Tobacco

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Executive summary

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Tobacco use remains one of the most significant public health challenges. Smoking causes more deaths each year than any other preventable cause:

- Smoking; 79,700 deaths (Health & Social Care Information Centre (HSCIC),2013, published 2014)
- Obesity; 34,100 deaths (HSCIC, 2013, published 2014)
- Alcohol; 21,485 deaths (Local Alcohol Profiles for England (LAPE), 2012, published 2014).

The percentage of people who smoke across Nottinghamshire County is 18.4%, in line with the England average. This figure masks differences across the county with 11.3% of the population of Rushcliffe smoking whilst this figure is 25.8% for the population of Mansfield (for the most up-to-date data visit: Local Tobacco Control Profiles)

Amongst certain groups, smoking prevalence is also higher. For example, both nationally and locally routine and manual workers have a higher smoking prevalence at 28.6% and 29.5% respectively. Smoking rates amongst this group also vary across the county.

Smoking is responsible for around 1,300 deaths across Nottinghamshire County every year (HSCIC, 2013). The main causes of death are;

- cardiovascular disease
- cancers
- respiratory disease

Smoking is the single biggest cause of inequalities in death rates and life expectancy between the richest and poorest in our communities. On average in Nottinghamshire County this difference in life expectancy is 8.5 years and tobacco contributes to half of this difference.

What we know and what we need to do

Stopping smoking

We know that:
- Approximately 70% of smokers want to stop smoking
- 6% of smokers access local stop smoking services annually
- 50% of these smokers are successful at stopping smoking at 4 weeks
- Variations exist in accessing support and stopping smoking based on personal characteristics e.g. where you live, how old you are, your employment status.

We need to:
- Provide services that are individualised for smokers and what they need
- Prioritise particular groups where smoking rates are higher and make services fit around smokers' lives and routines in locations that are accessible

Preventing uptake of smoking

We know that:
- Approximately 65% of long term smokers start before the age of 18.
- Smoking is largely an addiction started in childhood.

We need to:
- Stop young people from starting to smoke in the first place,
- Use the evidence we have on what works for example evidence based education/awareness programmes and campaigns that de-normalise smoking

Reducing harm from tobacco use

We know that:
- Illegal tobacco undermines all tobacco control efforts in bringing crime in to local communities and making cheap tobacco available to children.
- In Nottinghamshire 30,000 children up to the age of 15 live in a household that is not smokefree
- Tobacco use affects all in the community

We need to:
- Tackle the supply and demand of illegal tobacco in our communities through close working with trading standards and HMRC.
- Raise awareness of tobacco control beyond health-related organisations
- Work in partnership with other agencies and departments, including: fire and rescue; housing; social care; and Human Resources (HR), to identify and implement tobacco control measures.

How will we do this?

Tobacco Control is an evidence-based approach to tackling the harm caused by smoking. It includes strategies that reduce the demand for, and supply of, tobacco in communities through;

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to secondhand smoke
- Effective communication for tobacco control

We will review services to ensure that they optimise the chances of quitting for individuals, reduce the numbers of young people starting to smoke and work with partners to reduce the harm caused by tobacco to the population of Nottinghamshire County.

Policy and wider links for tobacco control

The Public Health White Paper *Healthy Lives, Healthy People: Our strategy for public health in England* (Department of Health, 2010) and the independent review into health inequalities in England *"Fair Society, Healthy Lives"* (2010), identified Tobacco Control as being central to any strategy to tackle health inequalities as smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216096/dh_127424.pdf

https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

The Department of Health (2011) *Healthy Lives Healthy People: A Tobacco Control Plan for England* highlights the commitment to maximise efforts to reduce tobacco use and builds on the achievements in tobacco control made over many decades. It sets out a comprehensive package of evidence-based action at a national and local level to drive down rates and impacts of tobacco use.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf

This current strategy ends in 2015 and will be replaced by a new strategy, Smoking Still Kills, which will be published June 2015.

Other relevant links with the JSNA are to sections on Maternities and Pregnancy, Cancer, Cardiovascular Disease, Chronic Obstructive Pulmonary Disease (COPD) and Stroke.

Full JSNA report

Smoking is the most prominent form of tobacco use. This chapter considers the impact smoking and tobacco use has across all ages and takes in to consideration the links to the wider determinants of health.

Due to the way in which services have been commissioned and the data that is currently available, this chapter focuses on smoking cessation but it is recognised that this is only one element of tobacco control. This becomes evident in the gaps and recommendations. For the purpose of this chapter, 3 themes will be used;

- Stopping smoking
- Preventing uptake of smoking
- Reducing harm from tobacco use

Where possible data will be reported for England, where this is not possible data will be reported at a UK level.

What do we know?

1) Who is at risk and why?

Stopping smoking

Smoking is the greatest cause of preventable death in England. It is costly to both individuals and the economy and is the greatest single cause of health inequalities placing a huge burden on local finances.

- On average, cigarette smokers die about 10 years younger than non-smokers. About half of all persistent cigarette smokers are killed by their habit. (Doll et al, 2004).
- About one fifth of the population in England smoke.

Table 1- National, regional and local smoking prevalence

Smoking Prevalence	
Nottinghamshire County	18.4%
England average	18.4%
East Midlands average	19.1%

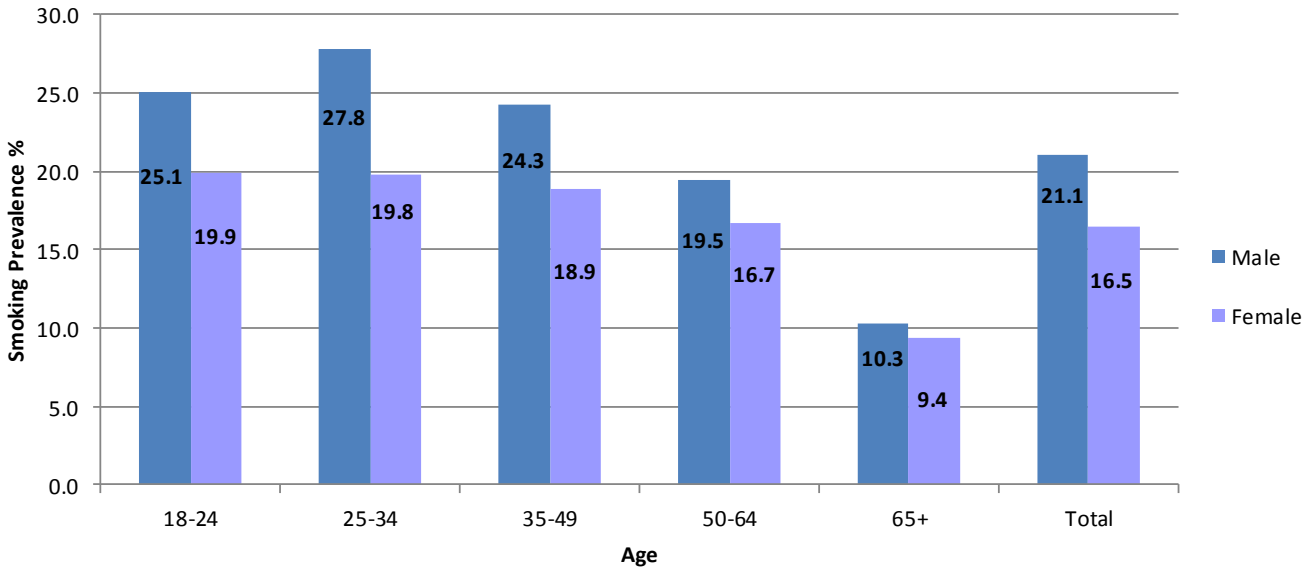
Source: Integrated Household Survey (2013, published by the Health and Social Care Information Centre, HSCIC, 2014)

Smoking age and gender

Figure 1 shows that males are more likely to be current smokers than females across every age group. This difference between males and females is more noticeable in adults aged 18-

49 years old, with the gap narrowing for adults aged 50 and older. The greatest difference is in the 25-34 age group, where 27.8% of males smoke compared to 19.8% of females.

Figure 1- Current Smoking Prevalence: by Age and Gender, UK, January to December 2013

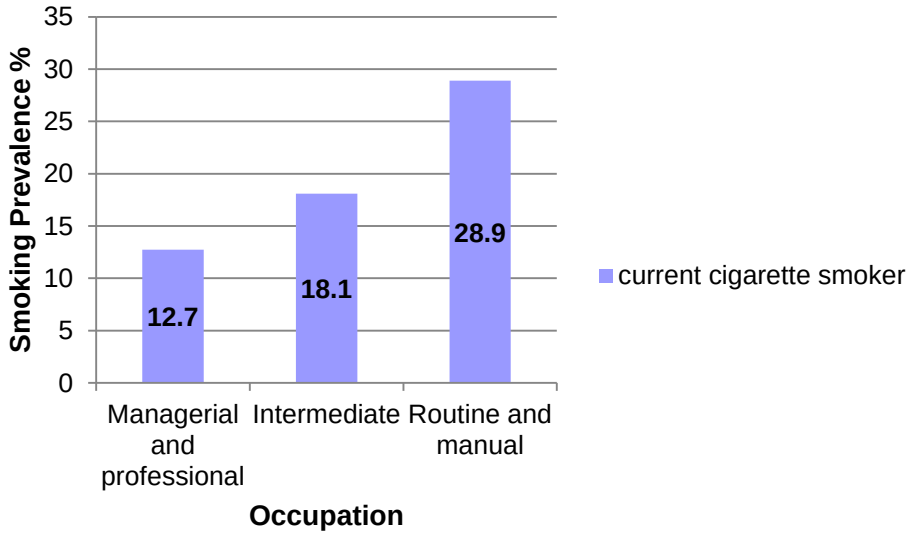


Source: Integrated Household Survey (2013, published by HSCIC in 2014)

Smoking and occupation

Smoking prevalence rates also differ by occupation. In the UK, 28.9% of adults in 'routine and manual'* occupations are smokers. This compares to 12.7% of adults in 'managerial and professional' occupations (Figure 2) (HSCIC, 2014).

Figure 2 - Current Smoking Prevalence by Occupation, UK, January to December 2013



Source: Integrated Household Survey (2013, published by HSCIC 2014)

* Routine and Manual (R & M) groups are defined those whose self-reported occupational grouping is of a R/M worker, as defined by the National Statistics Socio-Economic Classification – R/M occupations includes; Lower supervisory and technical occupations, Semi-routine occupations and routine occupations.

Smoking and pregnancy

Smoking prevalence is measured by Smoking at Time of Delivery (SATOD) rates, recorded at the time of giving birth. In England, SATOD rates have steadily been declining from 15.1% in 2006/7 to 12% in 2013/14 (Health and Social Care Information Centre).

Table 2 – Decline in SATOD rate from 2006/7 to 2013/14

	Number of maternities	SATOD (number)	SATOD (%)
2006/7	601,262	90,887	15.1
2013/14	632,956	75, 913	12

Source: HSCIC, (2013/14, published in 2014)

SATOD rates vary amongst certain groups. Women who smoke in pregnancy are more likely to be under 20 years old (57%) and from the routine and manual occupational group (40%) (Infant Feeding Survey, 2010).

Smoking and mental health

Whilst smoking rates amongst adults with disabilities varies, smoking rates are higher amongst those with mental health problems than the general population. Sufferers of psychiatric disorders have a deep dependence on tobacco; and they are likely to be heavier, more dependent smokers and have smoked longer than smokers in general population.

It is estimated that a third (33%) of people with mental health problems and more than two-thirds (70%) of patients in psychiatric units smoke tobacco. This compares with about one in five adults in the general population (McManus et al 2010).

Smoking and ethnicity

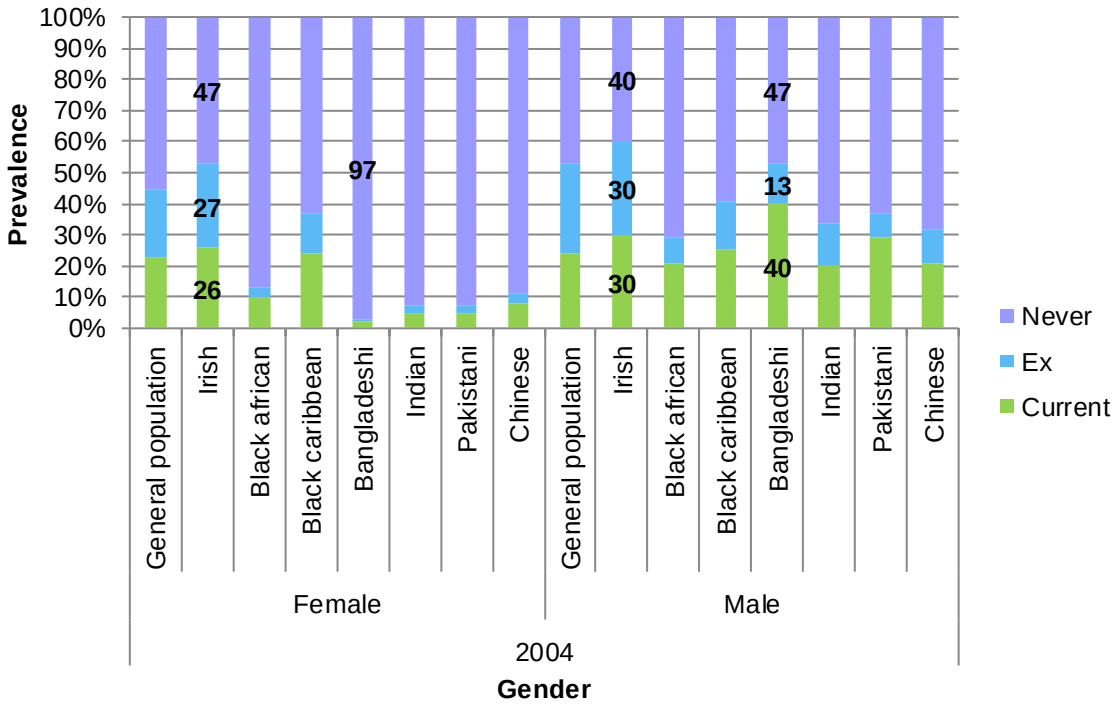
There is no straightforward relationship between smoking, tobacco related harm and ethnicity, with a complex interplay of factors affecting health in Black, Minority and Ethnic (BME) communities, although it is clear that different ethnic groups have very different levels of smoking and susceptibility to tobacco related harm.

Smokeless tobacco[†] comes in many different forms around the world. We know that the use of such products is inconsistent across communities and age groups but emerging evidence is highlighting that products are mainly imported from South Asia, and in England pockets of high prevalence have been identified amongst Bangladeshi, Indian and Pakistani populations.

The graph (figure 3) highlights that there is a variation across ethnic groups and the levels of smoking and also some differences between genders. For example there is a reported higher level of smoking in Bangladeshi men compared with Bangladeshi women, whereas the Irish population shows very little differences between genders.

[†] Smokeless tobacco is a blanket term that refers to a number of tobacco products that are used by means other than smoking – e.g. snuff, gutkha, Betel quid – with tobacco

Figure 3 - Self-reported cigarette smoking status, by ethnic group and sex, 2004



Source: Health Survey for England (2004, published 2006).

Smoking and sexual orientation

There is some evidence that minority groups such as lesbians, gays, bisexuals and transsexuals (LGBT) smoke at higher rates than the general population. The reasons behind this are not well known yet but there are suggestions that gay and lesbian social spaces (such as bars), violence, stress, and discrimination, as well as barriers to healthcare access and treatment services, contribute to the higher rates of smoking (Lee et al, 2009).

Alternative tobacco use

Shisha:
There has been a sudden and significant rise in the popularity of Shisha[‡]. Data obtained by the British Heart Foundation shows that Shisha use has increased by 210% over a 5 year period (BHF 2012).

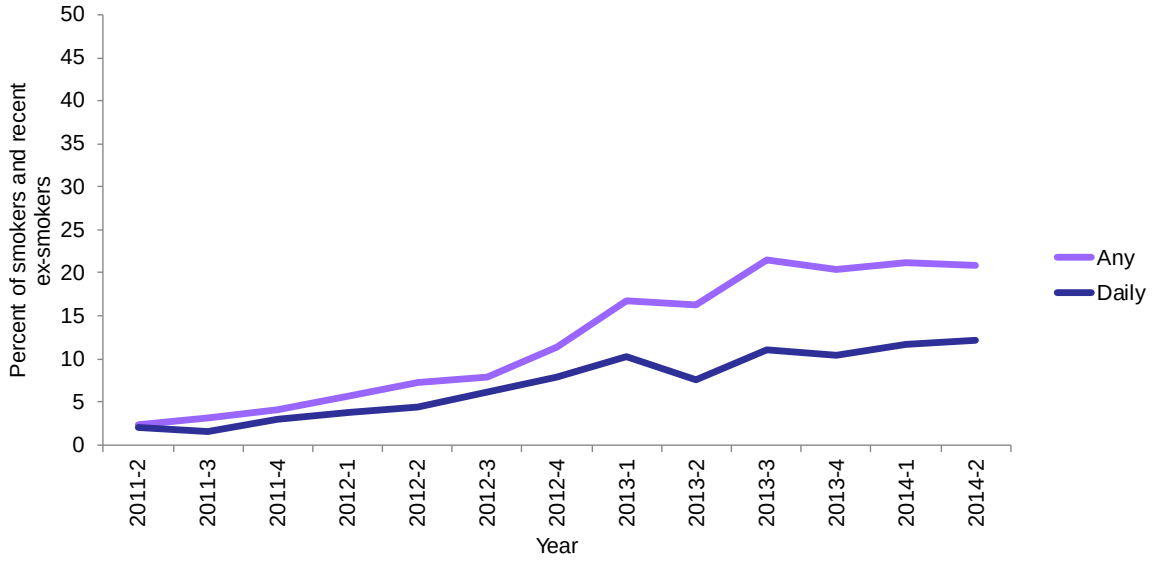
Recent data collected over a long period suggests an upwards trend which persists across all age groups, but is particularly noticeable in the younger population. In the UK the current prevalence is thought to be 8% amongst school pupils (Jawad et al (2013) and 8–19% amongst university students (Jackson and Aveyard 2008).

Electronic cigarettes (E-Cigs):
In the UK more than a million people are estimated to be using e-cigs[§]. Prevalence has increased dramatically since 2010 and has now plateaued at 16% of current and recent

[‡] Waterpipe tobacco smoking or Shisha involves the user inhaling smoke passed through water.
[§] Electronic Cigarettes (e-cigs) are designed as an alternative to tobacco smoking. Some look and feel like conventional cigarettes; however more recent models bear less of a resemblance. In general

smokers. Further information on e-cigarette use can be found at: http://www.smokinginengland.info/

Figure 4 - Prevalence of e-cigarette of current and recent smokers



Source: Smoking Toolkit Study, (2011published in 2014)

Preventing uptake of smoking

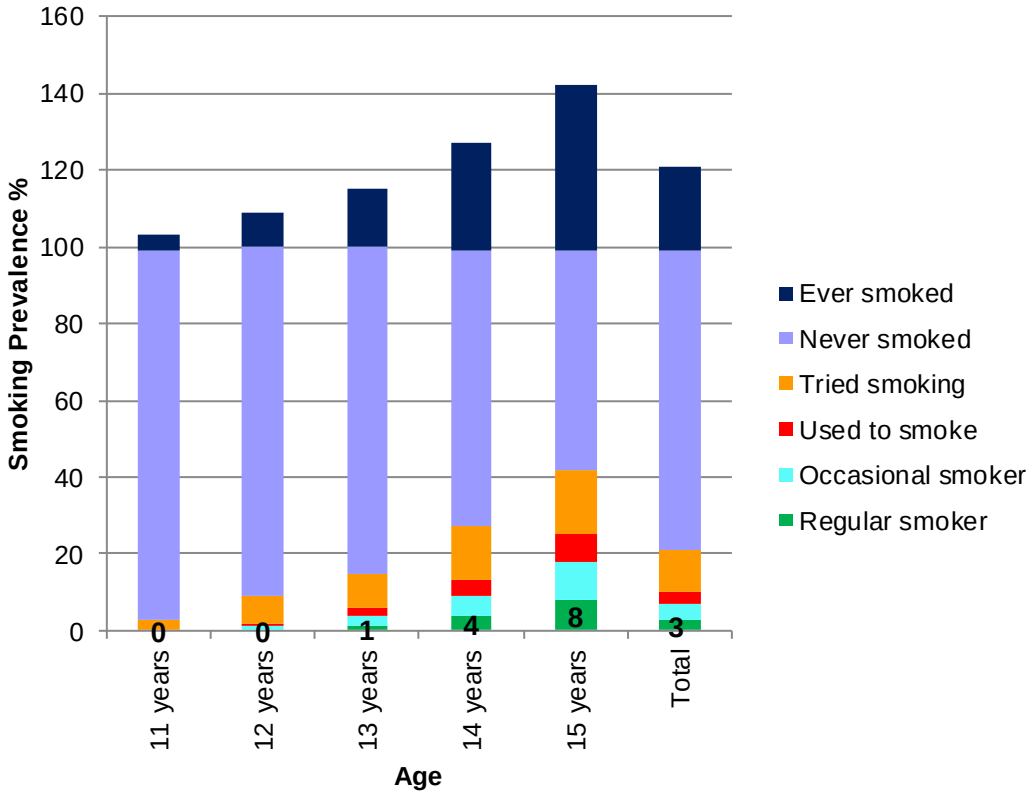
It is important to recognise that it is children who start smoking, not adults. Almost two thirds (65%) of smokers start before they are aged 18 (General Lifestyle Survey, 2010).

Children who grow up in households where those around them smoke are 3 times more likely to become an adult smoker. Exposure to household smoking (role models) generates about 20,000 new smokers by the age of 16 each year (Leonardi-Bee, 2011).

In 2013, 22% of young people in England aged 11 to 15 years said they had tried smoking at least once-the lowest level recorded since the smoking Drinking and Drug Use Survey began in 1982. 3% were regular smokers (9% in 2003). Older pupils were more likely to be regular smokers than younger pupils (8% of 15 year olds compared to less than 0.5% of 11 and 12 year olds) see figure 5 (HSCIC, 2014).

an e-cig contains a battery, an atomiser and a cartridge. The cartridge contains a liquid or 'juice which is generally propylene glycol or glycerine, water and varying amounts of nicotine.

Figure 5 – Smoking behaviour by age, 2013



Source: Smoking, drinking and drugs use among young people in England (2013 published by HSCIC in 2014)

Reducing harm from tobacco use

Harm reduction

Harm reduction (HR) is not a new concept for many working within tobacco control. In principle harm reduction is about adopting a strategy to reduce individual and/or social harms arising from a behaviour. With respect to tobacco control, harm reduction includes aspects of smokefree homes, assisting people to 'stop for the op' (pre-operation), supporting those in mental health facilities or prisons and providing people with advice and access to longer term Nicotine Replacement Therapy (NRT).

In June 2013 NICE produced public health guidance that brings together a review of the available evidence but there is still more that needs to be explored and new models of practice are likely to emerge over the coming years (NICE, 2013).

This guidance is about helping people, particularly those who are highly dependent on nicotine, who: may not be able (or do not want) to stop smoking in one step; may want to stop smoking, without necessarily giving up nicotine; may not be ready to stop smoking, but want to reduce the amount they smoke. Further information can be found at: http://publications.nice.org.uk/tobacco-harm-reduction-approaches-to-smoking-ph45

Secondhand smoke

About 2 million children in the UK live in households where they are exposed to tobacco smoke (Royal College of Physicians, 2010). The World Health Organisation (WHO) has identified the need to reduce parental smoking as a key action 'to encourage health and

development in early childhood, particularly amongst those living in difficult social and economic circumstances' (WHO, 1999).

The most important factors governing children's exposure to smoke are; whether their parents or carers smoke, and whether smoking is allowed in the home (Royal College of Physicians, 2010).

Table 3 Children's exposure to secondhand smoke in the home

	Exposure to tobacco smoke (compared with non-smoking families)
Father Smoking	3 times higher
Mother Smoking	6 times higher
Both Parents	9 times higher

Source: Royal College of Physician (2010)

Illegal** tobacco

There is no evidence that smoking illegal tobacco is any more harmful to health than smoking legal, duty-paid tobacco. Smoking kills half of all life-long users, whether it is illegal or duty-paid tobacco. However, illegal tobacco particularly impacts on our communities in the following ways:

- Funds and supports serious organised crime-there is evidence that illegal tobacco funds organisations such as the Taliban, Chinese Triads, and the Irish Republican Army (IRA) historically (Wilson, 2009 and Chen 2009 and Sharrock, 2006 respectively).
- At significantly less than half the price of legitimate tobacco, it makes tobacco affordable and accessible to everyone including children and young people, ensuring people start young and continue the habit into adulthood.
- Has a negative impact on legitimate retailers
- Creates a huge loss of revenue for the Government
- More likely to cause fires as often illegal tobacco products are not self-extinguishing (under UK and EU law, tobacco must have a reduced ignition propensity (RIP) i.e. self-extinguishing).

Impacts of tobacco use

Economic impact

- The overall economic impact of smoking is estimated at £13.74 billion a year (including factors such as lost productivity through sickness absence and smoking breaks, and littering) (Policy Exchange, 2010)
- In 2005/06 smoking was estimated to cost the NHS in the UK £5.2 billion, approximately 5.5% of total healthcare costs (Allender et al 2009)
- At least £9.7 million each year is spent on primary care visits and asthma treatment for children exposed to secondhand smoke (Royal College of Physicians, 2010)

Smokers take more sick leave than non-smokers and more breaks during the day. Cutting the level of smoking can improve productivity for small businesses (Featherstone and Nash, 2010).

** Illegal tobacco products are cigarettes, hand-rolling tobacco or niche products (such as beedis/bidis and sheesha/shisha) that have been smuggled, bootlegged or are counterfeit.

Affordability of cigarettes (the average price compared to available disposable income) has not changed significantly since the 1970s.

Economic impact of illegal tobacco

The UK has experienced high levels of illegal tobacco in the past, allegedly exacerbated by the actions of the major tobacco multinationals. In recent years a lot of progress has been made nationally. Action by HM Revenue & Customs (formerly Customs & Excise) since 2000 has helped reduce the proportion of smuggled cigarettes from 21% to about 9% (midpoint estimate, 2012-13) (HMRC 2012-13). Public opinion is largely in favour of increased taxation, according to various opinion polls (ASH, 2013).

High levels of illegal tobacco means there is a significant loss of revenue to the government. On average 77% of a packet of premium branded cigarettes are taxed resulting in approximately £12.1 billion total tobacco revenue each year (including VAT) (ASH 2013).

Fire impact

Cigarettes manufactured for the UK market must conform to a standard which serves to ensure that the cigarette self-extinguishes if left unattended and alight. Laboratory tests commissioned by Trading Standards and conducted on the three most commonly seized brands of illegal cigarettes have proven conclusively that a heightened risk of fire is associated with these products. This serves to highlight a real risk of harm to families and the wider community, particularly where the use of illegal cigarettes is more common.

- The leading cause of fatal accidental dwelling fires remains the careless handling of fire or hot substances (mostly cigarettes). This cause claimed 86 deaths in Britain in 2012-13.

- Smokers' materials (i.e. cigarettes, cigars or pipe tobacco) were the most common source of ignition causing accidental dwelling fire fatalities, accounting for over a third of all accidental dwelling fire fatalities in 2012-13.

- The injury rate was highest for fires started by cigarette lighters – 459 per 1,000 fires, a total of 105 injuries in 2012-13. The next highest was for fires caused by candles – 379 per 1,000 fires, a total of 401 injuries in 2012-13 (Department for Communities and Local Government 2014).

- For every 1,000 accidental dwelling fires, 35 fatal casualties are the result of smoker's materials.

Table 4 - Fatal and non-fatal casualties in accidental dwelling fires by source of ignition, Great Britain, 2012/13

		Fatal casualties	Non-fatal casualties
Total of all accidental fires	**36,384**	**217**	**7,354**
Smokers' materials	2,318	82	671
Cigarette lighters	229	3	105
Matches	250	8	76

Source: Department for Communities and Local Government (2014).

Health impacts

Smokers have an increased risk of:

- Heart disease
- Stroke
- Asthma
- Chronic Obstructive Pulmonary (lung) disease (COPD)
- Lung cancer
- Cervical cancer
- Sperm abnormalities
- Disease of blood vessels
- Starting the menopause up to 2 years earlier
- Developing osteoporosis

Table 5 – Health impacts associated with smoking

Smoking causes:	Secondhand smoke causes:
17% of deaths from heart disease	• Children to be born underweight, • Cot death • Upper and lower respiratory tract illness
An increased risk of heart attack-5 times greater for those under 40 than non-smokers	Babies and children to be twice as likely to have asthma and chest infections
Teenagers to have; • more asthma and respiratory symptoms • poorer health, • more school absences • lower fitness levels	10,000 children to be treated in hospital for exposure to secondhand smoke
80% of deaths from bronchitis and emphysema	An increased risk of lung cancer in non-smokers by 20-30%
80% of deaths from lung cancer	An increased risk of coronary heart disease by 25-35%
	• Around 2,700 deaths in people aged 20-63 • A further 8,000 deaths a year among people aged 65 years and older.

Sources: HSCIC (2012), Jamrozik (2005), ASH (2013), ASH (2011), Royal College of Physicians (2010).

Benefits of stopping smoking

Stopping smoking reduces the risk of developing many fatal diseases. Within hours of quitting, the chance of having a heart attack greatly diminishes and progressive conditions such a COPD can be better controlled.

Table 6 – Benefits of stopping smoking over time

Time after stopping smoking	Improvements to your health
20 minutes	blood pressure and pulse return to normal
8 hours	Nicotine and carbon monoxide levels in blood reduce by half, oxygen levels return to normal.
24 hours	Carbon monoxide is eliminated from the body
48 hours	There is no nicotine in the body. Ability to taste and smell is greatly improved
72 Hours	Energy levels increase and breathing becomes easier
2-12 weeks	Your circulation improves
3-9 months	Coughs, wheezing and breathing problems improve as lung function increases by up to 10%.
5 years	Risk of heart attack falls to about half that of a smoker
10 years	Risk of lung cancer falls to half that of a smoker and risk of a heart attack falls to the same as someone who has never smoked

Source: Smokefree NHS website.

- Families with two parents smoking a premium cigarette brand could save £5,800 a year by quitting smoking. Stopping smoking can make a significant difference to household incomes, supporting people to budget in difficult times.

2) Size of the issue locally

Stopping smoking

Locally we do not have data on smoking rates split by;

- Age
- Mental health
- Ethnicity
- Sexual orientation
- Alternative tobacco use

It is recognised that this list is not exhaustive and data gaps for other groups may emerge.

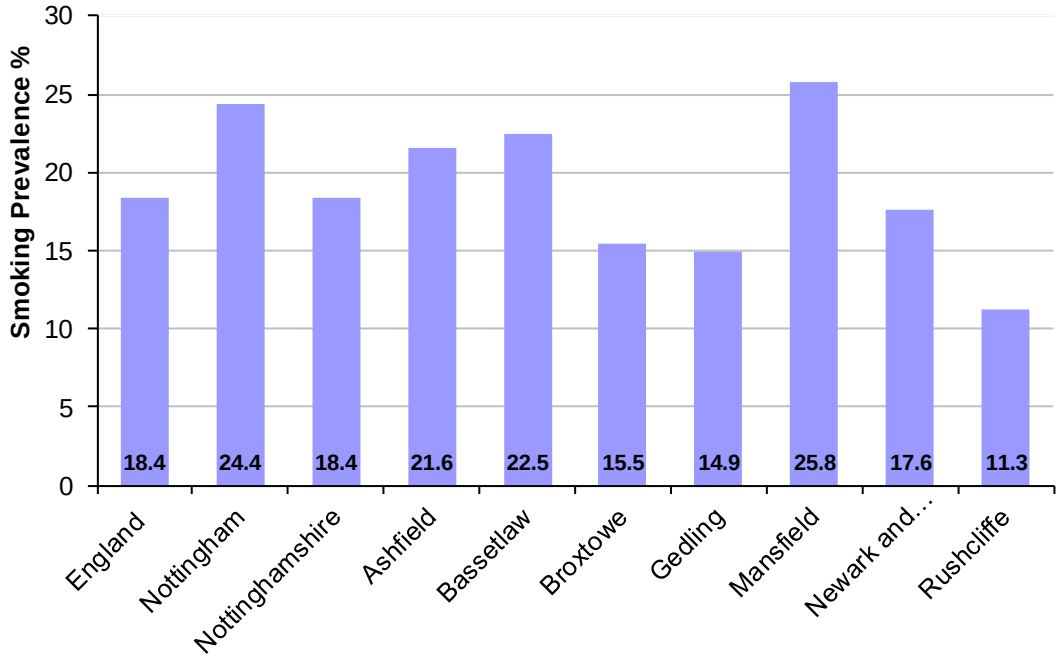
Some of this data is captured through the Health Equity Audit of Stop Smoking Services which can be accessed at: https://smokefreenotts.co.uk/local-resources-and-documents/

Smoking prevalence in Nottinghamshire is 18.4% in line with the England average at 18.4%.

This figure masks local variation;

- Rushcliffe (south of the county) 11.3%
- Mansfield (north of the county) 25.8%

Figure 6 – Smoking Prevalence for 18 years+, 2013



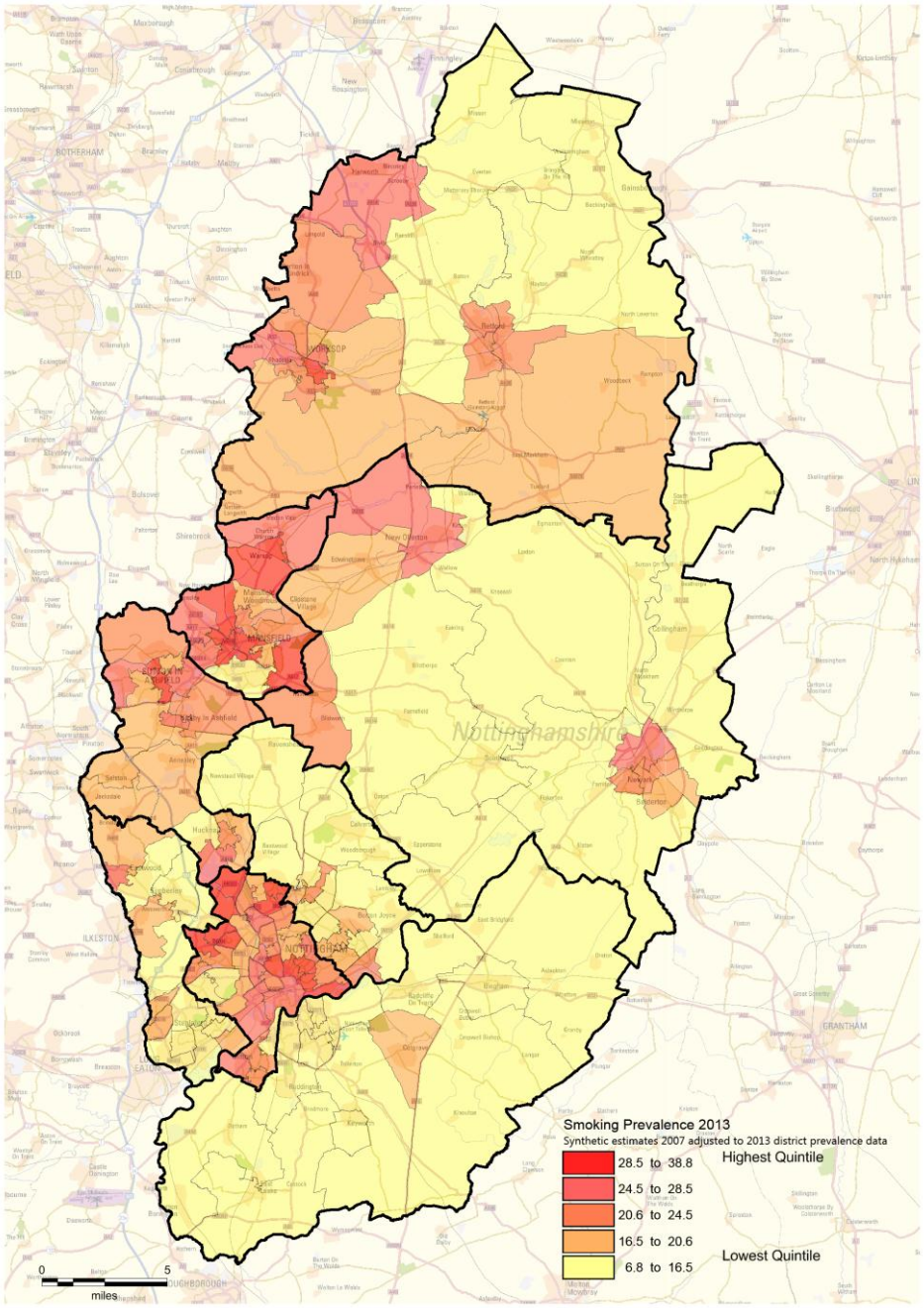
Source: Integrated Household Survey (2013, published in Local Tobacco Control Profiles and Public Health Outcomes Framework, 2014)

Figure 7 illustrates the extent to which high smoking levels are concentrated in the more deprived areas across the county. The areas with the highest proportion of smokers are:

- Ashfield e.g. Sutton in Ashfield,
- Bassetlaw e.g. Worksop,
- Mansfield e.g. Warsop

The map shows that although an area may appear to have a low overall smoking rate, there are pockets within these areas that have high smoking rates and these mirror deprivation across the county.

Figure 7 – Synthetic estimates 2007 adjusted to 2013 smoking prevalence across Nottinghamshire

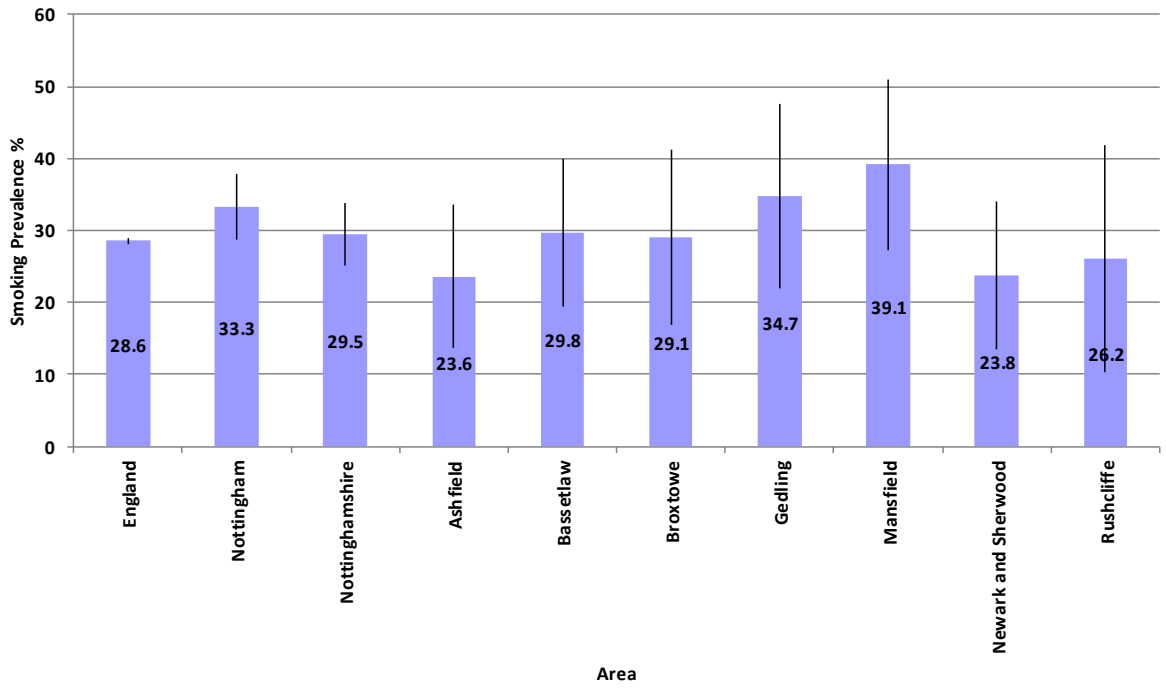


Source(s): Local Tobacco Control Profiles, NHSIC Model based MSOA estimates

Routine and manual workers have the highest smoking rate in Mansfield – 39.1% with the lowest smoking rate being in Ashfield and Newark and Sherwood – 23.6% and 23.8% respectively.

Although the overall smoking prevalence across Nottinghamshire is 18.4%, in routine and manual workers this increases to 29.5% - Even in Rushcliffe where the overall smoking prevalence is the lowest at 11.3%, the routine and manual workers' smoking prevalence is 26.2%. This indicates that there are particular populations in all areas across Nottinghamshire where smoking rates are high.

Figure 8 – Routine and Manual workers' smoking prevalence by district, 2013



Source: Integrated Household Survey (2013, published in Local Tobacco Control Profiles and Public Health Outcomes Framework, 2014)

Smoking and pregnancy

The SATOD rate for Nottinghamshire is 16.7% compared with England at 12% (HSCIC, 2014). SATOD rates are collected by each hospital and then reported by each CCG. There are varying rates across the county see table 7 and figure 9.

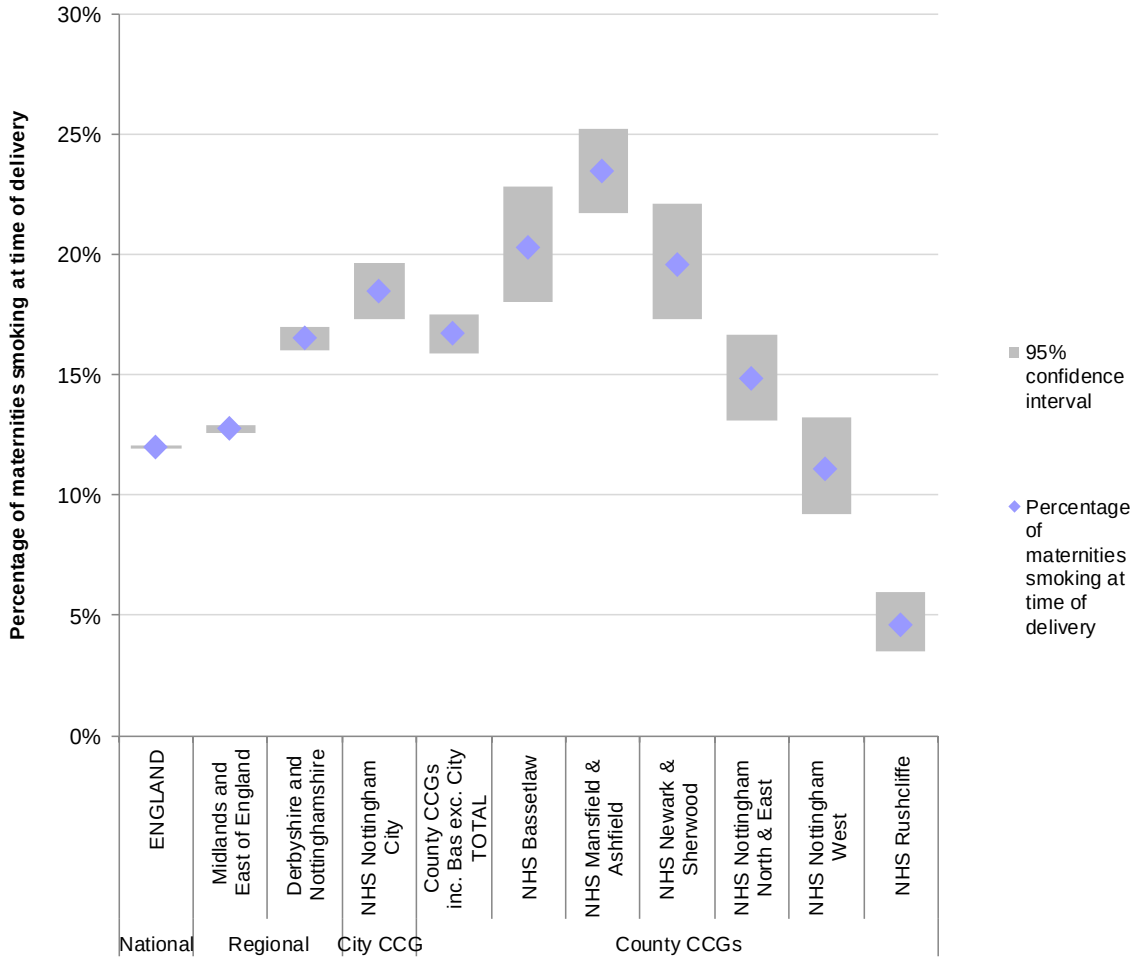
Table 7-Number and percentage of women smoking at time of delivery by CCG, 2013/14

Area/ Commissioning Group	Number of maternities	Number smoking at time of delivery	Percentage of maternities smoking at time of delivery %
ENGLAND	**632,956**	**75,913**	12.0
NHS Bassetlaw	1,074	218	**20.3**
NHS Mansfield & Ashfield	2,213	519	**23.5**
NHS Newark &	1,052	206	**19.6**

Sherwood			
NHS Nottingham North & East	1,561	231	**14.8**
NHS Nottingham West	957	106	**11.1**
NHS Rushcliffe	1,119	51	**4.6**
County CCGs TOTAL	**7,976**	**1,331**	16.7
NHS Nottingham City	**4,326**	**799**	**18.5**

Source: HSCIC (2014)

Figure 9 - Smoking status at time of delivery, by Commissioning Region, Area Team and Clinical Commissioning Group, 2013/14



Source: HSCIC (2014)

Three hospital trusts support women in Nottinghamshire; Nottingham University Hospitals NHS, (NUH) Sherwood Forest Hospitals NHS Foundation Trust (SFHFT) and Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBHFT). The differences in SATOD rates by CCG are influenced by the hospital trust locations and the populations they serve.

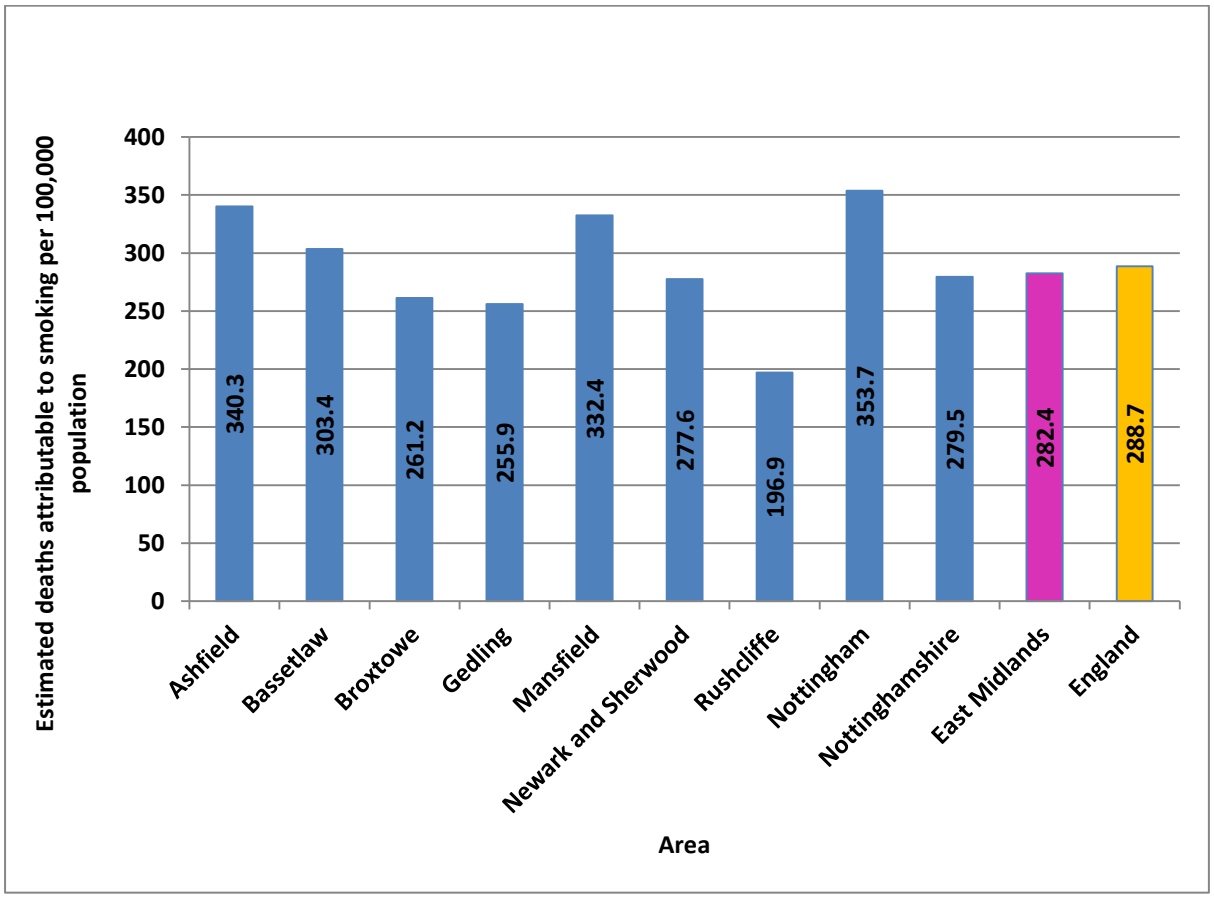
Health impacts

Smoking related hospital admissions and estimated attributable deaths across Nottinghamshire are similar to regional and national averages with higher rates of admissions and smoking attributable deaths in Mansfield and Ashfield (Figures 10 and 11).

These charts represent the scale of the burden within a resident population that smoking creates in terms of deaths and hospital admissions. For example Mansfield with a resident population of approximately 100,000 with a smoking attributable mortality rate of 340, would be estimated to have 340 deaths attributed to smoking.

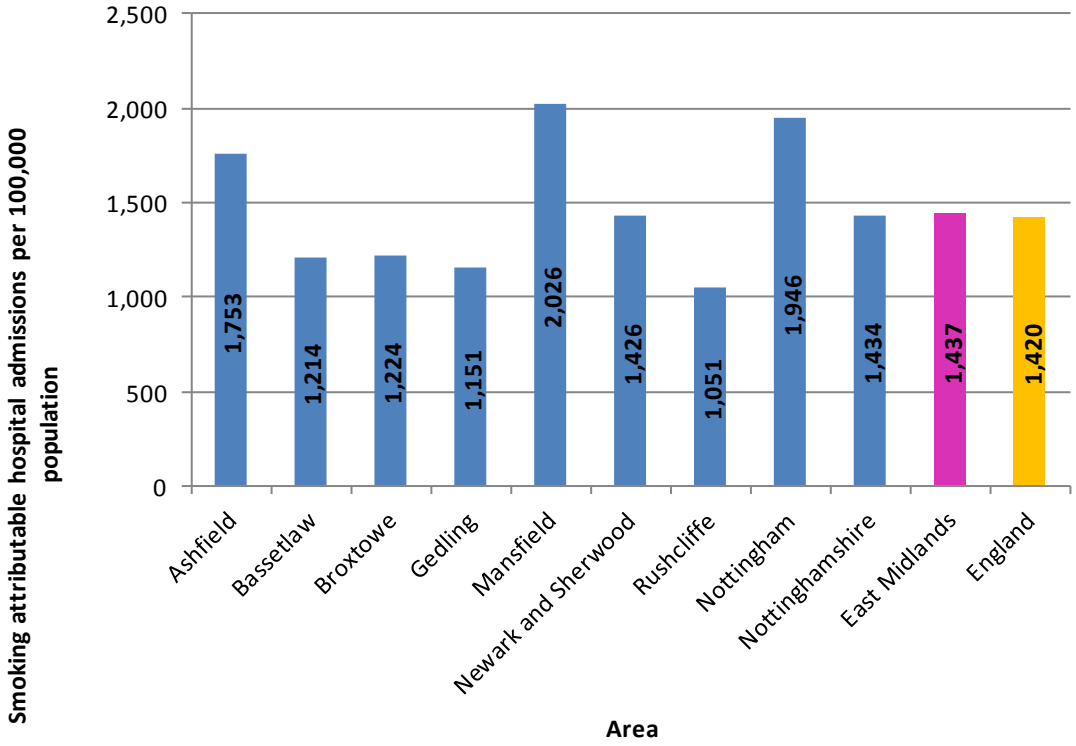
This burden can also be expressed in terms of the total number of deaths and hospital admissions. A local analysis suggests that smoking across Nottinghamshire County can be attributed to 17% of all deaths (3,845 of 22,697 deaths in 2011-13) and to 4.6% of all hospital admissions (17,128 out of 369,803 admissions in 2011-13).

Figure 10 - Estimated deaths attributable to smoking per 100,000 population, aged 35+. 2011-2013



Source: Local Tobacco Control Profiles/Public Health Outcomes Framework (2014)

Figure 11 - Total number of hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over, 2010/11



Source: Local Tobacco Control Profiles /Public Health Outcomes Framework (2014)

Local tobacco control profiles can be accessed at: http://www.tobaccoprofiles.info/

Local insight work

In March 2013, market research work was commissioned, to examine smoker's attitudes and behaviour using surveys and focus groups. The particular groups were those identified as routine and manual workers, pregnant women and young people under the age of 16. The full report can be found at: https://smokefreenotts.co.uk/local-resources-and-documents/

Below are some of the key findings;

- Key motivators to quitting smoking were;
    - Self-motivation
    - wanting to improve health,
    - pressure from relations
- Reason for continuing to smoke;
    - enjoyment
    - stress relief
    - boredom
- Two-thirds of respondents smoked cigarettes whilst a third smoked rolling tobacco.

Table 8– Age and number of cigarettes smoked by each group

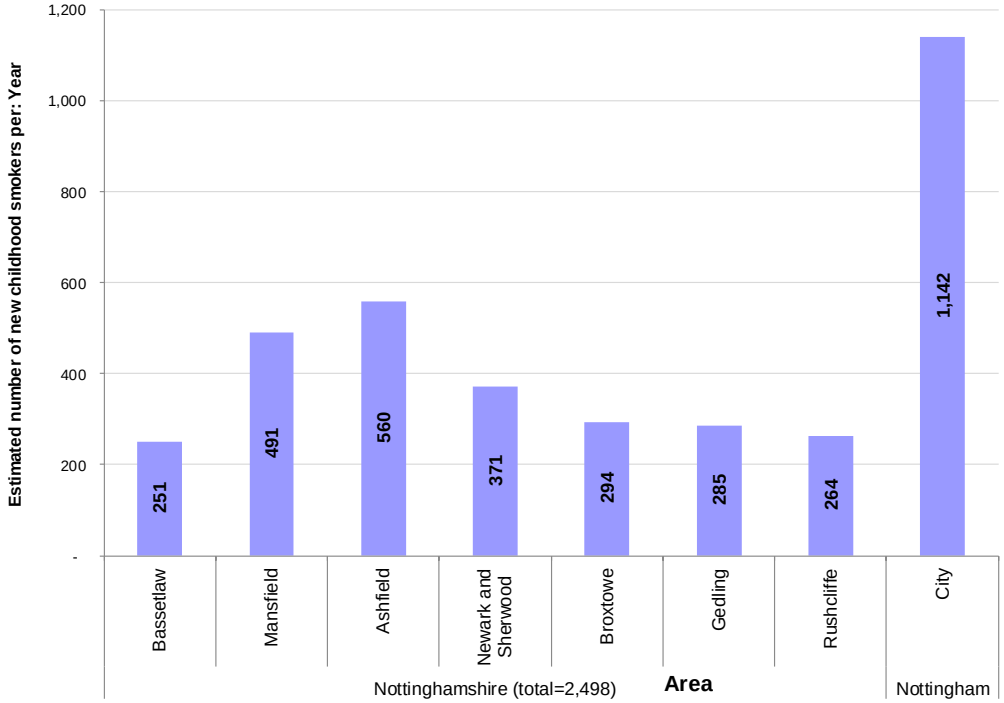
	Average age started smoking (years)	Average number of cigarettes per day
Routine and manual workers	12	15.5
Pregnant women	14.7	10.6
Young people	15.7	7.1

Source: Insight work (published 2013)

Preventing uptake of smoking

There is little smoking uptake/prevalence information in Nottinghamshire for children and young people. Hopkinson et al (2013) estimated uptake of smoking in 11-15 year olds based on adult smoking prevalence data in that area (ONS IHS 2011/1) and the Smoking, Drinking and Drug Use Survey (SDD) (HSCIC, cohort 2010 and 2011). Across Nottinghamshire County this is estimated to be 2,498 young people each year. The breakdown for each district is illustrated below.

Figure 12-Estimated yearly uptake of smoking in 11-15 year olds across Nottinghamshire



Source: Hopkinson et al., Child uptake of smoking by area across the UK (2013), BMJ online

D-vibe

There is data available based on a survey called D-Vibe. This web-based questionnaire was used in six schools (three primary, two secondary and one special needs school) in the Mansfield and Ashfield areas and found that;

- 70% of non-smokers said they are not likely to start smoking
- 13% of non-smokers said they were likely/possibly/probably likely to start smoking
- Nearly 50% of pupils' families smoke around them either 'sometimes' or 'all of the time'
- 52% of pupils said they would get no respect from their mates for smoking
- Approximately 52% of pupils would have the confidence to refuse cigarettes, alcohol or drugs
- 17% of pupils thought the information and advice on smoking needs to be better, although 44% believed it was 'good enough'

Source: SNB Strategic Analytical Unit, Nottinghamshire County Council (2012

North Nottinghamshire social marketing

A social marketing based study in 2009/10 (conducted in North Nottinghamshire) identified the significance of school years 9 and 10 as a time when young people begin to experiment more often with smoking and when the views of their peers become more dominant than those of their parents. In Newark, 61% of Year 9 pupils in five pilot schools considered smoking common practice. However, it is known that perceptions of other peoples' smoking amongst young people are often inflated and, whilst several peers may periodically pick up and drop the habit, relatively few are regular smokers at the age of 14.

Can be accessed at: https://smokefreenotts.co.uk/local-resources-and-documents/

Local insight work

The insight work for young people found;

- 12 years was the average age to start smoking
- 10.65 cigarettes were smoked a day
- The split between cigarettes and hand rolled tobacco was almost equal amongst young people (55% and 45% respectively).
- Flavours e.g. menthol, influenced smoking
- They were most likely to smoke when:
  - Out with friends (77%),
  - At a youth club (68%);
  - At school (59%).
- 13% purchased illegal cigarettes or rolling tobacco
- Stress at home was the most common reason for continuing to smoke and/or failed quit attempts.
- They intended to give up smoking within the next month

Reducing harm from tobacco use

Secondhand smoke

Within Nottinghamshire it is estimated that over 30,000 children up to the age of 15 live in a household that is not smokefree and nearly 100 children's hospital admissions a year are due to secondhand smoke (NHS Nottinghamshire County, 2012, based on crude estimates).

D-vibe

The D-Vibe survey gave a snap shot of this data for Mansfield and Ashfield, where nearly 50% of pupils surveyed in these areas stated that their families smoke around them either 'sometimes' or 'all of the time'.

Local insight

The majority of people surveyed in the insights work understood the dangers of second-hand smoke (91%).

Illegal tobacco

We know that illegal tobacco undermines efforts around tobacco control. Understanding the demand and supply of illegal tobacco in Nottinghamshire is key to tackling it. A key partner to help gather this information is Trading Standards.

It is apparent from the increased number of intelligence reports received and from the size and frequency of illegal tobacco seizures that a particular problem exists in shops located in town centres in close proximity to more deprived areas of the county, such as Sutton in Ashfield and Mansfield.

Of particular concern is the effect of illegal sales upon the wider community and legitimate traders who, when faced with a competitor selling illegal tobacco, must make the decision whether to engage in selling illegal tobacco themselves or not.

An increased number of complaints have been received by Trading Standards from traders facing this dilemma. Trading Standards are actively engaged in dissuading legitimate traders from becoming involved in criminal activity, whilst tackling those selling and supplying illegal tobacco.

Table 9 highlights recent findings and information gathered on illegal tobacco across Nottinghamshire from April 2012 to March 2014.

Table 9 – Local activity on illegal tobacco

Outcome measure	(2012-13)	(2013-14)
Number of reports of illicit tobacco by Nottinghamshire residents and businesses	Approx 52	Approx 105
Number of unique premises investigated (ie: # of sellers/shops inspected using powers or warrants)	5	13
Size of seizures and breakdown of type		
Counterfeit cigarettes	480	14,040
Counterfeit rolling tobacco (kg)	0.65	10.75
Non-duty paid cigarettes	3,660	26,680
Non duty paid rolling tobacco (kg)	2.9	12.95
Legal outcomes (inc:- prosecutions/cautions/warnings (including costs of fine/length of sentence/licence review etc)	1 prosecution	2 prosecutions 1 Licence review
Prosecution outcome (1)	100 hrs unpaid work (and costs)	100 hrs unpaid work (and costs)
Prosecution outcome (2)	n/a	£205 fine (and costs)
Proceeds Of Crime Act (POCA)	£8,000	

Source: Trading Standards Service at Nottinghamshire County Council

From April 2014, Trading Standards Officers have been commissioned specifically to reduce the supply and demand of illegal tobacco. This has resulted in;

- Over 20 inspections of retail premises.
- Recovery of approximately 100,000 illegal cigarettes and 40kg of loose tobacco.
- 16 prosecution cases against individuals engaged in selling and distributing illegal tobacco.

Smoking related fires

Homes with a smoker are at much greater risk of a fire than non-smoking households.

Across Nottinghamshire over the last 5 years fires in the home caused by smokers' materials account for on average 6% of all fires and 7% of the non-fatal casualties. However they are responsible for approximately 40% of the fatalities (table 11).

Between 2006 and 2013 there were 39 fatal fires. Of these, 23 (58.9%) of the fatalities involved cigarettes or smoking materials. The table below highlights the trend in accidental dwelling fires caused by smoking materials. The trend suggests a steady decline over the recent years.

Table 10 – Accidental dwelling fires across Nottinghamshire, 2012/13 (including Nottingham City)

Year	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	Total
Number of accidental dwelling fires caused by smokers' materials	45	54	40	34	36	**209**
Percentage of all accidental dwelling fires caused by smokers' materials	**6%**	**7%**	**6%**	**5%**	**5%**	**6%**

Source: Department for Communities and Local Government (2012 -2013, published 2014)

Table 11 – Fatalities and casualties caused by smoking materials across Nottinghamshire, 2012/13 (including Nottingham City)

Year	**09/10**	**10/11**	**11/12**	**12/13**	**13/14**	Total
Fatalities (% of all fatalities)	4 (50%)	4 (66%)	2 (50%)	1(20%)	0 (0%)	**11 (41%)**
Casualties (% of all casualties)	**5 (6.25%)**	**4 (5.4%)**	**2 (2.5%)**	**7(9%)**	**7 (12%)**	**25 (6.8%)**

Source: Department for Communities and Local Government (2012 -2013, published 2014)

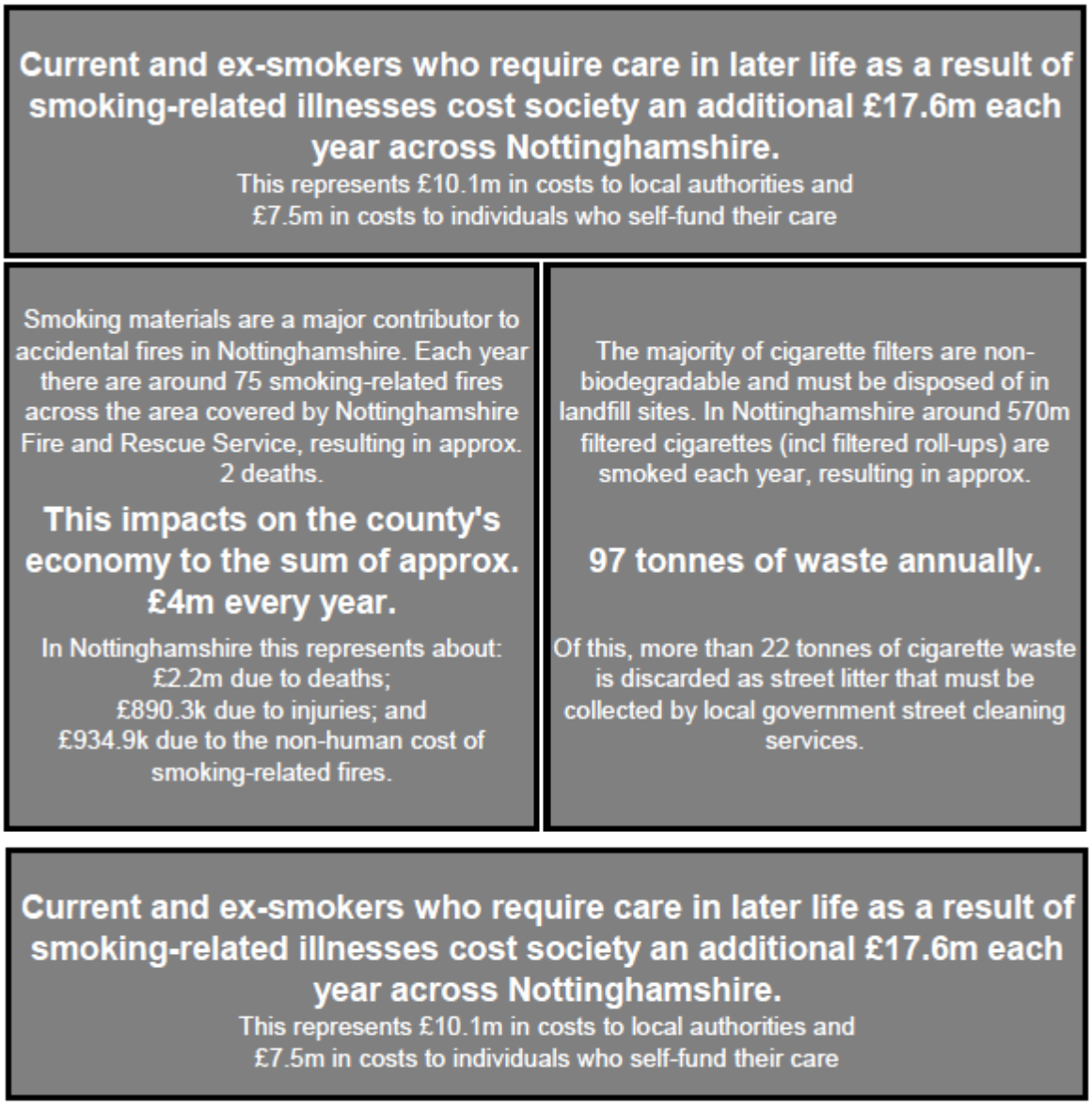
Cost of smoking to society

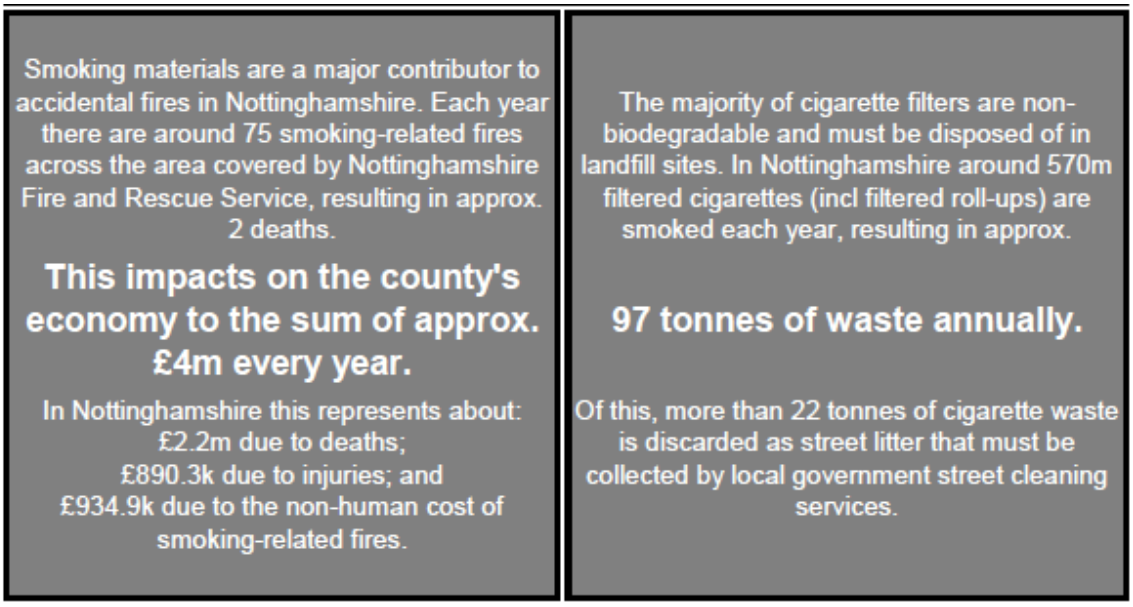
Smoking costs society billions of pounds each year. Using national data it is estimated that smoking costs Nottinghamshire County £200.9m a year (based on an estimated smoking population of 121,895). This includes aspects of lost output due to early deaths, costs of

cleaning materials for litter, costs to the NHS, and fires in the home (Nash and Featherstone, 2010). The following extract from the ASH Ready Reckoner (2014) (figure 13) illustrates these costs to Nottinghamshire (the most up to date data can be accessed using the 'Local costs of Smoking' ready reckoner)

In 2013/14, smokers in Nottinghamshire paid approximately £140.4m in duty on tobacco products. Despite this contribution to the Exchequer, tobacco still costs Nottinghamshire roughly 1.5 times as much as the duty raised. This results in a shortfall of about £60m each year.

Figure 13 Extract from the 'Local Cost of Tobacco', the ASH Ready Reckoner (2014)





3) Targets and performance – How we've provided support

The Tobacco Control Plan for England highlights three national ambitions. These ambitions are also highlighted as indicators within the Public Health Outcomes Framework (PHOF) 2013-2016:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/216159/dh_132362.pdf

For smoking in pregnancy, SATOD is an indicator for CCG's in the CCG Outcomes Indicator Set 2014/15:
http://www.england.nhs.uk/wp-content/uploads/2013/12/ccg-ois-1415-tech-guid.pdf

Table 12 – Domains of the Public Health Outcomes Framework 2013-2016

Domain	Objective	Indicator
Domain 2 Health Improvement	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	Smoking prevalence-adult (over 18's)
		Smoking prevalence – 15 year olds
		Smoking status at time of delivery

Source: Public Health England (PHE), published in 2012

The Tobacco Control Plan calls for local areas to identify local priorities and implement evidence-based best practice in order to contribute to the national ambitions. The national ambitions have been adopted locally, along with some locally specific targets. The national ambitions run until the end of 2015, when the current strategy will be replaced by a new strategy, 'Smoking Still Kills', which will be published June 2015.

Stopping smoking

Adults

- To reduce adult (aged 18 or over) smoking prevalence in Nottinghamshire to 18.5% or less by the end of 2015.

Currently in Nottinghamshire the prevalence target has already been achieved (18.4%), however, smoking rates in some areas and amongst certain populations is significantly higher. Whilst awaiting the publication of new national ambitions, Nottinghamshire aims to continue to reduce smoking prevalence year on year.

One way to reduce smoking prevalence is to support smokers to quit. Currently, smoking rates are set and measured locally by a 4-week quitter target. This is a proxy measure for prevalence. There are no a separate targets for particular groups e.g. young people, routine and manual workers, but activity is weighted towards these groups.

In 2013-2014, 6,858 people were supported to stop smoking, through Nottinghamshire New Leaf, Bassetlaw Stop Smoking Service, GPs and community pharmacies.

Public Health Committee – July 2014 performance report:
http://www.nottinghamshire.gov.uk/dms/Meetings/tabid/70/ctl/ViewMeetingPublic/mid/397/Meeting/3495/Committee/507/SelectedTab/Documents/Default.aspx

Children

- To reduce rates of regular smoking among 15 year olds in Nottinghamshire to 12% or less by the end of 2015.

We know that this target has been met nationally but locally we have little smoking prevalence information for Nottinghamshire for children and young people (currently at 8%, HSCIC, 2014). Additional work on gathering data will be required.

Smoking in pregnancy

- To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

The 2013/14 SATOD rate for Nottinghamshire was 16.7%, significantly higher than the national and regional levels.

A Commissioning for Quality and Innovation (CQUIN) payment framework has been put in place at one hospital in Nottinghamshire (SFHFT) to address SATOD, this is based on the SATOD data from this one hospital.

At a baseline of 26% in 2012 the CQUIN requires a reduction in SATOD year on year to meet the target of 11% SATOD rate by 2015/16. By quarter 4, 2014, SFHFT had reduced SATOD to 21.95% (for all patients giving birth at SFHFT), meeting the required first year reduction.

Table 13 – CQUIN requirements

	Percentage reduction required (%)	Percentage reduction achieved (%)
Year 1 – 2013/14	3	4
Year 2 – 2014/15	5	Data not yet available
Year 3 – 2015/16	7	Data not yet available
Total	15	Data not yet available

Source: SFHFT dashboard (baseline for CQUIN target taken in quarter 2 of 2012= 26%)

Preventing uptake of smoking

We know that in order to reduce smoking prevalence the initiation of smoking must be prevented as well as supporting current smokers to quit. A reduction in adult smoking plays a role in preventing the uptake of smoking in children and several previously mentioned targets are in place relating to this. However there is no target or commissioned services specifically related to preventing the uptake of smoking in young people.

Reducing harm from tobacco use

Smokefree environments

Another way in which families and communities can be protected from the harm caused by tobacco is through encouraging smokers to make their homes and cars smokefree. Nottinghamshire's secondhand smoke initiative, 'Steps to Go Smokefree' encourages individuals and families to pledge to take steps to make their home and car smokefree. There are no specific targets related to this initiative.

Illegal tobacco

From 1 April 2014, two Trading Standards Officers were employed to help reduce the supply and demand for illegal tobacco. Related to these posts are specific measures that feature in the Nottinghamshire Strategic Alliance Group Action Plan. Baseline line measures will be established in 2014/15 based on previous activity.

4) Current activity, service provision and assets

Stopping smoking

Support for adult smokers

Stop smoking support is provided by;

- Bassetlaw Stop Smoking Service
- New Leaf Stop Smoking Service (for the rest of Nottinghamshire)
- Local pharmacies
- GP surgeries.

The table below highlights the number of people committing to stopping smoking (measured by quit date set), number of people stopping smoking (measured by those successfully quit at 4 weeks) and the conversion rate (of those who set a quit date, the percentage who went on to be a successful quitter at 4 weeks) in 2013/14.

Table 14 – Nottinghamshire 4 week quitter figures for 2013/14

	Nottinghamshire
Numbers setting a quit date	10,518
Numbers of 4 week quitters	6,858
Conversion (%)	**65.2**

Source: Quit Manager Database (2014)

Long term quits

Since January 2013, New Leaf has been commissioned to provide data on people stopping smoking at 6 & 12 months post quit date. Follow up phone calls revealed an average of 13%†† of all clients remained non-smokers at 12 months and an average of 15% of all clients were still not smoking at 6 months.

Who accesses services and how successful are they?

The 2014 Health Equity Audit (HEA) analysed data collected by the stop smoking service providers from April 2011 to March 2013. The HEA highlighted differences in service users;

- Accessing services (across 2 years),
- Setting quit dates
- Going on to quit

The table below highlights the number of smokers accessing the service (registering with the service, but not necessarily setting a quit date) compared to the number of quit dates set and the number of quits for each.

Table 15 - Individuals using Stop Smoking Services by district from April 2011 to March 2013

Local Authority	Smokers	Initial Contact	Set Quit	Quit	*% smokers making initial contact per year*	*% smokers quitting per year*
Ashfield	25,091	2,729	2,593	1,639	*5.4*	*3.3*
Bassetlaw	17,452	5,578	3,458	2,037	*16*	*5.8*
Broxtowe	16,163	1,434	1,355	845	*4.4*	*2.6*
Gedling	17,997	2,401	2,219	1,577	*6.7*	*4.4*
Mansfield	25,187	2,608	2,484	1,544	*5.2*	*3.1*
Newark & Sherwood	19,423	2,532	2,440	1,454	*6.5*	*3.7*
Rushcliffe	14,858	1,232	1,177	911	*4.1*	*3.1*
Nottinghamshire	**136,171**	**18,514**	**15,726**	**10,007**	***6.8***	***3.7***
Nottingham City	**65,969**	**12,482**	**10,214**	**5,407**	***9.5***	***4.1***
All	**202,140**	**30,996**	**25,940**	**15,414**	***7.7***	***3.8***

Source: Quit Manager Database, 2013 ***Please note the figures above are based on 2 years aggregated data***

††6 & 12 months follows ups were conducted with all clients who accessed the specialist stop smoking service and quit.

The HEA also compared access ratios, conversion ratios and quit ratios by different variables. Some key findings were:

- Smokers in Bassetlaw had the highest access ratio (2.08, twice as many accessing services, than would be expected across Nottinghamshire) however the quit ratio was the lowest (0.73)
- Rushcliffe had the lowest access ratio (0.54, half as many accessing the services than would be expected across Nottinghamshire), but the highest quit ratio (1.49), meaning that fewer people from this area accessed services, but the outcome for smokers in Rushcliffe is the highest across Nottinghamshire.
- Overall there is very little inequity in access and outcome by sex. However there are more women (especially younger women who smoke) accessing services compared with young men and older people.
- Similarly young men and older people (over 60) are less likely to stop smoking using stops smoking services.
- A higher proportion of those who access services and live in the least deprived areas will quit compared to those that live in the most deprived areas.
- The conversion ratio is similar across all ethnic groups meaning that there is little difference in equity of outcome with respect to ethnicity in Nottinghamshire.
- Mosaic group N (Young people renting flats in high density social housing) had the highest access ratio but the conversion ratio was below what would be expected for that group, meaning that once engaged with a service, fewer people from this group go on to quit. This pattern is also similar for Group O (Families in low-rise social housing with high levels of benefit need). This highlights the desire to quit and access support, but support being provided by services may not be appropriate to their needs or this may be related to how services are commissioned.
- Other Mosaic groups (e.g. D – successful professional living in suburban & semi-rural homes, G – young, well-educated city dwellers, L – Active elderly people living in pleasant retirement locations) had low access, but the conversion ratio was high suggesting the need for knowledge of what services are out there.

Support for pregnant smokers

Through self-referral, or referrals from maternity or other related services, pregnant smokers are supported to stop smoking as part of the general stop smoking services offered across the county.

SFHFT offers a CO reading at the time of the dating scan, with an ‘opt out’ referral to the specialist stop smoking service. In addition SFHFT has started to undertake a ‘risk perception intervention’ delivered in the pregnancy daycare (antenatal) units, at the time of the dating scan, for women who continue to smoke in pregnancy.

Both Bassetlaw Stop Smoking Service and New Leaf have adapted their services to ensure it is flexible and responsive to the individual needs of pregnant women, including a smoking cessation advisor attending antenatal clinics and offering home visits.

In 2013/14, 328 referrals were received from midwifes to Bassetlaw Stop Smoking Service and 1297 from midwives to New Leaf.

Table 16-Access and quit rates for pregnant smokers, across Nottinghamshire, 2013/14

Number of maternities	Number of pregnant smokers	Number of referrals to stop smoking services	Numbers setting a quit date	Numbers quitting	Percentage of pregnant smokers who quit smoking
7,976	1,331	1,625*	928	430	32%

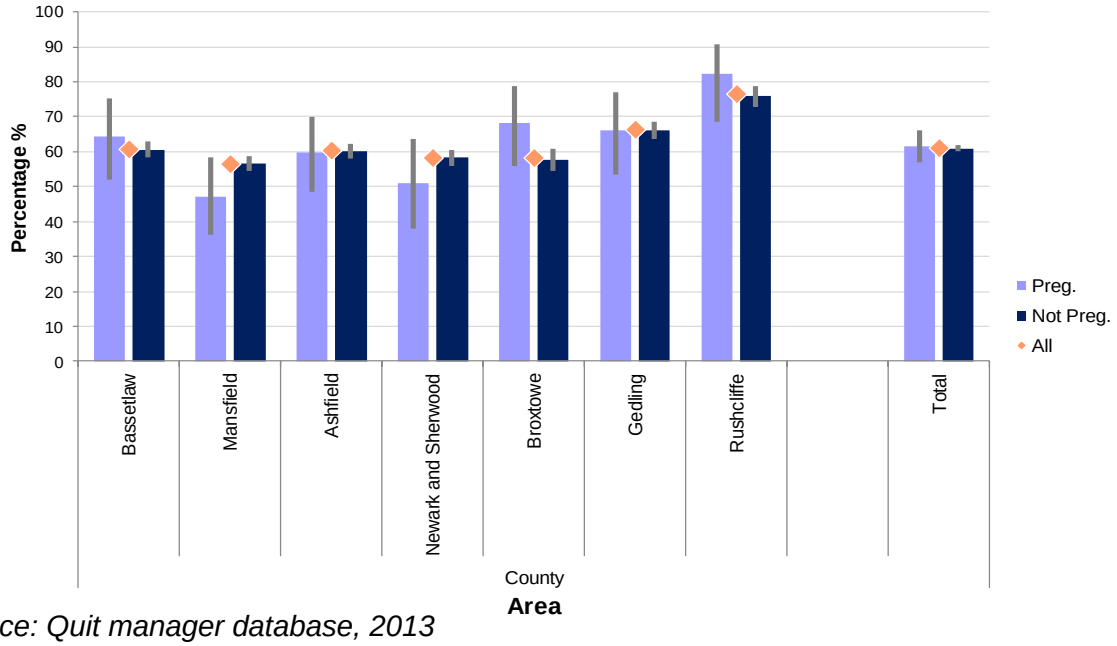
Source: HSCIC, 2014

*NB. Women can be referred more than once and referrals made by Midwives may be for non-Nottinghamshire residents.

A referral to the stop smoking services does not ensure engagement with the stop smoking service. Approximately 57% of referrals result in a quit date being set.

Figure 14 below illustrates that those who do sign up to quit smoking have a higher success rate (62%) compared with non-pregnant smokers (59%) with the exception of Mansfield and Newark and Sherwood. It must be noted that the confidence intervals are quite large due to the small sample size of pregnant smokers.

Figure 14 – Percentage of pregnant women setting a quit date and successfully quitting at 4 weeks 2012/13



Source: Quit manager database, 2013

Support for children and young people

In terms of directly supporting children to quit smoking, stop smoking services in Nottinghamshire can support children as young as 12 years old. The number of under 18 year olds accessing support services is significantly lower than those over 18. In Nottinghamshire only 3% of service users are under the age of 18. This is true across all localities. Of those setting a quit date in 2012/13 6,699 (60%) went on to successfully quit. This percentage varies by age (under 18, 18 and over) and by district. Overall a statistically lower proportion of under 18s go on to successfully quit than 18 and over.

Table 17 - Number of over 18 year olds and under 18 year olds setting a quit date 2012/13

District	Numbers of u18 setting a quit date	Percentage successfully quitting	Numbers of over 18 setting a quit date	Percentage successfully quitting
Bassetlaw	48	52%	1,825	61%
Mansfield	65	51%	1,944	57%
Ashfield	57	56%	1,991	60%
Newark & Sherwood	38	45%	1,830	58%
Broxtowe	27	33%	956	59%
Gedling	32	31%	1,395	67%
Rushcliffe	12	67%	765	76%

Source: Quit Manager Database, 2013

Motivating healthy behaviour training

In order to increase access to stop smoking services, our partners are encouraged to refer clients into services. One way that this is supported is by providing free 'motivating healthy behaviour' training for Nottinghamshire County Council (NCC) staff and the staff of partner organisations with a remit around children and /or health in order to increase knowledge and confidence around smoking and secondhand smoke, knowledge of the support services available and referral processes. This training usually takes place as part of a wider health and wellbeing motivating healthy behaviour training programme.

Table 18 – Groups receiving motivating healthy behaviour training, 2013/14

Organisations/groups	Total Staff trained by sector 2013-14
Clinical Commissioning Groups (CCG)	**71**
Health	**780**
Local Authority	**210**
Dental	**123**
Charity / Voluntary	**87**
Miscellaneous	**8**
Grand Total	**1279**

Source: Local training database, 2014

Preventing uptake of smoking

Given that children are three times more likely to start smoking if their parents smoke, a significant factor in reducing smoking initiation in children is to reduce the number of adult smokers through the services described above.

With respect to preventing the uptake of smoking, schools have a statutory requirement for drugs education (including tobacco) as part of the National Curriculum. They also have an important role to play in helping to deliver the Government's 'Drug Strategy' (2010).

Currently Nottinghamshire schools offer education around smoking delivered directly by the school or through commissioned services. For example, 'DARE' (Drugs and Alcohol Resistance Education) and Keepin' IT REAL programmes. These programmes are not consistent across Nottinghamshire and are often delivered as part of a wider health and wellbeing programme or drugs and alcohol awareness programme.

Reducing harm from tobacco use

From April 2014, two Trading Standards officers were commissioned to reduce the supply and demand of illegal tobacco. Trading Standards have previously supported the tobacco control agenda through gathering intelligence, seizing illegal tobacco, prosecuting sellers of illegal tobacco and promoting this work though the media to raise awareness of illegal tobacco and the detrimental impact on communities. The funding of these posts will ensure a dedicated resource to tackle the demand as well as the supply of illegal tobacco.

Assets

The Nottinghamshire Strategic Tobacco Alliance Group (STAG) was set up with the aim to support a coordinated approach to tobacco control, built on effective partnership working to de-normalise smoking.

The Group meets quarterly with each member reporting back to their respective organisations. The group works together to achieve the shared vision in Nottinghamshire by:

- **Taking action to reduce smoking rates and health inequalities caused by smoking across Nottinghamshire;** including reducing the smoking prevalence across the county, increasing the number of smokefree environments and addressing the issue of supply of cheap illegal tobacco in our county
- **Communicating the facts about the harmful effects of tobacco use and secondhand smoke;** including promoting learning and training for both adults and children on the need to be smokefree
- **Protecting children and young people from smoking;** including reducing young people's access to tobacco, reducing exposure to tobacco promotion and protecting children from secondhand smoke
- **Helping smokers to quit;** including promoting local stop smoking services and increasing access to and take up of these services among high smoking groups
- **Working in Partnership;** and establishing clear lines of communication and consultation with key partner organisations, sharing best practice
- **Developing, implementing, delivering and performance monitoring the STAG Action Plan**

Members include representation from District and Borough Councils, Her Majesty's Revenue and Customs (HMRC), Nottinghamshire Fire and Rescue Service, Nottinghamshire Police, academics (The University of Nottingham), Local Authority - including Trading Standards, Public Health and Children's department. The Nottinghamshire STAG is accountable to the sub group of the Health and Wellbeing Board called the Health and Wellbeing Implementation Group.

5) Evidence of what works

There is a wealth of evidence supporting tobacco control interventions. The National Institute for Health and Care Excellence (NICE) guidance predominantly focuses on smoking cessation interventions. Other government guidance and research addresses both smoking cessation and wider tobacco control. Further detail on the NICE and other recommendations can be found at: https://smokefreenotts.co.uk/local-resources-and-documents/

H*ealthy Lives, Healthy People; A Tobacco Control Plan for England* set out six internationally recognised strands for comprehensive tobacco control.

Tobacco control is an evidence-based approach to tackling the harm caused by tobacco use and smoking. The hexagon diagram below highlights the holistic model of tobacco control with multi-agency partnership working at its heart.

Even though there are several elements to tobacco control the majority of interventions are achieved through partnership working and are reliant on national policy legislation. Each petal, with examples of effective tobacco control interventions are highlighted below with links to the evidence and/or further information. Locally the main hexagons commissioned are;

- Helping tobacco users to quit
- Reducing exposure to secondhand smoke.

Figure 15 – Diagram of tobacco control hexagons



Source: Excellence in Tobacco Control: 10 high impact changes to achieve tobacco control (2008)

- **Stopping the promotion of tobacco**

Helping shape perceptions of tobacco use by adults and young people, by ensuring that non-price measures are in place, such as;

  - Advertising restrictions (point of sale display (POS) in large shops)

- Smokefree laws (the proposed ban on smoking in cars whilst children are present and smokefree review)
- Helping shape perceptions of tobacco use by young people
- Change social norms around smoking
- Standardised packaging – Chantler Review
- Peer lead interventions - Public Health guidance 23

- **Making tobacco less affordable**

Price is the single most effective lever helping people to stop smoking. The health gain from high-priced tobacco, however, can be undermined if the illicit market in tobacco products is allowed to thrive at the expense of legal, duty-paid products.

- Ensuring duty is paid on all tobacco products and the price mechanism is effective – HM Revenue & Customs, Tobacco Tax Gap
- Controlling and de-normalising illegal tobacco sales (All Party Parliamentary Group on Smoking and Health - Inquiry into the illicit trade in tobacco products) and Tackling tobacco smuggling

- **Effectively regulate tobacco products**
  - Enforcing tobacco sales legislation (minimum age) Smoking Drinking and Drug use survey
  - Reducing the availability of tobacco to young people through educating tobacco retailers - proxy sales through the Children and Families Act 2014
  - Regulation of nicotine-containing products – Revision of EU Tobacco Products Directive

- **Effectively communicate for tobacco control**
  - Educating the public & colleagues about the risks of smoking
  - Motivating smokers to quit, including pregnant smokers
  - De-normalising smoking amongst our communities – Be there tomorrow
  - Encouraging children & young people not to take up smoking – Public Health England Marketing Strategy

- **Help tobacco users to quit**
  - Provision of stop smoking services that are tailored to the needs of our communities & are;
    - Targeted at high prevalence groups – Reducing Health Inequalities through tobacco control
    - Provide value for money - All Party Parliamentary Group on Smoking and Health (2010)
    - Recognise diverse needs of our communities
  - Increase access to & uptake of stop smoking services – Evaluation of Stoptober campaign
  - New approaches to help tobacco users who cannot quit to instead use safer sources of nicotine – Harm Reduction
  - Widen professional & community involvement in providing basic stop smoking advice & referral pathways to stop smoking services – Making Every Contact Count and Brief Intervention

- **Reduce exposure to secondhand smoke**

Exposure to secondhand smoke is hazardous to health especially vulnerable adults & children. We can minimise this burden by;

- Encouraging smokers to quit – National campaigns and
- Encouraging people to recognise the effects their smoking has on others – Smokefree

- Extending smokefree areas – The impact of the smokefree legislation

Effectiveness and cost effectiveness

The All Party Parliamentary Group on Smoking and Health (2010) reported on the effectiveness and cost-effectiveness of tobacco control and found that there is a very strong evidence base for tobacco control interventions and that comprehensive tobacco control provides economic value and a positive return on investment. For example, there is strong evidence which demonstrates that Stop Smoking Services are highly effective both clinically and in terms of cost. Department of Health (2011) guidance recommends that all smokers should be routinely offered advice to quit and a referral to the Stop Smoking Service

There are now several models that can help develop the economic case for tobacco control interventions. These tools produce detail on return on investment for tobacco control. These can be used to estimate significant financial savings across an area in both the short and medium term if local stop smoking services are maintained, or if tobacco control programmes are in place (see below links).

http://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Tobacco-return-on-investment-tool

http://www.brunel.ac.uk/herg/research-programme2/the-economics-of-public-health2/building-the-economic-case-for-tobacco-control

6) What is on the horizon?

National policy/action

Tobacco use is the major cause of preventable death in England and harms not just smokers but the people around them, which is why tobacco control interventions are still an important priority across England at a national level. National activity to support local action includes;

- Standardised packaging for tobacco products
- The ban on smoking in cars whilst children are present
- Point of sale ban in small shops from April 2015
- Licensing of E-cigarettes
- Continued input to the annual budget submissions for tobacco products
- Continued support for resources to tackle the illegal tobacco trade
- *Smoking Still Kills* publication-Expected June 2015

Stopping smoking

Trends in other areas and for consideration/implementation locally

The current trend of smoking prevalence in Nottinghamshire suggests that levels are now reducing. We expect the trend in prevalence to follow England's downward trend, however health inequalities are still divided according to wealth in our society. In an attempt to reduce health inequalities, whilst still offering cost effective services for all smokers wanting to quit, many areas are changing the way in which services are delivered through;

- Targeted support services e.g. focusing on hard to reach groups and offering incentives to those groups, for example shopping vouchers for pregnant women
- Alternative ways to access support e.g. directing the most motivated smokers to self-help materials or offering online or text support to suit smokers' lifestyles
- Offering alternative ways to quit e.g. supporting cutting down before quitting and the use of non-licensed nicotine containing products e.g. e-cigarettes
- Moving away from the traditional health-based venues to services delivered in alternative settings by non-health professionals
- A lifestyle model e.g. integrating smoking cessation with weight management services

Preventing the uptake of smoking

Traditionally services have been focused on supporting people to quit smoking, however in order to reduce prevalence, investment in the prevention agenda is required. Many areas are looking at the integration of stop smoking services with the wider tobacco control agenda.

Due to the focus on stopping smoking, there are a lack of evidence based prevention models (the only current evidence-based model being 'ASSIST'). Given the greater emphasis on prevention, a greater evidence base in this area is likely to develop.

Reducing the harm from tobacco use

There is the acknowledgement that whilst ideally people would either quit smoking or not take it up in the first place, measures must be put in place to protect smokers and those around them who are not yet ready to quit or who are at risk from starting to smoke. Locally the following measures are in place/ in development:

- Nottinghamshire Declaration on Tobacco Control.
    - Local organisations (both public and private) are being encouraged to sign up to a set of principles and actions that will support a reduction in smoking prevalence across Nottinghamshire.
- Extending smokefree places
    - Newark and Sherwood District Council has agreed the introduction of a voluntary ban on smoking in council owned play parks. Other district councils are looking to follow suit.
- Continued investment in reducing the supply and demand of illegal tobacco

What we need to achieve the national ambitions?

All aspects of tobacco control must come together in order to achieve the smoking prevalence targets. Locally 2 of the 3 ambitions have already been met. Following the publication of a new national strategy 'Smoking Still Kills' in 2015, local ambitions will be reflected.

Adult smoking prevalence

The national ambition for 18+ years is to reduce the smoking levels to 18.5% by 2015.

Across Nottinghamshire County, smoking levels are 18.4% (according to the latest available data which relates to 2013), meaning that locally, the current national ambition has been achieved. Nevertheless, Nottinghamshire will continue to reduce smoking prevalence year on year

Smoking and pregnancy

The SATOD rates for Nottinghamshire County are significantly higher than the England levels for 2013/14. To reach the national ambition of 11% by the end of 2015/16 Nottinghamshire County will have to **reduce the number of women smoking at time of delivery by approximately 200 each year, equating to almost 3% of all maternities**.

Youth smoking prevalence

The national data for smoking prevalence for 15 years highlights that excellent work has been achieved already and the current smoking levels for this age group for 2013 are at **8% which is 4% under the national ambition of 12% by 2015**.

A health and wellbeing survey for children in Nottinghamshire that includes questions on smoking is planned to be rolled out in December 2014. A baseline will then be established and progress against the target monitored.

An integrated tobacco control approach

Reductions in smoking prevalence in general and across particular groups are dependent on a range of effective tobacco control actions at national, regional and local levels.

To continue to reduce prevalence across Nottinghamshire will require the continuation of evidence-based tobacco control interventions. Although very different to Nottinghamshire, Utah has demonstrated that, through evidence-based interventions it is possible to reduce smoking prevalence (from 30% in 1999 to 10.6% in 2012), (Centre for Disease Control and Prevention, 2012).

Many involved in tobacco control in the UK and further afield have started to consider 'the endgame'. Some countries have already set tobacco free targets such as having a 'tobacco free generation' by 2034 (Scotland) or for' Ireland to be tobacco free by 2025'. This notion was recently discussed at the Smokefree Generation Conference'. In July 2014, Cancer Research UK commissioned 'Tobacco Control Endgames', in which Malone et al assert: "Without an explicit engagement with the idea that an endgame for tobacco is possible, such an outcome cannot be achieved". Therefore a long term smokefree ambition is required to support the shorter term goals.

Going forward, services will therefore need to;

- reflect local priorities
- focus on reducing prevalence (as opposed to quit targets)
- target key populations agreed by the Health and Wellbeing Board [Young people; routine and manual workers, pregnant smokers, people with mental health problems (but not limited to these)]
- be integrated with the prevention agenda
- be integrated with the agenda to reduce tobacco related harm.

7) Local views

Stopping smoking

Service user views

The specialist stop smoking services in Nottinghamshire gain feedback from service users through 'Positive', Nottinghamshire Healthcare Trust's feedback survey for service users, patients and carers.
In 2012/13, service users submitted feedback. Quality of service was rated for both services as excellent by 91% of respondents. http://feedback.nottinghamshirehealthcare.nhs.uk/

Smoker's views on local support services

The local insight work revealed;

- 49% had heard of New Leaf support
- 35% of respondents suggested that support services weren't for them.
- 19% of all respondents said they didn't know about local services, the figure was far lower (9%) for pregnant smokers
- 5% of all respondents suggested they would rather attempt to quit smoking without the help of support services; however, this figure increases to 57% of pregnant smokers
- 60% of pregnant smokers believe one-to-one support would be the most effective form of stop smoking support.
- Views on the NRT voucher scheme were polarised, with 44% saying it would help them quit and 56% saying it would not.
- 19% of young people felt that a group setting would be most effective in helping them stop
- 49% of young people believed none of the support options offered (one-to-one, group, telephone/text, electronic media) would be effective

https://smokefreenotts.co.uk/local-resources-and-documents/

The table below summarises the views on services:

Table 19 – Insight views on services

Type of Support	Positive	Negative
Phone	✓ Acts as distraction ✓ Private ✓ Make you accountable	× Not 24/7 × Cost of calling on a mobile phone
Text	✓ Good for appointment reminder ✓ Good if you can't access other services	× Less personal × Waste of money
One-to-one	✓ Private ✓ Builds a relationship ✓ Tailored	× Feeling uncomfortable
Group	✓ Empathy with/from others ✓ Support from others	× Less personal × Not personal

Source: Mustard Research 2013

Preventing uptake of smoking

There are currently no specific services commissioned to prevent young people from starting to smoke so we are unable to gather views on these services.

Young current or ex-smokers

The North Nottinghamshire research revealed:

- 45% of pupils started smoking in year 8
- 23% of pupils started before year 7
- 27% felt pressured into saying 'yes' when offered a cigarette
- The main reasons for non-smokers not taking up smoking were health and fitness, image and parental concerns.
- Knowledge about the health impacts of smoking was felt by young people to be a 'good understanding'

Reducing harm from tobacco use

Views on illegal tobacco use and secondhand smoke

Local insight research also reinforced what is already known nationally;

- the price of tobacco is a motivation to stop smoking
- access to cheap tobacco dissuades smokers from making a quit attempt
- 13% of young people stated the reason for buying a certain brand was 'because it was the cheapest'
- Young people have access to illegal tobacco and that the price of the tobacco is an influencing factor in continuing to smoke
- 91% said that they did understand the dangers of secondhand smoke, and the main dangers cited were:
    - Danger to children;
    - Encouraging others to smoke;
    - Cancer (particularly lung cancer);
    - Breathing problems;
    - Heart attack; and
    - Ear problems.
- 23% of pregnant smokers reported not knowing the dangers of second hand smoking

https://smokefreenotts.co.uk/local-resources-and-documents/

What does this tell us?

8) Unmet needs and service gaps

What we know

- Approximately 70% of smokers want to quit smoking (ASH, 2013).
- Smokers are 4 times more likely to succeed in stopping smoking through stop smoking services.
- Nottinghamshire services reach around 12% of our smoking population.
- Approximately 50% of service users will go on to stop smoking.
- As a result 6% of Nottinghamshire's smoking population stop long term.
- Locally high numbers of smokers do not access Nottinghamshire's stop smoking services.
- Illegal tobacco undermines all tobacco control interventions.
- Smoking is largely an addiction started in childhood.
- Dangers from secondhand smoke are widely understood.
- Tobacco use affects all in the community.
- Some smokers are unwilling or unable to stop smoking completely.

What we still need to do

Stopping smoking

- Address the variation in the numbers of people accessing support and stopping based on their personal characteristics. This will be achieved by providing individualised support based on different factors for example; level of addiction, previous quitting and medical history and identified priority groups.

- Prioritise particular groups. This will result in the greatest reduction in tobacco use in communities, therefore reducing tobacco-related health inequalities. These groups include but are not limited to:
    - R & M wokers
    - Young people (particularly those from R & M families)
    - Pregnant women (particularly those from R & M groups)
    - People with mental health problems

- Make links between stop smoking services and other lifestyle services, particularly those that may play a role in relapse prevention.

Preventing uptake of smoking

- Ensure stop smoking education/awareness programmes are evidence based and consistent across schools and other education settings
- Create localised awareness campaigns that de-normalise smoking and discourage young people from starting to smoke and encourage them to give up smoking if they have already started.

Reducing harm from tobacco use

- Tackle demand and supply of illegal tobacco
- Fully embed a standardised secondhand smoke initiative across Nottinghamshire communities
- Raise awareness of tobacco control beyond health and illegal tobacco and highlight the impact on other agencies and departments, including: fire and rescue; housing; social care; and Human Resources (HR).
- Consider options to minimise the harm caused by addiction to tobacco

9) Knowledge gaps

Stopping smoking

- Understand the differences in access and stopping smoking across different Mosaic groups in particular;
    - where particular groups live
    - key characteristics
    - what they are receptive and non-receptive to in terms of accessing information
    - what they are receptive and non-receptive to in terms of accessing services
- Gather data on smoking prevalence of key groups including but not limited to;
    - Young people
    - People with mental illness
    - Lesbian, Gay, Bisexual, Transgender groups (LGBT)
    - Different ethnicities
    - Other minority groups
- Understand why few pregnant women access stop smoking services, particularly from R & M backgrounds and younger age groups
- Investigate the referral processes to stop smoking services from all services including public, community and the voluntary sector.
- Gather evidence of people stopping long term from all services
- Knowledge of how better to engage with our communities and partners

Preventing uptake of smoking

- Understand children's and young people's access to tobacco
- Gain evidence of the impact of local interventions on preventing children and young people from starting smoking (as highlight in guidance e.g. NICE)

Reducing harm from tobacco use

- Gather data and impacts on;
    - numbers of children exposed to secondhand smoke
    - number of families who have put in place smoking restrictions in the home and car
    - demand and supply of illegal tobacco across communities
    - voluntary extensions of smokefree environments
    - use of alternative nicotine delivery systems e.g. e-cigarettes
- Investigate how harm reduction strategies can be implemented locally

What should we do next?

10) Recommendations for consideration by commissioners

- Commission a tobacco control model that integrates prevention and stop smoking services across Nottinghamshire which includes;
    - Initiatives that prevent people, particularly young and vulnerable people from starting to smoke
    - Initiatives that protect people and communities from tobacco related harm - including elements of illegal tobacco, harm reduction and smokefree environments.
    - Stop smoking services that not only address individual needs but target priority groups.

Supported by;

- A tobacco control framework and monitored implementation plans
- Strong partnership working across health, social, private and voluntary organisations to make smokefree everybody's business through the Strategic Tobacco Alliance Group (STAG) and the Nottinghamshire Declaration on Tobacco Control
- Addressing gaps in knowledge and need
- Local and National policies
- Continued development of knowledge and skills of tobacco control across our community.

Key contacts

The Nottinghamshire Strategic Tobacco Alliance Group (STAG)

Tobacco leads

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