NHS
Leicester City
Clinical Commissioning Group

Leicester
City Council

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Tobacco

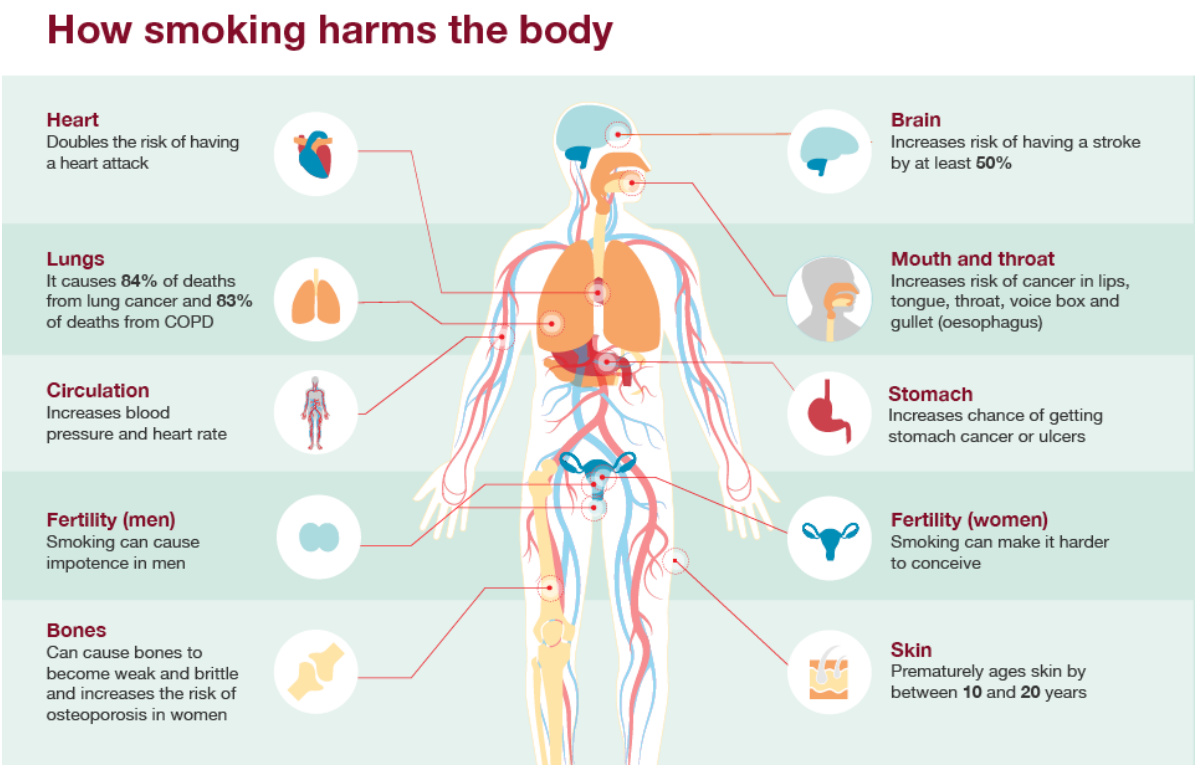
1 INTRODUCTION

Smoking is the leading cause of preventable illness and premature death in England causing harm in many parts of the body and accounting for 1 in 6 of all deaths in England.

There are many medical conditions (Figure 1 below) associated with or aggravated by smoking, which may not be fatal but still cause years of debilitating illness.[1]

1.1 SMOKING HARM TO THE BODY

Figure 1: Smoking harm to the body

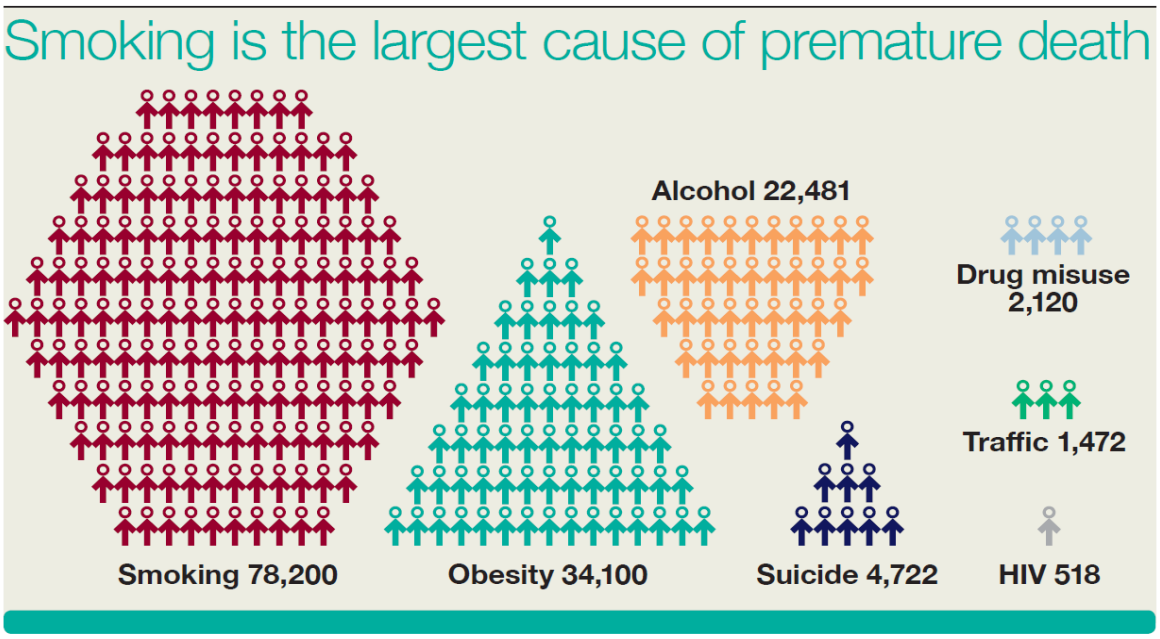


Source: *Health matters: tobacco standard packs, Public Health England, 2016.*

1.2 SMOKING AND DEATH

Despite the decline in smoking, about 6.5 million adults in England still smoke[2] and tobacco use remains the single greatest cause of preventable deaths in England – killing approximately 80,000 people per year. Smoking can be attributed to around 16% of all deaths. This is greater than the combined total of preventable deaths caused by obesity, alcohol, suicide, traffic accidents, illegal drugs and HIV infections.[3]

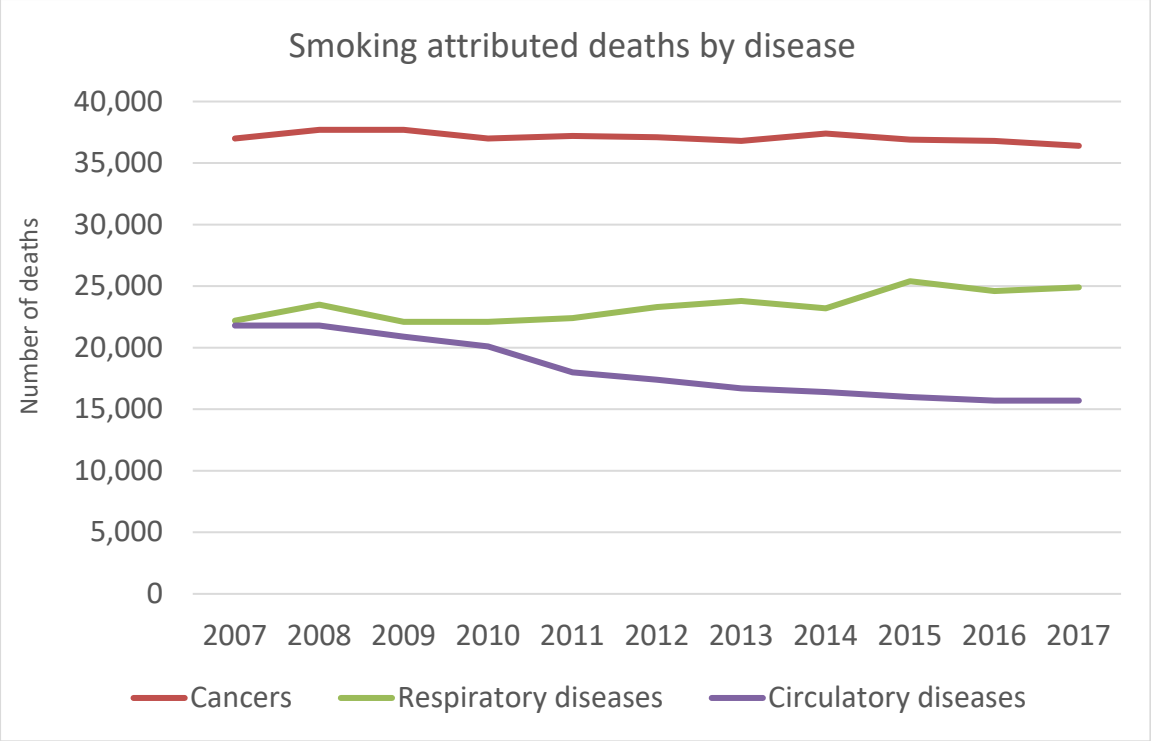
Figure 2: Premature death by cause



Source: *Comprehensive local tobacco control: Why invest? Public Health England. 2016.*

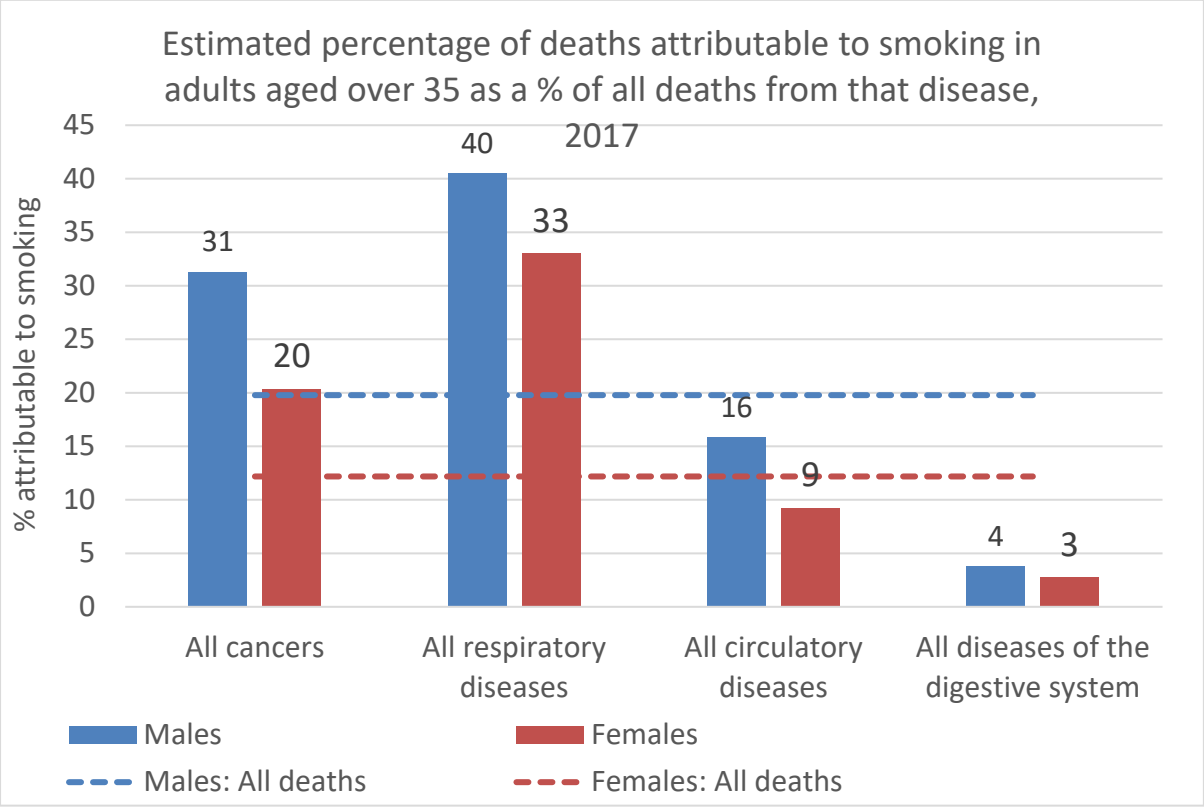
One in two regular smokers is killed by tobacco and half of them will die before the age of 70, losing an average 10 years of life.[4]

Figure 3: Trend of estimated deaths attributed to smoking by disease, 2007-2017, England



Data: *NHS Digital: Statistics on Smoking, 2019*

Figure 4: Estimated deaths attributed to smoking as a percentage of all deaths from that disease, 2017 (35 and over, by gender), England.



Data: *NHS Digital: Statistics on Smoking, 2019*

Figure 4 shows the percentage of deaths attributed to smoking by disease and gender. The proportion of smoking-attributed deaths for respiratory diseases (37%) and cancers (26%) is higher than circulatory diseases (13%) and diseases of the digestive system (3%). A larger proportion of deaths among men than women were attributable to smoking, with an estimated 20% (47,500) of all deaths among men aged 35 and over being attributable to smoking. This compares with 12% (30,400) of all deaths among women.[5]

Cancers of the trachea, lung, bronchus, and chronic airway obstruction account for over 40,000 smoking attributed deaths. The proportion of deaths for these diseases attributed to smoking are 79% and 77% respectively. Table 1 shows the full list of deaths and smoking attributed deaths among adults aged 35 and over in England by disease.

Table 1: Observed and smoking-attributable deaths in adults aged 35 and over in, England, 2018.

Cause of death	Observed deaths	Smoking Attributable number	Smoking Attributable percentage
All deaths	489,455	77,800	*16*
All cancers	139,013	36,400	*26*
All respiratory diseases	68,016	24,900	*37*
All circulatory diseases	123,924	15,700	*13*
All diseases of the digestive system	23,535	800	*3*
All deaths which can be caused by smoking	**236,583**	**77,800**	***33***
Cancers which can be caused by smoking	**68,078**	**36,400**	***54***
Trachea, Lung, Bronchus	28,147	22,200	*79*
Upper Respiratory Sites	2,415	1,500	*63*
Larynx	660	500	*79*
Oesophagus	6,438	4,200	*65*
Cervical	635	100	*10*
Bladder	4,729	1,800	*38*
Kidney and Renal Pelvis	3,756	900	*23*
Stomach	3,457	900	*20*
Pancreas	7,850	1,700	*22*
Unspecified site	7,565	2,600	*34*
Myeloid Leukaemia	2,426	400	*16*
Respiratory diseases which can be caused by smoking	**52,036**	**24,900**	***48***
Chronic Obstructive Lung Disease	1,160	1,000	*86*
Chronic Airway Obstruction	25,587	19,600	*77*
Pneumonia, Influenza	25,289	4,300	*17*
Circulatory diseases which can be caused by smoking	**114,752**	**15,700**	***14***
Other Heart Disease	24,036	2,900	*12*
Ischaemic Heart Disease	53,691	7,300	*14*
Other Arterial Disease	2,618	400	*15*
Cerebrovascular Disease	29,565	2,400	*8*
Aortic Aneurysm	4,781	2,700	*57*
Atherosclerosis	61	0	*17*
Diseases of the digestive system which can be caused by smoking	**1,717**	**800**	***45***
Stomach / Duodenal Ulcer	1,717	800	*45*

Data: *NHS Digital: Statistics on Smoking, 2019*

2 WHO'S AT RISK AND WHY?

2.1 SMOKING PREVALENCE IN ENGLAND

An estimated 14.4% of the adult population (18+) in England smoke, this is about 6.5 million adults. The data shows that levels of smoking vary across different population groups. Males (16%) are more likely to smoke than females (13%). Adults aged 25-34 (19%) are most likely to smoke and those aged 65 and over are least likely to smoke (8%). Smoking prevalence has been declining since 2011, with biggest decreases seen in 18-24 years olds, followed by 25-44 year olds.[2]

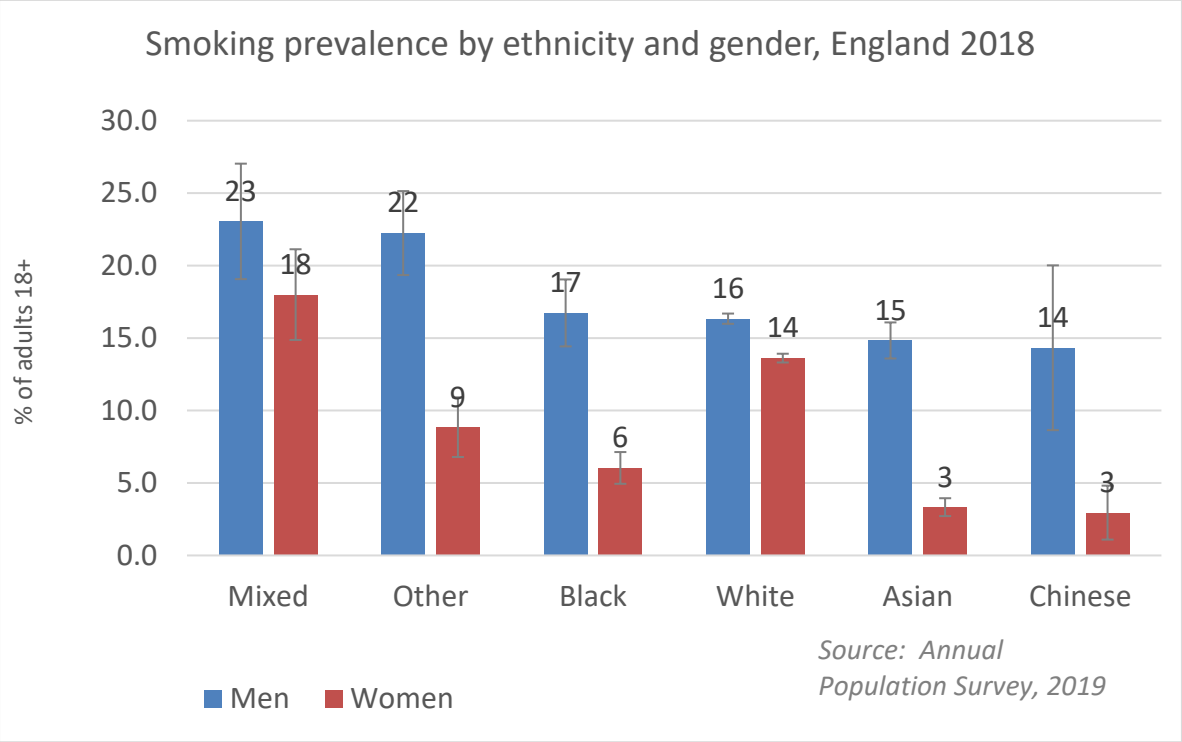
Smoking prevalence for routine and manual workers (26%) is higher compared to 1 in 10 people (10%) in managerial and professional occupations. The government aim to reduce this inequality gap in smoking prevalence.[6]

> 'Two adult smokers with a 20-a-day habit are likely to spend over £6,000 per year on cigarettes. Workers in routine and manual jobs are more than twice as likely to smoke as those in managerial and professional roles. Poorer smokers spend five times as much of their weekly household budget on smoking than richer smokers.'[7]

Figure 5 below shows smoking prevalence by ethnicity and gender. It identifies significantly higher rates in men than women across all ethnic groups except Mixed groups: Men from Mixed heritage (23%) and Other ethnic groups (22%) have significantly higher smoking prevalence and women from Asian and Chinese communities (3%) have significantly lower smoking prevalence.

> 'Smoking also varies greatly for some ethnic minority groups and those from the Lesbian, Gay and Bisexual community who remain far more likely to smoke than the general population..'

Figure 5: Smoking prevalence by ethnicity and gender, England



Data: *Annual Population Survey for England, 2019*

Reducing smoking in pregnancy is another key national objective, 10.6% of pregnant women in England were known to be smokers at the time of delivery during 2018/19. This compares to 10.8% for the previous year (2017/18) and is down from 13.6% in 2010/11.

> 'Smoking during pregnancy is a major health inequality, with prevalence varying significantly across communities and social groups. Smoking prevalence among pregnant women in more disadvantaged groups and those aged under 20 remains considerably higher than in older and more affluent groups… meaning those from lower socio-economic groups are at a much greater risk of complications during and after pregnancy. Children who grow up with a smoking parent are also more likely to become smokers themselves, further perpetuating the cycle of inequality and affecting their life chances.' [6]

3 THE LEVEL OF NEED IN THE POPULATION

3.1 SMOKING PREVALENCE IN LEICESTER

National data reveals a local smoking prevalence estimate of 17.3% for Leicester, this is statistically higher than the national rate (14.4%). Smoking prevalence recorded for

Leicester males (21%) is significantly higher than England males (16.4%). Smoking prevalence for Leicester females (13.6%) is similar to England females (12.6%).[2]

Local data from the Leicester Health and Wellbeing Survey 2018[8] estimates 19.6% of the Leicester 16+ population are current smokers. This is higher than nationally produced estimates for Leicester. Estimates can also be calculated by age, gender and ethnicity and compared against the previous Health and Wellbeing Survey in 2015[9] (see table 2 below).

Table 2: Smoking prevalence estimates in Leicester 2015/2018

Category		Smoking Prevalence 2015	Smoking Prevalence 2018
Overall	All	21.3%	19.6%
Gender	Males	23.5%	21.9%
	Females	19.1%	17.3%
Age	16-24	19.2%	18.2%
	25-34	27.3%	25.5%
	35-44	21.0%	22.1%
	45-54	24.4%	19.2%
	55-64	19.6%	20.6%
	65+	14.5%	12.1%
Ethnic Group	White British	28.1%	26.6%
	White other	31.8%	32.0%
	Asian British	11.8%	10.6%
	Black British	12.8%	9.8%
	Mixed heritage	32.4%	31.7%
Deprivation	Most deprived	29.0%	26.9%
	Least Deprived	12.6%	15.0%
Significantly higher than Leicester		**Significantly lower than Leicester**	

Data: *Leicester Health and Wellbeing Survey 2015 and 2018*

3.1.1 PREVALENCE BY AREA

Smoking prevalence varies across different communities. The Leicester Health and Wellbeing Surveys reveal that smoking prevalence is higher in areas to the west of the city. The west is known to have a higher White population and areas of high deprivation. Smoking prevalence is lower to the east of the city where there are predominantly South Asian communities.[9]

'Rich smokers have very similar life expectancy to poor smokers, and poor non-smokers live longer than rich smokers, showing that smoking not social status is the greatest cause of health inequalities. However more people in disadvantaged communities smoke, where smoking is more socially acceptable. Poorer smokers are usually more addicted and smoke more each day. On average all

smokers make similar numbers of quit attempts each year but, more affluent smokers are much more likely to succeed.'[10]

3.1.2 PREVALENCE AMONG RISK GROUPS

- **Smoking in pregnancy**

  Smoking prevalence in Leicester and nationally has seen a general decline since 2012/13.[12] The prevalence of smoking during pregnancy in Leicester in 2018/19 is 10.2% which is similar to the national rate of 10.6%.

- **Smoking amongst those with under 16s in household**

  In 2018, 18% of those with children under 16 in the household currently smoke. There has been a decline since 2015.

- **Smoking among routine and manual workers**

  The prevalence of smoking among routine and manual workers in Leicester in 2018 was 24.7%, which is similar to the national rate of 25.4%.[2]

- **Smoking among those with Poor Mental Wellbeing**

  The Leicester Health and Wellbeing Survey records a significantly higher rate of smoking amongst those with poor mental wellbeing (31.5%).

People with a mental health condition die on average 10 to 20 years earlier than the general population. It is estimated that a third of all cigarettes smoked in England are smoked by people with a mental health condition. Smoking among this population has changed little, if at all, over the past 20 years and in 2014/15, smoking prevalence among people with a serious mental illness was 40.5%.

Nationally around 80% of prisoners smoke compared with 14.4% in the general population, with similar levels recorded across the offender journey in police custody and community supervision where data are available. This high rate of smoking causes health problems to the smokers themselves and to non-smokers who are exposed to their tobacco smoke. The offender population has a high prevalence of poor mental health and other substance misuse, and offenders are predominantly from disadvantaged backgrounds, all of which are associated with elevated smoking prevalence. Offenders who smoke and those exposed to this smoke experience a marked increase in health inequalities.[8]

3.1.3 USE OF OTHER TOBACCO PRODUCTS IN LEICESTER

The Leicester Health and Wellbeing Survey 2018 estimated that 9% of residents had tried an e-cigarette and 4% currently vape/use e-cigarettes. Younger residents and White British residents report higher prevalence rates.

The Leicester Health and Wellbeing Survey 2018 reported that 2% of the 16+ population use Sheesha or Hookah. These products were more popular amongst younger residents, aged 16-34 (4%), Black and minority ethnic residents (3%) Muslim residents (5%). A smaller minority of residents reported using other tobacco products such as cigars, paan, gutka and bidi.

Against a background of apparent increase in the number and venues of waterpipe smoking (WPS) and in the absence of any national or local policy, Leicester Tobacco Control Steering Group produced evidence-based advice for the general public on WPS.[11]

3.1.4 SMOKING BEHAVIOUR AND ATTITUDES IN LEICESTER[8]

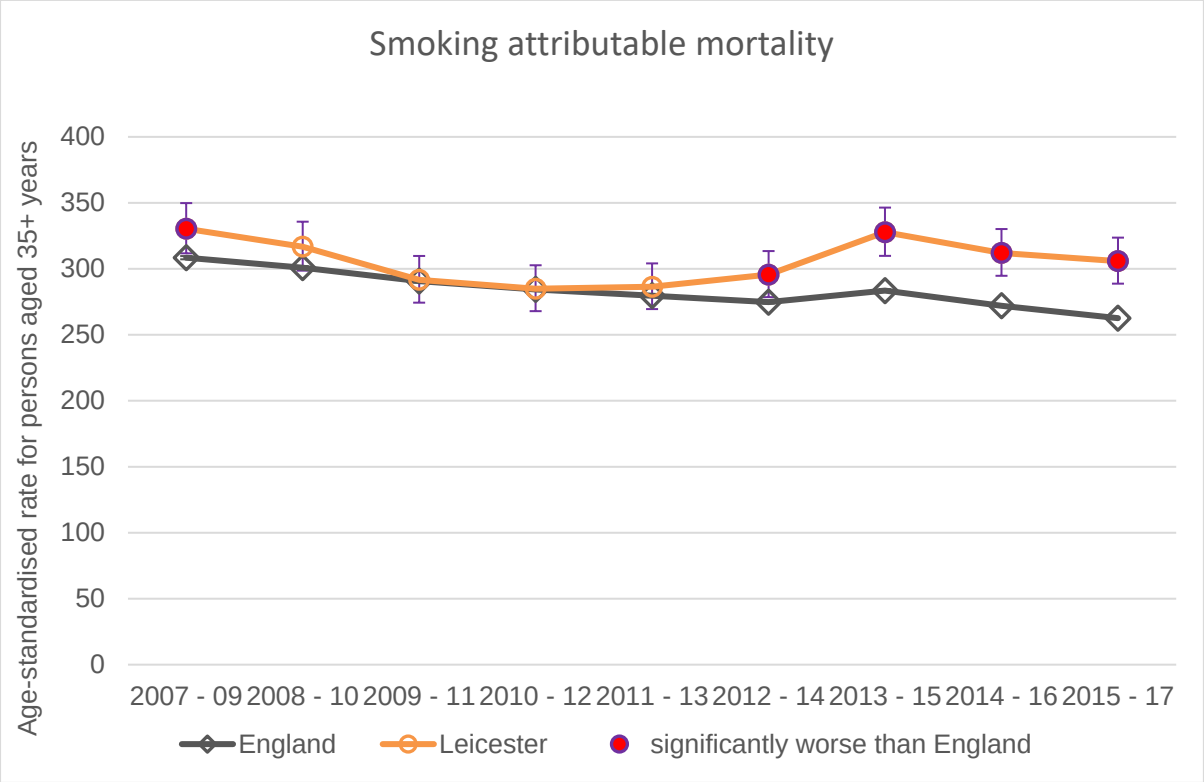
- 73% of smokers have tried to quit at some point in their lives and of these, the following services/aids had been used: E-cigarettes/vaping (27%), Nicotine replacement products (26%), STOP smoking service (11%), medication prescribed by your GP (9%). Over a third (37%), did not try using any service for their quit attempt.
- Currently three in five smokers (59%) want to give up smoking and 36% do not. 4% of smokers do not know whether they want to quit smoking or continue.
- Many smokers who want to quit smoking in the next 6 months have tried to quit previously. About a quarter did not previously use any aid (28%), others used nicotine replacement products (19%), e-cigarettes (18%), and 5% used other methods.
- In 2010, 31% of Leicester residents allowed smoking in their home – this has more than halved in 2018 to 15%.

> 'One of the most effective ways to reduce the number of young people smoking is to reduce the number of adults who smoke. We know that children are heavily influenced by adult role models who smoke: in 2014, 82% of pupils who regularly smoked reported having a family member who smoked. Continuing to encourage adult smokers to quit must therefore remain an important part of reducing prevalence amongst the young and achieving a smokefree generation.' [7]

3.1.5 SMOKING RELATED DEATHS AND HOSPITAL ADMISSIONS

Leicester has an estimated 312 smoking attributed deaths per 100,000 population compared to a national average of 272.[12] Figure 6 (below) shows the rate of smoking attributable mortality in Leicester has been significantly higher than England since 2012-14.

Figure 6: Smoking attributable mortality 2007 - 2017



Data: *PHE – Local tobacco control profiles, July 2019*

Note: Smoking attributable mortality uses an algorithm using underlying cause of death and smoking prevalence. Leicester's smoking prevalence from Integrated Lifestyle survey shows increases in 2013, 2015 which could account for increase in mortality rates.

In Leicester there are, on average, over 400 deaths per year attributable to smoking. The majority of these are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease. Table 3 shows that smoking attributable deaths from heart disease, deaths from oral cancer and deaths from COPD in Leicester are significantly higher than the national rate.[13]

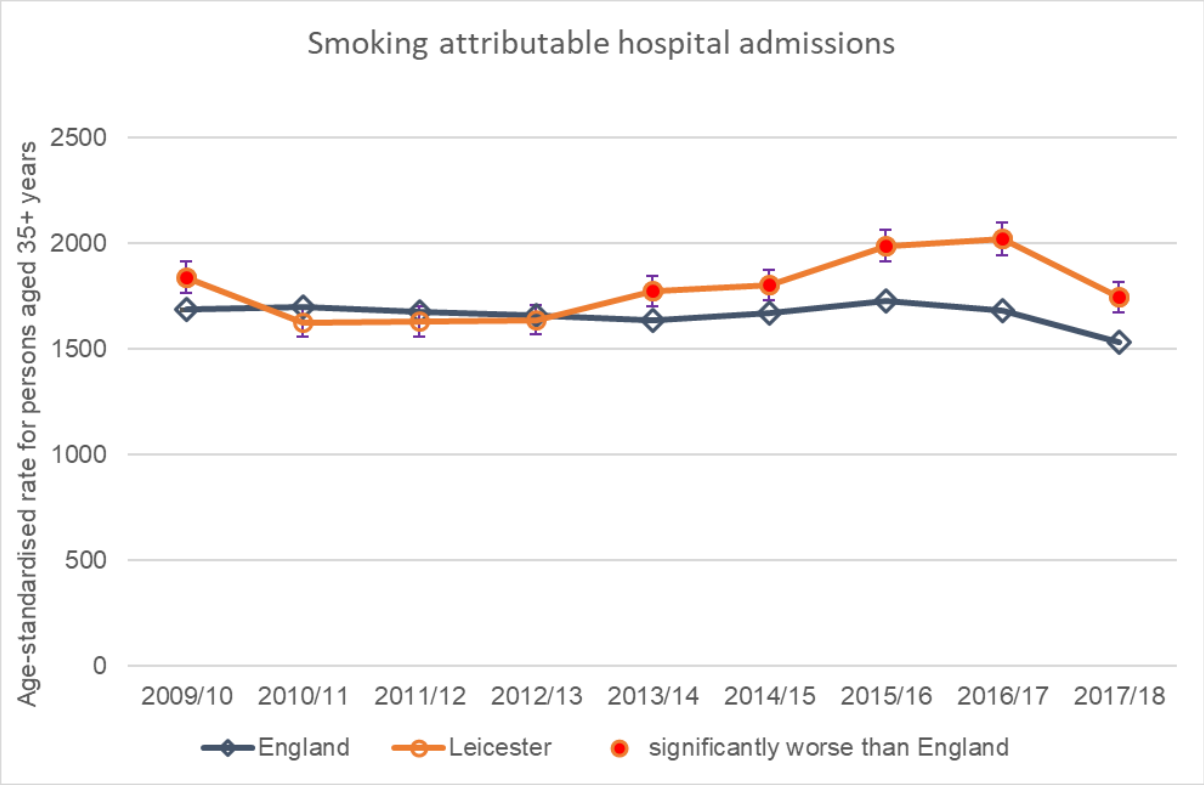
Table 3: Smoking attributable mortality rates (directly age-standardised rates per 100,000 2015-2017)

Indicator	Age	Leicester average deaths per year	Leicester rate	England rate
Smoking attributable mortality	35+ years	408	305.8	262.6
Smoking attributable deaths from heart disease	35+ years	51	36.0	24.7
Smoking attributable deaths from stroke	35+ years	15	11.1	8.2
Deaths from lung cancer	All ages	135	61.3	56.3
Deaths from oral cancer	All ages	21	9.0	4.6
Deaths from chronic obstructive pulmonary disease	All ages	134	61.6	52.7

Data: *Local Tobacco Control Profiles, July 2018*

The rate of smoking attributable hospital admissions in Leicester is significantly higher than the national rate and is equivalent to over 2,800 admissions per year. Figure 7 (below) displays the smoking attributable hospital admissions per 100,000 of the population (35+).

Figure 7: Smoking attributable hospital admissions 2009 - 2017

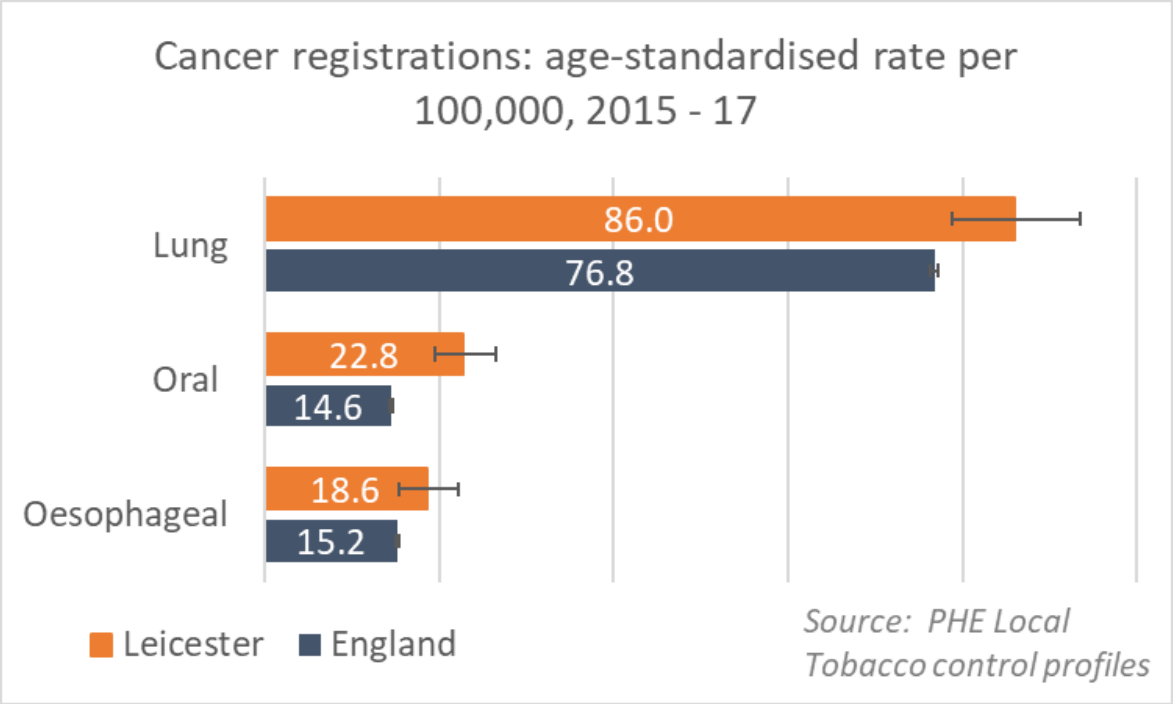


Data: *PHE – Local tobacco control profiles, July 2019*

Note: Smoking attributable hospital admissions uses an algorithm using underlying cause of death and smoking prevalence. Leicester's smoking prevalence from Integrated Lifestyle survey shows increases in 2013, 2015 which could account for increase in hospital admissions.

Smoking increases risk of cancers and is heavily linked to lung cancer, oral cancer and oesophageal cancer. Registrations for lung cancer and oral cancer in Leicester are significantly higher than England.

Figure 8: Cancer registration rate per 100,000 population, 2015-17



Data: *PHE – Local Tobacco Control Profiles*

4 CURRENT SERVICES IN RELATION TO NEED

4.1 SUPPORTING PEOPLE TO STOP SMOKING SUCCESSFULLY

From 1st July 2019 the *Stop* smoking service became part of Live Well Leicester, an Integrated Lifestyle Service, which uses a holistic approach to offer smoking cessation & physical activity support via a centralised referral hub. Live Well Leicester offers all smokers in Leicester access to a trained advisor, who can offer behavioural support alongside a stop smoking medication. Smoking cessation clinics are run in a number of venues across the city including: GP practices, UHL and community venues; clustering where the need is greatest. Smokers who are motivated to quit attend the most convenient venue and formulate a quit plan with their advisor.

Over 2,400 smokers accessed the service in 2018/19 to set a quit date and over half of these (55%) successfully stopped smoking.[13] Government guidelines[14] recommend that at least 5% of smokers in the population should be accessing a smoking cessation service each year. Regular health equity audits of the service are conducted to ensure that it is accessed by those

people living in communities with high smoking prevalence. The stop smoking service is annually engaging more than 5% of the local smoking population and has a higher uptake for smokers in routine and manual occupations, those who are unemployed or sick/disabled and Black and Minority ethnic groups.

4.1.1 SUPPORTING PREGNANT SMOKERS AND THOSE WITH INFANTS TO STOP SMOKING

Live Well Leicester continues to deliver training to midwives and other workers in contact with pregnant women who smoke (for example, in Children's Centres), to strengthen the care pathway (an opt-out approach) for any woman who wants to stop smoking while pregnant. Families of pregnant smokers are also offered support.

Data for smoking at time of delivery shows an improving trend in Leicester to 2018/19 with statistically similar percentages to the England average of 10.6%.[12] In 2018/19, 561 (546 in 2017/18) referrals were made to the *stop smoking service* from maternity services, 203 smokers set a quit date and 97 successfully quit at 4 weeks. 48% success rate is lower than the average for the service as a whole, but the client group is harder to engage.[14] Nationally, 45% of pregnant smokers were successful quitters at 4 weeks.

4.1.2 PREVENTING YOUNG PEOPLE FROM TAKING UP SMOKING

Tobacco control has a preventative effect among young people, as it reduces the number of smoking role models and denormalises smoking in the world in which they grow up. Youth targeted work varies significantly in cost and effectiveness. Low cost interventions such as supporting a school smokefree policy and educational content have been implemented; but engagement with schools varies. High cost peer led interventions are not delivered locally, as evidence shows that supporting adults to stop smoking has a greater preventative effect[15].

4.1.3 ENGAGING HARD TO REACH GROUPS – ROUGH SLEEPERS

The STOP service undertook a pilot project to gain a deeper understanding of some of the challenges faced by rough sleepers. This group experienced a range of poor health and wellbeing outcomes linked to mental health, social engagement, education, substance misuse, and physical disability. It was discovered that this group would benefit from a harm reduction approach as coming off all nicotine was an unrealistic challenge for them. Taking these findings on board we decided to offer a free e-cigarette to everyone who attended our stop smoking drop in sessions of which 45% showed a significant reduction in harm by carbon monoxide breath test and a further 20% successfully managed to stop smoking.

4.1.4 TACKLING CHEAP AND ILLICIT TOBACCO

Counterfeit, cheap and illicit tobacco have not been subjected to the same stringent testing for quality control and regulation that governs tobacco generally and therefore may contain even more harmful chemicals and toxins than are permitted by these tests. There is also concern that children and young people, and our most deprived residents may be easier to target by the low price of illicit cigarettes, and they may therefore act as an easier gateway into smoking.

Tackling illicit tobacco is delivered by Leicester City Council's business regulation department. This activity restricts availability of cheap and illegal tobacco, which often undermines the effect of price rises and health warnings. Activities include surveillance of local markets in illicit sales and sharing of intelligence on supply chains, in collaboration with HMRC and police. Regulation of tobacco products is intelligence-led and involves under age test purchasing and enforcement of the health warning requirements on retail sales and supplies.

4.1.5 TOBACCO HARM REDUCTION

People who are not ready or are unwilling or unable to stop smoking in one step, are offered a harm-reduction approach, as recommended by NICE guidance. This involves long term management of withdrawal and nicotine use beyond the treatment period.

Leicester was the first city nationally to become e-cigarette friendly, launched on national No Smoking Day in March 2014. This welcomed smokers to use e-cigarettes to stop smoking. In 2018/19 Leicester results showed an increase of 15% success rate for those using an unlicensed nicotine containing product (vaping device 65%) compared to a licenced medication (49%). In 2015 the Leicester smoking cessation service was part of large-scale research, Trial of Electronic Cigarettes (TEC) which looked at the comparative effectiveness of nicotine replacement therapy and e-cigarettes. Clients that took part in the study were randomised to use an E-cigarette (EC) or Nicotine Replacement Therapy (NRT). The results of the study showed:

- At 52-week follow up, 18% of clients that used an E-Cigarette remained abstinent compared to 10% for those using NRT.
- The cost to the NHS for supplying NRT for a 3-month period £120.00 compared to a one-off cost for a starter kit and replacement parts at £30.25

Full report of the TEC study is available at
https://www.nejm.org/doi/full/10.1056/NEJMoa1808779

4.1.6 SMOKE-FREE HOMES AND CARS

'Step Right Out' is an intervention programme which aims to raise awareness about the dangers of second-hand smoke and encourage people to sign up to a 'Step Right Out' pledge to keep their home and car smoke-free. The number of Step Right Out pledges for Leicester City currently stands at 10,554. On average, 21% of people who sign the pledge, also request support to stop smoking.[13]

4.1.7 SECONDARY CARE (ACUTE AND MENTAL HEALTH)

University Hospitals of Leicester has been funded for enhanced training to identify life-long smokers (particularly with cardiac and respiratory diseases) and offer referral to stop smoking services. *Live Well Leicester* runs clinics at the Leicester Royal and Glenfield General Hospital site for patients, staff and general public.

We are currently supporting Leicestershire Partnership NHS Trust to implement their Smoke-free Strategy, this includes representation at the quarterly Smoke Free Alliance Group.

'People with a mental health condition are just as likely to want to stop smoking as those without but are more likely to be heavily addicted to smoking and more likely to anticipate difficulty stopping smoking. There is an urgent need to address the widening inequalities which remain from stubbornly high smoking rates among this population. Routine identification of smokers in mental health services with systematic offers of evidence-based support, reflective of NICE guidance PH48, is essential to reducing this gap.' [8]

4.1.8 SMOKELESS TOBACCO

Live Well Leicester has the expertise to deliver treatment for smokeless tobacco in accordance with NICE guidance. Demand is low in comparison to cigarette smoking. All Leicester City GP's have been advised to refer clients who wish to stop using smokeless tobacco to the service. The clients are supported by an upskilled advisor who has the expertise to treat smokless tobacco service users.

4.1.9 MARKETING AND AWARENESS

Live Well Leicester promotes its services through face-to-face networks, training, briefing customer services, Making Every Contact Count, which involves training staff in public service organisations in Brief Interventions 'Ask, Advise, Act'. It produces clear, coherent and tested printed material, makes use of local and national media and supports and uses national campaigns, for example, "Stoptober".

4.1.10 TOBACCO CONTROL COORDINATION

Using national policy, scientific evidence and local data, the local programme is coordinated via the Tobacco Control Alliance which is a strategic group, jointly chaired by Leicester City Council and Leicestershire County Council. The group meets quarterly and monitors historic and planned activity across all themes highlighted above.

5 PROJECTED SERVICES USE AND OUTCOMES IN 3-5 YEARS AND 5-10 YEARS

Nationally and locally the number of people accessing stop smoking services has steadily fallen since its peak in 2011/12. People accessing the service in Leicester has fallen from over 6,000 in 2011/12 to about 2,400 in 2018/19. Local quit rates have remained consistent at around 50% indicating that the quality and effectiveness of services remains high.[11]

It has been suggested that this reduction is due to a shift in the smoking landscape. As there are, however, still almost seven million smokers in England,[2] local stop smoking services remain an important and effective clinical intervention, particularly among those experiencing health inequalities and for vulnerable groups. The following factors have contributed to the decrease in demand for smoking cessation services:

- The temporary withdrawal of national mass media campaigns and then a reformulation which placed less of an emphasis on stimulating uptake of local stop smoking services
- The increasing use of e-cigarettes by smokers who are trying to stop or cut down

Figures 9a and 9b (below) show the national trend is broadly mirrored in Leicester, although the decline has been slightly less locally than the England average. The rate of quit attempts per 100,000 smokers and rate of successful quits has consistently been significantly higher in Leicester compared to the national picture.

Figure 9a: Smokers setting a quit date per 100,000 smokers 2013-2019

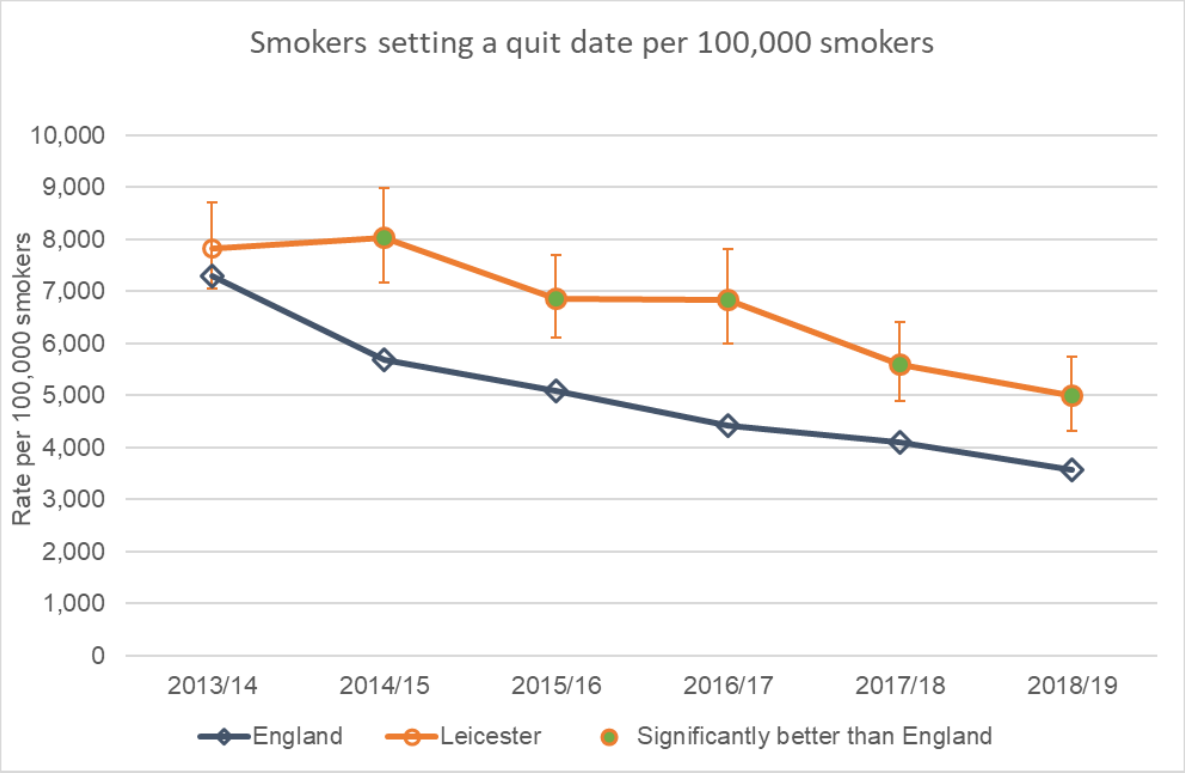
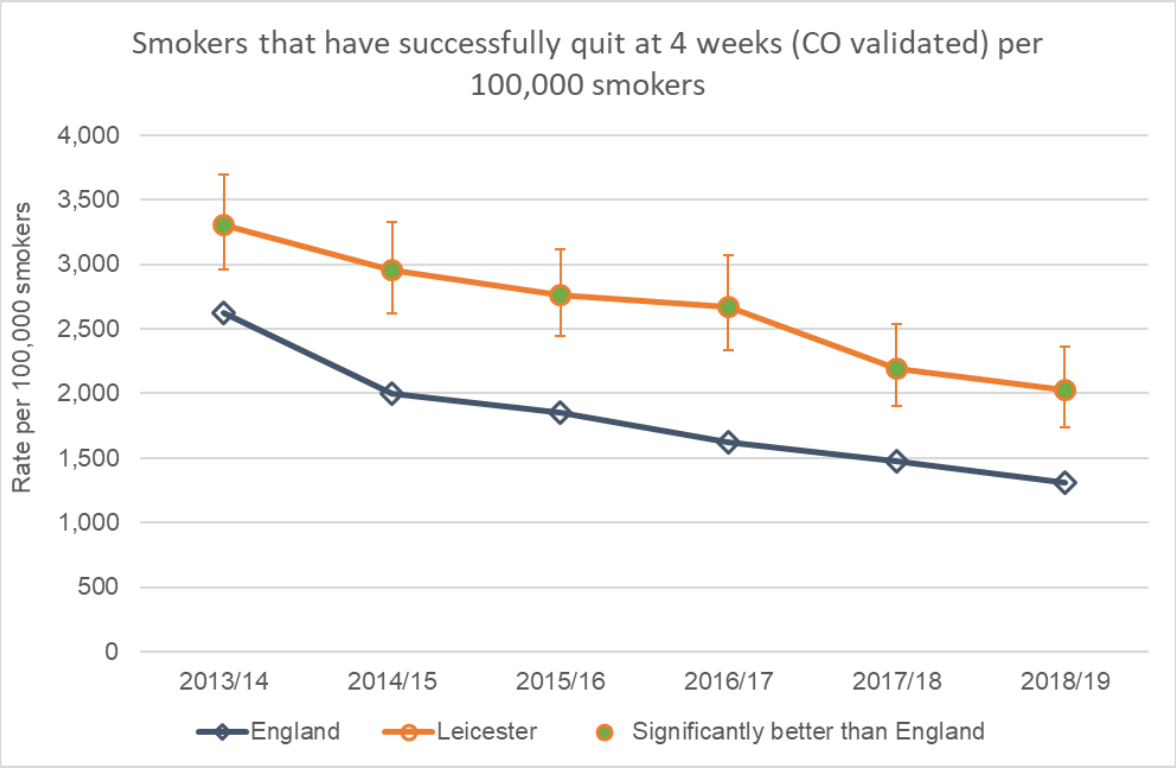

Smokers setting a quit date per 100,000 smokers
Rate per 100,000 smokers
10,000
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
2013/14
2014/15
2015/16
2016/17
2017/18
2018/19
England
Leicester
Significantly better than England

Figure 9b: 4 week quit rates per 100,000 smoking population



Data: *Public Health England Local Tobacco Control Profiles:*
https://fingertips.phe.org.uk/profile/tobacco-control

Communications and marketing effective incentives and methods to quit smoking to the local population, remains an important part of stimulating quit attempts. Encouraging people to quit via the stop smoking service or other proven methods, which fit their needs, remains a priority. It is known that smoking prevalence varies across the city and services will therefore need to continue to be concentrated in areas that are most accessible for those groups with a higher than average smoking prevalence.

6 UNMET NEEDS AND SERVICE GAPS

As the rate of smoking falls, those who still smoke are more entrenched in tobacco dependency. Therefore, success rates of engagement and subsequent quitting are likely to be lower and harder to obtain. Engaging with these populations requires sustained and concerted efforts to reduce health inequalities.

Uptake of the services by different population groups is regularly reviewed and new approaches sought to promote and encourage use of stop smoking services. Niche tobacco products, such as smokeless tobacco and waterpipe smoking, remains a minority activity in

comparison to cigarette smoking. We will continue to monitor use in relation to these products and prioritise efforts according to the risks from all types of tobacco use in Leicester.

7 RECOMMENDATIONS FOR CONSIDERATION BY COMMISSIONERS

Continue to invest in high quality stop smoking services.

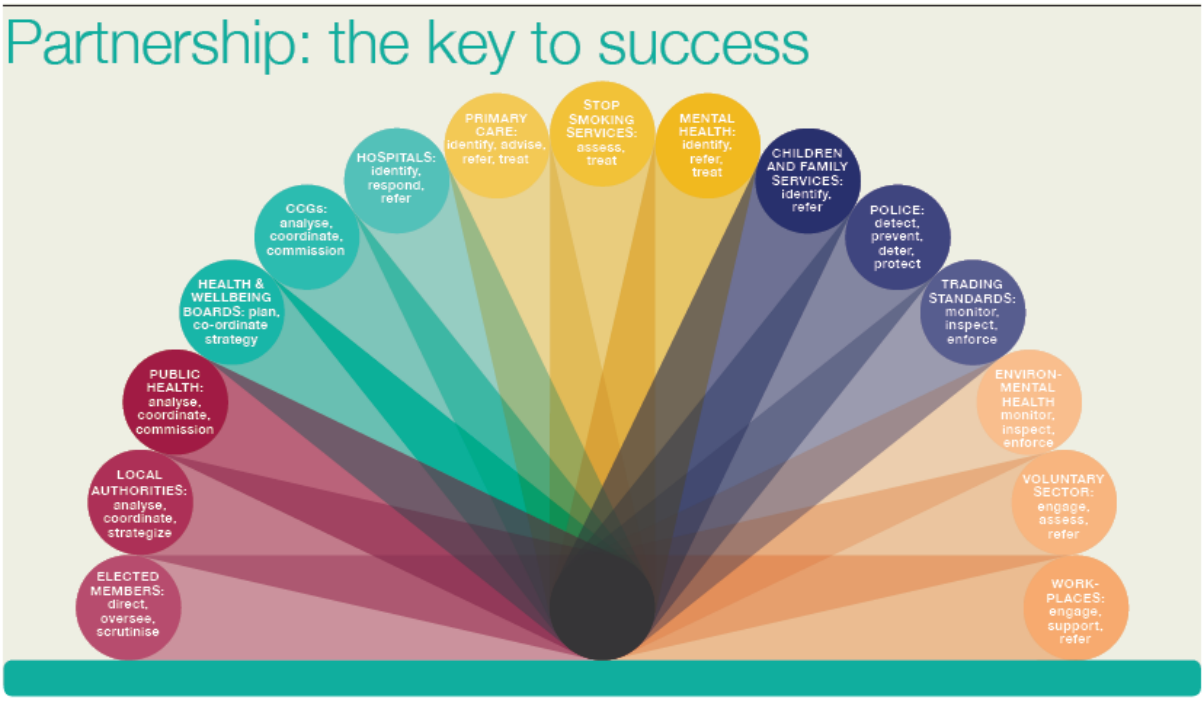
Ensure commissioned services provide high-quality, evidence-based support to those people who require it the most.

Ensure services offer support to adults who want to quit, thereby also preventing young people from taking up smoking.

Ensure commissioned services offer harm reduction interventions for those who are not able to or do not wish to stop in one step to move them closer to becoming smoke-free.

Provide tailored and targeted support for priority groups to stop smoking**.** All pregnant women who smoke, those who are planning a pregnancy or who have an infant aged less than one year, those with long-term conditions and people with poor mental health are all priority groups for stopping smoking. Investment and concerted efforts to influence and encourage them to stop smoking will result in better outcomes and reduced healthcare costs.

Local authority public health commissioners need to work closely with all relevant partners to coordinate and where appropriate commission high-quality, evidence-led, comprehensive tobacco control interventions, including tackling the demand and supply of illegal tobacco, increasing the number of smoke-free environments, and educating the public about the harms of niche products such as smokeless/chewed tobacco and shisha.



Source: *PHE. Comprehensive local tobacco control: Why invest?*

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