Smoking Cessation Needs Assessment

A Briefing for Public Health and Integrated Commissioning Unit

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1. Executive Summary

Smoking is a leading cause of preventable death and disease. Half of smokers will die from their smoking and around 77,800 people in England dying from smoking each year, with many more living with debilitating smoking-related illnesses.

In Southampton, an estimated 32,706 residents aged 16+ smoke. This equates to 1 in 6 adults (16.2%), compared with 15.8% for local authorities which are similar to Southampton and 14.4% in England.

Smokers are also linked with living in more deprived areas. Just over 20% of registered patients who smoke live in the 20% most deprived areas in Southampton compared to just 8.5% of registered patients are smokers in the 20% least deprived areas.

ASH estimate that smoking in Southampton costs society approximately £56m per year, this is a combination of £10.8m to the NHS, £41m potential wealth lost from the local economy as a result of lost productivity, £3.2m in additional social care costs from smokers and £1.1m in costs to fire and rescue services responding to house fires caused by cigarettes.

Three key documents have been published in recent year's highlighting the government's priority to tobacco control. These contain clear targets and challenging ambitions to achieve both for local authorities and the NHS.

There is significant evidence of which models in the past have been the most effective in terms of cost effectiveness and effectiveness in stopping smoking. However, new research is continuing to be published, in particular with regards to approaches within the NHS such as the Manchester CURE and the Ottawa models.

Local stakeholder's views reflect the importance of national priorities and strongly support the need for both wider public health approaches for a smokefree Southampton and targeted interventions supporting smokers to stop. This included suggestions of a mixed model with personalised care, for cost effective evidence-based interventions embedded into existing services.

Following the decommissioning of the previous service in April 2019, interim arrangements for 2019/20 were established within pharmacies and maternity services. The performance of previous and current services has been reviewed to inform the recommendations, alongside the current evidence base, NICE guidance, benchmarking and best practice.

The recommendations reflect the importance of key drivers such as the Long-Term NHS Plan and the Green Prevention Paper and aim to support a mixed model of services, while considering the needs of the local population.

2. Introduction

2.1. Smoking harms

Smoking is a common and deadly addiction. Nationally 1 in 6 adults smoke[1], rising to 1 in 4 of people in routine and manual work.

Smoking is a leading cause of preventable death and disease. Half of smokers will die from their smoking and around 77,800 people in England dying from smoking each year, with many more living with debilitating smoking-related illnesses. Smoking is also the largest cause of fatal house fires.

Smoking increases the risk of developing more than 50 serious health conditions including cancers, heart disease, other vascular diseases and Chronic Obstructive Pulmonary Disease (COPD). In 2017/18 there were estimated to be 489,300 hospital admissions attributable to smoking representing 4% of all hospital admissions with 26% of hospital admissions for conditions that can be caused by smoking[2]. In addition, one in ten pregnant women still smoke nationally with the associated risks of miscarriage, premature birth, still birth, low birth weight and neonatal complications.

Smoking is the largest cause of health inequalities. It accounts for half of the difference in life expectancy between the least and most deprived areas. Smoking is much more common among people who are unemployed or in routine and manual jobs than in salaried professions. The average smoker now smokes 11.3 cigarettes a day, costing smokers at least £1800 a year. The cost rises to at least £3180 for a 20-a-day addiction[3]. It thereby exacerbates relative poverty for individuals too.

Smoking also has a significant impact on the economy, with financial harm more than the amount raised through taxation, social care, (with smokers typically needing care 4 years sooner than non-smokers, costing an additional £1.4bn) employment, (with 16,717,470 days of lost productivity, costing £1.7bn) litter, (with smoking materials constituting 35% of all street litter).[4]

2.2. Tobacco control

There are a number of approaches to reducing smoking, referred to nationally and internationally as "tobacco control". The World Health Organisation has a Framework for Tobacco Control, which the UK has signed up to along with 180 other countries. It includes:

- restricting and regulating supply
- reducing demand through price and non-price measures including protecting people from second hand smoke through smoke free places, packaging, campaigns, support for people to stop smoking.
- not working with the tobacco industry, given their long history of being unreliable collaborators

[1] Office for National Statistics, 2017. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2015 Accessed 27/08/19.
[2] https://files.digital.nhs.uk/D9/5AACD3/smok-eng-2019-rep.pdf
[3] The law requires cigarettes to be sold in packs of 20 or more. Prices typically start at £8.70 per pack of 20. Illicit tobacco may be sold much cheaper than this and is sold illegally, "under the counter" without tax being paid.
[4] http://ash.lelan.co.uk/ accessed 13.9.19

Southampton City Council signed up to the Local Government Declaration on Tobacco Control in 2013. This mirrors the WHO framework. Southampton CCG signed up to the NHS equivalent in 2014. The 2012 Health and Social Care Act specifies areas of public health which local authorities must deliver. Local authorities are not required to work on or invest in tobacco control or smoking cessation.

2.3. Scope of this review

This review focusses on reducing the demand for smoking through supporting people to stop smoking. This work typically focusses on individuals with population-wide campaigns.

Smoking cessation is just one of the Council's tobacco control work streams. The recommendations of this review are made in the context of national policy for a Smokefree Southampton by 2030.

This rapid needs assessment is to inform the commissioning of smoking cessation approaches in the city. It can be read in conjunction with a profile of smoking in Southampton completed in October 2018 which has more detailed data in parts[5], as well as the Local Tobacco Control Profile[6] and the Public Health Outcomes Framework[7]

3. Smoking prevalence

3.1. National rates

Smoking prevalence has improved significantly over years, but the smoking rates have remained stubbornly higher amongst those in our society who already suffer from poorer health and other disadvantages. Smoking rates are almost three times higher amongst the lowest earners, compared to the highest earners, contributing to health inequalities.[8] 1 in 5 (18.2%) of smokers report they want to stop smoking and report they plan to quit in the next three months.[9]

Smoking is a relapsing addiction. The Department of Health refers to people who stop smoking for at least 4 weeks as having "quit" smoking. Estimates of relapse rates vary. A review in 2014 of smoking cessation services nationally found that 75% of people CO-validated as having quit at 4 weeks had returned to smoking a year later[10]. The Department of Health cites different research looking at those who set a quit date, rather than those that quit. It found 16% of people starting a quit attempt will still be a non-smoker a year later if they use the support of a trained specialist and a support aid, typically NRT[11].

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[5] https://data.southampton.gov.uk/images/jsna-smoking-needs-assessment-february-2019_tcm71-406521.pdf Completed in October 2018 and uploaded I February 2019.

[6] https://fingertips.phe.org.uk/profile/tobacco-control

[7] https://fingertips.phe.org.uk/profile/public-health-outcomes-framework

[8] Tobacco Control Plan for England, 2017. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england

[9] https://publichealthmatters.blog.gov.uk/2018/07/03/turning-the-tide-on-tobacco-smoking-in-england-hits-a-new-low/

[10] National Centre for Smoking Cessation and Training, 2014. Why use CO-verified 4-week quit rates as the primary measure of stop smoking service success? https://www.ncsct.co.uk/usr/pub/NCSCT%20briefing%20on%204%20week%20quit%20rates.pdf. Includes the statement "*It can be assumed that the current 36% (CO-validated) smoking cessation success rate at 4 weeks will result in approximately 9% long-term quitters [quitter at 52 weeks] among stop smoking service clients compared with around 3–4% among those who quit unaided*."

[11] https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works

3.2. Local prevalence of smoking

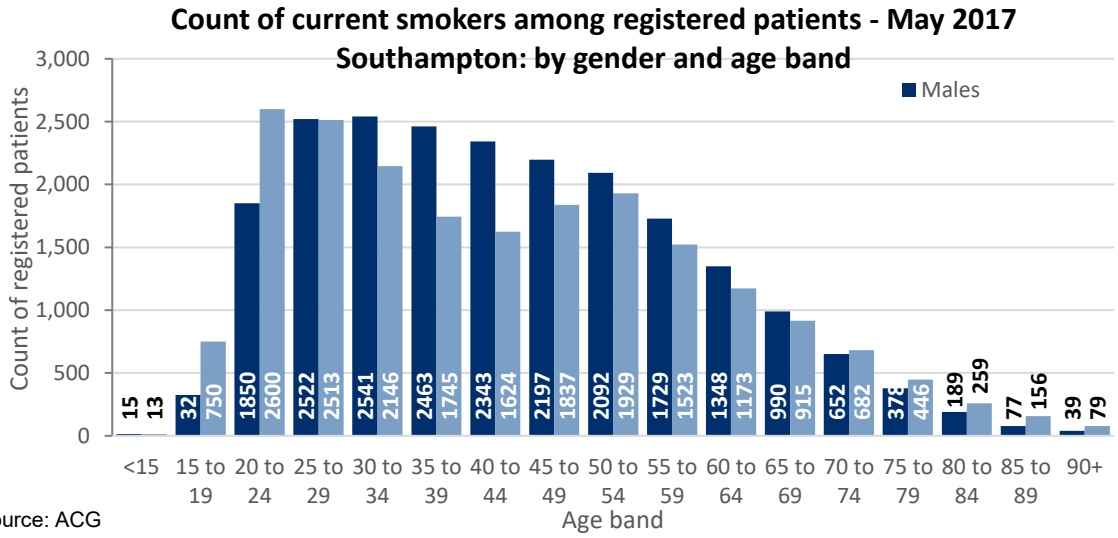
In Southampton, an estimated 32,706 residents aged 16+ smoke. This equates to 1 in 6 adults (16.2%), compared with 15.8% for local authorities which are similar to Southampton and 14.4% in England. While the Southampton rate is higher, the figures are estimates and the difference is not statistically significant. The estimates are calculated from the 2018 Annual Population Survey reported by Public Health England[12].

Unless specified otherwise, the comparators used here are the local authorities in the 4th most deprived decile, as used by Public Health England and in their Outcomes Framework and Local Tobacco Control Profiles. It consists of 15 authorities, including Southampton. It is reasonable for Southampton to aspire to be the best among equals. Portsmouth is also in the 4th decile.

Neighbouring authority Hampshire is in the most affluent decile nationally (or least deprived), with an estimated smoking prevalence of 12.3%. The Isle of Wight is in the 5th most deprived decile nationally and has an estimated smoking prevalence of 13.2%. The South East region as a whole is typically more affluent than the population of Southampton. The estimated smoking prevalence of 12.9% reflects this.

Gender and age

The chart below shows males smoke more than females and they are more likely to smoke between the ages of 25 and 54. Male smoking peaks between the ages of 30-34 of 2,541 registered patients. Whereas female smoking peak between the ages of 20 to 24 of 2,600 registered patients[13].



Source: ACG

Registered patients' means anyone registered with a Southampton GP practice, including some people who live in neighbouring areas. Our registered population is 13% larger than our resident population. 289,684 people (all ages) were registered with a Southampton GP practice as of January 2019 compared to an estimated resident population of 256,459 people (all ages)[14].

[12] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/0/gid/1938132886/pat/10039/par/cat-39-4/ati/102/are/E06000045 Accessed 27/08/19.
[13] Southampton Data Observatory "Southampton Strategic Assessment – Smoking (JSNA)" https://data.southampton.gov.uk/Images/JSNA-Smoking-Needs-Assessment-February-2019_tcm71-406521.pdf February 2019
[14] https://data.southampton.gov.uk/population/pop-structure/

Socio-economic groups

Local smoking prevalence for routine and manual workers has been higher than England since 2013. The difference has not been statistically significant, and the gap is closing. An estimate of 25.6% of routine and manual workers in Southampton smoke, compared to an average of 26% for comparator local authorities and 25.4% in England[15].

Smokers are also linked with living in more deprived areas. Just over 20% of registered patients who smoke live in the 20% most deprived areas in Southampton compared to just 8.5% of registered patients are smokers in the 20% least deprived areas. At sub-city level, smoking prevalence variation also shows a greater likelihood for those living in more deprived areas. There are three electoral wards where 1 in 5 registered patients smoke these are Millbrook (20.2%), Redbridge (20.7%) and Bitterne (23.5%).

Other characteristics

In Southampton, smokers are more likely to:

- Live in single households than married households
- Live in terraced houses or flats and/or renting
- Have lower household incomes
- Have 'difficult' or 'very difficult' financial stresses
- Have a high use of social networks (Facebook and Twitter - most popular)

Locally, smoking rates are thought to be higher among:

- Men who identify as gay and women who identify as gay or bisexual are more likely to smoke than people who identify as heterosexual. There is a higher prevalence rate among people who identify as LGBTQ+ nationally too, with different rates by socioeconomic deprivation too[16]
- Residents from Eastern European communities (over 50% among Latvians/ Lithuanians/Slovakians), traveller communities and men of Bangladeshi and Pakistani ethnicity.
- People diagnosed with serious mental illness (51%, 1229 people), classified as schizophrenia, bipolar and personality disorders[17]. This is significantly higher than nationally (41%) and the average for comparator authorities (42.2%)[18]. Nationally it is estimated that people with an SMI or a drug or alcohol problem buy 42% of all tobacco sold[19].

In England, around 60% of smokers want to quit, 10% of whom intend to do so within 3 months[20]. However, it can be difficult to get an accurate perspective given smokers are aware of the social expectation that they should say they want to quit. Taking these rates at face-value, this means that

[15] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132886/pat/10039/par/cat-39-4/ati/102/are/E06000045/iid/92445/age/183/sex/4 Accessed 27/08/19

[16] https://www.stonewall.org.uk/system/files/lgbt_in_britain_health.pdf Accessed 24/01/20. 15% respondents smoked almost every day, compared to national prevalence of 15% at the time including people smoking less than "almost every day".

[17] Southampton Data Observatory "Southampton Strategic Assessment - Smoking (JSNA)" February 2019 https://data.southampton.gov.uk/Images/JSNA-Smoking-Needs-Assessment-February-2019_tcm71-406521.pdf

[18] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132886/pat/10039/par/cat-39-4/ati/102/are/E06000045/iid/92536/age/168/sex/4

[19] https://www.ncsct.co.uk/usr/pub/mental%20health%20briefing%20A4.pdf

[20] https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works

19,624 smokers in Southampton might want to quit and 3,271 of these might intend to do so within 3 months.

3.3. Health impacts of smoking in Southampton

Half of all life-long smokers nationally will die prematurely, typically 10 years earlier than people like them who do not smoke[21].

In Southampton, an estimated 1,032 people aged 35+ died due to smoking during the 3 years from 2016-2018. This includes an estimated 399 deaths from chronic obstructive pulmonary disease (COPD), 368 from lung cancer, 101 from heart disease, 31 from oral cancers, 24 from stroke and the remaining 109 from a range of other cancers and other conditions.

The corresponding directly-standardised mortality rate for smoking-attributable deaths (326 per 100,000 people) was higher than the average for authorities with populations as deprived as Southampton (288 per 100,000 people) and the difference was statistically significant[22]

Smoking attributable hospital admissions and COPD hospital admissions in the city are significantly higher than the England average. Similarly, while the deaths from COPD have seen an overall decrease nationally, the rate has increased for Southampton, with the city having the second highest rates in the fourth most deprived decile and being statistically significantly higher than 8/14 comparator authorities.[23]

What this also demonstrates is that while life expectancy in Southampton appears to have now plateaued, the number of years spent in poor health continues to be significant. Data from 2014-16 shows male life expectancy to be 78.5 years with 16.6 years in ill health and female life expectancy to be 82.5 years with 19.7 years in ill health.[24]

Further data is available from the Local Tobacco Control Profile published by Public Health England[25] and in an epidemiological profile of smoking in Southampton, completed in 2018[26].

3.4. Wider impacts of smoking in Southampton

ASH have an evidence-based online "ready reckoner" tool which calculates the economic costs and other harms of smoking[27]. The tool estimates that for Southampton:

- The total annual cost of smoking to the NHS across Southampton is approximately £10.8 million. As smokers take more sick leave from work than non-smokers and smoking increases the risk of disability and premature death £41million of potential wealth is lost from the local economy each year as a result of lost productivity due to smoking.

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[21] https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works

[22] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132887/pat/10039/par/cat-39-4/ati/102/are/E06000045/iid/113/age/202/sex/4 Accessed 24/01/20

[23] Public Health Profiles: Smoking Indicators – accessed 31.7.19 https://fingertips.phe.org.uk/indicator-list/view/6VVtOoPLHk#page/0/gid/1/pat/156/par/Cl_L2_2ar/ati/101/are/E06000045

[24] Southampton Data Observatory "Southampton Strategic Assessment - Smoking (JSNA)" February 2019 https://data.southampton.gov.uk/Images/JSNA-Smoking-Needs-Assessment-February-2019_tcm71-406521.pdf

[25] Public Health England https://fingertips.phe.org.uk/profile/tobacco-control/data#page/0/gid/1938132885/pat/10039/par/cat-39-4/ati/102/are/E06000045 Accessed 27/08/19

[26] Southampton Data Observatory "Southampton Strategic Assessment - Smoking (JSNA)" February 2019 https://data.southampton.gov.uk/Images/JSNA-Smoking-Needs-Assessment-February-2019_tcm71-406521.pdf

[27] https://ash.org.uk/ash-ready-reckoner/ accessed 11/06/2021

- Smoking related social care due to smoking related illness, cost Southampton City Council £3.2m a year and self-funders an additional £562k a year. Nationally, the average age that smokers need care is 62 compared to 72 for people who have never smoked[28].
- Smoking materials constitute 35% of all street litter in Southampton with smokers consuming around 380,890 cigarettes everyday this results in 57kg of waste, 42% of which is discarded on the streets.
- Smokers in Southampton spend approximately £75.9 million on tobacco products per year, an average of £2,050 per smoker per year. Of the total expenditure on smoking products, £37.9 million is collected by the Exchequer as tobacco duty. Despite this extra revenue tobacco still costs the community in Southampton one and a half times as much as the duty raised, that's a net annual cost of £21.7 million.

In addition, fatalities are disproportionately high in smoking- related fires, representing 49% of all house fire deaths.

3.5. Smoking in pregnancy

3.5.1. National policy context

The Tobacco Control Plan in 2017 highlighted a specific target to aim for a smokefree pregnancy for all women with a national target of reducing the prevalence of smoking in pregnancy from 10.7% to 6 % or less. [29]

The NHS Long Term Plan (2019) has highlighted specific targets around maternity services as a priority including the new smokefree pathway. In addition, the plan outlines that women from the most deprived communities are 12 times more likely to smoke during pregnancy than women from more affluent areas. By 2023/24 the NHS will offer all pregnant women who smoke, and their partners, specialist smoking cessation support to help them quit. The plan does not detail where this support will be provided, to what scale or how it will be funded. [30]

Pregnant women are also highlighted in the government's green paper as a group in most need of support to stop smoking.

3.5.2. Local epidemiology

Public Health England reports that in Southampton in 2018/19, 384 women were smokers at the time of delivery. This is 12.3% (about 1 in 8) of women who gave birth. Southampton is the 7th highest for the 15 comparator authorities, which range from 3.4% to 17.5%. An average for the group of comparators is not provided. Nine of the 15 authorities, including Southampton, have a rate statistically significantly higher than England (10.6%).

In addition, the odds of a mother from the most deprived quintile smoking at time of delivery is 9.31 times higher than a mother from the least deprived quintile[31].

[28] https://ash.org.uk/wp-content/uploads/2019/09/Social-Care-Costs-Report-2019.pdf
[29] Department of Health "Towards a Smokefree Generation –A Tobacco Control Plan for England" July 2017
[30] NHS England, Long term Plan, 2019 https://www.england.nhs.uk/long-term-plan/
[31] Southampton Data Observatory "Southampton Strategic Assessment – Smoking (JSNA)" February 2019 https://data.southampton.gov.uk/Images/JSNA-Smoking-Needs-Assessment-February-2019_tcm71-406521.pdf

3.5.3. Impacts

Nationally, smoking in pregnancy is the largest modifiable risk factor for many poor birth outcomes including miscarriage, stillbirth and neonatal deaths. NHS Southampton CCG data for 2016 reports there were 3,212 births, with 18 stillbirths and 14 neonatal deaths.[32]

Smoking in pregnancy is also a major health inequality with prevalence varying across communities and groups. Smoking prevalence among pregnant women in more disadvantaged groups and those aged under 20 remains considerably higher than in older and more affluent groups. Mothers in routine and manual occupations are five times more likely to have smoked throughout pregnancy compared to women in managerial and professional occupations, meaning those from lower socio-economic groups are at a much greater risk of complications during and after pregnancy.

Children who grow up with a smoking parent are also more likely to become smokers themselves, further perpetuating the cycle of inequality and affecting their life chances. NHS Digital publishes a health survey of 11-15 years old secondary school pupils every other year. Respondents in 2016 who lived in a home where at least one other person smoked were 6-7 times more likely to regularly smoke than respondents who lived in a non-smoking home, with rates of 6-7% and 1% respectively[33].
Children of smokers are also exposed to the harms of second-hand smoking, which are difficult to avoid even with parental care. 62% of respondents to the school survey published by NHS Digital reported being exposed to smoke at home or in a car.

3.6. Smoking with mental illness

3.6.1. National policy context

The NHS Long Term Plan has highlighted a universal offer to be available as part of a specialist mental health services for long-term users of specialist mental health, and in learning disability services by 2023/24.

People living in mental health institutions are also highlighted in the government's green paper as a group in most need of support to stop smoking. Nationally 81% of people who are inpatients of mental health trusts smoke and a third of all tobacco is smoked by people with a mental health condition[34].

3.6.2. Epidemiology

Locally, just over 51% of people with serious mental illness in Southampton smoke (1229 people), significantly higher than nationally (41%). Local data shows higher smoking prevalence by condition

[32]Number of total births, stillbirths and neonatal deaths, by Clinical Commissioning Group, 2016, Englandhttps://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/adhocs/008362numberoftotalbirthsstillbirthsandneonataldeathsbyclinicalcommissioninggroup2016england

[33] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2018/part-4-smoking-patterns-in-children
[34] NCSCT website. https://www.ncsct.co.uk/publication_MH_specialty_module.php

in those diagnosed with schizophrenia, bipolar and personality disorders[35], although we do not know whether any of the higher rate is due to better identification and recording or not.

3.6.3. Impacts

People who have a serious mental illness (SMI), such as schizophrenia or bipolar disorder, die –on average- 16 years before people who do not have such a mental illness. Most of this difference is attributable to smoking[36]. Smokers usually need to be on higher doses of antipsychotic medication too, with more chance of the accompanying side effects, as smoking makes the medication less effective.

People with SMI want to stop smoking just as much as smokers who do not have an SMI[37]. People with SMI or more common mental conditions, such as depression or anxiety, experience physical illnesses more frequently and in some cases more severely. The reasons for this are multifaceted. Nevertheless, for people with mental illness who smoke, stopping smoking will have the greatest impact on their health.[38]

People with mental health conditions often experience anxiety and low mood as part of their condition and stopping smoking can help this. Contrary to popular belief, smoking is not calming. Having a cigarette simply returns people to the level of calm they would experience if they did not smoke. The constant addictive cycle of withdrawal in between cigarettes magnifies anxiety and low mood.

Importantly, smoking also exacerbates the social exclusion and poverty many people with mental ill health experience. Stopping smoking can boost self-confidence too.

4. Smoking cessation service provision in Southampton

4.1. Historic provision in Southampton

Stop smoking services were rolled out nationally in 2000 and since then have supported an estimated 1 million smokers to quit for good, often heavy smokers who have been at greatest risk from smoking related diseases. These services have been built around the principle of a universal offer of support available for all smokers, with a combination of behavioural support and pharmacotherapy.

Historically, Southampton had a specialist stop smoking service, Southampton Quitters, which was funded by the public health grant and was commissioned to deliver a universal specialist stop smoking service. This was augmented with locally commissioned services in GP practices and pharmacies.

In April 2017 a new integrated health improvement and behaviour change service was commissioned to replace the Quitters service and a number of other services including Health

[35] Southampton Data Observatory "Southampton Strategic Assessment - Smoking (JSNA)" February 2019 https://data.southampton.gov.uk/Images/JSNA-Smoking-Needs-Assessment-February-2019_tcm71-406521.pdf
[36] Tobacco Control Plan for England, 2017. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
[37] Tobacco Control Plan for England, 2017. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
[38] NCSCT website. https://www.ncsct.co.uk/publication_MH_specialty_module.php

Trainers, Health Promotion Services and the primary care smoking cessation services, amongst others. The new service, Southampton Healthy Living, was commissioned to provide a single point of access, evidence based health improvement and behaviour change interventions helping to tackle a range of behaviours including "increasing risk" or "higher risk" alcohol consumption; poor diet and eating patterns which lead to overweight and obesity, lack of physical activity and smoking. The service was commissioned to take a wellness approach that looked beyond single lifestyle issues focussing on a whole person, whole family and community approach to improving health.

SHL had five core functions:

- Health improvement and behaviour change hub
- Specialist behaviour change support
- Outreach and development of healthy communities
- Training and capacity development
- Data collection, monitoring, evaluation, governance and quality assurance.

The service was commissioned for just over £1m a year. It achieved some of its targets but not others and Southampton Healthy Living was de-commissioned in March 2019 by mutual agreement.

4.2. Interim service provision (April 2019 to date)

Commissioners committed to a subsequent review of need and prioritised interventions in the interim based on the most pressing need, evidence of effectiveness and impacts on other pathways. This included:

- Stop smoking support, including free pharmacotherapy and behavioural support, for pregnant women provided by the maternity services.
- Universal stop smoking support, including free pharmacotherapy and behavioural support provided by local pharmacies
- Ongoing campaigns including Stoptober and the promotion of the NHS smokefree website and helpline

These were services accessible to the target populations and with staff who already had the underlying skills to provide support well. They were also in keeping with the national Tobacco Control policy.

GPs can additionally prescribe nicotine replacement therapy, varenicline (branded as Champix) and bupropion (branded as Zyban) for their patients. The cost of prescribing is paid for locally by Southampton City Council from the public health grant, with no time limit to the length of time patients can be prescribed these medications. Patients also pay prescription charges unless they are exempt. National prescribing guidance highlights how the medicines should be prescribed.

In 2017/18 approximately £100,000 was spent on the prescribing of smoking cessation medicines by GP practices. This has increased year-on-year.

The Royal College of General Practitioners, the National Centre for Smoking Cessation and Training and others recommend that GP practices ask about the smoking status of their patients and provide very brief advice (VBA) to support patients to stop. Asking patients whether they want to stop smoking is not recommended.

4.3. Progress of current service provision (from April 2019 to date)

Maternity service
Following the decommissioning of Southampton Healthy Living, the UHS Maternity Services developed an alternative way of working to support pregnant women who smoke. This is a maternity led service model which had short, medium and long term development plans. The service began in April 2019 and the short-term phase is due to last until March 2020. The smoking cessation services moved to sit under the responsibility of the Public Health Midwife, along with other public health roles such as vaccination and healthy weight management. From experience the midwives locally felt the uptake of public health interventions by pregnant women is better when advice, support and treatment are delivered by a midwife. Lead midwives have been trained by specialist staff to offer this service following the Saving Lives Care Bundle v2 (March 2019)[39] and NICE Guidance NICE PH26[40] through CO readings, specialist stop smoking midwives and the provision of NRT. No data is currently available on the number of women accessing support through this service.

Local Pharmacy service
The first pharmacy started offering the service in August 2019 and 7 pharmacies are currently offering this service. Payments are paid for mostly on an activity basis. Current Q2 data (up to September 2019) shows 56 people have been engaged with this service with 7 stopping smoking. A further 10 pharmacies are preparing to offer the service for better coverage across the city.

Support for young people
No Limits are commissioned to provide substance use and generic support for young people in Southampton. They are not formally commissioned to provide specialist smoking cessation support but were trained as a local stakeholder by Southampton Healthy Living. They are not currently required to submit performance data on stop smoking interventions.

GP practices
GP practices have been encouraged to continue prescribing smoking cessation pharmacotherapy, with the medication costs funded by Southampton City Council and where appropriate refer patients to local pharmacies or the national Smokefree website.

Furthermore, 1 GP practice (Stoneham Lane) has a health care assistant who supports people to stop smoking. The practice decided to continue this work when the contracts with practices ended at the start of the SHL contract, because they see it as a clinical priority. Other practices have expressed interest in providing support too, subject to additional funding.

Specialist drug and alcohol services
No Limits and Change Grow Live provide substance use support for people aged up to 25 and over 25 respectively. As part of their service specifications, they encourage their service users to stop smoking. They do not currently provide intensive stop smoking support and are not yet commissioned to do so but are keen to explore this.

Hospital risky behaviour CQUIN
The acute hospital respiratory department have been delivering this NHS England funded CQUIN successfully for 2 years. This means they ask all inpatients whether they smoke and provide NRT to

[39] Saving Lives Care Bundle v2, March 2019. https://www.england.nhs.uk/publication/saving-babies-lives-version-two-a-care-bundle-for-reducing-perinatal-mortality/
[40] Smoking: stopping in pregnancy and after childbirth, 2010. https://www.nice.org.uk/guidance/ph26

those who do. Following the de-commissioning of SHL, the team have been referring patients to the local pharmacy service and informally following up with some telephone support to some of these patients. They are not formally commissioned to provide specialist smoking cessation support, nor currently required to submit performance data on stop smoking interventions other than CQUIN reporting.

Solent NHS Trust and Southern Health NHS Trust are similarly aiming to ask inpatients whether they smoke and providing them with NRT. NHS England expects all NHS Trusts to have smokefree sites and local Trusts have signed up to this as part of the Hampshire and Isle of Wight Sustainability and Transformation Plan (STP).

Stoptober and campaigns
The Stoptober campaign was promoted through the city council communications team using local digital screens, bus advertisements and social media.

Funding
Historically Southampton City Council has spent about £500k-£600k p.a. of the public health grant on commissioned smoking cessation services, nicotine replacement therapy, campaigns and trading standards work on underage sales and illicit tobacco. The exact figure is difficult to quantify as Southampton Healthy Living was a holistic service and amounts were not specified for particularly work streams. This figure does not include public health or commissioning time to oversee this work.

4.4. Adult smoking cessation and quit rates in Southampton

Smoking prevalence
The prevalence rate falls as:

- Smokers stop smoking
- Smokers die
- Fewer young people smoke than in previous generations

The estimated number of smokers in Southampton fell from 39,515 in 2011 to 32,691 in 2018[41]. We do not know how this reduction was comprised of smokers quitting or of the difference between starters and deaths.

[41] https://fingertips.phe.org.uk/search/smoking#page/4/gid/1/pat/10105/par/cat-105-4/ati/202/are/E06000045/iid/92443/age/168/sex/4

SHL – Smoking Cessation Performance Data 2018/19

Service Specification reference / descriptor	Annual target 2018-19	Performance	Variation
Number who had stopped smoking (CO validated and self- reported) at 4 weeks	1434	555	-876
Number of pregnant women who had stopped smoking (CO validated and self-reported) at 4 weeks	118	85	-33

Public Health England report comparative figures for[42]:

- The rate of smokers aged 16+ setting a quit date through services.
- The 4-week quit rate of all services in each area.

In 2018/19 Southampton ranked the 11th lowest out of the 15 local authorities in the 4th decile for 4 week quit rates. The quit rate of smoking cessation services in Southampton in 2018/19 was 1326 per 100,000 smokers which was lower than the England rate 1894 per 100,000 smokers.[43]

GP practice records show that 92.3% of patients recorded as smokers are also recorded to have had an offer of support and treatment within the previous 24 months. This was a Quality Outcomes Framework Indicator, so it was in the interest of practices to achieve comprehensive recording.

[42] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132890/pat/10039/par/cat-39-4/ati/102/are/E06000045/iid/91736/age/164/sex/4
[43] https://fingertips.phe.org.uk/profile/tobacco-control/data#page/3/gid/1938132890/pat/10039/par/cat-39-4/ati/102/are/E06000045/iid/1210/age/164/sex/4

5. Benchmarking

Local Authority	Has a smoking cessation service	No. of people accessing that service	PHOF reports comparative quit rates and cost per quit for 2018/19.
Sheffield	Yes	2,300 referrals 1,000 x 12 week quits commissioned annually Tariff contract PBR Universal offer and Priority Service	We pay £550 per 12 week quit and £600 per SMI quit for the Priority service
Kent	Kent Community Health Foundation Trust across the whole of Kent through their smoke free advisors. Smoke free advisors also provide brief health conversations regarding weight loss, healthy eating, physical activity, alcohol and wellbeing	12,041	3112 successful quits in 2018/19. KCC pay £20 per quit.
Plymouth	Yes. Specialist Stop Smoking Service provided as part of One You Plymouth. Practitioners provide the support needed to enable you to stop smoking and will be able to continue to offer support until you feel completely confident to remain smoke free.	1,506 people set a quit date	PHOF data £935 cost per quitter
Southampton	Yes, as part of integrated health & wellbeing service.	2018/19: 1,434 is target number to stop smoking 555 is the actual number who quit at 4 weeks. (SHL figures) 2,652 people per 100,000 smokers setting a quit date (PHOF) 886 people set a quit date (PHOF) 443 people quit at 4 weeks (PHOF)	£954 PHOF data

6. Policy and Guidance

6.1. Towards a smokefree generation – A Tobacco Control Plan for England 2017-2022[44]

In this plan the government set out the strategy to:

- reduce smoking prevalence among adults and young people
- reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.
- reduce smoking during pregnancy
- parity of esteem for those with mental health conditions.

6.2. NHS England Long Term Plan, 2019[45]

In this plan the government set out key ways for the NHS wants to improve care over the next ten years including preventing illness and tackling health inequalities. The smoking element of this focuses on three key points:

- By 2023/24, all people admitted to hospital who smoke will be offered NHS- funded tobacco treatment services, using proven models implemented in Canada, Ottawa Model for Smoking Cessation[46] and Manchester, CURE Project[47]
- A new smokefree pregnancy pathway including focused sessions and treatments.
- A new universal smoking cessation offer will also be available as part of specialist mental health services for long term users of specialist mental health, and in learning disability services.

6.3. Green paper on prevention, 2019 [48]

In this paper the government further highlighted the evidence in health inequalities.

> *"There is also a clear social gradient to healthy life expectancy. That is, people in deprived areas tend not only to live shorter lives, but they also spend more of those years in poor health. For example, women living in the 10% most deprived areas can expect to live 18 fewer years in good health than those in the 10% least deprived areas." Green paper pg10*

This link is strengthened through the proposals for a future smoke-free England by 2030, identifying certain groups where smoking is high:

- Areas of deprivation
- People who identify as LGBT
- People living with a mental health condition

The green paper summarises the future strategy for smoking as "tackling inequalities as a core challenge" while prioritising:

- ***Discouraging people from starting***: including work with young people and population approaches such as legislation and policy.

[44] Tobacco Control Plan for England, 2017. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
[45] NHS England, Long term Plan, 2019 https://www.england.nhs.uk/long-term-plan/
[46] BMJ, 2016 "Effectiveness of a hospital – initiated smoking cessation programme: 2 year health and healthcare outcomes" Mullen et al.

[47] https://thecureproject.co.uk/
[48] Prevention green paper

- ***Supporting smokers to stop:*** including "polluter pays" as alternative ways of funding tobacco control, using any funds to focus stop smoking support on groups in most need, such as,
    - Pregnant women, social renters, people living in mental health institutions and deprived communities.

6.4. NICE Guidance

Stop smoking interventions and services (NICE, 2018) (NG92)

Published in 2018 this guideline covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12. It aims to ensure that everyone who smokes is advised and encouraged to stop and given the support they need. It emphasises the importance of targeting vulnerable groups who find smoking cessation hard or who smoke a lot.

Smoking: acute, maternity and mental health services (NICE, 2013) (PH48)

This guideline covers helping people to stop smoking in acute, maternity and mental health services. It promotes smokefree policies and services and recommends effective ways to help people stop smoking or to abstain from smoking while using or working in secondary care settings.

Tobacco: harm-reduction approaches to smoking (NICE, 2013) (PH45)

This guidance is about helping people, particularly those who are highly dependent on nicotine and recommends harm-reduction approaches which may or may not include temporary or long-term use of licensed nicotine-containing products.

The National Centre for Smoking Cessation and Training and Public Health England recommend services are commissioned for 5% of the smoking population each year[49]. An average of 52% of people nationally stop smoking for 4 weeks when they use these services[50]. Of these, 75% may relapse and be smokers again within 12 months. Services can therefore be estimated to lead to a maximum of 0.65%% of smokers quitting long term each year (5% x 52% x 25%). The real figure will be lower as some of those quitting will relapse after a year and some will relapse many times.
It is impractical and unaffordable to commission services for much more than the 5% of smokers recommended by NICE. So additional and alternative approaches are clearly needed to support the thousands of smokers outside of this.

6.5. Cochrane reviews and NCSCT service delivery guidance

There have been a wide range of Cochrane reviews on all aspects of smoking cessation interventions, including behavioural change, pharmacological, community and other settings. In 2017, PHE published "Models of delivery for stop smoking services: Options and evidence" [51] which includes information from the Cochrane Collaboration, NICE and NCSCT Service and Delivery Guidance, with the aim of informing rapid appraisal of the evidence to enable informed decisions for public health and local authority decision making for the provision of local stop smoking support. A summary of these details follow in the next section.

[49] https://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf

[50] https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2018-to-march-2019

[51] "Models of delivery for stop smoking services. Options and evidence" PHE, 2017 https://www.gov.uk/government/publications/stop-smoking-services-models-of-delivery

7. Evidence base and best practice guidance

7.1. Public Health England "Models of delivery for stop smoking services – Options and Evidence" 2017

This document outlines details of interventions that may be included in the package of support offered by local stop smoking services.[52] Table 1 below summarise the ranking of the interventions.

7.1.1. Table 1: Ranking for stop smoking service interventions

Scoring A (Strong evidence base)	Scoring B (Some evidence base)	Scoring C (Limited evidence base)
• Face to face group support with pharmacotherapy • Face to face individual support with pharmacotherapy • Supported use of pharmacotherapy • Telephone support	• Text message support • Online	•Mobile digital applications

In addition to the intervention, consideration needs to be given to the models of service delivery commissioned. The preferred approach should be to ensure those in priority populations are offered and can easily access effective support (i.e. behavioural support and medication) to maximise reductions in smoking prevalence and health inequalities.
These may include:

- pregnant women
- people with mental health problems
- routine and manual workers
- those with long term conditions[53]

Locally people who use substance misuse services are a priority group, as part of improving respiratory health to reduce drug-related deaths, as well as reduce health inequalities. People who are unemployed also have high rates of smoking and are important locally.

The intensity of support offered is an important factor and this should be sufficient to address the needs of the population so as to have the required impact. The options and evidence conclude that if commissioning intensive behavioural support is not possible, a minimum service offering smokers access to medication and support with appropriate use should be made available.
Table 2 below summarise the Stop Smoking service models and recommendations for commissioning.

[52] "Models of delivery for stop smoking services. Options and evidence" PHE, 2017 https://www.gov.uk/government/publications/stop-smoking-services-models-of-delivery
[53] "Models of delivery for stop smoking services. Options and evidence" PHE, 2017 https://www.gov.uk/government/publications/stop-smoking-services-models-of-delivery

7.1.2. Table 2: Summary of stop smoking service models

• 1) Universal evidence-based service with specialist behavioural support and pharmacotherapy over (at least) a six week period, available for all smokers to access. (If funds are not available for a full universal offer, then consider offering this level of quality service to priority groups.) ***Recommendation:*** Will provide the best quality outcomes. E.g. all smokers are supported by a NCSCT standard trained practitioner to achieve a CO validated 4 week quit.
• 2) Stop Smoking +: a proposed new model for stop smoking services, with the aim of maintaining provision of a cost effective support for quitting, provided in a way that ensures priority groups are offered the most intensive and effective interventions. 3 levels of service: ○ Evidence based specialist support for smokers who need it and are willing to make the necessary commitment – needs to be targeted to the priority group of smokers to ensure no inequality or inequity. ○ Brief support and stop smoking medicine for those who want to quit but not willing to commit to a specialist course. ○ Self-support for those who to stop but do not want professional support. ***Recommendation:*** Has the potential to achieve efficiencies in targeted groups but has not yet been fully evaluated.
• 3) Integrated Lifestyle/ wellbeing services: a) Dedicated specialist stop smoking support within umbrella organisation, which can be targeted to specific groups. ***Recommendation:*** Assuming quality of intervention is maintained, outcomes similar to model 1 can be expected, but has not yet been fully evaluated. b) Multi –behaviour change interventions – addressing multiple risky behaviours concurrently. ***Recommendation:*** This approach is not found to be effective or cost effective in successfully supporting smokers to stop.
• 4) Pharmacy only services (delivered by pharmacist or pharmacy assistant) ***Recommendation:*** While these interventions can be successful if staff are trained in line with model 1 quality outcomes, the numbers accessing the service can be limited and may not target priority groups.
• 5) Hospital “in-house” stop smoking services. Jointly commissioned services for pregnant women, smokers with mental health conditions and those with long term conditions. ***Recommendation:*** This can make an important contribution to the sustainability of local health and social care services and can reduce inequalities.

NICE guidance recommends that local services should aim to treat around 5% of their smoking population each year with a success rate of at least 35%.

7.2. Reviews of effectiveness of integrated health services

Since 2011-12 attendance at stop smoking services has been declining nationally. This has prompted some localities to look at new models of delivery which address a variety of unhealthy behaviours within a 'lifestyle service'.

Public Health England published the "Health Economics Evidence Resource", 2019[54] and provides a collection of the economic evidence underpinning public health interventions, with over 60 examples referring to smoking cessation and tobacco control.

In a 2017 review of models,[55] where a variety of risky behaviours were addressed in combination found that, whilst this approach may show promise for addressing behaviours such as poor diet and physical inactivity, they have not been effective at helping people to quit smoking, particularly among the most vulnerable smokers prioritised within this plan.

In 2016, NCSCT published "Integrated health behaviour (lifestyle) services: a review of the evidence"[56] which summarised that health behaviours putting people at risk of increased morbidity and mortality tend to cluster together. While there is some evidence to support multiple risk behaviour interventions that target poor diet and physical inactivity, there is little evidence that targeting tobacco use in this manner is either effective or more cost-effective than single risk behaviour interventions. The evidence reviewed suggests that smoking should be targeted in isolation. In addition, it appears that smoking cessation interventions by themselves are more cost-effective than multiple risk behaviour interventions

7.3. "The End of Smoking" 2019, Department of Health and Social Care [57]

The report offers a brief guide for local authority members and officers and their partners on Health and Wellbeing Boards, highlighting how the smoking epidemic continues to cause immense harm to individuals, families and communities throughout England and exacerbate inequalities. Importantly, it recognises the timely opportunity to review tobacco control strategies and smoking cessation provision, building on public health being embedded within local authorities, the STP/ICS opportunities for collaboration and population-based strategies. Included are the potential for reducing inequalities in smoking prevalence through the NHS Long Term Plan. The report outlines public support, with a survey in 2019, where,
"77% of adults in England felt that what the government was doing to limit smoking was 'about right' or 'not enough' while only 7% thought the government was doing 'too much'."

Currently only 30% of smokers per year make a serious attempt to quit. Most of these are unsuccessful. So only 5% of smokers successfully quit each year. Of these successful quitters:

- 2% quit through stop smoking services
- 8% get some professional advice and use medication
- 14% use nicotine replacement therapy they bought at a pharmacy
- 35% succeed on their own without any help
- 41% use an e-cigarette

[54] Health economics evidence resource tool. Last updated July 2019: https://www.gov.uk/government/publications/health-economics-evidence-resource
[55] Tobacco Control Plan for England, 2017. https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england
[56] 2016, NCSCT published "Integrated health behaviour (lifestyle) services: a review of the evidence"
[57] *"The End of Smoking" 2019, Department of Health and Social Care*

While these numbers primarily reflect the volume of people who try these approaches, not the effectiveness of the methods themselves, specialist stop smoking services are easily the most effective approach to quitting smoking (three times as effective as trying on your own) but they are used by comparatively few smokers, and those smokers who do use them tend to be the most addicted and so struggle to quit even with the best possible support.

Happily, the most common quitting method used by smokers is no longer the least effective, as more people now use e-cigarettes than try without any help.

Stop smoking services are an essential service, especially for disadvantaged and highly addicted smokers and are also cost effective. But 98% of smokers currently do not use them. Increasing footfall to these services is important but, to end the epidemic, it is vital that the needs of the other 98% are considered as well.

"The End of Smoking", highlights where local strategies should focus and lists three key components for local smoking prevalence reduction:

- Reducing uptake
- Increasing the number of quit attempts among current smokers
- Improving the success of quit attempts and preventing relapse

The report suggests that local plans should include activity in each of these areas to ensure appropriate support is reaching all smokers in the local population, and not just those engaging with formal services.

7.4. Cochrane review October 2019 on Relapse prevention interventions for smoking cessation

The evidence found did not support the use of behavioural treatments to help prevent relapse after quitting smoking. This result was the same in all the different groups of people studied. The most promising treatments involved extending treatment with stop-smoking medicine, in particular, varenicline. Extending treatment with bupropion did not appear to help and there was not enough evidence on extending treatment with nicotine replacement therapy. [58]

7.5. Evidence around e-cigarettes

This needs assessment is focussed on cessation services rather than technologies. Briefly, Public Health England reviews the international research on e-cigarettes each year[59] [60]. Current guidance is that they are 95% safer than tobacco. The World Health Organisation has just released a statement that interprets the evidence differently and they advise that only NRT, behavioural support and other interventions proven to be safe are used by smokers wishing to smoke. [61]

E-cigarettes are not yet regulated as a medical device. Furthermore, they are costly for consumers to buy and are mostly produced by tobacco companies. While nicotine addiction is not seriously hazardous to health, it does impede sleep, mood and appetite. Using e-cigarettes can be a source of social exclusion. Smokers are better stopping smoking through safer means. Smokers using e-

[58] Livingstone-Banks J, Norris E, Hartmann-Boyce J, West R, Jarvis M, Chubb E, Hajek P. Relapse prevention interventions for smoking cessation. Cochrane Database of Systematic Reviews 2019, Issue 10. Art. No.: CD003999. DOI: 10.1002/14651858.CD003999.pub6.
[59] https://www.gov.uk/government/publications/vaping-in-england-an-evidence-update-february-2019/vaping-in-england-evidence-update-summary-february-2019
[60] https://www.gov.uk/government/publications/e-cigarettes-and-heated-tobacco-products-evidence-review/evidence-review-of-e-cigarettes-and-heated-tobacco-products-2018-executive-summary
[61] https://www.telegraph.co.uk/science/2020/01/21/world-health-organisation-e-cigarettes-harmful-health-not-safe/

cigarettes to stop smoking would ideally only use them for a short time. Non-smokers are not advised to use e-cigarettes.

8. Stakeholder Insights

•Methods

Phase 1 of the stakeholder engagement was conducted through one to one or group discussions with those that have an interest in smoking cessation provision in the city. Stakeholders were asked their views on current smoking cessation provision and what interventions might be appropriate in the future with limited public health funds. In addition to individual or group stakeholder discussions, a survey was circulated to various stakeholder groups including individual residents, health care professionals and employers, to gather views on how the council should use resources to improve the public's health. Primary care staff had an additional opportunity to contribute at a Target event

•Who was consulted?

Stakeholders included service managers, hospital consultants, primary care staff, commissioners, occupational health staff, councillors, third sector staff and managers and the general public.

•Results

Stakeholder comments fell into two broad categories:

A. Wider public health approaches:

- *Citywide vision for smokefree Southampton*

A strong recurring theme outlined the need for this approach following the de-commissioning of the previous service and to repair the damage this has done. A clear identity such as "Smokefree Southampton" brand was felt to be important to identify with and recognise across all services delivering tobacco control initiatives including smoking cessation. Strong PR and communications plans are needed along with a clear tobacco control strategy and action plan with widespread sign up from SCC, NHS and local organisations.

- *Primary prevention*

Population wide messages that discourage adults from starting to smoke and equip children and young people to resist the pressure to start smoking through school and non-school settings. Smokefree places such as NHS Trusts, workplaces and smokefree city zones with the possibility of sanctions.

- *Targeting well smokers with information and facts*

Developing the workforce across the city but within SCC and NHS to deliver MECC/VBA stop smoking interventions at every opportunity.

B. Targeted interventions supporting smokers to stop:

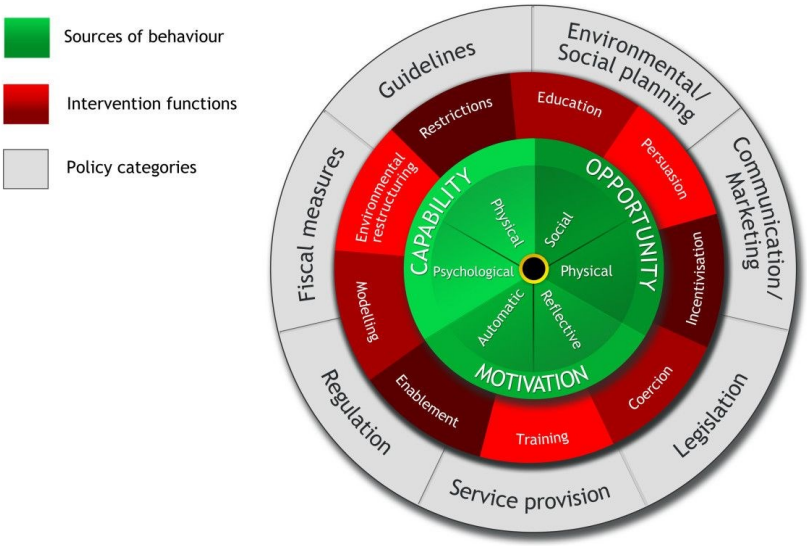
- Be clear about what we're not providing with intelligent commissioning and quality assurances in place
- Proportionate universalism approach
- Mixed model with care personalised, cost effective evidence-based interventions embedded into existing services.
- Led by local data to target vulnerable groups or whole communities E.g. Pregnant women, unemployed, LGBT and local communities
- Consider language and cultural barriers
- Identify new services to work with such as social prescribers and community navigators

- A small number of people requested a return to the standalone single point of access provide by SHL however a far larger number felt a mixed model approach with locally embedded services way the preferred way forward.

Phase 2 included feedback from the recommendations via the original forums and the suggested model of delivery. As a result of comments, further discussions were held with two local GP's and key stakeholders to refine the recommendations and options.

8.1. COM-B Behaviour Change Wheel

The behaviour change wheel is an evidence-based behaviour change framework developed by Michie et al and recommended by Public Health England and others. It shows that people need the capability, opportunity and motivation to change. It also shows that individuals cannot change their behaviour in a vacuum. We need a range of other interventions at a social and economic level. Michie et al noted that a target behaviour is part of a system and single intervention may have consequences for other parts of the system which may work for or against a sustainable change. [62]



9. Cost –effectiveness of Tobacco Control

CRUK state that; *"Stopping smoking is the best thing an individual can do for their health, and comprehensive tobacco control is the best thing a local authority can do for public health."*[63]

ASH estimate that smoking in Southampton costs society approximately £56m per year, this is a combination of £10.8m to the NHS, £41m potential wealth lost from the local economy as a result of lost productivity, £3.2m in additional social care costs from smokers and £1.1m in costs to fire and rescue services responding to house fires caused by cigarettes. [64]

[62] Michie, S., van Stralen, M. M., & West, R. (2011). The behaviour change wheel: a new method for characterising and designing behaviour change interventions. *Implementation science : IS*, *6*, 42. doi:10.1186/1748-5908-6-42

[63] https://www.cancerresearchuk.org/sites/default/files/economic_case_for_local_investment_in_smoking_cessation_printed_version.pdf

[64] https://ash.org.uk/ash-ready-reckoner/

According NICE, every £1 spent on smoking cessation saves £10 in future health care costs and health gains. [65] Smokers who manage to quit reduce their cost to the health and social care system by almost 50%.[66]A tobacco control strategy is therefore a long-term investment.

Specialist Stop Smoking Services been shown to be highly effective in improving long-term quit rates, offering smokers the best possible chance of quitting. Smokers who use these services are around three times more likely to successfully quit than those attempting to quit unassisted.[67] NICE PH10 guidance sets out recommendations to ensure that these services are as effective as possible.

Moreover, these specialist interventions have been shown to be among the most cost-effective interventions available in the healthcare sector: it is estimated that behavioural support and pharmacotherapy cost less than £6,000 per QALY (Quality Adjusted Life Years), well below the NICE 'cost-effective' threshold £20,000 - £30,000 per QALY.[68]

10. Conclusion

This review has focussed on the national guidance and local priorities for reducing the smoking prevalence rates in Southampton. It has addressed the need for individual support to stop smoking and the wider public health population campaigns. Smoking cessation is just one of Southampton City Council's tobacco control work streams. The recommendations of this review are made in the context of national policy for a Smokefree Southampton by 2030.

While smoking prevalence has improved significantly over the years, the smoking rates have remained stubbornly higher amongst those in our society who already suffer from poorer health and other disadvantages. Half of all life-long smokers nationally will die prematurely, typically 10 years earlier than people like them who do not smoke.

In Southampton, an estimated 1,032 people aged 35+ died due to smoking during the 3 years from 2016-2018. This includes an estimated 399 deaths from chronic obstructive pulmonary disease (COPD), 368 from lung cancer, 101 from heart disease, 31 from oral cancers, 24 from stroke and the remaining 109 from a range of other cancers and other conditions.

Historically, Southampton had a specialist stop smoking service, Southampton Quitters, which was funded by the public health grant and was commissioned to deliver a universal specialist stop smoking service. The replacement integrated service, Southampton Healthy Living, while effective in some lifestyle behaviour change, did not achieve the smoking cessation targets set. This confirms the national research evidence which reveals that generally integrated services perform poorly in terms of smoking cessation.

With the new direction for smoking cessation being driven by the Long-Term NHS Plan and the government's Prevention Green Paper, a more targeted and focussed approach for interventions are being recommended. The interim period, following the decommissioning of SHL, has provided the opportunity to explore and pilot some of these ideas. The new maternity led service has been established and while it's too early to tell, with little robust data available yet, the initial outcomes appear positive and in line with national aspirations to develop a smokefree pregnancy pathway.

[65] 12Public Health England. Comprehensive local tobacco control: why invest?
[66] http://www.nta.nhs.uk/uploads/t-jsna1516example.pdf
[67] Kotz, D., Brown, J., West, R. (2014). 'Real-world' effectiveness of smoking cessation treatments: a population study. Addiction. 2014 Mar;109(3):491-9. doi: 10.1111/add.12429. Epub 2013 Dec 20.
[68] Shahab, L. (2014). Effectiveness and cost-effectiveness of programmes to help smokers to stop and prevent smoking uptake at local level.

Continuing with this investment, over the coming year, along with careful support and monitoring will enable better evaluation.

The planned smoking cessation support for the Lung Health Check pilot (February 2020 to March 2021) to be provided through the UHS respiratory team, is another way of embedding the new approach. Excellent examples from the Manchester CURE and Ottawa models provide the evidence base for these and other acute service approaches.

Similarly, with more than 15 pharmacies trained and 8 already offering a smoking cessation service, this model enables a universal offer to Southampton residents while also developing Healthy Living Pharmacies in line with the new pharmacy contract for April 2020.

Typically, people with mental illness or learning disability, were not regularly contacting SHL for stop smoking support. While we are unable to identify the specific reasons for this, it is more likely to be about accessibility of the service than inability to work with the client group. Data shows that nationally, these groups have a higher smoking prevalence and poorer health as a result. The recommendations suggest that embedding stop smoking support would be beneficial to the clients while in line with national guidance.

Equally, supporting our drug and alcohol teams to offer smoking cessation to their clients is another recommendation and a way of targeting the resources where the greatest need is.

The strong evidence base for a specialist stop smoking service and the value of that expert skill and knowledge, is the rationale for including a small, core team who can offer that expertise, training and quality assurance to the wider workforce. In addition, this specialist service would be well placed to coordinate the wider public health campaigns across the city, in a comprehensive way, promoting the aspirations of a smokefree city, which is a vision held by many.

11. Recommendations – preferred options

As a result of the single point of access service, SHL, being de-commissioned, this year has provided the opportunity to commission a small mixed model of delivery which offers increased personalisation and choice for local people. The consensus from the stakeholder engagement was for broader more locally delivered support which reflects the strategic direction of local and national transformation plans. Following a needs assessment of the local population, a review of the evidence and national guidance several recommendations can be made:

- **Core specialist service**
    - Explore the potential for developing a small specialist stop smoking service to focus mainly on training, campaigns, clinical supervision, operational advice, monitoring, quality assurance, advice and expertise across the city. The intention would be to develop and support other settings to deliver cessation, while seeing a small number of clients where gaps are and to maintain skills. The service's primary purpose is to enable other services to deliver smoking cessation support, in line with the NHS Long Term Plan. The service will prioritise support to the priority groups in the first instance and any other groups with significant health inequalities.
    -
- **Pharmacy**
    - To continue to support and develop the existing stop smoking support in local pharmacies offering free behavioural support and NRT

- To provide ongoing training and CPD to all pharmacy staff involved through a Smoking Cessation Practitioner Network.

- **Maternity Services, UHS**
  - Continue with the Maternity Services Smoking Cessation Plan for the short, medium and long term, with regular monitoring of progress and impact.
  - Continue to assess the ongoing research and evidence of effectiveness into offering "incentives" to pregnant women to stop smoking, consider a pilot within the city.
  - Review the evidence available outlining the role of Health Visitors in supporting pregnant women and their families, post-natal, to remain smokefree, consider a pilot within the city.
  - Support the Family Nurse Practitioners in their role with young pregnant women, encouraging buddying with local pharmacies and exploring easier access to NRT, possibly through direct supply/PGD.
  - To provide ongoing specialist training and CPD to all midwifes involved.
  - Support the service to help any staff to stop smoking through the Occupational Health Service

- **UHS, services other than maternity**
  - Support UHS to deliver their STP commitment to be Smokefree
  - Support UHS to prepare to deliver develop hospital based smoking cessation services based on the Ottawa and Manchester CURE models, in line with the NHS Plan and Green Paper.
  - Lung Health Checks – continue working with the Lung Health Check pathway and evaluate the offer of stop smoking support and NRT to smokers who attend for a screening appointment.
  - Support UHS to ensure all their staff involved in smoking cessation have ongoing training and CPD, including by being able to attend a local smoking cessation practitioner network.
  - Support UHS to offer smoking cessation to their staff, through the Occupational Health Service

- **Mental health/ Learning disability services**
  - In line with the NHS Plan and Green Paper work with the specialist mental health services for long term users of specialist mental health and in learning disability services to embed a universal smoking cessation offer for their service users.

- **Drug and alcohol services**
  - Work with current service providers so they can support service users (and staff) to stop smoking. This is part of the local drug-related death action plan, as smoking impairs respirator health which makes people who use drugs more vulnerable to premature death. Also, neurological addictions research shows people with alcohol problems find it easier to recover if they also stop smoking. Clearly, the other smoking-related benefits outlined in this report are relevant too.

- **Primary Care**
  - To explore the options for primary care services to offer smoking cessation support

- **Other services**
  - To explore the potential for NHS services such as Dentists and Opticians to offer brief advice and referrals for smoking cessation support. This would include VBA/MECC training and resources.
  - To explore the potential for services such as social services, housing, planning and safeguarding to offer brief advice and referrals for smoking cessation support. This would include VBA/MECC training and resources.

- **Communications**
  - Continue with the campaigns programme for national awareness days such as World No Tobacco Day, No Smoking Day and Stoptober, exploring a wider Smokefree Southampton branding option.
  - Develop public health campaigns (working across STP) targeting women on healthy lifestyles for pre-conception and during pregnancy.

- **Tobacco Control plans, building on work that's already begun:**
  - Develop a new plan for smoking cessation
  - Develop a new plan for smoke free places – particularly around young people e.g. schools, parks, sports clubs
  - Develop a new plan for preventing young people from starting
  - Continue illicit tobacco plan (enforcement of underage sales, illicit tobacco)
  - Develop corporate responsibility work. To include a new steering group(s).
  - Develop a tobacco control scorecard of key indicators with annual reporting to the Health and Wellbeing Board[69].

[69] Smoking cessation is already a work-stream of the Prevention and Health Inequalities Group. Smoking is a priority of the Health and Wellbeing Strategy (2017-25). https://www.southampton.gov.uk/images/health-and-wellbeing-strategy_tcm63-391952.pdf