NOTTINGHAMSHIRE JOINT STRATEGIC NEEDS ASSESSMENT

Tobacco Control

January 2020

Topic information	
Topic owner	Virtual Tobacco Task & Finish Group
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Topic quality reviewed	October 2019
Topic endorsed by	Tobacco task and finish group - November 2019
Topic approved by	Health and Wellbeing Board - January 2020
Replaces version	February 2015
Linked JSNA topics	Cancer (2019) Mental Health (Adults and Older People, 2017) Substance Misuse: Young People and Adults (2018) Stroke (2017) 1001 days: From conception to age 2 (2019)

Nottinghamshire Health & Wellbeing Board

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Executive Summary

Introduction

Tobacco use remains a significant public health challenge. The main method of tobacco consumption is through smoking. Smoking is still the leading cause of preventable illness and premature death in England; in 2016, around 78,000 were attributable to smoking in the UK, representing 16% of all deaths[1].

Smoking causes harm to the heart (doubles the risk of a heart attack), the lungs (causes 84% of lung cancer and 83% of COPD deaths) and the brain (increases the risk of stroke by at least 50%) amongst many other health impacts[1].

Smoking also has a significant financial impact, costing the country approximately £12.5bn per year, including £2.4bn to the NHS and £8.9bn from lost productivity[2].

The percentage of people who smoke in Nottinghamshire is 15.4%, above the current England average and varies widely across the county- rising to 23.1% in Mansfield and 3.6% in Rushcliffe.

Smoking prevalence is higher amongst certain groups, such as routine and manual (R&M) workers (26.7%), people with serve mental illness (40.5%) and contributes to social inequalities (R&M workers in Newark and Sherwood are more than 6 times more likely to be a smoker than the rest of the population). Nottinghamshire also continues to have a higher rate of smoking during pregnancy than the England average (14.7% vs 10.8%)[3].

This chapter is a refresh of the 2015 Tobacco chapter. It considers all forms of smoking and tobacco consumption, alternate methods of nicotine delivery, such as e-cigarettes and the wider effects of tobacco upon the community, across all ages and takes into account the wider determinants of health. The smoking of illicit substances is out of scope and considered separately in Substance Misuse: Young people and adults (2018) .

Notable changes in Nottinghamshire since the previous JSNA was published include;

- In April 2016 Smokefree life Nottinghamshire run by Solutions 4 Health became the new provider for Nottinghamshire's stop smoking service.
- Smokefree polices have been implemented across all prisons nationally
- There has been a national increase in the use of e-cigarettes as an aid to quitting smoking with a better understanding of associated health risks.
- The development of the Integrated Care System (ICS), Integrated Care Partnerships (ICPs) and Primary Care Networks (PCNs).

A summary of the responses to the preceding assessment can be found in appendix 1.

Unmet needs and gaps - What we still need to improve

Stopping smoking

- a stop smoking approach that takes into account different personal factors such as age, sex, sexual orientation, ethnicity, level of education, mental health, levels of motivation and previous quitting methods or attempts
- services or support that is widely known, easily accessible and with as fewer barriers as possible
- the need to focus on geographical inequalities in smoking prevalence, with districts such as Ashfield, Newark and Sherwood and Mansfield having a much greater smoking prevalence than the rest of the county.
- the ongoing social inequalities in smoking prevalence which require equalising, particularly affecting groups such as R&M workers and those with a mental health condition.
- the ongoing challenges with smoking in pregnancy- the Nottinghamshire smoking at time of delivery (SATOD) rate is significantly worse than the England average
- the utilisation of popular novel technologies, such as e-cigarettes, as an adjunct to Nicotine Replacement Therapy (NRT) and behavioural support to help people to quit smoking.
- the links between stop smoking services and other lifestyle services, particularly those that may play a role in relapse prevention.

Preventing uptake

- evaluation of early-intervention programmes, such as ASSIST
- to reach more young people through social media awareness campaigns around the dangers of tobacco and the benefits of being smoke-free that are tailored to acknowledge the variations in local populations.

Reducing harm from tobacco use

- the demand and supply of illegal tobacco and be aware of the potential for the supply of newer counterfeit products, such as e-cigarettes
- a harm reduction approach, as specified in NICE guidance, for those who are unwilling to stop smoking or unable to stop completely, enabling the stop-smoking service to reach further into the smoking population
- enforcement of existing legislation designed to protect others from second-hand smoke (e.g. the ban on smoking in private vehicles with under-18s present).
- supporting the promotion and dissemination of guidance on safer smoking practices
- embedding routine brief advice on smoking and a healthy conversation approach across Nottinghamshire
- consistent knowledge and information on partner organisations work that supports the tobacco declaration
- supporting mechanism that allow for tobacco control activity to be planned and implemented across Nottinghamshire.

Recommendations for consideration

	Recommendations	Lead Organisations			
		Local Authority	Service Providers	District & Borough Councils	Others
Overall Tobacco Control Approach					
1	An approach that;				
	• targets the communities in which smoking prevalence is highest	✓	✓	✓	
	• engages further with known priority groups, such as young people, pregnant women and R&M workers in order to address smoking inequalities	✓	✓		
	• engages with 'at-risk' groups not currently targeted, such as the LGBT community, certain ethnicities and other minority groups	✓	✓		
	• addresses the challenge of reducing smoking prevalence in those suffering from a mental health condition.	✓	✓		
2	Informed future commissioning arrangements through understanding local in-depth insights in to the local population	✓	✓	✓	✓
Stopping Smoking					
3	A clear position guided by current evidence in the use of e-cigarettes as an effective quit method and to understand any cultural influences on their use	✓	✓		

4	Ensure support/services are evidence-based, widely known and are easily accessible, with as fewer barriers as possible	✓	✓		
Preventing the Uptake					
5	Understand the impact of the ASSIST peer led programme locally	✓	✓		
6	Understand the role for wider evidence-based prevention programmes across the county	✓			
Reducing harm for Tobacco use					
7	Locally self-assess work on a broad range of tobacco control issues through; • Evaluating local action on tobacco control • ensuring that local activity follows the latest evidence-based practice • identifying priority areas for development and help with effective planning • monitoring improvements to services over time	✓	✓	✓	✓
8	Target those that trade in illegal tobacco	✓	✓	✓	

9	Continue to support efforts to reduce the harm from tobacco use through; • Mass media campaigns • Extending smokefree environments • Supporting and enforcing current and emerging legislation • Safer smoking practices for those who continue to smoke	✓	✓	✓	✓

*NB – **services providers** includes but not limited to local stop smoking services, trading standards, acute, maternity and mental health trusts, primary care, youth services*
***Others** includes but not limited to Nottinghamshire fire and rescue service, ICS and ICP partners, Nottingham University, PHE, HMRC*

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Full JSNA report

What do we know?

1. Who is at risk and why?

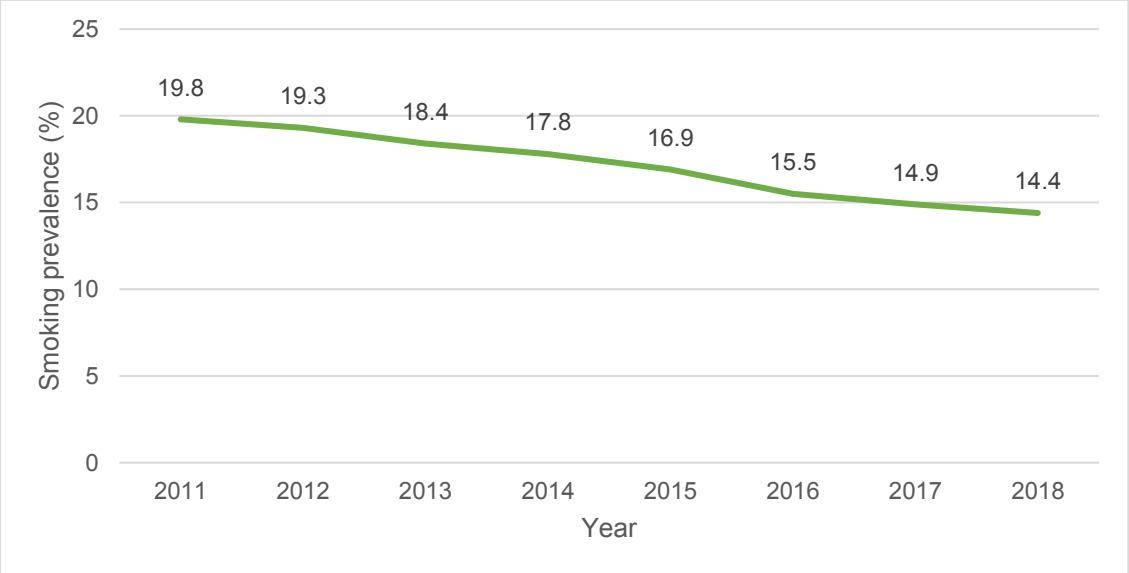
Smoking is the leading cause of preventable illness and premature death in England; around half of all life-long smokers will die prematurely, each losing on average around 10 years of life.[1] The costs to both individuals and the wider economy are vast, with smoking also playing a significant role in creating and maintaining health inequalities. These will be explored throughout the following chapters.

1.1 Demographics of smoking in England

1.1.1. Smoking age and gender

In England 14.4% of adults are current smokers, down from 14.9% in 2017 and 19.8% in 2011. This equates to around 1.8m fewer smokers today than in 2011. Men continue to be more likely than women to smoke, with 16.4% of men and 12.6% of women smoking in 2018[4].

Figure 1: Adult (18+) smoking prevalence in England (2011-18)



Source: Annual Population Survey (APS) (2018, published in Local Tobacco Control Profiles, Public Health Outcomes Framework [PHOF])

The likelihood of being a current smoker is highest in younger age groups, with adults in the 18-24 and 25-34 age groups most likely to smoke (17% and 19% respectively). Those aged over 65 were least likely to be current smokers (8%). Since 2011, smoking prevalence in younger age groups has seen the biggest decline, falling 8.5% in the 18-24 age group compared to 2% in the 'over-65' age group (figure 3)[4].

Figure 2: Smoking prevalence, by age (2018)

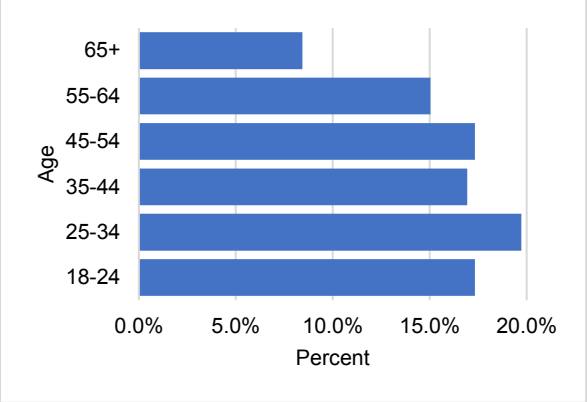
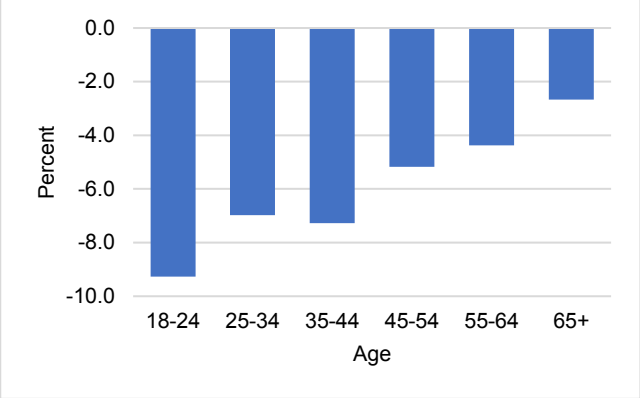


Figure 3: Percentage point change (2001-2017)



Source: Annual Population Survey (APS) (2018, published in Local Tobacco Control Profiles, Public Health Outcomes Framework [PHOF])

1.1.2. Smoking and occupation

There is a link between smoking, employment and type of occupation in England, with those working in routine and manual (R&M*) roles more than twice as likely to smoke as those in managerial and professional occupations† (25% vs. 10%). Those who have never worked, long-term unemployed or 'not elsewhere classified' were also more likely to be smokers (19%)[4].

Comparing those in employment and those unemployed directly demonstrates 15% of employed adults are current smokers compared to 29% of unemployed adults[4].

1.1.3. Smoking and education

There is an inversely proportional relationship between the level of education and smoking prevalence in England. Adults with higher levels of qualifications are less likely to be current

* Examples of routine and manual occupations include labourers, bar staff, lorry drivers, receptionists and care workers

† Managerial and professional occupations include lawyers, architects, nurses and teachers

smokers, with 7% of adults with a degree-level qualification smoking compared with 29% of adults with no formal qualifications[4].

1.1.4. Smoking and ethnicity

Smoking prevalence is lower amongst adults of black, Asian or Chinese ethnicities when compared with those of white, mixed or other ethnicities. Those of mixed heritage had the highest smoking prevalence (21%) while those of Chinese heritage were least likely to smoke (8%)[4].

It is important to note there is not a straightforward relationship between smoking, tobacco and ethnicity, with a complex interplay of factors affecting health across Black, Asian and Minority Ethnic (BAME) populations.

The use of smokeless tobacco products (tobacco consumed by means other than burning), such as gutkha and betel quid amongst many others, is particularly prevalent amongst British South Asian communities (Bangladeshi, Indian, Nepalese, Pakistani or Sri Lankan). The use of these products is not consistent across these communities, with the type of tobacco and the prevalence of use varying from region to region across England and the UK. There is also moderate evidence that smokeless tobacco is deemed more traditional and culturally acceptable for females among South Asian communities[5].

1.1.5. Smoking and pregnancy

Smoking in pregnancy is measured through the number of women known to be smoking at the time of delivery (SATOD). This number does not include women whose smoking status was recorded as 'unknown' at delivery, or those who use non-combustible nicotine products such as e-cigarettes, smokeless tobacco and other nicotine replacement products.

For the year 2018/19, 10.6% of women were recorded as smoking at time of delivery across England, which was equivalent to 61,399 out of 591,701 recorded pregnancies. The latest available data for Quarter 1 (April – June) 2019/20 was 10.4% (14,941 women). This is a slight decline but not significant. SATOD rates for the equivalent Quarter 1 period last year were also 10.4%. The trends show an overall fall of 4% over the past 10 years (14.6% in 2008/09)[6].

1.1.6. Smoking and mental health

Around 1 in 4 people in England experience a mental health condition in any given year and although these conditions vary widely, smoking prevalence amongst those with mental health conditions is consistently much higher than the general population and increases with the severity of the condition[7].

Smoking rates amongst those with a mental health condition have not fallen during the last 20 years, remaining at around 40% (40.5% in England in 2014/15). This is estimated to be around 60% in those with probable psychosis and up to 70% for those in psychiatric units[7,8].

1.1.7. Smoking and sexual orientation

There is evidence that smoking rates amongst the lesbian, gay, bisexual and transgender (LGBT) community are significantly higher than in the general population, with US data showing at least double the smoking rates of the general population.[7] In the UK, the most recent data (2017) shows that smoking prevalence was 1.5 times higher amongst LGBT people (23.1% gay/lesbian, 23.3% bisexual) than heterosexual people (15.9%).[8] The reasons for this are varied and not fully understood but are thought to include stress due to the effect of discrimination, harassment and violence, a lack of social support, perceived cultural or peer pressure to smoke and barriers to accessing appropriate smoking cessation services[9].

1.1.8. Smoking in prisons

People in prison often experience significant health inequalities but none starker than the difference in smoking rates. In England, 14.4% of adults smoke tobacco, but for people in prisons it is about 80%[10]. This has serious health risks for smokers and nonsmokers to both prisoners and staff.

In September 2015 it was decide that all prisons would be going smokefree in a staged approach. However, the policy for open prisons in England would be that smoking was prohibited indoors only, and this was implemented in October 2015. By July 2018 all closed prisons in England were smokefree (total of 103)[11]. With rollout complete the policy was reviewed regarding smoking outside in open prisons. The working group recommended that open prisons also go smokefree throughout to be consistent with the rest of the prison estate. However, it was decided not to proceed with this at the current time[11].

1.1.9. Alternative tobacco use

E-cigarettes‡

Data from the Opinions and Lifestyle survey, which covers Great Britain (England, Scotland and Wales) with respondents aged 16 and above, shows that in 2018, 6.3% of people reported current use of an e-cigarette, equating to 3.2m ‘vapers’ in the population. This is a

‡ An e-cigarette is a device that allows you to inhale nicotine in a vapour rather than smoke.E-cigarettes do not burn tobacco and do not produce tar or carbon monoxide, two of the most damaging elements in tobacco smoke. Using an e-cigarette is known as vaping. People using an e-cigarette are sometimes known as vapers.

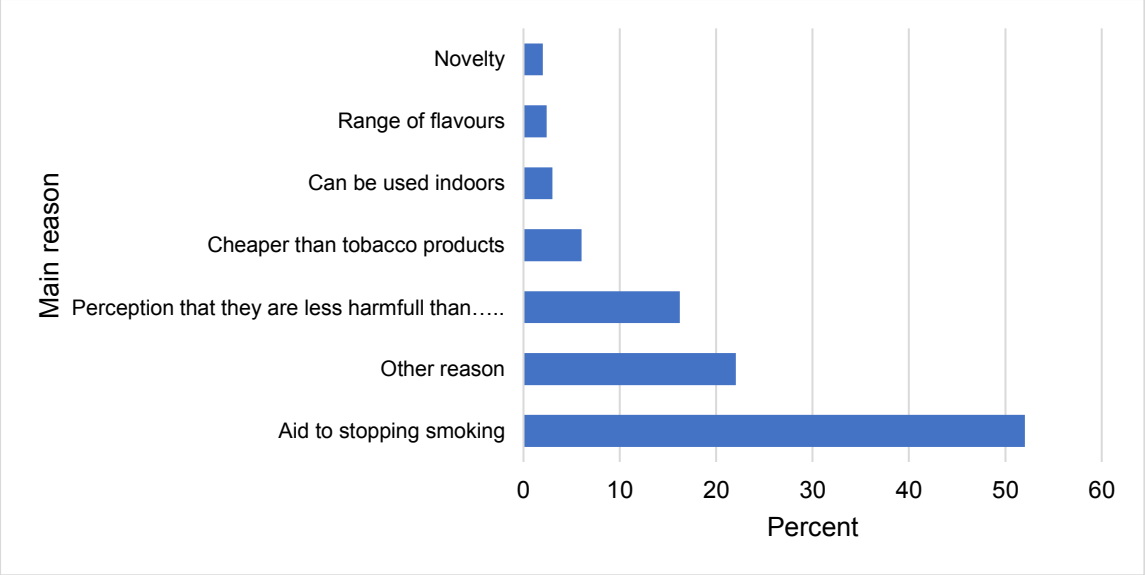
significant increase from 2014 levels, when data collection began, when only 3.7% reported vaping[12,13].

A higher proportion of men reported vaping (7.7%) when compared with women (5%) in 2018. Those aged 35-49 were most likely to use e-cigarettes (8.1%), with those aged 60 and over least likely (4.1%)[4].

The data also shows e-cigarette use is highest amongst those who are current or previous smokers. In 2018, the proportion of vapers was highest among current cigarette smokers (15%) and ex-cigarette smokers (12.8%), with 0.8% of people of who had never smoked reporting that they were currently vaping[12]. More details about e- cigarettes can be found in section 6.

The most common reason given for vaping is as an aid to stop smoking. Over half (52.8%) of vapers reported using e-cigarettes for this purpose in 2018 (figure 4)[12].

Figure 4: Main reason[§] for using e-cigarettes, England 2015 to 2018



Source: ONS – E-cigarettes use in England 2019

Shisha and chewing tobacco

Waterpipe smoking, or shisha, is a method of inhaling tobacco smoke that has been passed through water. There has been a significant increase in the use of waterpipes and shisha establishments over the past few years, thought in part to be due to the popularity of sweetened, flavoured tobacco[14].

Between 2007 and 2012, there was a 210% increase in the number of shisha bars across the UK, from 179 to 556. The number of adults who reported ever using a waterpipe rose

[§] Respondents were asked to choose the main reason from the list of options above

from 11% to 12.9% between 2012-2016, although the proportion who reported using a waterpipe up to once or twice a month remained at around 1% (0.9% 2012, 0.8% 2016). Use is highest amongst the 18-24 and 25-34 age groups, with little change demonstrated since 2012. There is substantial variation amongst ethnic groups, with the percentage of 'ever-users' from mixed/multiple ethnic groups at 32.6% and Asian/Asian British at 26.5% when surveyed in 2013[14].

There has been an increase in awareness of waterpipes amongst young people between 2012-2016 (up to 55.5% aware from 42.4%), however the percentage of young people who have tried shisha once or twice or use it more regularly have remained constant (7.2% and around 1% respectively)[14].

The use of chewing tobacco is comparatively low, although data is more limited. In 2016, 1.9% of adults aged 16 and over reported 'ever-use' of any non-smoked tobacco that is put in the mouth, with just 0.3% reporting use in the previous month[15].

1.2 Smoking in children and young people

Smoking remains an addiction that predominantly develops in childhood, with 90% of smokers in England reported to have started before the age of 19[16].

Data collected as part of the Smoking, Drinking and Drug Use among Young People survey (SDD) showed that school-age children (years 7-11) were more likely to smoke if they lived in a household with other smokers. Regular smoking was reported in 1% of children living with no other smokers, increasing to between 6-7% of children living with 1 or more other smokers in the household[4].

The number of children who had tried smoking at least once has reduced to 16% down from 19% in 2016, following a steady decline since 1996. 2% of year 7-11 pupils surveyed were regular smokers (defined as usually smoking at least one cigarette per week), with 3% occasional smokers (defined as usually smoking less than one cigarette per week) down from 22% in 1996. Prevalence of current smoking was the same for boys and girls (5%). The likelihood of being a regular smoker did increase with age, with less than 1% of 11-year olds compared with 11% of 15-year olds reporting current use[4].

<u>E-cigarettes</u>

There has been concern expressed about the potential for a large increase in e-cigarette use amongst young people. Data from the SDD survey has shown an increase in the number of Year 7-11s who have ever tried an e-cigarette from 22% in 2014, to 25% in 2016 and 2018 (confidence interval 23-26%). As with cigarettes, the number of regular users increased with age, with less than 1% of 11-year olds increasing to 3% of 15-year olds, according to the 2018 data[4].

However, a large study which aggregated the data from 5 UK-wide surveys, which accumulated data from 60, 000 pupils between 2015-17, suggested that while the prevalence of 'ever-use' may have increased, this rarely turns into regular use (for 2015/16, ever-use of e-cigarettes 7-18%; regular use [at least weekly] 1-3%). There was also very little evidence to suggest uptake of e-cigarette use amongst young people who wouldn't otherwise smoke, with ever e-cigarette use between 4-10% and regular use between 0.1-0.5% in the 'never-smoked' population. Suggesting that while some young people, particularly those who have tried smoking, experiment with e-cigarettes, regular use remains low. However, continued surveillance is needed[17].

1.3 Reducing harm from tobacco use

1.3.1 Second-hand smoke

Although the number of smoke-free households in the UK is increasing, breathing in other people's tobacco smoke (second-hand or passive smoking) still presents a significant risk to public health. Particular at-risk groups include children, pregnant women and those with pre-existing heart or respiratory illnesses. Childhood exposure to second-hand smoke increases the risk of cot death, glue ear, asthma and other respiratory disorders, including emphysema in later life[18].

The Royal College of Physicians (RCP) estimates that illnesses among children caused by second-hand smoke are responsible for over 300,000 GP consultations and around 9,500 hospital consultations each year. In 2003, it was estimated that second-hand smoke was responsible for 12,200 premature deaths in the UK, with most of them occurring in non-smokers living with a partner or family member who smoked[18].

Table 1: Children's exposure to second-hand 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 smoking	9 times higher

Source: Royal College of Physicians, 2010

1.3.2 Illegal tobacco

Illegal tobacco can be referred to in different ways:

- "Illicit Whites" – mass produced cigarettes in certain countries e.g. Russia and East Asia which are then illegally imported into the UK, no duty has been paid and health warnings and images are absent.
- Counterfeit – Illegally manufactured and sold by a party other than the original trademark.
- Genuine cigarettes – smuggled into the UK without duty being paid[19].

There is no evidence that smoking illegal tobacco is any more harmful to health than smoking legal, duty-paid tobacco. The health risks and consequences apply to all users whether their tobacco is illegal or duty-paid. However, illegal tobacco particularly impacts on our communities in the following ways:

- Helps to fund international terrorism and organised crime for organisations such as the Taliban, the Irish Republican Army, the Kurdistan Worker's Party, Hezbollah and the Chinese Triads[20].
- At significantly less than half the price of legitimate tobacco, it makes tobacco affordable and accessible to everyone, including children and young people, helping to begin their addiction.
- Has a negative financial impact on legitimate retailers.
- Creates a significant loss of tax 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. must be self-extinguishing).

The 'tax gap' created by the combined illicit tobacco market (both cigarettes and hand-rolled tobacco) fell to its lowest level in 5 years, £1.8bn, in 2017-18, down from £2.4bn the previous year, although the figure has fluctuated and not followed a consistent trend (previously £1.8bn in 2014-15)[21]. Action on Smoking and Health (ASH) state that as overall smoking prevalence has declined, illegal tobacco has increased its proportion of the total market, despite remaining relatively stable over the past 5 years[22].

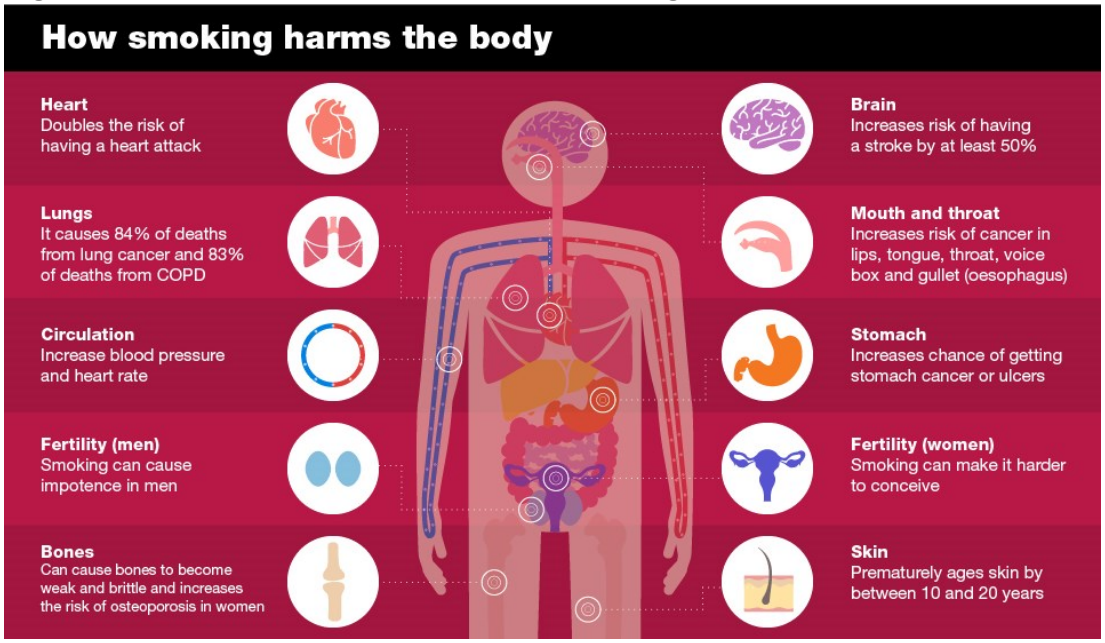
1.4 Impact of tobacco use

1.4.1 Health Impacts

It is estimated that around 100,000 people die in the UK every year because of smoking-related diseases[23]. Smoking causes more deaths each year than obesity, alcohol, road traffic accidents, illegal drugs and HIV combined. For every death caused by smoking, there are approximately 20 people living with a smoking related illness[24].

Smoking is known to cause or aggravate multiple serious medical conditions, see figure 5, Tables 2 and 3.

Figure 5: Associated health issues with smoking



Source: Public Health England

Table 2: Examples of health impacts associated with smoking & second-hand smoke

Smoking causes:	Second-hand smoke causes:
17% of all deaths among people aged >35	Increased risk of lung cancer in non-smokers of 20-30%
35% of respiratory disease deaths in those aged >35	Increased risk of heart disease in non-smokers of 25-35%
28% of cancer deaths in those aged >35	In UK estimated 2,700 annual deaths in those aged 20-63
14% of cardiovascular disease deaths	Estimated 8,000 annual deaths in those aged >65
489,300 hospital admissions due to related disease in 2017/18 in the UK	Increased risk of respiratory disease, dementia and stroke
Teenagers suffer: • Increased asthma/respiratory symptoms • Poorer health & fitness levels • Increased school absences	In pregnancy an increased risk of: • Low birth weight • Congenital abnormalities/malformation • Still birth
An estimated 12% of all cases of Type 2 diabetes	Increased risk of lower respiratory tract infections, asthma & ear infection in children
An estimated 14% of all cases of Alzheimer's disease	More than doubles risk of Sudden Unexpected Death in Infancy & meningococcal disease in children (with one or more smokers in home)

Source: ASH (2014), ASH (2016), ASH (2019), NHS Digital (2019)

Table 3: Impact of smoking and exposure to secondhand smoke in pregnancy

	Maternal Smoking	Second hand smoke exposure
Low Birth Weight	Average 250g lighter	Average 30-40g lighter
Stillbirth	Double the likelihood	Increased risk
Miscarriage	24-32% more likely	Possible risk
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden infant death	3 times more likely	45% more likely

Source: Smoking in Pregnancy Challenge Group. Review of the Challenge 2018. July 2018.

1.4.2 Economic Impacts

The annual 'cost to society' of smoking is estimated at £12.5bn, which can be broken down further into[2]:

- £883.5m annually from social care
- £2.5bn annually on the NHS
- £8.9bn annually from lost productivity (including smoke-breaks and smoke- related sickness absence)

The All-Party Parliamentary Group on Smoking and Health has estimated that, as a result of smoking-related health conditions, local councils face a demand pressure of £760m per year on domiciliary care services[1].

The amount of money generated through tobacco duties in the financial year 2017/18 for the Government was £8.8bn; this has been consistently falling for the past 5 years, down from £9.5bn[25]. When VAT is included, the total annual revenue is around £12bn, which amounts to less than 2% of total Government revenue[26].

1.4.3 Fire Impact

Smokers' materials (such as lighters, cigarettes, cigars or pipe tobacco) were the source of ignition in 7% of accidental dwelling fires and 9% of accidental dwelling fire non-fatal casualties in 2017/18. However, smokers' materials were the source of ignition in 20% of fire-related fatalities in accidental dwelling fires in the same year (this is normally the largest source of ignition in this category but was behind 'other electrical appliances' in this year due to the Grenfell Tower incident)[27].

1.4.4 Benefits of stopping smoking

Stopping smoking reduces the risk of developing many fatal diseases and the benefits, while not necessarily felt, are almost immediate, as seen in Table 4.

Table 4: 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 body
48 hours	No nicotine in body. Ability to taste and smell greatly improved.
72 hours	Energy levels increase and breathing becomes easier
2-12 weeks	Circulation improves
3-9 months	Coughing, 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 heart attack falls to same as someone who has never smoked

Source: NHS Smokefree website (2019)

There are also significant financial benefits to stopping smoking. In 2017, a 20-a-day smoker of a premium brand of cigarette would spend about £3,600 per year on their habit, while a person smoking the UK average of 11-a-day would spend around £1,800[26]. Tobacco is 30% less affordable now than in 2008, therefore stopping smoking would represent a significant saving for most households[4].

1.4.5 Multiple risk factors

The Global Burden of Disease study identified that around 40% of the UK's disability-adjusted life years lost are attributable to factors that include the use of tobacco or alcohol, as well as hypertension, being overweight or being physically inactive[28]. The EPIC-Norfolk cohort study found that the higher the number of risk factors an individual engages in, the greater the risk to their health[29]. "*An adult in mid-life who smokes, drinks to excess, is inactive* (doing less than 30 minutes moderate intensity physical activity per week) *and eats unhealthily is four times more likely to die in the next 10 years than someone who does none of these things*"[30].

The Kings Fund [30,31] highlight that multiple risk factors associated with smoking, drinking, physical inactivity and poor diet are a widespread problem in England. There was a reduction in the proportion of people engaging in multiple unhealthy behaviours between 2003 and 2008. However, the decline was greatest amongst those with higher levels of education and socio-economic status, thereby potentially increasing health inequalities.

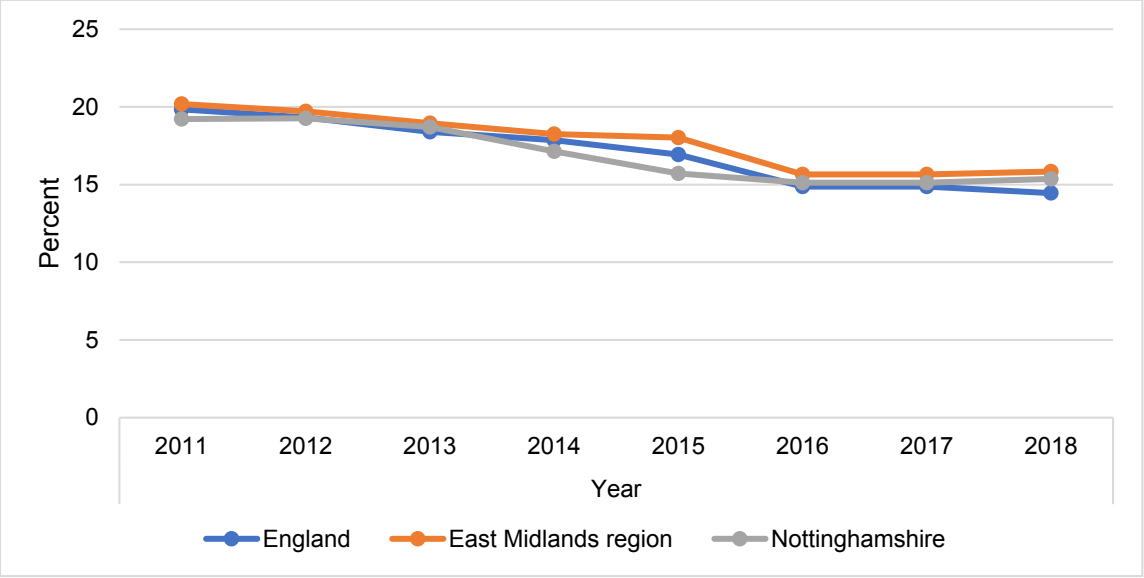
Risk factors such as cigarette smoking, heavy alcohol consumption, physical inactivity, having a diet low in fruit and vegetables and obesity are leading modifiable causes of non-communicable diseases worldwide. While empirical data exist about the health impacts of these separate risk factors, increasing evidence suggests that a substantial proportion of adults in the UK have multiple risks to their health[31].

2. Size of the issue locally

2.1 Smoking

In Nottinghamshire smoking prevalence has been on a steady decline from 19.2% in 2011 to around 15.4% in 2018, slightly higher than the England average (14.4%). This figure masks wide local variation see figure 7. *Please note latest data available from fingertips. Some of the data available may have small sample sizes and wide confidence intervals.*

Figure 6: Smoking prevalence trend in Nottinghamshire compared with East Midlands and England 2011-2018



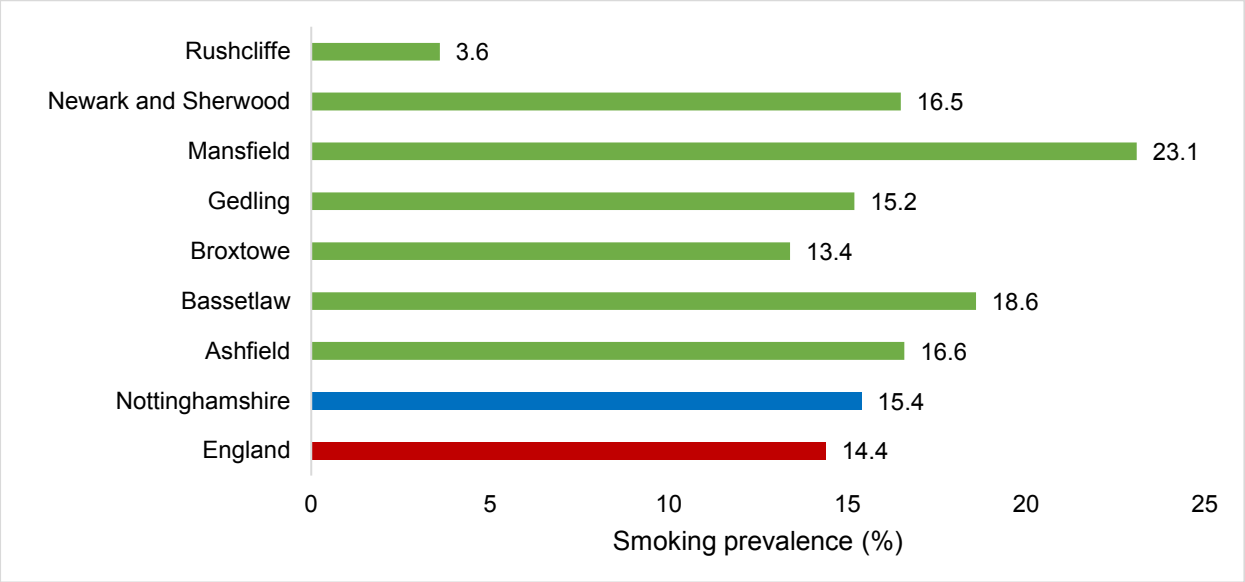
Source: Annual Population Survey (APS) (2018, published in Local Tobacco Control Profiles, PHOF)

Locally, there remains no or limited data on smoking rates split by:

- Age
- Ethnicity
- Sexual orientation

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

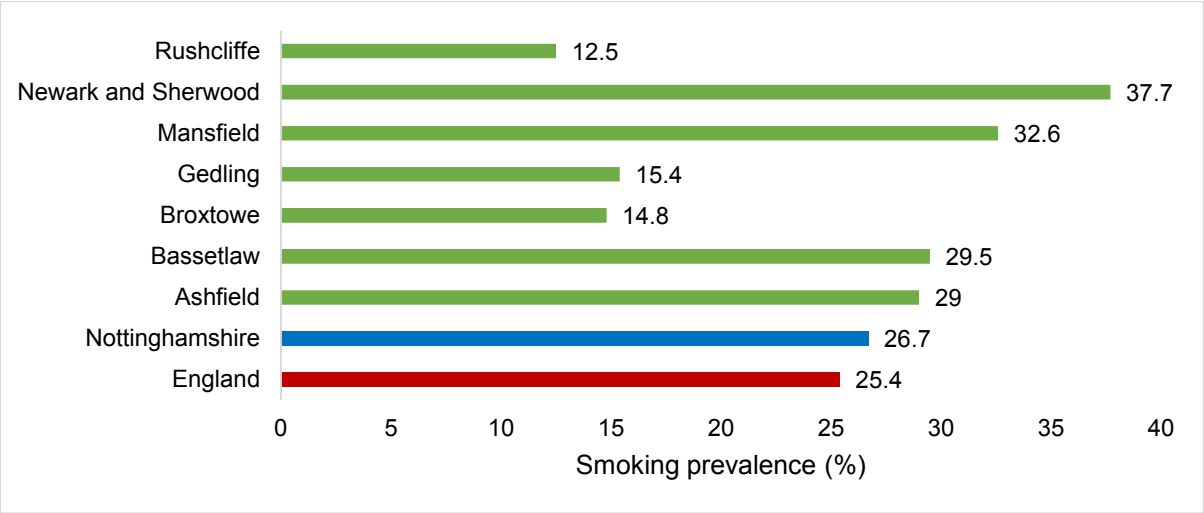
Figure 7: Smoking prevalence for 18+ years (2018)



Source: Annual Population Survey (APS) (2018, published in Local Tobacco Control Profiles, PHOF)

R&M workers have a significantly higher smoking prevalence than the general Nottinghamshire population. However, there is still large variation within the county, from 12.5% in Rushcliffe (4 times higher than the general rate) to 37.7% in Newark and Sherwood (2.5 times higher) (figure 8).

Figure 8: Smoking prevalence in R&M occupations by district (2018)

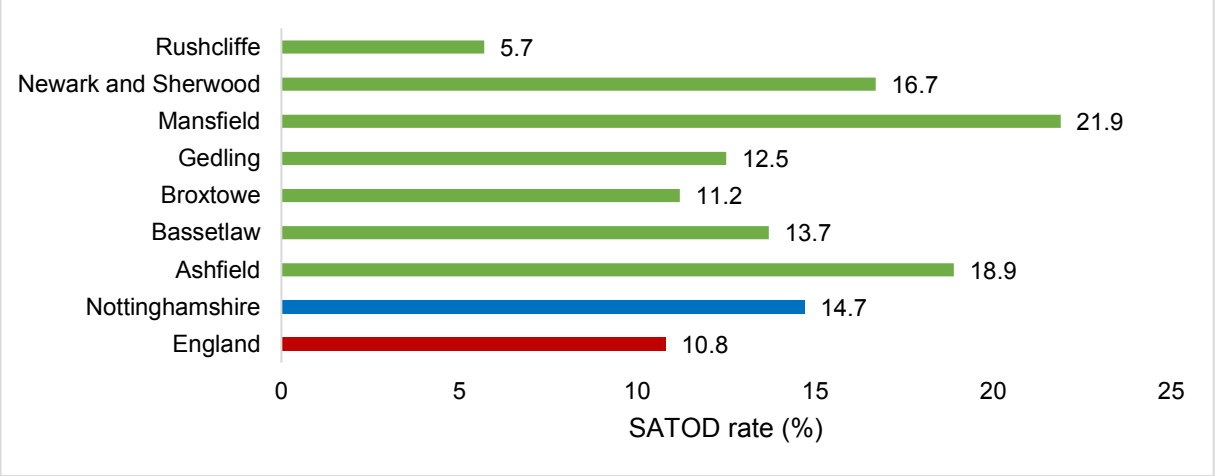


Source: APS (2018, published in Local Tobacco Control Profiles, PHOF)

2.1.1. Smoking and pregnancy

Nottinghamshire continues to perform significantly worse than the England average when looking at SATOD rates (Figure 9), although there is a downward trend from 17.3% in 2010/11 to 14.7% 2017/18. There is wide variation in the rate across the county, with the Nottinghamshire average masking particularly high levels of smoking in pregnancy in Mansfield, where the SATOD rate is more than double that of the England average and almost 4 times that of Rushcliffe. *Please note the data reported here is estimates based on the Local Authority footprint using the CCG level data that is collected and reported. There may be some slight variations between the data sets due to this.*

Figure 9: Smoking at time of delivery rate across Nottinghamshire (2018)



Source: NHS Digital (2018, published in Local Tobacco Control Profiles, PHOF)

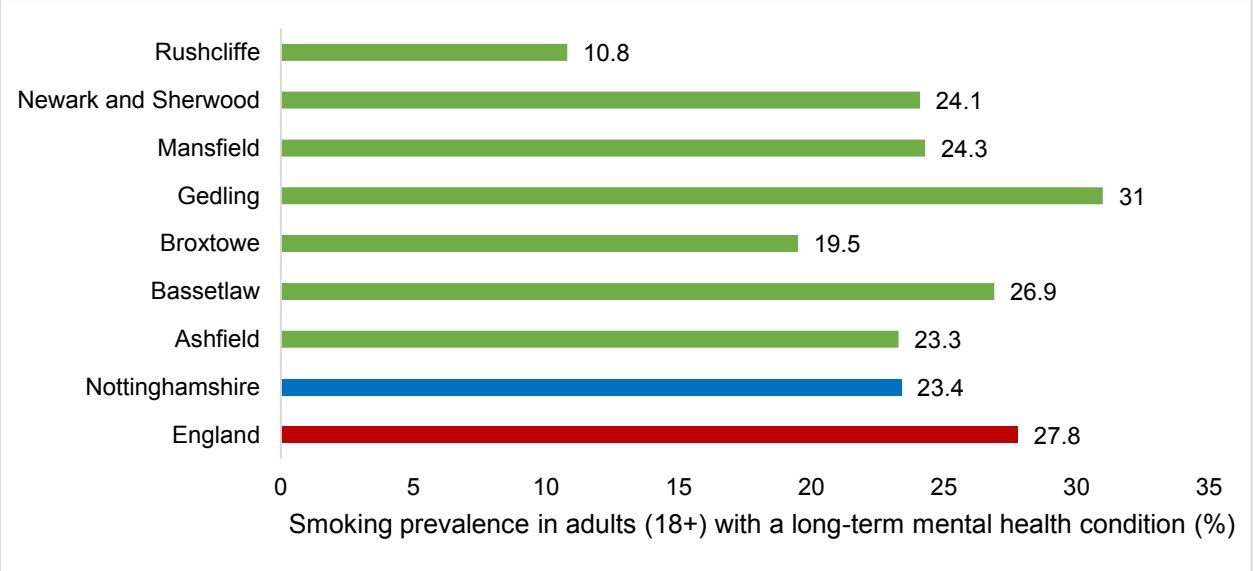
2.1.2 Smoking and mental health

The latest NHS Digital data, collected from 2014/15, found the smoking rate amongst those with a 'Serious Mental Illness' to be 40.5% in England and 38.7% in Nottinghamshire. However, there is more recent data available, from the GP Patient Survey (GPPS), which can be seen in Figure 10.

Despite seeming to show a decrease in the smoking prevalence, these two indicators are not directly comparable as the NHS Digital data includes only those who have a diagnosis code for bipolar disorder, schizophrenia or active psychosis while the GPPS data is broader, including any patient with a 'long-term mental health condition', including mild forms of depression and anxiety. The more serous the mental illness, the higher the smoking prevalence.

Whichever data source is analysed, Nottinghamshire performs better than the England average for smoking rates in those with mental health conditions.

Figure 10: Smoking prevalence in adults in Nottinghamshire (18+) with a long-term mental health condition (2017/18)

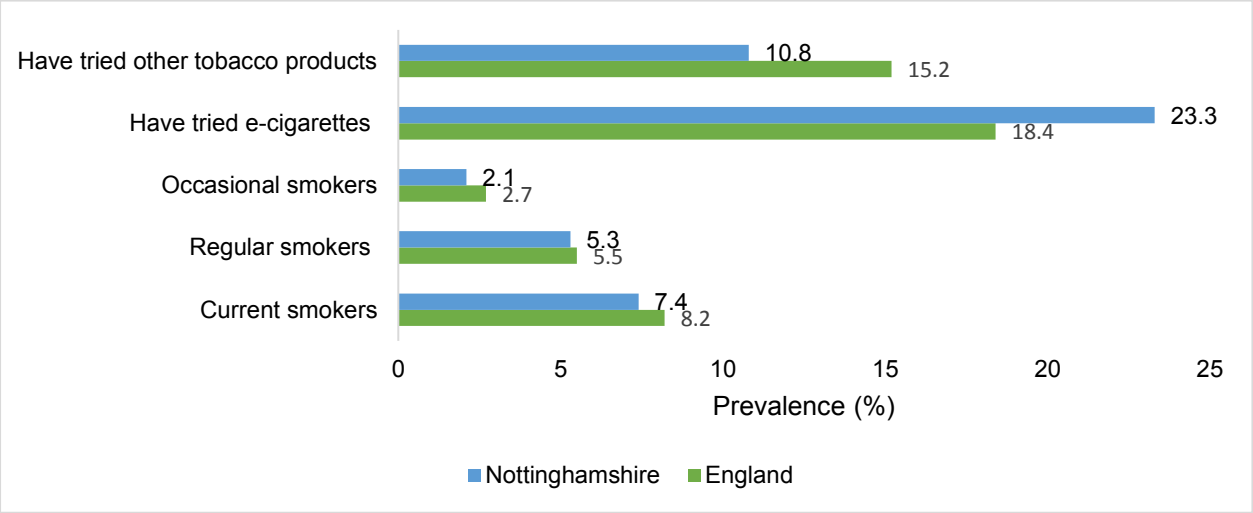


Source: GP Patient Survey [GPPS] (2018, published in Local Tobacco Control Profiles, PHOF)

2.1.3 Youth smoking

There is some limited data available at local level on youth tobacco usage from a one-off survey taken in 2014/15 (What About YOUth)[32]. This data showed the youth smoking rate to be similar than the England average, although there is no way to verify if this is still the case. Interestingly, almost a quarter of children reported having tried an e-cigarette (includes children who have tried one once only), which is likely to have increased over the past 4 years see section 1.2 about e-cigarette usage although this is national data not aggregated at a local level.

Figure 11: Youth smoking rates in Nottinghamshire (2014/15)



Source: What About YOUth survey (2014/15, published in Local Tobacco Control Profiles, PHOF)

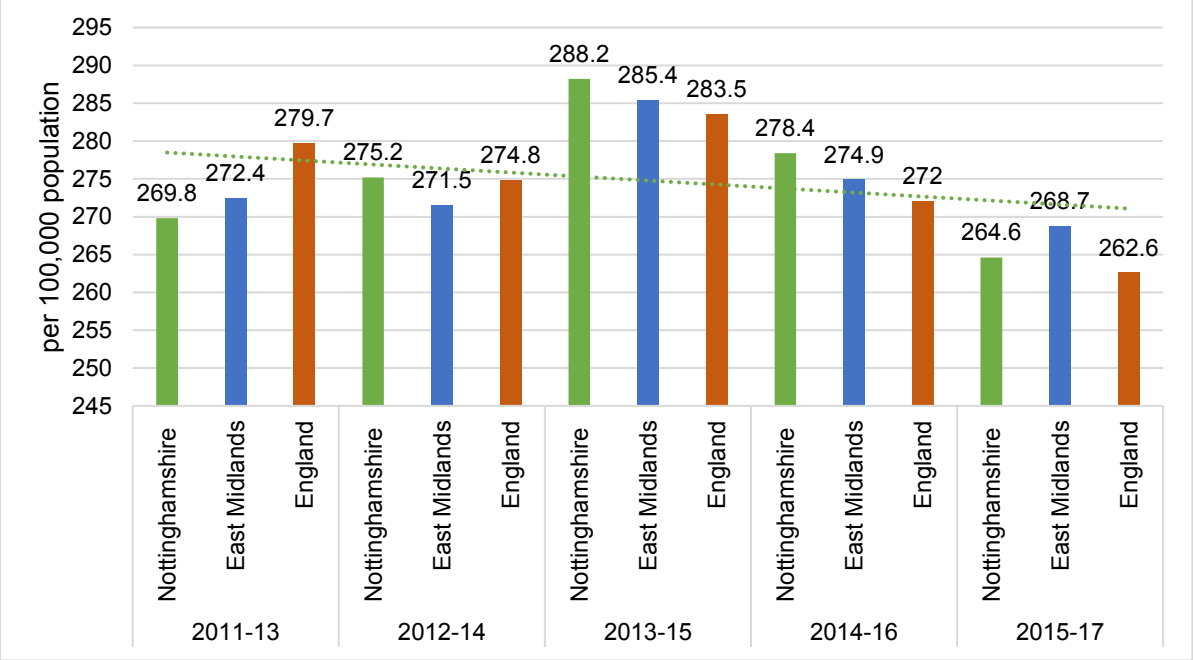
2.1.4 Health Impacts

Smoking attributable mortality (Figure 12) and smoking attributable hospital admissions (Figure 13) represent the scale of the burden across the county created by smoking in terms of deaths and hospital admissions. In Nottinghamshire 3, 928 deaths were attributed to smoking or smoking-related causes during the period 2015-17, with an estimated 1, 301 potential years of life lost to smoking across the same time period (PHOF).

There were 7,715 smoking-attributable hospital admissions in 2017-18, equivalent to 1, 519 per 100,000 of the Nottinghamshire population. This appears to be an increase in number from the previous year, however, it is important to note that there was an error in the Hospital Episode Statistics (HES) data collection at Nottingham University Hospitals (NUH) in 2016-17, which is likely to have caused the apparent drop in the number of smoking-attributable hospital admissions (over 30% of records from the Trust did not have a valid geography of residence assigned, requiring adjustments to be made to the data).

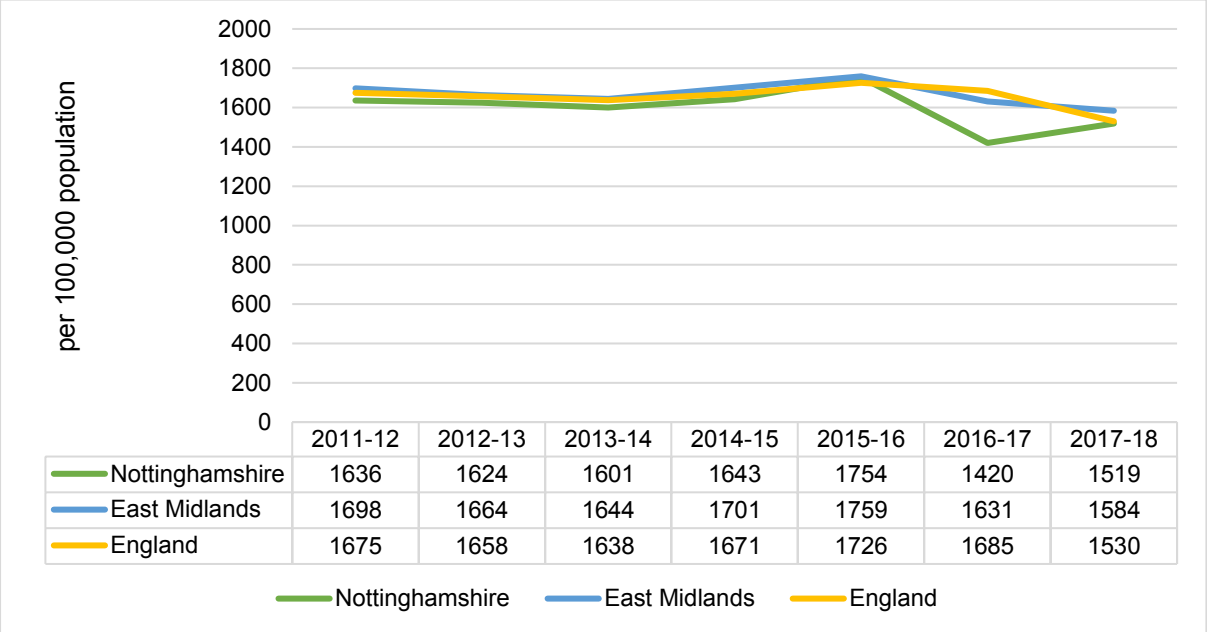
Both measures have seen a downward trend over the past 5 years and have remained largely in line with the England average. There is no data breakdown available lower than county level.

Figure 12: Trends in smoking attributable mortality in Nottinghamshire (2011-2017)



Source: ONS mortality file/APS (2017, published in Local Tobacco Control Profiles, PHOF)

Figure 13: Trends in smoking attributable hospital admissions in Nottinghamshire (2011-2017)

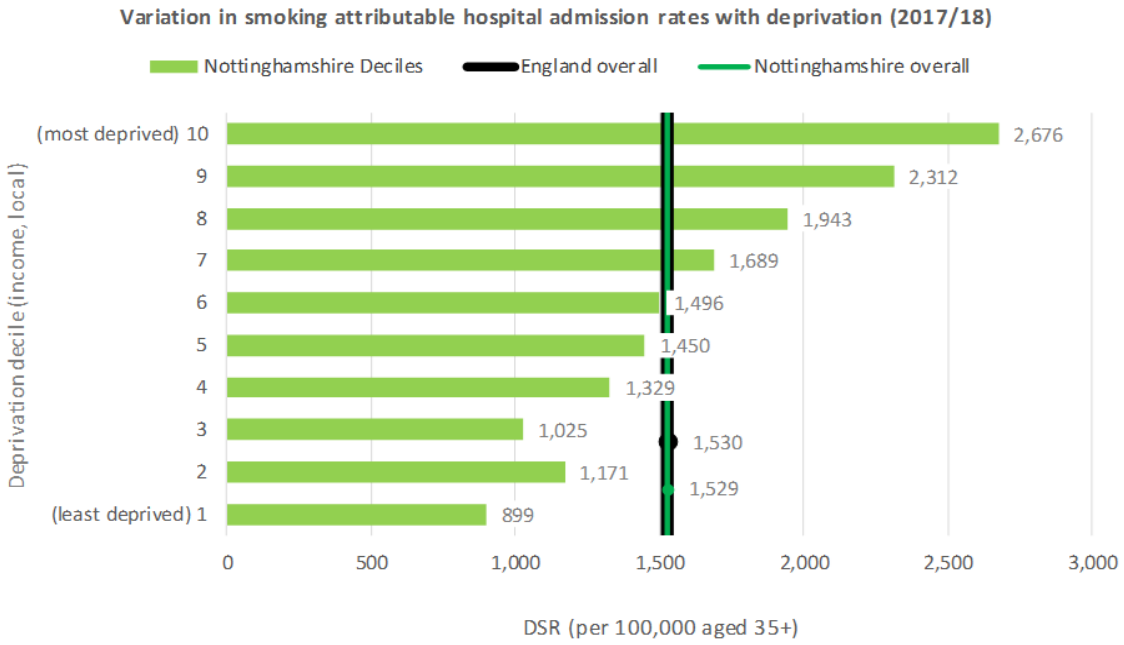


	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18
Nottinghamshire	1636	1624	1601	1643	1754	1420	1519
East Midlands	1698	1664	1644	1701	1759	1631	1584
England	1675	1658	1638	1671	1726	1685	1530

Source: NHS Digital/ONS (2018, published in Local Tobacco Control)

Figure 14: Slope Index of Inequality in Hospital admissions due to tobacco related conditions

DSR stands for Directly Standardised Rate. It is a commonly used public health statistic that allows comparison of rates between areas and over time by accounting for any differences in the underlying population age and sex structure. For further detail see "Commonly used public health statistics …"



Source(s): Local analysis of HES 2017/18, ONS APS Smoking prevalence, NHSD 2013 Relative Risks, ONS SAPE Resident Population 2017

In Nottinghamshire the overall smoking attributable hospital admission rate is similar to England however there is variation when looking at different areas by deprivation within Nottinghamshire.

The Slope Index of Inequality for Nottinghamshire (Figure 14) (1,878 per 100,000 aged 35+) when interpreted as the range between the most and least deprived areas in Nottinghamshire suggests that rates in the most and least deprived areas in Nottinghamshire may vary by +/-50% of the overall rate in Nottinghamshire (1,529 per 100,000 aged 35+).

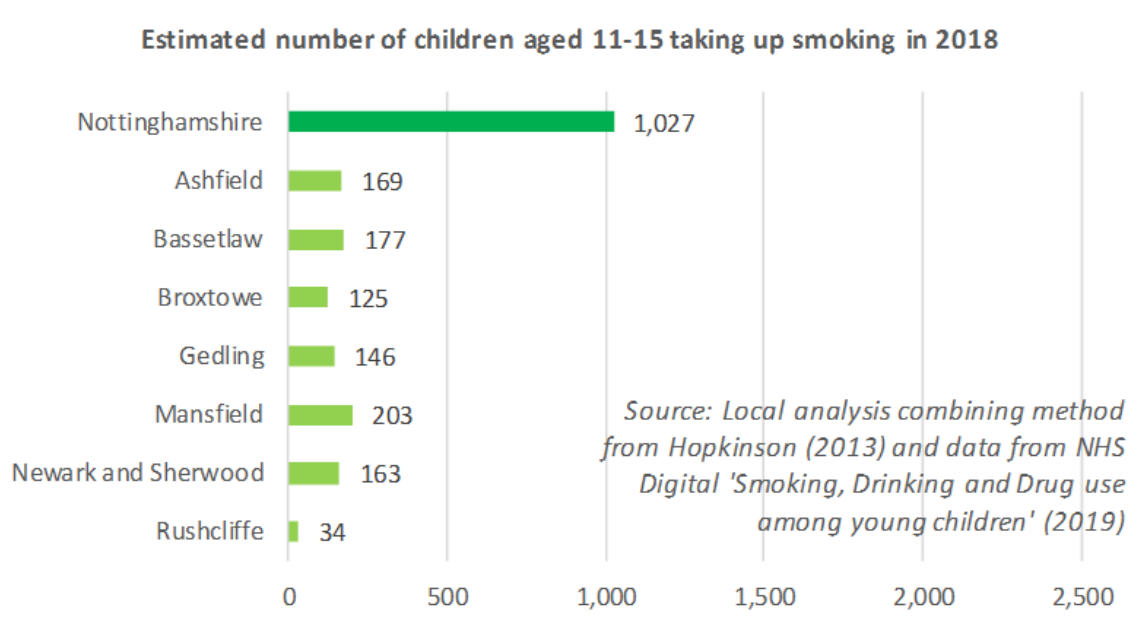
2.2 Preventing uptake

There remains little information around smoking uptake in Nottinghamshire for children and young people. The most recent data available is a modelled estimate by Hopkinson et al in 2013[33], where the uptake of smoking in 11 to15-year olds was estimated based on adult smoking prevalence data in that area[34] and the Smoking, Drinking and Drug Use Survey[35].

Recent estimates for Nottinghamshire suggest just over 1,000 young people aged 11-15 are estimated to have taken up smoking in 2018 which is almost half the total estimated for taking up smoking in 2011 (1,986).

These estimates are based on the method outlined in Hopkinson (2013) applied to available recent data.

Figure 15: Estimated yearly uptake of smoking in 11-15-year olds across Nottinghamshire in 2018



Source: Local analysis adapting Hopkinson methodology. Hopkinson et al., Child uptake of smoking by area across the UK (2013), BMJ Online

2.3 Reducing harm from tobacco use

2.3.1. Illegal Tobacco

Since 2014 Trading Standards, Public Health and Nottinghamshire Police have worked in partnership (with a dedicated budget) to reduce the demand and supply of illegal tobacco across the county. Illicit tobacco enforcement work falls within Nottinghamshire Trading Standards' Key Strategic Aims. Table 5 illustrates the activity of the Illicit/Illegal Tobacco Team from 2017 to 2019.

The number of inspections and seizures have decreased over the past year, as has the number of arrests, prosecutions and cautions, with 70% of seizures in 2018/19 leading to action compared with 98% in 2017/18. There has also been a decrease in the overall value of products seized, largely due to the decreased number of tobacco pouches seized this year. In 2018/19 the number of cigarette packs seized has increased almost tenfold, demonstrating the persistence of the illegal tobacco market strategies each year despite the

high value seizures in the previous year. This reinforces the important work that Trading Standards carry out in keeping illegal tobacco out of local retailers and off the street.

Table 5: Illicit tobacco seized by Trading Standards (2017-19).

	2017/18	2018/19
Number of inspections	124 (45 seizures)	100 (30 seizures)
Number of arrests/prosecutions/cautions	44	21
Total cash seized (£)	3,628.57	N/A
Number of cigarette packs seized	6,433	57,217
Number of cigarettes seized (sticks)	124,530	1,135,808
Number of tobacco pouches seized	120,623	655
Weight of tobacco seized (kg)	6,031.15	35.42
Retail value of cigarettes seized (£)	57,809	564,572
Retail value of tobacco seized (£)	2,412,406	14,200
Total value (£)	2,470,269	578,772

Source: Trading Standards annual performance data (2017/18-2018/19)

2.3.2 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 5% of all fires and 9% of the non-fatal casualties. However, they are responsible for approximately 30% of the fatalities (table 6).

The data below demonstrates a consistency in the number of fatalities attributed to fires caused by smoking materials, over the last five years. Whilst the number of incidents has remained consistent over recent years, the actual number of accidental dwelling fires caused by smoking materials has seen a change in 2018/19 from the previous downward trend of the preceding four years, matched by a rise in the number of non-fatal casualties too (Table 7).

Whilst this data focusses on fires within domestic dwellings, the fire service continues to see a large proportion of fires outside caused by carelessly discarded cigarettes and smoking materials, particularly during summer months, which have a significant draw on fire service resources and result in damage to property and the environment.

Table 6: Accidental dwelling fires across Nottinghamshire, 2018/19 (including Nottingham City)

Year	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	Total
Number of accidental dwelling fires caused by smokers' materials	33	33	29	24	31	**150**
Percentage of all accidental dwelling fires caused by smokers' materials	**6%**	**6%**	**5%**	**4%**	**5%**	**5%**

Source: NFRS Incident Reporting System (IRS) 2019

Table 7: Fatalities and casualties caused by smoking materials across Nottinghamshire, 2018/19 (including Nottingham City)

Year	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	Total
Fatalities (% of all fatalities)	1(20%)	3(100%)	1(17%)	2(33%)	2(20%)	**9 (30%)**
Casualties (% of all casualties)	**2 (4.9%)**	**7 (13.7%)**	**2 (4.8%)**	**3 (7.0%)**	**6 (12.8%)**	**20 (8.9%)**

Source: NFRS Incident Reporting System (IRS) 2019

2.3.3 Cost of smoking to society

Smoking costs society billions of pounds each year. Using national data, it is estimated that smoking costs Nottinghamshire County £178.1m per year (based on an estimated smoking population of 100, 899). This cost is accrued across a range of domains including;

- Healthcare - £37.1m annually
- Lost productivity- £119.6m annually
- Social care - £15.9m annually
- Fires - £5.6m annually
- Littering – 124kg of waste daily

The above is extract from the ASH Ready Reckoner this can also be further broken down by district[2].

In 2018, smokers in Nottinghamshire spent approximately £135.6m on tobacco products (£1,344 per smoker). Of this, £108.5m is collected by the Exchequer as tobacco duty but despite this extra revenue, tobacco still costs the community in Nottinghamshire roughly 1.5 times as much as the duty raised. This results a net annual cost to the local community of £69.6m.

3. Targets and performance

The Tobacco Control Plan (TCP) for England, published by the Government in 2017[36], sets out targets and ambitions following the conclusion of the previous TCP in 2015.

The plan outlines four ambitions:

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

The overarching aim is to work towards a 'smokefree generation', which the TCP states will have been achieved when smoking prevalence is reduced to 5% or less[36]. These new targets are monitored as indicators in the Public Health Outcomes Framework (PHOF), which will continue through 2019-2022 (see table 8)[3].

Smoking in pregnancy is measured through SATOD as part of the Clinical Commissioning Groups Outcomes Indicator Set (CCG OIS). Data is collected on smoking rates in serious mental illness (SMI) as a separate indicator in the CCG OIS[37].

Saving Babies' Lives Care Bundle published in March 2019, which the Trusts are working towards. Element 1 focuses on reducing smoking in pregnancy and provides a practical approach to reducing smoking in pregnancy by following NICE guidance. There also exists a Commission for Quality and Innovation schemes (CQUINs) relating to preventing ill health by risk behaviours alcohol and tobacco 2017-2019.

This CQUIN is targeting and influencing inpatients to change their behaviour to reduce the risk to their health from alcohol and tobacco. It was initiated in mental health trusts in 2017-18 and extended to acute trusts in 2018-19 for 2 years. 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[38,39]

Table 8: PHOF smoking indicators

Domain	Objective	Indicator
2: Health Improvement	People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities	2.03: Smoking status at time of delivery
		2.09iv: Smoking prevalence at 15 years- regular smokers (SDD survey)

		2.09v: Smoking prevalence at 15 years- occasional smokers (SDD survey)
		2.14: Smoking prevalence in adults (18+)- current smokers (APS)

Source: Public Health Fingertips (2019)

3.1 Stopping smoking

3.1.1. Adults

- **National target:** To reduce smoking prevalence amongst adults in England to 12% or less by 2022[36].

The target was set out as part of the new TCP for England, following year-on year reductions nationally in the number of adults smoking since the end of the previous TCP in 2015. The adult smoking prevalence in Nottinghamshire for 2018 was 15.4% (slightly higher than the England average,14.4%), which will require a reduction in the number of smokers by 5,533 per year in order to meet the target.

This is a slight increase from the prevalence in 2017 (15.1%), breaking a consistent downward trend since 2011, it is important to note that the 95% confidence intervals (CI) are wide for the 2018 data, from 13.0-17.8%. When compared to statistical neighbours (other local authorities with similar population demographics), Nottinghamshire is one of the higher counties, with only Lincolnshire (17.7%) and Somerset (15.9%) with a higher smoking prevalance[3].

The current smoking prevalence in R&M workers across the county is 26.7%, almost double that of the general population. This group will require a vastly increased focus if they are to reduce smoking prevalence in line with the rest of the county.

3.1.2. Children

- **National target:** To reduce smoking prevalence of 15-year olds who regularly smoke to 3% or less by 2022[36].

Similarly, to adult smoking prevalence, the number of under 15's smoking has been steadily decreasing nationally, from 22% in 1996 to its most recent level of 5% in 2018. The SDD survey is unable to provide smoking prevalence data at county level, therefore measuring Nottinghamshire's performance in this area is difficult. As mentioned in section 2 Data collected as part of the What About YOUth (WAY) survey in 2014/15 measured regular smoking prevalence at 15 at 5.3% in Nottinghamshire[32]. As there is no more recent data, we are unable to see if we meet this target locally. Based on the adult smoking trends across the county, it is likely to still exceed the target amount.

3.1.3 Smoking in pregnancy

- **National target:** To reduce the rate of smoking in pregnancy to 6% or less by 2022[36].

Nottinghamshire has historically not performed well when assessed by SATOD rates and this continues to be the case. The SATOD rate for 2017/18 was 14.7%, which is significantly higher than both the England (10.8%) and the statistical neighbour average (13.0%), even considering a margin for error within the 95% CI. There has also not been a significant reduction in the SATOD rate in Nottinghamshire since 2015/16, following year-on year improvements for the preceding 6 years[3]. To meet the target locally it would require a reduction in the number of pregnant smokers by 169 per year in order to meet the target.

There is a planned **local reduction** of SATOD rates to be delivered as part of the Local Maternity Systems Transformation trajectories with Nottingham City and to be monitored by the Local Maternity Systems Board (LMNS). This percentage reduction is to be agreed and the LMNS will continue to monitor ambitious trajectories in relation to smoking in pregnancy and work in partnership to achieve these.

3.1.4 Smoking and Mental Health

- **National target:** To make all mental health inpatient services sites smokefree by 2018[36].
- **ASH report ambition:** To reduce smoking prevalence among people with a mental health condition to <5% by 2035, with interim target of 35% by 2020[7].

The new TCP aims to give those with mental ill health equal priority to those with physical ill health, in an effort not to 'leave behind' the 40% of those with a mental health condition who smoke. Aside from the data collected at CCG level, there is little collected on smoking in mental illness, which is another area which the TCP plans to improve upon. The TCP aims to fully implement NICE guidance PH45 and PH48 in all mental health contexts to achieve the target of smokefree inpatient services[36].

A national survey carried out in 2018 found that 79% of mental health trusts had implemented a comprehensive smokefree policy, with 87% supporting vaping, although there was some variation in where this was permitted[40]. There was no local data available.

The ASH report (The Stolen Years) sets out 12 ambitions that should help achieve their ambitious target[7].

The latest figure for Nottinghamshire, based on the GPPS figures, shows the smoking rate to be 23.4%, well below the interim target.

3.2 Preventing uptake

There are currently no national targets specifically targeting the prevention of uptake of smoking in young people, but it is an important part of the TCP – work to eliminate smoking among under 18's and achieve the first smokefree generation.

The TCP wants to reduce the prevalence of 15-year olds who regularly smoke to 3% or less by the end of 2022.

We know that one of the most effective ways to reduce the number of young people smoking is to reduce the number of adults who smoke and therefore the initiation of smoking must be prevented as well as supporting current smokers to quit. A reduction in adult smoking plays a role in the reduction of uptake in young people and there are several previously mentioned targets in relation to this.

3.3 Reducing harm from tobacco use

3.3.1 Smokefree places

The ban on smoking in public places, transport and work vehicles, which was extended to include private vehicles carrying children under the age of 18 in 2015, has been effective in reducing exposure to second-hand smoke[36]. There are no specific local or national targets related to this legislation, but the TCP highlights the importance of raising awareness of the risks of exposure to secondhand smoke, especially for those who may be smoking around children.

3.3.2 Illegal Tobacco and taxation

The Government is continuing to maintain high duty rates for tobacco products, increasing the duty on hand-rolled tobacco by 3% in 2016[41].

The sale of illicit tobacco undermines public health policy by offering a cheaper option for those who might otherwise see price as a reason to stop smoking. Illicit tobacco damages legitimate business and makes tobacco more accessible to children. Tobacco smuggling is a serious organised crime and the proceeds made from it are used to fund further criminality, perpetuating the cycle of harm. Considerable progress has been made in addressing tobacco smuggling and the reductions we have seen have been achieved through regulatory changes, new sanctions, detection technology and partnership working across government and internationally.

The government will continue the implementation of its 2015 strategy 'Tackling Illicit Tobacco: From Leaf to Light'[41]

4 Current activity, service provision and assets

4.1 Stopping smoking

The stop smoking service in Nottinghamshire has been provided by Solutions 4 Health through the Smokefreelife Nottinghamshire service since April 2016, replacing the previous New Leaf and Bassetlaw Stop Smoking services.

The service model was designed to include;

- Evidence based programmes that prevent young people from starting to smoke
- Evidence based initiatives/programmes that protect people from tobacco use and prevent people from starting to smoke
- Evidence based initiatives/programme that prevent people from starting to smoke
- Universal stop smoking service
- Targeted stop smoking service

The service provides a combination of behavioural support and pharmacological support based on individual needs.

Table 9 highlights the number of people committing to stopping smoking (measured by quit date set), the number of people stopping smoking (measured by those successfully quit at 4 weeks) and the conversion ratio (the percentage of those who set a quit date going on to successfully quit) for 2018-19.

The rate of those aged 16 and over setting a quit date is similar-to the national rate (4,131 per 100,000 of smokers aged 16+ in Nottinghamshire compared with 4, 097 per 100,000 in England 2017-18)[3].

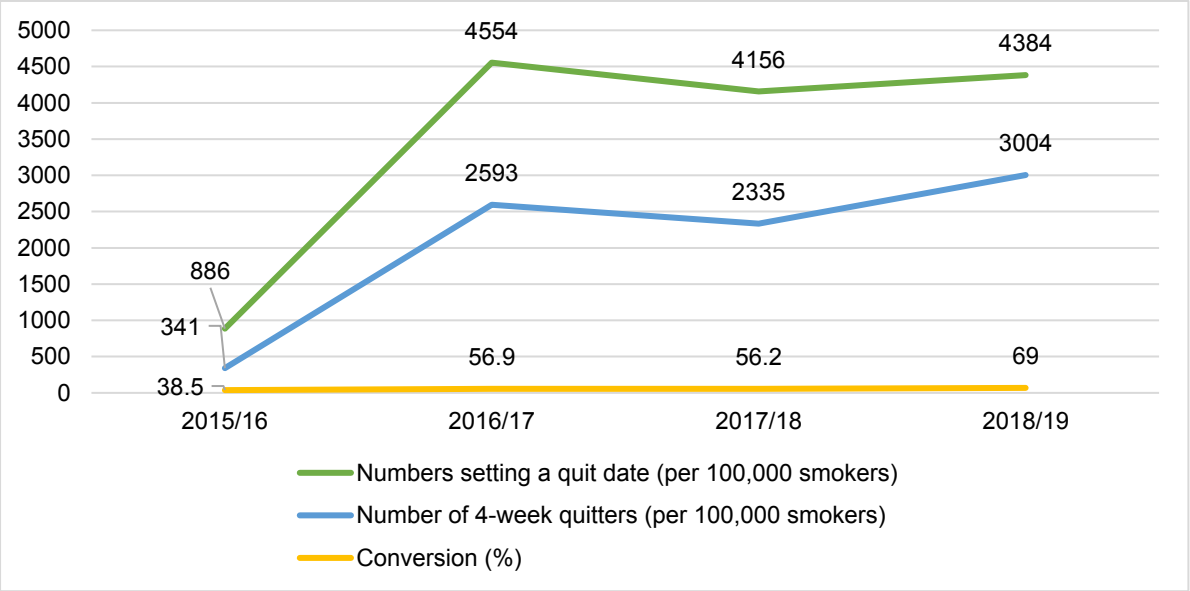
Table 9: Nottinghamshire 4-week quitter figures (2018/19)

	Nottinghamshire
Numbers setting a quit date	4348
Number of 4-week quitters	3004
Conversion (%)	69%

Source: Smokefreelife Nottinghamshire Annual Return, 2018/19

The conversion rate has also improved significantly since 2016, rising from 38.5% to 69% in 2018/19 (Figure 16).

Figure 16: Trends in number of quit dates set, 4-week quitters and conversion rate in Nottinghamshire (2015-19)



Source: NHS Digital Statistics on Stop Smoking services in England (2015-2019)

4.1.1. Long-term quits

Smokefreelife Nottinghamshire have collected data on the number of 4-week quitters going on to remain 'smoke-free' at 6 months. This is defined as having smoked no more than 5 cigarettes in the preceding 24 weeks and being recorded as 'quit' at -6 and +28 days from the date of the 6-month follow up date. For 2018/19, this was 35% in Nottinghamshire, although this information was only available for the 4-week quitters in the first two quarters of the year. Long term quits (6 months) was a measure included within the stop smoking contract to encourage longer term quits. It was defined as 6 months taking into consideration dropout rates and the resource implications.

4.1.2 Who accesses services and how successful are they?

The previous JSNA chapter 2015 had information relating to a health equity audit that was carried out 2014. To date we have not replicated this and so the information on who accesses the service and how successful they are has not been fully explored.

Table 10 shows the proportion of quit dates across the 7 districts, in comparison with the actual uptake, measured by the proportion of quit dates set within each district. It shows that all districts are meeting their desired targets other than Rushcliffe, which fell 0.5% short of the proportion of quit dates set.

Table 10: Proportions of quit dates set across Nottinghamshire by district (2018/19)

District	Target proportion of quit dates (%)	Actual proportion of quit dates set (%)
Ashfield	13.2-22.0	21
Bassetlaw	13.2-22.0	16
Broxtowe	9.0-15.0	9
Gedling	8.8-14.7	9
Mansfield	13.9-23.1	18
Newark and Sherwood	10.5-17.3	16
Rushcliffe	6.5-10.8	6

Source: Smokefreelife Nottinghamshire Annual Return, 2018/19

Smokefreelife Nottinghamshire also collects data on certain target populations who may be accessing the service, in particular those working in R&M occupations, pregnant women and young people. The data for these groups is shown in Tables 11 and 12.

Support for R&M workers

The number of 4-week quitters in the R&M group for the service was 889. The data shows that once workers accessed the service, they achieved a higher quit rate than the overall service average (72.8% for R&M vs 69% overall). The data also highlights that R&M workers are not being picked up and targeted as a group by local practitioners, as no referrals were made for this group to the service in 2018/19. The 6-month conversion rate for routine and manual workers (13.7%) is relatively low compared with other targets groups (pregnant women (28.9%), children & young people (22.2%)). This could be due to a range of factors including level of dependence, age, socio economic status.

Table 11: R&M workers accessing stop smoking service in Nottinghamshire (2018/19)

Number if referrals	Numbers accessing service	Numbers of 4-week quitters	Conversion (%)	Number of 6-month quitters	Conversion (%)
0*	1221	889	72.8	122	13.7

Source: Smokefreelife Nottinghamshire Annual Return, 2018/19

**smokers are able to access the service and self-refer through a freephone number distributed on cards and posters throughout the county or through the Smokefreelife website without being referred*

Support for pregnant smokers

The number of 4-week quitters in pregnant women for the service was 149. The figures show that despite a large number of referrals, the number going on to access the service was small in comparison (1455 referrals compared with 270 accessing service). A referral to

the stop smoking service does not ensure engagement with the stop smoking service, about 40% of the referrals results in a people accessing the service.

The proportion of women going on to quit was smaller when compared with the average quit rate in the county (pregnant smokers 55.2% vs 69% non-pregnant smokers).

Table 12: Pregnant women accessing stop-smoking services in Nottinghamshire (2018/19)

Number of maternities	Number of pregnant smokers	Number of referrals	Number accessing service	Number of 4-week quitters	Conversion (%)	Number of 6-month quitters	Conversion (%)
7441	1091	1455*	270	149	55.2	43	28.9

Source: Smokefreelife Nottinghamshire Annual Return, 2018/19

**the higher number of referrals than number pregnant smokers is accounted for by women being referred more than once during the same pregnancy*

Support for children and young people

The number of 4-week quitters for under 18s was 18. There were a small number of referrals, although they had a 100% referral to service-access success rate. Once within the service, performance was lower compared with the other groups, with just 39.1% going on to quit at 4 weeks, but this is still above the nationally recognised figure of 35%[42].

Table 13: Under-18s accessing stop-smoking services in Nottinghamshire (2018/19)

Number of referrals	Numbers accessing service	Number of 4-week quitters	Conversion (%)	Number of 6-month quitters	Conversion (%)
46	46	18	39.1	4	22.2

Source: Smokefreelife Nottinghamshire Annual Return, 2018/19

4.2 Preventing uptake

A Stop Smoking in Schools Trial (ASSIST)[43] is an evidence-based peer-led intervention recommended by NICE, which targets Year 8 pupils, a time where smoking begins to accelerate in young people. Influential pupils are selected by their peers and trained to become peer educators, learning about the health, financial and environmental impacts of

tobacco use. They then pass this information on to their peers through informal conversation about the risks of smoking and the benefits of being smoke-free. 18% of Year 8s, who are representative of their year group, are targeted to become peer educators.

ASSIST was commissioned in local areas known to have a high adult smoking prevalence as a 3-year pilot in 2015 but has since been recommissioned until 2020-21. It has been successfully implemented at 15 schools from a pre-approved list over the duration of the programme with some of those schools into the second, third and even fourth year of the project as it is delivered to each Year 8 cohort. It has been well-received, with many schools complimenting the programme and requesting to run it again the following academic year see local views section 5.

Due to the nature of the programme, there is no way of providing figures with regards to the number of children it may have prevented from smoking. However, there is a need to evaluate this provision.

4.3 Reducing harm

Local activity is intelligence-led and works across boarders where necessary to go further up the supply chain, linking with Trading Standards East Midlands (TSEM), GAIN (Government Agency Intelligence Network) and East Midlands Special Operations Unit (EMSOU) which is a combination of 5 police forces set up to tackle serious organised crime which includes illicit tobacco.

Nottinghamshire Trading Standards have a dedicated Police Officer within the enforcement team who liaises between the Trading Standards intelligence and on the Police systems MEMEX which is a restricted intelligence-sharing source. Crimestoppers have also been used for reporting anonymous intelligence. Trading Standards have a secure email address for partner agencies to use.

Year on year increases in these activities are not easily planned or predicted. The activity of the Team has focussed in recent years on disrupting the market further up the supply chain and involves a complex cross-border and intelligence-led approach.

Re-inspections are made of premises where illicit tobacco is found previously, and test purchases are made. Closed premises within the County are checked regularly to ensure offenders do not re-emerge.

Trading Standards sit on the East Midlands regional illicit tobacco group which feeds through to the National Trading Standards group. Intelligence is shared within the Authorities and a working partnership has been established with Nottinghamshire and HMRC. When necessary activities are co-ordinated within the region utilising resources. A yearly survey is conducted by TSEM to check the impact of illicit tobacco enforcement work.

Media work is co-ordinated as appropriate within the East Midlands regions and any National Trading Standards messages are also shared with the public. Trading Standards have worked with the media in TV, radio and the internet to publicise the safety and health impact of illicit tobacco.

Locally funding has been secured until March 2023.

4.4 Assets

Strategic support

The Nottinghamshire Strategic Tobacco Alliance Group (STAG) that was previously involved with supporting the tobacco control plan for the county now no longer meets. A new strategic group is planned following the outcomes of the CLeaR Programme (discussed in Chapter 6) for Nottinghamshire County and Nottingham City in the autumn of 2019.

Tobacco is a priority within the Nottingham and Nottinghamshire Integrated Care System (ICS) 5-year plan. The plan suggests actions including;

- A systematic approach to achieving the ambition of a smokefree generation via ensuring a systematic approach and integration of tobacco prevention agendas in the ICS, Hospitals, Primary care, Local Authorities and Voluntary Sector plans.
- Develop and oversee a tobacco control group to contribute to population and workforce wellbeing plans.
- Clear pathways for Nottingham City and Nottinghamshire County residents and GP-registered populations to access smoking cessation in primary care, acute and mental health settings (in line with the NHS long term plan) and in community smoking cessation services.
- Full implementation of the NICE guidance supporting cessation in secondary care (PH48) and NICE Guidance Smoking: stopping in pregnancy and after childbirth (PH26).
- Development of personal skills to train and support the workforce in having a healthy conversation across health, social care and voluntary sector. Specific development of skills within primary care, acute and mental health settings to have staff trained to relevant levels of the National Smoking Cessation Training.

Smokefree secondary care and mental health smokefree coordination

Since 2018/19 all secondary care providers and mental health trusts within Nottinghamshire have been provided with a grant agreement to enhance smokefree coordination within their organisations and support the delivery of NICE guidance PH48[44] across the whole county system. This funding has been agreed up to 20/21. This supports the NHS Long Term Plan[45] mentioned in section 7 (what's on the horizon) and aims for all people admitted to hospital who smoke to be offered NHS funded tobacco treatment services by 2023/24.

Local Tobacco Control Declaration

The original Local Government Declaration on Tobacco Control was a response to the on-going damage smoking causes to communities. It is a commitment to take action and a statement of a local authority's dedication to protecting their local community from the harm

caused by smoking. The declaration is an opportunity for local leadership and can be a catalyst for local action showing the way for partners both inside and outside the local council.

The Nottinghamshire County and Nottingham City Declaration on Tobacco Control (mainly referred to as the Tobacco Declaration) is an extension of the original Local Government document and the NHS statement of support.

The locally developed, innovative document enables organisations to sign up to the principles of the Local Authority Declaration and be supported to develop an action plan. This approach allows organisations in the public, private and voluntary sectors, which significantly extends the scope and impact of the initiative.

Good progress has been made with this innovative approach across the county. Member organisations work across different sectors and settings which has increased the reach of the Tobacco Control work from updating registers in GP practices to extending Smoke free zones across buildings and local areas such as parks. Secondary Care settings have been integrated into programmes which have also involved local partners and youth groups in planning and carrying out activities. It is importantly part of the Nottinghamshire Joint Health and Wellbeing Strategy 2018 - 2022 and reported on regularly.

The Nottinghamshire Wellbeing at Work (W@W) initiative

The Wellbeing @ Work initiative is a local scheme that acts as an umbrella for a range of public health and wider health related priorities to be implemented across adult working age population and their wider families and peers.

The Nottinghamshire Wellbeing@Work programme is led by Nottinghamshire County Council Public Health department. In 2014 a Nottinghamshire Workplace Health Action plan was developed and was devised in line with the evaluation findings of the Bassetlaw workplace health model, supported by the latest available evidence base. The scheme is designed with flexibility to suit all organisations and offers a structured approach to achieving the aims stipulated in the supporting Toolkit. There are approximately over 50 organisations signed to the W@W programme in Nottinghamshire.

It encompasses a very effective ‘community development’ model, whereby people in the workplace are supported to promote health and wellbeing in the workplace and uses the principles of having a **Healthy Conversation**. The Award Scheme comprises different levels and brings together a large network of interested businesses and provides robust information on the importance of health and well-being, promoting local business as exemplary employers and improving their public image.

Nottinghamshire Fire & Rescue Service

Nottinghamshire Fire and Rescue Service (NFRS) Arson Reduction & Investigation Team (ARIT) have utilised the findings from fatal fire investigations - in which carelessly discarded smoking materials were deemed the most probable cause of fire - to link with partner agencies and prevention colleagues to put control measures in place to prevent this

happening in the future. This revolves around the 'CHARLIE' profile formulated by the Service which highlights inappropriate smoking (smoking in bed or whilst under the influence of drugs or alcohol) as one of the indicators to a higher risk of death or serious injury from fire. Vulnerable persons fitting this demographic are offered a host of resources including a Safe and Well Visit; ensuring smoke alarms are working and correctly sited; offering flame retardant throws and bedding packs and education against the fire risks attributed to smoking.

- Furthermore, NFRS, through joint working with NHS Tissue Viability Nurses, are involved in an ongoing joint initiative to inform their staff on the risk of emollient creams and smoking - with persons receiving care packages, alongside air mattress use and how best to mitigate such risks.
- Police staff in the early stages of their career alongside CID officers in training are also being educated in how to make referrals to NFRS for persons which show signs of habitual carelessly discarding of cigarettes and recognising potentially counterfeit cigarettes which may not be Reduced Ignition Propensity (RIP) compliant, contravening recent EU legislation.
- RIP compliant cigarettes are those which contain bands of less porous paper, which cause the cigarette to be more prone to self-extinguish, particularly if no one actively draws air through it. However, fire incidents including fatalities have still been attributed to cigarettes which, when tested by a Fire Investigation Officer, were found to be RIP compliant".

5. Local views

5.1 Stopping smoking

Healthwatch

Local views presented in this section have been extracted from a consultation that took place over the summer of 2018 in the form of an online survey, a series of engagement events, some targeted work with specific groups and the involvement of Healthwatch to provide objective input from current and potential service users.

Healthwatch carried out a series of focus group discussions and semi-structured interviews with people who may benefit from the service.

Some of the issues raised around tobacco were:

- **Delays in referrals-** the importance of a timely referral to capitalise on high motivation levels. Smokers also reported frustration at having to be re-referred by their GP if they had dropped out of treatment.
- **Mental health-** many respondents felt that their underlying mental health issues, which were the root cause of their smoking, were not being addressed. Some also reported anxiety around initially accessing treatment services as a barrier.

- **Geographical barriers-** many reported difficulties in accessing a service that was taking place in a different community, whether the barrier be transport or unfamiliarity with the area.
- **Cost-** although easier to access NRT over the counter through a pharmacy, this could be up to 3 times more expensive than a prescription.
- **Awareness of what is on offer-** a lack of awareness of what options were available to support quitting, both on the NHS and through over the counter purchases (e.g. e-cigarettes)

Smokefree Great Britain 2018 - public opinion in the East Midlands

The YouGov Smokefree Britain Survey 2019 found that 76% 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 - 65% agreed[46].

5.2 Preventing uptake

The local ASSIST programme recently gathered some qualitative feedback from pupils engaged in the programme and teachers and schools.

"After the training I have more confidence in being able to talk to a variety of people"

"Some things I learnt about myself from working on this course are that I am influential"

"I learnt to be more aware of people around me and to be supportive of everyone's ideas and opinions"

"I learned to be approachable"

"My main achievement during the training course was learning all the facts and talking to people I wouldn't normally talk too at school"

"My main achievement during the training course was knowing my strengths and weaknesses"

"My main achievement during the training course was being given this special opportunity"

"It has been something that has been really worth committing to and hopefully we will see a positive impact"

"After we finished with you guys last year a small group of students that were part of the programme did an assembly about the dangers of smoking to the rest of the year group. We would definitely like to continue"

"It's great to spend time with students that I wouldn't normally have much interaction with"

5.3 Reducing harm from tobacco use

There has been no recent local insight work carried out regarding reducing the harm from tobacco use. The You Gov survey suggested that adults in the East Midlands strongly support tobacco manufacturers being required to pay a levy or license fee to Government for measures to help smokers quit and prevent young people from taking up smoking.

70% of the East Midlands support this approach, with only 8% opposing it. Most adults also supported increasing the age of sale for tobacco from 18 to 21 years (56%v18%).

Finally, 81% of adults in the East Midlands support the introduction of a licence to sell tobacco which can be removed if retailers are caught more than once selling to underage smokers, with only 4% opposing[46].

6. Evidence of what works

There is a wealth of evidence to support tobacco control interventions. The National Institute for Health and Care Excellence (NICE) guidance focuses predominantly on smoking prevention and cessation. Other government guidance and research addresses both smoking cessation and wider tobacco control.

The previous TCP (Healthy Lives, Healthy People: A Tobacco Control Plan for England[47]) based its strategy around 6 internationally recognised strands for comprehensive tobacco control, which is an evidence-based approach to tackling the harm caused by tobacco and smoking (figure 17).

The current TCP (Towards a Smokefree Generation) uses 4 distinct themes to base its aims[36]:

1. Prevention first
2. Supporting smokers to quit
3. Eliminating variations in smoking rates
4. Effective enforcement

The essential elements of tobacco control can only be fully achieved through partnership working and are often reliant on national policy legislation. As part of the aim to create a smokefree generation, the government hopes to implement recommendations from all relevant NICE guidance by 2022[36].

Figure 17: Diagram of tobacco control hexagons



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

6.1 Prevention first

NICE guidance PH14 sets out recommendations around preventing the uptake of smoking in children and young people, including guidance around targeting mass media campaigns for the younger population and tackling the illegal sale of tobacco to underage children by enforcing existing legislation and working with retailers[48].

There is additional NICE guidance around interventions in schools, academies and colleges for those up to the age of 19 (PH23). This contains advice around taking an organisation-wide approach to tobacco control, adult-led interventions, peer-led interventions (such as the ASSIST programme), training and developing staff to work in smoking prevention and ensuring coordination with other local organisations[43].

One of the most effective ways to reduce smoking in young people is to reduce the number of adults who smoke, as there is strong evidence children are heavily influenced by adult role-models who smoke[36]. Interventions to support adult smokers to quit will therefore play a vital role in reducing the number of young people smoking, as well as enforcement of smokefree laws (in particular, the ban on smoking in private vehicles with an under-18 present).

Other measures, such as advertising restrictions, standardised packaging and reducing the availability of tobacco to young people through educating tobacco retailers and enforcing the

minimum age legislation have all shown to reduce the number of young people taking up smoking[24].

6.2 Supporting smokers to quit

Historically, the majority of research in tobacco control has been into helping smokers to quit, although methods and recommendations change over time. The 2018 NICE guidance (NG92) gives the latest evidenced-based approaches to stop smoking interventions, such as tailoring the approach to the community, targeting high-risk groups, the use of carbon monoxide (CO) monitoring to assess abstinence, products to use, telephone quit lines, local awareness campaigns and policy around closed institutions and places of work[49].

Public Health England guidance on how to deliver stop smoking services, assesses the options and evidence, rating interventions on their effectiveness[50].

There is strong evidence that the most effective approach to smoking cessation is a combination of individual behavioural support or counselling, in combination with pharmacotherapy (drug treatment)[51,52]. There is also some limited evidence that group-based behavioural interventions may be more effective in helping young people (<20) to quit, compared to usual methods[53].

6.2.1 In the workplace

NICE PH5 guidance on workplaces includes information and support to staff, developing a smoking cessation policy and offering interventions. Employees who smoke should be signposted on how to access local stop smoking services, encouraged to do so and not be penalised with loss of pay for attending during working hours. Local stop smoking services should also target businesses with a high proportion of employees on low pay, who are heavy smokers or from disadvantaged backgrounds[54].

6.2.2 Pregnancy

ASH in 2018 assessed how it would be possible to meet the Government target on reducing SATOD rates to below 6% by 2022 and made 5 recommendations[55].

- Address variation in local implementation of NICE guidance
- Action where smoking pregnancy rates are high
- Improve the quality of data monitoring locally and nationally
- Maximise use of nicotine as a quitting aid
- Increase the proportion of the maternity workforce trained to address smoking in pregnancy

NICE PH26 reviews cessation during pregnancy and after childbirth, and PH48 gives guidance on how maternity services can support women to stop smoking. Ideally, pregnant women who smoke should be identified by their midwife at booking through discussion and

CO testing, with the risks to both herself and the unborn baby discussed. Once a referral has been made, the stop-smoking service should continue to engage throughout the pregnancy with brief interventions and offering individualised support based on the circumstances of the pregnant woman. Partners who smoke should also be offered help if possible. It is the responsibility of maternity units to maintain and enforce smokefree policy while identifying and supporting pregnant smokers to quit with appropriate advice, referring them to stop-smoking services and providing appropriately-dosed pharmacotherapies when required[44,56].

A recent review regarding incentives for smoking cessation concluded that incentives improve smoking cessation rates at long term follow-up in mixed population studies. There is also moderate-certainty evidence that incentive schemes conducted among pregnant smokers improve smoking cessation rates, both at the end of pregnancy and post-partum, particularly when coupled with evidence-based support in line with NICE guidance [57,58].

6.2.3 Mental Health

The ASH Stolen Years report sets out 12 national ambitions to enable a significant reduction in the number of people with mental health conditions smoking. They include empowering those with mental health conditions to take action to reduce their smoking, ensuring staff working with mental health patients see smoking cessation as part of their core role and mental health services providing effective support to quit smoking and access smoking cessation services[7]. NICE guidance PH48, as with maternity, advises how to reduce smoking across mental health services through an approach of offering support and advice tailored to the individual, appropriately trained staff to provide smoking cessation advice, supporting quitters by maintaining smokefree environments on-site and providing pharmacotherapies[44].

6.2.4 Harm Reduction

Harm reduction (HR) is the process of adopting a strategy to reduce individual and/or social harms arising from a behaviour. When applied to smoking, harm reduction includes aspects of smoke-free homes, assisting people to ‘Stop Before the Op’ (pre-surgery) and providing people with access to longer term Nicotine Replacement Therapy (NRT) if required.

NICE have published guidance (PH45) around helping reduce harm from smoking. It aims to help people who may not be able to stop smoking in one step, may want to stop without giving up nicotine or may not be ready to stop but want to reduce the amount they smoke. This can be achieved through raising awareness of and providing licensed nicotine-replacement products, providing appropriate behavioural support through stop-smoking services, selecting the most appropriate HR approach and providing follow-up appointments to assess progress. The commissioners of stop-smoking services should ensure that HR extends the reach of the service rather than detracting from it, while developing referral and treatment pathways for those that do opt for a HR approach[59].

6.2.5 E-cigarettes

E-cigarettes are one of the most popular methods smokers now use to quit[12,13]. They are estimated by PHE to be at least 95% safer than smoking tobacco, with a lifetime cancer risk that is under 0.5% that of smoking[60]. The main active ingredient of e-cigarette liquid is nicotine, similarly to cigarettes, which is an addictive drug that acts as a stimulant on users. However, it is the by-products of tobacco combustion that cause harm to cigarette smokers. In separate research, long-term use of NRT has not been found to increase the risk of serious health problems, therefore there are unlikely to be adverse effects as a result of users' nicotine consumption[60].

PHE has estimated that there are up to 57,000 additional quitters annually in England who may still be smoking without the devices, while in 2018, 52% of the e-cigarette users in Great Britain were ex-smokers (around 1.7m adults). In 2017/18, the smokers who achieved the highest quit rate (74%) were those who used e-cigarettes after using licensed medication[60].

A recent study found that e-cigarettes had almost double the sustained smoking abstinence rate compared to NRT when measured at 1 year (both used in combination with NHS behavioural support). However, there was an issue raised around the possibility for ongoing long-term use; a higher number of smokers continued to use their e-cigarette at 1 year following quitting when compared to NRT[61]. Currently, only 4% of those using stop smoking services are using an e-cigarette in their quit attempt[1].

There is still a lack of evidence around the long-term health effects of e-cigarettes and while no significant harms have been discovered to date, this is an area of research that is constantly evolving.

There has been some recent coverage regarding the use of e-cigarettes in the United States and their impact on health. PHE and partners have sent out communication to reassure vapers in the UK. Unlike the US, all e-cigarette products in the UK are tightly regulated for quality and safety by the Medicines and Healthcare products Regulatory Agency (MHRA) and they operate the Yellow Card Scheme, encouraging vapers to report any adverse effects. Public Health England's advice remains that vaping carries a small fraction of the risk of smoking. Using a nicotine-containing e-cigarette makes it much more likely someone will quit successfully than relying on willpower alone, three studies this year have found them twice as effective as NRT alone. But it's important to use UK-regulated e-liquids and never risk vaping home-made or illicit e-liquids or adding substances.

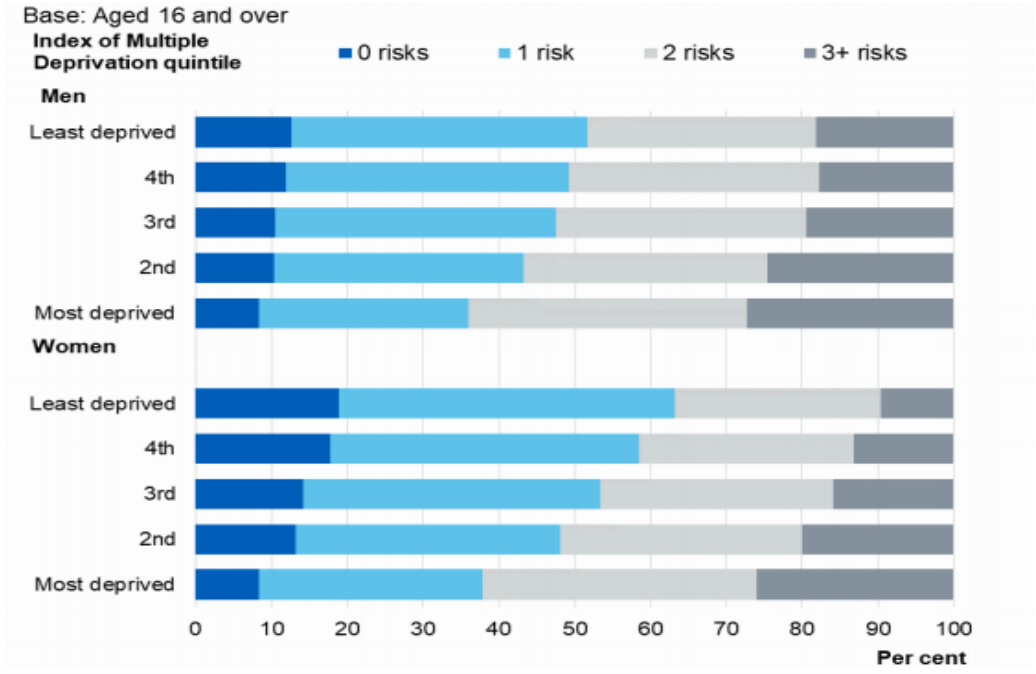
6.2.6 Multiple risk factors

The Kings Fund (2012 and 2018)[30,31] highlight that there was a reduction in the proportion of people engaging in multiple unhealthy behaviours between 2003 and 2008. However, the decline was greatest amongst those with higher levels of education and socio-economic status, thereby potentially increasing health inequalities.

Addressing multiple risks is important from a public health perspective as evidence suggests that the combination of risks is more detrimental to people's health than can be expected

from the added individual risks alone. In an analysis of the UK Health and Lifestyle Survey, persons with four risk behaviours (cigarette smoking, high alcohol intake, physical inactivity, and a low fruit and vegetable intake) had a 3.5-fold increase in risk of mortality compared with those with none of these behaviours[62,] The Health Survey for England[63] presents information on risk factors (smoking, alcohol, BMI, physical inactivity and fruit and vegetable consumption) combined. Figure 18 shows that the prevalence of these risks varies by deprivation with the proportion of adults with three or more risk factors being greater in the most deprived areas compared to the least deprived for men and women.

Figure 18: Age Standardised Prevalence of multiple risk factors by Index of Multiple Deprivation and sex. Health Survey England Report (Dec 2018)



Source: NHS Digital, 2018

6.2.7 Integrated lifestyle/wellbeing services

This term is often used to describe where a range of services are organised collectively through an umbrella organisation or brand offering a range of wellbeing interventions. Providing dedicated specialist stop smoking support and setting the stop smoking service within a broader wellbeing collaboration has advantages, particularly in relation to savings associated with administration and promotion. Assuming quality of interventions is maintained, outcomes similar to a universal evidence-based service with specialist behavioural support and pharmacotherapy available for all smokers to access can be expected[50].

6.3 Eliminating variations in smoking rates

Targeting interventions to groups known to have a higher smoking prevalence (R&M workers, LGBT) is an effective method to help reduce inequalities in smoking rates.[49,64] The CLeaR improvement model is an evidence-based tool developed by PHE for use by local authorities. It has 3 main focuses:

- Challenge existing tobacco control services, based on evidence of the most effective tobacco control methods, as outlined in NICE guidance and 'Towards a smoke-free generation'
- Leadership for comprehensive action on tobacco control
- Results demonstrated by the outcomes you have achieved measured against national and local priorities

Targeted mass-media interventions, including use of novel social media, are an effective method of reaching different audiences and a cost-effective method to reduce overall smoking prevalence, as well as inequalities. These must be culturally appropriate and tie in well to other local tobacco control activity.[36, 65]

Continuing to raise public awareness around the importance of smoke-free laws and the dangers of second-hand smoke will help to tackle the issue, especially when targeted at those who may be smoking around children.[18, 36, 66]

6.4 Effective enforcement

Maintaining high duty rates on legal tobacco sales, tackling the illicit tobacco market and enforcing existing legislation are all important methods in a comprehensive tobacco control strategy[36]. Even though there is a long-term decline, problems still exist in some communities. Effective approaches are coordinated across large geographical areas through collaborative work between health and enforcement to reduce the demand for and supply of illegal tobacco. Evidence-based social marketing and campaigns have raised awareness of the issue, helped to generate intelligence and have provided the facts on illicit tobacco by countering the misinformation circulated by the tobacco industry[70].

7 What is on the horizon?

Tobacco Control Plan

The TCP for 2017-2022 sets out an ambition for the UK to be 'smoke-free', which it defines as a smoking prevalence of 5% or below[36]. The Government have also recently announced their intention for this smoke-free target to be achieved by 2030 in a green paper (Advancing our health: Prevention in the 2020s)[67].

This includes an ultimatum for industry to make smoked tobacco obsolete, with smokers moving to reduced risk products like e-cigarettes. The paper also states that the Government are considering[67]:

- 'Polluter pays' approach- requiring tobacco companies to pay towards the cost of tobacco control, similar to in the United States and France.
- Increased targeting of funds towards groups most in need, such as pregnant women, people living in mental health institutions and those living in deprived communities.
- Improved trading standards enforcement to crack down on the illicit tobacco market.
- Run a call for independent evidence (not linked to tobacco companies) to assess further how effective heated tobacco products are in helping people quit smoking.
- Examine the possibility of inserting information on how to quit on tobacco products

ASH have also proposed further measures, which will help to achieve the ambitious smokefree target, supported by public opinion from a recent nationwide survey[68]:

- Requiring businesses to have a licence to sell tobacco which they can lose if they sell to underage smokers (81% of adults in England support, only 4% oppose)
- Prohibiting smoking inside all private vehicles, not just those carrying children under 18 (65% support, 14% oppose)
- Increasing the age of sale from 18 to 21 (56% support, 18% oppose)[46]

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%[69].

This is further supported through the secured funding for secondary and mental health trusts to support the continued implementation of PH48 NICE guidance up until 20/21.

There is a need for NHS organisations to focus on prevention activities and use the resources to support their in-hospital treatment and support. This may well be a challenge for organisations that are at different points in adopting this.

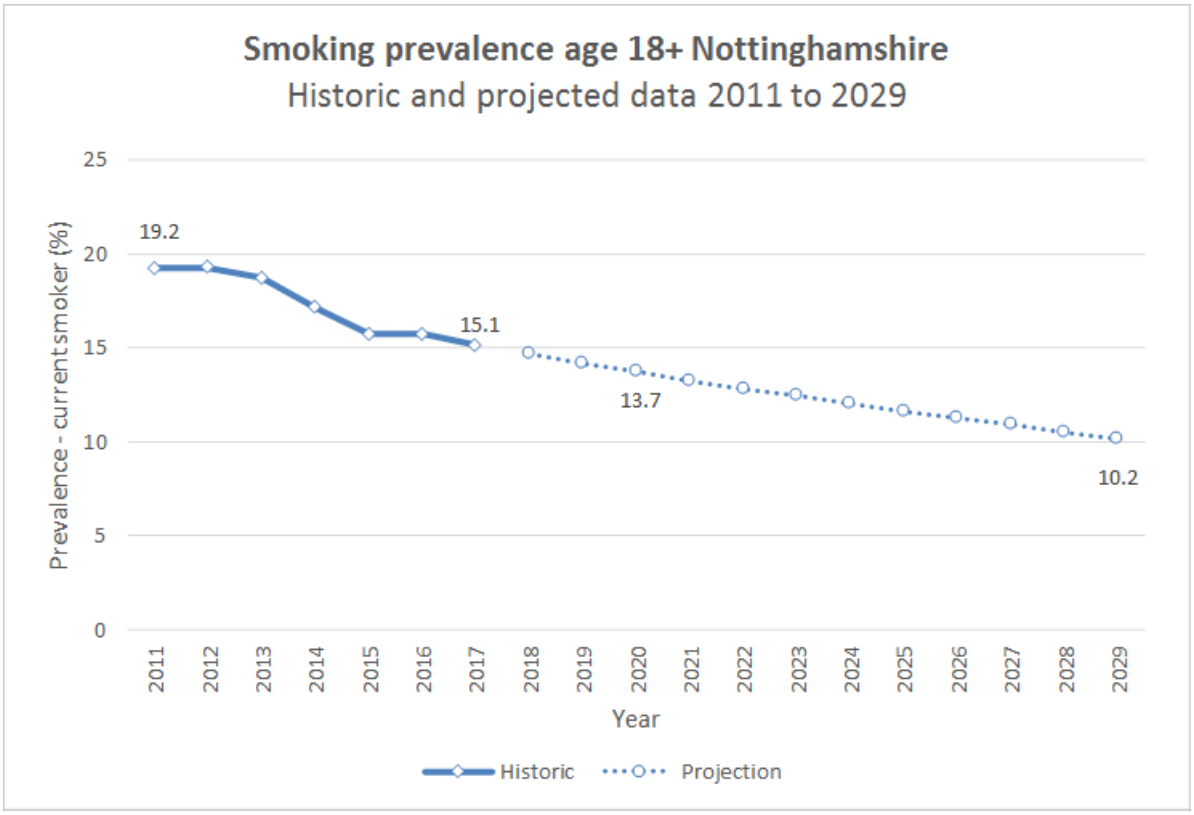
Action on Smoking and Health resource for Health and Wellbeing Boards

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. End of Smoking highlights the links with poverty, inequality, early death and productivity and prosperity.

7.1 Stopping smoking

Using current information, should the smoking rate in Nottinghamshire continue to decline at the current rate, it is predicted that 10% of adults will smoke by 2029.

Figure 19: Projected adult smoking prevalence in Nottinghamshire



Source: Nottinghamshire Public Health Analyst Team

As previously noted the prevalence of smoking in Nottinghamshire stopped falling in the PHOF in 2018, breaking a consistent downward trend however this may not be part of a significant long-term trend.

The trend 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 prevalence in future years.

Smoking in pregnancy has remained static for the previous 3 years, and locally is still significantly worse than the England average.

The popularity of e-cigarettes is likely to continue to rise, having become the most popular method of attempting to quit smoking. Along with growing evidence of their efficacy and safety, their further integration, for clients who express a preference into stop smoking services, alongside traditional medication, is likely to be an effective method of increasing the number of quits each year.

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.

The new Integrated Wellbeing Service will come in to effect on 1 April 2020. The Authority plans to bring lifestyle behaviour change functions together into one service model through commissioning an adaptable and dynamic delivery partner that can deliver an Integrated Wellbeing Service (IWS). This includes;

- stop smoking and tobacco control
- obesity prevention, diet and physical activity
- alcohol Identification and Brief Advice (IBA)
- underpinned by mental wellbeing

The integration of the IWS into the systems and structures in Nottinghamshire will pose some challenges in the coming months. It is important that this new approach ensures that it addresses gaps around those with mental ill health, and supports to reduce the gap between smoking rates in different groups whilst feeding in to the ICS system wide approach.

7.2 Preventing uptake

The prevention agenda, although now more widely recognised, continues to require further investment. There remains a shortage of evidence-based prevention strategies, other than the ASSIST model and more widely-accepted methods, such as health warnings on tobacco packaging, strict laws around sales to minors, smokefree places and increasing costs through taxation.

This remains an area to be monitored for any further advances.

7.3 Reducing harm from tobacco use

There is the acknowledgement that whilst ideally people would either quit smoking or not begin 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:

- CLeaR programme - Public Health England will support an open discussion between local partners working to reduce the harm from tobacco. This will be structured around the CLeaR questionnaire. This will explore local efforts around tobacco control themes such as: Leadership; Compliance; Prevention; Communications; Cessation; Partnership working, Innovation and Learning. This will then be used as the basis for future action planning, and will act as a baseline for measuring progress
- 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, this is part of the Nottinghamshire Joint Health and Wellbeing Strategy 2018-2022

- Extending smokefree places - There has been some good work across the districts to extend smokefree places including smokefree summer events and play parks.
- Continued investment in reducing the supply and demand of illegal tobacco
- Supporting the Wellbeing approach agreed at the Health and Wellbeing Board to bring together MECC ((Making Every Contact Count) also known as (Healthy conversations)), The Wellbeing at Work programme and the Tobacco Declaration.
- Adopting an ICS system wide approach to prevention with tobacco and alcohol as priorities.

What does this tell us?

8 Unmet needs and service gaps

8.1 What we know

- Smoking prevalence has stalled in Nottinghamshire for the first time in 7 years. Current prevalence 15.4%.
- There remains large variation across the county in smoking prevalence by district, occupation and during pregnancy.
- Nottinghamshire stop-smoking services helped around 4.3% of the smoking population to set a quit date in the year 17/18.
- Smokers are 4 more times more likely to stop smoking with the combined behavioural support and pharmacotherapy.
- There is a new Integrated Wellbeing Service model planned to start delivery in April 2020.
- Smoking remains largely an addiction started in childhood.
- Evidenced-based smoking prevention programmes, such as ASSIST, are nationally well received and effective in reducing smoking uptake.
- Novel technologies to assist in quitting, such as e-cigarettes, are now one of the most popular and effective methods of stopping smoking but there is some inconsistency around their use and safety.
- Some smokers are unwilling or unable to stop smoking completely.
- Illegal tobacco undermines all tobacco control interventions.
- Dangers from secondhand smoke are widely understood.
- Tobacco use affects all in the community
- 5% of Accidental Dwelling Fires in Nottinghamshire are caused by carelessly discarded smoking materials or poor smoking practices and 30% of fire fatalities are attributed to fire caused by carelessly discarded smoking materials or poor smoking practices

8.2 What we still need to improve

8.2.1 Stopping smoking

- a stop smoking approach that takes into account different personal factors such as age, sex, sexual orientation, ethnicity, level of education, mental health history, levels of motivation and previous quitting methods or attempts
- services or support that is widely known, easily accessible and with as fewer barriers as possible
- the need to focus on geographical inequalities in smoking prevalence, with districts such as Ashfield, Newark and Sherwood and Mansfield having a much higher smoking prevalence than the rest of the county.
- the ongoing social inequalities in smoking prevalence, particularly affecting groups such as R&M workers and those with a mental health condition.
- the ongoing challenges with smoking in pregnancy- the Nottinghamshire SATOD rate is significantly worse than the England average
- the utilisation of popular novel technologies, such as e-cigarettes, as an adjunct to NRT and behavioural support to help people to quit smoking.
- the links between stop smoking services and other lifestyle services, particularly those that may play a role in relapse prevention, for example robust referral pathways.

8.2.2 Preventing the uptake

- evaluation of early-intervention programmes, such as ASSIST
- to reach to more young people through more modern mass-media awareness campaigns around the dangers of tobacco and the benefits of being smoke-free that are tailored to acknowledge the variations in local populations.

8.2.3 Reducing harm from tobacco use

- the demand and supply of illegal tobacco and be aware of the potential for the supply of newer counterfeit products, such as e-cigarettes.
- a harm reduction approach, as specified in NICE guidance, for those who are unwilling to stop smoking or unable to stop completely, enabling the stop-smoking service to reach further into the smoking population.
- enforcement of existing legislation designed to protect others from second-hand smoke (e.g. the ban on smoking in private vehicles with under-18s present).
- supporting the promotion and promulgate guidance on safer smoking practices
- embedding routine brief advice on smoking and a healthy conversation approach across Nottinghamshire
- consistent knowledge and information on partner organisations work that supports the tobacco declaration
- supporting mechanism that allow for tobacco control activity to be planned and implemented across Nottinghamshire

9 Knowledge gaps

9.1 Stopping smoking

- Gather data on the smoking prevalence of key 'at-risk' groups, including but not limited to:
  - LGBT groups
  - Different ethnicities
  - Other minority groups
- Understand why the numbers of pregnant women accessing stop-smoking services continue to be small despite a large number of referrals in the past year.
- Detailed service user feedback to inform local commissioning.

9.2 Preventing the uptake

- Accurate and up-to-date model of the number of young people who may be taking up smoking across the county, down to district level if possible (national data is available), taking into account novel products such as e-cigarettes and heated tobacco
- Evaluate the impact on the ASSIT programme on smoking locally

9.3 Reducing harm from tobacco use

- Gather local data to support wider tobacco control initiatives as deemed realistic, relevant and appropriate to support work.
- Up-to-date local insight work around the harms of smoking, any new legislation and new technologies such as e-cigarettes.
- Delivery of tobacco control initiatives at district level for example smokefree public places

Nottinghamshire Health & Wellbeing Board

What should we do next?

10 Recommendations for consideration

	Recommendations	Lead Organisations			
		Local Authority	Service Providers	District & Borough Councils	Others
Overall Tobacco Control Approach					
1	An approach that;				
	• targets the communities in which smoking prevalence is highest	✓	✓	✓	
	• engages further with known priority groups, such as young people, pregnant women and R&M workers in order to address smoking inequalities.	✓	✓		
	• engages with 'at-risk' groups not currently targeted, such as the LGBT community, certain ethnicities and other minority groups.	✓	✓		
	• addresses the challenge of reducing smoking prevalence in those suffering from a mental health condition.	✓	✓		
2	Informed future commissioning arrangements through understanding local in-depth insights in to the local population	✓	✓	✓	✓
Stopping Smoking					
3	A clear position guided by current evidence in the use of e-cigarettes as an effective quit method and to understand any cultural influences on their use	✓	✓		

4	Ensure support/services are evidence-based, widely known and are easily accessible, with as fewer barriers as possible	✓	✓		
Preventing the Uptake					
5	Understand the impact of the ASSIST peer led programme locally	✓	✓		
6	Understand the role for wider evidence-based prevention programmes across the county	✓			
Reducing harm for Tobacco use					
7	Locally self-assess work on a broad range of tobacco control issues through; • Evaluating local action on tobacco control • ensuring that local activity follows the latest evidence-based practice • identifying priority areas for development and help with effective planning • monitoring improvements to services over time	✓	✓	✓	✓
8	Target those that trade in illegal tobacco	✓	✓	✓	
9	Continue to support efforts to reduce the harm from tobacco use through; • Mass media campaigns • Extending smokefree environments • Supporting and enforcing current and emerging legislation • Safer smoking practices for those	✓	✓	✓	✓

	who continue to smoke				

*NB – **services providers** includes but not limited to local stop smoking services, trading standards, acute, maternity and mental health trusts, primary care, youth services*

***Others** includes but not limited to Nottinghamshire fire and rescue service, ICS and ICP partners, Nottingham University, PHE, HMRC*

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Appendix 1

2014 JSNA recommendations progress and link to 2019 recommendations for consideration by commissioners

Summary Recommendations		Response
Stopping smoking	Provide services that are individualised for smokers and what they need	The stop smoking service was re commissioned in 2016 to provide an outcome focused, high quality, person centred, tobacco control service for adults and children across Nottinghamshire.
	Prioritise particular groups where smoking rates are higher and make services fit around smokers' lives and routines in locations that are accessible	The Tobacco Control model commissioned in 2016 consisted of an emphasis on an individualised service with targeted stop smoking service for priority groups including; • Routine & Manual workers • Pregnant women • Children and young people • Other priority groups including but not limited to smokers with mental health problems.
Preventing the uptake of smoking	Stop young people from starting to smoke in the first place	The Tobacco control model commissioned from 2016 included in its scope evidence-based initiatives that prevent people, particularly young people from starting to smoke.
	Use the evidence we have on what works for example evidence-based education/awareness programmes and campaigns that de-normalise smoking	The ASSIST – peer support programme was commissioned through Nottinghamshire's Children's Integrated Commissioning Hub in 2015 as a 3-year pilot and has since been recommissioned until 2020-21.
Reducing harm form tobacco use	Tackle the supply and demand of illegal tobacco in our communities through close working with trading standards and HMRC	Since 2014, Trading Standards officers have been commissioned by Public Health to reduce the demand for and supply of illegal tobacco.

	Raise awareness of tobacco control beyond health-related organisations	In 2014 the Nottinghamshire Declaration on Tobacco Control was developed. In October 2014 the Health and Wellbeing Board agreed to endorse the declaration and for Board members with to take the Nottinghamshire County and Nottingham City Declaration on Tobacco Control to their organisations for sign up. Good progress has been made with the declaration for example updating registers in GP practices to extending smokefree zones across buildings and local areas such as parks and it is part of the Nottinghamshire Joint Health and Wellbeing Strategy 2018 - 2022 and reported on regularly.
	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	
In summary	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.	During 2014 and 2015 Public Health undertook a procurement process to commission a new Tobacco Control Model that included; • Evidence based programme that prevent young people from starting to smoke • Evidence based initiatives/programmes that protect people from tobacco use and prevent people from starting to smoke • Evidence based initiatives/programmes that prevent people from starting to smoke • Universal stop smoking service • Targeted stop smoking service The service was designed as an outcome focused, high quality, person centred tobacco control service for adults and children across Nottinghamshire.