

---

# LEICESTERSHIRE JOINT STRATEGIC NEEDS ASSESSMENT 2018-2021

## TOBACCO CONTROL

DECEMBER 2019

Strategic Business Intelligence Team  
Leicestershire County Council

## **Public Health Intelligence**

Strategic Business Intelligence Team  
Strategy and Business Intelligence  
Chief Executive's Department  
Leicestershire County Council  
County Hall, Glenfield  
Leicester LE3 8RA

Tel                0116 305 4266  
Email            [phi@leics.gov.uk](mailto:phi@leics.gov.uk)

Produced by the Strategic Business Intelligence Team at Leicestershire County Council.

Whilst every effort has been made to ensure the accuracy of the information contained within this report, Leicestershire County Council cannot be held responsible for any errors or omission relating to the data contained within the report.

## FOREWORD

---

The purpose of the Joint Strategic Needs Assessment (JSNA) is:

- To improve the health and wellbeing of the local community and reduce inequalities for all ages.
- To determine what actions the local authority, the local National Health Service (NHS) and other partners need to take to meet health and social care needs, and to address the wider determinants that impact on health and wellbeing.
- To provide a source of relevant reference to the Local Authority, Clinical Commissioning Groups (CCGs) and NHS England for the commissioning of any future services.

The Local Authority and CCGs have equal and joint statutory responsibility to prepare a JSNA for Leicestershire, through the Health and Wellbeing Board. The Health and Social Care Act 2012 amended the Local Government and Public Involvement in Health Act 2007 to introduce duties and powers for Health and Wellbeing Boards in relation to JSNAs. The JSNA offers an opportunity for the Local Authority, CCGs and NHS England's plans for commissioning services to be informed by up to date information on the population that use their services. Where commissioning plans are not in line with the JSNA, the Local Authority, CCGs and NHS England must be able to explain why.

The Health and Wellbeing Board has agreed that the JSNA will be published in subject-specific chapters throughout a three-year time period. Chapters will be developed in line with CCG and local authority commissioning cycles. As many of the relationships required for the JSNA in Leicestershire are wide ranging, involving representation from NHS England, CCGs, Leicestershire Partnership Trust, University Hospitals of Leicester (UHL), District Councils and the voluntary sector, a JSNA Reference Group has been established. This Reference Group supports the JSNA work across the Health and Wellbeing Board. To examine the detail of the chapters, Task and Finish groups have been established to bring together local professionals, where they can share their expert knowledge on the work area being examined.

The outputs of the JSNA will include:

1. Subject-specific chapters of an assessment of current and future health and social care needs.
2. An online infographic summary of each chapter available on the internet.

The JSNA has reviewed the population health needs of the people of Leicestershire in relation to tobacco control. This has involved looking at the determinants of tobacco use, the tobacco control needs of the population in Leicestershire, the impact of smoking tobacco, the policy and guidance supporting tobacco control, existing services and the breadth of services that are currently provided. The unmet needs and recommendations that have arisen from this need's assessment are discussed.

Please note, the majority of indicators presented in this need's assessment are from national sources so are subject to a time lag due to the time required for data collection, data analysis and publication. Where possible, comparisons have been made to national averages and local context has been included. The term significance is used throughout the report and refers to statistical significance. This examines if the result presented is different to the national result, due to something other than chance. Most often, this is calculated using 95% confidence intervals. Due to the statistical tests applied when considering statistical significance, it is possible to observe seemingly large differences in numbers (say between Leicestershire and the England average) without this being considered statistically significant. Conversely, it is also possible to observe seemingly small differences between numbers in two areas and this difference achieve statistical significance.

## EXECUTIVE SUMMARY

---

This Joint Strategic Needs Assessment (JSNA) chapter sets out a picture of need in relation to tobacco control and mainly focuses on smoking tobacco in Leicestershire. A short section on e-cigarette use, or vaping, is included in this chapter. E-cigarettes are supported by Public Health England and the Royal College of Physicians as a smoking cessation aid. Some national data is available, but data is not available at a Leicestershire level regarding use of e-cigarettes.

Smoking is a major cause of preventable ill health and premature mortality in England. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking is a lifestyle risk factor that can be minimised; effective tobacco control measures can reduce the prevalence of smoking in the population.

In Leicestershire, in 2018, the prevalence of adults who were current smokers was 13.2%. This was similar to the national average prevalence of 14.4%. Although prevalence has decreased over time, this still equates to 73,535 smokers in Leicestershire in 2018. There is a geographical difference in smoking levels which will lead to a geographical inequality in the burden of smoking related illnesses. Smoking prevalence in Leicestershire ranges from 6.3% in Oadby and Wigston to 19.2% in North West Leicestershire. North West Leicestershire also has the highest level of smoking attributable mortality rate in Leicestershire.

More men than women smoke, so the burden of disease will disproportionately affect men too. Some young people are still starting to smoke. The smoking prevalence is higher in mixed and white ethnic groups. Lesbian, gay and bisexual people are more likely to be current smokers, with the gap being more pronounced for women. All these groups where smoking is more common represent groups who are at risk of smoking related diseases and complications, as well as bearing the financial burden that smoking places on an individual.

Excess mortality is seen for those with mental health problems due to increased smoking. This represents a huge health inequality in those with severe mental health problems. 20.2% of those with a long-term mental health condition in Leicestershire smoke.

There is also a link with deprivation. The prevalence of smoking in Leicestershire in those in routine and manual occupations is 22.4%. This means that those who are more economically deprived, and who are likely to be deprived in other areas of life, are also faced with a substantial health inequality as a result of smoking. This will manifest itself in

reduced life expectancy, more smoking related illnesses, more smoking related hospital admissions and more impacts on day to day activities as a result of the smoking.

There are population groups who are vulnerable for a number of reasons that have higher smoking prevalence and therefore are likely to face health inequalities as a result of their smoking, let alone any other factors. Looked after children (LAC), the homeless population, and the prison population all have higher smoking prevalence than the average. Again, these groups face a range of health inequalities, of which one major factor will be related to the levels of smoking in these groups.

Smoking in pregnancy is measured as 'smoking at the time of delivery'. In Leicestershire and Rutland the level is 8.5% of women which is significantly better than the national average. However, this represents nearly 1 in 10 pregnant women, and this group has a substantially higher risk of various complications. Smoking during pregnancy can cause serious complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. Neonatal mortality rates in Leicestershire are similar to the national average. However, all of these deaths are individual tragedies for the family and friends. Premature births are increasing over time; smoking increases the risk of premature births.

Smoking attributed hospital admissions have increased over time. At 1,619 admissions per 100,000 people in 2015/16 for Leicestershire, this is lower than the national average. However, this still represents a significant burden on inpatient hospital services, including on ambulance services, Emergency Department attendances and admissions units. Smoking is the single biggest cause of preventable deaths and illness and accounts for one in six deaths across England. Smoking increases the risk of various cancers, cardiovascular, respiratory and digestive system diseases. All these illnesses will represent a sizeable proportion of primary care and secondary care resources for both planned and emergency care. The mortality rate from oral cancer in Leicestershire has been increasing since 2011-13.

Generally speaking, those who access the Quit Ready stop smoking service reflect those groups where there is higher prevalence of smoking. There has been an increase in the number of people accessing the service over time, however with a lower proportion setting a quit date.

Smoking continues to be a major contributor to health inequalities in a range of more deprived or more vulnerable groups. Smoking related illness and disease accounts for a significant proportion of the work of the health service in primary and secondary care, and in all affiliated parts of the health and care system, in both planned and emergency activity.

There is an opportunity to develop and strengthen system and wider leadership regarding smoking cessation, tobacco control, and smoke free homes. The NHS Long Term Plan sets out the importance of leadership by NHS organisations to contribute to making England a smoke free society through needs-based commissioning (e.g. through utilising information in Joint Strategic Needs Assessments) and provision of inpatient stop smoking services, and a universal smoking cessation offer to long-term users of specialist mental health and/or learning disability services.

District councils should aim to provide leadership in the area of smoke free housing, to work with their housing providers to lead the way in improving the health of their population through smoke free tenancies and reducing second hand smoke exposure due to smoke drift.

As well as looking at data on smoking and its consequences, this chapter considers the relevant national and local policy and guidance context for smoking cessation and tobacco control. A set of recommendations have been made to tackle smoking with the aim of reducing smoking prevalence and the consequences of smoking in the people of Leicestershire.

The recommendations are:

- 1) Development of a Tobacco Control Strategy for Leicestershire to set out a clear vision and priorities for reducing smoking related health inequalities and reducing the burden of illness and disease from smoking, recognising the partnership between different organisations that will be required to fulfil this.
- 2) Reduce health inequalities due to smoking through a reduction in people starting smoking, supporting people to stop smoking (recurrently if needs be) and optimal management of smoking related illnesses and diseases in primary and secondary care.
- 3) To take a multiagency approach to prevention and stop smoking support in geographical areas where smoking prevalence is highest, alongside universal access to services.
- 4) To carry out an evaluation of the QuitReady service to ensure that those groups with higher smoking prevalence are appropriately targeted and reached by the service, alongside maintaining a universal offer to all smokers.
- 5) Working in partnership and utilising principles of system leadership across organisations in Leicestershire, and in Leicester and Rutland where appropriate, on areas such as smoke-free housing and in patient stop-smoking services.

- 6) Clinical commissioning groups to provide leadership on contributing to a smoke free society in England and work with NHS providers on: provision of inpatient stop smoking services, provision of a universal smoking cessation offer to long-term users of specialist mental health and/or learning disability services, development of smoke free NHS sites and embedding Making Every Contact Count.
- 7) District councils to provide leadership on smoke free housing, working with housing providers to lead the way in improving the health of their population through smoke free tenancies, and reducing second hand smoke exposure due to smoke drift (for example in flats/apartments), including utilising Making Every Contact Count principles.
- 8) Continue to consider equality of access to stop smoking services, including information and support, for those who may face challenges in accessing services, for example those with a learning disability and other groups under the Equality Act.
- 9) Ensure that smoking advice and information, and the stop smoking services are thoroughly embedded in the Making Every Contact Count plus (MECC+) workstream and training.
- 10) Work with Primary Care Networks in conjunction with social prescribing link workers to ensure that smokers are offered brief advice and relevant signposting to stop smoking services by social prescribing link workers.
- 11) University Hospitals of Leicester NHS Trust and Leicestershire Partnership NHS Trust (Acute mental health services) to strengthen their smoke free sites policies and the enforcement of these policies.
- 12) Work in partnership to reach LAC and support them and the places where they live to be smoke free and have tailored services to support quit attempts.
- 13) For specialist services such as prison healthcare, and homeless primary care services to ensure that accessible and relevant advice is provided to these groups in appropriate and pragmatic ways, with support from partners as appropriate and required.
- 14) Investigate why prevalence of smoking in Leicestershire may have increased from 2017 to 2018 and continue to monitor and respond to the trend of smoking over time.



## CONTENTS

---

1. Introduction .....	1
2. Who is at risk?.....	2
3. Level of need in Leicestershire.....	12
4. How does this impact?.....	33
5. Policy and Guidance.....	37
6. Current Services .....	42
7. Unmet needs/Gaps .....	44
8. Recommendations.....	46

### List of Tables

Table 1 Smoking prevalence (%) in adults (aged 18 and over) in Leicestershire in 2018 by District.....	13
Table 2 Smoking attributable mortality rate for Leicestershire 2012-14.....	19
Table 3: Access to QuitReady Stop Smoking Service, 2017/18 and 2018/19.....	31

### List of Figures

Figure 1: Smoking prevalence in England by age band .....	2
Figure 2: Trend in children in poverty in Leicestershire .....	6
Figure 3: Premature deaths per 100,000 adults of working age (25-64) by socio-economic group and gender, 2008-2010 (ONS).....	7
Figure 4: Trend in pupils with special educational needs (school age) in Leicestershire.....	8
Figure 5: Trend of Looked After Children in Leicestershire aged under 18.....	9
Figure 6: Example Tobacco packaging .....	11
Figure 7: Trend of smoking prevalence in Leicestershire .....	13
Figure 8: Trend of socio-economic gap in current smokers in Leicestershire.....	14
Figure 9: Trend of smoking prevalence of adults in routine and manual occupations in Leicestershire .....	14
Figure 10: Trend of smoking prevalence in adults with a long-term mental health condition in Leicestershire .....	15
Figure 11: Trend of smoking prevalence in adults with anxiety or depression in Leicestershire .....	16
Figure 12: Trend of smoking at the time of delivery in Leicestershire and Rutland .....	17
Figure 13: Trend of smoking attributable mortality in Leicestershire.....	19
Figure 14: Trend smoking attributable mortality by District in Leicestershire.....	20

Figure 15: Trend of smoking attributable deaths from heart disease in Leicestershire .....	20
Figure 16: Trend of smoking attributable deaths from stroke.....	21
Figure 17: Trend of mortality rate from oral cancer in Leicestershire .....	22
Figure 18: Mortality rate from Lung Cancer in Leicestershire.....	22
Figure 19: Trend of mortality rate from chronic obstructive pulmonary disease in Leicestershire.....	23
Figure 20: Trend of stillbirth rate for Leicestershire and Rutland .....	23
Figure 21: Trend of neonatal mortality rate for Leicestershire .....	24
Figure 22: Trend of the rate of premature births (less than 37 weeks gestation) for Leicestershire.....	25
Figure 23: Trend of the rate of smoking attributable hospital admissions for Leicestershire	26
Figure 24: Trend of the rate of emergency hospital admissions for COPD for Leicestershire	27
Figure 25: Trend of the rate of lung cancer registrations for Leicestershire.....	27
Figure 26: Trend of the rate of oral cancer registrations for Leicestershire .....	28
Figure 27: Trend of the rate of smokers setting a quit date for Leicestershire .....	29
Figure 28: Trend of the rate of smokers that have successfully quit after 4 weeks for Leicestershire.....	30
Figure 29: Trend of the cost per quitter for Leicestershire .....	30
Figure 30: Percentage of clients accessing the service by Gender, 2018/19 .....	31
Figure 31: Percentage of clients accessing the service by Local Authority of Residence, 2018/19.....	32
Figure 32: Percentage of clients accessing the service by type of Pharmacological support chosen, 2018/19 .....	32
Figure 33: Percentage of clients accessing the service by source of referral, 2018/19 .....	33

## 1. Introduction

Smoking is a major cause of preventable ill health and premature mortality in England. Smoking is a major risk factor for many diseases, such as lung cancer, COPD and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.<sup>1</sup>

Smoking is a lifestyle risk factor that can be minimised; effective tobacco control measures can reduce the prevalence of smoking in the population.

The Government's Tobacco Control Plan (Towards a Smokefree Generation: A Tobacco Control Plan for England, <https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england>) published in July 2017 sets out the Government's strategy to reduce smoking prevalence among adults and young people, and to reduce smoking during pregnancy.

The complete list of national ambitions is to:

- Reduce the prevalence of 15-year olds who regularly smoke from 8% to 3% or less by the end of 2022.
- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less by the end of 2022.
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population by the end of 2022.
- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less by the end of 2022.
- Improve data collected on smoking and mental health to help support people with mental health conditions to quit smoking.
- Make all mental health inpatient service sites Smokefree by 2018.
- Help people to quit smoking by permitting innovative technologies that minimise the risk of harm.
- Maximise the availability of safer alternatives to smoking.

In July 2019, the Government published a consultative Green paper, called 'Advancing our health: prevention in the 2020s – consultation document' which announced its ambition for the country to be smoke-free by 2030.<sup>2</sup>

## 2. Who is at risk?

Any individual is potentially at risk from tobacco smoke. However, there are certain groups within the population who are known to be at greater risk of starting smoking or having difficulties stopping smoking. This section explores these groups/risk factors.

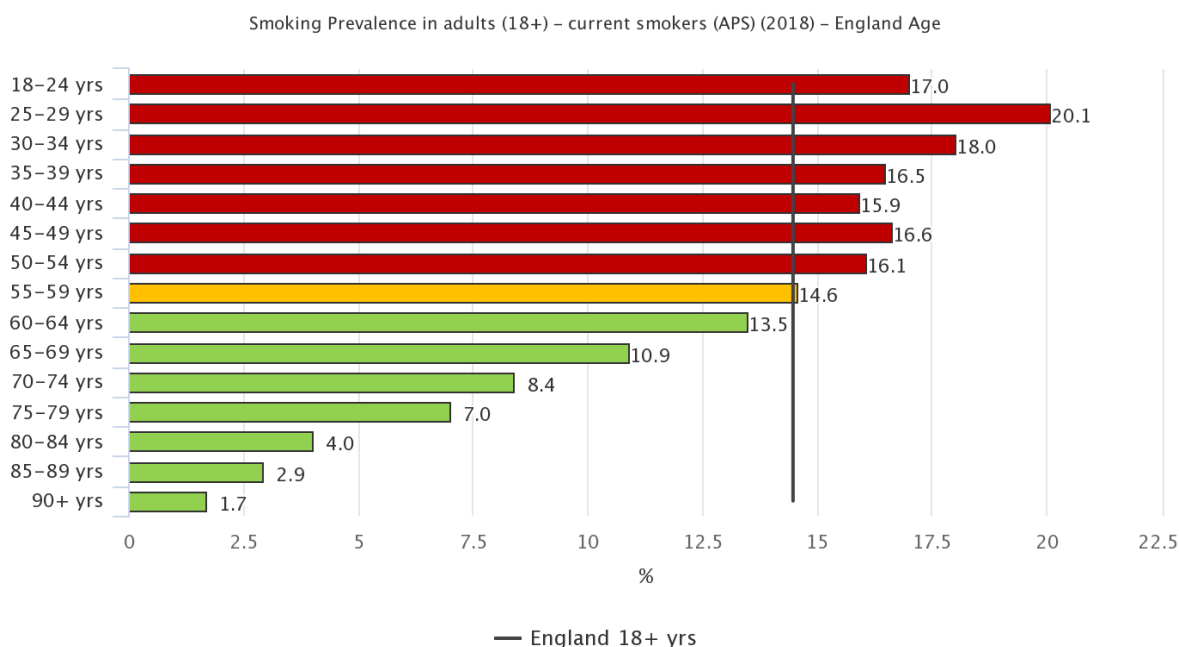
### 2.1. Protected characteristics and individual characteristics

#### 2.1.1. Age

Smoking is an addiction that largely begins in childhood, with most smokers starting as teenagers. Nationally, 77% of smokers aged 16 to 24 in 2014 began smoking before the age of 18.<sup>3</sup>

Figure 1 below shows that nationally, the proportion of smokers for each age group. The younger age groups had higher proportions of current smokers in 2018.

**Figure 1: Smoking prevalence in England by age band**



*Source: Public Health England, Public Health Outcomes Framework, 2019*

Children are influenced by the behaviour of adult role models - in 2014, 82% of pupils who regularly smoked reported having a family member who smoked.<sup>4</sup>

In Leicestershire, an estimated 14.7% of GP (General practice) registered patients aged 15 and over were smokers in 2017/18. This is significantly lower in comparison to the national percentage of 17.2%. Meanwhile, 28.6% of GP-registered patients aged 18 years and over in

Leicestershire reported themselves as ex-smokers in the 2017/18 GP Patient Survey, compared to the national figure of 27.2%. 58.4% of GP-registered patients aged 18 years and over in Leicestershire reported themselves as having never smoked – this is statistically similar to the national figure of 58.0%.<sup>5</sup>

### **2.1.2. Gender**

The 2018 Annual Population Survey found that in England men are more likely to be smokers than women, with 16.4% of men and 12.6% of women aged 18 and over self-reported as being a current smoker. In Leicestershire, the figures are statistically similar with 14.6% of males being smokers and 11.9% of females being current smokers.

### **2.1.3. Disability**

Adults with disabilities are more likely to smoke than adults without disabilities,<sup>6</sup> therefore it is important to ensure access to stop smoking services are available for people with disabilities.

The 2011 Census examined the proportion of the population that have a health problem or disability that limits their day-to-day activities and has lasted, or is expected to last, at least 12 months. In Leicestershire over 105,000 residents reported to have a long-term health problem or disability equating to 16.2% of the population. This is significantly lower than the national percentage of 17.6%.<sup>7</sup>

Local authorities provide support to people who (or whose representatives) seek it and whom they judge eligible. In 2017/18, the rate for adults with learning disability getting long term support from Local Authorities in Leicestershire was 2.9 (per 1,000 population aged 18 to 64), this is significantly lower in comparison to the England rate (3.4 per 1,000 population aged 18 to 64). In 2017/18, there were 2,786 (0.4%) patients recorded as having learning disabilities in Leicestershire. This is significantly lower in comparison to the national average of 0.5%.<sup>8</sup>

### **2.1.4. Mental Health**

As highlighted in the national strategy, 'No health without mental health'<sup>9</sup> it is important to consider both the cause and effect of mental health on an individual's overall health and wellbeing in particular regarding health risk behaviours such as smoking.

The prevalence of mental health problems in England is significant; at least one in four people will experience a mental health problem at some point in their life and at any one time, one in six adults have a mental health problem.<sup>10</sup>

In 2017/18, 781 people aged 18 and over that responded to the GP Patient Survey in Leicestershire stated that they had a long-term mental health problem (9.4%). This is statistically similar to the England average (9.1%).

For further information on mental health of adults in Leicestershire, please visit the published JSNA chapter, available here: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

Increased smoking is responsible for most of the excess mortality of people with mental illness. Adults with mental health problems, including those who misuse alcohol or drugs, smoke 42% of all the tobacco used in England.<sup>11</sup>

Nationally, over 40% of children who smoke have conduct and emotional disorders.<sup>12</sup> In 2015, the estimated prevalence of conduct disorders for children aged 5-16 was 5.1% for Leicestershire (compared to 5.6% nationally) and the estimated prevalence of emotional disorders for children aged 5-16 was 3.4% for Leicestershire (compared to 3.6% nationally).<sup>13</sup>

In 2018, 1.76% of secondary school aged pupils in Leicestershire had social, emotional and mental health needs. This is significantly lower (better) than the England proportion of 2.31%.

### **2.1.5. Pregnancy**

Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes.<sup>14</sup>

Encouraging pregnant women to stop smoking during pregnancy may also help them give up smoking for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant.

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy.

The Tobacco Control Plan contains a national ambition to reduce the rate of smoking throughout pregnancy to 6% or less by the end of 2022 (measured at time of giving birth). The inclusion of this indicator will ensure that the local tobacco control activity is appropriately focused on pregnant women, to try to achieve this national ambition.

### **2.1.6. Ethnicity**

In 2018, 14.4% of adults in England self-reported as current smokers in the Annual Population Survey. In England, rates of smoking were higher than the average in the Mixed and White ethnic groups (at 20.4% and 15.0% respectively). Rates of smoking were below the average in the Chinese, Asian and Black ethnic groups (7.7%, 9.1% and 11.0% respectively).

### **2.1.7. Sexual Orientation**

Following analysis of data in the Annual Population Survey (2016), the Office for National Statistics reported that lesbian, gay and bisexual people were more likely to be current cigarette smokers, when compared to heterosexual/straight people. The gap was more pronounced for women.<sup>15</sup>

### **2.1.8. Personal barriers/misconceptions**

In England, around 60% of smokers want to quit, 10% of whom intend to do so within 3 months. Currently, around half of all smokers in England try to quit unaided using willpower alone, despite this being the least effective method. Getting support can greatly increase a person's chances of quitting successfully.<sup>16</sup>

There is a widespread misconception amongst smokers and health professionals that most of the harm of smoking comes from nicotine. This leads to both nicotine replacement therapy (NRT) and e-cigarettes being perceived as harmful and as a result, smokers may not make a quit attempt using one of these routes.

However, while nicotine is the addictive substance in cigarettes, it is relatively harmless and almost all the harm comes from the thousands of other chemicals in tobacco smoke, many of which are toxic. Further, NRT is a safe form of treatment and licensed for use even in pregnancy and for people with cardiovascular disease.<sup>16</sup>

## **2.2. Wider determinants**

The wider determinants of health are described and measured within the English Indices of Deprivation 2015.<sup>17</sup> These are a group of measures which gauge different aspects of deprivation. Deprivation is a general lack of resources and opportunities, which includes financial poverty and a range of other aspects such as lack of access to education or good quality housing. The measures are combined into an overall measure of the amount of deprivation in an area called the Index of Multiple Deprivation (IMD), which can be used to compare different local areas.

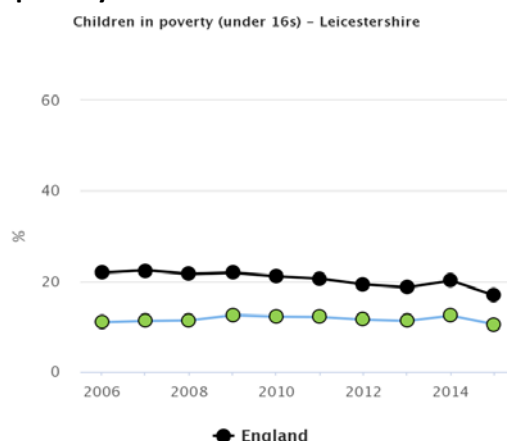
For further information on the wider determinants of health in Leicestershire, please visit the published JSNA chapters, available here: <http://www.lsr-online.org/leicestershire-2018-2021-jsna.html>

### 2.2.1. Poverty and deprivation

The Marmot Review (2010)<sup>18</sup> clearly identified the social gradient in England between deprivation and life expectancy, with the most deprived having lower life expectancy and disability free life expectancy than the least deprived communities. It is therefore important to ensure that all stop smoking services are equitably distributed across Leicestershire to ensure high levels of access across the county. Due to Charnwood and North West Leicestershire having some areas in the most deprived 20% in the country, these areas should be prioritised for stop smoking service delivery.

The percentage of children in low income families (children living in families in receipt of out of work benefits or tax credits where their reported income is less than 60% median income) for under 16s has remained significantly lower (better) than the national average since data recording (in 2006). The latest data (see Figure 2) shows in 2015 there were 11,795 children aged under 16 living in families in receipt of Child Tax Credit whose reported income is less than 60% of the median income or in receipt of Income Support or (Income-Based) Job Seeker's Allowance. This represents 10.4% of all children aged under 16 in Leicestershire.<sup>19</sup>

**Figure 2: Trend in children in poverty in Leicestershire**



Source: Public Health England, Public Health Outcomes Framework, 2019

### 2.2.2. Socio-economic Status

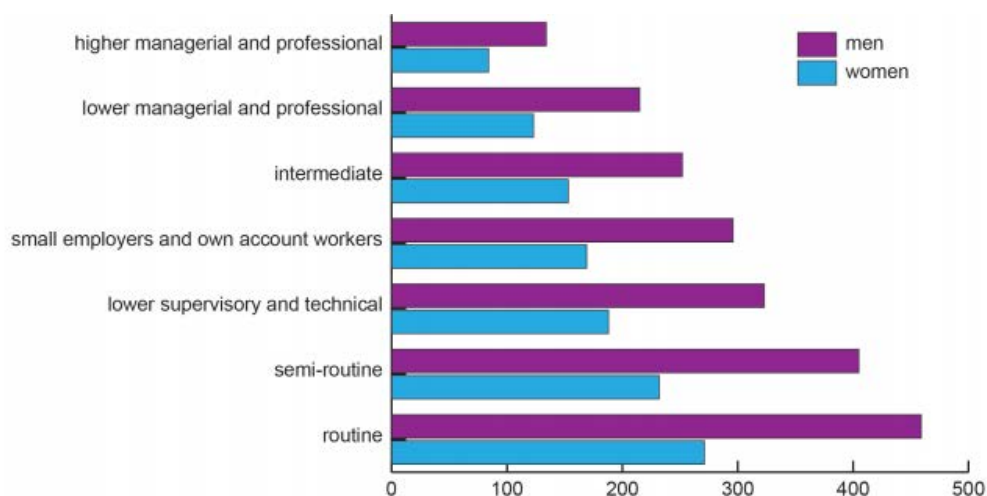
Nationally, people in manual or routine jobs, or those not in employment are more likely to smoke than those in other occupations. The more disadvantaged someone is, the more likely they are to smoke and suffer from smoking-related disease and premature death.<sup>20</sup>



Routine and manual workers tend to establish standard routines, and many of those routines include smoking. For many, smoking is seen as a reward and helps relaxation. Family and local community provide situations where smoking is a part of socialising. As such, quitting smoking can be an isolating experience and social situations provide opportunities for relapse. The short-term benefits of quitting are seen as minimal when compared against the difficulty of quitting and the fact that the long-term benefits will not be felt for some time.<sup>21</sup>

Figure 3 below shows the variation in the premature death rate per 100,000 working adults in England for 2008-10 by socio-economic group, with the premature death rate for adult working males in the routine group being almost three times the rate of those in the higher managerial and professional group.

**Figure 3: Premature deaths per 100,000 adults of working age (25-64) by socio-economic group and gender, 2008-2010 (ONS)<sup>22</sup>**



Source: *Action on Smoking and Health, 2016*

In Leicestershire in 2018/19, 5.2% of the population classed as economically active (i.e. available to work) were unemployed. This is higher than the value for Great Britain (4.1%).

Of those in employment, 49% were in occupations in the following groups: managers, directors and senior officials, professional occupations or associate professional and technical.<sup>23</sup>

In 2018, 14.4% of adults in Leicestershire self-reported as current smokers in the Annual Population Survey. For England, rates of smoking were higher than the average in the routine and manual and never worked and long term unemployed socioeconomic groups (at 25.4% and 18.5% respectively). Rates of smoking were below the average in the managerial and professional and intermediate socioeconomic groups (10.2% and 15.8% respectively).

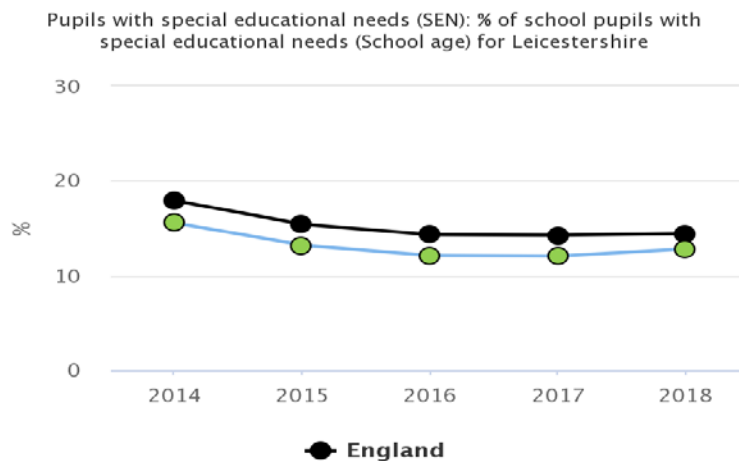
## 2.3. Vulnerable people

### 2.3.1. Special Educational Needs

A study that investigated the smoking behaviour of children aged 12 to 15 years with special educational needs identified the most at-risk group were children with emotional and behavioural disorders.<sup>24</sup>

In Leicestershire the percentage of pupils with special educational needs (SEN) of school age has remained significantly better (lower) than the national percentage for the past five years. In 2018, 12,461 pupils of school age in Leicestershire were identified as having special educational needs, 12.8% of all school pupils.<sup>25</sup> Leicestershire had a total of 4,222 children and young people with an Education, Health and Care Plan (EHCP), out of these 1,251 (29.6%) were aged between 16 and 25 years.<sup>26</sup>

**Figure 4: Trend in pupils with special educational needs (school age) in Leicestershire**



Source: Public Health England, Public health Outcomes Framework, 2019

### 2.3.2. Looked-After Children (LAC)

The term 'looked-after' was introduced by the Children Act 1989 and refers to children and young people under the age of 18 who live away from their parents or family and are supervised by a social worker. A looked-after child (LAC) may either be accommodated or subject to an order made by the family courts.<sup>27</sup>

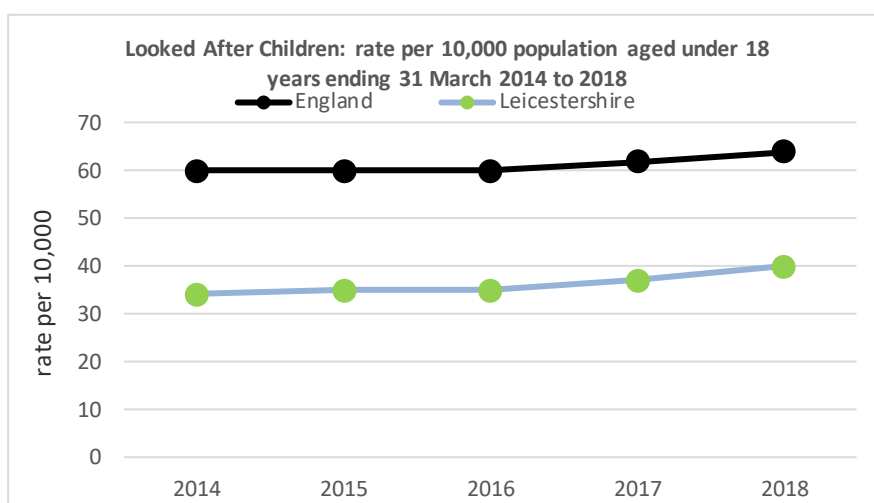
LAC are far more likely to smoke than children of the same age who are not in the care system. A study in 2003 found that as many as two thirds of children in residential care smoke.<sup>28</sup>

LAC are at high risk of long-term disadvantage, marginalisation and poor health and life

outcomes. Smoking is a key factor driving this risk, undermining health, well-being and financial security. It is therefore essential to reduce the risk of smoking uptake among looked-after children, particularly through placement in smoke free homes, while also ensuring that looked-after children who do smoke are provided with opportunities to quit.<sup>29</sup>

In Leicestershire the numbers and rates for LAC aged under 18 have been increasing since 2016. The rate for LAC has increased from 35 (per 10,000 children aged under 18) in 2016 to 40 (per 10,000 children aged under 18) in 2018. The rate for LAC aged under 18 has remained significantly better (lower) in comparison to the national rate since 2014.<sup>30</sup>

**Figure 5: Trend of Looked After Children in Leicestershire aged under 18**



*Source: Department for Education, Children looked after in England, 2017 to 2018*

### 2.3.3. Prison population

A study by the Department of Health and HM Prison Service found that smoking prevalence in two prisons was 78% and 88% in 2007.<sup>31</sup> It is not thought that prisons themselves are the driver for smoking, but the disadvantages already affecting those that become incarcerated for example, low income and mental health problems.

The 2015/16 National Partnership Agreement was formed by Her Majesty's Prison and Probation Service (HMPPS), with NHS England and Public Health England (PHE) with the aim of moving to a smoke free environment in all closed prisons in England and Wales.

Public Health Matters reports that prior to the project starting, around 50,000 prisoners were buying tobacco. By mid-2018, prison canteens were selling over 65,000 vaping products weekly to over 33,000 prisoners, which is a significant harm reduction impact.<sup>32</sup>

In March 2019, HMP Gartree had a population of 698 males, against an operational capacity

of 708. The majority of inmates were British nationals (84%). Two-thirds of inmates were White (67%), followed by Black ethnic groups (19%).

#### **2.3.4. Homelessness**

People whose control over their daily lives is highly limited and who do not have the resources and opportunities are most likely to be smokers and least likely to take the necessary steps to quit. In 2013, 73% of the single homeless clients supported by St Mungo's in London smoked.<sup>33</sup>

In Leicestershire in 2017/18, the statutory homelessness rate was 1.6 per 1,000 households (465 households).

#### **2.3.5. Armed Forces**

The prevalence of smoking within the Armed Forces is comparable with the general population in males under 25.<sup>34</sup> Within the Armed Forces there is variation by service and rank where the lower ranked army personnel are more likely to smoke however prevalence rates are unclear from the literature. The variation between service and rank is thought to be due to some lower ranking army recruits coming from lower socioeconomic backgrounds, where nationally 29% of people from the lowest income group smoke.<sup>35,36</sup>

#### **2.3.6. Illicit Tobacco**

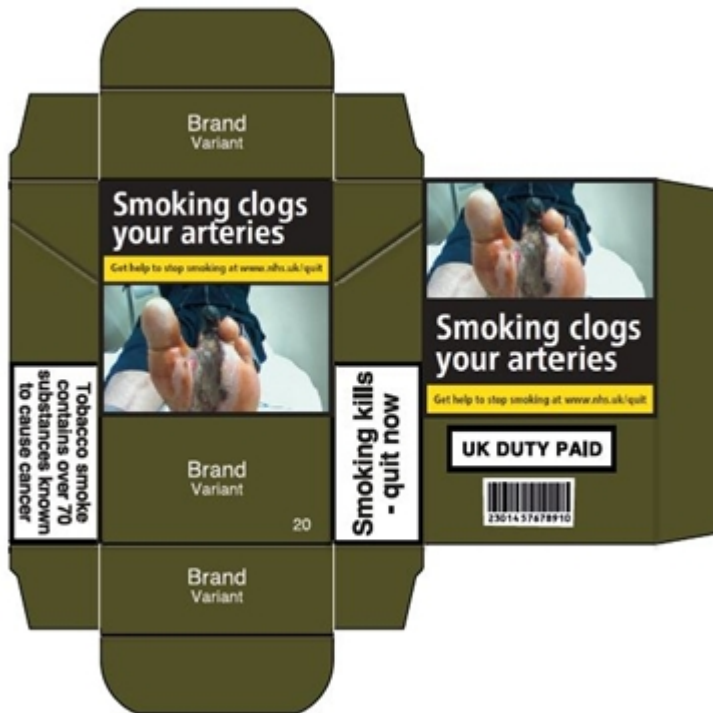
Illegal tobacco is rife and undermines efforts to reduce smoking.<sup>37</sup> Millions of cheap illegal cigarettes are flooding the market with criminals selling them in shops using sophisticated secret hiding places and on social media.<sup>53</sup>

This practice makes it easier for young people to get addicted to smoking and enables people to continue smoking and/or smoke more.<sup>27,28</sup> Trading Standards have a duty to enforce legislation relating to the packaging of illicit tobacco. This legislation includes:

- Trade Marks Act 1994<sup>38</sup> protects registered Trade Marks such as Mayfair, Benson and Hedges, Golden Virginia etc.
- Standardised Packaging of Tobacco Products Regulations 2015 and
- Tobacco and Related Products Regulations 2016

These Regulations are designed to reduce the appeal of the tobacco products (particularly to young people). They relate to the packaging and make health warnings more noticeable.

Figure 6: Example Tobacco packaging



Source: *Business, Energy and Industrial Strategy and Chartered Trading Standards Institute Guidance, 2019*

Research carried out by Trading Standards North West found that nearly a quarter of young smokers in Greater Manchester bought cigarettes they knew were illegal. Six in 10 purchases by under 18s of illegal tobacco were made at local shops.<sup>39</sup>

The 2017 North East Illegal Tobacco Survey reported that 55% of children aged 14 and 15 who smoke said they bought illegal tobacco from shops or “tab houses” – while 73% said they had been offered illegal tobacco at some point.<sup>40</sup>

### **3. Level of need in Leicestershire**

#### **3.1. Smoking Prevalence in adults**

Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, COPD and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.<sup>1</sup>

Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

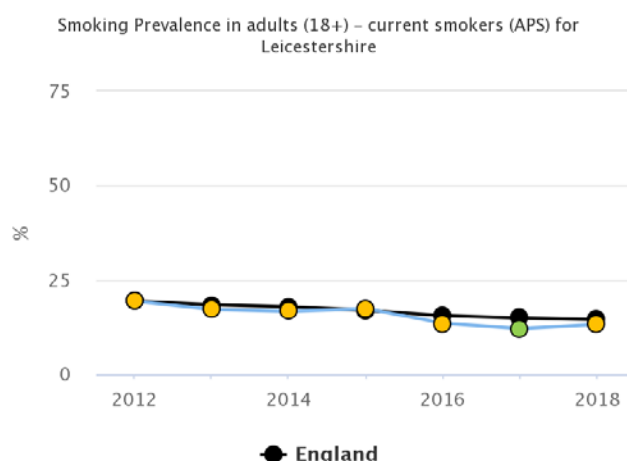
The Government's Tobacco Control Plan (Towards a Smokefree Generation: A Tobacco Control Plan for England, <https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england>) published in July 2017 sets out the Government's strategy to reduce smoking prevalence among adults and young people, and to reduce smoking during pregnancy.

##### **3.1.1. Current Smokers**

The Annual Population Survey collects the number of persons aged 18 and over who are self-reported smokers. In Leicestershire, in 2018, the prevalence of adults who were current smokers was 13.2%. This was statistically similar to the national average of 14.4%.

Figure 7 below shows that the percentage of adults smoking in Leicestershire has decreased from 17.7% in 2011 to 13.2% in 2018. This trend shows that apart from in 2017, the smoking prevalence in Leicestershire has remained statistically similar to the national rate. The Quality and Outcomes Framework (QOF) data provides estimates of patients aged 15 years and over that are registered at GP practices as current smokers. In 2017/18 in Leicestershire, 14.7% of patients aged 15 years and over were estimated smokers, this equates to 86,256 patients. This was significantly better (lower) in comparison to the national percentage of 17.2%.<sup>41</sup>

**Figure 7: Trend of smoking prevalence in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

Table 1 below shows the difference in percentage of current smokers by district – Oadby & Wigston and Harborough have significantly better (lower) percentages of adult smokers (6.3% and 8.2%) than England. Whilst the other districts in Leicestershire are statistically similar to the England percentage, North West Leicestershire (19.2%) has the highest percentage of smoking prevalence in adults within Leicestershire.

**Table 1 Smoking prevalence (%) in adults (aged 18 and over) in Leicestershire in 2018 by District**

District / Area	England	Leicestershire	Blaby	Charnwood	Harborough	Hinckley and Bosworth	Melton	North West Leicestershire	Oadby and Wigston
Smoking Prevalence (%)	14.45	13.2	11.4	12.8	8.2	15.0	17.3	19.2	6.3
<b>England</b>	<b>Better</b>	<b>Similar</b>	<b>Similar</b>	<b>Similar</b>	<b>Worse</b>	<b>Worse</b>	<b>Worse</b>	<b>Worse</b>	<b>Worse</b>

Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.1.2. Socio-economic gap in current smokers

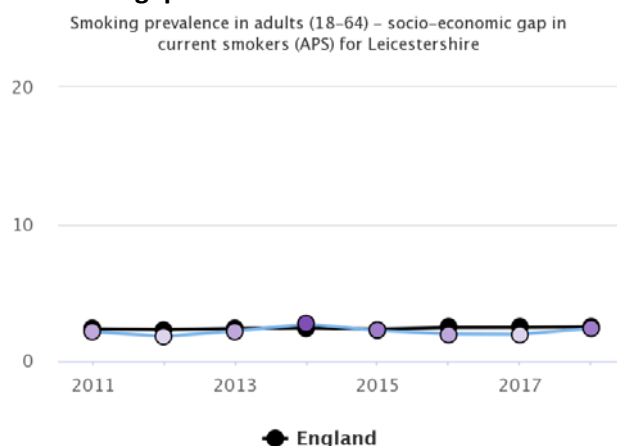
One of the main targets in the Government’s Tobacco Control Plan is to “reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population”.

This indicator helps to monitor the extent of the difference in smoking prevalence between their residents with routine and manual occupations compared with other occupations.

In Leicestershire, in 2018 the ratio was 2.35, putting Leicestershire in the middle quintile. The national average ratio was 2.47. Figure 8 below shows that the socio-economic gap in

Leicestershire smokers has increased from 2.11 in 2011 to 2.35 in 2018. However, the gap was less in 2016 and 2017 at 1.95 and 1.93 respectively.

**Figure 8: Trend of socio-economic gap in current smokers in Leicestershire**



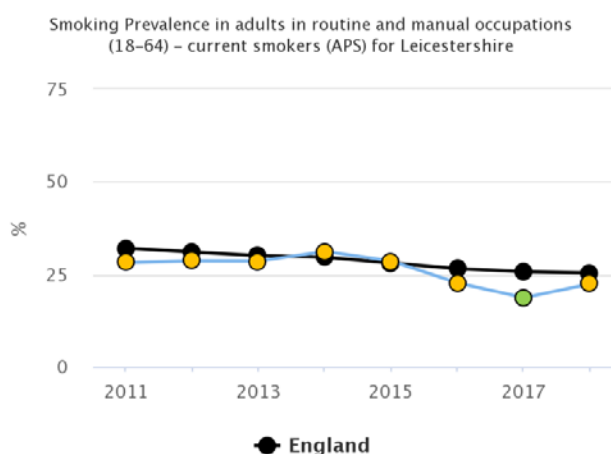
Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.1.3. Routine and manual occupations

The percentage of people aged 18-64 in routine and manual occupations who are self-reported smokers as collected by the Annual Population Survey was 22.4% for Leicestershire in 2018. This was statistically similar to the average for England (25.4%).

Figure 9 below shows that the percentage of workers in routine and manual occupations who smoke in Leicestershire has decreased from 28.2% to 22.4% in 2018.

**Figure 9: Trend of smoking prevalence of adults in routine and manual occupations in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019



### 3.1.4. Mental Health

#### 3.1.4.1. Serious mental health conditions

Serious mental illness (SMI) includes schizophrenia, bipolar affective disorder and other psychoses.<sup>42</sup> When compared to the general population, adults with schizophrenia or bipolar disorder are three times more likely to smoke. High smoking rates among people with mental health problems are the single largest contributor to their 10 to 20-year reduced life expectancy.<sup>43</sup>

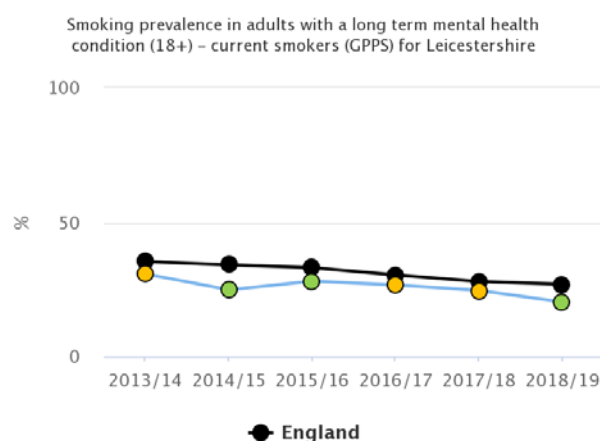
The percentage of people who are current smokers and have a diagnosis of SMI was 33.8% for Leicestershire in 2014/15. This was significantly better (lower) than the England average of 40.5%.<sup>1</sup>

#### 3.1.4.2. Long-term mental health conditions

Studies have shown that people with mental health conditions are more likely to smoke than the general public and that smoking rates increase with the severity of illness.<sup>44</sup> In addition, 40% of cigarettes smoked in England are smoked by people with a mental health problem.<sup>45</sup>

Smoking prevalence in adults with a long-term mental health condition in Leicestershire in 2018/19 was 20.2%. This was statistically similar to the national average of 26.8%. Figure 10 below shows that the smoking prevalence in adults with a long-term mental health condition has decreased from 30.6% in 2013/14 to 20.2% in 2018/19.

**Figure 10: Trend of smoking prevalence in adults with a long-term mental health condition in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

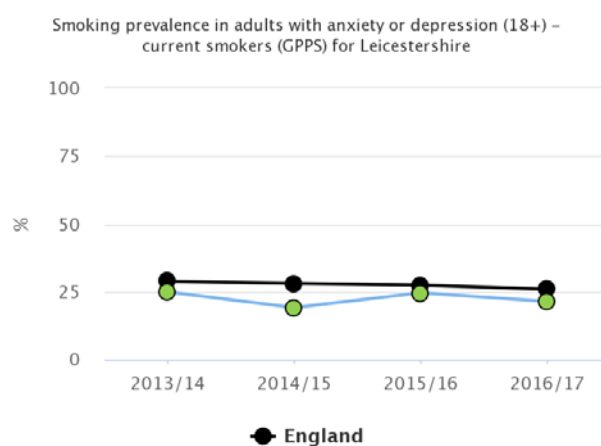
### 3.1.4.3. Anxiety or depression

When compared to the general population, adults with a common mental health disorder (such as depression or anxiety) are twice as likely to smoke. Studies have also 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 all.<sup>46</sup>

The smoking prevalence in adults self-reporting moderate, extreme or severe anxiety or depression for Leicestershire in 2016/17 was 21.3%. This was significantly better (lower) than the national average of 25.8%.

Figure 11 below shows that the smoking prevalence in adults with moderate, extreme or severe anxiety or depression in Leicestershire has decreased from 24.8% in 2013/14 to 21.3% in 2016/17 and has remained significantly better (lower) than the national average since 2013/14.

**Figure 11: Trend of smoking prevalence in adults with anxiety or depression in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.2. Smoking in pregnancy

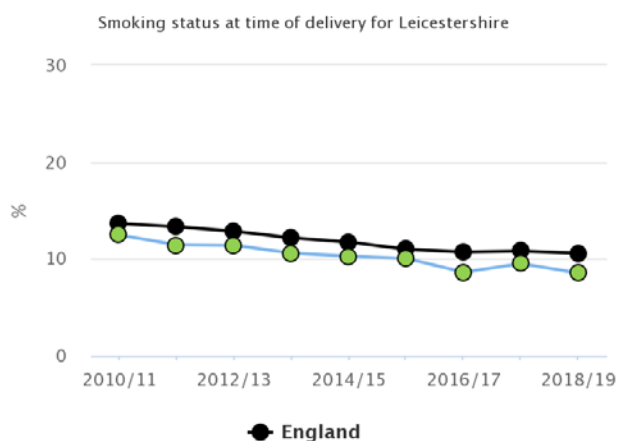
Smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour, including bleeding during pregnancy, placental abruption and premature rupture of membranes. Smoking during pregnancy can cause serious complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy.<sup>1</sup>

Encouraging pregnant women to stop smoking during pregnancy may also help them quit for good, and thus provide health benefits for the mother and reduce exposure to second-hand smoke by the infant as well as cost savings to the NHS.

In Leicestershire and Rutland combined, 8.5% of women smoked at the time of delivery in 2018/19. This was significantly better (lower) than the national percentage of 10.6%.

Figure 12 below shows that the percentage of women smoking at the time of delivery in Leicestershire and Rutland combined has decreased from 12.4% in 2010/11 to 8.5% in 2018/19. The trend shows there has been a significant decrease over the last 5 years and the percentage of women smoking at the time of delivery has remained significantly better (lower) than the national average since 2010/11.

**Figure 12: Trend of smoking at the time of delivery in Leicestershire and Rutland**



Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.3. Smoking prevalence in young people

There is a large body of evidence showing that smoking behaviour in early adulthood affects health behaviours later in life. The 2017 Tobacco Control Plan highlights the importance of reducing the number of young people taking up smoking. It states smoking is believed to be “an addiction largely taken up in childhood”. One of the national ambitions set out in the document was to reduce rates of 15-year-old regular smokers to 3% by 2022.

#### 3.3.1. Young people who are regular smokers

The number of 15-year-olds who responded in the ‘What About YOUth’ survey (WAY survey) from 2014 is used to estimate the smoking prevalence in young people across Leicestershire.

The prevalence of 15-year-olds who smoked more than one cigarette a week, also considered to be regular smokers, was 4.5% in the 2014/15 WAY survey for all of Leicestershire. This was statistically similar to the national prevalence of 5.5%.

Data at district level is based on modelled estimates of the smoking prevalence at age 15 (regular smokers) thus all districts have the same value.

### **3.3.2. Young people who have tried e-cigarettes**

Electronic cigarettes (e-cigs) are not subject to the same regulation as tobacco products. There is growing evidence that E-Cigs are safer with PHE stating that E-Cigs are 95% safer than combustible tobacco. There are several surveys that have looked at E-Cig use in young people with the conclusions that there is relatively low uptake of E-Cig use amongst young people with most young people who have tried E-Cig being ex-smokers themselves or currently smoking.<sup>47</sup>

In Leicestershire in 2014/15, 19.8% of young people had tried e-cigarettes at age 15. This figure is statistically similar to the national percentage of 18.4%.

### **3.3.3. Young people who have tried other tobacco products**

The use of other tobacco products such as shisha pipes, is also of concern. These products carry health risks and tobacco legislation also applies to them.

The percentage of 15-year-olds who had used or tried other tobacco products in Leicestershire in 2014/15 was 16.1%, which was statistically similar to the national percentage (15.2%).

### **3.3.4. Smoking prevalence in looked after children**

Each LAC receives an initial health assessment when they enter the care system. In 2018, 26% of LAC aged 12 to 18 years in Leicestershire smoked cigarettes.<sup>48</sup>

## **3.4. Smoking related mortality**

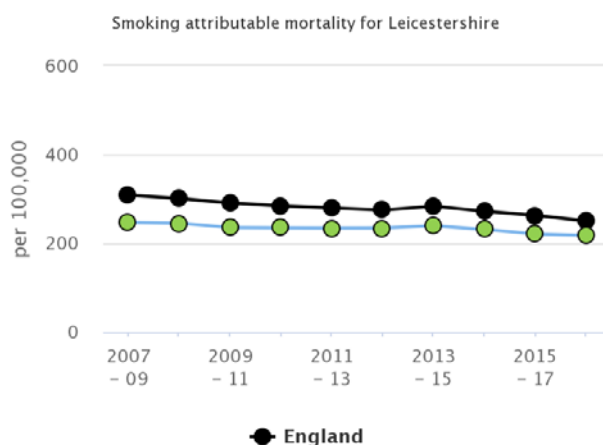
Smoking remains the biggest single cause of preventable mortality and morbidity in the world.<sup>49</sup> In England, it still accounts for one in six of all deaths across the country. Towards a Smokefree Generation: A Tobacco Control Plan for England states that tobacco use remains one of our most significant public health challenges and that smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities.<sup>50</sup>

### **3.4.1. Smoking attributable mortality**

Causes of death considered to be related to smoking are: various cancers, cardiovascular and respiratory diseases and diseases of the digestive system.

Figure 13 below shows that in 2016-18, the smoking attributable mortality rate in Leicestershire was 217.5 per 100,000 population aged 35 years and over. This was significantly better (lower) than the England rate of 250.2 per 100,000 population aged 35 years and over. The rate of smoking attributable mortality has remained significantly better (lower) than the England rate since 2007-09.

**Figure 13: Trend of smoking attributable mortality in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

At district level, the most recent data available is for 2012-14. Table 2 below summarises the smoking attributable mortality rates for 2012–14 for districts within Leicestershire. The trends by district are shown in

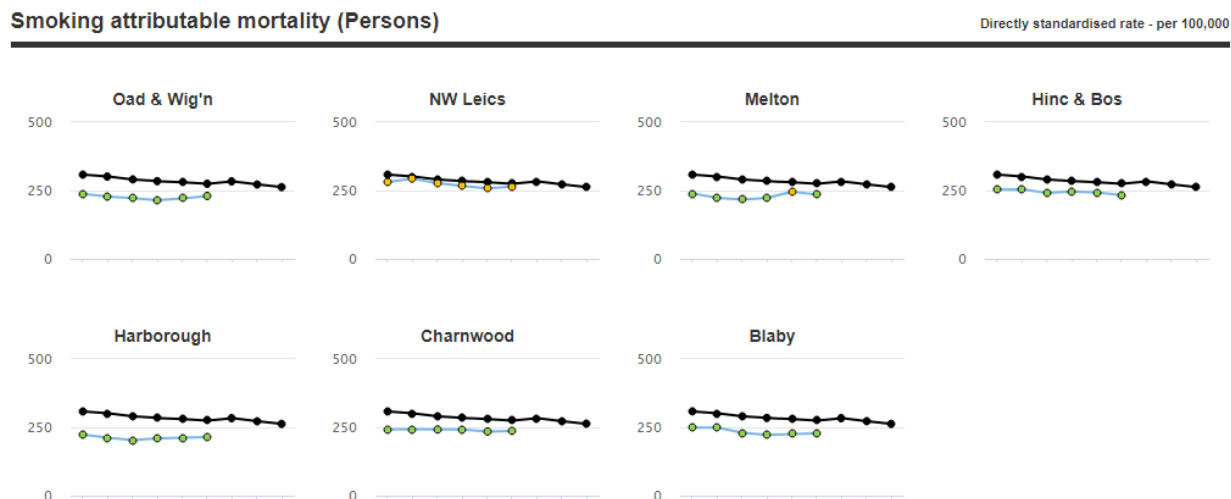
Figure 14 below. All district areas (apart from North West Leicestershire) within Leicestershire have significantly better (lower) rates of smoking attributable mortality in comparison to the national rate.

**Table 2 Smoking attributable mortality rate for Leicestershire 2012-14**

District / Area	England	Leicestershire	Blaby	Charnwood	Harborough	Hinckley & Bosworth	Melton	North West Leicestershire	Oadby & Wigston
Smoking attributable mortality rate	264.8	234.5	227.2	237.0	213.9	233.3	234.9	264.5	239.2
		Better	Better	Better	Better	Better	Better	Similar	Better

Source: Public Health England, Local Tobacco Control Profiles, 2019

**Figure 14: Trend smoking attributable mortality by District in Leicestershire**



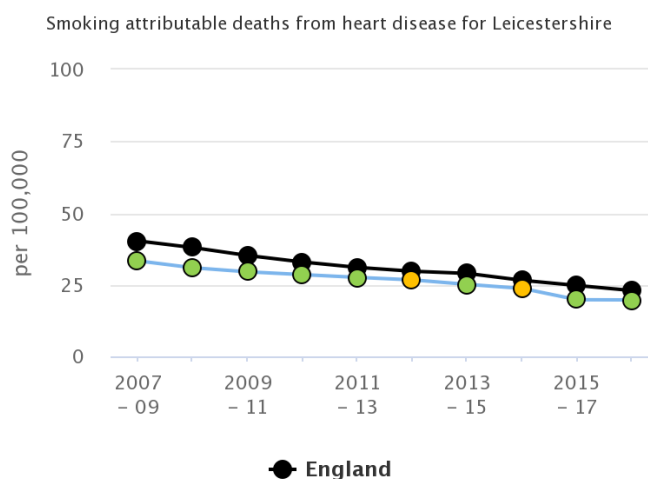
Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.4.2. Deaths from heart disease and stroke

The rate of smoking attributable deaths from heart disease between 2016-18 was 19.7 per 100,000 population aged 35 years and over in Leicestershire (251 deaths), which was significantly better (lower) than England average of 22.9 per 100,000 population aged 35 years and over in Leicestershire.

Figure 15 shows that the rate of smoking attributable deaths from heart disease in Leicestershire has steadily decreased from 33.3 per 100,000 population aged 35 years and over between 2007-09 to 19.7 per 100,000 population aged 35 years and over in 2016-18.

**Figure 15: Trend of smoking attributable deaths from heart disease in Leicestershire**

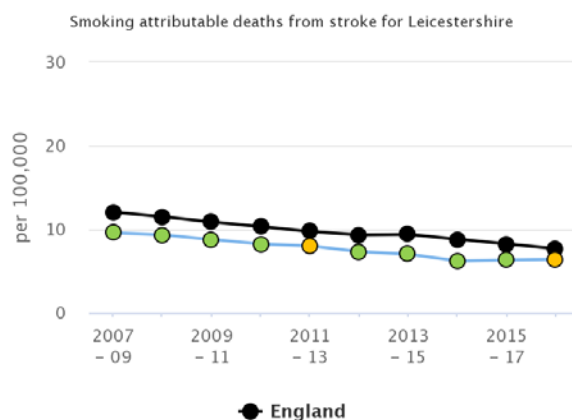


Source: Public Health England, Local Tobacco Control Profiles, 2019

The rate of smoking attributable deaths from stroke between 2016-18 was 6.4 per 100,000 population aged 35 years and over in Leicestershire. This is statistically similar to the England rate of 7.7 per 100,000 population aged 35 years and over.

Figure 16 shows that apart from 2011-13 and 2016-18, the rate of smoking attributable deaths from stroke has remained significantly better (lower) than England since 2007-09.

**Figure 16: Trend of smoking attributable deaths from stroke in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

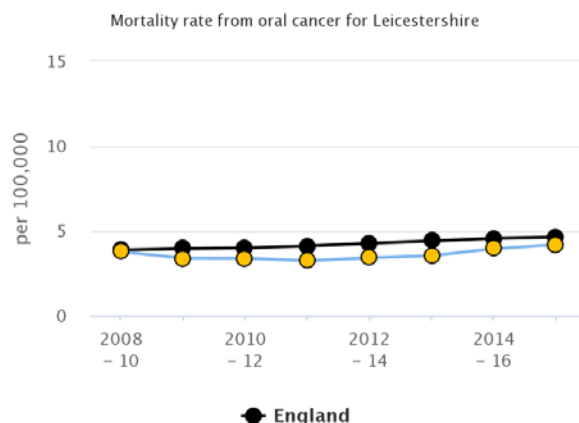
### 3.4.3. Mortality rate from oral cancer

Cigarette smoking is associated with an increased risk of developing oral cancer. The risk of developing oral cancer among smokers is estimated to be 10 times that for non-smokers.<sup>51</sup>

In Leicestershire, the mortality rate from oral cancer has increased from 3.8 per 100,000 population between 2008-10 to 4.2 per 100,000 population between 2016-18. In 2016-18, the rate for Leicestershire was statistically similar to the England rate of 4.7 per 100,000 population.

Figure 17 below shows that the mortality rate from oral cancer in Leicestershire has remained statistically similar to the national rate since 2008-10.

**Figure 17: Trend of mortality rate from oral cancer in Leicestershire**



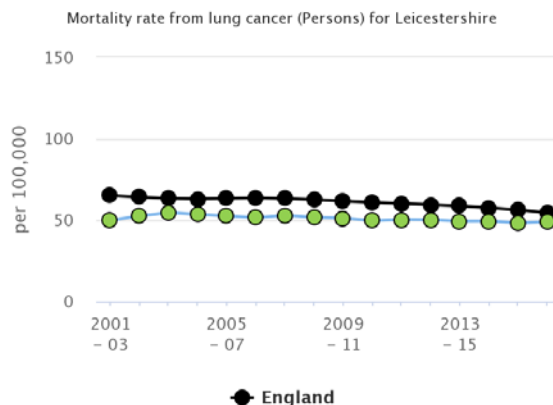
Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.4.4. Mortality rate from Lung Cancer

In Leicestershire, the mortality rate from lung cancer was 49.0 per 100,000 population between 2016-18. This was significantly better (lower) in comparison to the England rate of 54.7 per 100,000 population.

Figure 18 below shows that the mortality rate from lung cancer in Leicestershire has remained significantly better (lower) in comparison to the national rate since 2001-03.

**Figure 18: Mortality rate from Lung Cancer in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.4.5. Mortality rate from chronic obstructive pulmonary disease (COPD)

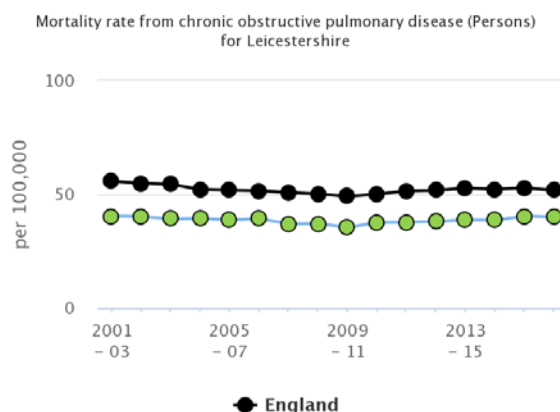
In the UK, COPD is the fifth biggest killer and accounts for 5% of all deaths each year. Around 86% of these deaths are caused by smoking, and hence considered preventable.<sup>1</sup>

In Leicestershire, between 2016–18, the mortality rate from COPD was 39.9 per 100,000 population (841 deaths), this was significantly better (lower) than the national rate of 51.7 per 100,000 population.



Figure 19 below shows that the mortality rate from COPD has remained significantly better (lower) in comparison to the national rate since 2001-03.

**Figure 19: Trend of mortality rate from chronic obstructive pulmonary disease in Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

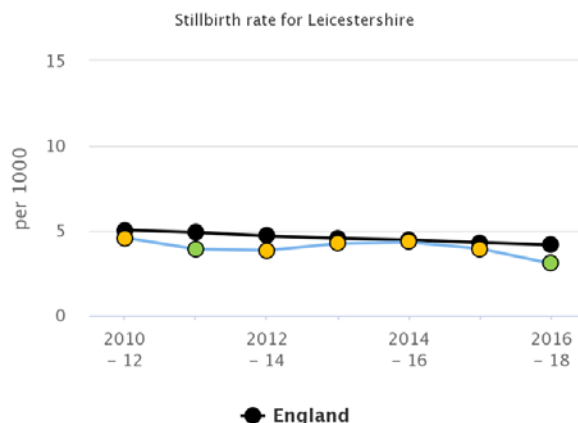
### 3.4.6. Stillbirth rate

Stillbirth refers to a foetal death occurring after 24 weeks gestation. Maternal smoking is a known risk factor for stillbirths. Stillbirth rates in the UK have shown little change over the last 20 years, and the rate remains among the highest in high income countries.<sup>1</sup>

The stillbirth rate in Leicestershire for 2016-18 was 3.0 per 1,000 births (64 stillbirths), this was significantly lower (better) than the England rate of 4.2 per 1,000 births.

Figure 20 below shows that apart from 2011-13 and 2016-18, the rate of stillbirths in Leicestershire has remained statistically similar to the national rate since 2010-12.

**Figure 20: Trend of stillbirth rate for Leicestershire and Rutland**



Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.4.7. Neonatal mortality

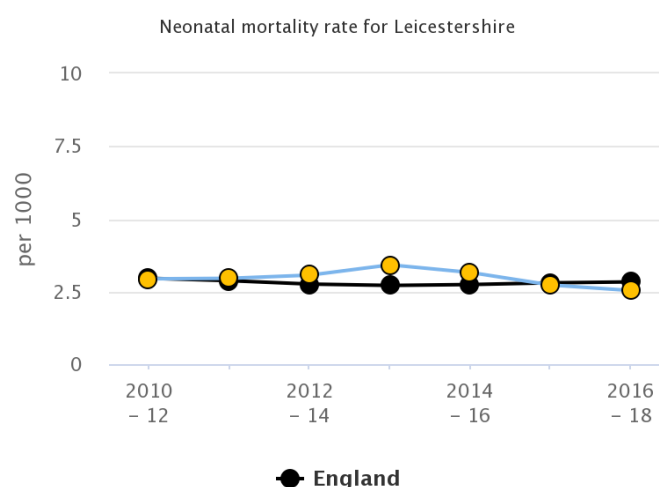
Infant mortality is an indicator of the general health of an entire population. It reflects the relationship between causes of infant mortality and upstream determinants of population health such as economic, social and environmental conditions. Deaths occurring during the first 28 days of life (the neonatal period) are considered to reflect the health and care of both mother and new-born. The first 28 days of life – the neonatal period – represent the most vulnerable time for a child’s survival.<sup>1</sup> Smoking is a major risk factor associated with both infant mortality and stillbirth.

In 2015, the Government announced an ambition to reduce the rate of stillbirths, neonatal and maternal deaths by 50% by 2030. The Maternity Transformation Programme brings together a range of organisations and stakeholders to deliver on this ambition, among others.

In Leicestershire for 2016-18, the neonatal mortality rate was 2.53 per 1,000 births, this was statistically similar to the national rate of 2.83 per 1,000 births.

Figure 21 shows that the neonatal mortality rate has decreased from 3.42 per 1,000 births for 2013-15 to 2.53 per 1,000 births for 2016-18 for Leicestershire. The neonatal mortality rate in Leicestershire has remained statistically similar to the national rate since 2010-12 (note – The neonatal mortality rate from 2010-12 to 2015-17 is a combined figure for Leicestershire and Rutland).

**Figure 21: Trend of neonatal mortality rate for Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.5. Smoking related ill health

#### 3.5.1. Premature births

Globally, premature births (less than 37 weeks gestation) are the leading cause of death for children under the age of 5. There is substantial evidence that smoking during pregnancy and exposure to second-hand-smoke can lead to premature birth. It can also lead to complications during labour, low birth weight at full term and increased risk of miscarriage and stillbirth.<sup>52</sup>

In Leicestershire, the number of premature births for 2015-17 was 1,692 – a rate of 80.2 per 1,000 live and stillbirths, which was statistically similar to the national rate of 80.6 per 1,000 live births and stillbirths.

Figure 22 below shows that for Leicestershire, the rate of premature births has increased from 67.6 per 1000 live and stillbirths for 2006-08 to 80.2 per 1,000 live births and stillbirths for 2015-17.

**Figure 22: Trend of the rate of premature births (less than 37 weeks gestation) for Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

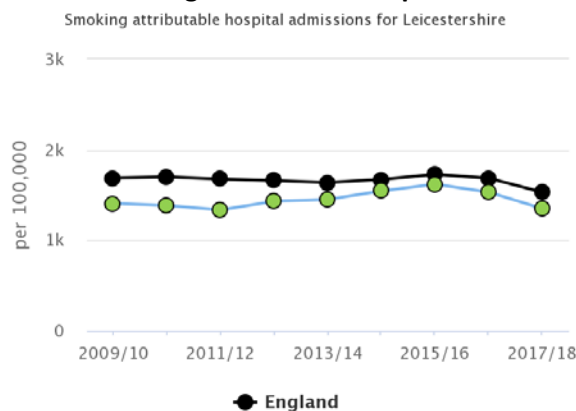
#### 3.5.2. Smoking attributable hospital admissions

Smoking accounts for approximately 5.5% of the 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. High smoking attributable admission rates are indicative of poor population health and high smoking prevalence.<sup>1</sup>

Smoking attributable hospital admissions refers to the total number of hospital admissions for diseases that are wholly or partially attributed to smoking in persons aged 35 and over.

Figure 23 below shows for 2017-18 the smoking attributable hospital admission rate for people aged 35 and over for Leicestershire was 1,350 per 100,000, this was significantly better (lower) in comparison to the national rate of 1,530 per 100,000 population. The rate has remained significantly better (lower) in comparison to the England rate since 2009/10.

**Figure 23: Trend of the rate of smoking attributable hospital admissions for Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

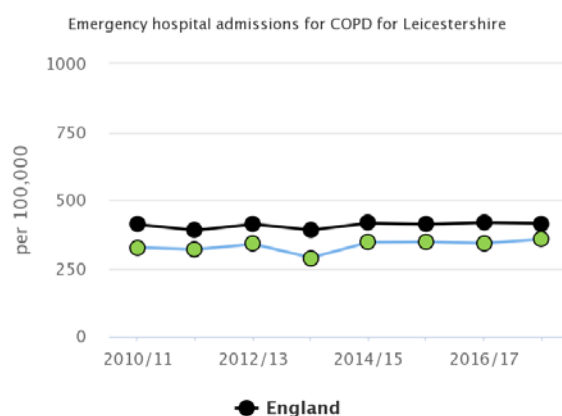
### 3.5.3. Emergency admissions for COPD

COPD is a serious lung disease for which smoking is the biggest preventable risk factor. People with COPD have difficulties breathing, primarily due to the narrowing of their airways and destruction of lung tissue.<sup>1</sup>

In Leicestershire, for 2017/18 the number of emergency hospital admissions for COPD was 1,503 which equates to a rate of 356 per 100,000 population aged 35 years and over. This was significantly better (lower) than the national rate of 415 per 100,000 population aged 35 and over.

The rate of emergency hospital admissions for COPD for Leicestershire has risen from 326 per 100,000 population aged 35 years and over in 2010/11 to 356 per 100,000 population aged 35 years and over in 2017/18 and has remained significantly better (lower) than the national rate since 2010/11 as shown in Figure 24 below.

**Figure 24: Trend of the rate of emergency hospital admissions for COPD for Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

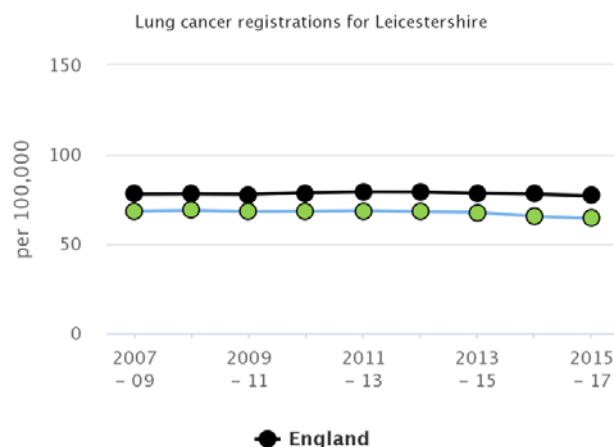
### 3.5.4. Lung cancer / Oral Cancer registrations

Lung cancer is the third most common cancer diagnosed in England and the most common cause of cancer death. The link between tobacco use and lung cancer is well established. In England, in 2014, 80% of hospital admissions and deaths due to lung cancer in persons aged 35 and over were attributed to smoking.<sup>1</sup>

Lung cancer registration is therefore a direct measure of smoking-related harm. In Leicestershire, for 2015-17 the lung cancer registrations were 64.2 per 100,000 population. This was significantly better (lower) than the England rate of 76.8 per 100,000 population.

Figure 25 below shows that for Leicestershire, the rate of lung cancer registrations has decreased from 68.3 per 100,000 population for 2007-09 to 64.2 per 100,000 population for 2015-17. The lung cancer registration rate has remained significantly better (lower) in comparison to the national rate since 2007-09.

**Figure 25: Trend of the rate of lung cancer registrations for Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

In 2014/15, in England, 65% of hospital admissions for oral cancer and 64% of deaths (2014) due to oral cancer were attributable to smoking. Therefore, oral cancer registrations are a direct measure of smoking-related harm.

In Leicestershire, for 2015-17 the oral cancer registration rate was 14.1 per 100,000, which was statistically similar to the national rate of 14.6 per 100,000.

Figure 26 below shows that for Leicestershire, the rate of oral cancer registrations has increased from 10.9 per 100,000 population for 2007-09 to 14.1 per 100,000 population for 2015-17.

**Figure 26: Trend of the rate of oral cancer registrations for Leicestershire**



*Source: Public Health England, Local Tobacco Control Profiles, 2019*

### **3.6. Illicit Tobacco**

There has been a long-term decline in the estimated volume of cigarettes in the illicit market from 2005-06, when the central estimate for the illicit market was ten billion cigarettes in the UK. Since 2010-11, the central estimate of the illicit market has been fairly stable, varying between three billion cigarettes and 5.5 billion cigarettes.<sup>53</sup> Currently there is no local data available.

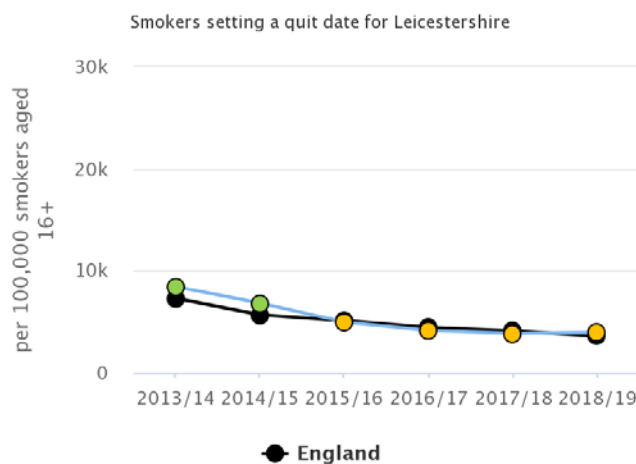
### **3.7. Smoking Cessation**

#### **3.7.1. Smokers setting a quit date**

The rate of people setting a quit date per 100,000 smokers aged 16 years and over was 3,969 in Leicestershire in 2018/19. This is statistically similar to the England rate of 3,614 per 100,000 smokers aged 16 years and over.

Figure 27 shows that for Leicestershire the rate of smokers setting a quit date has more than halved since 2013/14 when the rate was 8,429 per 100,000 smokers aged 16 years and over. The rate of smokers setting a quit date for England has decreased too from 7,302 per 100,000 in 2013/14 to 3,614 per 100,000 in 2018/19.

**Figure 27: Trend of the rate of smokers setting a quit date for Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.7.2. Smokers that have successfully quit at 4 weeks

This indicator is a guide to how effective local NHS Stop Smoking Services are at helping people quit smoking and how many people are stopping smoking as a result of the service in the area.

Figure 28 below shows that for Leicestershire, the rate of smokers that had successfully quit at four weeks has decreased from 4,355 per 100,000 smokers aged 16 and over in 2013/14 to 2,508 per 100,000 smokers aged 16 years and over in 2018/19. In 2018/19, the rate of smokers that had successfully quit at four weeks was significantly better (higher) than the national rate of 1,894 per 100,000 quitters aged 16 years and over.

**Figure 28: Trend of the rate of smokers that have successfully quit after 4 weeks for Leicestershire**



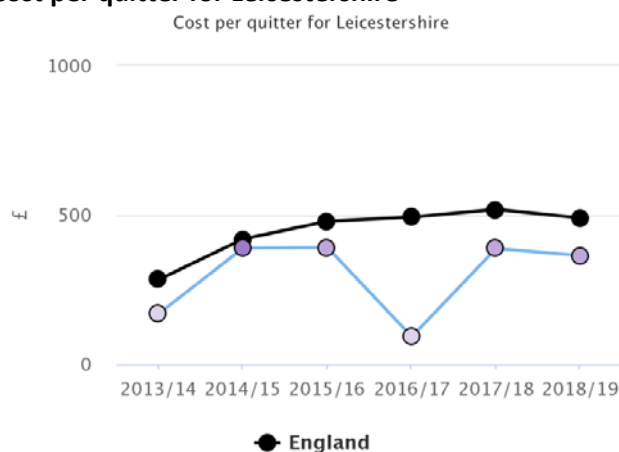
Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.7.3. Cost per quitter

This indicator is a guide to how cost-effective local NHS stop smoking services are. It is the amount spent to achieve each successful quitter. In 2018/19, the cost per quitter was £364 in Leicestershire. This is in the 2<sup>nd</sup> best quintile in England, and much less than the average national cost of £490.

Figure 29 below shows that for Leicestershire, the cost per quitter has increased from £169 in 2013/14 to £364 in 2018/19.

**Figure 29: Trend of the cost per quitter for Leicestershire**



Source: Public Health England, Local Tobacco Control Profiles, 2019

### 3.7.4. QuitReady Stop Smoking Service

QuitReady is a stop smoking service in Leicestershire, that offers a tailored stop smoking 12-week programme which is led by the patient. Individuals accessing the service will receive



support and coping mechanisms to help them stay smoke free.

There has been an increase in the number of people accessing the QuitReady service from 1,995 in 2017/18 to 2,614 in 2018/19. Table 3 below shows there has been an increase in the proportion of clients setting an agreed quit date from 98.8% in 2017/18 to 99.1% in 2018/19. The percentage of clients accessing the QuitReady service in 2018/19 who quit at 4 weeks was 63.4% and 45.9% quit at 12 weeks.

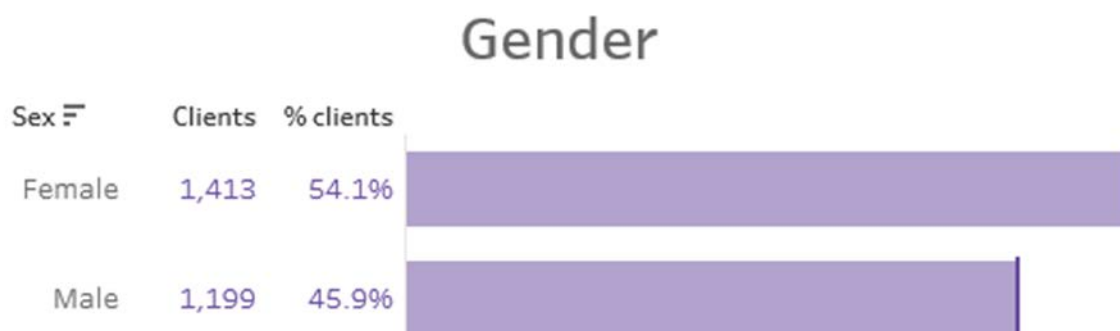
**Table 3: Access to QuitReady Stop Smoking Service, 2017/18 and 2018/19**

Period	Agreed a quit date	Quit at 4 weeks	Quit at 12 weeks
2017/18	1,971 (98.8%)	1,188 (59.5%)	803 (40.3%)
2018/19	2,590 (99.1%)	1,656 (63.4%)	1,199 (45.9%)

Source: QuitReady Referral Data, as at 19<sup>th</sup> September 2019

Figure 30 shows that 54.1% of clients accessing the services were females followed by 45.9% of males. Out of all female clients, 11.1% were pregnant women accessing the service.

**Figure 30: Percentage of clients accessing the QuitReady service by Gender, 2018/19**



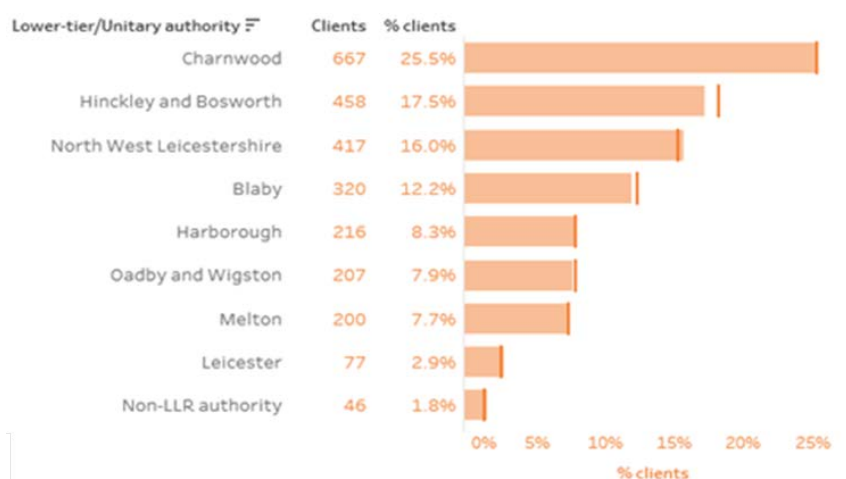
Source: QuitReady Referral Data, as at 19<sup>th</sup> September 2019

Note: The dark lines on the graph indicate the percentage of all service users to date.

In 2018/19, the largest proportion of clients accessing the QuitReady service were from those aged between 30 to 39 years (19.8%), followed by those aged between 40 to 49 years (18.9%). A majority of clients accessing the QuitReady service were of White ethnicity (91.5%) followed by those of Asian ethnicity (3.9%).

Figure 31 below shows that the largest proportion of clients accessing the QuitReady service were resident within Charnwood (25.5%), followed by Hinckley and Bosworth (17.5%) and North West Leicestershire (16%). Data where no local authority was allocated and for Rutland local authority have been suppressed due to small numbers.

**Figure 31: Percentage of clients accessing the QuitReady service by Local Authority of Residence, 2018/19**

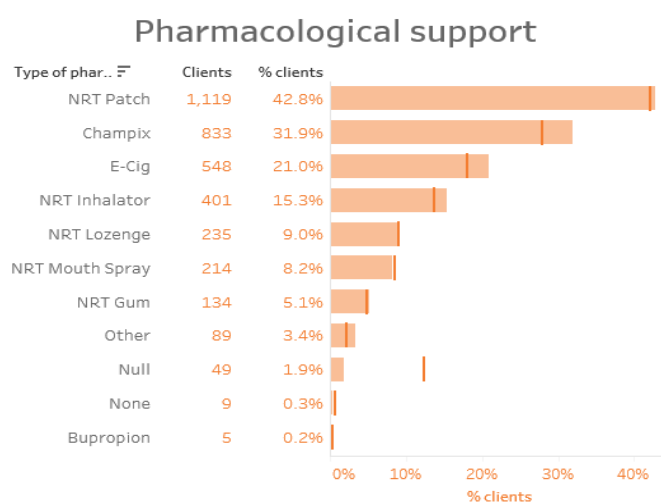


Source: QuitReady Referral Data, as at 19<sup>th</sup> September 2019

Note: The dark lines on the graph indicate the percentage of all service users to date.

Figure 32 shows the type of pharmacological support that was chosen by clients accessing the QuitReady service in 2018/19. It can be seen that 42.8% of clients chose to have NRT, followed by 31.9% who chose to have Champix and 21% chose to have E-cigarettes. Data for clients who chose willpower alone, NRT nasal spray and NRT microtabs have been suppressed due to small numbers

**Figure 32: Percentage of clients accessing the QuitReady service by type of Pharmacological support chosen, 2018/19**

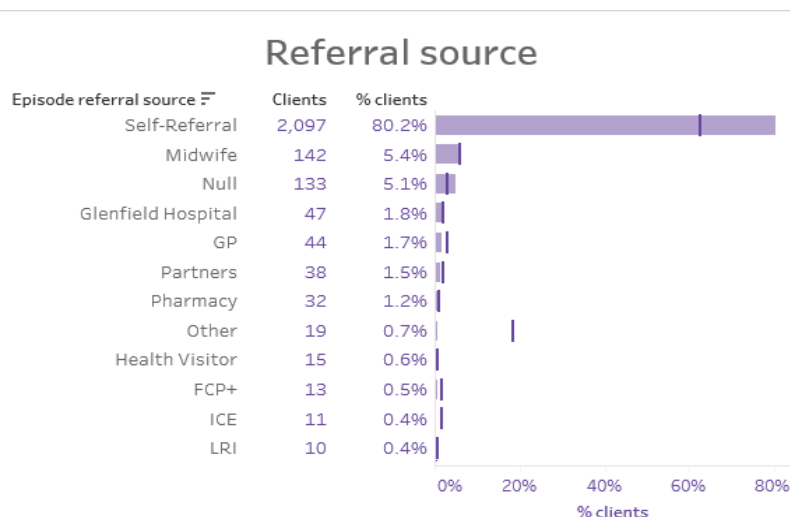


Source: QuitReady Referral Data, as at 19<sup>th</sup> September 2019

Note: The dark lines on the graph indicate the percentage of all service users to date.

Figure 33 shows that a majority of clients (80.2%) in Leicestershire referred themselves to the QuitReady service in 2018/19. Data for clients being referred from other healthcare services have been suppressed due to small numbers.

**Figure 33: Percentage of clients accessing the QuitReady service by source of referral, 2018/19**



Source: QuitReady Referral Data, as at 19<sup>th</sup> September 2019

Note: The dark lines on the graph indicate the percentage of all service users to date.

## 4. How does this impact?

### 4.1. Life Expectancy

Higher smoking rates are responsible for half the difference in life expectancy between those from affluent and deprived backgrounds.<sup>54</sup> Smokers lose on average 10 years of life, premature mortality which can be avoided if smokers quit by the age of 30, and halved if they quit by the age of 50.<sup>55</sup>

### 4.2. Financial Cost

Each year, it has been estimated that smoking in Leicestershire costs society a total of approximately £133.4m.<sup>56</sup> Action on Smoking and Health (ASH) provided local estimated costs that are accrued across a range of domains which are related to smoking:<sup>56</sup>

#### 4.2.1. Healthcare



## Healthcare

Smoking both causes and exacerbates long term health conditions and is the leading cause of preventable death and disease in England



▲  
top

The total annual cost of smoking to the NHS across Leicestershire is about **£32.3m**

**£10m** is due to approx 5,628 hospital admissions for smoking-related conditions

**£22.4m** is due to treating smoking-related illness via primary and ambulatory care services (that's as a result of around 293,700 GP consultations, 99,528 practice nurse consultations, 164,734 GP prescriptions, and 59,543 outpatient visits)

Source: Action on smoking and Health, Ready Reckoner, 2018

#### 4.2.2. Productivity



## Productivity

Smokers take more sick-leave from work than non-smokers and smoking increases the risk of disability and premature death



▲  
top

**£81.7m** of potential wealth is lost from the local economy in Leicestershire each year as a result of lost productivity due to smoking

959 early deaths due to smoking result in 1,251 years of lost economic activity, costing businesses about **£30.2m**

Each year absenteeism due to smoking-related illness results in about 179,896 days of lost productivity, costing a further **£16.5m**

Additionally, it is estimated that smoking breaks cost businesses in Leicestershire **£35m**

Source: Action on smoking and Health, Ready Reckoner, 2018

#### 4.2.1. Social Care



## Social Care



Many current / former smokers require care in later life as a result of smoking-related illnesses.

Each year this costs society in Leicestershire an additional **£16.9m**

**£9.2m** is funded from the local authority social care budget

**£7.7m** is paid by individuals or families who self-fund private care

Source: Action on smoking and Health, Ready Reckoner, 2018

#### 4.2.2. House Fires



## House Fires



Smoking materials are a major contributor to accidental fires in England, with around 7% being smoking-related. Fatalities are disproportionately high in smoking-related fires, representing 49% of all house fire deaths

It is estimated that Leicestershire Fire and Rescue Service will attend about 17 smoking-related house fires each year in Leicestershire

**£2.4m** is lost annually in the County as a result

Smoking-related fires are expected to be responsible for approx 1 fatality every 2 years, resulting in average annual societal losses of **£1m**

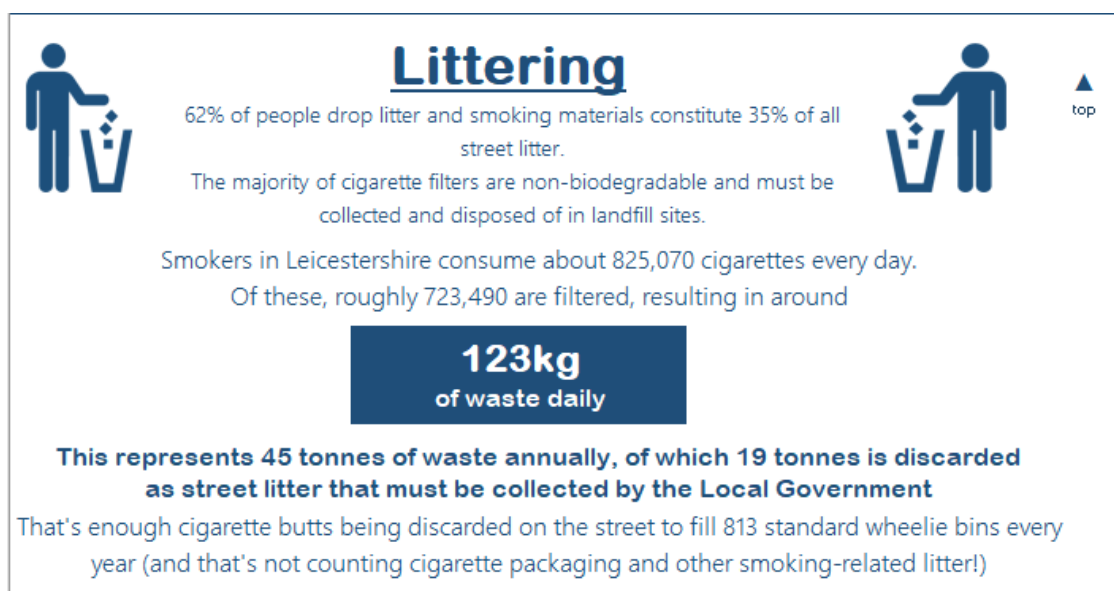
In addition to deaths, smoking-related fires are expected to result in 3 non-fatal injuries each year, further increasing the societal cost by **£456,260**

Smoking-attributable fires will also result in property damage at an average annual cost of **£889,270**

and the annual cost to Leicestershire Fire and Rescue Service for responding to these fires is **£61,220**

Source: Action on smoking and Health, Ready Reckoner, 2018

### 4.2.3. Littering



Source: Action on smoking and Health, Ready Reckoner, 2018

### 4.2.4. Tobacco Expenditure



Source: Action on smoking and Health, Ready Reckoner, 2018

## 4.3. Communities

Illicit tobacco impacts on legitimate businesses who cannot compete with the cheap price of illicit tobacco. The costs estimated by Her Majesty's Revenue and Customs (HMRC) in loss of revenue is 1.8 billion in 2017-2018.<sup>57</sup>

Intelligence from investigations carried out by Leicestershire Trading Standards and other enforcement agencies indicate links to modern slavery/trafficking. Modern slavery is the illegal exploitation of people for personal or commercial gain. It covers a wide range of abuse and exploitation including sexual exploitation, domestic servitude, forced labour, criminal exploitation and organ harvesting.<sup>58</sup>

## 5. Policy and Guidance

### 5.1. Towards a Smokefree Generation. A Tobacco Control Plan for England

In 2017 the government set out a commitment for a smoke-free generation in 'Towards a Smokefree Generation. A Tobacco Control Plan for England'<sup>59</sup>

The objectives of the tobacco control plan are to:

- reduce the number of 15-year olds who regularly smoke from 8% to 3% or less
- reduce smoking among adults in England from 15.5% to 12% or less
- reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population
- reduce the prevalence of smoking in pregnancy from 10.5% to 6% or less
- make all mental health inpatient services sites smokefree by 2018
- to back evidence-based innovations to support quitting, including maximising availability of safer alternatives to smoking

The aim is to achieve these objectives by the end of 2022.

A delivery plan was published in 2018 to accompany the tobacco control plan. 'Tobacco control plan: delivery plan 2017 to 2022'<sup>60</sup> sets out specific milestones and the actions expected at national and local levels. The delivery plan is updated as new actions are identified and existing ones are completed.

The local actions are:

- All CCGs, Trusts and local councils fully implementing The National Institute for Health and Care excellence (NICE) Guidance including Smoking: stopping in pregnancy and after childbirth (PH26) which recommends that all pregnant women are CO screened and those with elevated levels referred via an opt-out system for specialist support
- Local areas - especially those with smoking in pregnancy prevalence above the national average - identifying local Smokefree Pregnancy Champions to consider how prevalence can be reduced in their locality and lead action to achieve this

- Local areas developing their own tobacco control strategies, based on NICE evidence-based guidance
- Commissioners and providers of the local health and social care system assessing the need of stop smoking support for people with mental health conditions and delivering targeted and effective interventions
- NICE guidance PH48 and PH45 fully implemented in all mental health contexts. This will mean the full roll out of comprehensive smokefree policies in all mental health units by 2018, as recommended in the 2016 Independent Mental Health Taskforce Report 'The Five Year Forward View for Mental Health'
- All employers making good use of information and momentum generated by national campaigns such as 'Stoptober' and regional campaigns to promote stopping smoking amongst their employees
- All commissioners taking up the 2017-19 Commissioning for Quality and Innovation framework which includes tobacco as a national indicator for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status
- All NHS hospitals fully implementing NICE PH48 guidance supporting cessation in secondary care
- Regions and individual local councils coming together to agree local ambitions around which collective action can be organised
- Local health and wellbeing partners participating in 'CLear', an evidence-based improvement model that can assist in promoting local tobacco control activities
- Local councils identifying the groups and areas with the highest smoking prevalence within their local communities and taking focused action aimed at making reductions in health inequalities caused by smoking in their population
- Local areas working together to explore if regional and cross-regional approaches could offer a greater return on investment for stop smoking campaigns

## **5.2. Smoke Free legislation**

On 1st July 2007, Smoke Free legislation was introduced. This law made it illegal to smoke in all public enclosed or substantially enclosed areas and workplaces. The ban on smoking includes vehicles which serve the public and/or are used for work purposes. This legislation was brought in as a consequence of evidence demonstrating the harmful effects of being exposed to second-hand smoke. Second-hand smoke can have a particularly damaging effect on cardiovascular health. Since the introduction of smoke free legislation, there has been a statistically significant reduction in the number of hospital admissions for heart attacks. A study of bar workers showed that measures of their respiratory health significantly improved after the introduction of the legislation.<sup>61</sup>



### 5.3. Vaping in England: an evidence update February 2019

In February 2019 PHE released their annual update on e-cigarettes. 'Vaping in England: an evidence update February 2019'<sup>62</sup> provides the latest evidence on prevalence and characteristics of electronic cigarette use in young people and adults in England. The main findings are:

- Regular use of e-cigarettes by 11-18-year olds remains low with 1.7% of 11-18-year olds in Great Britain reporting at least weekly use in 2018.
- The proportion of young people who have never smoked who use e-cigarettes at least weekly remains very low (0.2% of 11-18-year olds in 2018).
- Vaping prevalence in adults in Great Britain has remained stable since 2015.
- Estimates for prevalence in adults in Great Britain are:
  - 5.4% to 6.2% of all adults
  - 14.9% to 18.5% for current smokers
  - 0.4% to 0.8% for people who had never smoked
  - 10.3% to 11.0% for ex-smokers
- Use of electronic cigarettes in quit attempts is similar across socio-economic groups.
- Among long-term ex-smokers, electronic cigarette use is higher in those from lower socio-economic groups. This suggests that those from higher socio-economic groups are using electronic cigarettes to quit smoking and then stop use, while those from more disadvantaged groups continue to use E Cigs.
- Quitting smoking remains the main reason for vaping in all socio-economic groups.
- Using electronic cigarettes as part of a quit attempt continues to be helpful for people attending stop smoking services in England.
- In stop smoking services, the proportion of quit attempts using an electronic cigarette remains very small (4.1% of all quit attempts in stop smoking services nationally.)
- Combining electronic cigarettes with stop smoking service support should be a recommended option available to all smokers.
- Stop smoking practitioners and health professionals supporting smokers to quit should receive education and training on using electronic cigarettes in quit attempts.

We do not have detailed information regarding use of e-cigarettes and vaping in Leicestershire as this information is not routinely collected at present. However, QuitReady keeps a record of those people who choose to use e-cigarettes as part of their quit attempt.

In 2019 there were reports in the media regarding e-cigarettes and vaping and cases of serious lung disease, particularly in the US. The cases in the US are largely related to using

vaping liquids containing THC, the main psychoactive chemical in cannabis, in young men with an average age of 24.<sup>63</sup>

In the UK nicotine containing vaping liquids are regulated by the Medicines Healthcare Regulatory Authority, and as such are subject to the yellow card reporting scheme for adverse events. The position of Public Health England and the Royal College of Physicians remains that vaping regulated nicotine containing liquids remains considerably safer than smoking tobacco.<sup>62</sup> However, non-smokers should not start vaping.

#### **5.4. NHS Long Term Plan**

The NHS Long Term Plan<sup>64</sup> sets out ambitions for how the NHS can contribute to making England a smoke-free society, including the following aims:

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

#### **5.5. NICE guidance**

There is a raft of NICE guidance available on smoking including documents covering guidance and care quality standards. Guidance on 'Stop smoking interventions and services [NG92]<sup>65</sup> covers stop smoking interventions and services delivered in primary care and community settings for everyone over the age of 12. It aims to ensure that everyone who smokes is advised and encouraged to stop and given the support they need. It emphasises the importance of targeting vulnerable groups who find smoking cessation hard or who smoke a lot.

Guidance on 'Smoking: acute, maternity and mental health services [PH48]<sup>66</sup> covers how to help people to stop smoking in acute, maternity and mental health services. It promotes smoke free policies and services and recommends effective ways to help people stop.

#### **5.6. Smoking in the Home. New solutions for a Smokefree Generation**

Other important guidance includes 'Smoking in the Home. New solutions for a Smokefree Generation'.<sup>67</sup> This report is written by ASH and explores the impact of smoking in our homes. It recommends policy measures to reduce the levels of smoking in the home, to

protect both children and adults and support healthy communities. The smoking ban in enclosed public places in July 2007 was transformative, protecting workers and customers but also instigating a cultural shift that encouraged many more people to quit smoking. However, significant numbers of children and adults continue to be exposed to second-hand tobacco smoke in the home. In a survey carried out by ASH 12% of people reported that someone smokes in the home most days. Second-hand smoke can also impact on others outside the home, with smoke from neighbours' houses drifting into other properties. Smoking can also affect communities through an increased risk of fire. Smoking-related fires are the main cause of fire fatalities in the home. Exposure to second-hand smoke is a major cause of childhood illness costing the NHS nearly £12 million a year. In addition, it is a major risk factor for the development of heart and respiratory conditions in adults and is also a risk factor for miscarriage, stillbirth and sudden infant death.

Many recommendations are made in the report with actions relevant at national, regional and local levels. The recommendations are grouped into the following categories:

1. Local and national leadership to secure smokefree homes.
2. Media campaigns and local health promotion to include smokefree homes messaging.
3. Support smokefree housing through smoking cessation.
4. Maximise the delivery of brief advice across sectors.
5. Utilise tobacco harm reduction methods to support smokefree homes.
6. Promote the financial gains from stopping smoking.
7. Specific action should be considered for vulnerable groups of tenants.
8. Standardise the approach to fire safety to reduce smoking in the home.
9. Local authorities and landlords should improve compliance and enforcement with existing legislation and support neighbours exposed to smoke drift.
10. Social and private landlords should review approaches to smoking within tenancies.
11. Local authorities and landlords should include measures to reduce smoking as part of new housing developments.
12. Employers should act to protect workers in the home.
13. Landlords, local government and the police should collaborate to tackle the sale of illicit tobacco in domestic settings.

#### **5.7. Trading Standards Enforcement programme for tobacco.**

Leicestershire County Council Trading Standards Service have an Enforcement programme,

which includes that the Service will: use an 'intelligence led' approach to achieve compliance with statutory controls and to respond to complaints alleging the illegal sale of tobacco products to young persons; allied to other enforcement activities, in particular other statutory controls for underage sales, undertake checks for compliance; work in partnership with other enforcement agencies to tackle the problem of underage sales, and of counterfeit and smuggled tobacco products; monitor the display of statutory notices, the restrictions on the display for sale of tobacco products, the plain packaging requirements and the labelling of products, as part of the Trading Standards Service's broader inspection work at retail premises; promote through the media and by other means, information about controls and penalties; liaise with other agencies to help identify problem areas or businesses in order to better target resources, and deal with alleged offences in accordance with the Trading Standards Service's Enforcement Policy, including putting matters before the Courts where appropriate.<sup>68</sup>

This Service complies with the 'Guidance to support Trading Standards in complying with article 5.3 of the Framework Convention on Tobacco Control', including refusing offers of support from the tobacco industry and only interacting with the tobacco industry when it is necessary for the purpose of investigating cases of counterfeit tobacco.<sup>69</sup>

## **6. Current Services**

### **6.1. QuitReady Stop Smoking Service**

QuitReady Stop Smoking Service is part of the provider arm of Public Health, Leicestershire County Council with no sub-contracted smoking cessation services in primary or secondary care. All services are provided in-house and as part of Public Health. The Stop Smoking Service Manager is also the strategic lead on tobacco control.

The QuitReady stop smoking service provides:

- A digital intervention programme which includes telephone support, text support and online support alongside face to face support for specialist groups including pregnant women, people with mental ill health and vulnerable communities including those with long term conditions
- Free to all residents of Leicestershire County, people who work in the county or are registered with a county GP
- Treatment includes 12 weeks of behavioural intervention and 12 weeks- worth of free stop smoking medication including E-cigarettes

- Evidence-based behavioural intervention including stop smoking advice and support and stop smoking pharmacotherapy as per NICE guidance and the national centre for smoking cessation training guidance and service recommendations (NCSCT)
- Provide brief opportunistic intervention training to stakeholders including midwifery services, primary and secondary care services, voluntary sector and council staff

The Stop Smoking Service Manager lends support and advice to key partners such as Leicestershire Partnership Trust in the development of their smokefree policies and strategy and contributes to various committees and meetings such as the Maternity Service Liaison Committee, Healthy Babies Strategy, UHL meetings and contributes to the respiratory delivery group which is hosted and facilitated by West Leicestershire CCG. The Stop Smoking Manager has also been involved with PHE in the development of the regional guidance for smoking in pregnancy.

## **6.2. Stakeholder Training Programmes**

The Stop Smoking Service provides training to all partners and in particular the midwifery mandatory training programme. There are currently over 60 training sessions per year. Other training involves the neonatal teams and children services which are part of UHL.

Primary care teams are also offered training on brief opportunistic training and referral pathways. This includes training to all GP staff and clinicians, pharmacy services and dental services. In Leicestershire there are currently 35 county pharmacists who are trained by the Stop Smoking Service to provide Champix/Varenicline via a patient group directive (PGD). These pharmacy services are sub-contracted to dispense medication only as part of direct supply thus omitting the need for patients to go via GP services with behavioural support provided by the stop smoking team.

## **6.3. The Tobacco Control Alliance**

The Tobacco Control Alliance has been set up by the tobacco control lead/ stop smoking service manager for Public Health Leicestershire. This group meets up once a quarter and is a joint alliance with Leicester City Council. The key contributors to this group are the following:

- Health leads and district council representation
- Public Health Consultant/s
- Trading Standards
- Leicestershire Fire & Rescue Service
- Communications Team
- Leicestershire Partnership Trust \*

- UHL
- Leicester City Council Tobacco Control Lead
- Environmental Health
- CCGs

The group provides:

- A robust Tobacco Control Alliance working with a variety of stakeholders within each strategic area.
- Primary tobacco control priorities:
  1. Protecting children from the harmful effects of smoking
    - a. Enabling and supporting people, particularly young people, resist the pressure to start smoking.
    - b. Target those most at risk including young people and those from areas of greatest need.
    - c. Protect Leicestershire citizens from the dangers of second-hand smoke.
  2. Motivate and assist every tobacco user to quit or reduce harm
    - a. Actively encourage and support citizens to stop smoking through the provision of high-quality evidence- based services.
    - b. Target those most at risk including pregnant women and mental health service users.
  3. Protecting communities
    - a. Ensure effective regulatory enforcement measures are implemented in relation to tobacco control including age of sale, smoke free public places, advertising and promotion of tobacco products and illicit tobacco

## 7. Unmet needs/Gaps

Whilst the smoking prevalence has been decreasing over time, there remains a substantial number of people smoking in Leicestershire, with a smoking prevalence of 13.2% in 2018. This represents 73,535 adults who are at risk of smoking related complications and diseases. Unfortunately, this is an increase from 66,678 smokers or 12.1% in 2017. The reasons for this increase are not yet fully understood.

More men than women smoke, so the burden of disease will disproportionately affect men too. Young people are still starting to smoke. The smoking prevalence is higher in mixed and white ethnic groups. Lesbian, gay and bisexual people are more likely to be current smokers, with the gap being more pronounced for women.

There is a geographical difference in smoking levels which will lead to a geographical inequality in the burden of smoking related illnesses. Smoking prevalence in Leicestershire

ranges from 6.3% in Oadby and Wigston to 19.2% in North West Leicestershire. North West Leicestershire also has the highest level of smoking attributable mortality rate in Leicestershire.

Excess mortality is seen for those with mental health problems due to increased smoking. This represents a huge health inequality in those with severe mental health problems. 24.5% of those with a long-term mental health condition in Leicestershire smoke.

There is also a link with deprivation. The prevalence of smoking in Leicestershire in those in routine and manual occupations is 22.4%. This means that those who are more economically deprived, and who are likely to be deprived in other areas of life, are also faced with a substantial health inequality as a result of smoking. This will manifest itself in reduced life expectancy, more smoking related illnesses, more smoking related hospital admissions and more impacts on day to day activities as a result of the smoking.

There are groups of people who are vulnerable for a number of reasons that have higher smoking prevalence and therefore are likely to face health inequalities as a result of their smoking, let alone any other factors. LAC, the homeless population, and the prison population all have higher smoking prevalence than the average. Again, these groups face a range of health inequalities, of which one major factor will be related to the levels of smoking in these groups. The numbers of LAC in Leicestershire are increasing and there is a risk that these LAC could potentially start smoking if they do not already do so.

There may be other groups where we do not have sufficient information on smoking prevalence to know whether they are an at-risk group or not. For example, data on smoking prevalence for children and adults with special educational needs is not available. We do not know if this group has unmet needs with regards to support to prevent them taking up smoking or in terms of smoking cessation support. Similarly, we do not have local information on the prevalence of smoking in people with learning disability.

Smoking in pregnancy is measured as 'smoking at the time of delivery'. In Leicestershire the level is 8.5% of women which is significantly better (lower) than the national average. However, this represents nearly one in 10 pregnant women, and this group has a substantially higher risk of various complication. Smoking during pregnancy can cause serious complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. Neonatal mortality rates in Leicestershire have remained similar to the national average since 2010-12. However, all these deaths are individual tragedies for the family and friends. Premature births are increasing over time; smoking increases the risk of premature births.

Smoking attributed hospital admissions are increasing over time. At 1,350 admissions per 100,000 people in 2017/18 for Leicestershire, this is lower than the national average. However, this still represents a significant burden on inpatient hospital services, including on ambulance services, Emergency Department attendances and admissions units. Smoking is the single biggest cause of preventable deaths and illness and accounts for one in six deaths across England. Smoking increases the risk of various cancers, cardiovascular, respiratory and digestive system diseases. All these illnesses will represent a sizeable proportion of primary care and secondary care resources for both planned and emergency care. The mortality rate from oral cancer in Leicestershire has been increasing since 2011-13.

Generally speaking, those who access the QuitReady stop smoking service reflect those groups where there is higher prevalence of smoking. There has been an increase in the number of people accessing the service over time, however with a lower proportion setting a quit date. This in the context of an increasing smoking prevalence. Residents of North West Leicestershire with the third biggest group by geographical area of residence despite having the highest smoking prevalence.

Smoking continues to be a major contributor to health inequalities in a range of more deprived or more vulnerable groups. Smoking related illness and disease accounts for a significant proportion of the work of the health service in primary and secondary care, and in all affiliated parts of the health and care system, in both planned and emergency activity.

## **8. Recommendations**

- 1) Development of a Tobacco Control Strategy for Leicestershire to set out a clear vision and priorities for reducing smoking related health inequalities and reducing the burden of illness and disease from smoking, recognising the partnership between different organisations that will be required to fulfil this.
- 2) Reduce health inequalities due to smoking through a reduction in people starting smoking, supporting people to stop smoking (recurrently if needs be) and optimal management of smoking related illnesses and diseases in primary and secondary care.
- 3) To take a multiagency approach to prevention and stop smoking support in geographical areas where smoking prevalence is highest, alongside universal access to services.
- 4) To carry out an evaluation of the QuitReady service to ensure that those groups with higher smoking prevalence are appropriately targeted and reached by the service, alongside maintaining a universal offer to all smokers.



- 5) Working in partnership and utilising principles of system leadership across organisations in Leicestershire, and in Leicester and Rutland where appropriate, on areas such as smoke-free housing and in patient stop-smoking services.
- 6) Clinical commissioning groups to provide leadership on contributing to a smoke free society in England and work with NHS providers on: provision of inpatient stop smoking services, provision of a universal smoking cessation offers to long-term users of specialist mental health and/or learning disability services, development of smoke free NHS sites and embedding Making Every Contact Count.
- 7) District councils to provide leadership on smoke free housing, working with housing providers to lead the way in improving the health of their population through smoke free tenancies, and reducing second hand smoke exposure due to smoke drift (for example in flats/apartments), including utilising Making Every Contact Count principle.
- 8) Continue to consider equality of access to stop smoking services, including information and support, for those who may face particular challenges in accessing services, for example those with a learning disability and other groups under the Equality Act.
- 9) Ensure that smoking advice and information, and the stop smoking services are thoroughly embedded in the Making Every Contact Count plus (MECC+) workstream and training.
- 10) Work with Primary Care Networks in conjunction with social prescribing link workers to ensure that smokers are offered brief advice and relevant signposting to stop smoking services by social prescribing link workers.
- 11) UHL NHS Trust and Leicestershire Partnership NHS Trust (Acute mental health services) to strengthen their smokefree sites policies and the enforcement of these policies.
- 12) Work in partnership to reach LAC and support them and the places where they live to be smoke free and have tailored services to support quit attempts.
- 13) For specialist services such as prison healthcare, and homeless primary care services to ensure that accessible and relevant advice is provided to these groups in appropriate and pragmatic ways, with support from partners as appropriate and required.
- 14) Investigate why prevalence of smoking in Leicestershire may have increased from 2017 to 2018 and continue to monitor and respond to the trend of smoking over time.

## GLOSSARY OF TERMS

---

ASH	Action on smoking & health
CCG	Clinical Commissioning Group
COPD	Chronic obstructive pulmonary disease
EHCP	Education, Health and Care plan
GP	General Practice
HMPPS	Her Majesty's Prison & probation service
HMRC	Her Majesty's revenue and customs
IMD	Index of multiple deprivation
JSNA	Joint Strategic Needs Assessment
LAC	Looked after children
MECC+	Make every contact count plus
NCSCT	National centre for smoking cessation and training
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NRT	Nicotine replacement therapy
PGD	Patient group directive
PHE	Public Health England
QOF	Quality and outcomes framework
SMI	Serious mental illness
UHL	University Hospitals of Leicester

---

## REFERENCES

---

- <sup>1</sup> Local Tobacco Profiles, PHE Fingertips. (2019). Available at <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/6/gid/1938132885/pat/6/par/E12000004/ati/102/are/E10000018>
- <sup>2</sup> Cabinet Office and the Department of Health and Social Care (2019). Advancing our health: prevention in the 2020s – consultation document. Available at: <https://www.gov.uk/government/consultations/advancing-our-health-prevention-in-the-2020s/advancing-our-health-prevention-in-the-2020s-consultation-document>
- <sup>3</sup> DH analysis on Health Survey for England 2014 data
- <sup>4</sup> NHS Digital (2015). 'Smoking, Drinking and Drug Use Among Young People in England - 2014'. Figure 4.1.
- <sup>5</sup> Public Health England (2019). Local Tobacco Control Profiles. Available at: <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/6/gid/1938132886/pat/6/par/E12000004/ati/102/are/E10000018/iid/91547/age/188/sex/4>
- <sup>6</sup> Emerson, E (2018). Smoking among adults with and without disabilities in the UK. Journal of Public Health, Volume 40, Issue 4, December 2018, Pages e502–e509, <https://doi.org/10.1093/pubmed/fdy062>
- <sup>7</sup> Public Health England (2018). Common Mental Health Disorders Profile. Available at: <https://fingertips.phe.org.uk/profile-group/mental-health/profile/common-mental-disorders>
- <sup>8</sup> Public Health England (2019). Learning Disability Profiles. Available at: <https://fingertips.phe.org.uk/learning-disabilities#page/0/gid/1938132702/pat/6/par/E12000004/ati/102/are/E10000018/iid/200/age/1/sex/4>
- <sup>9</sup> Department of Health and Social care (2011). No Health Without Mental Health. Available at: <https://www.gov.uk/government/publications/no-health-without-mental-health-a-cross-government-outcomes-strategy>
- <sup>10</sup> McManus et al. (2009). Adult Psychiatric Morbidity in England, 2007: Results of a household survey.
- <sup>11</sup> McManus S, Meltzer H and Campion J (2010). Cigarette smoking and mental health in England. data from the Adult Psychiatric Morbidity survey. national centre for social Research, available at: <http://www.natcen.ac.uk/media/21994/smoking-mental-health.pdf>
- <sup>12</sup> Green H, McGinnity A, Meltzer H et al. (2005). Mental Health of Children and Young People in Great Britain, 2004. Basingstoke: Palgrave Macmillan.
- <sup>13</sup> Public Health England (2018). Children and Young People's Mental Health and Wellbeing. Available at: <https://fingertips.phe.org.uk/cypmh>
- <sup>14</sup> Local Tobacco Profiles, PHE Fingertips. (2019). Available at <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/6/gid/1938132885/pat/6/par/E12000004/ati/102/are/E10000018/iid/93085/age/1/sex/2>
- <sup>15</sup> Office of National Statistics (2016). The Odds of Smoking by Sexual Orientation. Available at: <https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthinequalities/adhocs/009373theoddsfsmokingbysexualorientationinengland2016>
- <sup>16</sup> Public Health England (2018). Health Matters: Stopping smoking - what works? Available at: <https://publichealthmatters.blog.gov.uk/2018/09/25/health-matters-stopping-smoking-what-works/>
- <sup>17</sup> National Statistics (2015). English indices of deprivation 2015. Available at:

---

<https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015>

<sup>18</sup> The Marmot Review. Fair Society, Healthy Lives. (2010).

<sup>19</sup> Public Health England (2018). Public health Outcomes Framework. Available at:

<https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

<sup>20</sup> Public Health England (2018) Health matters: stopping smoking - what works? Available here

<https://www.gov.uk/government/publications/health-matters-stopping-smoking-what-works/health-matters-stopping-smoking-what-works>

<sup>21</sup> Tackling health inequalities – Targeting routine and manual smokers in support of the public service agreement smoking prevalence and health inequality targets, Department of Health National Support Team, 2009.

<sup>22</sup> ASH (2016) <http://ash.org.uk/information-and-resources/briefings/ash-briefing-health-inequalities-and-smoking/>

<sup>23</sup> Official Labour Market Statistics (2019). Available at: <https://www.nomisweb.co.uk/reports/lmp/la/contents.aspx>

<sup>24</sup> Fidler, W, Michell, L and Charlton A (1992). Smoking: a special need? British Journal of Addiction, VOL 87, Issue 11

<https://doi.org/10.1111/j.1360-0443.1992.tb02666.x>

<sup>25</sup> Public Health England (2018). Children and Young People's Mental Health and Wellbeing. Available at:

<https://fingertips.phe.org.uk/cypmh>

<sup>26</sup> Department for Education (2019), SEN2 collection (2019)

<sup>27</sup> HMSO (1989). Children Act 1989. Family Law 11, c.41

<sup>28</sup> Office for National Statistics (2002). The mental health of young people looked after by local authorities in England.

<sup>29</sup> ASH (2019). Health Inequalities and Smoking. Available at: [https://ash.org.uk/wp-content/uploads/2019/09/ASH-Briefing\\_Health-Inequalities.pdf](https://ash.org.uk/wp-content/uploads/2019/09/ASH-Briefing_Health-Inequalities.pdf)

<sup>30</sup> Department for Education (2018). Children looked after in England including adoption:2017 to 2018. Available at:

<https://www.gov.uk/government/statistics/children-looked-after-in-england-including-adoption-2017-to-2018>

<sup>31</sup> Department of Health and HM Prison Service (2007). Acquitted - Best practice guidance for developing smoking cessation services in prisons. Cited in <http://ash.org.uk/information-and-resources/briefings/ash-briefing-health-inequalities-and-smoking/>

<sup>32</sup> Public Health England (2018) <https://publichealthmatters.blog.gov.uk/2018/07/18/successfully-delivering-smokefree-prisons-across-england-and-wales/>

<sup>33</sup> St Mungo's Client Needs Survey (2013). Cited in <http://ash.org.uk/information-and-resources/briefings/ash-briefing-health-inequalities-and-smoking/>

<sup>34</sup> Fear NT, Horn O, Hull L, Murphy D, Jones M, Browne T, et al. Smoking among males in the UK Armed Forces: Changes over a seven-year period. *Prev Med (Baltim)* [Internet]. 2010 May [cited 2019 Nov 05];50(5–6):282–4. Available from: <https://linkinghub.elsevier.com/retrieve/pii/S0091743510001027>

<sup>35</sup> HSCIC. Health Survey for England: Smoking [Internet]. HSCIC. 2017 [cited 2019 Jan 11]. Available from: <http://healthsurvey.hscic.gov.uk/data-visualisation/data-visualisation/explore-the-trends/smoking.aspx>

<sup>36</sup> Thandi G, Fear NT. Factors associated with smoking behaviour change in UK military personnel. *Occup Med (Chic Ill)*.

---

2017;67(9):712–4.

<sup>37</sup> Illicit Tobacco Partnership, ‘Undermining efforts to cut smoking’ Available at: <https://www.illicit-tobacco.co.uk/problem/undermining-tobacco-control/>

<sup>38</sup> Legislation.gov.uk (2019). Trade Marks Act 1994. Available at: <http://www.legislation.gov.uk/ukpga/1994/26/contents>

<sup>39</sup> Greater Manchester Health and Social Care Partnership (2019). Illegal Tobacco Campaign aims to stop children getting hooked. Available at: <http://www.gmhsc.org.uk/illegal-tobacco-campaign-aims-to-stop-children-getting-hooked/>

<sup>40</sup> Durham University (2017). Nearly half of teenage smokers have brought illegal tobacco, so what are the dangers? Available at: <https://www.dur.ac.uk/news/allnews/thoughtleadership/?itemno=32982>

<sup>41</sup> Public Health England (2019). Dementia Profile. Available at: <https://fingertips.phe.org.uk/dementia#page/6/gid/1938132859/pat/6/par/E12000004/ati/102/are/E10000018/iid/91280/age/188/sex/4>

<sup>42</sup>Health & Social Care Information Centre. CCG Outcomes Indicator Set <http://www.hscic.gov.uk/catalogue/PUB20294/ccg-ind-mar-16-comm.pdf>

<sup>43</sup> RCP. Smoking and mental health - A joint report by the Royal College of Physicians and the Royal College of Psychiatrists. [https://cdn.shopify.com/s/files/1/0924/4392/files/smoking\\_and\\_mental\\_health\\_-\\_full\\_report\\_web.pdf?7537870595093585378](https://cdn.shopify.com/s/files/1/0924/4392/files/smoking_and_mental_health_-_full_report_web.pdf?7537870595093585378)

<sup>44</sup> ASH smoking and mental health factsheet <http://ash.org.uk/information-andresources/fact-sheets/smoking-and-mental-health/>

<sup>45</sup> Royal College of Physicians smoking and mental health leaflet <https://www.rcpsych.ac.uk/usefulresources/publications/collegereports/cr/cr178.aspx>

<sup>46</sup> Royal College of Physicians smoking and mental health report <https://www.rcplondon.ac.uk/projects/outputs/smoking-and-mental-health>

<sup>47</sup> Bauld et al (2017). Young People’s Use of E-Cigarettes across the United Kingdom: Findings from Five Surveys 2015–2017. International Journal of Environmental Research and Public Health.

<sup>48</sup> Health Needs Assessment for looked after children in Leicester, Leicestershire and Rutland, (2019).

<sup>49</sup> World Health Organization Report on the Global Tobacco Epidemic 2009 <http://www.who.int/tobacco/mpower/2009/en/index.html>

<sup>50</sup>Towards a Smokefree Generation: A Tobacco Control Plan for England, July 2017 <https://www.gov.uk/government/publications/towards-a-smoke-free-generation-tobacco-control-plan-for-england>

<sup>51</sup> La Vecchia C, Tavani A, Franceschi S et al. Epidemiology and prevention of oral cancer. Oral Oncology 1997; 33: 302–12

<sup>52</sup> The Lancet [http://thelancet.com/journals/lancet/article/PIIS0140-6736\(14\)60082-9/abstract](http://thelancet.com/journals/lancet/article/PIIS0140-6736(14)60082-9/abstract)

<sup>53</sup> HM Revenue & Customs (2016/17). Measuring tax gap estimates for 2016/17. Available at: [51](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/654490/HMRC-</a></p></div><div data-bbox=)

---

[tobacco-tax-gap-estimates-2017.pdf](#)

<sup>54</sup> Jha et al (2006). Social inequalities in male mortality and in male mortality from smoking. Lancet 2006 Jul 29;368(9533):367-70

<sup>55</sup> Doll, P and R. Peto (2004). Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004; 328 doi: <https://doi.org/10.1136/bmj.38142.554479.AE> (Published 24 June 2004)

<sup>56</sup> ASH – The Local Costs of Tobacco (2018). Ready Reckoner. Available at: <http://ash.lelan.co.uk/>

<sup>57</sup> HM Revenue & Customs (2016/17). Measuring tax gap estimates for 2016/17. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/820979/Measuring\\_tax\\_gaps\\_2019\\_edition.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/820979/Measuring_tax_gaps_2019_edition.pdf)

<sup>58</sup> Leicestershire Police (2019). Modern Slavery. Available at: organ harvesting.

<https://www.leics.police.uk/advice/advice-and-information/ms/modern-slavery/>

<sup>59</sup> Department of Health (2017). Smoke-free generation: tobacco control plan for England. Available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/630217/Towards\\_a\\_Smoke\\_free\\_Generation\\_-\\_A\\_Tobacco\\_Control\\_Plan\\_for\\_England\\_2017-2022\\_2\\_.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022_2_.pdf)

<sup>60</sup> Department of Health (2018). Tobacco control plan: delivery plan 2017 to 2022. Available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/714365/tobacco-control-delivery-plan-2017-to-2022.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/714365/tobacco-control-delivery-plan-2017-to-2022.pdf)

<sup>61</sup> University of Bath (2011). The Impact of Smokefree legislation in England: Evidence review. Available at:

[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/216319/dh\\_124\\_959.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/216319/dh_124_959.pdf)

<sup>62</sup> Public Health England (2019). Vaping in England: an evidence update February 2019. Available at:

<https://www.gov.uk/government/publications/vaping-in-england-an-evidence-update-february-2019>

<sup>63</sup> Belluz, J. (2019). Vaping appears to be making hundreds of people sick. Doctors have no idea why. Available here

<https://www.vox.com/science-and-health/2019/9/3/20847219/vaping-health-risks-2019-lung-damage-death>

<sup>64</sup> NHS (2019). The NHS Long Term Plan. Available at: [https://www.longtermplan.nhs.uk/wp-](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf)

[content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf](https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf)

<sup>65</sup> National Institute of Health and Clinical Excellence (2018). Stop smoking interventions and services. Available at:

<https://www.nice.org.uk/guidance/ng92>

<sup>66</sup> National Institute of Health and Clinical Excellence (2013). NICE Guidance: Smoking: acute, maternity and mental health services. Available at: <https://www.nice.org.uk/guidance/ph48>

<sup>67</sup> Action on Smoking Health (2018). Smoking in the home: New solutions for a Smokefree Generation. Available at:

<http://ash.org.uk/wp-content/uploads/2018/11/FINAL-2018-Smokefree-Housing-report-web.pdf>

<sup>68</sup> Enforcement Programme for Tobacco Products. Available at

<https://www.leicestershire.gov.uk/sites/default/files/field/pdf/2018/9/17/Enforcement-Programme-for-Tobacco-products-2018-19.pdf>

<sup>69</sup> Guidance to support Trading Standards in complying with article 5.3 of the Framework Convention on Tobacco

---

Control. Available at:

<https://www.illicit-tobacco.co.uk/wp-content/uploads/2019/01/Guidance-for-Trading-Standards-.pdf>