Nottingham City JSNA - Smoking and Tobacco Control

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Executive summary

Introduction

Smoking remains the single largest preventable cause of early death in the UK and worldwide. Half of all lifelong smokers will die prematurely, usually about 10 years younger than non-smokers. The main causes of death from smoking are heart disease and strokes, lung cancer and chronic obstructive pulmonary disease (COPD).

For every smoking related death, another ten smokers will be living with a smoking related disease. Smoking affects every organ and every cell of the body, causing conditions ranging from diabetes, tuberculosis, sudden infant death syndrome, osteoporosis, impotence and reduced fertility. A third of all cancers and over 90% of lung cancers are directly caused by smoking. Action on Smoking and Health (ASH), a public health charity campaigning to reduce the harm caused by tobacco, produce a series of 'at a glance' factsheets.

This chapter will focus on changes since the 2015 chapter. Smoking in pregnancy is considered in the Pregnancy JSNA chapter.

Unmet need and gaps

Smoking cessation services

- Stub it! smoking cessation service is being delivered at present from only city centre locations. This means that citizens who are disabled or have poor mobility may not be able to access the service.
- The service is still fairly new and is currently dealing with a backlog of clients, resulting in long waiting times
- In secondary care, ward based advisors are providing smoking cessation support to smokers admitted into secondary care. This supports them to achieve temporary abstinence. Following discharge, reports from advisors suggest that follow-up by community based services is patchy and inconsistent, resulting in many smokers relapsing
- The current smoking cessation service does not have provision for children who might need support to stop smoking
- Current evidence on e-cigarettes suggest that they are far less harmful than smoking and should be used as part of harm reduction or quitting smoking. Public perception has lagged behind the evidence with many people believing that they are just as harmful as cigarettes. Encouraging people who cannot quit to switch to e-cigarettes would be a productive harm reduction strategy
- Strategies to target inpatients in hospitals is evidence based, yet staff have often not received training in the delivery of Very Brief Advice, limiting the success of this strategy

Equality and deprivation

- Deprived areas within the City continue to have smoking rates that are significantly higher than the national average which continues to widen the inequalities gap
- Illicit tobacco prevalence remains high in deprived areas of the city which undercuts the effects of tobacco control legislation and contributes to crime

Environmental exposures

- Second hand smoke remains a significant concern with a quarter of deprived homes allowing smoking inside. There is currently no targeted work in these areas to tackle children's exposure to second hand smoke
- PH48 implementation in hospitals can be intermittent with patients and visitors continuing to smoke on hospital grounds, exposing other patients to second hand smoke
- Shisha lounges remain prevalent in Nottingham City, despite smokefree legislation, putting the customers and employees of the shisha lounges at risk
- There is a lack of information on the harms of social smoking in the 16-24 year old age group

Recommendations for consideration by commissioners

Recommendation	Responsibility		
	Local Authority	Service Providers	CCG/CCP
Ensure that all hospital staff are trained in Very Brief Advice		Secondary care education administrators	
More stringent implementation of PH48 in secondary care, addressing QMC main entrance and City hospital gates	x	Secondary care	
Making Every Contact count in GP practice, dentistry, opticians etc., using Very Brief Advice	x	Various health care delivery providers	
Give consideration to smokers with reduced mobility in order to address access to smoking cessation services	x		
Provide fast tracking to community smoking cessation services for smokers who have quit in hospital, allowing the continuation of treatment in the community at a reasonable time	x	x	x
Include a question in the Citizens Survey to assess the approximate percentage of homes which allow smoking inside and expose children to second hand smoking	x		

Continue to expand the scope of smokefree areas	x		
Consider a public awareness campaign to encourage smokers to switch to e-cigarettes	x		
Continue to review the compliance to smokefree legislation of shisha lounges and issue notices accordingly	X Environmental Health		
Improve education in schools, colleges and universities as to the harms of shisha smoking, especially in areas with a high proportion of Asian ethnic minorities		x	
Continue to target those trading in illicit tobacco	X Trading Standards and Nottinghamshire Police		
Promote e-cigarettes as the treatment of choice for smoking cessation	X	X	X

What do we know?

1) Who is at risk and why?

Smoking remains the largest modifiable risk factor for preventable death in England, causing the deaths of 79,000 people a year; more than the next six causes combined, including alcohol, obesity and illegal drugs(1,2). Smoking and tobacco usage varies from the more traditional smoking tobacco, shisha, smokeless tobacco and the increasingly popular e-cigarette.

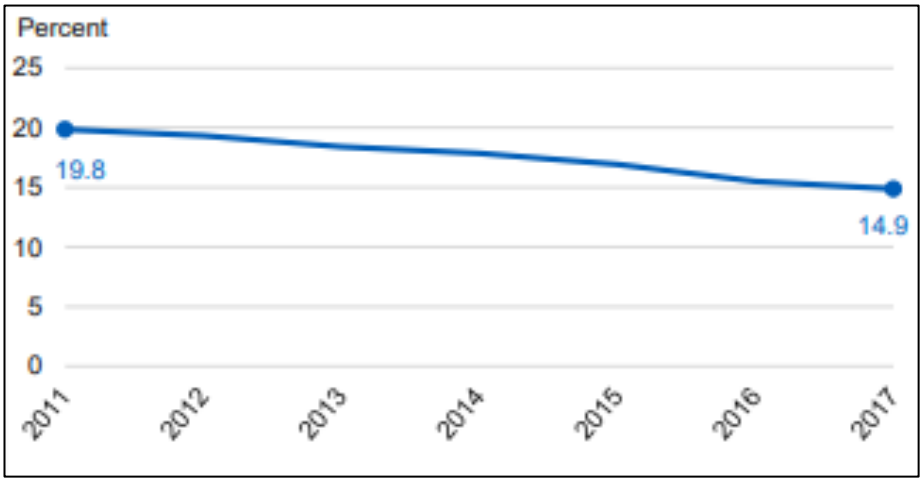


Figure 1. Smoking prevalence by year of adults in England.
Source: NHS Digital Statistics 2017.

1.1 Vulnerabilities

1.1.1 Age

Smoking prevalence across England has continued to fall with 14.9% of adults reported as smokers in 2017 compared with 15.5% in 2016 (see Figure 2 below). This is the lowest level since records began.

Men were more likely to smoke compared to women (17% of men, 13% of women). Adults aged 25 to 34 are most likely to smoke (20%), those aged 65 and over the least (8%). The prevalence of smoking in the youngest age group (18-24) has seen the largest decrease since 2011, falling nearly 8%. Children 15 years and younger who report smoking has fallen faster still, to 8% in 2014 from 30% in 1996 (see Figure 3 below). This is encouraging, given that 32% of smokers (current and ex-smokers) aged 18-24 started smoking when they were 16 or younger and 77% started before the age of 18 (1,3). Of the children who report smoking, 82% have a family member who smokes. A child with a smoking parent is 2-3 times more likely to smoke compared to those whose parents do not smoke. This highlights the importance of adult role models and the impact of the negative health spiral created by poor role models on future generations (3).

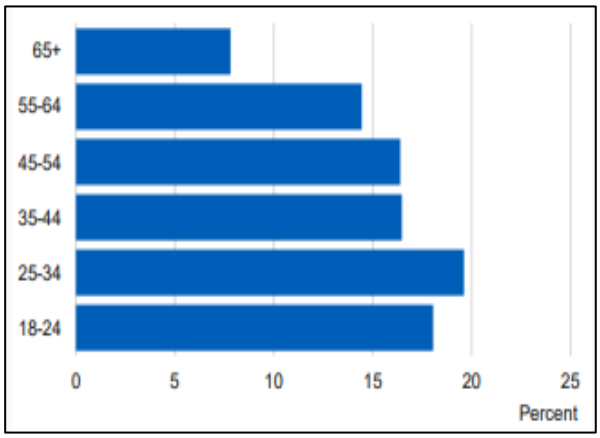


Figure 2. Smoking Prevalence by age. Source NHS Digital statistics

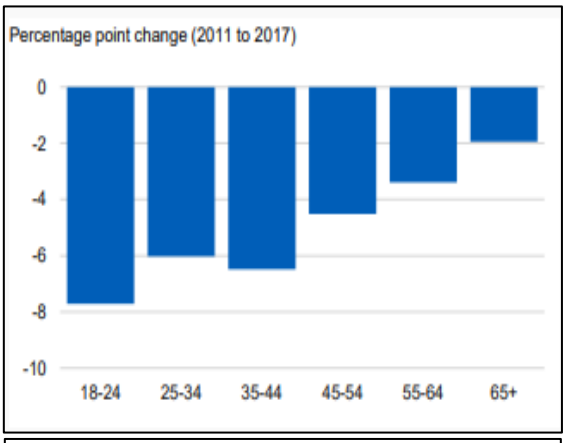


Figure 3. Percentage point change from 2011 to 2017 across age groups. Source: NHS Digital statistics

1.1.2 Poverty and socio-economic status

There is strong correlation between education, socio economic status and smoking. Only 8% of adults with a degree were smokers compared to those with no formal qualifications (28%); routine and manual workers were most likely to be smokers (26%) while those in professional occupations are the least likely (10%). There are three times as many smokers in the lowest earners compared to the highest earners(3). As addressed in the Prime Minister's first statement, the poorest in society will die, on average, 9 years earlier than the richest(4). Smoking accounts for half of this difference in life expectancy, making the impoverished a key target group in smoking cessation(3).

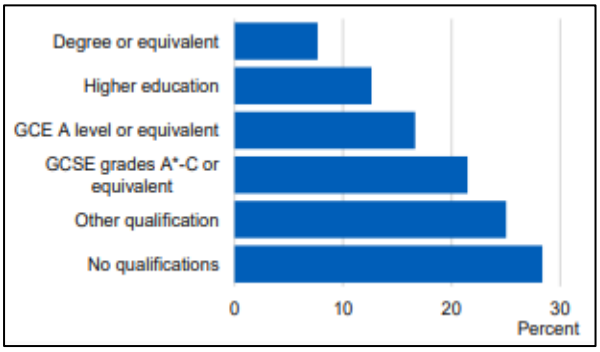


Figure 4. Smoking prevalence by qualifications. Source NHS Digital statistics

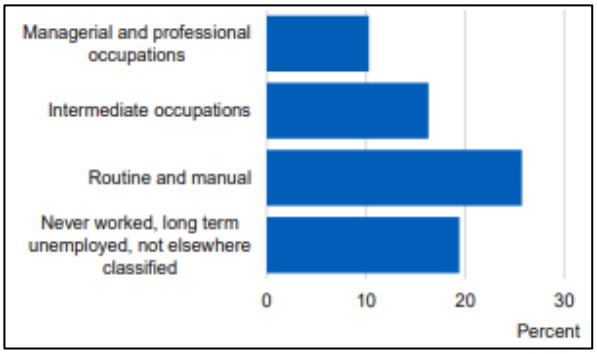


Figure 5. Smoking prevalence by socio-economic status of employment. Source NHS Digital statistics

1.1.3 Mental health patients

People with long standing mental health illnesses have long been known to be a high prevalence group for smoking, particularly in the inpatient setting. Across England, 27.8% of adults with a mental health condition report smoking compared to 18% of the general population(5). This widens inequalities and is the biggest contributor to the 10-20 year reduction in life expectancy of mental health patients.

People living with mental illness smoke at heavier rates and are more addicted than the general population, accounting for a third of tobacco consumption. There are several factors as to why the smoking prevalence is so high in this group including the prevailing, mistaken beliefs that smoking reduces depression and anxiety, mentally unwell patients do not want to quit and that quitting smoking might exacerbate their conditions(6).

1.1.4 People identifying as lesbian, gay, bisexual and transgender

People identifying as lesbian, gay, bisexual and transgender (LGBT) are more likely to experience health inequalities +(7). Data from the integrated household survey (2014) shows that LGBT groups are much more likely to smoke than the general population. LGBT people are also more likely to smoke and from a younger age than the general population. There are a number of risk factors associated with LGBT groups which puts them at a higher risk of smoking.

- Mental health: LGBT people are more likely to suffer from poor mental health which has a high association with smoking prevalence and tobacco consumption(7)
- Homelessness: LGBT people are more likely to be homeless with 24% of homeless youth identifying as LGBT(8). Homeless Link (2014) data suggests that up to 77% of homeless people smoke(7,9)
- Illegal drugs: LGBT people are at a significantly higher risk of illegal drug use which is associated with concurrent tobacco smoking(7)

1.1.5 Ethnicity

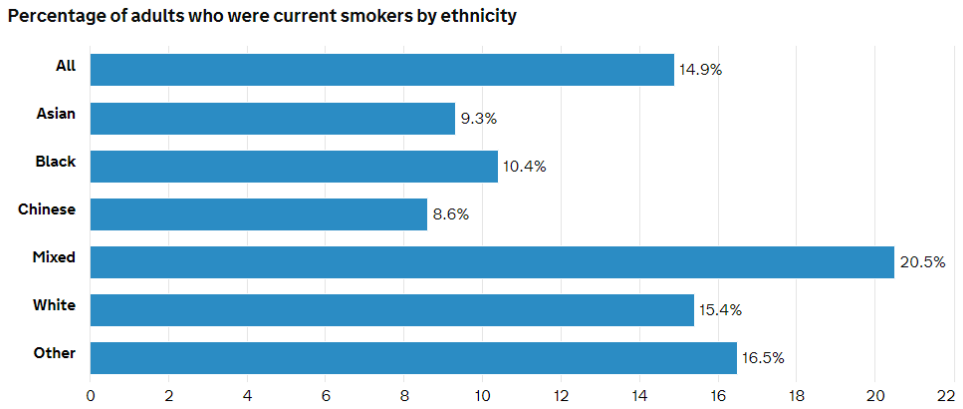


Figure 6. Current smokers by ethnicity. Smoking rates in mixed and white ethnic groups are higher than the average for England. Chinese, Asian and Black groups had below average smoking rates.
Source: Ethnicity facts and figures, Public Health England

The graph in Figure 6 above illustrates the smoking prevalence in England among different ethnic groups. Prevalence in white and mixed groups is significantly higher than the national average and overall, ethnic minority groups have a lower rate of smoking than the UK population.

In contrast to conventional smoking, South East Asians use smokeless tobacco at a high rate in England. One study in a deprived area of London estimated that 92% of males and 96% of females of Bangladeshi descent chewed betel-quid on a daily basis with 39% and 82% respectively including tobacco (10).

Chewing tobacco can be bought cheaply, and is poorly regulated with many products failing to comply with health warning requirements despite smokeless tobacco being a significant cause of oral cancer(10,11).

Water pipes, also known as Shisha, are common in the Middle East and parts of Asia and Africa but usage appears to be increasing in the West. A survey in 2015 found water pipe prevalence among adults was 12% and frequent usage was 1%(12). Frequent usage was more common among people of Asian descent (7%) and young people. There are misconceptions of the safety of shisha smoking as many people believe that herbal products are safe compared to tobacco. However, shisha smoking involves the burning of charcoal and inhaling known toxic chemicals (carbon monoxide and benzene). It is estimated that tobacco and herbal products both contain harmful chemicals at a similar rate(12). Second hand smoke from shisha is a concern as carcinogens in the smoke are present at significantly higher levels compared to conventional cigarette smoke(13). Currently, shisha cafes are legal so long as they comply with the Health Act 2006, known as the Smokefree legislation, which states that smoking is prohibited in virtually all enclosed and substantially enclosed public places and workplaces. Therefore water pipes may be smoked so long as they are not in an enclosed space(14), although this has been difficult to enforce.

1.1.6 Prison population

The prison population suffer from health inequalities compared to the general population: this is particularly noted in smoking rates. In England, 14.9% of adults smoke while 80% of prisoners smoke. This poses serious health risks for the smokers as well as non-smokers and exposes staff to second hand smoke(15).

In 2018, the final two prisons in England implemented smokefree policies. The smoking restriction has been met with reluctance by prisoners, only 22% of those surveyed agreed that it was a good idea(16). The ban was accepted if e-cigarettes were permitted, however prison staff experienced implementation and enforcement challenges.

1.2 What is the impact on health and wellbeing?

Smoking has been attributed to a vast number of chronic diseases and cancers which have a detrimental effect on health and wellbeing. Figure 7 below outlines the major illnesses that are causally linked to smoking.

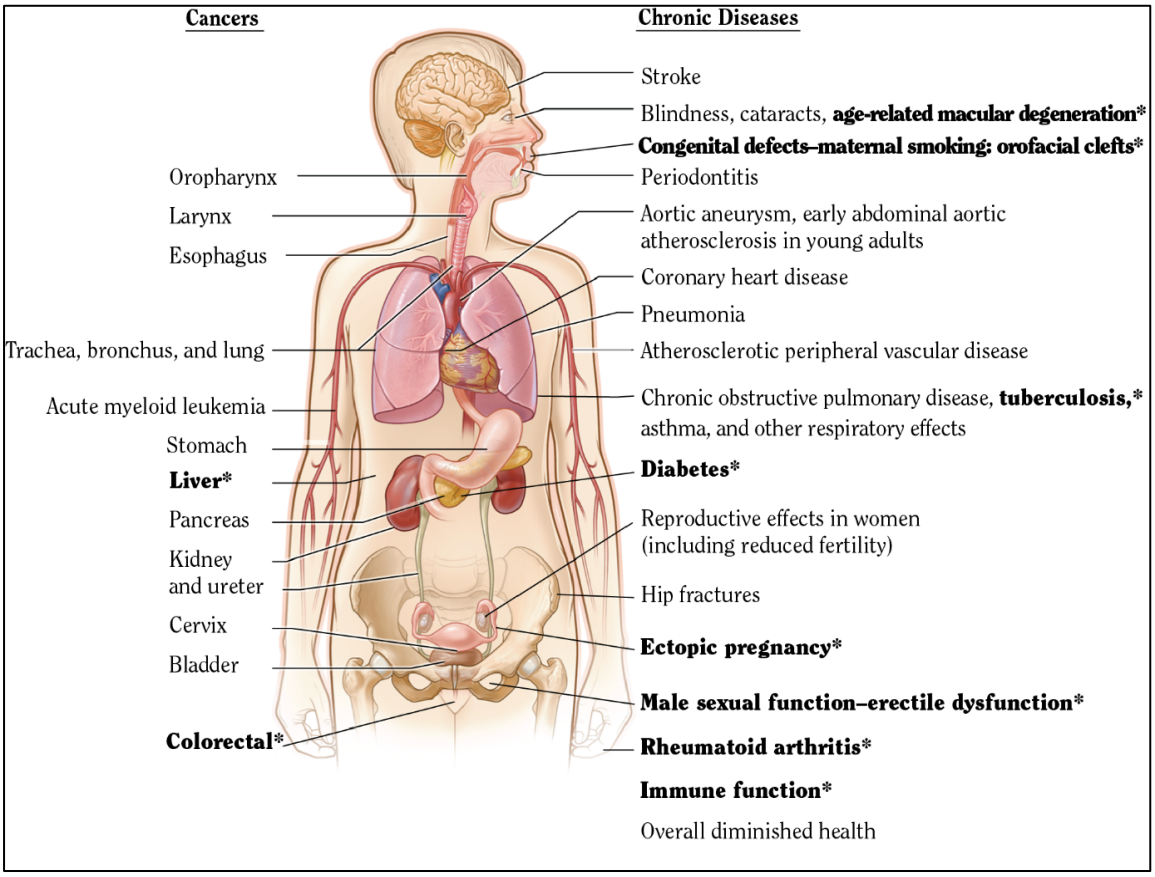


Figure 7. The health consequences causally linked to smoking. In bold, newly linked diseases discussed in the US Surgeon General's report 2014.
Source: USDHHS 2004, 2006, 2012.

Up to two thirds of life long smokers will be killed by smoking but it is important to note that quitting smoking can add years to life (17). The earlier an individual quits smoking, the more positive the outcomes: quitting by 30 years old, mitigates almost all the risks of smoking. There is also evidence to suggest that quitting smoking has a positive impact on depression and anxiety, equitable to antidepressants.

Second hand smoking also has significant health impacts, particularly in children. In England, 80% of non-smoking children living in a household with a smoking parent had detectable levels of cotinine. This is in contrast to the levels of cotinine observed in non-smoking children living in households where neither parent smoked where 23% of children had detectable cotinine (18). Exposure to second hand smoke in the homes where either parent is a smoker remains relatively high with 14% of pupils aged 11-15 years reporting that they are exposed to smoking at home every day and 62% of pupils stating that they had been exposed at home or in the car in the last year (16).

Exposure to second hand smoke is highest in the most deprived homes; ASH (Action on Smoking and Health) 2015 survey found that 25% of the most disadvantaged homes allow smoking in the home compared to 10% of the most advantaged (19).

The health impacts of second hand smoke are outlined in Figure 8 below:

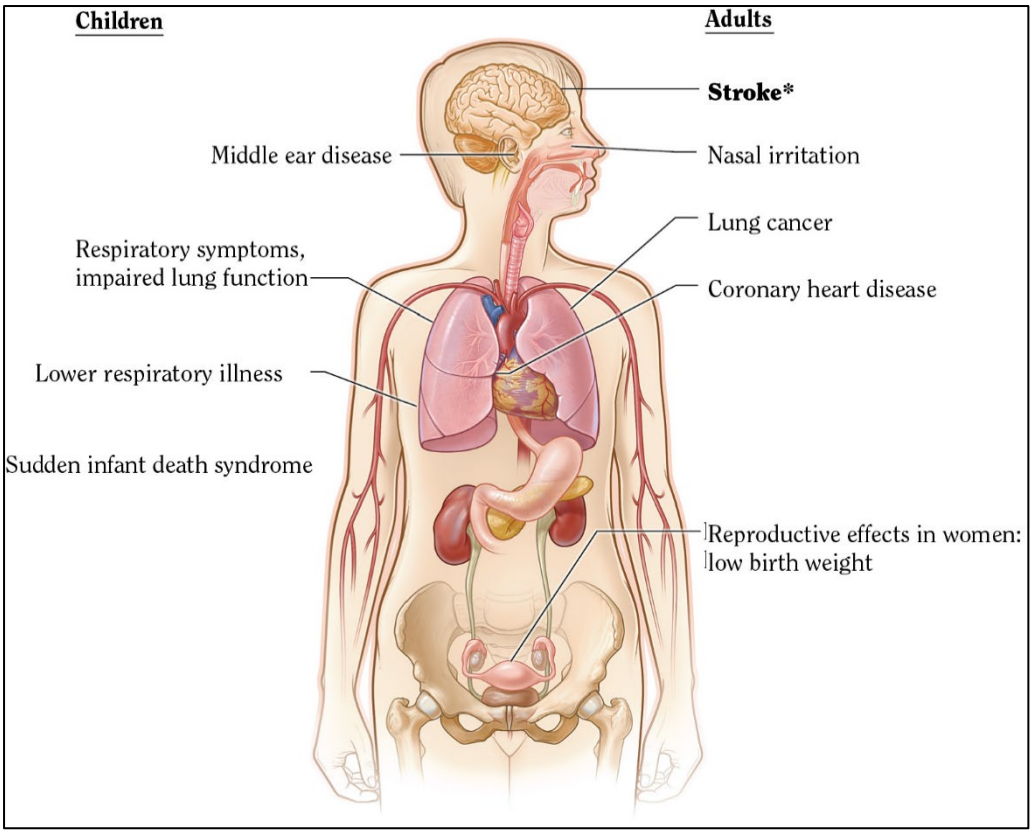


Figure 8. The effects of second hand smoke for children and adults.
Source: USDHHS 2004, 2006, 2012

The smokefree legislation introduced in 2007 attempts to minimise this harm by banning smoking in enclosed public areas and workplaces. NHS trusts across England have implemented smokefree site policies, preventing smoking on all hospital grounds. The aim of this is to encourage a smokefree environment, reduce the harm of second hand smoke and support inpatients quitting.

1.3 E-cigarette usage

First appearing on the market more than 10 years ago, 5.5% of the population (aged over 16) in Great Britain reported using E-cigarettes (ECs) in 2017- the vast majority of people being ex or current smokers - 98.5% of users (20). See Figure 9 below.

A review published in 2015 estimated that there was a 95% reduction in harm when smoking ECs compared to smoking (21). A Cochrane review published in 2016 found there was no evidence of an increased health risk after using ECs for two years. ECs containing nicotine were more effective in helping smokers quit compared to ECs without nicotine(20). By encouraging smokers to switch to e-cigarettes, there is a reduction in health inequalities and smoking related disease and an increase in smoking cessation.

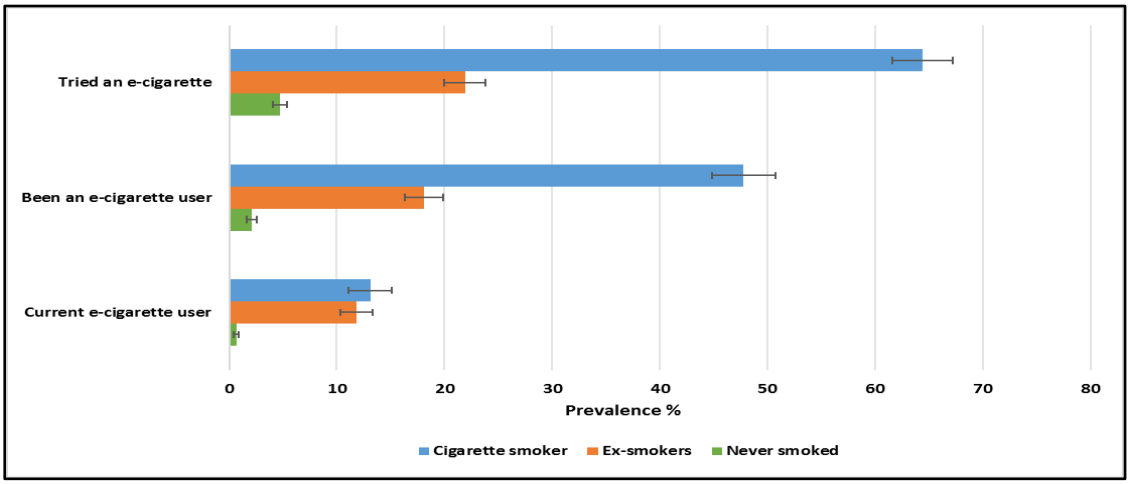


Figure 9. E-cigarette use by smoking status 2016 by percentage, England.
Tried an e-cigarette: this group includes current e-cigarette users, those who said they used an e-cigarette but no longer use one, and those who said they tried an e-cigarette but did not go on to use it regularly.
Been an e-cigarette user: this group includes current users and those who said they used to use an e-cigarette regularly but no longer use it.
Current e-cigarette user: those who are regularly using e-cigarettes.
Source: Office of National Statistics Lifestyle Survey 2016.

Encouragingly, the increased use of ECs appear to be attracting very few never smokers into regular use. Furthermore, ECs may be contributing to the overall decline nationwide in smoking(21). Figure 10 below illustrates the main reasons stated for using ECs. The majority of people are using ECs to either quit smoking or minimise harm of smoking (see Figure 10 below).

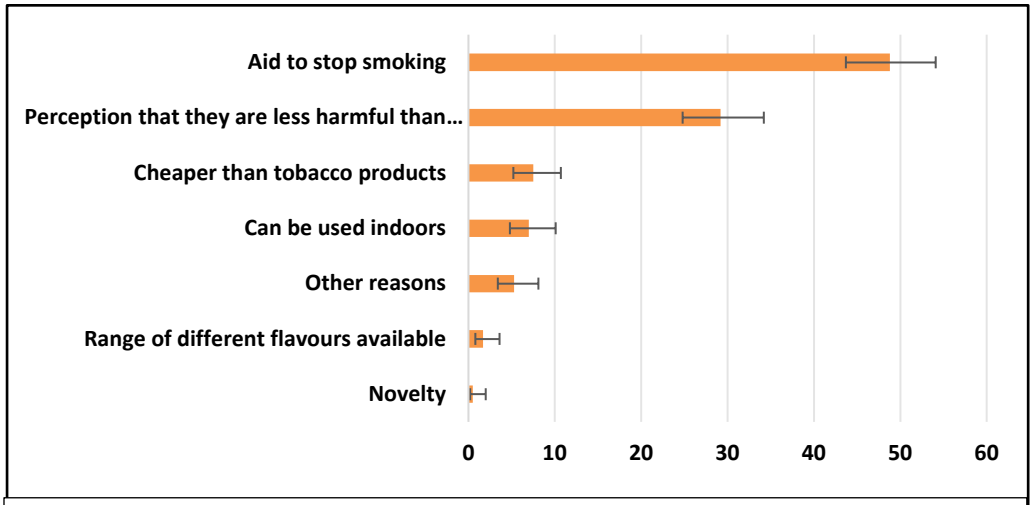


Figure 10: Main reason for using an E-cigarette- England
Source: Office of National Statistics Lifestyle Survey 2017

1.4 Illegal tobacco

Illegal tobacco can refer to several different substances:

- "Illicit Whites": cigarettes mass produced in Russia and East Asia which are then illegally imported into the UK. No duty has been paid and health warnings are not in place
- Counterfeit: Illegally manufactured and sold by a party which is not the copyright holder
- Genuine cigarettes: smuggled into the UK without duty being paid (22)

Illegal trade is an important issue to manage as it undermines attempts to curb smoking rates by providing a cheap alternative, thereby minimising the price incentive to quit. It has a serious impact on the community and society as a whole as it is often as a part of criminal activity and enables children to access cigarettes, putting them in contact with criminality. Illegal trade and price variation means that it is possible to obtain cigarettes at a price of 12 years earlier(22). In 2016/17, the cigarette tax gap was estimated to be £2.5 billion, an increase from the 2015-16 estimate of £2.4 billion(23). Figure 11 below shows the illicit tobacco percentage share of the market. While sales of illicit hand rolled tobacco have dropped, illicit cigarettes have remained steady.

There have been suggestions that tobacco companies may have manipulated data to suggest that illegal tobacco is a bigger issue than it is in actual fact, and that policies to curb smoking will fuel the illegal market. The aim of this marketing is to portray that illegal tobacco is more harmful than legal products, and that reducing tobacco control legislation on its own products is a better alternative(24).

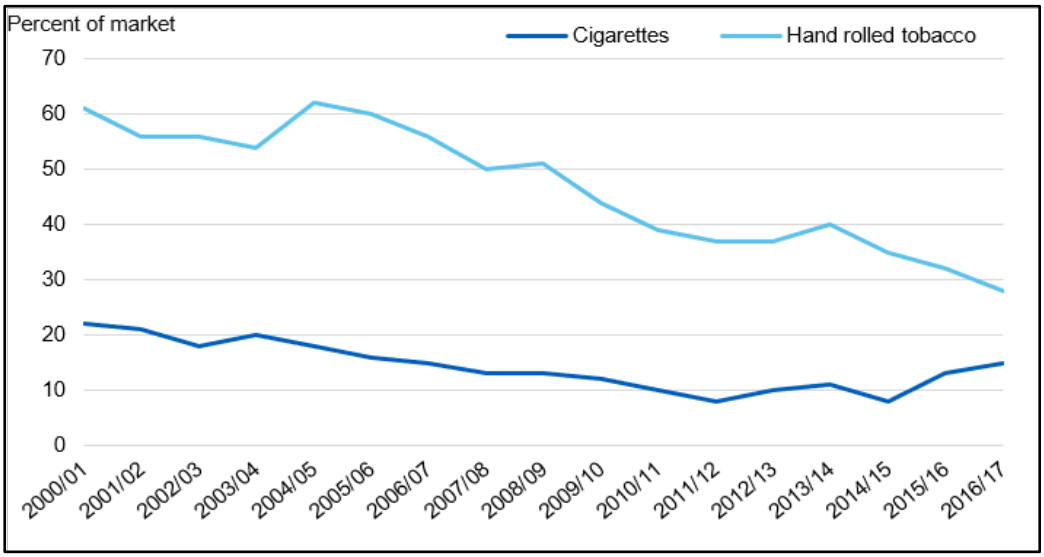


Figure 11. The illicit tobacco percentage share of the market. Hand rolled tobacco accounts for a far higher percentage of illicit sales than cigarettes. Sales of illicit hand rolled tobacco have seen a steady decline while illicit cigarette sales have remained fairly consistent
Source: NHS Digital Statistics on Smoking, Part 5: Patterns in tobacco consumption and spending

2) Size of the issue locally

The smoking prevalence in Nottingham has been falling steadily since 2013 although remains significantly higher than national average (see Figure 12 below).

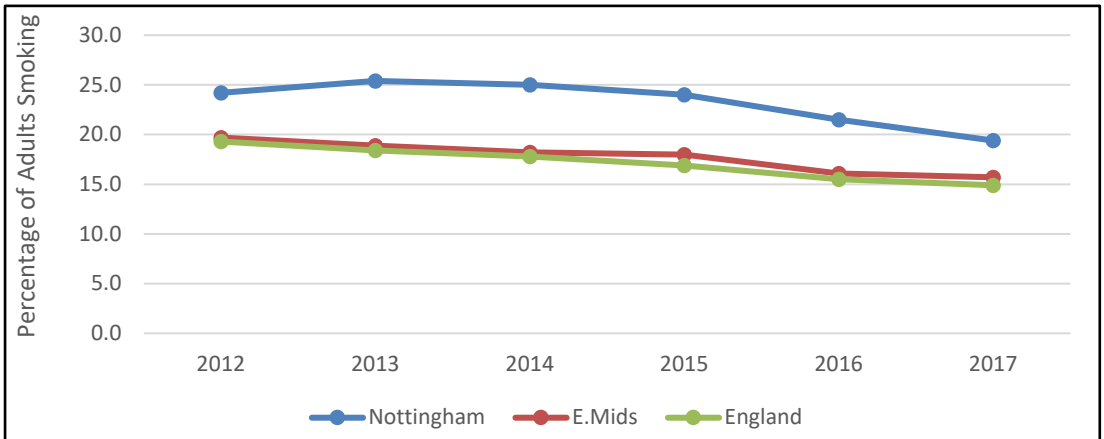


Figure 12: Smoking prevalence in Nottingham compared to East Midlands and England. Source: APS survey 2012-2017

In line with national statistics, men are more likely than women to be smokers, although the difference between sexes has fallen, with more women smoking than historically (see Figure 13 below).



Figure 13. Rates of smoking in Nottingham.
Source: Nottingham Citizens Survey 2017

In Nottingham, people aged 25- 64 are most likely to smoke daily or occasionally (37.4%), while more than 80% of 16-24 year olds are non-smokers or ex-smokers (see Figure 14 below). 16-24 year olds also have the largest percentage of people who are occasional smokers, perhaps reflecting the culture of 'social smoking'. Despite the perception that social smoking is low risk, there is still an increase in risk of cancer and heart disease (25).

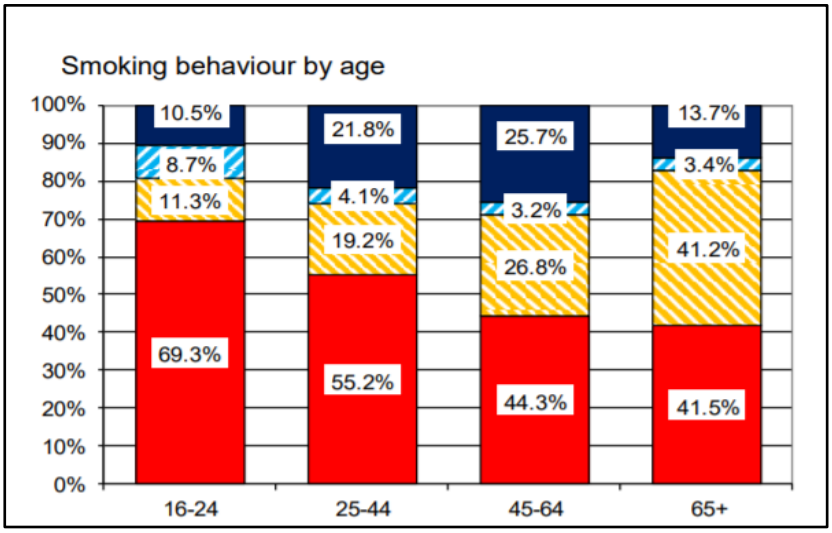


Figure 14: Smoking behaviour by age.
Key: Red- never smoked, Yellow- used to smoke but have quit, Light Blue- smoke occasionally, Dark Blue- smokes every day
Source: Nottingham Citizens Survey 2017

2.1 What people smoke in Nottingham

Cigarettes remain the most used tobacco substance in Nottingham across all demographics, followed by roll ups and e-cigarettes. The usage of e-cigarettes rose in Nottingham in 2016 with a corresponding fall in cigarette and roll-up smoking, suggesting that people are switching from tobacco to e-cigarettes: most e-cigarette smokers describe themselves as ex-smokers(26).

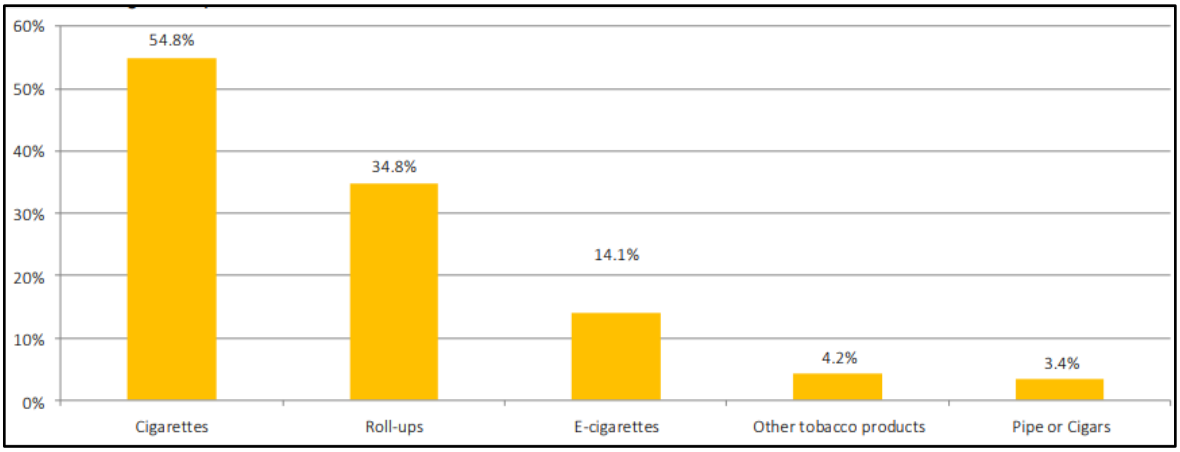


Figure 15. Percentage of respondents to Citizen's Survey who smoke different substances. The majority of Nottingham residents who smoke use cigarettes (54.8%).
Source: Nottingham Citizens Survey 2017

2.2 Smoking in High Risk Groups

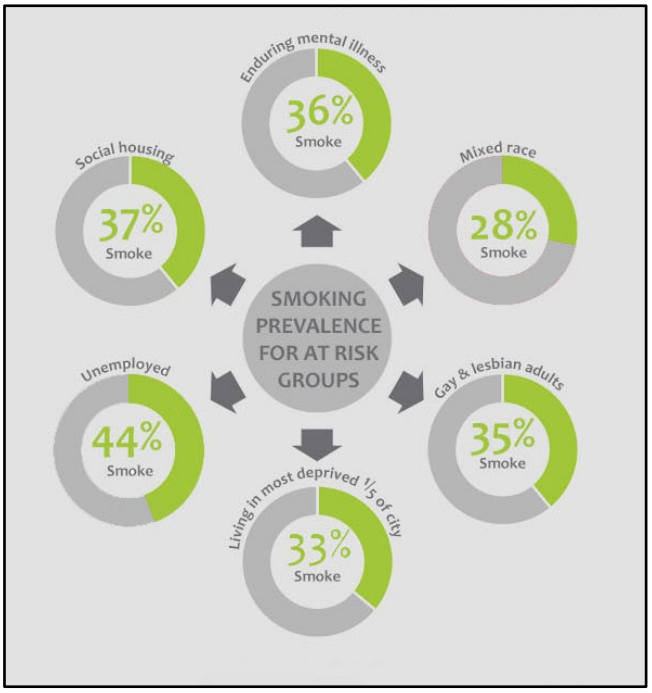


Figure 16. Smoking prevalence among high risk groups in Nottingham. These groups of people have a significantly higher rate of smoking than the national average of 14.9%. Source: Nottingham Citizens Survey 2016-18

As discussed in section 1, several groups of people are more likely to smoke compared to the general population. In Nottingham, many of these groups have more than double the rates of smoking compared to national average.

Deprivation is a significant risk factor for smoking, the most deprived in Nottingham having smoking rates of 33.2% compared to the least deprived (16%). However, even in the least deprived group, smoking prevalence remains higher than the national average.

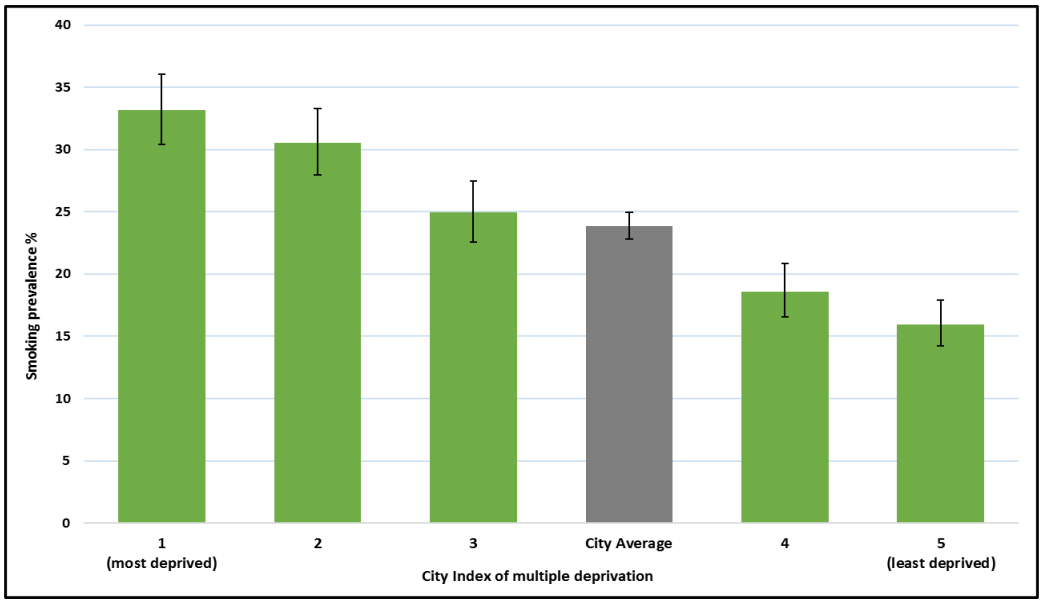


Figure 17. Smoking rates in Nottingham compared to deprivation.
Source: Nottingham Citizen Survey 2014-16

2.3 Smoking by wards of Nottingham

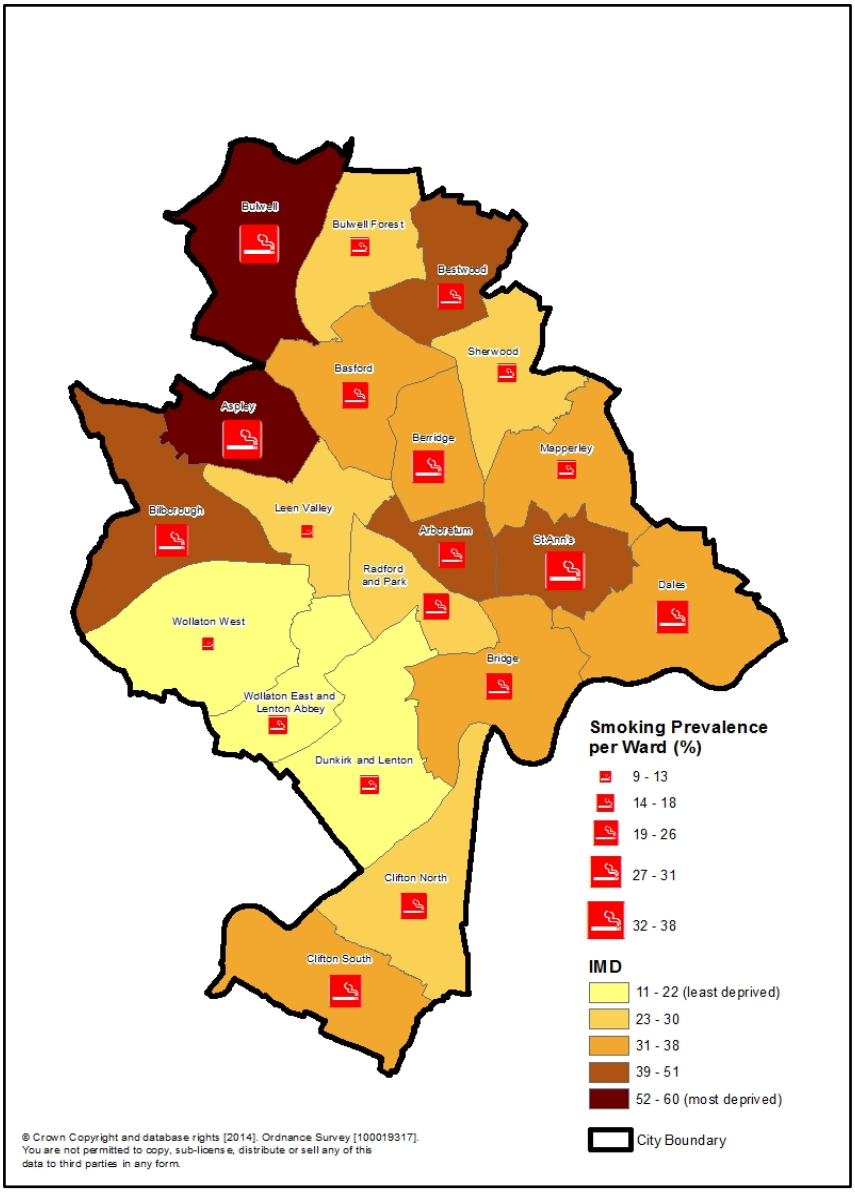


Figure 18. Smoking rates and deprivation in the wards of Nottingham.
Aspley, St Anns and Bulwell have the highest rates of smoking in Nottingham and are also the most deprived areas. Only Leen Valley and Wollaton West have smoking rates below the national average of 14.9%.
Source: Nottingham Citizens Survey 2014-16

Corresponding to deprivation risk factors, smoking prevalence is significantly higher in wards with lower average income (see Figure 18 above). Smoking prevalence among people in the most deprived areas of Nottingham is 17.2% higher than the least deprived.

The wards with the highest smoking rates in Nottingham are Aspley (38.5%), St Ann's (36.7%) and Bulwell (33.7%). Correspondingly, the most deprived wards are Aspley and Bulwell. Bilborough is the third most deprived area but has a slightly lower smoking rate of 29.5%. Table 1 below compares Nottingham with its statistical neighbours and England.

Indicator	England	Nottingham	Newcastle	Liverpool	Leicester	Salford	Kingston
Smoking prevalence in adults-current smokers by % (APS)	14.9%	19.4%	15.2%	15.5%	17.7%	21.2%	23.1%
Smoking attributable mortality (per 100,000)	262.6	387.7	383.4	430.6	305.8	404.4	474.7
Deaths from COPD per 100,000 population	52.7	79.3	82.8	95.3	61.6	91.1	103.5
Smoking attributable deaths from heart disease per 100,000 population	24.7	40.5	30.7	34.4	36.0	38.9	43.6
Smoking attributable deaths from stroke per 100,000 population	8.2	12.6	11.3	14.0	11.1	11.6	15.1
Lung cancer registrations per 100,000 population	78.6	102.5	134.7	142.2	88.5	128.2	138.3
Deaths from oral cancer per 100,000 population	4.6	8.1	7.6	7.6	9.0	5.3	6.9

Key:

	Benchmark rate
	Rate in this area is of a similar level compared to benchmark
	Rate in this area is significantly worse compared to benchmark

Table 1. Smoking prevalence and related health outcomes in Nottingham, compared to CIPFA neighbours and England benchmark. Source: Public Health Profiles 2018

2.4 Notable changes in Nottingham since previous JSNA published

- New Leaf stop smoking service for Nottingham has been decommissioned
- Smokefree hospital policies have been rolled out in all secondary care and mental health settings in Nottingham
- Smokefree policies have been implemented across all prisons
- Increasing prevalence of e-cigarettes with a better understanding of comparative health risks associated

3) Targets and performance

3.1 International- WHO Framework

The WHO Framework Convention on Tobacco Control was opened for signature in 2003 and has been ratified across the UK. The primary articles focus on:

- Reduction of demand for tobacco
- Reduction to supply of tobacco
- Protection of the environment
- Scientific and technical co-operation

3.2 Tobacco Control Plan for England- Smokefree generation

Towards a Smokefree Generation, the tobacco control plan for England outlines four ambitions:

- Smokefree generation
- Smokefree pregnancy
- Parity of esteem for mental health conditions
- Backing evidence based innovations to support quitting

3.3 Public Health Outcomes Framework

The Public Health Outcomes Framework (PHOF) has three indicators of health. Health outcomes related to smoking rates are discussed in section 2) Size of the issue.

Nottingham prevalence for smoking at time of delivery (17.2%) remains significantly higher compared to baseline (10.8%) and CIPFA neighbours. Smoking prevalence at age 15 is comparable to baseline while smoking prevalence in adults remains higher than national average.

3.4 CCG Outcomes Indicator Set

The CCG outcomes indicator set has two indicators related to smoking in 2018/19:

- 1.14 Maternal smoking at delivery
- 1.23 Smoking rates in people with serious mental illness(27)

3.5 Commission for Quality and Innovation (CQUIN) No.9:

Preventing ill health by risk behaviours- alcohol and tobacco 2017-19

This CQUIN is targeting and influencing inpatients to support quitting smoking. It was initiated in mental health trusts in 2017-18 and extended to acute trusts in 2018-19. Delivery of the CQUIN includes:

1. Establishing information systems to record alcohol and smoking interventions
2. Training staff to deliver brief advice and very brief advice for tobacco
3. Tobacco screening and recording the smoking status of each patient
4. Advising patients who smoke on the best way to quit
5. Tobacco referral and medication offer(28,29)

3.6 Nottingham Plan to 2020

Nottingham City Council laid out a 10 year plan for Nottingham in 2010. A target was to reduce smoking prevalence in adults to 20% by 2020 (baseline 39% in 2008). At the time the target was set, 20% was below the national average.

Nottingham smoking prevalence has met the target (19.4%) but the national average has also reduced. Smoking prevalence is still significantly higher than national average of 14.9%. (30,31).

3.7 Nottingham City Tobacco Control Strategy

Nottingham's Tobacco Control Strategy focuses on four priorities:

- Priority Action One: Protect children from the harmful effects of smoking
- Priority Action Two: Motivate and assist every smoker to quit
- Priority Action Three: Reduce the supply and demand of illegal tobacco
- Priority Action Four: Innovation, leadership and development in tobacco control

4) Current activity, service provision and assets

4.1 Community based smoking cessation

The local, community-based stop smoking service, New Leaf, was decommissioned following significant budget reductions in 2018/19. Between April 2018 and February 2019 smokers needing help to quit in Nottingham City have received support from Primary Care and online resources. In March 2019 a new stop smoking service was launched – *Stub it!* Commissioned by Nottingham City Council Public Health and delivered by the GP Alliance, it will deliver targeted smoking cessation support for specific groups:

- Pregnant and postnatal women, their partners and household who smoke
- Adults with mental health problems
- Adults with substance misuse problems
- Adults with long term health conditions and those recently discharged from secondary care

The service will provide a combination of behavioural and pharmacological support over 12 weeks to help smokers quit. The service will use carbon monoxide testing to monitor patients' abstinence.

4.2 Secondary Care

The National Institute for Health and Care Excellence outlines the strategy for smoking cessation in secondary care.

As outlined in the 2017-19 Annual Plan, Nottingham University Hospitals NHS Trust (NUH) has ward based, stop smoking advisers to whom patients may be referred. Staff at NUH have received smokefree training to better identify smokers and initiate referral processes for stop smoking support. NUH has made a target to refer 10% of smokers who are admitted on to stop smoking services, in March 2019 the referral figure was 1%.

To address this NUH have introduced an opt-out referral process in the electronic patient assessment, so that all smokers are seen by a stop smoking adviser on admission. Increasing the availability of stop smoking services in secondary care will support the achievement of the tobacco CQUIN. More recently, the Trust Board has approved vaping in the grounds to include patients, visitors and staff. They are also updating the smokefree site policy, which includes reviewing stop smoking support and medications for staff alongside seeking funding for an on-site Community Protection Officer. This will address the number of complaints received from patients and visitors regarding smoking at the QMC main entrance and other areas. Furthermore, they are progressing very brief advice on smoking being part of mandatory staff training for all staff and not just maternity staff.

4.3 Mental health trusts

As of 2016, smokefree policies have been implemented across Nottinghamshire Healthcare NHS Foundation Trust, in line with NICE Guidance PH48. Nicotine replacement therapy (NRT) and *E-Burn* e-cigarettes (which are tamper-proof, designed, and approved for secure units) are being offered where NRT is declined or ineffective in a pilot scheme. The latest report on implementing smokefree programme included feedback on e-cigarettes and this has received positive feedback from both staff and patients:

- 100% said the trust should continue to offer e-cigarettes
- 70% of managers stated that patients were more willing to comply with the smokefree policy when using *E-Burn* e-cigarettes
- 74% of staff noted a decrease in cigarettes smoked
- 43% of patients said they have quit smoking
- 40% of patients said they were smoking less(33)

Current strategy in mental health units include discussing smoking with patients on admission, including smoking in the multidisciplinary team care planning, and training staff in giving smoking cessation advice.

4.4 Trading Standards

Trading Standards work to reduce the supply of counterfeit and illicit tobacco across the City. The service works in partnership with Nottinghamshire Police, to stop the sale and distribution of these goods by seizing any illicit and counterfeit product sold from any premises, including retail shops and private addresses. The service also ensures the safety of consumer products, including the various electrical components and the associated liquids of e-cigarettes. Retailer training and the enforcement of underage sales of cigarettes, e-cigarettes and e-liquids is another Trading Standards responsibility.

4.5 Environmental Health

The Environmental Health and Safer Business team works closely with all shisha bar operators to ensure that smoking shelters are sufficiently open in accordance with the Health Act 2006. Existing businesses are monitored through routine compliance visits and investigation of complaints. New businesses are given advice and guidance to ensure that shelters will be suitable prior to construction. Operators of shisha bars are supported as far as reasonably possible, but legal action is taken against those who continue to operate against the law in accordance with Nottingham City Council's Enforcement Policy. In 2017, two successful prosecutions were taken against shisha bar operators for the offence of allowing people to smoke in a smoke-free place.

5) Evidence of what works

5.1 Tobacco control

As set out in the Tobacco Control Plan for England, the national strategy to reduce smoking centres around stopping the promotion of smoking, reducing the smoking incentive, and helping users to quit. Banning tobacco advertising and preventing tobacco from being immediately visible in shops reduces the promotion of smoking.

High duty tax has proven to be an effective disincentive to smoking for young people as well as increasing smoking cessation among adults and improving overall public health (34). There has been some criticism that cigarette taxes unfairly target low income families who are most likely to smoke and also be heavy smokers. 1.1 million children living in poverty in 2012 had at least one parent who smoked. A further 400,000 children would be classified as living in poverty once tobacco expenditure was subtracted from household income (35). ASH (Action on Smoking and Health) estimate that 28% of families currently living in poverty could be lifted out if they stopped smoking(19). Effective help for smoking cessation in low-income families is essential for overall public health and child wellbeing. The multi-factorial approach to tobacco control is outlined in the figure below.



Figure 19. Elements of effective tobacco control
Source: Department of Health, 2008

5.2 Smoking cessation services

There is good evidence that smoking cessation services are effective and are very cost effective(36). NICE analysis suggests that every £1 spent on an intervention combining bupropion with a nicotine lozenge would save the NHS £9.10 in costs and improve health by 0.003 quality adjusted life years. Even with more expensive and time intensive therapy, there is still cost effectiveness as the benefits to intervention are large. A 2016 study reported that current estimates that it requires six attempts to quit smoking, grossly underestimate the number of quit attempts required to stop smoking. On average, it may be as high as 30 attempts required before cessation is successful(37). Effective smoking cessation services can reduce the number of quit attempts needed to stop smoking.

5.3 NICE Guidance PH48

NICE Guidance PH48 covers smoking cessation help in acute, maternity and mental health services. It includes smokefree hospital sites and training for all health care professionals to deliver very brief smoking cessation advice. Identifying and supporting smokers to quit on admission to hospital has been shown to have a significant positive outcome on smoking (38).

However, there are notable difficulties in delivering this guidance. Hospital entrances at QMC and City Hospital are routinely used for smoking, despite prominent no smoking signs. Staff in hospital uniform are also seen smoking outside of the hospital perimeters.

5.4 Smokefree legislation

Implemented in 2007, smokefree legislation made it illegal to smoke in almost all enclosed work places and public places. Public support for the law has risen 5% in the 10 years since implementation and the high rates of compliance reflect this support. Public perception of the normalisation of smoking has also changed, with smoking being far less acceptable in day-to-day life. 52% of smokers now keep their homes smoke free(39).

5.5 E-cigarettes

The 2016 Cochrane Review of e-cigarettes (ECs) showed that using an EC containing nicotine increased the chances of smoking cessation compared to ECs with no nicotine and some evidence to suggest that ECs helped smokers quit compared to placebo. It could not be determined if ECs were superior to nicotine patches in promoting smoking cessation although there were fewer reported adverse side effects and higher adherence. Over a 2 year period, there were no increased health risks compared to smokers who did not use ECs(20). The British Psychological Society recommends improving education around ECs and the relative harm compared to smoking as well as investing and regulating ECs(40).

A 2019 randomised trial of ECs versus nicotine replacement therapy (NRT) in UK stop smoking services concluded that ECs should be the treatment of choice for cessation. ECs were more effective than NRT at 1 year (abstinence rate 18% ECs and 9.9% NRT) (42).

6) What is on the horizon?

6.1 Smoking projections

Based on current information, should the smoking rate in Nottingham continue to decline at the current rate, 10% of adults will smoke by 2030.

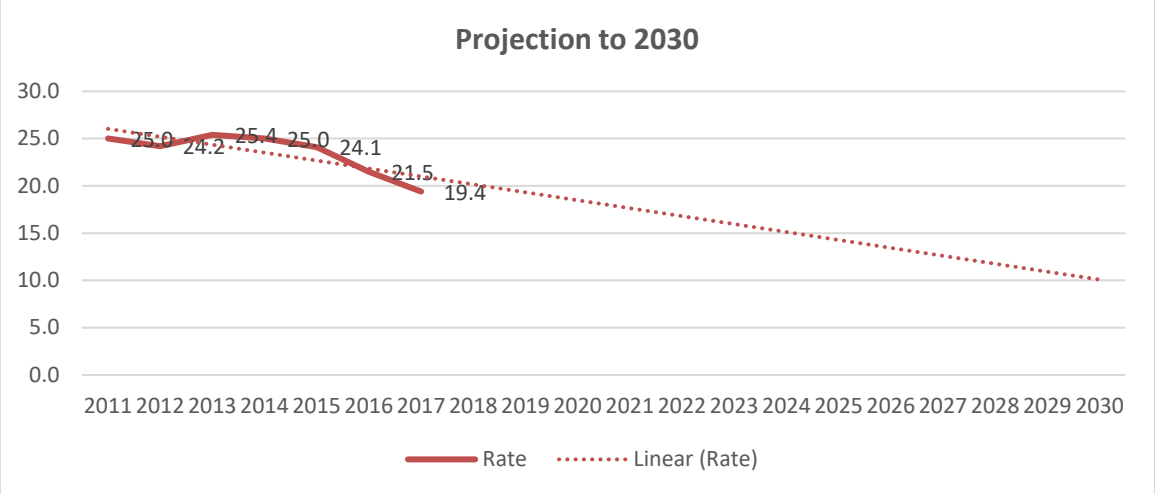


Figure 20: Smoking projection to 2030 in Nottingham.
Source: David Millington, Public Health Analyst, Nottingham City Council

However, it is difficult to predict due to the multifactorial causes of smoking including poverty and homelessness. Given market instability and economic uncertainty, it may be the case that there is an increase in smoking rate in the years to come.

6.2 NHS Long Term Plan

NHS Long Term Plan aims for all people admitted to hospital who smoke to be offered NHS funded tobacco treatment services by 2023/24. This will assume an adapted model for expectant mothers and their partners as well as universal smoking cessation offer available as part of specialist mental health services for long term users of mental health services. This follows the Ottawa Model for smoking cessation which has been shown to improve the quit rate by 11%.

6.3 Action on Smoking and Health new resource for Health and Wellbeing Boards

Action on Smoking and Health (ASH) have developed new strategic guidance for local authority members, officers, and partners on Health and Wellbeing Boards, on how to achieve a smokefree generation (where 5% or less of the population smoke). End of Smoking highlights the links with poverty, inequality and early death.

6.4 Smokefree areas

The smoking ban has created a positive change in culture and led to more people quitting. However, smoking remains a highly visible part of life in outdoor spaces – including in parks, on high streets and in pub gardens. Smoking therefore continues to be seen as a normal and desirable behaviour to children and young people, and this is unsupportive for those who are trying to quit.

The implementation of smokefree outdoor spaces has the potential to normalise smokefree environments. Consultation has also shown that the public favour the creation of smokefree outdoor spaces where children and young people are. Ultimately, reducing the visibility of smoking will help to support quit attempts and discourage children and young people from starting.

To this end, Nottingham City Council's Smokefree Team have lead on the implementation of a number of smokefree outdoor spaces initiatives. Namely smokefree parks, school gates and events: Splendour and Riverside Festivals have smokefree areas and the summer Beach on the Market Square is entirely smokefree.

The City Council will continue to work with partners to increase the numbers of smokefree outdoor spaces. This includes a 'Smokefree Side-Lines' campaign where people will be asked not to smoke around the side-lines of youth fixtures and training. It is also being extended to smokefree school gates in secondary schools and Nottingham Trent University is working with the council to reduce smoking on campus.

6.5 New smoking cessation service

The new smoking cessation service funded by Public Health, Nottingham City Council commenced provision from March 2019. The new service focuses on priority groups (stated in 4.1) using a targeted approach. It will be delivered from city centre locations in Nottingham's city centre and will provide a combination of behavioural and pharmacotherapy support for smokers who access the service.

7) Local views

7.1 Budget consultation 2018-19 - comments regarding smoking

The local views presented in this section have been extracted from feedback received from the public, partners and stakeholders following the decommissioning of New Leaf. A number of comments were in favour of the reduction in spending on smoking cessation services:

"Smoking is a choice and people are aware of the risks",

"Smoking cessation can be done online and cut costs of face-to-face interviews" and

"Smoking is a choice so stopping should also be a choice and people should pay for it themselves. Do not waste money on people who will just restart smoking anyway".

The majority of comments, however, were critical. Most people felt that the cut to funding for smoking cessation was a short-sighted measure that may cost far more in the long term. Many respondents expressed concerns that smoking, drug and alcohol cuts may increase crime in the city. A number of responses highlighted the concern that since most adults that smoke started smoking as teenagers, they need support to quit smoking. There is also a recognition that smoking disproportionately affects the poorest in society who are locked into a cycle of poverty.

A few of the comments are stated below:

"The impact of reducing these services on the health of the local population will be high. We are already dealing with the impact of lifestyle behaviours in acute care with high rates of respiratory, cardiovascular disease and type two diabetes. Reducing these services, which clearly impact on targets in relation to health of the local population, seems a short sighted intervention that will have long term and costly impact."

"Further cuts to these services would only increase pressure on the NHS and GP surgery who just can't cope with them."

"The majority of smokers do not choose to smoke, it's an addiction and the most effective way to stop is to access specialist support. Nottingham has one of the highest levels of smoking in the country and the numbers of pregnant women smoking is almost double the national average. The cost of smoking to local authorities is significant - the cost of social care for people living with smoking related long term conditions, tobacco related litter and tackling illegal tobacco - reduction in demand leads to a reduction in supply."

"As in this time of austerity prevention is one of the leading evidence based ways to save money in the long term how is this short term saving going to be balanced against the long term cost of ceasing the services that strongly assist the prevention agenda?"

"This is very short sighted. This is the prevention agenda at its heart. The benefits of prevention go far beyond improved health for individuals and reduced pressure on health and social care - the consequence of poor health have an impact on the economic prosperity and social wellbeing of the city. Prevention is everyone's business."

"This is a draconian and retrograde step. Smoking is the biggest, reversible public health problem and to not fund support for helping smokers to quit is a massive own goal for the city. In the longer term stopping smoking improves health and reduces ex-smokers' use of health services and their rates of work absenteeism. Smoking rates are much higher within under-privileged communities and so by encouraging cessation, particularly amongst pregnant women, the council reduces health inequalities."

"This is very short-sighted. Although it may lead to a short term cost saving, the long term health costs will be increased."

7.2 Smokefree Great Britain 2018 - public opinion in the East Midlands

The YouGov Smokefree Britain Survey 2018 found that 72% of adults in the East Midlands supported government action to tackle smoking, believing that the government was doing about right or should be doing more to address smoking in the UK. There is increasing support for a smoking ban in all cars - 68% agreed, a 5% increase from 2017.

7.3 Influencing lifestyle choices

In a local survey asking what influenced healthy living choices, the majority of respondents answered that they were most influenced by a health professional. Of the 594 responses received, 87% felt that health advice and information did influence their daily lifestyle choices whilst 13% did not think it had any effect (41). This data suggests that using the Very Brief Advice strategy by health care professionals could have positive influences on smoking cessation.

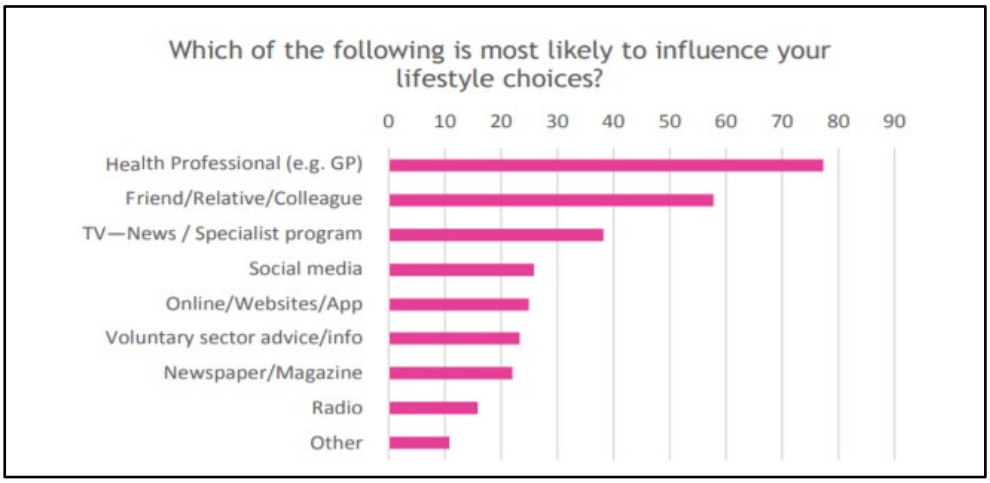


Figure 21: Respondents answering a survey as to who or what they felt influenced their lifestyle choices
Source: Healthwatch Nottingham and Nottinghamshire

What does this tell us?

8) Unmet needs and service gaps

8.1 Smoking cessation services

- Stub it! smoking cessation service is being delivered at present from only city centre locations. This means that citizens who are disabled or have poor mobility may not be able to access the service.
- The service is still fairly new and is currently dealing with a backlog of clients, resulting in long waiting times
- In secondary care, ward based advisors are providing smoking cessation support to smokers admitted into secondary care. This supports them to achieve temporary abstinence. Following discharge, reports from advisors suggest that follow-up by community based services is patchy and inconsistent, resulting in many smokers relapsing
- The current smoking cessation service does not have provision for children who might need support to stop smoking
- Current evidence on e-cigarettes suggest that they are far less harmful than smoking and should be used as part of harm reduction or quitting smoking. Public perception has lagged behind the evidence with many people believing that they are just as harmful as cigarettes. Encouraging people who cannot quit to switch to e-cigarettes would be a productive harm reduction strategy
- Strategies to target inpatients in hospitals is evidence based, yet staff have often not received training in the delivery of Very Brief Advice, limiting the success of this strategy

8.2 Equality and deprivation

- Deprived areas within the City continue to have smoking rates that are significantly higher than the national average which continues to widen the inequalities gap
- Illicit tobacco prevalence remains high in deprived areas of the city which undercuts the effects of tobacco control legislation and contributes to crime

8.3 Environmental exposures

- Second hand smoke remains a significant concern with a quarter of deprived homes allowing smoking inside. There is currently no targeted work in these areas to tackle children's exposure to second hand smoke
- PH48 implementation in hospitals can be intermittent with patients and visitors continuing to smoke on hospital grounds, exposing other patients to second hand smoke
- Shisha lounges remain prevalent in Nottingham City, despite smokefree legislation, putting the customers and employees of the shisha lounges at risk
- There is a lack of information on the harms of social smoking in the 16-24 year old age group

9) Knowledge gaps

- It is unknown as to the proportion of homes which allow smoking inside the house in Nottingham specifically and how this compares to the national average
- There is lack of robust data for smoking rates in young people under 16 years and the attitudes to quitting smoking

- Further information on the usage of e-cigarettes, particularly in young people

What should we do next?

10) Recommendations for consideration by commissioners

Recommendation	Responsibility		
	Local Authority	Service Providers	CCG/CCP
Ensure that all hospital staff are trained in Very Brief Advice		Secondary care education administrators	
More stringent implementation of PH48 in secondary care, addressing QMC main entrance and City hospital gates	x	Secondary care	
Making Every Contact count in GP practice, dentistry, opticians etc., using Very Brief Advice	x	Various health care delivery providers	
Give consideration to smokers with reduced mobility in order to address access to smoking cessation services	x		
Provide fast tracking to community smoking cessation services for smokers who have quit in hospital, allowing the continuation of treatment in the community at a reasonable time	x	x	x
Include a question in the Citizens Survey to assess the approximate percentage of homes which allow smoking inside and expose children to second hand smoking	x		
Continue to expand the scope of smokefree areas	x		
Consider a public awareness campaign to encourage smokers to switch to e-cigarettes	x		
Continue to review the compliance to smokefree legislation of shisha lounges and issue notices accordingly	X Environmental Health		
Improve education in schools, colleges and universities as to the harms of shisha smoking, especially in areas with a high proportion of Asian ethnic minorities.		x	
Continue to target those trading in illicit tobacco	X Trading Standards and Nottinghamshire Police		
Promote e-cigarettes as the treatment of choice for smoking cessation	X	X	X

Key contacts

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References

1. Public Health England. Tobacco commissioning support pack 2018-19: key data [Internet]. Nottingham; 2018 [cited 2019 Jan 14]. Available from: file:///C:/Users/iallso/AppData/Local/Microsoft/Windows/INetCache/Content.Outlook/UKO3W8CW/East Midlands - Nottingham - Tobacco commissioning support pack - key data 2018-19.pdf

2. All Party Parliamentary Group on Smoking and Health. Burning Injustice Reducing tobacco-driven harm and inequality [Internet]. 2017 [cited 2019 Jan 14]. Available from: http://cdn.basw.co.uk/upload/basw_53844-7.pdf

3. Department of Health. Towards a Smokefree Generation A Tobacco Control Plan for England 2 DH ID box Title: Towards a Smokefree Generation-A Tobacco Control Plan for England [Internet]. 2017 [cited 2019 Jan 14]. Available from: www.nationalarchives.gov.uk/doc/open-government-licence/

4. May T. Statement from the new Prime Minister Theresa May - GOV.UK [Internet]. 2016 [cited 2019 Jan 14]. Available from: https://www.gov.uk/government/speeches/statement-from-the-new-prime-minister-theresa-may

5. Public Health England. Public Health Profiles- fingertips [Internet]. [cited 2019 Jan 16]. Available from: https://fingertips.phe.org.uk/search/smoking#page/0/gid/1/pat/6/par/E12000004/ati/101/are/E06000018/nn/nn-1-E06000018

6. Harker K, Cheeseman H. The Stolen Years: the mental health and smoking action report [Internet]. 2016 [cited 2019 Jan 15]. Available from: file:///C:/Users/iallso/Downloads/MHreport29-07-16.pdf

7. Action on Smoking and Health (ASH). Smoking: LGBT Community [Internet]. 2016 [cited 2019 Jan 16]. Available from: file:///C:/Users/iallso/Downloads/ASH_985.pdf

8. The Albert Kennedy Trust. LGBT Youth Homelessness: A UK National scoping of cause, prevalence, response, and outcome [Internet]. 2015 [cited 2019 Jan 16]. Available from: https://www.akt.org.uk/Handlers/Download.ashx?IDMF=c0f29272-512a-45e8-9f9b-0b76e477baf1

9. Homeless Link. The Unhealthy State of Homelessness [Internet]. 2014 [cited 2019 Jan 16]. Available from: https://www.homeless.org.uk/sites/default/files/site-attachments/The unhealthy state of homelessness FINAL.pdf

10. Bedi R, Gilthorpe MS. The prevalence of betel-quid and tobacco chewing among the Bangladeshi community resident in a United Kingdom area of multiple deprivation. Prim Dent Care [Internet]. 1995 Sep [cited 2019 Feb 12];2(2):39–42. Available from: http://www.ncbi.nlm.nih.gov/pubmed/8941795

11. ASH- Action on Smoking and Health. ASH Fact Sheet on tobacco and ethnic

minorities. 2011 [cited 2019 Feb 12]; Available from: file:///C:/Users/iallso/Downloads/FS26Sept2011.pdf

12. ASH- Action on Smoking and Health. ASH Factsheet on Waterpipes. 2015 [cited 2019 Feb 12]; Available from: file:///C:/Users/iallso/Downloads/ASH_134.pdf

13. Daher N, Saleh R, Jaroudi E, Sheheitli H, Badr T, Sepetdjian E, et al. Comparison of carcinogen, carbon monoxide, and ultrafine particle emissions from narghile waterpipe and cigarette smoking: Sidestream smoke measurements and assessment of second-hand smoke emission factors. Atmos Environ [Internet]. 2010 Jan 1 [cited 2019 Feb 12];44(1):8–14. Available from: http://www.ncbi.nlm.nih.gov/pubmed/20161525

14. Guidelines for Shisha Premises: Is Shisha covered by the smokefree legislation? [Internet]. [cited 2019 Feb 12]. Available from: https://www.whatdotheyknow.com/request/230827/response/564200/attach/3/guidance for shisha businesses.pdf

15. Eamonn O'Moore. Successfully delivering smokefree prisons across England and Wales - Public health matters [Internet]. Public health matters. 2018 [cited 2019 Jan 21]. Available from: https://publichealthmatters.blog.gov.uk/2018/07/18/successfully-delivering-smokefree-prisons-across-england-and-wales/

16. NHS Digital. Smoking, Drinking and Drug Use Among Young People in England - 2016 - NHS Digital [Internet]. 2016 [cited 2019 Jan 21]. Available from: https://digital.nhs.uk/data-and-information/publications/statistical/smoking-drinking-and-drug-use-among-young-people-in-england/2016#resources

17. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ [Internet]. 2004 Jun 26 [cited 2019 Jan 15];328(7455):1519. Available from: http://www.ncbi.nlm.nih.gov/pubmed/15213107

18. Nottingham City Tobacco Control Strategy [Internet]. [cited 2019 Jan 14]. Available from: https://committee.nottinghamcity.gov.uk/documents/s29949/Enc. 1 for Tobacco Control Strategy.pdf

19. ASH (Action on Smoking and Health). Smoking: low income families [Internet]. 2015 [cited 2019 Feb 5]. Available from: file:///C:/Users/iallso/Downloads/ASH_981.pdf

20. Hartmann-Boyce J, McRobbie H, Bullen C, Begh R, Stead LF, Hajek P. Electronic cigarettes for smoking cessation. Cochrane Database Syst Rev [Internet]. 2016 Sep 13 [cited 2019 Jan 21];(9). Available from: http://doi.wiley.com/10.1002/14651858.CD010216.pub3

21. McNeill A, Brose L, Calder R, Hitchman S, Hajek P, McRobbie H. E-cigarettes: an evidence update A report commissioned by Public Health England [Internet]. 2015 [cited 2019 Jan 21]. Available from: www.facebook.com/PublicHealthEngland

22. Illicit Tobacco Partnership. What is illegal tobacco? - Illicit Tobacco Partnership [Internet]. [cited 2019 Jan 21]. Available from: http://www.illicit-tobacco.co.uk/problem/illicit-tobacco/

23. HM Revenue and Customs. Measuring tax gaps 2017 edition, Tobacco tax gap estimates for 2016-17 [Internet]. 2017 [cited 2019 Jan 21]. Available from: www.gov.uk/government/statistics/measuring-tax-gaps

24. Health T illicit tobacco for better. Illegal Tobacco: The facts protecting public health

from the tobacco industry [Internet]. [cited 2019 Jan 21]. Available from: http://www.cancerresearchuk.org/about-us/cancer-news/press-release/more-

25. Smokefree.gov. Social Smoking [Internet]. [cited 2019 Feb 28]. Available from: https://smokefree.gov/challenges-when-quitting/cravings-triggers/social-smoking

26. Nottingham City Council. Nottingham Citizens Survey 2017 Overview. Nottingham; 2017.

27. NHS Digital. CCG Outcomes Indicator Set - December 2018 - NHS Digital [Internet]. 2018 [cited 2019 Jan 22]. Available from: https://digital.nhs.uk/data-and-information/publications/clinical-indicators/ccg-outcomes-indicator-set/current

28. Public Health England. The national CQUIN scheme 2017-19 No.9: Preventing ill health by risky behaviours- alcohol and tobacco [Internet]. 2017 [cited 2019 Jan 22]. Available from: http://www.swsenate.org.uk/wp/wp-content/uploads/2017/12/IntroCQUIN.pdf

29. NHS England, Public health England. Guidance Health Matters: preventing ill health from alcohol and tobacco use [Internet]. 2017. Available from: https://www.gov.uk/government/publications/health-matters-preventing-ill-health-from-alcohol-and-tobacco/health-matters-preventing-ill-health-from-alcohol-and-tobacco-use#implementing-the-preventing-ill-health-by-risky-behaviours-cquin

30. One Nottingham. The Nottingham Plan to 2020 [Internet]. Nottingham ; 2010 [cited 2019 Jan 22]. Available from: www.onenottingham.org.uk

31. One Nottingham. The Nottingham Plan to 2020, Draft Annual Report 2016/17 Year 7 [Internet]. 2017 [cited 2019 Jan 22]. Available from: http://www.onenottingham.org.uk/wp-content/uploads/5.2-Draft-Nottingham-Plan-Annual-Report.pdf

32. Cordy N. Nottingham City Council Delegated Decision- Support for smoking cessation [Internet]. [cited 2019 Jan 23]. Available from: https://committee.nottinghamcity.gov.uk/documents/s77685/DD3261.pdf

33. Nottinghamshire healthcare trust. Implementing NICE public health smoking cessation guidance- smoke free programme update [Internet]. 2018 [cited 2019 Jan 23]. Available from: file:///C:/Users/iallso/Downloads/15-Smoke-Free-Progamme-Update.pdf

34. Chaloupka FJ, Straif K, Leon ME, Working Group, International Agency for Research on Cancer. Effectiveness of tax and price policies in tobacco control. Tob Control [Internet]. 2011 May 1 [cited 2019 Feb 5];20(3):235–8. Available from: http://www.ncbi.nlm.nih.gov/pubmed/21115556

35. Belvin C, Britton J, Holmes J, Langley T. Parental smoking and child poverty in the UK: an analysis of national survey data. BMC Public Health [Internet]. 2015 Dec 29 [cited 2019 Feb 5];15(1):507. Available from: http://www.ncbi.nlm.nih.gov/pubmed/26021316

36. Filby A. NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE Smoking Cessation Interventions and Services [Internet]. [cited 2019 Feb 7]. Available from: https://www.nice.org.uk/guidance/ng92/evidence/economic-modelling-report-pdf-4790596573

37. Chaiton M, Diemert L, Cohen JE, Bondy SJ, Selby P, Philipneri A, et al. Estimating

the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers. BMJ Open [Internet]. 2016 Jun 9 [cited 2019 Feb 7];6(6):e011045. Available from: http://www.ncbi.nlm.nih.gov/pubmed/27288378

38. Murray RL, Leonardi-Bee J, Marsh J, Jayes L, Li J, Parrott S, et al. Systematic identification and treatment of smokers by hospital based cessation practitioners in a secondary care setting: cluster randomised controlled trial. BMJ [Internet]. 2013 Jul 8 [cited 2019 Feb 5];347:f4004. Available from: http://www.ncbi.nlm.nih.gov/pubmed/23836616

39. ASH (Action on smoking and health). Smokefree: The First Ten Years [Internet]. 2017 [cited 2019 Feb 5]. Available from: http://www.vivid.at/uploads/Tabak/England_Smokefree-the-first-ten-years.pdf

40. Dawkins L, Mcrobbie H. The British Psychological Society Promoting excellence in psychology Electronic cigarettes [Internet]. [cited 2019 Feb 5]. Available from: www.bps.org.uk/behaviourchange

41. Healthwatch Nottingham and Nottinghamshire. Question of the month July and August 2017- What influences your healthy living choices? [Internet]. 2017 [cited 2019 Feb 27]. Available from: https://hwnn.co.uk/wp-content/uploads/2018/02/QOTM-STP-2-FINAL.pdf

42. Hajek P, *et al.* A Randomized Trail of E-cigarettes versus Nicotine-Replacement Therapy. New England Journal of Medicine [Internet]. 2019 February 14 [cited 2019 Jun 6]; 380:629-637. Available from: https://www.nejm.org/doi/full/10.1056/NEJMoa1808779