Making Smoking History Report to Board
15th February 2023
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<td>Title</td>
<td>Making Smoking History in Greater Manchester</td>
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<td>Executive Summary</td>
<td>A report on the progress over the last 5 years towards our ambition become a smokefree city-region and the vision for the next five years.</td>
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**Prepared by:**
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- Debbie Watson, Director of Public Health, Tameside MBC
- Katrina Stephens, Chair of GM Association of Directors of Public health, Director of Public Health, Oldham Council
- Andrea Crossfield, Population Health and Policy Consultant on behalf of NHS GM
- Liz Benbow, Making Smoking History Strategic Programme Lead, NHS GM

**Presented by:**
- Sarah Price, Chief Officer for Population Health and Inequalities, Deputy Chief Executive, NHS GM
SUMMARY

Greater Manchester (GM) is committed to becoming the first global city region to be smokefree and since 2017 has been delivering its unprecedented and evidence-based Making Smoking History (MSH) strategy through a partnership of city region, local authority borough and community-based programmes.

Built on a proven World Health Organisation (WHO) model, Greater Manchester Health and Social Care Partnership and now NHS GM Integrated Care has been investing in system-wide transformation at scale with national and international recognition for the success of the GM approach to Making Smoking History and for programmes including CURE, Smokefree Pregnancy and behaviour change campaigns which have significantly increased population level quitting. Click here to read the 5-year programme summary report.

Ahead of the pandemic this led to a reduction in smoking prevalence at twice the England average, beginning to close the gap between GM and England. Smoking rates among people in Routine and Manual jobs reduced faster in GM than in England and other parts of the North from 28.8% in 2016 to 24.5% in 2019 almost closing the gap with England at 23.2% according to Annual Population Survey (APS) data.

Despite declining smoking prevalence in GM and England, smoking remains responsible for around half the difference in life expectancy we see between our poorest and most affluent communities. It therefore remains the biggest, preventable driver for health inequality while the pandemic and subsequent economic challenges have seen smoking rates stall in England and GM in 2021 with APS adult smoking prevalence data at 13% and 15.4% respectively.

Smoking will kill two in three of our 340,500 current smokers in Greater Manchester unless they quit, half in middle age with devastating impacts on the health and wealth of our communities. Around 150,000 of these current smokers will be experiencing some form of smoking related illness with impacts on the NHS, social care and the wider economy.

This report notes and reviews the successes of the last five years, the challenges currently faced and the evidence base for the need to continue to focus on tobacco, increasing the pace and scale of our efforts to deliver a smokefree generation and a tobacco free society through a refreshed framework for Making Smoking History to tackle health inequalities and support equity of access to health care, building on the Core20PLUS5 approach as set out in both the aims of integrated care boards and the priorities within the NHS Operational Planning Guidance.

The Khan Review: Making smoking obsolete states prevention must become part of the NHS's DNA. Becoming a smokefree city region by 2030 creates a unique opportunity to reduce health inequality, level up, and build back fairer. ONS estimates that healthy life expectancy would increase by just over 6 years for men and 7 years for women if GM becomes smokefree by 2030 (a prevalence of >5%). It is therefore critical to offering the GM population the best chance to live healthier, prosperous lives while enabling the GM system to deliver the fastest and greatest improvements in health and wellbeing.
RECOMMENDATIONS

The NHS Greater Manchester Integrated Care Board is asked to:

- Review and note the progress on the Greater Manchester Making Smoking History Strategy since 2017
- Reaffirm the commitment for Greater Manchester to become a smokefree city-region by 2030
- Support an updated 5-year Making Smoking History Framework as part of an in-depth review delivered in partnership with Greater Manchester Directors of Public Health
- Commit NHS Greater Manchester to the sign up to the NHS Smokefree Pledge
- Recommend that all GM Integrated Care Partnership organisations commit to a consensus on vaping as a harm reduction approach
MAKING SMOKING HISTORY IN GREATER MANCHESTER

1. INTRODUCTION

1.1. The Greater Manchester Integrated Care Partnership serves a region with an average life expectancy amongst the lowest in England. Citizens of GM become ill earlier, spend more time in poor health, leave employment earlier and die earlier than the national average. Tobacco is a key contributor to this, affecting those in routine and manual jobs, those with mental health conditions, LGBTQ+ communities and some BAME communities who use shisha and chewed tobacco disproportionately. It remains the leading modifiable risk factor responsible for health inequalities, accounting for half the difference in life expectancy between the richest and poorest in GM and England. Reducing smoking therefore remains our single, greatest opportunity to close the gap in health outcomes, reduce inequalities and improve life expectancy.

1.2. Smoking rates have been declining steadily over decades however, national and international evidence has shown that comprehensive, sufficiently scaled, long term/sustained regional approaches such as that delivered by Fresh Smokefree North East or the New York Smokefree programme deliver accelerated prevalence reductions and associated health and health care system gains.

1.3. In 2017 Greater Manchester Health and Social Care Partnership with support from all 10 GM localities, the GM Mayor and with leadership from GM Association of Directors of Public Health, the GM Cancer Alliance and VCSE sector partners committed to becoming a smokefree city-region, ending an intergenerational cycle of harm for our residents. The 2017 Making Smoking History, A Tobacco Free Greater Manchester strategy set out, a comprehensive and evidence based approach to reducing smoking prevalence.

1.4. Against a challenging backdrop of higher-than-average smoking rates, GM has since led the way in tobacco control in England and influenced national and international policy for achieving a Smokefree 2030 ambition including through shaping treating tobacco dependency through the NHS Long Term Plan and through innovative behavioural insights driven approaches to quitting including vaping harm reduction (further information in section 4). This has included the implementation of GMs, now national, exemplar Smokefree Pregnancy programme which has reduced smoking at time of delivery (SATOD) by one third since implementation in 2018 (from 12.4% to 9.5%), closing the gap with England and delivering over 3,500 smokefree babies.

1.5. A pan GM, comprehensive, scaled approach has delivered population health gains with external evaluation confirming positive outcomes. When compared to other city regions, such as the West Midlands Combined Authority, which has never had a comparable regional tobacco control programme, GM has seen a faster reduction in smoking prevalence since 2016 (3 percentage points (ppp) compared to 0.5ppp respectively, with the West Midlands region as a whole declining by 1.6ppp). However, there is no doubt that the Covid-19 pandemic has had significant consequences on progress.

1.6. 2020 national APS data (published in December 2021 but subsequently revised) suggested GM was remaining on trajectory to achieve a Smokefree 2030 with 80,000 fewer smokers and prevalence at 14.9%. In December 2022, ONS published updated 2020 APS smoking data to
address discrepancies with the 2020 data, affected by the Covid-19 pandemic alongside the 2021 data. This has resulted in GM and England smoking prevalence being revised upwards for 2020 with both now off trajectory to meet the 2025 interim targets to achieve a Smokefree 2030, set out in the 2019 All Party Parliamentary Group Report: Delivering a Smokefree 2030 as detailed in Figure 1 below. There are also local inequities in prevalence that persist across and within boroughs in GM, so that while prevalence remains much higher overall in Oldham (19.3%) and in Tameside (19.2%), in Trafford and Bury where prevalence has fallen below the England average to 11.1% and 11.4% respectively, neighbourhoods in each of these boroughs have communities where around a third of adults still smoke and tobacco use is very much the social norm.

FIGURE 1: Office of National Statistics Adult Population Survey Data for Adult smoking prevalence in England and Greater Manchester and APPG Smokefree 2030 target trajectory to 2025

1.7. Further research also provides evidence that smoking, as with other lifestyle behaviours, has been negatively impacted by the pandemic. For example, August 2021 analysis of the England Smoking Toolkit Study (STS) data showed a worrying 25% increase in smoking by 18–34-year-olds during 2020, with similar increases in prevalence in this group in GM STS data.

1.8. Breaking the intergenerational cycle that has persisted between smoking and deprivation remains possible in GM and could still be delivered in less than a generation. The 2021 Smoking and Health APPG Report and the 2022 The Khan Review: Making smoking obsolete, each set out roadmaps to a smokefree 2030; GM is unique in having implemented more of the recommended local and regional measures than any other region providing exemplars and blueprints for action. As the first Marmot City Region GM is working collaboratively to shape places and deliver effective social and commercial determinants
approaches to reduce inequalities. Both the GM Marmot Report and Independent Inequalities Commission Report have strengthened our focus on wellbeing, prevention and population health.

1.9. To achieve our ambition to become a smokefree city-region we must hold steadfast to our commitment and get back on track to deliver the pace of smoking prevalence reduction we saw pre-pandemic. We have shown this is achievable with the evidence-based success and innovation seen between 2016 and 2019 which are likely to have contributed to the increases in life expectancy in GM highlighted by the University of Manchester research. Reducing prevalence further post pandemic and in the current economic climate will mean maintaining, if not increasing scale and momentum through a reviewed and refreshed Making Smoking History delivery framework.

2. WHY MAKE SMOKING HISTORY IN GREATER MANCHESTER?

HEALTH, WEALTH AND PUBLIC OPINION

2.1. Smoking and tobacco use has a detrimental effect to the GM economy. Costing more than £910 million per year, not only does it impact on health and care, but smokers are more likely to become ill while of working age, contributing to the 30% productivity gap due to ill health experienced in our city region.

2.2. Those who smoke are burdened with a costly addiction, each spending on average £2,000 a year on tobacco – money that is going up in smoke whilst people in our communities face increasing pressures from the rising cost-of-living. In Bolton alone, smokers spend over £67 million a year on tobacco. Nearly all this money goes straight out of the local economy as tobacco industry profits or tax.

2.3. GM has worked with Action on Smoking and Health (ASH) to support the development of its tools which demonstrate the economic and inequalities impacts of smoking. Whilst smoking is not a root cause of poverty, the addiction, and the loss of income it causes can significantly exacerbate and lock people and families into poverty and poor health, resulting in the widening of health inequalities. Almost 140,000 working age adults live in poverty in GM after smoking costs are considered, with 24,000 pensioners similarly impacted. Tackling tobacco harm and treating tobacco dependency must be built into the inequalities plans of all major systems programmes, supporting upstream models of care across the life course. ASH updates their Ready Reckoner Tool annually to show the scale of the staggering economic burden due to smoking. Detailed breakdowns of smoking costs to our GM economy and inequalities impacts can be seen in Appendix A.

2.4. Children living in smoking households are, often daily, subject to the detrimental effects of second-hand smoke, impacting their education, as well as their health, with one quarter to one third of school absences among 6-11 year olds who lived with a smoker in a 2011 US nationwide study due to household smoking. 40% of the children living in poverty in GM, live in a smoking household.

2.5. Smoking is far more common among people with lower incomes and is transmitted across generations due to social-norms and addiction. Smoking rates are also higher for those living in social housing (around 30%), those suffering with mental health conditions, looked after children, those in contact with the criminal justice system, for LGBTQ+ people and for BAME populations are diverse and mediated by intersectionality with gender and socio-economic
status. Smoking rates by ethnicity are highest among those identifying as of mixed ethnic origin (19.5%, more than a quarter higher than the England population average.)

2.6. In GM alone there are 5,784 smoking-related deaths each year. Two in three long term smokers will die prematurely from smoking related ill-health. For comparison, in 2020, the number of covid-19 deaths in GM was 5,476 and 838 in 2021. The number of annual deaths, therefore, is not inconsequential.

2.7. Smoking cessation and reducing smoking prevalence is recognised within NHS England’s targeted approach to drive action to reduce inequalities through the Core20Plus5 Model. Smoking impacts the five clinical areas of inequality and the specific impacts for Greater Manchester are indicated in the ASH published guide in Figure 2 below. Smokers who quit have better treatment outcomes for everything from cancer to cardiovascular disease, diabetes to dementia, maternity to mental health, stroke to surgery.

FIGURE 2: NHS Greater Manchester Guide to CORE20PLUS5 Smoking Impacts

<table>
<thead>
<tr>
<th>Maternity</th>
<th>Severe Mental Illness</th>
<th>Chronic Respiratory Illness</th>
<th>Early Cancer Diagnosis</th>
<th>Hypertension</th>
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<td>Smoking is the leading modifiable risk factor for poor birth outcomes</td>
<td>Smoking is the leading cause of the 10-20 year reduction in the expectancy for people with Severe Mental Illness.</td>
<td>Around 86% of all COPD deaths are caused by smoking.</td>
<td>Smoking is the leading preventable cause of cancer responsible for 27% of cancer deaths.</td>
<td>Smoking cessation is embedded in NICE guidelines on hypertension because smokers’ CVD risk is double that of non-smokers.</td>
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<td>In GM 9.5% of women smoke at time of delivery ~ 3,178 women annually</td>
<td>In GM 47% of people with SMI smoke.</td>
<td>In GM 1,672 people a year die from COPD.</td>
<td>In GM 1,658 people a year die from cancer caused by smoking.</td>
<td>In GM 615 people a year die from CVD caused by smoking.</td>
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2.8. Stop smoking services are the most cost-effective intervention after Flu vaccinations and are one of the few healthcare interventions which do not correspond to the inverse care law. New GM tools being developed to support strategic intelligence including the Public Health Intelligence Hub, will support better identification and linking of local smoking data with primary care, elective care, urgent care and cancer databases enabling both strategic and operational planning, and direct care provision. Additional digital work is being undertaken to ensure all system tackling tobacco dependency programme data including CURE, Smokefree Pregnancy and new Mental Health offers can be fully linked into the Intelligence Hub not only to secure reporting of standard outcomes framework data but to allow exploration of the health and care needs and assets in different communities (of geography, interest and identity) and to stimulate discussions about the root causes of these disparities and co-design of solutions.

2.9. GM has built a social movement around Making Smoking History with 7,350 residents responding to the 2018 ‘History Makers’ survey which showed overwhelming majority public support to Make Smoking History (4 out of 5 residents including half of all smokers), with a

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1https://www.ons.gov.uk/aboutus/transparencyandgovernance/freedomofinformationfol/deathsfromcovid19ingreatermanchesterbyage
representative sample across the city-region including 1686 people from diverse, marginalised and under-represented communities. The survey also showed majority support for all the measures within the GM Making Smoking History Strategy.

2.10. A tipping point has been reached in ending the tobacco epidemic in the UK and in GM and smoking has become far less visible for the majority. However, as smoking rates are declining, they remain disproportionately high within some communities. Most smoking starts in childhood because of environmental and commercial determinants. Once addicted, quitting is tough and taking on average 30 quit attempts before succeeding. This is harder when everyone around you is smoking, and it is ingrained within a community.

3. PROGRESS TO DATE THROUGH OUR GMPOWER APPROACH

3.1. Since 2017 we have shared a vision to make smoking history together across our 10 GM localities, maintaining a focus on person-centred and place-based approaches and supported through the convening power of a city region mayor who has been clear that tobacco has no place in the future of GM. Success is attributable to the programme’s ability to work system-wide and establish strong relationships, partnerships and distributed leadership across third, private and public sector workforces. This has provided opportunities for everyone to come together, share best practice, expertise and innovation within the evidence-based delivery framework. GM’s strong relationships with Smokefree Action Coalition partners and active participation in a range of regional, national and international forums have also provided a strong foundation for the programme.

3.2. Our uniquely ambitious Making Smoking History strategy builds on the proven ‘MPOWER’ World Health Organisation model described in Figure 3 and in detail in Appendix B. It features seven key components with system-wide delivery from neighbourhood to city region level. With a G added to the model to represent the “growth” of a social movement.

FIGURE 3: GMPOWER Model

3.3. Through collaborative working and maintained investment across the GM system, the programme is nationally recognised as an exemplar, and effective in delivering improved health outcomes and pioneering innovation. The CURE inpatient and Smokefree Pregnancy treating tobacco dependency services have been rolled out as best practice within the NHS Long Term Plan, have led the way for transforming and integrating tobacco dependency treatment within NHS GM including in the delivery of the Lung Health Check Pilot and are widely recognised as exemplars across the UK. Key achievements and outcomes from both programmes are highlighted in Figure 4 below. Our GM approach to delivering a Smokefree
2030 has been cited as best practice in the Khan Review, a Smoking and Health APPG Report and by WHO, with the GM Smokefree Pregnancy programme, CURE, Swap to Stop Vaping Pilots in social housing and the Never Quit Quitting Mass Media Behaviour Change Campaigns all cited as best practice. The programme has been nominated for and received several awards and been subject to peer reviewed publications detailed in Appendix C.

FIGURE 4: GMs Treating Tobacco Dependency Exemplar Programme Outcomes

3.4. The Khan Review: Making Smoking Obsolete reiterates the need for comprehensive, multi-component approaches to tobacco control to achieve the Smokefree 2030 ambition. GM has been delivering elements of all the recommendations through the MSH programme since 2017. This confirms that GM is on the right track for realising the ambition; and is ahead of the game in prioritising prevention compared to most integrated care systems nationally.

3.5. In 2022 GM joined the prestigious, global Partnerships for Health Cities (PHC), supported by Bloomberg Philanthropies, the World Health Organisation and Vital Strategies and championed by our city-region Mayor. In recognition of GM’s wide range of work to deliver a Smokefree 2030 to date, GM received a grant to deliver projects to support more outdoor smokefree public spaces.

3.6. A detailed review of the Making Smoking History programme and a full summary of the programmes five-year key achievements, outcomes and deliverables can be downloaded here.
4. VAPING AND ITS ROLE WITHIN TOBACCO HARM REDUCTION

4.1. E-cigarettes/Vapes have been on the market to help people stop smoking for over ten years and they have become one of the most popular and effective quitting aids. In the UK, products are tightly regulated for safety and the most recent OHID Report ‘Nicotine Vaping in England’ (published October 2022) shows the risk to a person’s health from vaping is substantially lower when compared to smoking.

4.2. Most people that vape do not vape long-term and vapour from e-cigarettes pose no known health risks to other people. This is in contrast to second-hand smoke from tobacco which is known to cause significant health risks to others. Whilst the annual ASH vaping survey shows that the number of adults who use a vape is increasing, 57% current vapers are ex-smokers and a very low proportion of vapers are never smokers (1.3%).

4.3. Youth smoking rates are steadily declining (6% in 2022), however recently published data from NHS Digital’s survey ‘Smoking, Drinking and Drug Use among Young People in England, 2021’ (September 2022) and Action on Smoking and Health’s report ‘Use of e-cigarettes (vapes) among young people in Great Britain’ (July 2022), shows there has been a significant increase in the number of youths vaping.

4.4. The data from the ASH Youth 2022 survey of 11-18 year-olds in England shows that current vaping prevalence is 8.6% in 2022, compared with 4.0% in 2021 and 4.8% in 2020 (including occasional and regular vaping). The ASH Survey is a representative sample of 2,613 young people in Great Britain aged 11-18 surveyed by YouGov for ASH and asked about their use of e-cigarettes. This survey has been carried out annually since 2013 and provides the most up to date national survey of youth vaping. This national picture does not identify any hot spots which may exist in some local authority areas or individual schools. Figure 5 below differentiates the trends over time in occasional (less than once a week) use and regular use (more than once a week), as well as showing rates of experimentation (tried once or twice) by 11-17 year old underage users.

FIGURE 5: Level of use of E-Cigarettes 2014-2022 ASH GB Youth Survey (11-17 years only)
4.5. Notably, the ASH survey highlights that young people who have never smoked are also not currently vaping (98.3%) and children under 16 are least likely to try e-cigarettes. This is supported by the 2019 GM data from the Trading Standards Northwest Schools Survey of young people’s attitudes and behaviours towards alcohol, smoking and knives (due to report again in March 2023) which indicated that less than 1% of young people who had never smoked were current vapers (5% of GM young people reported smoking).

4.6. There is growing concern about the increasing popularity of disposable vapes with young people among parents, schools and in the media. The increase in vaping shown by both surveys (referenced in 4.3) is a cause for concern. This issue needs continued close monitoring nationally and in GM through quantitative and qualitative research to provide up to date data and understand the source of these genuine anxieties including potential myths which are being reported in the media. The March 2023 TSNW survey will provide current GM data and several national research studies are currently being commissioned.

4.7. GM Integrated Care Partnership is working closely with local Trading Standards and with TSNW to prevent children and young people from accessing vaping products with enforcement activity to remove illegal vapes in retailers and distributors across the city region and working with producers to bring products into compliance. Local Trading Standards carried out 45 Test Purchases of disposable vapes across GM in the 9 months from 1st April to 31st December – the young volunteer (aged under 18) was sold to on 18 occasions which is a failure rate of 40%.

4.8. GM is also working with ASH and OHID nationally to improve the approach to youth vaping in light of the increase in youth use and have worked with ASH to produce a range of useful resources for local authorities and schools on youth vaping many of which are currently being used locally. Some localities have produced their own local resources to support schools. A North West tobacco leads group has been convened to reduce duplication of resource development with GM fully engaged.

4.9. GM would like to see the Government do more to improve the regulation of e-cigarettes, particularly disposable vape products, including further restrictions on advertising, marketing and pricing that appeals to under 18s. GM and TSNW are currently supporting ASH around Bob Blackman’s 10-minute rule bill on the retail sale of tobacco and nicotine containing products which proposes a DHSC led retail licensing system. Such a system would help tackle illegal vapes as well as illegal tobacco and more effectively deal with underage sales.

4.10. Deputy Chief Medical Officer Jeanelle de Gruchy said recently “Vaping is substantially less harmful than smoking so the message is clear, if the choice is between smoking and vaping, choose vaping. If the choice is between vaping and fresh air, choose fresh air.” OHID has published new content on vaping on its Better Health website that can be found here: https://www.nhs.uk/better-health/quit-smoking/vaping-to-quit-smoking/

4.11. Vaping has played a pivotal role in smoking cessation and stop smoking service offers in GM since the 2018 Salford Swap to Stop pilot. Several locality stop smoking services and GM implemented tobacco dependency treatment services now provide a vaping starter kit as part of the smoking cessation support offer. Consideration must be given to how interventions to
protect young people do not deter adult smokers from using vaping products to quit smoking or reinforce misperceptions about the relative harms of smoking and vaping. In 2021, only 34% of adults who smoked accurately believed that vaping was less harmful than smoking.

4.12. Ensuring a consistent GM approach to vaping enforcement, regulation and vaping device offers through stop smoking services will help clarify perceptions about harms and benefits of vaping devices and provide a basis on which there is city-region consensus. As part of the MSH programme review and refresh; and taking into consideration a similar approach that has been taken in the Northeast and Yorkshire, it is a recommendation that GM Integrated Care Partnership organisations commit to a Vaping Consensus Statement which will adopt a harm-reduction approach to tobacco control. There is already support for this through the GM Association of Directors of Public Health.

5. **A REVIEW AND REFRESH OF THE STRATEGY**

5.1. Five years since the implementation of the GM Making Smoking ambition and overarching GMPOWER strategy (2017-2021), a review and refresh process is underway in partnership with the GM Association of Directors of Public Health. The review will take stock of the learnings to date and work within GM Integrated Care Partnership’s governance to formulate and co-produce an updated Making Smoking History (MSH) five-year framework. The headline ambitions of which will be reflected in the emerging NHS Integrated Care Partnership Strategy recognising that becoming a smokefree city region is integral to tackling inequalities and aligned to the Building Back Fairer framework.

5.2. Maintaining programme investment will be key to achieving the ambition, however the way funding is invested, programmes and services are commissioned, and the programme is delivered will change and innovate.

5.3. As a new integrated care organisation, it is recommended that NHS GM Integrated Care publicly commits to Making Smoking History, achieving a smokefree 2030 and delivering the programmes within the Long-Term Plan by signing up to the NHS Smokefree Pledge. This is a mechanism for NHS organisations to publicly pledge their commitment to reducing inequalities through delivery of the Core20Plus5 model and enhanced tobacco control programmes. Additionally, work will be progressed through the Integrated Care Partnership to recommend that all GM Local Authorities renew their commitment to the Local Authority Smokefree Declaration.

5.4. The review process will include a deep-dive analysis into the GM Smoking Toolkit Study data. This is a quarterly boost to the national Smoking Toolkit Study and provides data on smoking prevalence, quit attempt rates and smoking behaviours over the last 5 years. Additionally, colleagues at University College London Tobacco & Alcohol Research Group (UTARG) utilising this data to conduct an external academic review of the programme since implementation.

5.5. The review will also include a round table and workshops with key system leaders, colleagues and stakeholders from across GM, the North and national and international tobacco experts. This will explore learning from the first 6 years of strategy implementation,
the current evidence base and generate a co-produced ambitions for a 5-year delivery framework.

5.6. The delivery framework will be centred on addressing inequalities by scaling up, accelerating and targeting stop smoking support and consideration of providing further protection from tobacco through programmes which denormalise smoking and introducing more smokefree spaces within communities turning off the tap of new young smokers. A proposed timeline for review and refresh activity can be found in Appendix D.

6. SUMMARY

6.1. GM has made good progress in tackling tobacco related inequalities over the last 5 years, delivering an impactful and internationally recognised, comprehensive approach to tobacco control. Making Smoking History and becoming a smokefree city-region 2030 is in sight.

6.2. Significant progress was made pre-pandemic. Smoking prevalence was reducing at an unprecedented rate, closing the gap with England and remaining on trajectory to become a smokefree city region. Whilst there remains a downward trend in smoking prevalence, GM must now refocus and recommit. There is no single measure that will accomplish a smokefree city-region; change will continue to be needed in every part of the integrated care system and wider partnership including the business, voluntary and community sector. Success can be achieved with the right investment and delivery of a comprehensive, innovative, ambitious, and well-executed programme. National policy measures such as an increase in the Age of Sale remain important and GM has a role to advocate for action to break the cycle of addiction in young people just as it did on plain packaging of tobacco.

6.3. Smoking is linked to almost every indicator of socioeconomic disadvantage. Tobacco control programmes are extremely cost-effective compared to the cost burdens associated with smoking on the GM economy, therefore the case for prioritising a refresh of our comprehensive MSH plan couldn't be clearer. Reducing smoking prevalence and achieving a smokefree 2030 is GMs biggest chance to level up, build back fairer and reduce inequalities. The strategy review and refresh work, currently underway, will ensure that the vision of partners, stakeholders and the public are imparted into a new five-year Making Smoking History framework.

6.4. We must continue GMs long-standing tradition of transformation, engagement and working collaboratively. This will save thousands of lives, relieve thousands from the burdens of addiction, loss of employment and living with ill-health and provide opportunity for our communities to become healthier and wealthier. Together we will Make Smoking History.

7. RECOMMENDATIONS

7.1. As described within the paper above, the board is asked review and commit to the following recommendations and actions
• Review and note the progress on the Greater Manchester Making Smoking History Strategy since 2017
• Reaffirm the commitment for Greater Manchester to become a smokefree city-region by 2030 delivered in partnership with Greater Manchester Directors of Public Health
• Support an updated 5-year Making Smoking History Framework as part of an in-depth review
• Commit NHS Greater Manchester to the sign up to the NHS Smokefree Pledge
• Recommend that all GM Integrated Care Partnerships organisations commit to a consensus on vaping as a harm reduction approach
APPENDICES

APPENDIX A

FIGURE A: ASH Ready Reckoner Tool for Greater Manchester

- **Each year we estimate that smoking costs:**
  - **CA-Greater Manchester**
  - **£910.79M**

**SMOKING STATISTICS**
- **350,358**
- **15.96%**
- Number of adults who smoke.

**SMOKING RELATED SPEND**
- **£681.59M**
- Estimated to be spent on tobacco annually (legal and illicit).
- **£1,945**
  - Is spent on average per smoker on tobacco.

**LITTER DUE TO SMOKING**
- **3.19M**
- Cigarette butts make up the vast majority of litter items (88%) in terms of litter numbers.
- **2.72M**
- The majority of cigarette filters are non-biodegradable and end up in landfill sites.
- **169**
  - Tonnes of waste annually.
- **71**
  - Tonnes of discarded as street litter annually.

**HEALTHCARE COSTS DUE TO SMOKING**
- **£115.48M**
- These costs are a result of smoking related hospital admissions and the cost of treating smoking related illness via primary care services.

**SOCIAL CARE COSTS DUE TO SMOKING**
- **£62.74M**
- Many current / former smokers require care in later life as a result of smoking-related illnesses. The estimated costs to local authorities is:
  - **£30.79M**
  - **£32.05M**
  - Cost of residential care
  - Cost of domiciliary care

**IMPACT OF SMOKING ON PRODUCTIVITY**
- **£713.45M**
- Smoking negatively affects earnings and employment prospects. The cumulative impact of these effects amounts to productivity losses of:
  - **£318.89M**
    - Smoking related lost earnings
  - **£309.64M**
    - Smoking related unemployment
  - **£84.92M**
    - Smoking related early deaths

**FIRE COSTS DUE TO SMOKING**
- **£19.13M**
- Smoking materials are a major contributor to accidental fires. Smoking related fires result in annual losses of:
  - **£6.00M**
    - Cost of death
  - **£6.00M**
    - Cost of injuries
  - **£7.33M**
    - Property damage
  - **£591.4K**
    - Fire and Rescue Services each year.

If this was replaced with formal paid care, it would cost the social care system an additional **57,728 people**.

**741.76M**
FIGURE B: ASH Economic and Inequalities Dashboard for Greater Manchester

Smoking affects many aspects of peoples lives in England

SMOKING STATISTICS

- 20% of adults with serious mental health issues who are smokers.
- 24.5% of adults in routine and manual occupations who are smokers.
- 9.8% of women who smoke at the time of delivery.

** Not available at combined authority level

SMOKING BY HOUSING TENURE

Percentage of the population in England who are smokers by type of housing. Smoking rates in people living in social housing are double the national average.

Rent from social housing
Rent Private
Owns outright
Owns with mortgage

** Not available at combined authority level

POVERTY DUE TO SMOKING

When income and smoking expenditure is taken into account each year in CA-Greater Manchester it is estimated that 80,982 households with a smoker fall below the poverty line.

- 130,894 Number of working age adults below poverty line after smoking costs
- 23,952 Number of pensioners below poverty line after smoking costs
- 61,928 Number of children below poverty line after smoking costs

SMOKING RELATED MORTALITY

Smoking is the leading cause for the gap in life expectancy between the rich and poor. About half of all life-long smokers will die prematurely, losing on average about 10 years of life. 33,968 people in England die as a result of smoking each year.

Male
Female

** Not available at combined authority level

SOCIAL CARE COSTS DUE TO SMOKING

Smoking greatly increases a person’s chances of needing social care. Current smokers are 2.5 times more likely to require social care support at home and need care on average 10 years earlier than non-smokers.

- 923 Number of people with need
- 4,461 Number of people in funded domiciliary care
- 23,724 People with unsure need
- 57,728 People needing informal care from family and friends

UNEMPLOYMENT AND LOSS OF EARNINGS DUE TO SMOKING

Smoking has a significant negative effect on individual earnings and employment prospects. Current smokers are 5% less likely to be employed than non-smokers and long-term smokers are 7.5% less likely to be employed.

14,730

Number of people out of work in DA-Greater Manchester due to smoking

SMOKING AND PREGNANCY

Smoking in pregnancy is the single biggest modifiable risk factor for miscarriages, stillbirths, premature birth and birth defects. Women in the most deprived group are five times more likely to smoke in pregnancy than those in the least deprived.

3,178

Number of women smoking at time of delivery

SMOKING AND CHILDREN

It is estimated that 157,976 children live in smoking households. The children in a home with a parent who smokes are 4 times more likely to become a smoker themselves. Two thirds of those who try smoking on to become daily smokers.
A Framework for Success – GMPOWER

Based on the WHO ‘MPOWER’ model, Greater Manchester’s Making Smoking History strategy uses the ‘GMPOWER’ framework to deliver a comprehensive approach to tobacco control.

**Grow a social movement for a tobacco free GM**

In the 2018 ‘History Makers’ public consultation, 8 in 10 people said they supported our ambition to make smoking history. Through third sector collaboration we have enabled and inspired communities and individuals to grow a social movement and be part of our ambition to end tobacco harm in GM.

**Monitor tobacco use and prevention policies**

We want to make sure everything we do is shaped by evidence and data. Data and knowledge is gathered locally and nationally. We invest in regular insight, evaluation and monitoring to understand smoking rates, behaviours and attitudes, ensuring our innovation is data driven and our programmes are effective.

**Protect people from tobacco smoke**

There is no safe level of exposure to second-hand smoke. Through local and global networks and collaboration, such as the prestigious Partnerships for Health Cities initiative, we are making more outdoor spaces smokefree to provide healthier spaces for people to enjoy and protect children and vulnerable people from second-hand smoke.

**Offer help to quit**

Most smokers want to quit and smokers in GM now have more offers of help to quit than ever before, including a phone line, Smoke Free app, and locality specialist Stop Smoking Services. We have trailblazed acute and maternity tobacco dependency treatment services, now seen as national exemplars, and more recently have implemented stop smoking support for NHS Staff and in Mental Health settings.

**Warn about the dangers of tobacco**

Targeted multi-media campaigns are effective in reaching large population groups. We deliver regular insight-driven behaviour change campaigns and ‘always on’ digital campaigns to motivate smokers to quit and give them the confidence and tools to do so. These consistently encourage positive quit actions, receive a high recall rate and maintain our quit attempt rate at 10 percentage points higher than the England average (currently 45% vs 35%).

**Enforce tobacco regulation**

GM regulatory teams work together to ensure national tobacco legislation is effectively enforced. Through our commitment to the Smokefree Action Coalition and our partnership with Action on Smoking and Health charity, we continue to advocate for further national tobacco control measures including increasing age of sale, introducing a licensing scheme for tobacco and all nicotine containing products and a tobacco industry levy.

**Raise the real price of tobacco**

Illicit tobacco undermines all tobacco legislation. We deliver a 7-strand Tackling Illicit Tobacco Programme aimed at tackling illicit tobacco supply and demand. Through our delivery of localised Keep-It-Out campaigns we have seen illicit tobacco use significantly reduce since programme implementation from 20% in 2018 to 16% in 2021. This protects children and young people from ever starting smoking and is critical to tackling inequalities.
APPENDIX C: Proposed Strategy Review and Refresh Timeline

Proposed Timeline

- **Nov 2022**: Establish small MSH review and refresh working group
- **Nov 2022**: Commence peer lead review of GM stop smoking services and offers
- **Dec 22 - Feb 23**: Internal appraisal and review of programme including SWOT analysis
- **January 2023**: Agree dates and organise Leadership Roundtable and Stakeholder Engagement Workshop Event
- **Mid-Feb 2023**: Ipsos Mori Smoking Toolkit Study in-depth data analysis
- **Mid-Feb 2023**: UCL Academic Evaluation
- **March 2023**: Academic review of data analysis and framing
- **March 2023**: Senior Leadership Roundtable
- **March-April 2023**: Stakeholder Engagement Workshop Event
- **April-May 2023**: Stakeholder Engagement follow up survey

Timeline:

- **Nov-22**: Review, co-production and collaboration
- **Dec-22**: Synthesisation of review, events and survey
- **Jan-23**: Check and Challenge
- **Feb-23**: Writing room
- **Mar-23**: Refreshed plan through GM Governance process
- **Apr-23**: Greater Manchester Making Smoking History Strategy Launch
- **May-23**: TBC
- **Jun-23**: TBC
APPENDIX D: PUBLICATION AND CITATION

- **Salford Swap to Stop Vaping Pilot**: A social housing targeted intervention offering vaping devices and incentives to encourage smokers to quit. This was cited as best practice in the Khan Review and the APPG Report mentioned above and is subject to several journal publications.
- Publication of a case study in the World Health Organisation Panorama Paper - *Making Smoking History in Greater Manchester*
- Multiple publications on the effectiveness of the CURE Inpatient Tobacco Dependency programme
  - Building the case for comprehensive hospital-based tobacco addiction services: Applying the Ottawa Model to the City of Manchester
  - Feasibility, uptake and impact of a hospital-wide tobacco addiction treatment pathway: Results from the CURE project pilot
  - Understanding the implementation strategy of a secondary care tobacco addiction treatment pathway (the CURE project) in England: a strategic behavioural analysis
  - Patient survey examining the experience of care of a hospital-based opt-out tobacco dependency treatment service (the CURE Project)
  - Health economic analysis for the ‘CURE Project’ pilot: a hospital-based tobacco dependency treatment service in Greater Manchester
- **GM Smokefree Pregnancy Programme** – multiple journal paper publications pending
- Multiple award nominations for the Smokefree Pregnancy programme and Never Quit Quitting Campaigns, including 2021 and 2022 HSJ Awards
- Winners of the **GM Cancer Educational Impact Award** in 2022