Local tobacco control policy statement

Purpose of this document

This policy statement provides local authorities in England with an overview of Cancer Research UK's local tobacco control policies.

The statement provides practical recommendations to support the implementation of comprehensive tobacco control activity in councils to reduce the impact of tobacco in communities and improve the health and wellbeing of residents.

Context

Preventable disease and mortality continue to have an impact on our health, the NHS and the economy. This has only come into sharper focus since the emergence of COVID-19, with preventable causes of cancer such as obesity[1] being associated with a higher risk of adverse outcomes from COVID-19.[2,3] Local authorities have also experienced a sustained programme of funding reductions since 2015/16[4] which has compromised their ability to provide the vital functions and services that improve population health and prevent ill health, including tobacco control measures. We understand the challenging funding environment that local authorities in England operate in. We therefore appreciate that some of the recommendations below will not be suitable for all. We would be pleased to work with all local authorities to help them implement the measures that suit their circumstances and population needs.

Key messages

Tobacco use is a major public health issue. It causes ill health and death, carries a substantial financial cost on individuals, families and communities, and places an avoidable burden on our public services. Local government is in a good position to support whole system approaches to tobacco control and encourage integration with other public services, including the wider health and social care system, environmental health, housing, and children's services, to name a few.

With this in mind, local authorities should develop a comprehensive tobacco control strategy that:

- **Is delivered via a Tobacco Control Alliance that is sufficiently tailored to local needs and regularly audited**
- **Recognises and aligns with the World Health Organisation's Framework Convention on Tobacco Control**
- **Prioritises and maintains sustainable funding for tobacco control**
- **Provides evidence-based smoking cessation interventions and services, including:**
  - **Stop Smoking Services and treatment options such as pharmacotherapy and e-cigarettes**
  - **Local media campaigns to dissuade smoking uptake and promote smoking cessation**
  - **Measures to tackle illicit trade**
- **Focuses on reducing smoking inequalities and the health inequalities arising from them**
- **Ensures stop smoking advisors are supported through training**
- **Promotes smokefree environments**

Contents

1. Background

1.1 Cancer Research UK's tobacco-free ambition

Cancer Research UK has bold ambitions to beat cancer sooner. Because around 4 in 10 cancers in the UK can be prevented,[1] taking action to reduce prevalence of cancer risk factors is critical to achieving our ambition. Smoking is the biggest preventable cause of cancer in the UK,[1] and not smoking or using other tobacco products is the most important thing people can do to reduce their risk of cancer.

At Cancer Research UK, we want to end all death and ill-health caused by tobacco by bringing forward the day where no one smokes tobacco. As part of this, we support the UK Government's vision for a tobacco free England, where less than 5% of the adult population smokes by 2030. Thanks to the continued and successful action on tobacco control, smoking prevalence has significantly declined in recent decades. But with the latest data showing that 13.9% of adults in England smoke (2019) and the gap in smoking rates between lower and higher socioeconomic groups widening,[5] we still have a long way to go.

To achieve this tobacco-free ambition, continued action across national and local governments and the health service is critical.

1.2 Why is tobacco control important?

The health impacts of tobacco use are undisputed

- Tobacco is the largest preventable cause of cancer and death in the UK[1,6] and one of largest preventable causes of illness and death in the world.[6]
- Smoking causes at least 15 different types of cancer: lung, larynx, oesophagus, oral, nasopharynx, pharynx, bladder, pancreas, kidney, liver, stomach, bowel, cervix, leukaemia, and ovarian cancers.[7]
- In 2019 adult smoking prevalence in England was 13.9%, which is similar to that for the UK as a whole (14.1%).[5]
- Tobacco (both active smoking and secondhand tobacco smoke) caused around 3 in 20 (15.1%) cancer cases in the UK, or around 54,300 cancer cases, in 2015.[1]
- Tobacco smoking caused an estimated 125,000 deaths in the UK in 2015 – around a fifth (21%) of all deaths from all causes.[8]
- Smoking is also associated with a range of other diseases including coronary heart disease, heart attack, stroke, vascular disease, asthma, dementia, and chronic obstructive pulmonary disease (COPD), and it increases the risk of miscarriage and still-birth.

Resources:
Local tobacco statistics are available through Public Health England's Local Tobacco Control Profiles.

Tobacco use drives health inequalities

Differences in smoking rates among different groups or subgroups of the population translate to different rates of illness and mortality: these unfair differences in experiences and outcomes are known as health inequalities.[9] Smoking is one of the leading causes of socioeconomic inequalities in health in England,[9] and accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.[10]

In the UK, smoking prevalence is highest among certain groups or subgroups of people, including:

- people from lower socioeconomic groups[11,5]
- unemployed people[11,5]

- people with lower levels of qualification, or no qualifications[11,5]
- people with mental health conditions[12,13]
- people who identify as LGBTQIA+[14]
- people who are incarcerated[15]
- looked after[a] children[16]

Decades of comprehensive policy action meant smoking prevalence in England in 2019 was at a record low,[5] but this masks significant inequality. In fact, the smoking prevalence gap between people in routine and manual occupations and those in other occupations has widened significantly since 2012.[5] Reducing the gap in smoking prevalence that still exists between the most and least deprived in society will greatly reduce smoking-related health inequalities.

Tobacco costs the government, public services, the economy and the taxpayer

The impact of tobacco on the English economy is sizeable. It is estimated that smoking costs the economy £12.5 billion per year, £2.4 billion of which falls to NHS services for treating smoking-related illness.[17] Treating people who developed smoking-related illnesses in later life also costs the social care system £883.5 million a year.[17] £720 million of these social care system costs are funded directly by local authority social care budgets.[17]

The impact of tobacco also affects economic productivity. It is estimated that £8.9 billion is lost in productivity costs from tobacco-related workplace absenteeism, smoking breaks, illness and premature death every year.[17]

An analysis has shown that over a million people – including 263,000 children – live in poverty as a direct result of income lost to tobacco.[18] People in England spend roughly £8.6 billion on tobacco products each year, equating to around £2,050 per person who smokes.[17] Of the total expenditure, £6.8 billion is collected by the Treasury. However, despite this extra revenue, tobacco still costs the community in England twice as much as the duty raised, having a net additional cost to society of £5.7 billion.[17]

Action to tackle tobacco nationally, regionally and locally is therefore vital to reduce the impact of tobacco and tobacco-related disease on public services, including the NHS and social care services, the local economy and residents.

Nationally, Cancer Research UK is calling on the UK Government to introduce a 'Smokefree 2030 Fund', making the tobacco industry pay for tobacco control but without letting them influence how the money is spent. A Smokefree Fund would pay for the recurring costs of tobacco control measures, help free up local authority budget for use in other important areas of public health, and address a significant contributor of health inequalities.

1.3 Realising national ambitions and supporting the NHS

Achieving the smokefree ambition

In 2017 the UK Government published their *Tobacco Control Plan for England*, which set out bold ambitions to create a smokefree generation[b] across the nation.[19] In 2019 the UK Government's prevention green

[a] A child who has been in the care of their local authority for more than 24 hours.
[b] "Smokefree" is defined in the 2017 Tobacco Control Plan for England as adult smoking prevalence being 5% or fewer.

paper, *Advancing our health: prevention in the 2020s*, committed to achieving this **smokefree ambition by 2030**.[20]

To achieve a smokefree England, the Tobacco Control Plan calls for a shift of emphasis "from action at the national level – legislation and mandation of services", to "focused, local action, supporting smokers, particularly in disadvantaged groups, to quit."[19] This places responsibility on local government to contribute towards a reduction in smoking rates across England.

However, if current prevalence trends continue, analysis by Cancer Research UK has shown that England will not reach this smokefree ambition until 2037, with the most deprived quintile not reaching smokefree until the mid-2040s. The pace of change needs to be 40% faster than current trends to reach smokefree by 2030,[21] further highlighting the need for local action to support people to stop smoking.

Supporting the sustainability of the NHS

Tobacco smoking caused an estimated 125,000 deaths in the UK in 2015.[8] It is also estimated that around 500,000 hospital admissions every year in England are attributable to smoking, [22,c] and that people who smoke see their GP 35% more than those who don't.[19] Reducing tobacco smoking will therefore provide substantial benefits and reduce avoidable morbidity and mortality on the overburdened NHS.

In January 2019 the **NHS Long-Term Plan**[23] signalled a renewed commitment to treat smoking in the NHS by funding smoking cessation treatment for all patients admitted to hospital, expectant mothers and their partners, long-term users of specialist mental health services and those in learning disability services. This is expected to be rolled out across England by April 2024. However, implementing a smoking cessation model in hospitals, which supports inpatients for a limited period during and after their hospital admission, will only be sustainable if locally commissioned smoking cessation support is available to provide follow-up support when they return to the community.

Smoking tobacco is the biggest cause of lung cancer in the UK, with around 7 in 10 lung cancers caused by smoking.[1] Lung cancer is also the leading cause of cancer death in the UK,[24,25,26] and has extremely poor survival[27] primarily because most cases are diagnosed at a late stage.[28,29,30] The **NHS Targeted Lung Health Check** programme seeks to diagnose lung cancer earlier and give patients a better chance of successful treatment and survival by offering at-risk patients a low-dose CT scan.[31,32] An initial fourteen Clinical Commissioning Groups (CCG) pilot sites were announced in February 2019 and screening started in selected sites from the end of 2019. Participants are invited for a Lung Health Check if they are over 55 and younger than 75 years old, registered with a GP, and are recorded as having ever smoked on GP records. It is important that smoking cessation is an integrated part of the Targeted Lung Health Check programme — with local stop smoking service support incorporated into the clinical pathway.

[c] Tobacco-related hospital admissions are based on an average of the last three years of available NHS Digital data. These figures are likely to be an underestimate of the true burden of smoking on the NHS, because they do not allow any latency between smoking and disease/death. The smoking-related disease and death we see today is the legacy of smoking in decades past when prevalence was much higher.

2. Tobacco control principles

Tobacco use is a major public health issue. It causes ill health and death, carries a substantial financial cost on individuals, families and communities, and places an avoidable burden on our public services. As the biggest preventable cause of cancer,[1] reducing smoking and tobacco use is the best way to help reduce cancer risk among local populations across England. Therefore, a comprehensive and strategic approach to tobacco control should be a priority for local authorities.

The World Health Organisation recognises six key elements of comprehensive tobacco control through the MPOWER framework:[33]

M Monitor tobacco use and prevention policies

P Protect people from tobacco smoke

O Offer help to quit tobacco use

W Warn about the dangers of tobacco

E Enforce bans on tobacco advertising, promotion and sponsorship

R Raise taxes on tobacco

While raising taxes on tobacco is the responsibility of the UK Government and delivering nation-wide smoking cessation campaigns and activities remains the responsibility of central government departments and agencies, local authorities have a role to play in delivering other tobacco control functions and services across local footprints. This includes commissioning stop smoking services, tackling illicit tobacco, running local smoking cessation campaigns (including amplifying national campaigns) and promoting smoke-free public places. More broadly, local public health departments should also play a system leadership role in councils, championing comprehensive tobacco control policies to support healthy places and supporting tobacco control policies to be embedded in all areas of council business.

The current situation

In England, the extent to which local authorities deliver tobacco control varies significantly, in part because of differences in local needs. In 2020, 77% of surveyed local authorities in England offered a specialist stop smoking service though only 62% offered a service to all those who smoked locally.[34] Nearly all local authorities (94%) were engaged in some form of wider tobacco control activity, including tackling illicit tobacco (86%), enforcing legislation (81%), communications and campaigns (72%), and promoting smokefree public spaces (63%).[34]

What should local authorities do?

Local authorities should take a comprehensive and strategic approach to reducing tobacco use locally.

- Local authorities should consider **completing a Joint Strategic Needs Assessment (JSNA) specific for tobacco** to better understand the local needs and to inform the development of a comprehensive and meaningful local tobacco control plan.
- **Developing a Tobacco Control Alliance** is one important way local authorities can bring local partners together to reduce smoking rates and tackle health inequalities. Refer to Local governance: Smokefree alliances and forums for further detail.
- Quality assurance and improvement should be built into local tobacco control strategies. **Local authorities should regularly audit their local tobacco control plans** using the CLeaR self-assessment tool.[35] CLeaR (Challenge, Leadership and Results) is an evidence-based improvement

model designed to support local authorities, tobacco alliances, health and wellbeing boards and influential partners in taking effective action to reduce the use of tobacco and the costs of smoking. As well as providing self-assessment support, peer assessment is available and includes wider assessment with stakeholders as part of the review process.

Resources:

Local Government Association and Cancer Research UK. Must know guide on tobacco control. 2019.

Action on Smoking and Health. Local Toolkit. 2019.

Public Health England and Association of Directors of Public Health. What good local tobacco control looks like. 2019.

Public Health England. CLeaR local tobacco control assessment. Published 2014, updated March 2020.

Department of Health and Social Care. Towards a Smokefree Generation: A Tobacco Control Plan for England. 2017.

3. Local governance

3.1 Smokefree alliances and forums

Local government is in a good position to support whole system approaches to tobacco control and encourage integration with other public services, including the wider health and social care system, environmental health, housing, and children's services, to name a few.

Tobacco Control Alliances are local partnerships that work to reduce smoking rates and tackle health inequalities. They typically include a wide range of members from inside and outside local authorities, as diversity is key to delivering all elements of comprehensive tobacco control. They can operate across local authority, Strategic Transformation Partnerships (STPs), Integrated Care Systems (ICSs), regional or other footprints according to local needs. These Alliances should drive partnership working to develop a local tobacco control plan.

Case study: Hull Alliance on Tobacco

The Hull Alliance on Tobacco (HALT) is a multi-agency partnership working to reduce smoking prevalence across Hull. Partners include the council, CCG, local colleges, Hull and East Yorkshire Hospital Trust, public protection and trading standards, local pharmacies and Cancer Research UK. The group's aim is to achieve a smokefree generation in Hull. It draws on partner expertise to focus on specific work areas, such as: children and young people, communication and marketing, community engagement, e-cigarettes, illegal tobacco, maternal smoking, mental health and a smoke-free NHS.

The Alliance has developed a work plan that contributes to the Health and Wellbeing Strategy and the local STP and CCG strategic plans. In September 2018, the Alliance hosted a 'Tackling Tobacco Together' conference, which brought partners together with local NHS services to highlight the importance of reducing smoking prevalence and working as a whole system.

What should local authorities do?

- **Develop and maintain a Tobacco Control Alliance** to facilitate collaboration and partnership working across tobacco control priorities.

- **Ensure the Alliance reports in to, and back to, other council committees**, such as the Health and Wellbeing Board or the Health Scrutiny Committee. Having an elected member in the Alliance may help to provide oversight and build political support for the work.
- Demonstrate your support to tobacco control by **signing the Local Government Declaration on Tobacco Control**.

Resources:

Action on Smoking and Health. Local Alliances Roadmap. 2019.

Smokefree Action Coalition. The Local Government Declaration on Tobacco Control.

3.2 Eliminating tobacco industry involvement in local policy and decision-making

The UK is a signatory to the WHO Framework Convention on Tobacco Control.[36] Article 5.3 of the Convention states that: "*In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law*".

To turn this framework into practical action, WHO has made several recommendations. These broadly explain that the tobacco industry should not be a partner in any initiative linked to setting or implementing public health policies, given that its interests are in direct conflict with the goals of public health. These recommendations include:

- limiting interactions with industry and ensuring transparency regarding the interactions that do occur;
- rejecting partnerships and non-binding or non-enforceable agreements with industry; and
- to de-normalise and regulate activities described as "socially responsible" by the tobacco industry.[37]

The current situation

Across the UK, the tobacco industry continues to position itself as part of the solution to achieving smokefree ambitions. Various companies are developing their own versions of a 'smoke-free' ambition in the UK while continuing to both circumvent existing tobacco control laws in the UK and aggressively market deadly tobacco products in low- and middle-income countries.

Cancer Research UK is also aware of reports that the tobacco industry has offered councils additional funding for a range of public services, including stop smoking services, and for particular products such as e-cigarettes.

There is also evidence of tobacco industry involvement in the illicit tobacco market. For more information, see the section on Illicit tobacco control and trading standards.

The 2020 Global Tobacco Industry Interference Index ranked the UK among the best nations at tackling tobacco industry interference;[38] however, compared with 2019 the UK performed worse in its ability to implement and comply with tobacco industry interference and dropped from the number one spot in 2019 to fourth in 2020.[38,39]

What should local authorities do?

To ensure the UK's commitments to the WHO Framework Convention on Tobacco Control are met, **under no circumstances should local authorities engage or partner with the tobacco industry.** It is essential that **staff and elected members understand the framework commitment and any internal policies** for managing, reporting and recording any interactions with the tobacco industry.

Resources:

World Health Organisation. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control on the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry. 2008.

Action on Smoking and Health. Toolkit: Article 5.3 of the WHO Framework Convention on Tobacco Control. 2018.

4. Towards a smokefree England

Reducing smoking prevalence on the way to becoming smokefree requires concerted action, both to reduce smoking uptake and to increase successful quit attempts by people who currently smoke.

There has been good progress on reducing smoking uptake in England, and the greatest gains can be made by supporting people who smoke to stop.[40] Despite current challenges, we encourage local authorities to do all they can to increase smoking cessation attempts in their communities.

4.1 Supporting people to stop using tobacco

Stop smoking services

Local stop smoking services, which provide a combination of behavioural support and prescription medication (also known as pharmacotherapy), offer people who smoke the best chance of stopping successfully.[41,42,43] People using these services are around three times more likely to stop smoking successfully than those attempting to quit unaided.[42,43] The latest complete figures suggest that more than half (51%) of those using these services reported being smoke-free after 4 weeks; 62% of the people who had successful quit had their results confirmed by carbon monoxide verification (which equates to a verified quit rate of around 32% for those using the service).[44] The verified quit rate for people using these services has remained relatively stable between 2009/10 and 2019/20.[44]

Reducing health inequalities

These free-to-use stop smoking services can play an important role in reducing tobacco-related health inequalities, but more needs to be done in order for these services to reach their potential. For example, it is established that people from lower socioeconomic groups are more likely to smoke than those from higher socioeconomic groups.[11] Research from Cancer Research UK has found that people who smoke from lower socioeconomic backgrounds are more likely to access stop smoking services but are less likely to be successful in their smoking cessation attempt.[45] This may be due to a range of additional barriers including higher levels of nicotine/tobacco dependence, positive or accepting social norms around smoking, and the difficult or challenging life circumstances they face.[45] As well as investing in services to ensure they are available to all, these services should be promoted and targeted to reach those groups with higher smoking prevalence, such as people from lower socioeconomic groups, to improve their chances of stopping smoking successfully. More research is needed to identify interventions which could disproportionately promote cessation among more deprived groups to improve smoking equity.

The current situation

Recent results show that the number of people accessing local stop smoking services has reduced significantly. In 2009/10, 8,630 people per 100,000 people who smoke set a quit date with a local stop smoking service, compared with just 3,512 per 100,000 in 2019/20; a decrease of around 59%.[44] This is despite the verified quit rate for people using these services remaining high and relatively stable throughout this period.[44] One of the main reasons for this is funding reductions.

Sustained central UK Government funding reductions to the public health grant—the funding provided to local authorities to deliver a range of important public health functions and services, including stop smoking services—has meant that these vital services are being increasingly threatened, which could be driving a reduction in footfall to these services. In 2020, 77% of local authorities in England commissioned a specialist stop smoking service and only 62% commissioned a specialist service open to all local residents who smoke.[34] The shift away from specialist services may save money in the short term but puts effective specialist smoking cessation support at risk. This could cost local authorities and the wider economy more in the long term due to the cost of treating and caring for people with smoking related disease.[17]

What should local authorities do?

- Demonstrate a tangible commitment to prioritising tobacco control by **protecting the council's budget** to commission stop smoking services wherever possible.
- **Commission specialist stop smoking services, available to everyone who smokes, to provide people with the best possible support to stop smoking.** These services should be commissioned to meet the specifications set out in National Institute for Health and Care Excellent (NICE) NG92 guidance,[46] and should offer free one-to-one and group behavioural support, along with nicotine replacement therapies (NRT) and other stop smoking medications, such as varenicline and bupropion.
- The NICE guideline sets out that **stop smoking services should be commissioned and delivered according to local and national priorities to reduce health inequalities.** In practice, this may mean locating services in areas with a higher smoking prevalence or targeting services to specific populations who have higher rates of smoking and may experience poorer health outcomes. This will be dependent on local needs, but may include routine and manual workers, people with mental health problems, those who misuse substances, those with smoking-related illnesses, people in prisons, or pregnant women.
- Local authorities should **repeal any restrictions placed on the availability of pharmacotherapy for smoking cessation through local stop smoking services.** There is evidence that some local authorities are limiting which pharmacotherapy treatments from the NICE-approved formulary are available through local stop smoking services.[47] Pharmacotherapy for smoking cessation, including NRT, is highly effective and cost-effective,[48, 49, 50] and has been billed as amongst 'the best buys in modern medicine'.[50] With smoking costing local authorities an estimated £720 million a year in social care costs,[17] and the NHS £2.4 billion a year,[17] pharmacotherapy for smoking cessation is a worthwhile investment. **In line with this, local authorities should advocate for keeping these medications on formularies with local commissioners.**
- Local authorities should **ensure that stop smoking advisors employed to deliver behavioural support are trained to National Centre for Smoking Cessation and Training (NCSCT) standards** and undertake refresher training at least annually to stay up to date with the latest developments in smoking cessation.

Resources:

National Institute for Health and Care Excellence (NICE) guideline [NG92]: Stop smoking interventions and services. 2018

National Centre for Smoking Cessation and Training. Online training.

National Institute for Health and Care Excellence (NICE) guidelines. Smoking: stopping in pregnancy and after childbirth. 2020.

UK Government. COVID-19 Guidance: advice for smokers and vapers. 2021.

Public Health England. Stop smoking options: guidance for conversations with patients. 2018.

E-cigarettes

E-cigarettes are a relatively new smoking cessation tool. They are not risk free and their long-term effects are unknown. However, the long-term harms of tobacco are indisputable and e-cigarettes represent an opportunity for harm reduction. Evidence to date indicates that e-cigarettes are not only far less harmful than tobacco smoking[40,51,52,53,54,55] but can also help people to stop smoking.[56,57,58,59] E-cigarettes therefore have the potential to help people who smoke to stop and avoid relapse.

For people who smoke and want to stop smoking by using e-cigarettes, evidence suggests people need to switch completely from smoking to vaping.[60] This is based on a 2017 study which found no significant difference in exposure to key chemicals in people who 'dual used' both cigarettes and e-cigarettes and those who exclusively smoked.[60]

Cancer Research UK believes that people who do not smoke should never use e-cigarettes. Additionally, e-cigarettes should be effectively regulated to ensure they are only used by people who smoke when making a cessation attempt or to prevent relapse to smoking.

Heat-not-burn tobacco products (also called heated tobacco)

Unlike e-cigarettes, there is little independent evidence on the safety of heat-not-burn products and there is no good evidence to show that switching to heated tobacco products helps people to stop smoking. Cancer Research UK does not consider heat-not-burn products as a less harmful alternative to smoking or promote them as a smoking cessation aid.

Reducing health inequalities

The popularity of e-cigarettes is roughly equal across the social gradient.[61] They have potential to reduce health inequalities by helping people in more disadvantaged communities to stop smoking. This is important as smoking prevalence rates are far higher in the most deprived compared with the least deprived populations.[62] There is also evidence that smoking rates are decreasing more slowly in routine and manual workers compared with other occupation groups[63] and that people experiencing financial difficulty are less likely to be successful in a quit attempt.[64] Smoking cigarettes costs more than two-and-a-half times as much as using e-cigarettes,[65] making them more financially viable.

The current situation

Vaping prevalence in 2020 declined for the first time from 7.1% to 6.3% of the adult population in Great Britain – amounting to 3.2 million people currently using e-cigarettes. In 2020, over half (58.9%) of current e-cigarette users used to smoke while 38.3% of e-cigarette users were dual users (smoke and use e-cigarettes).[66] Only approximately 2.9% of users had never smoked in 2020.

In England, e-cigarettes have remained the most popular tool used to stop smoking since 2013.[61] The main reasons given by people who used to smoke for using e-cigarettes is to help them quit (41%) and to prevent a relapse (20%).[66] A Cancer Research UK-funded study suggested that e-cigarettes may have contributed to an additional 18,000 long-term ex-smokers in England in 2015 alone.[67]

There are some concerns that young people are increasingly experimenting with e-cigarettes as these products gain popularity. UK data suggests that, in 11-18 year olds who have used e-cigarettes, 49.8% do so '*just [to] give it a try*'.[68] However, regular use (more than once a week) remains very low at 1.8% in 2020, and 82.9% of 11-18 year olds have never tried them.[68] Also, regular vaping in young people is almost

entirely restricted to young people who have smoked. In a representative survey of 11 to 18 year olds in Great Britain in 2020, out of 1,926 people who have never smoked, not a single person reported vaping daily.[68] Youth tobacco smoking has also declined since e-cigarettes gained popularity,[11,69] suggesting that e-cigarettes are not acting as a gateway into tobacco use.

What should local authorities do?

A balanced approach to e-cigarettes is advisable — one that maximises their potential to help people who smoke to stop and avoid relapse, while minimising uptake by people who have never smoked:

- It may be helpful to **develop a position statement, in conjunction with local commissioners, which can form the basis of an evidence-based local approach to e-cigarettes**.
- Quitting with an e-cigarette is around 60% more effective than quitting unaided or with nicotine replacement therapy bought over the counter.[58] When both are combined with behavioural support from stop smoking services, evidence shows e-cigarettes may be more effective than NRT.[59] Given their popularity and effectiveness for cessation, **local authorities and stop smoking services should**, in line with official guidance,[46] **be supportive of e-cigarette use for smoking cessation in order to reach and support as many people who smoke as possible.** This should include providing information and advice about e-cigarettes, as well behavioural support.
- **Stop smoking advisors should be trained to deliver evidence-based support on e-cigarettes**. The NCSCT provides training and assessment for stop smoking advisors, which includes guidance on e-cigarettes.[70]

Resources:

Royal College of General Physicians and Cancer Research UK. Position Statement on the use of electronic nicotine vapour products (E-Cigarettes). September 2017.

Cancer Research UK. Our policy on e-cigarettes. October 2019.

National Centre for Smoking Cessation and Training. Electronic cigarettes: A briefing for stop smoking services. 2016.

4.2 Preventing smoking and tobacco use uptake

Preventing youth uptake

While fewer young people are starting to smoke,[69] most 16-24 year olds who smoke (77%) started smoking before the age of 18.[19] Smoking initiation is associated with a wide range of risk factors including: parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members, socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media.[71] The younger a person takes up smoking, the greater the harm to their health because early uptake is associated with heavier smoking, higher levels of dependency and likely higher mortality.[71] Therefore, it is important to prevent young people from taking up smoking.

What should local authorities do?

NICE recommends a number of ways that councils can help prevent young people from taking up smoking:

- **Develop local media campaigns to prevent smoking among young people** under 18 years of age.[72] These campaigns should be informed by research that identifies and understands the target audiences, considers existing and emerging priority groups, and should be developed in partnership with a wide range of stakeholders (excluding the tobacco industry).

- **Ensure retailers are aware of legislation prohibiting underage tobacco sales** (*Children and Young Persons (Sale of Tobacco etc.) Order (2007)*) and make it as difficult as possible for young people under 18 to obtain cigarettes and other tobacco products.[72]
- Ensure **smoking prevention interventions in schools form part of the local tobacco control plan**,[73] and that these interventions are **informed by the evidence**, **integrated into the curriculum** and **evaluated.**[73]

Resources:

National Institute for Health and Care Excellence (NICE) guideline. [PH14] Smoking: preventing uptake in children and young people. Published 23 July 2008.

National Institute for Health and Care Excellence (NICE) guideline. [PH23] Smoking prevention in schools. Published 24 February 2010.

Promoting smokefree public spaces

The evidence that exposure to other people's smoke is dangerous to health is incontrovertible. Exposure to secondhand smoke also has immediate health effects and can reduce lung function, exacerbate respiratory problems, trigger asthma attacks, reduce coronary blood flow, irritate eyes, and cause headaches, coughs, sore throats, dizziness and nausea.[74,75] There is no safe level of exposure to tobacco smoke and there are long-term health effects, including heart disease and lung cancer,[74] especially with continued exposure over time.

The current situation

In response to these health risks and growing public demand for smokefree public places, smokefree legislation came in to effect on 1 July 2007. From this date it became unlawful to smoke in all enclosed or substantially enclosed work and public places. Public support for the legislation, referred to as the 'smoking ban' was strong at the point of implementation and has grown year-on-year since it was implemented.[76]

The smoking ban has reduced exposure to secondhand smoke in public and has driven a cultural shift that has since seen many more people stop smoking. It has also helped to de-normalise smoking indoors and smoking behaviours.[77] In fact, the ban was effective in reducing smoking consumption by people who smoke.[77] In addition, the ban inspired many to stop smoking, as was reflected in the significant increase in numbers making a quit attempt after the legislation was introduced.[77] Research also shows this has been effective in reducing smoking-related hospital admissions.[78]

In Greater Manchester a public consultation exercise found that 8/10 people agreed with extending smokefree public spaces. However, national-level legislation is not yet in place to enable councils to create enforceable smokefree zones outdoors. There is scope to explore further restrictions of smoking in public spaces through voluntary measures like smokefree parks, schools and events. There are many examples of where this has been successfully implemented including train stations, sports stadia/events and beaches.

Case study – Barnsley's 'Make Smoking Invisible' programme

Barnsley's *Make Smoking Invisible* programme is an example of how public health leadership and an effective tobacco control alliance can drive innovation and unprecedented action to develop smokefree places and protect children from secondhand smoke.

Through the programme, Barnsley successfully worked with local primary schools to make all 24 play parks throughout Barnsley smokefree. Barnsley was also the first place in the north of England to have an outdoor smokefree public space. Following innovative work with local college students to identify and

address any barriers to implementation, the Town Hall Centenary Square became smokefree on 30th June 2017, marking the ten-year anniversary of smokefree legislation. Barnsley's subsequent town centre redevelopment programme has included *Make Smoking Invisible* from the outset in its planning and development, with its smokefree market being launched in October 2017.

What should local authorities do?

Local authorities should **protect and enforce smokefree legislation** and **promote smokefree environments** through public health campaigns**.**

Resources:

Action on Smoking and Health. Smokefree Legislation. April 2015.

Action on Smoking and Health. Smoking in the home: New solutions for a Smokefree Generation. November 2018.

Bauld L. The impact of smokefree legislation in England: Evidence review. March 2011.

Illicit tobacco control and trading standards

The phrase 'illicit tobacco' refers to tobacco that is illegally manufactured (or counterfeit) or smuggled into the UK without the payment of relevant customs excise duties or tax.[79] These tobacco taxes increase the price of tobacco products and can be effective in:[80]

1. Reducing the amount of tobacco consumed
2. Discouraging uptake of smoking by young people
3. Encouraging people who smoke to stop

Illicit tobacco undermines these factors. It also undermines local tobacco control interventions by national and local governments.

Reducing health inequalities

Illicit tobacco may disproportionately affect poorer communities and young people because its reduced price may make it more affordable and attractive. In this way, illicit tobacco may play a part in exacerbating health inequalities.

The current situation

Since 2000, the UK Government has made considerable progress in tackling the illicit trade in tobacco at a national level,[81] but it continues to be a problem in many communities. HM Revenue and Customs reporting suggests the illicit tobacco market costs the UK economy around £1.9 billion annually in lost revenue.[82]

There have been previous reports of tobacco industry involvement in illicit trade[83,84,85,86,87,88,89]. Due to the deep concern about the impact of illicit tobacco trade *"which poses a serious threat to public health"* negotiations under the World Health Organisation Framework Convention on Tobacco Control saw the development and adoption of an Illicit Trade Protocol in 2012.[79] The protocol aims to eliminate all forms of illicit trade in tobacco products and provides a blueprint for the regulation of tobacco production and distribution, as well as international cooperation between enforcement authorities. The UK has ratified the protocol, and therefore it is legally binding within the UK.

What should local authorities do?

- **Local authorities should address illicit tobacco issues on a local and regional level.** Effective approaches are often coordinated across larger geographical areas where health and enforcement

partners can collaborate to reduce the supply of, and demand for, illicit tobacco. By working together councils can more effectively engage key partners such as HM Revenue and Customs, police, trading standards and the public.

- **Local communities can be a vital source of intelligence on which enforcement agents can act.** Making sure people are clear on how to make a report, and how to do so in confidence, is important to ensure the public can provide anonymous tips.
- **Social marketing and public campaigns** can also counter misinformation from the tobacco industry[83, 89,90,91,92,93] on illicit tobacco locally.
- To ensure the UK's commitments to the WHO Framework Convention on Tobacco Control continue to be met, **under no circumstances should local authorities engage or partner with the tobacco industry**.

Resources:

The Illicit Tobacco Partnership resources, including:

- Illicit Tobacco Programme Strategic Framework
- Illegal tobacco PR guide
- Guidance for Trading Standards

World Health Organisation. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control on the protection of public health policies with respect to tobacco control from commercial and other vested interests of the tobacco industry. 2008.

4.3 Anti-tobacco media campaigns

Anti-tobacco mass media campaigns can be highly effective[94,95,96] and cost-effective[97] in motivating people to stop smoking and discouraging uptake. Mass media campaigns in England have been found to trigger quit attempts and have been associated with reductions in smoking prevalence,[95] but they must have sufficient intensity and be sustained to see continued benefit.[98] The suspension of anti-smoking mass media campaigns in 2010 markedly reduced quitting activity across England.[99] Anti-smoking media campaigns and communications will therefore be important to achieve England's smokefree ambitions.

The current situation

While some funding is still available for these national anti-smoking mass media campaigns, this funding continues to be reduced, meaning anti-smoking campaign activity is increasingly limited. In 2017/18, only £1.99 million was spent on smoking cessation advertising campaigns by Public Health England[100], far below the internationally recognised level[101] which would see approximately £60 million per year earmarked to reduce the impact of smoking across the country.[102]

The sustained reductions to local authority public health budgets,[4, 103] which has disproportionately impacted tobacco control, also mean that stand-alone and local media activity that support these national campaigns are being increasingly threatened.

Case study: Fresh North East "Don't be the 1" campaign

One in two people who smoke will die from a tobacco-related disease, but a survey in the North East found that 9 in 10 smokers wrongly believed the risks to be much lower. The "Don't be the 1" campaign, launched by Fresh in 2014, raised awareness of these risks and made people who smoke think about the devastating impact smoking can have on them and their loved ones.

The campaign featured TV and radio advertising, cinema advertising, social media and testimonials from people who used to smoke, including sharing the journey of someone from the North East in her 40s diagnosed with lung cancer. It also generated extensive news coverage on TV, radio and in print, increasing the reach and depth of engagement. The campaign saw a 125% increase in people who smoke becoming aware of the 'one in two' risk, won two national awards and has since been rolled out in other areas, including Wales and Greater Manchester.

Nearly 2 in 3 (63%) people who smoke that saw it said they were more concerned as a result, while nearly 1 in 3 (31%) took action - from quitting, seeing their GP, cutting down, setting a future quit date or switching to a pure nicotine replacement. Visit Dontbethe1.tv for further information.

What should local authorities do?

- **Local authorities should fund local media and health promotion activity to promote smoking cessation and discourage tobacco uptake.** This includes local amplification of national campaigns. Funding and delivering local media campaigns will form an important part of the regional effort to support the delivery of the UK Government's 2030 smokefree target. See Preventing youth uptake for further information on how campaigns can discourage youth uptake of smoking.
- Given local public health budgets are under increasing pressure, councils may also wish to **pool resources across larger geographical footprints to increase impact** by helping messages reach larger populations.

5. Supporting local communities

5.1 Place-based approaches to reduce health inequalities

Communities, both place-based and where people share a common identity or affinity, contribute to health and wellbeing.[104] However, evidence suggests that inequalities across a number of important population health measures, such life expectancy[105] or smoking prevalence,[62] are widening between the most and least deprived groups. Because health inequalities result from a complex mix of environmental and social factors, local areas have a critical role to play in both identifying and reducing health inequalities, including those driven by tobacco.

Other recommendations mentioned throughout this statement may also help to reduce smoking-related health inequalities across your communities (please see the 'reducing health inequalities' sections throughout this document for more information). NICE has also developed guidance for community engagement approaches to reduce health inequalities, ensure health and wellbeing initiatives are effective and help local authorities and health bodies meet their statutory obligations.[106] Key principles mentioned in these recommendations include working across and drawing on local communities and organisations to 'plan, design, develop, deliver and evaluate' health and wellbeing initiatives, as well as ensuring additional efforts are made to involve local communities at risk of poor health.[106] It is important that tobacco control is integrated as part of wider health and wellbeing initiatives and considered in any place-based approaches.

What should local authorities do?

Local authorities are well-placed to respond to local needs and tailor public services to meet the needs of local people. **Local authorities should consider and embed tobacco control policy in all public policies to promote the health of its residents and staff.** Policies should be person-centred and should build on the human, social and physical capital that exists within communities to promote meaningful change to the

public's health. For example, developing smoke-free public green spaces which encourage physical activity, social interaction and promote smoke-free norms will provide a number of health benefits.

Resources:

Public Health England. Health inequalities: place-based approaches for reducing health inequalities. 2019.

NICE guideline [NG44]: Community engagement: improving health and wellbeing and reducing health inequalities. 2016.

6. What Cancer Research UK does on tobacco control and how we can help

Through research and advocacy, Cancer Research UK works with local authorities in England to help prevent people from starting smoking and improve the availability and effectiveness of support to help people stop. In the past, we have successfully advocated for laws protecting people from secondhand smoke in public places, helped put an end to vending machines and tobacco displays in shops, and campaigned for the introduction of standardised packing for tobacco products.

Cancer Research UK is currently calling on the UK Government to introduce a 'Smokefree 2030 Fund', to make the tobacco industry pay for the recurring costs of tobacco control at a local, regional and national level but without letting them influence how the money is spent. We also fund and commission research on tobacco control and smoking cessation (see here for our latest publications in the space). For more information on the work Cancer Research UK does on tobacco control, please have a look at our policy on tobacco control and cancer.

If you would like further information on any of the areas covered above, or on how to reduce preventable fires and litter caused by tobacco, please get in contact with LocalPublicAffairs@cancer.org.uk.

Acronyms and abbreviations

COPD	Chronic obstructive pulmonary disease
ICS	Integrated Care System/s
JSNA	Joint Strategic Needs Assessment
LGBTQIA+	Lesbian, Gay, Bisexual, Trans, Queer/Questioning, Intersex, Asexual, + stands for all of the other sexualities, sexes, and genders that aren't included in the aforementioned groups
NICE	National Institute for Health and Care Excellence
NCSCT	National Centre for Smoking Cessation and Training
NHS	National Health Service (which, in this statement, is used to refer exclusively to the NHS in England)
NRT	Nicotine replacement therapy
STP	Strategic Transformation Partnership/s
WHO	World Health Organisation

Glossary

E-cigarette	Means electronic cigarettes, which are devices that product vapour from nicotine dissolved in propylene glycol or glycerine. Unlike cigarettes, they do not contain tobacco, do not create smoke and do not rely on combustion.
Heat-not-burn products	Heat-not-burn products, also known as heated tobacco products, are electronic devices that, unlike e-cigarettes, contain tobacco leaf and heat it to a high temperature, without setting it alight. Heated tobacco products work by using electricity to heat sticks of tobacco, producing a vapour that's inhaled. The vapour contains nicotine, chemicals and other tobacco particles that are also found in traditional tobacco smoke.
Looked after child/children	A child in the care of a Local Authority either through a Care Order made by a Court or voluntary agreement with their parent(s) to accommodate them.
Pharmacotherapy	The treatment of disease through the administration of drug. For the purposes of this briefing, this is used to exclusively refer to drugs used to treat tobacco dependence in the UK: nicotine replacement therapy (NRT), varenicline or bupropion.
Secondhand smoke	Means smoke that comes from the burning of a tobacco product or smoke that is exhaled by people who smoke. Inhaling secondhand smoke is often referred to as passive smoking. Secondhand smoke is also known as environmental tobacco smoke.
Smoking	Means the action or habit of inhaling and exhaling the smoke of tobacco.
Smokefree	Means when adult smoking prevalence is equal to or less than 5%, as defined in the 2017 Tobacco Control Plan for England.[19]
Smoke-free	Means to no longer be actively smoking tobacco.

Tobacco control	Means 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.[36]
Tobacco industry	Means tobacco manufacturers, wholesale distributors and importers of tobacco products.[36]
Tobacco products	Tobacco products means products entirely or partly made of the leaf tobacco a raw material which are manufactured to be used for smoking, sucking, chewing or snuffing.[36]
Tobacco use	Tobacco use includes smoking, sucking, chewing or snuffing any tobacco product.
Vaping	Means the action or habit of inhaling and exhaling the vapour of an e-cigarette.

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