Tobacco Control

Health Needs Assessment

February 2023

Derby City Council

Acknowledgements:
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Confidentiality
Public document

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Caveat on inclusive language

Public Health at Derby City Council are working with the wider local authority and Local Maternity and Neonatal System partners to review language to ensure it is inclusive. This includes the addition of gender inclusive language. In the development of this health needs assessment, terms such as 'pregnant women and birthing people' have been used in places; in other places the language used is in line with that used in national reporting, published evidence and guidance which has informed this document.

CONTENTS

Executive Summary

Tobacco use remains a significant public health challenge. The main method of tobacco consumption is through smoking.

Nationally, smoking is the main cause of preventable illness and early death. It is also a substantial driver of health inequalities. In 2019, 74,600 people in England died as a result of smoking, with many more living with debilitating smoking-related illnesses.

As a major cause of ill-health, smoking increases a person's risk of developing more than 50 serious health conditions, including heart disease, lung disease and lung cancer. It also damages the health of children and non-smokers who are exposed to secondhand smoke and increases the risk of complications during pregnancy.

Each day in Derby approximately 300,000 cigarettes are smoked. There are opportunities to strengthen our efforts to reduce the harms caused by smoking locally.

This summary highlights the key messages from a health needs assessment, which brings together data and evidence to guide the development and delivery of tobacco control activities in Derby.

Who is smoking in Derby?

The latest data (2021) shows that 13.2% of adults in Derby are estimated to smoke, which is similar to the England average (13.0%). However, similar to the national picture, smoking prevalence in Derby is recognised to be higher among people living in social housing (37.8%), people with long-term mental health conditions (29.5%) and those working in routine and manual occupations (26.2%) when compared to the general population. Derby also continues to experience a significantly higher prevalence of smoking during pregnancy (measured at the time of delivery) than the England average (11.9% in Derby vs 9.1% for England).

What are the impacts of smoking in Derby?

Health impacts

Smoking is responsible for approximately half of the differences in life expectancy between the most and least advantaged in society. In Derby, smoking attributable mortality and hospital admissions remain significantly higher than the national average. The latest data shows that between 2017-2019, there were 982 deaths in Derby due to smoking-related causes. In 2019/20, there were 2,647 hospital admissions attributable to smoking in the City.

Societal impacts

Smoking is estimated to cost the economy in Derby £108 million per year. This is made up of:

- £89 million in costs due to lost productivity
- £10.8 million in costs to the NHS
- £6.6 million in social care costs
- £1.9 million in fire-related costs.

Tobacco addiction, and the loss of income it causes, can exacerbate and lock people into poverty, which perpetuates health inequalities. In Derby, it is estimated that smokers spend approximately

£64.3 million on tobacco products each year. This equates to around £1,945 on average per smoker. It is estimated that 6,704 households in Derby could be lifted out of poverty if the cost of tobacco addiction was returned to the household.

Environmental impacts

Tobacco use has an environmental impact in our communities. Cigarette butts constitute 66% of all street litter items. Most cigarette filters are non-biodegradable and must be collected and disposed of in landfill sites. In Derby, smoking generates approximately 16 tonnes of waste annually, of which 7 tonnes are collected as discarded street litter by the council. There is also increasing recognition around the environmental impacts of vaping devices, although this is not yet fully understood. Incorrect disposal of these items can potentially release plastic, electronical and hazardous chemical waste into the environment. The environmental impacts of vaping will be considered in more detail in future needs assessment updates as the evidence base continues to develop.

What is tobacco control?

Tobacco control is an internationally recognised evidence-based approach which incorporates a range of strategies to reduce the supply, demand and harms associated with tobacco use. The aim of tobacco control is to improve health and wellbeing by eliminating or reducing tobacco consumption and exposure to tobacco smoke.

The Tobacco Control Plan for England sets out an ambition for a smokefree generation, which is defined as a population smoking prevalence of 5% or less. To achieve this the national Tobacco Control Plan outlines four priority areas for action:

- prevention first
- supporting smokers to quit
- eliminating variation in smoking rates
- ensuring effective enforcement.

Following on from this, in 2019, the government set an objective for England to become a smokefree society by 2030.

What progress has been made in reducing smoking in Derby?

There has been substantial progress over recent years to reduce smoking prevalence among adults and routine and manual workers. Smoking prevalence in these groups is now similar to the England average. However, the proportion of adult smokers (13.2%) is above the government ambition to reduce adult smoking prevalence to 12% or less by the end of 2022.

Both locally and nationally, smoking is concentrated among more disadvantaged groups in society. There are ongoing social inequalities in smoking prevalence, particularly affecting routine and manual workers, people with long-term mental health conditions and people living in social housing, where the proportion of people smoking continues to be substantially higher than in the general population.

While smoking prevalence at the time of delivery has reduced over recent years, this continues to be significantly higher than the national average. Further multiagency work and leadership will be needed to reduce the rates of smoking during pregnancy. This remains an ongoing priority area for

focus, including through the work to implement the new NHS Tobacco Dependency Treatment Programme.

What is being implemented for tobacco control in Derby?

Stop smoking support

Tobacco dependence is one of the hardest addictions to break. Effective Stop Smoking Services continue to offer smokers the best chance of quitting. In 2021/22, 61% of Livewell clients who set a quit date reported successful 4-week quit attempts. This was higher than the England average of 55%. However, there are variations in quit rates among different sociodemographic groups. Successful quit outcomes were lower among service users who were pregnant, certain ethnic groups and certain age groups when compared to the local service average. Plans are underway to enhance the local service offer to better support key 'at-risk' and priority populations known to be at greater risk of smoking and its related harms. This includes a planned service review to enhance the smoking cessation support offer provided to children and young people. It is recognised that further insight work is needed to continue to optimise engagement and the local service offer to reduce smoking-related inequalities.

Healthcare organisations across the Integrated Care System (ICS) footprint have demonstrated a commitment to reducing smoking prevalence in the local population. Across the local system work is underway to develop a programme to deliver the ambitions set out in the NHS Long-term Plan, which aims to ensure that all acute and mental health inpatients who smoke are offered NHS funded tobacco dependency treatment services by 2023/24. The Long-term Plan service model also extends to include those who are pregnant and their partners, and certain high-risk outpatient groups. A Tobacco Dependency Board has been established to coordinate this work with membership of partners across the ICS. One area not explored in detail in this needs assessment are smoking cessation outcomes among hospital inpatients and people with mental health conditions. Once fully established, data gathered as part of the NHS Tobacco Dependency Treatment Programme will support local understanding of engagement and quit rates among these groups.

Smokefree places

Smokefree environments aim to protect people from the harms of secondhand smoking, demonstrating the importance of continued enforcement of existing smokefree legislation and policies. There may be opportunities to extend smokefree environments through implementing voluntary smokefree zones at school gates, playgrounds and as part of new planning and regeneration projects. This could be beneficial for reducing the harms of secondhand smoking, particularly among children and other vulnerable groups. The implementation of voluntary smokefree zones could be explored through local consultation work, which could also increase public awareness of the harms of secondhand smoke. There may also be opportunities to work with social housing providers to integrate stop smoking support into their existing health and wellbeing activities.

Preventing uptake

Smoking is an addiction that is largely established in childhood. Discouraging young people from smoking remains a priority. In Derby, the School Nursing Team works more intensively with schools that have identified tobacco dependency among their top 3 priority health needs, providing staff training and delivering targeted group work sessions to students. However, there are local insight

gaps around smoking and vaping prevalence among children and young people and the impacts of current school-based prevention activities. This is recognised as an area for development.

Tackling the illegal tobacco trade

The illegal tobacco trade undermines the effectiveness of tobacco control initiatives. Over recent months Derby Trading Standards has made substantial seizures of illegal tobacco and illegal vapes, despite changes in service capacity. This highlights the need for ongoing enforcement operations supported by the appropriate capacity, resource and intelligence to reduce the supply and demand of illegal tobacco and illegal vaping products across the City.

Collaboration across organisations

Effective tobacco control requires a multi-agency and multi-component approach. This needs assessment has highlighted the need for whole systems approach to tobacco control encompassing a broad range of areas. Consideration of developing a strategic group across the Derby and Derbyshire ICS footprint, as well as engaging with regional activities through the Midlands Tobacco Control Network, could provide opportunities to upscale cross-organisational working. This would also optimise strategic leadership and coordination of efforts across system partners to facilitate sustained and cohesive local action.

Recommendations for consideration

Recommendations
An overarching approach to tobacco control that:

1. Strengthens local action to address smoking-related inequalities through:
• A place-based approach to target communities and populations where smoking prevalence is highest.
• An approach that engages and supports known priority and 'at-risk' groups. This includes:
  ○ children and young people
  ○ during pregnancy
  ○ routine and manual workers
  ○ hospital inpatients
  ○ people with long-term mental health conditions
  ○ people living in social housing
  ○ certain ethnic minority groups
  ○ LGBTQI+ groups.
• Development of mass media campaigns to reduce tobacco-related harms, linking with regional and national initiatives, as appropriate.

2. Gathers local insight, as appropriate and feasible, to inform: • future commissioning arrangements • service provision • wider tobacco control initiatives.
3. Builds system capacity through strategic leadership and collaborative action: • Strengthen system-wide leadership and action via the Derby Health and Wellbeing Board to raise the local profile of tobacco control initiatives. • Consider developing a Derby and Derbyshire Tobacco Control Strategic Group to upscale cross-organisational working and coordination of local efforts. This includes working with Derbyshire County Council and other partners at an ICS level, as appropriate • Invite the development of shared commitments across multi-agency partners.

- Identify priority areas for action to support effective planning and service development.
- Establish links to the Midlands Tobacco Control Network to strengthen advocacy for local tobacco control initiatives, partnership work and action at a regional and national level.

4. Self-assesses work on a broad range of tobacco control issues through:

- Evaluating and monitoring the impacts of local tobacco control initiatives.
- Ensuring activities follow the latest evidence-based practice.

Stop smoking support

- Ensure support and services are evidence-based and easily accessible.
- Consider more targeted support for priority and 'at-risk' groups who are most vulnerable to tobacco-related harms.
- Consider targeted work with local employers to support reductions in smoking prevalence among routine and manual workers.
- Develop a consensus across ICS partners on vaping, informed by the latest evidence and guidance.

Preventing uptake

- Understand the impact of current prevention activities and the role for wider evidence-based prevention initiatives.
- Local insight work to understand the numbers of young people who may be taking up smoking and vaping.

Illegal tobacco

- Continue enforcement action to target the illegal tobacco trade.
- Ensure this is supported by the appropriate local capacity, resource and intelligence.

Smokefree places

- Continue to support and enforce existing smokefree legislation and policies.
- Consider extending smokefree environments, supported by local public consultation.
- Consider opportunities to work with local social housing providers to integrate stop smoking support into their existing health and wellbeing activities.


Tobacco Control (2023)
A Call to Action
Derby City Council
Smoking is the main cause of preventable illness and premature death
Tobacco control is an evidence-based approach to tackle the harms caused by tobacco
13.2%
of adults in Derby smoke, which is SIMILAR to the England average
There are inequalities associated with smoking and the harm it causes
Smoking accounts for half the differences in life expectancy between the richest and poorest in society
People living in the most deprived communities are more likely to smoke and less likely to quit
Children are more likely to take up smoking if they live with people who smoke
37.8% of people living in social housing smoke
Smoking rates are higher among people with long-term mental health conditions and routine and manual workers compared to the general population
At 11.9% smoking rates in pregnancy are significantly HIGHER than the England average (9.1%)
Adult smoking rates
2021 13.2% Derby
2021 13.0% England
Smoking rates in routine and manual workers
2020 26.2% Derby
2020 24.5% England
Smoking rates in people with long-term mental health conditions
2020/21 29.5% Derby
2020/21 26.3% England

Stop Smoking Services

In 2021/22:

762 **people quit smoking** through Stop Smoking Services

61% **of people setting a quit date** reported **successfully stopping smoking** at 4 weeks

Quit rates in Derby were **HIGHER** than the England average

The impacts of smoking affect the whole community in Derby

Smoking attributable hospital admissions and **death rates** are **HIGHER** than the England average. There were:

982 deaths
attributable to smoking between 2017-19

2,647 hospital admissions
for smoking-related conditions in 2019/20

Smoking is estimated to cost society in Derby **£108 million** per year. This consists of:

£89 million
in lost productivity

£17.4 million
in NHS and social care costs

£1.9 million
in fire-related costs

300,000 cigarettes are smoked in Derby every day. This generates **16 tonnes** of waste annually, of which **7 tonnes** are discarded as street litter

A whole systems approach to tobacco control

The national vision is to create a smokefree society by 2030, which is achieved when the national smoking prevalence is 5% or less.

Tobacco control is everybody's business.

To be effective at reducing smoking rates and the harms caused by tobacco we must work in partnership, using a whole systems approach to tobacco control. This includes:

- Preventing children and young people from taking up smoking
- Supporting people who smoke to quit
- Addressing inequalities in smoking rates
- Reducing the harm caused by tobacco in our communities through creating smokefree environments and tackling illegal tobacco.

1 Aims and Objectives

A health needs assessment is *"a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities"* [1].

Tobacco smoking damages the health of people who smoke and those around them [2]. It is the leading cause of preventable death and ill-health in England. Around half of all lifelong smokers die prematurely, each losing on average around 10 years of life [3]. The damaging effects of smoking negatively impacts individuals, communities and wider society, with smoking also being a significant cause of health inequalities [3] [4]. While smoking rates in England have declined significantly in recent years, it is estimated that around 5.4 million adults in England are current smokers [5].

The Derby Tobacco Health Needs Assessment has been undertaken to comprehensively collate data and intelligence on tobacco control to guide the development and delivery of a local tobacco control action, working with partners across organisations. This aligns with the aims of the Derby Health and Wellbeing Strategy "to improve the health and wellbeing of the people of the City and to reduce inequalities" and the Council Plan 2022-25, which outlines an ambition to reduce smoking prevalence to below the national average, as part of its 'Resilient City' objectives.

2 Introduction to Tobacco control

2.1 Tobacco control

Tobacco control is an internationally recognised, evidence-based approach to addressing the harm caused by tobacco use [6]. The World Health Organisation (WHO) defines tobacco control as a *"range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke"* [7].

2.2 International priorities

The WHO Framework Convention on Tobacco Control [7] provides a global framework for tobacco control activities. To support its implementation at a country level the WHO have developed six MPOWER measures, which have been shown to save lives and reduce costs from averted healthcare expenditure [8] [9]:

1. Monitor tobacco use and prevention policies
2. Protect people from tobacco smoke
3. Offer help to quit tobacco use
4. Warn about the dangers of tobacco
5. Enforce bans on tobacco advertising, promotion and sponsorship
6. Raise taxes on tobacco [9].

The WHO highlights that effective and sustainable national tobacco control programmes require a multi-component approach underpinned by the appropriate infrastructure [10]. Globally, there is now an increasing focus on moving towards a tobacco 'endgame'. This envisions a smokefree future for countries, which is typically defined as a national smoking prevalence of 5% or less [11] [12].

2.3 National Tobacco Control Plan

The Tobacco Control Plan for England 2017-2022 [13] sets out an ambition for a smokefree generation. This aims to reduce smoking prevalence to 5% or less. To achieve this the National Tobacco Control Plan outlines four main areas for action (Table 1):

- Prevention first
- Supporting smokers to quit
- Eliminating variations in smoking rates
- Effective enforcement [13].

The Plan also identifies the following specific priority areas for action, to be achieved by 2022:

- Reducing smoking prevalence among 15 year-olds to 3% or less
- Reducing adult smoking prevalence to 12% or less
- Reducing smoking prevalence in pregnancy to 6% or less
- Reducing the inequality gap in smoking prevalence between those in routine and manual occupations and the general population
- Parity of esteem for people with mental health conditions, including making all mental health inpatient services sites smokefree by 2018 [13].

In 2019, the government set an objective for England to become a smokefree society by 2030 (meaning only 5% of the population would smoke by then). A new National Tobacco Control Plan is anticipated for publication, which is expected to outline the government's strategy for achieving the smokefree 2030 ambition [14] [15].

Table 1: Tobacco Control Plan for England ambitions and actions

Ambition	Action

Prevention First	• Work to eliminate smoking among under 18s and achieve the first smokefree generation:
	  • Training health professionals on smoking cessation
	  • Sanctions for tobacco retailers
	• Stamping out inequality: smokefree pregnancy - reduce the prevalence of smoking during pregnancy to improve life chances for children

Supporting smokers to quit	• Stop Smoking Services • Parity of esteem: supporting people with mental health conditions - reduce the prevalence of smoking in people with mental health conditions • Backing evidence based innovation: develop a strong evidence base on the full spectrum of nicotine delivery products • A Smokefree NHS, leading by example: create and enable working environments which encourage smokers to quit
Eliminating Variation in smoking rates	• A whole system approach: develop all opportunities within the health and care system to reach out to the large number of smokers engaged with healthcare services on a daily basis • Local inequalities: eliminating health inequalities through targeting those populations where smoking rates remain high • Public awareness: use mass media campaigns to promote smoking cessation and raise awareness of the harms of smoking • Smokefree places: explore further opportunities to protect people from the harm of secondhand smoke

	• Tobacco control intelligence: ensure our strategies are effective and evidence based
Effective enforcement	• Taxation: maintain a robust tax regime for tobacco and reduce discrepancies in product prices • Illicit tobacco: implement the illicit tobacco strategy and reduce the market share of these products • Regulation and enforcement: improve the use and effectiveness of sanctions and monitor the development of novel products • Leaving the European Union: review where the UK's exit from the EU offers us opportunities to further improve public health

Source: Tobacco Control Plan for England [13]

2.4 Additional national policy and guidance

There are a number of resources developed by the National Institute for Health and Care Excellence (NICE), Public Health England (now the Office for Health Improvement and Disparities)*, public health charities and other organisations to inform local tobacco control work. The NHS Long-term Plan [16] also recognises the important role of the NHS in preventing tobacco-related ill-health and supporting people to stop smoking across inpatient, maternity and outpatient/community settings.

NICE guidance

The NICE guideline NG209 'Tobacco: preventing uptake, promoting quitting and treating dependence' was published in 2021 [17]. This brings together and updates all NICE's previous guidelines on tobacco use, covering:

- Stop smoking support for all people aged 12 years and over
- Harm reduction measures for people who smoke who are not ready to stop smoking in one go
- Prevention of smoking uptake in children and young people under the age of 24 [17].

NHS Long-term Plan

The NHS Long-term Plan [16] sets out a commitment to provide NHS funded tobacco dependency treatment services by 2023/24 for all people who smoke who are:

- Inpatients in acute and mental health hospitals
- Pregnant women and their partners
- Higher risk outpatients, as part of specialist mental health and learning disability services [16].

Core20PLUS5

Core20PLUS5 [18] is a national NHS England approach to support Integrated Care systems to drive targeted action to reduce healthcare inequalities at a system and national level. The approach focuses on the 20% most deprived areas nationally (as defined by the Index of Multiple Deprivation) and additional population groups who are recognised to experience poorer than average health access, experience and/or outcomes, such as inclusion health groups. The Core20PLUS5 initiative is centred around five key clinical areas for focus:

- Maternity
- Severe mental illness

* *In October 2021, Public Health England (PHE) was disbanded. Functions related to health improvement, including tobacco control, were transferred into the Office for Health Improvement and Disparities (OHID). Information and resources referred to in this report that were published prior to October 2021 are cited as PHE, while those published after this date are referenced as OHID.*

- Chronic respiratory disease
- Early cancer diagnosis
- Hypertension case-finding

with smoking cessation identified as an overarching area for action, which can positively impact health outcomes across each of the five clinical domains [18].

Public Health England Resources: CLeaR

CLeaR is an evidence-based approach to tobacco control that is based on the National Tobacco Control Plan. The CLeaR model enables local authorities and their partners to undertake an in-depth self-assessment of their tobacco control work to strengthen the impact of local actions. CLeaR is designed to be implemented through discussion between partners. It provides opportunities for peer review and benchmarking of local tobacco control work in comparison with other areas and over time [19].

Public health charities and other organisations

Action on Smoking and Health (ASH): is a public health charity that works to eliminate the harms caused by tobacco [20]. ASH have developed a number of resources to support local areas in delivering tobacco control activities:

- The ASH local toolkit includes a number of resources to support local authorities to effectively make the case for tobacco control [21].
- The End of Smoking sets out strategic guidance for local authorities and their Health and Wellbeing Board partners to reduce smoking rates and achieve the government's 2030 smokefree ambition [22].
- 10 high impact actions for local authorities and their partners offers practical guidance for local authorities on the ten main actions they can take to reduce smoking rates and inequalities in their communities. The guide offers ideas and suggestions that may be useful in developing a local tobacco control strategy. This complements the more comprehensive guidance outlined in 'The End of Smoking' [23].

ASH have also produced a briefing document for Health and Wellbeing Boards and Integrated Care Boards (ICBs) on why addressing smoking should be a priority. This sets out the rationale for including tobacco control in Health and Wellbeing Board plans and ICB strategies to prevent ill-health and reduce health inequalities, with suggested evidence-based actions [24].

The National Centre for Smoking Cessation and Training (NCSCT): is a social enterprise that works to support the delivery of effective evidence-based tobacco control programmes and smoking cessation interventions. The NCSCT has developed a number of resources to support local Stop Smoking Services. The organisation also offers training, assessment and support services for local and national smoking cessation service providers [25].

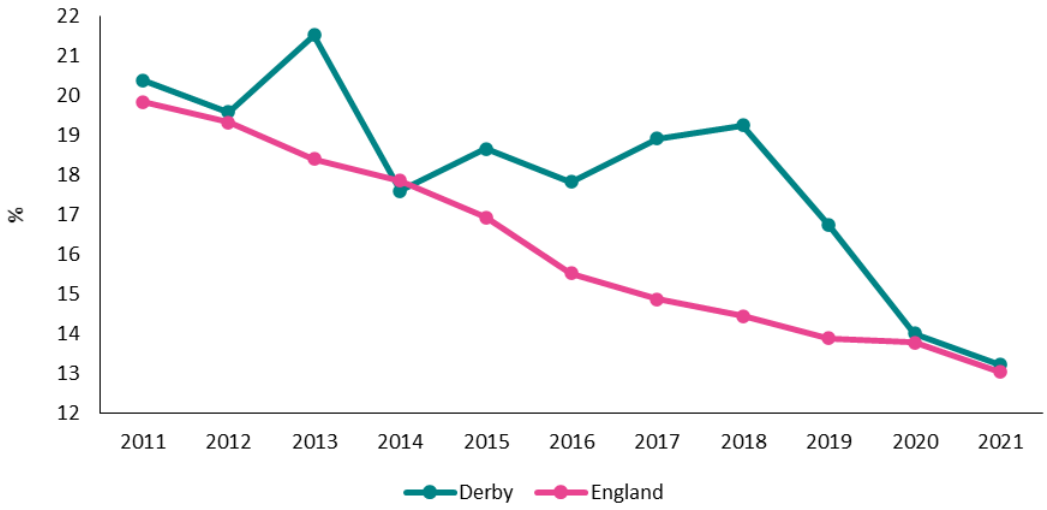
3 Population profile and tobacco use

The following section provides information on the extent of tobacco use among different sociodemographic groups. Derby level data for smoking prevalence estimates is mainly sourced from OHID's Local Tobacco Control Profiles. This tool enables comparisons of smoking rates among different population groups in Derby, and with other similar local authority areas and England overall [26].

3.1 Adults

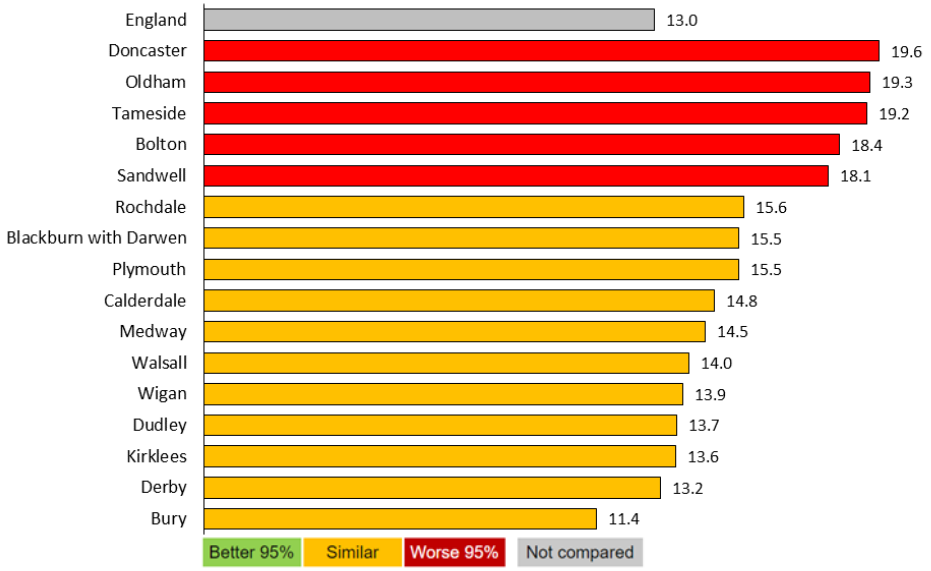
The gap in adult smoking prevalence between Derby and England has narrowed substantially in recent years. Since 2019, adults smoking rates in the City have been similar to the England average. In 2021, 13.2% of adults in Derby were current smokers, compared to the England average of 13.0%. This was second lowest among our CIPFA nearest neighbours. However, adult smoking prevalence in Derby remains above the government's ambition to reduce the proportion of adults smoking to 12% or less by the end of 2022 (Figures 1 and 2) [26].

Figure 1: Adult (aged 18+) smoking prevalence (%) in Derby compared to England: 2011-2021



Source: Annual Population Survey (APS) 2021 - published in Local Tobacco Control Profiles [26]

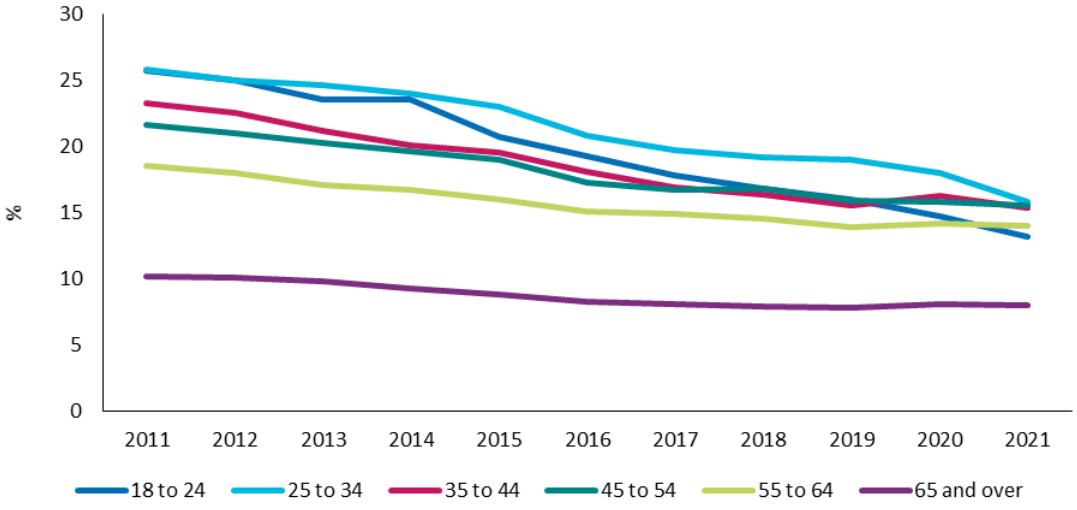
Figure 2: Adult (aged 18+) smoking prevalence (%) in Derby compared to CIPFA nearest neighbours: 2021



Source: Annual Population Survey (APS) 2021 - published in Local Tobacco Control Profiles [26]

Locally, no data is available on smoking prevalence by age and sex. However, smoking rates in the UK are known to vary by these characteristics. In 2021, men continued to be more likely to smoke than women, with 15.1% of men and 11.5% of women smoking. Smoking rates remained highest among 25-34 year olds (15.8%), and lowest in people aged 65 and over (8.0%). Since 2011, smoking rates have fallen the most among 18-24 year olds. 25.7% of this age group smoked in 2011 compared with 13.2% in 2021, which is a reduction of around 12.5% (Figure 3) [5].

Figure 3: Proportion of adults who were current smokers by age group in the UK: 2011-2021



Source: Office for National Statistics-Annual Population Survey (APS) 2021 - published in Adult smoking habits in the UK: 2021 [5]

3.2 Vulnerable and priority groups

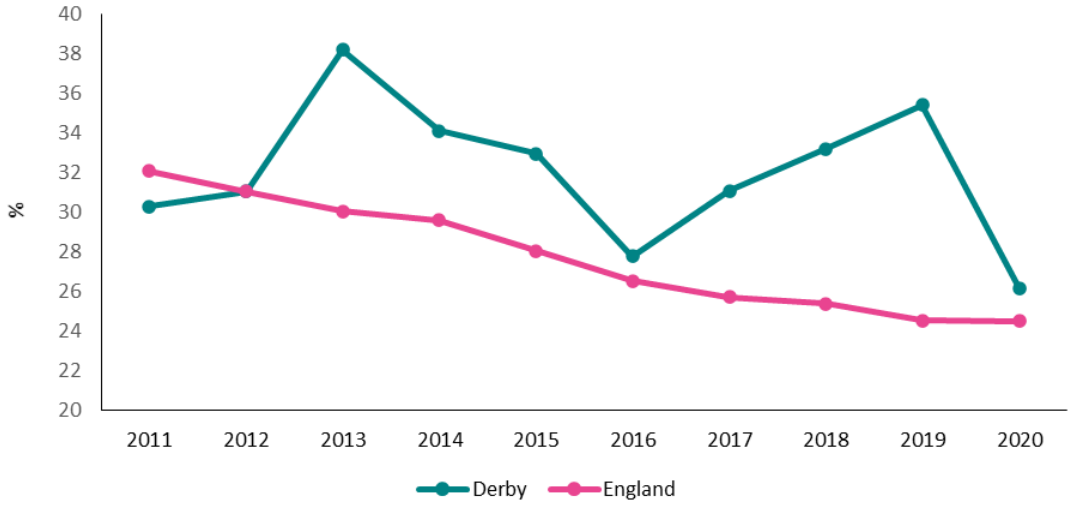
Nationally, smoking is the single most important driver of health inequalities [27]. Declines in smoking rates have not been equal across all population groups. Smoking and its related harms are concentrated among more vulnerable and disadvantaged groups in society who are already at risk of poorer health outcomes [3] [4].

3.2.1 Smoking and deprivation

There is a link between smoking and deprivation. People living in the most deprived communities are four times more likely to smoke than those living in the least deprived areas [28]. Derby has higher levels of deprivation compared to the England average, with 26.3% of the population living in the most deprived communities compared to 21.7% nationally [29]. Smoking rates are also known to be higher among people from socioeconomically disadvantaged groups, such as those with lower levels of education attainment, people who are unemployed, and unskilled and low income workers [5] [30].

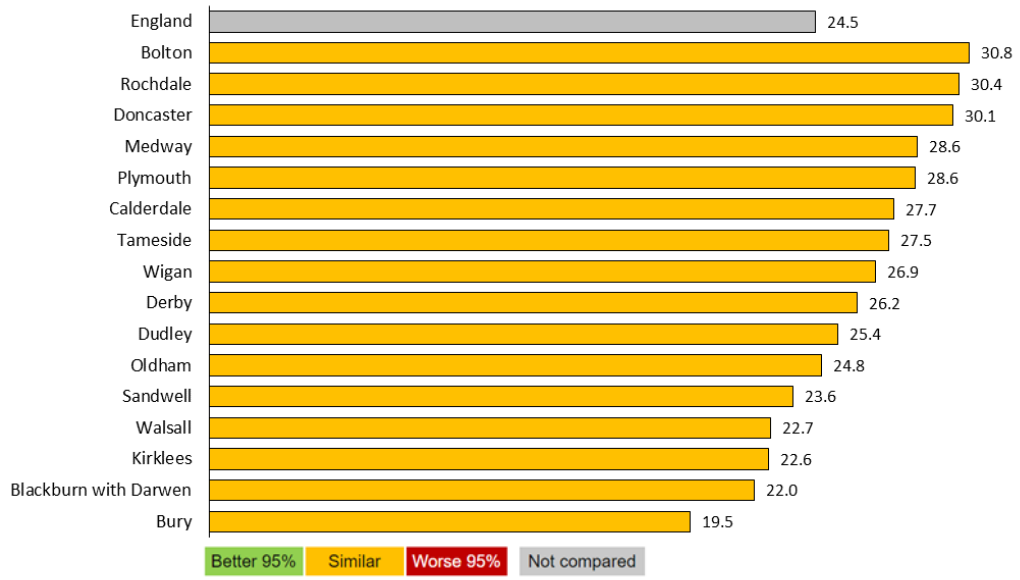
Both locally and nationally, people working in routine and manual (R&M) occupations are more than twice as likely to smoke compared to those working in other occupations. In recent years the gap in smoking prevalence among R&M workers between Derby and England has narrowed. In 2020, 26.2% of people working in R&M occupations were current smokers. This was similar to the national average of 24.5% and in the middle of our CIPFA nearest neighbours distribution (Figures 4 and 5) [26].

Figure 4: Smoking prevalence among adults aged 18-64 working in routine and manual occupations in Derby compared to England: 2011-2020



Source: Annual Population Survey (APS) 2020 - published in Local Tobacco Control Profiles [26]

Figure 5: Smoking prevalence among adults aged 18-64 working in routine and manual occupations in Derby compared to CIPFA nearest neighbours: 2020



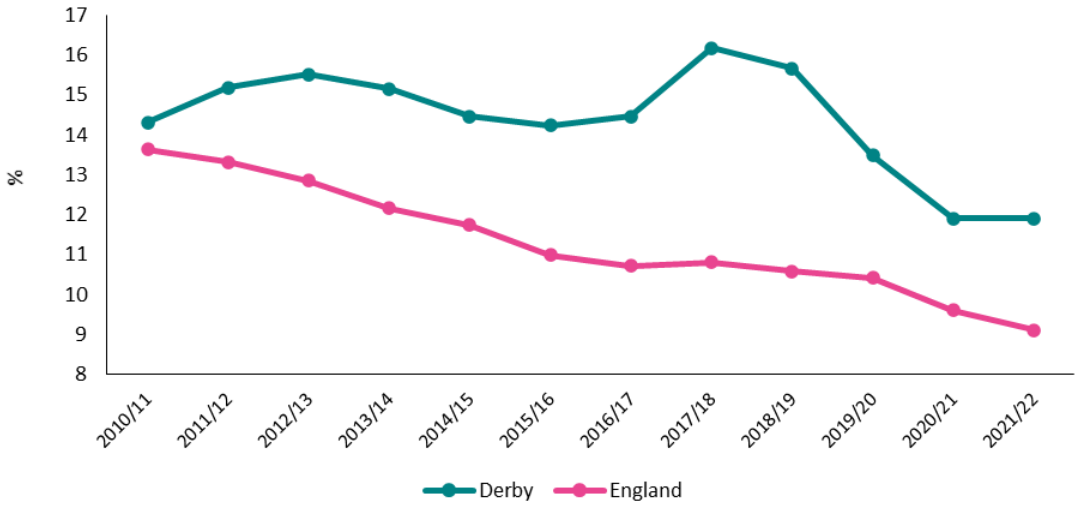
Source: Annual Population Survey (APS) 2020 - published in Local Tobacco Control Profiles [26]

3.2.2 Smoking in pregnancy

Smoking is the single most important modifiable risk factor in pregnancy. It is associated with an increased risk of several poor pregnancy outcomes [2]. National data shows there are substantial inequalities linked to smoking during pregnancy. Smoking prevalence remains substantially higher among pregnant women in more disadvantaged groups and those aged under 20, compared to more affluent and older age groups [3].

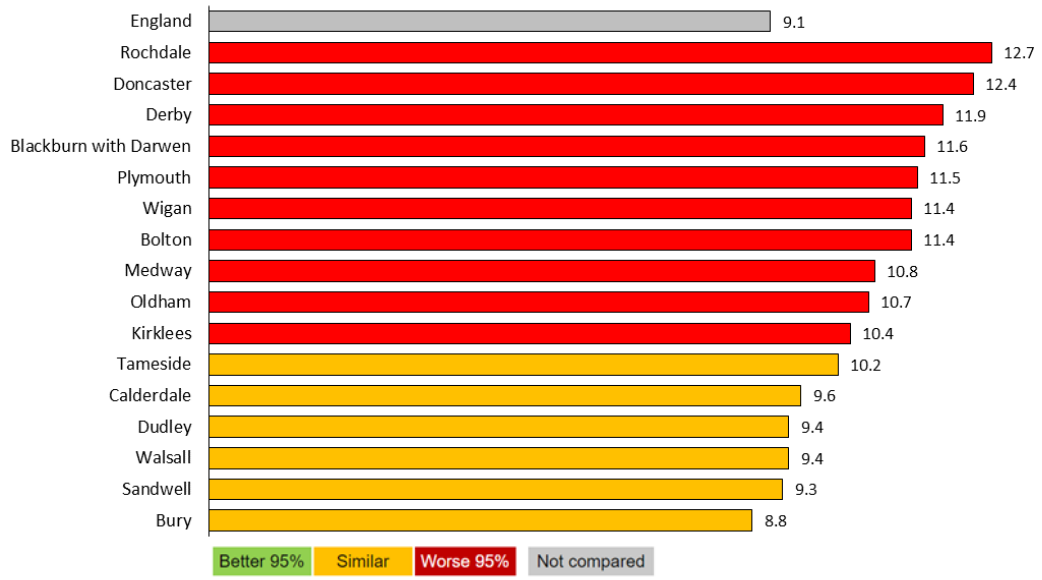
The latest data on smoking status at the time of delivery (SATOD) shows that in 2021/22 11.9% (331) of pregnant women were smoking at the time of delivery of their baby. Despite a decreasing trend in recent years, the prevalence of SATOD in Derby continues to be significantly worse than the England average (9.1%) (Figure 6). Derby ranks third highest when compared to our CIPFA nearest neighbours (Figure 7) [26]. Based on the latest prevalence data, the City is not on track to achieve the government ambition to reduce smoking prevalence in pregnancy to 6% or less by the end of 2022.

Figure 6: Smoking status at the time of delivery in Derby compared to England. Proportion (%): 2010/11-2021/22



Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)- published in Local Tobacco Control Profiles [26]

Figure 7: Smoking status at the time of delivery in Derby compared to CIPFA nearest neighbours. Proportion (%): 2021/22



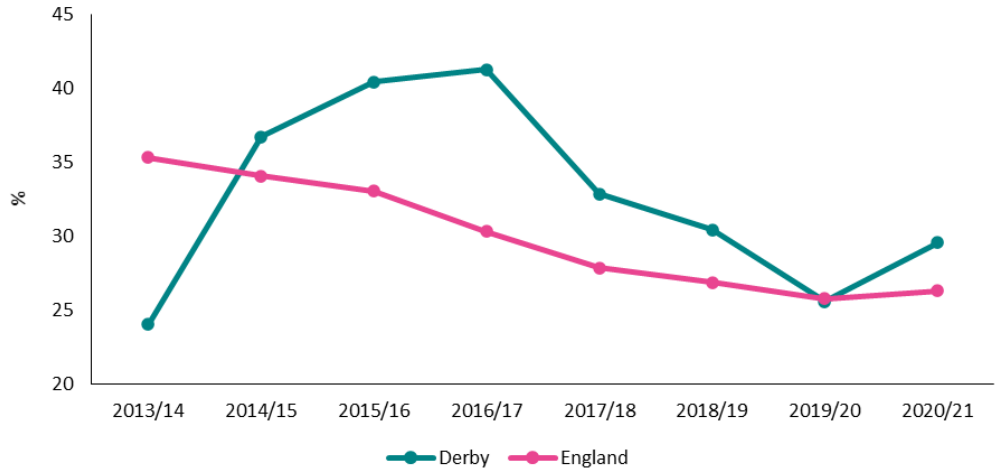
Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)- published in Local Tobacco Control Profiles [26]

3.2.3 Smoking and mental health

People with long-term mental health conditions are twice as likely to smoke compared to the general population, with the highest rates among people with severe mental health disorders, such as psychosis or bipolar disorder. A third of all cigarettes smoked in England are by people with a mental health condition. People with long-term mental health conditions also experience physical health inequalities, dying on average 10-20 years earlier than the general population. Smoking is the biggest cause of this gap in life expectancy [31].

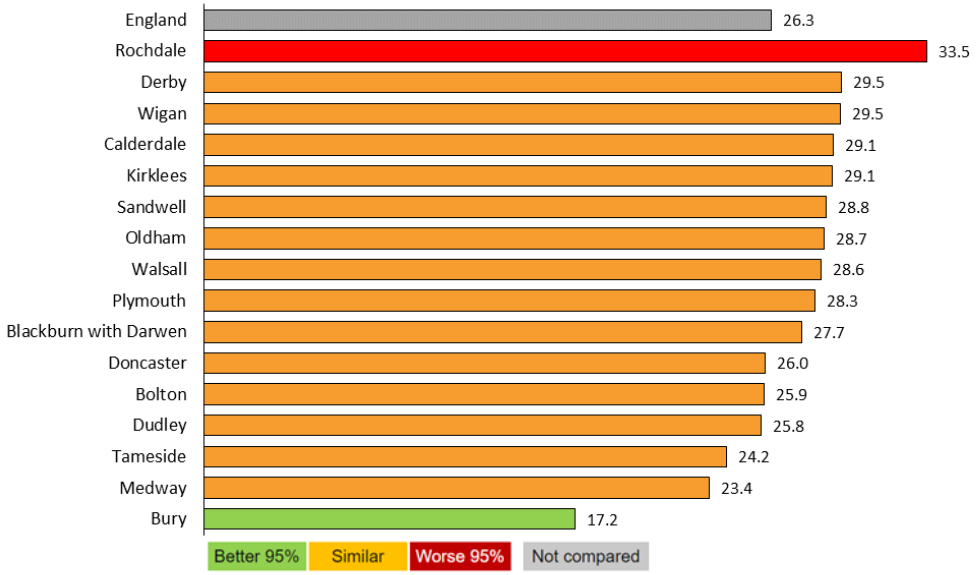
The latest data for 2020/21 shows that smoking prevalence among people with long-term mental health conditions in Derby (29.5%) remains similar to the England average (26.3%) (Figure 8). However, Derby had the second smoking rates among people with long-term mental health conditions when compared to our CIPFA nearest neighbours (Figure 9) [26].

Figure 8: Smoking prevalence in adults (18+) with a long term mental health condition in Derby compared to England - current smokers. Proportion (%): 2013/14-2020/21



Source: GP Patient Survey (GPPS) - published in Local Tobacco Control Profiles [26]

Figure 9: Smoking prevalence in adults (18+) with a long term mental health condition in Derby compared to CIPFA nearest neighbours - current smokers. Proportion (%): 2020/21



Source: GP Patient Survey (GPPS)- published in Local Tobacco Control Profiles [26]

3.2.4 Smoking and social housing residents

Smoking prevalence among social housing residents is one of the highest in England. People living in social housing are disproportionately affected by the health and socioeconomic inequalities caused by smoking. Nationally, the gap in smoking rates between social housing residents and those living in other types of housing has widened in recent years. A 2022 report by ASH and the Housing Learning and Improvement Network (LIN) estimated that around 1 in 3 people living in social housing were current smokers, compared to around 1 in 10 people who own their home and 1 in 7 of the general

adult population. Approximately 1 in 5 children living in social housing were in a home where someone smoked inside most days. This is compared to 1 in 8 children living in privately rented accommodation and 1 in 10 children living in owner occupied homes [32].

In Derby, 19.8% of households live in social housing, compared to 17.7% nationally [33]. Data published by ASH shows that for both Derby and England overall, smoking rates among social housing residents are substantially higher than among those living in privately rented or owner occupied housing. Locally, 37.8% of people living in social housing are estimated to smoke. This is above the England average of 28.6%, and substantially higher than among those who rent privately (28.8%) or who own their own home, either outright (7.3%) or with a mortgage (11.0%) (Figure 10) [34].

Figure 10: Smoking prevalence by housing tenure type in Derby compared to England. Proportion (%): (2019)

Source: Calculated by ASH from the Annual Population Survey (APS) 2019-published in the ASH Economic and Health Inequalities Dashboard [34]

3.2.5 Other vulnerable groups

National data indicates that smoking inequalities exist by ethnicity and sexual orientation. Evidence also shows that children and young people, people in contact with the criminal justice system, hospital inpatients and social housing residents may be at greater risk of smoking and its related harms. However, there is a lack of routinely available local data on smoking rates in these groups.

Smoking in children and young people

Smoking is mainly an addiction that starts in childhood, with two thirds of adult smokers starting before the age of 18 [13] [35].

Data collected as part of the Smoking Drinking and Drug Use (SDD) survey shows that smoking prevalence among school-aged children (11-15 year olds) in England has steadily declined since the late 1990s. In 2021:

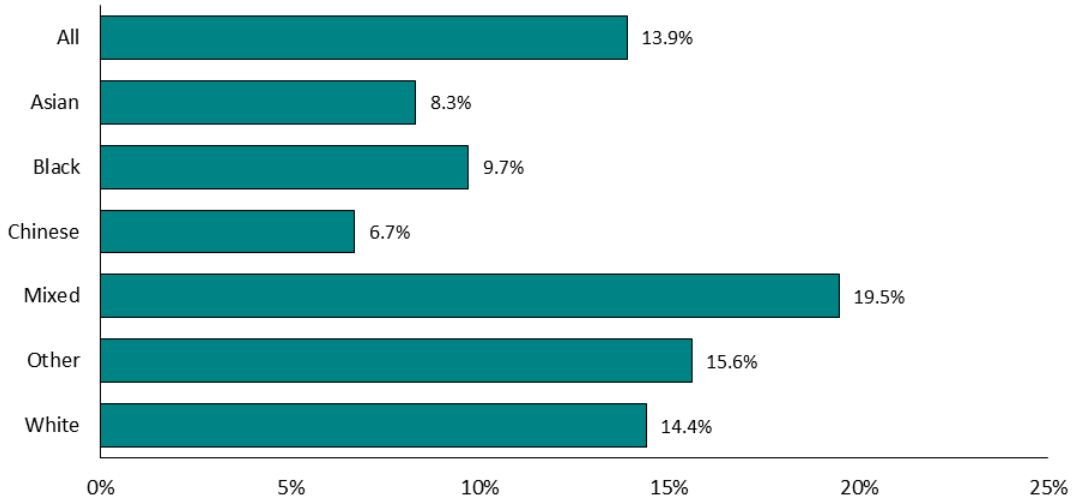
- 12% of young people had tried smoking at least once compared to 49% in 1996.
- 1% reported being regular smokers (defined as smoking at least one cigarette per week) compared to 12% in 1996.
- 3% were current smokers (defined as regular and occasional smokers) compared to 22% in 1996 [36].

Smoking prevalence increased with age. The proportion of children who had tried smoking at least once increased from 2% of 11 year olds to 25% of 15 year olds. Almost three quarters (72%) of current smokers were aged 15, whereas 9% were aged 11-13. Although a similar proportion of girls and boys were regular smokers (both 1%), girls were more likely to have ever smoked than boys (13% of girls vs 10% of boys). The profile of current smokers was also weighted towards girls, with 58% of current smokers being girls [36]. Children and young people were also more likely to smoke if they lived in a household with other smokers. 16% of children who lived with three or more smokers were current smokers themselves, compared to 1% of children living in households with no other smokers [36].

Smoking and ethnicity

Data shows that in 2019 smoking rates in England were lowest among people from black, Asian and Chinese ethnic backgrounds when compared to people of mixed, white and other ethnicities. People from mixed (19.5%) and white (14.4%) ethnic groups had the highest smoking rates, while people of Chinese ethnicity (6.7%) were least likely to smoke (Figure 11) [37].

Figure 11: Percentage of adults who smoked cigarettes in England, by ethnicity: 2019



Source: Annual Population Survey (APS) 2019 - published in Ethnicity Facts and Figures GOV.UK [37]

With the exception of mixed ethnic groups, smoking rates on average were lower among people from ethnic minority backgrounds when compared to the general population [37]. However, there is evidence to suggest that smoking prevalence among ethnic minority groups in the UK differs substantially by gender, with men from black, Asian and Chinese ethnic backgrounds smoking considerably more than women [30].

The relationship between smoking, tobacco use, and ethnicity is not straightforward and is influenced by a complex interplay of factors affecting health among people from ethnicity minority populations. Derby is an ethnically diverse city which is home to 261,400 people, 23.5% of whom are from ethnic minority backgrounds [38]. Locally, there is anecdotal evidence that smoking inequalities exist among certain ethnic minority groups, particularly people from Eastern European ethnic backgrounds, where smoking rates are recognised to be particularly high.

Smoking and sexual orientation

Lesbian, gay, bisexual and transgender people are more likely to smoke than the national average. While the reasons for this are unclear, people from the LGBTQI+ community are disproportionately affected by wider social inequalities, which can increase the risk of smoking initiation and tobacco addiction [39]. The most recent data (2019) shows that in the UK, the proportion of current smokers was significantly higher among people who identified as gay or lesbian (22.2%) than among heterosexual people (15.5%) [30]. However, there is some evidence that this gap in smoking prevalence has narrowed in recent years [40].

Smoking and hospital inpatients

A national audit carried out by the British Thoracic Society in 2021 [41] found that 21% of hospital inpatients were current smokers. Smoking prevalence was highest among patients aged 26-35 years and emergency admissions. Out of all medical and surgical specialities, respiratory inpatients had the highest smoking rates, with 23% being current smokers [41]. Between 2016-2021, the proportion of hospital inpatients who were offered smoking cessation support increased from 28% to 40%. However, only 1 in 7 current smokers were referred to a hospital or community-based tobacco dependency treatment service [41]. During the same period, the proportion of hospitals with a stop smoking service on site decreased from 56% to 41% [41] [42]. While 1 in 3 smokers were offered treatment with pharmacotherapy, only 5% were actually prescribed the most effective tobacco dependency treatments, as recommended by NICE [41].

Smoking and the criminal justice system

Smoking rates among people in prisons are much higher than in the general population, which exacerbates existing health inequalities. In England, 80% of people in prisons smoke. This is over four times higher than the national average [43]. While there are no prisons located in Derby, the City has a higher number of people entering the criminal justice system for the first time, compared to the East Midlands and England averages [44]. A recent survey of people in contact with the criminal justice system across Derby and Derbyshire found that 63.5% reported being smokers, while 72.7% of those living in Derby said they were either current or ex-smokers [45].

In recent years, considerable progress has been made to reduce smoking-related harms in prisons. As of July 2018, all closed prisons in England have implemented smokefree policies [46]. This has significant public health benefits for both staff and prisoners, helping to protect them from the harmful effects of secondhand smoke and providing an environment conducive to non-smoking [43] [46]. Despite the high smoking prevalence, people in prisons are just as likely as other smokers to want to quit [46]. Alongside smokefree policies, it is important that people in contact with the criminal justice system have access to effective treatment for tobacco dependency.

3.2.6 Alternative tobacco use

There is a lack of routinely available local data on the use of shisha and smokeless tobacco products. However, national data can provide some insights into the prevalence of use, including among different sociodemographic groups.

Shisha or waterpipe smoking

Waterpipe smoking (commonly referred to as shisha in the UK), is a method of inhaling tobacco smoke passed through water. It is a traditional practice in Middle Eastern and South Asian countries. In recent years shisha use has grown in popularity in western countries, including the UK, particularly among young adults. Likely drivers for this include the introduction of flavoured waterpipe tobacco, the growth of café culture and the role of the internet, mass media and social media in promoting shisha products. There is also a relative lack of shisha-specific policies and regulations [47].

Shisha users often perceive this a less harmful, less addictive and more socially acceptable than cigarette smoking, which is likely to contribute to its use [47] [48]. While the health effects of shisha use have been less extensively researched than cigarette smoking, existing evidence shows that it is associated with many of the same health risks as smoking [48].

Shisha use in the UK has steadily declined from its high point in 2015, when 13% of people had ever tried shisha, compared to 11% in 2019 [48]. While shisha use in the general population is low, there are variations by sociodemographic group [47]. Use is highest among the 18-24 and 25-34 age groups [47] and people from ethnic minority backgrounds [48]. However, there is substantial variation among ethnic groups, with the proportion of 'ever users' being highest among people of mixed or other (29%) and South Asian (21%) ethnicities [48]. As with other non-smoked tobacco products, shisha use is more concentrated among smokers than never or ex-smokers [48].

Smokeless tobacco

Smokeless tobacco refers to tobacco-containing products, such as gutkha and betel quid (amongst others), that are placed in the mouth or nose and not burned. In the UK, smokeless tobacco use is most common among people from British South Asian communities (Bangladeshi, Indian, Nepalese, Pakistani or Sri Lankan) [17]. While smokeless tobacco use is more prevalent among men and current smokers [49], there is some evidence that this is deemed more traditional and culturally acceptable for females among South Asian communities [50]. It should be noted that the prevalence, product type and demographic characteristics of people using smokeless tobacco varies among South Asian communities across the country. It is important to ensure that Stop Smoking Services provide culturally appropriate support that is tailored to meet local needs [50].

3.2.7 Vaping[†]

There is a lack of routinely available data on vaping prevalence at a local level. However, a recent evidence review by OHID [14], showed that in 2021, between 6.9% to 7.1% of adults in England were current vapers. This equates to around 3.1 to 3.2 million people and was an increase of

[†] *Vapes - also referred to as electronic cigarettes or e-cigarettes- are devices that allow you to inhale nicotine in a vapour rather than smoke. They can also be used to inhale vapours that do not contain nicotine. Vaping devices do not burn tobacco and do not produce tar or carbon monoxide, two of the most damaging elements in tobacco smoke. Using a vape or an e-cigarette is known as vaping. People who use vaping devices or e-cigarettes are sometimes known as vapers.*

approximately 1% compared to the previous year. In 2022, the findings of an ASH survey estimated that adult vaping prevalence could be as high as 8.3% [14].

Across all age groups vaping prevalence was lower than smoking prevalence. However, vaping prevalence varied by sociodemographic groups and smoking status, with the highest prevalence among:

- men (7.8%)
- people living in the north of England (8.3%)
- people from lower socioeconomic groups (8.8%)
- current (22%) or former smokers (11.6%) compared to those who had never smoked (0.6%) [14].

The most common reasons reported for vaping were to quit (27.9%) or stay off (17.7%) smoking tobacco or because people enjoyed it (12.6%). While most adults who had previously vaped (57.2%) stopped after 6 months or less, there is some evidence that the prevalence of long-term vaping is increasing. In 2021, 43.7% of current vapers had done so for 3 years or more, compared to 23.7% in 2018. While the proportion of people who vape and also smoke has declined since 2012 (73.7%-91.9%), between 33.4%-51.7% of current vapers also smoke [14].

Among 11-18 year olds, the review identified that vaping and smoking prevalence (including occasional and regular use) appeared to have decreased between 2020 and 2021 but increased in 2022. In 2022, vaping prevalence among 11-18 year olds was 8.6% compared to 4% in 2021, while smoking prevalence increased to 6% compared to 4.1% the previous year. In contrast to earlier years:

- Overall, vaping prevalence exceeded smoking prevalence in this age group.
- Smoking and vaping prevalence were similar among more affluent groups compared to more disadvantaged groups. However, in 2020 and 2021, the estimates for smoking and vaping prevalence were higher among more advantaged groups [14] [51].

Similar to previous years, most young people who had never smoked were also not currently vaping (98.3%). Most 11-18 year olds who had tried vaping had smoked first (38.7%). However, 24.7% said they had vaped before smoking and 29.7% said they had tried vaping but never tried smoking. The main reasons reported for vaping among young people were to "give it a try" and "liking the flavours". However, among young people who smoked, or had smoked, harm reduction and quitting related reasons were common [14] [51].

Among both adults and young people, fruit flavours remained the most popular, followed by menthol or mint. In 2022, there was a substantial increase in the use of disposable vaping devices[‡] among young people. These were the most popular vaping devices used by 11-18 year olds, with 52.8% of current vapers using them, compared with 7.8% in 2021. This is a stark difference to previous years where tank models[‡] were the most commonly used vaping products in this age group. While the use of disposable vaping devices has also increased among adult vapers, with 15.2% using them in 2022 compared with 2.2% in 2021, tank models remained the most popular vaping devices (used by 64.3% of current vapers in 2022). Despite sales to under-18s and proxy

[‡]*Disposable vaping devices are pre-filled with liquid and used only once. Tank models are reusable and rechargeable kits that users can refill with liquid* [14] [51].

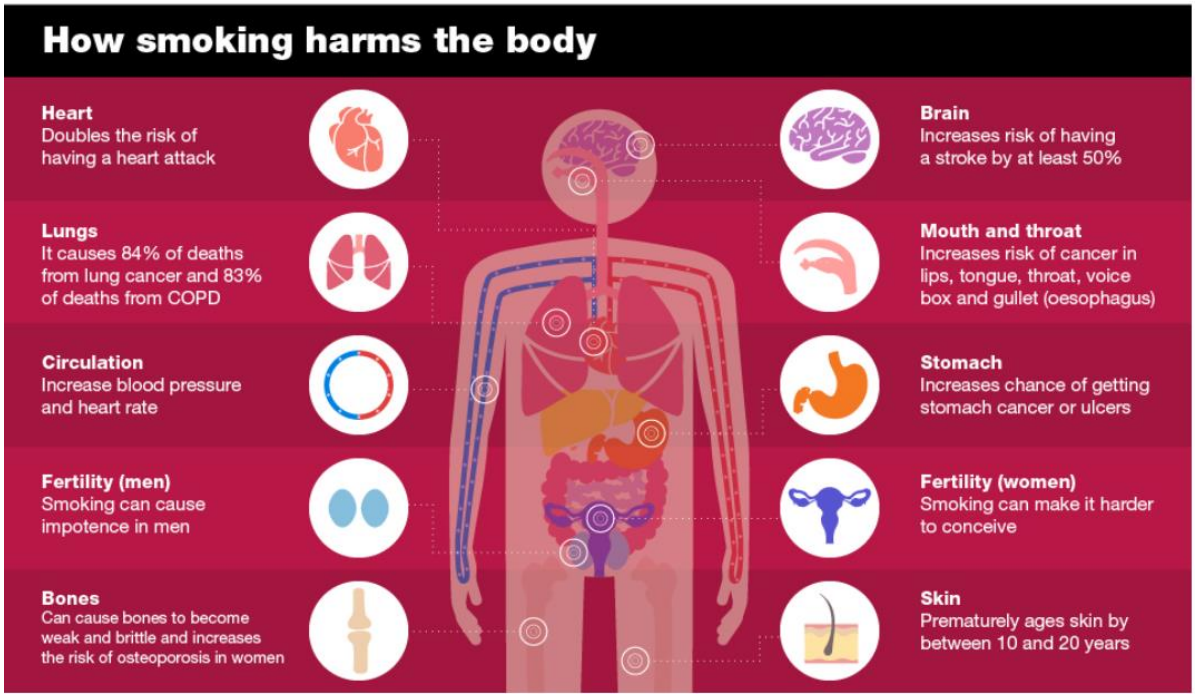
purchases being illegal, 60.5% of current vapers aged 11 to 17 had purchased their vaping products [14] [52].

4 Impacts of tobacco use and smoking

4.1 Impacts on health

Smoking is harmful to health throughout the life course. It increases the risk of developing more than 50 serious health conditions, including lung disease, heart disease and several cancers [2] [3] [53] (Figure 12).

Figure 12: The impacts of smoking on health



Source: Health matters: stopping smoking – what works? [3]

Smoking in pregnancy is associated with a range of poor pregnancy outcomes, including miscarriage, stillbirth, premature birth, neonatal complications, low birth weight and sudden infant death syndrome. It is also a major cause of child health inequalities [2] [3] [4].

The earlier someone starts smoking, the higher their risk of harm. People who start smoking at a young age are more likely to be heavy smokers, experience higher levels of dependency and find it harder to quit. In the short-term, children and young people who smoke are more prone to respiratory symptoms, such as coughing, phlegm and wheezing than those who don't smoke. In the longer-term, people who start smoking at a young age and continue to do so as adults, are at higher risk of developing lung cancer, heart disease and chronic obstructive lung disease later in life [35].

Smoking not only harms the health of people who smoke, but those around them. People who regularly breathe in secondhand smoke (also known as passive smoking) are more likely to develop the same diseases as smokers [54]. Pregnant women, children and those with underlying heart and lung conditions are particularly vulnerable to the effects of secondhand smoke(SHS) [55]. Childhood exposure to SHS has been linked to an increased risk of respiratory infections, middle ear infections, asthma and sudden infant death syndrome [56].

4.1.1 Smoking-related morbidity and mortality

Smoking reduces both life expectancy and healthy life expectancy. It is also responsible for approximately half the differences in life expectancy between the richest and poorest in society [57].

For people living in Derby, life expectancy at birth is significantly lower than the England average at 77.7 years for men (England average 79.4 years) and 81.5 years for women (England average 83.1 years). Similarly, healthy life expectancy in Derby is estimated to be 57.7 years for men and 61.6 years for women, which is below the national average (63.1 years for men and 63.9 years for women) [58].

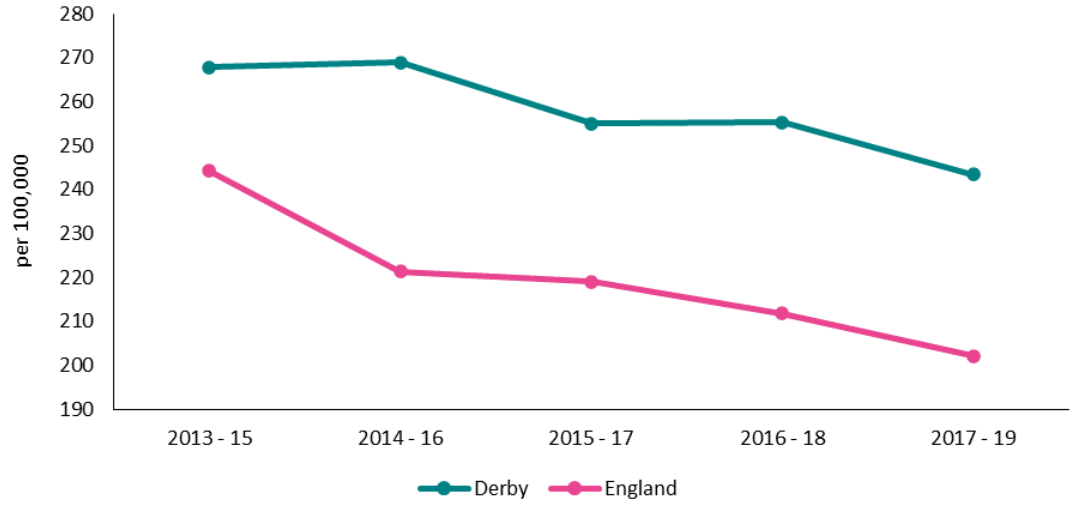
As the leading cause of preventable illness and premature death, smoking is a significant contributor to healthcare service use and preventable deaths. In 2019, 74,600 people in England died as result of smoking. Between 2019-20, there were around half a million hospital admissions due to smoking-related causes [2].

Local statistics on smoking attributable mortality (Figures 13 and 14) and hospital admissions (Figures 15 and 16) represent the scale of the burden created by smoking in terms of deaths and hospital admissions.

In Derby, smoking attributable mortality rates remain significantly higher than the England average (Figure 13). Between 2017-2019, there were 982 deaths from smoking-related causes in the City. This is equivalent to around 244 deaths per 100,000 of the Derby population, which was towards the lower end of our CIPFA nearest neighbours (Figure 14) [26].

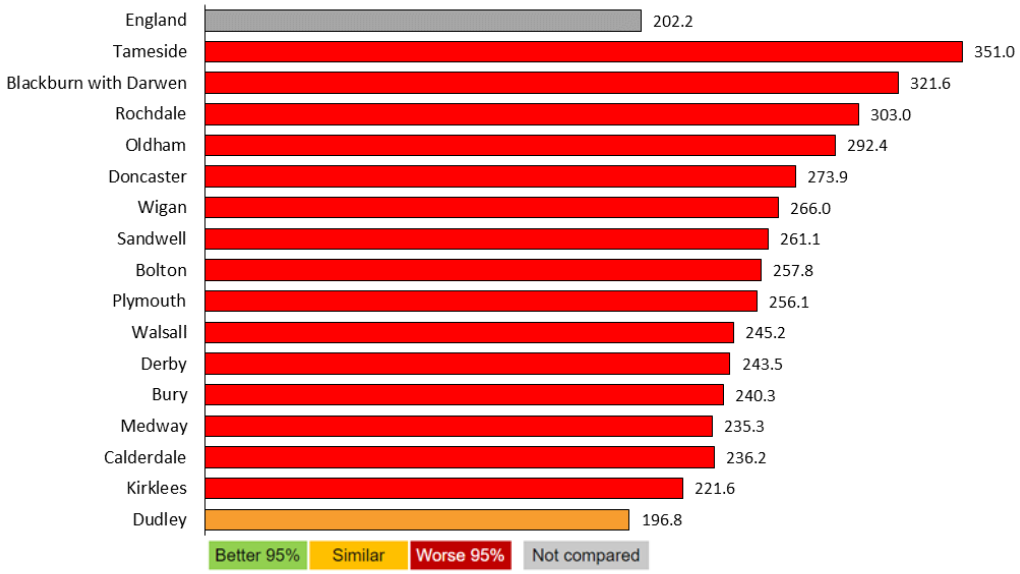
Data from the Global Burden of Disease tool [59] estimates that in 2019, there were 7,317 years of life lost in Derby through smoking, with smoking contributing to 2,323 years of life lived with disability in the City [59].

Figure 13: Smoking attributable mortality in Derby compared to England. Directly standardised rate- per 100,000: 2013-2015 to 2017-2019



Source: Mortality data from the Office for National Statistics (ONS) mortality file; ONS mid-year population estimates; Smoking prevalence data from Annual Population Survey; and relative risks from the Royal College of Physician's Report 'Hiding in Plain Sight'- published in Local Tobacco Control Profiles [26]

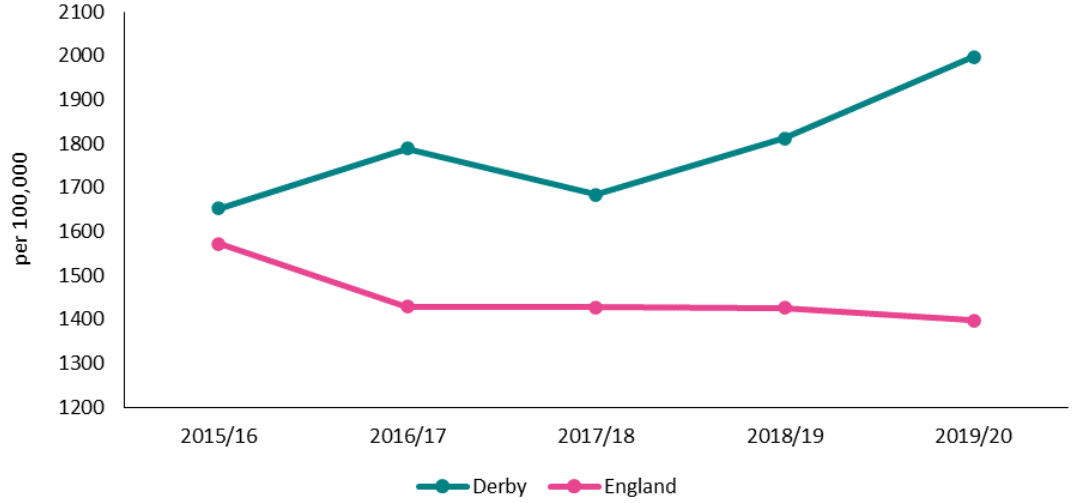
Figure 14: Smoking attributable mortality in Derby compared to CIPFA nearest neighbours. Directly standardised rate-per 100,000: 2017-2019



Source: Mortality data from the Office for National Statistics (ONS) mortality file; ONS mid-year population estimates; Smoking prevalence data from Annual Population Survey; and relative risks from the Royal College of Physician's Report 'Hiding in Plain Sight'- published in Local Tobacco Control Profiles [26]

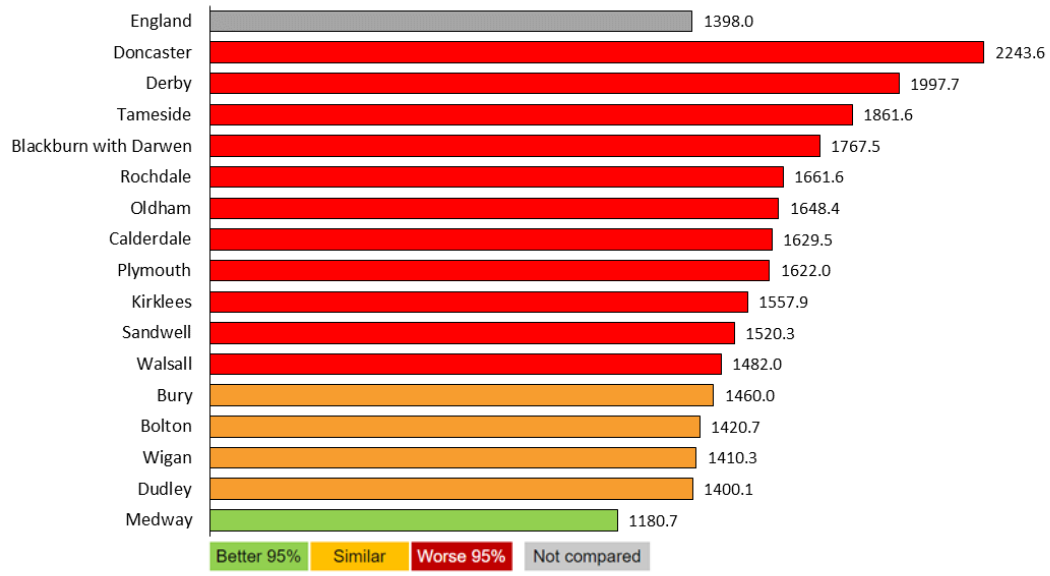
Smoking-attributable hospital admissions in Derby are also significantly higher than the England average (Figure 15). In 2019/20, there were 2,647 smoking-attributable hospital admissions, which was equivalent to 1,998 admissions per 100,000 of the Derby population (Figure 16). This was second highest among our CIPFA nearest neighbours and an increase from the previous year when there were 2,376 smoking-attributable hospital admissions across the City [26].

Figure 15: Smoking attributable hospital admissions in Derby compared to England. Directly standardised rate-per 100,000: 2015/16-2019/20



Source: Admissions data from Hospital Episode Statistics (HES); Office for National Statistics (ONS) - mid-year population estimates; Smoking prevalence data from Annual Population Survey; and relative risks from the Royal College of Physician's Report 'Hiding in Plain Sight'- published Local Tobacco Control Profiles [26]

Figure 16: Smoking attributable hospital admissions in Derby compared to CIPFA nearest neighbours. Directly standardised rate-per 100,000: 2019/20



Source: Admissions data from Hospital Episode Statistics (HES); Office for National Statistics (ONS) - mid-year population estimates; Smoking prevalence data from Annual Population Survey; and relative risks from the Royal College of Physician's Report 'Hiding in Plain Sight'- published Local Tobacco Control Profiles [26]

4.2 Impacts on society

Smoking costs society in England approximately £17 billion per year. In Derby, it is estimated that the total cost of smoking is around £108 million per year. This can be further broken down into costs due to lost productivity, costs to the NHS, social care and fire-related costs (Table 2) [60].

Table 2: Annual costs of smoking to society in Derby and England

Costs	Derby	England
Costs due to lost productivity	£89 million	£13.2 billion
Costs to the NHS	£10.8 million	£2.4 billion
Social care costs	£6.6 million	£1.2 billion
Fire-related costs	£1.9 million	£283 million
Total	£108 million	£17 billion

Source: ASH ready reckoner [60]

Smoking materials are a major contributor to accidental fires and fire fatalities in England. In 2020/21, 8% of accidental dwelling fires were fire related. Fatalities are disproportionately high in smoking related fires, representing 32% of all fire-related fatalities deaths in accidental house fires [61].

Both locally and nationally, smoking rates are recognised to be much higher in low income groups. Tobacco addiction, and the loss of income it causes, can exacerbate and lock people into poverty, which perpetuates health inequalities [62]. In Derby, smokers spend approximately £64.3 million on tobacco products each year, which equates to around £1,945 on average per smoker [60]. It is estimated that 6,704 households in Derby could be lifted out of poverty if the cost of tobacco addiction were returned to the household [34].

4.3 Environmental impacts

Tobacco use has an environmental impact in our communities. Cigarette butts constitute 66% of all street litter items. Most cigarette filters are non-biodegradable and must be collected and disposed of in landfill sites. Smokers in Derby consume about 300,000 cigarettes every day. This results in approximately 16 tonnes of waste annually, of which 7 tonnes are collected as discarded street litter by the council [60].

There is increasing recognition around the environmental impacts of vaping devices. Although, this is not yet fully understood. Vapes are classed as waste electrical and electronic equipment. This means that consumers should dispose of them at household recycling centres or at the shops where they bought the devices. Incorrect disposal of these items can potentially release plastic, electronical and hazardous chemical waste into the environment. In particular, incorrect battery disposal can cause fire and health and safety risks at landfill sites. There is also concern about the use, and subsequent loss, of lithium contained in these products; a critical material which is in high demand. The environmental impacts of vaping devices will be considered in more detail in future needs assessment updates, as the evidence base continues to develop [63].

4.4 Cheap and illegal tobacco

Cheap and illegal tobacco can be referred to in different ways:

- “Illicit or cheap whites”: cigarettes specifically manufactured for the illegal market, usually in countries outside of the European Union, which are illegally imported and have no legal market in the UK.
- Counterfeit/fakes: illegally manufactured tobacco products that are made to look like recognised brands.
- Smuggling: genuine UK brands that are illegally imported into the country and sold without duty being paid [64].

All tobacco, both legal and illegal, is harmful to health. Tobacco control measures are crucial in reducing smoking prevalence and the rates of smoking-attributable diseases. The illegal tobacco trade undermines the effectiveness of a range of tobacco control measures, including taxation (which is one of the most effective measures for reducing smoking prevalence), age restrictions and point-of-sale display bans [13] [64] [65]. It also negatively impacts our communities in the following ways:

- The illegal tobacco trade is often linked to other forms of criminality and helps to fund serious organised crime at a regional, national and international level [13] [64].
- At significantly less than half the price of legitimate tobacco products, illegal tobacco makes smoking more affordable and accessible to everyone. This includes children and young people, helping to begin their addiction, and more socioeconomically disadvantaged groups, which perpetuates health inequalities. It also makes it harder for people who smoke to quit and remain smokefree [13] [64] [66].
- Illegal tobacco creates a significant loss of tax revenue for the government and can undermine legitimate local retailers [13] [64].
- Increased fire risks through not complying with the regulations on reduced ignition propensity (under UK and EU law, legal cigarettes must have a reduced ignition propensity – i.e. be designed to self-extinguish when left ‘unpuffed’ [67]).

5 Current tobacco control activities in Derby

5.1 Stopping smoking

5.1.1 What works?

Providing support to smokers to quit is highly cost-effective. Smoking is not a lifestyle choice but a dependency requiring treatment [2]. Smoking cessation refers to activities that aim to support people who smoke to quit. There is strong evidence that the most effective approach to smoking cessation is combined face-to-face behavioural support and pharmacotherapy[§] [68] [69] [70]. A 2017 evidence review by Public Health England identified that when done correctly, face-to-face individual or group behavioural support, combined with pharmacotherapy, can boost quit rates by up to 300%. The review also identified that telephone support alone can boost quit rates by 50-100%. However, the review did not assess the effectiveness of combined pharmacotherapy and telephone support [68].

The NICE guideline NG209 [17] outlines the latest evidenced-based approaches for preventing smoking uptake, promoting quitting and treating tobacco dependence. It also provides specific advice for commissioners and Stop Smoking Service providers.

Recommended approaches for treating tobacco dependency include behavioural support and pharmacotherapy, and the use of nicotine-containing vapes. The guidance also recommends the provision of telephone quit lines and communications strategies to raise awareness of tobacco-related harms and promote smoking cessation support [17].

Stop Smoking Services should be commissioned and designed to meet local needs:

- Using sustainability and transformation plans, health and wellbeing strategies, and any other relevant local strategies and plans to ensure evidence-based stop smoking interventions and services are available for everyone who smokes.
- Using OHID's Local Tobacco Control Profiles to estimate smoking prevalence in the population.
- Prioritising specific groups who are at high risk of tobacco-related harm [17].

Healthcare services and reducing smoking
Both the NICE guideline NG209 [17] and NHS Long-term Plan [16] highlight the important contribution of healthcare services in supporting people who smoke to quit.

The NICE guideline NG209 [17] contains advice for frontline healthcare professionals in community, primary and secondary care services, including setting-specific guidance on the delivery and provision of stop smoking support and interventions. Local stop-smoking care pathways and referral procedures should ensure that there is continuity of care between primary, community and secondary care services. Recommended approaches in healthcare settings to identify and offer people who smoke support to quit include:

- At every opportunity, ask people if they smoke or have recently stopped smoking.
- Advise people who smoke that stopping smoking in one go is the best approach and explain how stop smoking support can help.

[§] *Pharmacotherapy refers to medicinally licensed treatments for tobacco dependency such as nicotine replacement therapy (NRT), Champix or bupropion.*

- Provide advice on stopping smoking in a way that is sensitive to an individual's needs and preferences.
- Discuss any stop smoking aids the person has used before, including personally purchased nicotine-containing products.
- Offer advice on using nicotine-containing products on general sale, including nicotine replacement therapy (NRT) and nicotine-containing vapes.

For people who do not want, or are not yet ready, to stop smoking in one go, healthcare professionals should ensure they understand that stopping smoking reduces the risks of developing or worsening smoking-related illnesses. A harm reduction approach should be considered. These individuals should be encouraged to stop smoking completely in the future with the offer of help and support left open for the next time they are in contact [17].

NHS Tobacco Dependency Treatment Programme

Evidence shows that smoking cessation interventions are effective for hospital patients regardless of their reason for admission [71]. Research as part of the smoking cessation intervention for severe mental illness (SCIMITAR+) trial also found that smoking cessation support is effective in this population. However, the waning of this effect by 12 months highlights more effort is needed for sustained quitting [31] [72].

The NHS Long-term Plan, published in 2019, sets out a specific commitment around smoking cessation [16]. This states:

- The NHS will support people in contact with NHS services to quit based on a proven model implemented in Canada and Manchester[**]. By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- The model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.
- A new universal smoking cessation offer will also be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services. On the advice of PHE, this will include the option to switch to e-cigarettes while in inpatient settings [16].

Recommendations set out in the NHS Long-term Plan are supported by the NICE guidance, which also outlines:

- The importance of working with people who smoke before a planned or likely inpatient admission to identify how they will manage their smoking while in hospital.
- Encouraging people being referred for planned surgery to stop smoking before their operation and referring them to Stop Smoking Services.

Commissioners should ensure that hospitals have on-site stop-smoking support and provide frontline healthcare workers with smoking cessation training [17].

Smoking in pregnancy

In 2021, ASH, in partnership with the Smoking in Pregnancy Challenge Group, published a series of recommendations to deliver the government's ambitions for reducing smoking prevalence in

[**] This is based on the Ottawa model for smoking cessation, which has been shown to improve long-term quit rates by 11% [16] [73]

pregnancy and achieving a smokefree society. These were focused on the following key areas for action:

- Setting more ambitious national targets for reducing SATOD and developing targets to reduce smoking at the time of booking.
- Addressing variation in local implementation of NICE guidance.
- Action to address smoking in pregnancy in high prevalence communities.
- Improving the quality of data monitoring locally and nationally.
- Maximising the use of nicotine as a quitting aid.
- Building back better after COVID-19 to reduce smoking inequalities.
- Strengthening training to increase the proportion of the healthcare and maternity workforce trained to address smoking in pregnancy. This includes midwives, obstetricians, GPs, health visitors, paediatricians and professionals in mental health and children's services [74].

The NICE guideline NG209 [17] outlines a number of updated recommendations for identifying and treating tobacco dependency during pregnancy. Routine CO (carbon monoxide) testing is recommended to be offered at all antenatal booking appointments, the 36-week appointment and other antenatal appointments for some groups (as outlined in the NICE guideline NG209). Those with raised CO levels or who identify themselves as smokers should receive an opt-out referral for stop smoking support, and be offered NRT and behavioural support. Providers of Stop Smoking Services should also consider offering voucher incentives. For interventions to be most effective, all relevant staff should be trained in using CO monitors, provision of Very Brief Advice (VBA) on smoking and have knowledge of the pathways and processes for referral to treatment in local maternity systems. The guidance also recommends a tailored approach to identify and treat tobacco dependency among partners and other household members who smoke. These individuals should also receive information and advice to reduce the harms of SHS both during and after pregnancy, including in the home environment [17].

Workplaces

The NICE guideline NG209 [17] includes information and advice for employers to support smoking cessation among their workforce. This includes the provision of a smokefree workplace policy agreed with employees and/or their representatives. Information on local stop smoking support should be made easily available at work. Employees who smoke should be permitted to attend Stop Smoking Services during work hours without the loss of pay. Local Stop Smoking Services should also offer support to employers who want to help their workforce to stop smoking, prioritising small-medium sized businesses and those enterprises with a high proportion of employees on low pay and/or at high risk of tobacco-related harms [17].

Harm reduction

Harm reduction is the process of adopting a strategy to reduce individual and/or social harms arising from a behaviour. The NICE guideline NG209 [17] includes guidance around reducing the harms of smoking. This aims to support people who smoke who do not want, or are not yet ready, to stop smoking in one go. This can be achieved through:

- Raising awareness of and providing licensed nicotine-containing products
- Providing appropriate behavioural support via Stop Smoking Services
- Selecting the most appropriate harm reduction approach. This may include smoking reduction, cutting down before stopping fully or temporarily stopping smoking.

Options for harm reduction should be tailored the individual's needs and preferences. Commissioners should ensure that investment in harm reduction approaches does not detract from but supports and extends the reach and impact of existing stop-smoking support [17].

Vaping

Vaping has become one of the most popular methods used by smokers to quit [75]. It is also recommended by NICE as a smoking cessation aid [17].

Evidence has shown that nicotine-containing vapes can help adults to stop smoking and are of similar effectiveness to other cessation options, such as pharmacotherapy [17]. A 2021 Cochrane review found moderate-certainty evidence that nicotine-containing vapes help more people to stop smoking than NRT or nicotine-free vapes. The review also identified that nicotine-containing vapes may provide benefit in helping people to quit smoking compared with no support or behavioural support, although the evidence for this was less certain [76].

While not risk free, vaping is likely to be substantially less harmful than smoking [17] [77]. As vaping devices are relatively new technologies, there is still a lack of evidence around their long-term health effects. In 2022, OHID published its 8th evidence review on vaping in England. This focused on the potential health effects of vaping. The main findings of the review concluded that:

- In the short and medium term, vaping poses a small fraction of the risks of smoking.
- Vaping is not risk-free, particularly for people who have never smoked.
- Evidence is mostly limited to short and medium-term effects and studies assessing longer term vaping (for more than 12 months) are necessary.
- More standardised and consistent methodologies in future studies would improve interpretation of the evidence [14].

The evidence review outlines that these findings, combined with the results of the aforementioned Cochrane review, were consistent with encouraging people who smoke to switch completely to vaping (or medicinally licensed products) for stopping smoking, or as alternative nicotine delivery devices to reduce the health harms of smoking. Additionally, findings of higher absolute exposure to toxicants from vaping compared with not using any nicotine products reinforces the need to discourage people who have never smoked from taking up vaping or smoking [14].

The review also identified that a substantial proportion of young people and adult smokers and vapers in England still hold inaccurate perceptions of the relative harms of vaping compared with smoking (that vaping is equally or more harmful than smoking). The review highlighted that:

- People's perceptions about vaping harms can influence their subsequent vaping and smoking behaviour.
- Communicating accurate information about the relative harms of vaping compared with smoking can help to correct misperceptions of vaping, particularly among adults.
- Interventions on absolute harms of vaping compared to smoking that aim to deter young people need to be carefully designed so they do not misinform people (particularly smokers) about the relative harms of smoking and vaping [14] [52].

<u>Regulation of vaping products</u>

In the UK, there are well-established regulations for vaping products. Under the Tobacco and Related Products Regulations (2016), nicotine containing vaping products are subject to minimum standards of quality and safety, as well as packaging and labelling requirements to provide consumers with the information they need to make informed choices. Advertising is tightly restricted, and all products must be notified by manufacturers with detailed information to the UK Medicines and Healthcare products Regulatory Agency (MHRA), which prohibits certain ingredients [77].

NICE guidance and vaping

At the time of writing nicotine-containing vapes are not currently available as licensed medications, but are regulated by the Tobacco and Related Products Regulations (2016). The NICE guideline NG209 [17] sets out the following recommendations around vaping as a smoking cessation aid for professionals providing stop smoking support and advice:

- Give clear, consistent and up-to-date information about nicotine-containing vapes to adults who are interested in using them to stop smoking.
- Provide advice to adults on how to use nicotine-containing vapes.
- Explain that:
  - Vapes are not licensed medicines
  - There is not enough evidence to know whether there are long-term harms from vaping.
  - Vaping is likely to be substantially less harmful than smoking.
- Advise that any smoking is harmful, so people who vape should stop smoking tobacco completely.
- Discuss how long a person intends to use nicotine-containing vapes, using them long enough to prevent a return to smoking and how to stop using them when they are ready to do so.
- Ask adults using nicotine-containing vapes about any side effects or safety concerns that they may experience. These should be reported to the MHRA Yellow Card scheme, and let people know they can report side effects directly.
- Explain to adults who choose to use nicotine-containing vapes the importance of getting enough nicotine to overcome withdrawal symptoms [17].

Vaping and pregnancy

The NHS provides the following advice around vaping as a smoking cessation aid during pregnancy:

- Little research has been conducted into the safety of vaping and e-liquids in pregnancy. It is not known whether the vapour is harmful to a baby in pregnancy.
- Licensed NRT products are the recommended option to help someone stop smoking during pregnancy. However, if a pregnant woman finds vaping helpful for quitting and staying smokefree, it is a much safer option for them and their baby than continuing to smoke [75].

5.1.2 What is being delivered?

Livewell provides Stop Smoking Services for people aged 12 and above in Derby as part of a wider integrated lifestyle services offer. The provision is evidence based, in line with NICE guidance and the National Centre for Smoking Cessation and Training (NCSCT).

Telephone and face to face support is provided for 12 weeks, with flexibility to support clients for up to 12 months. Clinics are run throughout the week including evening sessions and Saturdays in a

range of locations. Free NRT is provided for 12 weeks. Champix[††] is provided through the client's GP. During the COVID-19 pandemic an NRT delivery service was established to distribute NRT directly to clients' homes.

The service is vaping friendly and provides support to smokers who are using vaping devices as part of their quit attempt. The service uses a range of promotional materials, including highlighting the national Stoptober campaign and accepts self-referrals as well as professional referrals and signposting.

From 2022/23, Livewell will be providing a new community offer to better support groups at higher risk of tobacco dependency and smoking-related harms, who may experience barriers to accessing and engaging with stop smoking support services. This includes men, people of Eastern European ethnicities, people working in R&M occupations and people from the LGBTQI+ community. There is also a specialist programme for people with learning disabilities and the provision of pre and post-natal support. The service has also previously worked with several local employers to support smoking cessation among their workforce.

Across the local system work is underway to develop a programme to deliver the ambitions set out in the NHS Long-term Plan, which aims to ensure that all acute and mental health inpatients who smoke are offered NHS funded tobacco dependency treatment services. The Long-term Plan service model also extends to include those who are pregnant and their partners, and certain high-risk outpatient groups. A Tobacco Dependency Board has been established to coordinate this work with membership of partners across the ICS. Task and finish groups have been established for the main areas of tobacco dependency treatment: acute inpatients, maternity and mental health.

5.1.3 What are our outcomes?

Stop Smoking Services
Data on the uptake and effectiveness of Stop Smoking Services are reported nationally. Outcomes are reported for:

- The numbers and rates of smokers setting a quit date
- Successful quitters at 4 weeks, ascertained by self-report and CO validation.

The latest data available covers the period for the 2021/22 financial year.

Notably, there were significant changes to Livewell's service delivery during 2020/21 due to the COVID-19 pandemic. Throughout the pandemic, the service delivered 100% telephone support. As a result, CO validation did not take place[‡‡]. Telephone support remains the default and NRT home deliveries will continue for the most vulnerable clients accessing the service.

Derby compares well to the England average for self-reported quit rates and smokers setting a quit date. 3,649 clients per 100,000 smokers set a quit date compared to 2,809 per 100,000 smokers nationally. Overall, 61% of clients who set a quit date reported successful 4-week quit attempts, which equates to 762 people. This was above the national average of 55% (Table 3) [78].

[††] *Champix is currently unavailable nationally*
[‡‡] *CO validation should be attempted on all clients who self-report as having successfully quit smoking at the 4 week follow-up, with the exception of those who were followed up by telephone* [78].

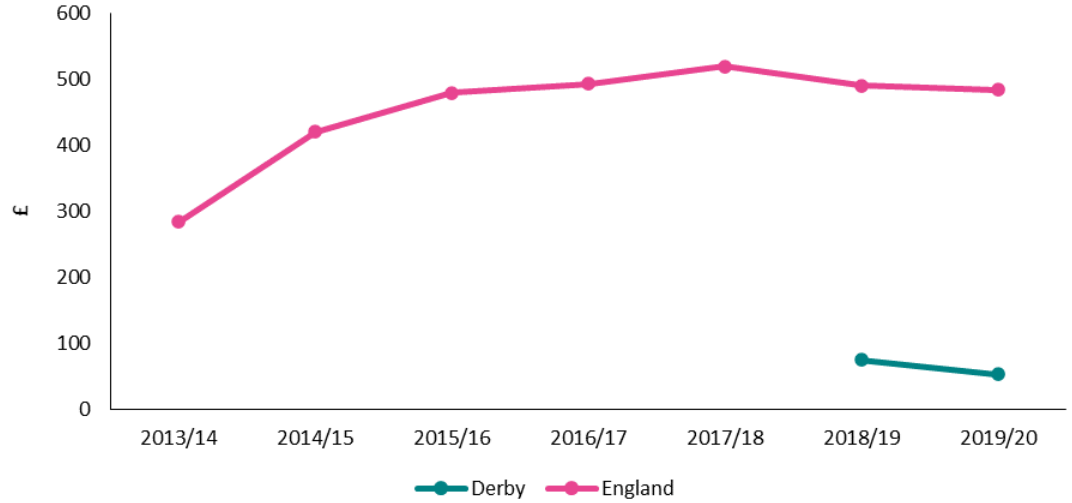
Table 3: Outcomes Stop Smoking Services in Derby compared to England: 2021/2022

2021/22	Number setting quit dates	Number of successful quitters (self-reported)	Percentage of successful quitters (self-reported)	Number of successful quitters (CO validated)	CO validated quitters as a percentage of clients setting a quit date	CO validated quitters as a percentage of successful quitters
Derby	1,241	762	61	0	0	0
England	178,198	97,654	55	6,651	4	7

Source: NHS Digital statistics on Stop Smoking Services in England 2021/22 [78]

The latest available data shows that in 2019/20, the cost per quitter in Derby was £53, which remains substantially below the national figure of £484. The cost per quitter will be a function of the trend in service costs, and the level of intensity of support required by the clients coming through for smoking cessation support (Figure 17) [26].

Figure 17: Cost per quitter in Derby compared to England



Source: NHS Digital - Statistics on NHS Stop Smoking Services, England- published Local Tobacco Control Profiles [26]

Support by gender and age

Derby compares well to the national average for successful quit outcomes among both men and women. 61% of males and 62% of females who set a quit date reported successful 4-week quit attempts compared to the England average of 57% and 53%, respectively (Table 4) [78].

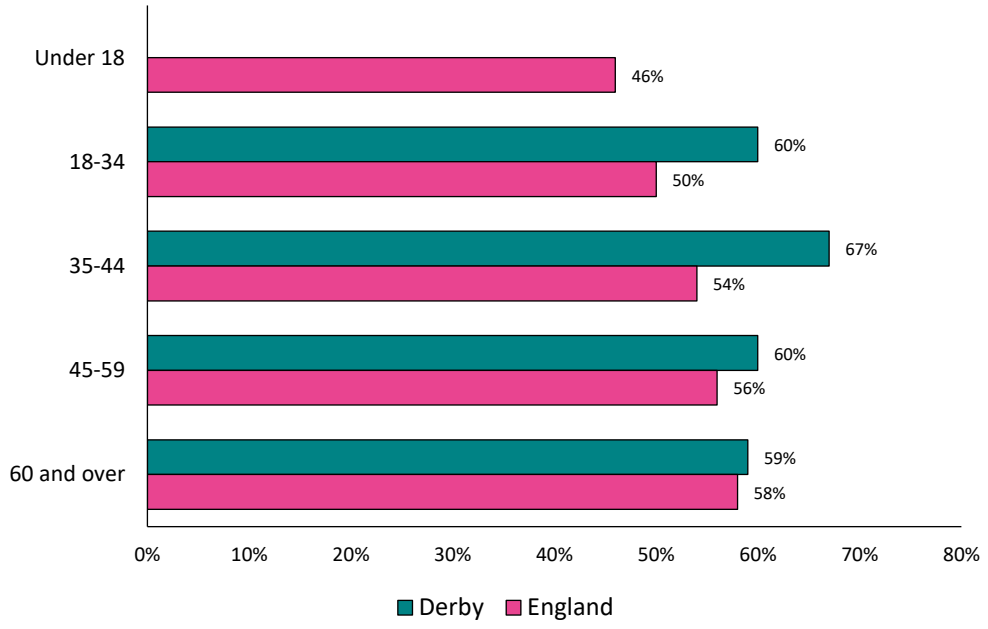
Table 4: Outcomes for Stop Smoking Services in Derby by gender compared to England: 2021/22

2021/22		Number setting quit dates	Number of successful quitters (self-reported)	Percentage of successful quitters (self-reported)	Number of successful quitters (CO validated)	CO validated quitters as a percentage of clients setting a quit date	CO validated quitters as a percentage of successful quitters
Males	**Derby**	619	375	61	0	0	0
	England	77,216	44,183	57	2,669	3	6
Females	**Derby**	622	387	62	0	4	7
	England	100,982	53,471	53	3,982	0	0

Source: NHS Digital statistics on Stop Smoking Services in England 2021/22 [78]

Across all age groups, where local data was available, the proportion of people reporting successful quit attempts exceeded the England average. However, the percentage of successful quitters varied by age group. Successful 4-week quit attempts were highest among 35-44 year olds (67%) and lowest in people aged 60 and above (59%). This contrasts with the national picture, where successful quit attempts were highest in the 60 and over age group (58%) and lowest among under 18s (46%). It should be noted that no local data was available on successful quit attempts for the under 18 age group due to the small denominator, which prevented robust comparisons (Figure 18) [78].

*Figure 18: Percentage of self-reported successful 4-week quit attempts by age group in Derby compared to England: 2021/22**



* Derby level data for under 18s was suppressed by NHS Digital due to the small denominator as the resulting percentage output was not deemed robust enough for comparative purposes

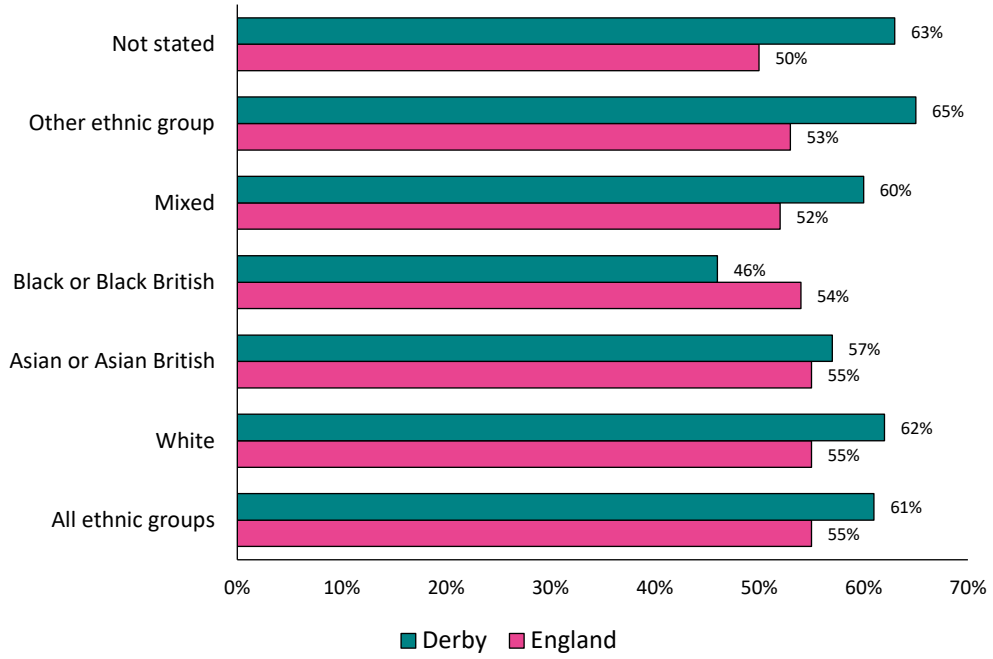
Source: NHS Digital statistics on Stop Smoking Services in England 2021/22 [78]

Support by ethnicity

Successful 4-week quit attempts exceeded the national average among most ethnic groups. However, people of Black or Black British ethnicities experienced poorer quit outcomes compared to the national average (46% in Derby vs 54% nationally). Successful quit outcomes were also lower

among people from Black or Black British (46%), Asian or Asian British (57%) and Mixed (60%) ethnic groups when compared to the local service average (61%) (Figure 19) [78].

Figure 19: Percentage of self-reported successful 4-week quit attempts by ethnic group in Derby compared to England: 2021/22



Source: NHS Digital statistics on Stop Smoking Services in England 2021/22 [78]

Support for R&M workers

The proportion of R&M workers reporting successful 4-week quit attempts in Derby (65%) was higher than the national average (57%). The data also shows that once workers accessed the local service, they achieved a higher quit rate than the overall service average (61%) (Table 5) [78].

Table 5: Outcomes for R&M workers accessing Stop Smoking Services in Derby compared to England: 2021/22

2021/22	Number setting quit dates	Number of successful quitters (self-reported)	Percentage of successful quitters (self-reported)
Derby	316	206	65
England	45,830	25,956	57

Source: NHS Digital statistics on Stop Smoking Services in England 2021/22 [78]

Support during pregnancy

Derby compares well to the national average for successful quit outcomes achieved by pregnant women and birthing people who engage with stop smoking services and set a quit date, with 55% reporting successfully quitting at 4 weeks (England average 46%). However, the proportion of successful 4 week quits in this group was below the local service average of 61%. During 2021/22, 73 pregnant women set a quit date, while 331 were recorded as smoking at the time of delivery. This comparison provides an indication of the scale of need in addressing smoking in pregnancy locally (Table 6) [78].

Table 6: Outcomes for pregnant women accessing Stop Smoking Services in Derby compared to England: 2021/22

2021/22	Number setting quit dates	Number of successful quitters (self-reported)	Percentage of successful quitters (self-reported)	Number of successful quitters confirmed by CO validation	CO validated quitters as a percentage of clients setting a quit date	CO validated quitters as a percentage of successful quitters
Derby	73	40	55	0	0	0
England	15,993	7,360	46	1,305	8	18

Source: NHS Digital statistics on Stop Smoking Services in England 2021/22 [78]

NHS Tobacco Dependency Treatment Programme

Healthcare and integrated lifestyle service partners are in the process of implementing the new Derby and Derbyshire NHS Tobacco Dependency Treatment Programme. As a result, the outcomes of the service have not yet been established.

5.1.4 Where are the gaps?

Both locally and nationally a key issue is that of inequalities. Certain population groups are recognised to be disproportionately affected by higher smoking rates and tobacco-related harms. It is acknowledged that there are some gaps in insight to inform local practice. This includes intelligence on the proportion of people making initial contact with Derby Stop Smoking Services who set a quit date. Further insight work is needed to support continued optimisation of the local service offer and engagement, particularly among key 'at-risk' and priority groups. A detailed analysis of the characteristics and patterns of use among people accessing Stop Smoking Services, such as through a health equity audit, could help to inform local measures to address smoking-related inequalities. While Livewell provides stop smoking support to children aged 12 and above, there is currently no specialist support offer for this age group. A service review is planned to optimise the provision of stop smoking support for children and young people.

One area not assessed in detail as part of this needs assessment are successful quit outcomes among hospital inpatients and people with long-term mental health conditions. This is recognised as an area for development. Data gathered as part of the new NHS Tobacco Dependency Treatment Programme, once fully established, will provide valuable insights into smoking cessation outcomes among these populations.

5.2 Smokefree places

5.2.1 What works?

The WHO FCTC outlines recommendations for smokefree public places, including indoor public spaces, workplaces and public transport [7]. These measures aim to protect people, especially non-smokers, from the harmful effects of SHS. But they also have many other benefits, such as providing smokers with a stronger incentive to cut down or quit, as well as discouraging children and young people from starting to smoke [79].

In 2007, legislation was introduced in England which made it illegal to smoke in nearly all enclosed public spaces and workplaces, including work vehicles. In 2015, the legislation was extended to cover private vehicles carrying children, to further protect them from the harms of SHS [13]. Nationally,

there is clear evidence that the implementation of smokefree laws has been associated with a reduction in premature births [80], and childhood hospital admissions for asthma [81] and respiratory infections [82]. There is also some evidence to suggest that the legislation has helped to reduce smoking uptake among teenagers, particularly in girls [83].

Over recent years, there has been an increasing policy emphasis on establishing voluntary smokefree zones in a range of other outdoor public settings. These measures aim to further reduce SHS and protect those groups most vulnerable from harm, such as under-18s and adults with underlying health conditions. A 2021 YouGov survey, funded by ASH, found that most (67%) adults were supportive of a smoking ban in outdoor seating areas of restaurants, pubs and cafes [66] [84].

An evidence synthesis produced by Public Health England in 2018 [85], examined the effect of banning smoking in outdoor public places on attitudes, behaviours and associated harms. This identified that UK data and research is currently limited, largely because such policies are less widely adopted here than in some other countries. The report also identified the following key findings:

- Most of the research available comes from cross-sectional studies that are of mixed quality and have wide methodological differences, making comparison across studies difficult.
- The international literature shows that public attitudes towards outdoor smokefree policies varies considerably depending upon individual level factors or settings, such as non-smokers and females tending to hold more favourable views towards outdoor smoking restrictions.
- The effect of smokefree outdoor policies on behaviour and associated harms is mixed with some studies reporting no effects and others reporting positive effects when outdoor spaces become smokefree, such as significantly reduced smoking prevalence post-ban across smokefree universities (from a good quality systematic review) and significant reductions in SHS (from a moderate quality study) one year after a university became smokefree.
- Compliance with smokefree areas can also sometimes be low. This is likely due to the voluntary nature of some outdoor smoking restrictions or limited awareness, even where smokefree outdoor policies are mandatory.
- Smoking remains the UK's largest cause of preventable illness and death; should an outdoor smokefree policy be trialled despite an overall lack of evidence of the effectiveness, a rigorous evaluation of this would greatly help to further build the evidence base [85].

Healthcare settings

The National Tobacco Control Plan set out an ambition to achieve a completely smokefree NHS estate by 2020, and to implement comprehensive smokefree policies in all mental health services by 2018 [13].

The NICE guideline NG209 [17] recommends that secondary care services implement policies for smokefree hospital grounds and support compliance among staff, service users and visitors [17]. However, a national audit conducted by the British Thoracic Society in 2021, identified poor enforcement of smokefree areas regardless of whether hospitals had entirely smokefree grounds or designated smoking areas, with only one in five hospitals completely enforcing restrictions [41].

A 2019 report by ASH also identified that 1 in 5 mental health trusts still did not have comprehensive smokefree policies in place, despite the government deadline for implementation by 2018 [86]. There is a common misconception that quitting smoking may exacerbate symptoms in people with underlying mental health conditions, such as depression and anxiety. However, the opposite is true.

Smoking cessation improves both physical and mental health, even in the short term, and reduces the risk of premature death [31]. A study evaluating the experience of 12 mental health wards before and after implementing smokefree policies identified Increases in patients being referred for smoking cessation support, positive changes in patients' smoking behaviours, motivation to maintain these behaviours after discharge and fewer challenging behaviour incidents. However, the most commonly identified barriers to implementing smokefree policies were staff and patient resistance, insufficient resources and lack of senior management leadership [87].

School policies and school gates

The NICE guideline NG209 [17], outlines recommendations for smokefree school policies, although this does not explicitly mention smokefree school gates. In 2021, Wales introduced further smokefree laws, which required school grounds and public playgrounds, as well as outdoor day care and child-minding settings, to be smokefree [88]. This legislation has not been introduced in England. However, several local authority areas have introduced voluntary schemes. This includes the provision of locally developed guidance and resources to support the implementation of smokefree school gates.

Playgrounds and recreational areas, and other outdoor areas

Currently, most of the formal literature is from settings outside the UK such as Canada, Australia and Ireland. The discourse for smokefree recreational areas is often related to their public perception, the process of establishing smokefree zones, the contrast between mandatory and voluntary schemes, and issues of enforcement. Similar to smokefree school zones, there are a number of examples from local authorities across England where voluntary initiatives have been implemented to introduce smokefree playgrounds and recreational areas. However, these are mostly forms of grey literature to raise awareness of the policies that are being proposed or implemented, as opposed to assessments or evaluations of their impact.

In 2022, "The Khan Review: Making Smoking Obsolete" [89] was published. This outlined several recommendations for central government to help achieve its ambition of a smokefree society by 2030. The review included proposals to increase smokefree places to de-normalise smoking and protect young people from SHS, with recommendations to strengthen smokefree legislation in hospitality settings, hospital grounds and outdoor public spaces [89]. At the time of writing, it is unknown if these recommendations will be implemented by national government.

The home environment

Beyond public settings, reducing SHS in the home is one of the main areas for further consideration to protect children and non-smokers from tobacco-related harms. There is significant exposure to SHS in the home environment when children and non-smokers live with people who smoke. There is also increasing concern that pollution from SHS (also known as thirdhand smoke) can remain on clothes, soft furnishings and in the environment long after it has dissipated from the air [52] [90]. Research has shown that the most reliable way of reducing SHS in the home is by making the indoor environment completely smokefree [55]. An ASH briefing, published in 2020, concluded that population-level initiatives, such as awareness campaigns, may be important for influencing attitudes and behaviours to reduce SHS in the home [55].

It is recognised that adult smoking rates and SHS exposure among children in the home environment are substantially higher for people living in social housing compared to those living in other types of

housing. This exacerbates existing health and socioeconomic inequalities. A recent joint report by ASH and the Housing and Learning Improvement Network (LIN) outlines the clear benefits of embedding tobacco control within the social housing sector, by integrating stop smoking support into social landlords' existing health and wellbeing activities. There is a strong case for collaborative action across the NHS, public health and social housing providers to share expertise and resources to reduce smoking rates among social housing residents. This has the potential to deliver on shared ambitions for all partners through radically improving the health and wellbeing of residents, as well as maximising the social value delivered by housing providers [32].

Nationally, there are already examples of effective partnership work being undertaken in this area, providing replicable models and lessons for action in other localities. However, practice remains inconsistent and greater support and leadership is needed by central government, including additional resource. The joint report by ASH and the LIN sets out the following recommendations for partner agencies:

Recommendations for social housing providers

- Recognise and embed support to help smokers quit, in consultation with residents
- Establish and build relationships with local authority public health teams
- Explore options for delivering stop smoking support and aids directly to residents.

Recommendations for local authority public health teams and the NHS

- Engage social housing providers to help support residents who smoke to stop
- Support the implementation of tobacco control approaches in social housing in consultation with residents
- Embed social housing-based tobacco control programmes within ICS level prevention and inequalities strategies.

Recommendations for central government

- Provide funding for targeted programmes supporting people to quit in social housing
- Set targets for reducing smoking prevalence in social housing [32].

There are also recommendations in the Khan review centred around reducing the harms of smoking and SHS among social housing residents. This includes ambitions for local authorities to make a significant proportion (70% or more) of new social housing tenancies and developments smokefree. This should incorporate measures to improve compliance and enforcement with existing legislation, and support neighbours exposed to smoke drift [89].

5.2.2 What is being delivered?

Derby City Council
The City Council's website provides information on smokefree regulations to facilitate compliance with the legislation among local businesses and employers.

NHS smokefree policies
Local healthcare trusts, such as the University Hospitals of Derby and Burton, have developed a smokefree grounds policy. The Trust's 'Think Again' campaign aims to support people to keep the hospital and grounds smokefree and highlights that smoking is not allowed anywhere on hospital grounds.

5.2.3 Where are the gaps?

The evidence for smokefree zones is still emerging, particularly in measuring the outcomes on smoking behaviours and on health. It is not possible to determine which settings have the greatest impact for reducing smoking-related health inequalities to inform prioritisation decisions. As children are especially vulnerable to the effects of SHS, and have less choice over their environments, protecting their health is a clear focus.

Local consideration of promoting voluntary smokefree zones at school gates, play areas and as part of new planning and regeneration projects, could be beneficial for reducing the harms of SHS, especially among children and young people. Identification of sites for proposed smokefree zones, accompanied by public consultation, would provide valuable insights into residents' views on creating additional smokefree public spaces.

There may also be opportunities to strengthen initiatives to reduce SHS in the home environment. This includes consideration of partnership work with local social housing providers, in consultation with residents, to support people living in social housing to stop smoking and access existing professional support.

Insights and learning from other areas that have implemented similar smokefree policies and/or social housing initiatives could be valuable for informing local work. This includes any successful approaches to increase awareness of the harms of SHS and compliance with smokefree zones to maximise the effectiveness of these interventions.

5.3 Prevention first

5.3.1 What works?

The NICE guideline NG209 [17] sets out a number of recommendations around preventing smoking uptake in children and young people. This includes 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. The guidance also outlines recommendations around interventions in schools, academies and further education colleges. This contains advice around:

- Taking a whole-school or organisation-wide approach to tobacco control through smokefree policies
- Adult-led interventions
- Peer-led interventions
- Training and developing staff to work in smoking prevention
- Ensuring coordination with other local organisations [17].

Other effective measures to help prevent smoking uptake among children and young people include advertising restrictions, standardised packaging and reducing the availability of tobacco to young people through educating tobacco retailers and enforcing the minimum age legislation [17] [91]. NICE also recommends that part of the curriculum on tobacco, alcohol and drug misuse, children, young people and young adults who do not smoke should be discouraged from experimenting with or regularly vaping [17].

As highlighted in earlier sections, smoking is an addiction that is largely established in childhood. [13]. Children are also particularly vulnerable to the effects of SHS [56]. Children and young people growing up in an environment where smoking is prevalent are not only more likely to be exposed to SHS but are also more likely to start smoking themselves [32]. Reducing the number of adults who smoke is recognised as one of the most effective ways to reduce smoking in young people, as there is strong evidence children are heavily influenced by adult role-models who smoke [13]. Therefore, interventions to support adult smokers to quit [13], as well as enforcement of existing smokefree policies and legislation (in particular the ban on smoking in private vehicles with an under-18 present), will play a vital role in reducing smoking and tobacco-related harms among children. Beyond public settings, there is also increased recognition of the importance of reducing SHS in the home environment to protect younger age groups from smoking-related harms.

5.3.2 What is being delivered?

In Derby, the Health Visiting Service follows NHS and Lullaby Trust guidance to provide parents with information and advice around safe sleeping and how they can protect their child from SHS. Advice is provided to parents at the birth visit and 6-8 week review. Parents are also given information about Livewell's smoking cessation services so they can opt-in to access stop smoking support. Locally, additional training resources are being made available to support staff to engage in person-centred conversations with parents and families around smoking.

The School Nursing Team works more intensively with schools that have identified tobacco dependency among their top 3 priority health needs, providing staff training and delivering targeted group work sessions to students.

In Derby, young people aged 12-17 years who smoke can self-refer to Livewell to access stop smoking support. The School Nursing Team also links into Livewell, providing signposting advice or referring young people directly to the service. Children and young people can request help to stop smoking via the School Nursing Team through the ChatHealth text message service and school-based or virtual drop-in sessions. Young people needing support may also be identified through routine health reviews.

Locally, young people and their families are able to complete routine school health questionnaires and development reviews via the innovative TLM online portal, empowering them to take greater control over their own health wellbeing.

The school nursing service are also exploring if social media platforms can be used in the future to reach more young people to provide information and advice about the harms of smoking and benefits of being smokefree.

5.3.3 What are our outcomes?

The outcomes of current school-based smoking prevention activities are yet to be established.

5.3.4 Where are the gaps?

There is currently no routinely available data on smoking prevalence among children and young people in Derby. Gathering local intelligence on smoking behaviours among young people, and analysis of the provision and impacts of school-based prevention initiatives, could be beneficial for

informing local practice. There also remains a question about how well issues related to SHS in the home and outdoor public spaces are understood, raised and promoted.

5.4 Cheap and illegal tobacco

5.4.1 What works?

Maintaining high duty rates on legal tobacco sales, tackling the illegal tobacco trade and enforcing existing legislation are all important components of a comprehensive tobacco control strategy [13]. Enforcement powers relevant to addressing illegal tobacco exist across a range of organisations and agencies, including:

- The Police
- HM Revenue and Customs (HMRC)
- Trading Standards
- The UK Border Force.

Nationally, the HMRC and UK Border Force Strategy [92] on tackling illegal tobacco outlines four priority areas for action:

- Creating a hostile global environment for tobacco fraud through intelligence sharing and policy change.
- Improving coordination with partners in the UK and internationally to tackle fraud at all points in the supply chain from production to retail.
- Changing public perceptions through raising awareness of the links between illicit tobacco and organised criminality to reduce tolerance of the fraud in the UK.
- Optimising the impact of the sanctions available across government and introducing new ones when needed [92].

The NICE guideline NG209 [17] also contains specific recommendations for local authorities and Trading Standards organisations to support retailers to avoid illegal tobacco sales through:

- Providing training, guidance and awareness campaigns to publicise legislation prohibiting underage sales.
- Making test purchases and utilising data and intelligence to identify and monitor underage sales.
- Partnership work with other agencies to improve intelligence, inspection and enforcement activities.
- Ensuring sustained efforts to reduce illegal tobacco sales, including prosecution of retailers who persistently break the law [17].

Intelligence from local communities plays a vital role in reducing the harms from illegal tobacco, enabling further investigation by the relevant Trading Standards organisations and/or Law Enforcement Agencies, as appropriate. Members of the public can report concerns about illegal tobacco anonymously via a number of organisations. This includes through Crimestoppers, the national Citizens Advice consumer line, the Keep It Out website [93][§§] or directly to their local Trading Standards department.

[§§] *The Keep It Out website is a platform which provides information around illegal tobacco and a platform for people to report concerns anonymously.*

5.4.2 What is being delivered?

Derby Trading Standards works with the police, HMRC and other partners to carry out enforcement operations to reduce the demand and supply of illegal tobacco and illegal vaping products in the City. Enforcement activities are intelligence led. There are mechanisms for members of the public and legitimate businesses impacted by the illegal tobacco trade to report concerns anonymously.

In response to intelligence received, the service may carry out further investigations, inspections, test purchases and seizures of goods to stop the sale and distribution of illegal tobacco and illegal vapes from retail shops and private addresses. Enforcement action may be brought against individuals where appropriate. Test purchase operations identify underage sales of both legal and illegal tobacco and illegal vaping products, to reduce access to smoking among children. Locally, 'disruption' through dialogue with landlords of problem shops has been an important approach, which can result in the terminations of tenancies held by tenants acting illegally. The service also works with local media, as appropriate, and National Trading Standards messages are shared with the public to publicise the safety and health impacts of illegal tobacco.

Derby Trading Standards is part of the Trading Standards East Midlands (TSEM) illegal tobacco group, which feeds into the National Trading Standards group. Enforcement operations, where necessary, work across borders to disrupt the market further up the supply chain, linking with TSEM, HMRC and the East Midlands Special Operations Unit (EMSOU). The EMSOU is a combination of 5 police forces set up to tackle serious and organised crime, including illegal tobacco and illegal vaping products. Intelligence is shared within the authorities, with activities coordinated across and within regions, where required. This involves a complex cross border and an intelligence-led approach.

Locally, funding has been secured until 2025, with additional short-term funding to increase targeted and intelligence-informed activities to disrupt the illegal tobacco and illegal vape trade.

5.4.3 What are our outcomes?

Tables 7 and 8 illustrate the activity undertaken by Trading Standards in relation to illegal tobacco from 2016/17 to 2021/22.

Since 2018/19, the number of complaints received by Trading Standards related to illegal tobacco have decreased. The number of seizures has also shown a decreasing trend in recent years, particularly in 2020/21. This reflects the increasingly sophisticated methods used by those in the illegal tobacco trade to evade detection and the impacts of the COVID-19 pandemic on enforcement activities.

In 2021/22, a large quantity of illegal tobacco was seized, the greatest in the last 3 years. Most of these seizures were for counterfeit cigarettes. The estimated retail value of the seized tobacco was £42,873, with an estimated £51,460 evaded in tax duties. Enforcement activities have been supported by the additional funding to increase targeted intelligence-led operations. These seizures demonstrate the persistence of illegal tobacco market strategies and the important role of enforcement operations to stop the sale and distribution of illegal tobacco.

Table 7: Complaints on illegal tobacco made to Derby Trading Standards

Year	Number of Complaints
2016/17	69
2017/18	61
2018/19	100
2019/20	51
2020/21	50
2021/22	45

Source: Derby Trading Standards

Table 8: Tobacco Seizures in Derby by Trading Standards

Year	Cigarette Sticks	Hand Rolled Tobacco (kg)
2016/17	457,600	39.75
2017/18	275,000	22
2018/19	84,160	71.75
2019/20	56,820	8.80
2020/21	12,540	3.95
2021/22	124,600	46.50
Total	**1,010,720**	**192.75**

Source: Derby Trading Standards

Under-age sales

Trading Standards work includes a remit on enforcing the laws on age-restricted products. The service carries out regular intelligence-led visits to premises where concerns about underage sales of tobacco products and alcohol are identified. In addition, the service recruits local volunteers who conduct test purchases with volunteers aged under 18 years.

The number of test purchasing exercises during the financial year will be dependent on the resources available and volume of actionable intelligence. Due to the COVID-19 pandemic and associated restrictions, there was a reduction in visits conducted in 2021/22. During this time, from complaints received:

- One advice visit was made related to underage sales of cigarettes
- 3 advice visits and 7 advice letters were sent out in relation to vaping products.

Illegal vaping products

Vaping products in the UK are subject to strict regulations to ensure they meet minimum and quality and safety standards. The legal UK limit on nicotine content in disposable vapes and refill containers is no more than 2% (20mg/ml). Vapes must not exceed a maximum tank capacity of 2ml (approximately 600 'puffs'[***]) and all vaping products should comply with the appropriate labelling requirements and warnings [94].

Over recent months, Trading Standards have seized large quantities of illegal vapes. This mainly related to disposable devices and included products which did not show the correct labelling and/or

[***] *Information from Derby Trading Standards*

were destined for non-UK markets. Some illegal disposable vapes seized in Derby contained more than double the legal concentration of nicotine, with others found to offer more than 7000 'puffs'.

For the 2022/23 financial year to date, data from Trading Standards shows that 33,453 illegal vapes were seized across the City. Of these, 32,047 devices were seized from a distributor, with the remaining 1406 devices seized from retailers. This is compared to 16 illegal vapes seized in 2021/22, which was the first year that data collection began.

It is envisaged that complaints related to vapes will increase as use continues to become more prevalent. The service will continue to monitor data and intelligence, including underage sales, with enforcement activities undertaken as appropriate.

5.4.4 Where are the gaps?

Across the City, there is evidence of an effective multi-agency, intelligence-informed response with demonstrable seizures of illegal tobacco and illegal vapes. This reinforces the important work of Trading Standards in keeping illegal tobacco and illegal vaping products out of local retailers and communities. It also highlights the need for continued enforcement activities supported by the appropriate local capacity, resource and intelligence.

Year on year increases in illegal tobacco activity are difficult to predict and plan for. Increasingly, those involved in the illegal tobacco and illegal vape trade are becoming more covert in their operations, requiring greater resources to facilitate enforcement operations. Trading Standards has also experienced increased capacity demands in its other areas of work outside of tobacco control. The local service will increasingly have to prioritise operational work due to resource constraints.

Crimestoppers will soon cease to be a source of intelligence and consideration is needed on the development of intelligence roles to support enforcement operations. Developing local insight work alongside intelligence to support targeted enforcement activities will be beneficial in informing action to address the illegal tobacco and illegal vape trade, as well as wider tobacco control initiatives. This includes awareness of any new legislation and technologies, and the potential supply of newer counterfeit products, such as vaping devices.

6 A smokefree society by 2030

6.1 The Khan review and updated National Tobacco Control Plan

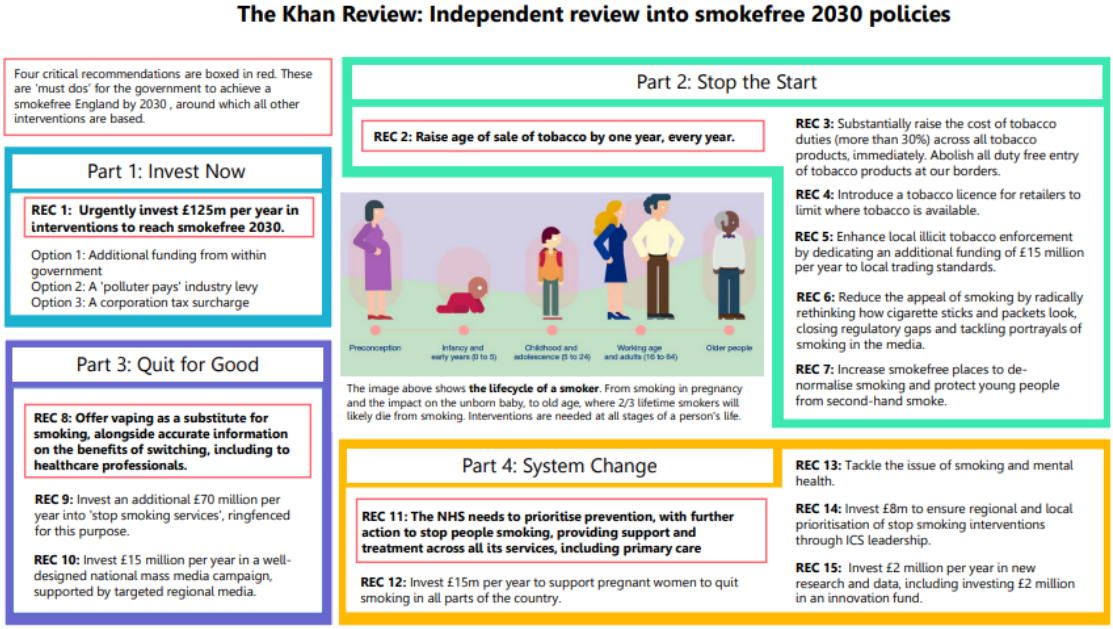
An updated Tobacco Control Plan for England is expected to be published. This is anticipated to outline the government's strategy for England to become a smokefree society by 2030 [14].

In 2022, 'The Khan review: Making Smoking Obsolete' [89], was published. This independent review was commissioned by the Secretary of State for Health and Social Care to look into whether the government would achieve its 2030 smokefree ambition. Although good long-term progress has been made in reducing smoking rates to their lowest ever level, the Khan review outlines that the 2030 smokefree ambition is likely to be missed. The review sets out 15 evidence-based recommendations to reduce smoking prevalence and inequalities to support achievement of the national smokefree target. Figure 20 summarises the recommendations outlined in the review, which includes the following four critical recommendations:

- Urgently invest £125 million per year in a comprehensive smokefree 2030 programme. Options to fund this include a 'polluter pays' levy.
- Increase the age of sale by one year, every year.
- Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.
- For the NHS to prioritise further action to stop people from smoking, by providing support and treatment across all of its services, including primary care [15] [89] [95].

It is unknown if the new National Tobacco Control Plan will incorporate all recommendations outlined in the Khan review. Once published, it will be important to ensure that local tobacco control initiatives align with the latest national strategic priorities and ambitions.

Figure 20: The Khan review: making smoking obsolete: visual summary of recommendations



Source: Making smoking obsolete: visual summary of recommendations [95]

6.2 Considerations for the Health and Wellbeing Board and Integrated Care Board

6.2.1 The End of Smoking

In June 2019, ASH and Fresh (the regional tobacco control programme in the North East) published 'The End of Smoking'. This sets out an overarching strategy for local authorities and their health and wellbeing board partners to reduce smoking rates and achieve the smokefree 2030 ambition. The document proposes a target for local areas to reduce smoking prevalence to below 5% in all socioeconomic groups by 2029 [22]. Alongside this, ASH have produced a complementary practical guide. This sets out ten high impact interventions local authorities can take to reduce smoking rates and inequalities in their communities:

1. Prioritise health inequalities
2. Work in partnership
3. Support every smoker to quit
4. Communicate the harms and the hope
5. Promote harm reduction

6. Tackle illicit tobacco
7. Promote smokefree environments
8. Enable young people to live smokefree
9. Set targets to drive progress
10. Protect and promote progressive tobacco control policies [23].

The End of Smoking also highlights a pertinent question that is usually not addressed within a needs assessment, and is vital for informing local tobacco control action. This is "how many smokers in your population try to quit each year, and how do they go about it?". Data from the toolkit for England indicates the following:

Currently only 30% of smokers per year make a serious attempt to quit. Most of these are unsuccessful, so only 5% of smokers successfully quit each year. Of these successful quitters:

- 2% quit through Stop Smoking Services
- 8% get some professional advice and use medication
- 14% use nicotine replacement therapy they bought at a pharmacy
- 35% succeed on their own without any help
- 41% use a vaping device.

To reduce smoking prevalence overall requires reducing the uptake of smoking, increasing the number of quit attempts, and increasing the success of quit attempts made (Figure 21) [22].

Figure 21: Drivers of a smokefree future

	Drivers of a smokefree future		
	Reduce uptake	Increase smokers' quit attempts	Increase the success of smokers' quit attempts & prevent relapse
Make smoking unappealing to both smokers and non-smokers ('denormalise' smoking)	✓	✓	✓
Enforcement of smokefree regulations	✓	✓	✓
Promotion of smokefree environments including smokefree homes	✓	✓	✓
Enforcement and promotion of good trading practice	✓	✓	✓
Control of the supply of illicit tobacco	✓	✓	✓
Online, social and mass media	✓	✓	✓
Communicate hope: promote the annual quit attempt		✓	
Professional-client encounters of all kinds		✓	
Communication and engagement through all council services		✓	
Online, social and mass media		✓	
Provide diverse stop smoking support		✓	✓
Specialist stop smoking services		✓	✓
Brief advice and medicines		✓	✓
Treating tobacco dependency in the NHS		✓	✓
Telephone/app and online advice		✓	✓
Communication about quitting aids including e-cigarettes		✓	✓

Source: ASH "The End of Smoking" [22]

The implications of this for Derby include:

- To consider what our local ambition is in terms of smoking prevalence, and any targets beyond those for Stop Smoking Services.
- Recognising that the majority of people attempting to quit aren't coming through Stop Smoking Services and therefore the value of 'make every contact count' type approaches.
- Maintaining work to keep smoking unappealing, including reducing the demand and supply of illegal tobacco.
- Driving up quit attempts, for example in normalising the idea that smokers may try to quit each year: "Have you made your annual quit attempt yet?" and thinking about how we can communicate this.
- Noting that Stop Smoking Services are essential, particularly for disadvantaged and highly nicotine dependent smokers, and ensuring the quality and diversity of the stop smoking offer.
- Considering settings for more targeted work, for example with people who live in social housing, and people receiving adult care support.
- Exploring opportunities to drive or contribute to regional work especially around mass media campaigns.

6.2.2 Why addressing smoking should be a priority

ASH have recently published a briefing for Health and Wellbeing Boards and Integrated Care Boards (ICBs) on why addressing smoking should be a priority [24]. The document sets out the rationale for including tobacco control in Health and Wellbeing Board plans and ICB strategies to prevent ill-health and reduce health inequalities. It also makes suggestions about specific evidence-based actions that these strategies and plans could include:

Actions for Health and Wellbeing Boards

- Understand the impacts of smoking locally using OHID's Local Tobacco Control Profiles, the ASH Ready Reckoner tool and ASH Economic and Health Inequalities Dashboard.
- Assess smoking prevalence in key populations and define targets for reduction.
- Include tobacco in the Joint Strategic Needs Assessment.
- Include treating tobacco dependence as a priority in the local authority's health and wellbeing strategy. This should be informed by ASH's ten high impact actions for local authorities and their partners.
- Ensure the local authority has a strategy/plan on tobacco which links to the health and wellbeing strategy and delivers on ASH's ten high impact measures.
- Sign the Local Government Declaration on Tobacco Control. The declaration is a statement of a local authority's commitment to ensure tobacco control is part of mainstream public health work and commits councils to taking comprehensive action to address the harm from smoking.

Actions for ICBs

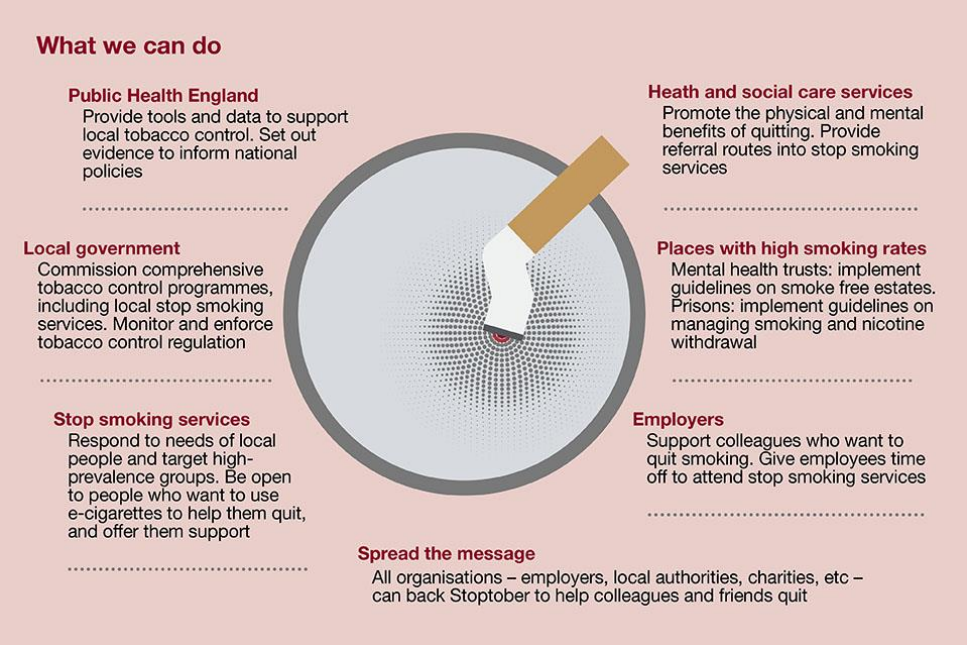
- Assess smoking prevalence across the ICB geography noting variation by population group and region. Set targets for reducing smoking among high prevalence groups.
- Implement smokefree policies in inpatient settings as recommended by the NICE guideline NG209.
- Ensure local authorities are active in ICB delivery groups.

- ICB strategies covering health inequalities and prevention should specifically link to the impact of reducing smoking prevalence on the Core20PLUS5 areas of clinical focus.
- Ensure that NHS Long Term Plan tobacco dependency treatment services are fully implemented and sustained beyond the end of the transformation period.
- Sign the NHS Smokefree Pledge. The Pledge is designed to be a clear and visible way for NHS organisations to demonstrate their commitment to helping smokers quit.
- Develop system-wide strategy for addressing smoking learning from the impact of Fresh in the North East and in line with recommendations from ASH and the Khan Review: making smoking obsolete [24].

6.3 Collaboration across organisations

This needs assessment has highlighted the necessity of a whole systems approach to tobacco control involving a multi-agency and multi-component approach. Research has shown that effective tobacco control cannot be achieved by a single organisation or intervention in isolation [96]. At a local level, local authorities, healthcare services, emergency services, enforcement agencies, communities, schools, employers and businesses (including tobacco retailers) have an important role in tobacco control. Public Health England have developed the following infographic (Figure 22) which outlines the roles of several organisations involved in tobacco control across a range of different sectors [4].

Figure 22: Roles in tobacco control



Source: Health matters: smoking and quitting in England [4]

Across Derby and Derbyshire a number of multi-agency partnership groups have been established to progress local action in treating tobacco dependency. This includes:

- **The Tobacco Dependency Board -** has been established to coordinate the local implementation of commitments set out in the NHS Long-Term Plan for the provision of NHS-funded tobacco dependency treatment services [16] .
- **The Maternity Tobacco Dependency Group** - was set up to oversee the implementation of the maternity element of the NHS Long-term Plan tobacco dependency treatment pathway where pregnant women and birthing people are offered free NRT and support within

maternity services (as outlined in the NHS Long-term Plan commitments around smoking cessation) [16].

- **Derby and Derbyshire Smoking in Pregnancy Group**- considers system-wide work relating to health pre, during and post-pregnancy. The Group reports into the Derbyshire Local Maternity and Neonatal System (LMNS) governance structure and Tobacco Dependency Board.

Further work is planned to develop a joint Derby and Derbyshire tobacco control strategic framework to deliver the national ambitions for a smokefree future. In addition to linking with regional work through the OHID-led Midlands Tobacco Control Network, consideration of establishing a Derby and Derbyshire Tobacco Control Strategic Group could be beneficial. This would provide an opportunity to strengthen collaborative action among key partners across the local system, beyond healthcare and local authorities, to optimise our tobacco control initiatives.

7 Conclusions and Recommendations

This needs assessment brings together data and information on tobacco use and its impacts on the community, considering the wider determinants of health. It also considers how tobacco control activities are being implemented in Derby, with specific focus on the ambitions set out in the National Tobacco Plan. Overall, its findings provide the insight to inform the co-development of an action plan for tobacco control in Derby, in terms of the key needs, challenges and areas for focus.

What are the important needs in relation to tobacco control?

1. **Reducing smoking prevalence among socioeconomically disadvantaged groups, including people with long-term mental health conditions**

The data profile shows that smoking rates remain particularly high among certain groups when compared to the general population. Both locally and nationally, there are ongoing social inequalities in smoking prevalence, particularly affecting people with long-term mental health conditions, people living in social housing and those working in R&M occupations. These groups are already at higher risk of experiencing socioeconomic disadvantage and poorer health outcomes. Reducing smoking prevalence among these populations will be important for supporting action to address health inequalities, of which smoking is recognised to be one of the leading causes.

2. **Reducing smoking rates in pregnancy**

While smoking prevalence during pregnancy has declined over recent years, Derby continues to experience a significantly higher rate of smoking at the time of delivery compared to the England average (11.9% in Derby vs 9.1% for England). The City is not on track to achieve the government ambition to reduce smoking prevalence in pregnancy to 6% or less by the end of 2022. Gaps in local insight exist in terms of understanding the reasons for the high prevalence locally. Addressing tobacco dependence in pregnancy remains an ongoing priority area for focus.

3. **Ensuring the effectiveness of local Stop Smoking Services**

Increasing the number of successful quitters will have health and economic benefits for individuals, families and communities in Derby. The current model for local community-based Stop Smoking Services compares favourably to the national average for overall successful self-reported quit attempts and cost-effectiveness. However, there are variations in quit outcomes by

sociodemographic group, with a lower proportion of successful quit attempts among pregnant women, certain ethnic minority groups and certain age groups.

Current plans are underway to enhance the local service offer to better support key 'at-risk' and priority groups. This includes a planned service review to optimise the smoking cessation support offer provided to children and young people. These activities should be evaluated to assess whether they are having an impact on the proportions of people engaging with the service, setting a quit date and successfully stopping smoking. It is recognised that further insight work is needed to continue to optimise engagement and the local service offer to reduce smoking-related inequalities.

Livewell has previously worked with several local employers to support smoking cessation among their workforce. There may be opportunities to consider more targeted work with local employers to support reductions in smoking prevalence among R&M workers, where smoking rates remain substantially than in the general population.

One area not assessed in detail as part of this needs assessment are successful quit outcomes among hospital inpatients and people with long-term mental health conditions. This is recognised as an area for development. Data gathered as part of the new NHS Tobacco Dependency Treatment Programme, once fully established, will support understanding of smoking cessation outcomes among these populations to inform local practice.

4. Maximising environmental measures on smoking to reduce secondhand smoke exposure and increase public awareness

Continued enforcement of smokefree legislation and policies remains important for reducing the harms of SHS. Additionally, there is scope locally to extend smokefree environments through the provision of voluntary smokefree zones. This includes at school gates, play areas and as part of new planning and regeneration projects across the City. While it is acknowledged that the evidence base is still emerging in this area, this could be beneficial for reducing the harms of SHS, particularly among vulnerable groups, such as children and young people. Identification of potential sites for voluntary smokefree zones, accompanied by public consultation, could also provide opportunities to raise awareness of the impacts of secondhand and thirdhand smoking, particularly on younger children.

Partners must continue to recognise the substantial harms to children and non-smokers linked to SHS exposure in the home. Any resources developed around voluntary smoke free zones could be sensitively designed to increase public awareness of the harms of SHS in all environments. This includes tailored information signposting families and care givers to stop smoking support. There may also be opportunities to enhance collaboration with non-traditional partners beyond healthcare and educational settings in promoting these messages.

It is recognised that adult smoking rates and SHS exposure in the home environment among children is substantially higher for people living in social housing compared to people living in other types of housing. This exacerbates existing health and socioeconomic inequalities. There may be opportunities for partnership work with local social housing providers, in consultation with residents, to integrate stop smoking support into their existing health and wellbeing activities.

5. Ensuring continued enforcement action to tackle the illegal tobacco trade

Cheap and illegal tobacco undermines the effectiveness of tobacco control initiatives. This perpetuates the cycle of harm by making smoking more accessible to everyone, particularly children and low income groups. Additionally, it makes it harder for smokers to quit and remain smokefree. The illegal tobacco trade also brings crime into the community. It is often linked to other forms of criminality, including organised crime.

Derby Trading Standards has made substantial seizures of illegal tobacco and illegal vapes over recent months. This is despite changes in service capacity and the increasingly covert tactics used by those involved in the illegal tobacco trade to evade detection. Continued enforcement activities are required to address illegal tobacco activities across the City, including underage sales and illegal vaping products. It is important that this is underpinned by the appropriate local capacity, resource and intelligence, alongside support from multi-agency partners, to inform targeted enforcement action.

6. Strengthening action to prevent smoking uptake among children and young people

Smoking is an addiction that is largely established in childhood. However, there are gaps in local intelligence around smoking prevalence among children and young people and the outcomes of current prevention initiatives. This is an area for development. There may be opportunities to build local insights to inform practice through:

- Consideration of school-based surveys to understand the numbers of young people who may be taking up smoking and vaping.
- Evaluation of existing prevention activities in educational and other settings.
- Consideration of the role of wider evidence-based prevention initiatives.

What are the challenges for tobacco control in Derby?

Data and insight

There are limitations in the data available to inform the targeting of local tobacco control measures. This includes information on smoking prevalence by gender, ethnicity and among other key 'at-risk' groups, such as children and young people, hospital inpatients and people from the LGBTQI+ community.

Derby level data may also mask variations in smoking rates at a small area level. Nationally, it is recognised that smoking and its related harms are largely concentrated among the most deprived communities. From an enforcement perspective, Crimestoppers will soon cease to be a source of intelligence. Exploring opportunities to develop local insight work, as appropriate and feasible, could be beneficial for informing wider tobacco control initiatives.

Strategic leadership and oversight

There is currently no local Tobacco Control Strategic Group which brings together and coordinates the activities of all system partners involved in tobacco control activities. In Derby, there is a strong case for investment in tobacco control. Smoking costs the City an estimated £108 million per year, including £89 million in lost productivity and £17.4 million in combined health and social care costs. However, tobacco control measures themselves require investment and are not immediately cost saving. In the context of significant cost and resource pressures affecting local authorities and healthcare services, this will require a strong commitment and strategic leadership to support sustained and cohesive local action. Furthermore, many important tobacco control measures are determined and implemented nationally, such as taxation policies and legislation. Local advocacy on

these issues could be supported through thematic work and/or the establishment of a broader Tobacco Control Strategic Group.

The Midlands Tobacco Control Network may also provide a forum for advocacy and lobbying for tobacco control at a national level. Additionally, this could provide further opportunities to strengthen the coordination and impact of tobacco control activities at both a local and regional level. For example, through supporting shared learning, increased consistency of messaging, development of data insights and pooling of resources to facilitate joined up working and collaborative action across system partners.

Where should the focus be?

The data and information in this needs assessment highlights the need for a life-course approach to tobacco control. Nationally, smoking remains the leading cause of preventable illness and premature death. There is clear evidence of the damaging health effects of smoking from conception through to later life.

Over recent years, substantial progress has been made in Derby to reduce adult smoking rates, with adult smoking prevalence now similar to the England average. However, at 13.2% the proportion of adults smokers remains above the government ambition to reduce adult smoking rates to 12% or less by the end of 2022.

Derby continues to experience significantly higher rates of smoking related mortality and hospital admissions compared to the national average. This demonstrates the substantial impacts of smoking on population health and wellbeing and its significant burden on healthcare services. Reducing smoking prevalence will also contribute positively to life expectancy and healthy life expectancy in Derby, which are below the England average. However, tobacco-related harms are not evenly distributed throughout society. As highlighted above, there are ongoing social inequalities linked to smoking prevalence, particularly affecting R&M workers, social housing residents and people with long-term mental health conditions. There is a strong association between smoking, deprivation and health inequalities. Therefore, a place-based approach that focuses on the most disadvantaged communities is likely to have the greatest impact in improving population health outcomes and reducing tobacco-related inequalities.

Addressing tobacco dependency in pregnancy continues to be an ongoing priority area for focus. While smoking prevalence at the time of delivery has reduced over recent years, this continues to be significantly higher than the national average. Further multiagency work and leadership will be needed to reduce smoking rates in pregnancy. Growing activity to address maternal tobacco dependence demonstrates the commitment to reducing the prevalence locally. This includes work to implement the new NHS Tobacco Dependency Treatment Programme, which outlines specific support for pregnant women and birthing people, and their partners.

Effective tobacco control is dependent on a clear commitment to a smokefree future. This requires a whole systems approach, applying evidence-based and multi-component interventions. It also requires collaborative action across multi-agency system partners. Establishing a Derby and Derbyshire Tobacco Control Strategic Group, and engagement with regional activities through the Midlands Tobacco Control Network, could provide opportunities to optimise strategic leadership and partnership working to amplify local efforts.

Mass media campaigns remain a key area of work within tobacco control that is not currently evident and is an area for further development. This would also provide opportunities to bridge across geographic boundaries, including collaboration across the ICS footprint and wider Midlands region.

Recommendations for consideration

This needs assessment was undertaken on behalf of the Derby Health and Wellbeing Board. The needs assessment Steering Group has developed the following recommendations for consideration:

Recommendations
An overarching approach to tobacco control that:

5. Strengthens local action to address smoking-related inequalities through:
• A place-based approach to target communities and populations where smoking prevalence is highest.
• An approach that engages and supports known priority and 'at-risk' groups. This includes:
  ○ children and young people
  ○ during pregnancy
  ○ routine and manual workers
  ○ hospital inpatients
  ○ people with long-term mental health conditions
  ○ people living in social housing
  ○ certain ethnic minority groups
  ○ LGBTQI+ groups.
• Development of mass media campaigns to reduce tobacco-related harms, linking with regional and national initiatives, as appropriate.

6. Gathers local insight, as appropriate and feasible, to inform: • future commissioning arrangements • service provision • wider tobacco control initiatives.
7. Builds system capacity through strategic leadership and collaborative action: • Strengthen system-wide leadership and action via the Derby Health and Wellbeing Board to raise the local profile of tobacco control initiatives. • Consider developing a Derby and Derbyshire Tobacco Control Strategic Group to upscale cross-organisational working and coordination of local efforts. This includes working with Derbyshire County Council and other partners at an ICS level, as appropriate • Invite the development of shared commitments across multi-agency partners. • Identify priority areas for action to support effective planning and service development. • Establish links to the Midlands Tobacco Control Network to strengthen advocacy for local tobacco control initiatives, partnership work and action at a regional and national level.
8. Self-assesses work on a broad range of tobacco control issues through: • Evaluating and monitoring the impacts of local tobacco control initiatives. • Ensuring activities follow the latest evidence-based practice.
Stop smoking support
• Ensure support and services are evidence-based and easily accessible. • Consider more targeted support for priority and 'at-risk' groups who are most vulnerable to tobacco-related harms.

• Consider targeted work with local employers to support reductions in smoking prevalence among routine and manual workers. • Develop a consensus across ICS partners on vaping, informed by the latest evidence and guidance.
Preventing uptake
• Understand the impact of current prevention activities and the role for wider evidence-based prevention initiatives. • Local insight work to understand the numbers of young people who may be taking up smoking and vaping.
Illegal tobacco
• Continue enforcement action to target the illegal tobacco trade. • Ensure this is supported by the appropriate local capacity, resource and intelligence.
Smokefree places
• Continue to support and enforce existing smokefree legislation and policies. • Consider extending smokefree environments, supported by local public consultation. • Consider opportunities to work with local social housing providers to integrate stop smoking support into their existing health and wellbeing activities.

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