

NOTICE  
OF  
MEETING  
  
**HEALTH AND WELLBEING BOARD**

will meet on

**TUESDAY, 29TH MARCH, 2022**

at

**3.00 pm**

by

**VIRTUAL MEETING - ONLINE ACCESS AND ON [RBWM](#)  
[YOUTUBE](#)**

TO: MEMBERS OF THE HEALTH AND WELLBEING BOARD

COUNCILLOR STUART CARROLL (CHAIRMAN)  
HUW THOMAS (NHS) (VICE-CHAIRMAN)  
COUNCILLOR DAVID COPPINGER  
COUNCILLOR DONNA STIMSON  
HILARY HALL (EXECUTIVE DIRECTOR OF ADULTS, HEALTH AND HOUSING  
RBWM)  
KEVIN MCDANIEL (EXECUTIVE DIRECTOR OF CHILDREN'S SERVICES  
RBWM)  
TRACY HENDREN (HEAD OF HOUSING & ENVIRONMENTAL HEALTH, RBWM)  
CAROLINE FARRAR (EXECUTIVE MANAGING DIRECTOR FOR RBWM, CCG)  
JANE HOGG (FRIMLEY INTEGRATED CARE SYSTEM)

Karen Shepherd  
Head of Governance  
Issued: 21<sup>st</sup> March 2022

Members of the Press and Public are welcome to attend Part I of this meeting.  
The agenda is available on the Council's web site at [www.rbwm.gov.uk](http://www.rbwm.gov.uk) or contact the Panel Administrator **Mark Beeley** 01628 796345 / [mark.beeley@rbwm.gov.uk](mailto:mark.beeley@rbwm.gov.uk)

**Recording of Meetings** – In line with the council's commitment to transparency the Part I (public) section of the virtual meeting will be streamed live and recorded via Zoom. By participating in the meeting by audio and/or video, you are giving consent to being recorded and acknowledge that the recording will be in the public domain.

If you have any questions regarding the council's policy, please speak to Democratic Services or Legal representative at the meeting.

## AGENDA

### PART I

<u>ITEM</u>	<u>SUBJECT</u>	<u>PERSON</u>	<u>TIMING</u>	<u>PAGE NO</u>
1.	<u>APOLOGIES FOR ABSENCE</u> To receive any apologies for absence.	Chairman		-
2.	<u>DECLARATIONS OF INTEREST</u> To receive any declarations of interest.	Chairman		5 - 6
3.	<u>MINUTES/ACTIONS</u> To confirm the minutes of the meeting held on 18 <sup>th</sup> January 2022 and to consider any relevant actions from the meeting.	Chairman		7 - 14
4.	<u>UPDATE IN GENERAL PRACTICE</u> To receive an update from Huw Thomas.	Huw Thomas		Verbal Report
5.	<u>SMOKING CESSATION</u> To note the report.	Anna Richards/ Charlotte Fox		15 - 64
6.	<u>TERMS OF REFERENCE FOR THE STRATEGIC PARTNERSHIPS</u> To consider the report.	Hilary Hall		65 - 74
7.	<u>HEALTH AND WELLBEING STRATEGY PRIORITY FOCUS - CHAMPIONING MENTAL HEALTH AND REDUCING SOCIAL ISOLATION</u> To receive a presentation.	Hilary Hall/ Jayne Reynolds		Verbal Report
8.	<u>LOCAL OUTBREAK ENGAGEMENT BOARD AND COVID-19 UPDATE</u> To receive an update on the work of the Outbreak Engagement Board.	Hilary Hall		Verbal Report
9.	<u>UPDATE ON THE HOUSING STRATEGY AND THE HOMELESSNESS &amp; ROUGH SLEEPING STRATEGY</u> To receive an update on the strategies.	Tracy Hendren		To Follow

10.	<u>BETTER CARE FUND UPDATE</u>	Lynne Lidster/ Prince Obike	Verbal Report
	To hear an update on the Better Care Fund.		
11.	<u>FORWARD PLAN</u>	Chairman	-
	To discuss items which will be considered at a future meeting of the Board.		
12.	<u>FUTURE MEETING DATES</u>	Chairman	-
	<ul style="list-style-type: none"> <li>• Tuesday 12th July 2022 – 3pm - Zoom</li> <li>• Tuesday 18th October 2022 – 3pm - Zoom</li> </ul>		

## MEMBERS' GUIDE TO DECLARING INTERESTS AT MEETINGS

### Disclosure at Meetings

If a Member has not disclosed an interest in their Register of Interests, they **must make** the declaration of interest at the beginning of the meeting, or as soon as they are aware that they have a Disclosable Pecuniary Interest (DPI) or Other Registerable Interest. If a Member has already disclosed the interest in their Register of Interests they are still required to disclose this in the meeting if it relates to the matter being discussed.

Any Member with concerns about the nature of their interest should consult the Monitoring Officer in advance of the meeting.

### Non-participation in case of Disclosable Pecuniary Interest (DPI)

Where a matter arises at a meeting which directly relates to one of your DPIs (summary below, further details set out in Table 1 of the Members' Code of Conduct) you must disclose the interest, **not participate in any discussion or vote on the matter and must not remain in the room** unless you have been granted a dispensation. If it is a 'sensitive interest' (as agreed in advance by the Monitoring Officer), you do not have to disclose the nature of the interest, just that you have an interest. Dispensation may be granted by the Monitoring Officer in limited circumstances, to enable you to participate and vote on a matter in which you have a DPI.

Where you have a DPI on a matter to be considered or is being considered by you as a Cabinet Member in exercise of your executive function, you must notify the Monitoring Officer of the interest and must not take any steps or further steps in the matter apart from arranging for someone else to deal with it.

*DPIs (relating to the Member or their partner) include:*

- *Any employment, office, trade, profession or vocation carried on for profit or gain.*
- *Any payment or provision of any other financial benefit (other than from the council) made to the councillor during the previous 12-month period for expenses incurred by him/her in carrying out his/her duties as a councillor, or towards his/her election expenses*
- *Any contract under which goods and services are to be provided/works to be executed which has not been fully discharged.*
- *Any beneficial interest in land within the area of the council.*
- *Any licence to occupy land in the area of the council for a month or longer.*
- *Any tenancy where the landlord is the council, and the tenant is a body in which the relevant person has a beneficial interest in the securities of.*
- *Any beneficial interest in securities of a body where:*
  - a) *that body has a place of business or land in the area of the council, and*
  - b) *either (i) the total nominal value of the securities exceeds £25,000 or one hundredth of the total issued share capital of that body or (ii) the total nominal value of the shares of any one class belonging to the relevant person exceeds one hundredth of the total issued share capital of that class.*

Any Member who is unsure if their interest falls within any of the above legal definitions should seek advice from the Monitoring Officer in advance of the meeting.

### Disclosure of Other Registerable Interests

Where a matter arises at a meeting which **directly relates** to one of your Other Registerable Interests (summary below and as set out in Table 2 of the Members Code of Conduct), you must disclose the interest. **You may speak on the matter only if members of the public are also allowed to speak at the meeting** but otherwise **must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation**. If it is a 'sensitive interest' (as agreed in advance by the Monitoring Officer), you do not have to disclose the nature of the interest.

*Other Registerable Interests (relating to the Member or their partner):*

*You have an interest in any business of your authority where it relates to or is likely to affect:*

- a) any body of which you are in general control or management and to which you are nominated or appointed by your authority*
- b) any body*
  - (i) exercising functions of a public nature*
  - (ii) directed to charitable purposes or*

*one of whose principal purposes includes the influence of public opinion or policy (including any political party or trade union)*

### **Disclosure of Non- Registerable Interests**

Where a matter arises at a meeting which **directly relates** to your financial interest or well-being (and is not a DPI) or a financial interest or well-being of a relative or close associate, you must disclose the interest. **You may speak on the matter only if members of the public are also allowed to speak at the meeting** but otherwise **must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation**. If it is a 'sensitive interest' (agreed in advance by the Monitoring Officer) you do not have to disclose the nature of the interest.

Where a matter arises at a meeting which **affects** –

- a. your own financial interest or well-being;
- b. a financial interest or well-being of a friend, relative, close associate; or
- c. a body included in those you need to disclose under DPIs as set out in Table 1 of the Members' code of Conduct

you must disclose the interest. In order to determine whether you can remain in the meeting after disclosing your interest the following test should be applied.

Where a matter **affects** your financial interest or well-being:

- a. to a greater extent than it affects the financial interests of the majority of inhabitants of the ward affected by the decision and;
- b. a reasonable member of the public knowing all the facts would believe that it would affect your view of the wider public interest

**You may speak on the matter only if members of the public are also allowed to speak at the meeting** but otherwise **must not take part in any discussion or vote on the matter and must not remain in the room unless you have been granted a dispensation**. If it is a 'sensitive interest' (agreed in advance by the Monitoring Officer, you do not have to disclose the nature of the interest.

### **Other declarations**

Members may wish to declare at the beginning of the meeting any other information they feel should be in the public domain in relation to an item on the agenda; such Member statements will be included in the minutes for transparency.

**HEALTH AND WELLBEING BOARD**  
**VIRTUAL MEETING - ONLINE ACCESS AT 3.00 PM**

**18 January 2022**

PRESENT: Councillor Stuart Carroll (Chairman), Huw Thomas (Vice-Chairman), Councillor David Coppinger, Councillor Donna Stimson, Hilary Hall, Kevin McDaniel and Caroline Farrar

Also in attendance: Councillor Simon Bond, Councillor Simon Werner, Councillor Maureen Hunt, Councillor Gurpreet Bhangra, Councillor Samantha Rayner, Prash Patel, Edward Harrison and Prince Obike

Officers: Mark Beeley, Charlotte Littlemore, Becky Campbell and Anna Richards

**PART I**

281/15 **APOLOGIES FOR ABSENCE**

Apologies for absence were received from Neil Bolton-Heaton and Tracy Hendren.

282/15 **DECLARATIONS OF INTEREST**

The Chairman declared a personal interest as he was an independent healthcare consultant, infectious disease specialist and vaccines expert and he had formerly worked for Sanofi Pasteur. He was currently working as an adviser for the Vaccines Taskforce and Antiviral and Therapeutics Taskforce. Councillor Carroll declared this in the interests of full transparency and to highlight that should for any reason during the meeting, or indeed during future meetings, the Health and Wellbeing Board discussed anything directly related to Sanofi Pasteur's business he would abstain from the discussion and leave the room as required.

283/15 **MINUTES**

**RESOLVED UNANIMOUSLY: That the minutes of the meeting held on 2<sup>nd</sup> November 2021 were agreed as a true and accurate record.**

284/15 **PHARMACEUTICAL NEEDS ASSESSMENT**

Becky Campbell explained that the Pharmaceutical Needs Assessment (PNA) was a statutory responsibility of the Health and Wellbeing Board. It considered the pharmaceutical needs of the population on a 3 yearly basis, with the last one being carried out in 2018. Due to a delay with Covid, the next PNA had been pushed back but it was now planned to be refreshed by October 2022. In 2018, the PNA was done across Berkshire with each Health and Wellbeing Board having added into this collective piece of work. An external provider called Healthy Dialogues had been brought in to carry out the PNA and it would provide each local authority with their own statement of needs. The assessment would link in with work being done by the East Berkshire Public Health Hub which would be the check and balance to ensure that the process was carried out correctly.

A steering group had been created and had met twice already, the group consisted of a

number of people and was scheduled to meet every six weeks. The first task for the group was to gather feedback, a survey had been created and the questions to be asked had been agreed. The survey would go out to pharmacies, while the public would also be asked the questions. It was planned that the survey would be launched at the end of the month. Healthy Dialogues were also undertaking some work on targeted groups, for example older generations, those whose first language was not English, those in care, sheltered housing and younger generations were all examples. It was proposed that the first draft of the PNA would be ready for April 2022, after this there would be a 60-day consultation. The PNA could then be signed off by the Board in September 2022, ready for publication in October 2022.

The Chairman asked how the steering group planned to publicise and communicate with residents about the consultation period.

Becky Campbell said that Healthy Dialogues had put together a plan, working in partnership with the public health hub and the local authority communications leads. Each local authority would advertise the consultation using their own channels and Healthwatch were also going to help. A wide range of communication methods were planned to push the consultation out once it was ready.

Kevin McDaniel, Executive Director of Children's Services, asked how young people could get involved with the consultation.

Becky Campbell explained that Healthy Dialogues were keen to use current channels to engage with this age group, for example by using youth ambassadors.

Kevin McDaniel said that he was happy to be involved and investigate ways to help ensure that young people were aware and participated in the consultation.

**ACTION – Becky Campbell to contact Kevin McDaniel to discuss how young people could be more involved in the consultation on the PNA.**

Councillor Werner joined the meeting.

Anna Richards, Consultant in Public Health, suggested that the Board could be used to help reach the targeted groups that had been mentioned, she asked if there was an email contact for Healthy Dialogues.

Becky Campbell said that she was happy to pass on the contact details after the meeting.

**ACTION – Becky Campbell to provide Anna Richards with contact details for Healthy Dialogues.**

Anna Richards added that there would be two further updates from the PNA required to be considered by the Board, the draft assessment and approval from the Board once the PNA had been completed. She asked how this would fit in with the Board's schedule of meetings.

Becky Campbell said the PNA would need to be signed off by the Board in August or September 2022, so that it could be submitted by the start of October 2022. Officers could investigate closer to the time to see when it would be appropriate for the PNA to be considered by the Board.

## 285/15 HEALTH AND WELLBEING STRATEGY FOCUS

Kevin McDaniel gave a presentation and spoke about the third priority, which was to target prevention and early intervention to improve wellbeing. People were good at reacting to things that had happened because the impact could be seen, but less good at investing in preventing things from happening in the first place. There were three types of prevention;



primary, secondary and tertiary. For every £1 invested in prevention, the return could be around £14 saved across the rest of the healthcare system. Research showed that prevention was a long-term game, some benefits came through in a year or two, but it could be as long as 15-20 years before some benefits of prevention were seen after the initial investment had been made. Considering the RBWM Corporate Plan, two of the main objectives in the plan linked to prevention:

- Investing in prevention and intervene early to address problems before they escalated.
- Promoting health and wellbeing and focus on reducing inequalities across all areas.

Kevin McDaniel outlined the gap in expected progress at school between those children living with financial deprivation, compared to the rest of the cohort. There was early help available to young people, for example there was a 'starting well ambition' across the Integrated Care System which had funded community led projects for young people. Family Hub services had been refocused on hard to reach groups, while edge of care services provided help to families to allow them to deal with the pressures experienced in everyday life.

Prash Patel said that when looking to make patients lives better, it often started at the reactionary level. He felt that RBWM was ahead of the curve when it came to ensuring that prevention was a focus, the idea of getting prevention into communities would allow it to be more prosperous in the long term. It was clear where the problems were but it could often be difficult to achieve changes in these areas. Prash Patel considered the film Jaws, where the impact of the shark attacks on the community could have been prevented if a preventive approach had been taken, but this would not have been easy to do. Prevention was a leap of faith, long term goals meant that the outcome would not be known for a significant number of years. Broad stroke targeting had its place but Prash Patel felt that there needed to be innovation to discover the inequalities in communities and understand exactly what they needed. The council had the tools to look at these inequalities at a ward level and this would allow prevention to be implemented in the right areas. One particular issue in RBWM was the ageing population, who could be using resources in both primary and secondary care. If frail members of the community could be identified, interventions could be offered. This was currently being trialled in primary care. Other innovations included using opportunistic screening at vaccination centres across the borough. Prash Patel concluded by explaining that it was important for health leaders, clinicians, public health colleagues and local authority representatives to work together on prevention across the borough.

The Chairman said it was important to take an integrated approach to prevention, there needed to be a proactive approach. One example was the launch of mental health teams within RBWM schools. Prevention was a critical principle and it needed to be delivered as a core reality. An ageing population was a good thing but the health service needed to be aware of the additional resources that would be required.

Caroline Farrar, Executive Place Managing Director CCG, said that the Population Health Management Development Programme had two main objectives, accelerating changes to care delivery and advising the systems infrastructure. This would allow the CCG to take more preventive steps. Population Health Management was the practical arm of prevention, it was about using health data to work with local communities so that preventions could be designed and targeted effectively. The programme had currently one introductory session and would be resumed shortly, it had been paused over winter due to pressures on the service.

Ed Harrison said that there was an exciting opportunity to use the Population Health Management programme. Cycling lanes coming to Windsor could see improvements to the number of residents that chose to cycle, the council needed to ensure that things in the borough were easily accessible by bike. Smoking support was variable from each service, this was a crucial area of self-care. Self-care weeks and programmes were something that the primary care network was keen to engage in. Edward Harrison said that when he worked in Bracknell Forest, there was a self-care week which worked well and helped to raise

awareness.

Anna Richards said that the public health team had established a smoking cessation service in the borough, a health needs assessment had recently been taken around smoking to better understand what the needs of residents were. There was in general a low prevalence of smoking in RBWM, but in some communities it was higher and RBWM needed to support these individuals. Anna Richards said that she was happy to discuss the needs assessment with Edward Harrison.

The Chairman suggested that it would be good to have an item on smoking cessation at the next meeting of the Board.

**ACTION – Item on smoking cessation to be added to the agenda for the next meeting of the Health and Wellbeing Board.**

Councillor Stimson said that she in favour of partnerships between health and wellbeing, and sustainability and climate change. Looking at sustainable development goals, Councillor Stimson said that she would love to work with people in this area along with schools in the borough. There were so many issues with inequalities that many people did not realise.

Prash Patel said that targeting children in the right way was key. He was intrigued to know how communities could be motivated in the right way.

The Chairman suggested that different things needed to be tried. One example was around vaccine confidence, it was important to understand the reasons behind hesitancy which could often show a lack of trust for government institutions. The correct information and context could then be provided to encourage those to take up the vaccine and have confidence in coming forward. The Chairman suggested that a structured workshop could take place around the issue and could be discussed with Anna Richards and Hilary Hall.

**ACTION – Councillor Carroll to discuss the issue with officers and determine whether a structured workshop should take place to discuss the issue.**

Councillor Rayner agreed with the points that had been raised on cycling in the borough. The council was looking at how cycling could be improved, Councillor Rayner suggested that she could put Edward Harrison in contact with the relevant Cabinet Member and lead officer at RBWM to discuss his ideas. Councillor Rayner said that a healthy lifestyle should be encouraged in RBWM, there was a cycle hub run at the Swan pub in Windsor which ran local routes from the pub. She supported the idea of a workshop to explore these ideas further.

Prash Patel felt that this was a good outcome as a result of the discussion on this topic.

Anna Richards said that the impact of Covid had led to a number of good conversations with communities, which had not occurred prior to the pandemic.

## 286/15 SUICIDE PREVENTION STRATEGY

Anna Richards explained that this agenda item continued the theme of prevention, the Suicide Prevention Strategy was a Berkshire wide plan covering the period from 2021-2026. Councils had a responsibility to develop a plan and appropriate action plan.

Charlotte Littlemore, Public Health Programme Officer, explained that she had been representing RBWM at the steering group. There were a number of national strategy themes and principles, with the new strategy being a refresh of the previous strategy. A working group had been established within the steering group who had worked together to identify the key principles. The data underpinning the strategy had come from a variety of sources, including the Berkshire suicide prevention 2018 audit along with the impact of Covid on

mental health. Suicide rates in RBWM had been significantly below the national average, however since 2019 this rate has risen to be similar to the national average. The vision of the strategy was to reduce deaths by suicide in Berkshire and ensure better knowledge and actions around self-harm.

Charlotte Littlemore explained that suicide represented the extreme end point of mental ill-health, there were a number of people who experienced suicidal thoughts, self-harmed and attempted suicide that were not recorded in the figures. Self-harm was an area that the steering group wanted to explore, it was considered the strongest predictor of suicide and made up a number of hospital admissions. There had been a growing increase in female suicides, with a decrease in the rate of male suicide. Three key areas of concern were linked to female suicide; perinatal mental health, domestic abuse and parent or carer stress. Economic factors also needed to be considered and that those suffering were able to receive support. The final focus in the strategy was around those who had been bereaved by suicide. People who had been bereaved by suicide were at greater risk of suicide themselves and there was also an increase in self-harming. Charlotte Littlemore concluded by outlining some of the overall recommendations within the strategy.

The Chairman said it was vital that suicide was talked about openly and the strategy was in place to provide support to those who were at risk of taking their own life. Prevention was again a key focus which linked in with the previous agenda item.

Hilary Hall, Executive Director of Adults, Health and Housing, asked if there were any particular local issues and what was the RBWM response, as some things could be missed at the Berkshire wide level.

Anne Richards explained that the strategy was overarching and was a collaborative approach across Berkshire in terms of resources. The next steps for the steering group were to develop action plans for specific areas and consider the next steps for each local authority.

Charlotte Littlemore said that the strategy covered the period 2021-26 and there were therefore a significant number of recommendations included. The steering group agreed that there would be a reactive nature to the data as there was a time lag. A separate working group had been set up to see where actions could be taken forward with regard to the increased rates of female suicide. Work was being done closely with mental health services in the borough to understand any emerging themes.

Councillor Bhangra asked what more could be done to educate people on the role of the media and communications and how it linked to poor mental health.

Charlotte Littlemore said that the steering group had put communications on the agenda to be considered. The group was working closely with the Samaritans, it was a priority to take forward.

The Chairman suggested that the steering group should look to engage with local media and ensure that reporting is handled in the appropriate way. The role of social media could also lead to significant negativity, the government was looking to bring forward an online digital bill to deal with the issue. The Chairman also felt that internet providers should do more to prevent negative and harmful content being posted online.

**RESOLVED UNANIMOUSLY: That the Health and Wellbeing Board approved the Berkshire Suicide Prevention Strategy 2021-26.**

287/15 LOEB AND COVID-19 UPDATE

Hilary Hall said that the Outbreak Engagement Board had continued to meet monthly in public, with every meeting streamed live on the RBWM YouTube channel. There was a focus

on communications and engagement, it had been proving difficult to promote messages that still had an impact. With the Omicron variant, cases had increased and there had been a subsequent push around vaccinations. There was an opportunity for public questions to be submitted in advance of meetings which would be answered by Board Members. Looking forward, there would be a standing item around long Covid and its impact.

Anna Richards said that the Local Outbreak Management Plan had been updated as a lot had changed since the plan was created. Up to date information was shared on the Public Health Berkshire website. The plan worked to deal with outbreaks and stop them from happening. A shortened version of the plan was publicly available on the RBWM website, with the update being done collaboratively with all relevant stakeholders.

Huw Thomas encouraged the public to come forward to get vaccinations, no one would be judged if they were receiving their first dose.

The Chairman said it was important that there was no judgement and that RBWM wanted people to come forward to receive their vaccinations. He passed on his thanks to Huw Thomas and his colleagues for their continued hard work.

## 288/15 COP26 UPDATE

Councillor Stimson had spent two weeks in Glasgow for the COP26 event. She was a trustee of a rewilding charity which looked at re-healing land, where land could be purchased in each county around the UK. It was important that the borough was careful on funding around climate change and sustainability in order to effectively finance initiatives. Councillor Stimson had spoken and networked with a number of colleagues at the conference. There had been a significant number of young people present, those from island communities and more diverse communities had been well represented too. There were four key aims from COP26:

- Net zero by 2050 at the latest
- Keeping the limit of 1.5 degrees alive
- Protecting the most vulnerable communities
- Mobilise finance

Councillor Stimson said that over 100 countries had signed up to reverse deforestation by 2030 and there were almost 90 countries who had agreed to methane commitments. Councillor Stimson concluded by saying that she felt positive for the future.

The Chairman thanked Councillor Stimson for her commitment and work in this area. He had been pleased to see an increase in the number of residents in his ward using their food recycling bins.

Anna Richards said that she would be interested in knowing what school children felt about sustainability, she asked how this could be fed back to the council.

Councillor Stimson said that her next engagement with schools was in early March 2022, she was aiming to deliver a presentation on sustainable development goals.

Kevin McDaniel said that the RBWM Youth Council were keen for their voices to be heard, they would be interested in having a conversation with the Public Health team on a range of topics.

## 289/15 HOUSING AND HOMELESSNESS

The Chairman said that Tracy Hendren had been unable to attend the meeting due to

pressures in the service area. A briefing note had been produced which was circulated to Board Members after the meeting.

290/15 FORWARD PLAN

The Board noted the items which would be considered at future meetings.

291/15 FUTURE MEETING DATES

The next Health and Wellbeing Board would be held on Tuesday 29<sup>th</sup> March 2022, starting at 3pm.

The meeting, which began at 3.00 pm, ended at 5.10 pm

CHAIRMAN.....

DATE.....

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Report Title:	Smoking Cessation Health Needs Assessment
Contains Confidential or Exempt Information	No - Part I
Cabinet Member:	Councillor Carroll, Cabinet Member Adult Social Care, Health, Mental Health and Children's Services
Meeting and Date:	Health and Wellbeing Board – 29 <sup>th</sup> March 2022
Responsible Officer(s):	Anna Richards – Consultant in Public Health
Wards affected:	All

## **REPORT SUMMARY**

This report presents the Smoking Cessation Health Needs Assessment (annexed as Appendix A) for discussion.

This Health Needs Assessment has been developed through the work of the Public Health team and is founded upon local data, intelligence, and knowledge.

The Smoking Cessation Health Needs Assessment supports a specific goal detailed in the Corporate Plan (2021-26); a decrease in the numbers of adults who are current smokers and in adults who drink more than the UK's Chief Medical Officer's weekly guideline.

### **1. DETAILS OF RECOMMENDATION(S)**

**RECOMMENDATION:** That the Health and Wellbeing Board notes the Smoking Cessation Health Needs Assessment as set out in Appendix A.

### **2. KEY IMPLICATIONS**

- 2.1 The health needs assessment positively compliments, and directly contributes towards, one of the Corporate Plan (2021-2026) goals; a decrease in the numbers of adults who are current smokers and in adults who drink more than the UK's Chief Medical Officer's weekly guideline.

The health needs assessment gives six recommendations which the public health team will review and consider in relation to the current service.

### **3. FINANCIAL DETAILS / VALUE FOR MONEY**

- 3.1 There are no direct financial implications arising from this Health Needs Assessment.

## **4. LEGAL IMPLICATIONS**

4.1 Not applicable.

## **5. POTENTIAL IMPACTS**

5.1 Equalities.

The Smoking Cessation Health Needs Assessment uses various data sources to look at smoking prevalence in RBWM, broken down by age and sex, ethnicity, geographical location, deprivation, occupational status, long term mental health conditions, and pregnancy. The commitment remains to reduce smoking prevalence across the borough.

5.2 Climate change/sustainability

The Smoking Cessation Health Needs Assessment does not address climate impact directly or indirectly, as it is focussed upon smoking and smoking cessation in the borough.

5.3 Data Protection/GDPR

This Health Needs Assessment does not require a Data Protection Impact Assessment as no personal data was used.

## **6. CONSULTATION**

6.1 There will be no public consultation as this is a review of current population need and public health evidence on best practice.

6.2 The public health team will work collaboratively with stakeholders across RBWM to consider how the recommendations of the health needs assessment can be achieved.

## **7. APPENDICES**

7.1 This report is supported by the following appendices:

- Appendix A – Smoking Cessation Health Needs Assessment
- Appendix B - Equality Impact Assessment

## **8. BACKGROUND DOCUMENTS**

8.1 This report is supported by these background documents:

- The National Health Service Long Term Plan [NHS Long Term Plan » Smoking](#).



- National Institute for Health and Care Excellence (NICE) guidelines for smoking cessation [Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk/guidance/TA251).

## 9. CONSULTATION

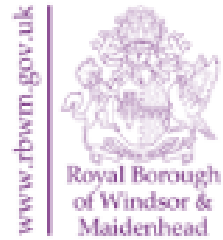
Name of consultee	Post held	Date sent	Date returned
<i>Mandatory: Statutory Officers (or deputies)</i>			
Adele Taylor	Executive Director of Resources/S151 Officer	14/03/2022	
Emma Duncan	Deputy Director of Law and Strategy / Monitoring Officer	14/03/2022	15/03/2022
<i>Deputies:</i>			
Andrew Vallance	Head of Finance (Deputy S151 Officer)		
Elaine Browne	Head of Law (Deputy Monitoring Officer)		
Karen Shepherd	Head of Governance (Deputy Monitoring Officer)		
<i>Mandatory: Procurement Manager (or deputy) - if report requests approval to award, vary or extend a contract</i>			
Lyn Hitchinson	Procurement Manager		
<i>Other consultees:</i>			
<i>Directors (where relevant)</i>			
Duncan Sharkey	Chief Executive		
Andrew Durrant	Executive Director of Place		
Kevin McDaniel	Executive Director of Children's Services		
Hilary Hall	Executive Director of Adults, Health and Housing		
<i>Heads of Service (where relevant)</i>			
Anna Richards	Head of Public Health	10/03/2022	14/03/2022
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Confirmation relevant Cabinet Member(s) consulted	Cabinet Member for Cabinet Member Adult Social Care, Health, Mental Health and Children's Services	No
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## REPORT HISTORY

<b>Decision type:</b>	<b>Urgency item?</b>	<b>To follow item?</b>
For information	No	No

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**Smoking Cessation Health Needs Assessment**  
**The Royal Borough of Windsor and Maidenhead**  
February 2022

## Contents

1.0 Summary.....	4
1.1 Introduction and Aim.....	4
1.2 Key Findings.....	5
1.3 Recommendations.....	6
2.0 Defining the Smoking Population.....	7
3.0 Who smokes in RBWM.....	7
3.1 Total number of people who smoke in RBWM.....	9
3.2 Smoking prevalence by age.....	11
3.3 Smoking prevalence by ethnicity.....	12
3.4 Smoking prevalence by geographical location.....	13
3.5 Smoking prevalence and deprivation.....	15
3.6 Smoking prevalence by occupational status.....	16
3.7 Smoking prevalence in adults with long term mental health conditions.....	16
3.8 Smoking in pregnancy.....	17
3.9 Hospital admissions.....	18
4.0 Conclusion from latest data.....	18
5.0 Evidence Best Practice.....	18
5.1 Universal Support.....	18
5.2 Structured Support.....	19
5.3 NHS Long Term Plan.....	19
6.0 Current Service Provision in RBWM.....	20
6.1 National campaigns and resources.....	20
6.2 NHS services.....	20
6.3 Community smoking cessation service.....	21
6.4 Service level data for community smoking cessation service.....	22
6.5 Conclusion of current service provision.....	25
7.0 Comparisons with services across Berkshire.....	26
7.1 Variation in outcomes across the South East.....	26
7.2 Variation in service delivery and budget across Berkshire.....	26

8.0 Feedback from professionals.....27

9.0 Feedback from servicer users, patients, and residents.....27

10.0 Cost-effective solutions.....27

## 1.0 Summary

### 1.1 Introduction

This Health Needs Assessment (HNA) has been developed to inform the commissioning of interventions to support people to stop smoking in the Royal Borough of Windsor and Maidenhead (RBWM). This document provides a summary of the evidence base for commissioned services that best meet the needs of the local adult population.

Although smoking behaviours are influenced by exposures starting in the early years of life, this HNA focuses on data and interventions for the adult population only. This is because prevention work for children and young people in RBWM is commissioned and provided separately through Achieving for Children and is outside of the scope of this work.

Smoking is the leading cause of preventable illness and early death (before the age of 75) in England with about half of all lifelong smokers dying prematurely, losing on average around 10 years of life ([Health matters: stopping smoking – what works? - GOV.UK \(www.gov.uk\)](#)).

In 2019/20, in England there were estimated to be 506,100 hospital admissions attributable to smoking, representing 4% of all hospital admissions. In 2019, an estimated 74,600 deaths were attributable to smoking representing 15% of all deaths in 2019 (NHS Digital, 2019/20 [Part 1: Smoking-related ill health and mortality - NHS Digital](#)). Latest figures from May 2018 show smoking caused an annual cost to the NHS of £2.5 billion with a further £760 million to local authorities from smoking-related social care needs (ASH, 2018. [True cost of smoking revealed in advance of World No Tobacco Day - Action on Smoking and Health \(ash.org.uk\)](#)).

This HNA summarises the most recent data on smoking in RBWM and the evidence of what works to best meet the needs of residents. The recommendations should inform the commissioning of interventions for smoking cessation and reducing harm related to combustible tobacco products (e.g., cigarettes, cigars, rolling tobacco, and pipe tobacco) in RBWM.

The aim of this HNA is to answer three key questions:

- How many residents smoke and does it vary across different groups?
- What services do residents have to support them to stop smoking?
- Is there anything we should be doing differently to help people to stop smoking?

We recognise that broader tobacco control systems (e.g., underage sales, illicit tobacco, and trading standards) can influence the prevalence of smoking behaviours, health outcomes, and quit rates within the population. These issues are not covered in this HNA.

A range of data sources have been used to inform this HNA, including Public Health Outcomes Framework (PHOF), data from the National Centre of Smoking Cessation and Training (NCSCCT), Local Insights and ACORN data from Frimley Integrated Care Systems' (ICS) System Insights, RBWM community smoking cessation service data, scientific literature, and policy/guidance (such as the National Institute for Health and Care Excellence (NICE) guidance).

In this HNA, the smoking population is defined as any individual within RBWM who uses combustible tobacco products; rather than any method of inhaled tobacco/nicotine product (e.g., electronic cigarettes).

## 1.2 Key Findings

### Who smokes in RBWM?

- Across the population in RBWM, 9.97% of residents (16,195 people) are known to be current smokers (Frimley Health and Care ICS System Insights, Local Insights Report. Data Accessed 17/12/21).
- Of the current smokers in RBWM, 6,495 are female and 9,700 are male. The highest prevalence of smokers (females and males) is the 30-39 age group (Frimley Health and Care ICS System Insights. Local Insights Report. Data Accessed 17/12/21).
- Of the 16,195 current smokers in RBWM, where ethnicity is known, 77.7% are of White ethnicity (Frimley Health and Care ICS System Insights, Local Insights Report. Data Accessed 17/12/21).
- The wards with a disproportionately high number of current smokers, relative to their population, are Datchet, Horton and Wraysbury, Clewer and Dedworth East, Oldfield, St Mary's, Bray, Cox Green, Clewer and Dedworth West, and Hurley and Walthams (Frimley Health and Care ICS System Insights, Local Insights Report. Data Accessed 17/12/21).
- In line with the national picture, we see higher rates of smoking in residents from routine or manual occupations (20.8%) ([Local Tobacco Control Profiles - Data - PHE](#)) and those with mental health conditions (19.5%) ([Local Tobacco Control Profiles - Data - PHE](#)). These figures are statistically similar to the South East and England averages. There is a lower percentage of RBWM women who are smoking in early pregnancy (6.4%) or smoking at time of delivery (6.5%), compared with the South East and England averages ([Local Tobacco Control Profiles - Data - PHE](#)).

### Evidence of what works

- NICE suggests that all frontline health professionals (inclusive of social prescribers, community champions and voluntary sector workers) provide either brief or very brief advice to anyone they come into contact with, identified as a smoker.
- NICE also suggest services should aim to treat at least 5% of the smoking population per annum. Of those accessing services for smoking cessation support, 35% or more should achieve a successful 4 week quit.
- Along with brief advice/very brief advice, NICE recommends behavioural / psychosocial support and pharmacotherapy (Varenicline, Nicotine Replacement Therapy (NRT) and Bupropion) is made available to adults that smoke.
- Research shows that investment into stop smoking interventions (as well as wider tobacco control measures) could lead to significant long-term savings for health partners and reduced loss of earnings due to illness and loss of productivity in all work settings. This could equate to a saving of £11.38 (over the lifespan of someone who quits smoking) for every £1 invested. Case studies and evaluations of schemes/projects in other areas have shown personal financial incentives and e-cigarette provision to be cost effective interventions that increase successful 4 week quits.

### Local services and outcomes

- In RBWM, a part time smoking cessation adviser delivers behavioural support. The service does not currently provide pharmacotherapy or Carbon Monoxide (CO) monitoring.
- Based on 2019/20 data, the service supported approximately 0.5% (55 people) of the *estimated* smoking population of RBWM to set a quit date. This is 1/10<sup>th</sup> of the percentage recommended by NICE. However, of those 55 people, 73% (40 people) achieved a successful (self-reported) 4 week quit – over double the NICE recommended successful quit rate of

35%. The service is seeing small numbers of people, but those it does see appear to be benefiting from the service.

- In 2019/20, RBWM had the second lowest rate (crude rate, unadjusted for age or sex) of individuals *setting a quit date* and *successful 4 week quits*, across the South East (19 local authorities).
- Individuals accessing the community smoking service in 2019/20 were more likely to be of a White ethnic background, female, or over 45 years old.
- Community smoking cessation services vary across the Frimley ICS and Berkshire County in provider, resources, and performance.
- The NHS Long Term Plan (LTP) sets out to increase provision for smoking related interventions across ICSs, with specific focus on acute, mental health, and maternity settings.

### 1.3 Recommendations

This HNA puts forward the following recommendations:

- 1) To work collaboratively (with Frimley ICS, Primary Care Networks, and General Practices) to identify any current gaps to improve how smoking status data is recorded on patient records.
- 2) Undertake targeted work, in the most appropriate format, with those residents and communities who have disproportionately high rates of smoking.
- 3) Use the evidence within the Health Needs Assessment to start discussions and develop a costed appraisal to determine the health impact of providing pharmacotherapy with psychosocial support, balanced against the financial impact.
- 4) Continue to commission a psychosocial support service that delivers a combination of in person, online and telephone support for any adult in RBWM that wishes to quit smoking. Focusing on increasing access in line with NICE guidance for smoking cessation services to treat 5% of current smokers each year, working towards an ambition to achieve a smoke-free society by 2030.
- 5) Explore opportunities for joint commissioning with Frimley ICS, and East Berkshire Public Health and Commissioning colleagues, to procure a joint smoking cessation contract in the future. Consideration should also be given to including smoking cessation as an integral part of an integrated healthy behaviours service, which has the potential to improve outcomes by taking a person-centred approach to health behaviour needs.
- 6) Acquire in depth quantitative and qualitative feedback from the local service and service users, to build an evidence base to drive future commissioning proposals and decisions.



## 2.0 Defining the Smoking Population

For the purposes of this HNA, the “smoking population” will be defined as:

**“Any individual within RBWM who uses combustible tobacco products; rather than any method of inhaled tobacco/nicotine product (e.g., electronic cigarettes).”**

Based on a recent South East England review of electronic cigarettes, these products have been found to have 95% less toxicity (thus significantly reduced physiological impact), compared with combustible tobacco products. Therefore, electronic cigarettes are considered a viable option for smoking reduction, cessation and/or replacement to reduce smoking related harm. For more information, please see [adph-south-east-newposition-statement-on-electronic-cigarettes-sps-v9.pdf](https://www.adph.org.uk/sites/default/files/2019/09/adph-south-east-newposition-statement-on-electronic-cigarettes-sps-v9.pdf) ([stopforlifeoxon.org](http://stopforlifeoxon.org)).

Though electronic cigarettes have shown to aid in quit attempts, it cannot be recommended as a preventative measure, nor as an alternative that poses no risk. In this sense, it could be viewed as a ‘harm reduction’ approach. Individuals who use electronic cigarettes as well as combustible tobacco products will still be considered for the purposes of this HNA.

All *current smokers* will be considered, regardless of frequency, with a particular focus on pregnant women, people in routine & manual occupations and people with mental illness. People in these groups are either more likely to smoke or are at high-risk of harm (e.g. pre, ante and post-natal mothers), where foetal and child health outcomes are adversely impacted by direct (antenatal) or second-hand (postpartum) smoke as identified in *Saving Babies’ Lives Care Bundle V.2* ([saving-babies-lives-care-bundle-version-two-v5.pdf](https://www.nhs.uk/england/publications/saving-babies-lives-care-bundle-version-two-v5.pdf) ([england.nhs.uk](http://england.nhs.uk))).

The data will also be looked at by sex, age, ethnicity, geographical area, and deprivation to identify any health inequalities.

## 3.0 Who smokes in RBWM?

This chapter details what the current smoking picture looks like in RBWM. To do this, different data sets have been used to give as full a picture as possible.

### Explanation of data used

The PHOF ([Public Health Outcomes Framework – OHID](#)) examines indicators that help us understand trends in public health.

Frimley Integrated Care System’s (ICS) System Insights enables data to be visualised and filtered for specific conditions. This HNA utilises Population Insights from the Local Insights Report in which population health can be explored at different levels. This platform is refreshed daily so provides up to date data. However, these data rely on clinical coding from patient records meaning there could be an over- or under-representation of current smokers. The data could show an underrepresentation of current smokers as it is likely that some individuals who smoke are not marked as a current smoker on their patient record. The data could also show an overrepresentation as individuals may have stopped smoking but may still be marked as a current smoker on their patient record. Hence, data should be interpreted with caution.

ACORN data has also been used from Frimley ICS’ System Insights dashboard, but these data are no longer available to access. CACI’s *Wellbeing ACORN* categorises every postcode in the UK to make it easier to understand the potential health behaviours of different communities. It divides neighbourhoods into four primary groups (‘Health Challenges’, ‘At Risk’, ‘Caution’ and ‘Healthy’) which are underpinned by 25 sub-groups/types). More information can be found using the [CACI Wellbeing Acorn User Guide](#).

ACORN defines “smoking behaviour” as an *individual smoking 20+ cigarettes per day*. Figures 1-3 describe the three sub-groups predicted to have the highest smoking rates compared with the national average. These three sub-groups are named Hardship Heartlands, Perilous Futures, and Struggling Smokers.

In Figures 1-3, an index value above 100 indicates that the smoking rate in that sub-group is higher than the national average. For example, an index value of 250 indicates that in that sub-group the likely rate of smoking 20+ cigarettes per day is 2.5 times higher than the national average. Other health behaviours associated with each subgroup are also shown in Figures 1-3.

**Figure 1: Hardship Heartlands (Health Challenges): Likely rate of smoking 20+ cigarettes per day and other health behaviours associated with this group.**

Theme	Variable	Value	Index
HEALTH	Behaviours	Smokes 20+ per day	250
HEALTH	Behaviours	Never eats fruit	208
HEALTH	Behaviours	Eats vegetables 3 or less days per week	187
HEALTH	Behaviours	Usually drinks whole fat milk	148
HEALTH	Behaviours	Eats fruit 3 or less days per week	147
HEALTH	Behaviours	Usually eats white bread	144
HEALTH	Behaviours	Never does moderate intensity sports	141
HEALTH	Behaviours	Never does mild intensity sports	135

**Hardship Heartlands broadly defined as:** “The population of these neighbourhoods are more likely to be either living alone or be a lone parent family in a small social rented terrace or flat. These relatively young people are likely to be employed in lower skilled trades with many being long term unemployed.”

Source: Frimley Health and Care System Insights, ACORN smoking profiles for RBWM, 2019

In all three subgroups, smoking 20+ cigarettes per day is more likely than the national average. Individuals in the Hardship Heartlands subgroup are 2.5 times more likely to smoke 20+ cigarettes per day than the national average. Individuals in the Perilous Futures and Struggling Smokers subgroups are 2.28 and 2.08 times, respectively, more likely to smoke 20+ cigarettes per day than the national average.

**Figure 2: Perilous Futures (At Risk): Likely rate of smoking 20+ cigarettes per day and other health behaviours associated with this group.**

Theme	Variable	Value	Index
HEALTH	Behaviours	Smokes 20+ per day	228
HEALTH	Behaviours	Never eats fruit	196
HEALTH	Behaviours	Eats vegetables 3 or less days per week	181
HEALTH	Behaviours	Usually drinks whole fat milk	160
HEALTH	Behaviours	Eats fruit 3 or less days per week	148
HEALTH	Behaviours	Usually eats white bread	144
HEALTH	Behaviours	Never does mild intensity sports	125
HEALTH	Behaviours	Never does moderate intensity sports	124

**Perilous Futures broadly defined as:** “The population in these neighbourhoods tend to be younger with many children. Much of the housing is social rented with a mix of terraces and flats. These households are likely to suffer from a shortage of space whilst the residents feel that noise and vandalism and crime are an issue in their neighbourhoods. They are often found in the less affluent pockets of commuter belt towns in areas such as Ashford (Kent), the outskirts of Glasgow and areas to the north of Bury St Edmunds in Suffolk.”

Source: Frimley Health and Care System Insights, ACORN smoking profiles for RBWM, 2019

**Figure 3: Struggling smokers (At Risk): Likely rate of smoking 20+ cigarettes per day and other health behaviours associated with this group.**

Theme	Variable	Value	Index
HEALTH	Behaviours	Smokes 20+ per day	208
HEALTH	Behaviours	Never eats fruit	160
HEALTH	Behaviours	Eats vegetables 3 or less days per week	159
HEALTH	Behaviours	Usually drinks whole fat milk	146
HEALTH	Behaviours	Eats fruit 3 or less days per week	135
HEALTH	Behaviours	Usually eats white bread	131
HEALTH	Behaviours	Never does mild intensity sports	125
HEALTH	Behaviours	Never does moderate intensity sports	123

**Struggling Smokers broadly defined as:** *“In these neighbourhoods the residents, often younger adults, are likely to be living in large, terraced and semi-detached homes with many school age children. The proportion in receipt of Job Seeker’s Allowance and Illness or disability benefits are more than double the national average. Those that are in work tend to be in routine occupations.”*

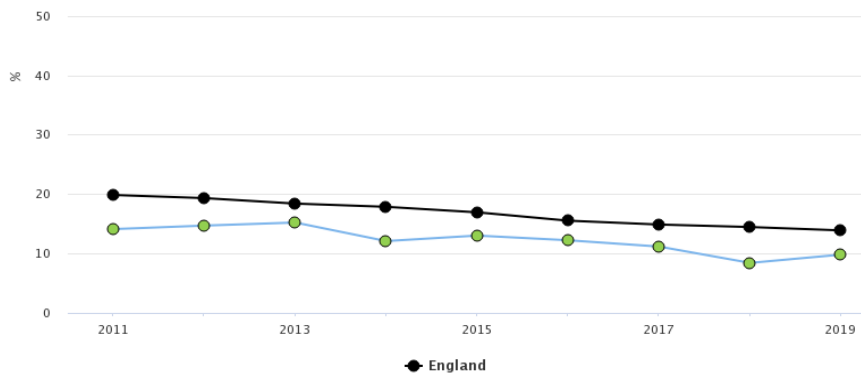
Source: ACORN smoking profiles for RBWM, 2019

### 3.1 Total number of people who smoke in RBWM

The latest available data, outlined below, are based on best estimates (rather than confirmed count) generated by the PHOF, derived from the Annual Population Survey (APS) or General Practice Patient Survey (GPPS).

Predictive analysis based on data sourced from the APS suggests that 9.8% of RBWM’s 18+ population (11,445 adults) were current smokers in 2019. This is statistically better than the South East (SE) regional average (12.2%) and England average (13.9%) (Figure 4) (PHOF, 2019, [Local Tobacco Control Profiles - Data - PHE](#)).

**Figure 4: Smoking Prevalence in adults (18+) – current smokers (APS) for Windsor and Maidenhead.**



Source: APS, [Local Tobacco Control Profiles - Data - PHE](#). England (black circles). RBWM (green circles).

The smoking prevalence in adults (18+) has been declining in RBWM, the South East, and England between 2011 and 2019. Prevalence in RBWM has consistently remained significantly lower than the England average over this period. Since 2011, the lowest recorded prevalence in RBWM was in 2018, at 8.4% (9,785 adults) ([Local Tobacco Control Profiles - Data - PHE](#)).

In 2019, the UK Government released a green paper announcing the ambition to go ‘smoke free’ in England by 2030 ([Advancing our health: prevention in the 2020s \(publishing.service.gov.uk\)](https://www.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/421117/advancing_our_health_prevention_in_the_2020s.pdf)), equating to an adult smoking prevalence of 5% or less. This is a far more aggressive reduction in national smoking prevalence than that predicted by scientists (Source: BMJ, 2020, [Future smoking prevalence by socioeconomic status in England: a computational modelling study | Tobacco Control \(bmj.com\)](https://www.bmj.com/content/361/n8000/e000000)) (GOV.UK, 2019, [Health matters: stopping smoking – what works? - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/news/health-matters-stopping-smoking-what-works)).

Of RBWM’s “statistical neighbours”, RBWM ranks 2<sup>nd</sup> for lowest prevalence of smokers aged 18+ (Figure 5); but this prevalence is only statistically significantly different to Milton Keynes and Wiltshire.

**Figure 5: Number of people (count) and percentage (value) who smoke in RBWM and statistical neighbours.**

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	-	-	6,144,703	13.9	13.6	14.1
Neighbours average	-	-	-	-	-	-
Milton Keynes	-	13	30,202	15.1	12.4	17.7
Wiltshire	-	9	57,527	14.6	12.2	17.0
Cheshire East	-	10	42,362	13.8	10.4	17.2
Central Bedfordshire	-	5	30,831	13.7	10.7	16.7
Bath and North East Somerset	-	6	20,484	13.0	10.5	15.6
Solihull	-	7	21,225	12.6	10.2	14.9
Bracknell Forest	-	4	11,170	11.9	9.5	14.2
Cheshire West and Chester	-	15	31,125	11.3	8.2	14.4
North Somerset	-	11	19,276	11.3	9.0	13.5
South Gloucestershire	-	12	25,299	11.2	8.8	13.6
Bedford	-	8	14,262	10.8	7.3	14.2
West Berkshire	-	1	12,712	10.3	8.0	12.7
Rutland	-	14	3,258	10.2	6.5	13.8
Windsor and Maidenhead	-	-	11,445	9.8	7.9	11.7
Wokingham	-	2	10,998	8.4	6.5	10.3
Buckinghamshire UA	-	3	-	-	-	-

Source: APS, 2019 [Local Tobacco Control Profiles - Data - PHE](#)

Smoking Status is a health information filter on the local insights dashboard found on Frimley Health and Care ICS’ System Insights. The current RBWM population size is 162,406 (Frimley Health and Care ICS System Insights, Local Insights Report. Data Accessed 17/12/21) of which:

- 9.97% (16,195 people) are current smokers.
- 17.58% (28,557 people) have smoked in the past.
- 49.64% (80,617 people) have never smoked.
- 22.81% (37,037 people) do not have their smoking status recorded.

It is important to note that the data above, taken from System Insights, includes all ages. Whereas data in Figures 4 and 5, only includes adults aged 18 and above.

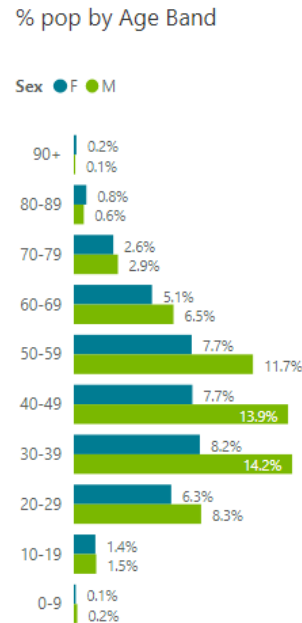
A caveat of the data on System Insights is that the data relies on clinical coding on patient records. This is explained further in section 3.0. The NICE guidance states that when identifying and quantifying people’s smoking, health and social care professionals should ask people if they smoke or have recently stopped smoking at every opportunity ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk/guidance/TA254)).

**Recommendation 1:** To work collaboratively with Frimley ICS, Primary Care Networks, and General Practices to identify any current gaps to improve how smoking status data is recorded

### 3.2 Smoking prevalence by age

Of the 16,195 known current smokers in RBWM, 6,495 are female and 9,700 are male. The highest prevalence of smokers (females and males) is the 30-39 age group, followed by the 40-49 age group. In both sexes, smoking prevalence increases from 0-39 years and decreases in people aged 40 and above, as shown in Figure 6.

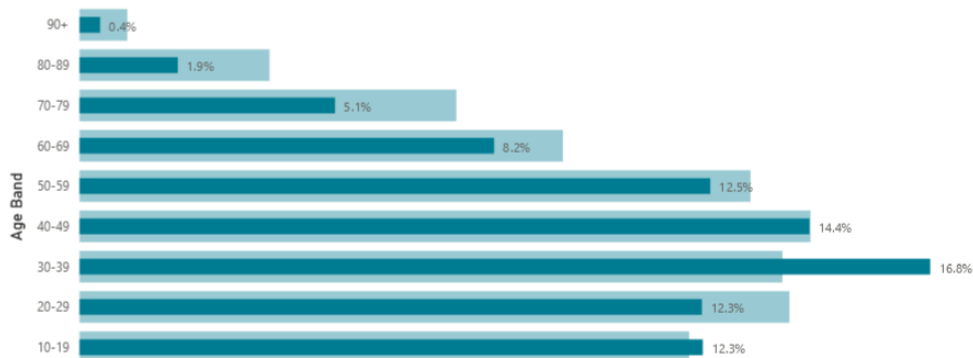
**Figure 6: Percentage of population (by age range and sex) who are current smokers in RBWM as recorded on General Practice records.**



Source: Frimley Health and Care ICS, System Insights. Data Accessed 17/12/21.

The data shown in Figure 6 is coherent with the predictive ACORN data shown in Figure 7. Based on the top three sub-group types, ACORN predicts an over representation of smoking behaviours within the 30 – 39 age range. This differs slightly from predictive analysis provided by PHOF, where it is suggested slightly higher rates of smoking may be seen in the 25 – 29 age range. Note these two datasets are defined/filtered differently, therefore a degree of caution must be applied when comparing.

**Figure 7: ACORN profile of smoking prevalence within the RBWM population, by age groups (in top three sub-groups predicted to have the highest smoking rates compared with the national average).**



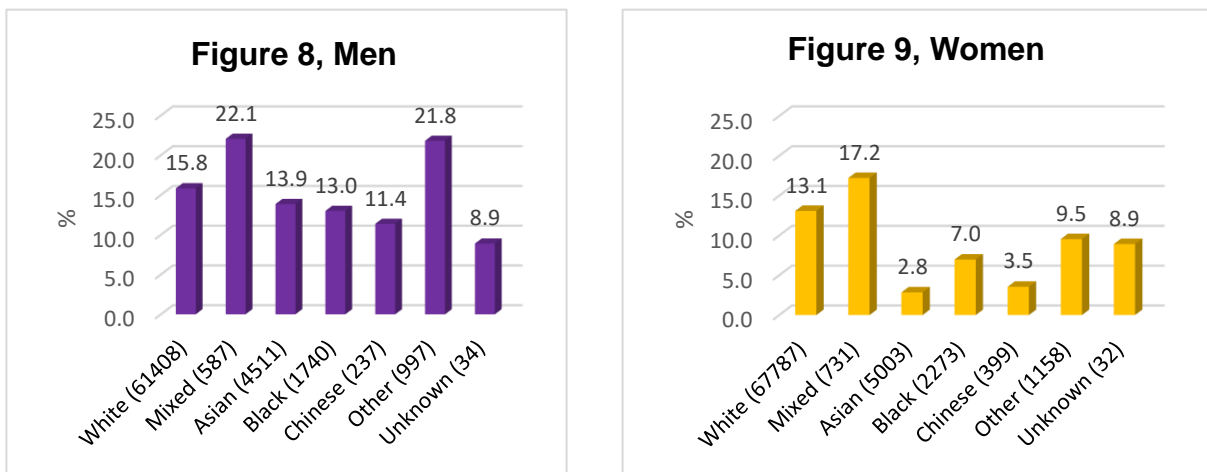
Source: Frimley Health and Care System Insights, ACORN smoking profiles for RBWM, 2019

Please note that over representation within the 10 – 19 age range could be skewed by children and young people who reside within geographical locations where greater rates of smoking has been predicted, but might not actually be smoking themselves (i.e., those under the age of 18). Therefore, caution should be applied when interpreting these data.

### 3.3 Smoking Prevalence by ethnicity

The APS data provides a breakdown of smoking prevalence by ethnicity for England in 2019 (Figures 8 & 9). This shows higher prevalence rates in males from mixed and other ethnic groups. Prevalence rates in females are highest in mixed and white ethnic groups.

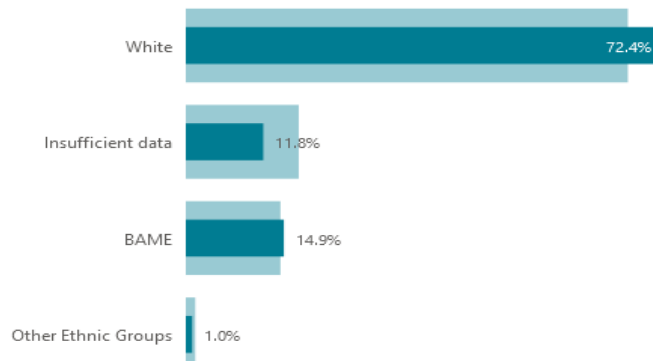
**Figures 8 & 9: Percentage of England residents (18+) in each ethnic group who are current smokers (2019).**



Source: APS, 2019 [Local Tobacco Control Profiles - Data - PHE](#)

More locally, of the 16,195 current smokers in RBWM, 77.7% are white ethnicity, 8.7% are from Black, Asian Minority Ethnic (BAME) groups, and 0.8% are from other ethnic groups. There is insufficient data to group the remaining 12.9% by ethnicity (Frimley Health and Care ICS, System Insights. Data Accessed 17/12/21). This breakdown of current smokers in RBWM by ethnicity, is similar in the ACORN predicted data, with Figure 10 showing that those of White ethnicity are more likely to have smoking 20+ cigarettes per day behaviours than other ethnicities.

**Figure 10: ACORN profile of smoking prevalence within RBWM population, by Ethnicity (in top three sub-groups predicted to have the highest smoking rates compared with the national average).**



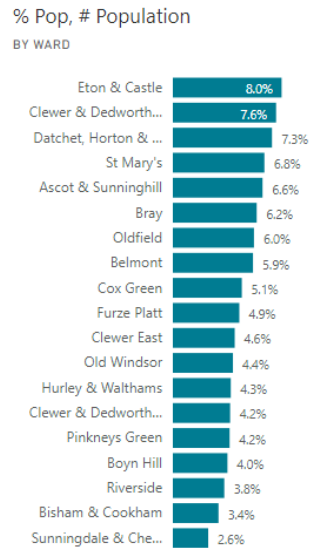
Source: Frimley Health and Care System Insights, ACORN smoking profiles for RBWM, 2019

This supports data provided by PHOF. There is indication that a disproportionate number of people from BAME communities in RBWM are smokers, which supports predictive analysis data from PHOF.

### 3.4 Smoking Prevalence by Geographical Location

It is possible to examine the percentage of current smokers in RBWM at ward level (Figure 11). Of the 16,195 people that are current smokers in RBWM, 8.0% live in the Eaton and Castle ward, and 7.6% live in Clewer and Dedworth East.

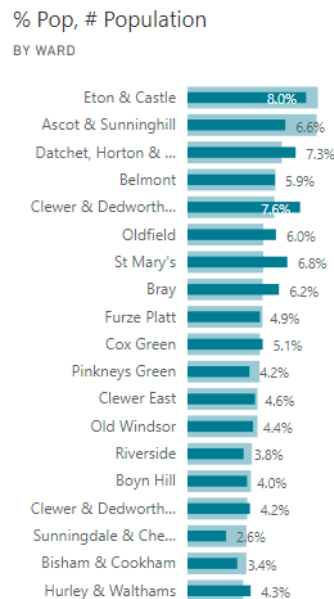
**Figure 11: Percentage of Current Smokers (as recorded on General Practice records) in each ward in RBWM.**



Source: Frimley Health and Care ICS, System Insights. Data Accessed 17/12/21.

However, each ward in RBWM has a different population size which is important to consider when interpreting the data. Figure 12 highlights which wards have a disproportionate number of current smokers given the ward's population size.

**Figure 12: Percentage of current smokers (as recorded on General Practice records) in each ward in RBWM (dark blue line), compared to the percentage of the RBWM population that live in each ward (light blue line).**



Source: Frimley Health and Care ICS, System Insights. Data Accessed 17/12/21.



Where the dark blue line exceeds the light blue line, there is a disproportionate number of current smokers in these wards, given the ward’s population size. Using Clewer and Dedworth East as an example; 7.6% of current smokers in RBWM live in the Clewer and Dedworth East ward, but only 5.9% of the RBWM population live in Clewer and Dedworth East. Therefore, there is a disproportionate number of current smokers in this ward.

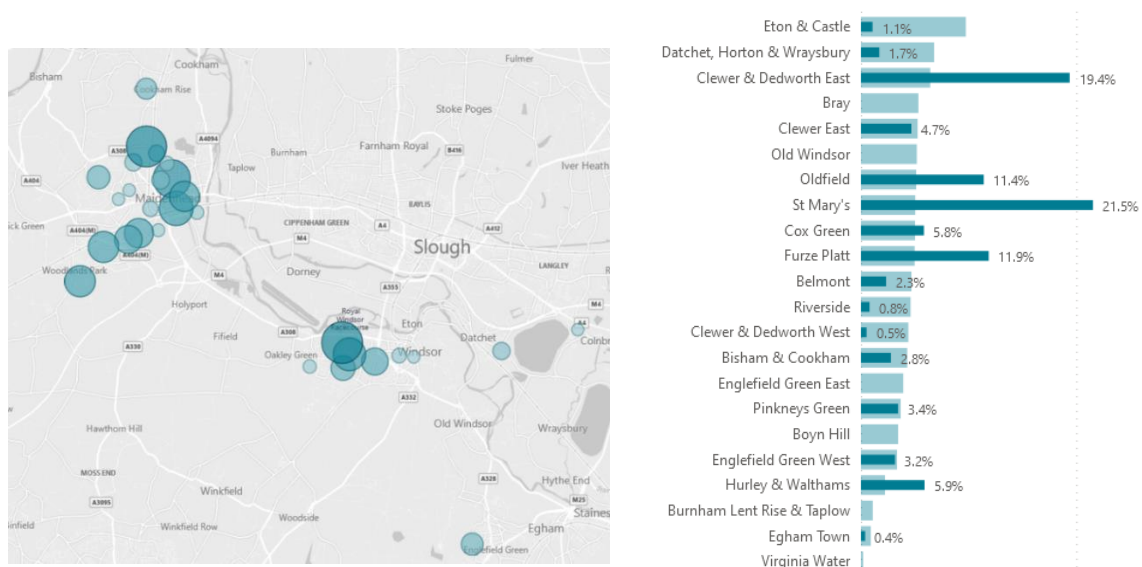
Looking at these data, it can be concluded that the wards with a disproportionately high number of current smokers are:

- Datchet, Horton and Wraysbury
- Clewer and Dedworth East
- Oldfield
- St Mary’s
- Bray
- Cox Green
- Clewer and Dedworth West
- Hurley and Walthams

This conclusion is supported by the predicted data from the ACORN segment. Figure 13 identifies small geographical areas in RBWM where the three sub-groups, predicted to have the highest smoking rates compared with the national average, may live (based on predictive analysis). These three sub-groups are called: *Hardship Heartlands*, *Perilous Futures* and *Struggling Smokers*.

Co-existing behaviours associated with these sub-groups (e.g., “never does mild intensity sport”) could help to identify additional/compounding factors to smoking. Other wider determinants, such as neighbourhood type or housing/living situation, may also provide further factors that could be impacting on smoking rates within these given groups. For further information on groups in the *Wellbeing ACORN* profile data, visit [CACI Wellbeing Acorn User Guide](#).

**Figure 13: ACORN profiling of heat map of RBWM wards where the top three sub-groups (predicted to have the highest smoking rates compared with the national average) are more likely to be geographically located (2019). This data is PCN level data.**



Source: *Frimley Health and Care System Insights, ACORN smoking profiles for RBWM, 2019.*

Where the blue bubbles intersect in Figure 13, there is likely to be greater prevalence of ACORN segments with higher concentrations of excessive smoking behaviours (*Hardship Heartlands*,



Perilous Futures, and Struggling Smokers). The pale blue line on the right-hand side of Figure 13 represents the proportion of the population within each RBWM ward, in relation to the total RBWM population. Where the dark blue line exceeds the length of the pale blue line, there is an over-representation of the ACORN segments where smoking 20+ cigarettes per day is more likely than the national average. Where the dark blue line is equal to the length of the light blue line, there is a proportionate representation of individuals smoking in that ward, relative to the population size. Therefore, a disproportionately high prevalence of smoking 20+ cigarettes per day is predicted within the wards of:

- St Mary's
- Clewer & Dedworth East
- Furze Platt
- Oldfield
- Hurley & Walthams
- Cox Green

From this predicted data, five out of the six wards highlighted above are also highlighted from the Frimley ICS System Insights data.

### 3.5 Smoking Prevalence and Deprivation

People living in deprived areas are more likely to smoke than those living in affluent areas. The Index of Multiple Deprivation (IMD) is used to classify the level of deprivation of specific areas. In this instance, the IMD Decile is giving the average IMD Decile for smokers in these wards, not the deprivation for the ward as a whole. A lower IMD Decile indicates greater deprivation. Figure 14 highlights deprivation levels in current smokers in RBWM, and the number of people that are currently smokers in each ward.

**Figure 14: Average Index of Multiple Deprivation (IMD) Decile for smokers in each ward in RBWM, and the number of people that are currently smokers in each ward.**

Ward	IMD Decile	# Pop
Eton & Castle	7.83	1,301
Clewer & Dedworth East	5.53	1,235
Datchet, Horton & Wraysbury	6.18	1,186
St Mary's	5.59	1,095
Ascot & Sunninghill	9.01	1,073
Bray	8.92	1,003
Oldfield	5.94	970
Belmont	7.46	959
Cox Green	7.93	825
Furze Platt	6.96	795
Clewer East	8.97	740
Old Windsor	8.50	719
Hurley & Walthams	5.85	693
Clewer & Dedworth West	8.50	685
Pinkneys Green	7.22	679
Boyn Hill	8.76	653
Riverside	8.92	615
Bisham & Cookham	8.23	546
Sunningdale & Cheapside	9.62	423
<b>Total</b>	<b>7.49</b>	<b>16,195</b>

Source: Frimley Health and Care ICS, System Insights. Data Accessed 17/12/21.

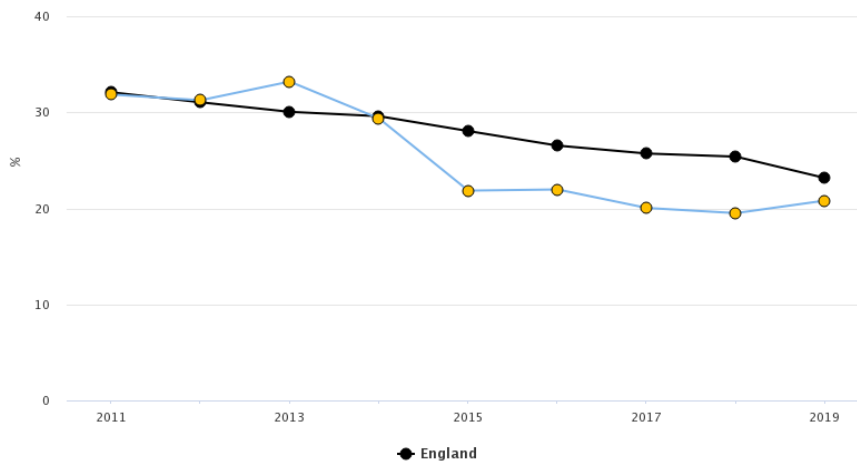
According to these IMD deciles, the most deprived people who smoke in RBWM are in the following wards: Clewer and Dedworth East, St Mary’s, Hurley and Walthams, Oldfield, Datchet, Horton and Wraysbury, and Furze Platt.

**Recommendation 2:** Undertake targeted work, in the most appropriate format, with those residents and communities who have disproportionately high rates of smoking.

### 3.6 Smoking prevalence by occupational status

Latest data (2019) for RBWM show that the prevalence of smoking amongst adults (18-64) in routine or manual occupations was 20.8%. This is statistically similar to the SE region of 23.7% and the England average (23.2%) (PHOF, 2019, [Local Tobacco Control Profiles - Data - PHE](#)). Trends show an overall reduction in prevalence within this cohort both nationally and locally, from 2011 to 2019 (Figure 15).

**Figure 15: Percentage of people in routine & manual occupations (aged 18-64) who are current smokers in England (black circles) and RBWM (amber circles).**

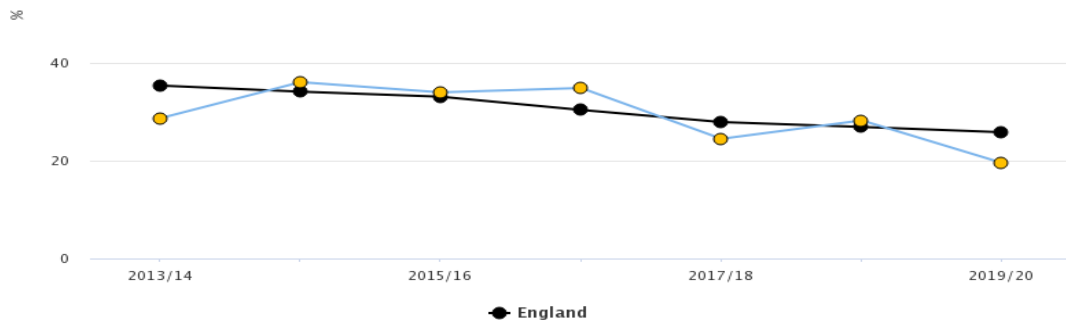


Source: APS, (2011-19): [Local Tobacco Control Profiles - Data - PHE](#)

### 3.7 Smoking prevalence in adults with long term mental health conditions

The prevalence of smoking amongst adults (18+) in RBWM with long term mental health conditions is 19.5%. This is statistically similar to the SE regional average of 24.0% and the England average (25.8%) (PHOF, 2019/20, [Local Tobacco Control Profiles - Data - PHE](#)). In England, smoking prevalence in adults with long term mental health conditions has on average declined in recent years; this pattern has been similar in RBWM (Figure 16).

**Figure 16: Percentage of adults with long-term mental health conditions who smoke in England (black circles) and RBWM (amber circles).**



Source: GPPS [Local Tobacco Control Profiles - Data - PHE](#)

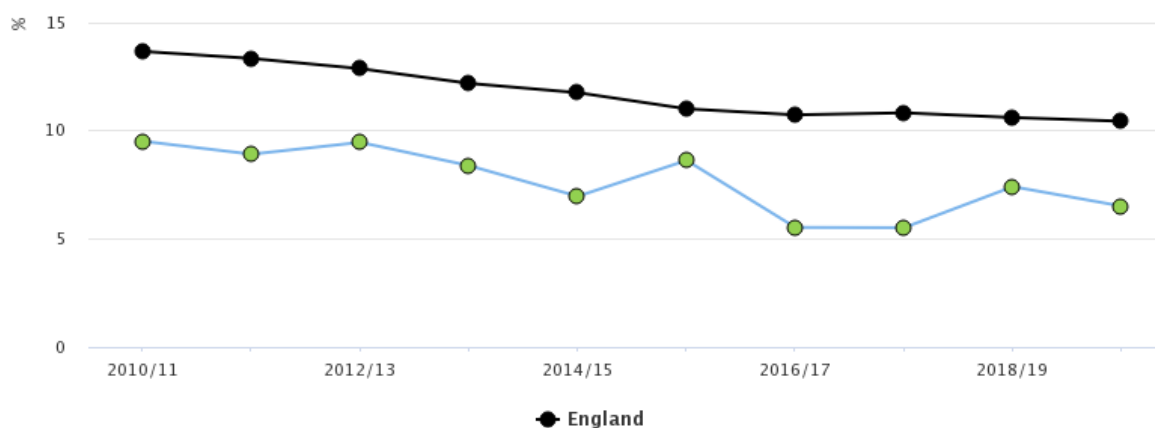
### 3.8 Smoking in pregnancy

Smoking during pregnancy can cause premature births, miscarriage and perinatal deaths. It also increases risk of stillbirth, complications in pregnancy, low birthweight, and the child developing other conditions in later life. This is a key area of health inequalities that is one of the priorities of the NHS LTP.

Prevalence of *smoking in early pregnancy* (up to 12 weeks gestation) & *smoking at time of delivery* (SATOD) was 6.4% & 6.5% (94 women SATOD) respectively (PHOF, 2018/19 & 2019/20 respectively). Both rank statistically better than the South East regional averages (11.3% & 9.7%) and England averages (12.8% & 10.4%) (PHOF, 2018/19 & 2019/20 respectively, [Local Tobacco Control Profiles - Data - PHE](#)).

*Smoking in early pregnancy* has only been recorded by maternity services since 2018/19 and no further data are available, therefore trends cannot be identified. Trends from PHE of smoking at time of delivery (Figure 17) shows that on average prevalence has decreased since 2010/11.

**Figure 17: Percentage of women Smoking at Time of Delivery (SATOD) in England (black circles) and RBWM (green circles) (2010-19).**



Source: PHE/NHS Digital return SATOD: [Local Tobacco Control Profiles - Data - PHE](#)

Premature birth and low birth weight are two potential outcomes associated with ante-natal smoking (direct or second-hand), which can lead to poor health outcomes and health inequalities for those babies later in life. Whilst smoking is not the sole cause of these outcomes, they could provide proxy indicators to health inequalities caused by smoking within the local population.

Between 2016 and 2018, 411 incidents of *premature births* (<37 week gestation) were recorded in RBWM, equating to a prevalence of 82.2 per 1,000 (latest figures for rate of premature live births [gestational age between 24-36 weeks] and all stillbirths per 1000). This is statistically similar to the South East regional average of 78.1 per 1000 births and England average of 81.2 per 1000 (PHOF, 2019, [Local Tobacco Control Profiles - Data - PHE](#)).

In 2019, 33 incidents of *low birth weight of term babies* were recorded, equating to a prevalence of 2.4%. This was statistically similar to the South East regional average of 2.5% and the England average of 2.9% (PHOF, 2019, [Local Tobacco Control Profiles - Data - PHE](#)).

### 3.9 Hospital admissions

In line with lower overall smoking prevalence in RBWM, smoking attributable hospital admissions (749 per 100,000 population) were also significantly better than that of the SE, (1012 per 100,000) and England (1612 per 100,000) (PHOF, 2018/19 and 2019/20 respectively, [Local Tobacco Control Profiles - Data - PHE](#)).

## 4.0 Conclusion from latest data

Key findings suggest:

- The smoking prevalence in RBWM is better (lower) than the England and South East averages as well as statistical neighbours.
- The rates of smoking are higher in RBWM residents in routine or manual occupations or those with mental health conditions, in line with the national picture.
- Residents who identify as *White* are more likely to be current smokers than individuals from other ethnicities.
- Residents aged 30-39 (particularly men) are most likely to be current smokers, closely followed by the 40-49 age group.
- ACORN insights suggest that disproportionately higher rates of residents smoking 20+ cigarettes per day are found in people:
  - Aged 30-39 age range.
  - Who identify as White or Black, Asian and Minority Ethnic groups.
  - Live in St Mary's, Clewer and Dedworth East, Furze Platt, Oldfield, Hurley and Walthams, and Cox Green.

## 5.0 Best Practice

### 5.1 Universal Support

NICE suggests all frontline health professionals (inclusive of Social Prescribers, Community Champions and voluntary sector workers) provide either brief advice (BA) or very brief advice (VBA) to anyone they come into contact with, identified as a smoker ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](#)). For information on V/BA, visit [6 Glossary | Behaviour change: individual approaches | Guidance | NICE](#). This builds upon the Making Every Contact Count (MECC) approach; a nationally recognised framework, seeking to create positive behaviour change through opportunistic interactions with the public, thus improved health outcomes for the community (both individually and as a whole). Best practice suggests health professionals should encourage smokers to reduce or quit smoking ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](#)). It is also advised that NRT/nicotine containing electronic cigarettes use should be given (if the health professional is trained to do so).

For more information on MECC, visit [Making Every Contact Count \(nice.org.uk\)](https://www.nice.org.uk). NRT means products that are medicinally licensed for use as a stop smoking aid and for harm reduction ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk)).

Where structured support for smoking cessation is not desired (as part of NICE clinical guidance 138; *treating patients with dignity and respect*), signposting to universal [digital/remote] resources is recommended. A Cochrane review assessing effectiveness of self-help materials vs. having no intervention, on quit rates, concluded that “standard self-help materials may increase quit rates compared to no intervention, but the effect is likely to be small.” Furthermore, tailored self-help materials vs. standard self-help materials may prove more helpful toward quit success. This may partly be due to additional contact or assessment required to obtain individuals’ data (Lancaster & Stead, 2009, [Self-help interventions for smoking cessation \(ncsct.co.uk\)](https://www.ncsct.co.uk)).

## 5.2 Structured Support

NICE suggest services should aim to treat at least 5% of the smoking population per annum. Of those accessing services for smoking cessation support, ≥ 35% should achieve a successful 4 week quit ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk)). Additional recommendations are made to confirm successful quit via CO testing, showing <10 parts per million (ppm) at point of test (4 weeks on from quit date).

Along with brief advice/very brief advice, NICE recommends behavioural / psychosocial support and pharmacotherapy is made available to adults that smoke ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk)). Pharmacotherapy covers medication licensed for smoking cessation such as varenicline or bupropion, as well as NRT. Services should provide advice on these and agree an approach with service users, based on the individual’s preferences. In cases where NRT is prescribed/used, it is recommended that a combination of both short-action and long-action forms are used in conjunction ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk)).

Behavioural support is an evidence-based approach for behaviour change, utilising a variety of methods (such as ‘Cognitive behavioural therapy’, ‘motivational interviewing’ and ‘strengths-based approach’), aimed to improve health outcomes via lifestyle/behavioural adaptations.

## 5.3 NHS LTP

The [NHS LTP](https://www.nhs.uk) sets out to increase provision for smoking related interventions across Integrated Care Systems, with specific focus on; Acute, Mental Health, and Maternity settings. The aim being to increase opportunities to identify and/or support those seen within those services to quit smoking.

The NHS LTP sets out new commitments for action that the NHS will take to improve prevention. For smoking the actions are:

- The NHS will make a significant new contribution to making England a smoke-free society, by supporting people in contact with NHS services to quit based on a proven model implemented in Canada and Manchester [Building the case for comprehensive hospital-based tobacco addiction services: Applying the Ottawa Model to the City of Manchester - Lung Cancer \(lungcancerjournal.info\)](https://www.lungcancerjournal.info). By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- The model will be adapted for expectant mothers, and their partners, with a new smoke-free 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. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings.

## 6.0 Current Service Provision in RBWM

### 6.1 National campaigns and resources

There are a number of national campaigns that support smoking cessation:

- Stoptober (national stop smoking campaign over the month of October)
- Love your lungs week in June (British Lung Foundation)
- No Smoking Day in March (British Heart Foundation)
- Smokefree by 2030 (national initiative to get smoking rates below 5% of total population)

Early-help/digital resources include:

- Smokefree national helpline (0300 123 1044, England only)
- NHS Quit Smoking app ([Quit smoking - Better Health - NHS \(www.nhs.uk\)](https://www.nhs.uk/quit-smoking))
- Daily email support (<https://quitnow.smokefree.nhs.uk/>)

These are free and available to everyone. These options provide much of the community Universal / Tier 1 (low-level) intervention / support, in achieving a successful quit. This forms the initial “fabric” of a “patchwork effect” of provisions and services that aim to reduce rates of current smokers within the community. The benefits of national resources are that they are wide reaching, accessible to many (with access to computers or smart phones) and incur no cost to the service users or local authorities.

### 6.2 NHS services

There is currently no in-house Tobacco Dependency service for maternity or inpatients within Frimley Health NHS Foundation Trust. However, there is NRT available on all wards to support inpatient smokers.

The NHS provision for smoking cessation is currently changing in line with the ambitions set out by the NHS LTP (section 5.3). The NHS LTP sets out its ambition to support a smoke-free society through providing an effective smoking cessation offer. This includes comprehensive inpatient tobacco treatment, a smoke-free pregnancy pathway for expectant mothers and their partners, and a universal smoking cessation offer for long-term users of specialist mental health services. This means everyone admitted to hospital who smokes, will be offered help and support to quit, offering NHS-funded tobacco treatment services to all inpatients who smoke, regardless of why they are in hospital, by 2023/24. There will be timely access to medications and specialist support, provided as an ‘opt-out’ model with all healthcare professionals taking responsibility for their part in the service.

#### Maternity

At antenatal booking appointments, all women are CO monitored. If the woman is a person who smokes, the risks of smoking are explained, and an onward referral is made to the community smoking cessation service.

In line with the requirements of Saving Babies’ Lives Care Version Two ([saving-babies-lives-care-bundle-version-two-v5.pdf \(england.nhs.uk\)](https://www.england.nhs.uk/saving-babies-lives-care-version-two-v5)), all women are CO monitored throughout pregnancy and are made aware of the hospital’s smoke free policy. Women are provided with NRT to help them prepare to be smoke free during their time in the hospital.

In line with NHS LTP commitments, a delivery model for maternity services has been co-developed with a range of national, regional, and system partners with an aim to support delivery of NHS-funded tobacco dependence treatment services in maternity settings. Plans are being made on how an ‘in-house’ service could be piloted and implemented. The expectation is it will be in addition to the community smoking cessation service.

## Primary care

Primary care settings/workers (including General Practices (GPs), Social Prescribers, Health Coaches, Health Champions and Community Navigators) form a critical element of support, resources, and signposting. This is a significant area where the public may intersect with health services and health care professionals. It can often be the initial interface with a health professional where very brief / brief advice can be given, signposting / onward referral provided and building of rapport between the individual / community and services begin – all contributing to MECC. Though smoking may often not be a primary cause of engagement or concern to service users, these interactions can provide key opportunities to raise conversations, provide information, motivate behaviour change and signpost to relevant services (where appropriate/desired). In the case of smoking cessation, this can often be a challenging conversation to raise, especially for individuals who are ambivalent (pre-contemplative) around their smoking. Primary care settings are a fundamental referral source to locally commissioned services and help to initiate or continue positive behaviour change with their service users.

Pharmacotherapy is not currently commissioned locally in RBWM, so it is up to the discretion of GPs whether they wish to prescribe pharmacotherapy. It is important to note that there has been a supply issue with Champix (produced by Pfizer) in the UK since June 2021. The NICE guidance highlights that in November 2021, Champix was unavailable in the UK.

Pharmacies are able to give out pharmacotherapy based on a prescription. Pharmacotherapy is not currently commissioned locally in RBWM, so pharmacies can provide over the counter NRT products, at a cost to the patient.

### 6.3 Community smoking cessation service

The public health ring-fenced grant funds a smoking cessation service, which is delivered by Cranstoun. This service includes a smoking cessation specialist practitioner, who provides behavioural support for adult (18+) residents with current smoking behaviours. Service users are supported through a one-to-one format, receiving 4 sessions over the course of 4 weeks (1 session per week) prior to reviewing outcome of intervention. This model of approach is recommended by NICE ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk/guidance/TA252)) and reflected in training for practitioners by NCSCCT ([Stop smoking interventions and services \(NICE, 2018\) \(ncsct.co.uk\)](https://www.ncsct.co.uk/)).

RBWM's stop smoking service does not use CO validation to confirm quits. Successful quits are self-reported by service users.

### Referrals

The smoking cessation service in RBWM receives referrals through multiple pathways. In Quarter 2 of 2021/22 (July-September 2021) there were 40 referrals, and in Quarter 3 of 2021/22 (October-December 2021), the service received 49 referrals. The total number of referrals in Quarter 2 and 3 2021/22 was 89 individuals. Of these 89:

- 28 Service Users reported no support needed
- 42 Service Users reported support needed
- 17 Service Users have now been closed (unable to make contact after 3 attempts)
- 2 Service Users have moved out of borough



## Nicotine Replacement Therapy (NRT)

NRT is not currently offered as part of RBWM’s stop smoking service but advice around NRT use is provided (where appropriate). Licensed NRT products are available over the counter across a wide range of outlets within RBWM. NRT is competitively priced, respective to combustible tobacco products. NRT is available in a wide range of application options (patches, gum, inhalation cartridges, sublingual tablets, lozenges, and mouth and nasal sprays) providing choice, based on the individual’s preference. Electronic cigarettes are not currently licensed in the UK for medical use but can be advised as a viable alternative to traditional smoking cessation aids; as outlined in the South East Position Statement on Electronic Cigarettes ([adph-south-east-newposition-statement-on-electronic-cigarettes-sps-v9.pdf](https://www.adph-south-east.nhs.uk/sites/default/files/2019-05/adph-south-east-newposition-statement-on-electronic-cigarettes-sps-v9.pdf) ([stopforlifeoxon.org](http://stopforlifeoxon.org))).

**Recommendation 3:** Use the evidence within the Health Needs Assessment to start discussions and develop a costed appraisal to determine the health impact of providing pharmacotherapy with psychosocial support, balanced against the financial impact.

### 6.4 Service level data for community smoking cessation service

Data from 2019/20, show that 55 smokers accessed the service. Everyone referred in must complete an assessment and is then encouraged to set a 4-week quit date. If a service user disengages prior to setting a quit date (pre or post assessment), these individuals are not counted toward numbers outlined below. RBWM service level data is sourced from (NHS Digital, 2019/20, [Local Tobacco Control Profiles - Data - PHE](#)).

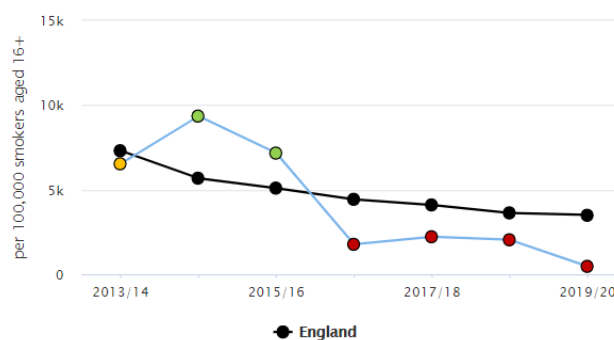
The type of interaction was through drop-in clinics (45%), one-to-one support (49%), telephone (5%) and other (1%). The coronavirus pandemic has reshaped the way in which the service has engaged service users; far greater numbers of service users (since April 2020) will have engaged with support in digital/remote forms, due to national restrictions and guidance.

In 2019/20, those accessing the service were more likely to be women (Figure 22), older adults aged 45-59 (Figure 23) and from a *White* ethnic background (Figure 24).

#### People setting a quit date

Data from 2019/20 (most recent annual figures), show that 55 smokers set a quit date giving a rate of 465 per 100,000 smokers aged 16+ ([Public health profiles - OHID \(phe.org.uk\)](#)). As outlined in Figure 18 this is significantly lower than the South East (3884 per 100,000) and England (3512 per 100,000) averages.

**Figure 18: Smokers setting a quit date per 100,000 smokers aged 16+ in England (black circles) and RBWM (amber, green and red circles) (2013-20).**



Source: [Public health profiles - OHID \(phe.org.uk\)](#)



A full annual report has not been published for 2020/21, but data from April -December 2020 (9 months) shows that 20 people accessed the community smoking cessation service during this period.

All individuals accessing the service are required to set a 4-week quit date at point of assessment.

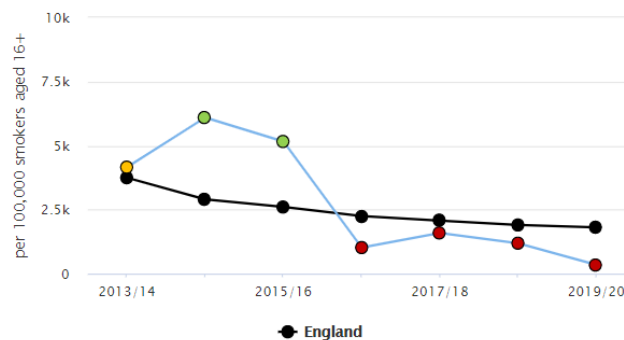
**Recommendation 4:** Continue to commission a psychosocial support service that delivers a combination of in person, online and telephone support for any adult in RBWM that wishes to quit smoking. Focusing on increasing access in line with NICE guidance for smoking cessation services to treat 5% of current smokers each year, working towards an ambition to achieve a smoke-free society by 2030.

### Smokers that have successfully quit in 4-weeks

In 2019/20, 40 out of 55 setting a quit date had successfully quit (73% success rate). This is higher than the 53% success rate of all setting a quit date within the SE (NHS Digital, 2019/20 [Local Tobacco Control Profiles - Data - PHE](#)).

This represents a rate of successful quitters at 4-weeks of 338 per 100,000 smokers aged 16+. As outlined in Figure 19 this is significantly lower than the South East (2060 per 100,000) and England (1808 per 100,000) averages.

**Figure 19: Smokers that have successfully quit at 4-weeks per 100,000 smokers aged 16+ in England (black circles) and RBWM (amber, green and red circles) (2013-20).**

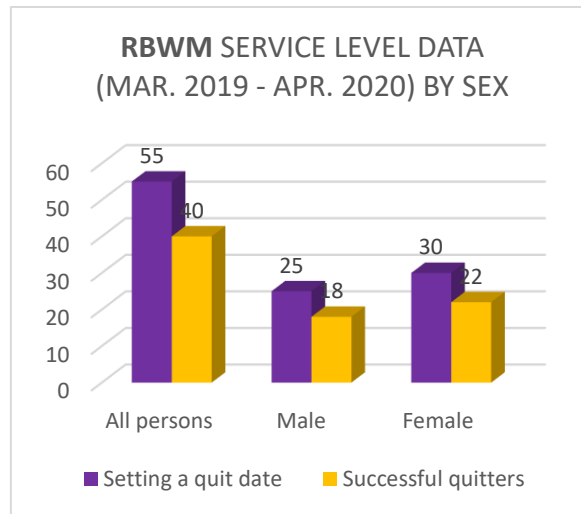


Source: [Local Tobacco Control Profiles - Data - OHID \(phe.org.uk\)](#)

Between April 2020 – December 2020, 13 out of 20 setting a quit date had successfully quit (65% success rate).

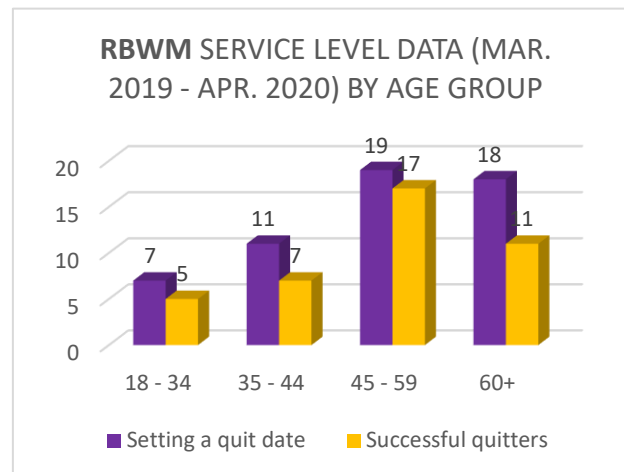
Figures 20-22 show the successful quit rates by gender, age, and ethnicity. The low number of service users mean it is difficult to draw conclusions, but both male and female service users had a similar successful quit rate (72% and 73%, respectively).

**Figure 20: Number of residents accessing community stop smoking services in 2019/20, segmented by sex.**



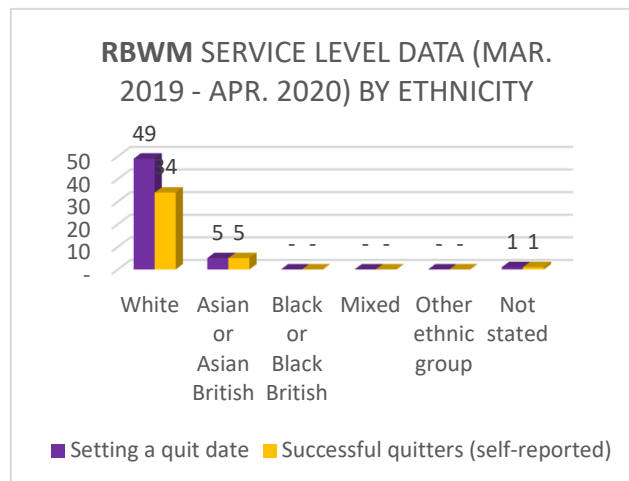
Source: NHS Digital Stop Smoking Services annual report, 2019/20

**Figure 21: Number of residents accessing community stop smoking services in 2019/20, segmented by age group.**



Source: NHS Digital Stop Smoking Services annual report, 2019/20

**Figure 22: Number of residents accessing community stop smoking services in 2019/20, segmented by ethnicity.**



Source: NHS Digital Stop Smoking Services annual report, 2019/20

### 6.5 Conclusions on current service provision

- Recommendations for incumbent provider to continue to record and report on referral sources to assess and target work with stakeholders to increase referrals into service / referral pathways. This would work toward the guidelines set by NICE, to see >5% of the smoking population per annum ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk/guidance/ta252)), comparatively to the 0.5% seen in 2019/20. Though rates of successful 4 week quits are 73%, which is over double that recommended by NICE (35%) ([Tobacco: preventing uptake, promoting quitting and treating dependence \(nice.org.uk\)](https://www.nice.org.uk/guidance/ta252)). This should be interpreted with caution as the number of people using the service is low.
- Numbers of males and females “*setting a quit date*” & “*successful quitters*” are similar, thus low evidence of inequity. Though more females access community support, despite estimated smoking prevalence being lower amongst females. This could be indicative of evidence that shows women (in general) are more likely to seek support and/or access health services. Recommendations could be made to target men to increase engagement with locally commissioned services.
- Individuals from the age group 45-59 were the most likely to access community services and more likely to successfully quit, compared with all other age groups. Though data from Frimley System Insights suggests that residents between the age of 30-39 are more likely to be smokers.
- Individuals identifying as *White* make up the majority presenting to the community service. This is reflected by ethnic breakdown of the RBWM population.
- Work associated to the NHS LTP could influence referral rates to community-based smoking cessation services. This could increase or decrease referral rates, depending on effectiveness of treatment, referral pathways and patient/service user engagement (with the above services).
- Most appointments in 2019/20 (94%) were delivered through a face-to-face means. This percentage decreased due to the coronavirus pandemic where behavioural support was remote, delivered through telephone and digital means. Recommendations could be made that a hybrid model of access/treatment be made available.
- Recommendations could be made that a hybrid model of access/treatment be made available.

## 7.0 Comparisons with services across Berkshire

### 7.1 Variation in outcomes across the South East

There is variation across Berkshire and the South East, in the rate of smokers setting a quit date (Figure 23) and the rate of smokers that have successfully quit at 4 weeks (Figure 24).

**Figure 23: Smokers that have set a quit date per 100,000 smokers aged 16+ in Local Authorities across the South East region, 2019/20.**

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	221,678	3,512	3,497	3,527
South East region	-	35,042	3,884*	3,842	3,925
Medway	-	2,336	7,546	6,340	8,994
Slough	-	1,225	6,889	5,883	8,049
East Sussex	-	3,973	6,795	6,578	7,015
Milton Keynes	-	1,666	5,348	4,597	6,219
Hampshire	-	5,243	4,653	4,526	4,783
Portsmouth	-	1,334	4,627	4,001	5,376
Oxfordshire	-	2,815	4,187	4,031	4,347
West Sussex	-	2,922	4,123	3,971	4,273
Brighton and Hove	-	1,627	3,778	3,260	4,395
Kent	-	6,510	3,736	3,644	3,828
Wokingham	-	378	3,332	2,676	4,124
West Berkshire	-	395	3,009	2,427	3,718
Surrey	-	2,364	2,451	2,353	2,550
Reading	-	425	2,381	1,980	2,875
Buckinghamshire UA	-	1,094	2,236*	2,102	2,366
Southampton	-	469	1,357	1,156	1,592
Isle of Wight	-	211	1,220	1,007	1,469
Windsor and Maidenhead	-	55	465	328	620
Bracknell Forest	-	-	-	-	-

Source: [Public health profiles - OHID \(phe.org.uk\)](http://publichealthprofiles-ohid.phe.org.uk)

**Figure 24: Smokers that have successfully quit at 4-weeks per 100,000 smokers aged 16+ in Local Authorities across the South East region, 2019/20.**

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	-	114,153	1,808	1,798	1,819
South East region	-	18,580	2,060*	2,029	2,090
Slough	-	787	4,426	3,748	5,220
Medway	-	1,127	3,641	3,052	4,371
Milton Keynes	-	1,042	3,345	2,862	3,919
East Sussex	-	1,838	3,143	2,995	3,289
Oxfordshire	-	1,952	2,904	2,774	3,033
Hampshire	-	3,069	2,724	2,627	2,823
Kent	-	3,898	2,237	2,167	2,309
Wokingham	-	239	2,107	1,674	2,652
Portsmouth	-	589	2,043	1,741	2,398
West Berkshire	-	245	1,866	1,487	2,333
Brighton and Hove	-	655	1,521	1,296	1,793
Reading	-	271	1,518	1,240	1,847
Surrey	-	1,221	1,266	1,193	1,337
Buckinghamshire UA	-	581	1,188*	1,089	1,284
West Sussex	-	766	1,081	1,005	1,158
Isle of Wight	-	126	729	580	900
Southampton	-	134	388	309	478
Windsor and Maidenhead	-	40	338	224	468
Bracknell Forest	-	-	-	-	-

Source: [Local Tobacco Control Profiles - Data - OHID \(phe.org.uk\)](http://localtobaccocontrolprofiles-data-ohid.phe.org.uk)

Figures 23 and 24 highlight that in 2019/20, RBWM had one of the lowest rates of residents setting 4-week quit dates and successfully quitting smoking at 4-weeks in the South East. There are many factors which may explain these findings. For example, variation in underlying smoking rates and differences in age, ethnicity, or levels of deprivation.

### 7.2 Variation in service delivery across Berkshire

The way in which smoking services are delivered varies across Berkshire. The three local authorities in Berkshire West (Reading, West Berkshire, and Wokingham) jointly commission the Berkshire West

Stop Smoking Service (Smokefreelife Berkshire). They also jointly commission the Berkshire West Tobacco Control Alliance.

Slough's smoking cessation service sits within its integrated wellbeing service. This may be advantageous, as negatively impacting health behaviours rarely exist in isolation (as suggested by Acorn profiles).

In Bracknell Forest and RBWM, the smoking cessation services are commissioned as individual services.

All Local Authorities within Berkshire and Frimley ICS provide behavioural support and pharmacotherapy (in the form of NRT) as part of treatment; aside from RBWM which only provides behavioural support and not pharmacotherapy.

**Recommendation 5:** Explore opportunities for joint commissioning with Frimley ICS, and East Berkshire Public Health and Commissioning colleagues, to procure a joint smoking cessation contract in the future. Consideration should also be given to including smoking cessation as an integral part of an integrated healthy behaviours service, which has the potential to improve outcomes by taking a person-centred approach to health behaviour needs.

## 8.0 Feedback from professionals

Professionals within maternity and respiratory physiotherapy services have suggested that because RBWM do not commission NRT provision within their community smoking cessation service, there is an inequity with the other Local Authorities within Frimley ICS (all of which do commission NRT through their community services). No evidence is available to understand how many RBWM residents are unable to access NRT as a result of the local commissioning arrangement or how prescriptive provision of NRT would affect quit rates seen within the RBWM community service.

## 9.0 Feedback from service users, patients, and residents

RBWM's smoking cessation service does not currently receive feedback provided by service users.

**Recommendation 6:** Acquire in depth quantitative and qualitative feedback from the local service and service users, to build an evidence base to drive future commissioning proposals and decisions.

## 10.0 Cost-effective solutions

A PHE publication in September 2015, showed a cost to benefit analysis that for every £1 spent on tobacco control interventions, we could save £2.07 by year 5, £3.92 by year 10 and approximately £11.38 over a lifetime of a smoker who quits. These would be savings from a combination of reduced demands on primary care / NHS resources and productivity gains from quality adjust life years (PHE, 2015, [Health matters: smoking and quitting in England - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/474442/Health_matters_smoking_and_quitting_in_England_-_GOV.UK_(www.gov.uk).pdf)).

A 2019 Cochrane review has found that financial incentives (vs. no incentives) for smoking cessation in pregnancy increased [smoking] abstinence in late pregnancy/post-partum from 7.2% to 17%. As

previously discussed, this can lead to onward savings (stated above) for both mother and child (Cochrane, 2019, [Incentives for smoking cessation - Notley, C - 2019 | Cochrane Library](#)).

**ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD  
EQUALITY IMPACT ASSESSMENT**

**EqlA : Title of EQIA**

**Essential information**

Items to be assessed: (please mark 'x')

<b>Strategy</b>		<b>Policy</b>		<b>Plan</b>		<b>Project</b>	X	<b>Service/Procedure</b>	
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<b>Responsible officer</b>	Charlotte Fox	<b>Service area</b>	Public Health	<b>Directorate</b>	Adults, Health, and Housing
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<b>Stage 1: EqlA Screening (mandatory)</b>	Date created: 09/03/2022	<b>Stage 2 : Full assessment (if applicable)</b>	N/A
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**Approved by Head of Service / Overseeing group/body / Project Sponsor:**

*"I am satisfied that an equality impact has been undertaken adequately."*

**Signed by (print):** Anna Richards

**Dated:** 14/03/2022

47

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

### EqlA : Title of EQIA

#### Guidance notes

##### What is an EqlA and why do we need to do it?

The Equality Act 2010 places a 'General Duty' on all public bodies to have 'due regard' to:

- Eliminating discrimination, harassment and victimisation and any other conduct prohibited under the Act.
- Advancing equality of opportunity between those with 'protected characteristics' and those without them.
- Fostering good relations between those with 'protected characteristics' and those without them.

EqlAs are a systematic way of taking equal opportunities into consideration when making a decision, and should be conducted when there is a new or reviewed strategy, policy, plan, project, service or procedure in order to determine whether there will likely be a detrimental and/or disproportionate impact on particular groups, including those within the workforce and customer/public groups. All completed EqlA Screenings are required to be publicly available on the council's website once they have been signed off by the relevant Head of Service or Strategic/Policy/Operational Group or Project Sponsor.

##### What are the "protected characteristics" under the law?

The following are protected characteristics under the Equality Act 2010: age; disability (including physical, learning and mental health conditions); gender reassignment; marriage and civil partnership; pregnancy and maternity; race; religion or belief; sex; sexual orientation.

##### What's the process for conducting an EqlA?

The process for conducting an EqlA is set out at the end of this document. In brief, a Screening Assessment should be conducted for every new or reviewed strategy, policy, plan, project, service or procedure and the outcome of the Screening Assessment will indicate whether a Full Assessment should be undertaken.

##### Openness and transparency

RBWM has a 'Specific Duty' to publish information about people affected by our policies and practices. Your completed assessment should be sent to the Strategy & Performance Team for publication to the RBWM website once it has been signed off by the relevant manager, and/or Strategic, Policy, or Operational Group. If your proposals are being made to Cabinet or any other Committee, please append a copy of your completed Screening or Full Assessment to your report.

##### Enforcement

Judicial review of an authority can be taken by any person, including the Equality and Human Rights Commission (EHRC) or a group of people, with an interest, in respect of alleged failure to comply with the general equality duty. Only the EHRC can enforce the specific duties. A failure to comply with the specific duties may however be used as evidence of a failure to comply with the general duty.



# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

### EqlA : Title of EQIA

#### Stage 1 : Screening (Mandatory)

##### 1.1 What is the overall aim of your proposed strategy/policy/project etc and what are its key objectives?

The Smoking Cessation Health Needs Assessment (HNA) has been developed to inform the commissioning of interventions to support people to stop smoking in the Royal Borough of Windsor and Maidenhead (RBWM). The HNA provides a summary of the evidence base for commissioned services that best meet the needs of the local adult population.

The HNA summarises the most recent data on smoking in RBWM and the evidence of what works to best meet the needs of residents. The recommendations should inform the commissioning of interventions for smoking cessation and reducing harm related to combustible tobacco products (e.g., cigarettes, cigars, rolling tobacco, and pipe tobacco) in RBWM.

The aim of the HNA is to answer three key questions:

- How many residents smoke and does it vary across different groups?
- What services do residents have to support them to stop smoking?
- Is there anything we should be doing differently to help people to stop smoking?

For the purposes of this HNA, the “smoking population” will be defined as: “Any individual within RBWM who uses combustible tobacco products; rather than any method of inhaled tobacco/nicotine product (e.g., electronic cigarettes).”

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

**EqIA : Title of EQIA**

**1.2 What evidence is available to suggest that your proposal could have an impact on people (including staff and customers) with protected characteristics? Consider each of the protected characteristics in turn and identify whether your proposal is Relevant or Not Relevant to that characteristic. If Relevant, please assess the level of impact as either High / Medium / Low and whether the impact is Positive (i.e. contributes to promoting equality or improving relations within an equality group) or Negative (i.e. could disadvantage them). Please document your evidence for each assessment you make, including a justification of why you may have identified the proposal as “Not Relevant”.**

**ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD  
EQUALITY IMPACT ASSESSMENT**

**EqIA : Title of EQIA**

<b>Protected characteristics</b>	<b>Relevance</b>	<b>Level</b>	<b>Positive/negative</b>	<b>Evidence</b>
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# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

### EqlA : Title of EQIA

	<b>Age</b> Relevant	Medium	Positive 2	<p>The current RBWM population size is 162,406 of which 16,195 are current smokers (as coded on GP records). Of the 16,195 known current smokers in RBWM, 6,495 are female and 9,700 are male. The highest prevalence of smokers (females and males) is the 30-39 age group, followed by the 40-49 age group. In both sexes, smoking prevalence increases from 0-39 years and decreases in people aged 40 and above, as shown in Figure 6. (Data Source: Frimley Health and Care ICS System Insights, Local Insights Report. Data Accessed 17/12/21).</p> <ul style="list-style-type: none"> <li>- This data relies on clinical coding from patient records meaning there could be an over- or under-representation of current smokers. The data could show an underrepresentation of current smokers as it is likely that some individuals who smoke are not marked as a current smoker on their patient record. The data could also show an overrepresentation as individuals may have stopped smoking but may still be marked as a current smoker on their patient record. Hence, data should be interpreted with caution.</li> </ul> <p>ACORN data is predictive data that looks at areas that are more likely to smoke 20+ cigarettes a day. Based up on the top three sub-group types, ACORN predicts an over representation of smoking behaviours within the 30 – 39 age range. This differs slightly from predictive analysis provided by PHOF, where it is suggested slightly higher rates of smoking may be seen in the 25 – 29 age range. Note these two datasets are defined/filtered differently, therefore a degree of caution must be applied when comparing. (Data Source: Frimley Health and Care ICS System Insights, ACORN data. Data Accessed 17/12/21).</p>
<b>Disability</b>	Not Relevant	N/A	N/A	

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

**EqlA : Title of EQIA**

<b>Gender re-assignment</b>	Not Relevant	N/A	N/A	
<b>Marriage/civil partnership</b>	Not Relevant	N/A	N/A	

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

### EqlA : Title of EQIA

<p><b>Pregnancy and maternity</b></p>	<p>Relevant</p>	<p>Medium</p>	<p>Positive</p>	<p>Smoking during pregnancy can cause premature births, miscarriage, and perinatal deaths. It also increases risk of stillbirth, complications in pregnancy, low birthweight, and the child developing other conditions in later life. This is a key area of health inequalities that is one of the priorities of the NHS Long Term Plan.</p> <p>Prevalence of <i>smoking in early pregnancy</i> (up to 12 weeks gestation) &amp; <i>smoking at time of delivery</i> (SATOD) was 6.4% &amp; 6.5% (94 women SATOD) respectively (PHOF, 2018/19 &amp; 2019/20 respectively). Both rank statistically better than the South East regional averages (11.3% &amp; 9.7%) and England averages (12.8% &amp; 10.4%) (PHOF, 2018/19 &amp; 2019/20 respectively, <a href="#">Local Tobacco Control Profiles - Data - PHE</a>).</p> <p>Premature birth and low birth weight are two potential outcomes associated with ante-natal smoking (direct or second-hand), which can lead to poor health outcomes and health inequalities for those babies later in life. Whilst smoking is not the sole cause of these outcomes, they could provide proxy indicators to health inequalities caused by smoking within the local population.</p> <p>Between 2016 and 2018, 411 incidents of <i>premature births</i> (&lt;37 week gestation) were recorded in RBWM, equating to a prevalence of 82.2 per 1,000 (latest figures for rate of premature live births [gestational age between 24-36 weeks] and all stillbirths per 1000). This is statistically similar to the South East regional average of 78.1 per 1000 births and England average of 81.2 per 1000 (PHOF, 2019, <a href="#">Local Tobacco Control Profiles - Data - PHE</a>).</p> <p>In 2019, 33 incidents of <i>low birth weight of term babies</i> were recorded, equating to a prevalence of 2.4%. This was statistically</p>
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# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

### EqIA : Title of EQIA

				similar to the South East regional average of 2.5% and the England average of 2.9% (PHOF, 2019, <a href="#">Local Tobacco Control Profiles - Data - PHE</a> ).
<b>Race</b>	Relevant	Medium	Positive	<p>The Annual Population Survey data provides a breakdown of smoking prevalence by ethnicity for England in 2019 (Figures 8 &amp; 9). This shows higher prevalence rates in males from mixed and other ethnic groups. Prevalence rates in females are highest in mixed and white ethnic groups.</p> <p>More locally, of the 16,195 current smokers in RBWM, 77.7% are white ethnicity, 8.7% are from Black, Asian Minority Ethnic (BAME) groups, and 0.8% are from other ethnic groups. There is insufficient data to group the remaining 12.9% by ethnicity (Frimley Health and Care ICS, System Insights. Data Accessed 17/12/21). This breakdown of current smokers in RBWM by ethnicity, is similar in the ACORN predicted data, with Figure 10 showing that those of White ethnicity are more likely to have smoking 20+ cigarettes per day behaviours than other ethnicities. This supports data provided by PHOF. There is indication that a disproportionate number of people from BAME communities in RBWM are smokers, which supports predictive analysis data from PHOF.</p>
<b>Religion and belief</b>	Not Relevant	N/A	N/A	

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

### EqlA : Title of EQIA

<b>Sex</b>	Relevant	Medium	Positive	<p>The current RBWM population size is 162,406 of which 16,195 are current smokers (as coded on GP records). Of the 16,195 known current smokers in RBWM, 6,495 are female and 9,700 are male.</p> <p>(Data Source: Frimley Health and Care ICS System Insights, Local Insights Report. Data Accessed 17/12/21).</p> <ul style="list-style-type: none"> <li>- This data relies on clinical coding from patient records meaning there could be an over- or under-representation of current smokers. The data could show an underrepresentation of current smokers as it is likely that some individuals who smoke are not marked as a current smoker on their patient record. The data could also show an overrepresentation as individuals may have stopped smoking but may still be marked as a current smoker on their patient record. Hence, data should be interpreted with caution.</li> </ul> <p>The data also suggests that women are more likely to access the service which could be indicative of evidence that shows women (in general) are more likely to seek support and/or access health services.</p>
<b>Sexual orientation</b>	Not Relevant	N/A	N/A	

56

**Outcome, action and public reporting**



# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

### EqIA : Title of EQIA

Screening Assessment Outcome	Yes / No / Not at this stage	Further Action Required / Action to be taken	Responsible Officer and / or Lead Strategic Group	Timescale for Resolution of negative impact / Delivery of positive impact
Was a significant level of negative impact identified?	No	No		N/A
Does the strategy, policy, plan etc require amendment to have a positive impact?	No	No		N/A

57

If you answered **yes** to either / both of the questions above a Full Assessment is advisable and so please proceed to Stage 2. If you answered “No” or “Not at this Stage” to either / both of the questions above please consider any next steps that may be taken (e.g. monitor future impacts as part of implementation, re-screen the project at its next delivery milestone etc).

### Stage 2 : Full assessment

#### 2.1 : Scope and define

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

**EqIA : Title of EQIA**

**2.1.1 Who are the main beneficiaries of the proposed strategy / policy / plan / project / service / procedure? List the groups who the work is targeting/aimed at.**

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**2.1.2 Who has been involved in the creation of the proposed strategy / policy / plan / project / service / procedure? List those groups who the work is targeting/aimed at.**

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### **2.2 : Information gathering/evidence**

**2.2.1 What secondary data have you used in this assessment? Common sources of secondary data include: censuses, organisational records.**

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**ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD**

**EQUALITY IMPACT ASSESSMENT**

**EqIA : Title of EQIA**

59

**2.2.2 What primary data have you used to inform this assessment?** *Common sources of primary data include: consultation through interviews, focus groups, questionnaires.*

**Eliminate discrimination, harassment, victimisation**

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

EqlA : Title of EQIA

Protected Characteristic	Advancing the Equality Duty : Does the proposal advance the Equality Duty Statement in relation to the protected characteristic (Yes/No)	If yes, to what level? (High / Medium / Low)	Negative impact : Does the proposal disadvantage them (Yes / No)	If yes, to what level? (High / Medium / Low)	Please provide explanatory detail relating to your assessment and outline any key actions to (a) advance the Equality Duty and (b) reduce negative impact on each protected characteristic.
Age					
Disability					
Gender reassignment					
Marriage and civil partnership					
Pregnancy and maternity					
Race					
Religion and belief					
Sex					
Sexual orientation					

60

**Advance equality of opportunity**

# ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD

## EQUALITY IMPACT ASSESSMENT

EqlA : Title of EQIA

Protected Characteristic	Advancing the Equality Duty : Does the proposal advance the Equality Duty Statement in relation to the protected characteristic (Yes/No)	If yes, to what level? (High / Medium / Low)	Negative impact : Does the proposal disadvantage them (Yes / No)	If yes, to what level? (High / Medium / Low)	Please provide explanatory detail relating to your assessment and outline any key actions to (a) advance the Equality Duty and (b) reduce negative impact on each protected characteristic.
Age					
Disability					
Gender reassignment					
Marriage and civil partnership					
Pregnancy and maternity					
Race					
Religion and belief					
Sex					
Sexual orientation					

61

**ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD**  
**EQUALITY IMPACT ASSESSMENT**

**EqlA : Title of EQIA**

**Foster good relations**

Protected Characteristic	Advancing the Equality Duty : Does the proposal advance the Equality Duty Statement in relation to the protected characteristic (Yes/No)	If yes, to what level? (High / Medium / Low)	Negative impact : Does the proposal disadvantage them (Yes / No)	If yes, to what level? (High / Medium / Low)	Please provide explanatory detail relating to your assessment and outline any key actions to (a) advance the Equality Duty and (b) reduce negative impact on each protected characteristic.
Age					
Disability					
Gender reassignment					
Marriage and civil partnership					
Pregnancy and maternity					
Race					
Religion and belief					
Sex					
Sexual orientation					

62

**2.4 Has your delivery plan been updated to incorporate the activities identified in this assessment to mitigate any identified negative impacts? If so please summarise any updates.**  
*These could be service, equality, project or other delivery plans. If you did not have sufficient data to complete a thorough impact assessment, then an action should be incorporated to collect this information in the future.*

**ROYAL BOROUGH OF WINDSOR AND MAIDENHEAD  
EQUALITY IMPACT ASSESSMENT**

**EqIA : Title of EQIA**

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<b>Subject:</b>	Strategic Partnership Boards
<b>Reason for briefing note:</b>	To advise the Health and Wellbeing Board of the establishment of two strategic boards, one for adults and one for children.
<b>Senior leader sponsors:</b>	Hilary Hall, Executive Director of Adults, Health and Housing Kevin McDaniel, Executive Director of Children's Services Caroline Farrar, Executive Place Managing Director
<b>Date:</b>	29 March 2022

www.rbwm.gov.uk



## 1 BACKGROUND

- 1.1 A paper developed in late summer 2021 set out the current position with strategic partnership boards in RBWM:
- There are no strategic partnership boards existing in the Royal Borough where agencies come together to agree strategy and monitor actions.
  - Where strategic partnership boards exist, they tend to be at an East Berkshire/Frimley level.
  - Where there are “partnership boards” in existence (autism and learning disabilities), they are, in reality, quasi user forums, albeit not fully representative.
  - With the exception of autism, there are no place-based strategies which set out the ambitions for specific cohorts of people in the borough.
- 1.2 The paper set out a proposal to develop six strategic partnership boards to support the development of partnership strategic and action plans with meaningful co-production, and to monitor the implementation and delivery of those plans within the wider context of the existing Frimley-wide and East Berkshire arrangements.

## 2 KEY IMPLICATIONS

- 2.1 Strategic partnership boards were proposed for the following cohorts of people, each with representation from the relevant agencies, together with a carer representative and a person with lived experience:
- Autistic people
  - People with learning disabilities
  - Older people and people with dementia
  - Carers
  - People with physical disabilities and those with sensory needs
  - People with mental health needs
- 2.2 Subsequently, it has been identified that strategies in relation to transitions and dementia would also be beneficial.

- 2.3 Feedback from the group was that although there was merit in the proposals, the time and resource requirement was too great and so alternative proposals have been developed for a single Adults Strategic Partnership Board and alongside it a Children and Young People's Strategic Partnership Board. Additionally, there is other partnership activity, such as the Mental Health Transformation Plan and the Accelerated Action Plan for SEND, which would benefit from increased strategic oversight.
- 2.4 Terms of reference for each board are attached at appendix 1, and have been framed within the vision, principles and priorities of the Health and Wellbeing Strategy/Place Strategic Framework. The role of each board is to:
- Develop and agree its strategy/strategies using all the principles of co-design and co-production.
  - Develop and agree an action plan to deliver the strategy/strategies.
  - Monitor and hold partners to account for the delivery of the action plans.
  - Respond to system and government initiatives and consultation.
- 2.5 Both boards are proposed to report direct to the Health and Wellbeing Board, including reporting on progress on a six monthly basis.

### **3 RECOMMENDATIONS**

#### **3.1 The Health and Wellbeing Board is asked to:**

- a) **Note the terms for reference for the two Strategic Partnership Boards.**
- b) **Note that a progress report from each Board will come to the Health and Wellbeing Board in six months' time.**

## Royal Borough of Windsor and Maidenhead

### Adults Strategic Partnership

#### TERMS OF REFERENCE

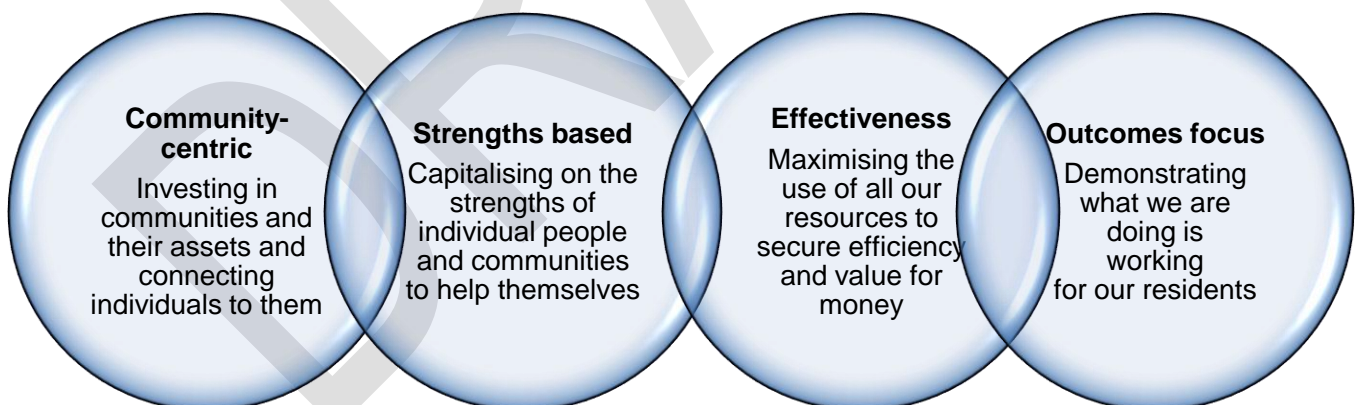
##### Scope and purpose

The Adults Strategic Partnership brings together agencies sharing responsibility for the successful delivery of outcomes and services for adults in the borough. In line with the objectives of the Health and Wellbeing Strategy, the Partnership enables strategic integrated decision making across the sector and robust monitoring of strategies for those adults facing particular challenges due to age, disability or long term conditions.

Our vision is that *“Everyone in the borough lives a healthy, safe and independent life, supported by thriving and connected communities”*. As system leaders, the individual members of the Partnership are collectively accountable for the impact of the system as a whole and not just for the individual priorities of their own organisations.

##### Principles

Our partnership will be driven by the core principles enshrined in the Joint Health and Wellbeing Strategy-Place Strategic Framework:



##### Measures of success

We believe we will have **succeeded** when all adults in the borough:

- ✓ Have the best start in life as children, which continues through adolescence, adulthood and older age.
- ✓ Lead active and independent lives for as long as possible.
- ✓ Enjoy sustained emotional health and wellbeing throughout their lives.
- ✓ Live in good quality homes in sustainable and supportive communities.
- ✓ Experience a good quality of life for longer, no matter where they live.

## **Priorities and responsibilities**

The work of the Partnership is framed within the key **priorities** identified in the Joint Health and Wellbeing Strategy-Place Strategic Framework:

- Coordinating integrated services around those residents who need it most.
- Championing mental wellbeing and reducing social isolation.
- Targeting prevention and early intervention to improve wellbeing.
- Investing in the borough as a place to live in order to reduce inequalities.

The specific **responsibilities** of the Partnership are to:

1. Establish and develop a set of strategies for adults facing particular challenges due to age, disability or long term conditions in the Royal Borough of Windsor and Maidenhead, based on information from the Joint Strategic Needs Assessment, intelligence across all partner agencies and co-production with residents and carers.
2. Monitor and review the effectiveness of the strategies through an agreed outcomes framework framed around the agreed measures of success.
3. Be an active decision-making body within the borough helping to create collaborative working arrangements between organisations to deliver shared objectives.
4. Discuss developments within the wider adults sector, including the Government's reform of adult social care, and agree mechanisms for addressing any implications.
5. Be a shared space for partners to collaborate and actively promote and champion their own organisational priorities to key stakeholders within the sector to enable engagement and buy-in.
6. Address challenging issues that impact on the outcomes for people in the borough, developing and forming appropriate and shared mitigation actions.
7. Pool resources where this would be beneficial.
8. Deliver an annual impact report to demonstrate progress against the agreed strategies.

## **Governance**

The Partnership reports to the Royal Borough of Windsor and Maidenhead's Health and Wellbeing Board on the contribution it is making to the delivery of the overarching Health and Wellbeing Strategy-Place Strategic Framework.

It works closely with other partnerships, including the Children and Young People's Strategic Partnership, Safeguarding Partnership, Community Safety Partnership, Housing Strategy Group and Climate Change Partnership, to ensure that activities and outcomes are aligned across the borough.

The Partnership will also actively engage with all user groups/networks and other representative bodies to ensure that people's voice is heard and that it influences and informs decision making. Groups/individuals will be encouraged to participate in the work of the Partnership through a number of different methods.

## **Membership**

Membership will be drawn from the following organisations:

- Royal Borough of Windsor and Maidenhead
- Optalis
- Frimley CCG
- Berkshire Healthcare Foundation Trust
- Frimley Health Foundation Trust
- Primary Care Networks
- Achieving for Children
- Berkshire Care Association
- Thames Valley Police
- Berkshire Fire and Rescue Service
- Voluntary Sector organisations
- South East Central Ambulance Service

Members of the Partnership will be nominated by their organisation and will operate at an appropriate level of seniority and delegation. Representatives may be sent in the event of unavailability.

A minimum of 60% attendance will be required for formal decision making.

Membership will be reviewed on an annual basis.

## **Operating procedures**

- Members must have the authority to speak, make decisions and, where appropriate, commit resources to the work of the Partnership, on behalf of their organisation/sector.
- A Chair and Vice-Chair will be elected at the first meeting of the year and hold office for one year.
- Administrative support for the Partnership will be provided by the Royal Borough of Windsor and Maidenhead.
- Time limited task and finish groups will be established, as required, to take forward agreed work.
- The Partnership will meet five times a year, with meetings taking place virtually.

## **Responsibility of the chair**

1. Provide leadership for the Partnership.
2. Ensure the Partnership operates within the terms of reference.
3. Provide guidance and direction to lead officers tasked with activity within the strategies.
4. Hold agencies to account, where necessary, to ensure work to progress the targets within the strategies is achieved.
5. Challenge individual agencies, where required, in the event of continued non-attendance/engagement by their nominated representative.

**Conflicts of interest**

Members and any representatives/substitutes with a personal, financial or service interest in a matter being discussed, must declare that interest at the beginning of the meeting or as soon as they become aware of the potential conflict.

Date: March 2022

Date of review: March 2023

**Royal Borough of Windsor and Maidenhead**

**Children and Young People’s Strategic Partnership**

**TERMS OF REFERENCE**

**Scope and purpose**

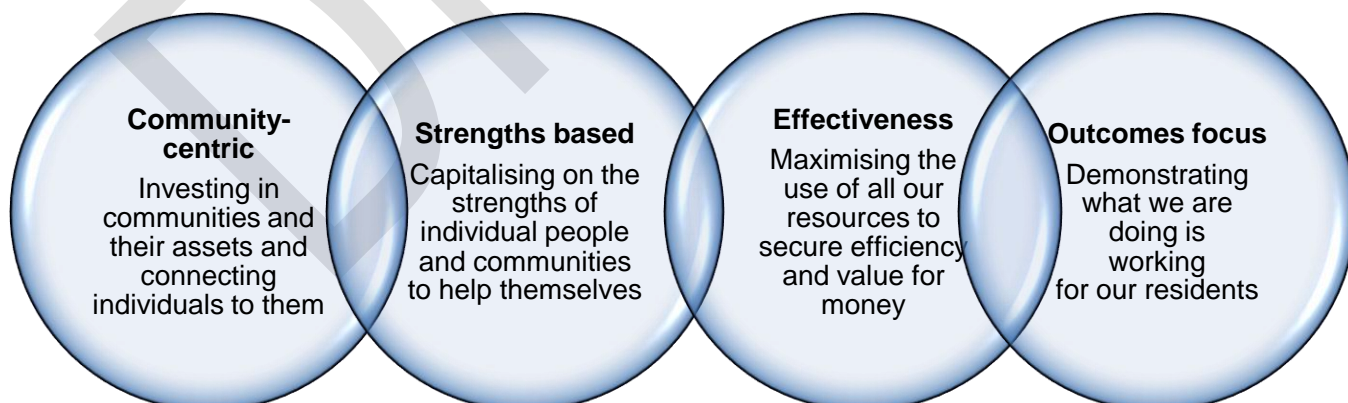
The Children and Young People’s Strategic Partnership brings together agencies sharing responsibility for the successful delivery of outcomes and services for children and young people in the borough. In line with the objectives of the Health and Wellbeing Strategy, the Partnership enables strategic integrated decision making across the sector and the development, delivery and monitoring of the Children and Young People’s Plan.

Our vision is that “*Everyone in the borough lives a healthy, safe and independent life, supported by thriving and connected communities*”. As system leaders, the individual members of the Partnership are collectively accountable for the impact of the system as a whole and not just for the individual priorities of their own organisations.

Under section 10 of the Children and Families Act 2014 the local authority is under a duty to make arrangements to promote cooperation between itself and organisations and agencies to improve the wellbeing of local children. The Children and Young People’s Strategic Partnership fulfils this duty.

**Principles**

Our partnership will be driven by the core principles enshrined in the Joint Health and Wellbeing Strategy-Place Strategic Framework:



### Measures of success

We believe we will have **succeeded** when all children in the borough:

- ✓ Have the best start in life, which continues through adolescence, adulthood and older age.
- ✓ Lead active and independent lives for as long as possible.
- ✓ Enjoy sustained emotional health and wellbeing throughout their lives.
- ✓ Live in good quality homes in sustainable and supportive communities.
- ✓ Experience a good quality of life for longer, no matter where they live.

### Priorities and responsibilities

The work of the Partnership is framed within the key **priorities** identified in the Joint Health and Wellbeing Strategy-Place Strategic Framework:

- Coordinating integrated services around those residents who need it most.
- Championing mental wellbeing and reducing social isolation.
- Targeting prevention and early intervention to improve wellbeing.
- Investing in the borough as a place to live in order to reduce inequalities.

The specific **responsibilities** of the Partnership are to:

1. Establish and develop the Children and Young People's Plan for the Royal Borough of Windsor and Maidenhead, based on information from the Joint Strategic Needs Assessment, intelligence across all partner agencies and co-production with children, young people and families. The plan will act as a priority setting to represent the council's statutory plan for children and young people.
2. Monitor and review the effectiveness of the plan through an agreed outcomes framework framed around the agreed measures of success.
3. Be an active decision-making body within the borough helping to create collaborative working arrangements between organisations to deliver shared objectives.
4. Discuss developments within the wider children and young people's sector and agree mechanisms for addressing any implications.
5. Be a shared space for partners to collaborate and actively promote and champion their own organisational priorities to key stakeholders within the sector to enable engagement and buy-in.
6. Address challenging issues that impact on the outcomes for people in the borough, developing and forming appropriate and shared mitigation actions.
7. Pool resources where this would be beneficial.
8. Deliver an annual impact report to demonstrate progress against the agreed plan.

### Governance

The Partnership reports to the Royal Borough of Windsor and Maidenhead's Health and Wellbeing Board on the contribution it is making to the delivery of the overarching Health and Wellbeing Strategy-Place Strategic Framework.



It works closely with other partnerships, including the Adults Strategic Partnership, Safeguarding Partnership, Community Safety Partnership, Housing Strategy Group and Climate Change Partnership, to ensure that activities and outcomes are aligned across the borough.

The Partnership will also actively engage with all user groups/networks and other representative bodies to ensure that people's voice is heard and that it influences and informs decision making. Groups/individuals will be encouraged to participate in the work of the Partnership through a number of different methods.

### Membership

The Partnership aims to be a holistic collection of children and young people's service providers across Windsor and Maidenhead, as well as partners who play an important role in supporting the needs of children and young people in their everyday lives.

<b>Royal Borough of Windsor and Maidenhead Council</b>	<b>Name of Member</b>
Director of Children's Services (Achieving for Children)	Kevin McDaniel
Director of Social Care and Early Help (Achieving for Children)	Lin Ferguson
Consultant in Public Health (RBWM)	Anna Richards
Education Lead	Clive Haines
Chair of Schools Forum	Martin Tinsley
Windsor 3-Tier rep	Nina Adamson
Maidenhead/Ascot 2-Tier rep	Gemma Donnelly
Housing Head of Service (RBWM)	Tracy Hendren
<b>NHS Organisations</b>	
Place Managing Director, Frimley CCG	Caroline Farrar
Director Children and Young People, Berkshire Healthcare Foundation Trust	Karen Cridland
Director of Operations, Frimley CCG	Alex Tilley
Senior Transformation Lead, Frimley CCG	Pauline Peters
General Practitioner	Placeholder
<b>Community Organisations</b>	
Representative of the Voluntary Sector Forum	Placeholder
<b>Partners</b>	
Thames Valley Police, Borough Command Team	Superintendent Mick Greenwood
Parent Representative	PaCiP
Environment/Leisure Representative	Placeholder

Members of the Partnership will be nominated by their organisation and will operate at an appropriate level of seniority and delegation. Representatives may be sent in the event of unavailability.

A minimum of 60% attendance will be required for formal decision making.

Membership will be reviewed on an annual basis.

### **Operating procedures**

- Members must have the authority to speak, make decisions and, where appropriate, commit resources to the work of the Partnership, on behalf of their organisation/sector.
- Arrangements for the Chair are to be agreed.
- Administrative support for the Partnership will be provided by the Royal Borough of Windsor and Maidenhead.
- Time limited task and finish groups will be established, as required, to take forward agreed work.
- The Partnership will meet five times a year, with meetings taking place virtually.

### **Responsibility of the chair**

1. Provide leadership for the Partnership.
2. Ensure the Partnership operates within the terms of reference.
3. Provide guidance and direction to lead officers tasked with activity within the plan.
4. Hold agencies to account, where necessary, to ensure work to progress the targets within the plan is achieved.
5. Challenge individual agencies, where required, in the event of continued non-attendance/engagement by their nominated representative.

### **Conflicts of interest**

Members and any representatives/substitutes with a personal, financial or service interest in a matter being discussed, must declare that interest at the beginning of the meeting or as soon as they become aware of the potential conflict.

Date: March 2022  
Date of review: March 2023