

Tobacco Control

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DRAFT

Public Health
LONDON BOROUGH OF LEWISHAM



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Lewisham JSNA: Tobacco Control 2018

Key Messages

- Smoking is the primary cause of premature mortality and preventable illness¹.
- Smoking kills half of all lifelong users; an average 20 years prematurely²
- People on low incomes are twice as likely to smoke as the more affluent,³ to have started younger and to be more heavily addicted
- People on the lowest incomes who smoke, spend up to 15% of their total weekly income on tobacco
- Lewisham has one of the highest rates of smoking attributable deaths in London⁴
- More than 40% of total tobacco consumption is by those with mental illness⁵
- Passive (second-hand) smoking in the home is a major hazard to the health of millions of children in the UK who live with smokers⁶
- Children with a mother or both parents who smoke are 2-3 times as likely to take up smoking themselves⁷
- Only 8% of smokers access a stop smoking service when they try to quit⁸

¹ Healthy Lives, Healthy People: A Tobacco Control Plan for England. HM Government 2011.

² Doll R, Peto, R, Boreham J & Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004; 328: 1519 <http://www.bmj.com/content/328/7455/1519.long>

³ ONS General Lifestyle Survey 2009

⁴ PHE Fingertips (<https://fingertips.phe.org.uk/>): Local Tobacco Control Profiles for England

⁵ PHE Fingertips (<https://fingertips.phe.org.uk/>): Local Tobacco Control Profiles for England

⁶ Passive Smoking and Children: A Report by the Tobacco Advisory Group of the Royal College of Physicians March 2010

⁷ As in 6 above

⁸ Office for National Statistics (2010) Smoking and drinking among adults, 2008. ONS

WHAT DO WE KNOW?

1. Facts and figures

Tobacco is the only legally available consumer product that kills people when it is used entirely as intended.⁹

1.1 Smoking burden

Smoking is the single greatest cause of preventable illness and premature death in the UK, and is one of the main determinants of health inequalities. It is a major contributing factor to the mortality divide between the most deprived areas in England and England as a whole. It is estimated that the direct cost to the NHS for smoking attributable conditions was estimated to be £5.17 billion (5.5% of total healthcare costs) in 2005–6.¹⁰

It is a major contributor to ill health, including circulatory disease, cancer and chronic obstructive pulmonary disease (COPD). Worldwide 1 billion adults (800 million men and 200 million women) currently smoke cigarettes. This is an underestimate of total tobacco exposure worldwide, as it does not include childhood smoking, smokeless tobacco or second-hand smoke. Cigarette smoking prevalence varies widely around the world, and over 80% of the world's adult male smokers, and half of the world's adult female smokers, live in low- or middle-income countries. Tobacco use kills almost 6 million people worldwide each year, with nearly 80% of these deaths in low- and middle-income countries. Each year 600,000 non-smokers worldwide die from exposure to environmental tobacco smoke. By 2030 tobacco will kill a predicted 8 million people worldwide each year. Tobacco use caused 100 million deaths worldwide during the 20th century, and if current trends continue it will kill 1 billion people in the 21st century. About 114,513 people died last year and the tobacco related cost to economy was almost £30,424,000. Worldwide smoking prevalence is overall increasing.¹¹

In 2017, the proportion of current smokers in the UK was 15.1%, which equates to around 7.4 million in the population based on estimate from the Annual Population Survey. The latest figure represents a significant reduction in the proportion of current smokers since 2016, when 21.2% smoked.¹²

Tobacco is the largest preventable cause of death in the world.¹³ Tobacco smoking caused an estimated 105,000 deaths in the UK in 2015 - almost a fifth (19%) of all deaths from all causes; it caused an estimated 43,000 cancer deaths in the UK in 2010 - more than a quarter (27%) of all cancer deaths.¹⁴

⁹ Oxford Medical Companion 1994

¹⁰ S Allender, R Balakrishnan, P Scarborough, P Webster, M Rayner. The burden of smoking-related ill health in the UK. *Tob Control*. 2009 Aug;18(4):262-7. doi: 10.1136/tc.2008.026294. Epub 2009 Jun 9.

¹¹ World Lung Foundation/American Cancer Society. *The Tobacco Atlas*. Available from: <http://www.tobaccoatlas.org>. Accessed April 2014.

¹² Office for National Statistics. *Adult smoking habits in the UK: 2017*. 2018. [cited 03 July 2018].

¹³ World Lung Foundation/American Cancer Society. *The Tobacco Atlas*. Accessed March 2018.

¹⁴ Peto R, Lopez A, Boreham J, et al. *Mortality from smoking in developed countries 1950-2010*. Accessed April 2014.

Tobacco (both active smoking and environmental tobacco smoke) causes 3 in 20 (15%) cancer cases in the UK.¹⁵ One in every two regular smokers is killed by tobacco and half of all smokers will die before the age of 70, losing on average 10 years of life.¹⁶

In 2016/17, 484,700 hospital admissions in England are attributable to smoking which is an increase of 2% on the previous year and this represents 4% of all admissions; 22% of all admissions for respiratory diseases, were estimated to be attributable to smoking; 47% of admission for cancers that can be caused by smoking were estimated to be attributable to smoking. In 2016, 77,900 deaths were attributable to smoking, which is a decrease of 2% on the previous year, but this represents 16% of all deaths; 37% of all deaths for respiratory diseases, were estimated to be attributable to smoking; 54% of deaths for cancers (that can be caused by smoking) were estimated to be attributable to smoking.¹⁷

Smoking is the leading cause of preventable death and disease in the UK. About half of all life-long smokers will die prematurely, losing on average about 10 years of life.¹⁸ Smoking kills more people each year than the preventable causes of death combined obesity, alcohol, road traffic accidents, drug misuse, HIV infection.¹⁹

Most smoking-related deaths arise from one of three types of disease: lung cancer, chronic obstructive pulmonary disease (COPD which incorporates emphysema and chronic bronchitis) and coronary heart disease (CHD). In 2015, 16% (79,000) of all deaths of adults aged 35 and over in England were estimated to be attributable to smoking.²⁰ Of these smoking caused 27% of all cancer deaths, 35% of all respiratory deaths and 13% of all circulatory disease deaths.

1.2 Smoking prevalence

Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population. Prevalence of smoking among persons 18 years and over for England was estimated to be 14.9% whereas smoking prevalence in London is 14.6% based on the Annual Population Survey (APS).²¹

1.3 Young people and smoking

Child and adolescent smoking causes serious risks to respiratory health both in the short and long term. Children who smoke are two to six times more susceptible to coughs and

¹⁵ Brown KF, Rumgay H, Dunlop C, et al. [The fraction of cancer attributable to known risk factors in England, Wales, Scotland, Northern Ireland, and the UK overall in 2015](#). British Journal of Cancer 2018.

¹⁶ NHS Information Centre (2011). Statistical Bulletin.

¹⁷ NHS Digital. Statistics on Smoking - England, 2018 [PAS]. <https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-smoking/statistics-on-smoking-england-2018>

¹⁸ Doll R, Peto, R, Boreham & Sutherland I. Mortality in relation to smoking: 50 years' observations on male British doctors. BMJ 2004; 328: 1519

¹⁹ Action on Smoking and Health (ASH). [Smoking Statistics](#). This fact sheet includes statistics on tobacco consumption and smoking related illness and death. November 2017.

²⁰ NHS Digital (2017). Statistics on Smoking: England: 2017. Available at: <http://content.digital.nhs.uk/catalogue/PUB24228/smokeng-2017-rep.pdf>

²¹ Local Tobacco Control Profiles. <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/qid/1938132885/pat/6/par/E12000007/ati/102/are/E09000023/iid/92443/age/168/sex/4> (accessed 11 July 2018)

increased phlegm, wheeziness and shortness of breath than those who do not smoke.²² Smoking impairs lung growth and initiates premature lung function decline which may lead to an increased risk of chronic obstructive lung disease later in life. The earlier children become regular smokers and persist in the habit as adults, the greater the risk of developing lung cancer or heart disease.²³

Most long term smokers start smoking in their teens. Experimentation is an important predictor of future use. Children who experiment with cigarettes can quickly become addicted to the nicotine in tobacco. Children may show signs of addiction within four weeks of starting to smoke and before they commence daily smoking.²⁴

Children are also more susceptible to the effects of passive smoking. Parental smoking is the main determinant of exposure in non-smoking children. Although levels of exposure in the home have declined in the UK in recent years, children living in the poorest households have the highest levels of exposure as measured by cotinine, a marker for nicotine.²⁵

It is estimated that each year around 207,000 children aged 11-15 start smoking in the UK.²⁶ 77% of smokers aged 16 to 24 in 2014 began smoking before the age of 18, however, 32% of smokers (current and ex-smokers) aged 16-24 started when they are 16 or 17.²⁷ As a result many young people become addicted before they fully understand the health risks associated with smoking. Research shows that in 2014, 46% of pupils aged 11 to 15 who are current (regular and occasional) smokers were usually bought their cigarettes in shops, despite the law which prohibits the sale of cigarettes to those under the age of 18.²⁸

An estimated 7% of 15 year olds were classified as current smokers in Lewisham in 2014/15 and use of e-cigarettes is 9.5% and use of the other tobacco products are as high as 21.2% compared to England's 15.2%.²⁹

It is very important to reduce the number of young people who take up smoking, as it is an addiction largely taken up in childhood and adolescence. Most smokers start smoking before they are 18.

There is a strong association between smoking, other substance use, alcohol consumption and truanting or school exclusion.

The WAY Survey (Figure 1 below) indicates less 15 year olds in Lewisham (6.7%) smoke than in England (8.2%) but higher than London (6.1%), however the confidence intervals for this indicator are wide at borough level.

²² Royal College of Physicians. Smoking and the young. *Tobacco Control*. 1992;1:231-235.

²³ Seddon C. Breaking the cycle of children's exposure to tobacco smoke. *British Medical Association*. 2007.

²⁴ DiFranza J, Rigotti N, McNeill A, Ockene J, Savageau J, Cyr D, Coleman M. Initial symptoms of nicotine dependence in adolescents. *Tobacco Control*, 2000;(9)3.

²⁵ Royal College of Physicians. [Going smoke-free: The medical case for clean air in the home, at work and in public places](#). A report by the Tobacco Advisory Group. 2005.

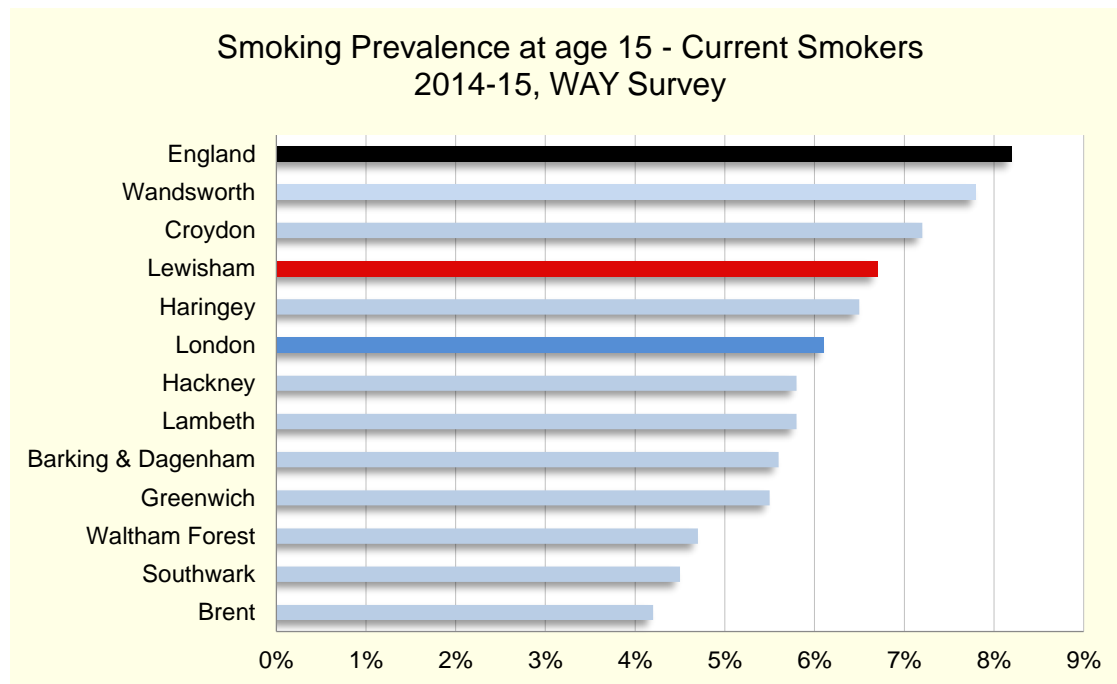
²⁶ Hopkinson N, Lester-George A, Ormiston-Smith N, Cox A, Arnott D. [Child uptake of smoking by area across the UK](#). *Thorax*. 2013;69(9):873-875.

²⁷ DH analysis on Health Survey for England 2014 data.

²⁸ NHS Digital. 'Smoking, Drinking and Drug Use Among Young People in England - 2014'. Table 3.1. 23 July 2015 (viewed June 2017)

²⁹ Local Tobacco Control Profile, Public Health England 2018

Figure 1: Smoking Prevalence of 15 year olds by London borough³⁰



1.4 Mental health and smoking

Smoking rates amongst people with a mental health condition are significantly higher than in the general population and there is a strong association between smoking and mental health conditions. This association becomes stronger relative to the severity of the mental condition, with the highest levels of smoking found in psychiatric in-patients. It is estimated that of the 10 million smokers in the UK about 3 million have a mental health condition.³¹

Those with severe mental illness die on average 25 years earlier than the general population and are 10 times more likely to die from respiratory disease. Most of this increased mortality can be attributed to higher rates and levels of smoking. Doses of many psychiatric medications can be reduced by up to 50% if a mental health service user stops smoking, with a reduction in side effects.

Smoking rates are much higher among people with mental illness. Over 70% of psychiatric inpatients smoke; 50% of them heavily, and 76% of people with first episode psychosis are smokers. More than 40% of total tobacco consumption is by those with mental illness. Over 50% of smokers with mental illness say they would like to stop, but are less likely to be offered help to do so.

1.5 Pregnancy and Smoking

Maternal smoking is a major risk factor for low birth weight. Babies born to women who smoke are on average 200-250 grams lighter than babies born to non-smoking mothers. Furthermore, the more cigarettes a woman smokes during pregnancy, the less well the

³⁰ <https://fingertips.phe.org.uk/profile/child-health-profiles/supporting-information/health-behaviours>

³¹ Royal College of Physicians, Royal College of Psychiatrists. [Smoking and mental health](#). London, RCP, 2013

foetus grows and develops. It is estimated that one third of all peri-natal deaths are caused by maternal smoking. More than one quarter of the risk of Sudden Infant Death Syndrome is attributable to smoking. Women who smoke in pregnancy are more likely to be younger, single, of lower educational achievement and in unskilled occupations.

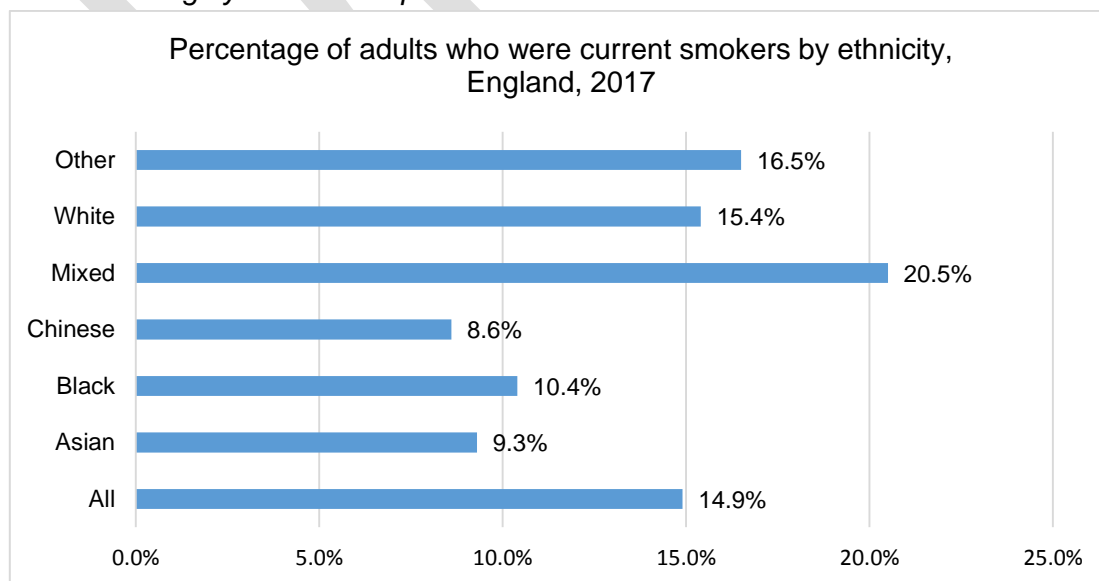
The 2005 Infant Feeding Survey found that almost half (49%) of women who smoked before pregnancy managed to stop once they became pregnant but 17% of mothers-to-be continued to smoke throughout their pregnancy. In 2010, the percentage of mothers reported to be smoking at delivery in England had dropped to 13.6% in 2010/11 (Quarter 1 figures) to 10.8% in 2017/18. However it is widely felt that these self-reported figures are likely to be inaccurate³². Following the attainment of the Government's 11% target, the Smoking in Pregnancy Challenge Group has proposed a new target to reduce the percentage of women smoking during pregnancy to 6% or less by 2020.

1.6 Ethnicity and Smoking

The data on smoking habits in the UK come from the Annual Population Survey (APS). The data on smoking is collected on the Labour Force Survey, which forms a component of the APS. In 2017, there were 158,889 survey respondents to the question on smoking habits. Interviews are carried out either on a face-to-face basis or on the telephone. The main facts and figures for adult smokers in England show³³ that:

- overall, in 2017, 14.9% of adults in England said they were current smokers
- rates of smoking were higher than the England average in the Mixed and White ethnic groups (at 20.5% and 15.4% respectively); although the rate for the Other ethnic group also appears to be higher than the England average, the difference and the size of the group were too small to draw firm conclusions
- rates of smoking were below the England average in the Chinese, Asian and Black ethnic groups (8.6%, 9.3% and 10.4% respectively)

Figure 2: Smoking by Ethnic Group - Prevalance



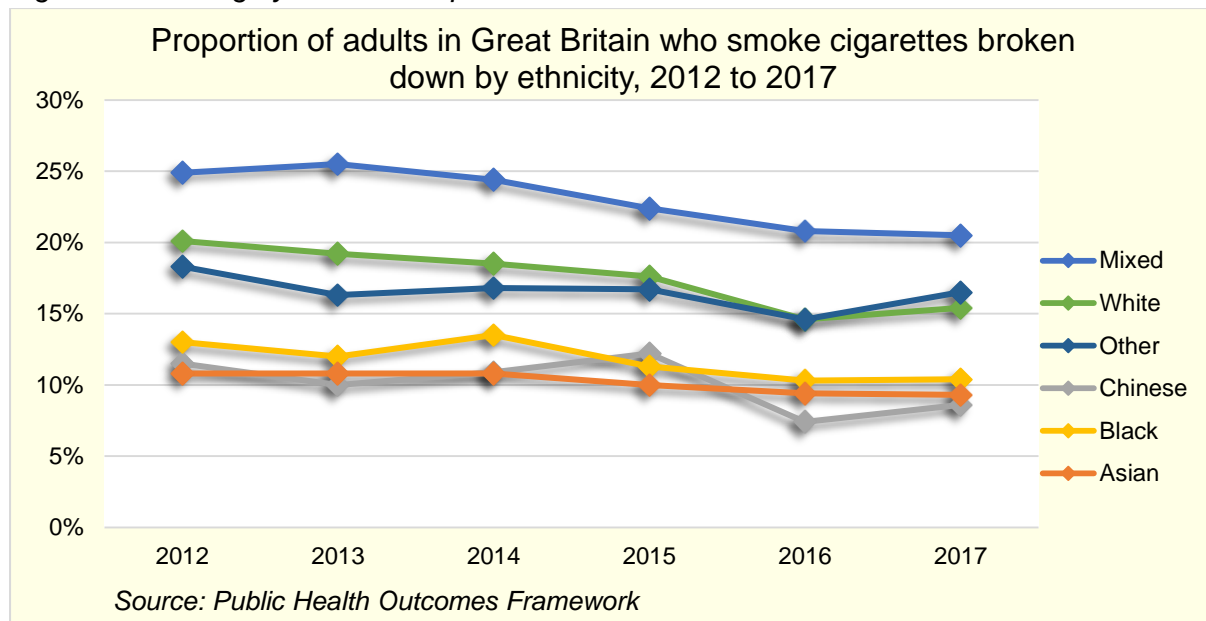
³² Action on Smoking and Health Fact Sheet 2011

³³ Adult Smokers in England by ethnicity. <https://www.ethnicity-facts-figures.service.gov.uk/health/preventing-illness/adult-smokers/latest#>

This data shows that:

- overall, from 2012 to 2017, the percentage of adults who were smokers went down by 4.4 percentage points, from 19.3% to 14.9%
- in the same period, the smoking rate decreased for adults in the White ethnic group (from 20.1% to 15.4%), the Black ethnic group (from 13.0% to 10.4%), and the Asian ethnic group (from 10.8% to 9.3%); it is not possible to draw firm conclusions about the change in smoking rates for the other ethnic groups because of the wide variation in responses and small number of responses for these groups.

Figure 3: Smoking by Ethnic Group - Trend Data



1.7 Deprivation and smoking

Smoking is responsible for more than half the difference in premature death rates between people on high incomes and those on low incomes.

Smoking rates are markedly higher among poorer people. The General Lifestyle Survey (conducted by ONS) has consistently shown striking differences in the prevalence of cigarette smoking in relation to socio-economic status, with smoking being much more prevalent among those in manual groups than among those in non-manual groups. Smoking prevalence is higher in lower socio economic groups and the number of cigarettes smoked per day is also high in this group. Cigarette smoking is higher among households classified as routine and manual (26%), than those classified as professional and managerial (15%)³⁴. Smoking prevalence among low income groups is declining at a slower rate than the general population of smokers. People in deprived circumstances are not only more likely to take up smoking but generally start younger, smoke more heavily and are less likely to quit smoking, each of which increases the risk of smoking-related disease.

In poorer families, parents' addiction to tobacco can sometimes divert scarce funds away from meeting basic needs. The UK government's independent inquiry on inequalities in health

³⁴ ONS Smoking and drinking among adults, 2009 General Lifestyle Survey 2009

reported that parents smoked in more than 70% of two-parent households on income support, spending about 15% of their disposable income on cigarettes. Children in these families were more likely to lack basic amenities such as food, shoes and coats. Interviews with smokers in low socioeconomic groups support the idea that the majority will find the money or use other strategies to obtain cigarettes, even when circumstances are difficult.

1.8 Second Hand smoking

Breathing in other people's cigarette smoke is called passive smoking, or secondhand smoking. The US Environmental Protection Agency classifies environmental or secondhand tobacco smoke as a Class A carcinogen. The British Medical Association says that there is no safe level of exposure to secondhand smoke. Exposure to other people's smoke increases the risk of lung cancer by 20-30% and coronary heart disease by 25-35%. In babies and children it can cause respiratory disease, cot death, middle ear infections and asthma attacks.

Table 1: Main health risks of Second Hand Smoking

Main health risks of Second Hand Smoking	There is conclusive evidence that exposure to SHS causes:	There is substantial evidence that exposure to SHS causes:
Adults	Lung cancer Coronary heart disease Asthma attacks in those already affected Onset of symptoms of heart disease Worsening of symptoms of bronchitis	Stroke Chronic obstructive pulmonary disease Reduced lung function Onset of asthma
Children and pregnancy	Cot death Middle-ear disease (ear infections) Respiratory infections Asthma attacks in those already affected Reduced lung function	Reduced fetal growth Premature birth Development of asthma in those previously unaffected

Promote Smokefree Homes:

Children exposed to tobacco smoke are at much greater risk of cot death, meningitis, lung infections and ear disease³⁵. Each year it results in over 300,000 GP visits, 9,500 hospital visits in the UK and costs the NHS more than £23.6 million³⁶.

Millions of children in the UK are exposed to secondhand smoke that puts them at increased risk of lung disease, meningitis and cot death. It results in over 300,000 GP visits, 9,500 hospital visits in the UK each year and costs the NHS more than a staggering £23.6 million

³⁵ Royal College of Physicians (2010) Passive Smoking in Children - <https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf>

³⁶ NICE (2018) London: National Institute for Health and Clinical Excellence (NICE) Guideline 92. Stop smoking interventions and services. <https://www.nice.org.uk/guidance/ng92>

every year. A survey³⁷ undertaken of 1,000 young people aged 8-13, on behalf of the Department of Health in October 2011, demonstrated that children want smokefree lives.

This found:

- 98% of children wish their parents would stop smoking
- 82% of children wish their parents wouldn't smoke in front of them at home
- 78% of the children wished their parents wouldn't smoke in front of them in the car
- 41% of children said cigarette smoke made them feel ill
- 42% of children said cigarette smoke made them cough

Exposure to second-hand smoke in confined spaces such as a car is particularly hazardous, as there is no safe level of exposure to tobacco smoke.

1.9 Smoking in Lewisham

Tobacco use is the biggest single factor in the gap in healthy life expectancy between Lewisham and England.

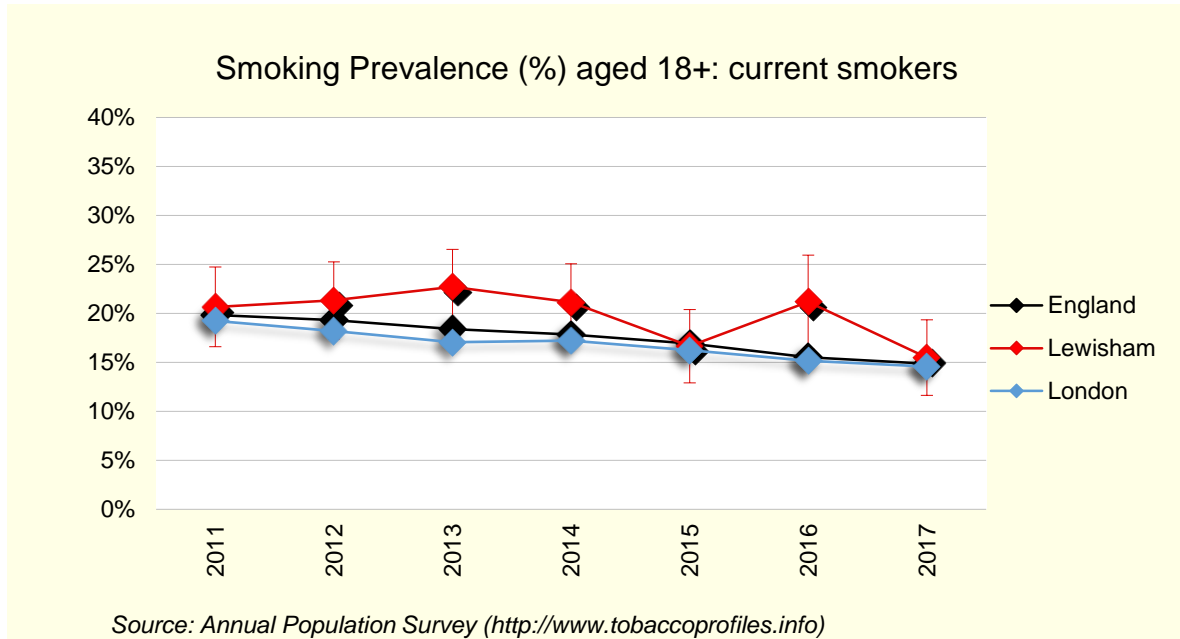
In Lewisham, the prevalence of smoking among adults (current smokers) is 15.5% (35,780) - higher than both London and England (14.6% and 14.9%, respectively).³⁸ Further, this prevalence is higher than that of our neighbouring boroughs of Lambeth and Southwark (14.6% and 12.2%, respectively) and 11th amongst all London Boroughs. Smoking prevalence has been declining in Lewisham since the initiation and redesign of our Stop Smoking services (e.g. prevalence was 22.7% in 2013), however we still have significant improvements to make if we are to achieve the target set out in the national tobacco control strategy (of 12%).

The burden of smoking-related ill health is particularly great in Lewisham, as indicated by many of the commonly cited measures of public health impact (such as hospital admissions and cause-specific mortality) which show a relatively greater impact of smoking in our borough as compared to the London and national averages.

³⁷ Children call for smokefree homes. Published by Department of Health and Social Care and The Rt Hon Andrew Lansley CBE. 31 March 2012. <https://www.gov.uk/government/news/children-call-for-smokefree-homes>

³⁸ Public Health England, Local Tobacco Control Profiles, <https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132885/pat/6/par/E1200007/ati/102/are/E09000023/iid/92443/age/168/sex/4>

Figure 4: Smoking Prevalence in Lewisham



In 2016/17, there were an estimated 1,954 per 100,000 hospital admissions attributable to smoking in Lewisham – a much higher proportion than in Lambeth, Southwark or London as a whole (e.g. 1,549 per 100,000 in the London region). The importance of targeting smoking cessation in Lewisham is also demonstrated by our high level of smoking-attributable mortality, which is statistically significantly higher than the national or London average at 327.1 per 100,000 (and the third highest in London). In Lewisham, smoking attributable deaths from stroke are the highest in London (at 13.6 deaths per 100,000). Smoking attributable deaths from heart disease are also the fourth highest in London at 30.8 deaths per 100,000. Furthermore, it is estimated that 1,669 per 100,000 potential years of life are lost due to smoking related illness.

Figure 5: Smoking Attributable Hospital Admissions

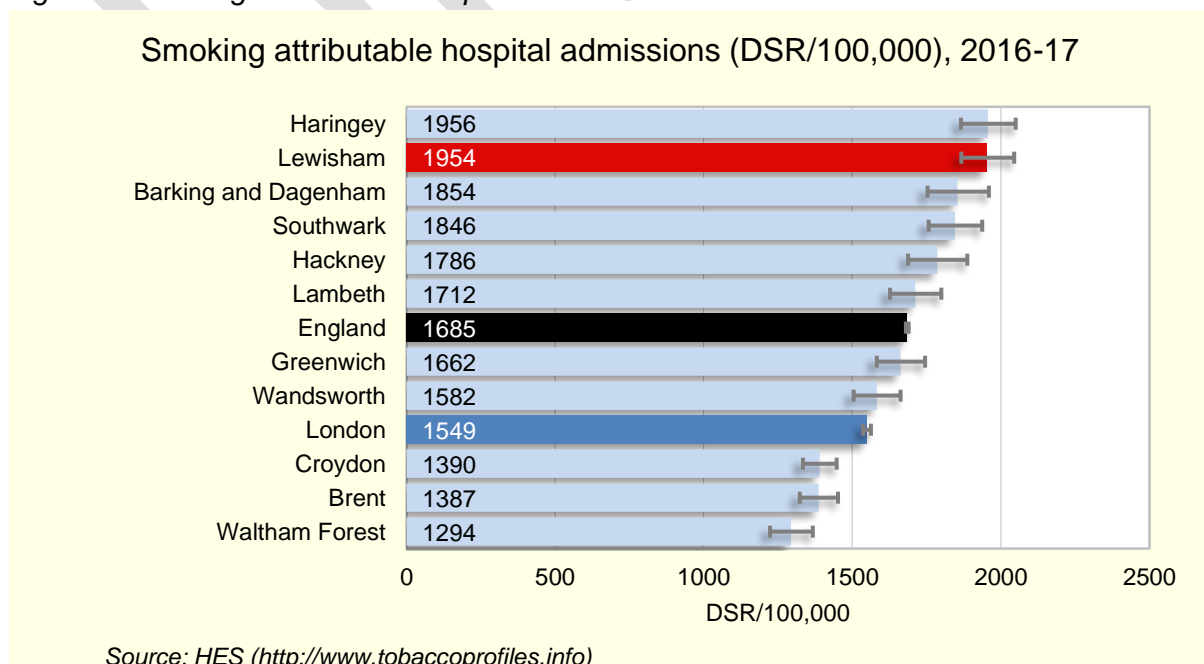
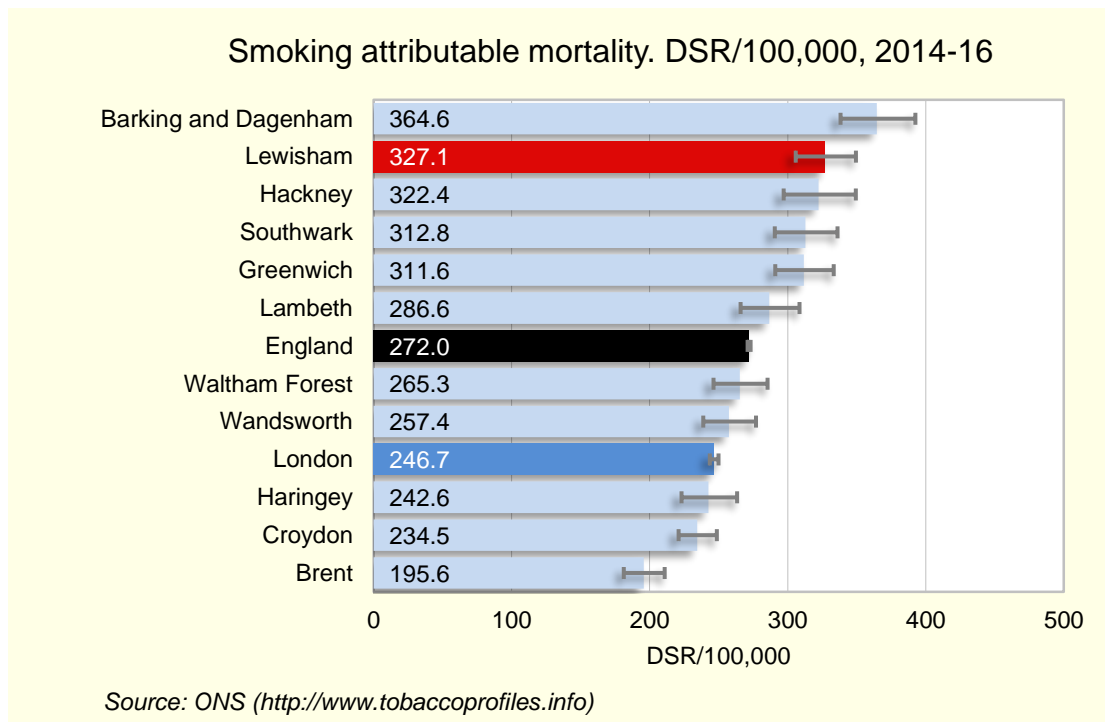
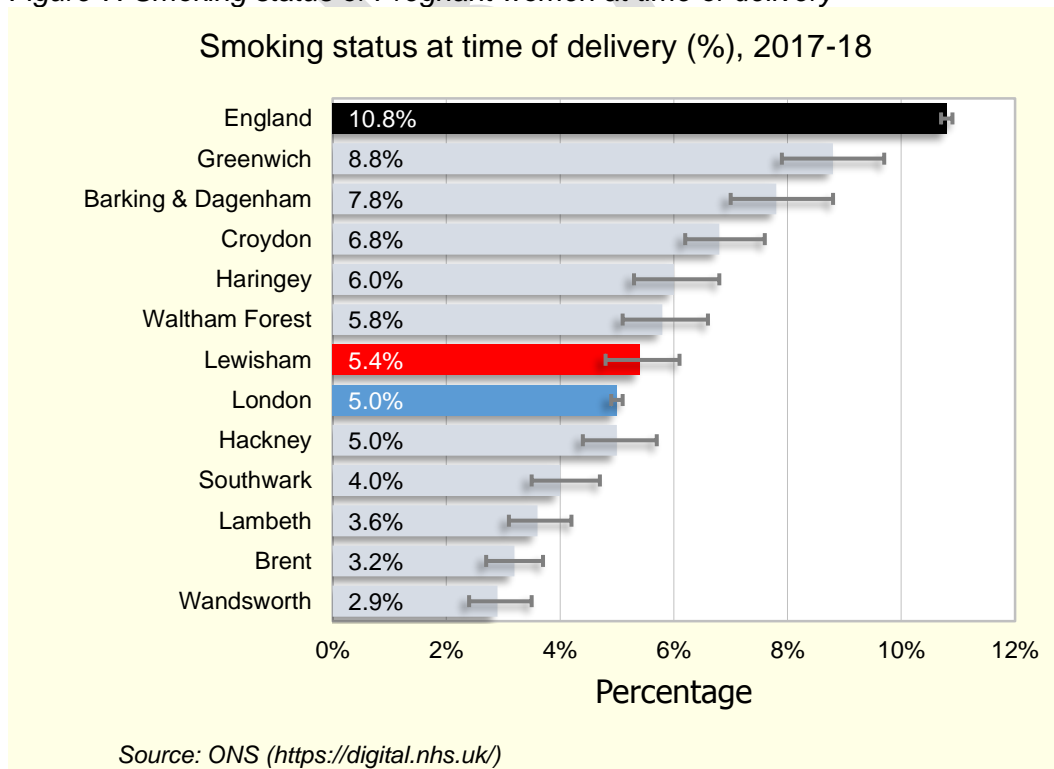


Figure 6: Smoking Attributable Mortality



Data is available on the numbers of pregnant women smoking at the time of delivery in Lewisham. The 2017/18 data shows that 5.4% of pregnant women were still smoking throughout pregnancy in Lewisham. This is taken from data collected by various hospitals in Lambeth, Southwark and Lewisham, however, this is much lower than England rate but higher than London rate.

Figure 7: Smoking status of Pregnant women at time of delivery



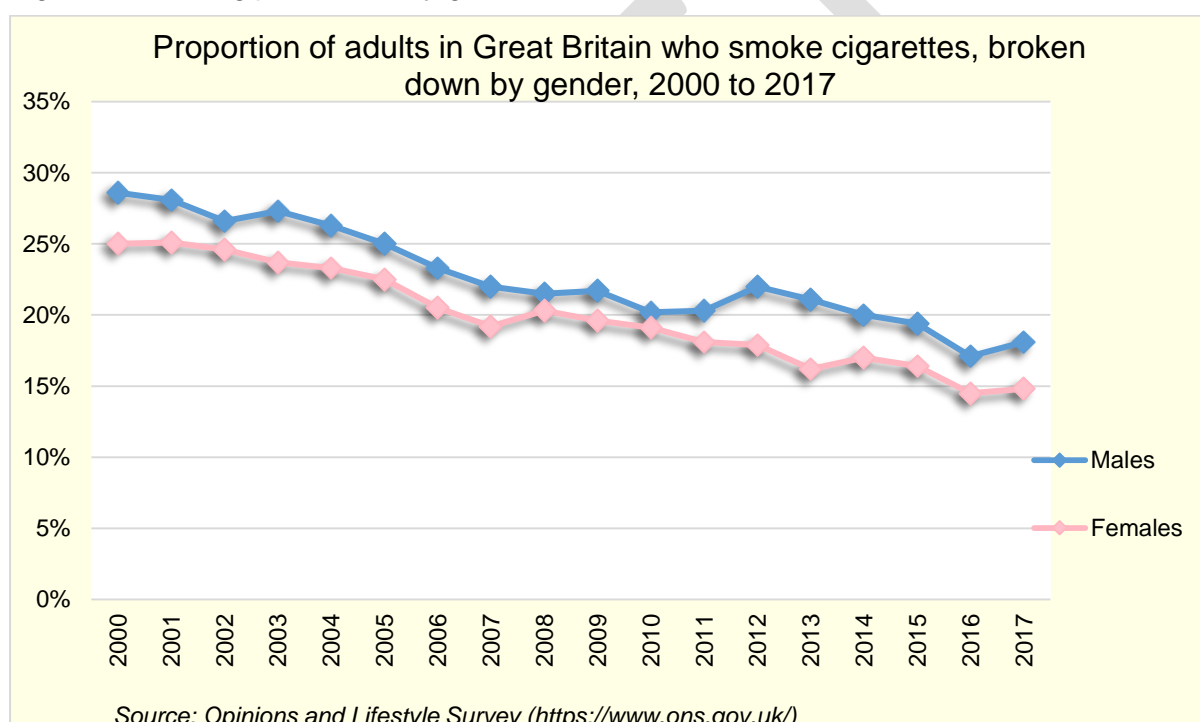
2. Trends

The overall prevalence of smoking in England has been around 21% since 2007. The prevalence of cigarette smoking fell substantially in the 1970s and the early 1980s, from 45% in 1974 to 35% in 1982. The rate of decline then slowed, with prevalence falling by only about one percentage point every two years until 1994, after which it levelled out at about 27% before resuming a slow decline in the 2000s⁶.

2.1 Gender

The smoking prevalence difference between men and women in England has substantially dropped to 18% in men and 15% in women in 2017, from the 2000 level of 29% in men and 25% in women.³⁹ In the UK, 17.0% of men smoked compared with 13.3% of women.

Figure 8: Smoking prevalence by gender



Throughout the period in which the Opinions and Lifestyle Survey (for ONS) has been monitoring cigarette smoking, prevalence has been higher among men than women and this continues to be the case, with 18% men and 15% women smoking in 2017. In 1974, 51% of men smoked cigarettes, compared with 41% of women. Since the early 1990s there has been an increase in the proportion of women taking up smoking before the age of 16. In 1992, 28% of women who had ever smoked started before the age of 16. In 2009 the corresponding figure was 37%. There has been little change since 1992 in the proportion of men who had started smoking regularly before the age of 16.

³⁹ Adult smoking habits in England, 2017, Office for National Statistics as part of the Opinions and Lifestyle Survey

2.2 Age

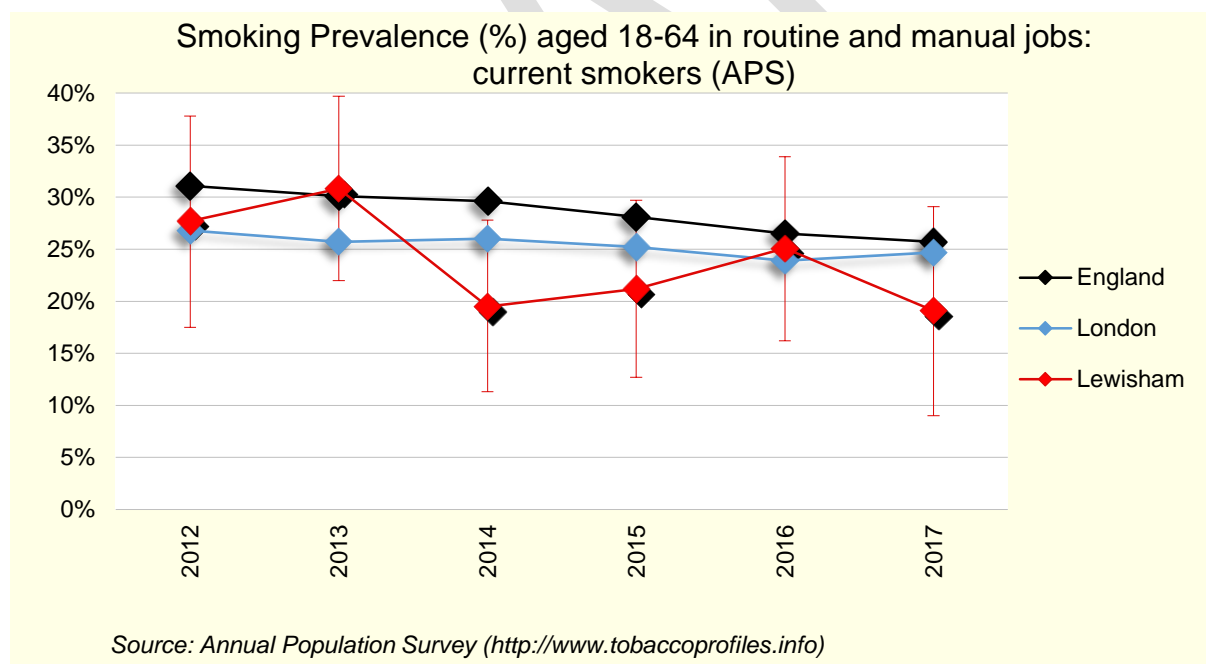
Since the early 1990s, the prevalence of cigarette smoking has been higher among those aged 20-34 than among those in other age groups. In 2009, 25% 16-24 year olds and 29% of 25-34 year olds were current smokers. Smoking prevalence continues to be lowest in those aged over 60 years at 14%. Since the survey began, it has shown considerable fluctuation in prevalence rates among those aged 16 to 19 years. However, this is mainly due to the small sample size in this age group and has occurred within a pattern of overall decline in smoking prevalence in this age group from 31% in 1998 to 25% in 2009.

In the UK, those aged 25 to 34 years had the highest proportion of current smokers (19.7%).⁴⁰

2.3 Socio-economic status

In the 1970s, 1980s and 1990s, the prevalence of cigarette smoking fell more sharply among those in non-manual than in manual groups, so that differences between the groups became proportionately greater.⁴¹ Smoking prevalence in adults in routine and manual jobs is lower in Lewisham than England and London and it has been low for the last few years.

Figure 9: Smoking Prevalence for those in routine and manual jobs



2.4 Ethnicity

The proportion of cigarette smokers in adults fell to 14.9% in 2017, from 19.3% in 2012. In the same period, the smoking rate decreased for adults in the White ethnic group (from

⁴⁰ Adult smoking habit in the UK, 2017

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>

⁴¹ Office for National Statistics (2010) Smoking and drinking among adults, 2008. ONS

20.1% to 15.4%), the Black ethnic group (from 13.0% to 10.4%), and the Asian ethnic group (from 10.8% to 9.3).

Use of chewing tobacco was most prevalent among the Bangladeshi group, with 9% of men and 16% of women reporting using chewing tobacco. Among Bangladeshi women, use of chewing tobacco was greatest among those aged 35 and over (26%). Among men, there was no difference in use of chewing tobacco by age.

2.5 Smoking in Lewisham

The trend in smoking prevalence in Lewisham is shown above in Figure 4, however it is definite that smoking prevalence has decreased in Lewisham as it has in England.

2.6 Stopping smoking

In the UK, 60.8% of people aged 16 years and above who currently smoked said they wanted to quit and 59.5% of those who have ever smoked said they had quit, based on the estimates from the Opinions and Lifestyle Survey.⁴²

3. Targets

There are two targets, one which is set out nationally for smoking prevalence and one which is set locally for stop smoking services.

Department of Health published a tobacco control plan 'Towards a Smoke free Generation – A Tobacco Control Plan for England 2017-2022' which aims to, by the end of 2022:⁴³

- reduce the number of 15-year-olds who regularly smoke from 8% to 3% or less;
- reduce smoking among adults in England from 15.5% to 12% or less;
- reduce the inequality gap in smoking prevalence, between those in routine and manual occupations and the general population;
- reduce the prevalence of smoking in pregnancy from 10.5% to 6% or less.

Local targets are set for achieving four week quits set by the Department of Health. A quit is defined as someone who has stopped smoking for four weeks from an agreed quit date, with not a single puff in weeks three and four of the quit attempt. This should be confirmed by carbon monoxide testing. The quit is supported by a stop smoking advisor trained to the standard set by the National Centre for Smoking Cessation and Training. The Client's data is entered onto a database, and the date they wish to stop is recorded. The outcome measure is the smoking status at four week follow up. Clients are followed up for longer than this, but data is not always recorded. The target for Lewisham Stop Smoking Service for 2018/19 is 1,000 quits.

⁴² Adult smoking habit in the UK, 2017

<https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2017>

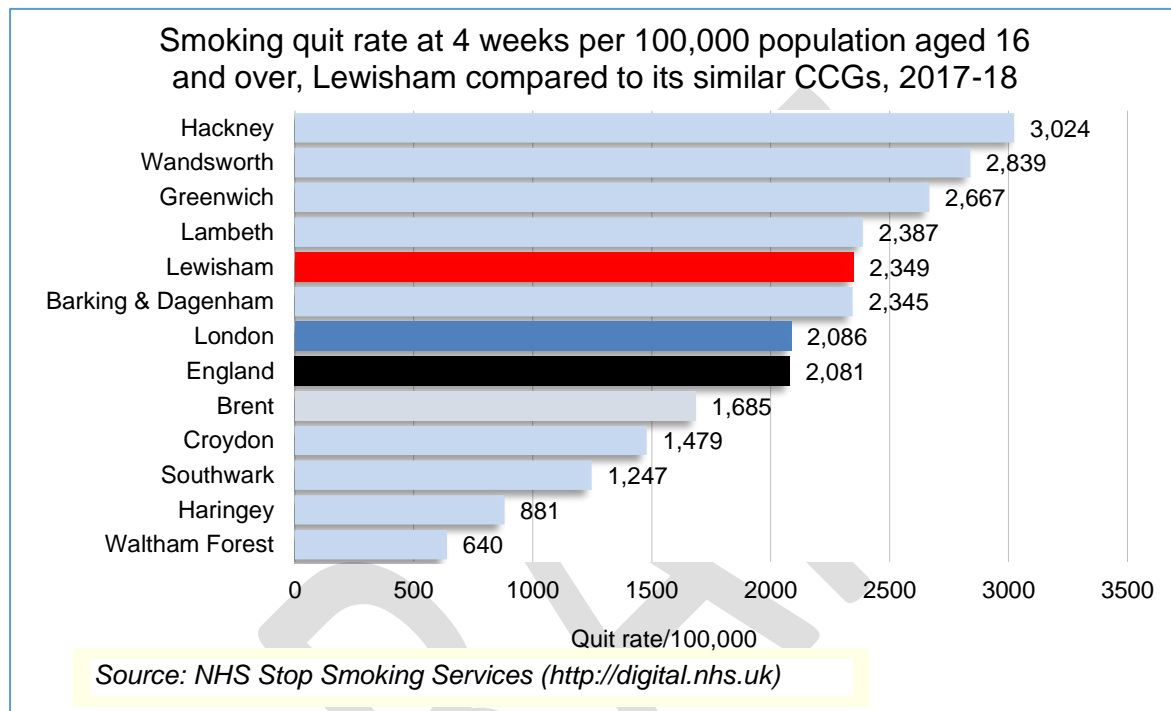
⁴³ Department of Health: Towards a Smoke free Generation – A Tobacco Control Plan for England 2017-2022. https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022_2_.pdf

4. Performance

The main measurable method for tobacco control is the number of smoking quitters at 4 weeks (expressed as a percentage per 100,000 of the adult population) through the Lewisham Stop Smoking Service. The latest full year analysed data at the time of writing was that for 2017/18.

4.1 Overview

Figure 10: Smoking Quit Rate



In 2016/17:

- Lewisham recorded 1,120 quits; 12% over target.
- Lewisham's performance on quits was 2,203 per 100,000 population; 17th of 31 CCGs in London. Both Greenwich and Islington achieved 2,899.
- Only 1% of Lewisham's estimated smokers aged under 18 set a quit date with the service
- 52% of those setting a date to quit were successful at 4 weeks
- 48 pregnant women set a date to quit and 24 quit: 49% success rate.
- Lewisham's poorest wards recorded the highest number of smoking quits, a correlation which halved in 2017/18.
- 15% of those setting a date to quit were of black Caribbean or black African background; 67% were white.

In 2017/18:

- Lewisham recorded 863 quits; 14% under target
- 1,676 people set a date to quit. This is approximately 6-10% of Lewisham's smokers.
- 80 pregnant women set a date to quit and 39 quit: 49% success rate.

- 51% of all those who set a quit date had quit at 4 weeks
- 30% of those who quit were from ethnic minorities; 8.5% black Caribbean, 5.3% black African, 1.5% other black groups, 5.2% all Asian groups, 5.4% mixed parentage, 3.6% Chinese and other groups, 1% not stated.

Lewisham’s Stop Smoking Service level of performance was lower than other similar boroughs, (Figure 11 below).

4.2 Deprivation and quitting

There is a correlation between dates set to quit smoking and the Index of Multiple Deprivation (IMD), this correlation has become stronger in 2009/10 compared with 2008/09. It shows there has been an increase in the numbers of people setting a date to quit smoking in the most deprived wards of Lewisham (figure 5). Figure 6 shows the breakdown of those setting a date to quit by ward, in descending order of IMD.

Figure 11: Smoking Quits by Ward IMD Score (2015)

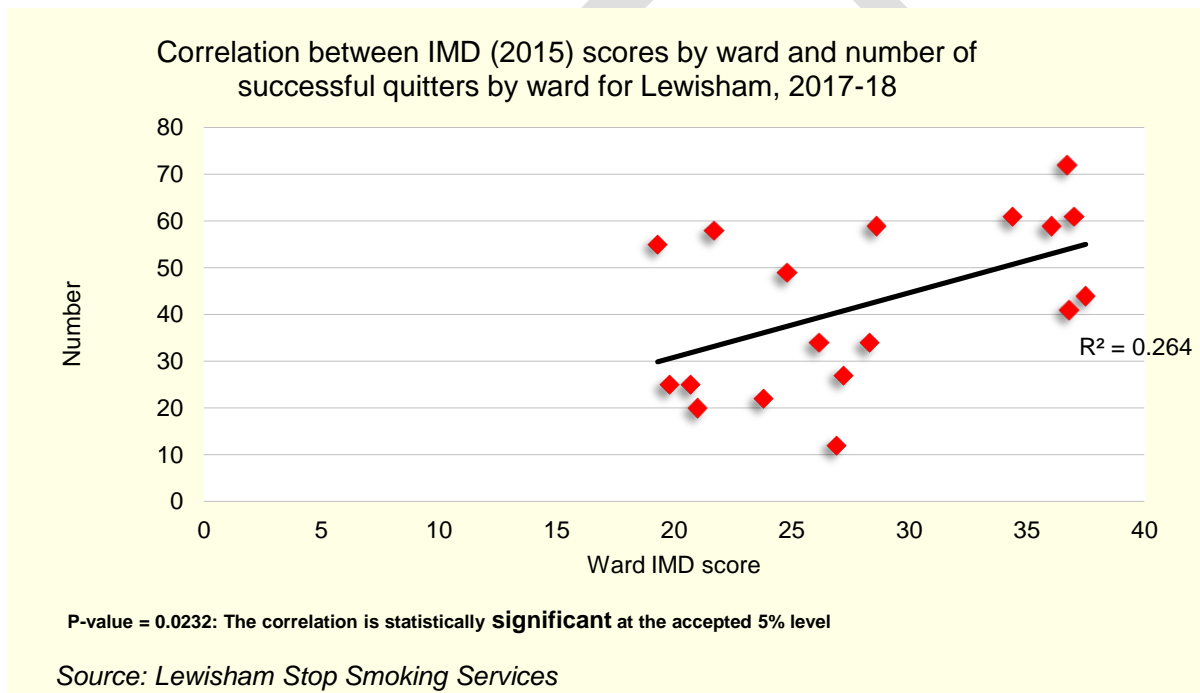
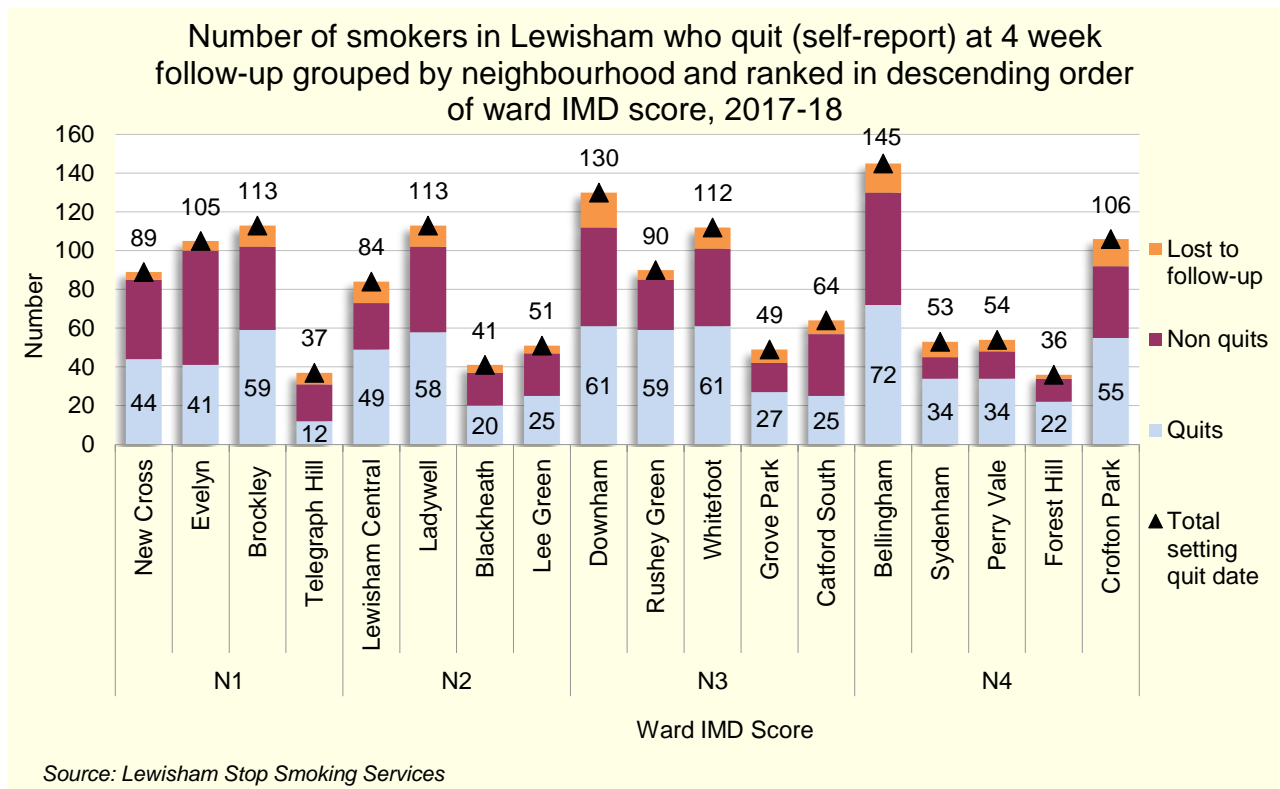


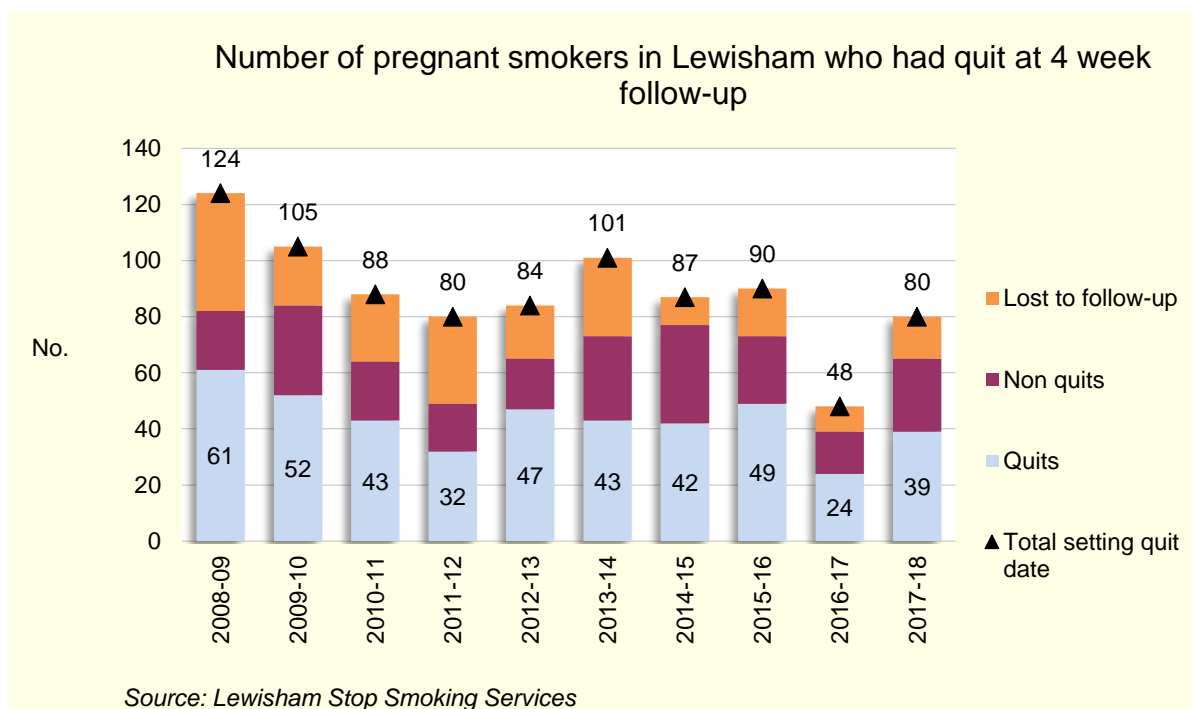
Figure 12: Smoking Quits by Ward



4.3 Pregnant Women quits

In 2017-18, more than 300 midwives and support workers were trained and were provided with CO monitor to better support pregnant women to quit smoking while pregnant. There is always a provision to refer pregnant women to Lewisham stop smoking service. Midwives and health visitors refer pregnant women, their partners or parents of a child aged 0-5yrs, who smoke. The systematic approach to referring pregnant women would increase the number of pregnant women and their partners who use the stop smoking service to quit smoking.

Figure 13: Number of Pregnant Women who Quit Smoking



4.4 Quits by age

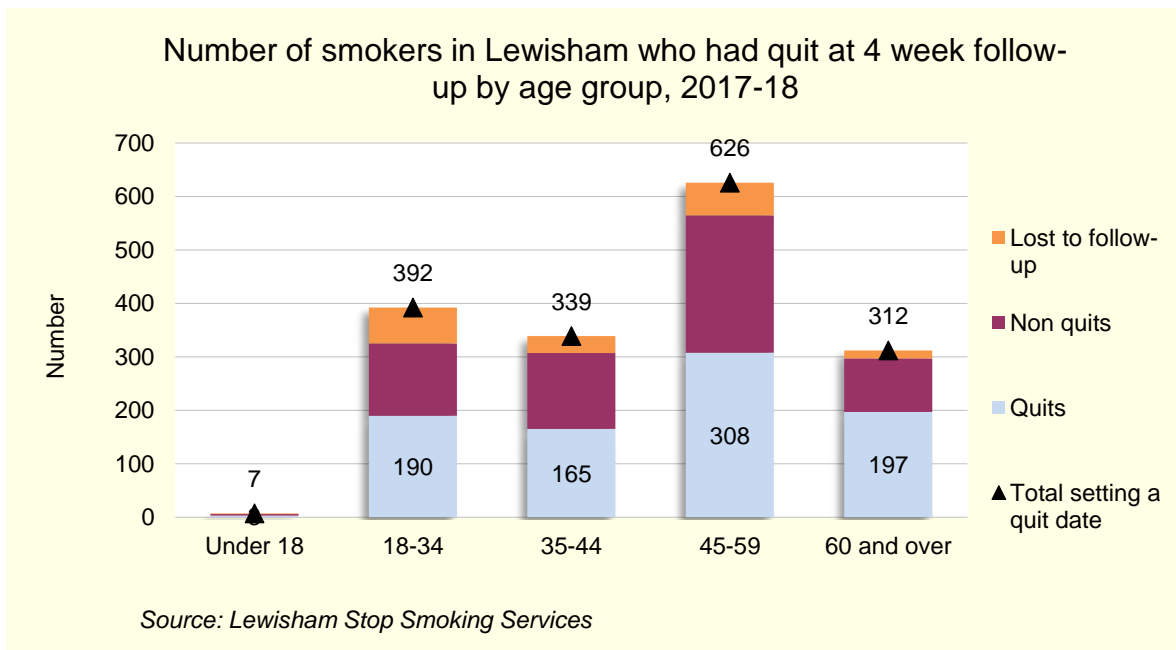
Table below shows the distribution of quitters by age for 2016/17 and 2017/18. It shows that there were very few people under the age of 18 who set a quit date. However, the number of young people accessing the service is increasing. The rate of successful quitting appears to increase with age. The number for under 18s is too small to draw conclusions, however over 60 appear to have the highest success rates. Table 2 shows those setting a date to quit and the proportions that are successful, by age group, in Lewisham 2016/17 - 2017/18.

Table 2: Lewisham Smoking Quits by Age

Age band	2016-17		2017-18	
	Quit date set	Successfully quit	Quit date set	Successfully quit
under 18	13	3 (23%)	7	3 (43%)
18-34	479	207 (43%)	352	166 (47%)
35-44	409	175 (43%)	310	143 (46%)
45-59	696	302 (43%)	582	282 (48%)
over 60	396	216 (54%)	291	182 (62%)

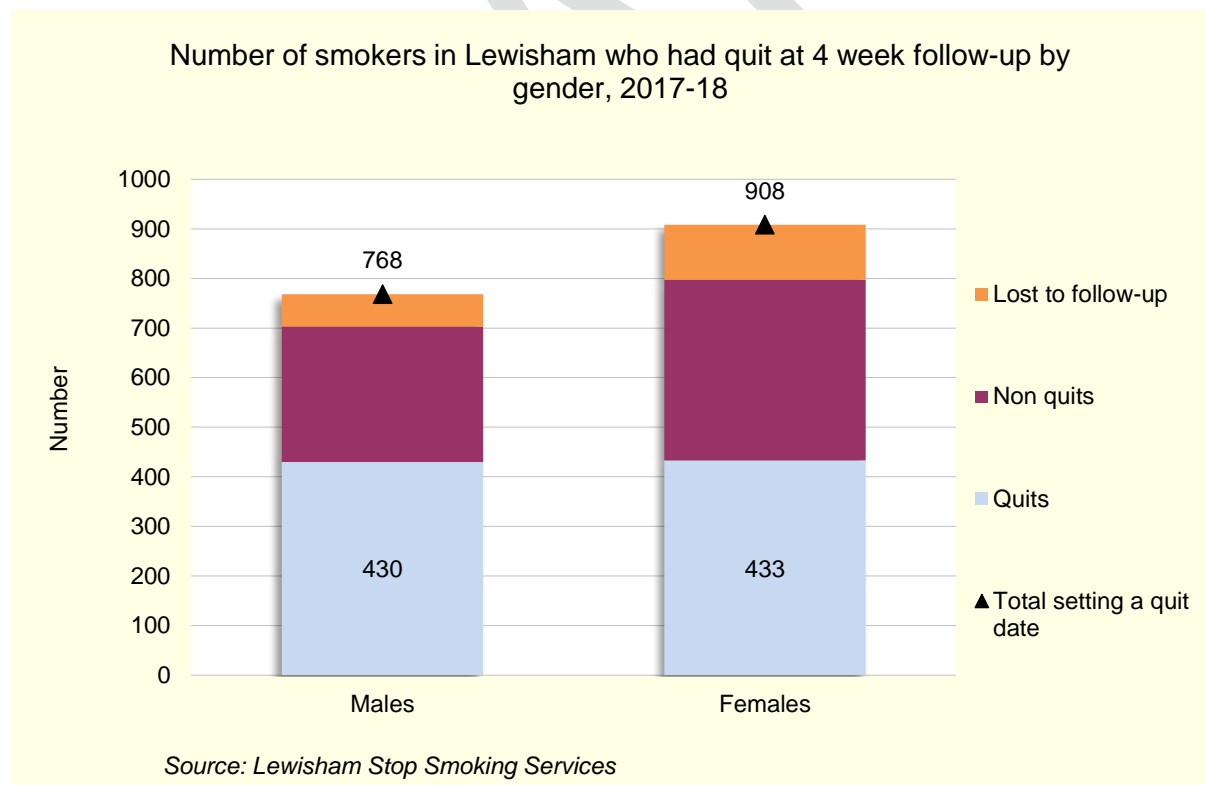
Source: Lewisham Stop Smoking Service

Figure 14: Lewisham Smoking Quits by Age



4.5 Ethnic Minorities who Quit Smoking

Figure 15: Lewisham Smoking Quits by Gender

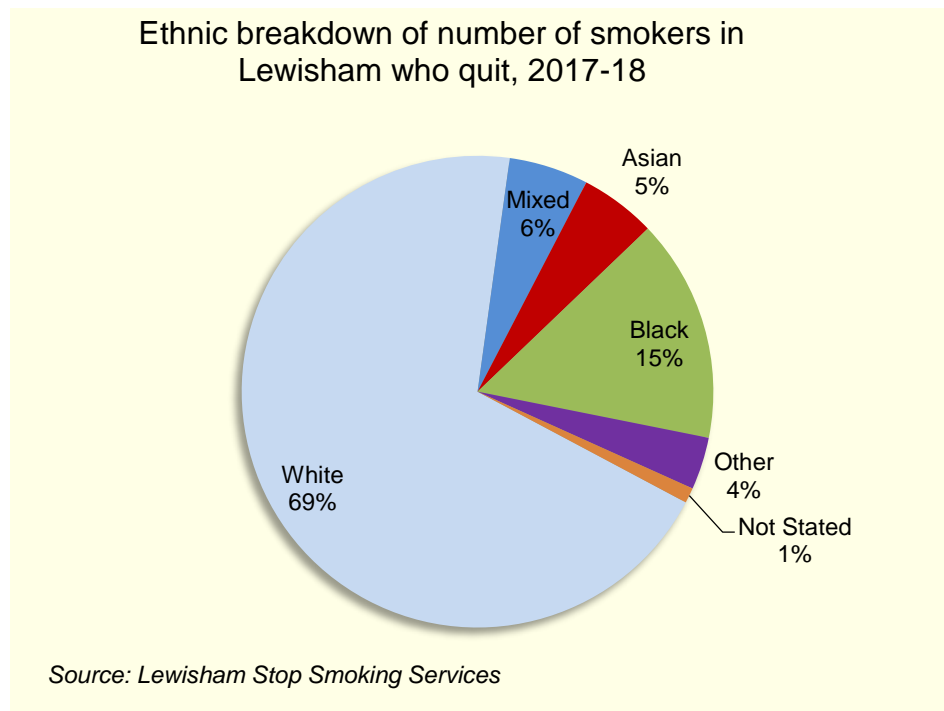


In Lewisham, 433 females quit compared to 430 males. However, the number of females setting a quit date was 908 compared to 768 males, of which 111 females and 65 males were lost to follow up and 364 females and 273 males did not quit smoking even after setting a quit date.

4.5 Ethnic Minorities who Quit Smoking

In Lewisham, 11.6% of the general population are black African and 9.9% are black Caribbean and around 15% of the total number of people who quit were black Caribbean or black African. Those from Asian backgrounds make up almost 10% of the population of Lewisham, 5% of those accessing the Lewisham stop smoking service were from an Asian background. However, just over 50% of Lewisham residents are white, yet 69% of residents who quit smoking through the service in 2017/18 are white.

Figure 16: Lewisham Smoking Quits by Ethnic Group



5. Local Views

Lewisham stop smoking service gathers view on the service from those who have used it. The service makes follow up calls to clients recorded in the database. There is a good level of satisfaction overall from people who use the service.

Overall the customer care survey report from December 2017 suggests that the service is achieving its aims of delivering a high quality, accessible service to the people of Lewisham. The report is limited to clients who have been able to access the service, and any information that the service receives regarding lack of accessibility are acted upon accordingly. 98% of clients were satisfied or very satisfied with the service. This is the highest rating that the service had in the last three years. The service users provided very positive feedback in terms of accessibility and time for appointments with positive reflections on the quality of interventions including the availability of medication support. Suggestions for improvement included organising group sessions for more peer support. How to cope with stress without smoking is cited by smokers as the main reason for smoking, relapsing and lack of confidence in being able to quit for good.

6. National and Local Strategies

The Government's 1998 White Paper 'Smoking Kills' was a landmark public health strategy. Since then progress has been made to reduce the harm from tobacco use, by implementing the following:

- Stop Smoking Services were set up in 1999 to help people to quit
- Most forms of advertising and sponsorship were banned in 2003/4
- In 2007 a landmark piece of legislation made all enclosed public spaces and workplaces smoke-free to protect people from exposure to secondhand smoke
- The legal age for buying tobacco was raised to 18 in 2007
- Pictorial health warnings on cigarette packets started in 2008

In July 2017, the government published its Tobacco Control Plan for England, to pave the way for a smokefree generation. The comprehensive plan sets out the following national ambitions for achievement by the end of 2022.⁴⁴

- To reduce smoking prevalence among adults in England from 15.5% to 12% or less.
- To reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less.
- To reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.
- To reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.

Since publication of the last Tobacco Control Plan, smoking prevalence among adults in England has dropped from 20.2% to 14.9% - the lowest level since records began.

In January 2019 the Long Term NHS Plan was published. It states that the NHS will make a significant new contribution to making England a smoke-free society. Action to achieve this includes:

- by supporting 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.

Lewisham's Smokefree Future Delivery Group is implementing this strategy in Lewisham. A work plan is developed to match the Tobacco Control Plan for England.

⁴⁴ Department of Health: Towards a Smoke free Generation – A Tobacco Control Plan for England 2017-2022. [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards a Smoke free Generation - A Tobacco Control Plan for England 2017-2022_2_.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/630217/Towards_a_Smoke_free_Generation_-_A_Tobacco_Control_Plan_for_England_2017-2022_2_.pdf)

7. Current Activity and Services

7.1 Stopping the inflow of young people recruited as smokers

Lewisham Council's Trading Standards, with the assistance of young volunteers, periodically carries out supervised test purchase attempts at premises selling tobacco to ensure that the over 18yrs requirements are complied with. Premises are also monitored to ensure that the relevant tobacco warning signs are displayed. The service provides signs to retailers along with other informative material on age restricted goods, including tobacco.

There were three sessions of underage test purchases in 2009/10 resulting in 32 attempts with 1 sale made. A warning was issued to this trader. In 2010/11, 30 premises were visited over 3 operations and 3 sales were made; 2011/12, 1 operation visiting 8 premises and no sales was made; 2012/13, 3 operations 28 premises and 3 sales; 2013/14, 3 operations 31 premises and 2 sales; 2014/15, 2 operations 15 premises and 6 sales; 2015/16 1 operation 19 premises 0 sales; 2016/17 2 operations 21 premises 0 sales and in 2017/18 so far 1 operation 13 visits 0 sales were made.

Tobacco vending machines are now illegal and there is no known vending machine in the borough. The exception to this is wholesaler machines that are not for public use.

7.2 Motivating and assisting every smoker to quit

Lewisham's Stop Smoking Service is provided by Lewisham and Greenwich Trust (<https://www.lewishamandgreenwich.nhs.uk/>) and commissioned by Lewisham Public Health. It offers evidence based interventions: a combination of behavioural support and medication for up to 12 weeks, in line with NICE guidance, which states that all smokers who wish to stop smoking should be offered intensive support usually at an NHS Stop Smoking Service. The service is provided in a variety of ways, including:

- Specialist clinics in various locations throughout the borough including 11 GP surgeries
- 6 pharmacies provide Champix through Patient Group Directive (PGD), previously a prescription only medication, to increase access
- 300+ trained midwives, nurses, pharmacists, health care assistants and pharmacy staff provide a service in primary care
- A Clinic at University Hospital Lewisham runs four days a week
- Specialist advisors run clinics in the most deprived wards in health centres
- Specialist advisors contact everyone who smokes during pregnancy and mental health patients and parents of children under five
- An online quit tool has been launched that can be used from phone, tablet or PC which is simple to use, helps to work out the best treatment for the quitter, and provide moral support or a boost to help through text messages as needed.
- There is a dedicated Freephone, text, e-mail and website

Referrals come from all health staff: midwives, GPs, health visitors, acute trust staff and from individuals. People who want to quit are offered support and motivational counselling, together with medication. The outcome measure is smoking status at 4 week follow up, as defined by the Department of Health. However, an additional 12 week quit status check is

likely to be introduced in future. This should increase the quality of the service provided, and ensure more long term health gain.

Advice on smokefree homes is also given to people in pregnancy and to parents of under 5s.

The Lewisham Stop Smoking Service also launched an online platform in December 2017 (<https://www.smokefreelewisham.co.uk/services/iquit/>) which all Lewisham residents can access. This website provides two main functions. Firstly, it directs users to the relevant parts of the service (e.g. behavioural support, medications, and specialist services). Secondly, it provides Lewisham residents with an online personalised step-by-step tool to aid smoking cessation (iQUIT).

7.3 Protecting families and communities from harm

7.3.1 *Reducing the attraction of tobacco products.*

While most forms of tobacco advertising and promotion in the UK are banned, the tobacco industry has continued to promote its products through packaging and “below the line” marketing. Also, the UK has become the first country in Europe to require cigarettes to be sold in standardised packaging.

7.3.2 *Taking action on illicit tobacco*

The government’s pricing policy has had an impact on the number of young people taking up smoking. Easy access to cheap illicit cigarettes is a particular risk to people on lower incomes including most young people. Lewisham Council’s work combating illicit and counterfeit cigarettes is an important aspect of protecting children from tobacco harm.

Illegal tobacco undermines efforts to improve the health of our residents by making low cost illegal tobacco available to smokers including under-age children. In particular it entrenches inequalities in disadvantaged communities and lower income groups in which smoking rates remain high, despite overall drops in the prevalence of smoking across the population. The trade is a very lucrative one controlled by criminal gangs which also deals in drugs, people trafficking and prostitution further entrenching inequality and deprivation.

7.3.3 *Counterfeit Tobacco Seizures*

Lewisham Council advises residents to be wary about buying cheap hand rolling tobacco from unregulated sources. Officers from the council seized significant amounts of counterfeit hand rolling tobacco from itinerant sellers who target customers of pubs and betting shops, as well as approaching people on the street. The tobacco does not meet the standards set by the UK Government for levels of tar, nicotine and carbon monoxide and may contain harmful chemicals and other substances that are hazardous to peoples' health.

It is found that around 11% of all cigarettes and 49% of all hand rolling tobacco consumed in the UK are illicit, whether smuggled, counterfeit, stolen or bootlegged. Possibly as many as third of cigarettes sold across London are illegal. Four times as many people die from illegal tobacco than all illicit drugs combined. Organised criminal gangs play a key role in the supply of illicit tobacco, especially counterfeit and smuggled cigarettes. This illegal trade can support other criminal activity such as the supply of controlled drugs, stolen goods and illegal alcohol. Some counterfeit and smuggled tobacco contains asbestos, mould and human faeces.

Lewisham Council is working with other councils across south east London to curb the sale of illicit tobacco. The work also involves the police and fire services. The council is also working with the police and HM Customs to carry out targeted raids on premises considered to be selling illegal tobacco. Any proprietor found to stock or sell these are prosecuted.

Lewisham Public Health works closely with the Pan London Illegal Tobacco Group that collaborated with other London Councils, London Trading Standards and ADPH London to deliver the London Illegal Tobacco Campaign in 2016/17:

- Over 21,000 illegal tobacco products were seized in a series of raids carried out by local Trading Standards teams across London as the result of the local intelligence gathered during the campaign.
- A total of 572 surveys were completed which reveal prevalence and attitudes.

During 2018/19 the London Illegal Tobacco Campaign hosted an illegal tobacco unit roadshow which included sniffer dog demonstrations in July 2018 for three weeks. Lewisham participated in the communications for the campaign.

7.4 Shisha

Shisha has a negative health impact⁴⁵. Public Health in collaboration with the Trading Standards and Smokefree Lewisham intends to work together to raise awareness of the dangers of smoking shisha. It is hoped that shisha bar owners will cooperate with this intervention allowing shisha smokers greater information. Trading Standards have a key responsibility to ensure the labelling of the shisha product meet the legal requirements, that the premises are displaying correct price lists and that age restriction notices are displayed. Both the teams strive to make businesses compliant with respective legislations to make shisha smoking as 'safe as possible'.

7.5 Electronic Cigarettes

An 'electronic cigarette' is a product that can be used for consumption of nicotine-containing vapour via a mouth piece, or any component of that product, including a cartridge, a tank and the device without cartridge or tank. E-cigarettes can be disposable or refillable by means of a refill container and a tank, or rechargeable with single use cartridges.⁴⁶

Electronic cigarettes are marketed as a cheaper, safer alternative to conventional cigarettes. As they do not produce smoke, research suggests that electronic cigarettes are relatively harmless in comparison with smoking. The charity Action on Smoking and Health (ASH)⁴⁷ produced a briefing which reviews the safety of e-cigarettes and how effective they are as an aid to stopping smoking. It is estimated that there are currently 2.8 million adults in Great Britain using e-cigarettes (6% of the adult population). Of these, approximately 1.3 million (47%) are ex-smokers while 1.4 million (51%) continue to use tobacco alongside e-cigarettes. Current use of electronic cigarettes amongst self-reported non-smokers is negligible (0.1%) and only around 1% of non-smokers report ever trying electronic cigarettes. Awareness of electronic cigarettes is widespread among adults.

⁴⁵ <http://www.adph.org.uk/wp-content/uploads/2017/03/PHE-ADPH-Shisha-Report-February-2017-.pdf>

⁴⁶ <https://www.gov.uk/guidance/e-cigarettes-regulations-for-consumer-products#keyterms>

⁴⁷ <http://ash.org.uk/stopping-smoking/ash-briefing-on-electronic-cigarettes-2/>

In May 2016, the Tobacco Products Directive implemented legislation for e-liquids used in vapes to contain a maximum of 20 mg/ml and tank sizes must be 2ml. The legislation also extended to re-fill bottles with a capped quantity of 10ml.⁴⁴

In January 2016, the increasing use of e-cigarettes as a method of quitting or harm reduction led to the National Centre for Smoking Cessation and Training (NCSCT) creating a national document on the use of Nicotine Containing Products (NCPs) in combination with behavioural support to aid a quit attempt. Data from English smoking cessation services for the year 2014-15 show that 2,221 smokers used an unlicensed NCP alone and 1,932 used an unlicensed NCP in combination with a licensed stop smoking medicine to support their quit attempt. These are relatively small numbers of people, although there may be some underreporting, given that 450,582 quit attempts were made with the services during that 12 months. E-cigarettes can support people to quit smoking. Clients of stop smoking services who combined e-cigarettes with behavioural support had the highest quit-rates in 2014–15. Public Health England (PHE)⁴⁸ published an independent expert e-cigarettes evidence review in February 2018, which provides an update on PHE's 2015 review. The report covers e-cigarette use among young people and adults, public attitudes, the impact on quitting smoking, an update on risks to health and the role of nicotine. It also reviews heated tobacco products.

The main findings of PHE's evidence review are that:

- vaping poses only a small fraction of the risks of smoking and switching completely from smoking to vaping conveys substantial health benefits
- e-cigarettes could be contributing to at least 20,000 successful new quits per year and possibly many more
- e-cigarette use is associated with improved quit success rates over the last year and an accelerated drop in smoking rates across the country
- many thousands of smokers incorrectly believe that vaping is as harmful as smoking; around 40% of smokers have not even tried an e-cigarette
- there is much public misunderstanding about nicotine (less than 10% of adults understand that most of the harms to health from smoking are not caused by nicotine)
- the use of e-cigarettes in the UK has plateaued in recent years at just under 3 million
- the evidence does not support the concern that e-cigarettes are a route into smoking among young people (youth smoking rates in the UK continue to decline, regular use is rare and is almost entirely confined to those who have smoked)

Lewisham Stop Smoking Service welcome smokers who want to use an e-cigarette to help them quit. The South London and Maudsley NHS Foundation Trust ensures that all patients who are admitted to Ladywell Unit, Lewisham Hospital are screened for smoking status, provided with support and offered the opportunity to engage with specialist tobacco dependence interventions with easy access to nicotine replacement therapy and e-cigarettes are also essential components of the plan.

7.6 Cigarette related fire

Smoking is the most common cause of fire fatalities. The London Fire Brigade believes that the best way to stay safe is to stub out the cigarettes for good, for smokers who are not ready to quit yet, e-cigarettes (vapes) are a better option from a fire safety perspective. Dropping a vape on a carpet, duvet or armchair will not start a fire. So if quitting completely is not possible, it is a simple swap that can save lives.

⁴⁸ <https://www.gov.uk/government/news/phe-publishes-independent-expert-e-cigarettes-evidence-review>

Table 3 provides statistics on fire incidents related to smoking in the last four years but the smoking related fire incidents fluctuate every year.

Table 3: Fire incidents in Lewisham

	2014-15	2015-16	2016-17	2017-18
Accidental Dwelling Fires	646	697	350	201
Smoking related fires	30 (4.6%)	48 (6.9%)	21 (6.0%)	38 (18.9%)
Smoking related Accidental Dwelling Fires				13
Fatalities from smoking related fires	0 (0%)	1 (50%)	0 (0%)	
Serious injuries from smoking related fires	9 (20.5%)	7 (17.1%)	1 (4.0%)	3

WHAT IS THIS TELLING US?

8. What are the key inequalities?

Smoking in itself contributes to health inequalities; anyone who smokes is increasing their likelihood of numerous health and social problems. There are four broad population groups amongst whom smoking is likely to have a greater effect, and therefore a need to focus efforts on reducing smoking among these groups of people. The groups amongst whom there is the greatest need are pregnant women, young people, those with mental health problems and those from a low socio economic group.

Pregnant women are an important group to focus on due to the potential consequences for their unborn child. The risks of smoking during pregnancy are serious, from premature delivery to increased risk of miscarriage, stillbirth or sudden infant death. It is also known that children with parents who smoke are more likely to become smokers themselves, therefore parents need to be encouraged to stop smoking in order to break this cycle.

The emphasis for young people should be to stop them from coming into contact with smoking or accessing cigarettes in order to reduce the likelihood of them starting to smoke. Young people are in particular danger from the effects of smoking and therefore targeting this group before they start is essential.

Due to the fact that those with mental health issues are more likely to smoke, but are less likely to be offered help to stop; this group of people needs an increased input from services in order to reduce this inequality.

Those living in poorer communities are more likely to smoke, which in itself exacerbates the inequalities experienced by people in this group. If those who are in lower socio economic groups can be helped to reduce smoking, this will reduce both health and economic inequalities. The Lewisham Stop Smoking Service is successful in reaching those people living in areas of high deprivation and that the proportion of smokers who quit are higher in these areas and is increasing. This trend should be continued.

It is encouraging to see that smoking prevalence is decreasing nationally and more people are setting a date to quit smoking, through the stop smoking service. The overall numbers of those managing to give up for four weeks is increasing. The numbers using the service,

although increasing, are small and represent only around 6-10% of the smoking population of Lewisham.

9. What are the key gaps in knowledge or services?

Even though the local smoking prevalence has reduced with the implementation of the various strategies on tobacco control, there are gaps in local knowledge about how much people smoke and who is smoking.

In terms of assisting people to stop smoking, there are gaps in the Lewisham stop smoking service provision for those who are most heavily addicted, in specialist services for people with poor mental health, for minority ethnic groups with high tobacco use for example Polish, Vietnamese, and Somali people. The stop smoking service will need to work more closely with people who want to stop and have additional difficulties in achieving this. Referral systems will need to be improved across all care pathways with specific focus on pregnant women and people with mental illness.

Most importantly there is a gap in between the capacity of the stop smoking service and the number of smokers.

10. What is coming on the horizon?

A more strategic approach to implementing smoke free policies and raising awareness will be needed to help protect children and young people from tobacco harm through secondhand smoke and reduce the number of young people who take up smoking.

Reorganisation of the NHS and reductions in local authority funding will challenge partnership working, and investment in initiatives to prevent premature mortality. The Lewisham 'smoke free future delivery group' will continue to work towards their current goals and aim to adapt to the forthcoming challenges they will encounter.

11. What should we be doing next?

There is a need to scale up the provision of Stop Smoking Services so that they are able to reach more smokers. This is particularly important as those people who are still smoking are likely to be more heavily addicted than those who have already quit smoking. However, with the shrinking Public Health Grants and local authority savings plan, this is difficult to achieve, indeed some of the London and out of London councils have completely stopped funding stop smoking services.

One of the key priorities must be to prevent as many young people as possible taking up smoking in the first place through the de-normalising of tobacco.

Plans for future include delivering Lewisham's Smoke Free Future Action Plan, and adapting to changes from national plans. The Action plan focuses on 'de-normalising' smoking to reduce uptake by young people, on implementing policies to protect children from the harm of secondhand smoke, and increasing the contribution to prevalence reduction. The Stop Smoking Service aims to improve referral systems from GP practices and hospitals and develop expertise and effectiveness in supporting people to stop smoking. It will focus on helping parents and pregnant women, those most heavily addicted, those with mental health problems, as well as those in poorer communities and in some minority ethnic groups.

Public Health will continue to work with the wider tobacco control network to strengthen partnership working around: tackling the sale of illegal tobacco (which is typically sold at cheaper prices increasing accessibility of tobacco for children and young people); encouraging partners e.g. health, education and community services to recognise their role in prevention through providing very brief advice around smoking through initiatives such as 'Making Every Contact Count'; and supporting smokefree initiatives in public spaces, particularly those where children and young people may be affected by second hand smoke e.g. playgrounds and community spaces. We would also encourage Lewisham CCG to contribute to the cost of medications that would have been covered by the service.

DRAFT