The Khan review

Making smoking obsolete

Independent review into smokefree 2030 policies

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Foreword

Most people don't see smoking as a problem anymore. As a nation, we've moved on. Smoking in restaurants, pubs and clubs has long gone. It's no longer common for living room ceilings to be stained yellow from chain-smoking in front of the TV. You have to be my age to have any memory of tobacco adverts on TV and billboards. The problem is less visible.

When the Rt Hon Sajid Javid MP, the Secretary of State for Health and Social Care, asked me to carry out an independent review of 'smokefree 2030', the government ambition to get smoking rates down from 13.5% (reference 1) to 5%, my initial reaction was much the same. Is this really still an issue?

But as the smoke clears, the facts are that:

- almost 6 million people still smoke in England (reference 2)
- smoking remains the single biggest cause of preventable illness and death (reference 3)
- approximately 64,000 people are killed by smoking each year (reference 4), that's around twice as many people as have died from coronavirus (COVID-19) in the last 12 months (reference 5)
- when used exactly as recommended by the manufacturer, cigarettes are the one legal consumer product that will kill most users – 2 out of 3 smokers will die from smoking unless they quit (reference 6)
- in 2019, a quarter of deaths from all cancers were connected to smoking (reference 7)
- smokers are 36% more likely to be admitted to hospital and need social care 10 years before they should (reference 8)
- around one third of adult tobacco consumption is by people with a current mental health condition, with smoking rates more than double that of the general population
- people with mental health conditions die 10 to 20 years earlier, and the biggest factor in this is smoking (reference 9)
- smokers lose 10 years of life, or around 1 year for every 4 years of smoking after the age of 30 (reference 10)

- the annual cost to society of smoking is around £17 billion (reference 11), with the cost to the NHS alone about £2.4 billion – this dwarfs the £10 billion income from taxes on tobacco products (reference 12)

- making smoking obsolete in England would lift around 2.6 million adults and 1 million children out of poverty (reference 13)

The millions of people who still smoke – young people, parents, grandparents, friends – are heading towards becoming one of these stark statistics soon if they don't stop smoking.

The lethal health outcomes that come with smoking are not felt equally across communities with huge differences in rates across the country. At its most extreme, smoking prevalence is 4.5 times higher in Burnley than in Exeter (reference 14). While smokers from deprived communities are as likely to want to quit and to try to quit, they are much less likely to succeed. Industry-funded influencers make out that smokers are young, cool, affluent, and healthy. But the truth is that year by year England's smoking population gets older, sicker, and poorer. It's clear that to truly 'level up' health and wealth, the government must tackle the crippling burden that smoking has on our most disadvantaged communities.

During this review, I have asked myself, "if cigarettes had never existed and were invented tomorrow, what would happen?" The answer was simple. They would not be legalised. They would not be allowed into our shops and supermarkets.

Not even smokers like smoking. Most smokers say they want to quit (reference 15). But without support, 95% of quit attempts end in relapse within a year (reference 16). Ask any ex-smoker. You have to try again and again. Yet the public are often led to believe that smoking is a personal choice, when really this is an addiction promoted by an industry with no concern for life or health. And in doing so, the tobacco industry makes about £1 billion profit every year in the UK (reference 17), with estimated profit margins of up to 67% (reference 18), off the back of our most disadvantaged communities.

In this review I have looked at our current smokefree policy, along with looking at the very best practice from around the world. It's clear that we have been a world leader in reducing smoking over the last few decades but are now at risk of stagnating. The government needs to raise its ambition if it wants to continue leading the way.

My review has found that without further action now, England will miss the smokefree 2030 target by at least 7 years, with the poorest areas not meeting it until 2044 (reference 19).

If we do nothing different, by 2030 over half a million more people in England will have died from smoking. Even if we reached the target of 5% by then, we would still have 2

million smokers, two-thirds of whom will die from smoking unless they quit. Is that ambitious enough?

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

In this review, I make 15 far-reaching recommendations. Only 6 of these require an additional financial investment.

This holistic response will not only give the government the best chance of meeting its national target to be smokefree by 2030, but also support the government's ultimatum 'for industry to make smoking obsolete'. In 2019 the government's prevention green paper set this aim, but during the course of my Review I have seen no evidence of a plan or movement by industry in this direction. That is why I am setting an ambitious, but realistic, target to:

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

Most critically, I believe this would improve the health and wealth of our country’s most disadvantaged communities more than any other measure. England should lead the way and be the first nation to introduce this holistic response to smoking.

To deliver this, I am calling on the government to invest an additional £125 million per year. My report sets out how this money should be spent and what it will deliver.

There is no room for complacency, delay, or under-investment. Action now will save lives, save money, address health disparities and increase productivity.

In presenting this report, I am greatly indebted to the varied contributions to this review made by a vast array of people and organisations (listed in Annex A and B). This includes expert advice from Professor John Britton along the way, which was highly valued. I thank them all and hope that I have done justice to their voices.

Levelling up

The government's Levelling up white paper talked about the striking geographical differences that can be seen in the country. Smoking is no exception. In fact, it's a significant contributor to health inequalities.

The lethal dependence of smoking is not being shared between the richest and poorest. Rates of smoking in areas like Wakefield (18.6%) and Doncaster (18.3%), are decades behind rates in wealthier areas such as Richmond upon Thames (6.2%). Three in 5 of all households containing smokers living in poverty are in the North and Midlands, while fewer than 1 in 5 are in London and the South East (reference 20).

We are facing a cost of living crisis that will hit the poorest hardest. And yet too often it is those who can afford it the least who spend the most on their smoking addiction. In Bolton alone, smokers spend over £67 million a year on tobacco (reference 21). Nearly all this money goes straight out of the local economy as tobacco industry profits or tax.

Helping our most disadvantaged smokers will restore thousands of pounds to family budgets up and down the country. Once smoking is obsolete in England, over £11.4 billion will be going back into communities' and families' pockets (reference 22). One million less children will live in poverty.

And there are other concerns.

1. The proportion of young adults (18 to 24 year olds) who have smoked rose during the COVID-19 pandemic, from a quarter to a third (reference 23).

2. People with long-term mental health conditions are much more likely to smoke at 26% (reference 24). There is a myth that smoking is a relaxant, when in fact it increases anxiety.

3. Nearly 10% of pregnant women smoke at the time of giving birth, something which increases the risk of stillbirth, miscarriage and sudden infant death syndrome. Children of parents who smoke are almost 3 times as likely to take up smoking (reference 25).

4. People in routine and manual occupations are 2.5 times more likely to smoke than people in other occupations (reference 26).

5. People living in social housing are 3 times as likely to be smokers than those who have a mortgage (reference 27).

We need to reach these target groups with the highest smoking rates, break generational smoking patterns, and offer good quality support to those who need it most, to level up the nation.

Figure 1: percentage of adults who are currently cigarette smokers, by local authority in the UK in 2019

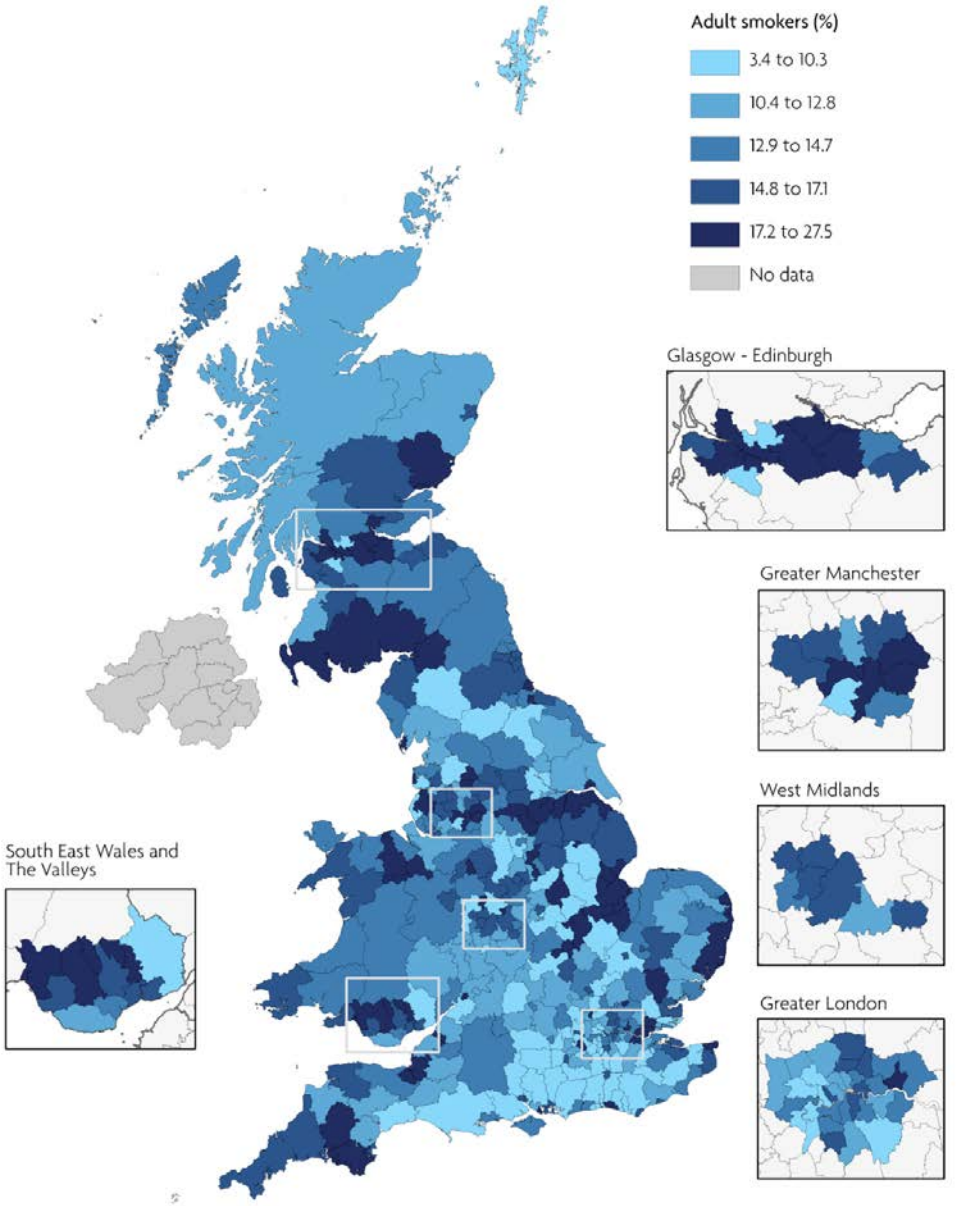

Figure 1 shows a map of Great Britain with adult smoking prevalence marked in a range of colours representing increasing ranges of prevalence, from the 3.4% to 10.3% range, up to the 17.2 to 27.5% range. The highest prevalence range is found in parts of the North West, East Midlands, South Yorkshire, East of England, and in the South West.

Executive summary

Overview

In 2019, the government set an objective for England to be smokefree by 2030 (reference 28), meaning only 5% of the population would smoke by then. Without achieving this objective, the government will simply not meet its manifesto commitment "to extend healthy life expectancy by 5 years by 2035" (reference 29). It will also prevent the government from fulfilling its ambition to save more lives as part of a new 10-Year Cancer Plan.

My review found that without further action, England will miss the smokefree 2030 target by at least 7 years, and the poorest areas in society will not meet it until 2044 (reference 30). To have any chance of hitting the smokefree 2030 target, we need to accelerate the rate of decline of people who smoke, by 40%.

The Rt Hon Sajid Javid, Secretary of State for Health and Social Care, said in a speech on health reform on 8 March 2022:

> "Richer communities get healthier – and healthier communities get richer. Healthy people work more, learn more and earn more".

Figure 2: smoking prevalence in England (trend and projections)

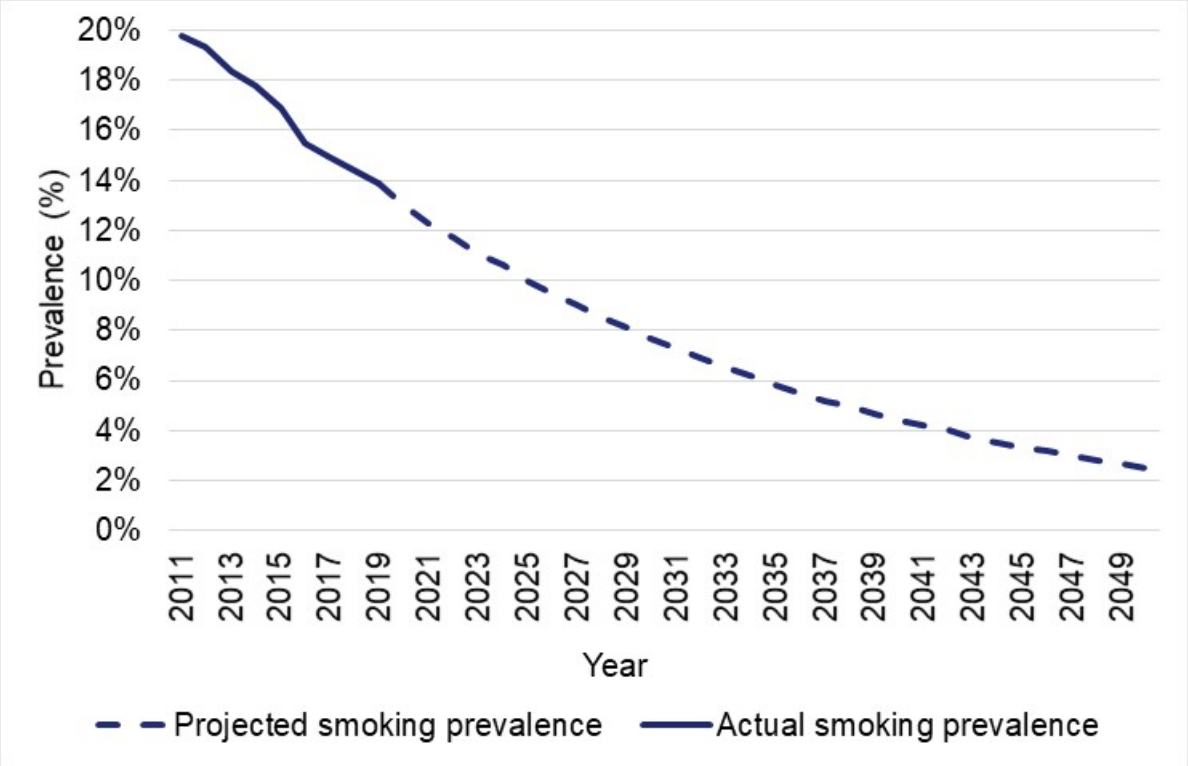

Figure 2 shows the prevalence of smoking in England, reducing from 19.8% in 2011 to 13.9% in 2019. The chart then shows the projected trend downwards to 2.5% in 2050.

Public support for government action to limit smoking has grown significantly in the last 10 years. Those who think the government is not doing enough to tackle smoking has risen from 29% in 2009 to 46% in 2022 (reference 31).

Figure 3: public attitudes about government activities to limit smoking

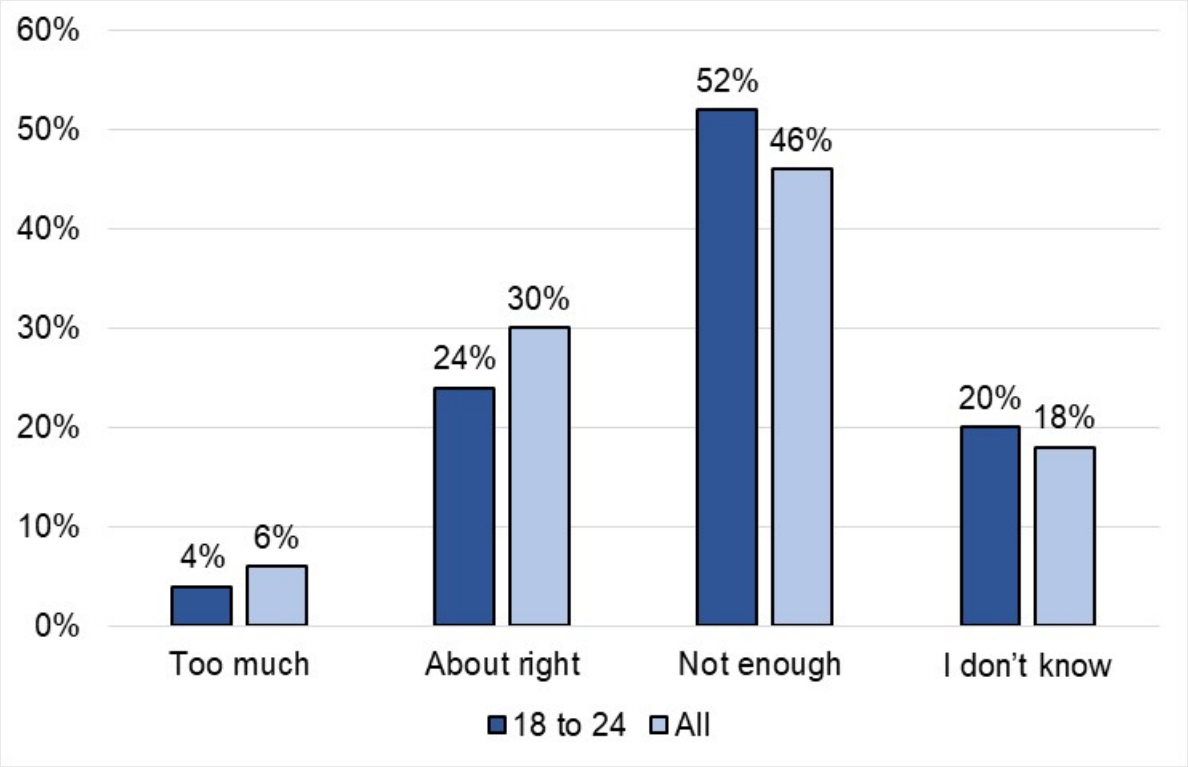

Figure 3 compares the responses from 18 to 24 year olds and everyone, to a question asking if they think that the government is doing enough to limit smoking. The responses are:

- too much: 4% of 18 to 24 year olds and 6% of everyone
- about right: 24% of 18 to 24 year olds and 30% of everyone
- not enough: 52% of 18 to 24 year olds and 46% of everyone
- don't know: 20% of 18 to 24 year olds and 18% of everyone

Critical recommendations

These 4 recommendations are my critical ‘must dos’ for the government, around which all other interventions are based.

1. Increased investment

I have set out the case for comprehensive investment now of an additional £125 million per year in smokefree 2030 policies, to fund the easily accessible, high quality support that smokers need to help them quit. This includes investing an extra £70 million per year in stop smoking services, ringfenced for this purpose.

If the government cannot fund this themselves, they should 'make the polluter pay’ and either introduce a tobacco industry levy, or generate additional corporation tax, with immediate effect.

2. Increase the age of sale

The government must stop young people starting to smoke, which is why I recommend increasing the age of sale from 18, by one year, every year until no one can buy a tobacco product in this country.

3. Promote vaping

The government must embrace the promotion of vaping as an effective tool to help people to quit smoking tobacco. We know vapes are not a 'silver bullet' nor are they totally risk-free, but the alternative is far worse.

4. Improve prevention in the NHS

Prevention must become part of the NHS’s DNA. To reduce the £2.4 billion that smoking costs the NHS every year, the NHS must deliver on its commitments in the Long Term Plan. It must do more, offering smokers advice and support to quit at every interaction they have with health services, whether that be through GPs, hospitals, psychiatrists, midwives, pharmacists, dentists or optometrists. The NHS should invest to save, committing resource for this purpose.

Other recommendations

I have also made several other recommendations throughout my report, presenting a holistic response to the challenge of delivering smokefree 2030, and setting the country on the path to making smoking obsolete.

I have called on the government to introduce a tobacco license for retailers, to limit the availability of tobacco across the country. I have proposed a fundamental rethink of the way cigarette sticks and packets look, to reduce their appeal. A smokefree society should be the social norm, which is why there should be even more smokefree places (in hospitality and outdoor places where children congregate), where people cannot smoke.

Investing in a well-designed mass media campaign will help create this smokefree culture, while encouraging smokers to quit. Substantially raising the cost of duties (more than 30%) across all tobacco products will also encourage smokers to quit, by increasing the cost of smoking. Abolishing all duty free entry of tobacco products at our borders.

I am also asking the government to accelerate the path to prescribed vapes and provide free Swap to Stop packs in deprived communities. Alongside this they should do everything they possibly can to prevent children and young people from vaping, including by banning child friendly packaging and descriptions.

The government must do more to support the most deprived areas and groups who are disproportionately impacted by smoking. In particular, pregnant women and people with mental health conditions who show substantially higher negative health impacts of smoking. I am calling on integrated care systems (ICS) across the country to lead on meeting smoking cessation targets. To achieve all of this, it will also be important to tackle illicit tobacco, which often sells tobacco cheaply and to underage young people. The government must also invest in new research and data, including commissioning further research on smoking related health disparities.

My proposals are a plan for England. They are not simply a plan for this government, but successive governments too. As we make progress, we will need to refine our proposals, adjusting spend to match changing needs, responding to the evolving challenges and opportunities. So, I also propose the government introduces progress checkpoints in 2026, 2030 and 2035.

Summary of recommendations

Part 1. Invest in reaching smokefree 2030

Recommendation 1. Urgently invest £125 million per year in interventions to reach smokefree 2030, and make smoking obsolete, addressing the health disparities smoking creates (critical intervention). Within this, invest an increase of £70 million per year into stop smoking services, ringfenced for this purpose, distributed according to prevalence data.

Part 2. Stopping the start – reduce the number of people taking up smoking, particularly young people

Recommendation 2. Raise the age of sale of tobacco from 18, by one year, every year, until no one can buy a tobacco product in this country (critical intervention). This will create a smokefree generation.

Recommendation 3. Substantially raise the cost of tobacco duties (more than 30%) across all tobacco products, immediately. This includes increasing duty rates for cheaper tobacco products, such as hand rolled tobacco, so they are the same as standard cigarette packages. It also includes banning tobacco products at duty-free entry points.

Recommendation 4. Introduce a tobacco licence for retailers to limit where tobacco is available. The government should also ban online sales for all tobacco products, ban supermarkets from selling tobacco and freeze the tobacco market to stimulate innovation in tobacco-free alternatives.

Recommendation 5. Enhance local illicit tobacco enforcement by investing additional funding of £15 million per year to local trading standards. Give trading standards the power to close down retailers known to be selling illicit tobacco. Alternative tobacco products such as shisha need enhanced enforcement.

Recommendation 6. Reduce the appeal of smoking by radically rethinking how cigarette sticks and packets look, closing regulatory gaps and tackling portrayals of smoking in the media.

Recommendation 7. Increase smokefree places to de-normalise smoking and protect young people from second-hand smoke. Strengthen smokefree legislation in hospitality, hospital grounds and outdoor public spaces. Local authorities should make a

significant proportion (70% or more) of new social housing tenancies and new developments smokefree.

Part 3. Quit for good – encouraging smokers to quit for good

Recommendation 8. Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals (critical intervention). The government should accelerate the path to prescribed vapes and provide free Swap to Stop packs in deprived communities, while preventing young people's uptake of vapes by banning child friendly cartoon packaging and descriptions.

Recommendation 9. Invest an additional £70 million per year into stop smoking services, ringfenced for this purpose. The government should commission an update to existing quality of service standards guidance and build the provision of good quality stop smoking support across the country. The government should also ensure that any national helpline complements existing local (and national) virtual offers of support. Employers should follow National Institute for Health and Care Excellence (NICE) guidance on stopping smoking to support their employees to quit.

Recommendation 10. Invest £15 million per year in a well-designed national mass media campaign, supported by targeted regional media. This should be nationwide, direct smokers to support and dismantle myths about smoking and vaping.

Part 4. System change – the critical role of the NHS, the importance of collaborative working and improving data and evidence

Recommendation 11. The NHS needs to prioritise prevention, with further action to stop people smoking, providing support and treatment across all its services, including primary care (critical intervention). First and foremost, the NHS must meet its existing commitments in the Long Term Plan. Healthcare professionals should use every 'teachable moment' to deliver very brief advice on quitting, and this should form part of revised core training curriculums. The NHS should invest to save, committing resource for this purpose and incentivise its services to implement the NICE guidance on stopping smoking. All hospitals must integrate 'opt-out' smoking cessation interventions into routine care. Hospital trusts should report on progress towards implementing these measures in their annual reports and have a named lead. The NHS must ramp up its messaging on stopping smoking.

Recommendation 12. Invest £15 million per year to support pregnant women to quit smoking in all parts of the country. The NHS should provide treatment at every stage. The government needs to create a national funding pot for evidence-based financial incentives to support all pregnant women to quit. There should be a stop-smoking midwife in every maternity department to provide expert support and advice at the front line.

Recommendation 13. Tackle the issue of smoking and mental health. Disseminate accurate information that smoking does not reduce stress and anxiety, through public health campaigns and staff training. And make stopping smoking a key part of mental health treatment in acute and community mental health services and in primary care.

Recommendation 14. Invest £8 million to ensure regional and local prioritisation of stop smoking interventions through ICS leadership. ICSs and directors of public health must set, and annually report against, clear targets to reduce smoking prevalence in their areas and commission services to allow that reduction to be achieved. The government should set up a support fund to which ICSs can bid for funding to support regional collaboration and partnership.

Recommendation 15. Invest £2 million per year in new research and data. The government should invest in an innovation fund to support the commissioning of new research, data and monitoring of impact at all levels. This will provide improved and accessible information to identify effective evidence-based interventions that should be rolled out. The government must also commission further research on smoking related health disparities, particularly on ethnic disparities and young people.

Part 1. Invest in reaching smokefree 2030

Recommendation 1. Urgently invest £125 million to achieve smokefree 2030, setting us on a path to make smoking obsolete

Critical intervention: this is a ‘must do’ to successfully achieve smokefree 2030.

The problem

At current rates of decline, the government will miss the smokefree 2030 ambition by at least 7 years, and the poorest in society will not meet it until 2044 (reference 32). To meet smokefree 2030, and move towards making smoking obsolete, the government must invest in comprehensive smokefree policies across the system. No single intervention on its own will work. The problem must be tackled from all angles.

Michelle Mitchell, CEO of Cancer Research UK said:

> “Smoking is not only the biggest cause of cancer, but it also hits the most deprived the hardest. Amidst the current cost of living crisis, smoking continues to pull our most disadvantaged communities further into poverty by costing them billions each year. All the while, the tobacco industry continues to profit significantly at the expense of our nation’s health.
>
> This review suggests the vital measures needed to achieve a smokefree world for all by preventing young people from starting to smoke and supporting those who do to stop. But these will only be possible with investment. It is high time the industry foots the bill and pays for the damage it causes.”

Over the last decade, smoking interventions have been skinned to the bone by reductions in funding. This decline must be reversed. Local stop smoking services provide a highly cost-effective approach to help people quit smoking. Yet since 2016, local authority spending for these services has declined by 40% (in real terms) compared to a 21% decline for the public health grant overall (reference 33). These vital services are viewed by local authorities, facing budget pressures, as an area of optional spend. Additionally, budgets for marketing campaigns to encourage smokers to quit have dropped from £23 million to £2 million in 10 years (reference 34).

The results of disinvestment are stark. Since 2010, the number of people using stop smoking services reporting a successful quit attempt has fallen by 72%. From 380,000 people then to 105,000 now (reference 35).

The benefits

I understand this is a difficult time for government budgets and resources and finding new pots of money means sacrifice elsewhere. However, the Prime Minister has repeatedly stated his commitment to levelling up the nation. Reducing smoking is one of, if not the most, effective ways to ‘level up’ health and wealth. Preventing smoking saves lives and saves money: the benefits far exceed the costs.

Without significant funding, the government will be unable to level up the health and wealth of disadvantaged smokers across the country. If the money cannot be found within the government, then I have given alternative proposals for a ‘polluter pays’ approach. Whichever approach the government settles on, investment now will deliver exponential benefits.

The estimated annual cost to society of smoking in England is around £17 billion (reference 36), with the cost to the NHS alone around £2.4 billion. This significantly exceeds the £10 billion per year generated from tobacco duties (reference 37).

Figure 4: cost of tobacco to society

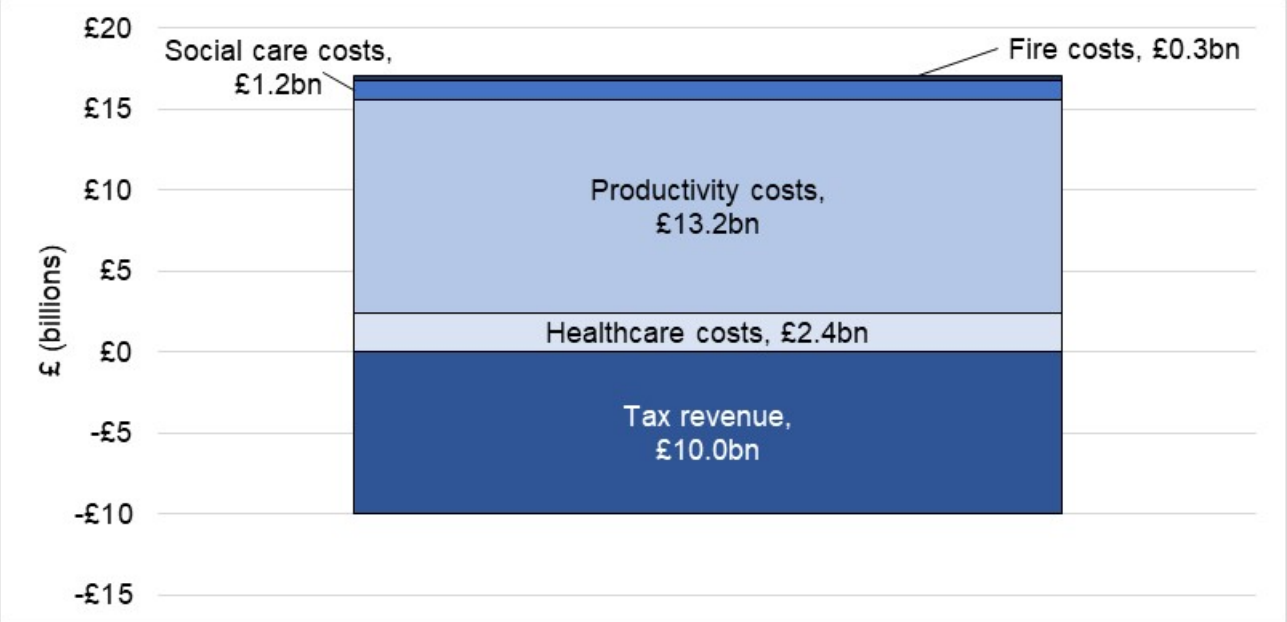

Figure 4 shows the cost of tobacco to society compared to tax revenue, which is £10 billion. The costs are to:

- productivity of £13.2 billion, including:
    - £6.05 billion on smoking related lost earnings
    - £5.70 billion on smoking related unemployment
    - £1.45 billion on smoking related early deaths
- healthcare of £2.4 billion
- social care of £1.2 billion
- fire of £0.3 billion

Investing now will save the NHS billions in care for patients who could have lived healthier lives for longer. A smokefree society would give:

1. A £2.4 billion saving for the NHS, freeing beds and resource to tackle waiting lists (reference 38).

2. Cash back into the pockets of the poorest people, lifting around 2.6 million adults and one million children out of poverty in England (reference 39).

3. Large productivity gains in the workforce and across the economy.

4. A substantial reduction in inequalities in life expectancy and quality of life.

The detail

I have set out 3 options for the government to generate the additional funding of £125 million to achieve all the recommendations in this report.

Option 1: additional funding from within government

This funding should be ringfenced and targeted.

Option 2: a 'polluter pays' industry levy

Introduce a ‘polluter pays’ industry levy on profits from cigarette sales, which can directly fund the full range of comprehensive measures to help us reach smokefree 2030 and make smoking obsolete. This is my preferred option.

Despite high tobacco duties (around £10 billion per year), tobacco manufacturers still make significant profits – approximately £1 billion every year in the UK (reference 40). And the tobacco industry’s profit margin is as high as 67%, far higher than the margins for any other consumer staple product, which typically range from 12 to 20% (reference 41).

Professor Chris Whitty, Chief Medical Officer said

> “The tobacco industry makes its massive profits from getting young people addicted to smoking, something that will kill or severely disable many of them. It drives a high proportion of cancer deaths, heart disease, stroke and chronic lung disease, and is the preventable cause of many of our health inequalities. Second-hand smoke also harms non-smokers."

So, I am asking why should taxpayers have to pay for the health and other consequences of the tobacco industry’s lethal products?

A tobacco ‘polluter pays’ levy could be introduced in the form of a charge applied as a percentage of these profits. This has wide public support. A recent Action on Smoking and Health (ASH) and YouGov survey suggests that 76% of adults support a levy (reference 42). A levy was put forward by the All-Party Parliamentary Group (APPG) on Smoking and Health in their 2021 report on delivering a smokefree 2030 (reference 43). The smokefree 2030 fund model, developed by ASH, projects that this could raise £700 million each year (across the UK) (reference 44).

Tobacco is a dying industry. Its days are numbered. A tobacco levy can help tilt the balance against the industry’s dependence on tobacco as a profitable product.

The ‘polluter pays’ principle has been widely accepted for over 30 years, including by Conservative governments, starting with the landfill levy, running through to the sugar tax on soft drinks, the post-Grenfell cladding levy and more recently the windfall tax on energy firms . This principle applies as much, if not more, to the tobacco industry. Tobacco manufacturers make lethal products, which have killed 8 million people in the UK over the last 50 years. That’s more than 400 people a day, and far more than COVID-19 (reference 45).

Bob Blackman MP, Chair of the All-Party Parliamentary Group on Smoking and Health said:

> "The bold action that the government states is needed to reach Smokefree 2030 is not possible without investment. We need to establish new sources of funding and a 'polluter pays' levy will free up millions to support stop smoking services across the country."

Option 3: a corporation tax surcharge

A corporation tax surcharge would impose a surcharge of a percentage on the profits of manufacturers. The surcharge would effectively be an additional percentage of corporation tax. There is already a corporation tax surcharge for banks.

Alternatively, a levy could be designed to deliver a fixed sum annually to the government, with contributions of individual firms based on a measure such as market share. In the US they do this. The Food and Drug Administration collects user fees from tobacco manufacturers and importers, based on market share.

Part 2. Stopping the start – reducing the number of people taking up smoking, particularly young people

Recommendation 2. Raise the age of sale of tobacco from 18, by one year, each year

Critical intervention: this is a ‘must do’ to make smoking obsolete.

The problem

No other consumer product kills over half its lifelong users. There is no more addictive product that can be legally sold in our shops. Above all, smoking is an addiction of childhood. We must act now for the smokers of the future and 'stop the start' before it grabs and kills.

Figure 5: smoking instigation rate by age

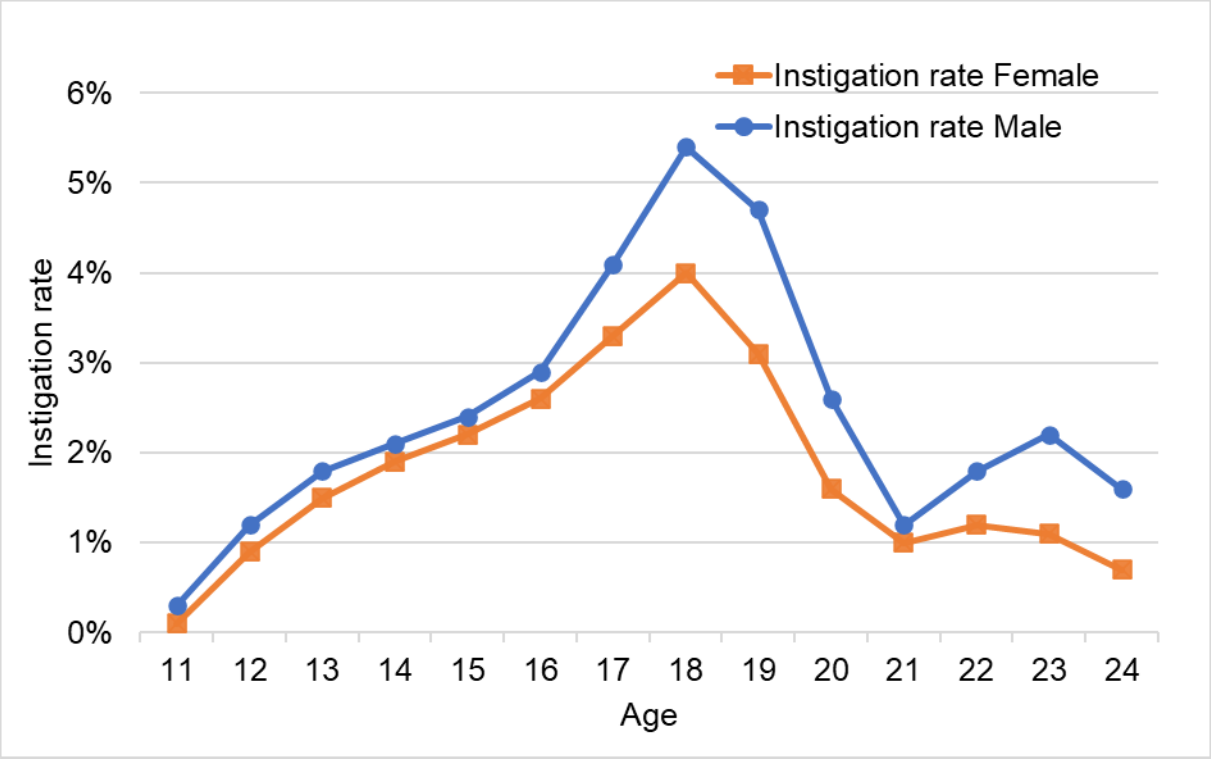

Figure 5 shows the rate at which people start smoking across a range of ages from 11 to 24 years old. The most common age to start smoking is 18, where the rate increases to 4% for women and 5% for men. The rates increase to 18 years old and decrease afterwards, apart from a lower peak around 2% for men at 23 years old.

These are the same young people who are most likely to grow up in smoke filled homes, to have friends who smoke, to have never known their grandparents because they have died early from smoking related diseases. For these young people especially, we must make smoking obsolete.

The benefits

Never starting to smoke is much easier than having to quit. This recommendation will lead to a new smokefree generation, where young people below a certain age are legally prevented from buying tobacco products, including cigarettes, throughout their entire lifetime.

While other recommendations will help us reach smokefree 2030, this is about that as well as the long-term impact that will make smoking obsolete.

New Zealand, which is banning all sales of tobacco to anyone born after 2008, estimates that it could half smoking rates within 10 to 15 years of implementation, assuming effective enforcement of the law (reference 46).

Hon Dr Ayesha Verrall, New Zealand Associate Minister of Health, said in a speech at the launch of the Smokefree 2025 Action Plan, 9 December 2021:

> “We want to make sure young people never start smoking so we are legislating a smokefree generation … As they age, they and future generations will never be able to legally purchase tobacco, because the truth is there is no safe age to start smoking.”

Current smokers would not be prohibited from their addiction, but over time this action would help to protect millions of children and young people from ever becoming addicted. It will create a future society where smoking is no longer in demand or even relevant, as the legal age of sale to smoke tobacco becomes higher and future generations avoid becoming addicted to this deadly and costly practice.

The short term impacts for raising the age of sale of tobacco are already proven. When the age of sale was increased from 16 to 18 in 2007, it led to a 30% reduction in smoking prevalence for 16 and 17 year olds in England (reference 47). Evidence from the US showed that when the age of sale was increased from 18 to 21, the chance of a person in that age group smoking decreased by 39% (reference 48).

So, the potential impact that raising the age of sale by one year, every year is clear, as the benefits multiply each year as less and less young people take up smoking.

Professor Chris Whitty, Chief Medical Officer said:

> “Stopping young people from starting to get addicted to cigarettes, helping everyone quit and pushing the smoking rates right down is essential to preventing avoidable disease.”

The government must send a clear message that smoking is a thing of the past by implementing this measure as a priority. The harms are too high to continue to allow another generation to get addicted. It will also signal to the tobacco industry that it is not welcome here.

The detail

I have considered various options for raising the age of sale. Should the government raise it from the current age of 18 to 21 in one go? Why not jump to 25? Will this be the 'nanny state' or 'big government' in action? How would this sit alongside the legal age to buy alcohol, to get married, to vote? Note none of the others are likely to kill you!

It is clear that raising the age of sale has high public support. Of 10,000 adults surveyed in England, 63% supported raising the age of sale of tobacco from 18 to 21. Almost half (46%) of smokers supported raising the age of sale too (reference 49).

New Zealand has already outlawed smoking for the next generation and is moving the country closer to its goal of being smokefree by 2025. They too are planning a gradual increase of the legal smoking age, which will extend to a ban on the sale of cigarettes and tobacco products to anyone born after 2004. Denmark is now considering doing the same for its 5.8 million population (reference 50).

Our challenge is even greater than theirs, with England’s 6 million smokers outnumbering the adult populations of New Zealand and Denmark. The UK has taken pride in being a world leader in stop smoking policies and must now take this next bold step to raise the level of ambition even further.

My considered view is that raising the age of sale over time, one year at a time, presents a significant longer term signal, leading to a genuine smokefree generation. The gradual impact will be less pronounced than one single leap to either 21 or 25.

Recommendation 3. Limit the affordability of all tobacco products, raising the cost of tobacco through duties in one stroke

The problem

One of the most effective ways of stopping someone smoking tobacco is making it too expensive to buy (reference 51). The government routinely increases duties year on year and has committed to a duty escalator where duties increase more than 2% above inflation until the end of the current Parliament. However, we need to go further to have that moment of impact with smokers, where it tips the balance in favour of quitting, bringing immediate benefits in health and wealth. This may seem paradoxical, especially as many disadvantaged families approach a cost-of-living crisis, but this is a key strand in a comprehensive plan to help people spend less, not more, on tobacco.

Australia has the most expensive cigarettes in the world, at around £22 per 20 pack (reference 52), compared to around £13 in England (reference 53). Evidence from Australia, the US and South Africa shows that substantial real increases in the price of tobacco products have been followed by larger than usual declines in apparent and reported tobacco use (reference 54). Since the UK, compared to Australia and New Zealand, may be geographically more vulnerable to illicit trade run by criminal gangs, it will be important for HM Revenue and Customs (HMRC) to continue to tackle smuggled tobacco too, especially in our most disadvantaged communities.

The tobacco industry employs elaborate pricing strategies (reference 55) to undermine the impact of increasing tobacco taxes, including phasing in increases and cross-subsidising cheaper brands from more expensive products (reference 56). The government needs to do more to mitigate against this.

The benefits

Increasing duties even further will incentivise smokers to quit and is well evidenced to reduce demand for tobacco products. In 2003, the World Health Organization (WHO) concluded that increasing taxes on all tobacco products is the most effective means of tobacco control (reference 57). There is also evidence that increasing the price of tobacco products through taxes is the intervention with the greatest potential to reduce socioeconomic inequalities in smoking.

Professor John Britton, Emeritus Professor, University of Nottingham said:

> “The most effective way of reducing the uptake of smoking and encouraging people to quit, and for that to stick…is to raise the cost of

> tobacco. This should be done for all products, and in one full sweep. To be most effective, it should be coordinated with investment in marketing campaigns and stop smoking services."

Increasing duties by 30% would represent a substantial increase. This would mirror the largest increase in duty rates between 2010 and 2011, when the specific duty rate increased by 30%.

It is estimated that a 30% increase in price would reduce demand by around 12% in the short term (reference 58), and by as much as nearly 35% in the long run (reference 59). Initial estimates, based on expected reduction in demand for tobacco products, suggest that a 30% increase in duty on all tobacco products would raise more than £1 billion in revenue.

An argument the tobacco industry often makes against increasing taxation on their products is that it will increase the size of the illicit tobacco market. However, evidence suggests that taxes and prices only have a limited impact on the illicit tobacco market share. Instead, non-price factors, such as the availability of illicit tobacco and enforcement, appear to be more important determinants of the size of the illicit tobacco market (reference 60).

The detail

I recommend that the government takes the following actions to make sure that it can effectively limit the affordability of tobacco.

Implement a substantial increase in tobacco duty

The government must commit to a substantial increase in duties (more than 30%), on all tobacco products. This should be done in one stroke (alongside continued year-on-year increases), so it is felt by smokers to encourage them to quit. While the poorest smokers are most likely to feel the greatest impact from this policy, they will also have the most benefit from quitting through a cash injection in their wallets.

To not unfairly penalise the most deprived communities, a significant rise in duties would be best timed alongside a national mass media campaign directing smokers to stop smoking services and support and more cost-effective alternatives to smoking. This should help smokers break free from their addictions and ensure that they do not feel priced out of smoking.

Increase duty rates for all tobacco products

The government must increase duty rates for all tobacco products, including hand rolled tobacco (HRT), so they are the same as standard cigarette packages. This will help tackle

the increasing use of cheaper products such as HRT which are particularly attractive to young adult smokers.

The use of cigars is increasing (reference 61), as they can be bought one at a time. Duties on HRT are significantly less than for the same volume of tobacco bought as cigarettes. Duty rates for HRT are currently around 30% lower than for cigarettes and cigarettes are subject to a minimum excise tax which HRT is not. If the government committed to a substantial increase in duties on all tobacco products, an even greater increase in HRT duties would be required to equalise them with cigarettes.

Increasing duty rates on all tobacco products will also help reduce tobacco companies' ability to undermine tobacco tax policy and circumvent measures by offering customers cheaper alternative products. The government should also explore other measures to do this, such as increasing the minimum excise tax for cigarette packs.

Abolish duty free entry of tobacco products at our borders

The government should ban duty-free cigarettes. People can currently bring 10 packs (200 cigarettes) duty-free into the country (reference 62). Duty free is often a way that smokers legally import cheap tobacco for their personal use. This must stop. Other countries like Singapore are already doing this (reference 63).

Introduce high tobacco tariffs on tobacco coming into the UK

The government has introduced a public health commitment to work together on tobacco control in its free trade agreement with the Australian government. All future trade agreements with other countries should reference addressing the harms from tobacco.

As a measure to deter the tobacco industry selling their products in the UK market, the government should ensure all free trade agreements include high tariffs on tobacco products to deter their sale in the UK.

Recommendation 4. Introduce a tobacco licence for retailers – limiting the availability of tobacco and prevent illicit sales

The problem

Currently, anyone and any enterprise can sell tobacco. Retailers need a licence to sell alcohol, but not cigarettes. Most of the public are surprised there is no similar requirement, particularly since tobacco is an even more harmful product.

This can mean shops that sell to underage children, or stocking illicit tobacco, can go unnoticed. Unfortunately, it is clear that trading standards and HMRC lack the capacity to effectively tackle the problem.

Online is even worse, with a wild west of products available for purchase at the click of a button. This applies to online purchasing of unregulated vapes too. The government has already cut off some routes for underage sales by banning vending machines, but online sales present a new threat.

Supermarkets should lead the way for retailers, considering the harm tobacco causes to their customers and their families across the country. The Netherlands is banning the sale of cigarettes in supermarkets from 2024. Some supermarkets in the UK, such as Lidl and Aldi, are leading the way and do not sell cigarettes, but most supermarkets have not followed suit.

The benefits

A licensing scheme is not just a measure to protect young people. It protects the honest small businesses up and down the country who sell only tax paid products to adults but are undercut every day by an illicit trade run by criminal gangs who sell smuggled tobacco to anybody who wants it.

Eighty-three per cent of adults support a retail licence, making it the most popular intervention among adults surveyed (reference 64). A retailers' licensing scheme would reduce underage and illicit sales and protect law abiding businesses. It would also revitalise the ability of local communities to tackle tobacco use. We need to make tobacco very difficult to buy. Retailers want this. Even most smokers want this (reference 65).

This would be further bolstered by ending the online sale of all tobacco products and banning supermarkets from selling tobacco products – limiting the availability and convenience of buying tobacco products particularly for young people.

The detail

I recommend that the government takes the following actions to make sure that it is limiting the availability of tobacco and preventing illicit sales.

Introduce a tobacco licence for retailers to sell tobacco

The government should introduce a tobacco licence for retailers to sell any tobacco products. The new tobacco licencing scheme should:

1. Be a national scheme administered by local authorities. The cost of the licence should be determined by the local authority (with a national minimum set).

2. Protect the public and law-abiding traders by ensuring that criminal retailers lose their tobacco licence for the premises. Any loopholes for transferring licences to new names or to alternative premises should be closed. Selling tobacco without a license must be an offence attracting heavy financial penalties.

3. Enable local authorities to attach public health criteria to the licence. For example, prohibiting sales near schools, requiring the sale of less harmful alternatives, and displaying of stop smoking advice on retail premises.

End online sales of all tobacco products

The government must completely end the online sale of all tobacco products. This will prevent underage online sales, and further limit the availability and convenience of buying tobacco products. More research should be commissioned on how young people access vaping products online, and an extension through an online ban of vape sales should be considered in the future.

Ban supermarkets from selling tobacco products instore and online

The government must ban supermarkets across the UK from selling tobacco products instore and online as soon as possible. I have spoken to several supermarkets and I know that they increasingly want customers to have the choice to make healthier decisions as part of their company's vision.

Freeze the tobacco market and allow no new tobacco products

The government must freeze the tobacco market and not allow any new tobacco products to be introduced to the market. This will stagnate the market, with no newly available or attractive products. It will also help avoid the industry circumventing any new tax duties or measures by introducing new products to the market that are cheaper. For example, when there has been an increase in duties some companies have created new hand rolled cigarette products so they can still offer cheaper and affordable products to their customers.

Recommendation 5. Enhance illicit tobacco monitoring and enforcement

The problem

Illicit tobacco (reference 66) preys on the most disadvantaged in our community, stealing health and hope. The estimated size of the illicit market was 16.6% of all tobacco trade in 2019 to 2020 (reference 67).

Illicit tobacco undermines the work that the government is doing to regulate the tobacco industry and protect public health. Efforts to reduce disparities will fall flat if this is permitted to continue by government inaction.

Over half of smokers who have ever bought illicit tobacco are from the most deprived socioeconomic group, compared to around 1 in 20 from the least deprived. A study from the North East showed 55% of children aged 14 and 15 who smoke say they buy illegal tobacco, and almost 3 out of 4 say they have been offered illegal tobacco.

This problem can be more pronounced in certain communities, for example in South Asian communities, where all too often extremely harmful smokeless tobacco products can be sold in flagrant disregard for the regulations and taxes that apply to all tobacco products.

Smuggled tobacco is almost always linked to organised crime. Criminal gangs flood our most deprived communities with illicit tobacco, which is sold to children at pocket money prices. The proceeds are often used to fund wider organised crime like drug dealing and sex trafficking (reference 68).

The benefits

Putting these criminal gangs out of business is key to the governments ambition to protecting the most vulnerable children in our society and levelling up deprived communities.

Legitimate retailers who follow the rules suffer because these cheap products undercut their businesses and put the money in the hands of criminals. Price is a big driver for people cutting down or quitting and illegal tobacco stops people from giving up smoking or switching to less harmful products like vapes.

Tackling the scourge of illicit tobacco in our most deprived communities will support honest retailers and amplify the efforts of our health service in supporting smokers to quit.

The detail

The government must improve the monitoring and enforcement of the illicit tobacco market supporting a multi-agency approach (HMRC, trading standards, police, and public health) to reduce the supply of, and demand for, illicit tobacco in our communities. I recommend that the government takes the following actions to achieve this.

Invest £15 million a year to fund local trading standards to tackle illicit tobacco

The government must dedicate additional funding of £15 million per year to local trading standards, specifically on smokefree interventions. This will allow trading standards, with support from the police, to respond as a multi-agency team to every tip-off. The number of

visits and enforcement action has decreased in recent years as trading standards functions have been scaled back. It is unacceptable that these services lack the capacity to respond.

Depending on progress against clear targets, this level of funding should be reviewed in 2026, 2030 and 2035.

Close down retailers selling illicit tobacco

The government should give trading standards the power to close down retailers known to be selling illicit tobacco. Deterrents need to be strong, swift, and sure. The legitimate traders and criminals alike must know that offenders will be found, and the penalty will be effective. That is what really stops illicit tobacco traders, suppliers, and retailers.

There are currently too few incentives for agencies to spend enough of their limited resources to find illicit tobacco, as the sentences are often so light. Local trading standards officers should have the powers to issue financial penalties up to £10,000 against retailers who flout the law and should be able to confiscate assets. This would mean that enforcement action is effective and viable. Closure orders will allow the local authority to physically shutdown premises. This would mean businesses persistently selling illegal tobacco would close rather than carry on trading.

Enhanced enforcement for alternative tobacco products

Alternative tobacco products such as khat (officially illegal), paan, bidi, naswar and shisha also need enhanced enforcement, because they are routinely sold with no regard for regulations on packaging, display or notification.

These products are especially a blight on our South Asian communities but are most often ignored by enforcement agencies. I hope this is because they think these communities do not mind, and not because they think these communities do not matter.

Case study: growing concern about illicit ‘pop up shops’ and a local approach to illicit enforcement

Medway, like many other local authorities in England, has seen a new trend of organised criminal activity in creating false illicit ‘pop-up shops’ with, for example, tiled walls that conceal hidden chambers or tobacco being dropped to order from the floor above.

Low prices encourage smokers to continue to smoke, and there are wider concerns such as modern-day slavery being used in these illegal shops.

A recent successful prosecution saw an offender receive a 90-day custodial sentence; however, this process took 15 months. During this period, the defendant continued to trade

in illicit cigarettes. In a two-and-a-half-day operation in Medway, one shop suffered a seizure of 82,000 cigarettes, but was back in operation selling illegal tobacco within hours.

Recommendation 6. Reduce the appeal of smoking through dissuasive cigarettes, closing regulatory loopholes and introducing anti-smoking messages on TV and film

The problem

We need to reduce the demand for tobacco, as well as the supply. There is little use in supporting current smokers to quit if a whole new generation of smokers is ready to replace them. While progress has been made over the last few decades, there is certainly scope to go further.

Stark ‘smoking kills’ warnings on cigarette packs have played their part in preventing a generation of young people from smoking, but now unsightly packs are less common, and it is only the cigarette itself being smoked which is displayed on screen. Health warnings are long overdue a shake-up.

Exposure to smoking imagery in the media normalises smoking among young people. Although paid-for tobacco product placement in films such as Superman is a thing of the past, smoking imagery continues to occur frequently in popular UK films, television programmes, video-on-demand services, internet channels and social media. UK regulators are aware that this exposure is harmful but have not prevented it.

Some tobacco accessories have a long track record of egregious promotion that would never be permitted for cigarettes. Other tobacco companies have exploited the same loophole by shifting to promote devices used for heated tobacco rather than the tobacco itself.

The benefits

Providing novel and effective messages for smokers to prompt quit attempts and discourage uptake could result in significant public health benefits.

Every person has a right to be protected from starting a lethal addiction, or at least to be informed of all the facts before they start smoking. Imagine being offered your first cigarette from a friend and reading the message on the actual stick about the ‘minutes of your life lost’ per cigarette.

Addressing portrayals of smoking in the modern media is vital to protect the public from harmful exposure to tobacco imagery. We know that the content people watch, particularly

young people, has massive influence. UK regulators preventing these images and messages from reaching children or requiring the display of health warnings at the same time, would give children and adults greater awareness of the harms caused by tobacco.

The detail

I recommend that the government takes the following actions to reduce the appeal of smoking.

Rethink how cigarettes look

The government should use every part of the cigarette, and what's in the pack**,** to communicate the harms of smoking and offer opportunities to quit. For example, through:

- mandating anti-smoking messages on cigarette sticks, such as the number of 'minutes of life lost' per cigarette (reference 69)
- using dissuasive colours (like green or brown) on individual cigarette sticks or hand rolling papers (reference 70)
- cigarette pack inserts that provide information on the health benefits of quitting, supported by web links that direct smokers to support for stopping smoking (reference 71)

Figure 6: cigarette sticks with health warnings

Figure 6 shows cigarettes with 'smoking kills' on each stick.

Close regulatory gaps

The government should close the range of regulatory gaps to reduce the appeal of tobacco and related products to young people. This will involve action to:

- regulate tobacco accessories and introduce packaging, labelling, flavour description bans the same way as for smoked tobacco
- ban all counter displays for all tobacco products
- strengthen the packaging and product standards of smokeless tobacco products

Mandate anti-smoking health promotion messages in films and TV shows

The government should mandate anti-smoking health promotion messages to be shown in films and in TV shows containing smoking. Ofcom and the British Board of Film Classification must update and regulate standards in all films, TV shows and online media.

This will be a helpful way to promote anti-smoking messages to the audience, consistent with the principle of making the polluter pay. It would be effective in encouraging filmmakers to think twice before including actors' smoking, including considering more carefully how necessary depictions of smoking are for historical accuracy.

All films, TV shows and online media that contain tobacco imagery on screen should also:

- be classified as unsuitable for viewing by persons aged under 18 years, and television programmes that include tobacco imagery to be broadcast after the 9pm watershed
- be required to display an on-screen health warning while such imagery is visible
- ban corporate sponsorship and corporate social responsibility spend by the tobacco industry of any kind – these are often tools used for brand promotion to circumvent traditional marketing methods that are banned

There are also other ways that the tobacco industry retains its media influence, including with children, online and through social media. Children must be protected from exposure to tobacco imagery in social media, and this should be actively considered by the Department for Digital, Culture, Media and Sport as part of its approach to tackle online harms.

Recommendation 7. Increase smokefree places to make smokefree the social norm

The problem

Looking back, it's hard to believe that banning smoking inside pubs and restaurants could ever have been so controversial. Now, even smokers back the law. Yet we are still exposing children and families to second-hand smoke in pub gardens and pavement cafes across the country.

Worse still, some outlets have devised 'smoking shelters' so extreme, that while technically within the law, they offer staff and customers next to no protection from the toxic smoke. Indeed, for many shisha bars, this is a fundamental part of their business model.

The one factor that predicts smoking in England more precisely than any other is whether someone lives in social housing. The links between smoking and socio-economic groups is replicated in the housing market. People who rent with local authorities or are with a housing association are nearly 3 times more likely to smoke than those who have a mortgage (28.6% compared to 10% of people who have mortgages) (reference 72).

Figure 7: general adult smoking prevalence by housing tenure

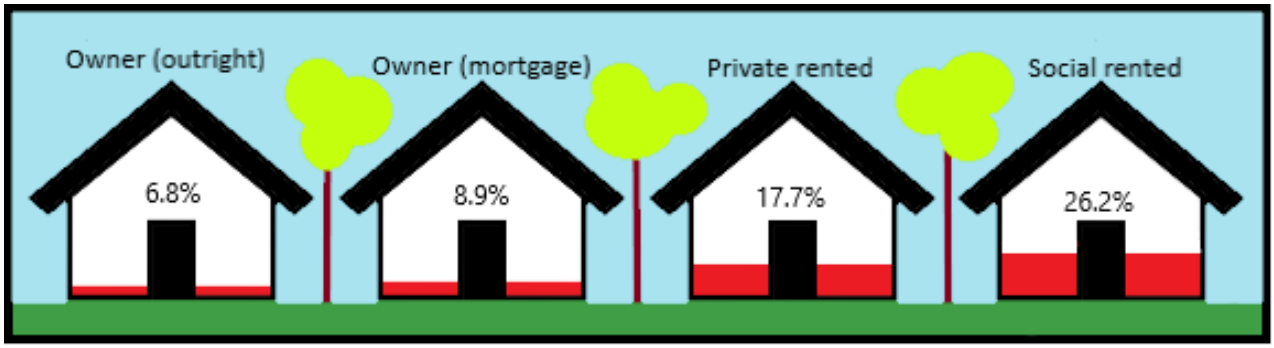

Figure 7 shows data from a 2020 Office for National Statistics report for adult smoking prevalence, based on whether people own or rent their home. The figures show smoking prevalence of:

- 6.8% for people who own their home outright
- 8.9% for people who own with a mortgage
- 17.7% for people in private rented accommodation
- 26.2% for people in social rented accommodation

The benefits

In 2007, smokefree legislation was introduced, banning smoking indoors and in bars and restaurants. It has been incredibly impactful, not only at preventing second-hand smoke, but also in de-normalising smoking.

Increasing smokefree spaces in hospitality, hospital grounds and outside public spaces, while protecting non-smokers in social housing, is the natural next step.

The detail

I recommend that the government takes the following actions to make smokefree places the social norm.

Make all hospitality smokefree

During the COVID-19 pandemic, temporary conditions were introduced to provide smokefree areas in all cafes and restaurants that had a ‘pavement license’ giving customers greater choice of where they sit outside. These provisions required clear smoking and non-smoking areas and allowed non-smokers to avoid the harm from second-hand smoke. It is now time for the government to amend the 2006 Health Act to prohibit smoking on all premises where food or drink is served.

Make all hospital grounds smokefree

At the doors of too many of our accident and emergency departments, patients and their families must pass through clouds of smoke on their way in. In too many informal 'smokers corners', staff and patients cluster under no smoking signs. It is time for a new approach. A commitment to smokefree hospitals should be included in the refresh of the NHS Long Term Plan and compliance should be made a formal criterion for inspections of quality of care.

Introduce more smokefree outdoor public spaces

Wales introduced further smokefree laws in March 2021. This required hospital grounds, school grounds and public playgrounds, as well as outdoor day care and child-minding settings, to be smokefree (reference 73). I want local authorities in England to go further and ban smoking in all outdoor areas where children are present. For example, public beaches and outside civic office grounds (central and local government buildings) should all be completely smokefree places.

Make social housing smokefree

In the USA, smoking is prohibited in all social housing, providing the tenants the same protection from smoke drift enjoyed by private tenants. I am not proposing that for now. But local authorities should have a clear strategy in place to support the reduction of smoking in the home, with specific actions for social housing and vulnerable groups of tenants.

A significant proportion (70% or more) of new tenancies and new developments should be smokefree to reflect the 70% of people in social housing that do not smoke (reference 74). This should include measures to reduce smoking as part of new housing developments, improve compliance and enforcement with existing legislation, and support neighbours exposed to smoke drift. Student housing, sheltered housing and hostels for homeless people, and accommodation for people transitioning from prison or inpatient mental health services should also explore doing the same.

Part 3. Quit for good – encourage smokers to quit, for good

Stopping smoking is the best thing a smoker can do for their health. It increases life expectancy, wellbeing and it also improves a smoker's wealth. And the benefits are immediate.

Recommendation 8. Offer vaping as a substitute for smoking, and provide accurate information to consumers on the benefits of switching

Critical intervention: this is a 'must do' to successfully achieve smokefree 2030

The problem

Some will argue that people should be encouraged to quit all forms of nicotine, and while I understand their concern, my priority is to help people quit smoking as quickly, completely, and permanently as possible. That must also be the overriding public health priority.

However, there is lots of confusion, even misinformation, about vaping. The most common relates to its harm. I have spoken to the very best academics and scientists across the country and internationally. They all told me that vaping is far less harmful than smoking.

In cigarettes, we know that it is not the nicotine that kills you but the other thousands of toxic chemicals such as tar and carbon monoxide. Vapes give smokers the nicotine they crave but protect them from the toxins they would inhale from a cigarette.

This is not saying that vaping is a 'silver bullet' solution. Or that vapes are totally risk free. Given vapes have only been around for about a decade, we do not yet have the longitudinal studies to show long term effects. However, the research we do have is clear that they are at least 50% and probably closer to 95% less harmful than a cigarette (reference 75).

So, with careful reflection, I believe we must not let the pursuit of perfection become the enemy of the good.

Of course, the healthiest option is not to vape or smoke at all. And the use of vapes should only be encouraged to quit smoking.

Vapes are cheaper and more effective than many quit medicines yet, currently, only 10% of quits in stop smoking services use vaping as a quitting tool and most of these are in a handful of areas (reference 76).

We know that some healthcare professionals are concerned about the safety of vaping. Much of this scepticism is based on myths. This needs addressing.

One possible response is to produce a medicinally licensed vape product. But currently, to do this, independent small and medium-sized enterprises (SME) face significant barriers and high costs. However, I am heartened to know that the licensing agency (the Medicines and Healthcare products Regulatory Agency, MHRA) is keen to work with government to address this as quickly as possible.

I have also heard from school and college leaders that vaping has become a problem in their playgrounds and common rooms. They say vapes have become too easily available to young people under 18. They have seen a rise in related disciplinary action and fear that numbers will rise further. They want to see restrictions on accessibility, in shops and online, and to reduce the marketing appeal of vapes to young people. They also believe the school curriculum should be adopted to include sessions about vaping, alongside smoking and alcohol.

Finally, it seems to me that our regulations on promoting vapes do not always have quite the effect we intend them to have. On the one hand, there is a loophole which means it is lawful for tobacco companies to give free vape samples to school children. On the other, we make it hard for vape shops to promote the benefits of quitting smoking to their customers.

Protecting our most vulnerable children means restricting access to nicotine products, but it also means helping the adults in their lives to quit smoking. The government has more to do to get the balance right.

Professor Linda Bauld, Usher Professor of Public Health at Edinburgh said

> “While not risk free, we know that vapes are far less harmful than smoking and they are an important tool to help people to quit. Considering the significant health benefits of stopping smoking, it is essential to get the right balance between helping smokers to quit while protecting young people from starting to vape.”

The benefits

Well over 90% of UK vapers are adult current or ex-smokers, and the proportion who have completely stopped smoking continues to grow (reference 77). In England, vaping is relatively common among younger current and former smokers, whereas older smokers

are less likely to vape or to have tried vaping (see figure 8). Given the effectiveness of vaping in smoking cessation, this suggests a missed opportunity in helping smokers in their 30s and over to quit.

Figure 8: smoking and vaping among adults in Great Britain by age

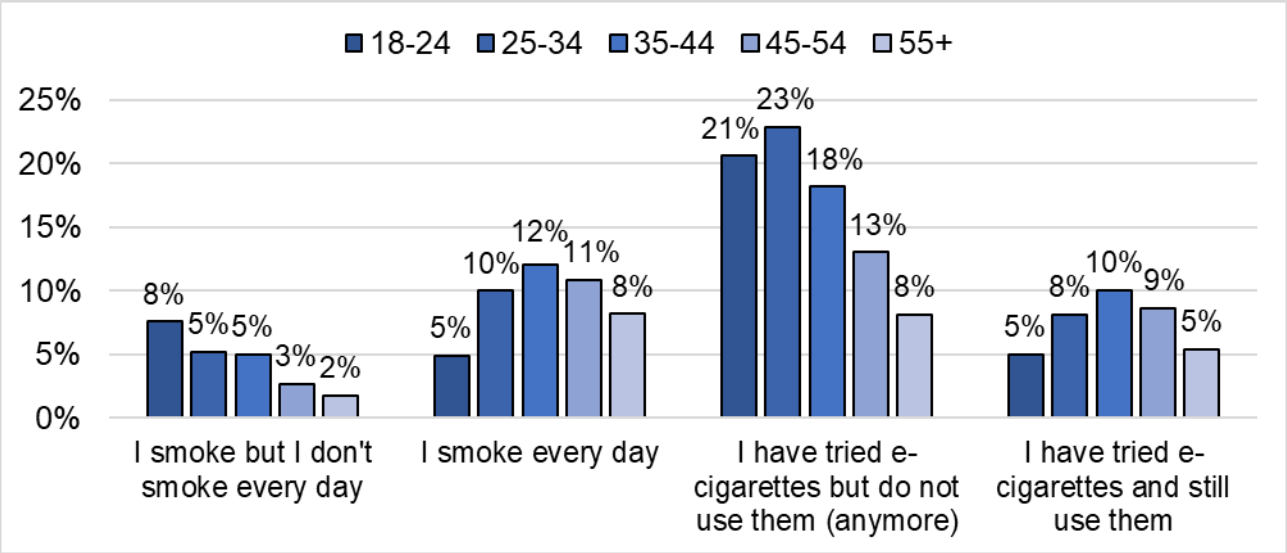

Figure 8 uses information from the annual survey, Smokefree GB, carried out for ASH by YouGov in 2021 (reference 78). It shows how behaviour and attitudes to e-cigarettes among adults aged 18 and over have changed over time.

The proportion of adults who said that they smoke but do not smoke every day ranged between 8% of people aged 18 to 24 and 2% of people aged 55 and over. People who said they smoke every day ranged between 5% of people aged 18 to 24, rising to 12% of people aged 35 to 44 and down to 8% of people aged 55 and over. People who said they have tried e-cigarettes but do not use them (anymore) ranged between 21% of people aged 18 to 24 and 23% aged 25 to 34. This was lower in the older age groups with 13% of people aged 45 to 54 and 8% aged 55 and over. The last group shows the proportion of people who said they had tried an e-cigarette and still used them. This ranged between 5% for people aged 18 to 24, up to 10% of people aged 35 to 44 and back down to 5% of people aged 55 and over.

Since cigarettes are such a harmful product, vaping can help someone stop smoking and dramatically decrease their risk of smoking related illnesses like cancer, heart disease, and stroke. A 4-country analysis (of the US, UK, Canada and Australia) indicated that the regulatory environment influenced the success of quitting using vapes, with more favourable policy frameworks being associated with greater quitting success (reference 79).

A 2022 report from Australia concluded that “use of e-cigarettes for a smoking cessation attempt appears to be associated with greater success among Australians who attempted to quit tobacco in 2019 compared with Australians attempting to quit without e-cigarettes [vapes], after adjusting for confounding effects (reference 80).”

Increasing the benefits of vaping for smokers attempting to quit will have numerous benefits. However, it is not the solution that on its own will get us to a smokefree society. It must be part of a comprehensive approach to tobacco control and be ‘risk-proportionate’.

The detail

I recommend that the government takes the following actions on vaping.

Provide accurate information to healthcare professionals about the benefits of vaping

The government must provide accurate and consistent information to healthcare professionals on vaping, to promote the benefits of switching to vaping and to dismantle longstanding myths. The government should launch a vaping facts website similar to New Zealand's Vaping Facts website, which has been incredibly useful at dispelling these myths.

The Cochrane Review on e-cigarettes for smoking cessation found that like for like, vapes are as effective for smoking cessation as licensed medicines, with no greater risk of adverse effects (reference 81). We need to take a scientific approach and stick to the evidence. Clinicians should follow NICE guidance on stopping smoking, which states that "healthcare professionals can recommend vaping devices, as a means to help patients stop smoking" (reference 82).

Offer all smokers vapes to help them quit smoking

Cigarettes contain 7,000 chemicals, mainly toxins. Using vaping as a quitting tool is about risk reduction. We must offer what’s better, rather than wait for what’s perfect.

Vaping products continue to be the most popular and effective aid used by people trying to quit smoking. In 2020, 27.2% of people used a vaping product in a quit attempt in the previous 12 months (reference 83).

To increase their availability as a quitting tool to current smokers, the government should do the following.

1. Provide free Swap to Stop starter packs for deprived communities and people in social housing. Those who struggle to quit need as many routes as possible, including the choice of a vape they choose and pay for themselves.

2. Accelerate the path to prescribed vapes through medicinal licencing. This would complement the Swap to Stop packs, and give hesitant professionals and the public more confidence in their safety and effectiveness. However, the high cost of producing a medicinally licensed product needs to be addressed, and I am calling for innovation and collaboration to achieve this. The government should invest in the science and technology to support the process, supporting small independent businesses, while excluding the tobacco industry.

3. Rebalance regulations on promotion. The government should modify advertising rules so vapes can be promoted as a less harmful product, particularly on the products themselves, and should allow vape shops to support campaigns like Stoptober. Smokers need to see more messages that switching to vapes is hugely beneficial to their health.

4. Reduce VAT on vaping devices in line with other nicotine products. Most people vape to quit smoking and to help them stay off tobacco. This will give people an added incentive to switch.

Prevent young people taking up vaping

Vapes should be a 'quit tool' and not become a 'cool tool'.

Young people and those who have never smoked should not vape. To ensure we are vigilant in our approach, the government should ensure the following:

1. Ban cartoon characters or images appealing to young people from vaping products. I see no justification for their use.

2. Review the way flavours are described – or even the flavours themselves – to ensure vapes do not appeal to young people.

3. Prohibit vaping companies from giving away vapes for free. This is a current loophole in our laws.

4. Make the use (or even the possession) of any age restricted products illegal on school and college premises. They do not belong in schools and colleges.

5. Update the school health education curriculum to talk about the risks of vaping and its age restrictions. This should include guidance on policies associated with cannabis vaping among young people. This can be added to the associated material that teachers use on the risks related to smoking and drinking.

Case study: Salford Swap to Stop vaping pilot

Salford City Council and its partners delivered a Swap to Stop e-cigarette (vaping) pilot to get people to stop smoking using vapes. Primarily aimed at social housing tenants, the pilot successfully engaged with over 1,000 smokers in Salford to obtain a vape as part of their stop smoking programme.

The support provided included advice and guidance on stopping smoking and how to use the vapes. An evaluation found that the cost per quit of using vapes is significantly lower than the standard stop smoking service offer, and number of quits increased by nearly three-fold. Offering and promoting free vapes significantly increased demand for stop smoking services, particularly in the most deprived quintiles.

A note on 'snus'

During this review, I carefully examined the case for permitting snus on the UK market. I have listened to a range of views from stakeholders. I was struck by how differently the evidence is understood and how polarised the discussion can become.

I understand that:

- snus is a tobacco product and its use carries risks, but is far less harmful than smoked tobacco
- smokers switching completely to snus can reduce their exposure to harmful chemicals (reference 84)
- snus can be effective for smoking cessation
- in some countries, such as Norway, snus use has all but replaced tobacco smoking among young adults (reference 85, 86)

However, in the US, for example, there is little evidence that smokers switch to smokeless tobacco (reference 87). Furthermore, research shows that snus use, although less harmful than smoking, is associated with increased all-cause deaths (reference 88).

While snus offers tobacco companies a useful alternative to cigarettes, it offers little that is new to smokers in the UK. Given the range of tobacco-free alternatives that we already have readily available in the UK, I have not been persuaded that snus adds additional value.

Introducing a new tobacco product, albeit a less harmful one, should not be a priority for the government’s legislative time. Instead, the government must facilitate access to the various already available safer alternative nicotine products such as nicotine pouches (a

tobacco-free equivalent of snus), maximising their value to help smokers to quit, without creating new risks to young people.

A note on heated tobacco products

Although all tobacco products can cause harm, it is important to recognise that smoked tobacco is by far the most harmful (reference 89). There are now newer tobacco products on the market that claim to reduce harm by modifying this process, such as heated tobacco products (HTP). These products heat tobacco through a device but do not ignite it. Like all tobacco products, HTPs are covered under UK tobacco regulations.

In practice, these products are quite diverse and there is differing evidence on the health harms related to them. Some evidence (reference 90) associates particular HTPs produced in the US with very high levels of carbon monoxide. Other evidence (reference 91) suggests considerable reductions in exposure to harmful chemicals for people who switch from cigarettes. A recent Cochrane Review (reference 92) found little evidence so far to conclude that they make a contribution to smoking cessation.

As with snus, I have come to the conclusion that with such an array of tobacco-free alternatives already available (vapes, patches and gum) the primary distinction in government policy-making and regulation should be between nicotine products that do or do not contain tobacco.

However, I do ask that the government supports further independent research into HTPs, and that manufacturers should be made to pay for independent toxicological testing of their products. The government should track the patterns of HTP use and population effects. Based on this research, the government should ensure the regulatory framework is appropriate for these products.

Recommendation 9. Local stop smoking services should be equipped to offer consistent support

The problem

Over the past 20 years, local stop smoking services (SSS) have delivered more than 5 million 4-week quits (reference 93). They are one of the most effective ways to help people to quit, and these services are particularly effective in the most disadvantaged parts of the country (reference 94).

An anonymous smoker, who attended one of the focus groups commissioned for the review (see Annex B for more information), said

> “It's gonna kill me one day. And I’ve got two young kids. I need to start. I need to try.”

However, as budgets have tightened, many local authorities have had to make challenging decisions on the use of the public heath grant, sometimes de-prioritising tobacco control and diverting funds to other issues. This has often diluted the availability and quality of stop smoking support. There is currently no ringfencing for spend on SSS, which has led to services becoming far less available and accessible. Some have combined diet, alcohol, and smoking teams into one, others have used funding to cover wider health related services, like leisure centres.

As a result, local SSS structures have changed significantly over the last decade, with fewer areas retaining a specialist service with dedicated staff. Some local authorities have responded innovatively to this challenge, but others have not. Some areas make titanic efforts, and some areas have no SSS.

The low levels of investment in local SSS has had a direct impact on the availability and quality of support offered. The top 20% of SSS in England last year (measured by number of successful quits per 100,000 smokers) spent an average of £23 per local smoker to achieve those quits. The remaining 80% of SSS spent £13 per smoker (reference 95). This difference in spend did not reflect local need, as local authorities with the highest smoking rates often spent less.

The number of smokers accessing SSSs has fallen by nearly 80% (reference 96). So, many smokers who try to act on advice from their GP to quit smoking cannot access services or find it too difficult or inconvenient.

Figure 9: number of people accessing stop smoking services who set a quit date and managed to quit successfully

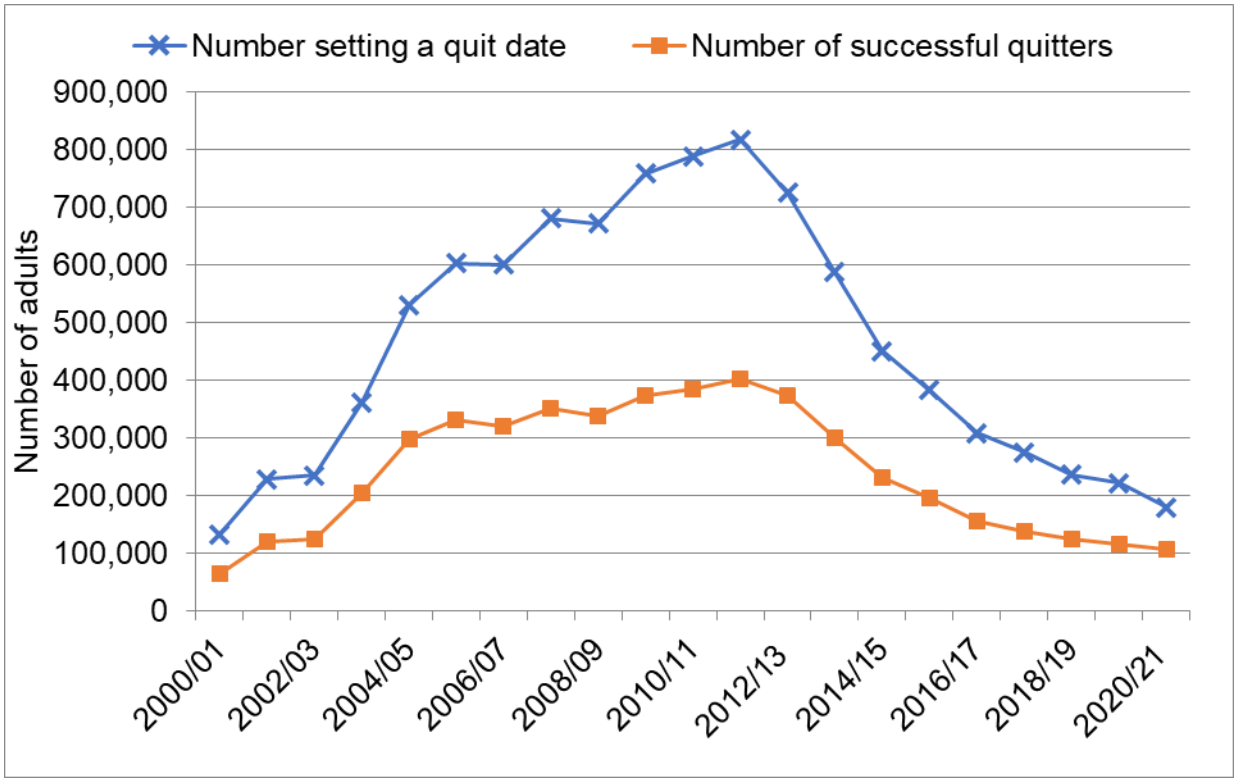

Figure 9 shows the number of people accessing stop smoking services between the years 2000 to 2001 and 2020 to 2021 who set a quite date and managed to quit smoking successfully. The numbers of people setting a quit date peaked at around 800,00 in 2012 to 2013. Similarly, the numbers of people successfully quitting peaked at around 400,000 in the same year. Numbers of both have been declining ever since.

Professor Jim McManus, President of the Association of Directors of Public Health said:

> "Smoking prevalence has been decreasing for decades as a result of consistent implementation of comprehensive tobacco control between partners at local, regional and national level. However, there is still much more to do. Multi agency partnerships are crucial to this. Tobacco control measures and helping smokers quit are both equally important. The job now for government is to get everyone into an effective partnership. Directors of public health are ready to work closely with government to develop a plan to make smoking obsolete and England smokefree by 2030."

The COVID-19 pandemic has also changed the way people interact with support services. More smokers want to access virtual support rather than visiting the service in person. The national smoking helpline currently directs smokers to their

local SSS, but for the most part, it is a helpline not a quit line. So, this helpline must be reviewed to ensure it is more than just a signposting service.

The benefits

Well-funded SSS are extremely cost-effective and form a key part of improving health outcomes and reducing the health inequalities gap (reference 97). They significantly improve people's chances of quitting smoking for good. This should be reflected in effective local commissioning, with updated guidance showing what the universal offer for every SSS should be, weighted to smoking rates in local areas to allow us to level up the communities which need it most.

An effective helpline is vital to provide a route into quitting: a central point of contact for the public and a central number for advertising campaigns.

For employers, supporting their staff to quit could have a significant impact on business productivity. It is estimated that smoking breaks and smoking-related sick days cost businesses in England around £6 billion a year (reference 98).

The detail

I recommend that the government takes the following actions.

Invest in local stop smoking services

The government must invest an additional £70 million a year as soon as possible, specifically ringfenced for SSS, to ensure they can offer vital quality support to smokers to quit. This will allow smokers to find services when they need them, and help healthcare professionals and mass media campaigns to confidently direct more smokers to SSS.

Don, ex-smoker and SSS user, said (quote provided by ASH)

> "Patches on their own didn't stop me smoking. It was the support I was given that made all the difference."

Services are most effective when configured according to local need. These new funds should be available to all areas, but the distribution should be weighted towards areas with the greatest smoking prevalence.

As smoking rates decline, levels of funding should be reviewed (in 2026, 2030 and 2035) to ensure that the funding allocated to SSS is targeted to the areas with the highest smoking rates. It will be important for the government to recognise that average funding per smoker is likely to increase the more entrenched a smoker is, and therefore the harder cessation support needs to work.

The Office for Health Improvement and Disparities (OHID) should refresh existing (but dated) guidance of quality standards from the National Centre for Smoking Cessation and Training (NCSCT) (reference 99). Commissioners of local stop smoking services should follow this guidance to ensure the most effective commissioning, delivery, and monitoring of SSS and to guarantee best use of public funds.

SSS should follow up after every quit attempt, and if the person has relapsed, re-enrol them, supporting smokers at every quit attempt. SSS should actively support smokers in the highest prevalence communities.

Additional funding to SSS should be used to bring all services in line with minimum quality standards that are set out by the updated NCSCT guidance. This should include creating capacity to engage with specific hard-to-engage smoking populations that typically do not access SSS without being targeted and directed to stop smoking support.

Local areas should have the final say in how the SSS funding is spent in their area. For example, hiring specialists who can train other providers in best practice, or engaging the hardest to reach smokers in their area. Additional funding should also be used to promote SSS locally, by raising awareness of the support available, and the variety of times and locations in which that support can be accessed.

Funding should also be used to ensure that every SSS has a fit for purpose data management system which will help to effectively manage a person's quit journey. This will help them keep smokers engaged and re-engaged if they relapse. The data management system should allow for referrals and data sharing between local organisations in the stop smoking support and treatment pathway.

Make effective and safe stop smoking medicines available to everybody

Effective and safe stop smoking medicines should be available on the market to everybody, to give smokers the choice about what works best for them.

Every smoker should be supported at each quit attempt to make an informed decision on the right method of quitting for them. The right combination of approaches can make people up to 6 times more likely to quit successfully (reference 100). So, the government must increase the availability, supply and access to drugs that have been proven to support quit attempts.

Ensure that a national helpline complements local support

The government needs to ensure that any national stop smoking helpline complements existing local (and national) offers of support.

As a result of the COVID-19 pandemic, there are many examples of how SSS are successfully using phone, video and other online support. In the context of this changing landscape, there is an opportunity to take stock and assess the potential for learning, identify service delivery improvements and economies of scale.

Encourage medium to large employers to help their employees quit smoking

The government should encourage all medium to large employers to follow the NICE guidance on stopping smoking to support their employees to quit smoking. Most employee assistance programmes could easily be adapted to include stop smoking support.

Case Study: Quit Right Tower Hamlets

Quit Right Tower Hamlets provide stop smoking services to all residents and people who work or study in Tower Hamlets.

They provide intensive behavioural and stop tobacco medication such as nicotine replacement therapy and Champix on prescription. They also have extensive experience with vaping, providing them as a stop smoking aid and can offer advice and guidance on using them.

They also provide culturally sensitive services for people from the Somali, South Asian and migrant communities who chew tobacco or use paan. Female advisors are available, and patients can be seen one-to-one or in a group setting.

A specialist service is available for pregnant women and those with high levels of addiction who may need extra behavioural support provided in groups or individually. People can self-refer or be referred through their GP practice.

Recommendation 10. Invest £15 million to create a successful mass media campaign to stop smoking

The problem

We face an enormous challenge. We need to create a climate that supports quitting.

There are deadly misconceptions held about smoking and vaping that stops smokers quitting.

For example, many people wrongly think smoking relieves their stress, but the science shows us that it is quitting that reduces anxiety and depression (reference 101).

And as each year goes by, more smokers are wrongly persuaded that vaping is as bad for them as smoking, but the science shows us that vaping is far less harmful (reference 102).

Industry-funded influencers make out that smokers are young, cool, affluent, and healthy. But the truth is that year by year England's smoking population gets older, sicker, and poorer.

As is the story across the stop smoking landscape, spending on stop smoking campaigns has gone down dramatically. Marketing budgets have dropped from £23 million to £2 million, over the past 10 years.

Yet, at the height of the COVID-19 pandemic, the government was reported to have spent upwards of £50 million on marketing the key messages, with great success. When there is a will to save lives, money can be found.

Figure 10: government spending on stop smoking campaigns

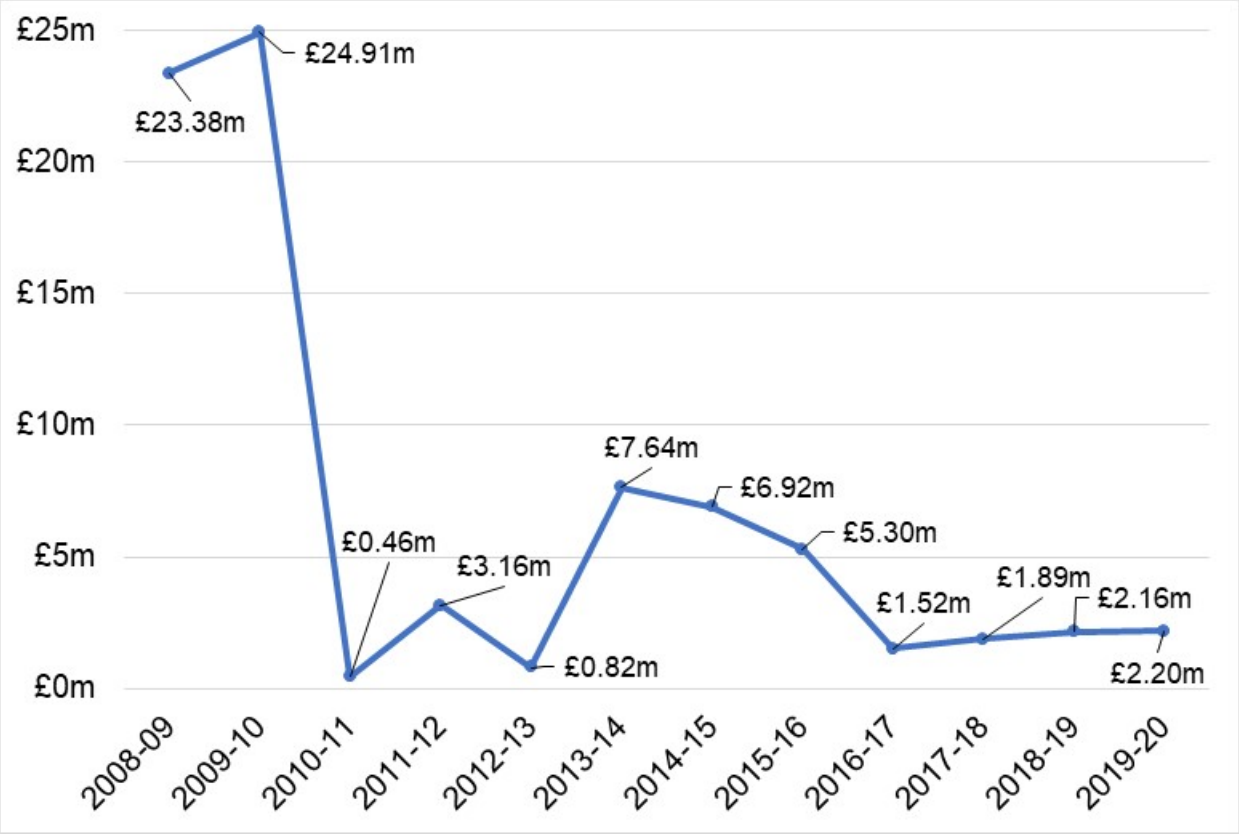

Figure 10 shows government spending on stop smoking marketing campaigns between the years 2008 to 2009 and 2019 to 2020. The greatest spend was £24.91 million in 2009 to 2010, which then dropped off sharply to £0.46 million in 2010 to 2011. The amount spent has fluctuated since then, with the greatest spend being £7.64 million in 2013 to 2014. The latest figure is £2.2 million.

There is no time to lose. With things as they are, even if we get to the smokefree 2030 ambition, smoking will have killed another half a million people alive in England today.

We can turn that around. The UK has a history or producing some of the most effective stop smoking campaigns in the world. They make a difference and are cost effective. They are backed by evidence and must be a core part of any serious national smokefree programme.

The benefits

There is good international evidence that exposure to media campaigns significantly reduces the number of people smoking, through encouraging people to make quit attempts. Plus, 70% of the public (18 years old and over) support increasing campaigns on tobacco (reference 103).

Mass media campaigns are cost-effective in terms of life years or quality-adjusted life-years gained (reference 104). Research in the US has found that marketing campaigns are directly associated with more quit line calls, more quitting and lower tobacco sales (reference 105). When you take your foot off the pedal everything grinds to a halt. When we froze government mass media expenditure in England in in 2010, hits to the national stop smoking website fell by a third, calls to the quit line fell by a two-thirds and requests for stop smoking information stopped almost completely – a drop of 98% (reference 106).

The US Center for Disease Control (CDC) Best Practices for Comprehensive Tobacco Control Programs recommend an investment in anti-smoking mass media campaigns of $0.65 to $1.95 per person per year at 2014 prices (reference 107). According to a study by University College London, £1 million of advertising buys us 2,500 permanent quitters (reference 108). Investing an additional £15 million would secure almost 40,000 extra quitters every year.

I am convinced we could spend that money at least as well in the UK as they do in the US. Our Stoptober campaign is effective and has been copied by many countries. We turned October from the gloomy post-holiday month when people were least likely to quit, to the month filled with pre-Christmas optimism when friends and family rally round and quit together. The independent academic reviews showed it worked. Or at least, they showed it worked when we were willing to fully invest in it (reference 109).

The detail

I recommend that the government takes the following actions.

Invest £15 million to fund a nationwide, all year stop smoking campaign

The method is clear. We need a new stop smoking campaign, which needs to have the following features:

1. Nationwide. Smoking remains a national problem and while prevalence may vary, smokers are distributed widely across the country. The North East has the highest prevalence, but in terms of volume there are still more smokers in London.

2. Always on, all year round. Ongoing social media and digital support can direct people to effective support where they live.

3. Focused on specific times. Stoptober, New Year, No Smoking Day. We know that putting in the extra effort raises awareness and motivates different quitters at different times. Hard hitting campaigns work for smokers who have attempted to quit before and know it is time to try again. 'Gain framed' upbeat campaigns can reach smokers who have been too uncertain to try on their own.

4. Focused on specific places. Of course, we need national campaigns but not all neighbourhoods need the same scale of support. Kingston upon Thames is not the same as Kingston upon Hull. And regional campaigns from Manchester to Macclesfield have shown us how to speak authentically in a voice that people recognise through the Never Quit Quitting campaign.

The media landscape has seen radical changes in recent years. A new campaign needs to use multiple channels in reaching smokers of all ages through streaming and social media, online gaming, TikTok and even more data-driven approaches in the use of broadcast media.

Have stop smoking campaigns back on TV

We also need to do what we know works. To get back on the national agenda, we need to see stop smoking campaigns back on daytime and primetime TV, alongside the latest and most impactful social media channels, with compelling spokespeople, including celebrities and media medics.

The key messages should be focused on the following actions.

1. Direct people to stop smoking support. We need to tell people it’s normal to quit, and that quality support is available.

2. Inform people about hope and harms. Campaigns should talk about the benefits of quitting as well as the risks of continuing to smoke, informed by evidence-based marketing research that shows what messages would cut through to current smokers.

3. Dismantle harmful myths about smoking and vaping. The public understanding of the relative harms of vaping has worsened over time and is less accurate today than it was in 2014 (reference 110). So, campaigns should focus on switching to vaping as a safer alternative. Campaigns also need to bust the myth that smoking relaxes you and reduces stress and anxiety. It should show how smokers can improve their mental wellbeing as well as their physical health by quitting.

Case study: the Fresh programme's marketing in the North East

Quit campaigns conveying the risks of smoking and benefits of quitting have been a cornerstone of the Fresh programme in the North East, which has seen the highest falls in adult smoking prevalence in England since 2005. Fresh has followed the international evidence that campaigns, especially broadcast TV, can trigger and sustain quit attempts and convey information about the biggest benefits to socially disadvantaged smokers.

Campaigns have included Every Breath, Don’t Be the 1, 16 Cancers and most recently the Don’t Wait campaign featuring an appeal from Dr Ruth Sharrock, ICS clinical lead on tobacco in TV adverts. These campaigns have been targeted towards the routine and manual worker population and in areas of highest deprivation. Independent evaluation found that 51% of smokers recalled the campaign, and around 1 in 6 (17%) North East smokers successfully cut down or quit because of seeing Don’t Wait (around 55,250 smokers).

Part 4. System change – the critical role of the NHS, the importance of collaborative working and improving data and evidence

Recommendation 11. The NHS needs to prioritise prevention, with further action to help people stop smoking, providing treatment for stop smoking across all its services, including primary care

Critical intervention: this is a ‘must do’ to successfully achieve smokefree 2030.

The problem

The NHS must invest to save. Invest time and resources into preventing smoking attributable diseases as well as treating them. The NHS must play a central role in identifying smokers and offering them advice, support and treatment.

Over the last decade, the NHS has spent billions on treating the effects of smoking. 4% of all hospital admissions are attributable to smoking, and 25% of hospital admissions for conditions that can be caused by smoking were attributable to smoking (reference 111).

Too often in our NHS, hard-working clinicians have assumed that somebody else would treat the cause as long as they treated the effects. But the NHS, along with local authorities, has responsibility for encouraging smokers to quit and improving the lives of their patients and local populations.

Amanda Pritchard, Chief Executive Officer of NHS England said:

> “Smoking remains one of the biggest causes of poor health, which is why in 2019 the NHS Long Term Plan made significant commitments to support our colleagues in local government to help people to quit."

Professor Sanjay Agrawal, Chair of the Royal College of Physicians Tobacco Advisory Group said:

> "All clinicians in every setting and speciality will see their patient’s medical problems improve by supporting them to quit smoking. Smoking cessation

> treatment should be prioritised in the allocation of health service resources to reflect the impact of quitting smoking on health."

The NHS Long Term Plan commitments to tackling smoking in secondary care mark a welcome step change, but the NHS must still do more to make smoking prevention part of its service offer to all patients and not limit it to people who have been admitted to hospital. By the time a person is admitted to hospital for an operation or an illness directly attributable to their smoking, many key opportunities to help them stop smoking have been missed.

At every contact with the healthcare system there is a brief ‘teachable moment’ when a 30 second conversation could help a smoker quit for good. But the opportunity is often lost, and in some places more often than others. Many healthcare professionals, such as GPs and hospital staff, are not confident or sufficiently aware of the impact that a brief intervention might have, or the value of referring their patients to stop smoking services. They may not even know what help is available.

The benefits

Helping the hundreds of thousands of smokers admitted to hospital can save lives within a few years and saves money within a few months. Smokers see their GP 35% more than non-smokers (reference 112).

Very brief advice (VBA) by healthcare professionals is a small change that can have a big effect. In 2020, Cancer Research UK published a report that modelled the potential for health improvement from VBA. It found that by 2039, there would be:

- over 430,000 fewer cases of smoking related disease
- economic savings of over £9.4 billion in costs to the UK health service
- over £15 billion in costs to wider society through morbidity and mortality
- personal savings to the average smoker of £2,000 per year (reference 113, 114)

Including smoking cessation in the core curriculum of training healthcare professionals will result in a future healthcare system populated by staff who are equipped to offer smokers the treatment needed to quit. This is particularly relevant for smokers from more deprived groups, who are even more likely to benefit from treatment.

The detail

I recommend that government, through the NHS, takes the following actions.

Meet all the existing commitments in the NHS Long Term Plan

The Long Term Plan sets out new commitments for action that the NHS will take to improve prevention. Helpfully, the plan also sets out specific action to cut smoking in pregnancy and for people with long term mental health problems.

It is vital that the NHS continues to invest in each of these commitments to prevent avoidable illness in patients and the spiralling strain on resources they have on the NHS. Emerging budget constraints must not derail or deprioritise this action.

Offer smokers treatment using the very brief advice (VBA) model

Advice on stopping smoking is more effective when it comes from a healthcare professional. The VBA model offers a simple way to do this that is evidence based and cost effective (reference 114). This 30 second conversation, ideally face to face, can have a significant impact on patients' health.

Figure 11: very brief advice on smoking

Figure 11 shows a leaflet for healthcare staff about very brief advice. It's split into 3 areas: ask, advice and act, and has advice for staff on what they can ask patients at each stage. While GPs have a key role to play, it’s not up to GPs alone. Dentists, pharmacists, psychologists, psychiatrists, social workers, nurses, midwives, optometrists; therapeutic support staff and mental health workers should all direct smokers to stop smoking support and treatment.

The NHS must ensure that all smokers in primary or secondary care, whether inpatient or outpatient, are given advice to quit directly by their clinician or health professional. Just as staff who might be involved in resuscitating patients are trained in the Airway, Breathing, Circulation, Disability, Exposure (ABCDE) approach, any healthcare professional who is likely to encounter smokers should be trained in VBA. Additionally, all inpatients who smoke should be seen by a smoking cessation practitioner during their stay.

All key training bodies should incorporate stop smoking and VBA training into their mandatory curricula for doctors, dentists, pharmacists, psychologists, psychiatrists, social workers, nurses, midwives, optometrists, therapeutic support staff and mental health workers. NCSCT should provide the training modules.

The Quality and Outcomes Framework (QOF) system should be changed to ask GPs to offer treatment rather than an ‘offer of support'. This would incentivise GPs to offer evidence-based treatment routinely and proactively, for example, through behavioural support, pharmacotherapy or vapes.

Ideally, the government should ask all ‘point of contact’ settings to provide referrals to stop smoking support, for example job centres, libraries and leisure centres.

Ensure that all hospitals integrate ‘opt-out’ support and treatment for all smokers into routine care

While hundreds of thousands of smokers are admitted to hospital each year, millions are seen in hospital outpatient clinics, pre-operative screening services and in A&E departments.

'Opt-out' support means that people will be referred to stop smoking support by default, rather than asking if they would like to be referred into an SSS.

As committed in the NHS Long Term Plan, stop smoking treatment should be provided at the bedside as a matter of routine for all smokers who have a hospital stay. And patient record systems need to be aligned, to enable rapid referrals into local SSS. The NHS should fund and incentivise the implementation of the 2021 NICE guidance on treating smoking in secondary care.

Ensure that hospital trusts report on progress in their annual reports

NHS trusts should be publicly accountable for delivering opt-out interventions and VBA, and their impact on the healthcare outcomes of patients who smoke. Trusts should publish annual, audited data for stated outcomes and each trust should have a named lead for smoking cessation commitments and smokefree premises.

Furthermore, an indicator in the NHS oversight framework should require ICSs to report on how many trust sites are offering cessation services, broken down by acute, maternity and mental health services.

Broader NHS messaging should also be targeted on encouraging people to stop smoking

People listen to their healthcare professionals individually, but they also listen to the NHS collectively. So, it's important that the NHS is providing messages to patients through VBA and the Better Health campaign, but also providing wider stop smoking messaging as an organisation.

The NHS communications campaigns and communications channels are a key opportunity to direct smokers to treatment and remind them of the risks. Senior leaders in the NHS need to champion prevention and stop-smoking treatment as an organisational priority.

Recommendation 12. Invest £15 million to support pregnant women to quit smoking, offering financial incentives, in all parts of the country

The problem

Smoking in pregnancy is a leading cause of health inequality for mothers and babies. It increases the risk of stillbirth, miscarriage, and sudden infant death syndrome, and babies born to mothers who smoke are more likely to be born underdeveloped and in poor health.

An anonymous smoker, mum of 2, who attended one of the focus groups commissioned for the review (see Annex B for more information), said:

> "I don't really know the impact of it. The only obvious one that I was told was the impact could be is that the baby could be small. If I had known more things about it, I think I would have stopped."

The government's target for smoking in pregnancy is 6% by 2022 (reference 115). In 2020 to 2021, 10% of mothers were smokers at the time of delivery. Rates vary dramatically across the country. Smoking rates are generally much higher in younger women from

poorer areas. They are as high as 1 in 4 in the most deprived areas, and almost 1 in 3 among teenage mothers (reference 116).

Carbon monoxide monitoring is an important tool to help midwives have brief meaningful conversations about smoking with pregnant women, particularly where a woman may find it hard to admit that they smoke. In its guidance 'Smoking: stopping in pregnancy and after childbirth', NICE recommends that all women should be carbon monoxide tested at all antenatal appointments. In many areas this does not happen, meaning women who smoke, or who have relapsed, are not identified and do not receive the support they need to be smokefree.

Figure 12: age distribution of women smoking in early pregnancy

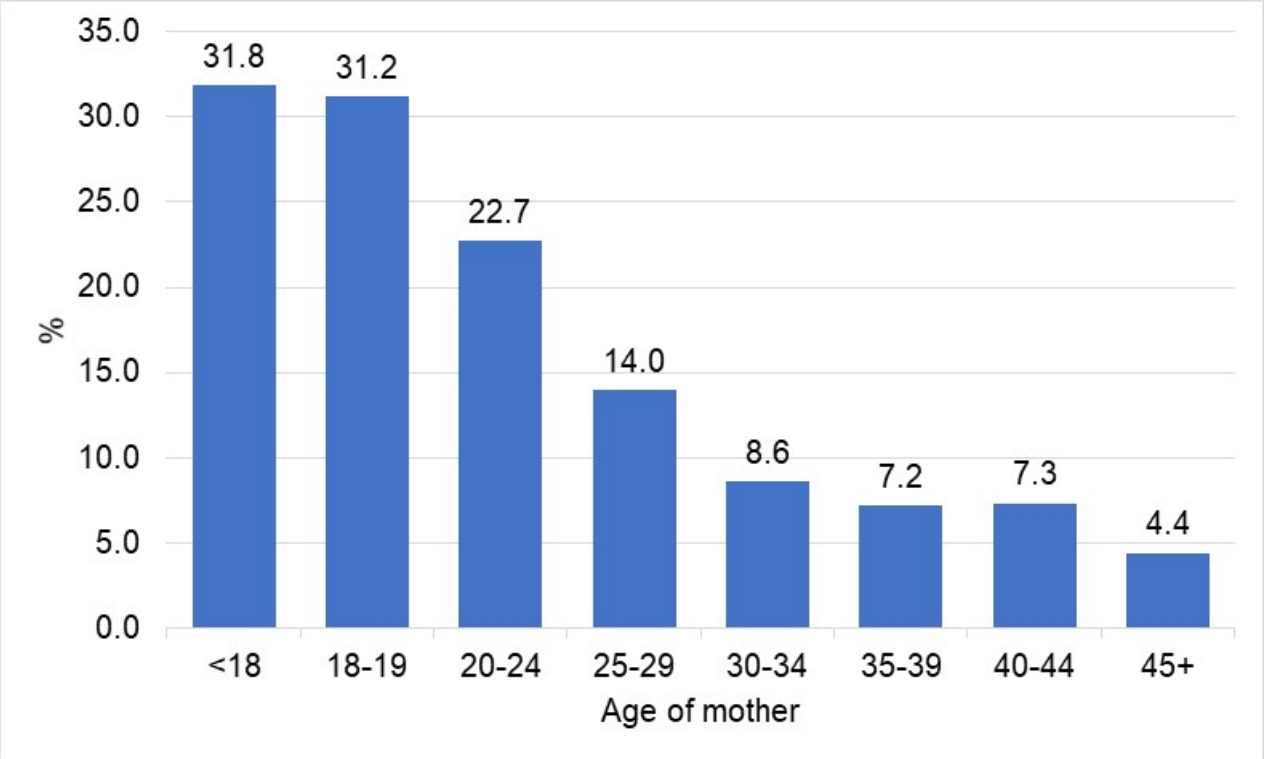

Figure 12 shows the proportion of women who smoke in early pregnancy, across a range of ages from under 18 to 45 years and over. The highest prevalence of smoking is in the youngest (under 18) age range, at 31.8%. The 18 to 19 age range also has a high prevalence, at 31.2%. After that, the proportion of women smoking declines with age, with pregnant women 45 and over only having a 4.4% smoking rate.

The NHS Long Term Plan has committed to implement “a new smoke-free pregnancy pathway for expectant mothers and their partners” by 2023 to 2024. This must be achieved, and there is more that can be done, now.

Many evidence-based interventions are not implemented. For example, financial incentive schemes are an efficient and cost-effective way (with an estimated return on investment of £4 for every £1 invested) to increase the rates of quitting among pregnancy women (reference 117). Yet they are not widely used across maternity services.

The benefits

Stopping smoking is one of the most beneficial things a pregnant woman can do for her own health, and to improve the health and development of her baby.

The health benefits of quitting smoking before pregnancy or in early pregnancy are significant and rapid. Babies born to non-smokers are, on average, 250 grams heavier than those born to smokers, and those who quit in early pregnancy achieve similar baby birthweights to never smokers (reference 119).

Tackling smoking in pregnancy would save the NHS up to £87 million a year, just in terms of the costs of treating complications during pregnancy (reference 120). This does not take into account the cost of treating infant diseases as a result of maternal smoking.

Carbon monoxide monitoring is an important tool to help midwives have brief meaningful conversations about smoking with pregnant women, particularly where a woman may find it hard to admit that they smoke.

The detail

I recommend that the government, through the NHS, takes the following actions.

Pre-pregnancy: help more women to start pregnancy smokefree

Rates of smoking in the population are highest among people in their twenties, so producing a shift in social norms will make it easier for young mums to quit and stay smokefree. Quitting during pregnancy is harder because the body metabolises nicotine faster, meaning that there is a drive to smoke more rather than less. We need to reduce smoking among young women in general. This not only means fewer women will be smokers when they become pregnant, but it will make quitting easier, as there will be less peer pressure to relapse.

Investing in stop smoking marketing campaigns (recommendation 10) will also have the benefit of reaching this audience, particularly young women and their partners.

During pregnancy: help pregnant smokers to quit

It is vital to identify women who are still smoking as early as possible in pregnancy and refer them for support and treatment to stop. This must also include partners, who are often key to help women quit.

There are a number of important actions that the NHS can take to help women quit smoking during pregnancy, in particular:

Offer financial incentives

The government should create a national funding pot of £15 million to support all pregnant women to quit. There is strong evidence that women who receive incentives (in the form of shopping vouchers on condition of carbon monoxide verified abstinence) are 2.5 times more likely to quit (reference 122).

Enhance clinical support to help pregnant women stop smoking

This support should include the following:

1. Every NHS trust needs a senior designated 'smoking in pregnancy champion' driving change at the highest level.

2. Every maternity department needs a ‘stop smoking midwife’, providing expert support, advice and treatment at the front line. A Royal College of Midwives survey found almost 70% of heads of midwifery did not have a stop smoking specialist midwife in their maternity team (reference 121). In areas with high smoking rates, there should also be a sufficient number of trained advisors to support. These roles should be funded by the NHS.

3. Every clinician needs the skills and confidence to lead the conversation with smokers, giving effective but brief VBA advice on quitting.

The NHS should offer safer alternatives to smoking. The Royal College of Midwives says “E-cigarettes [vapes] contain some toxins, but at far lower levels than found in tobacco smoke. If a pregnant woman who has been smoking chooses to use an e-cigarette (vaping) and it helps her to quit smoking and stay smokefree, she should be supported to do so” (reference 122).

For smokers who have recently quit before their pregnancy, midwives and health visitors should regularly check in with them during their pregnancy. This will ensure they are offered support and treatment if they have started smoking again or feel at risk of relapse.

Post-pregnancy: enable community action and address inequalities

Women smoke in communities where people smoke, reinforcing the extreme geographic variability in smoking in pregnancy. Relapse rates after babies have been born in these areas are also extremely high. Targeting smoking rates in priority areas will dramatically level up the chances of disadvantaged children.

There should be specific outreach to pregnant woman and their partners. Relapse prevention support post-pregnancy by midwives and health visitors is key to ensure the continued benefits of quitting for parents and their children's lives. Health visitors and community stop smoking services have an active role to play in following up and ensuring there is follow up support post-pregnancy.

Case study: Greater Manchester Smokefree Pregnancy Programme

The Greater Manchester Smokefree Pregnancy Programme aims to reduce the number of women smoking during pregnancy and has been supporting pregnant smokers and their partners to quit since early 2018. This involves working collaboratively with foundation trusts, clinical commissioning groups and maternity services across their 10 local authorities.

Women who smoke are identified as early as possible in pregnancy and receive rapid referral to specialist maternity-led stop smoking services. They also run a financial incentives scheme, which gives women access to shopping vouchers at certain time points during pregnancy and beyond, conditional on them remaining smokefree.

Outcomes from this integrated approach include an increase in the number of women successfully stopping smoking, higher average birth weight of babies and reductions in the number of babies requiring neonatal care. As of January 2022, the maternity stop smoking services across Greater Manchester are seeing a 75% 4-week quit rate, with over 90% of those remaining quit until birth. There has also been more engagement from partners and an increase in smokefree homes.

Greater Manchester's success in supporting pregnant women and their partners to quit since they started running their programme shows the substantial benefits of a system-wide approach that reaches women as early as possible.

Recommendation 13. Tackle the prevalence of smoking among people with poor mental health

The problem

People with poor mental health are more likely to smoke, and people who smoke are more likely to have poor mental health. The more severe the mental health condition, the higher the rates of smoking, smoking dependence, and the chance of relapse. And on average, people with a pre-existing mental health condition were twice as likely to increase their smoking during the COVID-19 pandemic, compared to those not reporting one (reference 123).

And this is not just a problem for a small number of people with severe mental health conditions. One in 6 people report experiencing a common mental health problem (like anxiety and depression) in any given week in England (reference 124). This is not a problem that will be solved by waiting until people are in an acute crisis before we offer them help.

It is not that smokers with poor mental health do not want to quit. The reverse is true: 1 in 4 of people who seek medicine to help them quit smoking are currently taking antidepressants (reference 125) and half have a history of antidepressant prescription use (reference 126). We need to value mental health equally to physical health (the parity of esteem), and so must make take additional action to support people with poor mental health.

Many people wrongly believe that smoking actually improves their mental wellbeing, helps them to relax, or to deal with stress and anxiety. This is a stubborn myth, that many frontline mental health support workers seem to also believe, when the reverse is true.

Smoking does not relieve stress. It only relieves the symptoms of nicotine withdrawal.

Dr Adrian James, President, Royal College of Psychiatrists said:

> “It’s a myth that smoking is beneficial to mental health. This misconception undermines progress towards improving the health of our nation, both physically and mentally, and allows a vast number of people to justify a habit that is killing them.”

People with mental health conditions die 10 to 20 years earlier, and the biggest preventable factor in this is smoking.

The benefits

The single most important thing you can do to improve someone's physical health, mental health and to get them to live a longer life is to help them to give up smoking. Once people have got past the short-term withdrawal stage of quitting, they have reduced anxiety, depression and stress and increased positive mood compared with people who continue to smoke (reference 127).

Stopping smoking boosts mental health and wellbeing. For symptoms of anxiety and depression, stopping smoking is as effective as taking antidepressants. Just 6 weeks after quitting, people start feeling happier as well as healthier (reference 128).

Joanne, an ex-smoker, said (quote provided by ASH):

> "I have a history of depression and knew if I quit smoking it would help – it has. The benefits have rippled across my life – more self-esteem, job satisfaction, losing weight and losing my tobacco cravings!"

The detail

I recommend that the NHS takes the following actions.

Reach the communities where smoking is most prevalent

The NHS should correct misperceptions about smoking and mental health and motivate smokers with poor mental health to quit through:

- public-facing campaigns that correct the myths and stress how smokers can improve their mental wellbeing as well as their physical health
- staff training for all mental health care professionals to equip them with the capability, opportunity and motivation to provide very brief advice to all their patients who smoke

Make stop smoking a key part of mental health treatment

Quitting smoking improves long term anxiety and depression indicators. And it has been shown to improve mental and physical health substantially (reference 129). Addressing smoking should be standard care in mental health services.

We must offer effective smoking cessation treatment within acute and community mental health services and in primary care.

Recommendation 14. Invest £8 million to ensure regional prioritisation of stop smoking interventions though integrated care systems (ICS) leadership

The problem

The current approach to stop smoking interventions is often fragmented. Local systems need to come together to coordinate systematic and equitable support. Despite good intentions, a historical barrier exists between the prevention and the treatment of smoking-related illnesses, with local authorities often on one side and the NHS on the other.

The arrival of ICSs presents an opportunity that must be seized. ICSs bring together the NHS, local authorities, primary care and the voluntary sector, working interdependently to improve population health. As local system leaders are responsible for improving population health, they should be held to account for achieving smokefree 2030 targets. They should be transparent about progress.

Directors of public health have provided vital local leadership, promoting and driving action in their areas. They need to focus their energies not only at their immediate borough level but also beyond, whether that is at city region, combined authority or sub regional level.

There is a good evidence base for the effectiveness of regional collaboration to help meet smokefree targets. Successful models, such as the work of Fresh in the North East and good practice in Yorkshire and Humber, have shown how an intense joined-up focus on addressing regional smoking rates and inequalities can yield results. Oxfordshire County Council has set its own smokefree target, Smoke free Oxfordshire by 2025, which is 5 years more ambitious than the national target.

Yet most areas, due to funding cuts and re-prioritisation, have not built up collaboration models that work for them.

The benefits

We have seen the impact of regional smoking cessation programmes, where the evidence shows that these programmes reduce prevalence faster and further. Collaboration is critical.

The ICSs' aim to better join up health and care services, improve population health and reduce health inequalities, in all of which smokefree policies are a key element.

Amanda Pritchard, Chief Executive Officer of NHS England said:

> "The legal creation of integrated care systems now offers an exciting opportunity for local council and NHS leaders to work together, and with communities, to maximise the impact their collective resources can make in reducing smoking rates, and tackling the health inequalities highlighted so starkly by COVID-19."

There is an opportunity here for ICSs to organise the efforts of the local system and ensure smokefree 2030 is prioritised at all levels, with partners working interdependently to achieve the smokefree goal. ICSs have the potential to combine the best evidence with effective planning, local assets and local insights into the lives people actually lead.

The detail

I recommend that government, through the NHS and ICSs, take the following actions.

Make planning across the ICS more integrated

Integrated planning, led by ICSs, is essential to deliver an effective response to smoking. Recognising the intended independence of ICS leadership, I would strongly encourage every ICS to adopt an approach that includes:

- a mandatory stop smoking impact objective for each ICS chief executive
- prioritising smoking cessation and pooling funds accordingly
- prioritising the commitments set out in the NHS Long Term Plan and ensure that there is ongoing smoking cessation treatment and support
- prioritising targeted interventions for specific target groups with high smoking prevalence rates (for example, people with mental health conditions; people living in social housing), setting clear targets for reduction from the best available baseline data
- demonstrating local system leadership, accountability, and performance through an annual report to show progress towards making smoking obsolete

Invest £8 million for a new fund to support regional partnership working

Create a new £8 million fund which ICSs can bid into, managed by OHID. The funding would support regional collaboration and partnership, for example through the recruitment of dedicated tobacco control staff, through local campaigns and targeted activity to tackle illicit tobacco.

This funding pot should be available each year until 2026, and then reviewed in line with other funding proposals in this report.

Enhance working in 'place based partnerships' (PBP)

Every PBP should provide evidence-based tobacco control interventions and stop smoking support conforming to a renewed NCSCT standard (see recommendation 9).

Every PBP should prioritise a range of interventions, working to ensure that the ICS activity reflects local needs, working across the range of local delivery partners ensuring coherence and impact. They should include local stop smoking services and trading standards (through local authorities), to tackle the illicit tobacco market and underage sales. They should also maximise the opportunities of the voluntary sector to deliver local stop smoking reduction services and interventions.

PBPs should ensure that in every neighbourhood there is at least one high street pharmacy offering pharmacotherapy and skilled behavioural support, not just to people referred from hospitals. Maximising the role that pharmacists and pharmacies can play is important in helping smokers to quit. The new pharmacy contract is encouraging but does not go far enough.

Where pharmacies sell vapes, they should do so alongside an offer of behavioural support for smoking cessation.

Case study: integrated care in Yorkshire and Humber

Yorkshire and Humber is a diverse region. There are areas of relative affluence, with a greater number of areas of relative poverty and economic depression. This is reflected in an overall rate of smoking that is much higher than the national average. Reducing smoking prevalence requires coordination and a combined effort.

The Yorkshire and Humber region has 3 ICSs, each with their own identity and each with a clear mandate to tackle tobacco and smoking. The 3 ICSs have pooled funds to support the Breathe 2025 collaboration. This acts as a coordinating hub to bring the whole programme of smokefree interventions together as one.

Breathe 2025 is a programme initiated and led by the directors of public health, with expertise and leadership from OHID. This collaboration enables ICSs, NHS providers, local authorities, regulatory services and the voluntary sector to act in a coordinated way, beyond their individual means or boundaries.

The Breathe 2025 collaboration adds value by doing things centrally, for example by:

- coordinating national and local campaigns across media
- providing training

- providing forums for shared learning
- disseminating information

The programme also provides a central resource to share knowledge and skills and provides easy access to academics, national leads, subject experts, and policy makers.

Case study: Smoke free Oxfordshire by 2025

Oxfordshire County Council has set its own smokefree target, 'Smoke free Oxfordshire by 2025', which is 5 years more ambitious than the national target.

While the overall smoking levels in Oxfordshire are below the national average (10.1% in 2018), they are on what they call the final push. There are also still inequalities among people who smoke in Oxfordshire, with increased rates in people in routine and manual occupations and those with long term mental health conditions.

There is a strong focus on a 'place-based approach' bringing together the council, regulatory enforcement, local stop smoking services, and the local NHS together to achieve the joint target. The Oxfordshire Tobacco Control Alliance is a partnership of local organisations who are working together to end the use of tobacco in Oxfordshire. The alliance was formed in 2018, and it reports to the Oxfordshire Health Improvement Board, which acts as a driver for political and financial support for effective tobacco control in the county.

Recommendation 15. Improved and accessible data, insight, and research on tobacco use, smoking and the impact of cessation interventions

The problem

In making smoking obsolete, we are leading the way. There is nobody who has gone before us to provide a road map. No one to say, “this route is fastest” or “that one more treacherous”. As COVID-19 has reminded us, the most fundamental tool of public health is data. It directs our efforts to where they are most needed and sharpens them so that they are most effective.

This review has shown that the current breadth of research and available data on the use of tobacco products does not fully reflect our needs. For example, we need to better understand the behaviours of, and impacts on, people who smoke shisha, the various forms of chewed tobacco, as well as the prevalence of vaping among school age children and any associated long-term health risks. The government needs to commit to

addressing these gaps in our knowledge so that future policy and interventions can be better informed.

The recommendations in this review call for evidence-based interventions, but also approaches that have never been done before. Without bold thinking, we will not get to smokefree 2030, let alone make smoking obsolete. New approaches will need close monitoring and evaluation to make sure we see the expected benefits and value for money. For example, the impact of raising the age of sale by one year, every year.

The benefits

Good quality data, monitoring and evaluation are essential to achieving positive outcomes for individual smokers and value for money for taxpayers. We need to implement what works, achieve economies of scale and to share learning between local places.

Ann McNeill, Professor of Tobacco Addiction, National Addiction Centre, King's College London Institute of Psychiatry and Deputy Director of the UK Centre for Tobacco Control Studies said:

> “I am especially pleased with Dr Khan’s emphasis on the need for policy to be underpinned by evidence and the need to continue to build evidence in uncertainty. As the UK continues to provide world leading policy on vaping and smoking, so too must we continue to provide world leading research.”

We need to invest resource to analyse the data and address research gaps. Often individual pilots are successfully run, in silo, with no mechanism (or funding) to support their further rollout, even if they are proven effective.

Good monitoring and evaluation will be needed over the next 8 years as we approach the smokefree 2030 ambition, and beyond to make smoking obsolete.

The detail

I recommend that government take the following actions to improve data and research on tobacco use and quitting smoking.

Invest £2 million per year in an innovation fund for new research

The government should invest in a collaboration that integrates existing diverse data with a new £2 million innovation fund to support the commissioning of new research, data and monitoring of impact in meeting smoking cessation targets at national, regional, and local levels.

Commission further research on health disparities

Within this innovation fund, the government must commission further research on health disparities, particularly ethnic disparities, where we do not know enough about the different impact of smoking on those communities.

This should include commissioning research on the effects of shisha and chewed tobacco (for example, paan), especially for people from ethnic minority backgrounds. It is already well known that shisha, paan and khat are linked to increased risk of cavities and oral cancer.

The government should also invest in closely monitoring the prevalence of vaping among school children and any associated long-term health risks.

Conclusion

Smoking kills and ruins lives. But it doesn’t have to be like that.

By commissioning this review, the government sent out a powerful message that the status quo is not acceptable. I have taken on that challenge and responded with recommendations that are as comprehensive as they are bold. Anything less would have been an abdication of my duty. We now need to make it as hard as possible to smoke, and as easy as possible to quit, leading to a smokefree generation.

The effects of policy changes linger for decades and have already shown how successful smoking cessation policies can be. We just need to look back to the initial reaction to the 2007 smoking ban in all English pubs and clubs. While there was much opposition at the time, we would never go back now. It has changed social norms. We now need to go further.

While we have had great success in reducing smoking rates, the rate of decline has now become a small trickle, year on year. If we do nothing different, smoking will cause over half a million more deaths by 2030. Alongside the emotional impact, this will also cost society many billions of pounds along the way.

The benefits of making smoking obsolete are a multitude- whether in population health, social or economic benefits. Recognising that the poorest, the least educated and least skilled, the underemployed suffer the most from smoking and its effects, the government’s levelling up ambitions can’t be fully delivered without tackling smoking.

The government now has the opportunity to make our country a place where cigarettes disappear from our shops. To make this a country where the tobacco industry won't want to trade. To invest now to save lives, helping people to live longer with more fulfilling lives with higher standards, particularly for the disadvantaged communities who need it most. To help smokers quit, improving the chance of our children having smoke-free childhoods and improved life chances. To get more adults and children out of poverty. To deliver large productivity gains in the workforce. And to help our cherished NHS free up beds and resource and help tackle waiting lists.

In this report I have set out 4 critical interventions, without which smokefree 2030 will not be met:

1. The case for investment now: provide a minimum additional investment of £125 million per year to fund comprehensive smokefree interventions.

2. Increase the age of sale for all tobacco products from 18, by one year, every year, so we achieve a smokefree generation in this country.

3. Embrace the promotion of vaping as the most effective tool to help smokers quit.

4. Prevention must become part of the NHS's DNA.

These interventions are critical as they will lead to exponential gains in reducing health disparities. The supporting recommendations I have set out, present a holistic response to the challenge we face. Taken together, and if implemented in full, I believe these actions will get the government to its 2030 target and then lead to a smokefree generation. But to get there, there can be no short cuts, no quick fixes, no excuses.

So, I urge the government to seize this moment and commit to making smoking obsolete.

Dr Javed Khan OBE

Annex A: contributors to evidence gathering

I could not have completed this work without support from a superb team of civil servants. My sincere thanks go to director Rosanna O'Connor and her excellent team at OHID for supporting the review.

With their support to organise meetings, I heard a wide range of evidence from stakeholders and experts from the UK and across the world. I am very grateful to all those who contributed, and their names are listed here:

Expert advisor

Professor John Britton, emeritus professor of epidemiology at the University of Nottingham and a former consultant in respiratory medicine at Nottingham City Hospital. He chaired the Royal College of Physicians tobacco advisory group from 1996 to 2018 and was director of the UK Centre for Tobacco and Alcohol Studies from 2008 to 2020.

Roundtables

Between February and April 2022, a series of online roundtable discussions were held. I met groups of experts from across the smokefree landscape to inform and guide the review.

1. All-Party Parliamentary Group on Smoking and Health

Bob Blackman MP

Alex Cunningham MP

Lord Finlay

Lord Rennard

Mary Foy MP

Lord Young

2. All-Party Parliamentary Group on Vaping

Mark Pawsey MP

Mary Glindon MP

Adam Afriyie MP

David Jones MP

Andrew Lewer MP

Mark Jenkinson MP

3. Civil society

Deborah Arnott, CEO, Action on Smoking and Health (ASH)

Jyotsna Vohra, Director of Policy, Royal Society of Public Health

Alizee Froguel, Policy Manager, Cancer Research UK

Jon Foster, Policy Officer, Asthma + Lung UK

4. Academia (research focus)

Ann McNeill, Professor of Addictions, Kings College London

Kamran Siddiqi, Professor of Public Health, University of York

Deborah Robson, Senior Lecturer in Tobacco Harm Reduction, Kings College London

Paul Aveyard, Professor of Primary Care, University of Oxford

Jamie Brown, Professor of Behavioural Science, University College London

Tessa Langley, Associate Professor, University of Nottingham

5. Academia (clinical focus)

Dr Melody Redman, Deputy Chair, British Medical Association Board of Science

Dr Andy McEwen, Chief Executive, National Centre for Smoking Cessation and Training

Professor Sanjay Agrawal, Consultant in Respiratory and Intensive Care Medicine, University Hospitals of Leicester NHS Trust (UHL) and National Clinical Advisor on Tobacco Dependency for NHS England and Chair of the Royal College of Physicians

6. Devolved administrations

Officials from Wales, Northern Ireland, and Scotland

7. Regional directors of public health

Kevin Fenton, Regional Director of Public Health (London), OHID

Peter Kelly, Regional Director of Public Health (North East), OHID

Andrew Furber, Regional Director of Public Health (North West), OHID

8. Mental health

Andy Bell, Deputy Chief Executive, Centre for Mental Health

Gemma Taylor, Assistant Professor in Clinical Psychology, University of Bath

Adrian James, President, Royal College of Psychiatrists

Joanne Hart, Improving Access to Psychological Therapies therapist, NHS

Regional visits

In February and March 2022, regional visits were held. These visits were used to inform our regional case studies:

1. Representatives from Yorkshire and Humber region (virtual visit)

Corinne Harvey, Deputy Director, Health, Wellbeing and Workforce Development Yorkshire and the Humber, OHID

Greg Fell, Vice President, Association of Directors of Public Health and Director of Public Health, Sheffield City Council

Peter Roderick, Consultant in Public Health, City of York Council and Vale of York Clinical Commissioning Group

Stephen Eames CBE, CEO, Humber Coast and Vale Health and Care Partnership

Dave Jones, Tobacco Control Lead Yorkshire and the Humber, OHID

Joanne Nykol, Tobacco Control Programme Manager, Yorkshire and the Humber, OHID

Azariah Jenny, Health Improvement Practitioner Advanced, Kirklees Council

Garreth Robinson, Senior Public Health Officer, Barnsley Metropolitan Borough Council

Heather Thomson, Head of Public Health for Health Improvement, Leeds City Council

Sarah Hepworth, Health Improvement Principal and Lead for Tobacco Control Strategy and Commissioning, Sheffield City Council

Amanda Longdon, Manager Yorkshire Smokefree, Barnsley

Sonia Brown, Manager Yorkshire Smokefree, Wakefield

David Clutterbrook, Senior Trading Standards Officer, Sheffield Council

Peter Roderick FFPH, Consultant in Public Health, City of York Council

Leah Holtam, Head of Cancer Insight, Yorkshire Cancer Research

Amy Deptford, Policy Officer, Yorkshire Cancer Research

2. Representatives from Medway Stop Smoking Service (in person visit)

James Williams, Director of Public Health, Medway Council

Julia Thomas, Senior Public Health Manager, Medway Council

Georgina Crossman, Programme Manager, CVD Prevention, Medway Council

Jemima Ward, Health Improvement Project Manager, Medway Council

Kate Bell, Senior Public Health Manager, Medway Council

Scott Elliott, Public Health Principle and Head of Health and Wellbeing, Medway Council

Ian Gilmore, Head of Trading Standards, Medway

Dr Nandita Divekar, Anaesthetic Consultant, Medway NHS Foundation Trust

Direct meetings

The majority of meetings were held online. Some were one-to-one, and others were group meetings. This included:

- NHS and third sector organisations
- professional bodies
- academics who specialised in tobacco control policy
- international representatives working on tobacco control policy
- representatives from government departments

The meetings involved the following people and groups.

Government counterparts

UK devolved administrations

Officials from Wales, Northern Ireland, and Scotland

Canadian tobacco control officials

Sonia Johnson, Director General, Tobacco Control Directorate (TCD)

Director, Tobacco Products Regulatory Office, TCD

Director, Office for Policy and Strategic Planning, TCD

New Zealand tobacco control officials

Sally Stewart, Manager, Tobacco Control Programme, Ministry of Health

Leigh Sturgiss, Senior Advisor, Tobacco Control Programme, Ministry of Health

Australian tobacco control officials

Jack Quinane, Director, Tobacco Control, Australian Department of Health

Jo Foster, Assistant Director, Tobacco Control, Australian Department of Health

Singapore tobacco control officials

Representatives from the Singapore Health Promotion Board

US (Food and Drug Administration) tobacco control officials

Representatives from the Center for Tobacco Products

Norwegian tobacco control officials

Dr Karl E Lund, Senior Researcher, Norwegian Institute of Public Health

NHS England

Matthew Fagg, Director of Prevention, NHS England and Improvement

Stephen Powis, National Medical Director, NHS England and Improvement

Yvonne Doyle, Medical Director, NHS Public Health

Clinicians

Dr Andrew Goddard, President, Royal College of Physicians

Jamie Waterall, Deputy Chief Nurse, Department of Health and Social Care

Suzanne Wood, Head of Population Health, British Medical Association

David Strain, Chair of the Board of Science, British Medical Association

Dr Peter Byrne, Director Public Mental Health Implementation Centre, Royal College of Psychiatrists

Tom Ayers, Director of National Collaborating Centre for Mental Health, Royal College of Psychiatrists

Dr Jonathan Campion, Consultant Psychiatrist and Director for Public Mental Health, Royal College of Psychiatrists

Clare Livingstone, Professional Policy Advisor, Royal College of Midwives

Dr Mary Ross-Davie, Director of Professional Midwifery, Royal College of Midwives

Experts

Prof Anna Gilmore, Director, Tobacco Control Research Group, University of Bath

Prof Robert West, Professor of Health Psychology, University College London

Prof Geoffrey Fong, Founder and Chief Principal Investigator, ITC Policy Evaluation Project, Canada

Ailsa Rutter, Director, FRESH

Andrea Crossfield, Public Health Consultant, Population Health Policy and Strategy Specialist, Greater Manchester Health and Social Care Partnership

Prof John Newton, Director of Public Health Analysis, OHID

Linda Bauld, Chief Social Policy Advisor to the Scottish government

Kamran Siddiqui, Professor of Public Health, University of York

Dr Ruediger Krech, Director Health Promotion, World Health Organization

Civil society

Hazel Cheeseman, DCEO, ASH

Clare Livingstone, Professional Policy Advisor, Royal College of Midwives

Maeva May, Head of Policy British Heart Foundation

Louise Ross, Chair New Nicotine Alliance

Sarah Jakes, Member New Nicotine Alliance

Sarah Hannafin, Senior Policy Advisor, National Association of Head Teachers

Dr Anne Murdoch OBE, Senior Advisor, Association of School and College Leaders

Cllr David Fothergill (Somerset), Local Government Association

Cllr Joanne Harding (Trafford), Local Government Association

Paul Ogden, Local Government Association

Other organisations

David Halpern, CEO Behavioural Insights Team

Additional Parliamentarians

Wes Streeting MP, Shadow Secretary of State for Health and Social Care

Andrew Gwynne MP, Shadow Minister for Public Health

Directors of public health

Jim McManus, president of The Association of Directors of Public Health, Director of Public Health (DPH) Hertfordshire

Ruth Tenant, DPH Solihull

Retailers

Andrew Goodacre, Chief Executive, British Independent Retailers Association

Edward Woodall, Government Relations Director, Association of Convenience Stores

James Lowman, Chief Executive, Association of Convenience Stores

Corporate Affairs and Pharmacy Team, Asda Stores Ltd

Corporate Affairs Team, Morrisons

Official statistics, research reports and academic literature

Wherever possible, the review ensured that the recommendations are evidence-based and are supported by the available academic literature, relevant statistical data, and research findings.

As part of a grant scheme already in place with ASH, the Office for Health Improvement and Disparities extended quantitative data collection in 18 to 24 year olds to provide further insights into this important age group when occasional smoking can become regular use.

Annex B: focus groups and in-depth interviews

Research carried out

This review commissioned ASH to work with an expert team of qualitative researchers at Bluegrass to provide insights on attitude and behaviours to smoking. This work concentrated on seeking the views of people from more disadvantaged communities and included focus groups and in-depth interviews. Groups approached as part of the research included:

- smokers in social housing
- smokers with common mental health conditions (anxiety or depression)
- pregnant smokers
- LGBTQ+ smokers

Other groups approached included:

- young adult smokers
- ex-smokers and relapsed smokers from disadvantaged communities
- healthcare professionals

Summary of findings

Here is a list of the main points from the groups that were approached in this research.

Attitudes to smoking

Most smokers who attended the focus groups have smoked since being teenagers.

Attitudes of the focus group participants to their own smoking reflect that seen generally among smokers. They express feeling a volatile, love-hate relationship, with both enjoyment and guilt.

Most wish they had never started smoking.

There is a notable lack of drive or even inclination to quit smoking among many.

Participants considered smoking was an essential tool for dealing with life.

Attitudes to quitting

The focus group participants mainly cited the usual reasons smokers give for not wanting to smoke, with some differences in priorities. Finance was a key factor, and often first mentioned.

Awareness of health risks is high but can be rationalised, justified or ignored.

Many are able to justify not quitting. Often linking their smoking to supporting mental health – this is a significant barrier to quitting.

Many perceived that there is no point trying unless you are ‘ready’; but little attempt to, or understanding of how to be ‘ready’.

Messaging around repeated attempts being linked to success do encourage some.

Quitting: attitudes towards support services

Not top of their mind; much disinterest in quit support services; some rejection.

A main barrier is a lack of desire to quit; but some actively do not want to engage.

Lack of clarity as to nature and format of support.

Seen by some as a potential 'plan B' if quitting alone does not work.

GPs and pharmacists were top of mind as credible sources when prompted. Some barriers to going to GP.

Remote support appeals; interest in app-based support.

Messaging around increased rates of success do encourage some.

Policy ideas

Reaction muted and negative. In some instances, negativity linked to perceived increased difficulty to smoke.

Firmly believe that no notice would be taken of inserts; on-cigarette messaging; but positive messaging more interesting.

Interest in free e-cigarette to encourage quitting.

Increased restrictions of where smoking is allowed provoked strongest negative reaction, indicating that this would be at worst an irritant, but potentially encouragement to reduce smoking occasions.

Smokers who have relapsed

Causes of lapsing reflect the challenges of sustaining the quit. Can be something specific (such as an occasion or event) but can also be about simply escaping the difficulty of the attempt.

The disappointment of lapsing and the recency of the difficult quit attempt can serve to discourage smokers from further attempts – certainly immediately.

The relief and pleasure of smoking again can underpin this reluctance to try quitting again, at least for a while.

The recognition that what made you lapse this time is not going away can also discourage retrying to quit.

Key groups

Routine and manual workers and unemployed smokers' lives

Many smokers have challenging, stressful, chaotic lives. They do minimal long-term planning and life is day-to-day.

Most are financially "close to the wire", some cross it.

The pandemic has had extensive financial consequences, and these are now being continued and made worse by the cost of living crisis.

Impacts of the pandemic on mental health cannot be understated, and these are being exacerbated by renewed or increased financial worry.

Smoking behaviours have been affected by the pandemic and cost of living crisis in varying ways and to different degrees.

Pregnant smokers

Most feel guilt and shame.

Some feel can justify smoking, often linked to mental health; others reassured by previous problem-free pregnancies.

Still very mixed, patchy awareness of the specific harms to unborn baby, and much less association with harm manifesting after birth.

Greatest awareness around oxygen deprivation, underweight babies.

Experience of smoking through previous pregnancies and delivering healthy babies significant to attitudes.

Recognition and acceptance that the midwife has a role to support and encourage quitting.

Evidence that positive relationships with midwives can encourage women to persevere in quit attempts.

Student smokers (who took up smoking at university)

Students are positive, upbeat about the future.

Peer pressure: desire to fit in, be included; perception that it's the 'norm'; are behind take up and continuation of smoking.

Notably, most are without care about their smoking.

Health harms recognised as something in the distant future – and not relevant as they are convinced, they will be quit.

No urge or desire to quit.

Generally minimal concern about ability to quit when they want to; related lack of interest in support services.

Ethnic minority smokers

Generally aligned with other smokers regarding situations, behaviour, and attitudes to smoking.

Although most feel their own smoking [of cigarettes] is not culturally influenced, nevertheless, indications that acceptability and behaviour differs across cultures.

Shisha smoking is often social – for some completely unrelated to culture, for others rooted in heritage or their community.

Wide range of opinions regarding how health harms and addictiveness of shisha compare to cigarettes.

LGBTQ+ smokers

Generally aligned with other smokers regarding situations, behaviour and attitudes to smoking.

Many are moving in circles where there are lots of smokers, but they are not necessarily solely from the LGBTQ+ community, and most don’t recognise that smoking is more prevalent amongst the community.

Many have been victims of discrimination, and most said they had mental health issues, although not necessarily related to LGBTQ+ status.

Annex C: terminology and approach

Smoking harms

The harms from smoking are threefold.

1. The primary harms are those suffered by smokers themselves, causing long lasting illness and early death.

2. The secondary harms are suffered by those who breath in the smoke of others, particularly in private homes.

3. The tertiary harms are suffered indirectly by families where much of the family budget goes on feeding tobacco dependence, where parents are unable to work and grandparents unable (or no longer around) to help with the care of the next generation.

The life course approach

My proposals can be seen through multiple frames. They can be considered in a simple 'life course' approach. Our concern begins even before the cradle.

Conception to delivery

Reducing rates of smoking in pregnancy has been a longstanding priority for the government, but progress in recent years has been disappointing. Families, almost always in our most deprived communities, continue to suffer from miscarriages, stillbirth, low birthweight, and sudden infant death because of smoking.

Infancy

Exposure to second-hand smoke has continued to decline as part of a huge shift in social norms. None the less, the most deprived infants continue to suffer the most from the secondary and tertiary harms from smoking.

Adolescence

It his heartening to see that teen smoking – at least in our more affluent communities – is fast becoming a thing of the past. However, the more adult smokers in an adolescent’s social network, the more likely they are themselves to start to smoke. This could be whether that first cigarette is stolen from mum’s purse or a rite of passage with an older sibling.

Adulthood

Smokers start trying to quit almost as soon as they start to smoke. Helping them succeed is what this report is all about. That is the key not just to improving their own health but making smoking history for the next generation. We will ultimately succeed in reducing smoking in pregnancy, not by waiting till smokers become pregnant and are least likely to be able to quit successfully, but by working with the entire age cohort so that they are less likely to smoke when they are pregnant and have fewer, friends and partners who smoke who (despite their best efforts) will undermine quitting attempts and trigger relapse.

Aging well

All the woes of ageing come earliest to smokers, from poorer mobility to concerns about life limiting disease. By retirement age, most smokers have either quit or died but those who continue to smoke (and continue to try to quit) have been smoking for decades and find hardest to quit for good.

Behaviour change

The underpinning conceptual framework is West and Michie's Behaviour Change Wheel, based on the understanding that to enable behaviour change we must address capability, opportunity, and motivation. This applies equally to the behaviour of smokers and to the healthcare professionals there to help them.

The wheel also encourages us to consider the full range of policy levers including:

- guidelines that steer professionals toward giving help that works
- environmental measures such as housing and air quality
- communications including encouragement to use the most effective routes to quit
- legislation that tips the balance against the most harmful products in favour of those that prevent harm
- services that give quitters the best chance of success
- regulations that correct the problems arising from market failure
- fiscal measures that make it easier for people to make the right choices for them and their families

Annex D: where the new money should be spent

The estimate of the total funding request is a sum of the requests for the individual recommendations.

Estimated funding requests

Table 1: summary of recommendations and funding requests

Recommendation	Estimated annual funding request for 10 years
Improve local monitoring and enforcement of the illicit tobacco market by funding local trading standards.	£15 million
High quality local stop smoking services, equipped to offer consistent support. Funding to be distributed according to prevalence data, via the local authority public health grant. In addition to this, resources should be allocated by the NHS for stop smoking support offered at every contact with healthcare services, on an ‘opt out’ basis.	£70 million
Invest to create a successful mass media campaign to stop smoking.	£15 million
Financial incentives provided for all pregnant women to quit, by default. (This should be administered through a national government funding pot.)	£15 million
Ensure regional prioritisation of stop smoking interventions though ICS leadership. OHID to administer a national fund, into which ICSs can bid.	£8 million
Improved and accessible data, insight, and research with an innovation fund to identify effective evidence-based interventions that should be rolled out. A focus on further research on smoking related health disparities, particularly on ethnic disparities and young people.	£2 million
Total	£125 million [note]

[note]: as we make progress, we will need to adjust spending to match changing needs. The review proposes checkpoints in checkpoints in 2026, 2030 and 2035.

Further detail

£15 million per year to tackle illicit tobacco will fund local trading standards and partners to gather and develop intelligence, deliver enforcement activity and work with retailers and other businesses to help stop the scourge of illicit tobacco in their communities.

£70 million per year for stop smoking services is required so that all local authorities are able to spend the same amount per smoker as the local authorities that currently deliver the highest number of quits per 100,000 smokers. We must ensure that stop smoking services can offer vital, high-quality support consistently across the country.

£15 million per year invested in mass media campaigns to create a nation-wide, all year stop smoking campaign. International evidence demonstrates that exposure to media campaigns significantly reduces the number of people smoking, through encouraging people to make quit attempts.

£15 million per year to offer financial incentives for all pregnant women to quit smoking. This will enable the government to roll out the successful evidence-based pilot programme in Greater Manchester, at a national scale. This will enable pregnant women to be offered a voucher of about £300 if they successfully manage to quit smoking. Financial incentive schemes have an estimated return on investment of £4 for every £1 invested.

£8 million per year national fund, into which ICSs can bid to support regional collaboration and partnership. For example, through enabling recruitment of dedicated tobacco control staff, through local campaigns and targeted activity to tackle illicit tobacco.

£2 million per year for a research and innovation fund to improve the way we use data to track fast-changing behaviours and risks in a rapidly evolving market. It would help fund a renewed commission of the government’s independent Vaping in England reports, sharing and analysis of under-used data already held by researchers and regulators and allow better use of existing surveys to provide vital insights on behaviours of young people and ethnic minorities.

Annex E: NICE guidance recommendations to employers

Employers have a crucial role to play as a setting where large numbers of people can be reached. Interventions delivered in workplaces will encourage more people to access support to stop smoking, reduce absenteeism and increase productivity. Many employers already have employee assistance programmes in place, which should be extended to include cessation support for smokers.

The NICE guidance Tobacco: preventing uptake, promoting quitting and treating dependence (2021) makes the following recommendations to employers:

1. Make information on local stop-smoking support easily available at work. Include details on the type of help available and when, where and how to access the services. Publicise these interventions.

2. Be responsive to individual needs and preferences of employees. If feasible, and if there is sufficient demand, provide on-site stop-smoking support.

3. Allow staff to attend stop-smoking support during working hours without loss of pay.

4. Negotiate a smokefree workplace policy with employees or their representatives. This should:

- state whether or not smoking breaks may be taken during working hours and, if so, where, how often and for how long

- include a stop-smoking policy developed in collaboration with staff and their representatives

- direct people who wish to stop smoking to local stop-smoking support

Annex F: the cost of tobacco to society

Figures on the cost to society have been provided by ASH.

The total estimated cost of tobacco to society is £17.0 billion. This is made up of:

- costs to NHS of £2.4 billion
- costs to social care of £1.2 billion
- costs to productivity of £13.2 billion, including:
    - £6.05 billion on smoking related lost earnings
    - £5.70 billion on smoking related unemployment
    - £1.45 billion on smoking related early deaths
- costs of smoking related fires of £0.3 billion

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