Tobacco Control in Derbyshire: Health Needs Assessment – 2023 Update

Version control

Version 1.0	Updated data and sections	Public Health
Version 2.0	Editing	Public Health AD

This document is a 2023 update of the full HNA that was published in 2019 and is available here on the Derbyshire Observatory.

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Original authors of 2019 report:

Helen Johnston, Specialty Registrar in Public Health

Chris McManus, Advanced Practitioner (Epidemiology)

Contributors to 2023 update:

Joe Williams, Specialty Registrar in Public Health

Chris Craig, Knowledge and Intelligence Officer (Epidemiology)

Jenny Godfrey, Public Health Practitioner (Best start)

Hayley Gleeson, Public Health Lead (Strategic Intent)

Carol Ford, Public Health Lead (Best start)

Louise Noon, Public Health Lead (Tobacco Control)

Alex Carlow, Service Manager (Live Life Better Derbyshire)

Darran West, Group Manager (Health Improvement)

Thom Dunn, Assistant Director Public Health

Martyn Shore, Public Health Practitioner

Richard Flint, Advanced Public Health Practitioner (Epidemiology)

Steve Allen, Head of Trading Standards

Sue Morris, Knowledge and Intelligence Officer (Epidemiology)

Andrea Barber, Public Health Practitioner

For any further information please contact:

Louise.Noon@Derbyshire.gov.uk

Caveat on inclusive language

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

Contents

Executive summary

- Smoking represents the most important cause of preventable morbidity and mortality. In 2021 it was estimated that smoking accounted for approximately 74,600 deaths a year in England, and huge inequalities can be seen in smoking-related deaths. Tobacco accounts for the largest proportion of the gap in life expectancy between the most and least deprived areas for men (9.4 years) and women (7.6 years). Smoking is the single most important driver of health inequalities: a larger contributor to inequalities than social position.

- The prevalence of smoking in England has been gradually decreasing in recent decades. In 2022, an estimated 12.7% of the adult population smoked (14.6% of men and 11.2% of women) – a decrease from 19.8% in 2011. In 2022, an estimated 14.0% of adults in Derbyshire smoked. When compared to 15 similar local authorities, Derbyshire had the third highest smoking rate.

- Smoking in Derbyshire creates an estimated societal cost of £255.9 million each year. This includes an estimated £27.7m for treating smoking-related illness; £203.2 million in lost productivity, and more than £19.2 million in social care costs as a result of smoking related illnesses.

- Using data obtained from NHS England covering England for the 2021/22 reporting period, 178,198 quit attempts were made (100,982 females and 77,216 males). Of these, 57% of men and 53% of women were self-reported to have quit smoking, although only 3% of men and 4% of women had this confirmed by carbon monoxide testing. Since the onset of the Covid-19 pandemic, the number of quit attempts that are validated by CO readings has remained much lower than the 2019/20 rate of 32%.

- Approximately 50% of smokers who attempt to quit do so through their own willpower, despite this being the least effective method. Those who access local stop smoking services are three times more likely to successfully quit when compared to willpower alone.

<u>Key Findings</u>

- The proportion of adults estimated to smoke in Derbyshire in 2022 (14.0%) was similar to the England average (12.7%). The challenge remains to reduce this figure to 5% by 2030 in line with the national ambition for a smokefree country by that date.

- There is limited recent data to enable comparisons of smoking prevalence in young people between areas. In the 2014/15 period, 5.4% of 15-year-olds in Derbyshire were regular smokers. This was similar to the England average of 5.5%.

- Vaping is uncommon in under 18’s, however, there is emergent data showing an increase in young people who have never smoked. This is evidenced in a local representative survey ‘My Life My View’ and links to national data. Rates vary by district with highest rate in Bolsover and lowest in North East Derbyshire. There is

currently no specific service and/or agreed approach to address vaping in young people.

- Smoking rates are higher in people who work in routine and manual occupations with a Derbyshire rate of 25.5% and similarly in people with Serious Mental Illness have a smoking rate of 39.9% for Derbyshire.

- Prevalence of smoking in pregnancy in Derbyshire has reduced in recent years. Despite this, the proportion of people smoking at the time of delivery in Derbyshire in 2021/22 (11.8%) remains significantly higher than the England average (9.1%).

- Derbyshire has high rates of premature births, smoking attributable hospital admissions, and oesophageal cancer registrations. The Derbyshire rate of lung cancer registrations is lower than the England average.

- It is estimated that more than 1,000 people in Derbyshire die of smoking attributable deaths each year (rate of 199.5 per 100,000). This is similar to the England average.

- There are many different harms caused to the body by smoking. For example, smoking causes 84% of deaths from lung cancer, increase the risk of stroke by at least 50%, can cause impotence in men, can make it harder to conceive and doubles the risk of a heart attack.

- Smoking in Derbyshire creates an estimated societal cost of £255.9 million each year. This includes an estimated £27.7m for treating smoking-related illness; £203.2 million in lost productivity, and more than £19.2 million in social care costs as a result of smoking related illnesses.

- Rates of success from Live Life Better Derbyshire's stop smoking service are relatively high. In 2021/22, 68% of users of the Derbyshire service who set quit dates successfully quit smoking. This is higher than the East Midlands (61%) and England (55%) rates.

- The Tobacco Dependency Treatment service provided by Live Life Better Derbyshire at both main hospitals has broadened access to stop smoking services to the hospital inpatient population. This service also extends to those who are pregnant and their partners.

- Trading Standards make an important contribution to tobacco control in Derbyshire. Current resource constraints result in less activity on tobacco control.

- Smoke Free policies have been developed across the two main hospitals at Chesterfield Royal Hospital, Derbyshire Healthcare NHS Trust and University Hospitals of Derby and Burton.

- The status of the stop smoking policies of local NHS organisations is not known. These organisations have the potential to significantly impact smoking because of their frequent contact with patients and family members who smoke and their role as major employers.

- There is currently no strategic group across the Derby and Derbyshire Integrated Care System for tobacco control and no agreed framework for action.

Recommendations

- Develop a strategic group across the Derby Derbyshire Integrated Care System for tobacco control and an agreed framework for action.
- Explore notable geographical variations in local data, including rate of lung cancer registrations in Bolsover (2017-19) and relatively high levels of school aged children in Chesterfield and Bolsover reporting having tried cigarettes through the My Life, My View survey 2014/15-2018/19).
- Explore reasons for rapid increase in youth vaping in Derbyshire and consider approaches to tackle this. Continue to monitor with My Life My View survey.
- Explore reasons for higher smoking rates locally in routine and manual populations and in those with serious mental illness and consider approaches to tackle this.
- Increase access to stop smoking services including providing e cigarettes for adults as a quitting aide– those who access Live Life Better Derbyshire's services are three times more likely to successfully quit compared to attempting without support.
- Continue with the Tobacco Dependency Treatment service to support inpatient smokers and reduce the impact of smoking on hospital admissions.
- Continue with work to reduce smoking in pregnancy. Review evidence and new policy on incentives for smoking in pregnancy as per forthcoming national guidance. Work towards ambitions around quits and carbon monoxide (CO) validations (SBLCB v3).
- Consider how best to work in partnership with Trading Standards to support their enforcement work regarding point-of-sale displays, underage sales, packaging, and removing illicit / illegal tobacco from the market.
- Consider how to understand lived experience of people in Derbyshire relating to tobacco control.
- Complete a review of NHS Smokefree Pledge status of local NHS organisations.
- Across local authorities, healthcare and the voluntary and community sector provide training and support to enable the workforce to maximise opportunities with a Quality Conversations approach to identify smokers, provide very brief advice (VBA) and actively signpost to stop smoking support.
- Draw on resources developed by Action on Smoking and Health[1] to develop a local tobacco control plan with strategic aims and ambitious, measurable targets.

1 Introduction to tobacco control

1.1Tobacco control

1.1.1 Definition

Tobacco is a harmful legal substance and impacts the health of the user and when smoked, people around them. Tobacco smoking is the leading cause of preventable morbidity and premature mortality in England[2]. Tobacco control is an umbrella term for the science, policy, and practice mobilised towards reducing tobacco use and its associated harms.

The Framework Convention on Tobacco Control (FCTC)[3] developed by the World Health Organisation (WHO) defines Tobacco Control as: *"a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing their consumption of tobacco products and exposure to tobacco smoke".*

1.1.2 International priorities

To support tobacco control policies at country-level WHO has defined six 'MPOWER'[4] measures:

- Monitor tobacco use and prevention policies
- Protect people from tobacco smoke
- Offer help to quit tobacco use
- Warn about the dangers of tobacco
- Enforce bans on tobacco advertising, promotion and sponsorship
- Raise taxes on tobacco.

In *Building Blocks for Tobacco Control*, the WHO emphasised that tobacco control policies should not be pursued in isolation and that effective multi-layered strategies are required.[5] An economic evaluation of tobacco control policies published in 2008 by two US-based academics found indications of multiplicative effects between four types of restrictions[6] aligning with the emphasis on comprehensive policy approaches. A Tobacco Control Scale scoring the implementation of these policies has been applied to European countries as part of work by the European Network for Smoking Prevention.[7] In the most recent report (2021), the UK ranked highly, scoring second of the 37 included nations.

Commentators have suggested moving towards a tobacco 'endgame', usually defined as a smoking prevalence rate of 5% or below[8]. Achieving this will require ongoing consensus around harm reduction and eradication approaches within the tobacco control movement, alongside cessation measures. UK health organisations and charities including the British Medical Association and Cancer Research UK have promoted the ambition of a smoke free UK by 2030, where less than 5% of the adult population are smokers.

1.1.3 National priorities

The Tobacco Control Plan: delivery plan for England 2017 to 2022 set out the national vision for a smokefree generation and outlined four ambitions and the actions required at a national and local level towards this vision[9]. This Delivery Plan provided more detail for the implementation of this plan, including identifying key programmes or activities, milestones, lead agencies, and metrics. The Delivery Plan made calls for action within local systems with roles for local authorities, the NHS and civic society.

The priorities in the 2017-22 Plan were:

- Prevention first
- Supporting smokers to quit
- Eliminating variation in smoking rates
- Effective enforcement

On 9th June 2021, the All-Party Parliamentary Group (APPG) on Smoking and Health launched its report[10] and recommendations for the forthcoming tobacco control plan to secure the Government's ambition of a Smokefree country by 2030 (which refers to less than 5% of the adult population smoking tobacco)

The APPG recommendations include actions deliverable at a local, regional and national level.

Setting course for a Smokefree 2030

- Recommendation 1: Legislate to make tobacco manufacturers pay for a Smokefree 2030 Fund to bring an end to smoking
- Recommendation 2: Take our place on the world stage as a global leader in tobacco control.
- Recommendation 3: Set interim targets for 2025, and update our strategy if we are not on track to a Smokefree 2030 by then

Behaviour Change Policy and Interventions for a Smokefree 2030

Levelling up through targeted investment

- Recommendation 4: Deliver anti-smoking behaviour change campaigns targeted at routine and manual and unemployed smokers (C2DE).
- Recommendation 5: Ensure all smokers are advised to quit at least annually and given opt-out referral to Stop Smoking Services.
- Recommendation 6: Target support to give additional help to those living in social housing or with mental health conditions, who have high rates of smoking.
- Recommendation 7: Ensure all pregnant smokers are given financial incentives to quit in addition to smoking cessation support.
- Recommendation 8: Fund regional programmes to reduce the use of illicit tobacco in deprived communities.

Shaping the Consumer Environment

- Recommendation 9: Legislate to put health warnings on individual cigarettes, quit messaging on pack inserts and close other loopholes in existing regulations.
- Recommendation 10: Reduce the appeal and availability of e-cigarettes and other nicotine products to children.
- Recommendation 11: Make the route to medicinal licensing fit for purpose to allow e-cigarettes to be authorised for NHS prescription.
- Recommendation 12: Consult on raising the age of sale for tobacco from 18 to 21.

An independent review by Dr Javed Khan OBE into the government's ambition to make England smokefree by 2030 was published in June 2022[11]. This review made four "critical recommendations":

- Increased investment – fund easily accessible and high-quality support to help smokers quit
- Increased the age of sale – increasing by one year, every year, until no one can buy a tobacco product in this country
- Promote vaping – embrace the promotion of vaping as an effective tool to help people to quit smoking tobacco
- Improve prevention in the NHS – offering smokers advice and support to quit at every interaction they have with health services.

Further detail on the Khan Review is included in section 5.1.

There was an announcement on 4th October 2023 of the English Government's intention to introduce an historic new law to protect future generations of young people from the harms of smoking. It covers the following:

- Smoking is the UK's biggest preventable killer – causing around 1 in 4 cancer deaths and 64,000 in England alone – costing the economy and wider society £17 billion each year.
- The Government plan to create the first smokefree generation by bringing forward legislation so that children turning 14 this year or younger will never be legally sold tobacco products. This will prevent future generations from ever taking up smoking, as there is no safe age to smoke.
- Move would be the most significant public health intervention in a generation, saving tens of thousands of lives and saving the NHS billions of pounds.
- Additional money for stop smoking services and enforcement agencies.
- Further crackdown on youth vaping will see government consult on restricting disposable vapes and regulating flavours and packaging to reduce their appeal to children.

A detailed policy paper 'Stopping the Start: our new plan to create a smokefree generation' has been published.[12]

1.1.4 National policy and guidance

There are resources from National Institute for Health and Care Excellence (NICE), Office for Health Improvement and Disparities (OHID) and public health charities and organisations to advise and inform local tobacco control work.

NICE guidance

NICE Guidance NG209 Tobacco: preventing uptake, promoting quitting and treating dependence, published in November 2021, brought together and updated NICE's previous guidelines on using tobacco, including smokeless tobacco and covers:

- support to stop smoking for everyone aged 12 and over
- help to reduce people's harm from smoking if they are not ready to stop in one go
- ways to prevent children, young people and young adults aged 24 and under from taking up smoking

- nicotine replacement therapy and e-cigarettes to help people stop smoking or reduce their harm from smoking.

It does not cover using tobacco products such as 'heat not burn' tobacco including e-cigarettes/vapes.

Public Health England resources: CLeaR

CLeaR is an evidence-based approach to tobacco developed from NICE Guidance and the Tobacco Control Plan for England[13]. The CLeaR model offers a self-assessment tool, and an optional peer-assessment process. It is designed to be implemented through discussion with local partners and to provide the opportunity to benchmark local work on tobacco control in comparison with other areas, and over time.

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

Public health charities and organisations

Action on Smoking and Health (ASH)[14] have compiled a local resource toolkit with other partners, which includes resources to make the case effectively for tobacco control. The resources include guidance on development and implementation of policy and tools to gather and record local opinion and estimate local impact and costs of smoking.

Cancer Research UK issued a Tobacco Control Local Policy Statement in December 2017[15] stating that local authorities should develop a comprehensive tobacco control strategy that includes:

- prioritisation and sustained funding for tobacco control
- provision of evidence-based Stop Smoking Services
- coordinated tobacco control alliance to provide:
    - mass media campaigns
    - measures to target illicit trade
- an acceleration in progress to reduce health inequalities
- recognition of the WHO Framework Convention on Tobacco Control.

1.2 Health needs assessment

"Health needs assessment is a systematic method for reviewing the health issues facing a population, leading to agreed priorities and resource allocation that will improve health and reduce inequalities".[16]

A health needs assessment (HNA) approach requires developing a shared understanding of health, and, of people's needs. The concept of 'needs' in a population was set out by Bradshaw[17] in 1972 across four groups:

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

Health needs assessments are conducted to understand the influences, overlaps and gaps between the need, demand, and supply, of healthcare or the implementation of policy. The assessments often reframe needs in terms of the capacity to benefit from services or interventions at individual, community or population level.

1.3 Aims and objectives

The aim of this health needs assessment is to take a deep dive into tobacco control in Derbyshire.

The objectives are to comprehensively describe the data, evidence, insight, and guidance and make recommendations for local action.

2. Profile of population and tobacco use

2.1. Smoking prevalence estimates

There are number of sources of data on the prevalence of smoking in the UK. Those considered here are reported on the OHID Fingertips tool. These include the GP Patient Survey (GPPS), the Annual Population Survey (APS), the Quality and Outcomes Framework (QOF), the GP Extraction Service (GPES) and the What About YOUth (WAY) survey. These surveys give different estimates of how many people smoke (prevalence) as they report on different populations. These surveys are useful as they provide different insights into smoking amongst sub-groups of the population.

In the main this report focusses on the APS estimates for adults and the WAY survey for young people for the purposes of consistency.

Further detail on the 2021 data is in appendix 1.

2.1.1. Adults

In 2022, an estimated 14.0% (n=90,084[1]) of adults in Derbyshire smoked. This is similar to the England average of 12.7%. When compared to 15 similar local authorities, Derbyshire has the third highest smoking rate. These comparators are from the Chartered Institute of Public Finance and Accountancy (CIPFA) neighbours[2] (see figure 1). An estimated 28.3% (n=169,681) of Derbyshire adults are ex-smokers and an estimated 57.5% of Derbyshire adults have never smoked (n=344,758). Confidence intervals (which give an estimate of statistical significance) are very wide as rates are estimated from the Annual Population Survey (APS) which has a small sample size at local authority level. Therefore, these prevalence estimates should be interpreted with some caution.

[1] 14.0% published on fingertips, numerator published as part of 'Local Stop smoking services: methodology for allocating indicative funding, which quotes estimated 90,084 smokers
In Derbyshire based on application of 14.0% to mid-2021 population estimate of 645,265. More information can be found here.

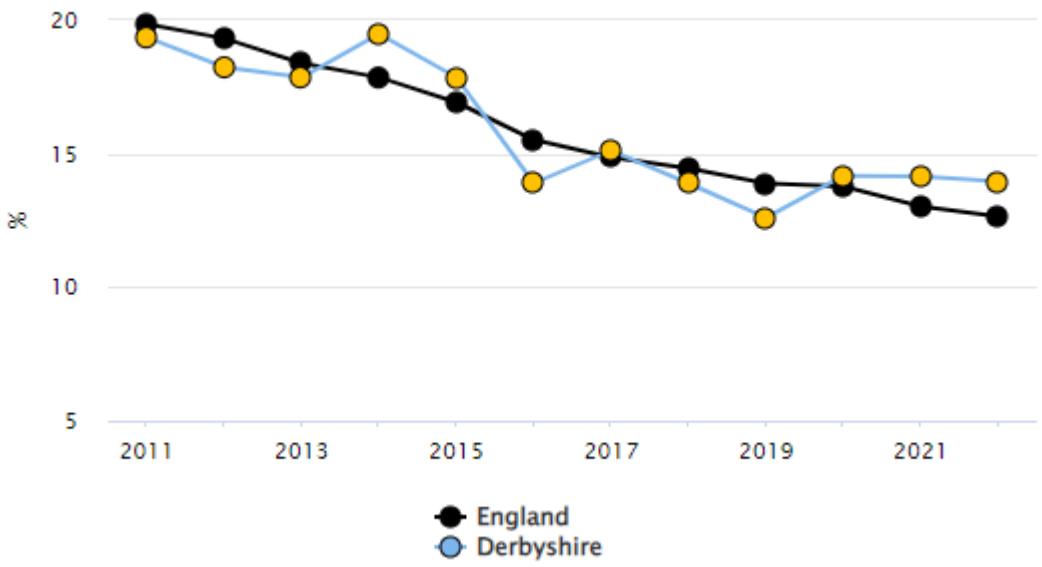
[2] The Chartered Institute of Public Finance and Accountancy (CIPFA) Nearest Neighbours model seeks to measure similarity between Local Authorities. There are 15 counties that are comparable with Derbyshire and can be used to benchmark health indicators.

Figure 1 Smoking prevalence in adults (18+) - current smokers - proportion (%) 2022

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	12.7	12.3	13.0
Neighbours average	–	-	-	-	-	-
Lincolnshire	–	3	-	16.0	12.7	19.3
Suffolk	–	4	-	14.0	11.1	16.8
Derbyshire	–	-	-	14.0	11.0	16.9
Devon	–	14	-	13.9	11.4	16.4
Warwickshire	–	7	-	13.9	11.0	16.7
Lancashire	–	9	-	13.4	10.9	15.8
Essex	–	13	-	13.2	11.0	15.5
Norfolk	–	5	-	13.2	10.4	16.0
Cumbria	–	11	-	13.1	10.4	15.8
Nottinghamshire	–	1	-	12.6	10.0	15.2
Somerset Cty	–	8	-	12.6	9.7	15.4
Gloucestershire	–	10	-	11.5	9.2	13.9
Worcestershire	–	6	-	11.5	8.7	14.3
North Yorkshire Cty	–	15	-	9.6	7.1	12.2
Leicestershire	–	12	-	9.4	7.0	11.7
Staffordshire	–	2	-	9.3	7.0	11.6

Source: Annual Population Survey (APS)

Figure 2 Smoking prevalence in adults (18+) - current smokers (APS) - Derbyshire trend



When the APS survey began in 2011, smoking prevalence in Derbyshire was 19.8%. In the decade since then the proportion of adults smoking in Derbyshire has decreased. The English smoking prevalence continues to fall, of concern is that from 2019, there has been a slight upwards trend in Derbyshire however this has since appeared to have levelled off. The overall trend is downwards.

There is some variation in the estimated prevalence of adults smoking across Derbyshire (see figure 3). Confidence intervals for the district data are wide. The district with the highest estimated prevalence is Erewash (estimated 18.9% of adults smoke) which is similar to the England average (12.7%). The district with the lowest estimated prevalence is Derbyshire Dales (estimated 6.8% of adults smoke) which is also similar to the England average. As all

the Derbyshire districts have overlapping confidence intervals, caution must be exercised in making any comparisons as the observed differences are not statistically significant.

Figure 3 Smoking prevalence in adults (18+) - current smokers (APS) - geographical variation 2022 Proportion - %

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	12.7	12.3	13.0
Derbyshire	–	-	14.0	11.0	16.9
Erewash	–	-	18.9	10.4	27.5
Bolsover	–	-	17.3	4.8	29.9
High Peak	–	-	15.9	8.2	23.6
Amber Valley	–	-	15.6	8.0	23.3
Chesterfield	–	-	12.9	4.4	21.5
North East Derbyshire	–	-	11.1	4.6	17.7
South Derbyshire	–	-	10.9	3.2	18.7
Derbyshire Dales	–	-	6.8	0.0	13.7

Source: Annual Population Survey (APS)

There is variation in estimated smoking prevalence by occupation. In 2022, an estimated 25.5% of adults aged 18 to 64 who live in Derbyshire and work in routine and manual occupations smoked. This is similar to the England average of 22.5%. Derbyshire ranks fourth worst for this measure when compared to its 15 CIPFA neighbours (see figure 4).

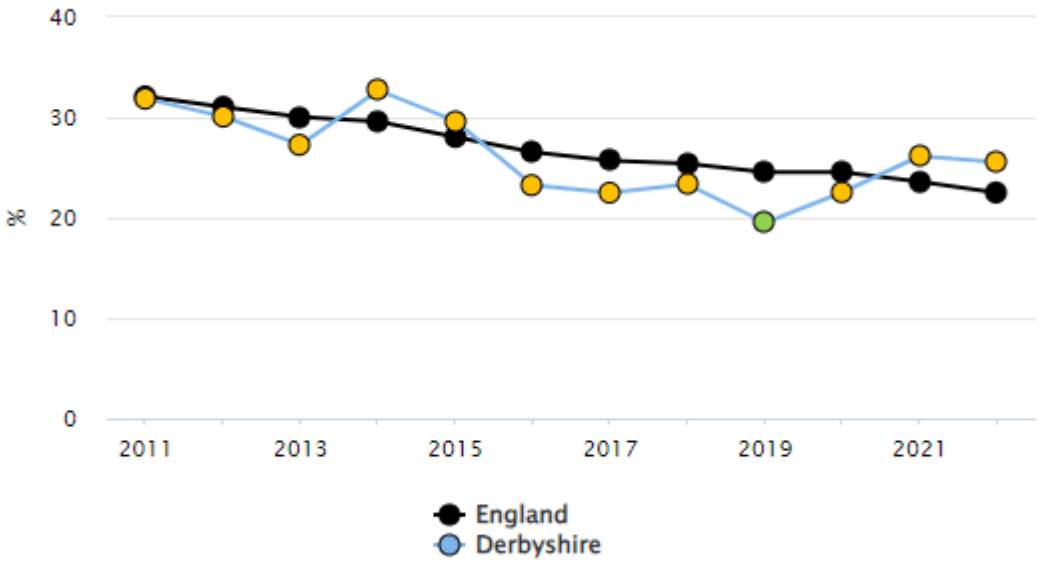
Figure 4 Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers (APS) – proportion (%) 2022

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	22.5	21.6	23.4
Neighbours average	–	-	-	-	-	-
Lincolnshire	–	3	-	29.3	21.7	36.9
Essex	–	13	-	28.5	21.5	35.5
Devon	–	14	-	26.0	18.5	33.5
Derbyshire	–	-	-	25.5	17.5	33.6
Norfolk	–	5	-	25.5	17.7	33.4
Warwickshire	–	7	-	25.1	16.8	33.5
Nottinghamshire	–	1	-	23.4	15.5	31.2
Gloucestershire	–	10	-	23.3	16.0	30.7
Cumbria	–	11	-	23.1	16.5	29.7
Worcestershire	–	6	-	22.3	13.5	31.1
Lancashire	–	9	-	22.3	15.9	28.6
Suffolk	–	4	-	21.0	13.6	28.3
Somerset Cty	–	8	-	20.9	12.9	28.8
North Yorkshire Cty	–	15	-	19.4	10.9	28.0
Staffordshire	–	2	-	15.8	9.9	21.7
Leicestershire	–	12	-	15.0	8.9	21.1

Source: Annual Population Survey (APS)

The estimated prevalence of adults aged 18 to 64 who work in routine and manual occupations who smoke in Derbyshire has been gradually, though not consistently, decreasing since 2011. 2019 saw the lowest estimated prevalence of smoking among this group (19.5%), after which this figure has increased to 25.5% in 2022 (see figure 5).

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



In 2022, there was some variation in the estimated prevalence of adults aged 18 to 64 who work in routine and manual occupations who smoke in Derbyshire. The district with the highest estimated prevalence was North East Derbyshire with 37.1% which was statistically similar to the England average (22.5%). The district with the lowest estimated prevalence was Chesterfield (9.6%) which is significantly lower than the England average (see figure 6) but similar to Derbyshire. Caution should be applied when interpreting this data as the 95% confidence intervals are very wide as rates are estimated from a national survey with small counts at a Lower Tier Local Authority (LTLA) level. Results were not available for Bolsover for data quality reasons.

Figure 6 Smoking prevalence in adults in routine and manual occupations (18-64) - current smokers - geographical variation – proportion (%) 2022

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	22.5	21.6	23.4
Derbyshire	–	-	25.5	17.5	33.6
North East Derbyshire	–	-	37.1	6.0	68.1
Amber Valley	–	-	33.2	12.7	53.7
High Peak	–	-	31.9	8.7	55.2
Erewash	–	-	25.6	4.0	47.1
Derbyshire Dales	–	-	22.3	0.0	53.0
South Derbyshire	–	-	13.5	0.0	28.9
Chesterfield	–	-	9.6	0.0	21.8
Bolsover	–	-	*	-	-

Source: Annual Population Survey (APS)

2.1.2. Young people

The 2017 Tobacco Control Plan highlighted the importance of reducing the number of young people taking up smoking, as it is "an addiction largely taken up in childhood"[18]. The data in the following figures come from the QOF, published by OHID on Fingertips.

In the 2020/2021 period, an estimated 15.2% of adults aged 15 years and above currently smoked. This is significantly lower than the England average of 15.9%. Derbyshire ranks in the middle when comparing it to its CIPFA neighbours (see figure 7). The 2021/22 result for Derbyshire was suppressed for data quality reasons therefore this has not been updated.

Figure 7 Smoking prevalence in adults (15+) – current smokers (QOF) – proportion (%) 2020/2021

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	8,041,280	15.9	15.9	15.9
Neighbours average	–	-	-	-	-	-
Lincolnshire	↓	3	114,015	17.1	17.0	17.2
Norfolk	↓	5	133,393	16.7	16.6	16.7
Lancashire	↓	9	172,414	16.6	16.5	16.6
Somerset	↓	8	80,768	16.3	16.1	16.4
Suffolk	↓	4	108,687	16.0	15.9	16.0
Worcestershire	↓	6	80,693	15.5	15.4	15.6
Nottinghamshire	↓	1	106,083	15.5	15.4	15.6
Essex	↓	13	194,917	15.2	15.2	15.3
Derbyshire	↓	-	104,709	15.2	15.1	15.3
Cumbria	↓	11	65,523	15.0	14.9	15.1
Staffordshire	↓	2	107,520	14.9	14.8	15.0
Warwickshire	↓	7	74,361	14.5	14.5	14.6
Gloucestershire	↓	10	81,067	14.5	14.4	14.6
Devon	↓	14	96,254	13.8	13.8	13.9
Leicestershire	↓	12	83,656	13.8	13.7	13.9
North Yorkshire	↓	15	66,501	12.9	12.8	13.0

In the 2014/15 period, 8.0% of 15-year-olds in Derbyshire currently smoked. This was similar to the England average of 8.2%. Derbyshire ranked in the middle when comparing it to its 15 CIPFA neighbours (see figure 8). There are no recent sources of national data that allow these comparisons.

Figure 8 Smoking prevalence at age 15 - current smokers (WAY survey) - proportion (%) 2014/15

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	8.2	8.1	8.3
Neighbours average	–	-	-	-	-	-
Norfolk	–	5	-	11.4	9.5	13.3
Essex	–	13	-	10.5	8.6	12.4
Devon	–	14	-	10.0	8.2	11.8
Somerset	–	8	-	9.5	7.8	11.2
Worcestershire	–	6	-	9.4	7.7	11.1
Lancashire	–	9	-	9.0	7.3	10.7
Gloucestershire	–	10	-	8.9	7.2	10.6
Suffolk	–	4	-	8.6	7.0	10.2
Warwickshire	–	7	-	8.2	6.7	9.7
Derbyshire	–	-	-	8.0	6.4	9.6
Lincolnshire	–	3	-	7.9	6.4	9.4
Staffordshire	–	2	-	7.9	6.3	9.5
Nottinghamshire	–	1	-	7.4	5.9	8.9
Cumbria	–	11	-	7.3	5.9	8.7
Leicestershire	–	12	-	6.9	5.5	8.3
North Yorkshire	–	15	-	5.5	4.2	6.8

In the 2014/15 period, 5.4% of 15-year-olds in Derbyshire were regular smokers. This is similar to the England average of 5.5%. Derbyshire ranked in the middle when compared it to its 15 CIPFA neighbours (see figure 9).

Figure 9 Smoking prevalence at age 15 - regular smokers (WAY survey) - proportion (%) 2014/15

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

In the 2014/15 period, 2.7% of 15-year-olds in Derbyshire were occasional smokers. This was similar to the England average of 2.7%. Derbyshire ranks in seventh worst when comparing it to its 15 CIPFA neighbours (see figure 10).

Figure 10 Smoking prevalence at age 15 - occasional smokers (WAY survey) - proportion (%) 2014/15

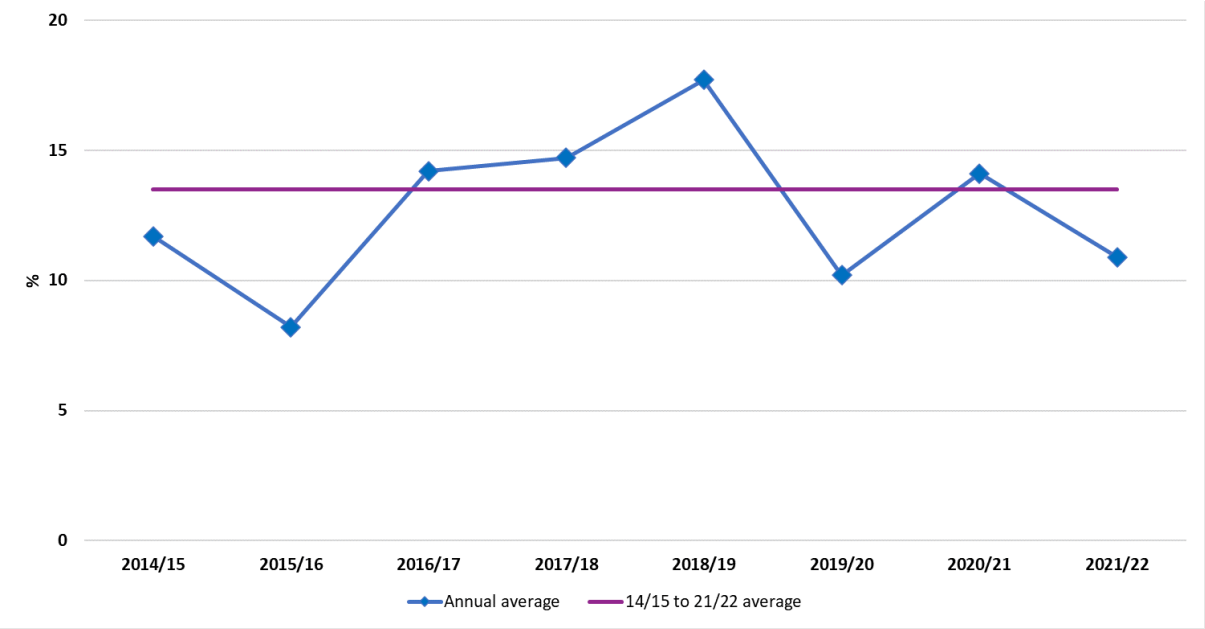
Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	2.7	2.6	2.8
Neighbours average	–	-	-	-	-	-
Essex	–	13	-	4.5	3.2	5.8
Gloucestershire	–	10	-	4.0	2.8	5.2
Devon	–	14	-	3.9	2.8	5.0
Norfolk	–	5	-	3.5	2.4	4.6
Lancashire	–	9	-	3.3	2.2	4.4
Worcestershire	–	6	-	3.2	2.2	4.2
Derbyshire	–	-	-	2.7	1.8	3.6
Suffolk	–	4	-	2.7	1.8	3.6
Staffordshire	–	2	-	2.7	1.8	3.6
Leicestershire	–	12	-	2.5	1.6	3.4
Somerset	–	8	-	2.4	1.5	3.3
Lincolnshire	–	3	-	2.3	1.4	3.2
North Yorkshire	–	15	-	2.3	1.5	3.1
Warwickshire	–	7	-	2.3	1.5	3.1
Cumbria	–	11	-	2.2	1.4	3.0
Nottinghamshire	–	1	-	2.1	1.3	2.9

Figure 11 Attitudes to smoking in 15-year-olds - 'smoking causes harm to others' - proportion (%) 2014/15

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

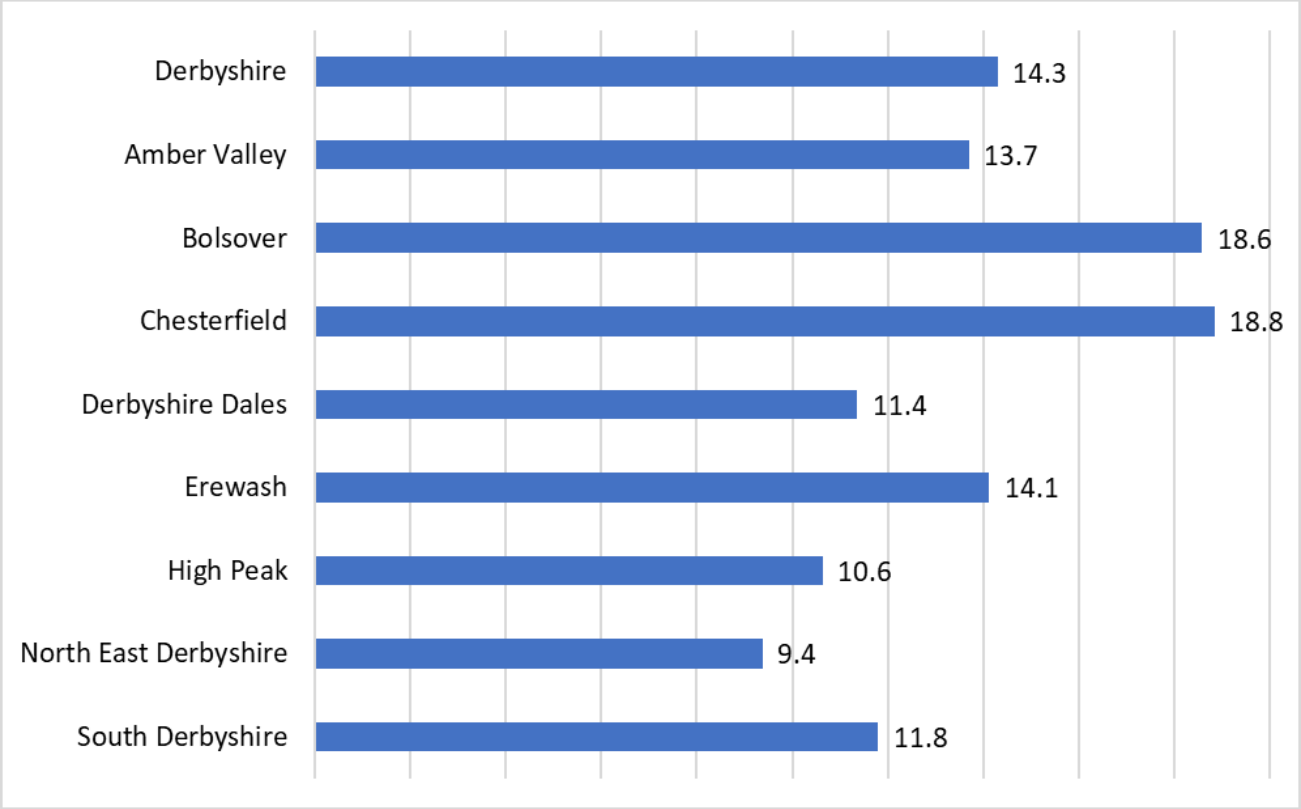
Between 2014/15 and 2021/22, the local 'My Life, My View' representative survey questioned pupils in years 8, 9, 10 and 11 in Derbyshire about their behaviours and beliefs. Over this period, 13.5% (4198 children out of a sample of 31063) said that they had tried a cigarette. As can be seen in Figure 12, there are differences between years. The lowest prevalence was 8.2% (248/3041) in the 2015/16 school year, with the highest prevalence of 17.7% (1024/5783) in the 2018/19 school year (Figure 12). The 2019/20 data collection was disrupted by COVID, with a lower sample than previous and subsequent reporting periods.

Figure 12 'My Life, My View Survey' – Have you ever tried a cigarette? Derbyshire trend 2014/15-2021/22



The Derbyshire average of children who had ever tried a cigarette over the 5-year period (2014/15 to 2019/20) was 14.3%. The districts with the highest prevalence were Bolsover (18.6%) and Chesterfield (18.8%). The district with the lowest prevalence was North East Derbyshire (9.4%) (Figure 12). The district proportions in the figure below do not include data from the 2019/20 'My Life, My View' survey so comparisons require care. This is due to a change in the way the geography was captured – Derbyshire Dales was split in to 'North Dales' and 'South Dales'. These were absorbed into the High Peak and South Derbyshire district's results respectively.

Figure 13 My Life, My View survey - My Life, My View Survey – Have you ever tried a cigarette? Proportion (%) 2014/15-2018/19



Of the 2677 children who had ever tried a cigarette:

- 555 smoked once a day (20.7%)
- 234 smoked once a week (8.7%)
- 506 smoked once a month (18.9%)
- 1382 did not provide a response (51.6%)

This data does not include results from the 2019/20 'My Life, My View' survey. This is because the question was phrased differently in the 2019/20 survey. From 2014/15 to 2018/19, this section asked children "*If you have ever tried a cigarette how often do you smoke?"* with the possible responses of 'once a day', 'once a week' or 'once a month'. The 2019/20 survey instead asked *"Which statement describes you best for your experience of each of these? Smoking tobacco e.g., cigarettes (from a packet or roll-up)"* with the possible responses of 'never tried', 'have tried', 'used in the past', 'use sometimes' or 'use every week'.

2.1.3. Vulnerable groups

The rate of decline of smoking prevalence has not been equal among all populations including people with a mental health condition. High smoking rates among people with mental health conditions are the single largest contributor to their 10 to 20-year reduced life expectancy[19].

2.1.3.1 Smoking in adults with serious mental illness

In the 2014/15 reporting period, an estimated 39.9% (n=1703) of adults with serious mental illness in Derbyshire smoked (1,703 adults). This is similar to the England average of 40.5%. Derbyshire ranks sixth worst when comparing it to its 15 CIPFA neighbours (see figure 14). There is only one observation point, therefore it is not possible to determine a trend for this cohort.

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

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	146,442	40.5	40.4	40.7
Neighbours average	–	-	25,968	39.2*	38.8	39.6
Lancashire	–	9	3,771	42.9*	41.9	43.9
Devon	–	14	1,662	42.1*	40.6	43.7
Norfolk	–	5	2,078	40.7*	39.3	42.0
Cumbria	–	11	1,481	40.2	38.6	41.8
Lincolnshire	–	3	1,114	40.1*	38.3	41.9
Derbyshire	–	-	1,703	39.9*	38.5	41.4
Essex	–	13	1,911	39.4*	38.1	40.8
Somerset	–	8	1,249	39.1	37.5	40.8
Nottinghamshire	–	1	1,505	38.7*	37.2	40.2
Suffolk	–	4	1,534	38.6*	37.1	40.1
Warwickshire	–	7	1,299	38.3	36.6	39.9
Gloucestershire	–	10	1,305	38.1	36.4	39.7
Staffordshire	–	2	1,624	37.2	35.7	38.6
Worcestershire	–	6	1,321	37.0	35.5	38.6
North Yorkshire	–	15	1,160	35.1*	33.5	36.7
Leicestershire	–	12	1,251	33.8	32.3	35.4

2.1.3.2 Smoking in adults with a long term mental health condition

Data from the GP Patients Survey (GPSS) 2021/22 reporting period estimates that 25.8% of adults with a long-term mental health condition in Derbyshire smoke. This is similar to the England average of 25.2%. Derbyshire ranks third worst when compared to its 15 CIPFA neighbours (see figure 15).

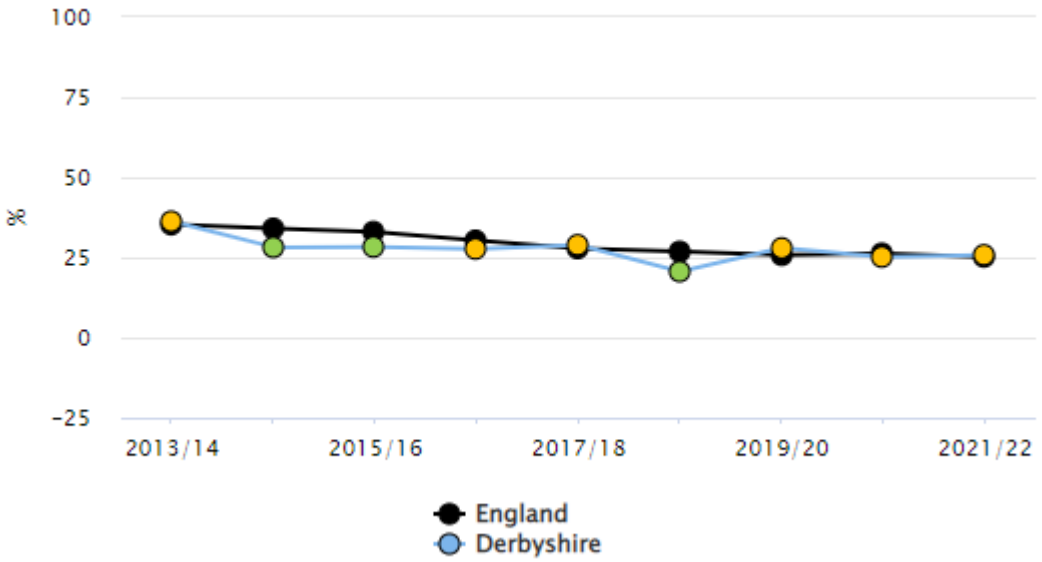
Figure 15 Smoking prevalence in adults (18+) with a long-term mental health condition - proportion (%) 2020/21

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	25.2	24.9	25.6
Neighbours average	–	-	-	-	-	-
Staffordshire	–	2	-	27.1	24.3	29.9
Suffolk	–	4	-	25.9	22.4	29.4
Derbyshire	–	-	-	25.8	23.0	28.6
Somerset Cty	–	8	-	25.4	21.8	29.0
Cumbria	–	11	-	25.2	21.3	29.2
Nottinghamshire	–	1	-	24.6	21.8	27.4
Worcestershire	–	6	-	24.4	20.8	28.0
Essex	–	13	-	23.5	21.3	25.8
Norfolk	–	5	-	23.2	20.4	25.9
Leicestershire	–	12	-	23.1	19.9	26.3
Lincolnshire	–	3	-	22.8	19.9	25.8
Gloucestershire	–	10	-	22.1	18.7	25.5
Lancashire	–	9	-	21.8	19.6	24.1
Warwickshire	–	7	-	21.6	18.3	25.0
Devon	–	14	-	21.4	18.5	24.3
North Yorkshire Cty	–	15	-	20.4	17.2	23.6

Source: GP Patient Survey (GPPS)

The prevalence of adults with a long-term mental health condition who smoke in Derbyshire gradually, but not consistently, decreased since from 36.3% in 2013/14 to 25.8% in 2021/22 (see figure 16). The 2018/19 period saw the lowest estimated prevalence of adults with a long-term mental health condition who smoked (20.6%).

Figure 16 Smoking prevalence in adults (18+) with a long-term mental health condition - Derbyshire trend



There is some variation in the estimated proportion of adults with a long-term mental health condition who smoke. The district with the highest estimated prevalence is Chesterfield (32.6%) which is similar to the England average (25.2%). The district with the lowest estimated prevalence is South Derbyshire (16.5%) which is statistically significantly lower (see figure 17).

Figure 17 Smoking prevalence in adults (18+) with a long-term mental health condition – geographical variation - proportion (%) 2021/22

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	-	25.2	24.9	25.6
Derbyshire	–	-	25.8	23.0	28.6
Chesterfield	–	-	32.6	23.5	41.6
High Peak	–	-	31.0	22.6	39.3
Derbyshire Dales	–	-	27.3	18.0	36.7
Amber Valley	–	-	26.8	19.4	34.2
Erewash	–	-	24.9	18.0	31.7
North East Derbyshire	–	-	23.1	15.7	30.4
Bolsover	–	-	20.9	13.3	28.5
South Derbyshire	–	-	16.5	8.9	24.0

Source: GP Patient Survey (GPPS)

2.1.3.3 Smoking in adults with anxiety or depression

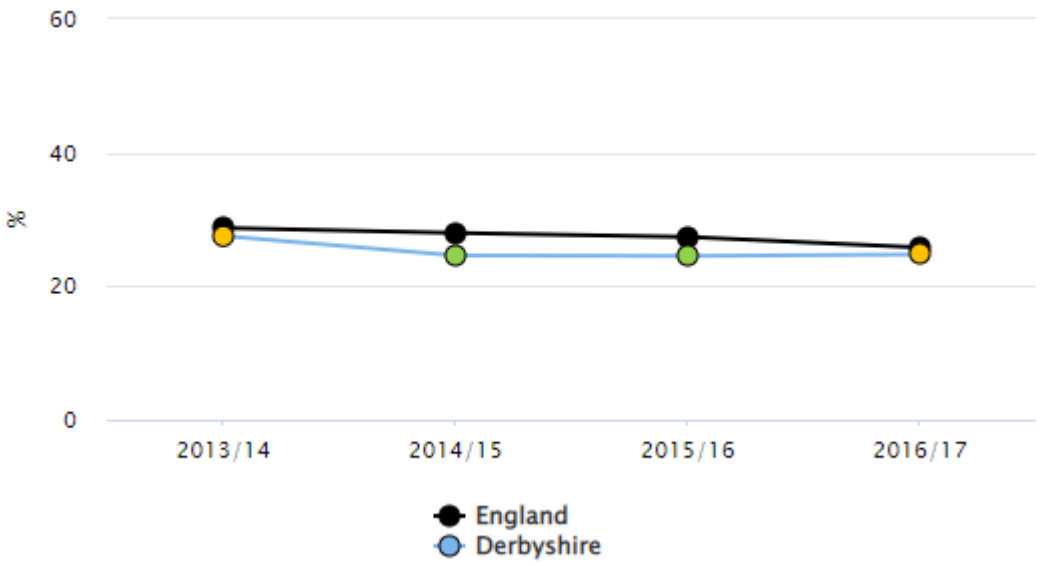
Data from the GPSS 2016/2017 reporting period highlights that an estimated 24.8% of adults with anxiety or depression in Derbyshire smoked, which is similar to the England average of 25.8%. Derbyshire ranked in the middle when compared to its 15 CIPFA neighbours (see figure 18).

Figure 18 Smoking prevalence in adults (18+) with anxiety or depression - Proportion (%) 2016/17

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	-	25.8	25.6	26.1
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	-	28.3	26.5	30.1
Lincolnshire	–	3	-	26.4	24.0	28.9
Cumbria	–	11	-	26.1	23.3	29.0
Suffolk	–	4	-	25.6	22.9	28.3
Gloucestershire	–	10	-	25.5	22.7	28.3
Warwickshire	–	7	-	25.0	22.3	27.8
North Yorkshire	–	15	-	25.0	22.2	27.7
Somerset	–	8	-	25.0	22.1	27.8
Derbyshire	–	-	-	24.8	22.5	27.1
Devon	–	14	-	24.1	21.8	26.4
Nottinghamshire	–	1	-	24.0	21.8	26.1
Norfolk	–	5	-	23.4	21.2	25.6
Worcestershire	–	6	-	22.5	19.8	25.3
Essex	–	13	-	22.3	20.7	24.0
Staffordshire	–	2	-	21.5	19.5	23.4
Leicestershire	–	12	-	21.3	18.8	23.9

The estimated prevalence of adults with anxiety or depression who smoke in Derbyshire gradually, but not consistently, decreased from 27.5% in 2013/14 to 24.8% in 2016/17 (see figure 19).

Figure 19 Smoking prevalence in adults (18+) with anxiety or depression – trends



There is also some variation in the estimated prevalence of adults with anxiety or depression in Derbyshire who smoke. The district with the highest estimated prevalence is Chesterfield (31.8%) which is similar to the England average. The districts with the lowest estimated prevalence are Derbyshire Dales (18.1%) and South Derbyshire (14.2%), both of which are significantly better than the England average (see figure 20).

Figure 20 Smoking prevalence in adults (18+) with anxiety or depression - proportion (%) 2016/17

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

2.1.3.4 Smoking in prisoners and offenders

The smoking prevalence in prisoners, another vulnerable group, is estimated at 80% - substantially higher than the general population. Smoking rates are higher in offenders than the general population, as a group they are more likely to come from deprived communities and experience greater health inequalities. A survey for the Derbyshire Offenders' Health Needs Assessment 2018 found that of those that responded, 54.9% (45 of 82) of the respondents in Derbyshire were smokers, with a great proportion of smokers in the younger end of the age spectrum.[20] There are challenges in meeting cessation needs: people in contact with the criminal justice system are classed as a "mobile population", making it difficult to offer joined-up smoking cessation support.[21]

2.1.3.5 Smoking in homeless people

Similarly, an estimated 76% of homeless people smoke, with 50% of them reporting that they would like to give up.[22] Notably, the quantity of cigarettes smoked is particularly high, with many homeless people smoking more than 20 cigarettes per day.[23]

2.1.3.6 Smoking in people who identify as gay, lesbian or bisexual

Nationally people who identify as gay, lesbian or bisexual are more likely to be smokers than heterosexual people[24].

2.1.3.7 Other groups with higher smoking prevalence

Other groups that are known to have a higher smoking prevalence than the general population include care leavers and lone parents as well as people from White and from Mixed ethnic groups.[25]

2.1.4. Smoking in pregnancy

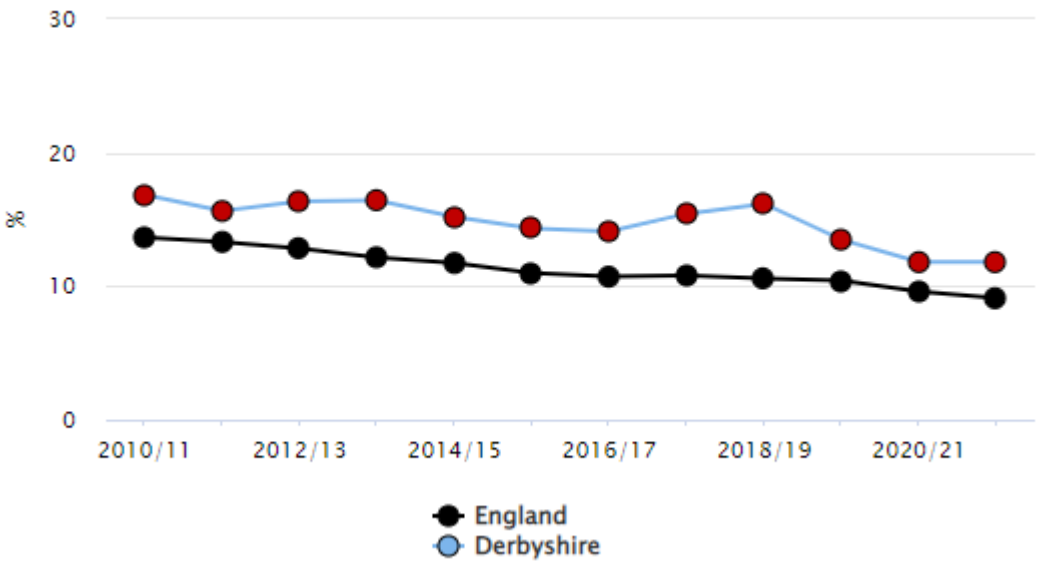
The NHS England return for 2021/22 on Smoking status at time of delivery (SATOD) shows that 11.8% (834) of pregnant women in Derbyshire were smoking at the time of delivery of their child. This is significantly worse than the England average of 9.1% (49534). Derbyshire ranks twelfth (fifth worst) when compared to its 15 CIPFA neighbours (see figure 21).

Figure 21 Smoking status at time of delivery (female, all ages) - proportion (%) 2021/22

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	49,534	9.1	9.0	9.2
Lincolnshire	→	3	931	15.0	14.1	15.9
Lancashire	↓	9	1,283	12.7	12.1	13.4
Nottinghamshire	↓	1	893	12.6	11.9	13.4
Norfolk	→	5	909	12.1	11.4	12.8
Derbyshire	↓	-	834	11.8	11.1	12.6
Devon	→	14	636	11.6	10.8	12.4
Worcestershire	↓	6	560	10.8	9.9	11.6
Gloucestershire	→	10	596	10.3	9.5	11.1
Staffordshire	↓	2	782	10.1	9.5	10.8
Somerset	→	8	480	10.0	9.2	10.9
Cumbria	↓	11	386	9.5	8.7	10.5
Warwickshire	→	7	538	9.3	8.6	10.1
Essex	↓	13	1,058	8.7*	8.2	9.2
North Yorkshire	↓	15	406	8.3	7.6	9.1
Leicestershire	→	12	389	8.3	7.6	9.2
Suffolk	↓	4	483	7.6	7.0	8.3

The prevalence of pregnant women who were smoking at the time of delivery has fluctuated in the past decade. More recently prevalence appears to be decreasing, although the rate remained the same in 2021/22 as in 2020/21 (see figure 22).

Figure 22 Smoking status at time of delivery (female, all ages) - Derbyshire trend



2.1.5 Derbyshire maps

Applying Office for National Statistics (ONS) smoking inequalities in England estimates of prevalence by deciles of deprivation to the Derbyshire population allows to roughly estimate the numbers of smokers in each area. Lower Super Output Areas (LSOA) are used. These geographies comprise between 400 and 1,200 households and have a usually resident population between 1,000 and 3,000 persons. These estimates are illustrated in the following maps and suggest that smokers are most likely to be found in the north east, extreme south and north west of the county.

Figure 233 Estimated number of smokers per census lower super output area – males 2017

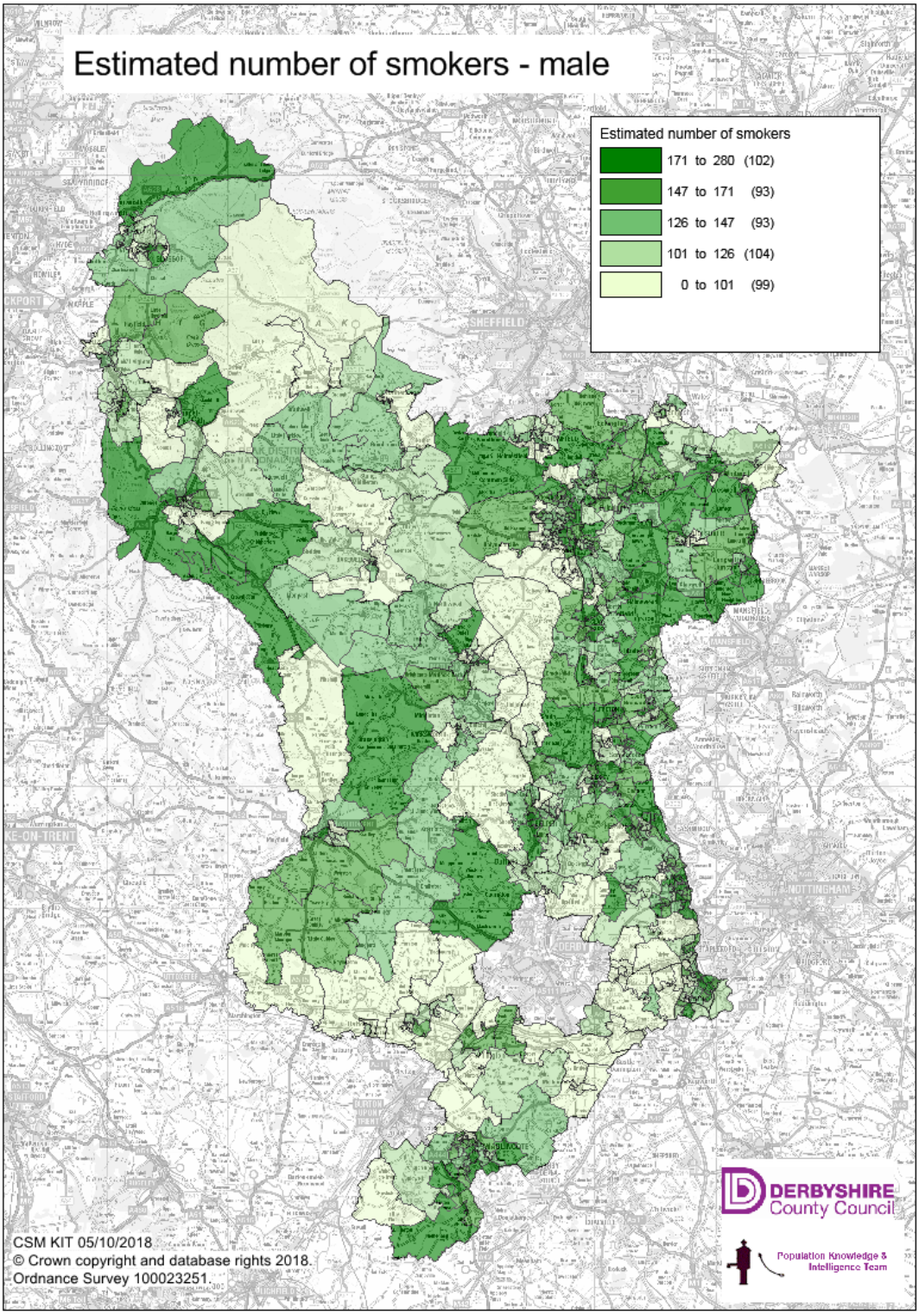
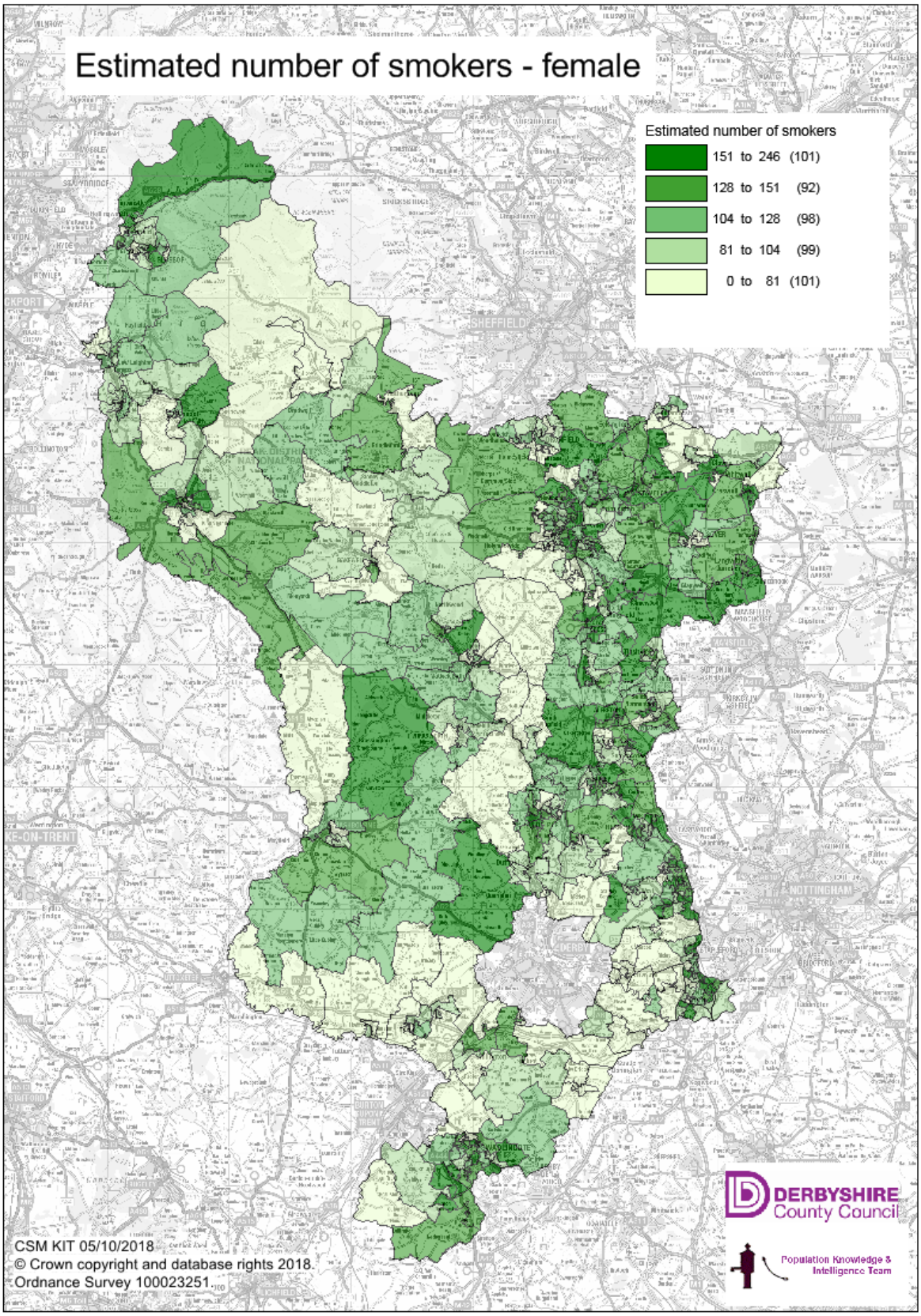


Figure 24 Estimated number of smokers per census lower super output area – females 2017



2.1.6 Use of alternative forms of tobacco

Shisha

Waterpipe smoking (commonly known in the UK as shisha), is a method of inhaling smoke – usually tobacco smoke, although non-tobacco forms of shisha are used. Tobacco shisha is subject to the UK smoke-free legislation. Estimated population level prevalence in the UK is low for both adults (around 1%) and young people (around 2%), but more common in Asian and Asian British populations (around 7%).[26] There are no indications that shisha use is common in Derbyshire.

Heat-not-burn products

Smokeless tobacco products include chewing tobacco and heated tobacco products (also known as 'heat-not-burn' products). The use of chewing tobacco such as 'paan' or 'bidi' is more common among people from South Asian communities, particularly Bangladeshi groups. These populations are not numerous within Derbyshire; in the 2021 census 1.5% of Derbyshire residents identified in the Asian/Asian British category, mainly concentrated in South Derbyshire (3.6% of South Derbyshire population), Chesterfield (1.9% of the Chesterfield population) and Erewash (1.6% of the Erewash population).

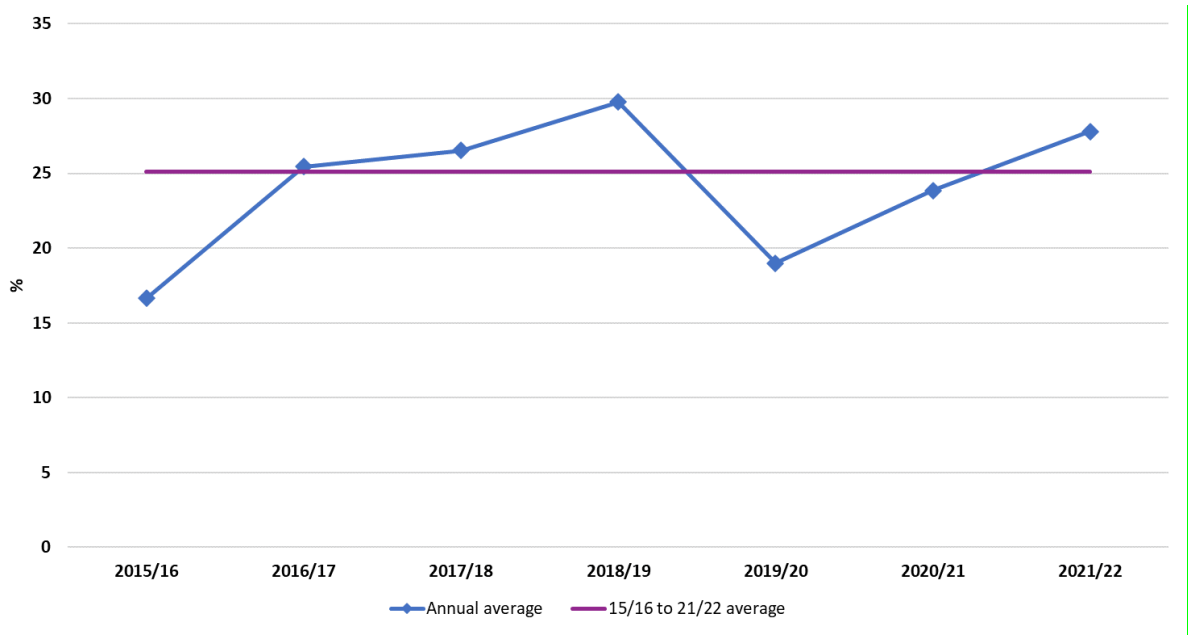
E-cigarettes

E-cigarettes or 'vapes' (nicotine delivery systems) do not contain tobacco. The nicotine is vaporised within a solution of propylene glycol or glycerine and flavouring and inhaled. In Great Britain, the prevalence of e-cigarette usage in adults in 2021 was estimated at between 6.9% and 7.1% (between 3.1 and 3.2 million adult vapers in England).[27] Figures from OHID show that the East Midlands region had the highest regional rate (11.9%) of smokers using e-cigarettes as part of their quit attempts using stop smoking services between the period of April 2020 to March 2021.[28] Over a quarter (25.2%) of 15-year-olds have tried e-cigarettes, significantly more than for England as a whole and towards the higher end of the range of the 15 CIPFA neighbours (see figure 26).

ASH's Smokefree GB survey has helped monitor the evolving youth use of e-cigarettes in Britain since 2013. Their 2022 survey found that a large majority (83.8%) of 11-17 year olds had never tried or were unaware of e-cigarettes. The 2022 survey found that 15.8% of 11-17 year olds had tried vaping, compared to 11.2% in 2021 and 13.9% in 2020. In 2022, 7.0% of 11-17 year olds were current users, compared to 3.3% in 2021 and 4.1% in 2020[29].

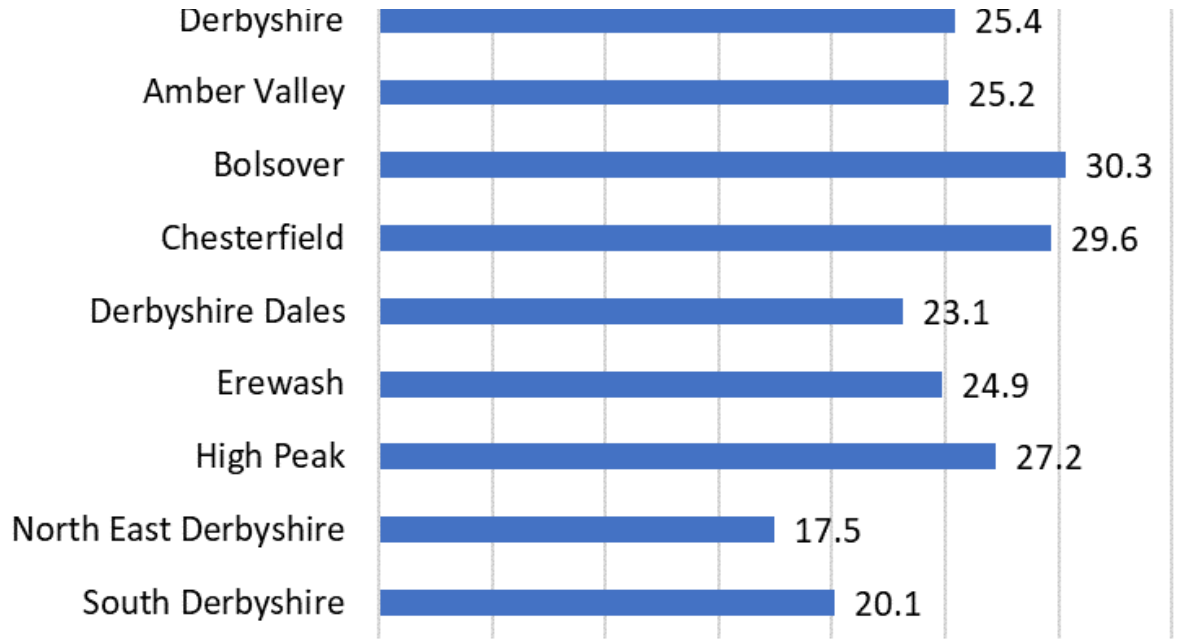
Between 2015/16 and 2021/22, the 'My Life, My View' survey questioned pupils in years 8, 9, 10 and 11 in Derbyshire about their behaviours and beliefs. Over this period, 25.1% (7213 children out of a sample of 28,721) said that they had tried an electronic cigarette. The values have fluctuated between the 2015/16 and 2021/22 period. The lowest prevalence was 16.6% (506/3041) in the 2015/16 school year, with the highest prevalence of 29.8% (1722/5783) in the 2018/19 school year (Figure 25). The 2019/20 data collection was disrupted by the Covid-19 pandemic, with a lower sample than previous and subsequent reporting periods.

Figure 24 My Life, My View Survey – Have you ever tried using an electronic cigarette? Derbyshire trend 2015/16 – 2021/22



The highest rate was in High Peak schools, at 30.3%, and the lowest in North East Derbyshire schools at 17.5% (Figure 26). Please note the district proportions in the figure below do not include data from the 2019/20 'My Life, My View' survey. This is due to a change in the way the geography was captured – Derbyshire Dales was split in to 'North Dales' and 'South Dales'. These were absorbed into the High Peak and South Derbyshire district's results respectively.

Figure 25 My Life, My View Survey – Have you ever tried using an electronic cigarette? Geographical variation. 2015/16- 2018/19



Of the 4261 children who had ever tried an electronic cigarette:

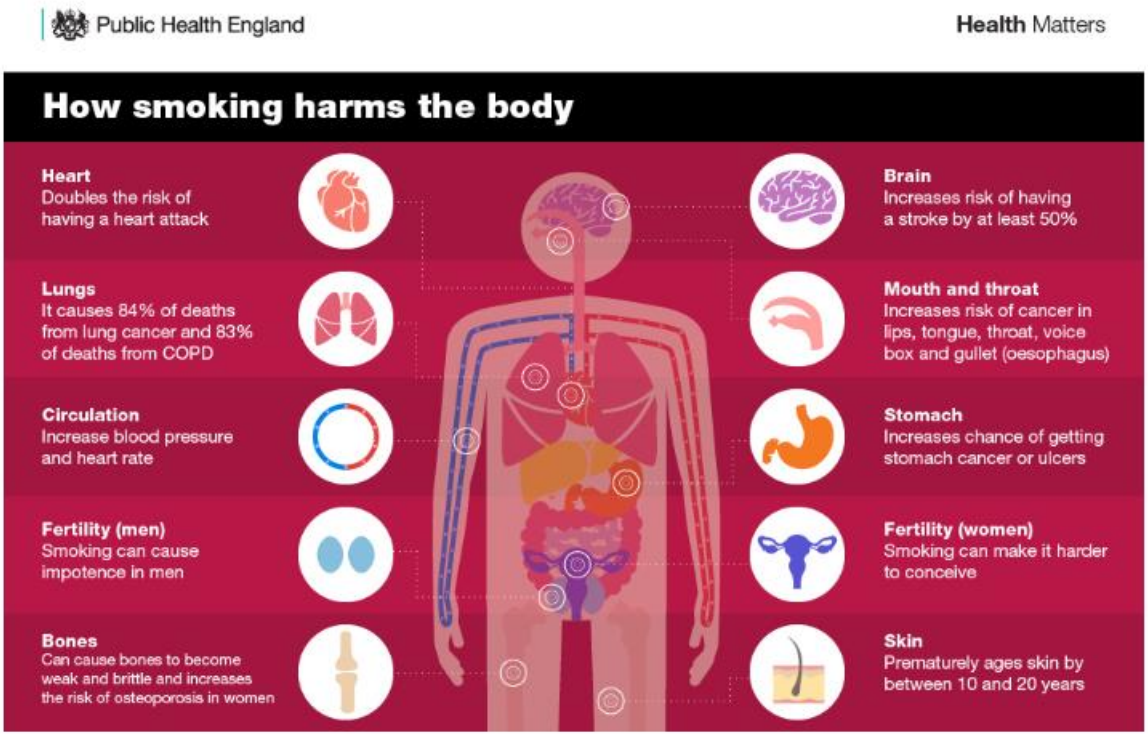
- 575 smoked once a day (13.5%)
- 415 smoked once a week (9.7%)
- 789 smoked once a month (18.5%)
- 2482 did not provide a response (58.2%)

Please note these numbers do not contain the results from the 2019/20 'My Life, My View' survey. This is because the question was phrased differently in the 2019/20 survey.

2.2 Smoking related morbidity

Smoking has multiple harmful effects on the organs and systems of the body. These harms occur for the person who is smoking themselves, and as a result of second-hand smoke. Smoking is harmful for health throughout the life course, from conception through to later life. The data in this section for Derbyshire is presented for the illnesses associated with smoking across the life course.

Figure 26 How smoking harms the body[30]



2.2.1 Premature and low weight births

Smoking is the most important preventable cause of adverse outcomes during pregnancy.[31] There is substantial evidence[32] that smoking and exposure to second-hand smoke during pregnancy increases the risks of miscarriage, stillbirth, premature birth, low-birth weight babies, and complications during labour.

Smoking during pregnancy is also estimated to increase the risk of infant mortality by 40%, and the likelihood of wheezy illnesses during childhood.[33] Smoking during pregnancy is a significant contributor to health inequalities. There are substantial costs for the NHS in treating the problems arising from smoking during pregnancy, estimated in 2010 to be between £8.1 and £64 million for mothers and between £12 and £23.5 million for infants each year.[34]

In the 2019-21 reporting period, the premature birth rate (babies born with a gestational age of between 24 and 36 weeks) in Derbyshire was 84.9 per 1,000 births (approximately 1848 per year). This is significantly worse than the England average of 77.9 premature births per 1,000 births. When ranked against its 15 CIPFA neighbours, Derbyshire ranks second worst (see figure 28).

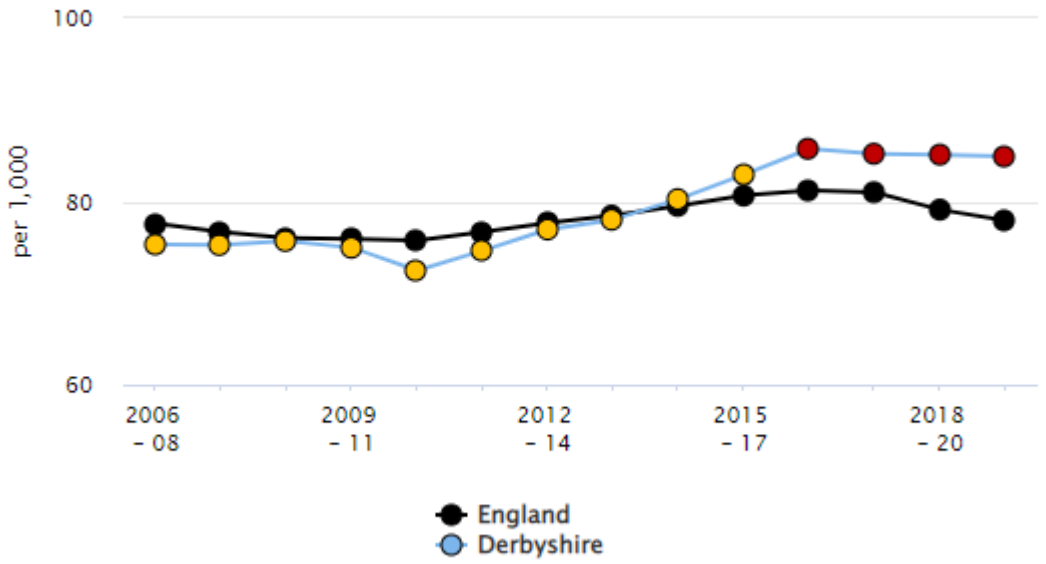
Figure 27 Premature births (less than 37 weeks gestation) – rate per 1,000 – 2019-2021

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	140,031	77.9	77.5	78.3
Neighbours average	–	-	-	-	-	-
Warwickshire	–	7	1,532	86.7	82.4	91.1
Derbyshire	–	-	1,848	84.9	81.1	88.9
Worcestershire	–	6	1,381	83.5	79.1	88.0
Staffordshire	–	2	2,035	82.8	79.2	86.5
Suffolk	–	4	1,707	80.8	77.0	84.7
Leicestershire	–	12	1,608	80.4	76.5	84.5
Lancashire	–	9	2,905	80.2	77.3	83.2
Lincolnshire	–	3	1,598	80.0	76.1	84.0
Norfolk	–	5	1,857	78.5	75.0	82.2
Cumbria	–	11	986	78.1	73.4	83.2
Somerset Cty	–	8	1,151	76.2	71.9	80.7
Gloucestershire	–	10	1,366	75.5	71.5	79.6
Nottinghamshire	–	1	1,766	74.9	71.4	78.5
Essex	–	13	3,457	73.2	70.8	75.6
North Yorkshire Cty	–	15	1,088	72.0	67.8	76.4
Devon	–	14	1,362	69.6	66.0	73.4

Source: Office for National Statistics adhoc table request

The Derbyshire value steadily increased from the 2010-2012 period until 2016-2018. Since 2016-2018, the rate of premature births has remained significantly worse than the England average, though a definite trend could not be calculated (see figure 29).

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



There is some variation in the rate of premature births in Derbyshire. The district with the highest rate of premature births is Erewash (90.9 premature births per 1000 births) which is significantly worse than the England average (77.9 premature births per 1000 births). The district with the lowest rate of premature births per 1000 births is High Peak (77.2 premature births per 1000 births), similar to the England average (see figure 30).

Figure 28 Premature births (less than 37 weeks gestation) - geographical variation 2019-21

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	140,031	77.9	77.5	78.3
Derbyshire	–	1,848	84.9	81.1	88.9
Erewash	–	282	90.9	80.6	102.2
Bolsover	–	216	89.0	77.5	101.7
Amber Valley	–	297	87.4	77.7	97.9
South Derbyshire	–	294	86.8	77.1	97.3
Chesterfield	–	250	84.5	74.3	95.6
Derbyshire Dales	–	115	81.9	67.6	98.3
North East Derbyshire	–	209	77.9	67.7	89.2
High Peak	–	185	77.2	66.5	89.2

Source: Office for National Statistics adhoc table request

Low birth weight increases the risk of childhood mortality and of developmental problems for the child and is associated with poorer health in later life. At a population level there are inequalities in low birth weight and a high proportion of low-birth-weight births could indicate lifestyle issues of the mothers and/or issues with the maternity services.[35]

In 2021, the proportion of low birth weight of term babies (defined as babies with a recorded birth weight under 2500g and a gestational age of at least 37 complete weeks as a percentage of all live births with recorded birth weight and a gestational age of at least 37 complete weeks) in Derbyshire was 1.9%. This is significantly better than the England average of 2.8%. Derbyshire ranks fourth best when comparing it to its 15 CIPFA neighbours (see figure 31).

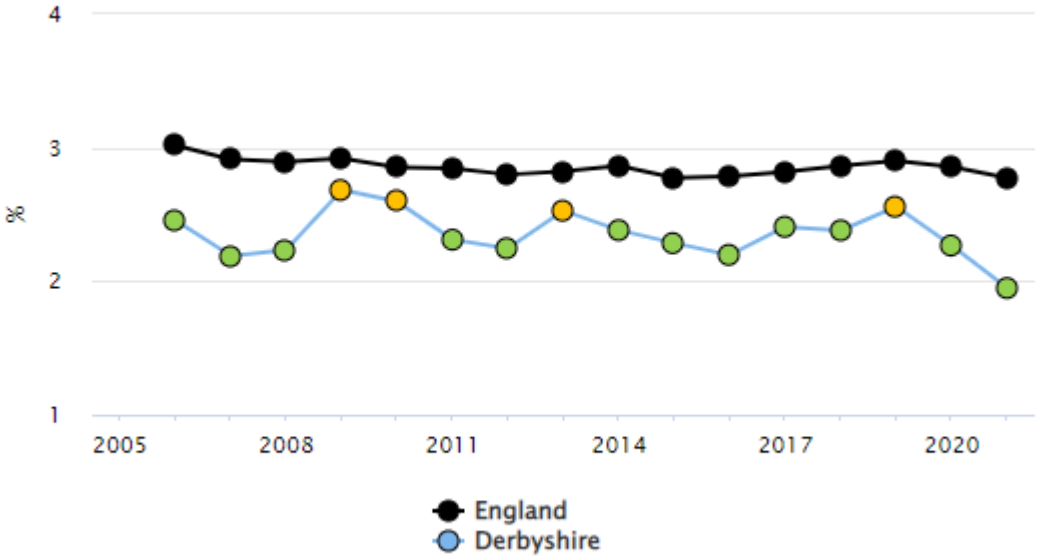
Figure 29 Low birth weight of term babies – 2021 proportion (%)

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	➡	-	14,986	2.8	2.7	2.8
Neighbours average	–	-	-	-	-	-
North Yorkshire Cty	➡	15	82	1.7	1.4	2.1
Gloucestershire	➡	10	102	1.8	1.5	2.2
Essex	➡	13	288	1.9	1.7	2.2
Derbyshire	➡	-	131	1.9	1.6	2.3
Cumbria	➡	11	81	2.1	1.7	2.6
Worcestershire	➡	6	117	2.3	1.9	2.8
Warwickshire	➡	7	128	2.3	2.0	2.8
Staffordshire	➡	2	179	2.4	2.1	2.7
Devon	➡	14	147	2.4	2.0	2.8
Nottinghamshire	➡	1	176	2.5	2.1	2.8
Norfolk	➡	5	181	2.6	2.3	3.0
Somerset Cty	➡	8	126	2.7	2.3	3.2
Leicestershire	➡	12	167	2.7	2.3	3.1
Lincolnshire	➡	3	163	2.7	2.4	3.2
Suffolk	➡	4	169	2.8	2.4	3.2
Lancashire	➡	9	320	2.9	2.6	3.2

Source: Office for National Statistics

The proportion of low birth weight of term babies has been steady since 2006 with a more recent drop, and has often been significantly better than the national average (see figure 32).

Figure 30 Low birth weight of term babies – Derbyshire trend



2.2.2 Hospital admissions

A 2021 report estimated the NHS spends £2.5 billion (equivalent to 2%) of its annual budget on smoking-related conditions.[36] In the year of 2019/20, admissions to hospital due to smoking-related conditions were estimated to amount to more than half a million, representing a large demand on NHS resources.[37] Hospital admissions due to smoking can also be used as a proxy for variations in smoking-related ill health in the general population across England.[38] The conditions causing these admissions are cancers, cardiovascular disease, respiratory diseases, disease of the digestive system, age-related cataract, hip fracture, and spontaneous abortion.

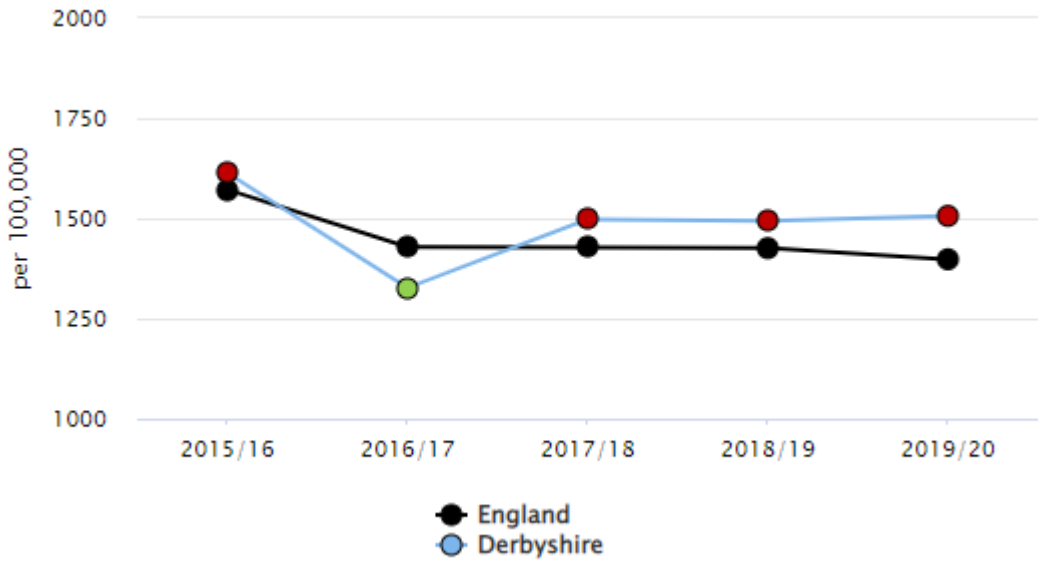
In the 2019/20 reporting period, the incidence rate of smoking attributable hospital admissions in adults over the age of 35 in Derbyshire was 1,506 per 100,000 (7,978 in the reporting period). This is significantly worse than the England average incidence rate of smoking attributable hospital admissions, which was 1,398 per 100,000. Derbyshire ranks twelfth (fifth worst) when compared to its CIPFA neighbours (see figure 33).

Figure 31 Smoking attributable hospital admissions – directly standardised rate (per 100,000) 2019/20

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	↓	-	448,031	1,398	1,394	1,402
Neighbours average	–	-	-	-	-	-
Nottinghamshire	↑	1	8,453	1,609	1,575	1,644
Staffordshire	↑	2	9,275	1,607	1,574	1,640
Norfolk	→	5	10,087	1,574	1,543	1,605
Cumbria	↓	11	5,500	1,524	1,484	1,566
Derbyshire	→	-	7,978	1,506	1,473	1,540
Lancashire	↓	9	11,182	1,465	1,437	1,492
Worcestershire	→	6	5,746	1,426	1,389	1,463
North Yorkshire	→	15	6,420	1,425	1,390	1,460
Lincolnshire	→	3	7,252	1,383	1,351	1,415
Somerset	→	8	5,266	1,303	1,268	1,339
Suffolk	→	4	6,696	1,280	1,250	1,312
Warwickshire	↑	7	4,497	1,242	1,206	1,279
Essex	↓	13	11,532	1,241	1,219	1,264
Leicestershire	→	12	5,352	1,219	1,186	1,252
Gloucestershire	→	10	4,653	1,125	1,093	1,158
Devon	↓	14	6,392	1,086	1,060	1,114

The incidence rate of smoking attributable hospital admissions per 100,000 in adults over the age of 35 has been steady in the past few reporting periods (see figure 34).

Figure 32 Smoking attributable hospital admissions – Derbyshire trend



2.2.3 Chronic obstructive pulmonary disease exacerbations

Smokers can often dismiss the early signs of chronic obstructive pulmonary disease (COPD) as a 'smoker's cough', but if they continue smoking and the condition worsens, it can greatly impact on their quality of life.[39]

In the 2019/20 reporting period, the rate of emergency hospital admissions for COPD in people over the age of 35 in Derbyshire was 403 per 100,000 of the population (2,145 admissions). This is similar to the England average of 415 emergency hospital admissions for COPD in people over the age of 35 per 100,000 of the population. Derbyshire ranks third worst for

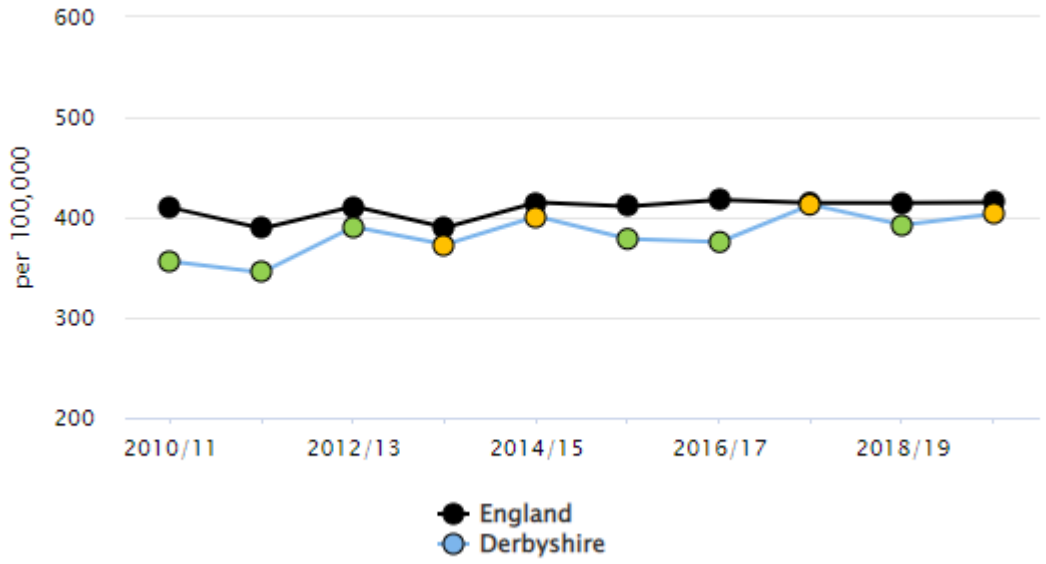
emergency hospital admissions for COPD in people over the age of 35 when ranked alongside its 15 CIPFA neighbours (see figure 35).

Figure 33 Emergency Hospital Admissions for COPD (people aged over 35) – directly standardised rate (per 100,000) 2019/20

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	→	-	133,103	415	413	417
Neighbours average	–	-	-	-	-	-
Lancashire	→	9	3,795	494	478	510
Lincolnshire	↑	3	2,200	410	393	428
Derbyshire	→	-	2,145	403	386	421
Staffordshire	↑	2	2,325	398	382	414
Leicestershire	↑	12	1,730	390	372	409
Nottinghamshire	→	1	1,995	377	360	394
Cumbria	→	11	1,375	374	354	394
Worcestershire	→	6	1,455	357	339	376
Essex	→	13	3,310	351	339	363
Warwickshire	→	7	1,275	345	326	365
Norfolk	→	5	2,240	341	327	355
Suffolk	→	4	1,755	327	311	342
Somerset	→	8	1,265	306	289	323
North Yorkshire	→	15	1,315	284	269	300
Gloucestershire	→	10	1,155	276	260	292
Devon	↑	14	1,615	268	255	281

The Derbyshire trend of emergency hospital admissions for COPD in people over the age of 35 has been quite steady over the past few reporting periods (see figure 36).

Figure 34 Emergency hospital admissions for COPD (people aged over 35) – Derbyshire trend



In the 2019/20 reporting period, there was notable variation in emergency hospital admissions for COPD in people over the age of 35 across Derbyshire (see figure 37). The district with the lowest rate of admissions per 100,000 was Derbyshire Dales, where there were 187 admissions per 100,000. This is significantly lower than the England average. The district with the highest rate of admissions per 100,000 was Chesterfield, where there were 537 admissions per 100,000. This is significantly higher than the England average.

Figure 35 Emergency hospital admissions for COPD (people aged over 35) – Geographical Variation – 2019/20

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	→	133,103	415	413	417
Derbyshire	→	2,145	403	386	421
Chesterfield	→	365	537	483	595
Bolsover	→	235	473	414	538
South Derbyshire	→	270	451	399	509
Erewash	↑	320	437	390	488
High Peak	→	255	423	372	478
Amber Valley	→	335	389	348	433
North East Derbyshire	→	260	345	304	390
Derbyshire Dales	→	110	187	154	226

2.2.4 Cancer registrations

Smoking causes at least 15 different types of cancer: lung, larynx, oesophagus, oral cavity, nasopharynx, pharynx, bladder, pancreas, kidney, liver, stomach, bowel, cervix, leukaemia, and ovarian cancers.[40]

2.2.5 Lung cancer

Lung cancer is the most common cause of cancer death in the UK, accounting for more than 1 in 5 (21%) of cancer deaths.[41] The link between tobacco and lung cancer was established almost 70 years ago. In England in the period of 2019/2020, 77% of hospital admissions and 78% of deaths (in 2019) due to cancer of the trachea, lungs and bronchus in persons aged 35 and over were attributed to smoking.[42]

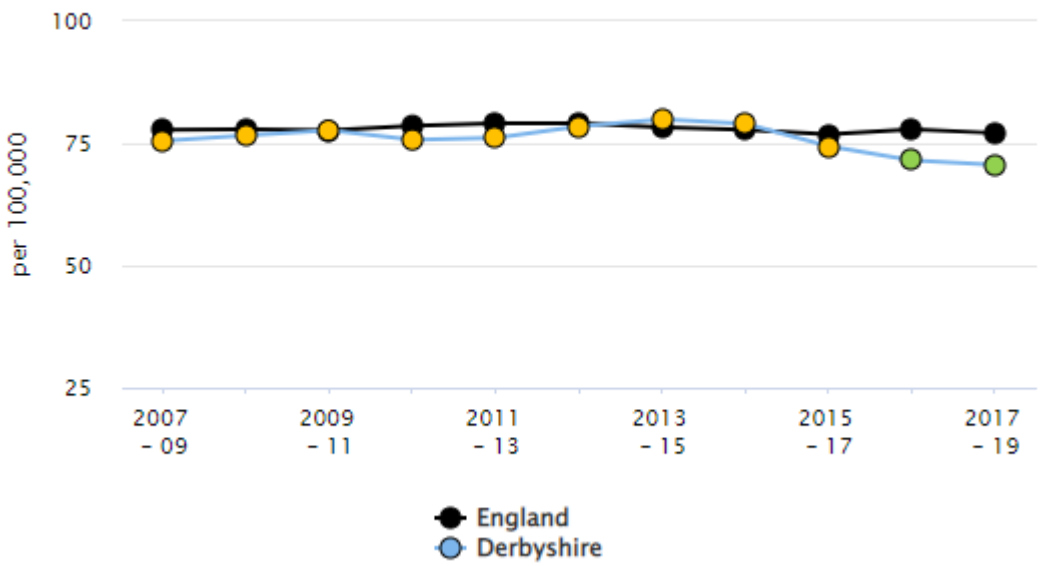
In the 2017 to 2019 reporting period, the incidence of lung cancer registrations was 70.6 per 100,000 of the population (approximately 1,813). This is significantly better than the England average of 77.1 registrations per 100,000 (see figure 38). However, Derbyshire ranks as the fifth worst performing county compared to its 15 CIPFA neighbours.

Figure 36 Lung cancer registrations (persons, all ages) - directly standardised rate (per 100,000) 2017-19

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	119,263	77.1	76.6	77.5
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	3,073	82.1	79.2	85.1
Nottinghamshire	–	1	1,926	75.4	72.1	78.9
Lincolnshire	–	3	1,922	74.2	70.9	77.6
Cumbria	–	11	1,307	73.0	69.1	77.1
Derbyshire	–	-	1,813	70.6	67.4	74.0
Leicestershire	–	12	1,471	69.7	66.1	73.4
Staffordshire	–	2	1,971	69.7	66.7	72.9
Essex	–	13	3,153	69.6	67.1	72.1
Norfolk	–	5	2,145	66.8	64.0	69.7
North Yorkshire	–	15	1,473	66.6	63.2	70.1
Warwickshire	–	7	1,133	64.1	60.4	68.0
Suffolk	–	4	1,634	63.1	60.1	66.3
Worcestershire	–	6	1,229	62.7	59.2	66.4
Somerset	–	8	1,252	62.5	59.1	66.1
Devon	–	14	1,784	61.6	58.7	64.6
Gloucestershire	–	10	1,095	54.4	51.2	57.8

The trend of lung cancer registrations has been gradually decreasing in the past few reporting periods (see figure 39).

Figure 39 Lung cancer registrations (persons, all ages) – Derbyshire trend 2017-19



There is notable variation in the incidence of lung cancer registrations across Derbyshire. The district with the highest rate was Bolsover, which reported 103.2 registrations per 100,000. This is significantly worse than the England average. The district with the lowest rate was Derbyshire Dales, which reported 49.0 registrations per 100,000. This is significantly better than the England average (see figure 40).

Figure 37 Lung cancer registrations (persons, all ages) – geographical variation 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	119,263	77.1	76.6	77.5
Derbyshire	–	1,813	70.6	67.4	74.0
Bolsover	–	243	103.2	90.2	117.5
Chesterfield	–	261	79.3	69.9	89.7
High Peak	–	223	77.8	67.7	89.0
North East Derbyshire	–	267	72.0	63.5	81.2
Erewash	–	243	69.1	60.6	78.4
Amber Valley	–	271	66.0	58.3	74.5
South Derbyshire	–	163	55.5	47.2	64.9
Derbyshire Dales	–	142	49.0	41.2	57.9

2.2.6 Oral cancers

Tobacco is a known risk factor for oral cancers.[43] In England, 62% of hospital admissions (2018/19) for cancers of the upper respiratory sites and 61% of deaths (2018) due to cancers of the upper respiratory sites were attributed to smoking.[44]

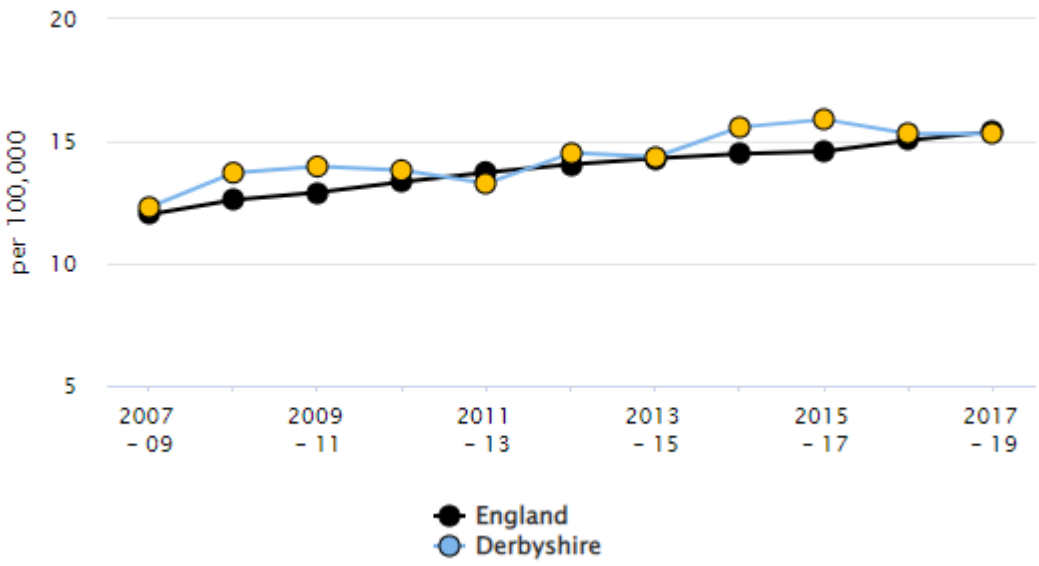
In the 2017-19 reporting period, the incidence rate of oral cancer registrations in Derbyshire was 15.3 per 100,000 (389 cases). This is similar to the England incidence rate of 15.4 oral cancer registrations per 100,000. Derbyshire ranks fourth worst when comparing it to its 15 CIPFA neighbours (see figure 41).

Figure 38 Oral cancer registrations (persons, all ages) – directly standardised rate (per 100,000) 2017-2019

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	24,115	15.4	15.2	15.6
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	617	16.7	15.4	18.1
Somerset	–	8	299	16.2	14.4	18.2
Devon	–	14	429	15.6	14.2	17.2
Derbyshire	–	-	389	15.3	13.8	16.9
Norfolk	–	5	447	15.1	13.7	16.5
Warwickshire	–	7	263	15.0	13.3	17.0
Cumbria	–	11	256	14.9	13.1	16.8
Worcestershire	–	6	284	14.8	13.1	16.6
Lincolnshire	–	3	351	14.3	12.8	15.9
Nottinghamshire	–	1	365	14.2	12.8	15.8
North Yorkshire	–	15	292	13.9	12.4	15.6
Essex	–	13	622	13.9	12.9	15.1
Gloucestershire	–	10	275	13.8	12.2	15.5
Leicestershire	–	12	284	13.4	11.9	15.1
Staffordshire	–	2	362	13.1	11.8	14.5
Suffolk	–	4	320	13.0	11.6	14.5

The incidence rate per 100,000 of oral cancer registrations in Derbyshire has been gradually increasing since the 2007-09 reporting period (see figure 42).

Figure 39 Oral cancer registrations (persons, all ages) – Derbyshire trend



There is slight variation in oral cancer registrations across Derbyshire, but all districts report an incidence rate per 100,000 which is similar to the England average (Figure 43). The district with the lowest incidence rate of oral cancer registrations per 100,000 is Derbyshire Dales (12.6) and the district with the highest incidence rate is Chesterfield (19.1).

Figure 40 Oral cancer registrations (persons, all ages) – geographical variation 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	24,115	15.4	15.2	15.6
Derbyshire	–	389	15.3	13.8	16.9
Chesterfield	–	63	19.1	14.6	24.4
Bolsover	–	43	17.5	12.7	23.6
North East Derbyshire	–	52	15.1	11.2	19.9
Erewash	–	53	15.1	11.3	19.8
Amber Valley	–	62	15.0	11.5	19.3
South Derbyshire	–	40	13.8	9.7	19.0
High Peak	–	41	13.5	9.7	18.4
Derbyshire Dales	–	35	12.6	8.7	17.6

2.2.7 Oesophageal cancers

Oesophageal cancer is a cancer that's found anywhere in the oesophagus, sometimes called the gullet or food pipe. Cancer Research UK estimated that 59% of oesophageal cancer cases in the UK in 2015 were preventable and 34% of oesophageal cancer cases were caused by smoking[45]. Oesophageal cancer survival has tripled in the last 50 years in the UK[46]. More than one in ten (12.4%) people diagnosed with oesophageal cancer in England survive their disease for ten years or more (2013-2017)[47].

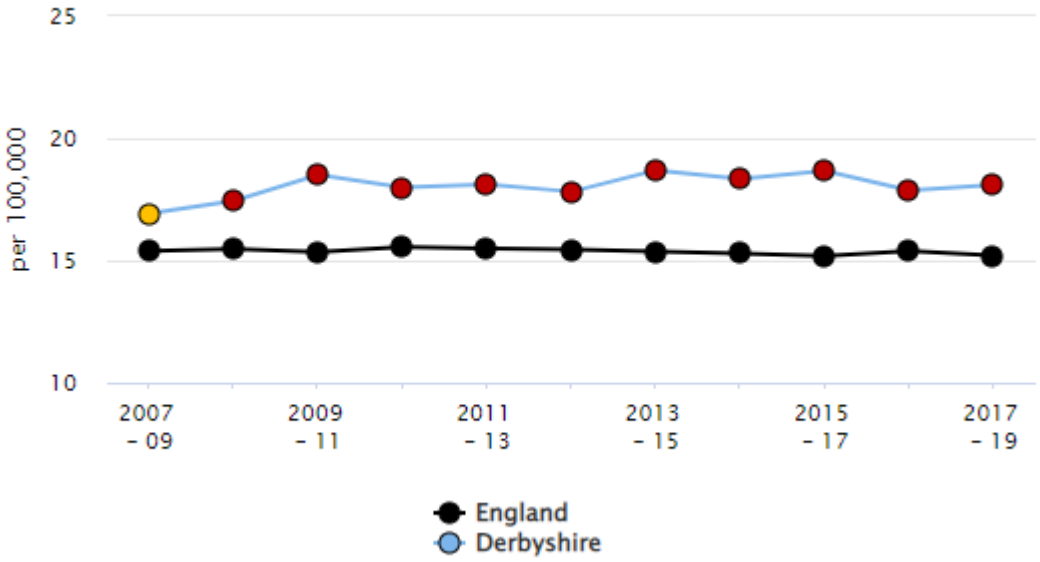
In the 2017-19 reporting period, the incidence rate of oesophageal cancer registrations in Derbyshire was 18.1 per 100,000 (459 cases). This is significantly worse than the England incidence rate of 15.2 oesophageal cancer registrations per 100,000. Derbyshire ranks second worst when comparing it to its 15 CIPFA neighbours (see figure 44).

Figure 41 Oesophageal cancer registrations (persons, all ages) – directly standardised rate (per 100,000) 2017-19

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	23,283	15.2	15.0	15.4
Neighbours average	–	-	-	-	-	-
Worcestershire	–	6	363	19.0	17.1	21.1
Derbyshire	–	-	459	18.1	16.4	19.8
Staffordshire	–	2	487	17.7	16.2	19.4
Lancashire	–	9	647	17.6	16.2	19.0
Cumbria	–	11	290	16.4	14.6	18.5
Norfolk	–	5	516	16.4	15.0	17.9
Nottinghamshire	–	1	414	16.4	14.8	18.1
Warwickshire	–	7	282	16.1	14.2	18.1
Suffolk	–	4	403	15.7	14.2	17.3
Lincolnshire	–	3	406	15.7	14.2	17.3
Leicestershire	–	12	319	15.5	13.8	17.4
Gloucestershire	–	10	301	15.2	13.5	17.0
North Yorkshire	–	15	322	14.7	13.1	16.4
Essex	–	13	641	14.4	13.3	15.6
Devon	–	14	390	13.6	12.3	15.1
Somerset	–	8	255	12.8	11.3	14.5

The incidence rate per 100,000 of oral cancer registrations in Derbyshire has been steady since the 2007-09 reporting period (see figure 45).

Figure 42 Oesophageal cancer registrations (persons, all ages) – Derbyshire trend



There is some variation in oesophageal cancer registrations across Derbyshire. The district with the highest incidence rate of oesophageal cancer registrations per 100,000 is the High Peak (24.5) which is significantly worse than the England average (15.2). The district with the lowest incidence rate of oesophageal cancer registrations per 100,000 is North East Derbyshire (13.6) which is similar to the England average (Figure 46).

Figure 43 Oesophageal cancer registrations (Persons, All Ages) – geographical variation 2017-19

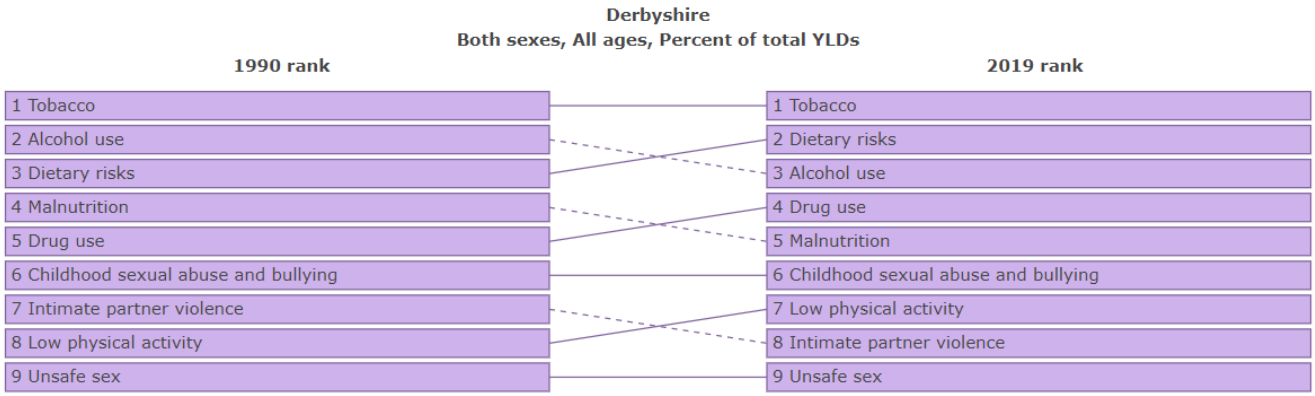
Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	23,283	15.2	15.0	15.4
Derbyshire	–	459	18.1	16.4	19.8
High Peak	–	70	24.5	19.0	31.2
Bolsover	–	52	22.3	16.3	29.6
Amber Valley	–	82	20.3	16.1	25.3
South Derbyshire	–	55	19.5	14.5	25.6
Derbyshire Dales	–	46	17.2	12.4	23.1
Chesterfield	–	52	15.5	11.5	20.3
Erewash	–	53	15.0	11.2	19.7
North East Derbyshire	–	49	13.6	10.0	18.1

2.2.8 Years lived in disability

The Global Burden of Disease tool[48] can be used to assess the contribution of different risks to health. Tobacco use is, and has been since at least 1990, the leading behavioural cause of years lived in ill-health[3] in Derbyshire. In 2019 over 52,841 years of were lived with disability due to metabolic, environmental, and behavioural causes; approximately 9,413 of these are thought to have been due to tobacco use[4] (see figure 47).

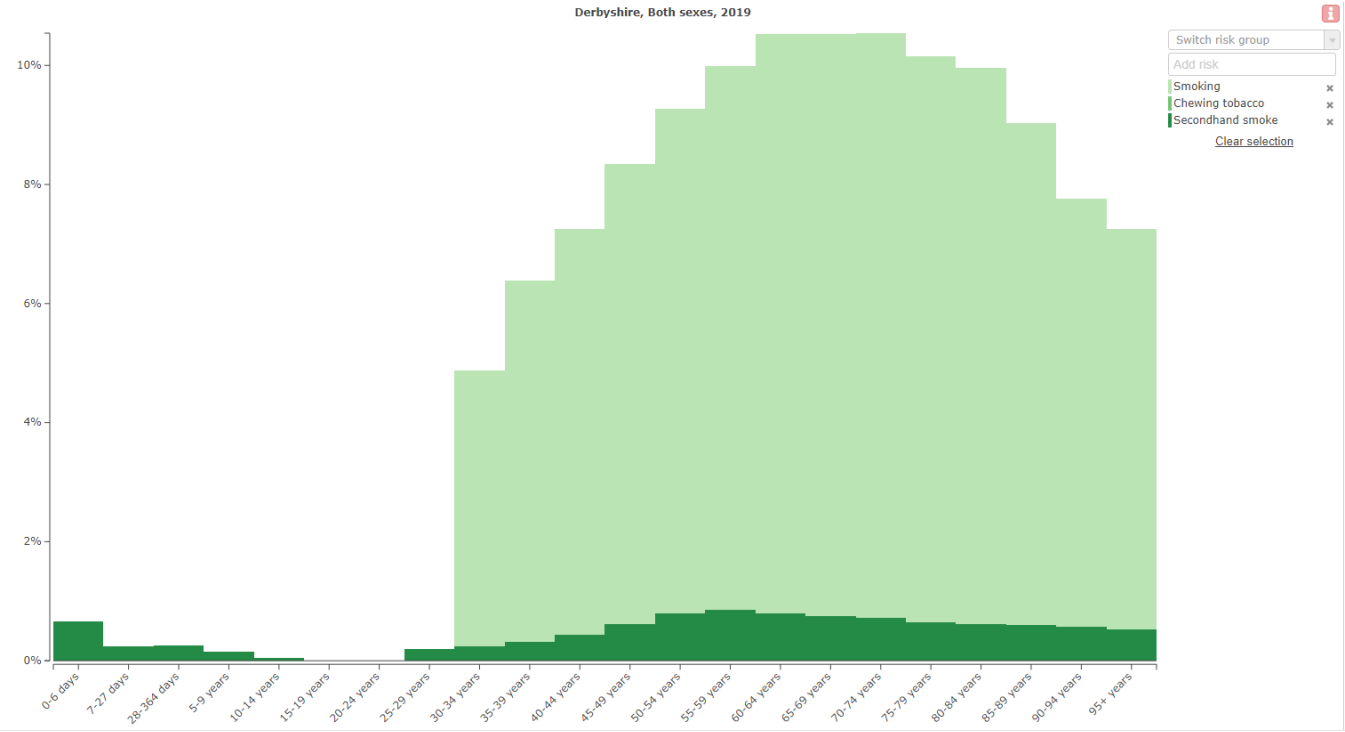
[3] Years lived with disability (YLDs): Years of life lived with any short-term or long-term health loss.
[4] Estimated using https://vizhub.healthdata.org/gbd-compare/#0

Figure 44 Rank of risk by percentage of total years lived with disability, 1990 and 2019



The bulk of the burden of disability falls in the mid to later years of life, as might be expected, for both smoking and the effects of second-hand smoke. However, figure 48 demonstrates that as a proportion of all threats to health in the early years, second-hand smoke has a notable effect.

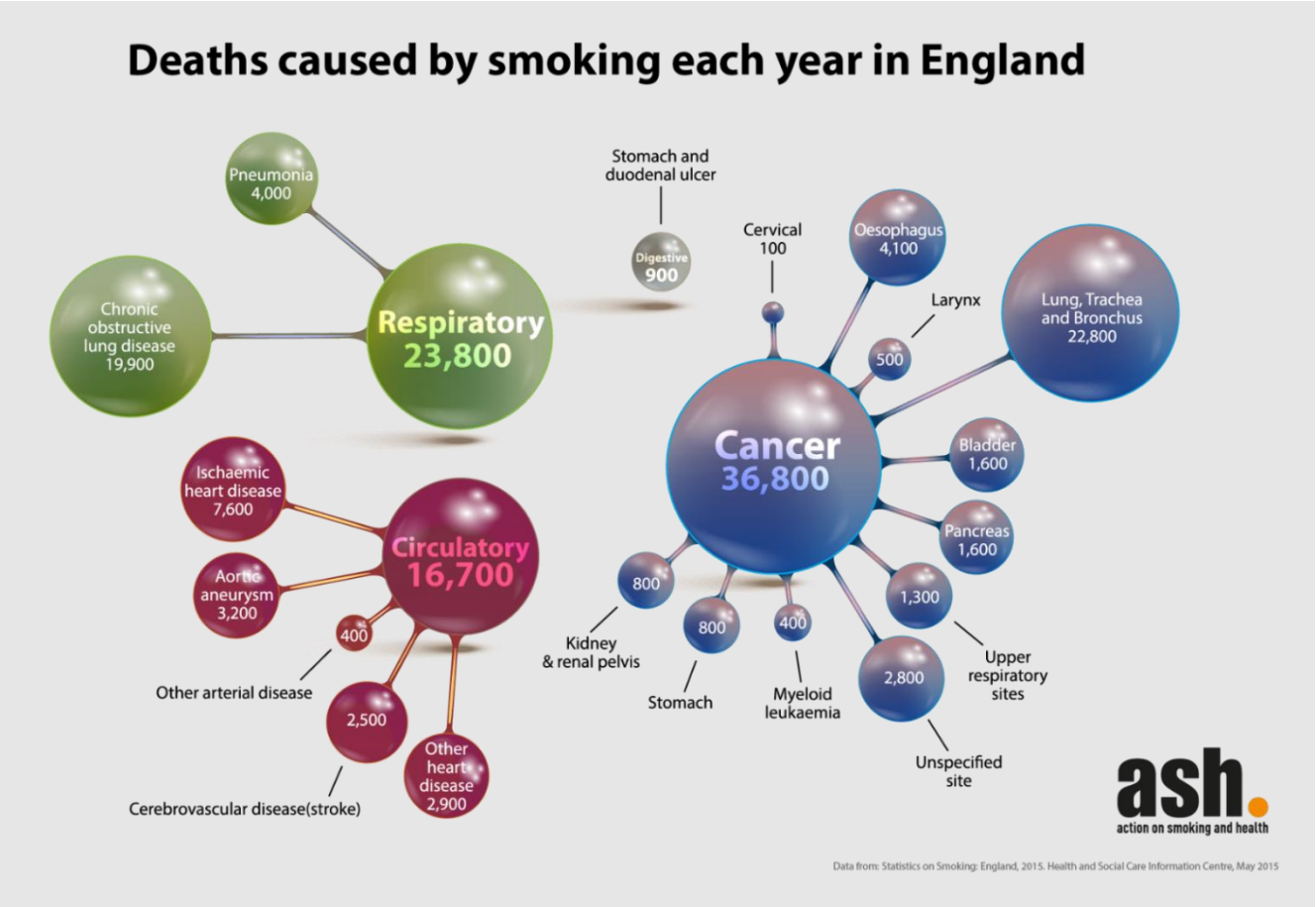
Figure 45 Proportion of total years lived with disability, by 5-year age band, 2019



2.3 Smoking related mortality

Smoking represents the most important cause of preventable morbidity and mortality.[49] In 2021 it was estimated that smoking accounted for approximately 74,600 deaths a year in England, and huge inequalities can be seen in smoking-related deaths.[50] Tobacco accounts for the largest proportion of the gap in life expectancy between the most and least deprived areas for men (9.4 years) and women (7.6 years). Smoking accounts for half of the difference in life expectancy between the poor and rich in England.[51] In addition, areas with the highest death rates from smoking are around three times as high than areas with the lowest death rates attributable to smoking.[52]

Figure 49 Estimates of deaths caused by smoking by underlying cause of death 2015 - ASH



2.3.1 Overall smoking-related deaths

In the 2017-19 reporting period, the estimated incidence rate of smoking attributable deaths for people over the age of 35 in Derbyshire was 199.5 per 100,000 (3,079 deaths in the 3-year period).[5] This is similar to the England incidence rate of 202.2 per 100,000. Derbyshire ranks fourth worst when comparing it to its 15 CIPFA neighbours (see figure 50).

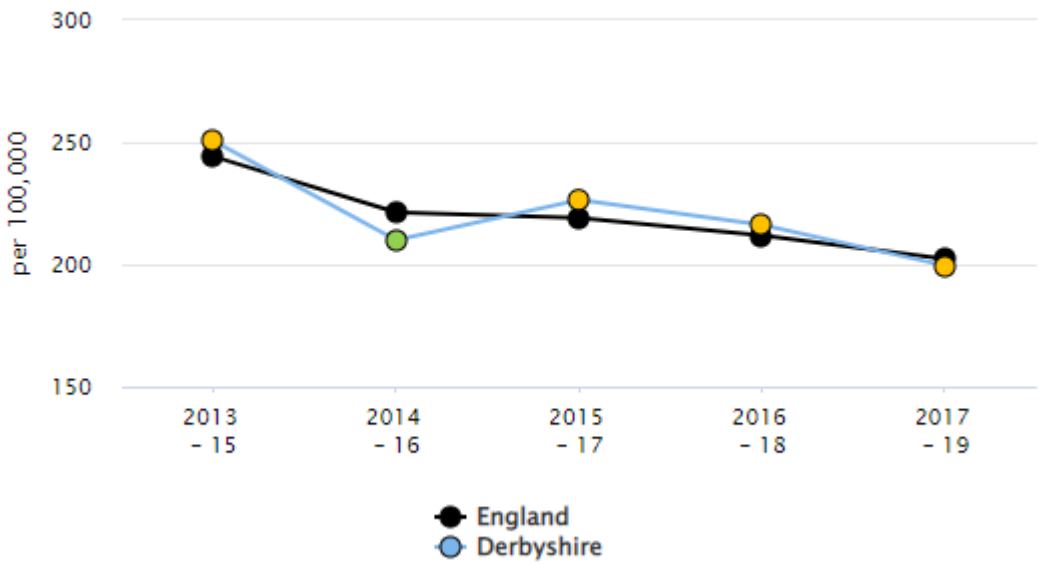
[5] The estimated number of smoking-attributable deaths is calculated by multiplying the observed number of deaths (smoking attributable deaths) by the SAFs (Smoking Attributable Fraction). This indicator uses updated smoking attributable fractions, based on new relative risks published by the Royal College of Physicians in 2018.

Figure 46 Smoking attributable mortality (persons, aged 35+ years) – directly standardised rate (per 100,000) 2017-2019

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	191,903	202.2	201.3	203.1
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	5,174	229.1	222.9	235.5
Nottinghamshire	–	1	3,373	218.7	211.3	226.2
Lincolnshire	–	3	3,365	213.3	206.2	220.7
Derbyshire	–	-	3,079	199.5	192.5	206.7
Cumbria	–	11	2,151	197.3	189.0	205.9
Essex	–	13	5,499	195.8	190.6	201.0
Staffordshire	–	2	3,284	193.6	187.0	200.3
Norfolk	–	5	3,716	185.9	179.9	192.0
North Yorkshire	–	15	2,444	179.1	172.0	186.4
Suffolk	–	4	2,912	178.9	172.4	185.5
Leicestershire	–	12	2,232	172.3	165.2	179.6
Warwickshire	–	7	1,842	168.6	161.0	176.5
Somerset	–	8	2,110	167.9	160.7	175.2
Gloucestershire	–	10	2,070	166.6	159.5	174.0
Worcestershire	–	6	2,008	165.2	158.0	172.6
Devon	–	14	2,934	159.4	153.6	165.3

The estimated incidence rate per 100,000 of smoking attributable deaths for people over the age of 35 in Derbyshire has been gradually decreasing since the 2013 – 15 reporting period (see figure 51).

Figure 47 Smoking attributable mortality (persons, aged 35+ years) – Derbyshire trend



There is no data available at a district level for the estimated rate of smoking attributable deaths in Derbyshire.

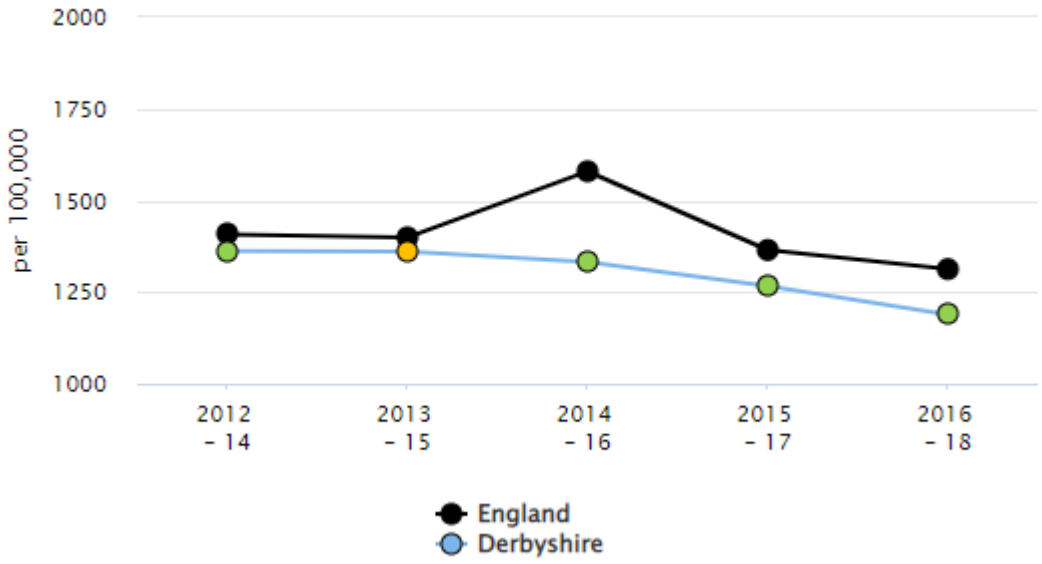
In the 2016-18 reporting period, the estimated incidence rate of potential years of life lost due to smoking related illness in those over 35 Derbyshire was 1,189 per 100,000 (a total of 15,632 years). This is significantly better than the England average incidence rate of 1,313 per 100,000. Derbyshire ranks sixth worse when comparing it to its 15 CIPFA neighbours (see figure 52).

Figure 48 Potential years of life lost due to smoking related illness (persons, aged 35+ years) - directly standardised rate (per 100,000) 2016-18

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	1,056,032	1,313	1,310	1,315
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	28,584	1,538	1,521	1,556
Lincolnshire	–	3	17,210	1,398	1,377	1,419
Nottinghamshire	–	1	17,252	1,329	1,309	1,349
Cumbria	–	11	11,061	1,309	1,285	1,334
Norfolk	–	5	17,676	1,232	1,213	1,250
Derbyshire	–	-	15,632	1,189	1,170	1,208
Staffordshire	–	2	16,391	1,170	1,152	1,188
Essex	–	13	26,216	1,157	1,143	1,171
Warwickshire	–	7	10,080	1,152	1,130	1,175
Somerset	–	8	10,485	1,131	1,109	1,153
Suffolk	–	4	13,158	1,094	1,076	1,113
Leicestershire	–	12	11,407	1,058	1,039	1,078
Gloucestershire	–	10	10,522	1,046	1,026	1,067
Worcestershire	–	6	10,026	1,046	1,025	1,066
Devon	–	14	13,762	1,044	1,026	1,061
North Yorkshire	–	15	10,820	1,021	1,002	1,041

The incidence rate per 100,000 of potential years of life lost due to smoking related illness in those over 35 has seen a very modest decline since the 2012-14 reporting period (see figure 53).

Figure 49 Potential years of life lost due to smoking related illness (persons, aged 35+ years) – Derbyshire trends



2.3.2 Deaths from cardiovascular disease

Cardiovascular disease (CVD) is one of the major causes of death and disability in England[53]. There have been significant declines in cardiovascular mortality over the past decades as a result of progress prevention and treatment[54]. A 2021 study found that for those aged 60 years

and above, those who smoked faced double the risk of cardiovascular mortality in comparison with non-smokers in the same age group.[55]

Preventable and treatable causes of mortality are defined as follows:[56]

- preventable mortality: causes of death that can be mainly avoided through effective public health and primary prevention interventions (that is, before the onset of diseases or injuries, to reduce incidence)
- treatable mortality (previously known as amenable mortality): causes of death that can be mainly avoided through timely and effective healthcare interventions, including secondary prevention and treatment (that is, after the onset of disease, to reduce case fatality)

In the 2017-2019 reporting period, the estimated incidence rate of deaths from cardiovascular diseases considered preventable in people aged under 75 in Derbyshire was 26.2 per 100,000 (640 in the 3-year period).[6] This is similar to the England average incidence rate of 28.1 per 100,000. Derbyshire ranks in the middle when comparing it to its 15 CIPFA neighbours (see figure 54).

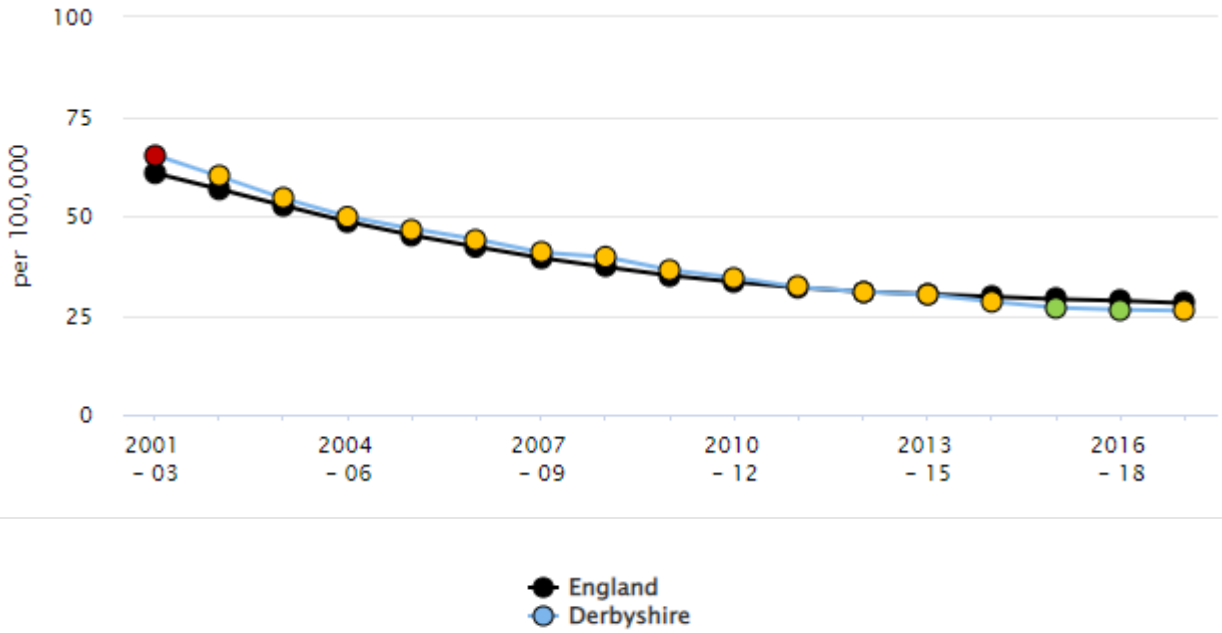
Figure 50 Under 75 mortality rate from cardiovascular diseases considered preventable (persons, 3 year range) – directly standardised rate (per 100,000) 2017-2019

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	40,666	28.1	27.8	28.3
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	1,168	33.7	31.8	35.7
Cumbria	–	11	500	30.9	28.2	33.7
Lincolnshire	–	3	708	29.8	27.6	32.1
Staffordshire	–	2	712	27.2	25.2	29.3
Warwickshire	–	7	438	26.9	24.4	29.5
Nottinghamshire	–	1	643	26.9	24.8	29.0
Derbyshire	–	-	640	26.2	24.2	28.3
Norfolk	–	5	723	25.6	23.7	27.5
Gloucestershire	–	10	471	25.2	23.0	27.6
Leicestershire	–	12	487	24.2	22.1	26.4
Worcestershire	–	6	434	24.0	21.8	26.4
North Yorkshire	–	15	485	24.0	21.9	26.3
Essex	–	13	986	23.4	22.0	24.9
Suffolk	–	4	536	23.1	21.2	25.2
Devon	–	14	604	23.0	21.2	24.9
Somerset	–	8	388	21.6	19.4	23.8

The estimated incidence rate per 100,000 of deaths from cardiovascular diseases considered preventable in people aged under 75 in Derbyshire has been gradually decreasing since the 2001–03 reporting period (see figure 55).

[6] This indicator uses the 2019 definition of preventable mortality – more information at https://fingertips.phe.org.uk/search/cardiovascular%20disease#page/6/gid/1938133056/pat/6/par/E12000004/ati/402/are/E10000007/iid/93722/age/163/sex/4/cat/-1/ctp/-1/yrr/3/nn/nn-12-E10000007/cid/4/tbm/1/page-options/car-do-0- link accessed 03/01/23.

Figure 51 Under 75 mortality rate from cardiovascular diseases considered preventable (persons, 3 year range) – Derbyshire trend



There is some variation of deaths from cardiovascular diseases considered preventable in people aged under 75 across Derbyshire. The district with the highest incidence rate of deaths from cardiovascular diseases considered preventable in people aged under 75 per 100,000 is Bolsover (33.6) which is slightly worse than the England average (28.1) although it is not statistically significant. The district with the lowest incidence rate of deaths from cardiovascular diseases considered preventable in people aged under 75 per 100,000 is Derbyshire Dales (20.0), which is significantly better than the England average (see figure 56).

Figure 52 Under 75 mortality rate from cardiovascular disease considered preventable (persons, 3 year range) – geographical variation 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	40,666	28.1	27.8	28.3
Derbyshire	–	640	26.2	24.2	28.3
Bolsover	–	78	33.6	26.5	41.9
Chesterfield	–	95	30.8	24.9	37.6
Erewash	–	95	29.1	23.5	35.6
Amber Valley	–	103	25.7	21.0	31.2
North East Derbyshire	–	86	25.5	20.4	31.6
South Derbyshire	–	70	24.3	19.0	30.7
High Peak	–	61	21.1	16.1	27.2
Derbyshire Dales	–	53	20.0	14.9	26.2

2.3.3 Deaths from cancer

Cancer is the highest cause of death in England in under 75s.[57] To ensure that there continues to be a reduction in the rate of premature mortality from cancer, there needs to be concerted action in both prevention and treatment. A substantial proportion of smoking-related deaths are from lung and oral cancers.

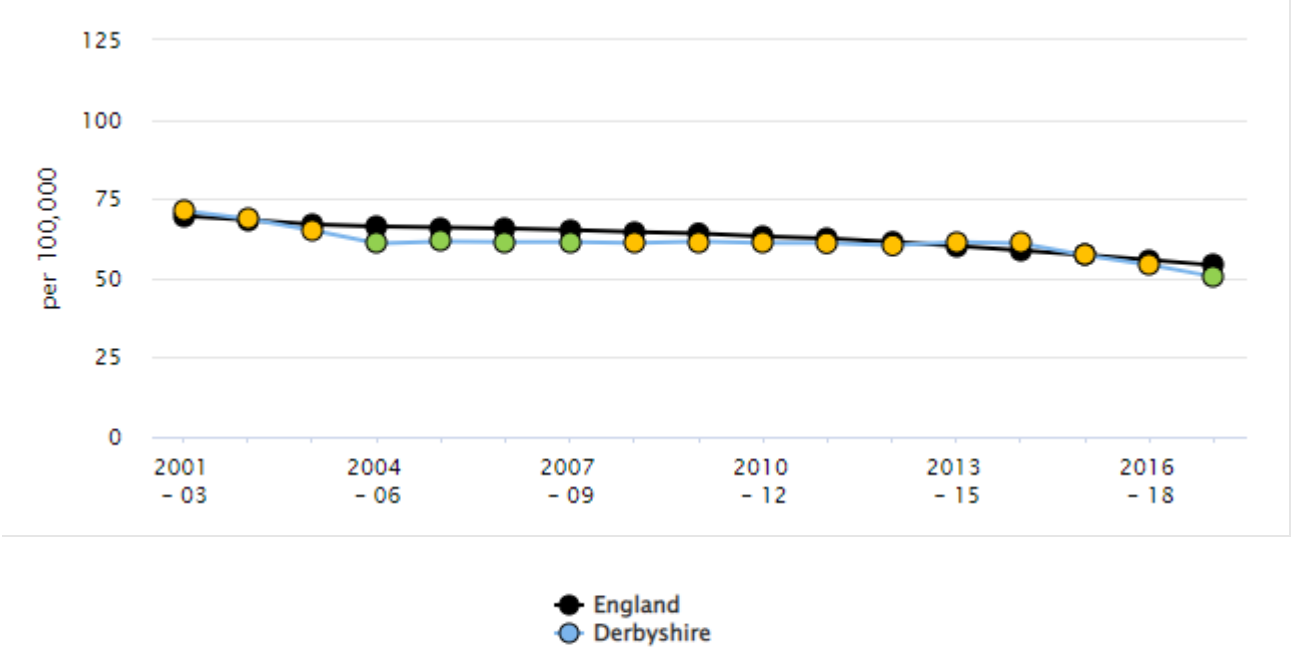
In the 2017-19 reporting period, the incidence of deaths from cancer considered preventable in people under the age of 75 in Derbyshire was 50.4 per 100,000 (approximately 1,237 over the three-year period). This is significantly better than the England average incidence rate of 54.1 per 100,000. Derbyshire ranks seventh worst when comparing it to its 15 CIPFA neighbours (see figure 57).

Figure 53 Under 75 mortality rate from cancer considered preventable (persons, 3 year range) – directly standardised rate – per 100,000 – 2017-2019

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	78,191	54.1	53.7	54.4
Neighbours average	–	-	-	-	-	-
Devon	–	14	1,126	43.1	40.6	45.8
Suffolk	–	4	1,053	45.1	42.4	47.9
Somerset	–	8	814	45.2	42.1	48.4
Gloucestershire	–	10	856	46.2	43.1	49.4
North Yorkshire	–	15	944	46.6	43.7	49.7
Leicestershire	–	12	956	47.7	44.8	50.9
Norfolk	–	5	1,359	48.0	45.4	50.6
Worcestershire	–	6	904	49.9	46.7	53.3
Staffordshire	–	2	1,316	50.1	47.4	52.9
Derbyshire	–	-	1,237	50.4	47.6	53.3
Warwickshire	–	7	820	50.5	47.1	54.1
Essex	–	13	2,133	50.8	48.7	53.0
Cumbria	–	11	877	53.7	50.2	57.4
Nottinghamshire	–	1	1,316	54.9	51.9	57.9
Lincolnshire	–	3	1,326	54.9	52.0	57.9
Lancashire	–	9	2,138	61.3	58.8	64.0

The incidence rate per 100,000 of deaths from cancer considered preventable in people aged under 75 in Derbyshire has been gradually decreasing since the 2001 – 03 reporting period (see figure 58).

Figure 54 Under 75 mortality rate from cancer considered preventable (Persons, 3 year range) – Derbyshire trend



There is some variation of deaths from cancer considered preventable in people aged under 75 across Derbyshire. The district with the highest incidence rate of deaths from cancer considered preventable in people aged under 75 per 100,000 is Bolsover (63.7) which is

similar to the England average (54.1). The district with the lowest incidence rate of deaths from cardiovascular diseases considered preventable in people aged under 75 per 100,000 is Derbyshire Dales (38.0) which is significantly better than the England average. The Amber Valley incidence rate (44.9) and North East Derbyshire incidence rate (45.0) are also significantly better than the England average (Figure 59).

Figure 59 Under 75 mortality rate from cancer considered preventable (persons, aged under 75 years) – geographical variation 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	78,191	54.1	53.7	54.4
Derbyshire	–	1,237	50.4	47.6	53.3
Derbyshire Dales	–	100	38.0	30.9	46.3
Amber Valley	–	180	44.9	38.5	52.0
North East Derbyshire	–	154	45.0	38.1	52.8
High Peak	–	150	52.1	44.1	61.2
South Derbyshire	–	152	52.5	44.5	61.5
Erewash	–	176	54.1	46.4	62.8
Chesterfield	–	177	56.6	48.5	65.6
Bolsover	–	149	63.7	53.9	74.8

2.3.4 Deaths from respiratory diseases

Respiratory disease is the third biggest cause of death in England and smoking is the major cause of chronic obstructive pulmonary disease (COPD), one of the major respiratory diseases.[58]

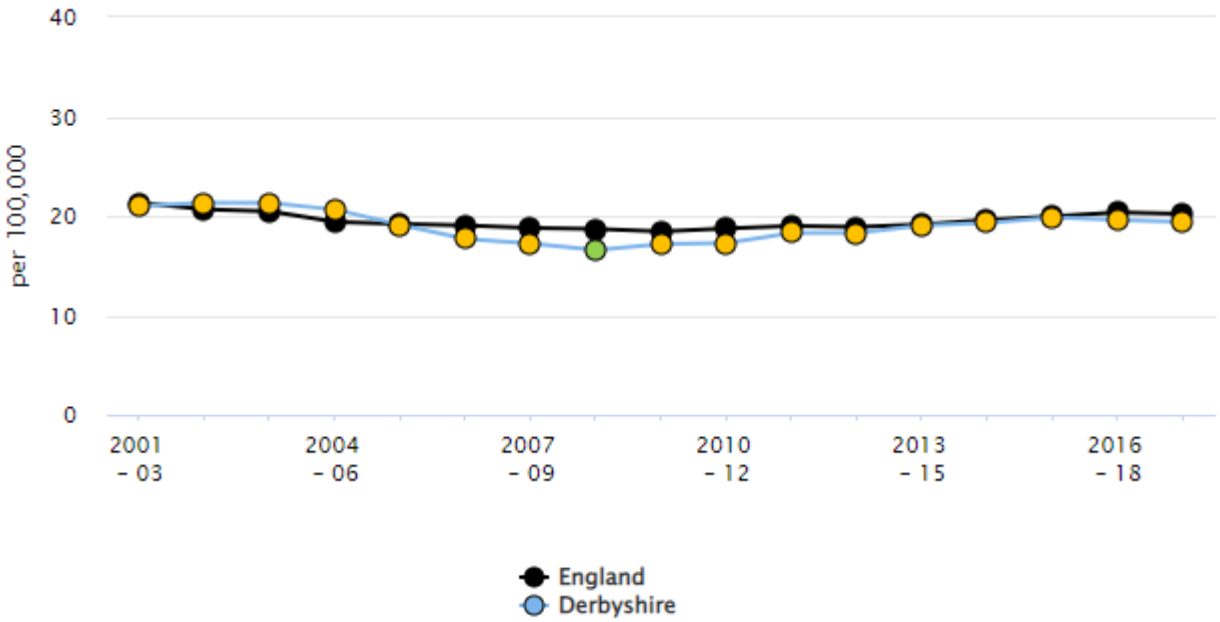
In the 2017-19 reporting period, the incidence rate of deaths from respiratory diseases considered preventable in people aged under 75 in Derbyshire was 19.4 per 100,000 (479 in the 3-year reporting period). This is similar to the England average incidence rate of 20.2 per 100,000. Derbyshire ranks the third worst when comparing it to its 15 CIPFA neighbours (see figure 60).

Figure 55 Under 75 mortality rate from respiratory diseases considered preventable (persons, 3 year range) – directly standardised rate (per 100,00) – 2017-2019

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	29,265	20.2	20.0	20.5
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	883	25.1	23.5	26.8
Nottinghamshire	–	1	490	20.2	18.5	22.1
Derbyshire	–	-	479	19.4	17.7	21.2
Lincolnshire	–	3	467	19.0	17.3	20.8
Staffordshire	–	2	489	18.4	16.8	20.1
Cumbria	–	11	285	17.2	15.2	19.3
Norfolk	–	5	490	16.9	15.4	18.4
Essex	–	13	720	16.8	15.6	18.1
Gloucestershire	–	10	314	16.7	14.9	18.7
North Yorkshire	–	15	316	15.1	13.5	16.9
Warwickshire	–	7	245	14.9	13.1	16.9
Leicestershire	–	12	297	14.5	12.9	16.3
Somerset	–	8	264	14.2	12.5	16.0
Worcestershire	–	6	263	14.2	12.5	16.0
Devon	–	14	377	14.0	12.6	15.5
Suffolk	–	4	335	14.0	12.5	15.6

The incidence rate per 100,000 of deaths from respiratory diseases considered preventable in people aged under 75 in Derbyshire has been quite steady since the 2001–03 reporting period (see figure 61).

Figure 56 Under 75 mortality rate from respiratory diseases considered preventable (persons, 3 year range) – Derbyshire trend



There is some variation in deaths from respiratory diseases considered preventable in people aged under 75 across Derbyshire. The district with the highest incidence rate of deaths from respiratory diseases considered preventable in people aged under 75 per 100,000 is Bolsover (33.1) which is significantly worse than the England average (20.2). The district with the lowest incidence rate of deaths from respiratory diseases considered preventable in people aged under 75 per 100,000 is Derbyshire Dales (12.4) which is significantly better than the England average (Figure 62).

Figure 57 Under 75 mortality rate from respiratory diseases considered preventable (Persons, aged under 75 years) –geographical variation – 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	29,265	20.2	20.0	20.5
Derbyshire	–	479	19.4	17.7	21.2
Bolsover	–	78	33.1	26.1	41.3
Chesterfield	–	86	27.9	22.3	34.4
Amber Valley	–	73	17.9	14.0	22.5
Erewash	–	59	17.8	13.6	23.0
North East Derbyshire	–	61	17.2	13.1	22.1
South Derbyshire	–	47	16.1	11.8	21.4
High Peak	–	46	15.7	11.5	21.0
Derbyshire Dales	–	31	12.4	8.4	17.6

2.3.5 Deaths from lung cancer

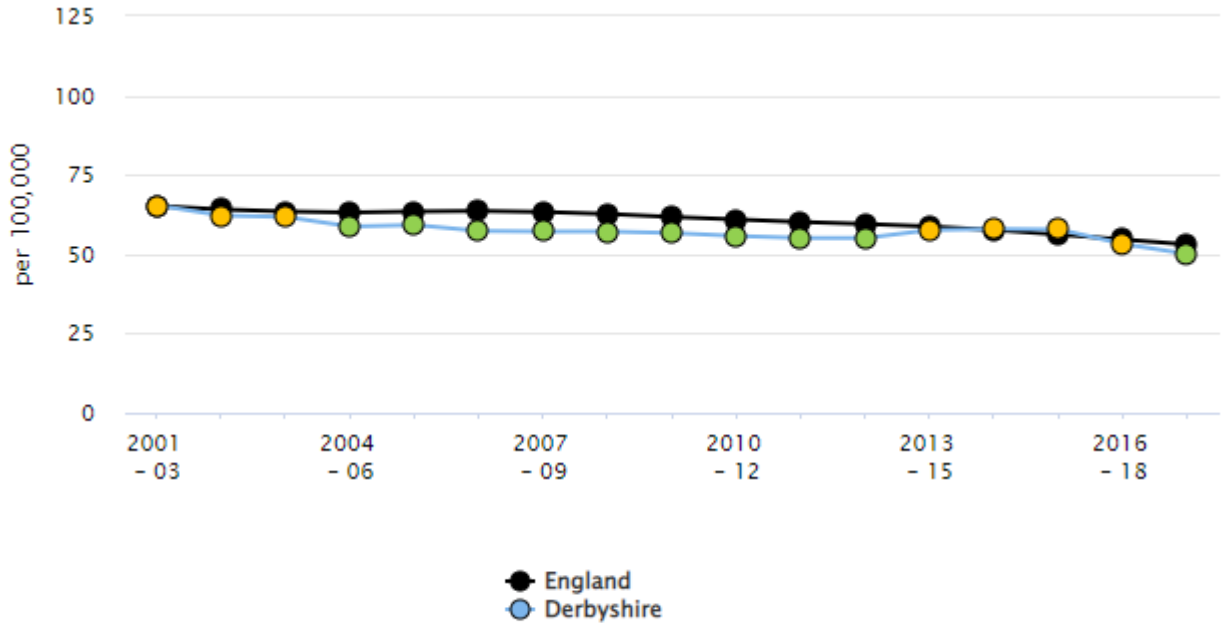
In the 2017 to 2019 reporting period, the mortality rate from lung cancer in Derbyshire was 50.0 per 100,000 of the population (approximately 435 per year). This is significantly better than the England average of 53.0 per 100,000 of the population (approximately 83,383). This ranks Derbyshire sixth worst when comparing it to its 15 CIPFA neighbours (see figure 63).

Figure 58 Mortality rate from lung cancer – directly standardised rate (per 100,000) - 2017-2019

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	83,383	53.0	52.6	53.3
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	2,285	60.3	57.9	62.9
Nottinghamshire	–	1	1,447	55.8	52.9	58.7
Lincolnshire	–	3	1,409	53.0	50.2	55.8
Cumbria	–	11	949	52.2	48.9	55.6
Essex	–	13	2,383	51.2	49.2	53.3
Derbyshire	–	-	1,305	50.0	47.3	52.8
Staffordshire	–	2	1,397	48.7	46.1	51.3
North Yorkshire	–	15	1,066	47.0	44.3	50.0
Leicestershire	–	12	1,001	46.2	43.4	49.2
Suffolk	–	4	1,215	45.6	43.0	48.2
Warwickshire	–	7	803	44.5	41.5	47.7
Norfolk	–	5	1,461	44.5	42.3	46.9
Worcestershire	–	6	874	43.4	40.6	46.4
Somerset	–	8	849	41.3	38.6	44.2
Gloucestershire	–	10	843	41.1	38.4	44.0
Devon	–	14	1,189	39.6	37.3	41.9

The mortality rate per 100,000 from lung cancer has been modestly decreasing since the 2001-03 reporting period (see figure 64).

Figure 59 Mortality rate from lung cancer - Derbyshire trends



There is some variation in the mortality rates from lung cancer across Derbyshire. The district with the highest mortality rate is Bolsover (65.1 per 100,000 of the population) which is significantly worse than the England average (53.0 per 100,000 of the population). The district with the lowest mortality rate is Derbyshire Dales (34.5 per 100,000 of the population) which is significantly better than the England average (Figure 65).

Figure 60 Mortality rate from lung cancer – geographical variation – 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	83,383	53.0	52.6	53.3
Derbyshire	–	1,305	50.0	47.3	52.8
Bolsover	–	158	65.1	55.3	76.1
High Peak	–	162	55.5	47.3	64.8
Chesterfield	–	180	53.7	46.2	62.2
Erewash	–	191	53.1	45.8	61.2
North East Derbyshire	–	190	50.8	43.8	58.6
Amber Valley	–	200	47.9	41.5	55.0
South Derbyshire	–	123	41.9	34.7	50.0
Derbyshire Dales	–	101	34.5	28.1	42.0

2.3.6 Deaths from COPD

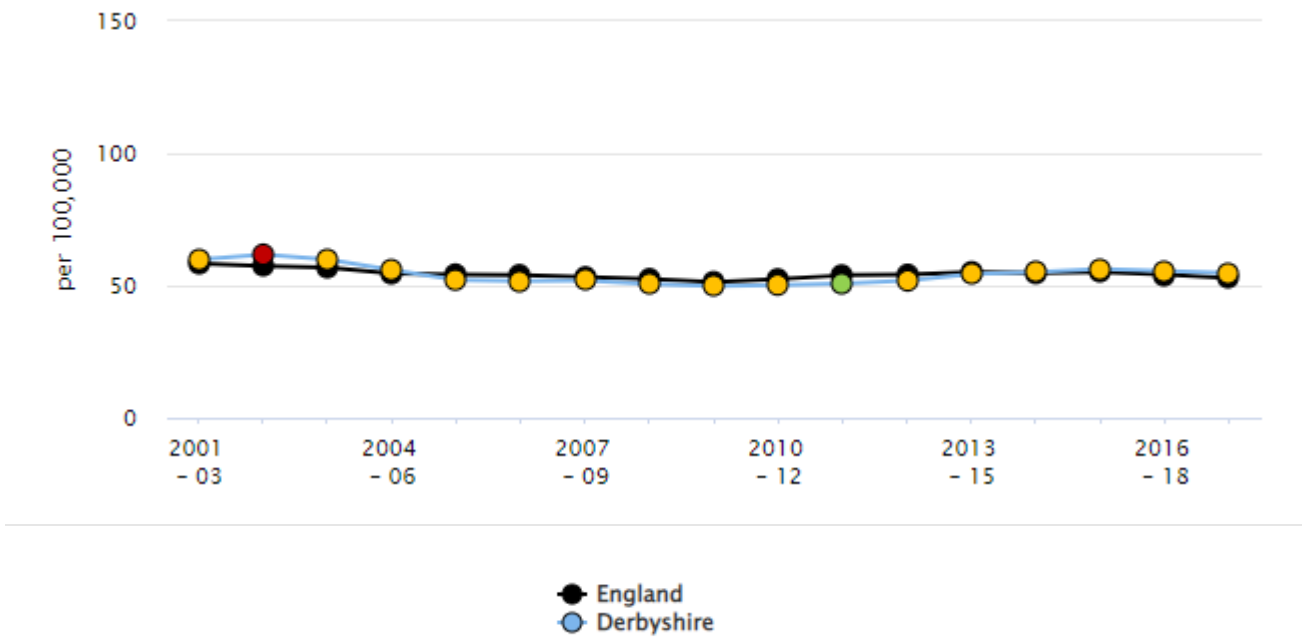
In the 2017 to 2019 reporting period, the mortality rate from COPD in Derbyshire was 54.8 per 100,000 of the population (approximately 1,410 in the 3-year reporting period). This is similar to the England average of 52.8 per 100,000 of the population (approximately 83,467). This ranks Derbyshire second worst when comparing it to its 15 CIPFA neighbours (see figure 66).

Figure 61 Mortality rate from chronic obstructive pulmonary disease - directly standardised rate (per 100,000, 3 year range) 2017-19

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	83,467	52.8	52.4	53.1
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	2,362	62.4	59.9	65.0
Derbyshire	–	-	1,410	54.8	52.0	57.7
Essex	–	13	2,445	52.0	49.9	54.1
Lincolnshire	–	3	1,365	51.3	48.6	54.1
Staffordshire	–	2	1,453	51.1	48.5	53.8
Nottinghamshire	–	1	1,315	50.9	48.2	53.8
Cumbria	–	11	859	46.8	43.8	50.1
Norfolk	–	5	1,509	44.7	42.4	47.0
Worcestershire	–	6	903	44.4	41.5	47.4
Leicestershire	–	12	914	42.2	39.5	45.0
Somerset	–	8	887	41.8	39.1	44.7
North Yorkshire	–	15	958	41.8	39.1	44.5
Gloucestershire	–	10	865	41.5	38.8	44.3
Suffolk	–	4	1,105	40.3	37.9	42.8
Warwickshire	–	7	715	38.9	36.1	41.8
Devon	–	14	1,090	35.1	33.0	37.2

The mortality rate per 100,000 from COPD has been steady since the 2001-03 reporting period (see figure 67).

Figure 62 Mortality rate from chronic obstructive pulmonary disease - Derbyshire trends



There is some variation in the mortality rates from COPD across Derbyshire. The district with the highest mortality rate is Bolsover (74.0 per 100,000 of the population) which is significantly worse than the England average (52.8 per 100,000 of the population. The district with the lowest mortality rate is Derbyshire Dales (33.9 per 100,000 of the population) which is significantly better than the England average (Figure 68).

Figure 63 Mortality rate from chronic obstructive pulmonary disease – geographical variation – 2017-2019

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	–	83,467	52.8	52.4	53.1
Derbyshire	–	1,410	54.8	52.0	57.7
Bolsover	–	177	74.0	63.5	85.9
Chesterfield	–	213	63.5	55.3	72.7
High Peak	–	168	59.2	50.5	68.9
South Derbyshire	–	162	58.7	49.9	68.5
Erewash	–	204	56.1	48.7	64.4
North East Derbyshire	–	188	51.8	44.6	59.8
Amber Valley	–	200	48.0	41.6	55.2
Derbyshire Dales	–	99	33.9	27.5	41.3

2.3.7 Deaths from oral cancer

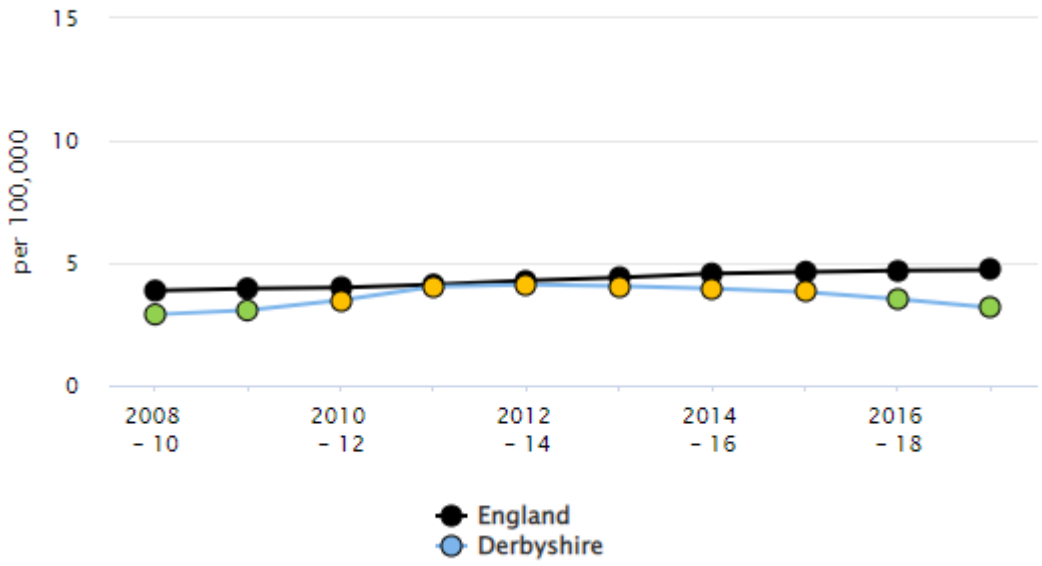
In the 2017 to 2019 reporting period, the mortality rate from oral cancer in Derbyshire was 3.2 per 100,000 of the population (approximately 82). This is significantly better than the England average of 4.7 per 100,000 of the population (approximately 7445). This ranks Derbyshire as the best area when comparing it to its 15 CIPFA neighbours (see figure 69).

Figure 69 Mortality rate from oral cancer - Directly standardised rate (per 100,000) 2017-19

Area	Recent Trend	Neighbour Rank	Count	Value	95% Lower CI	95% Upper CI
England	–	-	7,445	4.7	4.6	4.8
Neighbours average	–	-	-	-	-	-
Lancashire	–	9	200	5.3	4.6	6.1
Warwickshire	–	7	93	5.2	4.2	6.4
North Yorkshire	–	15	102	4.7	3.9	5.8
Lincolnshire	–	3	119	4.6	3.8	5.5
Worcestershire	–	6	88	4.5	3.6	5.5
Devon	–	14	128	4.4	3.6	5.2
Cumbria	–	11	75	4.3	3.4	5.4
Nottinghamshire	–	1	107	4.1	3.4	5.0
Norfolk	–	5	128	4.0	3.3	4.8
Suffolk	–	4	104	4.0	3.2	4.8
Essex	–	13	181	3.9	3.4	4.5
Leicestershire	–	12	82	3.9	3.1	4.8
Gloucestershire	–	10	77	3.8	3.0	4.7
Somerset	–	8	71	3.6	2.8	4.5
Staffordshire	–	2	101	3.6	2.9	4.3
Derbyshire	–	-	82	3.2	2.5	3.9

The mortality rate per 100,000 from oral cancer has fluctuated slightly since the 2008-10 reporting period (Figure 70).

Figure 64 Mortality rate from oral cancer – Derbyshire trends



Due to the relatively low numbers of people who have been diagnosed with oral cancer in Derbyshire, it is not possible to determine if there is much variation across the Derbyshire districts.

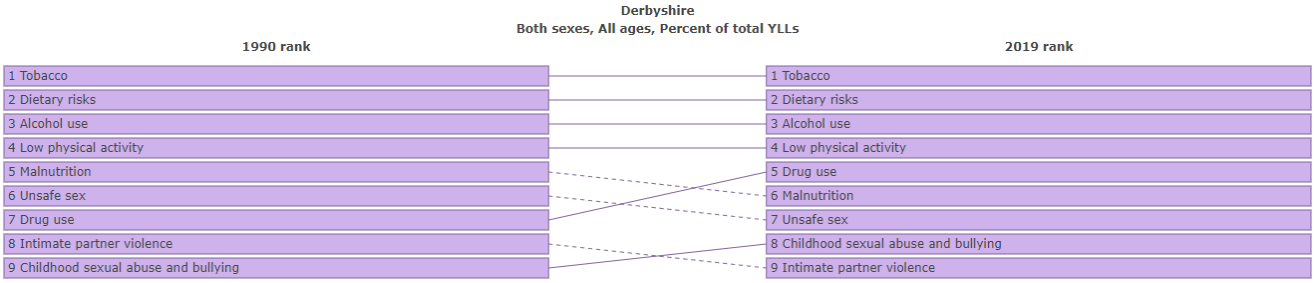
2.3.8 Years of life lost

The Global Burden of Disease[7] tool allows the calculation of Years of Life Lost (YLLs) related to tobacco smoke. Tobacco use is, and has been since at least 1990, the leading behavioural cause of years lost from expected lifespan in Derbyshire. In 2019, over 100,445

[7] https://vizhub.healthdata.org/gbd-compare/#0

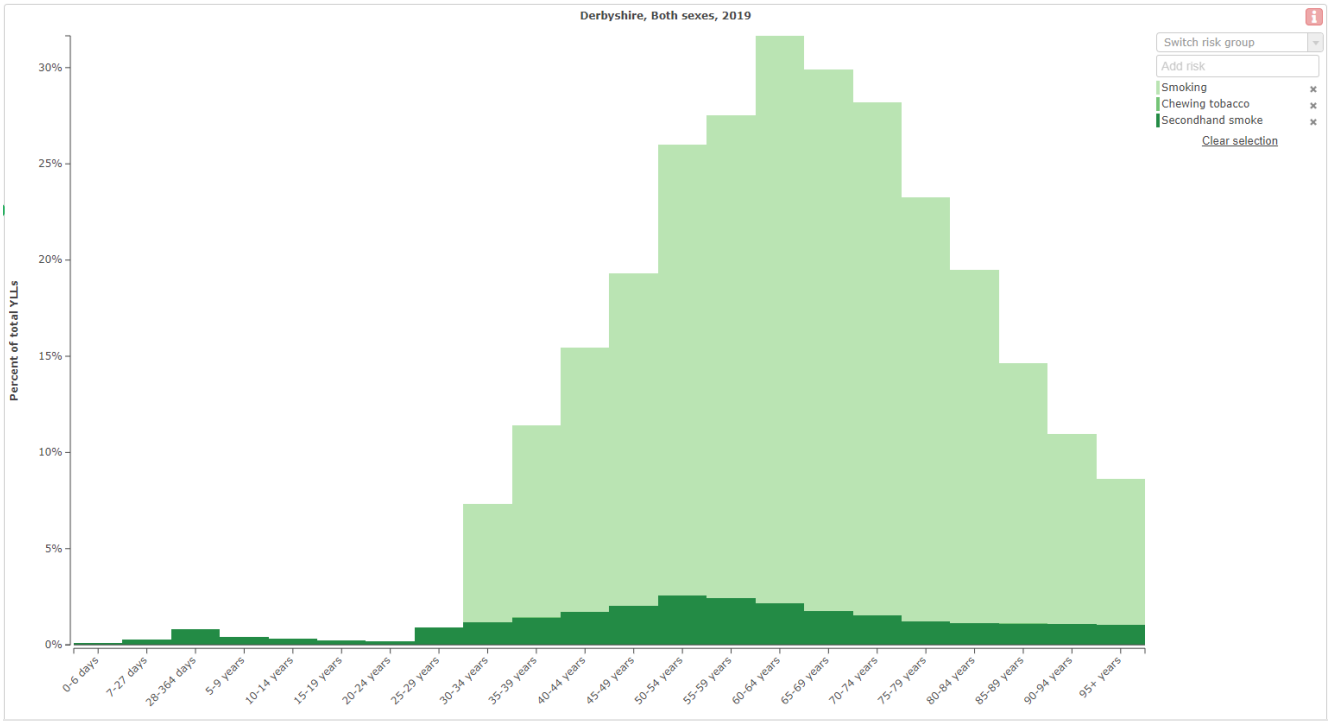
years of life were lost through metabolic, environmental, and behavioural risks; approximately 27,592 of these are thought to have been through tobacco use[59].[8]

Figure 65 Rank of risk by percentage of total years of life lost, 1990 and 2019



The bulk of life years lost (i.e., premature mortality) falls in the mid to later years of life, as might be expected, for both smoking and the effects of second-hand smoke. However, figure 72 demonstrates that second-hand smoke makes a notable contribution as a proportion of all threats to premature mortality in the early years.

Figure 66 Proportion of total years of life lost, by 5-year age band, 2019



[8] https://vizhub.healthdata.org/gbd-compare/#0. Accessed 03.01.2023

3. Impacts of tobacco and smoking

3.1 Attributable health impacts

The data profile in section 2 provides the nationally available data on morbidity and mortality from conditions that are related to smoking compared with CIPFA nearest neighbours and time trends. This section quantifies the health impacts for Derbyshire that can be attributed to smoking from the most recent time point.

3.1.1 Deaths

Using pooled data between 2017 and 2019, there were 3,079 deaths in Derbyshire which were attributed to smoking (approximately 1,026 per year) for people aged 35 and over.

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

There were approximately 1,300 deaths in males and 900 deaths in females attributable to smoking in Derbyshire. Notably there are important differences by sex, with smoking linked to higher numbers of deaths in males than females. The majority of deaths due to smoking were in people with cancer or respiratory diseases.

Table 1 Deaths estimated to be attributable to smoking in adults aged 35 and over, by sex (rounded values)

	Total		Male		Female	
	Attributable number[9]	**Attributable %[10]**	**Attributable number**	**Attributable %**	**Attributable number**	**Attributable %**
All deaths	2200	16	1300	20	900	12
All cancers	1000	26	600	31	300	20
All respiratory diseases	1200	37	700	40	500	33
All circulatory diseases	2000	13	100	16	100	9
All diseases of the digestive system	0	3	0	4	0	3

Overall, 2200 deaths in Derbyshire were caused by smoking in 2018. In other words, smoking was responsible for 6 deaths each day, or 42 deaths each week, in Derbyshire.

3.1.2 Hospital admissions

Using data from 2019/20, there were 7,978 smoking attributable hospital admissions for diseases that were wholly or partially attributed to smoking in people aged 35 and over.

[9] Estimated attributable number, rounded to the nearest 100. Totals may not sum due to rounding.
[10] Estimated attributable percentages are based on unrounded attributable estimates for England.

A similar calculation has been made to estimate the number of hospital admissions from diseases which can be caused by smoking (Table 2). These data refer to admissions in 2017/18.

There were 2,300 admissions for males and 1,200 admissions for females that were due to diseases caused by smoking (Table 2). 22% of the admissions for respiratory diseases in Derbyshire can be attributed to smoking.

Table 2 NHS hospital admissions estimated to be attributable to smoking in adults aged 35 and over, by sex (rounded values)

	Total		Male		Female	
	Attributable number[11]	Attributable %[12]	Attributable number	Attributable %	Attributable number	Attributable %
All admissions	3500	4	2300	6	1200	3
All cancers	2900	9	2000	12	900	6
All respiratory diseases	2500	22	1300	24	1200	21
All circulatory diseases	1800	15	1200	18	500	10
All diseases of the digestive system	300	1	200	1	100	1
Other diseases which can be caused by smoking[13]	500	9	200	10	300	8

3.1.3 Ill health in children

Children are particularly vulnerable to the effects of second-hand smoke. Children living in a household where there is at least one smoker are at greater risk of developing asthma, chest infections and other respiratory conditions.[60] Smokefree legislation was passed in the UK in 2007 and in 2015, smoking in a car in which a child is travelling was made illegal.

In 2010 the Royal College of Physicians calculated the annual impact of passive smoking exposure for children in the UK:[61]

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

[11] Estimated attributable number, rounded to the nearest 100. Totals may not sum due to rounding.
[12] Estimated attributable percentages are based on unrounded attributable estimates for England.
[13] Age related cataract 45+; Hip fracture 55+; Spontaneous abortion. Calculated for adults of specific age ranges

Further research has estimated the health risks for maternal smoking and second-hand smoking in pregnancy for poor health outcomes for mothers and infants (Table 3). Again, this is estimated on a national basis.

Table 3 Impact of smoking in pregnancy

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

Source: Smoking in pregnancy challenge group. Review of the Challenge 2018.[62]

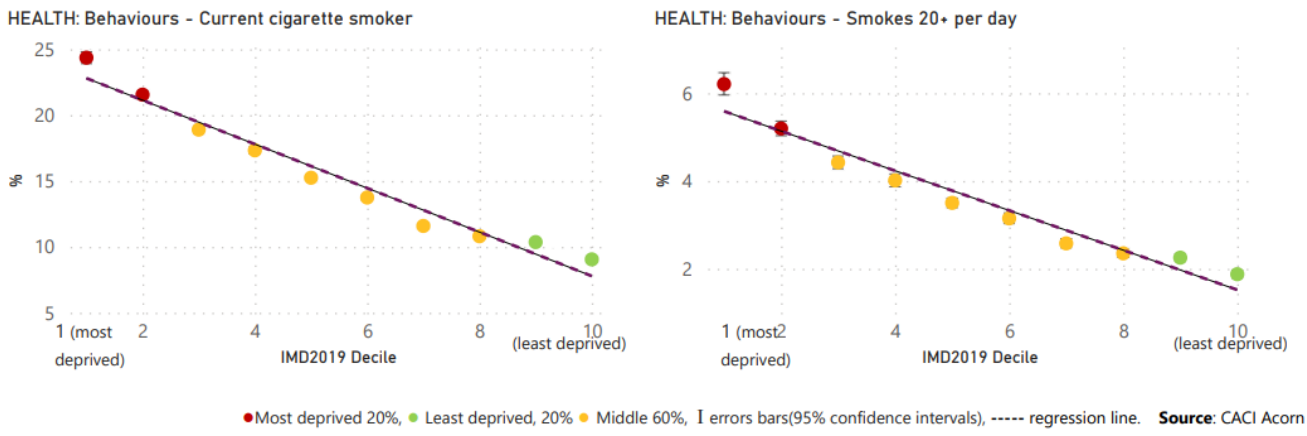
It was not possible to specifically estimate the impacts for ill health among children and women in Derbyshire attributable to passive smoking or smoking in pregnancy from these figures.

In the reporting period 2020/21, there were 800 mothers who smoked at the time of delivery, accounting for 11.8% of all births in Derbyshire in the same period. This figure has decreased from 16.8% in 2010/11 but this is still significantly worse than the national average for mothers smoking at the time of delivery (9.6%) (see figure 22).

3.2 Impacts on health inequalities

Smoking is the single most important driver of health inequalities: a larger contributor to inequalities than social position.[63] Smoking is associated with almost all indicators of marginalisation and deprivation.[64] Smoking is more common among unskilled and low-income workers, and there are generational cycles of smoking and smoking-related culture in disadvantaged communities.[65] Approximately a third of tobacco consumption in the UK is by people with a mental health condition.[66] Other disparities in smoking are seen among disadvantaged groups including people who are homeless, prisoners, and looked-after children. The distribution of smoking in Derbyshire is correlated with the index of multiple deprivation in common with the national picture.[67]

Figure 67 Smoking prevalence by deprivation decile, Derbyshire



3.2.1 Life expectancy

Smoking reduces both life expectancy and healthy life expectancy. According to research, smoking is responsible for approximately 50% of the difference in death rates between men of differing socioeconomic status.[68]

Life expectancy at birth in Derbyshire has been significantly lower than the value for England for both men and women in recent years. The life expectancy at birth (see figure 74) is 82.8 years for females and 79.2 years for males (figure 75, 2018-2020 data). The healthy life expectancy at birth (see figure 76) is 62.6 years for females and 61.5 years for males (figure 77, 2018-2020 data).

Figure 68 Life expectancy at birth for females in Derbyshire (3-year range)

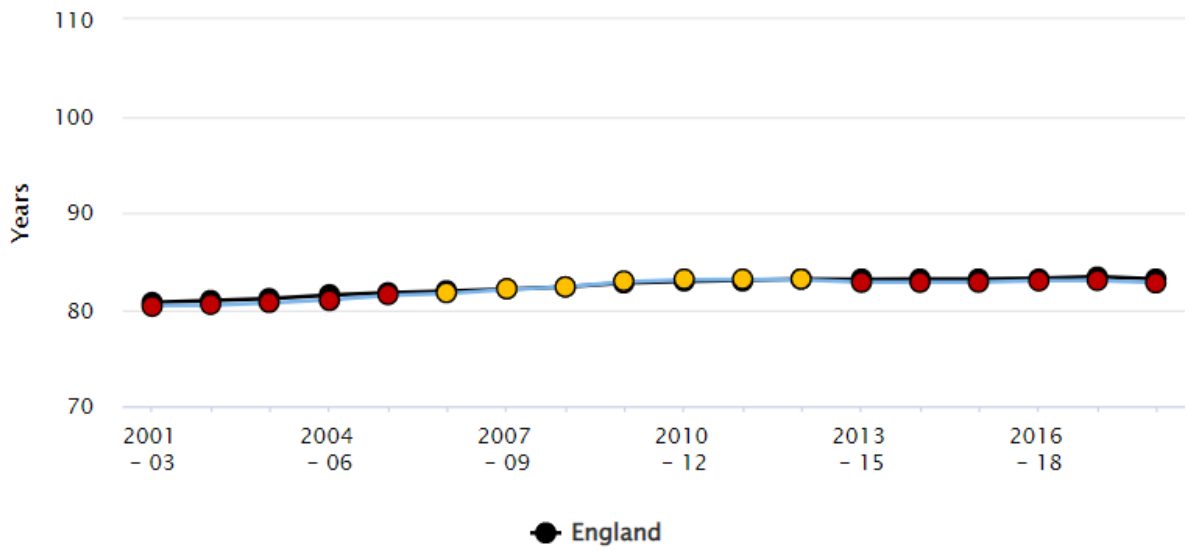


Figure 69 Life expectancy at birth for males in Derbyshire (3-year range)

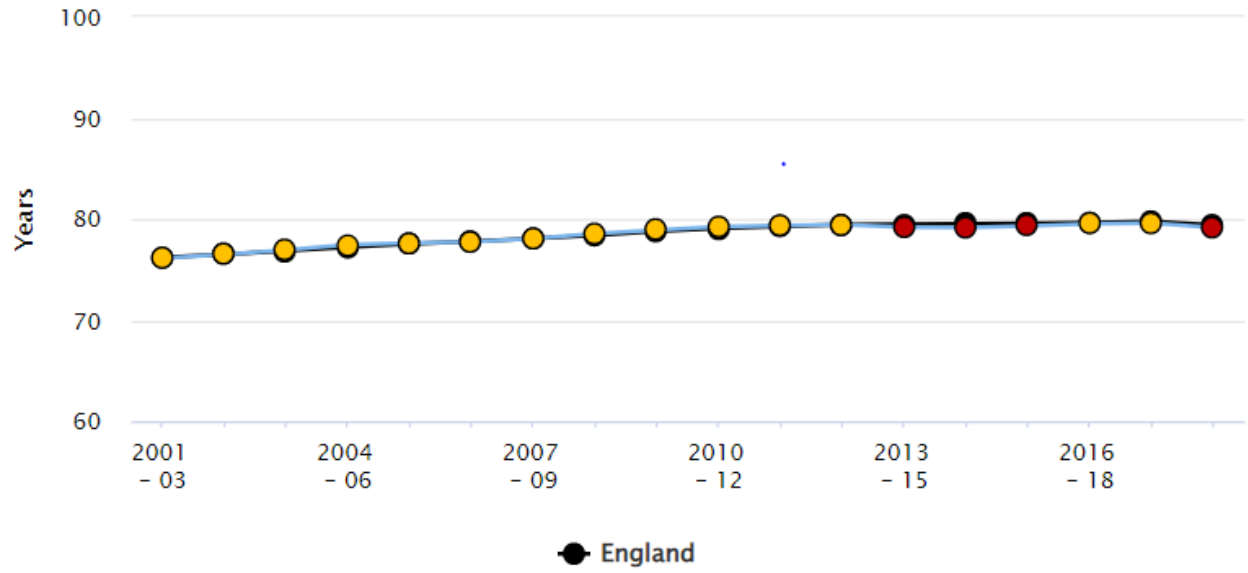


Figure 70 Healthy life expectancy at birth for males in Derbyshire (3-year range)

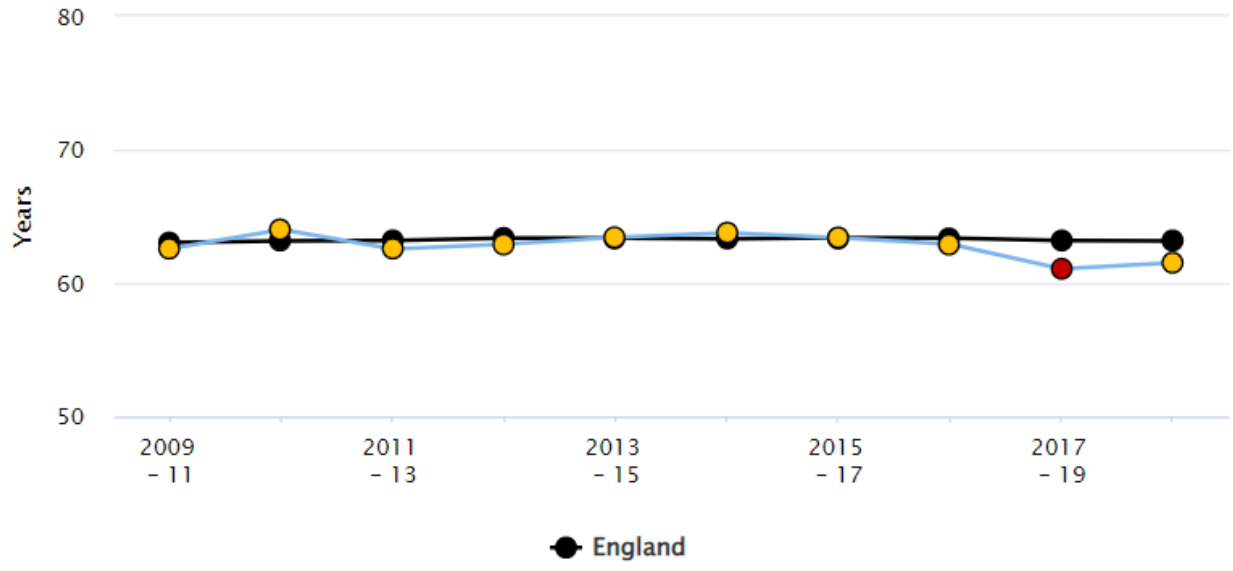
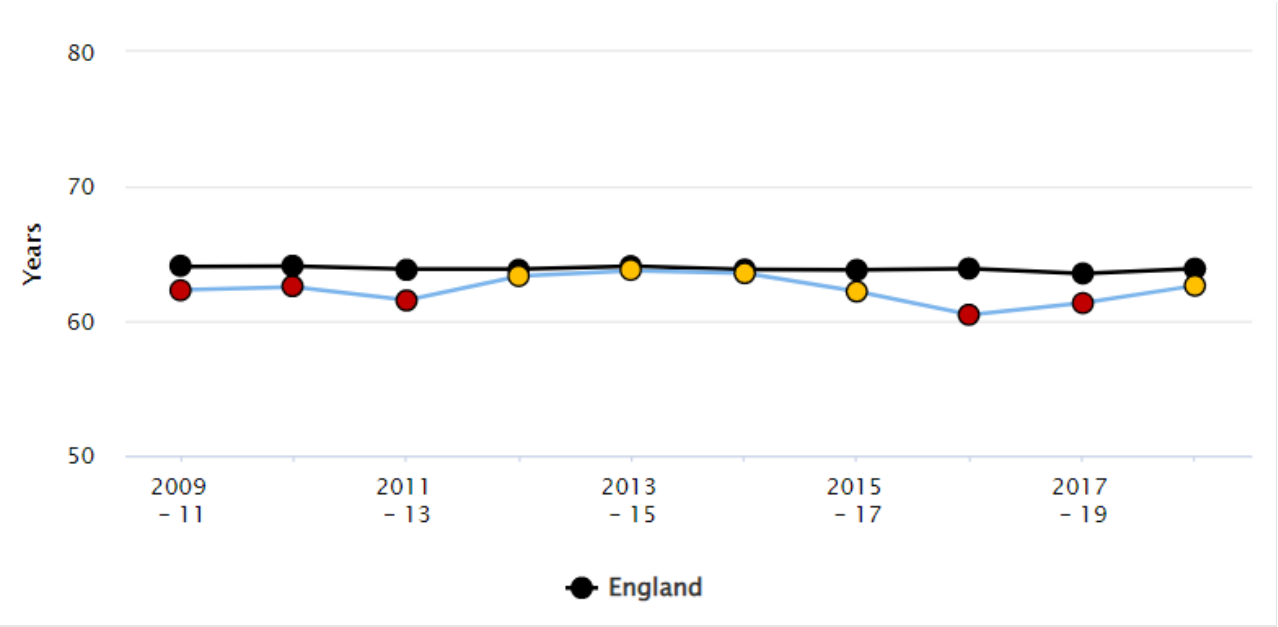


Figure 71 Healthy life expectancy at birth for females in Derbyshire (3-year range)



Based on data from 150 local authorities in England, the ONS developed estimates for the population level impacts on healthy life expectancies (HLE) associated with a change in the number of smokers in an area. Table 4 shows this.

Table 4[69]

Table 4 Change in healthy life expectancy (HLE) per quitter (ONS Life Expectancy Tool)

Modelled Change[14]	Impact on HLE for Men	Impact for HLE for Women
No change	No change	No change
1 in every 100 men/women quit smoking	HLE rises by 7 months	HLE rises by 8 months
2 in every 100 men/women quit smoking	HLE rises by 1 year, 3 months	HLE rises by 1 year, 5 months
3 in every 100 men/women quit smoking	HLE rises by 1 year, 10 months	HLE rises by 2 years, 1 month
5 in every 100 men/women quit smoking	HLE rises by 3 years, 1 month	HLE rises by 3 years, 6 month
10 in every 100 men/women quit smoking	HLE rises by 6 years, 1 month	HLE rises by 7 years, 1 month

For Derbyshire, the number of quits needed to achieve an improvement in the population healthy life expectancy can be modelled in relation to the population size and prevalence of smoking. These values indicate the impact of a step change in the prevalence of smoking, and the scale required for population level benefits. Modelled data for Derbyshire on changes in the numbers of smokers and the impact on healthy life expectancy is shown in Table 5.

[14] This analysis reports the linear relationships between individual lifestyle factors and population level HLE to estimate the change in HLE if smoking prevalence were to change.

Table 5 Change in healthy life expectancy per quitter - Derbyshire

Males			Females		
Number of smokers quitting	Proportion of smokers quitting	Revised Healthy Life Expectancy	Number of smokers quitting	Proportion of smokers quitting	Revised Healthy Life Expectancy
0	0%	63.4 years	0	0%	62.2 years
3200	4.8%	64.0 years	3361	6.6%	62.9 years
6400	9.6%	64.7 years	6722	13.2%	63.3 years
9599	14.4%	65.2 years	10084	19.8%	64.3 years

3.2.2 Household incomes

Between 2009 and 2019, the price of tobacco (based on the Tobacco Price Index) increased by 100%, although the proportion of household income which is spent on tobacco in 2019 was 1.4%, compared to 2.8% in 1985.[70] In 2021, it was estimated that when expenditure on tobacco is taken into account, around 500,000 extra households, 180,000 pensioners and 330,000 children, are classified as in poverty in the UK compared to the official Households Below Average Income figures.[71] The average cost of a packet of 20 cigarettes in July 2023 was £14.54.[72] Someone smoking 20 cigarettes per day could save £435 per month (£5,300 per year).[73] These figures do not account for expenditure on e-cigarettes, so supporting people to access stop smoking support and nicotine replacement therapy will reduce individual costs. Reducing the prevalence of smoking increases disposable income at household level and contributes to improved economic prosperity within local communities[74].

3.3 Impacts on society

3.3.1 Health system use

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

Using the most recent data from 2019/20, the rate of smoking attributable hospital admissions in Derbyshire (1506 admissions per 100,000 population or 7,978 per year) is significantly worse than the England average (1,398 admissions per 100,000 of the population or 448,031 per year) and is the sixth worse when compared to Derbyshire's 15 CIPFA neighbours.

The annual burden in Derbyshire of treating smoking-related illnesses via primary and ambulatory care services is estimated to require 367,430 GP consultations, 132,950 practice nurse consultations, 206,650 GP prescriptions, and 77,190 outpatient visits.[75]

3.3.2 Costs

The costs associated with smoking in Derbyshire have been estimated by calculating the amount of service use or societal impacts caused by smoking, and then costing these impacts using Action on Smoking and Health's Ready Reckoner tool[76]. Smoking in Derbyshire creates an estimated societal cost of £255.9 million every year accrued across a range of domains:

Healthcare: the estimated total annual cost of smoking to the NHS across Derbyshire is £27.7m for treating smoking-related illness. These costs are a result of smoking-related hospital admissions and the cost of treating smoking-related illness via primary care services.

Productivity: Smoking negatively affects earnings and employment prospects. ASH estimate:

- £203.2 million is lost in productivity costs in Derbyshire (£85.0 million in smoking related lost earnings; £98.0 million in smoking related unemployment; £20.3 million due to smoking related early deaths)

Social care: Many current and former smokers require care in later life as a result of smoking-related illnesses. This is estimated to be almost £19.2 million in domiciliary care (£10.1 million) and residential care (£9.1 million) costs for Derbyshire.

- 17,000 people in Derbyshire are estimated to be receiving informal care because of smoking
- Formalising this care would be estimated to cost the social care system in Derbyshire £224.1 million

House fires: Smoking materials are a major contributor to accidental fires. Fatalities are disproportionately high in smoking-related fires, representing 49% of all house fire deaths. Derbyshire Fire and Rescue Service will attend an estimated 25 smoking-related house fires each year with £5.8m lost annually in the county as a result:

- Estimated cost of £3.0m in Derbyshire each year as a result of deaths in smoking-related fires
- Estimated cost of £1.3m in Derbyshire each year as a result of injuries in smoking-related fires
- Smoking-attributable fires in Derbyshire are estimated to result in property damage of £1.3m
- The annual response cost for the Derbyshire Fire and Rescue Service of £93,000

It is estimated that smokers in Derbyshire spend roughly £223.8 million on tobacco products each year (£2451 per smoker). The estimated revenue from tobacco taxation in Derbyshire is £145.3 million per year.

3.3.3 Environmental impacts

Smokers in Derbyshire consume an estimated 740,000 cigarettes every day. This generates an estimated 40 tonnes of waste annually, particularly because the majority of cigarette filters are non-biodegradable. This includes 17 tonnes of waste from discarded cigarettes as street litter.[77] Cigarette packaging contributes additional litter and waste.

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

The trend for smoking is continued decline. The prevalence of smoking in England has been gradually decreasing in recent decades. In 2021, an estimated 13% of the adult population smoked (14.9% of men and 11.2% of women)[78] – a decrease from 19.8% in 2011. Smoking in 18 to 24 years olds has fallen the fastest compared to other age groups, from 25.8% in 2011 to 13.2% in 2021.[79] The decline in smoking since 2011 has been observed across the adult

population. While the prevalence of smoking has decreased, there is still a noticeable gap between those from different occupations who smoke which presents a future challenge.

Electronic cigarettes (e-cigarettes/vapes) have increased in popularity in recent years, and have made a contribution to declining smoking rates, and continued to be the most popular aid used by people trying to quit smoking in 2020.[80] In 2017, over 50,000 smokers in England were able to quit smoking with the use of a vape.[81] Similar proportions of men and women currently use e-cigarettes, although usage varies widely according to age group. In 2022, e-cigarette usage was highest among 18–24-year-olds (11%), 35-44-year-olds (11%) and 45-54-year-olds (10%), and lowest among those aged 75 and over (2%).[82]

Evidence published in 2022 by Action on Smoking and Health (ASH) suggests that 15.8% of 11-17-year-olds in Great Britain have tried an e-cigarette, an increase from 11.2% in 2021.[83] The vaping prevalence in adults in Great Britain has increased since 2021 and is now at its highest ever rate of 8.3%, with 2022 prevalence estimates of:

- 8.3% for all adults
- 22% for current smokers
- 1.3% for never smokers
- 57% for ex-smokers[84]

The evidence on the use of e-cigarettes containing nicotine was compiled and reviewed by OHID in their Nicotine Vaping in England: 2022 evidence update[85]. The report is the most comprehensive to date, its main focus being a systematic review of the evidence on the health risks of nicotine vaping.

Based on the evidence within the review, the evidence suggests that:

- In the short and medium term, vaping poses a small fraction of the risks of smoking, but that vaping is not risk-free, particularly for people who have never smoked.
- There is significantly lower exposure to harmful substances from vaping compared with smoking, as shown by biomarkers associated with the risk of cancer, respiratory and cardiovascular conditions. However, there is similar or higher exposure to harmful substances from vaping compared with not using any nicotine products.
- There is no significant increase of toxicant biomarkers after short-term second-hand exposure to vaping among people who do not smoke or vape

The evidence base for using e-cigarettes containing nicotine as a quitting aid is growing and the consensus is that e-cigarettes are at least of similar effectiveness to other cessation options such as varenicline or long-acting and short-acting NRT, especially when combined with behavioural support.[86]

A systematic living review undertaken by the Cochrane Collaboration concluded that E-cigarettes containing nicotine increased quit rates at six months compared to NRT and non-nicotine containing e-cigarettes[87]. The review suggested that more people would quit smoking through use of e-cigarettes (ten in 100) than using NRT (six in 100) None of the included studies (short- to mid-term, up to two years) detected serious adverse events considered possibly related to e-cigarettes use. However, the studies relative short length may have impacted on the detection of serious adverse events.

The use of e-cigarettes as a quit aid to help people stop smoking is recommended by the Khan review, which advocated the key role that e-cigarettes can play as part of an effective tobacco control strategy[88].

However, the use of e-cigarettes is not risk free, and e-cigarettes should only be used as intended and as an aid to stop smoking completely. They are not products to be used by children or non-smokers.

In households where tobacco smoking occurs, vaping offers a less harmful alternative for non-smokers. Exposure to second-hand tobacco smoke is dangerous. Compared with cigarettes, vaping products produce no or little side-stream emissions[89].

There is a lack evidence about the effectiveness or safety of using nicotine-containing e-cigarettes to help women stop smoking in pregnancy. However, it is likely that the effectiveness of e-cigarettes for helping to stop smoking are as applicable to pregnant women who smoke as they are to other adults who smoke. A 2022 RCT study comparing e-cigarettes and NRT to help pregnant women who smoke to quit, found that e-cigarettes were as effective as NRT and that their safety for use in pregnancy is similar to NRT[90].

Most smoking-related health problems are caused by other components in tobacco smoke, not by the nicotine. E-cigarettes are likely to be significantly less harmful than tobacco since they do not involve the inhalation of carbon monoxide, and many other harmful substances produced by cigarettes[91].

Pregnant women who smoke should therefore be encouraged to try NRT alongside behavioural support before considering e-cigarettes to help them quit.

If a pregnant woman has been fully counselled that there is not yet enough evidence to say that e-cigarettes are safe in pregnancy, and they choose to use an e-cigarette to help them to quit, they should not be discouraged from doing so and should be supported in their quit attempt.[92]

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

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

Using data obtained from NHS England covering England for the 2021/22 reporting period, 178,198 quit attempts were made (100,982 females and 77,216 males).[93] Of these, 57% of men and 53% of women were self-reported to have quit smoking, although only 3% of men and 4% of women had this confirmed by carbon monoxide testing.[15] Since the onset of the Covid-19 pandemic, the number of quit attempts that are validated by CO readings has remained much lower than the 2019/20 rate of 32%. Of the quit attempts made in 2021/22, 57.4% of the support was administered by telephone (n=102,277).[94]

[15] A self-reported quitter is defined as a treated smoker who reports not smoking for at least days 15-28 of a quit attempt and is followed up 28 days from their quit date. Further to this, a self-reported quitter is considered to be CO-verified if their CO reading is assessed 28 days from their quit date and is less than 10 parts per million (ppm). https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2021-to-march-2022/introduction

Approximately 50% of smokers who attempt to quit do so through their own willpower, despite this being the least effective method.[95] Those who access local stop smoking services are three times more likely to successfully quit when compared to smoking alone.

Figure 72 Effectiveness of smoking cessation methods, Public Health England, 2019

Data for England from 2021 shows that only 2.8% of smokers set a quit date with a stop smoking service, and only 1.5% of smokers successfully quit using a local stop smoking service. This represents a decline of more than two thirds in comparison to 2011. This is a missed opportunity considering that local stop smoking services are the most cost effective and successful means of smoking cessation. Much of the necessary step change in smoking prevalence is likely to be facilitated by greater availability and accessibility of stop smoking services, e-cigarette use and other types of quit attempts. Effective enforcement of legislation e.g., point of sale displays, underage sales, packaging, and removing illicit tobacco from the market is important alongside behaviour changes.

4. Tobacco control measures in Derbyshire

4.1 Stop smoking services

4.1.1 What works

Providing support for smokers to quit is highly cost effective[96]. Smokers who receive a combination of stop smoking aids (e.g., NRT) and skilled behavioural support are three times as likely to quit successfully. The most effective intervention to support smokers to quit is face-to-face group-based support with pharmacotherapy. A universal and evidence-based service model will achieve the highest quality outcomes.[97]

The NICE Guidance: Tobacco: preventing uptake, promoting quitting and treating dependence (NG209)[98] includes recommendations on policy, commissioning and training:

- Use integrated care systems plans, health and wellbeing strategies, and other relevant local strategies and plans to make the range of interventions in the section on stop-smoking interventions accessible to adults who smoke
- Ensure service specifications require providers of stop-smoking support to offer nicotine replacement therapy (NRT) for as long as needed to help prevent a relapse to smoking
- Use OHID's local tobacco control profiles to estimate smoking prevalence among the local population
- Prioritise groups at high risk of tobacco-related harm.

4.1.2 What is being delivered?

Live Life Better Derbyshire

Live Life Better Derbyshire (LLBD) provide stop smoking services for people aged over 12 years in Derbyshire as part of a wider integrated lifestyle services offer. The emphasis is on one-to-one cessation support for 12 weeks, with flexibility to support clients beyond this, and with telephone support; nicotine replacement therapy is provided. Clinics are run throughout the week including evening sessions in a range of locations. A Saturday morning telephone support session is also available. Group-based support is being planned for introduction in late 2023.

The LLBD service is evidence based, in line with NICE guidance and is supported by the National Centre for Smoking Cessation and Training (NCSCT). The service is e-cigarette friendly in providing support to smokers who are using e-cigarettes as part of their quit attempt, in line with the Derbyshire Public Health position statement on e-cigarettes. The service is planning to provide e-cigarettes as a quitting aid from Autumn 2023. The service uses a range of promotional materials, including highlighting the national Stoptober campaign and accepts self-referrals as well as professional referrals and signposting.

4.1.3 What are the service outcomes?

Outcomes are reported for numbers and rates of smokers setting a quit date, and successful quitters at four weeks ascertained by self-report and by carbon monoxide (CO) validation.

Table 6 LLBD outcomes for stop smoking services 2020/21

2020/21	Number setting quit date	Number of successful quitters (self-reported due to Covid-19restrictions)	Percentage of successful quitters	Successful quitters (CO-validated)	CO validated quitters as a percentage of clients setting a quit date	CO validated quitters as a percentage of successful quitters*
Derbyshire 2020/21	2,299	1,555	68%	0%	0%	0%
East Midlands	16,603	10,587	63%	0%	0%	0%
England	178,815	105,403	58%	3,115	1.7%	3%

Source: NHS Digital [99]

Table 7 LLBD outcomes for stop smoking services 2021/22

2021/22	Number setting quit date	Number of successful quitters (self-reported due to Covid-19restrictions)	Percentage of successful quitters	Successful quitters (CO-validated)	CO validated quitters as a percentage of clients setting a quit date	CO validated quitters as a percentage of successful quitters*
Derbyshire 2021/22	2,644	1,808	68%	5	0.2%	0.3%
East Midlands	20,263	12,290	61%	109	0.5%	0.9%
England	178,198	97,654	55%	6,651	3.7%	6.8%

Source: NHS Digital [iii]

Due to the COVID-19 pandemic and telephone support delivery, successful quits were self-reported and limited CO validation took place in England.

4.1.4 Where are the gaps?

There continues to be a drop off from when clients enter the LLBD service to setting a quit date, although this has improved in recent years. Activity is ongoing within the LLBD service to review the pathway and explore opportunities for additional support. Similarly, activity is underway to refine promotional materials and ensure the service consistently uses evidence-informed communication approaches and resources. The use of text messaging to improve service uptake has increased engagement and immediate communication. Clients often set quit dates several times with LLBD and in England generally, therefore LLBD are exploring opportunities for additional support past the 12-week quit point to aid relapse prevention. LLBD will be implementing a group offer as recommended in NICE guidance. LLBD have re-introduced CO reading appointments to increase CO validated quits.

A health equity audit was completed in 2022 and an action plan is being created with the aim to improve the accessibility and outcomes for people accessing the stop smoking service[100]. Benchmarking local performance with other stop smoking services has allowed a review of effectiveness such as in progressing with individuals who make initial contact through to offering support.

NICE Guidance NG209[101] includes recommendations on Stop smoking interventions (section 1.12.2):

Ensure the following are accessible to adults who smoke:

- Behavioural interventions
- Medicinally licensed products
- Nicotine-containing e-cigarettes

4.2 Maternal tobacco dependence

4.2.1 What works?

Factors associated with smoking in pregnancy

Public Health England's (PHE) analysis of maternity service data from April 2018 to March 2019 gave insight into the characteristics of women who stop smoking during pregnancy[102]. PHE found that those of white ethnicity and those living in more deprived areas were more likely to have smoked throughout pregnancy. Those not in employment, with complex social factors, and those currently misusing or who had previously misused substances were more likely to smoke and less likely to stop successfully, and therefore more likely to smoke at delivery. Those experiencing a subsequent pregnancy were also more likely to have smoked throughout pregnancy than those for whom this was their first pregnancy. Those aged under 20 years were more likely to have stopped smoking in late pregnancy, suggesting that this age group may not have been aware of the risks around smoking in pregnancy but responded well to public health messages and when offered help from stop smoking services. Factors found to be associated with smoking cessation in pregnancy include level of education, socio-economic status, smoking status of partner/other members of the household, and depression[103].

Effective interventions

National guidance recommends that CO testing should be offered at all antenatal booking appointments and at other antenatal appointments for some groups (as identified by NICE Guidance NG209). Those with elevated CO or who identify themselves as smokers should be referred to an in-house tobacco dependence advisor and be offered behavioural support, NRT[104], and voucher incentives[105]. For interventions to be most effective, relevant staff should be trained in the use of CO monitors, Very Brief Advice (VBA) about smoking, and the pathways and processes in local maternity systems. A tailored approach to identifying and treating smoking among partners and other household members is recommended[106].

4.2.2. National guidance

NICE guidance

NICE Guidelines NG209 Tobacco: preventing uptake, promoting quitting, and treating has various recommendations[107] for supporting pregnant women to stop smoking.

Maternity high impact areas

In 2020, PHE published the maternity high impact area documents, developed to assist local maternity systems to embed prevention approaches to better support women before, during and after pregnancy through a whole system life-course approach. The PHE "Supporting

parents to have a smokefree pregnancy" document provides guidance to local maternity systems to implement prevention into their work[108].

Saving Babies Live Care Bundle

NHS England Saving Babies Lives Care Bundle (Version 3)[109] is one of a series of interventions which aims to help reduce perinatal mortality and preterm birth. It sets out guidance on reducing perinatal mortality and preterm birth for commissioners and maternity services. Reducing smoking in pregnancy is the first of the six elements of evidence-based care. Element 1 focuses on reducing smoking in pregnancy by implementing NHS-funded tobacco dependence treatment services within maternity settings, in line with the NHS Long Term Plan and NICE guidance. The care bundle details the key factors for implementation of the interventions for reducing smoking in pregnancy, the relevant indicators for monitoring progress and it notes the necessity of continuous learning by maternity providers.

The care bundle includes CO testing and asking about smoking status at antenatal booking, and as appropriate, throughout pregnancy.

4.2.3 What is being delivered?

Addressing maternal tobacco dependence in Derbyshire has been an ongoing priority as rates of smoking status at time of delivery in the County, although declining, remains significantly higher than national prevalence.

Growing activity to address maternal tobacco dependence demonstrates local commitment to reducing the prevalence locally, despite significant system challenges during and since Covid-19.

Derby and Derbyshire Smoking in Pregnancy Group

The Derby and Derbyshire Smoking in Pregnancy Group considers system-wide work relating to health pre-pregnancy, during pregnancy, and post-pregnancy as well as reviewing and updating the Derbyshire Smokefree Pregnancy Care Pathway document. This group reports into the Derbyshire Local Maternity and Neonatal System (LMNS) governance structure and the Tobacco Dependency Board. Partners include Midwifery, Public Health, Live Life Better Derbyshire, 0-19 Public Health Nursing Service, Children's Services and Integrated Care Board (ICB) colleagues.

Maternal Tobacco Dependency Group

The Derby and Derbyshire Maternal Tobacco Dependency Group was established in March 2022 to oversee the implementation of the Tobacco Dependency Pathway where all pregnant women and birthing people who smoke are now offered free nicotine replacement therapy and support within maternity services as outlined in Chapter 2 of the NHS Long Term Plan[110].

Tobacco Dependency Treatment in pregnancy

Tobacco Dependency Treatment services during pregnancy are provided through Tobacco Dependency Advisors employed by Derbyshire County Council Public Health on behalf of the NHS hosted by Live Life Better Derbyshire. These advisors work alongside midwives at Chesterfield Royal Hospital (CRH) and University Hospitals of Derby and Burton (UHDB) to implement the Tobacco Dependency Treatment Pathway. In line with NICE guidance NG209[99], an opt-out referral for support from a tobacco dependency adviser to offer a

personalised care plan and provide support throughout their pregnancy, will be made for all pregnant women and birthing people who smoke.

Ongoing service improvement work began in September 2022 to ensure staff are adequately trained, routine CO monitoring and recording is completed, appropriate and swift referral process is in place, and effective tobacco dependency support is provided.

Additional resources were allocated to all LMNS's in 2021 to implement the Maternal Tobacco Dependency Pathway. Due to COVID-19 there was some disruption to planned training for midwives. Since 2019, CRH have had a Tobacco Dependency Champion Midwife in place with dedicated time to drive forward changes to culture and upskill maternity staff in treating tobacco dependence in pregnancy. UHDB appointed a Tobacco Dependency Champion Midwife in July 2022. Both champions are making an impact on the implementation of the Maternal Tobacco Dependency Pathway.

Activity in development

Saving Babies Lives Care Bundle Version 3 highlights the clinical importance of reducing the rates of smoking during pregnancy on stillbirth rates and preterm birth and outlines clinical practice and surveillance pathways (such as serial growth scans) based on risk. Pregnant women and birthing people with raised level of CO (4 ppm and above) may receive serial growth scans to monitor the growth of the foetus. There is a commitment to embed CO monitoring of pregnant women and birthing people in Derby and Derbyshire, by CRH and UHDB regardless of self-reported smoking status.

4.2.4 What are the outcomes?

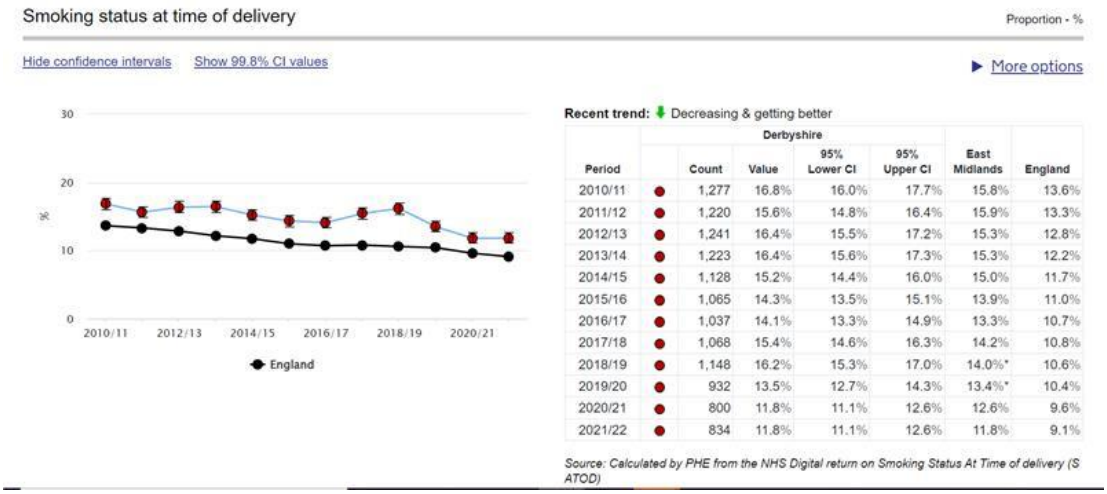
The UK Government set an ambition to reduce smoking in pregnancy rates to less than 6% by 2022[111] – this was not achieved nationally or in Derbyshire. There is currently no new national target in place specifically for smoking in pregnancy or SATOD.

SATOD data

Prevalence of SATOD was 11.8% (832 people) in Derbyshire in 2021/22. The trend for SATOD in Derbyshire is decreasing, though annual figures fluctuate (Figure 81)[16]Prevalence of SATOD in Derbyshire is consistently above England throughout the period of 2010 to 2021, as shown in figure 81 below.

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

Figure 73 Smoking status at time of delivery – trend data Derbyshire and England 2010/11 to 2020/21



Period		Derbyshire Count	Value	95% Lower CI	95% Upper CI	East Midlands	England
2010/11		1,277	16.8%	16.0%	17.7%	15.8%	13.6%
2011/12		1,220	15.6%	14.8%	16.4%	15.9%	13.3%
2012/13		1,241	16.4%	15.5%	17.2%	15.3%	12.8%
2013/14		1,223	16.4%	15.6%	17.3%	15.3%	12.2%
2014/15		1,128	15.2%	14.4%	16.0%	15.0%	11.7%
2015/16		1,065	14.3%	13.5%	15.1%	13.9%	11.0%
2016/17		1,037	14.1%	13.3%	14.9%	13.3%	10.7%
2017/18		1,068	15.4%	14.6%	16.3%	14.2%	10.8%
2018/19		1,148	16.2%	15.3%	17.0%	14.0%*	10.6%
2019/20		932	13.5%	12.7%	14.3%	13.4%*	10.4%
2020/21		800	11.8%	11.1%	12.6%	12.6%	9.6%
2021/22		834	11.8%	11.1%	12.6%	11.8%	9.1%

Source: Calculated by PHE from the NHS Digital return on Smoking Status At Time of delivery (SATOD)

Data on pregnant people quitting smoking in Derbyshire in 2021/22

Data on the uptake and effectiveness of stop smoking services for the number and percentage of successful quits are reported nationally. Table 8, below, shows data for 2021/22. Derbyshire compares well regionally and nationally for the successful quit outcomes achieved by the pregnant women and birthing people who engage with stop smoking services and set a quit date, including the use of CO-validation for these quits.

Table 8 Data on pregnant women quitting smoking 2021/22

	Number setting quit date	Number successful quitters*	Percentage successful quitters* from setting quit date	Number successful quitters (CO-validated)	Percentage successful quitters (CO-validated) from setting quit date	Percentage successful quitters (CO-validated) from successful quitters*
Derbyshire	225	109	48%	2	0.9%	1.8%
East Midlands	1,509	683	45%	3	2%	0.4%
England	15,993	7,360	46%	1,305	8%	17%

Source: NHS Digital[112]; *self-reported data

During 2021/21, 225 pregnant women engaging with stop smoking services in Derbyshire set a quit date, whilst 834 were recorded as smoking at time of delivery. This comparison gives an indication of the scale of need in addressing smoking in pregnancy locally. The number of CO-validated quitters is low because stop smoking support is largely being provided over the telephone.

4.2.5 Where are the gaps?

The Derby and Derbyshire Smoking in Pregnancy Group will lead collaborative system efforts to reduce smoking in pregnancy. Since early 2023, the group has taken a wider view of the topic, including exploring further opportunities for prevention.

There may be opportunities to improve support to prevent postpartum relapse, which supports smoke-free subsequent pregnancies.

Improving how stop smoking services engage with partners and significant others of pregnant women and birthing people to help to reduce exposure to second-hand smoke, improve chances of quitting, and reduce chances of relapse[113].

Local NHS trust data does not yet include all the information required to fully understand hospital-based maternal tobacco dependence activity. Complete and accurate data can support efforts to understand and improve outcomes. Behavioural science approaches and health psychology could also have a role in this improvement work.

National guidance is expected to be published soon on the implementation of financial incentives to support pregnant women and birthing people to quit smoking.

4.3 Cheap and illicit tobacco

There are three main categories of illegal tobacco:

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

Illicit tobacco is more accessible to children and young people, and to people living in more deprived areas compounding the health inequalities experienced by these groups[114]. It is estimated that illicit tobacco makes tobacco two to three times more affordable than legitimate products, and therefore can make smoking more accessible financially[115]. In addition, there are other health risks associated with counterfeit products including the presence of contaminants within the tobacco and cigarettes and the products not meeting manufacturing standards – for example ongoing burning and having a higher fire risk. Nationally it was estimated in 2020 to 2021 that there was a £2.5 billion tax gap associated with the combined illicit tobacco markets; illicit tobacco comprised an estimated 9% of cigarette sales[116].

4.3.1 What works?

NICE have a placeholder quality standard for: Smoking: reducing and preventing tobacco use[117]' This is a 'placeholder' standard as it is a priority of the Advisory Group, but there is a lack of source guidance.

Nationally, Operation CeCe, a HM Revenue and Customs (HMRC) sponsored operation delivered by national Trading Standards through local authorities, is now fully implemented and achieving significant results. The strategy has four aims:

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

National Tobacco Control Plan 2017-2022

The National Tobacco Control Plan Delivery Plan 2017-2022 emphasised the role of local tobacco control.

There are enforcement powers relevant to tackling illicit tobacco across a range of organisations and agencies including the Police, HMRC and Trading Standards.

The Illicit Tobacco Partnership is a collaboration between FRESH (the tobacco control work in North East England), ASH, UKCTAS and others. The Partnership have collated

resources to provide strategic advice, including guidance for Trading Standards, and communications resources.

Similarly, Stop Illegal Tobacco, from Smokefree West provides information and a platform for people to share anonymous information. Crimestoppers is another organisation to whom the public can report issues anonymously.

There is also a national Citizens Advice Consumer Service for the public to report complaints. In all cases this information will be reported to Trading Standards.

4.3.2 What is being delivered?

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

Illicit tobacco

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

Enforcement

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

Between April 2022 and March 2023, nine letters of warning were issued, and seven premises were closed[118].

Age-restricted products

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

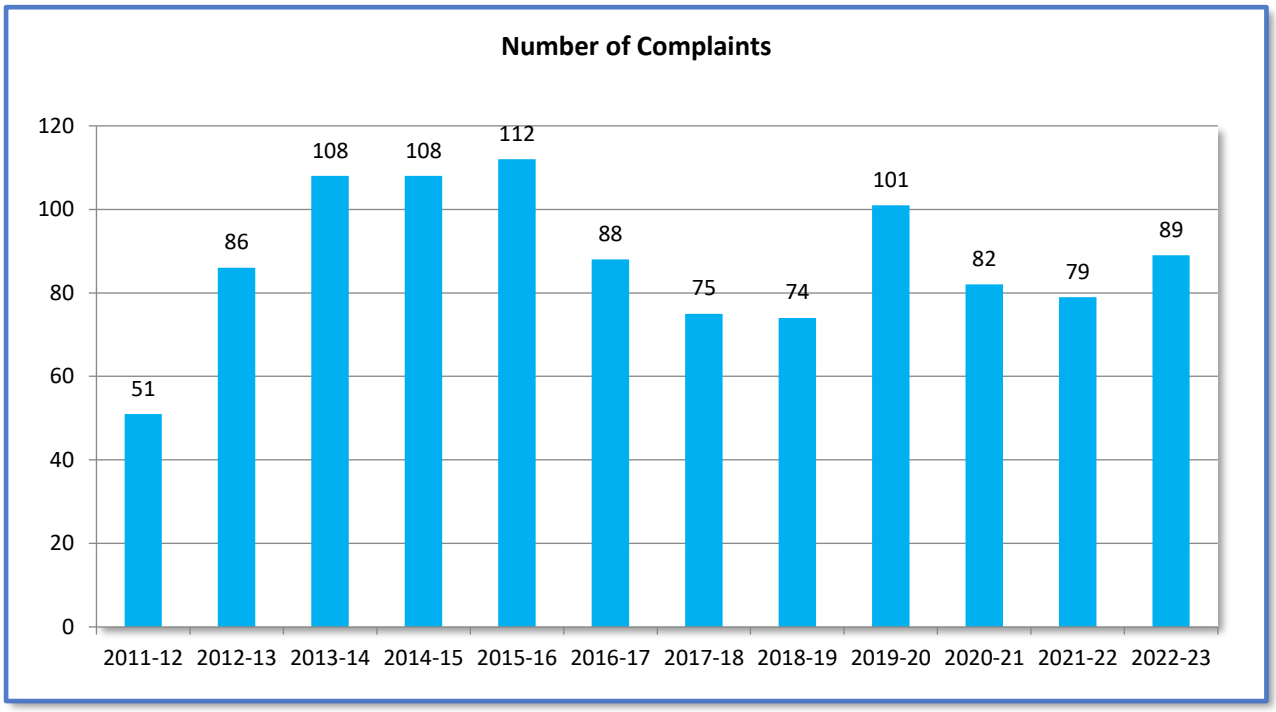
The Derbyshire Trading Standards Service underwent a restructure in 2018/19 which has had significant influence on capacity within the service. Enforcement in areas of illegal tobacco and underage issues are continuing, but at a reduced level, based on local intelligence only.

HMRC have a national role in enforcement and disruption of the illicit tobacco supply. The Police also have a role in tackling the organised crime groups which effectively run the illegal tobacco trade and that are routinely involved in other serious criminality. However, these agencies do not effectively carry out any significant work on supply at a local level, which is where the majority of Trading Standards work lies.

4.3.3 What are our outcomes?

The latest annual report by Derbyshire Trading Standards (2022-23[119]) indicates that a substantial number of complaints about illicit tobacco have been received in recent years, although they seem to have reduced from a peak between 2013 and 2016. Some of these complaints will have been routed through the national Citizens Advice line which has handled fewer complaints in recent years, possibly due to changes in the capacity of the service, so the number of complaints may not directly correlate with the scale of the problem in Derbyshire.

Figure 74 Complaints about illegal tobacco made to Derbyshire Trading Standards



Source: Derbyshire Annual Tobacco Report 2022-23, Derbyshire County Council (unpublished)

A higher quantity of illicit cigarettes and tobacco was seized in 2021-22 than previous years. This was a time when the country was recovering from the effects of the COVID-19 pandemic and 'business' returned to normal for both the criminals and enforcement officers, although visits and inspections were paused for part of the year.

Most of these seizures were for counterfeit cigarettes. The retail value of the seized tobacco equates to £21,600 for the cigarettes and £14,000 for the tobacco. The Service received 89 reports about sales and supply of illegal tobacco. This resulted in 20 enforcement exercises where 40,720 cigarettes (estimated value) and 27.55kg of hand rolling tobacco (estimated value £14,000) were seized.

The combined tax element of these seizures is £24,713, representing a substantial loss to the Exchequer. Six shops selling illegal tobacco were closed down, and one Facebook user had their account removed after advertising the same. In September 2021 the Service made a seizure of approximately 11,000 cigarettes and 130 pouches of tobacco from an electro-magnetically operated concealment under a tiled floor in the rear of a shop, demonstrating the increasing lengths that the offenders are going to in order to avoid detection.

Table 9 Tobacco Seizures in Derbyshire by Trading Standards

Year	Cigarette Sticks	Hand Rolled Tobacco – Kg
2011/12	14,000	115
2012/13	62,000	26
2013/14	876,000	795
2014/15	347,000	108
2015/16	1,855,750	595
2016/17	52,120	26
2017/18	43,798	47
2018/19	253,000	117
2019/20	1,150,630	91
2020/21	35,020	18
2021/22	50,880	27
2022/23	40,720	28
Total	**4,781,510 sticks**	**1.993 tonnes**

Source: Derbyshire Annual Tobacco Report 2022-23, Derbyshire County Council (unpublished)

Underage sales

Approximately 75 visits were undertaken in 2022/23, often in response to local intelligence. These would be to provide advice on systems and due diligence to reduce the risk of sales to children and would cover all age restricted goods. Underage complaints about tobacco were a very small proportion of the total number of underage reports received in 2022/23. In the most recent financial year, 108 complaints were made about vapes, 47 relating to alcohol and five about cigarettes.

The risk assessment visits to premises were carried out as a response to credible allegations that sales of age restricted products to underage persons were taking place. In some cases, these visits were carried out in conjunction with the Police and the local Licensing Authority (often the district or borough council). These visits assess the due diligence and processes the trader has in place to avoid sales to those underage and bring the complaints/allegations to their attention and advise accordingly.

For premises where there are concerns, Risk Assessment visits are normally followed up by two further stages:

1. Age verification checks (using test purchasers over 18 years of age)
2. Test purchase Exercises (using test purchasers under 18 years of age)

Appropriate enforcement action can then be taken.

4.3.4 Where are the gaps?

There is evident experience of an intelligence-informed local response across agencies to addressing complaints, with demonstrable seizures of illicit products and work by Trading

Standards particularly in recent years. Due to constraints on resource and capacity, the local service increasingly prioritises other operational work. This limits capacity to enforce legislation around age restricted sales.

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

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

4.4 Smokefree places

Enclosed public spaces

Legislation introduced in England in 2007 has made it illegal to smoke in all public enclosed or substantially enclosed area and workplaces.

Voluntary smokefree zones

Since 2007 emphasis has moved towards establishing voluntary smokefree zones in a wide range of other outdoor public settings to reduce second-hand smoke exposure and to reduce the risk of uptake by children as a result of having a parent/carer who smokes.

Children are particularly susceptible to the harms associated with exposure to tobacco smoke. Children exposed to second-hand tobacco smoke within the home environment are at higher risk of asthma, chest infections, ear infections, and meningitis, and pregnant women who are exposed to passive smoke are more likely to have complications during their pregnancy and their baby is at higher risk of low birthweight and sudden infant death syndrome.[120]

Children whose parents both smoke are at a three-fold increased risk of taking up smoking themselves. Children are over 70% more likely to start smoking if just one parent smoked, and over twice as likely if that parent was the mother[121].

There is limited but emerging evidence on smokefree environments particularly in regard to public perception; smokefree places or zones adopt the precautionary principle as a means to provide protection from tobacco smoke exposure and may contribute to a de-normalisation effect.

Potential settings for smokefree zones[122]:

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

Thirdhand smoke

There is some concern about the impacts of thirdhand smoke, the contaminants from tobacco smoke that linger in the environment, particularly for children.[123]

4.4.1 What works?

The WHO recommendations for smokefree environments were written into the international Framework Convention on Tobacco Control, emphasising the need for the protection from exposure to tobacco smoke in public places. There are indications that the implementation of the UK smoke-free legislation for indoor spaces was associated with a reduction in smoking take up among teenagers, particularly among girls[124] and there is clear evidence that smokefree legislation is associated with substantial reductions in preterm births and hospital attendances for asthma[125].

The evidence for the impact of policies in particular outdoor settings such as school gates or playgrounds is very limited. In 2016 the Chartered Institute of Environmental Health called for smokefree zones in all parks and playgrounds following a YouGov poll that they

commissioned that found high levels of support for children's playgrounds to be a voluntary smokefree zone.[126]

Public attitudes to smokefree policies

An evidence synthesis report was produced by PHE in 2018[127] with the following key findings particularly pertaining to public attitudes of smokefree policies:

Most of the research available comes from cross-sectional studies that are of mixed quality and have wide methodological differences making comparison across studies difficult.

The international literature shows that public attitudes towards outdoor smokefree policies vary considerably depending upon individual level factors or setting, such as non-smokers and females tending to hold more favourable views towards outdoor smoking restrictions.

The effect of smokefree outdoors on behaviour and associated harms is mixed with some studies reporting no effects and others positive effects when outdoor spaces become smokefree, such as significantly reduced smoking prevalence post-ban across smokefree universities (from a good quality systematic review) and significant reductions in second-hand smoke exposure (from a moderate quality study) one year after a university became smokefree.

Compliance with smokefree areas can sometimes be low, likely due to the voluntary nature of some outdoor smoking restrictions or limited awareness even where smokefree outdoor policies are mandatory.

Smoking remains the UK's largest cause of preventable disease and death; should an outdoor smokefree policy be trialled despite an overall lack of evidence of the effectiveness, a rigorous evaluation of this would greatly help to further build the evidence base.

School gates and school policies

The authors of a Cochrane Systematic Review were unable to draw conclusions about the effectiveness of school tobacco policies from the data available in 2014.[128] Many local policies at school gates or other settings have been viewed as a social responsibility to protect children from exposure to the harm of tobacco smoke. A qualitative study from the Netherlands explored the barriers and facilitators to smokefree school zones and identified the necessity of stakeholder engagement, with the authors concluding that legislation is important.[129]

Playgrounds and recreational areas, and other outdoor areas

Most of the formal literature is from settings outside the UK such as Canada, Australia and Ireland. The discourse for smokefree recreational areas is often related to their public perception, the process of establishing smokefree zones, the contrast between mandatory and voluntary schemes, and issues of enforcement. There are examples from the UK where policies are being put into place, but as with the school zones, these are mostly forms of grey literature such as newspaper articles, case studies and web pages primarily to raise awareness of the policies that are being proposed or implemented, rather than assessments or evaluations of their impact.

Considerations for smokefree policies

Smokefree zones vary in whether vaping/use of e-cigarettes is permitted within the zone. It is recommended that vaping is only allowed in adult-only areas and not in areas where children and young people may be present.

4.4.2 What is being delivered?

Enclosed public spaces

Smoking has been prohibited in almost all enclosed work and public places in the UK since July 2007. Smokefree legislation in England forms part of the Health Act 2006 and The Children and Families Act 2014[130].

Voluntary smokefree zones

A public consultation was conducted in 2019 on proposed outdoor smokefree zones in Derbyshire[131]. Public support was high for introducing smokefree zones, particularly in outdoor spaces where children are likely to be, such as primary school gates, play areas and sports clubs.

Smokefree Derbyshire School Gates was the first initiative to be created as a result of the positive results of the consultation. A pilot for the project was conducted from November 2020 to February 2021. The project was due to start in March 2020 but due to the COVID-19 pandemic the roll out was severely restricted and had to stop multiple times due to lockdowns and schools being shut before being put on hold indefinitely in September 2021.

NHS smokefree policies

Hospitals have been developing smokefree policies within their grounds, for example the 'Proud to be Smoke free' campaign at CRH, the 'Think Again' campaign at UDHB and the Derbyshire Healthcare NHS Foundation Trust policy that all staff, service users and visitors are not allowed to smoke tobacco anywhere on their sites including wards, grounds, vehicles and during home visits.

4.4.3 What are our outcomes?

Voluntary smokefree zones

Forty-eight primary schools were at various stages of implementing the Smokefree Derbyshire School Gates initiative on site before being put on hold indefinitely in September 2021.

NHS smokefree policies

As of June 2023, the status of implementation of smokefree policies at local healthcare organisations is not known.

4.4.4 Where are the gaps?

Voluntary smokefree zones

The evidence base for smokefree zones is still emerging, particularly in measuring the outcomes on smoking behaviours and on health. It is not possible to determine which settings have the greatest impact for reducing smoking-related health inequalities to inform prioritisation decisions. As children are especially vulnerable to the risks from second-hand smoke, and have less choice over their environments, protecting their health is the clear focus, and many of the examples in the literature are for smokefree school gates and playgrounds.

One of the main areas for further consideration beyond the work on public settings is the home. There is significant exposure to second-hand smoke in the home when children or non-smokers live with smokers. Research has shown that the most reliable way of reducing passive exposure is when the indoor environment is completely smokefree. There is also concern about 'thirdhand smoke', the pollutants that remain on clothes, soft furnishings, and in the environment.[132] An ASH briefing on second-hand smoke in the home concluded that

population-level initiatives such as awareness campaigns may be important for influencing attitudes and behaviours.[133]

NHS Smokefree Policies

A review of hospital smokefree policies and how they have been implemented would provide direction with regards to this area of work.

4.5 Health services and reducing smoking

Health and care services, including those provided by the NHS, are key settings for tobacco control measures. People who smoke are more likely to have health needs and health use than non-smokers; smokers are estimated to make 35% more GP appointments than non-smokers.[134] In England in 2019 to 2020 there was an estimated 506,100 smoking related hospital admissions, equating to almost 1,400 per day and 1 in 4 patients in a hospital bed is a smoker[135] The NHS is the UK's largest employer with a workforce of approximately 1.5 million staff[136] who may be impacted by cultural changes around smoking. Tobacco policies in these settings have a vast potential reach. Because tobacco dependence has such substantial impacts on health and NHS care, helping people stop smoking is the single highest value contribution to health that any clinician can make.[137]

4.5.1 What works?

NICE guidance

NICE Guideline NG209 Tobacco: preventing uptake, promoting quitting and treating dependence (Section 1.13 Support to stop smoking in primary care and community settings) recommends that for people wanting to stop smoking, health and social care professionals should:

- discuss with them how they can stop (NCSCT programmes explain how to do this)
- provide stop-smoking interventions and advice
- if you are unable to provide stop-smoking interventions, refer them to local stop-smoking support, if available
- if they opt out of a referral to stop-smoking support, refer them to a professional who can offer pharmacotherapy and very brief advice.

Section 1.14 (Support to stop smoking in secondary care services) makes recommendation across the following domains:

- Information on stopping smoking for those using acute, maternity and mental health services
- Referring to behavioural support in acute, maternity and mental health services
- Behavioural support in acute and mental health services
- Stop-smoking pharmacotherapies in acute and mental health services
- Stop-smoking support in mental health services.

NHS Smokefree Pledge

NHS organisations can sign the 'NHS Smokefree Pledge' that was re-launched in March 2022 by the Smokefree Coalition.[138] 'The Statement provides a public commitment to work towards further reducing smoking prevalence; to demonstrate a commitment to take action;

and to publicise the NHS's dedication to protect local communities from the harm caused by smoking. It also reinforces the signatory's commitment to protect tobacco control work from the vested interests of the tobacco industry.'

Very brief advice (VBA)

The National Centre for Smoking Cessation and Training has developed a training module for health professionals on how to deliver VBA to patients.[139] This VBA approach has been developed from the evidence base on brief opportunistic smoking cessation interventions and is designed for implementation in fast-paced healthcare settings. It is also referred to as the *Ask, Assess, Act model*[140].

4.5.2 What is being delivered?

NHS Long Term Plan – tobacco aim

The NHS Long Term Plan, published in January 2019, set out its priorities for healthcare over the next ten years. Chapter 2 states that demand for NHS services continues to grow for at least five separate reasons. Three of those reasons are modifiable, including:

> *improving upstream prevention of avoidable illness and its exacerbations. So, for example, smoking cessation, diabetes prevention through obesity reduction, and reduced respiratory hospitalisations from lower air pollution*[141]

The smoking cessation specific commitment of the NHS Long Term Plan states:

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

Quality and Outcomes Framework

The Quality and Outcomes Framework (QOF)[142] is a voluntary annual reward and incentive programme for general practices in England, detailing practice achievement results. Its primary use is resourcing and providing financial rewards for good practice.

Smoking is part of the public health domain for the Quality and Outcomes Framework for general practices[143] with points for recording smoking status of patients, and for ongoing management, including an offer of literature and appropriate therapy or support and treatment.

NHS Health Checks

The NHS Health Checks are offered in Derbyshire for people aged 40 to 74 years, and smoking is one of the risk factors included in the health check. Staff who carry out the health checks are trained locally on assessing smoking history and providing advice.

Smokefree NHS Premises

Joined Up Care Derbyshire is a partnership of organisations and is based on a shared vision to improve the health and well-being of our local people- this is known as an Integrated Care

System (ICS). The benefit of an ICS is that it brings existing organisations closer together, working in an integrated way to improve care for our local people.

4.5.3 What are our outcomes?

NHS Long Term Plan – tobacco aim

A Tobacco Dependency Board has been established to coordinate this work and includes membership of partners across the ICS. Task and finish groups have then been established for the four main areas of the tobacco dependency treatment:

- University Hospitals of Derby and Burton
- Chesterfield Royal Hospital
- Maternity
- Mental Health.

The system has employed a project manager to lead on the implementation of this work. The ICS has employed eight Tobacco Dependency Advisors, two Tobacco Dependency Champions and two Maternity Champion across Derbyshire. Referrals and support pathways are now in place for all four parts of the pathway.

Quality and Outcomes Framework

Smoking is part of the public health domain for the QOF for general practices[144] with points for recording smoking status of patients, and for ongoing management, including an offer of literature and appropriate therapy or support and treatment.

In 2021/22, 117 GP practices in Derby and Derbyshire achieved[145]:

- 93% of patients with any or any combination of the following conditions: chronic heart disease (CHD), peripheral arterial disease (PAD), stroke or transient ischemic attack (TIA), hypertension, diabetes, COPD, chronic kidney disease (CKD), asthma, schizophrenia, bipolar affective disorder or other psychoses had notes recording smoking status in the preceding 12 months. Nationally, this ranges from 89% to 93%.
- 85% of patients with any or any combination of the following conditions: CHD, PAD, stroke or TIA, hypertension, diabetes, COPD, CKD, asthma, schizophrenia, bipolar affective disorder or other psychoses and were recorded as current smokers had a record of an offer of support and treatment within the preceding 12 months
- 80% of patients aged 15 or over and were recorded as current smokers had a record of an offer of support and treatment within the preceding 24 months. Nationally, this ranges from 60% to 80%.

NHS Health Checks

In Derbyshire in 2021/22, there were 4,534 NHS Health Checks conducted, of which 454 (10%) were classed as current smokers. Of these:

- 339 were offered stop smoking advice
- 51 were signposted to an NHS Stop Smoking Service
- 13 were referred to an advisor at an NHS Stop Smoking advisor.

Smokefree NHS Premises

In the 2019 version of this HNA, it was highlighted that, while there is a commitment to smokefree NHS settings locally, none of the NHS organisations within Joined Up Care

Derbyshire are signatories of the NHS Smokefree Pledge. A more detailed review of progress and next steps could renew and develop this commitment.

4.5.4 What are the gaps?

NHS Smokefree Pledge

As of February 2023, no Derbyshire NHS organisations are signed up to the NHS Smokefree Pledge[146].

5. Call to Action: A smokefree future

5.1 National and local commitment

Khan Review – Making smoking obsolete – An independent review into Smokefree 2030 policies

In June 2022, Sajid Javid, the then Secretary of State for Health and Social Care, asked Dr Javed Khan OBE to carry out an independent review of the 'smokefree 2030' ambition to get smoking rates in England down to 5% from the 2022 position of 13.5%.

The review found that without further action, England would miss the smokefree 2030 ambition by at least seven years, with the poorest areas not meeting it until 2044.

This would mean that the government would not meet its manifesto commitment to "to extend healthy life expectancy by 5 years by 2035" and would prevent the government from fulfilling its ambition to save more lives as part of a new 10-Year Cancer Plan.

The review found that to have any chance of hitting the smokefree 2030 target, the rate of decline of people who smoked would need to be accelerated by 40%.

The review stated that:

> *"To truly achieve a smokefree society in this great country of ours, smoking should be obsolete. I cannot, in all conscience, endorse a strategy that settles for anything less. So, I am asking the government to go further than its current ambitions. It needs to go faster. It needs to be bolder. It needs to do more to protect future generations from this highly addictive and deadly product. Along the way, the government should do all it can to dissuade the tobacco industry from selling tobacco products. The ambition for tackling smoking should aim for 'net zero' – to make smoking obsolete."*

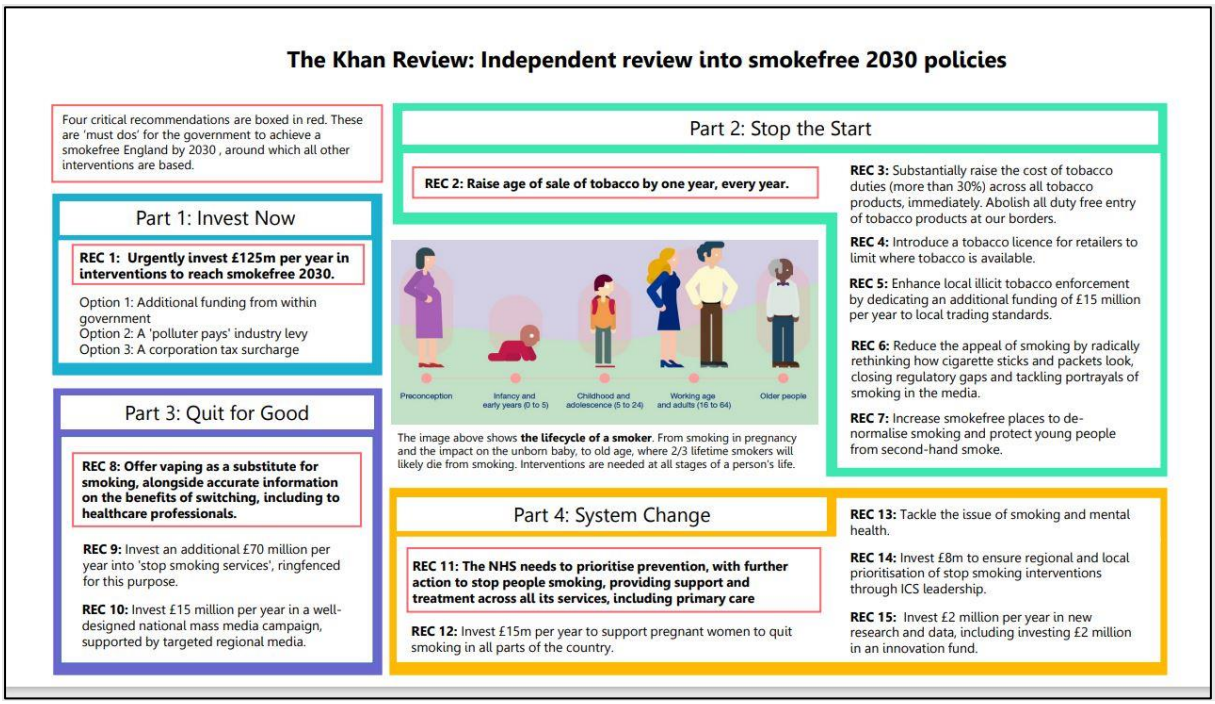
The review also stated that there was no evidence of a plan or movement by the industry to act following the governments ultimatum of 'making smoking obsolete'.

The review recommended that there should be an ambitious, but realistic target to:

- Ensure rates of smoking in every community in every area is below 5% by 2035
- drive a new ambition of making smoking obsolete by 2040

The review included 15 recommendations, of which four are classed as 'critical recommendations' or 'must do's' around which all other interventions are based.

Figure 75 The Khan Review (2022): visual summary of recommendations



Joined Up Care Derbyshire 5-year Strategic Delivery Plan

Organisations within the ICS - Joined Up Care Derbyshire (JUCD) are signed up to *'*be a leader in enabling staff, patients and visitors to become smoke-free"[147]. In addition to the NHS organisations listed in section 4.5.2., JUCD member organisations includes Derbyshire Voluntary Sector Alliance, Healthwatch Derby, Healthwatch Derbyshire, Derby City Council, and Derbyshire County Council.

Derbyshire County Council Plan 2022-2023

The Council plan 2023/25 has a priority of 'Resilient, healthy and safe communities' and a deliverable underneath that priority of 'Work with partners to enable people to lead healthier lives by supporting people to take part in physical activity, to stop smoking and manage their weight'[148].

Derbyshire Health and Wellbeing Strategy

Derbyshire Health and Wellbeing Strategy for 2022 Refresh includes a priority to 'Enable people in Derbyshire to live healthy lives', including a reduction in smoking particularly among pregnant women at the time of delivery. [149]

6 Conclusions and recommendations

What does this health needs assessment provide?

This health needs assessment has brought together data and information on the use and impact of tobacco within Derbyshire and has considered how tobacco control measures are being implemented within several areas of work. It provides a focus for future work highlighting the key areas and challenges for Derbyshire and suggested way forward.

6.1 Main findings

The proportion of adults estimated to smoke in Derbyshire in 2021 (14.1%) was similar to the England average (13.0%). The challenge remains to reduce this figure to 5% by 2030 in line with the national ambition for a smokefree country by that date.

There is limited recent data to enable comparisons of smoking prevalence in young people between areas. In the 2014/15 period, 5.4% of 15-year-olds in Derbyshire were regular smokers. This was similar to the England average of 5.5%.

Vaping is increasing in young people who have never smoked according to my life my view data and national data. Rates vary by district with highest rate in Bolsover and lowest in North East Derbyshire. There is currently no specific service and/or agreed approach to tackle this.

Smoking rates are higher in people who work in routine and manual occupations with a Derbyshire rate of 22.6% and similarly in people with Serious Mental Illness have a smoking rate of 39.9% for Derbyshire.

Prevalence of smoking in pregnancy in Derbyshire has reduced in recent years. Despite this, the proportion of people smoking at the time of delivery in Derbyshire in 2021/22 (11.8%) remains significantly higher than the England average (9.1%).

Derbyshire has high rates of premature births, smoking attributable hospital admissions, and oesophageal cancer registrations. The Derbyshire rate of lung cancer registrations is lower than the England average.

It is estimated that more than 1,000 people in Derbyshire die of smoking attributable deaths each year (rate of 199.5 per 100,000). This is similar to the England average.

There are many different harms caused to the body by smoking. For example, smoking causes 84% of deaths from lung cancer, increase the risk of stroke by at least 50%, can cause impotence in men, can make it harder to conceive and doubles the risk of a heart attack.

Smoking in Derbyshire creates an estimated societal cost of £255.9 million each year. This includes an estimated £27.7m for treating smoking-related illness; £203.2 million in lost productivity, and more than £19.2 million in social care costs as a result of smoking related illnesses.

Rates of success from Live Life Better Derbyshire's stop smoking service are relatively high. In 2021/22, 68% of users of the Derbyshire service who set quit dates successfully quit smoking. This is higher than the East Midlands (61%) and England (55%) rates.

The Tobacco dependency service provided by LLBD at both acute trusts has broadened access to stop smoking services to the hospital inpatient population. This service also extends to those who are pregnant and their partners.

Trading Standards make an important contribution to tobacco control in Derbyshire. The resources currently available mean their work on tobacco is relatively limited.

Smoke Free policies have been developed across local hospitals including Chesterfield Royal Hospital, Derbyshire Healthcare NHS Trust and University Hospitals of Derby and Burton.

The status of the stop smoking policies of local NHS organisations is not known. These organisations have the potential to significantly impact smoking because of their frequent contact with people who smoke and their role as major employers.

There is currently no strategic group across the Derby Derbyshire Integrated Care System for tobacco control and no agreed framework for action.

6.2 Recommendations

1. Develop a strategic group across the Derby Derbyshire Integrated Care System for tobacco control and an agreed framework for action.

2. Explore notable geographical variations in local data, including rate of lung cancer registrations in Bolsover (2017-19) and relatively high levels of school aged children in Chesterfield and Bolsover reporting having tried cigarettes through the My Life, My View survey 2014/15-2018/19).

3. Explore reasons for rapid increase in youth vaping in Derbyshire and consider approaches to tackle this. Continue to monitor with My Life My View survey.

4. Explore reasons for higher smoking rates locally in routine and manual populations and in those with serious mental illness and consider approaches to tackle this.

5. Increase access to stop smoking services including providing e cigarettes for adults as a quitting aide– those who access LLBDs services are three times more likely to successfully quit compared to attempting without support.

6. Continue with the Tobacco Dependency Treatment service to support inpatient smokers and reduce the impact of smoking on hospital admissions

7. Continue with work to reduce smoking in pregnancy. Review evidence and new policy on incentives for smoking in pregnancy as per forthcoming national guidance. Work towards ambitions around quits and CO validations (SBLCB v3)

8. Consider how best to work in partnership with Trading Standards to support their enforcement work regarding point-of-sale displays, underage sales, packaging, and removing illicit / illegal tobacco from the market.

9. Consider how to understand lived experience of people in Derbyshire relating to tobacco control.

10. Complete a review of NHS Smokefree Pledge status of local NHS organisations.

11. Across local authorities, healthcare and the voluntary and community sector provide training and support to enable the workforce to maximise opportunities with a Quality Conversations approach to identify smokers, provide very brief advice (VBA) and actively signpost to stop smoking support.
12. Draw on resources developed by Action on Smoking and Health[150] to develop a local tobacco control plan with strategic aims and ambitious, measurable targets.

Appendices

Appendix 1 – Further detail on 2022 data included in Section 2

Counts are no longer included for those indicators which are based on survey data, such as the APS, as these are based on samples and any counts would therefore not be a true reflection of the population counts.

Methodological changes that were made to data collection during the coronavirus pandemic previously rendered any comparison with previous years unfeasible. Data collected during this period have since been updated using a weighting methodology, allowing the figures for 2020, 2021 and 2022 to be compared with those of previous years.

Self-reported smoking may be susceptible to respondent bias.

These data have not been age-standardised and, therefore, variation between areas values may be a result of differences in population structure.

Data are displayed for the Fingertips geography version of counties and UAs from April 2021, therefore CIPFA comparisons may not be directly comparable with data that is based on the previous geography version that was based on counties and UAs for the year 2020/21.

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