SHROPSHIRE HEALTH AND WELLBEING BOARD Report				
Meeting Date	**8th September 2022**			
Title of Paper	The Khan Review: making smoking obsolete - implications for Shropshire			
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Which Joint Health & Wellbeing Strategy priorities does this paper address? Please tick all that apply	Children & Young People		Joined up working	
	Mental Health	X	Improving Population Health	X
	Healthy Weight & Physical Activity		Working with and building strong and vibrant communities	
	Workforce		Reduce inequalities (see below)	X
What inequalities does this paper address?	Health and wellbeing inequalities			

1. Executive Summary

Smoking is the single biggest cause of preventable illness and death. Between 2017-2019 there were 191, 900 deaths attributable to smoking in England and smoking results in over 500,000 hospital admissions each year. Smoking is also the single most important cause of health inequalities. Smoking is associated with almost every indicator of deprivation and marginalisation, including sex, employment, gender identity, education, country of birth or housing status. The cost of smoking to society of smoking is approximately £17billion, higher than the £10 billion income from taxed tobacco products.

Smoking prevalence in Shropshire is 13.7%, matching the national average of 13.9%. In Shropshire, smoking rates are disproportionately high among pregnant mothers, those working in routine and manual occupations, and among those with certain mental health conditions. Smoking-attributable hospital admissions also remain high in Shropshire. It is estimated that 8,101 households with a smoker in the county fall below the poverty line, with 1,232 people out of work due to smoking. The wider costs of smoking in Shropshire are estimated at over £92 million in health and social care, loss of productivity and fire services costs.

The Khan Review: making smoking obsolete published on 9 June 2022 is an independent review of the 'smokefree 2030' ambition. This was set out by government in 2019 as an objective to reduce smoking rates in England to 5%. The review concludes that the government will miss the smokefree 2030 objective by at least 7 years, with the most deprived in society projected to not reach it until 2044. A number of key recommendations for accelerated action in tackling tobacco are therefore put forward:

1. Invest in smokefree 2030
2. Reduce the number who start to smoke, particularly young people
3. Encourage and support smokers to quit for good
4. Enable the NHS to both prevent smoking and provide treatment and support to smokers to quit

Action to tackle smoking in Shropshire currently consists of:

1.Tobacco Control through the Council's Trading Standards Team which prioritises enforcement activities aimed at tackling the illegal tobacco trade, including the supply of illegal nicotine inhaling products (vapes), and preventing the sale of all types of tobacco products to children (under 18 years).

2.Tobacco Dependency Treatment (TDT) services co-ordinated by NHS partners which is offered to patients admitted to hospital/maternity bookings on an opt-out basis as part of the NHS Long Term Plan. The expectation is that ongoing support (to total 12-weeks support) will be provided on discharge – either through a local public health commissioned stop smoking service or through a new service now being provided through community pharmacies (i.e. those that elect to provide the service). Support in pregnancy and for patients from mental health services are identified as priority areas for developing further community services.

3. Pharmacy smoking cessation support is offered to patients discharged from acute inpatient or mental health services through the new National Community Smoking Cessation Pharmacy Scheme which has been commissioned by NHSEI. This enables community pharmacies to deliver 12 weeks of follow up support from discharge (inclusive of behavioural stop smoking support and supply of Nicotine Replacement Therapy (NRT) for patients who have initiated a smoking cessation quit plan whilst in hospital. Pharmacies can register to deliver the service and in Shropshire a small number have signed up to date.

4. Shropshire Council does not commission a dedicated stop smoking service; the Community stop smoking service (Help2Quit) was decommissioned in 2019. However, there is support available through the social prescribing service. In addition, prior to COVID and as a response to this independent review there is a commitment to review service provision in Shropshire. As part of this, funding has been identified from Public Health reserves to prioritise provision of behavioural smoking cessation support for patients discharged from mental health inpatient care. Work is now underway to develop the specification for a local authority service that can operate alongside the community pharmacy offer in providing post-discharge support. The intention is that any community provision provided through public health will be restricted to behavioural support only, with NRT/pharmacotherapy either being prescribed (at the discretion of GPs) or self-funded. In this context it is important to note the significant contribution vaping can make in successfully supporting quit attempts and potentially presents a more affordable option for patients.

Shropshire Council has committed to reducing health inequalities in the Shropshire Plan 2022-2025. In light of this and the Khan Review, the recommendations below are suggested.

- Note the findings and recommendations made in the review, and the significant health social and economic benefits associated with making smoking obsolete
- The Board acknowledges that while the recommendations are primarily nationally focussed, the local need for investment in a tobacco control programme and smoking cessation services will need to be reviewed in light of the report
- The Board recognises the implications of the recommendations in relation to vaping and the extent to which local 'smokefree' policies should differentiate between smoking and vaping

2. Report

1.Introduction

This paper provides a brief summary of the Khan review: making smoking obsolete. This independent review concludes that the government target for 'smokefree 2030' i.e. smoking prevalence of less than 5% by 2030 will be missed by at least 7 years and longer in areas of deprivation.

This report also outlines the burden on smoking and smoking-related ill health and health inequalities in Shropshire. It summarises the current tobacco control efforts in Shropshire and provides

recommendations for increasing action to tackle smoking as a major public health risk factor, in line with the findings of the Khan review.

2.Background

As of 2019, approximately 6.9 million people aged 18years and above still smoke in England. This is equivalent to 14.1% of people aged 18 and above[1].Smoking is the single biggest cause of preventable illness and death. Between 2017-2019 there were 191, 900 deaths attributable to smoking in England[2]. Smoking is related to 500,000 hospital admissions every year, with smokers 36% more likely to be admitted[3]. All smoking deaths and admission rate are higher in the most deprived groups.

In the UK, smoking is the single largest cause of health inequality, accounting for 50% of the difference between the most and least deprived groups[4]. Smoking is associated with almost every indicator of deprivation and marginalisation, including sex, employment, gender identity, education, country of birth or housing status[5]. Those aged 25-34 years have the highest proportion of current smokers at 19%, and 2.5 times as many people working in routine and manual occupations smoke (23.4%) compared to people in managerial and professional occupations (9.3%)[1]. Whilst tobacco control policy has led to a significant reduction in smoking prevalence, the benefit is seen mostly among the most affluent with higher quit rates.

The cost of smoking to society of smoking is approximately £17billion, higher than the £10 billion income from taxed tobacco products[6]. The cost of smoking to the NHS was estimated at £2.6 billion in 2015[7].

The NHS Long Term Plan recognises smoking as the modifiable risk factor which accounts for more years of life lost than any other. This Plan therefore sets out a significant new contribution to making England a smokefree society, by supporting tobacco treatment and smoking cessation as part of NHS core services. This commitment to reducing smoking as a priority for health is mirrored in the Core20PLUS 5 approach set out by the NHS to enable integrated care systems (ICSs) to focus on key areas that would provide the most heath benefit in reducing health inequalities. This includes targeting resource on the most deprived 20% of the population as well as tackling inequality in 5 clinical areas. These key areas include maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis and hypertension case-finding. As shown in **Figure 1**, smoking cessation impacts on all 5 key clinical areas.

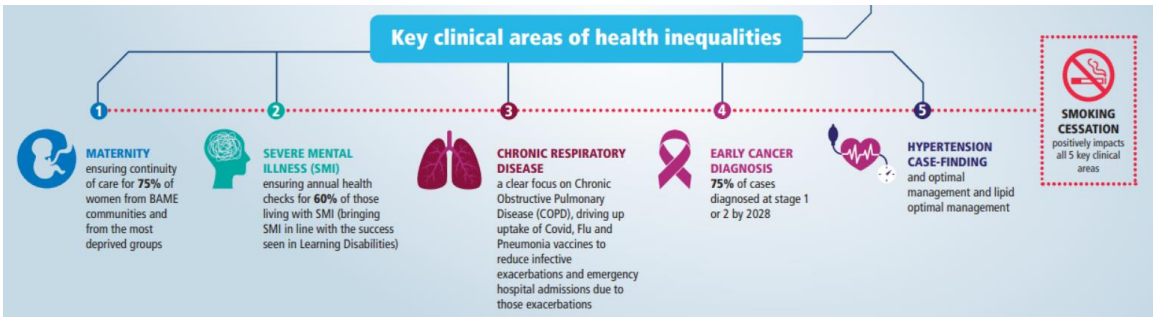

***Figure 1[8]** Key clinical areas of health inequalities in CORE20PLUS5 approach*

2.1 Smoking in Shropshire

Table 1 sets out the data for smoking in Shropshire compared to the national average in England and 15 comparable local authorities[9]. Smoking prevalence in Shropshire is similar to the national average and particularly higher in pregnant mothers, those working in routine and manual occupations, and among those with certain mental health conditions. Smoking-attributable hospital admissions also remain high in Shropshire.

Smoking is a cause of health inequalities in Shropshire. Approximately half of smokers will die on average 10 years earlier than non-smokers; 409 people in Shropshire die as a result of smoking every year. It is estimated that 8,101 households with a smoker in Shropshire fall below the poverty

line, with 1,232 people out of work due to smoking. The majority of smokers in Shropshire live in social housing (41%), only 7% are outright owners. It is estimated that 15,025 children in Shropshire live in smoking households-these children are four times more likely to become smokers than children in a home without a smoking parent.

Table 1. Smoking burden in Shropshire

Indicator	**Shropshire LA**	**National average (England)**	**Rank out of 15 'nearest neighbours' [(1)] 1=worst, 15=best**
Smoking burden			
Smoking prevalence (18yrs+) (2019 data) [(2)]	13.7%	13.9%	5
Smoking attributable mortality (directly standardised rate per 100,000) (2017-2019)	*173.7 per 100,000*	*202.2 per 100,000*	9
Smoking attributable hospital admissions (directly standardised rate per 100,000) (2019/20)	***1,475 per 100,000***	*1,398 per 100,000*	4
Mortality rate from lung cancer	*39.8*	*53.0*	12
Mortality rate from COPD (directly standardised rate per 100,000) (2017-2019)	*44.4 per 100,000*	*52.8*	7
Specific population groups			
Smoking status at age 15 (proportion % 2022) (modelled)	*4.7%*	*5.4%*	12
Smoking status at time of delivery (proportion %) (2020/21)	***11%***	*9.6%*	5
Smoking status at early pregnancy (proportion %) (2018/19)	***14.2***	*12.8*	-
Smoking prevalence in adults in routine and manual occupations *(proportion %) (2019)*	***25.6%***	*24.5%*	8
Odds of current self-reported smoking among adults aged 18-64 with a routine or manual occupation, compared to all other occupations (ratio) (2020) [(3)]	***3.1***	*2.1*	2
Smoking prevalence in adults with a long-term mental condition (proportion %) (2020/21)	23**%**	*26.3%*	10
Smoking prevalence in adults with anxiety or depression (proportion %) (2016/7)	**27%**	*25.8%*	3
Smoking prevalence in adults admitted for alcohol misuse (proportion %) (2019/20)	38.5	*43.9*	-
Smoking prevalence in adults admitted for treatment for opiate misuse (proportion %) (2019/20)	**83.3**	*70.2*	-

(1) 'Nearest neighbours' are determined based on the CIPFA model which is used to identify local authorities with similar geographies, resources and populations for more meaningful comparison

(2) The 2019 prevalence is displayed here rather than the 2020 estimate of 7.6%. It is estimated that this is not an accurate representation of true smoking prevalence for Shropshire. This is likely due to a change in data collection methods as a result of the Covid-19 pandemic.

(3) This estimate should be interpreted with caution. This is based on survey data affected by the COVID-19 pandemic.

NB: The emboldened values are where the value for that indicator for Shropshire is worse than the national value

2.3 Wider costs of smoking in Shropshire

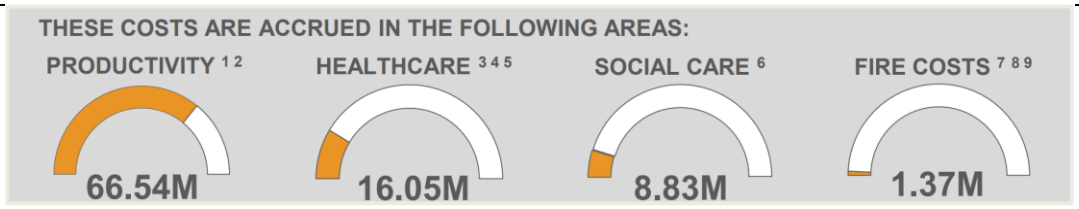

Figure 2: Costs of smoking per year in Shopshire[6] ASH Ready Reckoner 2022 - Action on Smoking and Health

Smoking represents a high level of cost to Shropshire's wider society as outlined in **Figure 2**. This is a total of £92.79 million every year. This compares with the £14 million that Shropshire council spends on Health & Wellbeing[10]. In Shropshire, £70.19 million is spent on tobacco (legal and illicit), with the average smoker spending £1,945 every year[6]. Cigarette butts are also an important pollutant, representing 66% of litter[11] and resulting in 17 tonnes of waste per year in Shropshire.

3.The Khan Review

The Khan Review: making smoking obsolete published on 9 June 2022 is an independent review of the 'smokefree 2030' ambition[12]. This was set out by government in 2019 as an objective to reduce smoking rates in England to 5%. The purpose of the report is to inform government action by setting out key recommendations for reaching this target.

3.1 Khan Review Findings

Main finding: The government will miss the smokefree 2030 objective by at least 7 years, with the most deprived in society projected to not reach it until 2044. A significant acceleration in the rate of decline of smoking prevalence is required if the target is to be reached. This will need to be supported by ambitious action at national and local level.

As a result of this review, Dr Khan calls on a new target to:

1. Ensure smoking prevalence in every community in every area is below 5% by 2035
2. Make smoking obsolete by 2040

Other important findings:

Crises such as the COVID-19 pandemic and the cost-of-living crisis exacerbate smoking-related inequalities. The proportion of young adults (18-24 years) who smoke rose from a quarter to a third during the COVID-19 pandemic. People in social housing are three times as likely to smoke than those with a mortgage. It is often the most deprived who spend most on smoking-thus reducing smoking prevalence in these groups would lift 2.6 million adults and 1 million children out of poverty. Over the past 10 years, public support for government action to limit smoking has increased, with 46% of people thinking the government is not doing enough to reduce smoking.

Out with the Khan Review, there is also concern of the wider association of smoking with other important modifiable risk factors. Evidence that those who smoke cigarettes at a young age are more likely to misuse alcohol or drugs are reported by some studies[13-14]. The reason for this remains unclear, with certain behavioural factors (likely socially mediated) potentially able to explain some of this association[15-17]. Understanding smoking initiation in young people as a risk factor for later drug and alcohol use may help to target those most at risk. Actions to prevent smoking and help smokers quit is likely to be of benefit to those who also seriously misuse alcohol or drugs given smoking prevalence in these groups is higher.

3.2 Khan Review Recommendations

*NB: See **Appendix 1** for a visual summary of the Khan Review recommendations*

The main recommendations made by the Khan Review focus on strengthening tobacco control by:

Investing in smokefree 2030

Reducing the number who start to smoke, particularly young people

Encouraging and supporting smokers to quit for good

Enabling the NHS to both prevent smoking and provide treatment and support to smokers to quit

Recommendation 1: (critical intervention): Urgently invest £125 million per year in interventions to reach smokefree by 2030.

This should be provided as ringfenced, targeted funding from government. If this is not possible, a tobacco industry levy placing a charge on tobacco company profits should be introduced.

Recommendation 2: (critical intervention): Raise the age of sale of tobacco from 19, by one year, every year

This will lead to a smokefree generation where young people below a certain age are legally prevented from becoming smokers throughout their entire lifetime.

Recommendation 3: Substantially raise the cost of tobacco duties (more than 30%) across all tobacco products, immediately.

This should include increasing tobacco duty on cheaper tobacco products (e.g. hand-rolled tobacco), and banning tobacco sales at duty-free entry points

Recommendation 4: Introduce a tobacco licence for retailers to limit where tobacco is available, and limit illicit sales.

This should include banning online and supermarket tobacco sales. This should also include disallowing new tobacco products into the market.

Recommendation 5: Enhance local illicit tobacco enforcement by investing additional funding of £15 million per year to local trading standards.

This means giving trading standards the authorities to close down retailers selling tobacco products illegally and should include higher enforcement on products such as shisha and nicotine-containing products. Trading standards found that one third of retailers were found to be willing to sell to under-18s.

Recommendation 6: Reduce the appeal of smoking.

This means both preventing new smokers and helping current smokers to quit. This should include reducing smoking media content and changes to cigarette packing, colour and form.

Recommendation 7: Increase smokefree places to de-normalise smoking and protect young people from second-hand smoke.

This should include increasing smokefree public places such as hospitality, hospital grounds and outside public spaces, but also in social housing.

Recommendation 8: (critical intervention): Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.

This should include both: 1) accelerating the uptake of Swap to Stop packs particularly in deprived communities, and 2) preventing the uptake of vaping by young people by reducing child-friendly packaging and presentation

Recommendation 9: Invest an additional ringfenced £70 million per year into stop smoking services

The numbers accessing Stop Smoking Services has reduced by 80%. Locally commissioned services based on targeted support for those most in need are an effective way to help people quit smoking and reduce inequalities. These services should be complemented by a national helpline and the availability of safe stop smoking medications.

Recommendation 10: Invest £15 million per year in a well-designed national mass media campaign, supported by targeted regional media

This should include nationwide, frequent stop smoking campaigns and messages across media outlets

Recommendation 11: (critical intervention): The NHS should prioritise smoking prevention, and provide support and treatment for smokers to quit across all its services including primary care

The NHS should uphold commitments made in the Long-Term Plan to reduce smoking in pregnant women and those with mental health conditions. Healthcare professionals should implement the 'very brief advice' method and offer medication rather than counselling support only. Hospitals should offer 'opt out' support for smokers in routine care

Recommendation 12: Invest £15 million per year to support pregnant women to quit smoking

This could include financial incentives and enhanced clinical support including a designated 'stop smoking midwife'.

Recommendation 13: Tackle the issue of smoking and mental health

This could include public-facing campaigns correcting the misperceptions of cigarette smoking as a stress reliever, as well as making smoking cessation part of mental health treatment in primary care as well as acute and community mental health services.

Recommendation 14: Invest £8 million to ensure regional and local prioritisation of smoking interventions through ICS leadership

This should include co-ordinated action and 'place-based partnerships' targeting a range of interventions including stop smoking services and trading standards. This should also include pharmacies supplying pharmacotherapy and behavioural support to the wider community, not only those discharged from hospital.

> *"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."*

Recommendation 15: Invest £2 million per year in new research and data.

This should include efforts to identify evidence-based interventions for tobacco control, and further understand smoking-related health disparities particularly on ethnic disparities and young people

4.Tobacco control and smoking cessation in Shropshire

4.1Tobacco control

The Council's Trading Standards Team has and continues to prioritise enforcement activities aimed at tackling the illegal tobacco trade, including the supply of illegal nicotine inhaling products (vapes), and preventing the sale of all types of tobacco products to children (under 18 years).

Work is being undertaken to tackle the illegal tobacco trade with funds provided by HMRC to National Trading Standards (NTS) to carry out this focused work. Co-ordination is carried out through

regional Trading Standards groups and in Shropshire the Trading Standards Team is part of the Central England Trading Standards Authorities (CEnTSA) group. The HMRC funded work commenced in the latter part of 2020/21 and will continue with funding that has been agreed by HMRC until the end of 2024/25. This work has focused on disrupting supply chains through detection and seizure of illegal and illicit tobacco products with investigations and legal action taken where perpetrators are identified. Further operations are being planned, the details of which need to remain confidential.

Visits (currently 17) have been undertaken across the county to a range of retail premises where 1044 illegal vaping products have been identified and seized. Underage test purchasing operations are undertaken every year for tobacco products, this means a volunteer minor attempts to purchase tobacco allowing a council officer to provide evidence of underage tobacco sales activity. In 2022/23 the focus is on vapes with 32 visits planned and to date 7 visits have resulted in one underage sale being made.

A number of the visits relating to vapes were conducted as part of a proactive intelligence gathering exercise. The project was implemented through the local Trading Standards tasking process in response to national, regional and local emerging trends, which had been identified through the Trading Standards tactical assessment. The intelligence gathering exercise has enabled Trading Standards to develop a greater understanding of the local market and this is ongoing.

4.2 NHS Tobacco treatment services

As mentioned above, tackling tobacco dependency is part of the NHS Long Term Plan with the aim that by 2023/24 all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services, including pregnant women and their partners and high-risk mental health outpatients. The TDT programme is based on learning from the Manchester CURE model[18] and the Canadian Ottawa model[19] for smoking cessation which provides evidence of the effectiveness of behavioural support and pharmacotherapy interventions for smoking.

The TDT service requires that patients who smoke are identified on admission/at maternity booking and are offered counselling support and pharmacotherapy on an 'opt out' basis to support a quit attempt. The expectation is that ongoing support (to total 12-weeks support) will be provided on discharge – either through a local public health commissioned stop smoking service or through a new service now being provided through community pharmacies (ie those that elect to provide the service).

To support local implementation a system Steering group was established in 2021 chaired by Shropshire CCG with representation from Shrewsbury and Telford Hospitals (SaTH), Midland Foundation Partnership Trust (MPFT), Local Authorities and NHSEI Leads. The programme's planned implementation was delayed until 2022-23 due to operational challenges from winter and the covid pandemic.

The maternity element is implemented as part of Shropshire's LMNS Healthier Pregnancy Programme. There is no requirement for community step down smoking cessation support as it provides behavioural support and Nicotine Replacement Therapy (NRT) for the full 12-week duration of smoking cessation support.

The acute in-patient element is an adaptation of the previous in-house smoking cessation service provided within SaTH, with step down smoking cessation support available via community pharmacies (i.e. those signed up to new advanced pharmacy service (see section 4.3 below).

The mental health in-patient element involves the introduction of a new service within MPFT and Shropshire Council is currently working with the trust to establish public health funded community step down support (see section 4.4 below).

4.3 Pharmacy smoking cessation support

The new national Community smoking Cessation Pharmacy Scheme has been nationally commissioned by NHSEI to enable community pharmacies to deliver the 12 week follow up at discharge (inclusive of behavioural stop smoking support and supply of NRT) for patients who have initiated a smoking cessation quit plan whilst in hospital.

Pharmacies can register to deliver the service and in Shropshire a small number have signed up to date. The original specification for the pharmacy service restricted the support to patients being discharged from acute inpatient services. Very recently the service specification has changed, and they can now receive referrals for patients discharged from mental health inpatient care as well.

4.4 Local authority smoking cessation support

Shropshire Council does not commission a dedicated stop smoking service; the Community stop smoking service (Help2Quit) was decommissioned in 2019. The service included smoking in pregnancy support, which has been maintained and this is now delivered by Shrewsbury and Telford Hospitals (SaTH) maternity as a core part of its Healthy Pregnancy Support Service. Local Support is available through the social prescribing service whereby one-to-one stop smoking behavioural support can be provided by a trained Advisor or patients can be supported to access universal information and app-based support available online via Better Health[20].

In addition, prior to COVID and as a response to this independent review there is a commitment to review service provision in Shropshire. As part of this, funding has been identified from Public Health reserves to prioritise provision of behavioural smoking cessation support for patients discharged from mental health inpatient care (as until recently pharmacies were not commissioned to provide this support). The cost of pharmacotherapy is being met by NHS Shropshire, Telford & Wrekin.

Work is now underway to develop the specification for a local authority service that can operate alongside the community pharmacy offer in providing post-discharge support. Whilst this was originally focused on providing support for mental health patients, the provision can be extended to include acute discharges and possibly wider community smokers (including the partners of maternity smokers). This will depend on further assessment of the number of smokers in the context of the limited resources. The intention is that any community provision provided through public health will be restricted to behavioural support only, with NRT/pharmacotherapy either being prescribed (at the discretion of GPs) or self-funded. In this context it is important to note the significant contribution vaping can make in successfully supporting quit attempts and potentially presents a more affordable option for patients.

5. Conclusion

Smoking accounts for more years of life lost than any other modifiable risk factor. It is also the single largest cause of health inequality. In Shropshire, smoking prevalence remains above the national average for key groups most affected by health inequalities, including pregnant women, those living with mental health conditions and people in routine and manual professions. Hospital admissions due to smoking are also high in Shropshire. Smoking currently costs the county over £92 million per year in productivity loss, health, social care and fire service costs. Shropshire council currently does not have a tobacco control strategy and following a 2019 service decommission there is limited funding for community smoking cessation services.

The Khan Review concludes that England is currently at least 7 years behind its target of making smoking obsolete by 2030, with more deprived groups much further behind. The review strongly recommends a new, accelerated commitment at national and local level to tackle smoking as a major cause of health inequalities. This will mean preventing people from starting to smoke, and helping smokers quit for good. The implications of this review for Shropshire is that smoking remains a problem for the local population, and investment into tobacco control and smoking cessation should be recognised as a key priority for achieving the objective of reducing health inequalities as set out in the 2022-2025 Shropshire Plan.

3.Recommendations

Shropshire Council has committed to reducing health inequalities in the Shropshire Plan 2022-2025. In light of this and the Khan Review, the recommendations below are suggested.

- Note the findings and recommendations made in the review, and the significant health social and economic benefits associated with making smoking obsolete

- The Board acknowledges that while the recommendations are primarily nationally focussed, the local need for investment in a tobacco control programme and smoking cessation services will need to be reviewed in light of the report

- The Board recognises the implications of the recommendations in relation to vaping and the extent to which local 'smokefree' policies should differentiate between smoking and vaping

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19. Ottawa Model for smoking cessation; University of Ottawa Heart Institute About OMSC | Ottawa Model for Smoking Cessation (ottawaheart.ca)
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Risk assessment and opportunities appraisal (NB This will include the following: Risk Management, Human Rights, Equalities, Community, Environmental consequences and other Consultation)	It is expected that health inequalities will persist in Shropshire between smokers and non-smokers, and particularly smokers in the most deprived groups if the action recommended in the Khan review is not taken. The significant health, social and economic costs will also persist, which threatens the extent to which communities will be able to thrive and reach their full health and wellbeing potential.
Financial implications (Any financial implications of note)	There are no immediate financial implications arising from this report. However, if the implications of this report lead to decisions on strengthening tobacco control and smoking cessation services provision then a financial cost (as well as wider savings) should be expected.
Climate Change Appraisal as applicable	This report anticipates no immediate impact on renewable energy use or carbon offsetting. There is also no direct impact on energy and fuel consumption predicted. However, the NHS currently accounts for 5% of the UK's total carbon emissions. Given the significant impact of smoking on NHS services it is likely that by reducing morbidity and mortality from smoking there will be an indirect reduction in associated NHS carbon emissions. Further, the clinical management of smoking-related respiratory disease most often involves the use of inhalers. Hydrocarbon inhalers have a significant impact on carbon emissions, accounting for 3% of total NHS emissions. As mentioned in this report, cigarette butts are the most common item found in rubbish bins (66% of total items). This causes both local and global pollution through plastic and landfill waste, as well as deforestation impacts related to tobacco production.
Where else has the paper been presented?	**System Partnership Boards** | **Voluntary Sector** | **Other**

List of Background Papers (This MUST be completed for all reports, but does not include items containing exempt or confidential information)

The Shropshire Plan 2022-2025, Shropshire Council

Cabinet Member (Portfolio Holder) or your organisational lead e.g. Exec lead or Non-Exec/Clinical Lead (List of Council Portfolio holders can be found at this link: https://shropshire.gov.uk/committee-services/mgCommitteeDetails.aspx?ID=130)

Cllr. Simon Jones Portfolio Holder Adult Social Care and Public Health

Appendices

Appendix 1 Visual summary of the Khan Review recommendations

The Khan Review: Independent review into smokefree 2030 policies

Four critical recommendations are boxed in red. These are 'must dos' for the government to achieve a smokefree England by 2030 , around which all other interventions are based.

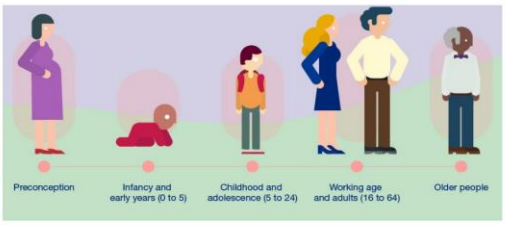
Part 1: Invest Now

REC 1: Urgently invest £125m per year in interventions to reach smokefree 2030.

Option 1: Additional funding from within government
Option 2: A 'polluter pays' industry levy
Option 3: A corporation tax surcharge

Part 2: Stop the Start

REC 2: Raise age of sale of tobacco by one year, every year.



The image above shows **the lifecycle of a smoker**. From smoking in pregnancy and the impact on the unborn baby, to old age, where 2/3 lifetime smokers will likely die from smoking. Interventions are needed at all stages of a person's life.

REC 3: Substantially raise the cost of tobacco duties (more than 30%) across all tobacco products, immediately. Abolish all duty free entry of tobacco products at our borders.

REC 4: Introduce a tobacco licence for retailers to limit where tobacco is available.

REC 5: Enhance local illicit tobacco enforcement by dedicating an additional funding of £15 million per year to local trading standards.

REC 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.

REC 7: Increase smokefree places to de-normalise smoking and protect young people from second-hand smoke.

Part 3: Quit for Good

REC 8: Offer vaping as a substitute for smoking, alongside accurate information on the benefits of switching, including to healthcare professionals.

REC 9: Invest an additional £70 million per year into 'stop smoking services', ringfenced for this purpose.

REC 10: Invest £15 million per year in a well-designed national mass media campaign, supported by targeted regional media.

Part 4: System Change

REC 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

REC 12: Invest £15m per year to support pregnant women to quit smoking in all parts of the country.

REC 13: Tackle the issue of smoking and mental health.

REC 14: Invest £8m to ensure regional and local prioritisation of stop smoking interventions through ICS leadership.

REC 15: Invest £2 million per year in new research and data, including investing £2 million in an innovation fund.