

Tobacco Control Health Needs Assessment 2019



Population Knowledge & Intelligence Team

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Executive Summary

Tobacco remains the single-most harmful legal substance to health. Smoking is the leading cause of preventable deaths and early deaths in the UK and in Derbyshire.

Sadly, smoking is responsible for six deaths a day in Derbyshire.

And tobacco use is a major cause of ill health particularly from cardiovascular disease, respiratory diseases, and lung cancer. There are particular health risks for children exposed to secondhand smoke, and from smoking in pregnancy.

Approximately 1 million cigarettes are smoked each day in Derbyshire. Yet there are opportunities to strengthen our efforts to reduce the harms associated with smoking.

This summary highlights the key messages from a health needs assessment that has been developed to bring together data and evidence to inform the development and implementation of local tobacco control work.

Who is smoking in Derbyshire?

Approximately 88750 adults (13.9% of the population) are current smokers.

There are higher smoking rates among lower socioeconomic groups and people with mental illness:

- o 23.3% of routine and manual workers are current smokers.
- \circ 39.9% (1703) adults with serious mental illness smoke.
- o 28.9% of adults with long term mental health condition smoke.

15% of young people have tried a cigarette, 3% of those who tried now smoke daily. 25.2% of 15 year olds have tried e-cigarettes.

Smoking prevalence varies slightly between the districts; more adult smokers live in Amber Valley and Chesterfield.

	Estimated number of smokers
Amber Valley	15,728
Bolsover	11,557
Chesterfield	14,658
Derbyshire Dales	5,620
Erewash	10,148
High Peak	11,536
North East Derbyshire	7,662
South Derbyshire	11,588

15.4% of pregnant women were smoking at the time of delivery (1068 women). This is significantly higher than the England average (10.8%).

What are the impacts of smoking locally?

Deaths

- 16 in every 100 deaths in Derbyshire can be related to smoking
- Approximately 2200 deaths in Derbyshire were caused by smoking in 2018 such that smoking was responsible for 6 deaths each day

• Smoking in pregnancy makes still birth twice more likely and sudden infant death three times more likely.

Reduced life expectancy

- Smoking is responsible for approximately half of the differences in life expectancy between the most and least affluent
- But if 3200 male smokers quit, the healthy life expectancy would rise to 64.0 years, higher than the national average
- And if 10084 female smokers quit, the healthy life expectancy would rise to 64.3 years, higher than the national average

Illness and use of health services

- Treating smoking-related illnesses such as cancers, respiratory diseases, and cardiovascular diseases annually requires:
 - 8138 hospital admissions
 - o 363,053 GP consultations
 - 127,055 practice nurse consultations
 - 202,626 GP prescriptions
 - o 73,269 outpatient visits

This costs the local NHS £39.6 million

Costs to the economy

- £108.9 million potential wealth is lost from the economy due to early deaths, sick leave and smoking breaks
- Overall across health, social care, fire and rescue service, and the impacts on productivity, smoking costs Derbyshire £174.7 million each year
- And then, most people who quit smoking save around £3000 per year which can boost household incomes

So what is tobacco control?

Tobacco Control refers to the supply, demand and harm reduction strategies that aim to improve health by eliminating or reducing the consumption of tobacco and exposure to tobacco smoke. The Tobacco Control Plan 2017-2022 for England includes ambitions to achieve a smokefree generation, support smokers to quit, eliminate variation in smoking rates and ensure effective enforcement. There is increasing emphasis on the tobacco 'endgame' in achieving a smoking prevalence rate of 5% or below. Action on Smoking and Health have set a challenge for local areas to seek to meet this by 2029.

And what progress has been made in reducing smoking locally?

There has been a decrease in the prevalence of smoking nationally and Derbyshire prevalence has been declining. If a linear trend continues the overall prevalence is likely to fall below 10% by 2024.

The key issue is that of inequalities – smoking is concentrated among people from more disadvantaged backgrounds. The smoking prevalence is projected to still be 15% in 2024 among adults in routine and manual occupations.



And smoking rates remain higher in people who are unemployed, and stubbornly high in people living with mental ill health.

There is also a slower decline in smoking rates among pregnant women. The Government ambition is to reduce the smoking in pregnancy rate to less than 6% by 2022. Yet following the current trend Derbyshire is projected to still have a rate of 13% in 2022/2023.

Effective tobacco control measures will reduce the uptake of smoking, increase the number of quit attempts, and improve the success of the quit attempts made. These outcomes need to be achieved within the population groups who are more tobacco dependent.

What is being implemented for tobacco control locally?

Last year 892 people successfully quit smoking through the Derbyshire stop smoking service (76% of these quits were validated). Half of the individuals making initial contact with the service do not set a quit date, and work is underway to improve the communication materials and standards.

During 2017/18 only 112 pregnant women in Derbyshire set a quit date, and smoking in pregnancy rates remain high. There is clear evidence for tackling smoking in pregnancy through implementation of NICE Guidance, Baby Clear and the NHS England Saving Babies' Lives Care Bundle. Further multiagency work and leadership will be required to achieve real progress.

Derbyshire Trading Standards has made substantial seizures of illicit tobacco in recent months, despite changes in service capacity. A local consultation on developing smokefree places is underway as a means of protecting children from secondhand smoke. There may be opportunities through this to increase public awareness of the harms of secondhand smoke.

Health and social care organisations have demonstrated a commitment to reducing smoking rates within the Joined Up Care Derbyshire Prevention Plan. There is variation in the offer of support within primary care to current smokers. The risky behaviour CQUIN is being rolled out in local hospitals, again highlighting that patients should be supported to access specialist services and be offered medication. Working with outpatients including those pre-surgery needs further consideration to tackle the harms of tobacco dependence.

And what more could be done?

The steering group recommend that we:

- 1. Discuss the findings with Derbyshire Health and Wellbeing Board, and with the Joined Up Care Derbyshire Board to:
 - a. raise the profile of the issues
 - b. call for system-wide leadership and action
 - c. invite the development of shared commitments, such as a target towards a tobacco free generation with prevalence of adult smoking below 5% within a fixed timeframe
- 2. Upscale the cross-organisational work particularly on addressing smoking in pregnancy, building on the commitment within organisations, and to amplify local efforts. And then to use the learning from the work on smoking in pregnancy to identify effective ways of collaboration that can support action on smoking in other population groups.
- 3. Consider reconvening a Tobacco Control group for Derbyshire to coordinate local efforts, draw attention to work across partners, and as a mechanism for advocacy for action at regional and national levels.



1. Introduction to Tobacco Control

1.1.Tobacco Control

1.1.1. Definition

Tobacco Control is an umbrella term for the science, policy, and practice mobilised towards reducing tobacco use and its associated harms. Tobacco remains the single-most harmful legal substance to health: smoking is the leading cause of preventable morbidity and premature mortality in the UK.

The Framework Convention on Tobacco Control (FCTC)¹ developed by 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'.*

1.1.2. International Priorities

To support the implementation of effective interventions at country-level WHO has defined six 'MPOWER'² measures:

- 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

WHO emphasises that tobacco control policies should not be pursued in isolation, and that effective multi-layered strategies are required.³ A policy index in 2009 found indications of multiplicative effects between four types of restrictions⁴ aligning with the emphasis on comprehensive policy approaches. A Tobacco Control Scale scoring the implementation of these policies has been applied to European countries as part of work by the European Network for Smoking Prevention.⁵ In the most recent report in 2016, the UK received the top score of 81 of 100.

There is increasing emphasis on the tobacco 'endgame' usually defined as a prevalence rate of 5% or below⁶. Achieving this will require ongoing consensus around harm reduction and eradication approaches within the tobacco control movement, alongside cessation measures. For the UK, health organisations and charities including the British Medical Association and Cancer Research UK are promoting the ambition of a tobacco free UK by 2035, where less than 5% of the adult population are smokers.

1.1.3. National Tobacco Control Plan

The Tobacco Control Plan for England 2017-22 sets out the national vision for a smokefree generation and outlines four ambitions and the actions required at a national and local level towards this vision. The Tobacco Control Delivery Plan provides more detail for the implementation of this plan, including identifying key programmes or activities, milestones, lead agencies, and metrics. The Delivery Plan makes calls for action within Local Systems with roles for local councils, the NHS and civic society.

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Ambition	Actions
Prevention	1.1 Work to eliminate smoking among under 18s and achieve the first smokefree
First	generation
	 training health professionals on smoking cessation
	- sanctions for tobacco retailers
	1.2 Stamping out inequality: smokefree pregnancy - reduce the prevalence of
	smoking during pregnancy to improve life chances for children
Supporting	2.1 Stop smoking services
smokers to	2.2 Parity of esteem: supporting people with mental health conditions - reduce the
quit	prevalence of smoking in people with mental health conditions
	2.3 Backing evidence based innovation: develop a strong evidence base on the full spectrum of picotipe delivery products
	2.4.4 Smokefree NHS leading by example: create and enable working
	environments which encourage smokers to quit
Eliminating	3.1 A whole system approach: develop all opportunities within the health and care
Variation in	system to reach out to the large number of smokers engaged with healthcare
smoking	services on a daily basis
rates	3.2 Local inequalities: eliminating health inequalities through targeting those
	populations where smoking rates remain high
	3.3 Public awareness: use mass media campaigns to promote smoking cessation
	and raise awareness of the harms of smoking
	3.4 Smokefree places: explore further opportunities to protect people from the harm
	of secondhand smoke
	3.5 Tobacco control intelligence: ensure our strategies are effective and evidence
	based
Effective	4.1 Taxation: maintain a robust tax regime for tobacco and reduce discrepancies in
enforcement	product prices
	4.2 Illicit tobacco: implement the illicit tobacco strategy and reduce the market
	snare or these products
	4.3 Regulation and enforcement: improve the use and effectiveness of sanctions
	and monitor the development of novel products
	4.4 Leaving the European Union: review where the UK's exit from the EU offers us
	opportunities to runner improve public nealth

1.1.4. Policy and Guidance

There are resources from NICE, PHE and public health charities and organisations to advise and inform local tobacco control work.

NICE Guidance

Existing NICE Guidance has been published between 2007 and 2018:

- Smoking: workplace interventions (PH5)
- Smoking: preventing uptake in children and young people (PH14)
- Smoking prevention in schools (PH23)
- Smoking: stopping in pregnancy and after childbirth (PH26)
- Smokeless tobacco: South Asian communities (PH39)
- Smoking: harm reduction (PH45)
- Smoking: acute, maternity and mental health services (PH48)
- Stop smoking interventions and services (NG92).

The components of tobacco control are distributed through these but are not summarised in one place. Newly updated Guidance (Tobacco: preventing uptake, promoting quitting and treating dependence) is in preparation for January 2020 will update and amalgamate these.

Public Health England Resources: CLeaR

CLeaR is an evidence-based approach to tobacco developed from NICE Guidance and the Tobacco Control Plan for England. The CLeaR model offers a self-assessment tool, and a voluntary peer-assessment process. It is designed to be implemented through discussion with local partners and to provide the opportunity to benchmark local work on tobacco control in comparison with other areas, and over time.

Additional resources are available in toolkits for deep dive work (standalone or combined) on stopping smoking in acute settings and maternity; stopping smoking in mental health settings; stopping smoking during and after pregnancy; illegal tobacco and compliance with regulations

Public Health Charities and Organisations

Action on Smoking and Health (ASH)⁷ have compiled a local resources <u>toolkit</u> with other partners, which includes resources to make the case effectively for tobacco control.

Cancer Research UK issued a <u>Tobacco Control Local Policy Statement</u> in December 2017⁸ stating that local authorities should develop a comprehensive tobacco control strategy that includes:

- Prioritisation and sustained funding for tobacco control
- Provision of evidence-based Stop Smoking Services
- A coordinated tobacco control alliance to provide:
 - Mass media campaigns
 - Measures to target illicit trade
- An acceleration in progress to reduce health inequalities
- Recognition of the WHO Framework Convention on Tobacco Control

1.1.5. Components of effective Tobacco Control in Derbyshire

The Derbyshire description of effective tobacco control is framed around the four ambitions in the national Tobacco Control plan, but ensuring that leadership is highlighted within this. Local strategic priorities will be identified within these ambitions.

Furthermore, Derbyshire County Council has a clear policy not to work in partnership with tobacco companies. This position is consistent with:

- Public Health England and the Association of Directors of Public Health position statements on working with tobacco companies
- Article 5.3 of the WHO Framework Convention on Tobacco Control
- Local Government Declaration on Tobacco Control

1.2. Health Needs Assessment

"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".⁹ The Health Needs Assessment (HNA) approach requires developing a shared understanding of health, and in particular, of needs. The concept of 'needs' in a population was set out by Bradshaw¹⁰ in 1972 across four groups:

- Normative needs defined by experts
- Felt needs perceived by the individual
- Expressed needs service demands
- Comparative needs identified by differences in demand or provision

Health needs assessments are conducted to understand the influences, overlaps and gaps between the need, demand, and supply, of healthcare or the implementation of policy. The assessments often reframe needs in terms of the capacity to benefit from services or interventions at individual, community or population level. The three main paradigms for needs assessment are epidemiological, comparative, and corporate¹¹; these can be described and considered specifically in relation to tobacco control as below:-

Paradigm	Epidemiological	Comparative	Corporate
Concerned with:	Measures of frequency - prevalence, incidence; and impact measures - effectiveness, cost- effectiveness; and existing services	Performance measures compared across communities, over time, between areas of health or providers	Structured collection of knowledge and views of stakeholders - commissioners, providers, service users, local population
Health needs focus:	Primarily normative and expressed needs	Comparative needs	Primarily expressed needs, some normative and felt needs
Advantages of approach:	Scientific rigour	Develops understanding of variation in costs and outcomes	Social model of health; informative for services/interventions in local context
Potential limitations of approach:	Tends towards a medical model; data availability	Subjectivity in determining comparators and assessing performance	Determining weighting of different voices
Opportunities in relation to Tobacco Control	Understanding tobacco use in the population; Quantifying the harms of tobacco; Quantifying the tobacco control responses	Interpreting implementation of tobacco control approaches; learning from best practice from other areas	Informing priorities for change and action planning

1.3. Aims and objectives

The purpose of the Derbyshire Tobacco Health Needs Assessment is to comprehensively collate information and intelligence on tobacco control, and to enable the development and subsequent delivery of a local strategy and action plan for tobacco control, working with partners across organisations. The focus aligns with the Health and Wellbeing Strategy 2018-2023 'Our lives, our health' priority to 'Enable people in Derbyshire to live healthy lives'.

2. Profile of Population and Tobacco Use

2.1.Smoking Prevalence Estimates

There are number of sources of data on the prevalence of smoking in the UK. Those considered here are reported on the Public Health England <u>Fingertips</u> tool. These include the GP Patient Survey (GPPS), the Annual Population Survey (APS), the Quality and Outcomes Framework (QOF), the GP Extraction Service (GPES) and the What About YOUth (WAY) survey. By their nature these return differing results for prevalence but also provide different insights into smoking amongst sub-groups of the population as a whole. In the main this report will focus on the APS estimates for adults and the WAY survey for young people for the purposes of consistency.

2.1.1. Adults

Around 13.9% of adults in Derbyshire in 2010, roughly 88,750, are currently smokers, similar to England and in the middle of the range for our CIPFA nearest neighboursⁱ (Figure 1). However more than half of adults have never smoked and the prevalence of smoking has been steadily decreasing (Figure 2). Smoking prevalence across the county is broadly similar to that in England as a whole, but is significantly lower in North East Derbyshire at 9.3% (7,662) Derbyshire Dales at 9.5% (5,620) (Figure 3). Confidence intervals are very wide as rates are estimated from a national survey.

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	6,321,931	14.4	н	14.2	14.7
Neighbours average	-	-	-	-		-	-
Lincolnshire	-	3	107,115	17.7		15.0	20.3
Somerset	-	13	70,810	15.9	⊢−−−−	13.1	18.7
Nottinghamshire	-	1	100,252	15.4		13.0	17.8
Northamptonshire	-	11	86,813	15.1	⊢−−−−	12.7	17.6
Norfolk	-	6	103,942	14.3	├	12.2	16.4
Lancashire	-	8	135,595	14.2	├	12.4	16.0
Warwickshire	-	5	63,487	14.1		11.7	16.5
Essex	-	12	162,439	14.0	⊢	12.3	15.7
Derbyshire	-	-	88,744	13.9	⊢	11.8	15.9
Cumbria	-	10	55,371	13.6	⊢−−−	11.5	15.8
Leicestershire	-	14	72,724	13.2	├	10.8	15.5
Suffolk	-	7	78,613	13.0	⊢	11.0	15.0
Staffordshire	-	2	86,763	12.4		10.4	14.3
Gloucestershire	-	9	60,801	12.1		9.9	14.3
North Yorkshire	-	15	59,449	12.0	H	9.8	14.3
Worcestershire	-	4	55,495	11.8		9.6	13.9

Figure 1 Smoking Prevalence in adults (18+) - current smokers - Proportion (%) 2018

ⁱ The Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours model seeks to measure similarity between Local Authorities. There are 15 counties that are comparable with Derbyshire and can be used to benchmark health indicators.





Figure 3 Smoking Prevalence in adults (18+) - current smokers (APS) - Geographical variation 2018

Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England	-	6,321,931	14.4	н	14.2	14.7
Derbyshire	-	88,744	13.9	H	11.8	15.9
Amber Valley	-	15,728	15.4	here and the second	10.3	20.5
Bolsover	-	11,557	18.2		11.1	25.4
Chesterfield	-	14,658	17.3	ا	10.7	23.8
Derbyshire Dales	-	5,620	9.5		4.7	14.3
Erewash	-	10,148	11.0	H	6.1	15.9
High Peak	-	11,536	15.5		8.5	22.5
North East Derbyshire	-	7,662	9.3	⊢−−−−−	4.9	13.7
South Derbyshire	-	11,588	14.4	·	8.0	20.7

Amongst adults of working age in manual and routine occupations an estimated 23.3% currently smoke (Figure 4), 24.1% are former smokers and 52.5% have never smoked. The proportion of smokers amongst routine and manual workers remains significantly higher than the proportion of smokers in the population as a whole, although falling more quickly from a higher baseline (Figure 5). Across the county, the prevalence similar to England's, except in North East Derbyshire (9.6%) and Erewash (13.5%) where it is significantly lower (Figure 6). Confidence intervals are very wide as rates are estimated from a national survey.

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	-	25.4	н	24.8	26.0
Neighbours average	-	-	-	-		-	-
Lincolnshire	-	3	-	31.6		25.2	38.0
Lancashire	-	8	-	27.9		22.9	32.9
Somerset	-	13	-	27.8	⊢−−−−	21.3	34.2
Suffolk	-	7	-	27.5	→−−−	21.5	33.4
Nottinghamshire	-	1	-	26.7	⊢−−−−	20.9	32.5
Essex	-	12	-	26.0	⊢−−−	21.3	30.7
Norfolk	-	6	-	25.8	⊢−−−−	20.5	31.1
North Yorkshire	-	15	-	25.1	⊢−−−−−	17.7	32.5
Cumbria	-	10	-	25.0	⊢−−−	19.8	30.1
Northamptonshire	-	11	-	24.7	⊢−−−−	18.6	30.7
Worcestershire	-	4	-	23.5	⊢	17.1	30.0
Derbyshire	-	-	-	23.3		18.6	28.1
Warwickshire	-	5	-	22.8		16.5	29.1
Leicestershire	-	14	-	22.4	⊢−−−−	16.4	28.5
Staffordshire	-	2	-	21.0	⊢−−−	16.2	25.8
Gloucestershire	-	9	-	19.8		14.2	25.5

Figure 4 Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers – Proportion (%) 2018

Figure 5 Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers - Derbyshire trend



Figure 6 Smoking Prevalence in adults in routine and manual occupations (18-64) - current smokers - Geographical variation 2018

Area	Recent Trend	Count	Value	95% Lower Cl	95% Upper Cl
England	-	-	25.4 H	24.8	26.0
Derbyshire	-	-	23.3	18.6	28.1
Amber Valley	-	-	31.0	18.1	43.9
Bolsover	-	-	25.1	11.7	38.5
Chesterfield	-	-	34.2	20.9	47.4
Derbyshire Dales	-	-	22.2	6.9	37.6
Erewash	-	-	13.5	3.9	23.1
High Peak	-	-	30.3	8.1	52.4
North East Derbyshire	-	-	9.6	1.5	17.6
South Derbyshire	-	-	16.8	6.6	26.9

2.1.2. Young People

The Tobacco Control Plan (July 2017)¹² highlights the importance of reducing the number of young people taking up smoking, as it is "an addiction largely taken up in childhood".

From the WAY survey, 8.0% of 15 year olds smoke (Figure 7), 5.4% being regularⁱⁱ smokers (Figure 8) and 2.7% occasionalⁱⁱⁱ smokers (Figure 9). These are similar to the figures for England and again mid-range of our CIPFA neighbours. The vast majority of 15 year olds recognised the harm that smoking can do to others; Derbyshire had the highest rate of its CIPFA neighbours (Figure 10).

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	-	8.2	H	8.1	8.3
Neighbours average	-	-	-	-		-	-
Norfolk	-	6	-	11.4		9.5	13.3
Essex	-	12	-	10.5		8.6	12.4
Somerset	-	13	-	9.5	⊢−−−	7.8	11.2
Worcestershire	-	4	-	9.4	⊢−−− −−−	7.7	11.1
Lancashire	-	8	-	9.0		7.3	10.7
Gloucestershire	-	9	-	8.9		7.2	10.6
Northamptonshire	-	11	-	8.7	→−−−	7.1	10.3
Suffolk	-	7	-	8.6	→−−−	7.0	10.2
Warwickshire	-	5	-	8.2	├	6.7	9.7
Derbyshire	-	-	-	8.0	⊢	6.4	9.6
Lincolnshire	-	3	-	7.9	⊢ I	6.4	9.4
Staffordshire	-	2	-	7.9	⊢	6.3	9.5
Nottinghamshire	-	1	-	7.4	→	5.9	8.9
Cumbria	-	10	-	7.3	i −−−i	5.9	8.7
Leicestershire	-	14	-	6.9	⊢	5.5	8.3
North Yorkshire	-	15	-	5.5		4.2	6.8

Figure 7 Smoking prevalence at age 15 - current smokers - Proportion (%) 2014/15

Figure 8 Smoking prevalence at age 15 - regular smokers - Proportion (%) 2014/15

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	-	5.5	н	5.4	5.6
Neighbours average	-	-	-	-		-	-
Norfolk	-	6	-	7.9		6.3	9.5
Somerset	-	13	-	7.2		5.7	8.7
Worcestershire	-	4	-	6.3	⊢−−−−	4.9	7.7
Northamptonshire	-	11	-	6.2	⊢−−−−	4.8	7.6
Essex	-	12	-	6.1		4.6	7.6
Suffolk	-	7	-	5.9		4.5	7.3
Warwickshire	-	5	-	5.9	⊢−−−−	4.6	7.2
Lancashire	-	8	-	5.7	⊢−−−− −−−−	4.3	7.1
Lincolnshire	-	3	-	5.6	⊢−−−−	4.3	6.9
Derbyshire	-	-	-	5.4	⊢−−−−	4.1	6.7
Nottinghamshire	-	1	-	5.3	⊢−−−−	4.0	6.6
Staffordshire	-	2	-	5.2	⊢	3.9	6.5
Cumbria	-	10	-	5.1		3.9	6.3
Gloucestershire	-	9	-	5.0	⊢−−−−	3.7	6.3
Leicestershire	-	14	-	4.5	⊢	3.3	5.7
North Yorkshire	-	15	-	3.2		2.2	4.2

ⁱⁱ Usually smoking 1 or more cigarettes per week

[&]quot; Sometimes smoking cigarettes but not as many as one per week

Figure 9 Smoking prevalence at age 15 - occasional smokers - Proportion (%) 2014/15

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	-	2.7	н	2.6	2.8
Neighbours average	-	-	-	-		-	-
Essex	-	12	-	4.5		3.2	5.8
Gloucestershire	-	9	-	4.0		2.8	5.2
Norfolk	-	6	-	3.5		2.4	4.6
Lancashire	-	8	-	3.3	├───	2.2	4.4
Worcestershire	-	4	-	3.2	⊢−−−−−	2.2	4.2
Derbyshire	-	-	-	2.7	⊢−−−−	1.8	3.6
Suffolk	-	7	-	2.7	⊢−−−−	1.8	3.6
Staffordshire	-	2	-	2.7	⊢−−−−	1.8	3.6
Leicestershire	-	14	-	2.5		1.6	3.4
Northamptonshire	-	11	-	2.5	⊢−−−−	1.6	3.4
Somerset	-	13	-	2.4	⊢−−−−	1.5	3.3
Lincolnshire	-	3	-	2.3		1.4	3.2
North Yorkshire	-	15	-	2.3	<mark>⊢</mark>	1.5	3.1
Warwickshire	-	5	-	2.3	→ → →→	1.5	3.1
Cumbria	-	10	-	2.2	⊢−−−−	1.4	3.0
Nottinghamshire	-	1	-	2.1		1.3	2.9

Figure 10 Attitudes to smoking in 15 year olds - 'smoking causes harm to others' - Proportion (%) 2014/15

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	-	90.9		90.8	91.1
Neighbours average	-	-	-	-		-	-
Derbyshire	-	-	-	92.4	н	90.8	94.0
Lincolnshire	-	3	-	92.2	Н	90.7	93.7
Gloucestershire	-	9	-	92.2	Н	90.6	93.8
Warwickshire	-	5	-	92.1	H	90.6	93.6
Essex	-	12	-	92.1	Н	90.4	93.8
Leicestershire	-	14	-	91.6	Н	90.0	93.2
Lancashire	-	8	-	91.1	Н	89.4	92.8
North Yorkshire	-	15	-	91.0	Н	89.4	92.6
Nottinghamshire	-	1	-	90.8	Н	89.1	92.5
Staffordshire	-	2	-	90.8	н	89.1	92.5
Suffolk	-	7	-	90.8	н	89.1	92.5
Cumbria	-	10	-	90.8	н	89.2	92.4
Worcestershire	-	4	-	90.7	н	89.0	92.4
Somerset	-	13	-	90.7	Н	89.0	92.4
Norfolk	-	6	-	89.7	H	87.9	91.5
Northamptonshire	-	11	-	89.3	н	87.5	91.1

Between 2014/15 and 2017/18, the My Life, My View survey questioned Y8, Y9 and Y10 pupils in Derbyshire about their behaviours and beliefs.

Over this period, 15% said that they had tried a cigarette, rising from 12% in 2014/15 to 15% in 2017/18 (Figure 11). The highest rates were in Bolsover and Chesterfield schools, at 17%, and the lowest in North East and South Derbyshire schools at 8% (Figure 12). 3% who had tried a cigarette now smoked daily (Figure 13).

Figure 11 My Life, My View Survey – Have you ever tried a cigarette? Derbyshire trend 2014/15-2017/18



Figure 12 My Life, My View Survey – Have you ever tried a cigarette? Proportion (%) 2014/15-2017/18

	Area Val	Je
Derbyshire		13%
Amber Valley		12%
Bolsover		17%
Chesterfield		17%
Derbyshire Dales		10%
Erewash		13%
High Peak		12%
North East Derbysh	nire	8%
South Derbyshire		8%

Figure 13 My Life, My View Survey – If you have ever tried a cigarette how often do you smoke? Proportion (%) 2014/15-2017/18

Once a month	2%
Once a week	1%
Once a day	3%

2.1.3. Vulnerable Groups

The rate of decline of smoking prevalence has not been equal among all populations including people with a mental health condition¹³. High smoking rates among people with mental health problems are the single largest contributor to their 10 to 20-year reduced life expectancy. In addition studies have shown that those smoking more than 15 cigarettes a day are more likely to experience a common mental health disorder than those who smoke fewer cigarettes or do not smoke at all¹⁴, and 40% of cigarettes smoked in England are smoked by people with a mental health problem¹⁵. In Derbyshire, smoking prevalence in people with serious mental illness is, at 39.9% (1,703 smokers), similar to that in England as a whole and is mid-range of the CIPFA nearest neighbours (Figure 14).

Figure 14 Smoking prevalence in adults (18+) with serious mental illness (SMI) - Proportion (%) 2014/15

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	146,442	40.5		40.4	40.7
Neighbours average	-	-	26,114	39.4*		-	-
Northamptonshire	-	11	1,808	45.1*	H	43.6	46.7
Lancashire	-	8	3,771	42.9*	-	41.9	43.9
Norfolk	-	6	2,078	40.7*	H	39.3	42.0
Cumbria	-	10	1,481	40.2	H	38.6	41.8
Lincolnshire	-	3	1,114	40.1*	⊢ <mark>-</mark> -	38.3	41.9
Derbyshire	-	-	1,703	39.9*	H	38.5	41.4
Essex	-	12	1,911	39.4*	H	38.1	40.8
Somerset	-	13	1,249	39.1	⊢ -(37.5	40.8
Nottinghamshire	-	1	1,505	38.7*	H	37.2	40.2
Suffolk	-	7	1,534	38.6*	H	37.1	40.1
Warwickshire	-	5	1,299	38.3	H	36.6	39.9
Gloucestershire	-	9	1,305	38.1	H-H	36.4	39.7
Staffordshire	-	2	1,624	37.2	н	35.7	38.6
Worcestershire	-	4	1,321	37.0	H	35.5	38.6
North Yorkshire	-	15	1,160	35.1*	H	33.5	36.7
Leicestershire	-	14	1,251	33.8	H-H	32.3	35.4

From the GPPS, the proportion of adults with a long term mental health condition who are smokers ranges from 14.5% in Derbyshire Dales, significantly lower than for England to 36.1% in Chesterfield (Figure 15).

Figure 15 Smoking prevalence in adults (18+) with a long term mental health condition - Proportion (%) 2014/15

Area	Recent Trend	Count	Value	95% Lower Cl	95% Upper Cl
England	-	-	27.8	27.4	28.2
Derbyshire	-	-	28.9	25.7	32.2
Amber Valley	-	-	32.1	23.3	40.9
Bolsover	-	-	24.6	14.6	34.6
Chesterfield	-	-	36.1	26.3	45.9
Derbyshire Dales	-	-	14.5	6.8	22.2
Erewash	-	-	29.0	20.2	37.7
High Peak	-	-	34.4	25.3	43.5
North East Derbyshire	-	-	32.3	23.5	41.0
South Derbyshire	-	-	20.6	11.6	29.7

Smoking prevalence amongst those with anxiety or depression ranges from 14.2% in South Derbyshire and 18.1% in Derbyshire Dales – both significantly lower than for England – to 31.8% in Chesterfield (Figure 16).

Area	Recent Trend	Count	Value	95% Lower Cl	95% Upper Cl
England	-	-	25.8	25.6	26.1
Derbyshire	-	-	24.8	22.5	27.1
Amber Valley	-	-	21.7	16.0	27.4
Bolsover	-	-	23.4	17.2	29.7
Chesterfield	-	-	31.8	24.7	38.8
Derbyshire Dales	-	-	18.1	I 11.1	25.2
Erewash	-	-	29.6	23.2	36.1
High Peak	-	-	26.5	19.7	33.3
North East Derbyshire	-	-	24.5	18.8	30.3
South Derbyshire	-	-	14.2	8.1	20.3

Figure 16 Smoking prevalence in adults (18+) with anxiety or depression - Proportion (%) 2014/15

The smoking prevalence in prisoners, another vulnerable group, is estimated at about 80%¹⁶ and substantially more than the general population. Smoking rates are higher in offenders than the general population, as a group they are more likely to come from deprived communities and experience greater health inequalities. A survey for the Derbyshire Offenders' Health Needs Assessment 2018 found that of those that responded, 54.9% (45 of 82) of the respondents in Derbyshire County were smokers, with a great proportion of smokers in the younger end of the age spectrum.¹⁷ There are challenges in meeting cessation needs: the transient nature of offenders often makes it difficult to offer joined-up support to offenders to quit smoking.¹⁸ Similarly, an estimated 77% of homeless people smoke.¹⁹ Notably, the quantity of cigarettes smoked is particularly high, with many homeless people smoking more than 20 cigarettes per day.²⁰ Other groups that are known to have a higher smoking prevalence than the general population include care leavers and lone parents²¹ as well as people from white and from mixed ethnic groups.²² Cumulative disadvantage increases the likelihood of smoking – and subsequently prevalence of smoking in community. Lesbian, gay, bisexual and trans (LGBT) people also have higher rates of smoking.²³

2.1.4. Smoking in Pregnancy

The NHS Digital return on Smoking Status At Time of delivery (SATOD), reveals that in Derbyshire, 15.4% (1,068) of mothers were still smoking, significantly more than in England as a whole and the second highest of our CIPFA neighbours (Figure 17), despite falling steadily (Figure 18). Smoking in pregnancy is significantly higher than in England as a whole everywhere in the county but Derbyshire Dales and Chesterfield, and is highest in Bolsover at 18.6% (Figure 19). At CCG level it is significantly higher in all but North Derbyshire CCG (Figure 20).

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	+	-	64,391	10.8		10.7	10.9
Neighbours average	-	-	14,123	12.7*		-	-
Lincolnshire	+	3	1,090	16.7*	⊢	15.8	17.6
Derbyshire	+	-	1,068	15.4		14.6	16.3
Nottinghamshire	+	1	1,142	14.7	⊢	13.9	15.5
Lancashire	+	8	1,619	13.9	H	13.3	14.6
Cumbria	+	10	588	13.7		12.7	14.8
Norfolk	+	6	1,099	13.5	H	12.7	14.2
Northamptonshire	+	11	1,071	13.1		12.4	13.9
Staffordshire	+	2	1,008	13.0	H	12.3	13.8
Worcestershire	+	4	625	12.5	⊢_	11.6	13.4
North Yorkshire	+	15	595	11.7		10.9	12.6
Somerset	+	13	634	11.6	⊢ <mark>⊣</mark>	10.7	12.4
Gloucestershire	+	9	372	10.9		9.9	12.0
Essex	+	12	1,437	10.6*	H	10.1	11.1
Suffolk	-	7	753	10.6	H	9.9	11.3
Warwickshire	+	5	538	10.1	H	9.4	11.0
Leicestershire	+	14	484	9.5*	⊢	8.7	10.3

Figure 17 Smoking status at time of delivery (Female, All ages) - Proportion (%) 2017/18

Figure 18 Smoking status at time of delivery (Female, All ages) - Derbyshire trend



Figure 19 Smoking status at time of delivery (Female, All ages) - Geographical variation 2017/18

Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England		64,391	10.8		10.7	10.9
Derbyshire		1,068	15.4		14.6	16.3
Amber Valley		180	16.2	⊢ −− 	14.1	18.5
Bolsover		126	18.6		15.8	21.7
Chesterfield		119	11.7	<mark> </mark>	9.8	13.8
Derbyshire Dales		60	13.5	├─── ┥	10.6	17.0
Erewash		191	18.1		15.9	20.6
High Peak		109	13.1		11.0	15.5
North East Derbyshire		121	15.6		13.2	18.3
South Derbyshire		161	16.2	⊢	14.0	18.6

	Recent			95%	95%
Area	Trend	Value		Lower CI	Upper Cl
NHS England		10.47			
Derbyshire STP	⇒	16.41			
NHS EREWASH CCG	⇒	18.75		14.7	24.9
NHS HARDWICK CCG	⇒	20.31		15.80	25.70
NHS NORTH DERBYSHIRE CCG	⇒	12.79	→	10.40	15.70
NHS SOUTHERN DERBYSHIRE CCG	>	16.89		15.00	19.00

Figure 20 Maternal smoking at delivery – Geographical variation - Q3 2017/18^{iv}

2.1.5. Derbyshire Maps

Applying ONS Smoking inequalities in England estimates of prevalence by deciles of deprivation to the Derbyshire population allows to roughly estimate the numbers of smokers in each Lower Super Output Area (LSOA). These estimates are illustrated in the following maps and suggest that smokers are more likely to be found in the north east of the county, but also in the extreme south and northwest.

^{iv} In April 2019 the four CCGs across Derbyshire merged to form Derby and Derbyshire CCG

Figure 21 Estimated number of smokers per census lower super output area – males 2017



Figure 22 Estimated number of smokers per census lower super output area – females 2017



2.1.6. Use of alternative forms of tobacco

Waterpipe smoking (commonly known in the UK as shisha), is a method of inhaling smoke – usually tobacco smoke, although non-tobacco forms of shisha are used. Tobacco shisha is subject to the UK smokefree legislation. Population level prevalence in the UK is low for both adults (around 1%) and young people (around 2%), but more common in Asian and Asian British populations (around 7%).²⁴ There are no indications that shisha use is common in Derbyshire. Previous trading standards seizures in Derbyshire have included shisha tobacco (740kg of shisha style tobacco without duty paid reported in June 2017).²⁵ 9.4% of 15 year olds have tried other tobacco products^v, significantly lower than for England and at the lower end of the CIPFA neighbours range (Figure 23).

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	-	15.2	н	14.9	15.4
Neighbours average	-	-	-	-		-	-
Gloucestershire	-	9	-	16.7	├	14.4	19.0
Essex	-	12	-	16.5	·	14.2	18.8
Worcestershire	-	4	-	16.2		14.1	18.3
Leicestershire	-	14	-	16.1	├	14.1	18.2
Suffolk	-	7	-	15.4		13.3	17.5
Northamptonshire	-	11	-	14.9		12.8	17.0
Staffordshire	-	2	-	14.1		12.1	16.2
Warwickshire	-	5	-	13.7	⊢	11.7	15.6
Somerset	-	13	-	13.2	⊢−−−−	11.2	15.1
Norfolk	-	6	-	12.3	⊢	10.3	14.2
Lancashire	-	8	-	11.1		9.1	13.0
Nottinghamshire	-	1	-	10.8		8.9	12.6
Derbyshire	-	-	-	9.4		7.7	11.2
North Yorkshire	-	15	-	9.3	⊢	7.7	10.9
Lincolnshire	-	3	-	9.2	⊢	7.6	10.9
Cumbria	-	10	-	6.8		5.4	8.2

Figure 23	Use of other tobacco products at age 15 - regular smokers - Proportion (%)
2014/15	

Smokeless tobacco products include chewing tobacco and, and heated tobacco products ('heat not burn'). The use of chewing tobacco such as 'paan' or 'bidi' is associated with people from South Asian communities, particularly Bangladeshi groups. These populations are not numerous within Derbyshire; at the last census 1.1% of Derbyshire residents identified in the Asian/Asian British category, mainly concentrated in South Derbyshire, Erewash and Chesterfield.

E-cigarettes (nicotine delivery systems) do not contain tobacco. The nicotine is vaporised within a solution of propylene glycol or glycerine and flavouring and inhaled. In Great Britain, the prevalence of e-cigarette use in adults is approximately 6% of the adult population.²⁶ A position statement for Derbyshire Public Health noted that the East Midlands region has the highest regional rates of smokers using e-cigarettes as part of quit attempts.²⁷ Over a quarter (25.2%) of 15 year olds have tried e-cigarettes, significantly more than for England as a whole and towards the higher end of the range of CIPFA neighbours (Figure 24).

The WAY survey was a one-off with data for 2014/15, so no trend data is available nor is any breakdown below county- level.

^v shisha pipe, hookah, hubble-bubble, waterpipe etc

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	-	18.4	H	18.1	18.6
Neighbours average	-	-	-	-		-	-
Lancashire	-	8	-	27.7		25.0	30.4
Derbyshire	-	-	-	25.2		22.6	27.7
Nottinghamshire	-	1	-	23.3		20.8	25.8
Staffordshire	-	2	-	21.1	⊢	18.6	23.5
Cumbria	-	10	-	19.9	⊢	17.7	22.2
Leicestershire	-	14	-	19.8	⊢ <mark> </mark>	17.5	22.0
Worcestershire	-	4	-	18.9	⊢	16.6	21.1
North Yorkshire	-	15	-	18.8	<mark> </mark>	16.6	21.1
Norfolk	-	6	-	18.6	┝━━┥	16.3	20.9
Gloucestershire	-	9	-	18.5	⊢ <mark> </mark>	16.1	20.9
Suffolk	-	7	-	17.6	⊢	15.4	19.9
Warwickshire	-	5	-	17.5	⊢	15.3	19.6
Northamptonshire	-	11	-	17.5	⊢	15.2	19.7
Somerset	-	13	-	16.9	⊢	14.7	19.1
Lincolnshire	-	3	-	16.3	⊢	14.2	18.5
Essex	-	12	-	13.6		11.5	15.8

Figure 24 Use of e-cigarettes at age 15 - Proportion (%) 2014/15

Between 2014/15 and 2017/18, the My Life, My View survey questioned Y8, Y9 and Y10 pupils in Derbyshire about their behaviours and beliefs.

Over this period, 18% said that they had tried an electronic cigarette, rising from 17% in 1014/15 to 27% in 2017/18 (Figure 25). The highest rate was in High Peak schools, at 24%, and the lowest in South Derbyshire schools at 12% (Figure 26). 2% who had tried a cigarette now smoked daily (Figure 27).

Figure 25 My Life, My View Survey – Have you ever tried an electronic cigarette? Derbyshire trend 2014/15-2017/18



Figure 26 My Life, My View Survey – Have you ever tried an electronic cigarette? Proportion (%) 2014/15-2017/18

Derbyshire	19%
Amber Valley	18%
Bolsover	23%
Chesterfield	20%
Derbyshire Dales	17%
Erewash	17%
High Peak	24%
North East Derbyshire	18%
South Derbyshire	12%

Figure 27 My Life, My View Survey – If you have ever tried an e-cigarette how often do you vape? Proportion (%) 2014/15-2017/18

	Area	Value	
Once a month		3%	
Once a week		2%	
Once a day		2%	

2.2. Smoking Related Morbidity

Smoking has multiple harmful effects on the organs and systems of the body. These harms occur for the person who is smoking themselves, and as a result of secondhand smoke. There is also increasing research on 'thirdhand smoke', the pollutants that remain on clothes, soft furnishings, and in the environment, although the magnitude of the health risk has not been fully quantified.²⁸ Smoking is harmful for health throughout the lifecourse, from conception through to later life. The data in this section for Derbyshire is presented for the illnesses associated with smoking across the lifecourse.

Figure 28 How smoking harms the body

Public Health England

Health Matters



Smoking is the most important preventable cause of adverse outcomes during pregnancy. There is substantial evidence that smoking and exposure to secondhand smoke during pregnancy increases the risks of miscarriage, stillbirth, premature birth, low-birth weight babies, and complications during labour.

Smoking during pregnancy is also estimated to increase the risk of infant mortality by 40%, and the likelihood of wheezy illnesses during childhood.²⁹ In addition there are well-described impacts of smoking for adult health including increased risks of heart disease and cancer. Smoking during pregnancy is a significant contributor to health inequalities. There are substantial costs for the NHS in treating the problems arising from smoking during pregnancy, estimated as between £8.1 and £64 million for mothers and between £12 and £23.5 million for infants each year (Godfrey 2010³⁰).

2.2.1. Premature and low weight births

The premature birth rate in Derbyshire, at 82.9 per 1,000 births (about 640 per year) is lower than that for England but has been rising steadily recently (Figure 29).



Figure 29 Premature births (less than 37 weeks gestation) – Derbyshire trend

Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low birth weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.

The proportion of low weight births is significantly lower in Derbyshire, at 2.41% (163 births per year), than for England as a whole and has changed little over time (Figure 30).



Low birth weight of term babies – Derbyshire Trend

2.2.2. Hospital admissions

Treating diseases caused by smoking accounts for approximately 5.5% of the total NHS budget. Admissions to hospital due to smoking related conditions not only represent a large demand on NHS resources, but can also be used as a proxy for variations in smoking related ill health in the general population across England. The rate of admissions^{vi} (Figure 31) in Derbyshire (at 1592 per 100,000 population or 8,138 per year) is significantly higher than that of England as a whole and at the higher end of the range of our CIPFA neighbours, but have been falling (Figure 32). The conditions causing these admissions are cancers, cardiovascular disease, respiratory diseases, disease of the digestive system, age related cataract, hip fracture and spontaneous abortion.

Figure 31	Smoking attributable hospital admissions - Directly standardised rate (per
100,000) 2017	//18

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	474,986	1,530		1,526	1,535
Neighbours average	-	-	-	-		-	-
Northamptonshire	-	11	7,206	1,748	H	1,707	1,789
Cumbria	-	10	5,962	1,706	H	1,663	1,750
Lancashire	-	8	12,565	1,705	Η	1,675	1,735
Norfolk	-	6	10,303	1,671	H	1,639	1,704
Derbyshire	-	-	8,138	1,592	H	1,557	1,627
Staffordshire	-	2	8,608	1,542	H	1,509	1,575
Essex	-	12	13,765	1,523	Н	1,498	1,549
Nottinghamshire	-	1	7,715	1,519	н	1,485	1,553
Lincolnshire	-	3	7,475	1,479	н	1,445	1,513
Somerset	-	13	5,482	1,414	Н	1,377	1,452
North Yorkshire	-	15	5,974	1,388	н	1,353	1,424
Worcestershire	-	4	5,266	1,364	н	1,327	1,401
Leicestershire	-	14	5,710	1,350	н	1,315	1,385
Suffolk	-	7	6,771	1,346	н	1,314	1,379
Gloucestershire	-	9	5,103	1,280	н	1,245	1,315
Warwickshire	-	5	4,211	1,201	H	1,165	1,238

Figure 32 Smoking attributable hospital admissions – Derbyshire trend



^{vi} Smoking attributable hospital admissions are calculated for the population aged 35 years and over to be consistent with the calculations for smoking attributable deaths.

COPD Exacerbations

Smokers can often dismiss the early signs of COPD (Chronic Obstructive Pulmonary Disease) as a 'smoker's cough', but if they continue smoking and the condition worsens, it can greatly impact on their quality of life. The rate of hospital admissions for COPD aged 35+ is significantly lower, at 375 per 100,000 population (2,106 per year), than the England average in Derbyshire but is towards the higher end of the range of CIPFA neighbour values (Figure 33). COPD admissions are significantly higher than for England in Bolsover and Chesterfield, but significantly lower in Amber Valley and Derbyshire Dales (Figure 38).

Figure 33 Emergency hospital admissions for COPD (Persons, 35+ yrs) - Directly standardised rate (per 100,000) 2017/18

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	128,063	415		412	417
Neighbours average	-	-	-	-		-	-
Northamptonshire	-	11	2,344	584	⊢I	560	608
Lancashire	-	8	3,673	496	H	480	513
Derbyshire	-	-	2,106	413	H	395	431
Cumbria	-	10	1,345	378	⊢-I	358	399
Lincolnshire	-	3	1,920	372	┝╼┥	356	389
Staffordshire	-	2	2,069	370	H	354	386
Nottinghamshire	-	1	1,850	364	H	348	381
Leicestershire	-	14	1,503	356	H	338	375
Essex	-	12	3,193	350	H	338	363
Somerset	-	13	1,389	349	H	330	368
Worcestershire	-	4	1,282	326	H-I	308	345
Norfolk	-	6	2,033	318	H	305	333
Warwickshire	-	5	1,081	305	H-H	287	323
Suffolk	-	7	1,567	304	H	289	319
Gloucestershire	-	9	1,149	286	H	270	303
North Yorkshire	-	15	1,145	258	H	243	274

Figure 34 Emergency hospital admissions for COPD (Persons, 35+ yrs) – Derbyshire trend



Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England		128,063	415		412	417
Derbyshire		2,106	413	H	395	431
Amber Valley		295	357	⊢−−− ↓	317	400
Bolsover		238	493	⊢	432	560
Chesterfield		358	546		491	606
Derbyshire Dales		98	172	⊢ −-1	140	210
Erewash		304	430	⊢- <mark></mark>	383	481
High Peak		193	337	┝━━━┥	291	388
North East Derbyshire		313	432	⊢- <mark> </mark>	385	483
South Derbyshire		307	541		482	606

Figure 35 Emergency hospital admissions for COPD (Persons, 35+ yrs) – Geographical variation – 2017/18

2.2.3. Cancer registrations

Smoking causes at least 15 different types of cancer: lung, larynx, oesophagus, oral cavity, nasopharynx, pharynx, bladder, pancreas, kidney, liver, stomach, bowel, cervix, leukaemia, and ovarian cancers.³¹

Lung cancer

Lung cancer is the most common cause of cancer death in the UK, accounting for more than 1 in 5 cancer deaths³².

The link between tobacco and lung cancer was established more than 50 years ago. In England in 2014, 80% of hospital admissions and deaths due to lung cancer in persons aged 35 and over were attributed to smoking³³. The incidence of lung cancer (74.4 per 100,000 or 610 per year) is similar to that for England but at the upper end of the CIPFA neighbours distribution (Figure 36). Lung cancer registrations are significantly higher in Bolsover, but significantly lower in Derbyshire Dales and South Derbyshire (Figure 38).

Figure 36 Lung cancer registrations (Persons, All ages) - Directly standardised rate (per 100,000) 2015/17

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	114,150	76.8		76.4	77.3
Neighbours average	-	-	-	-		-	-
Lancashire	-	8	2,994	84.0		81.0	87.1
Nottinghamshire	-	1	1,964	80.4	H	76.8	84.0
Northamptonshire	-	11	1,468	75.1	⊢	71.3	79.1
Derbyshire	-	-	1,830	74.4	⊢I	71.0	77.9
Lincolnshire	-	3	1,802	72.9	⊢	69.5	76.3
Cumbria	-	10	1,255	72.8	⊢	68.8	77.0
Essex	-	12	3,189	72.8	Н	70.3	75.4
Staffordshire	-	2	1,888	69.8	H	66.7	73.1
Norfolk	-	6	2,052	67.0	┝╾┥	64.1	70.0
North Yorkshire	-	15	1,415	66.8	┝╾┥	63.3	70.4
Leicestershire	-	14	1,285	64.2	H	60.7	67.8
Warwickshire	-	5	1,084	63.8	┝╼┥	60.0	67.7
Suffolk	-	7	1,566	63.4	┝╾┥	60.3	66.6
Worcestershire	-	4	1,174	62.5	H	59.0	66.2
Gloucestershire	-	9	1,120	58.5	H	55.1	62.1
Somerset	-	13	1,014	53.2	⊢ −+	49.9	56.5



Figure 37 Lung cancer registrations (Persons, All ages) – Derbyshire trend

Figure 38 Lung cancer registrations (Persons, All ages) – Geographical variation 2015-17

Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England	-	114,150	76.8		76.4	77.3
Derbyshire	-	1,830	74.4	H-H	71.0	77.9
Amber Valley	-	279	70.5	⊢ <mark> </mark>	62.4	79.2
Bolsover	-	219	93.6		81.6	106.8
Chesterfield	-	262	81.9	├	72.3	92.4
Derbyshire Dales	-	165	59.5	⊢−−−	50.8	69.2
Erewash	-	272	81.8	<mark>}−−−</mark>	72.3	92.0
High Peak	-	219	77.9	├	67.9	88.8
North East Derbyshire	-	241	68.7	⊢	60.3	77.9
South Derbyshire	-	173	63.3	⊢	54.2	73.4

Oral Cancers

Tobacco is a known risk factor for oral cancers³⁴. In England, 65% of hospital admissions (2014–15) for oral cancer and 64 % of deaths (2014) due to oral cancer were attributed to smoking³⁵. The incidence of oral cancer (15.9 per 100,000 or around 130 per year) in Derbyshire is similar to that in England as a whole, but the second highest of our CIPFA neighbours (Figure 39).

Figure 39 Oral cancer registrations (Persons, All ages) - Directly standardised rate (per 100,000) 2015-17

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	22,209	14.6	н	14.4	14.8
Neighbours average	-	-	-	-		-	-
Lancashire	-	8	580	16.1		14.8	17.4
Derbyshire	-	-	392	15.9	⊢ <mark> </mark>	14.4	17.5
Cumbria	-	10	257	15.5	├ <mark> </mark>	13.7	17.5
North Yorkshire	-	15	293	14.4	├	12.8	16.1
Warwickshire	-	5	242	14.2	→	12.5	16.1
Nottinghamshire	-	1	354	14.2	├	12.8	15.8
Staffordshire	-	2	385	14.2	⊢	12.8	15.6
Leicestershire	-	14	289	14.1	├	12.5	15.8
Northamptonshire	-	11	287	14.0	⊢	12.4	15.7
Norfolk	-	6	395	13.6	<mark>}</mark>	12.3	15.0
Gloucestershire	-	9	259	13.4	├	11.8	15.1
Lincolnshire	-	3	316	13.3	<mark> </mark>	11.8	14.8
Suffolk	-	7	314	13.1	⊢	11.7	14.6
Somerset	-	13	235	13.1	⊢ (11.5	14.8
Worcestershire	-	4	235	12.7	⊢−−− −	11.2	14.4
Essex	-	12	543	12.5	H	11.5	13.6



Figure 40 Oral cancer registrations (Persons, All ages) – Derbyshire trend



Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England	-	22,209	14.6	н	14.4	14.8
Derbyshire	-	392	15.9	⊢ <mark>−−</mark>	14.4	17.5
Amber Valley	-	57	14.6	→−−−−	11.1	18.8
Bolsover	-	37	15.8	⊢−−−−−	11.2	21.7
Chesterfield	-	59	18.6		14.3	23.9
Derbyshire Dales	-	32	12.7	⊢−−−−−	8.8	17.9
Erewash	-	49	14.1	h	10.5	18.5
High Peak	-	52	17.5		13.2	22.8
North East Derbyshire	-	56	16.6		12.6	21.5
South Derbyshire	-	50	17.2		12.8	22.7

Oesophageal Cancers

The relative risks of cancers that could be caused by smoking list oesophageal cancer as the third after lung cancer and head & neck cancers. In England, around 7,600 people were diagnosed with cancer of the oesophagus in 2015³⁶ and the one-year survival for patients diagnosed with oesophageal cancer between 2008 and 2010 was 40.4% and five-year survival at 13.2%³⁷. The incidence of oesophageal cancer (18.7 per 100,000 or around 150 per year) in Derbyshire is significantly higher than that in England as a whole, and the third highest of our CIPFA neighbours (Figure 42).

Figure 42	Oesophageal cancer registrations (Persons, All ages) - Directly standardised
rate (per 100,	000) 2015-17

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	22,345	15.2	Н	15.0	15.4
Neighbours average	-	-	-	-		-	-
Worcestershire	-	4	360	19.4		17.4	21.5
Staffordshire	-	2	500	18.8		17.2	20.5
Derbyshire	-	-	456	18.7		17.0	20.5
Lancashire	-	8	619	17.5	⊢	16.1	18.9
Gloucestershire	-	9	320	16.8	→	15.0	18.7
Cumbria	-	10	284	16.7	<mark> −−−</mark> −−−	14.8	18.7
Leicestershire	-	14	332	16.6	⊢	14.9	18.5
Northamptonshire	-	11	318	16.6	⊢	14.8	18.6
Norfolk	-	6	499	16.5	⊢ <mark>−</mark> −	15.0	18.0
North Yorkshire	-	15	337	16.1	⊢	14.5	18.0
Nottinghamshire	-	1	393	16.1	┝━━━┥	14.6	17.8
Warwickshire	-	5	260	15.5	<mark>}−−−</mark>	13.6	17.4
Lincolnshire	-	3	381	15.4	⊢	13.9	17.0
Essex	-	12	643	14.9	⊢- <mark></mark>	13.8	16.1
Suffolk	-	7	353	14.4	⊢ <mark> </mark>	13.0	16.0
Somerset	-	13	249	13.0		11.4	14.7





Figure 44Oesophageal cancer registrations (Persons, All ages) – Geographical variation2015-17

Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England	-	22,345	15.2	н	15.0	15.4
Derbyshire	-	456	18.7		17.0	20.5
Amber Valley	-	74	18.7	⊢−−−−	14.7	23.4
Bolsover	-	43	19.3	┝────	14.0	26.0
Chesterfield	-	60	18.5	H	14.2	23.6
Derbyshire Dales	-	53	19.5		14.6	25.5
Erewash	-	63	18.3	⊢	14.1	23.3
High Peak	-	60	22.7		17.3	29.4
North East Derbyshire	-	53	15.2	⊢	11.4	19.8
South Derbyshire	-	50	19.5	⊢−−−−	14.4	25.7

2.2.4. Years Lived in Disability

The Global Burden of Disease³⁸ tool can be used to assess the contribution of different risks to health. Tobacco use is, and has been since at least 1990, the leading behavioural cause of years lived in ill-health^{vii} in Derbyshire. In 2017 over 30,600 years of were lived with disability due to metabolic, environmental and behavioural causes; 7,060 of these are thought to have been due to tobacco use^{viii} (Figure 45).

Figure 45 Rank of risk by percentage of total Years Lived with Disability, 1990 and 2017

Derbyshire Both sexes, All ages, Percent of total YLDs					
1990 rank	integes, referre er tot	2017 rank			
1 Tobacco	[1 Tobacco			
2 Dietary risks	[2 Dietary risks			
3 Child and maternal malnutrition		3 Alcohol use			
4 Alcohol use		4 Drug use			
5 Drug use		5 Child and maternal malnutrition			
6 Childhood maltreatment	[6 Childhood maltreatment			
7 Low physical activity	[7 Low physical activity			
8 Intimate partner violence		8 Intimate partner violence			
9 Unsafe sex		9 Unsafe sex			

The bulk of the burden of disability falls in the mid to later years of life, as might be expected, for both smoking and the effects of secondhand smoke. However Figure 46 demonstrates that as a proportion of all threats to health in the early years, secondhand smoke has a notable effect.



Figure 46 Proportion of total Years Lived with Disability, by 5 year age band, 2017

vii Years lived with disability (YLDs): Years of life lived with any short-term or long-term health loss.

viii Estimated via: http://ghdx.healthdata.org/gbd-results-tool
2.3. Smoking Related Mortality

Smoking remains the biggest single cause of preventable mortality in the world. It still accounts for 1 in 6 of all deaths in England, and there exist huge inequalities in smoking related deaths: areas with the highest death rates from smoking are about three times as high as areas with the lowest death rates attributable to smoking.

Figure 47 Estimates of deaths caused by smoking by underlying cause of death 2015

Stomach and duodenal ulcer Cervical 100 Larynx Respiratory 23,800 Cancer 36,800 Kidney & renal pelvis Upper 2,800 respiratory Other arterial disease Myeloid leukaemia sites Stomach Unspecified . site Cerebrovascular disease(stroke) king: England 2015 Health and So

Deaths caused by smoking each year in England

2.3.1. Overall smoking-related deaths

The rate of death from smoking related diseases (aged 35+) in Derbyshire is similar to the England average, at 268.6 per 100,000 (or 1,330 per year), but towards the upper end of the range of our CIPFA neighbours (Figure 48).^{ix} It has been falling steadily (Figure 49). Around 16 of every 100 deaths in Derbyshire can be related to smoking.

^{ix} Attributable mortality is calculated for the population aged 35 years and over due to the data on the relative risks for death of smokers and ex-smokers

Figure 48	Smoking attributable mortality (Persons, 35+ yrs) - Directly standardised rate
(per 100,000)	2015-17

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	240,087	262.6		261.6	263.7
Neighbours average	-	-	-	-		-	-
Lancashire	-	8	6,520	299.5	H	292.3	306.9
Northamptonshire	-	11	3,203	274.3	H	264.9	284.1
Lincolnshire	-	3	4,100	271.0	H	262.7	279.4
Derbyshire	-	-	3,995	268.6	H	260.3	277.1
Nottinghamshire	-	1	3,928	264.6	H	256.4	273.0
Essex	-	12	7,046	260.0	Н	253.9	266.1
Cumbria	-	10	2,654	252.8	H	243.2	262.6
Staffordshire	-	2	3,902	239.6	H	232.1	247.2
Norfolk	-	6	4,567	238.6	H	231.7	245.7
Worcestershire	-	4	2,674	230.3	H	221.6	239.2
North Yorkshire	-	15	2,955	227.0	H	218.8	235.4
Somerset	-	13	2,679	223.6	H	215.1	232.2
Leicestershire	-	14	2,725	220.7	H	212.4	229.1
Suffolk	-	7	3,405	220.3	H	212.9	227.9
Gloucestershire	-	9	2,617	219.5	H-1	211.2	228.1
Warwickshire	-	5	2,261	216.1	н	207.3	225.2





The rate of potential years of life lost stands at 1,267 per 100,000 (a total of over 16,500 years), significantly lower than for England and mid-range of our CIPFA neighbours (Figure 50).

Figure 50	Potential years of life lost due to smoking related illness (Persons, 35+ yrs) -
Directly stand	dardised rate (per 100,000) 2015-17

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	1,086,600	1,365		1,362	1,367
Neighbours average	-	-	-	-		-	-
Lancashire	-	8	28,623	1,552	H	1,534	1,570
Northamptonshire	-	11	16,166	1,469	Η	1,446	1,491
Lincolnshire	-	3	17,594	1,440	Η	1,419	1,462
Cumbria	-	10	11,531	1,363	H	1,338	1,389
Norfolk	-	6	18,949	1,327	н	1,308	1,347
Nottinghamshire	-	1	16,792	1,301	н	1,282	1,321
Derbyshire	-	-	16,536	1,267	н	1,247	1,286
Essex	-	12	27,703	1,231	Н	1,217	1,246
Warwickshire	-	5	10,344	1,189	н	1,166	1,212
Staffordshire	-	2	16,147	1,154	н	1,136	1,172
Suffolk	-	7	13,628	1,144	Н	1,125	1,164
Somerset	-	13	10,478	1,136	н	1,114	1,158
Gloucestershire	-	9	11,006	1,109	н	1,089	1,130
Worcestershire	-	4	10,544	1,107	н	1,086	1,128
North Yorkshire	-	15	11,276	1,080	н	1,060	1,100
Leicestershire	-	14	11,410	1,070	н	1,050	1,090





2.3.2. Deaths from Cardiovascular disease

Cardiovascular disease (CVD) is one of the major causes of death in under 75s in England. There have been huge gains over the past decades in terms of better treatment for CVD and improvements in lifestyle, but to ensure that there continues to be a reduction in the rate of premature mortality from CVD, there needs to be concerted action in both prevention and treatment. A substantial proportion of smoking related deaths are from heart disease and stroke.

The rate of preventable mortality is 41.8 per 100,000 (330 per year) – 62% of all CVD deaths – significantly lower than for England and in the middle of the CIPFA range (Figure 52). It has been falling steadily (Figure 53). Rates are significantly higher in Chesterfield but significantly lower in Derbyshire Dales, High Peak, North East and South Derbyshire (Figure 54).

Deaths are considered preventable if they could potentially be avoided by public health interventions in the broadest sense. Deaths which could be avoided by public health policy or

interventions to prevent or reduce smoking, such as smoking cessation services, would be viewed as preventable.



Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	64,127	45.9	H	45.6	46.3
Neighbours average	-	-	-	-		-	-
Lancashire	-	8	1,754	52.4		50.0	55.0
Lincolnshire	-	3	1,192	51.9		48.9	54.9
Cumbria	-	10	752	48.2	⊢	44.8	51.8
Northamptonshire	-	11	919	47.8	⊢- <mark></mark> -	44.8	51.0
Staffordshire	-	2	1,124	44.1	⊢ <mark>⊷</mark> ⊣	41.5	46.7
Nottinghamshire	-	1	1,009	43.7	<mark>⊢</mark> I	41.0	46.5
North Yorkshire	-	15	828	42.8		39.9	45.8
Warwickshire	-	5	676	42.6	⊢	39.5	46.0
Derbyshire	-	-	987	41.8	┝━━┥	39.3	44.5
Gloucestershire	-	9	714	40.1	⊢−−−	37.2	43.1
Norfolk	-	6	1,087	39.9	⊢	37.6	42.4
Suffolk	-	7	868	39.0	┝━━┥	36.4	41.7
Essex	-	12	1,575	38.8	┝━┥	36.9	40.8
Leicestershire	-	14	739	38.6	⊢_ (35.8	41.4
Somerset	-	13	635	36.9		34.1	39.9
Worcestershire	-	4	630	36.3	⊢	33.5	39.2





Figure 54	Under 75 mortality rate from cardiovascular diseases considered preventable
(Persons,	<75 yrs) – Geographical variation 2015-17

Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England		64,127	45.9	1	45.6	46.3
Derbyshire		987	41.8	┝╼┥	39.3	44.5
Amber Valley		160	41.9	⊢	35.7	49.0
Bolsover		103	45.8		37.4	55.6
Chesterfield		179	59.3		50.9	68.6
Derbyshire Dales		74	29.1		22.8	36.7
Erewash		141	44.7		37.6	52.7
High Peak		105	37.9	⊢−−− −	31.0	45.9
North East Derbyshire		124	38.1		31.6	45.5
South Derbyshire		101	36.8		30.0	44.7

Smoking-related deaths from heart disease (aged 35+) occur at the rate of 23.2 per 100,000 and from stroke at 7.9. Both are similar to England and in middle of the CIPFA neighbours range.

2.3.3. Deaths from Cancer

Cancer is the highest cause of death in England in under 75s. To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment. A substantial proportion of smoking related deaths are from lung and oral cancers.

The rate of preventable mortality is 79.3 per 100,000 (620 per year) - 58% of all cancer deaths - significantly lower than for England but at the upper end of the CIPFA range (Figure 55) and has been falling steadily (Figure 56).

Preventable cancer mortality is significantly lower in North East Derbyshire but significantly higher in Bolsover and Chesterfield (Figure 57).

Deaths are considered preventable if they could potentially be avoided by public health interventions in the broadest sense. Deaths which could be avoided by public health policy or interventions to prevent or reduce smoking, such as smoking cessation services, would be viewed as preventable.

Figure 55 Under 75 mortality rate from cancer considered preventable (Persons, <75 yrs) - Directly standardised rate - per 100,000 2015-17

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	108,980	78.0	H	77.5	78.4
Neighbours average	-	-	-	-		-	-
Nottinghamshire	-	1	1,938	83.5	H	79.8	87.3
Lancashire	-	8	2,757	82.6		79.5	85.7
Northamptonshire	-	11	1,551	80.7	⊢ <mark>-</mark>	76.8	84.9
Derbyshire	-	-	1,869	79.3	⊢I	75.8	83.0
Staffordshire	-	2	1,965	76.9	┝╼┥	73.5	80.4
Cumbria	-	10	1,171	74.3	┝╼┥	70.1	78.7
Essex	-	12	3,004	74.2	H	71.6	76.9
Lincolnshire	-	3	1,702	74.0	⊢	70.5	77.6
Norfolk	-	6	1,985	73.2	H-4	70.0	76.5
Warwickshire	-	5	1,136	71.9	┝━━┥	67.8	76.2
Worcestershire	-	4	1,231	70.6	┝━┥	66.7	74.6
North Yorkshire	-	15	1,336	69.1	H	65.4	72.9
Suffolk	-	7	1,511	67.8	⊢ 1	64.4	71.3
Gloucestershire	-	9	1,196	67.1	┝━━┥	63.4	71.1
Leicestershire	-	14	1,282	66.9	⊢	63.3	70.7
Somerset	-	13	1,139	66.3	⊢	62.5	70.3

Figure 56 Under 75 mortality rate from cancer considered preventable (Persons, <75 yrs) – Derbyshire trend



Figure 57 Under 75 mortality rate from cancer considered preventable (Persons, <75 yrs) – Geographical variation 2015-17

Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England		108,980	78.0		77.5	78.4
Derbyshire		1,869	79.3	H	75.8	83.0
Amber Valley		284	74.3	F	65.9	83.5
Bolsover		229	102.1	⊢ <mark>⊢ →</mark>	89.3	116.2
Chesterfield		283	93.7	Hard and the second	83.1	105.3
Derbyshire Dales		171	70.3	► <mark></mark>	60.0	82.0
Erewash		268	84.5	⊢_ <mark></mark>	74.7	95.3
High Peak		191	69.0	I <mark></mark>	59.6	79.6
North East Derbyshire		217	66.4	⊢	57.8	76.0
South Derbyshire		226	82.7	ا- <mark></mark>	72.2	94.2

Deaths at all ages from lung cancer occur at the rate of 57.8 per 100,000 and from oral cancer at 3.8. Both are similar to England and but lung cancer is at the upper end of the CIPFA neighbours range, whereas oral cancer is toward the middle.

2.3.4. Deaths from Respiratory diseases

Respiratory disease is one of the top causes of death in England in under 75s and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases.

The rate of preventable mortality is 18.4 per 100,000 (145 per year) – 55% of all respiratory deaths – similar to that for England but at the upper end of the CIPFA range (Figure 58) and has changed little (Figure 59). Preventable mortality is significantly higher in Chesterfield, but significantly lower in Derbyshire Dales and Erewash (Figure 60).

Deaths are considered preventable if they could potentially be avoided by public health interventions in the broadest sense. Deaths which could be avoided by public health policy or interventions to prevent or reduce smoking, such as smoking cessation services, would be viewed as preventable.

Area	Recent Trend	Neighbour Rank	Count	Value		95% Lower Cl	95% Upper Cl
England	-	-	26,075	18.9	Н	18.6	19.1
Neighbours average	-	-	-	-		-	-
Lancashire	-	8	759	22.6		21.0	24.2
Northamptonshire	-	11	387	20.4	⊢	18.4	22.6
Derbyshire	-	-	436	18.4	⊢ <mark> </mark>	16.7	20.2
Cumbria	-	10	278	17.5	<mark>}</mark>	15.5	19.7
Lincolnshire	-	3	413	17.4	h	15.8	19.2
Nottinghamshire	-	1	392	16.8	┝━━━┥	15.2	18.6
Norfolk	-	6	465	16.6	⊢−−− ↓	15.1	18.2
Somerset	-	13	279	15.9	⊢ −−−−↓	14.1	17.9
Essex	-	12	651	15.9	┝╾╾┥	14.7	17.2
Staffordshire	-	2	411	15.9	┝━━━┥	14.4	17.5
Gloucestershire	-	9	284	15.9	⊢−−−− −	14.1	17.8
Warwickshire	-	5	236	14.8	⊢−−−− −	13.0	16.8
North Yorkshire	-	15	282	14.3	H	12.7	16.1
Worcestershire	-	4	255	14.1	<mark>}</mark>	12.5	16.0
Leicestershire	-	14	253	13.1	⊢−−− −	11.5	14.8
Suffolk	-	7	287	12.6	⊢	11.1	14.1

Figure 58 Under 75 mortality rate from respiratory diseases considered preventable (Persons, <75 yrs) - Directly standardised rate (per 100,000) 2015-17





Figure 60 Under 75 mortality rate from respiratory diseases considered preventable (Persons, <75 yrs) – Geographical variation 2015-17

Area	Recent Trend	Count	Value		95% Lower Cl	95% Upper Cl
England		26,075	18.9	1	18.6	19.1
Derbyshire		436	18.4	⊢ −-1	16.7	20.2
Amber Valley		72	18.5		14.4	23.3
Bolsover		54	23.9		18.0	31.2
Chesterfield		85	28.2		- 22.5	34.9
Derbyshire Dales		29	11.2		7.5	16.1
Erewash		42	13.2		9.5	17.8
High Peak		53	19.4	→−−−	14.5	25.4
North East Derbyshire		55	16.2	→	12.2	21.1
South Derbyshire		46	17.1	⊢−−− −−−1	12.5	22.9

Deaths at all ages from COPD occur at the rate of 53.7 per 100,000, similar to England and but at the upper end of the CIPFA neighbours range.

2.3.5. Years of Life Lost

The Global Burden of Disease³⁹ tool allows the calculation of Years of Life Lost related to tobacco smoke. Tobacco use is, and has been since at least 1990, the leading behavioural cause of years lost from expected lifespan in Derbyshire. In 2017, over 64,550 years of life were lost through metabolic, environmental and behavioural risks; more than 20,700 of these are thought to have been through tobacco use.^x

Figure 61 Rank of risk by percentage of total Years of Life Lost, 1990 and 2017

Both sexes, All ages, Percent of total YLLs							
1990 rank		2017 rank					
1 Tobacco]	1 Tobacco					
2 Dietary risks	<u> </u>	2 Dietary risks					
3 Low physical activity		3 Alcohol use					
4 Child and maternal malnutrition		4 Low physical activity					
5 Alcohol use		5 Drug use					
6 Unsafe sex		6 Child and maternal malnutrition					
7 Drug use		7 Unsafe sex					
8 Intimate partner violence		8 Childhood maltreatment					
9 Childhood maltreatment		9 Intimate partner violence					

The bulk of life years lost^{xi} (i.e. premature mortality) falls in the mid to later years of life, as might be expected, for both smoking and the effects of secondhand smoke. However Figure 61 demonstrates that secondhand smoke makes a notable contribution as a proportion of all threats to premature mortality in the early years.



Figure 62 Proportion of total Years of Life Lost, by 5 year age band, 2017

* Estimated via http://ghdx.healthdata.org/gbd-results-tool

^{xi} Years of life lost (YLLs): Years of life lost due to premature mortality.

3. Impacts of tobacco and smoking

3.1. Attributable health impacts

The data profile in section 2 provides the nationally available data on morbidity and mortality from conditions that are related to smoking compared with CIPFA nearest neighbours and time trends. This section quantifies the health impacts for Derbyshire that can be attributed to smoking from the most recent time point. Further data for the attributable deaths and hospitalisations broken down by each group of diseases and their diagnostic codes is provided in appendix 1.

3.1.1. Deaths

The deaths attributable to smoking in adults can be calculated. Table 1 provides modelled data for the deaths registered in Derbyshire in 2018 calculating the proportion of deaths attributable to smoking for each cause of death and rounded to the nearest 100. A detailed breakdown of the deaths attributable to smoking by specific causes is included as an appendix.

There were approximately 1300 deaths in males and 900 deaths in females caused by smoking in Derbyshire. Notably there are important differences by sex, with smoking linked to higher numbers of deaths in males than females. The majority of deaths due to smoking were in people with cancer or respiratory diseases.

	Total		Male		Female	
	Attributable number ^{xiii}	Attributable percentage ^{xiv}	Attributable number	Attributable percentage	Attributable number	Attributable percentage
All deaths	2,200	16	1,300	20	900	12
All cancers	1,000	26	600	31	300	20
All respiratory diseases	1,200	37	700	40	500	33
All circulatory diseases	200	13	100	16	100	9
All diseases of the digestive system	0	3	0	4	0	3

Table 1Deaths estimated to be attributable to smoking^{xii}, in adults aged 35 and over,by gender (rounded values)

Overall, 2200 deaths in Derbyshire were caused by smoking in 2018. In other words, smoking was responsible six deaths each day, or 42 deaths each week in Derbyshire.

3.1.2. Hospital Admissions

A similar calculation has been made to estimate the number of hospital admissions from diseases which can be caused by smoking (Table 2). These data refer to admissions in 2017/18, and again a much more detailed dataset is provided in the appendix.

There were 2300 admissions by for males and 1200 admissions for females that were due to diseases caused by smoking (Table 2). 22% of the admissions for respiratory diseases in Derbyshire can be attributed to smoking.

xii See Statistics on Smoking - England 2019: Appendix B for methodology for calculating attributable deaths.

xiii Estimated attributable number, rounded to the nearest 100. Totals may not sum due to rounding.

xiv Estimated attributable percentages are based on unrounded attributable estimates for England.

	Total		Male		Female	
	Attributable number ^{xvi}	Attributable percentage ^{xvii}	Attributable number	Attributable percentage	Attributable number	Attributable percentage
All admissions	3,500	4	2,300	6	1,200	3
All cancers	2,900	9	2,000	12	900	6
All respiratory diseases	2,500	22	1,300	24	1,200	21
All circulatory diseases	1,800	15	1,200	18	500	10
All diseases of the digestive system	300	1	200	1	100	1
Other diseases which can be caused by smoking ^{xviii}	500	9	200	10	300	8

Table 2NHS hospital admissions estimated to be attributable to smoking^{xv}, for adultsaged 35 and over, by gender (rounded values)

3.1.3. Ill health in children

In 2010 the Royal College of Physicians calculated the annual impact of passive smoking exposure for children in the UK⁴⁰ as:

- over 20,000 cases of lower respiratory tract infection
- 120,000 cases of middle ear disease
- at least 22,000 new cases of wheeze and asthma
- 200 cases of bacterial meningitis

More recent work has continued to quantify the health risks for maternal smoking and secondhand smoking in pregnancy for poor health outcomes for mothers and infants (Table 3). Again this is estimated on a national basis.

Table 3Impact of smoking in pregnancy

	Maternal smoking	Secondhand smoke exposure
Low birth weight	Average 250g lighter	Average 30-40g lighter
Stillbirth	2 times more likely	Increased risk
Miscarriage	24-32% more likely	Possible risk
Preterm birth	27% more likely	Increased risk
Heart defects	50% more likely	Increased risk
Sudden infant death	3 times more likely	45% more likely

Source: Smoking in pregnancy challenge group. Review of the Challenge 2018.⁴¹

It was not possible to specifically estimate the impacts for ill health among children and women in Derbyshire of attributable to passive smoking or smoking in pregnancy from these figures.

^{xv} See Statistics on Smoking - England 2019: Appendix B for methodology for calculating attributable admissions. The primary diagnosis is the first of up to 20 diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was admitted to hospital. See Appendix B for corresponding ICD 10 codes used with categories above.

^{xvi} Estimated attributable number, rounded to the nearest 100. Totals may not sum due to rounding.

^{xvii} Estimated attributable percentages are based on unrounded attributable estimates for England.

^{xviii} Age related cataract 45+; Hip fracture 55+; Spontaneous abortion. Calculated for adults of specific age ranges

3.2. Impacts on health inequalities

Smoking is the single most important driver of health inequalities: a larger contributor to inequalities than social position.⁴² Smoking is more common among unskilled and low income workers, and there are generational cycles of smoking and smoking-related culture in disadvantaged communities. Approximately 1/3 of tobacco consumption in the UK is by people with a mental health condition. Other disparities in smoking are seen among disadvantaged groups including homeless persons, prisoners, and looked-after children. The distribution of smoking in Derbyshire is patterned with the index of multiple deprivation.

3.2.1. Life Expectancy

Smoking reduces both life expectancy and healthy life expectancy. Smoking is responsible for approximately half of the differences in life expectancy between the most and least affluent.⁴³

Life expectancy at birth in Derbyshire has been significantly lower than the value for England for both men and women in recent years (Figure 63). Derbyshire's healthy life expectancy (Figure 64) is estimated to be 62.2 years for women and 63.4 years for men (2015-2017 data).



Figure 63 Life Expectancy at Birth in Derbyshire (a) Female (b) Male





Based on data from 150 local authorities in England, the Office of National Statistics have developed estimates for the population level impacts on Healthy Life Expectancies (HLE) associated with a change in the number of smokers in an area.

Table 4Change in Healthy Life Expectancy (HLE) per quitter (ONS Life ExpectancyTool) 44

Modelled Change ^{xix}	Impact on HLE for Men	Impact for HLE for Women
No change	No change	No change
1 in every 100 men/women quit smoking	HLE rises by 7 months	HLE rises by 8 months
2 in every 100 men/women quit smoking	HLE rises by 1 year, 3 months	HLE rises by 1 year, 5 months
3 in every 100 men/women quit smoking	HLE rises by 1 year, 10 months	HLE rises by 2 years, 1 month
5 in every 100 men/women quit smoking	HLE rises by 3 years, 1 month	HLE rises by 3 years, 6 month
10 in every 100 men/women quit smoking	HLE rises by 6 years, 1 month	HLE rises by 7 years, 1 month

For Derbyshire, the number of quits needed to achieve an improvement in the population Healthy Life Expectancy can be modelled in relation to the population size and prevalence of smoking. These values indicate the impact of a step change in the prevalence of smoking, and the scale required for population level benefits. Modelled data for Derbyshire on changes in the numbers of smokers and the impact on healthy life expectancy are as follows:-

Table 5	Change in Healthy	y Life Expectancy	y per quitter	- Derbyshire
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Males			Females		
Number of smokers quitting	Proportion of smokers quitting	Revised Healthy Life Expectancy	Number of smokers quitting	Proportion of smokers quitting	Revised Healthy Life Expectancy
0	0%	63.4 years	0	0%	62.2 years
3200	4.8%	64.0 years	3361	6.6%	62.9 years
6400	9.6%	64.7 years	6722	13.2%	63.3 years
9599	14.4%	65.2 years	10084	19.8%	64.3 years

3.2.2. Household Incomes

Tobacco has become 30% less affordable since 2007.⁴⁵ An estimated 1.1 million children in the UK are estimated to be living in poverty with at least one parent who is a current smoker.⁴⁶ Most people who quit smoking save around £250 per month, or £3000 per year.⁴⁷ These figures do not account for expenditure on e-cigarettes, so supporting people to access stop smoking support and nicotine replacement therapy will reduce individual costs. Reducing the prevalence of smoking increases disposable income at household level, and contributes to improved economic prosperity within local communities.

^{xix} This analysis reports the linear relationships between individual lifestyle factors and population level HLE to estimate the change in HLE if smoking prevalence were to change.

3.3. Impacts on society

3.3.1. Health System Use

Smoking both causes and exacerbates long term health conditions and is the leading cause of preventable death and disease in England. Therefore it is a substantial contributor to use of health services.

Estimated impacts on acute health care services: The rate of admissions in Derbyshire (at 1592 per 100,000 population or 8,138 per year) is significantly higher than that of England as a whole and at the higher end of the range of our CIPFA neighbours.

Estimated primary and community care impacts: the annual burden in Derbyshire of treating smoking-related illnesses via primary and ambulatory care services is estimated to require 363,053 GP consultations, 127,055 practice nurse consultations, 202,626 GP prescriptions, and 73,269 outpatient visit.⁴⁸

3.3.2. Costs

The costs associated with smoking in Derbyshire have been estimated by calculating the amount of service use or societal impacts caused by smoking, and then costing these impacts using a Ready Reckoner tool.^{49xx} Smoking in Derbyshire creates a total societal cost of approximately £174.7 million every year accrued across a range of social domains:

<u>Healthcare</u>: the total annual cost of smoking to the NHS across Derbyshire is about $\underline{\text{£39.6m}}$ for treating smoking-related illness.

- Smoking attributable hospital admissions in Derbyshire cost nearly 13 million pounds per year:
- Two thirds of the healthcare expenditure (over £27 million) is via primary and ambulatory care services

<u>Productivity</u> costs are incurred because smokers take more sick-leave from work than nonsmokers and smoking increases the risk of disability and premature death; £108.9m of potential wealth is lost from the local economy in Derbyshire each year:

- 1,353 early deaths result in 1,857 years of lost economic activity, costing businesses £45.2m
- Absenteeism with 225,549 days of lost productivity, costing £20.7m
- Smoking breaks cost businesses in Derbyshire £42.9m

<u>Social Care:</u> Many current and former smokers require care in later life as a result of smoking-related illnesses, costing society in Derbyshire an additional £21.3m:

- £11.6m is funded from the local authority social care budget
- £9.7m paid by individuals or families who self-fund private care

<u>House Fires:</u> Smoking materials are a major contributor to accidental fires. Fatalities are disproportionately high in smoking-related fires, representing 49% of all house fire deaths. Derbyshire Fire and Rescue Service will attend about 23 smoking-related house fires each year with £4.9m lost annually in the County as a result:

- 1 fatality each year in a smoking-related fire, with annual societal losses of £2.6m
- 8 non-fatal injuries each year, further increasing the societal cost by £1.1m
- Smoking-attributable fires will also result in property damage of £1.2m
- The annual response cost for the Derbyshire Fire and Rescue Service of £80,310

^{xx} Sources from the literature and data 2014-2018. Some of these costings may be an underestimate of the position in 2019.

It is sometimes contested that there is a net financial gain for society associated with the income from tobacco duty. It is estimated that smokers in Derbyshire spend roughly £183.5m on tobacco products each year (£2050 per smoker), and half of this expenditure on smoking products, £91.5 million, is collected by the Exchequer as tobacco duty. The duty raised is therefore much lower than the costs of tobacco to the Derbyshire community of £174.7 million.

3.3.3. Environmental Impacts

Smokers in Derbyshire consume about 1 million cigarettes every day. Smoking materials result in 54 tonnes of waste annually, particularly because the majority of cigarette filters are nonbiodegradable. This includes 23 tonnes of waste discarded as street litter (35% of all street litter).⁵⁰ Cigarette packaging contributes additional litter and waste.

3.4. Future impacts: trends in tobacco use and uptake of e-cigarettes

Overall the size of the smoking population in the UK has been declining, falling below 15% for England in 2017. Smoking in 18 to 24 years olds has fallen the fastest compared to other age groups.⁵¹ The decline in smoking has been observed across the population. However the gap has widened between the likelihood of smoking by people in routine and manual occupations compared with managerial and professionals posts.

Electronic cigarettes (e-cigarettes) have increased in popularity in recent years, and have made a contribution to declining smoking rates, as the most commonly used quitting aid since 2013.⁵² E-cigarettes are nearly completely used by people who have been or are still smokers, with peak use by the 25-35 and 35-49 year olds⁵³, and this evidence has allayed some initial public health concerns about young non-smokers taking up vaping.

There are no specific data on e-cigarette use for Derbyshire. The most recent national review found that experimenting with e-cigarettes by young people has increased to 1.7% of 11-18 year olds, with at least weekly use, and vaping is still highly associated with smoking. The vaping prevalence in adults in Great Britain has remained stable, with 2017 prevalence estimates of:

- 5.4% to 6.2% all adults
- 14.9% to 18.5% current smokers
- 0.4% to 0.8% never smokers
- 10.3% to 11.3% for ex-smokers

The use of e-cigarettes as a quitting aid is similar across socioeconomic groups. There are recommendations to continue to assess and monitor the impact of e-cigarettes on smoking, and on health for individuals and populations. The Derbyshire position statement on e-cigarettes acknowledges the lack of evidence on long term harms and equivocal evidence on the efficacy of e-cigarettes as a cessation aid⁵⁴. No evidence was located to suggest that demand or uptake of smoking cessation support has reduced since the widespread awareness of e-cigarettes as a potential aid for quitting. Tobacco control approaches will need to remain broad, smoking tobacco remains a key health risk, and as noted, there remains a substantial prevalence of smoking within the UK, particularly among disadvantaged groups.

3.5. Potential impacts: return on investment and the case for change

The rationale for tobacco control in Derbyshire is grounded in clear health and economic arguments.

By preventing uptake, promoting quitting and treating dependence, effective tobacco control will reduce the numbers of smokers and the harms associated with smoking tobacco.

The case for investment in tobacco control can be summarised as:-

Ca	ise for investment	Detailed in
•	Multi-layered (or multicomponent) strategies are required for effective	Section 1.1
	tobacco control as there are multiplicative effects between measures	
-	Tobacco control is embedded in governmental policy (Tobacco	Section 1.1; 5.1
	Control Plan) and prevention is integral within the NHS Long Term	
	Plan, with local commitments in the Derbyshire Health & Wellbeing	
	Strategy and Joined Up Care Derbyshire prevention plan	
•	Smoking is an important influence on healthy life expectancy.	Section 3.1-3.2
	Smoking is responsible for around half the differences in life expectancy	
	between the richest and poorest. Reducing smoking is a key priority in	
	tackling the differences in health outcomes between communities in	
	Derbyshire.	
•	Smoking is a cause of ill health and preventable mortality for people of	Section 2; 3.3
	all ages. Reducing smoking rates will improve multiple indicators in	
	the Public Health Outcomes Framework.	O setting 1.1
•	Secondhand smoke causes serious health harms especially for	Section 4.4
	children and pregnant women, and tobacco control measures help to	
_	protect children and others from this narmful exposure.	Section 2.2
•	Treating smoking related diseases costs the local NHS £39.6 million in	Section 5.5
	each year infough GP consultations, practice nurse consultations,	
	Overall smoking costs Derbyshire £174.7 million each year including	Section 3.3
-	f108.9 million from the local economy due to early deaths, sick leave	Section 5.5
	and smoking breaks	
	Reducing smoking will increase disposable income for individuals and	Section 3.2
	their families and promote economic prosperity at household and	0001011 0.2
	community level.	
	Helping smokers to guit is the single highest value contribution to	Section 4.5
	health that clinicians can make.	
	There is a return on investment at system level associated with	Section 3.5
	tobacco control measures.	

National data indicates that 98% of people who quit smoking do not use local stop smoking services⁵⁵ even though these are the most effective means of successful quits and cost effective. Much of the necessary step change in smoking prevalence is likely to be facilitated by e-cigarette use and other types of quit attempts. Effective enforcement of legislation e.g. point of sale displays, underage sales, packaging, and removing illicit tobacco from the market is important alongside behaviour changes.

The costings and impacts as modelled by the NICE return on investment (ROI) tool⁵⁶ for the current tobacco control measures (primarily the local stop smoking services) in Derbyshire suggest that the current package in Derbyshire:

- Costs £1,345,199
- Gains 9.32 quitters/1000 smokers

- Achieves 1014 quitters per year
- Achieves gross savings of £693,411
- Provides an overall ICER of £21,997 per QALY gained
- Costs £415,397 per smoking death averted

These estimates indicate that the current model in Derbyshire would be likely to be viewed as cost effective by a national group such as NICE for the amount of health gain (with QALYs as a measure of health utility) at a usual maximum threshold of £20,000-£30,000. This tool also provides a mechanism for thinking about how the ROI can be maximised to inform local planning. If the fullest package were implemented in Derbyshire, including participating in a regional package across the East Midlands for public awareness and social marketing, the costs could rise to £3,278,089 per year, achieving 5310 quitters (49 quitters/1000 smokers), the total gross savings would become £3,497,292.

The local stop smoking service will be introducing group based support for cessation in the coming months, which will improve the cost effectiveness profile locally. And it should be noted that the NICE ROI model has limitations particularly from a Local Authority perspective. The only cost benefits included for Adult Social Care are the costs specifically associated with stroke rehabilitation. It could therefore be considered as an underestimate of the gain.

4. Tobacco Control Measures in Derbyshire

4.1. Stop Smoking Services

4.1.1. What works?

Providing support for smokers to quit is highly cost effective. The evidence is clear that smokers who receive a combination of pharmacotherapy and skilled behavioural support are up to four times as likely to quit successfully. The most effective intervention to support smokers to quit is face-to-face group-based support with pharmacotherapy and a universal and evidence-based service model will achieve the highest quality outcomes.⁵⁷

NICE Guidance on Stop Smoking Interventions and Services (NG92)⁵⁸ recommends stop smoking services and interventions to meet local needs:

- Use 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
- Use Public Health England's public health profiles to estimate smoking prevalence among the local population.
- Prioritise specific groups who are at high risk of tobacco-related harm.

The NICE guidance NG92 also provides specific guidance for commissioners and providers of stop smoking support.

4.1.2. What is being delivered?

Live Life Better Derbyshire provide Stop Smoking Services for people in Derbyshire as part of a wider integrated lifestyle services offer. The emphasis is on one-to-one cessation support for 12 weeks, with flexibility to support clients beyond this, and with telephone support; nicotine replacement therapy is provided. Champix and Zyban are provided through the clients' GP. Clinics are run throughout the week including evening sessions in a range of locations, and group-based support is being planned.

The provision is evidence based, in line with NICE guidance and the National Centre for Smoking Cessation and Training (NCSCT). The service is e-cigarette friendly in providing support to smokers who are using e-cigarettes as part of their quit attempt, in line with the Derbyshire Public Health position statement on e-cigarettes. 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.

4.1.3. What are our outcomes?

Outcomes are reported for numbers and rates of smokers setting a quit date, and successful quitters at 4 weeks ascertained by self-report and by Carbon Monoxide (CO) validation. Notably, there were significant service changes in Derbyshire during 2017/18 including the transfer of the service and staff to the County Council, which will have had associated impacts on performance.

2017/18	Number setting quit date	Number of successful quitters*	Percentage of successful quitters*	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*
Derbyshire	1,504	892	58	680	45	76
East Midlands	24,007	2,121	53	1,300	33	61
England	274,021	2,081	51	1,485	36	71

 Table 6
 Service outcomes for Stop Smoking Services 2017/18

Source: NHS Digital⁵⁹; *self-reported data

The cost per quitter in Derbyshire has increased over recent years (Figure 65) to £451 per quitter in 2017/18, although it still lies below the national values. 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 cessation support.



Figure 65 Cost per quitter in Derbyshire – Trend data

Previous work on the equity of uptake and effectiveness of cessation services in Derbyshire has highlighted that the smoking population is concentrated towards those who have higher cigarette use (are more addicted to nicotine) and within communities that experience deprivation and where smoking remains a cultural norm.

4.1.4. Where are the gaps?

Approximately half of clients making initial contact with the service do not set a quit date, and work is underway within the LLBD service to review the pathway and explore opportunities for additional support. Similarly, work is underway to refine promotional materials and ensure the service consistently uses evidence-informed communication approaches and resources. The use of text messaging to improve service uptake has been proposed to increase engagement and immediate communication.

There are some gaps in insight to inform local practice. Benchmarking local performance with other Stop Smoking Services would allow a review of effectiveness such as in progressing with individuals who make initial contact through to offering support. Furthermore a detailed analysis of the patterns of use of the stop smoking services in Derbyshire, such as through a health equity audit, would inform local measures to tackle the health inequalities associated with smoking.

4.2. Smoking in Pregnancy

4.2.1. What works?

A literature search of research studies^{xxi} on smoking in pregnancy was carried out in September 2018. A brief evidence review was developed by synthesising the findings from the identified literature, and by checking the NICE Guidance, and the principles for good practice from the UK Centre for Tobacco and Alcohol Studies, the national Smoking in Pregnancy Challenge Group, and the National Centre for Smoking Cessation and Training. The evidence-based findings from this review can be grouped thematically around the SSS pathway, and a short summary is provided below.⁶⁰

Figure 66 Stop Smoking Services Pathway



Stop Smoking Services Pathway

Characteristics of pregnant smokers

- Women who smoke in pregnancy are more likely to younger, unmarried, first time mothers, underweight, with unintended pregnancy, and to initiate prenatal care later
- Additional predictors of smoking in pregnancy are having a partner who smokes, large number of children, and a high rate of tobacco consumption
- Smokers in their first pregnancy smoke fewer cigarettes and have less of an urge to smoke than in subsequent pregnancies

Predictors of quitting during pregnancy

 Factors associated with cessation were higher level of education, higher socioeconomic status, overseas maternal birth, living with partner or married, partner or other members of the household that don't smoke, lower heaviness of smoking index score, lower baseline cotinine level, lower exposure to second-hand smoke, not consuming alcohol before and/or during pregnancy, first pregnancy, planned breastfeeding, perceived adequate prenatal care, no depression, and low stress during pregnancy

^{xxi} In summary, a free text search of terms related to smoking in pregnancy was carried out on the OVID database through NHS Athens. 522 results were generated, only papers with full text available were included in the review.

• Intention and determination to quit, self-efficacy, non-smoker identity and not having previously smoked in pregnancy are predictors of making quit attempt

Access to SSS for pregnant smokers

- Self-reported smoking status underestimates true smoking status, pregnant smokers accept CO testing in antenatal care
- Opt out referrals increases referrals to SSS, increases quit date setting and numbers abstinent at 4 weeks
- Concern from women about lack of contact from SSS with opt-out service

Effective interventions

- Reach and effectiveness increased by providing majority of contact in clinic than at home
- Counselling (all types) increases smoking cessation in late pregnancy; self-help interventions may also increase quit rate
- Text messages are perceived to be convenient and increase rates of abstinence, but with lower validation rates; video cessation decreased number of days smoking and cigarettes smoked per day but made no difference on 30 day abstinence rate
- Social marketing increased recruitment of pregnant smokers into SSS
- Financial incentives increase smoking cessation compared to current interventions, and have been found to be cost effective
- Trials suggest NRT increases cessation rates, and most pregnant women are supportive of being offered NRT, but adherence to NRT is low
- The BabyClear intervention which was a multifaceted healthcare intervention applying NICE guidelines on universal CO monitoring, routine opt-out referrals, and skills training for staff, increased referral rates to SSS, and increased probability of quitting prior to delivery

Barriers to smoking cessation in pregnancy

- Belief that smoking is a way of coping with stress during and after pregnancy
- Motivation to quit for pregnancy rather than for good
- Midwives with insufficient knowledge to advise pregnant smokers and concerned about protecting patient-professional relationship; pregnant women report inconsistent or insufficient advice; lack of awareness of specific SSS for pregnant women

Facilitators to smoking cessation in pregnancy

- Receiving active praise and encouragement, and partner's emotional and practical support
- Increased visual information on risks to baby, and motivation to quit for health of foetus
- CO Monitoring and more information about SSS

Post-natal support

- 43% of quitters restart by 6 months post-partum. The reasons for relapse include:
 - Smoking for coping with stress (caring for newborn, lack of sleep and adjusting to mother identity)
 - \circ Motivation to quit for the health of the foetus is no longer relevant
 - o Belief that physiological changes postpartum influenced cigarette cravings
- Financial incentives post-partum have been found to increase quit rates

In summary, the Baby Clear intervention trialled in the Northeast provides the best demonstration of a comprehensive smoking in pregnancy pathway, and to implement NICE guidance on the routine use of CO monitors and opt-out pathways alongside staff training and culture.

NHS England have recently updated the <u>Saving Babies' Lives</u> care bundle on reducing perinatal mortality for commissioners and providers of maternity services, issued March 2019. Reducing smoking in pregnancy is the first of the five elements of evidence-based care. The care bundle specifies the following interventions:

- CO testing should be offered to all pregnant women at the antenatal booking appointment, with the outcome recorded.
- Additional CO testing should be offered to pregnant women as appropriate throughout pregnancy, with the outcome recorded.
- CO testing should be offered to all pregnant women at the 36 week antenatal appointment, with the outcome recorded.
- Referral for those with elevated levels (4ppm or above) for support from a trained stop smoking specialist, based on an opt-out system. Referral pathway must include feedback and follow up processes.
- All relevant maternity staff should receive training on the use of the CO monitor and having a brief and meaningful conversation with women about smoking (Very Brief Advice VBA).

The care bundle details the key factors for implementation of the interventions for reducing smoking in pregnancy, and the relevant indicators for monitoring progress. It notes the necessity of continuous learning by maternity providers.

4.2.2. What is being delivered?

Addressing smoking in pregnancy in Derbyshire has been an ongoing priority as the rates in the County although declining, remain significantly higher than national rates. The coordination of the local responses to smoking in pregnancy is owned by the Health & Wellbeing Delivery Group on behalf of Derbyshire Maternity Transformation Programme Board. The Health & Wellbeing Delivery Group have an action plan focussed around improvements in system leadership, training, treatment and services, and communications.

Stop Smoking Services for pregnant women are provided through Live Life Better Derbyshire who liaise with Midwives, particularly at Chesterfield Royal Hospital, and University Hospitals of Derby and Burton, to implement a smoking in pregnancy pathway. There is ongoing service improvement work to ensure staff training, routine use of CO monitors, appropriate and swift referrals, and effective stop smoking support. Other partners include maternity care staff including sonographers, and public health nurses and staff from the Family Nurse Partnership.

In 2019 there are additional resources and interventions in place or due to be implemented:

- Funding for two Smokefree Champion Midwife posts has been recently agreed, enabling 2 years of provision with a post for the North and for the South of the patch, and developing the work of a similar post from Erewash.
- A Design Council facilitated support programme for a team from Derbyshire County Council on applying design principles to reducing the prevalence of smoking in pregnancy
- The rollout out of a social marketing programme on smoking in pregnancy and breastfeeding 'You and your baby' across the County.

The scale of activity to address smoking in pregnancy demonstrates the commitment to reducing the prevalence locally, although it results in a complex landscape.

4.2.3. What are our outcomes?

The Government has set an ambition to reduce smoking in pregnancy rates to less than 6% by 2022.

Smoking at Time of Delivery was recorded at 15.4% (1068 women) in Derbyshire in 2017/18, with variation between districts (see data profile section above for more detail). There has been a general trend of gradual decline in the prevalence of smoking at time of delivery, though the annual figures fluctuate, and Derbyshire has not mirrored the national pattern (Figure 66)^{xxii}. On the basis of the current trajectory, it will take another 15 years to bring smoking in pregnancy rates under 6% in Derbyshire.

Figure 67 Smoking status at time of delivery – trend data



Smoking status at time of delivery – Derbyshire

Data on the uptake and effectiveness of services for the number and percentage of successful quits are reported nationally. The table below shows data for 2017/18. Derbyshire compares well regionally and national for the successful quit outcomes achieved by the women who engage with stop smoking support and set a quit date, including the use of CO-validation for these quits.

Table 7Data on pregnant women quitting smoking 2017/18

	Number setting quit date	Number successful quitters*	Percentage successful quitters* from setting quit date	Number successful quitters (CO- validated)	Percentage successful quitters (CO- validated) from setting quit date	Percentage successful quitters (CO- validated) from successful quitters*
Derbyshire	112	63	56%	52	46%	83%
East Midlands	1,181	495	42%	262	22%	53%
England	13,712	6,103	45%	3,668	27%	60%

^{xxii} Some caution should be applied in interpreting the 'Smoking at Time of Delivery' statistics, as the removal of a 'not known' data category locally may have improved the quality of the data for the statistic.

Source: NHS Digital⁶¹; *self-reported data

During 2017/18 112 women in Derbyshire set a quit date, whilst 1068 were recorded as smoking at time of delivery. This comparison gives an indication of the scale of need in addressing smoking in pregnancy locally.

4.2.4. Where are the gaps?

The review of policy and evidence to reduce smoking in pregnancy raises pertinent strategic and operational questions such as:

- Whether all the elements of Baby Clear have been implemented locally? Where are the gaps and how can these be addressed?
- Do local SSS services offer cessation support for partners, and post-natal provision? Are we thinking about the wider context around pregnant smokers?
- To what extent are we targeting provision for the most likely or least likely to quit smoking whilst pregnant?
- Are local approaches for assurance of delivery of Saving Babies' Lives sufficiently robust?

There seems to a challenge locally in bringing together a sufficiently well represented cross-agency and sufficiently authoritative group to consider these questions, and to advise on, and ensure the implementation of local action.

4.3. Cheap and illicit tobacco

There are three main categories of illegal tobacco:

- Counterfeit tobacco: illegally manufactured tobacco products which are often made abroad, but sometimes in the UK, and are designed to fool the public into thinking that they are the genuine product. They are sold cheaply and tax free and vast profits are made throughout the supply chain.
- Bootlegged/Smuggled: tobacco products which are purchased in a country with a low level of taxation and illegally brought into the UK, evading payment of tax.
- Illicit: generally legitimately manufactured tobacco products which have evaded payment of tax by being illegally transported, distributed and sold.

Illicit tobacco is more accessible to children and young people, and to more socioeconomically disadvantaged communities⁶², compounding the health inequalities experienced by these groups. It is estimated that illicit tobacco makes tobacco two to three times more affordable than legitimate products, and therefore can make smoking more accessible financially. In addition, there are other health risks associated with counterfeit products including the presence of contaminants within the tobacco and cigarettes, and the products not meeting manufacturing standards such as in regards to ongoing burning, and having a higher fire risk. Nationally it was estimated in 2016/17 that there was a £1,800 million tax gap associated with the combined illicit tobacco markets; illicit tobacco comprised 15% of cigarette sales.⁶³

4.3.1. What works?

NICE have a placeholder quality standard for: 'Preventing access to, demand for and supply of, illicit tobacco'.⁶⁴ This is a 'placeholder' standard as it is a priority of the Advisory Group, but there is a lack of source guidance.

Nationally, the HMRC and Border Force 2015 Strategy on Tackling Tobacco Smuggling⁶⁵ has four aims:

- Create a hostile global environment for tobacco fraud through intelligence sharing and policy change.
- Tackle the fraud at all points in the supply chain from production to retail.
- Change perceptions Raising public awareness of the links between illicit tobacco and organised criminality to reduce tolerance of the fraud in the UK.
- Optimise the use of the sanctions we have and, where we need to, develop tougher ones.

The national Tobacco Control Plan Delivery Plan 2017-2022 emphasises the role of local tobacco control. There are enforcement powers relevant to tackling illicit tobacco across a range of organisations and agencies including the Police, HMRC and Trading Standards. The Illicit Tobacco Partnership is a collaboration between FRESH (the tobacco control work in the northeast), ASH, UKCTAS and others. The Partnership have collated resources on their website⁶⁶ to provide strategic advice, including guidance for Trading Standards, and communications resources. Similarly, Stop Illegal Tobacco⁶⁷, from Smokefree West is a website providing information and a platform for people to share anonymous information. Crimestoppers is another organisation to whom the public can report issues anonymously. There is also a national Citizens Advice Consumer Service for the public to report complaints. In all cases this information will be reported to Trading Standards.

4.3.2. What is being delivered?

Derbyshire Trading Standards Service respond with test purchasing and enforcement operations to received intelligence on illicit and illegal tobacco. These operations are carried out with partners in the police and HMRC where required.

Analysis by Trading Standards staff suggests that there are two distinct supply chains of illicit tobacco which have prompted complaints within Derbyshire. The retail supply chain is perpetuated through a network of mini markets with links to organised crime nationally. These traders are becoming increasingly covert, on occasion only selling to identifiable groups of customers. The other supply route is through residential addresses (known as 'fag houses'), Trading Standards have reduced power to inspect these. The Trading Standards Service invites complaints from the public and also has a dedicated Facebook account for contact with those selling on the social media platform; complaints are also received from legitimate small retailers and other local businesses affected by the illicit trade.

In response to the complaints, the Service may carry out further investigations, inspections and seizures of illicit products, with prosecutions brought against individuals where appropriate. The Service works collaboratively with Derbyshire Police and their Safer Neighbourhood Teams, Border Force, Derbyshire Fire and Rescue Service, and District Councils, and on operations with the Immigration Service, HMRC, the Illegal Money Lending Team, trade mark representatives, landlords and letting agents. An important approach locally has been 'disruption' through dialogue with landlords of the problem shops, which can result in the terminations of tenancies held by problem tenants acting illegally.

The work of Derbyshire Trading Services includes a remit on enforcing the laws on age-restricted products. In addition to programme proactive risk assessment visits, the Service recruits local volunteers to support the work to tackle underage sales of tobacco. This is through age verification checks (where an over 18 year old is sent into a shop to purchase and see whether the shop conducts age verification), and via test purchases (with volunteers aged under 18 years).

The Derbyshire Trading Standards Service underwent a restructure in 2018/19 which may have an influence on future capacity, although all aspects of routine work are being continued in the short term. Of note, while Trading Standards have a duty to enforce intellectual property work, there is not a legally stipulated minimum level of activity, and the scale of activity is dependent on local decision making.

In addition other regulators exist who have a significant role in this area of work. HMRC have a national role in enforcement and disruption of the illicit tobacco supply. The Police also have a role in tackling the organised crime groups which effectively run the illegal tobacco trade and that are routinely involved in other serious criminality. However these agencies do not effectively carry out any significant work on supply at a local level, which is where the majority of Trading Standards work lies. This situation contrasts with other areas of Trading Standards work, such as food standards or product safety, where Trading Standards are effectively the sole regulators laid down in statute. Trading Standards will need to consider these factors when determining the priority it places on illegal tobacco work in the future. Other UK trading Standards services have already determined that they will not undertake any proactive work in this area of illegal tobacco and under age sales.

4.3.3. What are our outcomes?

Illicit tobacco

The annual report by Derbyshire Trading Standards (2018-19) indicates that a substantial number of complaints about illicit tobacco have been received in recent years, although they seems to have reduced from a peak between 2013 and 2016. Some of these complaints will have been routed through the national Citizens Advice line which has handled fewer complaints in recent years, possibly due to changes in the capacity of the service, so the number of complaints may not directly correlate with the scale of the problem in Derbyshire.



Figure 68 Complaints about illegal tobacco made to Derbyshire Trading Standards

Source: Derbyshire Annual Tobacco Report 2018-19, Derbyshire County Council

A large quantity of illicit tobacco was seized in 2018-19, the greatest in the last three years Table 8). The vast majority of these seizures were for counterfeit cigarettes. The retail value of the seized tobacco equates to £131,200 for the cigarettes and £52,400 for the HRT. The tax element of these seizures is £110,070 representing a substantial loss to the Exchequer. Six shops selling illegal tobacco were closed down. In early 2019/20 the Service made a large seizure of approximately 500,000 cigarettes from a self-storage unit, demonstrating work to stop the supply higher up the chain.

Year	Cigarette Sticks	Hand Rolled Tobacco - Kg
2011/12	14,000	115
2012/13	62,000	26
2013/14	876,000	795
2014/15	347,000	108
2015/16	1,855,750	595
2016/17	52,120	26
2017/18	43,798	47
2018/19	253,000	117
Total	3,504,258 sticks	1.889 tonnes

Table 8 Tobacco Seizures in Derbyshire by Trading Standards

Source: Derbyshire Annual Tobacco Report 2017-18, Derbyshire County Council

Under Age Sales

In 2018/19 the Service carried out multiple 'Risk Assessment Visits' to assess due diligence and the risk of sales in 6 specialist e-cigarette shops and 85 premises that sell tobacco products. These visits were considered as the first stage in seeking to address underage sales of tobacco and alcohol. For premises where there were concerns, these were followed up by two further stages:

- Age verification checks (test purchasers over 18 years) with a
 - o Tobacco 50% failure rate from 10 visits

- Nicotine Inhaling Products 71% failure rate from 7 visits.
- Test Purchases (test purchasers aged under 18 years)
 - Nicotine Inhaling Product test purchasing was done at one business following concerns by the Police and local residents. The premises failed to sell to our volunteers.
 - Tobacco test purchasing at 3 different premises. All 3 premises failed to sell to our volunteers.

It is envisaged that there will be a reduction of least 20% in the aforementioned initial 'risk assessment' inspections in 19/20. Numbers of age verification and test purchasing exercises during the financial year will be dependent on resources available and volume of actionable intelligence.

4.3.4. Where are the gaps?

There is evident experience of an intelligence-informed local response across agencies to addressing complaints, with demonstrable seizures of illicit products and work by Trading Standards particularly in recent years. The local Service will have to increasingly prioritise operational work due to resource constraints.

Trading Standards have further responsibilities in relation to tobacco control, such as responding to local premises who are flouting point of sale guidelines or labelling. However as the powers and penalties are stronger for counterfeiting offences (intellectual property/trademarks) than point of sale or labelling infringements, they are often dealt with in tandem with trademarks work rather than as an area of work in their own right.

As noted above HMRC and the Police also have enforcement powers on illicit tobacco and undertake activity on illicit tobacco. Information has not yet been gathered on any relevant activity in regards to this in Derbyshire (although HMRC provide nationally published statistics on their work).

4.4. Smokefree places

Legislation introduced in England in 2007 has made it illegal to smoke in all public enclosed or substantially enclosed area and workplaces. The policy emphasis has now switched to establishing voluntary smokefree zones in a wide range of other outdoor public settings to reduce secondhand smoke exposure, particularly to protect children, young people and vulnerable adults, such as those living with long term illnesses from the harmful effects of secondhand smoke. Children are particularly susceptible to the harms associated with exposure to tobacco smoke as they breathe more rapidly and have less developed airways. Children exposed to secondhand tobacco smoke within the home environment are at higher risk of asthma, chest infections, ear infections, and meningitis, and pregnant women who are exposed to passive smoke are more likely to have complications during their pregnancy and their baby is at higher risk of low birthweight and Sudden Infant Death Syndrome.⁶⁸ There is increasing concern about the impacts of thirdhand smoke, the contaminants from tobacco smoke that linger in the environment, particularly for children.⁶⁹ There is limited but emerging evidence on smokefree environments particularly in regards to public perception; smokefree places or zones adopt the precautionary principle as a means to provide protection from tobacco smoke exposure, and may contribute to a de-normalisation effect.

Potential settings for smokefree zones:

- around school gates and outdoor spaces on school sites
- hospital or medical centre grounds including entrance areas
- outdoor spaces at colleges and universities including entrance areas
- parks and recreation spaces including children's playgrounds and skate parks
- other green spaces including nature reserves, riverside walking areas, beaches
- bus and taxi waiting areas or shelters
- leisure centre entrances, and sports clubs and sport stadiums
- zoos, themeparks and other attractions
- town centre zones

4.4.1. What works?

A literature search was completed by the Public Health Knowledge and Intelligence Team at Derbyshire County Council on the evidence for the effectiveness of smokefree outdoor spaces, and evidence to inform the development of policies and measure the success of smokefree policies.

Overview of the literature on smokefree environments

WHO recommendations for smokefree environments were written into the international Framework Convention on Tobacco Control, emphasising the need for the protection from exposure to tobacco smoke in public places. There are indications that the implementation of the UK smoke-free legislation for indoor spaces was associated with a reduction in smoking take up among teenagers, particularly among girls⁷⁰ and there is clear evidence that smokefree legislation is associated with substantial reductions in preterm births and hospital attendances for asthma⁷¹. The evidence for the impact of policies in particular outdoor settings such as school gates or playgrounds is very limited. In 2016 the Chartered Institute of Environmental Health called for smokefree zones in all parks and playgrounds following a YouGov poll that they commissioned that found high levels of support for children's playgrounds to be a voluntary smokefree zone.⁷²

Public attitudes to smokefree policies

An evidence synthesis report was produced by PHE in 2018⁷³ with the following key findings particularly pertaining to public attitudes of smokefree policies:

- There is currently very limited routine UK data or research available about the effectiveness
 of smokefree outdoor policies, largely because such strategies are less widely adopted here
 than internationally.
- 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 vary considerably depending upon individual level factors or setting, such as non-smokers and females tending to hold more favourable views towards outdoor smoking restrictions.
- The effect of smokefree outdoors on behaviour and associated harms is mixed with some studies reporting no effects and others 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 secondhand smoke exposure (from a moderate quality study) one year after a university became smokefree.
- This synthesis also found that compliance with smokefree areas can also sometimes be low 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 disease 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.

School gates and school policies

The authors of a Cochrane Review were unable to draw conclusions about the effectiveness of school tobacco policies from the data available in 2014.⁷⁴ Many local policies at school gates or other settings have been viewed as a social responsibility to protect children from exposure to the harm of tobacco smoke. A qualitative study from the Netherlands explored the barriers and facilitators to smokefree school zones and identified the necessity of stakeholder engagement, with the authors concluding that legislation is important.⁷⁵ Several local toolkits have been written, such as by ASH Wales <u>Smokefree school gates</u>, and resources developed and shared through Council webpages from diverse areas such as Cheshire, Basingstoke, Devon, Glasgow and the Wirral.

Playgrounds and recreational areas, and other outdoor areas

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. There are examples from the UK where policies are being put into place, but as with the school zones, these are mostly forms of grey literature such as newspaper articles, case studies and web pages primarily to raise awareness of the policies that are being proposed or implemented, rather than assessments or evaluations of their impact.

Considerations for smokefree policies

Smokefree zones vary in whether vaping/use of e-cigarettes is permitted within the zone.

4.4.2. What is being delivered?

Derbyshire is compliant with existing smokefree legislation.

A consultation is being prepared on proposed smokefree zones in Derbyshire, with settings for consideration including the zone around infant, junior and primary schools, children's' play areas, and children's' sports clubs. The local priority has focussed on places that are primarily used by children.

Local healthcare trusts have been developing smokefree policies within their grounds, for example the 'Proud to be Smoke free' campaign at Chesterfield Royal Hospital, and the Derbyshire Healthcare Foundation Trust policy that all staff, service users and visitors are not allowed to smoke tobacco anywhere on their sites including wards, grounds, vehicles and during home visits.

4.4.3. What are our outcomes?

The outcomes of the smokefree zones consultation for school gates and other children's settings has not yet been established. The launch of this work demonstrates a commitment locally to developing smokefree places.

4.4.4. Where are the gaps?

The evidence base 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 risks from secondhand smoke, and have less choice over their environments, protecting their health is the clear focus, and many of the examples in the literature are for smokefree school gates and playgrounds. If the decision is made to progress with the promotion of voluntary smokefree settings by Derbyshire County Council, there will be opportunities to learn from other areas who have implemented similar policies, particularly in finding ways to overcome a lack of awareness and increase compliance to maximise the effectiveness of smokefree zones.

One of the main areas for further consideration beyond the work on public settings is the home environment. There is significant exposure to secondhand smoke in the home environment when children or non-smokers live with smokers. Research has shown that the most reliable way of reducing passive exposure is when the indoor environment is completely smokefree. There is increasing concern about 'thirdhand smoke', the pollutants that remain on clothes, soft furnishings, and in the environment.⁷⁶ An ASH briefing on secondhand smoke in the home concluded that population-level initiatives such as awareness campaigns may be important for influencing attitudes and behaviours.⁷⁷ There remains a question about how well these issues are understood in the Derbyshire population and raised and promoted appropriately.

4.5. Health services and reducing smoking

Health and care services, including those provided by the NHS, are key settings for tobacco control measures. People who smoke are more likely to have health needs and health use than non-smokers; smokers are estimated to make 35% more GP appointments than non-smokers.⁷⁸ Over a million smokers are likely to be treated in hospital each year.⁷⁹ The NHS is the UK's largest employer with a workforce of approximately 1.5 million staff⁸⁰ who may be impacted by cultural changes around smoking. Tobacco policies in these settings have a vast potential reach. Because tobacco dependence has such substantial impacts on health and NHS care, helping people stop smoking is the single highest value contribution to health that any clinician can make.⁸¹

4.5.1. What works?

NICE Guideline NG92⁸² Stop Smoking Interventions and Services has a section on 'Engaging with people who smoke' with recommendations for health and social care workers in primary and community settings:

1.4.1 At every opportunity, ask people if they smoke and advise them to stop smoking in a way that is sensitive to their preferences and needs.

1.4.2 Encourage people being referred for elective surgery to stop smoking before their surgery. Refer them to local stop smoking support.

1.4.3 Discuss any stop smoking aids the person has used before, including personally purchased nicotine-containing products.

1.4.4 Offer advice on using nicotine-containing products on general sale, including NRT and nicotine-containing e-cigarettes.

NICE Public Health Guideline PH48⁸³ Smoking: acute, maternity and mental health services states the smokefree policies and services within secondary care to enable people to stop or abstain from smoking while using or working within secondary care.

NHS organisations can sign the 'NHS Smokefree Pledge' that was launched in January 2018 by the Smokefree Coalition.⁸⁴ 'The Statement provides a public commitment to work towards further reducing smoking prevalence; to demonstrate a commitment to take action; and to publicise the NHS's dedication to protect local communities from the harm caused by smoking. It also reinforces the signatory's commitment to protect tobacco control work from the vested interests of the tobacco industry.'

The National Centre for Smoking Cessation and Training has developed a short training module for health professionals on how to deliver Very Brief Advice to patients.⁸⁵ This Very Brief Advice (VBA) approach has been developed from the evidence base on brief opportunistic smoking cessation interventions, and is designed for implementation in fast-paced healthcare settings. It is also referred to as the Ask, Assess, Act model.

4.5.2. What is being delivered?

National programmes are being implemented in NHS settings in Derbyshire through the QOF and CQUIN frameworks.

Smoking is part of the public health domain for the Quality and Outcomes Framework for GP Practices⁸⁶ with points for recording smoking status of patients, and for ongoing management, including an offer of literature and appropriate therapy or support and treatment.

The 'Preventing ill health by risky behaviours' national CQUIN for 2017-2019 set targets for alcohol screening and interventions in inpatient services in line with NICE guidance (PH24, QS11 and CG115). It also requires that staff receive training to equip them to deliver Very Brief Advice.⁸⁷ There is a 2019/20 CQUIN for NHS providers for Tobacco Screening and Tobacco brief advice.⁸⁸

The NHS Health Checks are offered in Derbyshire for people aged 40 to 74 years, and smoking is one of the risk factors included in the health check. Staff who carry out the health checks are trained locally on assessing smoking history and providing advice. A health equity report from 2015 found that 84% of smokers attending health checks were given education and advice on smoking, and 6.4% were referred to Stop Smoking Services 2010/11-2014/15 ⁸⁹.

Joined Up Care Derbyshire⁹⁰ is the Sustainability and Transformation Partnership for Derbyshire. The following NHS organisations are members of this:

- NHS Derby and Derbyshire Clinical Commissioning Group
- Chesterfield Royal Hospital
- Derbyshire Community Health Care Services
- Derbyshire Healthcare
- Derbyshire Healthcare United
- University Hospitals of Derby and Burton
- East Midlands Ambulance Service

These organisations are at different stages of progression on the journey to smokefree premises. The Joined Up Care Derbyshire Prevention plan brings together a commitment to enable people in Derbyshire to live healthier lives and make healthier choices, with the following strategic actions:

Healthier Choices: Smoking	 JUCD system organisations will be a leader in enabling staff, patients and visitors to become smoke-free through: 1. Implementing smoke free sites polices, normalising smoke-free 2. Provision of pharmacotherapy for inpatients 3. Systematic promotion, signposting and referral to stop smoking services especially at key opportunities like antenatal care 	 100% of hospital settings to be smoke- free Inpatients provided with pharmacotherapy All JUCD partners to promote/signpost/refer patients & staff to lifestyle services

4.5.3. What are our outcomes?

There are two QOF indicators that report on the offer of support and treatment for smokers recorded within primary care by the GP practices that participate in the QOF programme. These indicators record the offer of support and treatment for patients with 'current smoker' status recorded in their notes. The most recent complete year data (2017/18) are presented for Derbyshire in the table below. In both categories the smallest CCG, Erewash, has had a smaller percentage of patients being offered support and treatment recorded.

Table 9QOF Offer of support and treatment recorded within the last 24 months forcurrent smoker patients aged 15 years or over

	Number of eligible patients	% Patients receiving the intervention
NHS Erewash CCG	12,932	78.9%
NHS Hardwick CCG	16,938	87.9%
NHS North Derbyshire CCG	38,703	90.7%
NHS Southern Derbyshire CCG	77,568	88.8%
Glossopdale ^{\$}	4,659	93.2%

Source: QOF. ^{\$}Data for 6 Glossopdale Practices that lie within Derbyshire: Howard Medical practice; Manor House Glossop; Lambgates Health Centre; Cottage Lane surgery; Simmondley Medical Practice; Manor House Hadfield. In April 2019 the four CCGs across Derbyshire merged to form Derby and Derbyshire CCG.

Table 10QOF Offer of support and treatment recorded within the last 12 months forcurrent smoker patients aged 15 years or over living with long term condition(s)*

	Number of eligible patients	% Patients receiving the intervention
NHS Erewash CCG	3,611	89.7%
NHS Hardwick CCG	4,977	95.9%
NHS North Derbyshire CCG	10,536	96.6%
NHS Southern Derbyshire CCG	18,969	96.2%
Glossopdale	1,348	97.6%

Source: QOF. *Any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses. ^{\$}Data for 6 Glossopdale Practices that lie within Derbyshire: Howard Medical practice; Manor House Glossop; Lambgates Health Centre; Cottage Lane surgery; Simmondley Medical Practice; Manor House Hadfield. In April 2019 the four CCGs across Derbyshire merged to form Derby and Derbyshire CCG.

Data for the CQUIN on risky behaviours was sought from the local actuve services. A quarterly audit was carried out on patients in the Emergency Medical Unit and Pre-assessment Unit to gather data for the CQUIN on Tobacco for Chesterfield Royal 2018/19, with overall results for the year presented in the table below.

Table 11Results from the audit of tobacco screening and support for the CQUIN atChesterfield Royal

	Percentage of patients		
Did the patient receive a tobacco screen? (n= 2784)	81%		
ls the patient a current smoker? (n= 2266)	15%		
Was the patient given brief advice? (n=332)	77%		
Was the patient offered a referral to a	Both offered referral and medication 52%		
specialist service and offered medication?	Referral only 10%		
(n=332)	Medication only 7%		
	Neither 31%		
Did the patient accept the ofer and was	Accepted 10%		
the referral made?	Declined 29%		
(n=206)	No documentation 2%		
	Not sure 59%		

4.5.4. Where are the gaps?

There may be an opportunity to encourage the organisations within Joined Up Care Derbyshire, such as the new Derby City and Derbyshire CCG, to sign the NHS Smokefree Pledge, none are currently signatories. While there is a commitment to smokefree NHS settings locally, a more detailed review of progress and next steps could inform this is further. In particular, more concerted local efforts in regards to outpatients and patients awaiting surgery, as these are people in contact with the health system, and brief advice in the form of quality conversation may resonate particularly with them at this time point.

There is still work to be done throughout the local health and care system on identification of smokers, the provision of advice, and the offer of treatment such as medication, and referral to specialist cessation support. The London CO4 commitment described below provides one example of how one area of the country has developed a broad approach to smoking within their NHS organisations.

Case Study: London CO4 Campaign⁹¹

The London Clinical Senate launched the 'Helping Smokers Quit' Programme to support behaviour change within clinical teams and across care setting and specialities in London. Helping Smokers Quit ran from September 2014 until May 2016, focussing on the challenge for clinicians to shift from the mental model of 'smoking as a lifestyle choice' to smoking as a treatable dependency, a long-term, intermittent and relapsing condition that often begins in childhood. An important part of this was the development of the CO4 campaign for identifying and treating tobacco dependence, which clinical leaders were invited to commit to.

CO4 refers to 4 elements:

- 1. The 'right' COnversation for every patient and staff member who smokes that gives him or her a chance to quit, referring if necessary. This is a skilled conversation that requires the right training.
- 2. Make routine near-patient exhaled carbon monoxide (CO) monitoring by clinicians, at desktop, bedside and home, possible through the routine provision of CO monitors and training in how to use them with a patient as a motivational tool: "Would you like to know your level?"
- 3. COde smoking status and the intervention so we can evaluate effectiveness, including death certification.
- 4. COmmission the system to do this right: so the right behaviours are incentivised systematically.

CO4 has also been promoted by ASH and Public Health England as a positive example of tackling the problem of harm from tobacco dependence.

The final report⁹² emphasised the importance of addressing tobacco dependence and the evidence for this, and highlighted areas of good practice. The recommendations were written to support the planning and implementation of Sustainability and Transformation Plans (STPs) across London.

5. Call to Action: A smokefree future

5.1. National and local commitment

The NHS Long Term Plan commits the NHS in England to more action on prevention and health inequalities with action on smoking highlighted⁹³ and the following commitments:

- First, the NHS will therefore make a significant new contribution to making England a smokefree society, by supporting 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.
- Second, the model will also be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.
- Third, 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.

Organisations within Joined Up Care Derbyshire are signed up to *'*be a leader in enabling staff, patients and visitors to become smoke-free".

Derbyshire Health and Wellbeing Strategy for 2018-2023 'Our lives, our health' includes a priority to 'Enable people in Derbyshire to live healthy lives'.

5.2. Considerations for Derbyshire County Council and the Health and Wellbeing Board

In June 2019, Action on Smoking and Health (ASH) and Fresh Northeast published 'The End of Smoking', a new strategic guide for local authorities.⁹⁴ The guide is designed to provide a routemap for local authority members and officers, and for Health and Wellbeing Board partners. The guide is informed by the modelling from the University College London Smoking Toolkit. The proposed target for local areas to adopt is to: <u>reduce smoking prevalence to below 5% in all socio-economic groups by 2029</u>.

The guide highlights that there is a pertinent question that is usually not addressed within a needs assessment, and vital for informing programmatic responses which 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 an e-cigarette

To reduce the smoking prevalence overall within each area requires reducing the uptake of smoking, increasing the number of quit attempts, and increasing the success of quit attempts made.

	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		~	~

The implications of this for Derbyshire include:

- 1. To consider what our local ambition is in terms of the smoking prevalence, and any targets beyond those for stop smoking services
- 2. 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
- 3. Maintaining work to keep smoking unappealing, including reducing the demand and supply of illegal tobacco
- 4. 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
- 5. 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
- 6. Considering settings for more targeted work, for example with people who live in social housing, and people receiving adult care support
- 7. Exploring opportunities to drive or contribute to regional work especially around mass media campaigns.

5.3. Collaboration across organisations

This needs assessment has highlighted the evidence on the necessity of multiagency and multicomponent tobacco control work, Public Health England have set out the following slide indicating the types of roles for organisations across health and social care and beyond. In addition some of the issues raised lie across geographic boundaries. This report has focussed on the Derbyshire County area, and there may be further opportunities to collaborate with Derby City and health partners across Joined Up Care Derbyshire, in addition to linking with any regional work with PHE.




5.4. Developing a whole systems approach

The NHS Long Term plan makes reference to the model implemented in Manchester. Their strategy 2017-2021 'Making Smoking History: A Tobacco Free Greater Manchester' details the target of bringing down adult smoking prevalence by around a third, from the current 18.4% to 13% by the end of 2020, and to 5% by 2035.⁹⁵They have quantified specific targets and the numbers involved to achieve this, and specific actions. Local campaigns and activity since 2018 are all linked to this strategy. Of note is the time invested in developing the strategy working from December 2015, the plan was published July 2017 ahead of implementation, and the wide engagement with a multitude of partners:-

- Action on Smoking and Health
- Association Governing Group of CCGs
- Directors of Public Health Group
- Cancer Education Manchester
- Cancer Research UK
- Fresh Smokefree North East
- Greater Manchester Combined Authority Executive
- Greater Manchester Cancer VCSE Advisory
 Group
- Greater Manchester Fire and Rescue Service
- Greater Manchester VCSE Devolution Reference Group

- Greater Manchester LGBT Foundation
- Greater Manchester Health & Social Care Partnership
- Greater Manchester Population Health Programme Board
- Greater Manchester Tobacco Control Commissioners Group
- HMRC
- Healthier Futures CIC
- Joint Commissioning Board
- Joint Commissioning Board Executive
- Public Health England
- Trading Standards North West

Similarly Sheffield has set out a bold ambition of a Smokefree Generation by 2025.⁹⁶ The crossorganisational initiative has brought in partners across the Council, NHS, and local health providers, and includes a range of campaigns including on smokefree pregnancies, smokefree homes, shisha, and cheap and illicit tobacco. The work in Sheffield was underpinned by a Tobacco Control Health Needs Assessment completed in 2016.⁹⁷

5.5. Progress in Derbyshire

There has been an ongoing trend of a decline in the prevalence of smoking in Derbyshire, with progress towards a smokefree/tobacco free generation in the future. Local projections can be made by applying a linear trend (i.e. modelling an ongoing decline at the same rate) to smoking prevalence for the next few years.

If a linear trend continues the overall prevalence of smoking in adults is likely to fall below 10% by 2024.



Figure 70 Projection of smoking prevalence in adults in Derbyshire over time

However, the smoking prevalence is projected to still be 15% in 2024 among adults in routine and manual occupations (Figure 71). This emphasises the necessity of a focus on reducing smoking within the more socio-economically disadvantaged communities within Derbyshire where there are higher numbers of adults in routine and manual work, and unemployed people.

Figure 71 Projection of smoking prevalence in adults in routine and manual occupations in Derbyshire over time



There is also a slower decline in smoking rates among pregnant women. The Government ambition is to reduce the smoking in pregnancy rate to less than 6% by 2022. Yet following the current trend Derbyshire is projected to have a rate of 13% in 2022/2023 (Figure 72).





6. Conclusions and Recommendations

What does this Health Needs Assessment provide?

This Health Needs Assessment has brought together data and information on the use and impact of tobacco within Derbyshire, and has considered how Tobacco Control measures are being implemented within several areas of work. The focus of the steering group has been on the implementation of the four ambitions within the national Tobacco Control plan, specifically identifying and progressing actions that can be undertaken locally. This Health Needs Assessment provides information that can support the achievement of these ambitions. In addition there is detailed information on the impacts of tobacco (Section 3) for making the case for change.

Ambition	Contribution of this Health Needs Assessment
Prevention First	Data on smoking in young people. (Section 2.1.2)
Supporting smokers to quit	Information on stop smoking services (Section 4.1) Information on local work towards a smokefree NHS (Section 4.5)
Eliminating Variation in smoking rates	Detailed data profile to understand prevalence of tobacco use in the Derbyshire population (Section 2)
	the impacts of tobacco use (Section 3) Information gathered on local smokefree places (Section 4.4)
Effective enforcement	Information on local measures on illicit tobacco (Section 4.3)

There are several actions within the Tobacco Control Plan that have not been considered in detail here and further work will be required to assess the needs in relation to these objectives within Derbyshire at a later stage. These actions include:

- To ensure support for people with mental ill health who are smokers. This would include assessing needs in the offer, access to, and take up of stop smoking services and quitting smoking, and in achieving parity of esteem through working with Derbyshire Healthcare Trust, Primary Care, and local Stop Smoking Services.
- To prevent the take up of smoking by young people in Derbyshire. An assessment of this would include preventive activity within schools and other settings focussed on smoking and/or other risky behaviours, and ensuring that the insight from the My Life My View survey findings in Derbyshire is used to inform local work.
- To consider public awareness and understanding and beliefs about smoking within the County, and to consider communications or campaigns to engage on the basis of local insight.

Overall the Tobacco Health Needs Assessment provides insight to inform the co-development of an action plan for tobacco control in Derbyshire, in terms of the key needs, challenges, and areas for focus locally.

What are the important needs in relation to tobacco control?

Several needs are particularly evident from the data and intelligence that have been included within this needs assessment.

1. Tobacco use by people living in areas of socioeconomic disadvantage particularly including those with mental health conditions

The data profile shows that there are particular population groups in Derbyshire with higher use of tobacco. Smoking rates are higher nationally in people living with a mental health condition than in

people who do not experience mental ill health. The Derbyshire data shows indications of differences in the prevalence of smoking by people with a long term mental health condition and by people with anxiety or depression between the Districts within the County, and in particular with high smoking prevalence in Chesterfield, which has higher levels of economic deprivation than some other part of the county.

2. Smoking in pregnancy

Smoking status at time of delivery in Derbyshire remains comparatively high, with 15.4% of women smoking at time of delivery in 2017/18. Derbyshire is not on track to achieve the government ambition to reduce smoking in pregnancy to less than 6% by 2022. Smoking in pregnancy is associated with a long list of detrimental health risks for mother and for baby. For example the premature birth rate in Derbyshire has been rising steadily recently. There are gaps in terms of local insight and understanding of the reasons for the high rate locally. It is an area for ongoing focus.

3. Ensuring the effectiveness of local stop smoking services

Increasing the number of successful quitters in Derbyshire will have benefits for the individuals and their households and communities in terms of health and economic gains. Furthermore, reductions in the proportions of smokers within the population will contribute positively to healthy life expectancy within Derbyshire. The current model for the local stop smoking service may not be as cost effective as it could be, and there may be opportunities to make use of the national return on investment data (while noting the limitations of the tool) to consider how to maximise investment in the service. There have been recent service changes locally and data for 2017/18 was anticipated to reflect this. Current plans are underway to improve communications and engagement and these should be evaluated to assess whether they are having an impact on the proportions of people engaging with the service and going on to set a quit date, and achieve a successful quit.

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

The consultation on smokefree school gates and other settings in Derbyshire is to be welcomed, although the evidence based on smokefree environments is still emerging. It is important that the opportunities are taken through this process to raise public awareness about the harms of secondhand smoking and thirdhand smoke, and the impact in particular on younger children. Partners must continue to recognise that the children and young people who are at the greatest risk are those living with adults in the household who smoke, and that this continued exposure has substantially higher harms than exposure to cigarette smoke of shorter duration in outdoors settings. The resources developed around smokefree school gates and any other schemes could be designed to sensitively help improve awareness of the harms of secondhand smoke with information on smoking cessation support targeted to parents, grandparents, and other carers. There may also be opportunities to liaise with non-traditional partners beyond schools in promoting these messages and collaborating across the system.

What are the challenges for tobacco control in Derbyshire?

There are limitations to the data available to inform targeting of local tobacco control measures. The prevalence of smoking by adults, including adults from routine and manual occupational groups and among young people is in line with the national average and compares favourably with CIPFA nearest neighbours, and aligns with a national decline. The county and district level values can mask the fact that there are particular groups and geographic areas where smoking is particularly prevalent with the associated health impacts. The estimates for small area geographies (as per the maps) are calculated from the Index of Multiple Deprivation. The similarity with national values for

smoking overall means that the case for investment in tobacco control needs to be built up across a range of policy levers including health impacts and health system use and costs.

There is no current Tobacco Control Strategic Group to bring together system partners to have oversight and coordinate efforts. While there is committed work by different organisations and departments these efforts are not amplified. This is particularly evident around shared messages and effective efforts for a step change in tobacco control. The new Health and Wellbeing Strategy and Joined Up Care Derbyshire Prevention Plan state a level of ambition such as being 'a leader in enabling [people] to become smoke-free', although the steps to achieve that ambition are not detailed nor are the resources costed out. It is clear that simply providing a standard offer of a stop smoking service (no matter how high quality that service is), and relying on individual impetus to access this (no matter how well marketed) is insufficient, particularly for smokers from more disadvantaged communities. There is a strong rationale for the case for investment in tobacco control, however the measures require investment and are not immediately cost saving and in the context of very significant cost pressures within local authorities and the health and care system will require bold commitment. A key example is in addressing smoking in pregnancy, a little more of the same will not get us where we need to be. Many important tobacco control measures are determined and implemented nationally such as taxation policies and legislation, and there is an opportunity for more coordinated local advocacy on these issues, either through thematic work such as smoking in pregnancy or a broader tobacco control strategic group.

Where should the focus be?

Approximately 16 in every 100 deaths in Derbyshire can be related to smoking. This burden is not distributed evenly though the population. It is important that all partners recognise that we cannot continue to consider 'smoking as a lifestyle choice', but to recognise tobacco dependency, and the necessity of an appropriate scale response. In response to the data available, local tobacco control measures should be focussed particularly on the areas of the county with the highest levels of deprivation, as there is a strong association between smoking, deprivation and health inequalities, and this will mean working at sub-district level. The focus needs to be communities rather than on individuals, as a culture change around smoking is required, and in recognition that quitting smoking is difficult and all that can be done to make the environment more supportive is justified.

The data and information in this needs assessment point to the necessity of a lifecourse approach to tobacco control. The Years Lived in Disability and Years of Life Lost associated with smoking are evident at all ages of life from pre-conception through to the end of life. Reducing the harms associated with tobacco in children and young people particularly through secondhand smoke is an important priority, and aligns with public opinion. There is an important burden among adults of working age and in later life. This is more evident within the healthcare system, so supporting efforts for a smokefree NHS (at its fullest definition) is an important means of reaching and engaging across the population.

Effective tobacco control is dependent on a clear commitment to a smokefree future and multiagency work applying the evidence based interventions and initiatives. Mass media campaigns remains an important strand of work which is not currently evident to achieve a smokefree future and an area for further development. It would also offer an opportunity to bridge across some of the geographic boundaries and collaborate with Derby City and health partners across Joined Up Care Derbyshire, as well as across the East Midlands.

Recommendations

The Tobacco Health Needs Assessment Steering group has developed the following recommendations to call for action in response to this work:

- 4. Discuss the findings and conclusions with Derbyshire Health and Wellbeing Board, and with Joined Up Care Derbyshire Board (in partnership with Derby City) to
 - a. raise the profile of these issues
 - b. call for system-wide leadership and action
 - c. invite the development of shared commitments, such as a target towards a tobacco free generation with prevalence of adult smoking below 5% within a fixed timeframe
- 5. Upscale the cross-organisational work particularly on addressing smoking in pregnancy, building on the commitment within organisations, and to amplify local efforts. And then to use the learning from the work on smoking in pregnancy to identify effective ways of collaboration that can support action on smoking in other population groups.
- 6. Consider reconvening a Tobacco Control group for Derbyshire to coordinate local efforts, draw attention to work across partners, and as a mechanism for advocacy for action at regional and national levels.

Appendix: Attributable Health Impacts - further data for Derbyshire

Attributable Deaths

Total registered deaths, deaths from diseases which can be caused by smoking, and those estimated to be attributable to smoking¹, for adults aged 35 and over, by gender

	ICD 10 Code ²		Total			Male		Female		
		Observed deaths	Attributable number ³	Attributable percentage⁴	Observed deaths	Attributable number ³	Attributable percentage⁴	Observed deaths	Attributable number ³	Attributable percentage⁴
All deaths	A00- R99,U00-Y89	13,693	2,177	16	6,680	1,321	20	7,013	854	12
All cancers	C00-D48	3,692	968	26	2,014	630	31	1,678	342	20
All respiratory diseases	100-199	3,355	1,230	37	1,695	686	40	1,660	548	33
All circulatory diseases	100-199	1,937	245	13	944	149	16	993	92	9
All diseases of the digestive system	КОО-К93	694	23	3	326	12	4	368	10	3
All deaths which can be caused by sm	oking	6,523	2,146	33	3,424	1,298	38	3,099	846	27
Cancers which can be caused by smok	ing	1,835	982	54	1,066	643	60	769	343	45
Trachea, Lung, Bronchus	C33-C34	753	594	79	429	369	86	324	229	71
Upper respiratory sites	C00-C14	65	41	63	44	31	70	21	10	46
Larynx	C32	2	2	79	1	1	80	1	1	72
Oesophagus	C15	199	128	65	143	97	68	56	32	57
Cervical	C53	15	1	10				15	1	10
Bladder	C67	137	52	38	96	41	42	41	12	28
Kidney	C64-C66,C68	113	26	23	65	21	32	48	3	7
Stomach	C16	89	17	20	60	14	24	29	3	12
Pancreas	C25	211	46	22	116	23	20	95	22	23
Unspecified site	C80	214	72	34	92	47	51	122	23	19
Myeloid leukaemia	C92	37	6	16	20	4	21	17	2	10

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	ICD 10 Code ²		Total			Male		Female		
		Observed deaths	Attributable number ³	Attributable percentage⁴	Observed deaths	Attributable number ³	Attributable percentage⁴	Observed deaths	Attributable number ³	Attributable percentage⁴
Respiratory diseases which can be caused by smoking		1,535	736	48	732	390	53	803	344	43
Chronic obstructive lung disease	J40-J43	17	15	86	11	10	88	6	5	81
Chronic Airway Obstruction	J44	796	610	77	401	312	78	395	298	75
Pneumonia, Influenza	J10-J18	722	123	17	320	74	23	402	48	12
Circulatory diseases which can be caused by smoking										
Other Heart Disease	126-151	3,115	425	14	1,602	270	17	1,513	153	10
Ischaemic heart disease	120-125	682	83	12	271	45	16	411	37	9
Other Arterial Disease	172-178	1,484	201	14	912	139	15	572	61	11
Cerebrovascular Disease	160-169	63	9	15	31	4	14	32	5	15
Aortic Aneurysm	171	775	62	8	308	36	12	467	24	5
Atherosclerosis	170	109	62	57	79	48	61	30	15	51
Diseases of the digestive system which o	can be caused									
by smoking		38	17	45	24	12	49	14	6	40
Stomach/duodenal ulcer	K25-K27	38	17	45	24	12	49	14	6	40

Notes:

1. See Statistics on Smoking: England, 2013, Appendix B for methodology for calculating attributable deaths

ICD-10 refers to original cause of death
 Estimated attributable number, rounded to the nearest 100. Totals may not sum due to rounding.

4. Estimated attributable percentages are based on unrounded attributable estimates.

Attributable Admissions

Total NHS hospital admissions, admissions with a primary diagnosis of diseases which can be caused by smoking¹, and those estimated to be attributable to smoking², for adults aged 35 and over³, by gender⁴

	ICD 10									
	Code ²	Admissions	I Otal Attributable	Attributable	Admissions	IVIAIE Attributable	Attributable	Admissions	Female Attributable	Attributable
			number⁵	percentage ⁶		number⁵	percentage ⁶		number⁵	percentage ⁶
All admissions	A00-Y89	81,875	3,461	4	41,863	2,332	6	40,012	1,217	3
All cancers	C00-D48	32,563	2,917	9	16,356	2,030	12	16,207	908	6
All respiratory diseases	100-199	11,483	2,535	22	5,498	1,296	24	5,985	1,237	21
All circulatory diseases	100-199	12,068	1,753	15	7,056	1,237	18	5,012	515	10
All diseases of the digestive system	КОО-К93	25,761	311	1	12,953	165	1	12,808	146	1
All diseases which can be caused	by smoking	32,310	8,492	26	17,213	5,170	30	15,097	3,302	22
Cancers which can be caused by s	moking	6,731	3,152	47	4,128	2,119	51	2,603	1,025	39
Trachea, Lung, Bronchus	C33-C34	1,866	1,463	78	1,017	872	86	849	596	70
Upper Respiratory Sites	C00-C14	351	221	63	255	178	70	96	44	46
Oesophagus	C15	99	64	64	80	54	67	19	11	56
Larynx	C32	589	460	78	397	316	80	192	138	72
Cervical ⁷	C53	92	9	10				92	9	10
Bladder	C67	1,108	428	39	858	359	42	250	70	28
Kidney and Renal Pelvis	C64-C66,C68	372	89	24	259	83	32	113	8	7
Stomach	C16	272	55	20	196	46	24	76	9	12
Pancreas	C25	571	122	21	308	61	20	263	61	23
Unspecified Site	C80	150	49	33	76	39	51	74	14	18
Myeloid Leukaemia	C92	1,261	205	16	682	140	21	579	56	10

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	ICD 10		Tatal			Mala			Famala	
	Code	Admissions	IOTAI Attributable number ⁵	Attributable percentage ⁶	Admissions	IVIAIE Attributable number ⁵	Attributable percentage ⁶	Admissions	Female Attributable number⁵	Attributable percentage ⁶
Respiratory diseases which can b smoking	e caused by	7,008	2,744	39	3378	1,406	42	3630	1,337	37
Chronic obstructive lung disease	J40-J43	68	58	85	33	29	88	35	28	81
Chronic Airway Obstruction	J44	2,147	1,638	76	996	772	78	1151	866	75
Pneumonia, Influenza	J10-J18	4,793	927	19	2349	547	23	2444	379	15
Circulatory diseases which can be smoking	e caused by	11,798	1,980	17	6964	1,378	20	4834	594	12
Other Heart Disease	100-109, 126- 151	4,821	623	13	2595	420	16	2226	196	9
Ischaemic heart disease	120-125	4,441	929	21	2952	673	23	1489	251	17
Other Arterial Disease	172-178	375	53	14	229	32	14	146	21	15
Cerebrovascular Disease	160-169	1,618	234	14	799	133	17	819	100	12
Aortic Aneurysm	171	198	114	58	156	94	60	42	21	50
Atherosclerosis	170	345	67	20	233	58	25	112	10	9
Diseases of the digestive system caused by smoking	which can be	1,298	293	23	595	152	25	703	141	20
Stomach/duodenal ulcer	K25-K27	270	118	44	146	70	48	124	48	39
Crohns Disease	K50	1,010	128	13	441	62	14	569	65	11
Periodontal Disease / Periodonitis	K05	18	7	37	8	3	40	10	4	35
Other diseases which can be caus	ed by smoking	5,475	495	9	2148	217	10	3327	280	8
Age Related Cataract 45+	H25	3,878	359	9	1697	174	10	2181	186	9
Hip Fracture 55+	S720-S722	1,476	140	9	451	43	9	1025	97	9
Spontaneous Abortion ⁷	O03	121	4	3				121	4	3

Notes:

1. The primary diagnosis is the first of up to 20 diagnosis fields in the Hospital Episode Statistics (HES) data set and provides the main reason why the patient was admitted to hospital. See Appendix B for corresponding ICD 10 codes used with categories above.

2. See Statistics on Smoking: England, 2013, Appendix B for methodology.

3. Figures are presented for adults aged 35 and over unless otherwise specified

4. The figures exclude people whose gender was unknown or unspecified and whose country of residence was not confirmed as England.

5. Estimated attributable number, rounded to the nearest 100. Totals may not sum due to rounding.

6. Estimated attributable percentages are based on unrounded attributable estimates.

7. Figures exclude admissions for patients whose gender was specified as male.

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