For feedback, please contact Sandie.Harwood@leicester.gov.uk Last updated 14-Mar-16 Review date 30-Apr-17

Tobacco

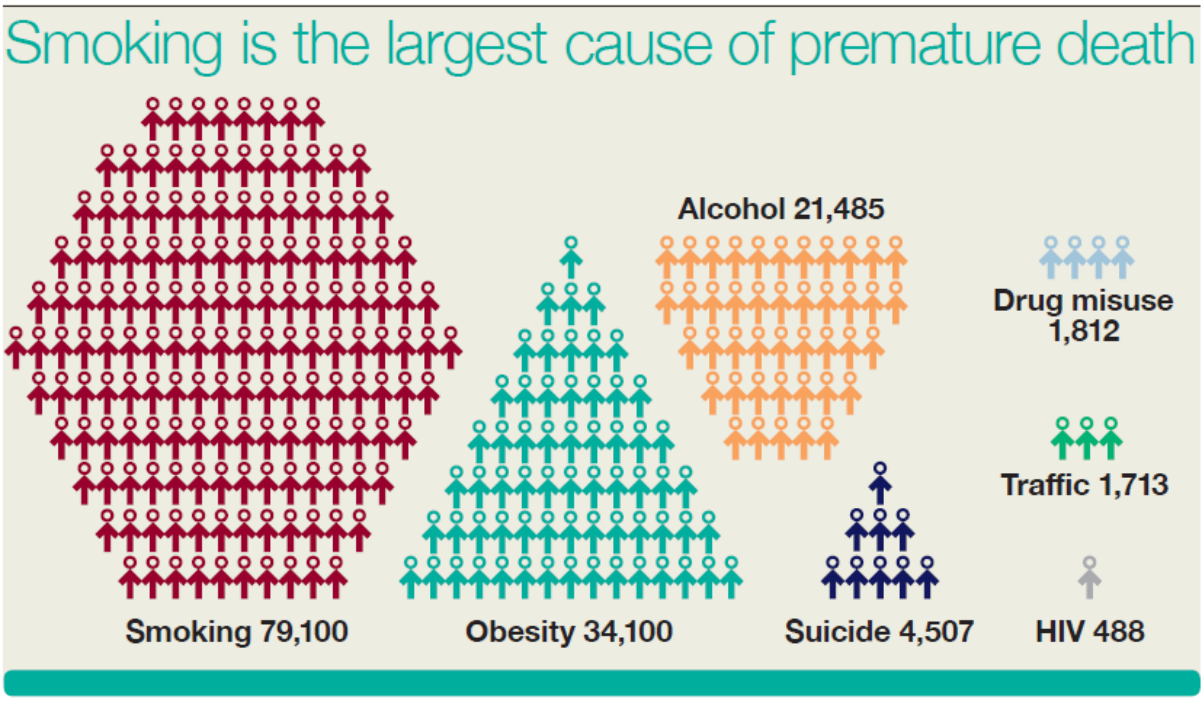
Introduction

This constitutes the full section on Tobacco for the Adults' JSNA 2016.

Who's at risk and why?

Tobacco and death

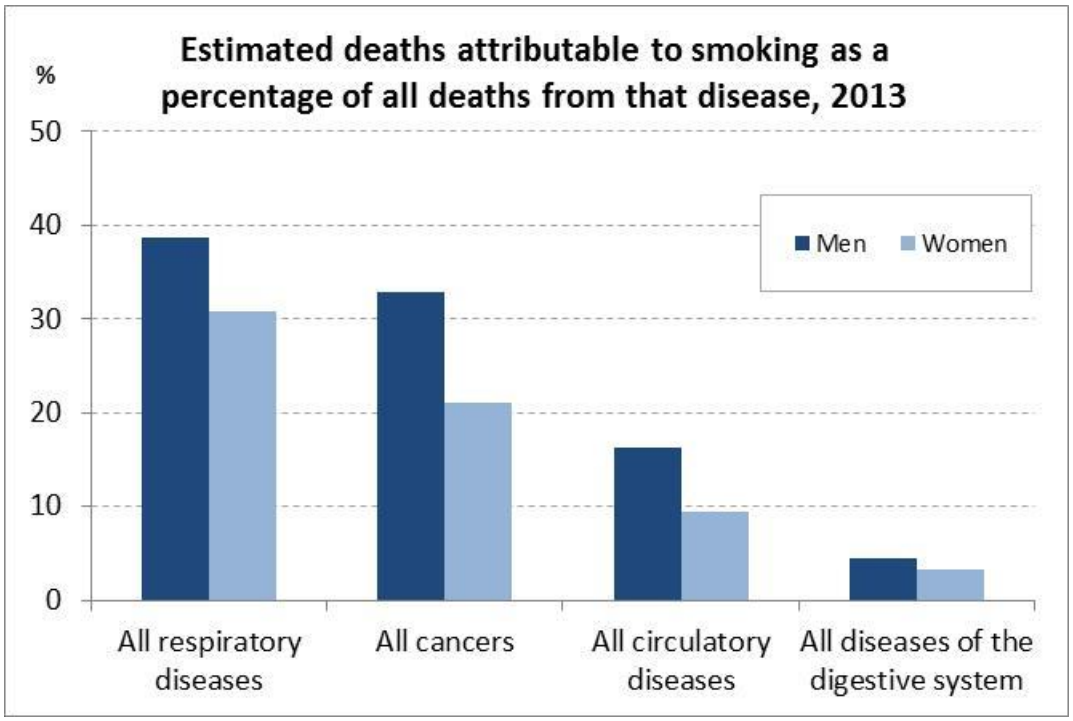
Tobacco use is the single greatest cause of preventable deaths in England – killing approximately 80,000 people per year (see graphic below). This is greater than the combined total of preventable deaths caused by obesity, alcohol, suicide, traffic accidents, illegal drugs and HIV infections (1, 2). 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 (5).



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

Figure 1 shows that in 2013, there were a total of 463,986 deaths of adults aged 35 and over in England, 78,200 (17%) of which were estimated to be attributable to smoking. It is estimated that in 2013, 35% (23,800) of all deaths due to respiratory diseases and 28% (36,800) of all cancer deaths were attributable to smoking. In addition, an estimated 13% (16,700) of deaths from circulatory diseases and 4% (900) of deaths from diseases of the digestive system were attributable to smoking (3).

Figure 1: Estimated deaths attributed to smoking as a percentage of all deaths from that disease, 2013, England



Data: *Health and Social Care Information Centre: Statistics on Smoking, 2015*

An estimated 85% of deaths from chronic obstructive lung disease were attributable to smoking. This compares with 81% of deaths from trachea, lung and bronchus cancer, which translates to the largest number of deaths of any disease (around 22,800). There were an estimated 18,900 smoking attributable deaths as a result of chronic airway obstruction, which accounted for 77% of observed deaths from this disease and the second largest number of smoking attributable deaths of any disease.

An estimated 79% of deaths from cancers of the larynx, 65% of deaths from cancers of the oesophagus, 63% from cancers of the upper respiratory sites and 58% from aortic aneurysms were attributable to smoking. A larger proportion of deaths among men than women were attributable to smoking, with an estimated 21% (47,200) of all deaths among men aged 35 and over being attributable to smoking. This compares with 13% (31,000) of all deaths among women(3).

Table 1 shows all deaths among adults aged 35 and over in England and deaths from diseases which can be caused by smoking, the estimated number of deaths that can be attributed to smoking and the percentage of deaths that can be attributed to smoking.

Table 1: International Classification of Diseases (ICD10) diagnoses against observed and attributable deaths, by number and proportion

Cause of death	Total		
	Observed deaths	Attributable number	Attributable percentage
All deaths	463,986	78,200	*17*
All cancers	134,969	36,800	*27*
All respiratory diseases	68,891	23,800	*35*
All circulatory diseases	129,968	16,700	*13*
All diseases of the digestive system	22,458	900	*4*
All deaths which can be caused by smoking	**241,683**	**78,200**	***32***
Cancers which can be caused by smoking	**67,194**	**36,800**	***55***
Trachea, Lung, Bronchus	28,521	22,800	*80*
Upper Respiratory Sites	2,059	1,300	*63*
Larynx	649	500	*79*
Oesophagus	6,324	4,100	*65*
Cervical	663	100	*11*
Bladder	4,226	1,600	*38*
Kidney and Renal Pelvis	3,423	800	*23*
Stomach	3,733	700	*20*
Pancreas	7,082	1,600	*23*
Unspecified site	8,019	2,800	*35*
Myeloid Leukaemia	2,495	400	*16*
Respiratory diseases which can be caused by smoking	**50,233**	**23,800**	***47***
Chronic Obstructive Lung Disease	1,135	1,000	*85*
Chronic Airway Obstruction	24,462	18,900	*77*
Pneumonia, Influenza	24,636	4,000	*16*
Circulatory diseases which can be caused by smoking	**122,417**	**16,700**	***14***
Other Heart Disease	22,901	2,900	*13*
Ischaemic Heart Disease	59,165	7,600	*13*
Other Arterial Disease	2,471	400	*17*
Cerebrovascular Disease	32,274	2,500	*8*
Aortic Aneurysm	5,448	3,200	*58*
Atherosclerosis	158	0	*18*
Diseases of the digestive system which can be caused	**1,839**	**900**	***47***
Stomach / Duodenal Ulcer	1,839	900	*47*

Data: *Health and Social Care Information Centre: Statistics on Smoking, 2015*

Tobacco and health

There are many medical conditions associated with or aggravated by smoking, which may not be fatal but still cause years of debilitating illness. These include:

Heart and circulation:
Angina, Buerger's Disease (severe circulatory disease), Peripheral vascular disease.

Respiratory:
Asthma, Common cold, Chronic rhinitis (inflammation of nose), Influenza, Tuberculosis.

Stomach/digestive system:
Colon polyps, Crohn's disease (chronic inflamed bowel), Duodenal ulcer, Stomach ulcer.

Mouth:
Acute necrotizing ulcerative gingivitis (gum disease), Tooth loss, Tooth discolouration.

Ligaments, muscles and bones:
Ligament, tendon and muscle injuries, Neck and back pain, Osteoporosis (in both sexes), Rheumatoid arthritis (in heavy smokers).

Eyes:
Cataract, Macular degeneration, Nystagmus (abnormal eye movements), Optic neuropathy (loss of vision), Ocular histoplasmosis (fungal eye infection), Tobacco Amblyopia (loss of vision), Diabetic retinopathy, Optic neuritis.

Skin:
Psoriasis, Skin wrinkling.

Reproductive functions:
Female fertility (30% lower), Menopause (onset 1.74 years earlier on average), Male fertility (Impotence, Reduced sperm count and motility, sperm less able to penetrate the ovum, increased shape abnormalities).

Other:
Depression, Hearing loss, Multiple sclerosis, Type 2 Diabetes (6).

Prevalence (England)

There are about 8 million adults who smoke cigarettes in Great Britain, 19% of the total population. Levels of smoking vary across different population groups.

Unemployed people (35%) (not working but seeking work) were almost twice as likely to smoke as those either in employment (19%) or economically inactive (16%) (for example, students or retired people). 11.4% of mothers were recorded as smokers at the time of delivery for 2014/15 (4), which is lower than 2013/14 (12.0%) and continues the steady year-on-year decline in the percentage of women smoking at the time of delivery from 15.1% in 2006/07.

Among 11 to 15 year olds in 2013, less than a quarter of pupils reported that they had tried smoking at least once. At 22%, this is the lowest level recorded since the data were first collected in 1982, and continues the decline since 2003, when 42% of pupils had tried smoking. Regular smokers aged 11 to 15 years consumed, on average (mean), 31.1 cigarettes a week. Occasional smokers consumed

3.4 cigarettes a week in 2013.

All Adults (16+)

Gender:

- 22% of adult men and 17% of adult women were smokers
- Among men smoking prevalence was highest in the 25-34 age group (30%). Among women, smoking was highest at 20% for 20-49 year olds (3)

Pregnant women

- Prevalence of smoking in at the time of delivery was 11.4% in 2014/15 (4)

'There are significant demographic differences and factors associated with inequalities related to [smoking in pregnancy by those with infants]. For instance, pregnant mothers under the age of 20 are more than three times as likely to smoke as mothers aged 35 or over. Those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke throughout pregnancy (29% and 7% respectively). Infants born to smokers are much more likely to become smokers themselves, which further perpetuates health inequalities.' (9)

Young People

- Current smoking by 15 year olds was 8.2% in 2014/15, with 5.5% of 15 year olds smoking regularly (8)

Socio-economic status:

- 14% of adults in managerial and professional occupations smoked compared with 29% in routine and manual occupations (3)

'Two adult smokers with 20-a-day habits are likely to spend over £5000 per year on cigarettes.
Workers in routine and manual jobs are 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.' (9)

Marital status:

- Those who identified as single or cohabiting had higher rates of smoking (27% and 29%) than those who were married (13%) (3)

Age:

Table 2 shows that those aged 16-24 and 25-34 years had highest prevalence of cigarette smoking at 23% and 25% respectively. The lowest prevalence was in those aged 60 and over (11%). In all ages, smoking prevalence is higher in men than women. (3)

Table 2: Proportion of people aged 16 and over who smoke cigarettes in Great Britain, 2013

Age group	Men	Women	All persons
16-24	26	20	23
25-34	30	20	25
35-49	24	20	22
50-59	20	19	19
60 and over	12	10	11
All aged 16 and over	**22**	**17**	**19**

Data: *Health and Social Care Information Centre: Statistics on Smoking 2015; General Lifestyle Survey*

The level of need in the population

Smoking prevalence in Leicester by gender, age and ethnic group

Local estimates of smoking taken from the Leicester Health and Wellbeing Survey 2015 show 21.5% of people in Leicester aged 16 and over smoked. The majority of people (62%) reported as never having smoked, with 16% reporting as ex-smokers.

The proportion who have smoked neither a cigarette or vaped an e-cigarette was highest amongst females (66%), those aged 16-24 (70%), BME residents (65%), and Hindus (82%), Muslims (81%) or Sikhs (85%). (9)

Table 3 shows that smoking levels are higher in men than women, highest in under 25-34 year olds and in those of white ethnic groups, as shown in Table 3 below.

Table 3: Smoking prevalence estimates in Leicester 2015

Category		Smoking prevalence
Gender	Males	23.5%
	Females	19.1%
Age	16-24	19.3%
	25-34	27.4%
	35-54	22.6%
	55+	16.4%
Ethnic group	White	28.5%
	Asian/Asian British	11.7%
	Black/Black British	12.7%
	All BME (non-white)	13.0%

Data: *Leicester Health and Wellbeing Survey, 2015*

Prevalence by area

Smoking prevalence in Leicester varies across different communities in Leicester. The Leicester Health and Wellbeing Survey of 2015, showed that smoking prevalence was generally higher in the more white population living in areas of high deprivation in the west of Leicester and lower in the areas in the east of Leicester with predominantly South Asian communities.

'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, well-off smokers are much more likely to succeed.' (1)

Prevalence in other groups

- **Smoking in pregnancy**
  The prevalence of smoking during pregnancy in Leicester in 2014/15 was 11.8%, which is similar to the national rate of 11.4% (4)
- **Smoking among routine and manual workers**
  The prevalence of smoking among routine and manual workers in Leicester in 2014 was 29%, which is higher than the national rate of 28% (4)
- **Young people**
  According to the new national 'What about youth' survey, regular smoking among 15 year olds in Leicester is 3.5% and occasional smoking is 1.4%; the lowest in the East Midlands (7).

Nationally around 80% of prisoners smoke compared with just under 20% 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.(9)

Some 2% of Leicester residents who took part in the Health and Wellbeing Survey 2015 reported using Sheesha or Hookah. These products were more popular than average amongst younger residents, aged 16-34 (5%), BME residents (3%) or Muslim residents (5%). 1% of residents said they smoked cigars – the proportion was highest amongst male residents (2%). A smaller minority of residents reported using other tobacco products such as paan, gutka and bidi, but the numbers were too low to calculate an accurate percentage.
The Tobacco Control Coordination Group has a separate brief report on shisha users and cafes, entitled *Challenges of waterpipe smoking in Leicester.* This can be found as a download in the Tobacco summary web section of the this JSNA.

Smoking behaviour and attitudes in Leicester

- 60% of smoker smoked between 1 and 10 cigarettes a day and 32% smoked between 11 and 20
- 74% of smokers had tried to quit and of these, the following services had been used: GP or nurse (27%), pharmacies (14%), Leicester NHS Stop smoking service (12%), Smokefree website or telephone helpline (3%), other (7%). The majority (53%), did not try using any service for their quit attempt
- 74% of ex-smokers quit smoking without assistance. The remaining ex-smokers did so using; nicotine replacement products (9%), e-cigarettes (8%), medication prescribed by a GP (4%) and support from the Leicester NHS Stop smoking service (4%)
- The majority of smokers (61%) wanted to give up smoking and 33% did not. 7% of smokers did not know whether they wanted to quit smoking or continue
- The main reasons for wanting to quit were health (92%) and family (38%)
- Among those trying to cut down their smoking, the majority did not use any aid (60%),

others used e-cigarettes (27%), nicotine replacement products (13%) and 4% used other methods

- 93% of people said they would be confident to ask someone not to smoke in their home

Table 4 shows that there has been substantial change in smokers' motivations for wanting to quit since the 2010 survey of Leicester residents. When compared to 2010 responses, the responses in 2015 showed a higher proportion of smokers citing health, financial and family as reasons for wanting to quit, as is shown below:

Table 4: Question: What are your main reasons for wanting to give up smoking?

Reason	2010	2015
Better for my health in general	68%	87%
Financial reasons	23%	44%
To reduce the risk of getting smoking related illnesses	22%	33%
Worried about the effect on my children	16%	23%
Makes house or clothes smell worse	1%	21%
Family/friends want me to stop	5%	18%
Worried about the effect on other family members	5%	13%

Data: *Leicester Health and Lifestyle Survey, 2010 and Leicester Health and Wellbeing Survey, 2015*

'A survey of 1,000 young people aged 8-13, undertaken on behalf of the Department of Health in October 2011, demonstrated that children want smokefree lives. It found that: 98% of children wish their parents would stop smoking; 82% of children wish their parents wouldn't smoke in front of them at home; 78% of the children wished their parents wouldn't smoke in front of them in the car; 41% of children said cigarette smoke made them feel ill; 42% of children said cigarette smoke made them cough' (9)

Smoking related deaths and hospital admissions

Deaths and hospital admissions attributable to smoking in Leicester

In Leicester there are, on average, 372 deaths per year attributable to smoking; of these 53 contributed to Coronary Heart Disease. There were an average of 135 deaths per year from lung cancer and 119 deaths from Coronary Obstructive Pulmonary disease (COPD).

Table 5: Smoking attributable mortality and hospital admissions rates (directly age-standardised rates per 100,000)

Indicator		Age	Leicester average number per year	Leicester rate	England rate
Deaths from lung cancer	2012 - 14	All ages	135	64	60
Deaths from chronic obstructive pulmonary disease	2012 - 14	All ages	119	56	52
Smoking attributable mortality	2011 - 13	35+ yrs	372	293	289
Smoking attributable deaths from heart disease	2011 - 13	35+ yrs	53	40	33
Smoking attributable deaths from stroke	2011 - 13	35+ yrs	16	12	11
Smoking attributable hospital admissions	2013/14	35+ yrs	2413	1794	1645

Data: *Local Tobacco Control Profiles, Nov 2015 (http://www.tobaccoprofiles.info/profile/tobacco-control/data)*

Smoking attributable deaths:

- The rate of smoking attributable deaths in over 35 year olds in Leicester is similar to the national rate. This equates to around 370 deaths per year. The majority of these are due to lung cancer, chronic airway obstruction and ischaemic (coronary) heart disease (4).

- Smoking attributable deaths from heart disease in Leicester are significantly higher than the national rate.

Smoking attributable hospital admissions:

- The rate of smoking attributable hospital admissions in Leicester is significantly higher than the national rate, and is equivalent to over 2,400 admissions per year. The majority of these are due to chronic airway obstruction, lung cancer and ischaemic heart disease.

Cancer

Smoking increases risk of cancers. In Leicester between 2011 and 2013 there were:

- 186 registrations of breast cancer per year
- 165 lung cancer registrations per year
- 140 colorectal cancer registrations per year
- 103 prostate cancer registrations per year

Current services in relation to need

Supporting people to stop smoking successfully

The Stop smoking service is the main, local provider in Leicester. It offers all smokers in Leicester access to a trained advisor, who can offer behavioural support alongside a stop smoking medication of the person's choice. Smoking cessation clinics are run in a number of venues across the city including: pharmacies, GP practices, 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 4,000 smokers accessed the Stop service in 2014/15 and just over 2,000 people were helped to stop smoking. 8% of smokers in Leicester accessed Stop in 2013/14. Government guidelines are that at least 5% of smokers in the population should be accessing a smoking cessation service each year. Regular health equity audits of the Stop Smoking service are conducted to ensure that it is accessed by those people living in communities with high smoking prevalence.

Supporting pregnant smokers and those with infants to stop smoking

Stop delivers 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 needs to stop smoking while pregnant, and her family. Stop has developed a network of community pharmacies upskilled to deliver smoking cessation for pregnant women, in order to maximise the opportunities to stop smoking.

Data for smoking at time of delivery for 2014/15 shows an improving trend in Leicester at 11.8%, close to the average for England of 11.4%. In 2014/15, 596 referrals were made to Stop from maternity services, 207 smokers set a quit date and 73 successfully quit at 4 weeks. 35% success rate is lower than the average for the service as a whole, but is reflective of the client group, who are harder to engage.

Preventing young people from taking up smoking

All 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 reducing smoking in the community is thought to have a greater preventative effect.

Tackling cheap and illicit tobacco

This 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 market 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.

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 no-smoking day March 2014. This welcomed smokers to use e-cigarettes to stop smoking. Results showed 20% improvement in stop smoking for those using e-cigarettes on their own or in combination with nicotine replacement therapy. Leicester is part of large scale research trial looking at the comparative effectiveness of nicotine replacement therapy and e-cigarettes.

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 smokefree. The number of Step Right Out pledges for Leicester City currently stands at 7,550. On average, between 21% to 25% of people who sign the pledge, also request support to stop smoking.

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. Stop runs clinics at every hospital site for patient staff and visitors. There has been a substantial rise in referrals from hospitals in recent years.

As part of the development of Leicestershire Partnership NHS Trust's Smokefree Strategy, Stop has set up a comprehensive training programme for staff, especially in mental health wards, and supports the delivery of smoking cessation treatments on hospital wards.

'Smoking is around twice as common among people with mental health problems and even higher in those with more severe disease.43 With up to three million smokers in the UK, 30% of them have evidence of mental disorder and up to one million have long-standing disease. A third of all cigarettes smoked in England are smoked by people with a mental disorder. In contrast to the marked decline in smoking prevalence in the general population, smoking among those with mental disorders has changed little, if at all, over the past 20 years. Smokers with mental disorders are just as likely to want to stop as those without, but are more likely to be heavily addicted smoking, more likely to anticipate difficulty stopping smoking, and historically much less likely to succeed in any attempt.' (9)

Smokeless tobacco

The Stop service has the expertise to deliver treatment for smokeless tobacco in accordance with NICE guidance. Demand is low in comparison to cigarette smoking. The service is marketed in areas where smokeless tobacco use is likely to be more prevalent.

Marketing and awareness

Stop 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 media and supports and uses national campaigns, for example, "Stoptober".

Tobacco control coordination

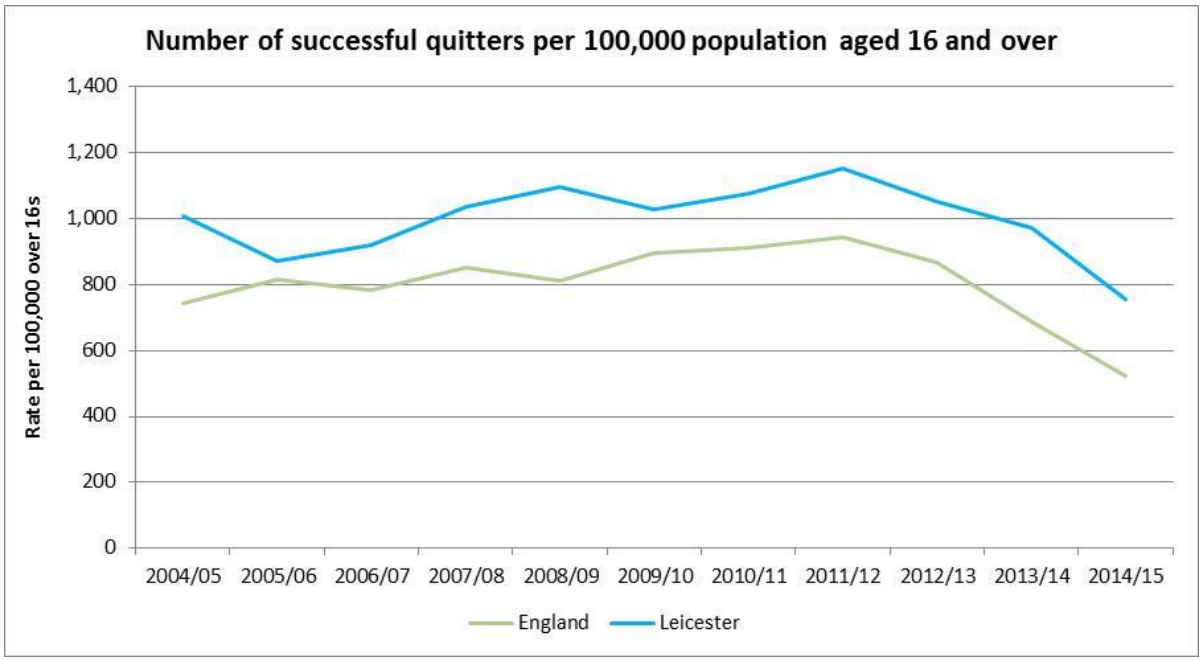
Using national policy, scientific evidence and local data, the local programme is coordinated via the Tobacco Control Coordination Group. The group meets quarterly and monitors historic and planned activity across all themes highlighted above.

Projected services use and outcomes in 3-5 years and 5-10 years

Figure 2 shows that nationally, the number of people accessing local stop smoking services has fallen since its peak in 2011/12, but local quit rates have remained consistent at around 50%, indicating that the quality and effectiveness of services remains high.

It has been suggested that this reduction is due to a shift in the smoking landscape, however as there are still almost eight million smokers in England, local stop smoking services remain an important and effective clinical intervention, particularly among those experiencing health inequalities and for vulnerable groups.

Figure 2: Numbers setting a quit date and successful quitters, April 2002 to March 2014



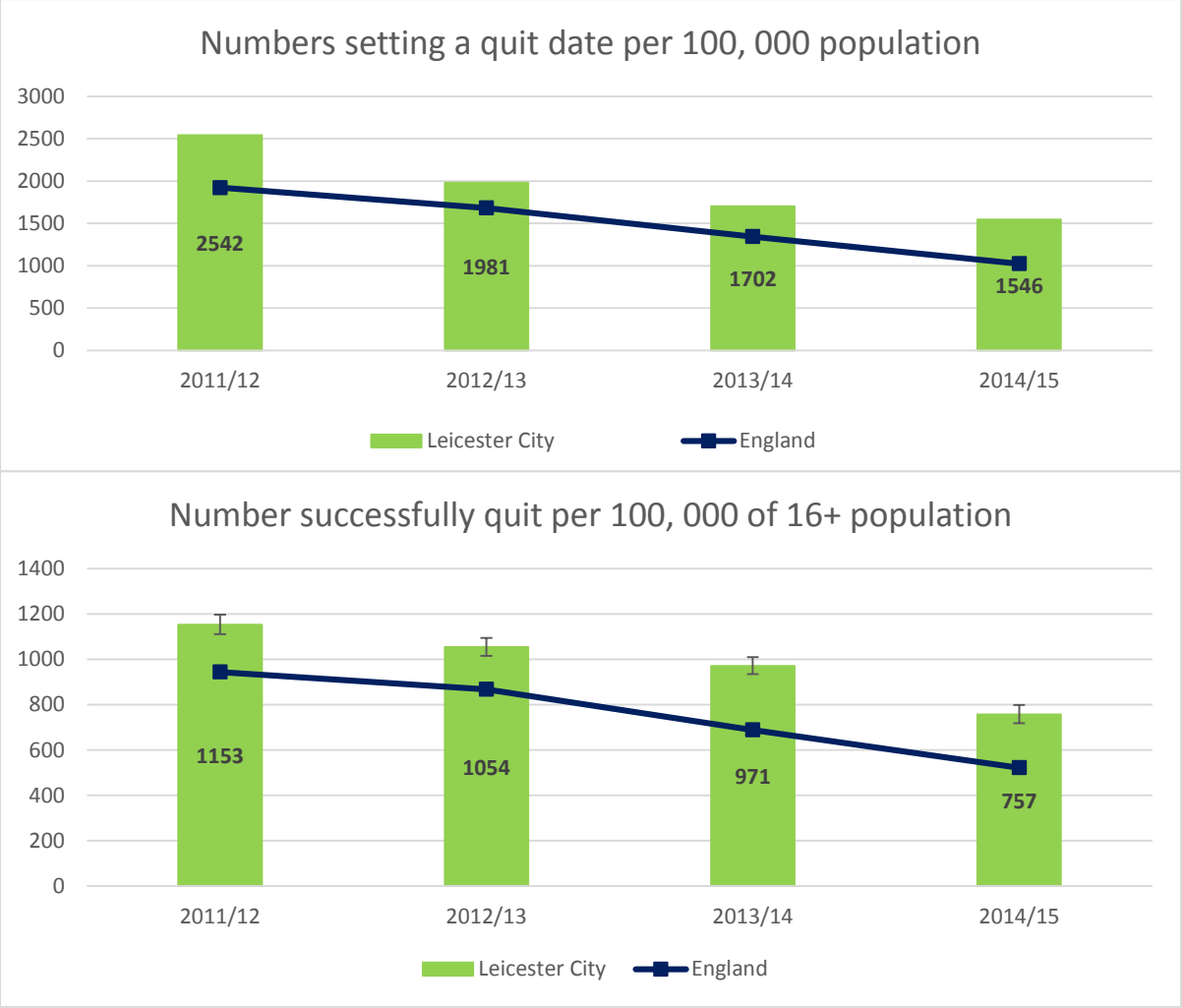
Source: *Health and Social Care Information Centre: Stop Smoking Service Statistics*

The following factors are likely to have contributed to the decrease in attendance:

- 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
- The impact of transition with public health moving to local authorities and changes in commissioning arrangements for stop smoking services

Figure 2a and 2b show that the national trend is broadly mirrored in Leicester, although the decline has been slightly less locally than the England average.

Figure 2a: Number setting a quit date per 1000,000 population, Leicester compared to England
Figure 2b: Number setting a quit date per 1000,000 population aged 16+, Leicester compared to England



Source: *Health and Social Care Information Centre: Stop Smoking Service Statistics*

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 be concentrated in areas that are most accessible for those groups with a higher than average smoking prevalence.

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.

Recommendations for consideration by commissioners

Page 15 from 'Building a strong future for our city Labour's Manifesto for Leicester 2015' states the following:

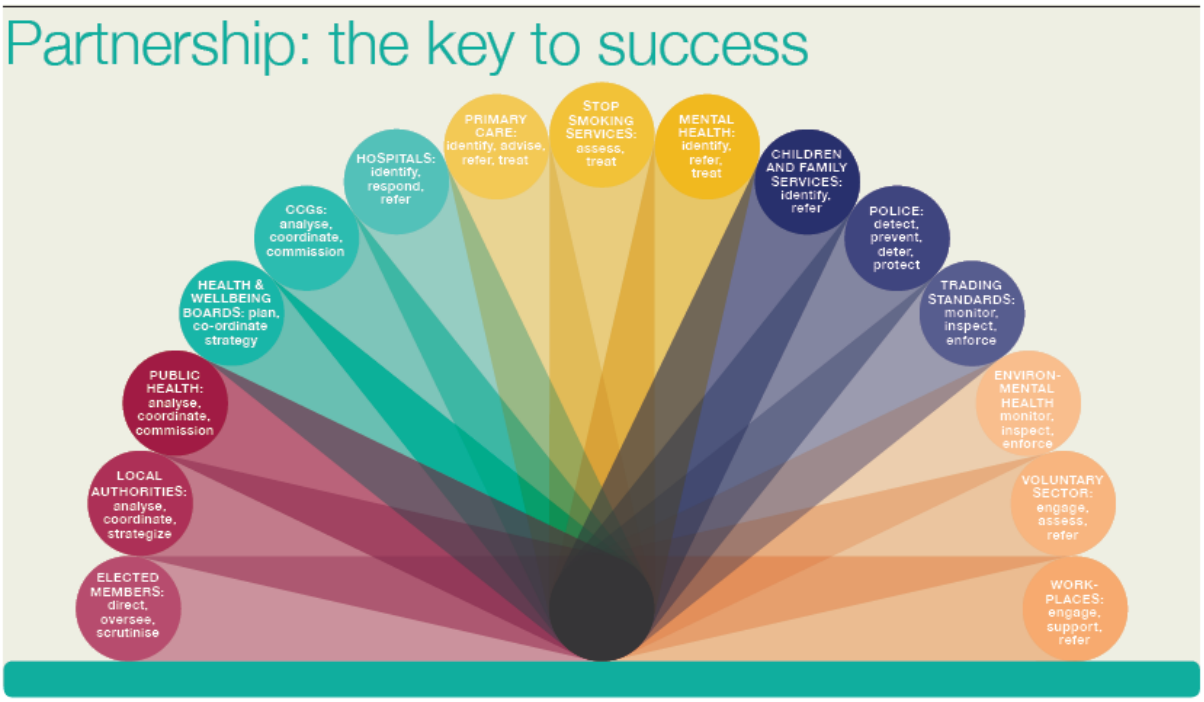
'We will continue to invest in Leicester's Stop Smoking Service. This service is now part of the City Council and will build links with other council services to improve access and take-up. We have called on the Government to introduce standardised cigarette packing to help bolster local efforts to support people who want to quit. Our priority is to support people who want to quit and to prevent young people from taking up smoking.'

Commissioners are recommended to:

- **Supporting Leicester people to stop smoking**
  The Council will continue to invest in Leicester's Stop Smoking Service. This is a targeted stop smoking service, providing high-quality, evidence-based support to those people who require it the most. The service is now part of the City Council and is building links with other council services to improve access and take-up. Our priority is to support adults who want to quit, thereby also preventing young people from taking up smoking. The best thing a smoker can do is to stop immediately, completely and permanently. However, not all smokers are able or wish to stop in one step, therefore harm-reduction interventions can move them closer to becoming smokefree.

- **Supporting 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.

- **Commissioning principles for comprehensive local tobacco control**
  Local authority public health commissioners will 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 smokefree 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?*

Key contacts

- Qasim Chowdary, Former Tobacco Control Lead, Leicester City Council
- Helen Reeve, Principal Public Health Analyst, Leicester City Council – helen.reeve@leicester.gov.uk

Input:

Louise Ross, Stop smoking service manager, Leicester City Council - louise.ross@leicester.gov.uk

References

1. PHE. Tobacco Control: JSNA Support Pack - Key data sources for planning effective tobacco control in 2016-17 - Leicester.

2. PHE. Comprehensive local tobacco control: why invest?

3. Health and Social Care Information Centre. Statistics on Smoking England 2015. 2015; Available from: http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf 4. Public Health England. Local Tobacco Control Profiles for England. Available from: http://www.tobaccoprofiles.info/ . -November 2015.

5. Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ. 2004 Jun 24;328(7455):1519.

6. ASPA. 50 Years of Progress: A Report of the Surgeon General, 2014. Available from: http://www.surgeongeneral.gov/library/reports/50-years-of-progress/50-years-of-progress-by-section.html

7. Health and Social Care Information Centre. Smoking, Drinking and Drug Use Among Young People in England - 2013. Available from: http://www.hscic.gov.uk/catalogue/PUB14579

8. Public Health Outcomes Framework [Internet]. Available from: http://www.phoutcomes.info/public-health-outcomes-framework#page/0/gid/1000042/pat/6/par/E12000004/ati/102/are/E06000015

9. Ipsos Mori. Leicester Health & Wellbeing Survey 2015.

10. PHE. Tobacco Control: JSNA Support Pack - Good practice prompts for planning comprehensive local tobacco control interventions in 2016-17 - Leicester.