, by ward (2023).

In partnership with North Somerset and South Gloucestershire Local Authorities, Bristol has been supporting two local Hospital Trusts (North Bristol Trust and University Hospitals Bristol and Weston) to mobilise and implement an in-house Treating Tobacco Dependency Service in line with the ambitions from wihtin the NHS Long Term Plan. Establishing this

service means that smokers who come into contact with hospital services will soon be reliably delivered a brief intervention in smoking cessation with an optional referral for support to make a quit attempt, and provided with nicotine replacement therapy.

Bristols's targeted smoking cessation continues to support adults with long term conditions made worse by smoking, as well as adults referred via NHS Health Checks and NHS Targeted Lung Health Checks.

Socioeconomic Gradient of Smoking

Smoking is the single largest driver of health inequalities in England[40]. There is a strong positive association between socioeconomic deprivation and likelihood of smoking, with people from deprived areas being more likely to smoke, suffer from smoking related disease, and die early. Smoking, as a behaviour, is transmitted across the generations within a family, underpinned by social norms, familiarisation and addiction.

As overall smoking prevalence has declined, inequality caused by smoking has widened, with smoking harms concentrated among more disadvantaged communities and groups. Around 1 in 4 people in routine and manual occupations smoke, compared with 1 in 10 people in managerial and professional occupations. People who are unemployed are almost twice as likely to smoke as those in work[41].

The latest data from the Bristol Quality of Life Survey[42] demonstrates that the proportion of households with at least one resident smoker, is highest amongst our most deprived wards and is very much higher than our least deprived wards (see figure 4 for an overview of deprivation deciles across Bristol).

[40] ASH-Briefing_Health-Inequalities.pdf
[41] Director of Public Health Report 2021 (bristol.gov.uk)
[42] Quality of life in Bristol

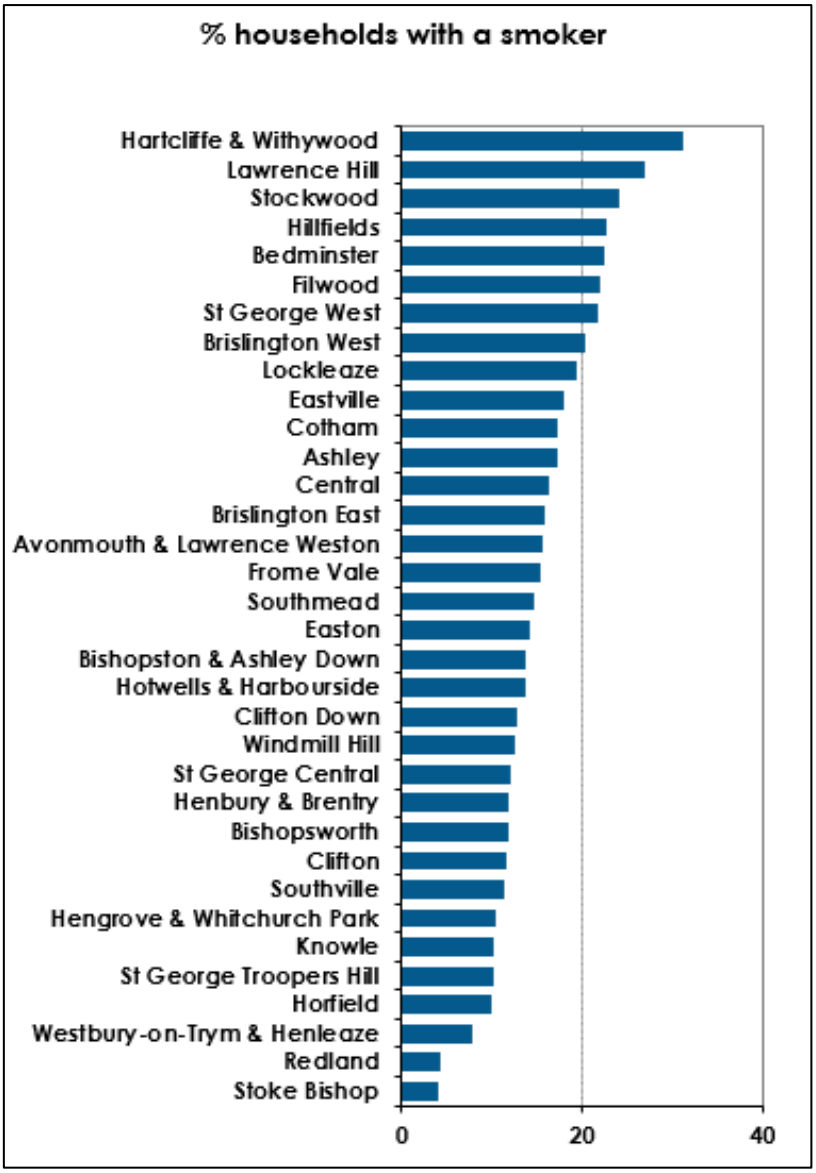


Figure 15: Proportion of households with a smoker, ranked by ward (Quality of Life survey 2022/23).

In the 5 years between 2015 and 2019, 35% of all premature deaths caused by respiratory disease occurred in the most deprived areas of Bristol, compared to only 7% occurring in the least deprived wards.

Smoking is far more common amongst people with lower income [43]. For this reason, routine and manual occupation is an additional marker of smoking risk.

If Bristol Quality of Life Survey data 'percentage of adults with no formal qualification' is used as a proxy measure for proportion of people reasonably likely to work in routine and manual occupations, then it may be reasonable to suggest that the highest of routine and

[43] ASH-Briefing_Health-Inequalities.pdf

manual workers are resident in St George Troopers Hill, Bishopsworth, and Hartcliffe and Withywood (figure 20).

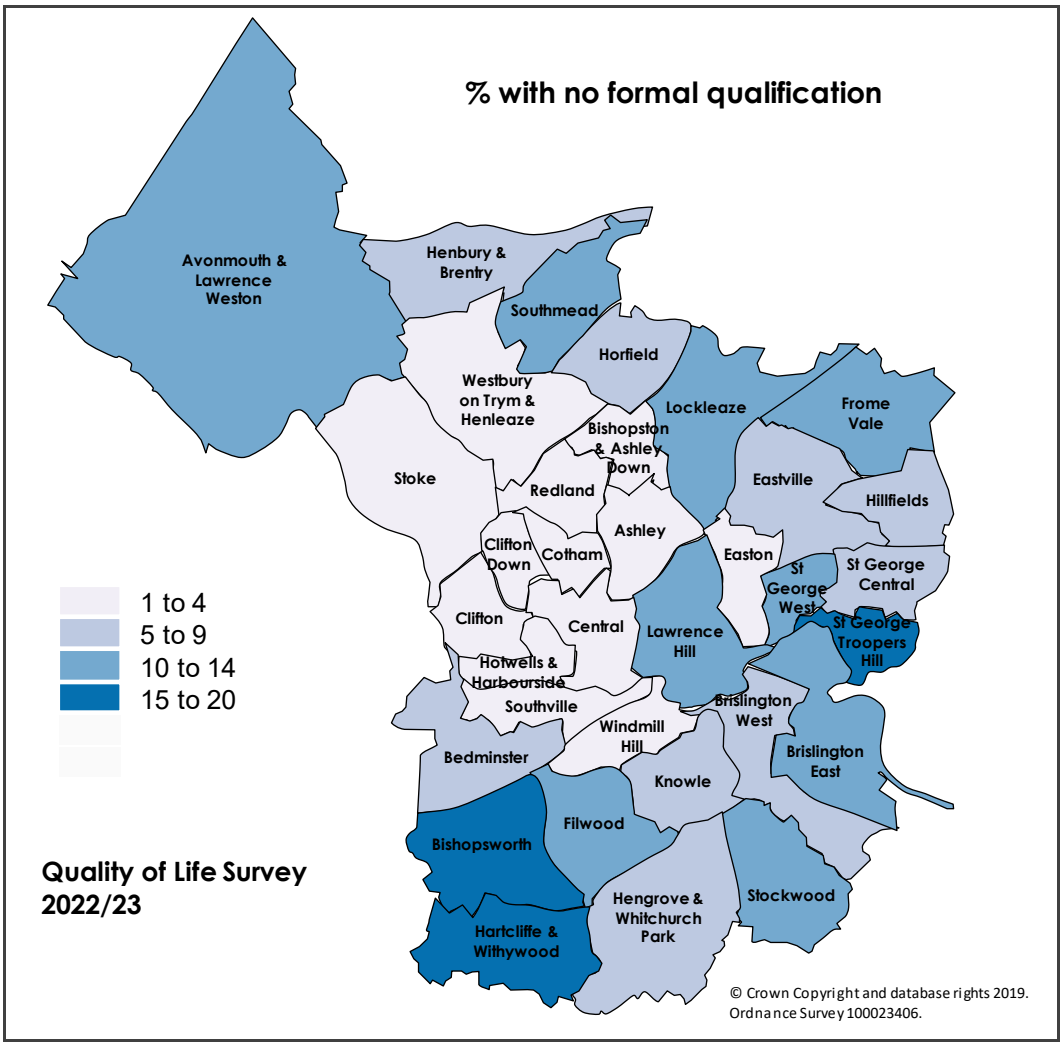


Figure 20: the proportion of residents with no formal qualification (Quality of Life Survey 2022/23).

Serious Mental Illness and Smoking

Smoking is the leading cause of the 10–20-year reduction in life expectancy seen between people with serious mental illness and those without. Despite the overall reduction in smoking prevalence demonstrated at both national and local levels, this reduction has not been seen amongst people with serious mental illness despite the same levels of motivation to quit[44].

[44] Health matters: smoking and mental health - GOV.UK (www.gov.uk)

As the severity of mental illness increases, so does smoking prevalence. In 2014 to 2015, prevalence in all adults in England (aged 18+) was 16.4% and prevalence in adults living with:

- anxiety or depression was 28%
- a long-term mental health condition was 34%
- serious mental illness was 40.5%

There is also a strong association between serious mental illness and socioeconomic deprivation, which is an additional risk factor for smoking.

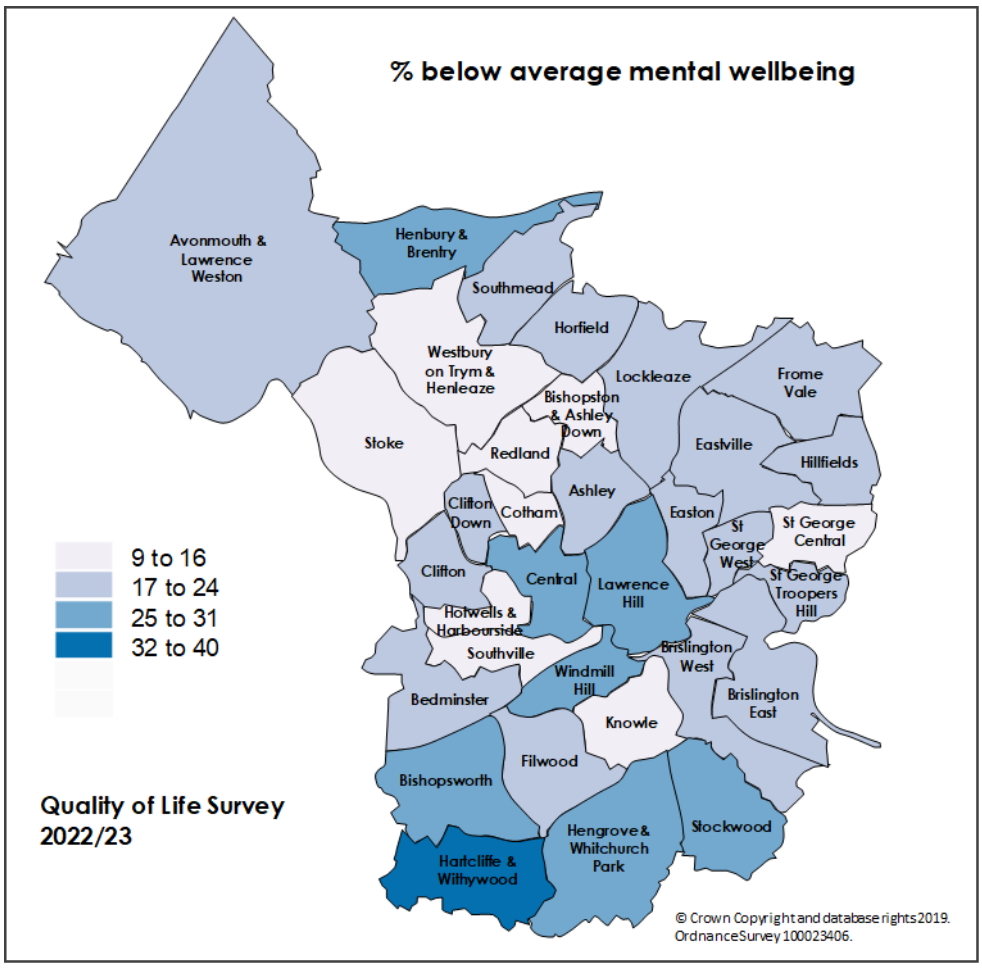


Figure 16: Proportion of Bristol residents who self-report a below average mental wellbeing (Quality of Life Survey 2022/23)

Data from the Bristol Quality of Life survey 2022/23 is shown in Figure 16 above. The Bristol Quality of Life survey asked a representative sample of residents to self-report their perceived mental wellbeing. The proportion of respondents who self-identified as having below average wellbeing are primarily clustered around the south of the city, most notably in Hartcliffe and Withywood.

Ethnicity and Smoking

Smoking tobacco presents the same health risks across any group of people, but there are meaningful differences between how different ethnic groups use tobacco, with people from south asian ethnic backgrounds being more likely to use smokeless tobacco and people from middle eastern and south asian ethnic backgrounds being more likely to use Shisha. Nonetheless, smoking cigarettes remains the most popular form of tobacco use across all ethnicities[45].

Across all ethnic groups, men smoke at higher rates than women overall. People of 'mixed' ethnicity have been historically more likely to smoke than any other ethnic group across both genders, although whilst this has remained true for women, men from 'other' ethnic backgrounds now have similar (possibly increasing) prevalence when compared to other men (see figures 17 and 18).

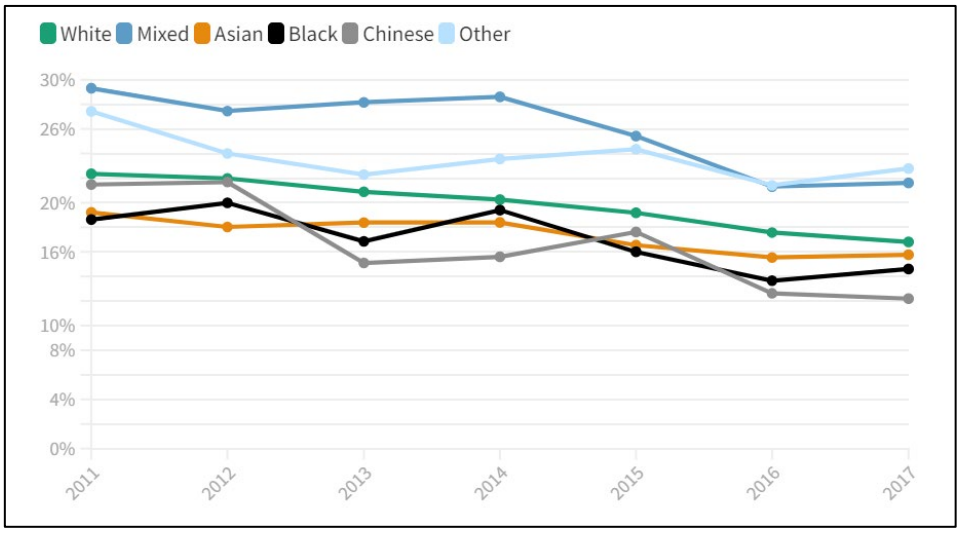


Figure 17: UK smoking prevalence (men) by ethnicity (2011-2017).

[45] Tobacco and Ethnic Minorities - ASH

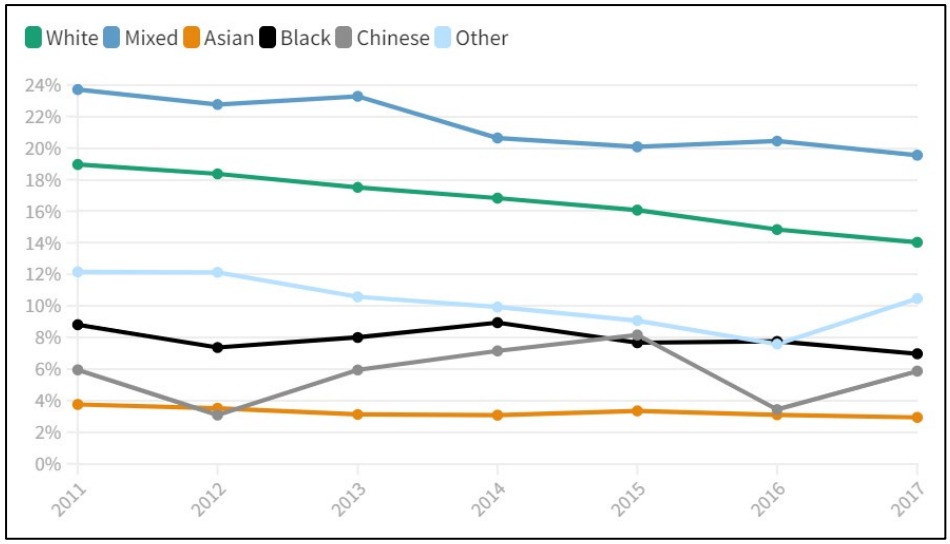


Figure 18: UK smoking prevalence (women) by ethnicity (2011-2017).

Figure 19 represents 2021 census data, which demonstrates that the majority of people who are from a Black, Asian or 'other' ethnic minority are resident in Lawrence Hill, and areas of Ashley, Lockleaze and Easton adjacent.

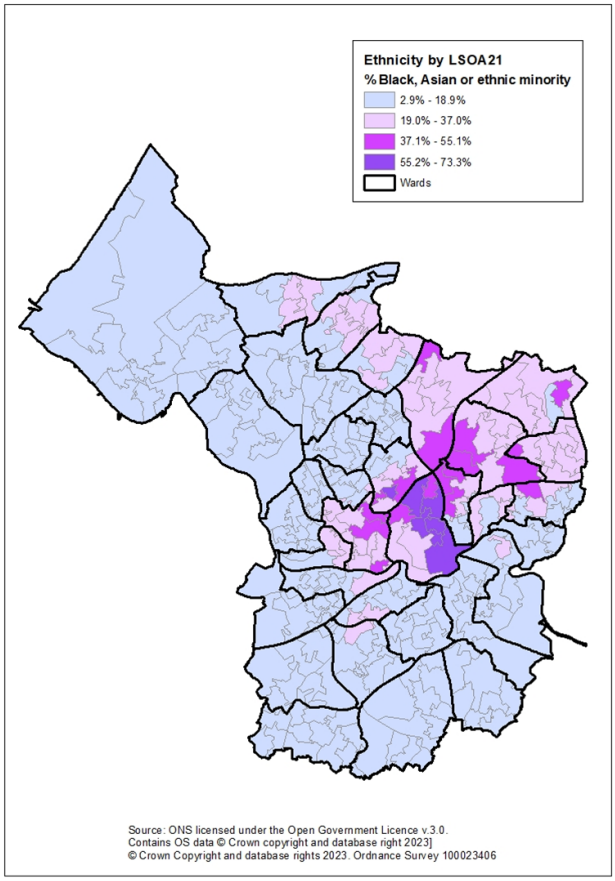


Figure 19: Proportion of people who are from a Black, Asian or other ethnic minority (Census ONS data, 2021).

Bristol Quality of Life Survyey data suggests that proportionately, people from black, asian or other minority ethnic backgrounds were more likely to report at least one regular smoker in their household (5.9%) compared to people from white ethnic backgrounds (3.4%). Asian or Asian British adults completing the survey were most likely to report having a resident smoker in their home (6.9%). It is notable that white minority ethnic respondents were more likely to report a resident smoker than white British respondents, with 4.5% versus 3.2% for white British respondees.

Impact of the Covid-19 Pandemic

Smoking is a well established risk factor for increased susceptibility to, and worse outcomes from, respiratory diseases. The Covid-19 pandemic therefore presented a particular concern for many current and former smokers. Indeed, reasonably strong evidence indicated that for hospitalised Covid-19 patients at least, smoking was associated with increased severity of disease and death[46].

Action on Smoking and Health commissioned qualitative research to explore smokers' experiences of quitting, relapsing and accessing support through the Covid-19 pandemic and emerging cost-of-living crisis[47]. This research identified that the pandemic had a very variable impact upon smoking behaviours, with some increasing their smoking out of boredom or stress; and others smoked less, either as a proactive cost-saving measure, because they routinely smoke less at home, because of the presence of children in the home, and some because the isolation of covid served to reduce their stress levels and consequent smoking. For most people, asking for help from smoking cessation services was not a priority. Many said they would attempt a self-supported quit in the first instance and seek support as a possible option following on from this.

The pandemic impacted significantly upon the delivery of community smoking cessation services. Whilst robust pathways for the referral of pregnant women between community maternity services and the Bristol smoking cessation service provider were already in place, complications around contacts with pregnant women, lack of face-to-face appointments in maternity to offer carbon monoxide appointments, and concerns for the safety of pregnant women led to fewer referrals and fewer women supported.

The long-term conditions element of the service was drastically impacted by Covid-19, as Hospitals and GP services focussed on responding to the pandemic.

[46] Smoking and COVID-19 (who.int)

[47] ASH/Bluegrass 1/4: Experiences of quitting, relapsing & accessing support during Covid-19 & the Cost of Living Crisis - ASH

During the Covid-19 pandemic, people from Black, Asian and other Minority Ethnic backgrounds experienced higher rates of transmission and higher mortality rates than white people. It is likely that this disproportionate impact was mediated by such variables as occupation, socioeconomic disadvantage, living arrangements and existing health conditions. Differences in mortality rates between different ethnic groups decreased over the course of the pandemic until 2022 when there was no longer any difference in mortality rates between people from ethnic minority groups and white British groups[48].

Poverty, the Cost-of-Living Crisis, and Smoking

A recent survey commissioned by the Royal College of Psychiatrists suggested that more than half of UK residents feel that their health has been negatively affected by the Cost of Living Crisis[49].

Amongst those still smoking, the impact of smoking related ill health upon earnings and unemployment is significant. At a Bristol level, smoking related ill health has generated £74.84 million in lost earnings in 2022 alone, and £93.53 million has been lost due to smoking related unemployment[50].

Although the average cost of smoking is £2,451 per year - the same as the average housholds energy bill[51], recent research from ASH suggests that for many smokers this has been cause for concern but not a trigger for action when it comes to stopping smoking[52]. For the people who are still smoking despite the downwards trend in prevalence at a national level, smoking is a source of stress-relief, 'me time', and heavily engrained within close-knit communities.

[48] The health of people from ethnic minority groups in England | The King's Fund (kingsfund.org.uk)
[49] Press release: Over half of Brits say their health has worsened due to rising cost of living | RCP London
[50] £14bn a year up in smoke – economic toll of smoking in England revealed - ASH
[51] Make a new year quit attempt to help with cost of living - ASH
[52] Sonya_22050-Webinar1v2.pptx (live.com)

SERVICE USER INSIGHT

I used to like the routine of smoking but now I hate everything about it.

Local and National NHS and Smoking Cessation

Treating Tobacco Dependency Services

Prevention has become a core function of the NHS. The NHS Long Term Plan[6] has indicated for the first time, a commitment to the establishment of in-house NHS Treating Tobacco Dependency (TTD) Services for maternity, inpatients and mental health patients. Across BNSSG these services are currently mobilising within local hospital Trusts North Bristol Trust and University Hospitals Bristol and Weston and are being supported closely by Local Authority Tobacco Control Commissioners.

Maternity

Nationally there is historically a large gap between numbers referred to local authority services by midwives, and the number of women who subsequently engage in a quit attempt with the community service. There has been recognition that pregnant women who smoke may be engaged more effectively in treatment with their midwifery team, as opposed to being directed to a separate smoking cessation service.

To address this drop-out of treatment, the Treating Tobacco Dependency Maternity provision is suggested by NHS England to be an in-house service located within hospitals and close parallel working with maternity services. This avoids the need for women to engage with a local authority service in addition to maternity services, and offers them the opportunity to quit smoking utilising the existing trust and expertise of their midwifery

service. Local authority smoking cessation services may continue to be available as a secondary option to pregnant women.

As the new TTD service develops at North Bristol Trust and secondarily at University Hospitals Bristol and Weston Trust, the maternity service is anticipated to generate a significant number of additional referrals of pregnant women to local authority smoking cessation services, above the amount routinely referred directly by midwives. Local data evidences that midwives consistently refer around 70-80% of pregnant smokers to community smoking cessation services, which suggests that there is enough room for additional referrals (i.e. a target of 90%+ pregnant women) to have an impact upon the capacity of local authority smoking cessation services.

Inpatient

Treating Tobacco Dependency Inpatient Services are designed to link closely with community smoking cessation services, ensuring a seamless transition between hospital and community for patients who spend only a few hours to days in hospital.

The TTD inpatient service aims to identify patients who are smoking, deliver a brief intervention and ensure access to nicotine replacement therapy, and then refer onwards to community services to support a quit attempt as agreed with the patient.

To support quit attempts in the community, NHS England have additionally commissioned new NHS smoking cessation support from pharmacies in England, to provide an additional opportunity for community-based support for those patients who began their quit attempt in hospital TTD services[7]. These services are in the process of becoming operational across BNSSG. It is unclear how many TTD patients will choose to utilise pharmacy services versus engage with a local authority community service.

The service began mobilisation at North Bristol Hospital Trust in May 2023 and whilst a correspondingly small number of TTD patients have received a service, 72% of patients who had contact from the service were Bristol residents. It is anticipated that the unique characteristics of Bristol's tobacco history and current population smoking prevalence means that this emerging trend for a larger impact upon Bristol than North Somerset and South Gloucestershire will continue. The TTD inpatient service for University Hospitals Bristol and Weston is in early stages of becoming established.

The extent of the impact on community services, in terms of both TTD referrals and numbers of hospital inpatients engaging with local authority community smoking cessation services, remains to be seen (at both national and local level) but has the potential to become significant. Again, there is no additional capacity available to local authority community smoking cessation services to meet this increase in demand for community services.

A whole system approach to tobacco services must consider the capacity / gaps across the whole system and ensure that all aspects of NHS, Pharmacy and Local Authority are

supported equally. Currently there is no additional capacity available to local authority community smoking cessation services to meet the anticipated increase in demand for community services resulting from the new TTD services. This must be identified as a risk and managed accordingly.

Serious Mental Illness

Avon and Wiltshire Mental Health Partnership NHS Trust (AWP) is the acute trust responsible for provision of care or those with serious mental illness across BNSSG. AWP has established an inpatient service in November 2022 to support service users to stop smoking across all 6 AWP sites within BNSSG. An opt-out initial consultation is provided to all tobacco smokers within acute, rehab, Psychiatric Intensive Care Unity, later life and specialised wards across multiple sites in BNSSG. Secure services can refer into the TTD service.

The service adheres to the NHSE model but is facing challenges common to many mental health trusts nationally; namely that the NHS funding does not support the provision of a seven-day service or to see newly admitted patients within 48 hours. Additionally, there has been a national pause in the ongoing rollout of the mental health arm of the TTD from inpatient to community settings.

AWP has been successful in a bid to join phase 1 of the Royal College of Psychiatrists QUITT Quality Improvement Project[8]. The TTD Lead advisor is working with two wards currently- one in Bristol and the other in South Gloucestershire.

NHS Trust Smoke Free Policies

As part of the TTD workstream, Trusts are reviewing their Smoke Free policies and within this, their offer of support to stop smoking to staff and service users, vaping policy, and smoke free grounds. Local Authority tobacco control colleagues are supporting this workstream.

NHS Targeted Lung Health Checks

The new NHS Targeted Lung Health Checks screening proramme[9] will target health checks to adults aged 55 - 74 who have ever smoked for lung cancer screening, referring patients onwards to local authority smoking cessation services if they remain smokers and want to quit. Bristol is working closely with NHS England colleagues to deliver this screening programme within targeted areas of Bristol.

Where the scheme has been established elsewhere in BNSSG it is observed that for every 4000 individuals who receive a screening, approximately 200 referrals will be generated to local authority smoking cessation services. It is estimated that around 700 additional

referrals from NHS Targeted Lung Health Check screening to local authority smoking cessation services, with approximately 350 of these engaging with the service to establish a quit attempt. This represents a need for an additional increase in capacity of 40% for Bristol's existing service (based upon 2022/23 performance figures).

Core 20 PLUS 5

The new Core20PLUS5 approach[10] is a method for ICSs to use to identify their local population who are at the highest risk of health inequalities, to target interventions that would reduce the disparity between the least and most deprived. This approach to targeting enables the biggest impact on avoidable mortality in these populations and contributes to an overall narrowing of the health inequalities gap. The five clinical areas of focus – maternity, severe mental illness, chronic respiratory illness, early cancer diagnosis, and hypertension – are all impacted by smoking. Addressing tobacco addiction at system level allows for far reaching positive impact upon these priority areas.

Primary Care Provision

In Bristol, contracts with primary care providers including GP and Pharmacy ended in 2019. This represented the end of a universal smoking cessation service provision. A new targeted service was recommissioned for 2020, and the successful bidder was the current provider – Everyone Health. No additional services are commissioned in Bristol.

Individual GPs at their own discretion may choose to offer smoking cessation medication (Nicotine Replacement Therapy) as part of their General Medical Services Contract. In this instance, NRT prescribed to Bristol residents and reimbursed by Bristol City Council Public Health.

Bristols Smoking Cessation Service may refer patients to their GP for continued prescribing of Nicotine Replacement Therapy where the patient is unable to provide this for themselves. This process has identified significant variation in the ability of service users to access NRT through GPs across Bristol, where some GPs will not prescribe this for their patients.

SERVICE USER INSIGHT

I had a scare, and had felt really ill for some time
I decided I would try to quit.
Also the day I attended the doctor with chest pains I
had seen the advert for help with giving up smoking
with Everyone health and began to consider it.
After attending the hospital I went back to the
surgery and copied down the contact details as I
now knew it was important to quit.

The Environmental Impact of Smoking

Tobacco use has a significant impact upon the environment. Locally to Bristol, cigarette smoking generates 32 tonnes of waste annually, of which 13 tonnes is street litter.

Cigarette filters contain microplastics and make up the second-highest form of plastic pollution worldwide. Discarded cigarettes leach microplastics, heavy metals, and other toxic chemicals into soil and waterways. When ingested, the hazardous chemicals in microplastics cause long-term mortality in marine life, including birds, fish, mammals, plants and reptiles[53].

Globally, tobacco production depletes water and land resources, and the use of hazardous pesticides in growing exposes local workers to dangerous chemicals. This environmental burden increases exponentially along the production and supply chain[54].

Similar concerns are raised concerning the safe disposal of 'disposable' vape products. These single-use products are officially classed as Waste Electrical and Electronic Equipment (WEEE) and should be recycled in line with local WEEE recycling arrangements. In Bristol, WEEE can be bagged and collected from homes along with other household recycling. Many disposable vape users are unaware of this and are littering or disposing of vapes in landfill. Incorrect disposal potentially release plastic, electronical and hazardous chemical waste into

[53] UN partnership aims to combat microplastics in cigarettes | UN News
[54] Environmental Impacts of the Tobacco Lifecycle | CDC

the environment. In particular, incorrect battery disposal can cause fire and health and safety risks at landfill sites. There is also concern about the use, and subsequent loss, of lithium contained in these products; a critical material which is in high demand[55].

Alternative Forms of Nicotine/Tobacco Delivery

Multiple methods of ingesting nicotine via tobacco are now common. Various methods for consuming nicotine include:

- Smoked tobacco (cigarettes, cigars, pipe tobacco, shisha/waterpipe, roll-your-own)
- Electronic cigarettes (these are reusable and commonly used by adults as part of quit attempts)
- Vapes (commonly disposable vapes and more frequently used recreationally/habitually and by younger people)
- Smokeless tobacco i.e., chewing tobacco and heated tobacco
- Nicotine pouches or 'Snus'

More information on alternative forms of nicotine delivery can be found here: Cigarettes and Other Types of Tobacco Products (tobaccofreelife.org)

Electronic Cigarettes and Disposable Vapes

Electronic cigarettes are small hand held electical devices which heat and vaporize 'vape liquid' in order for the user to inhale the vapour. The vape liquid and subsequent vapour are commonly nicotine-containing.

The lack of tobacco in electronic cigarettes means that they pose substantially less risk of harm to the user than traditional cigarettes, at least during the short-to-medium term and possibly over the long term (more research is needed). Electronic cigarettes have been shown to be used primarily by adult current or ex-smokers, and have been demonstrated to be helpful for quitting smoking[56]. Some research suggets that electronic cigarettes, combined with behavioural support, may be more effective than traditional Nicotine Replacement Therapy for quitting smoking[57].

Disposable vapes are similar devices which are meant to be single use. For this reason they are typically priced more accessibly, and open to customisation via colour, theme or flavour, therefore making them more attractive to young people than rechargeable devices.

[55] Environmental impact of disposable vapes - House of Commons Library (parliament.uk)
[56] Electronic Cigarettes - ASH
[57] (Electronic cigarettes for smoking cessation - Hartmann-Boyce, J - 2021 | Cochrane Library

Vaping prevalence amongst young people has increased in recent years, with current vaping prevalence amongst young people in England (including occasional and regular vaping) at 8.6% in 2022, compared with 4% in 2021 and 4.8% in 2020[58].

UK tobacco products, including electronic cigarettes, are regulated for safety purposes within the UK (regulations apply to tank size, nicotine fluid strength and toxicology, child resistance etc)[59].

Electronic cigarettes, despite their efficacy for quit attempts, are licenced for commerical sale but not for medical use. Electronic cigarettes are not available on prescription in the UK. Despite this, the greatly diminished health risks of electronic cigaretttes relative to cigarettes and their efficacy in supporting quit attempts means that smoking cessation interventions are encouraged to be 'vape friendly', should the service user wish to supply their own electronic cigarette or vape device as part of a quit attempt. In some specific circumstances, smoking cessation services have been able to provide serivce users with electronic cigarettes purchased from a commercial provider.

Illegal Tobacco

Illegal tobacco is an umbrella term that may include:

- Sales of legal products to young people aged under 18
- Counterfeit cigarettes or tobacco products
- Cigarettes or tobacco products legal elsewhere in the world but not in the UK
- Legal products which have been smuggled into the UK without duty paid

The market in illegal tobacco undermines efforts to help people stop smoking, primarily by reducing the impact of increased taxation and making cigarettes more affordable and accessible. Illegal products may be sold through a wide variety of channels typically well-embedded within close-knit local communities. This increased accessibility has a particularly damaging impact on children, ensuring that they become addicted to tobacco at a young age.

The illegal tobacco industry is often part of organised criminal activity and has been associated with illegal alcohol and DVD production, people-trafficking, drug smuggling and terrorism.

The sale of illegal tobacco in Bristol is persistent. Bristol Trading Standards has long taken a proactive approach in relation to preventing the sale of illicit tobacco. A range of

[58] Nicotine vaping in England: 2022 evidence update main findings - GOV.UK (www.gov.uk)
[59] The Tobacco and Related Products Regulations 2016 (legislation.gov.uk)

enforcement methods are utilised, including as business advice, inspections, seizures, prosecution, closure orders and convictions to deter offending.

Officers from Bristol Trading Standards work in partnership with multiple agencies including the Police and HMRC to combat this illegal trade. The illegal tobacco enforcement work of Bristol Trading Standards has had a particularly positive impact on the local community in the south of Bristol with the Local Police Beat teams commenting that the Anti-Social Behaviour in the area has significantly improved following the enforcement work.

Trading Standards have provided 3 maps detailing reported locations of illegal tobacco activity since 1st April 2020 focussing upon illegal tobacco, age-restricted sales of vapes, and product safety (see appendices 2,3 and 4).

Smoke Free Spaces

In 2007 the UK introduced a ban on smoking in enclosed spaces. The ban has been well received and has been shown to be useful in protecting non-smokers from second-hand smoke, as well as beneficially impacting smoking cessation attempts and reduce smoking initiation[60].

October 2015 saw the introduction of smoke free cars, making it illegal for adults to smoke in a private car with young children present[61]. To date, no known prosecutions have been made.

It is widely considered to be good practise to encourage outdoor spaces predominantly designed for children, such as play areas and schools, to be made smoke free. These efforts are generally encouraged on a good-will basis, with the main argument for doing so being the significant impact that the modelling of and exposure to adult smoking behaviour has on children and young peoples likelihood of starting smoking[62].

The impact that the Covid-19 pandemic had on the utilisation of new public spaces for recreational use, such as café seating in streets and roadways, represents a new opportunity for more smoke free conversations.

Benchmarking Stop Smoking Service Provision

[60] Smoke-free spaces: a decade of progress, a need for more? | Tobacco Control (bmj.com)
[61] Smoking in vehicles - GOV.UK (www.gov.uk)
[62] Young people and smoking - ASH

Action on Smoking and Health and Cancer Research UK undertake a tobacco control survey of all local authorities in England, Scotland and Wales on an annual basis[63] . Notable findings from the 2022 survey include:

- 33% of all surveyed local authorities commission targeted services
- Where activities were targeted to high priority groups of smokers, these were most commonly pregnant women, socio-economically disadvantaged areas, and people with mental health conditions.
- 52% local authorities provide electronic cigarettes to smokers, directly or indirectly
- 86% local authorities are involved in the roll-out of NHS Treating Tobacco Dependency Services. Many were optimistic about the programme but expressed significant concerns about the impact of the TTD work on demand for local authority services.
- 59% of surveyed local authorities had a local tobacco alliance and 79% collaborated with other local authorities in their tobacco control or stop smoking work.

Horizon Scanning

Potentially significant developments include:

- Implication of national government tobacco control interventions, particularly 'Swap to Stop' electronic cigarette scheme, financial incentives for smoking cessation for pregnant women, and activity around children and young people vaping at national level.
- Mobilisation of local NHS interventions which will create additional referrals (and therefore possible capacity challenges) for local authority smoking cessation services i.e. Treating Tobacco Dependency Services, NHS Targeted Lung Health Checks.
- Ongoing development of novel nicotine delivery systems and associated marketing of non-traditional nicotine delivery products by Tobacco Companies i.e. new varieties of electronic cigarette, rebranding of nicotine pouches etc.
- The possibility of provision of electronic cigarettes (medically licenced or otherwise) within hospital formularies, GP provision and smoking cessation services.
- New opportunties to tackle nicotine addiction at an ICS level in BNSSG.
- The Public Health team at Bristol City Council have a dedicated team who work to address the needs of 'Inclusion Health Groups'. Health Needs analysis show that smoking prevalence is significantly higher than the Bristol average. Inclusion Health groups such as people experiencing homelessness often find barriers to accessing standard health services.

[63] New-paths-and-pathways.pdf (ash.org.uk)

Local views

An engagement activity was undertaken to understand how the needs of the priority communities may better be met. An online survey and semi-structured interviews took place over a four-week period between the 12th of July and 9th of August, which was open to members of the public, service users, partners, stakeholders, and community representatives. The survey was circulated via the smoking cessation service, professional networks and community organisations and all recipients were asked to share onwards as widely as possible. All survey respondees were offered the opportunity to expand upon their response via interview with a researcher and some key partners were proactively invited to interview also.

In total, the survey captured 49 voices, four of which belonged to members of the public and 45 belonging to professionals and partners from a diverse set of backgrounds including NHS trusts, medical practices, pharmacies, and university hospitals. Three questions around effective engagement were asked, these were qualitative in nature in order to minimise risk of bias and maximise richness of data obtained.

The equalities data captured by the survey as standard equality protection, demonstrates that the majority of responses were from white-British, heterosexual, middle-aged women.

There were a total of seven interviews with professionals from NHS delivery, third sector organisations and partnering local authorities. The same three qualitative questions from the survey were asked, although participants were given the opportunity to expand on any points in a 15–30-minute confidential space.

The anonymous responses from the survey and interview were then thematically analysed and used to inform the conclusions below. The raw data has not been made publicly available in order to comply with General Data Protection Regulations (GDPR).

Outcomes

Question 1: *What can we do to let more people know that there is a free service available in Bristol to help them stop smoking? In your answer, please think about what helped you stop smoking and/or what might help your friends and family.*

The top three themes from question one are: working with communities, promotion and use of or collaborations with GPs/pharmacies.

The communities theme included references to community centres, community venues and local community assets and was the most frequently occurring theme and is therefore a priority.

Question 2: *We want people from all sorts of diverse backgrounds to feel comfortable using the stop smoking service. What could we do to help you, or your friends and family feel more welcome?*

The main theme that was identified in response to this question was the effective use of languages, for example using native languages in a way that was both culturally sensitive and accessible to people with different health literacies.

Other prevalent themes from this question include community engagement and working with pre-existing community groups.

Question 3*: Is there anything else that you think we should know about making the service accessible and inclusive to everyone?*

The third question was not answered by 36% of the survey participants. The main themes from this question were the use of languages and effective promotion of the stop smoking service. Six comments were made about commissioning a service without eligibility criteria, to ensure maximum inclusivity.

The themes identified from the three quantitative questions helped to establish two primary themes, the first being community and the second being promotion, and one secondary theme of languages.

Primary theme one: Community

A strong theme throughout the survey was that of working closely and effectively with our targeted communities, focussing on location and communications modalities which are local, accessible and acceptable by these groups of people. Responses also centred around working with trusted community figures and groups.

Primary theme two: Promotion

Promotion of the service with partners was identified as a priority, as well as promotion which is effectively targeted to priority groups.

Examples of suggested ways of doing this include posters or materials that communicate the health benefits of quitting or the health risks of smoking, use of social media, merchandise, shared lunch and community events, leaflets, text messages, websites and videos in the local community venues.

Secondary theme: Language

The engagement responses suggested that promotional materials should be diversified and distributed in the native and cultural languages of the specific target populations, as well as ensuring that the message is accessible to people of all literacies and audiences to increase engagement. Similarly, many survey responses included themes around the use of a translator for inclusivity to these groups.

Summary

The large proportion of responses regarding community working and communication and effective promotion within communities are indicative of a co-production and community development approach to addressing smoking cessation.

Survey respondents repeatedly discussed opportunities for effective promotion of the service. The service, with incumbent provider Everyone Health, has been delivering at close to capacity for the duration of the current contract. This suggests that general promotion of the service overall is not a priority but communication about the service may be improved.

Key Gaps

In order to determine the key issues around smoking cessation and tobacco control in Bristol, the epidemiological data was considered alongside an understanding of local services, views from stakeholders and the best practise evidence base.

Key gaps identified from this needs assessment include:

1. Bristol continues to hold a high smoking prevalence within specific population groups, which are generally to be found in similar geographic locations across the city.
2. Heterogeneity of local authority smoking cessation service provision (with regards to eligibility criteria, access, model of delivery in particular) represents a challenge for BNSSG-wide organisations wanting to make referrals.
3. BNSSG Smoke Free Alliance and Tobacco Control Strategy is at an embryonic stage, requiring ongoing collaboration and contributions from Bristol Public Health and BNSSG partners. This represents a strong opportunity to impact smoking at regional level, but room must be made to consider nuance specific to Bristol as well.
4. NHS Treating Tobacco Dependency Services offer an opportunity to engage some of BNSSGs most vulnerable residents in smoking cessation treatment, and also presents significant and meaningful capacity challenges for local authority services.
5. NHS Treating Tobacco Dependency Services for patients with Serious Mental Illness have not progressed to community mental health provision, meaning that only a relatively small amount of people with serious mental illness are receiving a smoking cessation intervention.
6. NHS Targeted Lung Health Checks represent a crucial opportunity to intervene early in lung cancer and in doing so, encourage residents to engage in a new quit attempt. Referrals from this screening programme to community services presents additional capacity challenges for local authority services.
7. GP provision of NRT varies across Bristol and can negatively impact a quit attempt undertaken by smoking cessation service users.

8. Pregnant women of mixed ethnicity, whilst relatively small in number, have a higher smoking prevalence than all other ethnic groups. Men and women from mixed ethnic backgrounds (and men from 'other' ethnic backgrounds) have the highest smoking prevalence compared to other ethnicities. People from mixed ethnic backgrounds are under-represented within current service provision.
9. Safe disposal of e-cigarettes and vapes is of concern at a national level
10. E-cigarettes continue to represent a strong opportunity to encourage people who smoke to swap from cigarettes or to quit entirely. Local authority smoking cessation services increasingly embrace the use of this technology, and this is likely to develop further considering national plans for a 'Swap to Stop' scheme using e-cigarettes.
11. The tobacco industry continues to develop and market novel nicotine delivery technology, as well as rebranding existing products. This may encourage young people to experiment with new nicotine containing products as well as present an additional challenge for professionals and services supporting young people.
12. Some partners and stakeholders report that communication around service provision could be improved.

Recommendations for Consideration

Review of the identified gaps and analysis of tobacco control needs and priorities in Bristol has given rise to the following recommendations:

18. Smoking cessation efforts in Bristol would continue to benefit from taking a targeted approach given both the ongoing popularity of self-quit attempts utilising electronic cigarettes and the very entrenched and localised nature of the remaining smoking population. This service must target those at the highest risk of harms from smoking who are least likely to successfully quit through a self-quit attempt.
19. Any smoking cessation efforts in Bristol would reasonably take a place-based approach. Those residents who are at highest risk of harm from smoking tend to be resident within the same (or very similar) wards – notably Hartcliffe and Withywood, Southmead and Lawrence Hill (possibly including close surrounds).
20. Primary prevention is effective – interventions which target or prioritise pregnant women, young families, children and young people are likely to reduce or avoid substantial and lifelong health risks as well as positively impact broader smoking prevalence.
21. Continue to support the emerging BNSSG Smoke Free Alliance and tobacco control strategy, advocating for the needs of Bristol residents as appropriate, as well as collaborating on regional interventions.
22. The impact of smoking cessation interventions within the NHS upon local authority commissioned smoking cessation services has potential to be significant and must be

monitored closely. Learning must be considered from other ICSs across the South West and nationally. Opportunities to jointly support the Bristol residents impacted by these interventions must be explored, in order to effectively manage demand for smoking cessation support in the community and avoid overloading the capacity of community services.

23. In collaboration with local Trusts and other partners, explore methods to effectively support Bristol residents with serious mental illness to stop smoking.
24. Continue to support NHS England roll-out of Targeted Lung Health Checks, jointly ensuring pathways are in place to support a quit attempt for residents and working to avoid overloading the capacity of community services.
25. Establish a task-and-finish group to identify methods for reliable access to NRT for those Bristol residents who are unable to access this from their GPs.
26. Ensure that the needs of black, Asian and minority ethnic backgrounds – and in particular people from mixed ethnic backgrounds – are identified and addressed within smoking cessation services from 2024. This may include community engagement and targeted work with this population at Bristol or BNSSG level.
27. Commissioners to maintain an awareness of environmental issues relating to incorrect disposal of e-cigarettes and vaping devices; linking with local and regional Trading Standards and waste/refuse companies to address unsafe disposal.
28. Tobacco control commissioners and smoking cessation services must maintain an awareness of developing technology around electronic nicotine delivery devices as well as the re-branding of existing nicotine containing products from the Tobacco Industry.
29. As services begin to fully recover from the impact of the Covid-19 pandemic, consider opportunities to better engage eligible service users in smoking cessation treatment i.e., NHS Health Checks.
30. Sustain an understanding of local and national movement and opportunities pertaining to supporting smokers to quit using electronic cigarettes.
31. Maintain an awareness of the health needs of Bristol's 'Inclusion Health' population groups and work collaboratively with colleagues to explore opportunities to offer support.
32. Continue to work closely with BNSSG tobacco control commissioners to ensure local authority services are as easy as possible for BNSSG-wide partners to navigate. Explore opportunities for future joint commissioning.
33. Commissioners to explore options to work collaboratively with local communities to design and implement tobacco control interventions.
34. Commissioners and providers to jointly consider targeted promotional activities to specifically engage those communities currently under-represented within the service. Consideration could also be given towards effective promotion of the service with key partners and stakeholders.

Appendices

Appendix 1 – Case studies provided by service users from Bristol's stop smoking service.

Bristol Stop Smoking Service

Case Study Form (1)

About you

Practitioner Name: Sarah

About the Patient

Patient's ID 17101

Please Tick Patient's Gender

Male	
Female	X

Consent:

X I give consent for my name being included in the case study

- I would like to be anonymous

Smoking habits:
How long have you been smoking and how many did you/do you smoke per day?

Client worked most of her life at Wills tobacco factory and was given 200 cigarettes a week free as part of her employment and has been a smoker for 60 years, never really tried to quit before.

How has smoking affected you?
Hasn't affected her, feels healthy

What do you like or dislike about smoking?
It was more a habit.

Quit attempts:
Have you tried to quit smoking before? no If yes, how many times have you tried to quit?
This is my first serious quit attempt in 60 years

What made you want to quit and why was now the right time for you?
Felt If I didn't do it now I never would, getting older

How did you feel about quitting at the beginning? (confidencemotivation levels)
I just knew I could quit

Did you use medications to help you quit, if so what did you choose to use and why?
21mg nicotine patch and 4mg and then 1.5mg mini lozenges. Also tried the mint mouth spray – preferred the lozenges

Behavior change:

How have you found the process of quitting smoking?
Found it very easy

What challenges have you faced and how did you overcome them?
I haven't had any

Smoke free future:

How have you been smoke free and what benefits have you noticed? (Health, finances etc.)
6 weeks

How confident that you will continue to be smoke free? (please underline)

Not confident Somewhat confident Confident Very confident

What do you hope the long-term benefits will be?
Health and financial

Service feedback:

Did the support from your smoking practitioner help, and if so, how?
Very good, excellent

What sort of things did they say or do that helped you?
Everything

Is there anything we could have done differently or better to support you?
No

Would you recommend our service to others? Yes/no, why/why not?

Yes – I already have to a neighbour who has had her IA

Bristol Stop Smoking Service
Case Study Form (2)

Photo/video consent:

X I give consent for my name being included in the case study

☐ I give consent for photo to be shared

☐ I give consent for video to be shared

☐ I would like to be anonymous

Gemma Dumayne

About you

Practitioner Name:

About the Patient

Patient's ID

47122

Patients Occupation: Lab technician

Please Tick Patient's Gender

Male	
Female	x

Smoking habits:

How long have you been smoking and how many did you/do you smoke per day?

I started smoking when I was 17, I am now 52. On average I smoked 20/day but that could easily exceed 30 if socializing. The last 5-6 years I started smoking roll-ups and reduced the quantity down to between 5-10 a day but this incorporated cannabis.

How has smoking affected you?

I was diagnosed as asthmatic around the age I started smoking and went on to suffer with regular chest infections which twice developed into pneumonia, and I was hospitalized.

I continued smoking and around the age of 45 was diagnosed with COPD.

I lost both my mum and dad to smoking related illness but this still didn't deter me from the habit.

What do you like or dislike about smoking?

The price was horrific but it never stopped me.

Disliked the smell.

Quit attempts:

Have you tried to quit smoking before? Yes/no If yes, how many times have you tried to quit?
No.

What made you want to quit and why was now the right time for you?
I had a small heart attack and it made me realize time is important.

How did you feel about quitting at the beginning? (confidence, motivation levels)
Because I had a scare, and had felt really ill for some time I decided I would try.
Also the day I attended the doctor with chest pains I had seen the advert for help with giving up smoking with Everyone health' and began to consider it.
After attending the hospital I went back to the surgery and copied down the contact details as I now knew it was important to quit.

Did you use medications to help you quit, if so what did you choose to use and why?
Vapes and Nicotine patches.

Behavior change:

How have you found the process of quitting smoking?
At first It was surprisingly easy (except in the mornings!) but as time goes past I seem to get nostalgic for the smoking experience. ie popping outside and idling away a few minutes.

What challenges have you faced and how did you overcome them?
The smell of other people smoking, especially my son at home challenges my decision as I love the smell!

Smoke free future:

How long have you been smoke free and what benefits have you noticed? (Health, finances etc.)
I have been smoke free for 6 weeks and have noticed a massive improvement in my sleep. I used to have a very chesty cough which disturbed me and my family every night.
My teeth also feel much cleaner 😊

How confident that you will continue to be smoke free? (please underline)

Not confident Somewhat confident x Confident Very confident

What do you hope the long-term benefits will be?
Living longer and not being smelly.

Service feedback:

Did the support from your smoking practitioner help, and if so, how?
Gemma has been an inspiration from the start.

She has been utterly factual and allowed me to be very honest in return. This meant I trusted her and all along felt like the process was MY decision.

What sort of things did they say or do that helped you?
Remained encouraging and always had clear non biased facts to support me through times when I questioned why was I doing it.

Is there anything we could have done differently or better to support you?
No.
You have been incredible.

Would you recommend our service to others? Yes/no, why/why not?
I already have recommended you to my sister and some close friends and work colleagues. Mostly because you offer sound, factual advice and information and are prepared to support us (strangers who dislike ourselves for our habits) weekly with kindness and compassion.
You also offer free products which is a massive incentive especially as they are quite pricey.
All round excellent service, thankyou.

Bristol Stop Smoking Service

Case Study Form (3)

About you

Practitioner Name: Gemma

Photo/video consent:

YES- I give consent for my name being included in the case study

- I give consent for photo to be shared
- I give consent for video to be shared

About the Patient

Patient's ID
47086 Adrian

Please Tick Patient's Gender

Male	x
Female	

Patients Occupation:

Smoking habits:

How long have you been smoking and how many did you/do you smoke per day? I have smoked around 20 a day for 50 odd years

How has smoking affected you? Smoking made me tired, out of breath and I had high blood pressure

What do you like or dislike about smoking? How it affects my energy levels and health

Quit attempts:

Have you tried to quit smoking before? Yes/no If yes, how many times have you tried to quit? I have tried to quit 2-3 times before and failed miserably. I didn't have the support that I had this time round, and it made all the difference.

What made you want to quit and why was now the right time for you? I had my blood pressure checked and it was high. The nurse at the doctors surgery made me aware of all the support that is available now. Having a stop smoking practitioner and NRT being available made it much easier to quit.

How did you feel about quitting at the beginning? (confidence, motivation levels) unsure at first but mentoring from Gemma got my confidence up and made it all possible. She was so positive and enthusiastic and it made me feel strong enough to stay smoke free.

Did you use medications to help you quit, if so what did you choose to use and why? I used patches and lozengers, they worked very well to help me deal with cravings.

Behavior change:

How have you found the process of quitting smoking? The first two weeks were the worst. After that things started to get easier. I will never smoke again now.

What challenges have you faced and how did you overcome them? I went through a stressful time with work, but even under those circumstances I was able to stay smoke free.

Smoke free future:

How long have you been smoke free and what benefits have you noticed? (Health, finances etc.) 11th April I gave up. Since then I feel 100% better. I have more energy, I don't have a terrible cough, and my blood pressure is lower.

How confident that you will continue to be smoke free? (please underline)

Not confident Somewhat confident Confident **Very confident**

What do you hope the long-term benefits will be? Longer life and stay feeling better

Service feedback:

Did the support from your smoking practitioner help, and if so, how? Without Gemma I would not be here smoke free, it would not have been possible for me. She is worth her weight in gold. She is professional and clearly loves her job. I would send her flowers to say thank you if I could. She was so good at her mentoring and leading me through the process. She really has been fantastic.

What sort of things did they say or do that helped you? It was just the regular support, motivation and accountability. She gave some great advice on how to deal with cravings.

Is there anything we could have done differently or better to support you? No, the service is truly fantastic.

Would you recommend our service to others? Yes/no, why/why not? Absolutely, it really is wonderful.

Bristol Stop Smoking Service

Case Study Form (4)

About you

Practitioner Name: Gemma

About the Patient

Patient's ID
44570- Penelope

Please Tick Patient's Gender

Male	
Female	x

Photo/video consent:

x give consent for my name being included in the case study- YES

- I give consent for photo to be shared
- I give consent for video to be shared

Patients Occupation:

Unable to work.

Smoking habits:

How long have you been smoking and how many did you/do you smoke per day? 40 a day and I smoked for 25 years

How has smoking affected you? I have had a bad cough and pneumonia. It worried me that I would die early like my mum.

What do you like or dislike about smoking? It was just a habit. Due to my age I felt it was time to change, I just didn't want to smoke anymore.

Quit attempts:

Have you tried to quit smoking before? Yes/no If yes, how many times have you tried to quit? Yes, I tried once before coming to this service. I didn't have success last time but I did this time.

What made you want to quit and why was now the right time for you? My Mum died of long cancer at 52. I am 48 so that age seems close now. I want a long life.

How did you feel about quitting at the beginning? (confidence, motivation levels) I was quite nervous at first but Gemma increased my confidence.

Did you use medications to help you quit, if so what did you choose to use and why? Patches and inhaler, I got on well with them and they took the edge off cravings and withdrawal.

Behavior change:

How have you found the process of quitting smoking? I have been surprised that this time it has worked and I have enjoyed using the service. The stop smoking calls from my practitioners really helped.

What challenges have you faced and how did you overcome them? I cant think of particular challenges right now. I just got on with it!

Smoke free future:

How long have you been smoke free and what benefits have you noticed? (Health, finances etc.) I have been smoke free for 4 months now

How confident that you will continue to be smoke free?

Very confident

What do you hope the long-term benefits will be? Saving money, spending time with family and a longer lifespan

Service feedback:

Did the support from your smoking practitioner help, and if so, how? Yes Gemma was a big help to me. The weekly then fortnightly calls made a big difference to me becoming smoke free

What sort of things did they say or do that helped you? Gemma gave me the confidence I needed to quit for good. It was a real boost.

Is there anything we could have done differently or better to support you? Happy with the service, there is nothing I needed to be different

Would you recommend our service to others? Yes/no, why/why not? I would recommend the service and I would also recommend the app. Both brilliant! I would recommend because it works!

Bristol Stop Smoking Service

Case Study Form (5)

About you

Practitioner Name: Estella

About the Patient

Patient's ID: 47535
Date of Study: 24/05/23

Please Tick Patient's Gender

Male	
Female	Yes

Photo/video consent:

I give consent for my name being included in the case study: Yes

I give consent for photo to be shared: Yes

Patients Occupation:

Health care assistant

Smoking habits:

How long have you been smoking and how many did you/do you smoke per day?
36 years 10-20 a day

How has smoking affected you?
Short of Breath, smell, health-diabetes and arthritis

What do you like or dislike about smoking?
Calmed me down,

Disliked habit
Smelt
Couldn't be without a fag.

Quit attempts:

Have you tried to quit smoking before?
Yes
If yes, how many times have you tried to quit?
3

What made you want to quit and why was now the right time for you?
Because last year I was diagnosed with Cancer
Meeting people with terminal Cancer made me realize I had a chance to change.
The Diabetic nurse said I needed to quit or there was a chance I could get throat cancer.
For my grandchildren

How did you feel about quitting at the beginning? (confidence, motivation levels)
Petrified, didn't think I would be able to do it. My motivation at the beginning of the process was 8/9-10 and my confidence was lower at 7-10.

Did you use medications to help you quit, if so what did you choose to use and why?
Patches and the inhalator,
Used to the patches but choose the inhalator because I needed something to do with my hands.

Behavior change:

How have you found the process of quitting smoking?
The support of the stop smoking practitioner was invaluable and the inhalator, having something in my hand has also been invaluable.

What challenges have you faced and how did you overcome them?
Faced challenges with my daughter and stressful situations with her, throughout this I have taken time to breath and walk through the process instead of doing what I would normally do and reach for the fag. Also, the inhalator would be in my hand.

Smoke free future:

How long have you been smoke free and what benefits have you noticed? (Health, finances etc.)
I have been smoke-free for 49 days, so that's seven weeks and counting.
Blood flow and sugar levels have improved and enabled me to have had my toe surgery.
Don't get out of breath so much anymore.

How confident that you will continue to be smoke free? (please underline)

Not confident Somewhat confident Confident <u>Very confident</u>

What do you hope the long-term benefits will be?
Health continues to improve.
Continues to smell of flowers as my grandson said, now I no longer smoke.
To live longer'
To help other people I care about to quit long term.

Service feedback:

Did the support from your smoking practitioner help, and if so, how?
Yes, she helped me loads.
She gave me the motivation and confidence to quit, also to stay quit.

What sort of things did they say or do that helped you?
I had it in me but it was hidden, I needed something else to show me I could and the practitioner managed to pulled the confidence out and show me I could continue with a smoke-free life.
Really helped to show me the products and how to use them.

Is there anything we could have done differently or better to support you?
No, she gave me loads of support even when it was out of appointments.
Advisable to have other back up support from friends or family.
Word of mouth, through certificate to help others to get motivated to quit.

Would you recommend our service to others? Yes/no, why/why not?
Definitely would highly recommend the service to others and I do.

Bristol Stop Smoking Service

Case Study Form (6)

About you

Practitioner Name: Jeremy Ward

Photo/video consent:

- I give consent for my name being included in the case study
- I give consent for photo to be shared
- I give consent for video to be shared

✓I would like to be anonvmous

About the Patient

Patient's ID 20994

Please Tick Patient's Gender

Male	
Female	✓

Patients Occupation:

Smoking habits:

How long have you been smoking and how many did you/do you smoke per day?
I have quit but I was smoking up to 20 roll ups every day.

How has smoking affected you?
I have asthma and smoking doesn't help it.

What do you like or dislike about smoking?
I no longer like anything about smoking.

Quit attempts:

Have you tried to quit smoking before? Yes/no If yes, how many times have you tried to quit?
Yes I have tried in the past but would end up smoking again when offered or stressed out, I don't think that I was motivated enough in the past.

What made you want to quit and why was now the right time for you?
Protecting my children from smoking and setting a good example.

How did you feel about quitting at the beginning? (confidence, motivation levels)
I was excited and a little nervous!

Did you use medications to help you quit, if so what did you choose to use and why?
At first I used patches and inhalators but stopped using the patches after about a month because I wasn't finding them helpful. I went a day without one and forgot to take them on holiday with me and I didn't notice a change in cravings.

Behavior change:

How have you found the process of quitting smoking?
I quit with my partner and so it hasn't been too much of a challenge because we have both been motivating and supporting each other.

What challenges have you faced and how did you overcome them?
The main challenge was getting my prescription on time from the doctors.

Smoke free future:

How long have you been smoke free and what benefits have you noticed? (Health, finances etc.) I have not smoked since July. I have noticed much better breathing and I can taste food better now.

How confident that you will continue to be smoke free? (please underline)

Not confident Somewhat confident Confident Very confident

What do you hope the long-term benefits will be?
I'm mainly quitting for my sons health so to protect his future is what I hope the benefit will be.

Service feedback:

Did the support from your smoking practitioner help, and if so, how?
Very much so. I am sure I would not have been able to quit without his help, the phone calls gave me a lot of confidence and drive to continue.

What sort of things did they say or do that helped you?
We spoke about many different things, how to handle cravings, vaping and other questions I had, but the most important part was just knowing I was going to get a phone call each week. I didn't struggle too much with anything.

Is there anything we could have done differently or better to support you?
No I was very pleased.

Would you recommend our service to others?
Yes.

Bristol Stop Smoking Service

Case Study Form (7)

About you

Practitioner Name: Jeremy Ward

Photo/video consent:

- I give consent for my name being included in the case study
- I give consent for photo to be shared
- I give consent for video to be shared

✓I would like to be anonvmous

About the Patient

Patient's ID 34059

Please Tick Patient's Gender

Male	
Female	✓

Patients Occupation:

Does not work

Smoking habits:

How long have you been smoking and how many did you/do you smoke per day?
I sometimes would smoke up to 20 a day its hard to know the exact number. I started when was a teenager at thirteen or fourteen.

How has smoking affected you?
I have asthma but I never linked the two because smoking became such a normal part of my life but it made it progressively worse. I then got covid and luckily I hadn't smoked for a while.

What do you like or dislike about smoking?
I used to like the routine of smoking but now I hate everything about it.

Quit attempts:

Have you tried to quit smoking before? Yes/no If yes, how many times have you tried to quit?
Yes I think it was twice in the past and I managed to not smoke for 8 weeks and then started again when my mother got terminal cancer which was a shock.

What made you want to quit and why was now the right time for you?
My health and money, and my cats health!

How did you feel about quitting at the beginning? (confidence, motivation levels)
I was nervous, I tried before but failed, but I also felt more committed this time. I was also fed up with it.

Did you use medications to help you quit, if so what did you choose to use and why?
I used patches and white inhalers, the ones you sent and then I got them on prescription. I used them for the first 2 months and then transitioned to just the inhalers. And now I am very strict with just using one cartridge a day.

Behavior change:

How have you found the process of quitting smoking?
When I found my motivation it wasn't too hard. There were times I thought "I could really do with a fag", but I was very committed and it helped me through the challenging times. Also I would not have been able to do it without your help.

What challenges have you faced and how did you overcome them?
Getting started with it was the main challenge for me. I did have cravings of course but I just stayed focus, and knowing that you were phoning was helpful with that, and speaking about ways to fight the cravings. I would tell myself that they only last 15 minutes, and then I'd wait, or sometimes do the dishes or something else.

Smoke free future:

How long have you been smoke free and what benefits have you noticed? (Health, finances etc.) I haven't smoked since March, so yeah I guess that is almost 12 weeks?

How confident that you will continue to be smoke free? (please underline)

Not confident Somewhat confident <u>Confident</u> Very confident

What do you hope the long-term benefits will be?
Having longer to spend with my cat! No having longer to live I hope!

Service feedback:

Did the support from your smoking practitioner help, and if so, how?
Yes, Jeremy's advice got me where I am and I would not have had the motivation or positivity to do it without his support.

What sort of things did they say or do that helped you?
I remember all of the little tips such as waiting out the cravings and not fighting them for 15 minutes, and changing my morning routine.

Is there anything we could have done differently or better to support you?
Not at all thank you very much.

Would you recommend our service to others?
Yes I already have I think they're already with your service.

Bristol Stop Smoking Service

Case Study Form (8)

About you

Practitioner Name: Jeremy Ward

Photo/video consent:

- I give consent for my name being included in the case study
- I give consent for photo to be shared
- I give consent for video to be shared

✓I would like to be anonvmous

About the Patient

Patient's ID 41652

Please Tick Patient's Gender

Male	✓
Female	

Patients Occupation:

Unemployed

Smoking habits:

How long have you been smoking and how many did you/do you smoke per day?
I started at the age of 22 but quit in the past for 14 years. Before speaking to you I was smoking between 11-20 cigarettes per day.

How has smoking affected you?
Mostly financially because it's so expensive, but I've noticed improvement in my gym routine after quitting.

What do you like or dislike about smoking?
Literally nothing I like about it, I'm so glad to get rid of it from my life.

Quit attempts:

Have you tried to quit smoking before? Yes/no If yes, how many times have you tried to quit? I quit in the past for 14 years but ended up smoking again after the loss of a friend.

What made you want to quit and why was now the right time for you? I just came to a point where enough was enough, and I'm in my 50's now, I know its not good for me so now was the right time.

How did you feel about quitting at the beginning? (confidence, motivation levels)
I wasn't sure, but nervous definitely. I felt very driven to quit though and I knew that I would be successful with it because when I set my mind to something I do it.

Did you use medications to help you quit, if so what did you choose to use and why?
Only the things you sent me.

Behavior change:

How have you found the process of quitting smoking?
It wasn't as challenging as I thought it might be but maybe thinking it would be harder made it easier. It wasn't easy though, but I remember speaking to you about consistency which helped. I think having my questions answered as they arose was helpful too but honestly mate I'm thankful for all of the support you've given.

What challenges have you faced and how did you overcome them?
The cravings in the first few weeks were terrible, but I stuck to the program and used the stuff you sent in the post as you said and got through it. I didn't once think that I'd smoke and I think having that resolve in my mind helped.

Smoke free future:

How long have you been smoke free and what benefits have you noticed? (Health, finances etc.)
Almost five weeks. Money, my performance doing cardio and my mood but I don't know if that's as a result of not smoking.

How confident that you will continue to be smoke free? (please underline)

Not confident Somewhat confident Confident <u>Very confident</u>

What do you hope the long-term benefits will be?
Health, especially coughing and wheezing and money.

Service feedback:

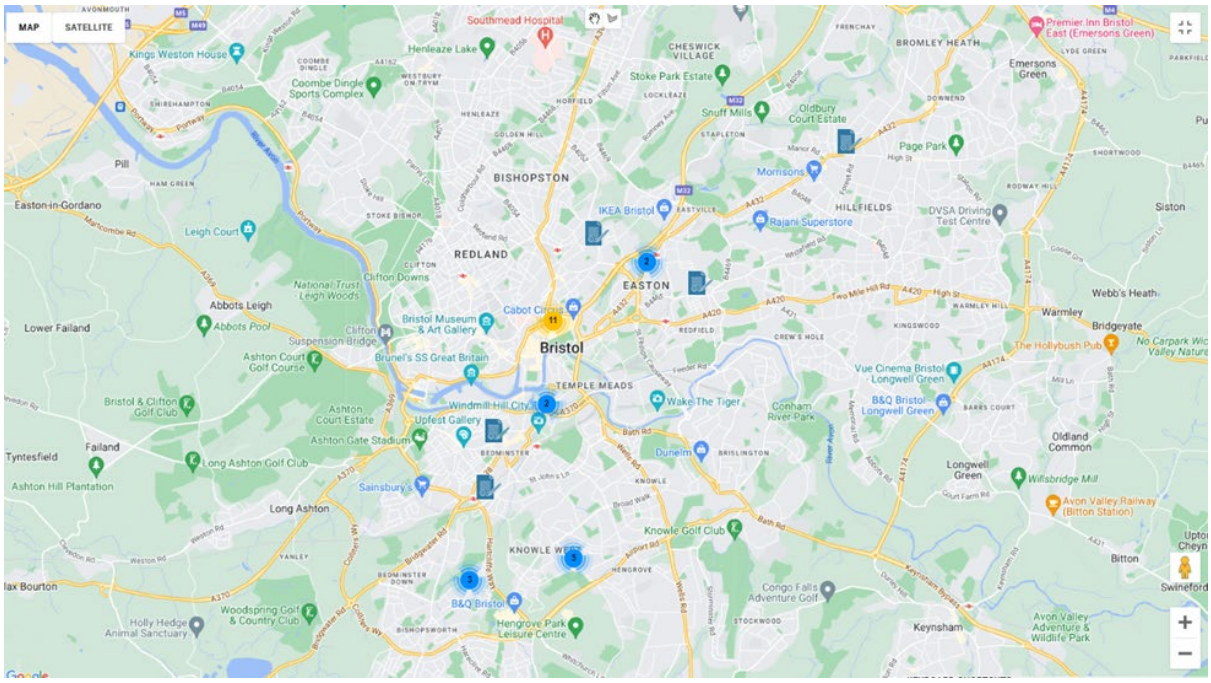
Did the support from your smoking practitioner help, and if so, how?
Very much and I have spoken about your support to friends recommending him to them. I can't thank him enough.

What sort of things did they say or do that helped you?
The ongoing support, the advice when I was struggling, the checkups and phone calls, all of it was helpful.

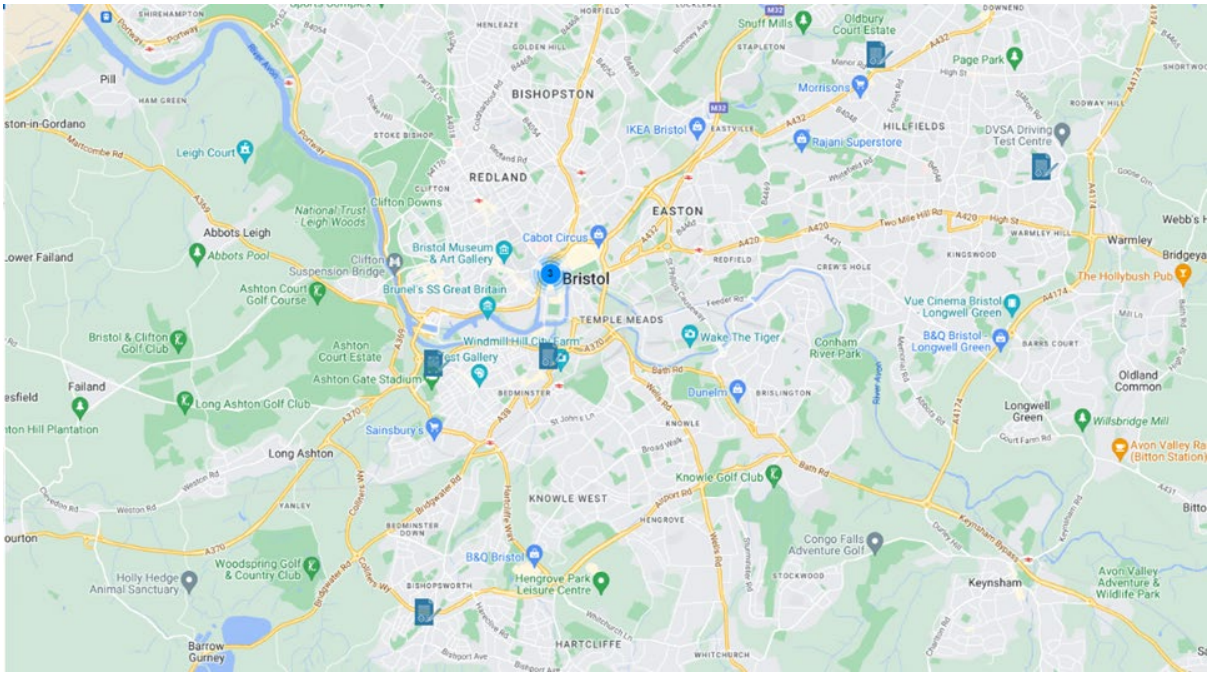
Is there anything we could have done differently or better to support you?
Honestly not really, I've managed to quit and it's been great.

Would you recommend our service to others? Yes. I already have recommended it to friends of mine.

Appendix 2 – map showing reports to Bristol Trading Standards: age restricted sale of vape devices 2020-2023



Appendix 3 – map showing reports to Bristol Trading Standards: product safety electronic cigarettes/vapes 2020-2023



Appendix 4 – map showing reports to Bristol Trading Standards: illicit tobacco 2020 – 2023