Smoking and Tobacco

JSNA Report

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Authorised for publication by Matthew Ashton, Director of Public Health

This report

This report has been prepared jointly by Knowsley Council, Knowsley Clinical Commissioning Group (CCG) and partners of the Knowsley Health and Wellbeing Board (HWB).
Further information

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| Related Information | A Tobacco Control Plan for Knowsley 2014-17 |
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1. WHY SMOKING AND TOBACCO HARM REDUCTION IS IMPORTANT?

1.1 Health Risks and Harms

Smoking is the biggest cause of preventable ill health and premature death in England, causing health inequalities across the UK such as life expectancy. The health implications of smoking are substantial and people who smoke are more at risk of developing cancer (lung, mouth, lip, throat, liver, kidney, stomach and cervical) chronic obstructive pulmonary disease (COPD), other respiratory conditions and heart disease.

Smoking in pregnancy increases the risk of serious harmful outcomes for the unborn baby, including miscarriage, stillbirth, preterm delivery and low birth weight. Nationally it is estimated to cost the NHS between £20 million and £87.5 million each year to treat smoking-related complications in mothers and babies (0-12 months)\(^1\).

The effects of smoking in pregnancy continue to negatively impact on the health and wellbeing of babies after birth with an increased risk of Sudden Infant Death Syndrome, the child becoming overweight or obese, lower educational attainment, frequent illness and becoming a smoker in adulthood\(^2\).

Passive smoking (or second-hand smoke) can also have a harmful effect on the health of non-smokers, particularly children. The impact of passive smoking in children is greater owing to their smaller lungs and underdeveloped immune systems.\(^3\) As a result they have an increased risk of developing asthma, serious respiratory conditions such as bronchitis or pneumonia and middle ear infections. Unlike most adults, children have little control over their home environment, and are therefore generally unable to remove themselves from areas of passive smoke exposure. Children from socio-economically disadvantaged backgrounds are usually more heavily exposed to smoke than other children, potentially because of heavier smoking inside the family home and in other places visited by children\(^4\).

1.2 Prevalence

There are around 7.3 million adult smokers in England and more than 200 people a day die from smoking (approximately 80,000 people die each year) due to smoking related illness\(^5\), accounting for 16% of all deaths\(^6\).

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\(^1\) Godfrey C. et al. (2010). Estimating the costs to the NHS of smoking in pregnancy for pregnant women and infants. York: Department of Health Sciences, The University of York


\(^5\) Department of Health analysis on Annual Population Survey 2015 data.

1.3 Cost

Smoking costs the UK economy £14.2bn per year\(^7\). The cost to the NHS of treating smoking related illnesses is estimated to be £2.0bn per year, including the costs of hospital admissions, GP consultations and prescriptions. Further costs to the UK economy include:

- £3.8bn loss in productivity (premature deaths)
- £5.8bn cost to businesses of smoking breaks
- £1bn smoking related sick days
- £1.4bn social care costs of older smokers
- £258m cost of fires caused by smoker’s materials
- £111m passive smoking\(^8\)

Not only does smoking cost society, but there are high costs for individuals and their families. For example, a 20-a-day smoker of a premium cigarette brand spent around £3,600 a year on cigarettes in 2017\(^7\).

Smoking exacerbates poverty for a large proportion of children in the UK with around 1.1 million children - almost half of all children in poverty - estimated to be living in poverty with at least one parent who smokes. A further 400,000 of them would be classed as being in poverty if parental tobacco expenditure is subtracted from household income\(^9\).

2. WHO IS MOST AT RISK?

- **Gender** - Nationally, smoking prevalence is higher among men than women (17.7% of men compared to 14.1%), with men smoking more cigarettes than women (12.0 cigarettes compared to 11.0 per day)\(^10\).

- **Age** - Prevalence of smoking decreases with age after 34 years; 21% compared to 8% of those aged 65 years or over\(^11\). As people get older they are more likely to have stopped smoking partly due to ill-health and/or increased awareness of effect of smoking on the health and wellbeing.

- **Deprivation** - Smoking rates are much higher among less affluent communities, with 12% of adults in managerial and professional occupations smoking compared with 28% in routine and manual occupations\(^12\). Furthermore, 30% of unemployed adults were smokers compared to 16% of employed adults.

- **Ethnicity** - Smoking rates vary considerably between ethnic groups. For example, those adults from mixed ethnic backgrounds experience the highest levels of smoking whilst those whose ethnicity is Asian experience

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\(^7\) ASH: The Local Cost of Tobacco. ASH Ready Reckoner. v5.7 (30 Jan 2017).
\(^8\) ASH (2016) Smoking: the true economic cost.
\(^12\) ASH (2017). Smoking Statistics.
the lowest rate. Men had higher rates of smoking in all ethnicities when compared to females. Overall, smoking rates among ethnic minority groups are lower than the UK population as a whole.

Smokeless tobacco is used by some ethnic minority groups, particularly those from South Asia and most commonly in the Bangladeshi community. However, there are often issues of underreporting in ethnic minority groups\(^\text{13}\). It is also important to note, there are other ethnic groups that are invisible in the standard ONS classification of ethnicity which have their own cultural and social norms within which smoking may play a part.

- **Lesbian, Gay, Bisexual and Transgender (LGBT)** - More than a quarter of gay and bisexual men currently smoke compared to heterosexual men\(^\text{14}\). Lesbian, gay and bisexual people aged 16 years plus are more likely to be current smokers and less likely to have never smoked or have given up smoking than the general population\(^\text{15}\). A higher proportion of transgender people (32%) smoke cigarette’s regularly compared to lesbian, gay and bisexual people in general\(^\text{16}\).

- **Mental Health** - There is long standing evidence that smoking prevalence is substantially higher among people with mental disorders than in the general population\(^\text{17}\) and smokers with mental health disorders tend to be heavier smokers and more dependent\(^\text{18}\). The strength of this association tends to increase with increasing severity of mental disorder, with the highest prevalence of smoking is found among psychiatric patients\(^\text{19}\).

- **Prison and the Criminal Justice System** - Nationally around 80% of prisoners smoke compared with around 20% in the general population\(^\text{20}\), causing them to suffer marked health inequalities compared with the general population, both through active and passive smoking. Offenders are over-represented among deprived and socially excluded communities; however, smoking prevalence is much higher among prisoners than among lower socio-economic groups as a whole\(^\text{21}\).

- **Young People** - The initiation of smoking is associated with a wide range of factors including: parental and sibling smoking\(^\text{22}\), smoking by friends and peer group members\(^\text{23}\), ease of obtaining cigarettes, socio-economic status, exposure to tobacco marketing\(^\text{24}\) and depictions of smoking in films, television and other media\(^\text{25}\). Cheap tobacco use is increasing among young and disadvantaged smokers. Thus, tobacco industry pricing

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\(^\text{21}\) Reducing Smoking in Prisons Management of tobacco use and nicotine withdrawal.
appears to play a key role in explaining smoking patterns and inequalities in smoking.  

3. NATIONAL POLICY DRIVERS

3.1 Towards a Smokefree Generation: A Tobacco Control Plan for England

On 18 July 2017, the Government published a five-year Tobacco Control Plan, which aims to achieve the following objectives by 2022:\textsuperscript{27}

i. Reduce smoking rates from 15.5\% down to 12\% or less.
ii. Reduce the prevalence of 15 year olds who regularly smoke from 8\% to 3\% or less.
iii. Reduce the prevalence of smoking in pregnancy from 10.7\% to 6\% or less.

To achieve these ambitions a range of actions have been identified including:

- **Prevention first**
  - Ensure the effective operation of legislation such as proxy purchasing and standardised packaging designed to reduce the uptake of smoking by young people.
  - Support pregnant smokers to quit. National Institute for Health and Care Excellence (NICE) has produced guidance on how pregnant smokers can be helped to quit. Public Health England and NHS England will work together on the implementation of this guidance.

- **Supporting smokers to quit**
  - Provide access to training for all health professionals on how to help patients - especially patients in mental health services - to quit smoking.
  - NHS Trusts will encourage smokers using, visiting and working in the NHS to quit, with the goal of creating a smokefree NHS by 2020 through the 5 Year Forward View mandate.

- **Eliminating variations in smoking rates**
  - Promote links to "stop smoking" services across the health and care system and full implementation of all relevant NICE guidelines by 2022.
  - Support local councils to help people to quit by working with Directors of Public Health to identify local solutions, particularly where prevalence remains high.

- **Effective enforcement**
  - Maintain high duty rates for tobacco products to make tobacco less affordable.


Ensure that sanctions in current legislation are effective and fit for purpose, using lessons from HMRC’s work on sanctions to stop illicit tobacco.

### 3.2 Legislative Framework

- **Removal of Cigarettes from Vending Machines** - The Secretary of State exercised powers conferred by the Children and Young Person (Protection from Tobacco) Act 1991 to prohibit the sale of tobacco from an automatic (vending) machine in 2010\(^{28}\). This came into force on 1 October 2011.

- **Smokefree Legislation: The Health Act 2006** - Smoking has been prohibited by law in virtually all enclosed and substantially enclosed work and public places throughout the United Kingdom since July 2007. Smokefree legislation in England forms part of the Health Act 2006\(^{29}\).

  Under the Health Act, “substantially enclosed” means premises or structures with a ceiling or roof (including retractable structures such as awnings) and where there are permanent openings, other than windows or doors, which in total are less than half the area of the walls.

- **Increase in Minimum Age for Purchase of Tobacco** - From 1 October 2007, the minimum age for the purchase of tobacco was raised from 16 to 18 across England and Wales\(^{30}\).

- **The Display of Cigarettes in Shops** - The Secretary of State exercised powers conferred by the Tobacco Advertising and Promotion Act 2002 to prohibit the display of cigarettes and tobacco products in shops\(^{31}\). These regulations came into force on 30 June 2011. The original Act comprehensively bans the advertising and promotion of tobacco products including the use of brand-sharing and sponsorship of cultural and sport events.

- **Smokefree Legislation: The Children and Families Act 2014** - The Children and Families Act 2014, granted Royal Assent on 13 March 2014, gave the Secretary of State for Health powers to make private vehicles smokefree when carrying children under the age of 18\(^{32}\). This came into force on 1 October 2015.

- **The Standardised Packaging of Tobacco Products Regulations 2015**\(^{33}\) - These Regulations come into force on 20 May 2016 at which time the UK became the second nation in the world after Australia to introduce standardised packaging of tobacco products.

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29 Health Act 2006 (c.28) London: The Stationery Office.
All cigarettes and rolling tobacco sold in the UK will appear in standard packs with prominent health warnings by May 2017. Colourful, glamorous and stylish packs are no longer allowed.

3.3 NICE Public Health Guidance

The relevant NICE guidelines are cited below:

PH1 - Smoking: brief interventions and referrals
PH5 - Smoking: workplace interventions
PH10 - Stop smoking services
PH14 - Smoking: preventing uptake in children and young people
PH23 - Smoking prevention in schools
PH26 - Smoking: stopping in pregnancy and after childbirth
PH39 - Smokeless tobacco: South Asian communities
PH45 - Smoking: harm reduction
PH48 - Smoking: acute, maternity and mental health services

3.4 Illicit Tobacco

Illicit tobacco relates to illegal products such as cigarettes, hand-rolling tobacco or niche products (e.g. blunts and Shisha) that have been smuggled, bootlegged or counterfeit. The effects of this practice can have a serious effect on the community.

In 2015/16 HM Revenue and Customs estimated 13% of cigarettes in the UK market were illicit, and 32% of hand-rolled tobacco in the UK market were illicit. The tobacco tax gap, made up of the illicit markets in cigarettes and hand-rolling tobacco, was estimated to be £2.4 billion in 2015/16. Of this £1.9 billion was lost in tobacco duties and a further £0.5 billion in VAT. The cigarette tax gap was estimated to be £1.6 billion and the hand-rolling tobacco tax gap was estimated to be £0.8 billion34.

Illicit Tobacco is known to harm local communities in many different ways:

- It damages local businesses as they are being undercut by criminals selling illegal tobacco cheaply.
- Illicit tobacco is normally sold alongside drugs and other counterfeit goods.
- It brings criminal activity to the area, helping to fund crime and organised gangs.
- Illicit tobacco helps young people start smoking from an early age.
- It discourages people from quitting smoking.

Illegal cigarettes do not meet the ‘Reduced Ignition Propensity’ safety standard. Since 2011, all cigarettes sold in the UK have to be manufactured to meet this standard (British Standard EN 16156:2010 - Cigarettes. Assessment of the ignition propensity – safety requirement35) to ensure that cigarettes left

34 ASH (2017). Illicit trade in tobacco.
unattended go out quickly. Since illegal cigarettes are not manufactured legitimately, it cannot be determined if this safety standard is being adhered to thus increasing the risk of fires.

4. LOCAL POLICY DRIVERS

4.1 A Tobacco Control Plan for Knowsley 2014-2017

The main aims of the local plan are:

- To reduce adult prevalence by a minimum of 2.5% from a 2011/12 baseline of 27.6%.
- To reduce smoking in pregnancy by a minimum of 2.5% from a 2012/13 baseline of 23.8%.
- To maintain a rate of 10% or less of young people who regularly smoke.

Among the ten key objectives outlined to reduce smoking in Knowsley are:

- High level leadership and multi-agency working to tackle tobacco.
- Tackle new and emerging issues including legislation changes, e-cigarettes and plain packaging.
- Tackle cheap and illicit tobacco to reduce its accessibility.
- Increase smoking cessation support for workplaces with targeted work to reach routine and manual smokers.
- Increase the number of pregnant women supported to stop smoking.
- Develop partnership with secondary care providers to provide smoking cessation support to their staff and users.

This plan is currently being reviewed, however it is anticipated that the actions highlighted will continue to be implemented to increase smoking cessation, reduce the numbers of smokers and restrict access to illicit tobacco.

4.2 Strategy for Knowsley

The Strategy commits the Council and its partners to achieving the following goals by 2023:

- Attractive, sustainable neighbourhoods with a wide choice of housing and excellent community facilities.
- Vibrant and welcoming town centres
- Residents and local communities who are able to make positive lifestyle choices.
- High quality employment areas which help to drive economic growth in the Liverpool City Region.
- Narrow the gap in deprivation levels both between different parts of the Borough and between Knowsley and elsewhere.
4.3 2017-2020 Knowsley Council Corporate Plan Priorities

The vision of the plan is to make Knowsley a place where all children have the best start in life, where every family thrives and where all young people aim high and achieve their potential.

- Relevant priority: Maximise the Council’s contribution to the health and wellbeing of Knowsley residents.

4.4 2016-2020 Knowsley Joint Health and Wellbeing Strategy

The vision of the strategy is to work together for a healthier and happier Knowsley.

- Relevant priority: Promoting healthy living which includes smoking cessation.

5. THE KNOWSLEY PICTURE

Knowsley Summary

- Smoking prevalence among adults is significantly higher when compared to the North West and England.
- Within Knowsley, smoking prevalence ranges from 6.6% in Halewood North ward to 27.5% in Stockbridge ward.
- Smoking at the time of delivery continues to decline in Knowsley but remains above the North West and England.
- 79% of 11 to 15 year olds had never smoked and those that do smoke don’t do very often.
- 28% of 11 to 15 year olds had tried e-cigarettes, with 15% having used one once or twice.

5.1 Smoking in Knowsley

- Adult Prevalence - Smoking prevalence among adults in Knowsley is significantly higher when compared to the North West and the national average (20.5% compared to 16.8% and 15.5% respectively). However, the smoking rate among those in routine and manual occupation is similar to the North West and national rate\(^{36}\).

Overall Knowsley ranks the 4\(^{th}\) highest in the North West (Blackpool, Tameside, Manchester, and Knowsley), while among those in the routine and manual occupations, Knowsley ranks the 5\(^{th}\) highest (Blackpool, Tameside, Rochdale, Blackburn with Darwen, Knowsley).

\(^{36}\) Annual Population Survey (2016).
The 2015 Merseyside Fire and Rescue Service survey showed that within Knowsley, smoking prevalence ranges from 6.6% in Halewood North electoral ward to 27.5% in Stockbridge electoral ward, the latter being more than 4 times higher than the former. Out of 111 electoral wards in Merseyside, Stockbridge had the 2nd highest proportion of smokers whereas Halewood North had the 6th lowest proportion of smokers (Figure 1). This pattern broadly mirrors the level of deprivation at ward level.

- **Smoking during pregnancy** - Smoking in pregnancy has well documented detrimental effects on the growth and development of the baby and the health of the mother. Those who smoke during pregnancy are more likely to be younger, single, and of lower socioeconomic status, to drink alcohol or use other substances, and to have psychiatric comorbidities.37 38

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In line with regional trends smoking prevalence at the time of delivery continues to decline in Knowsley but has remained above the North West and England average. The prevalence in 2016/17 was 18.6% compared with North West and England averages of 13.2% and 10.8% respectively. Knowsley ranks the 3rd highest in the North West based on the 2016/17 figure.

Figure 2: Smoking at the Time of Delivery, 2007/08-2016/17
Source: NHS Digital

- **Electronic Cigarette Usage** - Action on Smoking and Health (ASH) estimates indicate that approximately 2.9 million adults (equivalent to 5.8% of the adult population) currently use e-cigarettes in Great Britain. Between 2010 and 2014 there was a rise in the number of current cigarette smokers who use e-cigarettes and traditional cigarettes, from 2.7% in 2010 to 17.6% in 2014. However, since 2014, this increase has slowed and seems to have plateaued but the proportion of ex-smokers using e-cigarettes continues to rise from 4.5% in 2014 to 9.5% in 2017.\(^{39}\)

According to the ‘ONS Adult Smoking Habits in the UK’ survey a higher proportion of men were current e-cigarette users (6.3%) compared with women (4.9%). The most common age group for men to currently use e-cigarettes was the 16 to 24 age group, whereas this was the least common age group for women. The most common age group for women who were current e-cigarette users was those aged 50 to 59. All other age groups showed that men were more likely to currently use e-cigarettes than women.

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\(^{39}\) ASH (2017) Use of e-cigarettes (vapourisers) among adults in Great Britain.
Both current and ex-smokers stated their main reason for using e-cigarettes was as an aid to stop smoking (50.1% and 48.2% respectively). The second most common reason for both groups was that they perceived e-cigarettes to be less harmful than cigarettes, however, the proportion of ex-smokers stating this reason was almost twice that of current cigarette smokers (35.2% and 18.1% respectively).

Furthermore, between 2014 and 2016, young people in the UK aged between 16 and 24 years saw the biggest rise in the use of E-cigarettes from 1.4% in 2014 to 5.8% in 2016 (Figure 3). There also appears to be a shift in the North West in younger people trying e-cigarettes ahead of real tobacco cigarettes, more so amongst males.

The proportion of 15 year olds in Knowsley in 2014/15 that had ever tried an e-cigarette was 16.1%, which was lower than the North West (2nd lowest in the North West) and similar to England. The percentage of 11 to 15 year olds who have ever tried e-cigarettes in Knowsley in 2017 was 28%, with 15% having used one once or twice.

The proportion of 15 year olds in Knowsley in 2014/15 that had ever tried an e-cigarette was 16.1%, which was lower than the North West (2nd lowest in the North West) and similar to England. The percentage of 11 to 15 year olds who have ever tried e-cigarettes in Knowsley in 2017 was 28%, with 15% having used one once or twice.

At the time of writing this report, there is no information available on estimated the prevalence of electronic cigarette among Knowsley adults.

- **Young People Prevalence** - In 2017, the majority (79%) of 11 to 15 year olds in Knowsley had never smoked, a 43% increase when compared to 2007 (55%). Of the 21% that had tried smoking in 2017, 13% had tried once or twice, again a reduction of 43.5% in the last 10 years.

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41 What about YOUth survey, 2014/15.
When students were asked how many had cigarettes they had smoked in the last 7 days, 95% said none, similar to 2007, demonstrating that those that do smoke at this age, don't do very often.

However, secondary school children are more likely to smoke the older they get, as smoking prevalence for year 10 pupils tends to be higher than year 8 prevalence for both boys and girls, and has been since 2004. Furthermore, secondary school girls are more likely to smoke than boys in years 9 and 10. Similar was found in the North West.40

Over half (55%) of those surveyed in 2017 stated that they did not have any people smoking indoors at their home, a decrease of 11.3% in the last decade. Of the 45% that did have someone smoking at their home in 2017, 22% said there was only one person smoking indoors42 (See Figure 4).

An increasing proportion of young people aged 14 to 17 from Knowsley had tried Shisha smoking in 2015; 25% compared to 13% of young people in 2013, the North West reported similar figures.

In the North West young people mostly get their cigarettes from friends or buy them in shops and off licences and they identified local shops as the main source of illicit cigarettes44. Nationally, less than 5% of children aged eight to 15 in England have smoked, the lowest level on record43, with the percentage stating that they first tried or started smoking at 13 or under continues to fall44.

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40 National Centre for Social Research, 2016.
5.2 Health Impact of Smoking on Knowsley Residents

Knowsley Summary

- Lung cancer incidence is significantly higher than the North West and England and has increased by 14.5% in the last 10 years.
- Although lung cancer incidence is higher for males, there has been a 4.3% reduction in the rate of new male cases compared to a 44.3% in females in the last 10 years.
- COPD prevalence is the 2nd highest rate in the North West and the 4th highest rate nationally.
- 2nd highest smoking attributable mortality rate in the North West.
- Lung cancer deaths account for 30.2% of all cancer deaths.
- Female lung cancer mortality rate has increased by 10.5% in the last 10 years compared to a 23.0% reduction in males.
- COPD accounts for almost half of all respiratory deaths.
- Female COPD mortality rate has increased by 36.7% in the last 10 years compared to a 34.0% reduction in males.

- Smoking related health conditions - The outcomes of the majority of smoking related illness in Knowsley are significantly worse than the regional and national average for the following:
  - Premature births (less than 37 weeks gestation)
  - Hospital admissions for asthma (under 19 years)
  - Smoking attributable admissions
  - Emergency hospital admissions for COPD
  - Lung cancer registrations
  - Oral cancer registrations

- Lung Cancer Incidence - Lung cancer is the third most common cancer in the UK\textsuperscript{45} and is more common in people living in the most deprived areas. Survival is higher in women than men at one- and five-years but similar at ten-years\textsuperscript{46}.

  Around 86% of cases of lung cancer are caused by smoking, and the link between tobacco and lung cancer was established more than 50 years ago.

  Between 2013 and 2015, there were 593 new cases of lung cancer in Knowsley, around 198 per year. This gave a rate of 156.05 new cases per 100,000 population, significantly higher than England (78.99), the North West region (99.80) and the Liverpool City Region (121.43).

\textsuperscript{45} Cancer Research UK, 2014.
\textsuperscript{46} Cancer Research UK, 2010-2011.
In the ten years since 2003/05, the incidence of lung cancer has increased by 14.5% in Knowsley, however increases have also been observed in all of the other comparator areas over this period (Figure 5).

The rate of lung cancer incidence for males in Knowsley was higher than it was for females in 2013/15 (159.94 new cases per 100,000 males compared to 152.17 new cases per 100,000 females). Although lung cancer incidence is higher for males than females in Knowsley, there has been a reduction in the rate of new male cases of 4.3% since 2003/05. In contrast, the rate of new female cases of lung cancer has increased by 44.3% over the same period. This pattern is replicated for other comparator areas.

- **COPD Prevalence** - Chronic Obstructive Pulmonary Disease (COPD) is the name for a group of lung conditions that cause breathing difficulties. It is a common disabling condition with high mortality. The main cause of COPD is smoking.

In 2016/17 prevalence of COPD in Knowsley was 3.5% the same as 2015/16, but a 6.0% increase since 2011/12. This was almost twice the rate across England (1.9%) and also higher than the North of England region as a whole (2.4%). Knowsley had the 2nd highest rate in the North West region out of 31 clinical commissioning group areas and the 4th highest rate nationally (out of 207 areas).

Among 26 GP practices in Knowsley, COPD prevalence ranges between 2.1% and 5.5%, the former remaining similar to national levels and latter being almost three times higher than nationally. This indicates the impact that historically high smoking prevalence rates in Knowsley has had\(^{47}\).

\(^{47}\) Quality Outcomes Framework, 2016/17.
**Smoking Attributable Mortality** - Smoking attributable deaths are the number of deaths per 100,000 population aged 35 or over and that are thought to be due to smoking. Each cause of death is ascribed a relative risk and these risks are applied to the deaths in a given population over a period of time in order to calculate the number of deaths attributable to smoking.

The smoking attributable mortality rate in Knowsley between 2014 and 2016 was estimated to be 464.5 deaths per 100,000 population. This was significantly higher than the North West region (330.6) and England (272.0) (See Table 1).

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<th>England</th>
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<td>Smoking attributable deaths from Heart Disease</td>
<td>33.0</td>
<td>26.5</td>
</tr>
<tr>
<td>Smoking attributable deaths from Stroke</td>
<td>10.9</td>
<td>8.8</td>
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Table 1: Smoking Attributable Mortality, 2014/16
Source: PHE Profiles

Knowsley had the 2nd highest smoking attributable mortality rate in the North West region in 2014/16 (out of 23 local authority areas). Local analysis estimates that 25.4% of all deaths in Knowsley between 2014 and 2016 for people aged 35 or over were attributable to smoking. In comparison, 19.0% of deaths in the North West region and 17.1% of deaths across the whole of England were attributable to smoking.

Although the methodology for smoking attributable mortality is relatively new and has only been calculated over eight time periods, there has been a 2.4% reduction in Knowsley between 2007/09 and 2014/16, which was a smaller reduction when compared to the North West and England (11.1% and 11.8% reduction respectively). Similarly, the gap between Knowsley and England has widened by 15.0% between during the same period (Figure 6).

![Figure 6: Smoking Attributable Mortality, 2007/09 to 2014/16](source: Local Tobacco Control Profiles, Public Health England)
• **Lung Cancer Mortality** - Lung cancer is the most common cause of cancer death in the UK, accounting for more than 22% deaths (CRUK, 2014). There were 428 deaths due to lung cancer in Knowsley between 2014 and 2016, 30.2% of all cancer deaths. Of these deaths, 112 were people under the age of 75. The rate for premature lung cancer mortality during 2014/16 was 60.9 deaths per 100,000 population, significantly higher than the rate across the whole of England (32.2) and the North West region (40.8) (Figure 7).  

![Figure 7: Under-75 Lung Cancer Mortality, 2002-04 to 2013-2015. Source: Office for National Statistics](image)

Although premature lung cancer mortality in Knowsley is relatively high, the rate of mortality fell by 8.7% between 2004/06 and 2014/16. Over the same period, the absolute gap between Knowsley's premature lung cancer mortality rate and that of England narrowed by 2.7% in those 10 years.

Premature female lung cancer mortality was 60.8 deaths per 100,000 females in 2014/16, an increase of 10.5% since 2004/06. Over the same 10-year period, premature male lung cancer mortality decreased by 23.0% and was 61.1 deaths per 100,000 males between 2014 and 2016.

• **COPD Mortality** - There were 355 COPD deaths in Knowsley between 2014 and 2016, of which 38% were under the age of 75 years. COPD accounts for almost half of all respiratory related deaths. The premature COPD mortality rate in Knowsley during 2014/16 was 38.9 deaths per 100,000 resident population.
Knowsley's premature COPD mortality rate was significantly higher than England (18.3) and the North West Region (25.2) in 2014/16 (Figure 8).

![Figure 8: Under-75 COPD Mortality, 2004/06 to 2014/16](source: Office for National Statistics)

In the 10 years between 2004/06 and 2014/16, the premature COPD mortality rate for Knowsley decreased by 2.5%. Over the same 10-year period, the absolute gap between Knowsley's premature COPD mortality rate and England's premature COPD mortality rate narrowed by 1%.

Premature female mortality from COPD was 45.4 deaths per 100,000 females in 2014/16, an increase of 36.7% since 2004/06. Premature male COPD mortality was lower at 31.6 deaths per 100,000 males in the same period, however this represented a reduction of 34% over the previous 10 years.

5.3 Cost of Smoking to Knowsley

Managing health and social care problems associated with smoking costs Knowsley approximately £50.3m each year including the following (Figure 9):

- Cost of social care for adults aged 50 or older due to smoking-related conditions: £5.1m.
- Cost of treating smoking-related diseases and passive smoking: £7.3m.
- Cost to local businesses due to loss of productivity associated with smoking-related sick days: £3.0m.

It is estimated 19% of households in England are below the poverty line and when the cost of tobacco is take into account 27% of household fall below the poverty line. In Knowsley 31% would fall below the poverty line when expenditure on tobacco is considered\(^{48}\).

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The following services are in place in Knowsley:

- Specialist Services
  - Knowsley Specialist Stop Smoking Service
  - Smoking Services for Expectant Families
- Intermediate Stop Smoking Services
- Opportunistic Brief interventions

Knowsley Stop Smoking Service

- The rate of residents setting a quit date in 2016/17 was the third highest in England.
- Knowsley has a (self-reported) - a quit rate of 46.0%
- Smokers in Swanside ward had highest quit rate of 59.5%, while those from Stockbridge ward had the lowest of 38.5%.

6.1 Overview

Under the Health and Social Care Act 2012 responsibility for commissioning stop smoking services resides with local authorities in England.

There are three levels of smoking cessation service in Knowsley:

- Specialist services (e.g. smoking cessation clinics)
- Intermediate services (e.g. in primary care and/or pharmacies)
- Brief interventions made opportunistically by any health professional

Recently the distinction between the specialist and intermediate services has narrowed due to both types of service offering similar range of interventions.
6.2 Specialist Services

- **Knowsley Specialist Stop Smoking Service** - The Specialist Stop Smoking Service is commissioned by Knowsley Public Health Department and provides a wide range of interventions for residents who need support to stop smoking. This includes one-to-one support, group sessions, home visits, telephone, text (Quit Buddy) and online support (Quit Online) services. Services are provided in a number of settings including clinics within community, workplaces, schools and GP practices and are delivered across Knowsley each week.

There are several referral sources into the service including; GP, the Knowsley Lifestyle Hub, hospitals and self-referrals.

- **Smoking Services for Expectant Families** - The Specialist Stop Smoking Service offers a range of support for pregnant women, their partners and other family members, with all pregnant women offered home visits.

To support pregnant women who wish to stop smoking and as part of the poverty reduction plan, a reward scheme is in place. Additionally, in conjunction with maternity services, the specialist service is implementing the babyClear scheme\(^\text{48}\) which is an evidence-based pathway for pregnant women smoking at the time of booking to improve their chances of quitting successfully.

6.3 Intermediate Stop Smoking Services

Trained pharmacy advisors provide smoking cessation support to clients who want to stop smoking. Pharmacies also provide nicotine replacement therapy voucher scheme services. The intermediate service is delivered by 26 Pharmacies across Knowsley.

6.4 Opportunistic Brief Interventions

Brief interventions are delivered by health professionals across Knowsley. The Specialist Stop Smoking Service provides brief intervention training for professionals including those working with voluntary sector organisations. Additionally, Public Health has commissioned Making Every Contact Count (MECC) training to support the provision of brief interventions in various settings.

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6.5 Performance of Stop Smoking Services in Knowsley

NICE PH10 recommends that local stop smoking services should:

- Aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year
- Aim for a success rate of at least 35% at 4 weeks, validated by carbon monoxide monitoring.

- **Access to services and quit rate** - Access to services is measured by number of smokers setting a quit date per 100,000 smokers (aged 16 or above). The rate of residents in Knowsley in 2016/17 setting a quit date per 100,000 was 10,614, the third highest in England50.

![Service performance at population level, 2016/17](chart)

At service level, 2,585 smokers in Knowsley set a quit date in 2016/17 with 1,190 of them remaining smoke-free at the end of 4 weeks (self-reported) - a quit rate of 46.0% and 815 remaining smoke-free at the end of 4 weeks (self-reported - confirmed by CO validation) - a quit rate of 31.5%. The 4-week quit rate in Knowsley has been consistently below the England average which has plateaued at around 51% since 2013/14 (See Figure 11).

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When looking at the quit rate in Knowsley by electoral ward, smokers in Swanside ward had highest quit rate of 59.5%, while those from Stockbridge ward had the lowest of 38.5%.
• 4-week quit rate among pregnant women - Figure 13 shows the trend for 4-week quit rate among pregnant women in Knowsley compared with North West and England. In 2016/17, the 4-week quit rate Knowsley was 41.7% which was lower than the previous year's achievement. Since, 2012/13 Knowsley's 4-week quit rate in pregnant women has increased by 6.4% compared to a decrease in the North West and England; 2.2% and 2.3% respectively.

![Figure 13: Trend for 4-week quit rate among pregnant women in Knowsley compared with North West and England (2012/13 to 2016/17)](chart)

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</thead>
<tbody>
<tr>
<td>Knowsley</td>
<td>39.2%</td>
<td>42.1%</td>
<td>40.0%</td>
<td>43.5%</td>
<td>41.7%</td>
</tr>
<tr>
<td>North West</td>
<td>41.7%</td>
<td>44.8%</td>
<td>44.8%</td>
<td>43.2%</td>
<td>40.8%</td>
</tr>
<tr>
<td>England</td>
<td>46.9%</td>
<td>47.2%</td>
<td>46.8%</td>
<td>45.4%</td>
<td>45.3%</td>
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</tbody>
</table>

6.6 Enforcement - Knowsley Trading Standards

Knowsley Trading Standards has the statutory responsibility for enforcing Government legislation on illicit tobacco. Knowsley Trading Standards, in conjunction with partners aims to:

• Disrupt and eliminate criminal organisations which deal in illegal and non-duty paid tobacco products.
• Assist local agencies and other key partners to thoroughly investigate the importation and distribution of illegal and non-duty paid tobacco products.
• Raise awareness of the harmful effects of tobacco products on young people, peers and the Knowsley community.
• Investigate and prosecute any person concerned in the sale or supply of tobacco products to any child.

Knowsley Trading Standards undertake a number of key responsibilities pertaining to tobacco control within the borough, including the sale of illicit tobacco, enforcement, and the provision of information and guidance to the public.
In 2016/17, Knowsley Trading Standards undertook a number of enforcement activities leading to seizure of many illicit products and prosecutions. The highlights include:

A successful prosecution for offences under Trade Marks Act 1994, The Tobacco and Related Products Regulations 2016, and The Standardised Packaging of Tobacco Products Regulations 2015 resulted in an individual being fined £1,000 for each of the 3 offences plus £1,740 costs (£1540 TS, £200 legal) and £200 victims surcharge, a total of £4,940 payable at £40 month.

The court also made forfeiture order for the goods:

- 3 x warnings issued to businesses contravening the Children and Young Persons Act 1933 and Tobacco Advertising and Promotion (Display) Regulations 2010 for offering and supplying cigarettes to 15 and 16 year old test purchaser.
- 7 x businesses inspected and found to have non-compliant e-cigarette liquids and devices and as a consequence the items were signed over to the Authority for disposal for breaches of the CLP Regulations, Food Imitations (Safety) Regulations 1989 and Trade Marks Act 1994.

These seizures were the result of intelligence-led enforcement visits to residential and business premises with support from Merseyside Police, Trading Standards North West Illicit Tobacco team and Wagtails who supply tobacco detection dogs.

7. **COMMUNITY, PATIENT & STAKEHOLDER VIEWS**

Over the last ten years, a great deal of research has been carried out with Knowsley smokers. Insights summarised in this section are taken from the following report:

- **Evidence and Engagement for Knowsley’s Stop Smoking Services (2013)** - Comments from GPs showed that they have a keen interest in the stop smoking services and would like to be kept up to date both on the progress of patients and on the achievements and outcomes of the service overall. Some GPs expressed an interest in becoming more involved via a Locally Enhanced Service (LES) contract.

It was evident that pharmacies are still interested in providing a stop smoking service, however they sometimes felt under-resourced and that there was a lack of support and training. This was perceived to have an effect on the quality of support they could provide for patients; an issue that had been highlighted to current providers by patients and reinforced by a number of comments made by service users.
Current providers of stop smoking services in Knowsley were highly knowledgeable about their patients and the best ways of engaging with them to provide support that met their needs. Their comments show them to be dedicated, enthusiastic with a clear passion for providing comprehensive and effective support for patients. This is reinforced by the overwhelmingly positive comments received from patients.

However, some providers identified the need for more effective partnership working between the individual providers. The overall priority of each service must remain on meeting the needs of the patient and helping them receive the support that is best for them, regardless of whether this is the service they have contact with or not. It was suggested that the willingness of some service providers to ‘share patients’ may be affected by the targets set by the commissioner and therefore this issue needed further attention.

Members of the public generally felt that service users need regular, non-judgemental emotional support and encouragement, which could be provided in the form of counselling and/or therapy. Help and support would need to be provided close to home (including the option of home visits), at convenient and accessible times and venues, and also be complemented by a choice of available medicinal products e.g. patches. It was commented that increased advertising of the support available and times/venues was needed.

Service users were highly complementary about the support they received from the stop smoking services. It is evident that providers have a thorough awareness of the needs of all their clients and are reactive and flexible enough to adapt to meet all their needs. The ability to provide a variety of support, tailored to individuals is clearly beneficial to patients and reflected in the consistently exceptional number of quitters achieved across Knowsley in recent years.
8. **EVIDENCE OF WHAT WORKS**

### Knowsley Summary

The National Institute for Health and Care Excellence (NICE) has developed guidance on the following:

- PH1 - Smoking: brief interventions and referrals
- PH10 – Stop smoking services
- PH5 - Smoking: workplace interventions
- PH14 - Smoking: preventing uptake in children and young people
- PH23 - Smoking prevention in schools
- PH26 - Smoking: stopping in pregnancy and after childbirth
- PH45 - Smoking: harm reduction
- PH48 – Smoking: acute, maternity and mental health services

A series of NICE Guidance provide the evidence-base for what works in smoking cessation.

- **PH1 - Smoking: brief interventions and referrals**
  - Evidence directly applicable to UK health care settings supports the efficacy of physician advice as a brief intervention for smoking cessation.
  - Evidence directly applicable to the UK supports the efficacy of nurse structured advice as a brief intervention for smoking cessation in primary care and community settings.
  - Evidence directly applicable to the UK supports the efficacy of nicotine replacement therapy (NRT) as part of a brief intervention for smokers wishing to make a quit attempt.

- **PH5 - Smoking: workplace interventions**
  - A variety of workplace intervention types, offered in the context of a localised smoking ban involving more intensive interventions produce higher success rates than less intensive interventions.
  - There is strong evidence that group therapy, individual counselling and pharmacological treatments all have an effect in facilitating smoking cessation in the workplace. There is also evidence that minimal interventions, including brief advice from a health professional, are effective.
  - Evidence shows that men and women were equally successful in achieving abstinence in workplace smoking cessation programmes. Important gender differences exist in smoking attitudes and behaviours - women had less confidence in their ability to quit and required extra stimuli in order to quit smoking.
  - Evidence shows that a key way that employers can encourage smokers to quit is by offering smoking cessation support. Such support is particularly important in the context of workplace smoking bans.
Evidence shows that making a variety of smoking cessation strategies available to employees may meet the needs of more employees and increase participation in workplace programmes.

While the addition of incentives does not appear to increase the quit rates of smoking cessation interventions in the workplace, there is evidence that such incentives do improve recruitment rates into worksite cessation programmes, which may lead to higher absolute numbers of successful quitters in the long term.

**PH10: Stop Smoking Services**

- Intensive interventions for smoking cessation through the NHS Stop Smoking Services appear to be effective in the short term; on average, over half of the clients setting quit dates through the services self-report as quit at 4 weeks.

- Intensive interventions for smoking cessation through the NHS Stop Smoking Services appear to be reasonably effective in the long term. On average, between 13% and 23% of the clients who self-report as successful quitters at 4 weeks through the services self-report as abstinent at 52 weeks – a long-term success rate that is broadly consistent with international findings.

- Intermediate interventions delivered by community advisers achieve self-reported cessation rates of between 34% and 45% at 4 weeks.

- Systematic review indicates that pharmacy-delivered interventions may have a positive effect on smoking cessation rates.

- Group interventions may produce higher Carbon Monoxide-validated quit rates at 4 weeks than one-to-one interventions.

- Systematic reviews provide strong evidence that smoking cessation interventions among inpatients can be effective in creating modest to substantial increases in Carbon Monoxide-validated smoking cessation rates up to 12 months in this population.

- CO-validated quitting success at 4 weeks did not vary by ethnicity. However, because of the small numbers of people from black and minority ethnic groups in the study, interpretation of their results is difficult.

- Evidence shows that between 23% and 51% of pregnant women self-report as successful quitters at 4 weeks through the NHS Stop Smoking Services. However, given the unique challenges that pregnant smokers face, the utility of 4-week quit rates as a measure of service effectiveness is questionable.

- Evidence shows that the NHS Stop Smoking Services have been effective overall in reaching routine and manual groups.

- A consistent body of evidence shows that people from routine and manual groups are less successful in quitting successfully (based on both self-report and CO validation) at 4 weeks than other smokers.

- Evidence shows that NHS stop smoking services are making a modest contribution to reducing smoking-related inequalities in health in England.

- Meta-analysis of the available international literature indicates that the most effective smoking cessation interventions in workplace settings are those interventions that have proven effectiveness more broadly.
• **PH14 - Smoking: preventing uptake in children and young people**
  o There is evidence that mass-media campaigns can prevent the uptake of smoking and also influence knowledge, attitudes and intentions of children and young people.
  o Prevention campaigns produced by the tobacco industry are less effective than anti-tobacco campaigns produced by tobacco control bodies and adolescents perceive tobacco industry sponsored advertisements less favourably and as less effective in reducing smoking than other smoking prevention advertisements. However, neither the industry sponsored nor other prevention advertisements seem to change adolescent's intention to smoke.
  o Increased exposure to anti-tobacco messages over time decreases intent to smoke and smoking initiation and increases negative attitudes towards the tobacco industry.

• **PH23 - Smoking prevention in schools**
  o There is evidence from meta-analysis of 27 randomised controlled trials showing a significant intervention effect for school-based intervention for preventing uptake of smoking among children.
  o There is moderate evidence indicating that multi-component interventions incorporating both school and community components (with or without an additional family component) are ineffective in preventing the uptake of smoking compared to usual education.
  o There is moderate evidence that ethnicity is an important predictor of smoking behaviour, such that white students were less likely to be smokers. Similarly, there is moderate evidence that the observed association between race and smoking behaviour depended on how the outcome was measured.

NICE made the following recommendations based on the existing evidence:

  o The smoking policy should support both prevention and stop smoking activities and should apply to everyone using the premises.
  o Information on smoking should be integrated into the curriculum.
  o Anti-smoking activities should be delivered as part of personal, social, health and economic (PSHE) and other activities related to health promotion in schools.
  o Anti-smoking activities should aim to develop decision-making skills and include strategies for enhancing self-esteem.
  o All staff involved in smoking prevention should be trained to do so.

• **PH26 - Smoking: stopping in pregnancy and after childbirth**
  o Evidence shows that cessation interventions reduce smoking in late pregnancy and reduce the incidence of low birth weight and pre-term births whilst increasing birth weight. Smoking cessation interventions used in early pregnancy can reduce smoking in later pregnancy by up to 6%.
There is good evidence that financial incentives for promoting smoking cessation in pregnancy are effective.

There is mixed evidence on the effectiveness of nicotine replacement therapy (NRT) for promoting smoking cessation in pregnancy.

There is good evidence on the effectiveness of self-help interventions for smoking cessation in pregnancy, although the extent of UK evidence is limited.

There is evidence that NHS Stop Smoking Services are effective in supporting pregnant women to stop smoking.

There is limited evidence about whether the form of delivery can affect the effectiveness of smoking cessation interventions for pregnant women.

There is good evidence that women in the UK under-report smoking during pregnancy and that carbon monoxide monitoring can aid in the identification of pregnant smokers.

There is moderate evidence that multi-component interventions that include free nicotine replacement therapies are effective in encouraging partners who smoke to stop smoking.

**PH45 - Smoking: harm reduction**

- There is moderate evidence that NRT is more effective than placebo in percentage reduction in cigarettes per day.
- There is strong to moderate evidence from studies looking at 50% or more point prevalence reduction in cigarettes smoked per day compared to baseline, that NRT, with or without a brief motivational interviewing component, is more effective than placebo.
- There is strong evidence from studies investigating smoking cessation in populations not looking to quit that NRT, with or without associated behavioural interventions, has a statistically significant effect.
- There is moderate evidence relating to patients undergoing elective surgery that nicotine patch versus placebo is effective in reducing post-operative smoking consumption, a statistically significant self-reported reduction was observed 30 days post-operation but this was not maintained at 6 months.

**PH48 – Smoking: acute, maternity and mental health services**

- Economic analysis shows that stop smoking interventions are cost effective for groups of secondary care service users. This includes: pregnant women, patients presenting at secondary care with chronic obstructive pulmonary disease (COPD) and cardiac conditions, pre-operative and general inpatients, and hospital employees.
- There is a lack of evidence on the effectiveness and cost effectiveness of interventions that aim to increase the uptake of stop smoking interventions in secondary care settings.
- There is a lack of evidence about the effectiveness of interventions to support temporary abstinence for people who use, work in or visit secondary care services.
- There was very limited evidence, particularly from the UK, on strategies for ensuring compliance with smokefree legislation and local smokefree policies.
9. **FUTURE CHALLENGES**

- Financial pressures could make it difficult to sustain the provision of stop smoking services based on the current service delivery model.

- Engagement with partner agencies especially schools, acute trust and primary care.

- Achieving and sustaining high quit rate at service level especially among pregnant women

- Electronic cigarettes: 2015 Public Health England evidence\(^{51}\) showed the use of electronic cigarettes can be effective in helping smokers quit successfully. The debate relating to its use as a quit is raging and local use would be influenced by national guidance.

- Sustaining decline in smoking prevalence: there has been a significant reduction in smoking prevalence in Knowsley over the years. However, there are indications both at local and national levels that the numbers of clients using stop smoking services has been declining. Reversing this downward trend would be a major challenge especially in the face of dwindling financial resources to support health promotion campaign and stop smoking services at local level.

- Identifying effective models of service delivery that meets the needs of the population in the face of rapid technological developments influencing how clients use services.

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