Department of Health
An Roinn Sláinte
Männystrie O Poustie
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THE 10 YEAR TOBACCO CONTROL STRATEGY FOR NORTHERN IRELAND

FINAL REVIEW

2023

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Executive Summary

The Ten-Year Tobacco Control Strategy for Northern Ireland[1] ('the Strategy') was launched in 2012 and had an overall aim to create a tobacco-free society. Following the completion and publication of a Mid-Term Review in 2020[2], the Strategy was extended until 2024 to allow for work on an End Review and progression of a successor strategy.

This End Review report reflects on the achievements and progress made over the lifetime of the Strategy. It also identifies remaining challenges and areas for further consideration in the development of the successor strategy. Given the short passage of time since the Mid-Term Review, and limited opportunities for implementation of recommendations made in that report, the Mid-Term Review recommendations should also be considered in conjunction with this report and in the development of a successor strategy (these recommendations are attached at Annex 2).

The review was supported by the Institute of Public Health in Ireland (IPH) and the Public Health Agency (PHA). The IPH provided an analysis of local data relating to smoking and mental health and an overview of policy initiatives across the UK. The IPH also facilitated work by the University of Stirling which considers progress made in Northern Ireland in relation to second-hand smoke exposure and sets out recommendations for future work in this area.

Overall, significant progress has been made during the implementation of the Strategy. At population level we see a decline in smoking prevalence, and this is evident across all target groups.

However, there remain significant inequalities in smoking prevalence. We see that, over the lifetime of the Strategy, those living in the most deprived areas have consistently been between two and three times more likely to smoke as those living in the least deprived areas. Inequalities in smoking prevalence also persist amongst other groups, particularly those with mental ill-health; with probable clinical depression being four times more common among current smokers than among those who had never smoked. The COVID-19 pandemic has also impacted on smoking cessation services and our successor strategy will therefore need to consider how best to maximise smoking cessation uptake and target services to need.

Whilst we have made commendable strides in protecting people from second-hand smoke, further measures are needed aimed at reducing exposure in home settings. We also need to look at ways of protecting those still exposed to second-hand smoke in their workplaces.

Internationally, tobacco control has seen many changes over the lifetime of the current Strategy, and we need to reflect on such developments as we move forward. However, many of the challenges remain the same, with tobacco use still a leading cause of preventable illness and premature death. As we develop a successor strategy, we will also need to be mindful of the development of other nicotine-

containing products, and our next strategy will need to set out clearly our role and objectives in relation to these.

1. Background to the Tobacco Control Strategy

1.1 In recognition of the continuing high levels of preventable ill-health and premature deaths caused by tobacco use, the Ten-Year Tobacco Control Strategy for Northern Ireland was launched in February 2012. The Strategy's overall aim was to create a tobacco-free society and in pursuit of that aim three key objectives were set: fewer people starting to smoke, more smokers quitting, and protecting people from tobacco smoke. The Strategy identified 3 priority groups: Children and young people, disadvantaged people who smoke, and pregnant women (and their partners) who smoke. A number of specific targets were set, each to be achieved by 2020:

TARGETS BY 2020

- **Reduce the proportion of 11-16 years old children who smoke to 3% (from a baseline of 8%).**
- **Reduce the proportion of adults who smoke to 15% (from a baseline of 24%).**
- **Reduce the proportion of pregnant women who smoke to 9% (from a baseline of 15%).**
- **Reduce the proportion of smokers in manual groups to 20% (from a baseline of 31%).**
- **Ensure that a minimum of 5% of the smoking population in Northern Ireland accesses smoking cessation services annually.**

Mid-Term Review

1.2 A Mid-Term Review of the Strategy[3] was completed in February 2020. The review provided a comprehensive appraisal of progress which took account of stakeholder views, an evidence review, and the PHA summary of outputs.

1.3 The review reported on progress to the targets based on the results of the 2018/19 Northern Ireland Health Survey[4]. It acknowledged that whilst some progress had been made, there was still some way to go in relation to the majority of the 2020 targets and acknowledged that the overall prevalence target for adults was unlikely to be met.

1.4 In particular, the review found that several challenges remained in relation to disadvantaged groups, especially those living in areas of high deprivation and those with mental ill-health. The continued high smoking prevalence amongst those who are pregnant, especially in the most deprived areas where rates are more than four times that in the least disadvantaged areas, remained a concern.

1.5 There were also indications of progress, particularly in relation to the fall in smoking prevalence amongst children. There was evidence of extensive work by the PHA and stakeholders in addressing the strategic priorities and the evidence review found that much of that activity was in keeping with the review level evidence of best practice.

1.6 The Mid-Term Review made several recommendations for the remaining limited duration of the Strategy with a particular focus on the challenges identified. The action plan, developed to implement the 2012 Strategy, was subsequently refreshed to take account of the remaining duration of the Strategy and the recommendations made in the Mid-Term Review. It is acknowledged that not all the Mid-Term Review recommendations were integrated into the current action plan or completed and that, in the development of a successor strategy, it will be necessary to revisit outstanding and incomplete Mid-Term Review recommendations alongside the recommendations from this report.

Extension of the Strategy

1.7 Unfortunately, publication of the Mid-Term Review in February 2020 was swiftly followed by the COVID-19 pandemic. The resulting pressures on the PHA and the Department of Health meant that implementation of the recommendations has not been at the pace anticipated. In October 2021, the Minister of Health announced his decision to extend the current Strategy until 2024, to allow for continued strategic direction whilst work on an End Review, and on any recommended successor strategy, was progressed.

2. Strategy End Review Process

2.1 Given the proximity to the Mid-Term Review, and to avoid duplication of content and effort, the Tobacco Strategy Implementation Steering Group (TSISG) agreed to a proportionate End Review process whereby the evidence and conclusions established at the Mid-Term Review would be enhanced. It was also agreed that the Department should complete the review in conjunction with the PHA and the IPH. The review would also feed into considerations for a future strategy.

Evidence

2.2 The IPH conducted a comprehensive evidence review[5] as part of the Mid-Term Review process which captured evidence in relation to priority groups and the Strategy's aims.

2.3 The Mid-Term review also noted that smoking prevalence is high in relation to people reporting a possible psychiatric disorder. Those with severe mental illness are more likely to die prematurely due to modifiable health-risk behaviours such as tobacco smoke. The review recommended that TSISG formulate a plan for the development of actions and targets in relation to people with mental ill-health which should consider both short term actions and the potential for inclusion of those with mental ill-health as a priority group in any successor strategy.

2.4 Given the lack of progress on this recommendation, and to complete the evidence picture, it was determined that additional information was now required as part of the end review in relation to mental health and smoking.

2.5 The IPH agreed to complete this piece of work which consisted of a quantitative analysis of the survey data on mental health and tobacco use in Northern Ireland along with a document analysis looking at published accounts of smoking and mental health-related policy initiatives in the other UK nations and the Republic of Ireland.

2.6 In addition, the IPH agreed to facilitate a project capturing expert reflections on progress made in Northern Ireland on reducing second-hand smoke exposure. Protecting people from second-hand tobacco smoke is a specific aim of the Strategy and a review of progress was considered necessary to inform discussions for a future strategy. A rapid review was subsequently taken forward by experts in the University of Stirling.

Progress and Activity

2.7 The PHA was tasked with providing an overview of progress in delivering the Strategy. Activity and achievements, which were comprehensively captured in the

Mid-Term Review report, have been updated, and include any evidence of impact and/or evaluation material.

Stakeholder Engagement

2.8 Stakeholder engagement was undertaken by the IPH using a structured and facilitated workshop. This was held on 23rd August 2022 and included a post-workshop survey. The findings build on previous engagement during the Strategy's Mid-Term Review[6]. DoH, PHA, and IPH compiled a list of stakeholders that included those with an involvement in the Strategy delivery and in broader health service policy development, including members of TSISG, key voluntary sector interests, DoH policy colleagues, and delivery partners.

2.9 A selection of respondents attending the workshop were asked to provide feedback on the key achievements of the Strategy. Participants then worked in groups to discuss future strategic requirements.

2.10 28 people participated in the workshop and 7 provided written responses.

2.11 The questions posed were aimed at eliciting views on:

- The achievements of the strategy.
- The changes delivered for priority groups.
- What could have been done differently.
- The goals and ambitions of a future strategy.
- The components of the current strategy that should remain and those that should change.

3. Summary of Progress

Overall Aim: To create a tobacco-free society.

OBJECTIVES

- Fewer people starting to smoke.
- More smokers quitting.
- Protecting people from tobacco smoke.

3.1 While the Strategy set an overall aim of creating a tobacco-free society, it also identified several priority groups within the overall smoking population. In addition, the Strategy set specific targets for reducing prevalence within these priority groups by 2020.

PRIORITY GROUPS

- Children and young people (aged 11-16 years).
- Disadvantaged people who smoke.
- Routine and manual workers.
- Pregnant women and their partners who smoke.

Progress in relation to Strategy targets

Data collection

3.2 The Covid-19 pandemic led to a change in Health Survey methodology with surveys being conducted by telephone rather than face to face, and with a reduced sample size. As a result, the 2020/21[7] and 2021/22[8] Health Survey smoking estimates may not be directly comparable with previous years.

3.3 All the target groups have seen an overall decline in terms of smoking rates over the lifetime of the Strategy. However, despite considerable success in reducing smoking prevalence, the key targets set for 2020 were not achieved and smoking prevalence continues to remain higher than the 2020 targets.

Table 1 – Progress in relation to targets.

Target Group	Position in 2010	Target by 2020	2020 Position	2023 Position***
Children and young people (11-16 yrs.)	8%	3%	**4%**	**NO UPDATE AVAILABLE**
Adult population of Northern Ireland	24%	15%	**17%**	**17%**
Manual groups*	35%*	20%*	**26%***	**25%**
Pregnant Women	17%**	9%**	**12%****	**11.1%**

3.4 An additional target from the 2012 Strategy was to ensure that a minimum of 5% of the smoking population in Northern Ireland accesses smoking cessation services annually: In 2018/19 this figure was 5.2%. However, the COVID-19 pandemic has had a detrimental impact and post-pandemic figures from 2020/21 show a fall to 3.1% service reach.

** a change in classification methodology for National Statistics Socio-Economic Classification (NSSEC) applied from 2014/15. The 2010/11 baseline of 31% used in the original Strategy (which referred to the old classification of manual workers) does not directly equate in relation to the newer classification of routine and manual workers. The new classification methodology for NSSEC has been applied to 2010/11 with the new figure for routine and manual workers 35%.*

*** a change in data source for percentage of women that reported smoking in pregnancy has led to a revision of the baseline figure from 15% to 17%. The 2010/11 baseline of 15% used in the original Strategy was sourced from the Infant Feeding Survey (IFS) however, as the survey was discontinued in 2010, the Northern Ireland Maternity System (NIMATS) has replaced the IFS as the source for all figures.*

2020 position is based on The Health Survey 2019/20[9], The Young Persons Behaviours and Attitudes Survey 2019 (11-16 year olds)[10], and the Health Inequalities Annual Report 2022[11] via NIMATS (pregnancy).

****2023 position is based on The Health Survey 2021/22 and the Health Inequalities Annual Report 2023[12].*

The Young Persons Behaviours and Attitudes Survey 2019 (11–16-year-olds) remains the most up-to-date data so there is no update available for 2023 in relation to children and young people,

Smoking trends over the lifetime of the Strategy

3.5 Further trend data on smoking-related behaviours over the lifetime of the Strategy is set out in Annex 1. This information is primarily based upon extracts from the DoH publication: *Health Survey Smoking in Northern Ireland 2010/11 to 2019/20*[13]. To ensure valid reporting of trends, the trend information at Annex 1 refers to trends established through the most recent Health Survey figures where the survey was conducted face to face i.e., 2019/20.

3.6 In general, as Table 1 sets out, smoking prevalence has declined during the lifetime of the Strategy for all priority groups. Additionally, there has been progress in relation to exposure to second-hand smoke with the proportion of respondents that indicated smoking was not allowed in their house showing a gradual increase from 72% in 2010/11 to 86% in 2018/19.

3.7 However, there are notable trends that have either not changed during this time or have seen a negative trend. For example:

- Those living in the most deprived areas have consistently been between two and three times more likely to smoke as those living in the least deprived areas.
- The age that smokers have started smoking regularly has remained relatively unchanged over the ten years between 2010/11 and 2019/20, with approximately two-thirds of those who ever regularly smoked cigarettes having started smoking regularly before the age of 18.
- The proportion of births where the mother reported smoking during pregnancy in the most deprived areas remains over four and a half times the rate in the least deprived areas.
- From 2015/16 to 2019/20, current smokers were asked about their intentions to quit smoking. Over this time the proportion of current smokers who said they wanted to stop smoking and intended to do so in a set period decreased, while the proportion of current smokers who said they “don't want to stop smoking” doubled from 9% in 2015/16 to 18% in 2019/20.

Health Outcomes

3.8 The Strategy did not identify specific targets in terms of health outcomes. Since tobacco related harms occur mainly because of exposure over a sustained period, it is difficult to make direct correlations to the time-period of the most recent strategy. However, it is important to reflect on such trends over the longer term.

Hospital Admissions

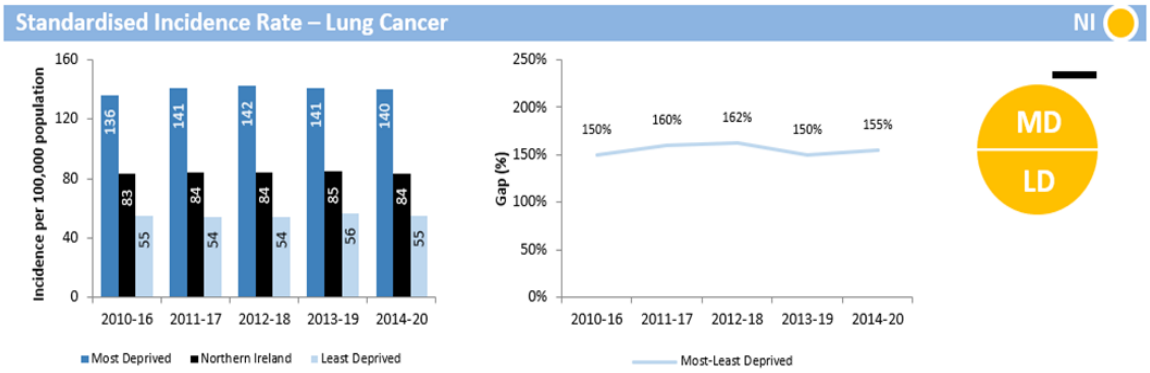
3.9 In 2021/22 there were 34,930 smoking attributable hospital admissions in Northern Ireland[14], but it should be noted that figures for 2021/22 may have been affected by the impact of the COVID-19 pandemic on service provision[15]. In 2019/20 there were 38,617 smoking attributable hospital admissions in Northern Ireland which was an 18% increase on the number in 2010/11 (32,607).

Incidence of Lung Cancer

3.10 Whilst smoking increases the risk of developing more than 50 serious health conditions, its role in causing lung cancer is particularly well documented. Although people who have never smoked can develop lung cancer, smoking is the most common cause (accounting for more than 70 out of 100 cases[16]).

3.11 Between 2010-16 and 2014-20, there was no notable change in the lung cancer incidence rate for Northern Ireland. In addition, the most-least deprived inequality gap remained at a similar level across the period, with the incidence rate in the most deprived areas around two and a half times the rate seen in the least deprived areas.

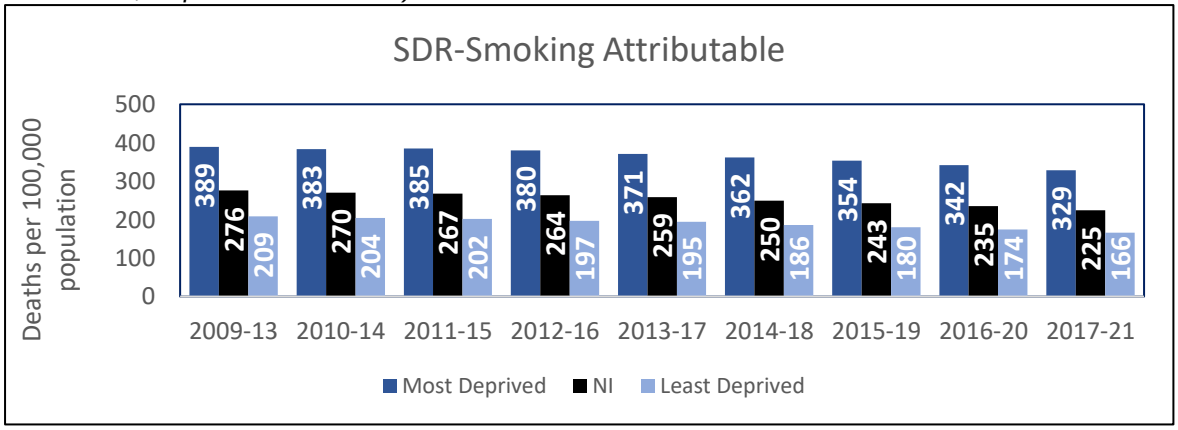
Figure 1 - Standardised Incidence Rate – Lung Cancer (provided by Information Analysis Directorate, Department of Health).



Standardised Death Rate

3.12 The latest official statistics show that death rates from smoking attributable causes have decreased between 2009-13 and 2017-21 in Northern Ireland and in the most and least deprived areas. However, the inequality gap has increased slightly over the period, with death rates in the most deprived areas double the rates seen in the least deprived areas.

Figure 2 – Standardised Death Rates – Smoking Attributable (provided by Information Analysis Directorate, Department of Health)

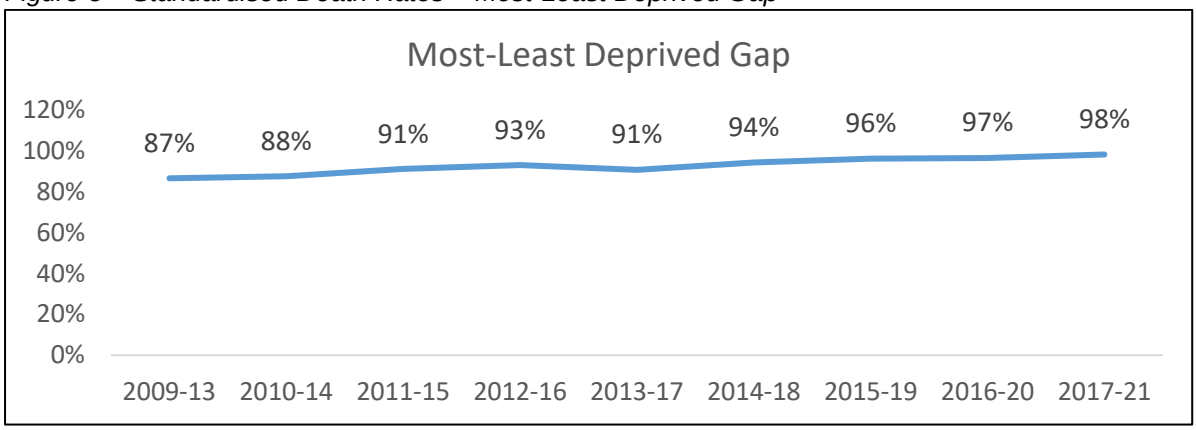


3.13 Between 2009-13 and 2017-21, the smoking attributable death rate in Northern Ireland decreased by almost a fifth (18%) from 276 to 225 deaths per 100,000 population.

3.14 Over the same period, the rate in the 20% most deprived areas of Northern Ireland decreased by 16% from 389 to 329 deaths per 100,000 population, however the rate in the 20% least deprived areas decreased to a greater extent (21%) from 209 to 166 deaths per 100,000 population, leading to a slight widening of the inequality gap from 87% in 2009-13 to 98% in 2017-21[17].

This means that smoking caused around 2,200 deaths a year in the 2017-21 period.

Figure 3 – Standardised Death Rates – Most-Least Deprived Gap



Note that figures relating to standardised death rates, deprivation gaps, and lung cancer rates may be subject to change in the future in light of the release of revised mid-year population estimates in Northern Ireland for 2011-2021

Summary of action plan activity

3.15 The following tables summarise the activity undertaken along with any evaluation material held by the PHA, and/or other evidence of impact. The tables also include a summary of the remaining challenges against each Strategy objective, based on evidence available, data, engagement with stakeholders, and issues highlighted in the reports that accompany this review.

OBJECTIVE 1: Fewer People Starting to Smoke

Strategic Priority	Action	Evaluation, Evidence, and Impact
Target Group: Children and Young People		
Preventing those under the legal age of sale from accessing tobacco products through legislative measures. There have been several key legislative achievements during the lifetime of the Strategy including:	Legislation to ban tobacco sales from vending machines.	In 2016, evaluation of vending machine legislation showed a high level of compliance with no recorded breaches of the ban.
	A ban on the display of tobacco products at point of sale.	In the mid-term review of the Strategy in 2020, the evidence review found that there is consistent evidence that standardised packaging reduces the appeal of smoking and that initiatives such as the ban on the display of tobacco products are significant in reducing the appeal, accessibility, and affordability of tobacco products to children[18].
	Standardised packaging of tobacco products.	Standardised Packaging of Tobacco Regulations post implementation review: standardised packaging regulations have been effective in meeting objectives.
	The Tobacco Retailers Act (Northern Ireland) 2014[19] which introduced a requirement for tobacco retailers to register, created several new offences, and provided for the application of fixed penalties and banning orders.	Post Project Evaluation confirmed that the tobacco retailer register had met its objectives, to improve tobacco control enforcement through the development of a central tobacco retailers register; to provide an information service to members of the public with regards to tobacco retailers in their area; and to enable the Department to gather relevant data on the sector to aid policy development.
	The Nicotine Inhaling Products (Age of Sale and	In evaluating the media campaign that accompanied the ban on e-cigarettes sales to under 18's respondents were asked if this advertising encourages

Strategic Priority	Action	Evaluation, Evidence, and Impact
	Proxy Purchasing) Regulations (Northern Ireland) 2021[20] banned the sale of nicotine inhaling products (NIPs) to children to address any potential gateway to tobacco use.	them to support the new legislation which makes it an offence to sell NIPs (e-cigarettes) to anyone who's under 18, and to purchase or attempt to purchase on behalf of someone under 18. Over seven in ten (71.7%) said it did.
Ensuring that educational establishments, from primary through to tertiary level, are educating and/or appropriately supporting awareness raising amongst children/young people as to the harm caused by tobacco. A number of programmes have been developed and delivered including:	Smokebusters – delivered to 9-11 year-olds and in 600 schools (annually).	**In 2022/23:** The Smokebusters programme was delivered to 6825 pupils aged 9-11 and 36% of those pupils attend schools in areas of greater socioeconomic deprivation. While throughout the Strategy the number of children participating has decreased, the % of children involved in the programme from areas of greatest deprivation has increased.
	Dead Cool – smoking prevention programme aimed at Year 9 pupils and delivered by teachers.	Dead Cool intervention was shown to deliver a significant positive short-term effect (over an academic year) on preventing smoking initiation in Year 9 pupils, equivalent to 1.5 fewer pupils taking up smoking per 100 pupils exposed to the intervention. However, its evaluation does note a limitation to be considered in terms of the representativeness of the sample population and the generalizability of the results.
	The ASSIST intervention which is designed to train influential pupils to encourage others not to smoke.	ASSIST was a time-limited Queen's University Belfast led programme but did not progress to a regional roll-out in Northern Ireland. Further consideration of the impact of social networks on social norms in preventing smoking initiation may be warranted.
	Smoking awareness sessions offered by HSCTs during fresher events and no smoking days/months at	An example of this work included a 2022 Fresher event at Belfast Metropolitan College attended by 1600 students of which 7 enrolled on stop smoking service offered by Cancer Focus Northern Ireland (CFNI). On-site clinic offered in BMC with 11 people attending. 13 students enrolled in 22/23 in total with 7 having

Strategic Priority	Action	Evaluation, Evidence, and Impact
	further/higher education colleges and university campuses. Stop smoking services also funded where there is a demand.	successfully quit at 4 weeks. No Smoking Month events (2023) held in all South Eastern Regional College campuses - 11 students enrolled in stop smoking services. In Northern Ireland 4% (approximately 5,700) 11-16 year-olds are current smokers (down from 8% in 2010). One in 10 young people have ever smoked (10%), down from 37% in 2000.
Target Group: General Population		
Further reducing the impact of tobacco marketing either through (a) legislation or (b) public information campaigns aimed at negating messages put out by the tobacco industry. Legislative	2011/12 – Things to do before you die/Never give up on giving up.	Results show that the campaign has been highly successful against all three objectives set. **Continuing to raise awareness of the health effects of smoking.** Independent research showed 75.8% of respondents (smokers) had seen at least one element of the health-based 'Things to do before you die' strand. 94.2% of smokers exposed to the campaign indicated that they found it to be 'very' or 'somewhat' thought provoking and 80.3% indicated that it was 'very' or 'somewhat' relevant to them – extremely high figures for a long-running public health topic such as smoking. **Encouraging smokers to request and use the new Quit Kit.** Independent research showed 60.3% of respondents (smokers) had seen at least one element of the 'Never give up on giving up' 'how' strand. In total, during the campaign period there were 19,453 Quit Kit requests. Analysis

Strategic Priority	Action	Evaluation, Evidence, and Impact
developments outlined above. Key Campaigns have included:		shows that Quit Kit requests were highly influenced by campaign activity with on average nearly three times as many kit requests when the campaign was live than when it was off air. Independent research amongst 1,000 Quit Kit requestors showed 58% were from the 3 lower socio-economic groups. **Increasing the numbers of smokers making a quit attempt.** The high level of awareness and strong levels of action have translated into a significant number of people attempting to quit smoking. In the survey amongst smokers who had requested a Quit Kit, three-quarters (74.7%) of respondents had attempted to quit smoking. At time of interview, 26.7% of respondents indicated that they had still successfully quit.
	2013/14 – Make them proud/Stop for good.	72 % of respondents (smokers) had seen at least one element of either the *Make them Proud* strand or *Stop for Good* strand. 61% of smokers were aware of *Make them Proud* and 46% of smokers were aware of the *Stop for Good* strand. In order to ascertain the impact of the various campaign elements of the *Make them Proud* strand, current smokers who indicated having seen or heard the advertisements were asked if it made them think about their current smoking behaviour. The television advertising had the greatest impact on making smokers think about their current smoking behaviour with 83.6% saying it either 'very much' or 'somewhat' made them think about their smoking (radio 71.2%, poster 70.1%). 40.6% of smokers who had seen the *Make them Proud* television advertisement had done something to change their smoking behaviour. The most common action taken by smokers was in trying to reduce the amount that they smoked (26.8% of those who had seen the TV advert, 15.4% of those who had heard the radio advert). A quit attempt was made by 6.7% of smokers who had seen the *Make them Proud* TV advert and 4.5% of smokers who had heard the *Make them Proud* radio advert.

Strategic Priority	Action	Evaluation, Evidence, and Impact
		Current smokers who indicated having seen or heard the *Stop for Good* strand were asked if it made them think about their current smoking behaviour. A high proportion of smokers said the advertising made them either 'very much' or 'somewhat' think about their current smoking behaviour (radio 72.5%, TV 64.5%, press 63.8%). A quit attempt was made by 5.9% of smokers who had seen the TV advert and 0.8% of smokers who had heard the radio advert.
	2015/16 – 1 in 2 smokers will die from a smoking related illness/You can quit, we can help.	**Awareness** - High level of exposure to the campaign - 80.6% of smokers recalled the campaign advertisements (TV and radio). Of those smokers exposed to the TV advert, 32.6% changed their smoking behaviour, as a result. The *want2stop* website experienced 26,000 visits and approximately 3,500 requests for the quit kit were received over the 3 months the campaign ran. The following comments were received from smokers: *"I'm off them over a month now. This (*1 in 2 advert) *put it into perspective for me. It really has hit home with me. I have no interest in smoking anymore."* *"I smoked for 43 years, and when I heard him say, 1 in 2 smokers die of cancer, I used to think I was a 2 but now I'm a 1, that stuck in my mind. I have now stopped for 6 weeks."*

Strategic Priority	Action	Evaluation, Evidence, and Impact
	2016/17 – Gerry Collins campaign.	**Awareness** - High level of exposure to the campaign 87% aware of the campaign (smokers 85% and recent ex-smokers 91%). **Behaviours** Of those **smokers exposed to the campaign**, when asked if, as a result of seeing or hearing any of the advertising, they had done anything to change their smoking behaviour, almost a third (32.6%) had tried to change their smoking behaviour. The majority had tried to reduce the amount they smoked. Being exposed to the campaign had a positive effect on smokers, as when asked if the advertising had made them more or less likely to quit smoking or made no difference, over a third indicated that it had made them more likely to quit smoking. Of those **ex-smokers exposed to the campaign***, almost a quarter (23%) said the campaign advertising encouraged them to quit and almost half (46%) said it helped them to stay quit. **Support** Pharmacies were promoted as part of the campaign advertising as somewhere smokers could go for help and support. 70.7% of smokers exposed to the TV advertising were aware they could access a pharmacy for stop smoking services. * Recent ex-smokers – quit in the last year.
	2017/18 – Continuation of Gerry Collins campaign.	Ran until May 2017 based on results above.
	March 2019 – Launch of new identify for stop smoking services along with new mass media campaign. This campaign ran from 04-	**Kerri's Story/launch of new stop smoking service identity –** the campaign was evaluated through an omnibus survey. The sample concentrated on smokers and a small number of recent ex-smokers. The survey achieved interviews with a total sample of 338 smokers and 137 ex-smokers (weighted sample).

Strategic Priority	Action	Evaluation, Evidence, and Impact
	31 March 2019 and featured local mum Kerri, who quit smoking with support from a local stop smoking service. Media advertising comprised of television, radio, outdoor and digital.	More than two-fifths could recall seeing the new stop smoking service identity (41.5%). Recent quitters were more likely to recall seeing the Stop Smoking Services logo than smokers, with almost 2 in 3 recent quitters (65.0%) compared to one third of smokers (32.0%) being able to recall the logo. Respondents were shown or played each element of the campaign advertising and asked if they had seen or heard any of the advertisements. Overall, 74.3% of respondents were able to recall at least one element of the advertising campaign. **All respondents were shown the campaign advertising.** • 68.4% agreed/strongly agreed with the statement *this advertising would encourage me to think positively about the Stop Smoking Service*. • 63.2% agreed/strongly agreed with the statement *this advertising would encourage me to use a stop smoking service*. • 59.5% agreed/strongly agreed with the statement *this advertising would encourage me to think about stopping smoking*. • Overall, almost three quarters (73.5%) of respondents reported that the advertising campaign would encourage them to agree with at least one of the above statements, with over half of respondents agreeing with all three statements.

<table>
<tr><th>Strategic Priority</th><th>Action</th><th>Evaluation, Evidence, and Impact</th></tr>
<tr><td rowspan="2">Raising public awareness as to the harm caused by smoking, through traditional methods as well as exploiting new media such as Facebook, Twitter etc.</td><td>Many new approaches to targeting audiences have been developed, including increased use of social media and a newly launched website.</td><td>In addition to the mass media campaigns an ongoing programme of communications activity is undertaken to highlight the harm caused by smoking and the support available to help smokers quit. This activity includes proactive engagement with the press and broadcast media, messaging, and video content on social media channels. Messaging on health effects of smoking also included in related campaigns such as Living Well community pharmacy Spot Cancer Early campaign.

Sample year 2018/19 - the website received 35,117 visits, with the highest number of visits in any one month occurring during the month of March when the public information campaign was aired.</td></tr>
<tr><td>A variety of educational and campaign support materials are available and the Quit Kit (aimed at those preferring a self-help approach) was updated in 2016.</td><td>In 2018/19, there were 2,317 requests for a Quit Kit (peaked in March – the month when the information campaign aired). The provision of Quit Kits has been paused pending review of contents and consideration of best practice in self-help resource provision.

<table>
<tr><th>Year</th><th>Number of hits on PHA stop smoking website</th><th>Number of requests for PHA quit kits</th></tr>
<tr><td>2013-14</td><td>47,085</td><td>7,629</td></tr>
<tr><td>2014-15</td><td>44,001</td><td>6,065</td></tr>
<tr><td>2015-16</td><td>47,529</td><td>4,070</td></tr>
<tr><td>2016-17</td><td>74,403</td><td>3,573</td></tr>
<tr><td>2017-18</td><td>34,932</td><td>2,324</td></tr>
<tr><td>2018-19</td><td>35,117</td><td>2,317</td></tr>
<tr><td>2019-20</td><td>32,358</td><td>Not available</td></tr>
<tr><td>2020-21</td><td>24,971</td><td>Not available</td></tr>
<tr><td>2021-22</td><td>25,270</td><td>Not available</td></tr>
<tr><td>2022-23</td><td>30,484</td><td>Not available</td></tr>
</table>
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OBJECTIVE ONE - REMAINING CHALLENGES

- Young people in the most deprived areas are more likely to have ever smoked (13%) than those in the least deprived (7%), although the rate of current smoking was similar (5% & 3% respectively). YPBAS 2019

- Availability of cheap illicit tobacco has continued potential to undermine legislative initiatives to reduce availability of tobacco to young people – there is a need to better understand the illicit market and work with other organisations to jointly address this where possible.

- Apparent increase in youth vaping in other parts of the UK – we need to better understand patterns developing and any correlation with smoking behaviours, establish appropriate communications on vaping, and identify the strategic response required.

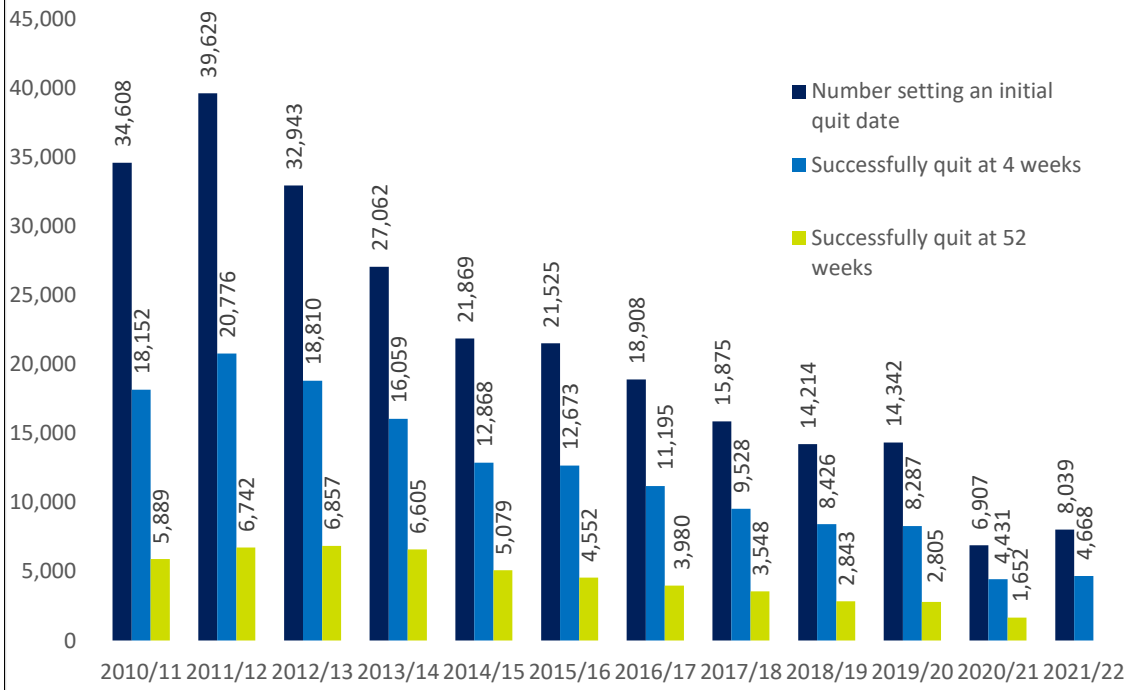
- Need for engagement and communications specifically targeted at young people.

OBJECTIVE 2: More Smokers Quitting

Strategic Priority	Action	Evaluation, Evidence, and Impact
Target Group: Children and Young People		
Increasing awareness of specialist cessation services. The PHA and HSC Trusts have promoted stop smoking services and messages at a variety of venues.	GAA smoke-free touchlines: the PHA funded the Healthy Club project to provide resources, promotion of quit services, brief intervention training, and signage for clubs.	36+ clubs signed up in Northern Ireland, including providing brief intervention to patrons and signposting to cessation services as per the 'Healthy Clubs' initiative.
	The PHA commission a youth-focused smoking reduction and awareness programme: this is currently delivered by CFNI and aligns with No Smoking Day activity.	This work happens in a variety of school and youth settings and in an example year of 2022/23 over 2000 children and young people received awareness raising sessions. While youth enrolment in services has been traditionally low compared to adults, youth services have demonstrated circa 54% 4 week Quit Rates, exceeding quality standards (see further detail in Quality Standards[21]).
Undertaking research to determine how to increase the uptake of cessation services by young people.	The PHA commissioned research to explore attitudes, knowledge, and behaviours of young smokers. This showed that whilst this group acknowledged some risk, the majority did not accept that this was relevant to them. The research also highlighted the importance of family	In response to this, and findings at mid-term review, the steering group has been restructured and now includes a workstream focusing on Early years, Children, and Young People. As this was a recent change, there has been limited opportunity to progress this, but refreshed action plan includes exploring possibility of a pilot service for children and young people.

Strategic Priority	Action	Evaluation, Evidence, and Impact
	behaviours on young people's smoking activity.	
Target Group: General Population		
Increasing the numbers of people accessing smoking cessation services. It should be noted that COVID-19 will have had an impact on the number of people accessing services and setting a quit date during 2020/21 and 2021/22.	The PHA continue to commission a range of specialist stop smoking services from 581 providers which include GPs, community pharmacies, hospitals, workplaces, and community/voluntary settings.	Since 2010, the proportion of smokers that have tried to quit smoking has remained around the three-quarters level (73% in 2019/20). ***"On the 6th June I had a heart attack. I was 40 so never did I think I would ever have one this young. On the advice of the doctors to stop smoking I did. It's been a hard journey so I'm glad I did as I never want to see the fear on my kids' faces of the thought of losing their mum. With the help of this team I haven't touched a cigarette since then."*** *Feedback: Stopping smoking after 22 years | Care Opinion.* **Sample year 2021-22:** a total of 8,039 people set a quit date through the smoking cessation services, an increase on the previous year (6,907 in 2020/21) however a decrease from the 13,847 recorded in 2019/20 [22]. At the 52-week follow-up of those that had quit at 4 weeks in 2020/21, over a third (37%) reported still being tobacco free, while a quarter (23%) had resumed smoking, and a further 39% could not be contacted.

Strategic Priority	Action	Evaluation, Evidence, and Impact
		Figure 4 : Number of clients accessing and quitting at 4 and 52 weeks with Smoking Cessation Services in Northern Ireland 2010/11 - 2021/22.



- *Please note that these figures are extracted from a live web-based computer system and may include a number of clients that were not included in the official smoking cessation statistics. For this reason, figures presented here may differ from those previously published.*

Strategic Priority	Action	Evaluation, Evidence, and Impact
		There has been a steady decline in the numbers accessing services in recent years. This is a pattern observed across the UK. The Northern Ireland service reach figure in 2018/19 (5.3%) still surpassed the 5% target of the Strategy (which is the figure recommended by the National Institute for Clinical Excellence), however the COVID-19 pandemic has had a detrimental impact and post-pandemic figures from 2020/21 show 3.1% service reach. Over the lifetime of the Strategy 218,603 accessed services (N.B individuals may have used the service more than once). £14.5 million has been spent on Nicotine Replacement Therapy (NRP) by cessation services over the lifetime of the Strategy.
	Innovative approaches to increase the numbers accessing services have included: the roll-out of brief intervention; consultation with service providers and service users on how to improve services; a revised training framework to increase numbers of specialists; enhanced marketing/promotional materials provided to pharmacists; and work with the Healthy Living Centre Network to provide service in low socio-economic areas.	• Following Engagement with service providers, the PHA launched a new brand identity in February 2019 which was launched through new promotional pack for service providers. • The website also features success stories where ex-smokers who have used the service share their experiences. • The website includes a 'service locator' function with all circa 500 services included to ensure service users can locate their nearest, most convenient service provider. • Following Mid-Term Review recommendations all organisations represented by the Healthy Living Centre Alliance have a dedicated 'Stop Smoking Champion'. • Following Mid-Term Review recommendations, a small grants scheme is proposed to enable uptake of service in low socio-economic areas.

Strategic Priority	Action	Evaluation, Evidence, and Impact
	The PHA provide funding to enable HSC Trusts to deliver No Smoking Month events (No Smoking Day events were extended to a month in 2018).	Research has supported the view that No Smoking Day is an extremely cost-effective public health intervention[23]. **In 2010/11 – 24% of population were smokers and in 2019/20 this had dropped to 17%.**
	Pilot projects such as Stop Smoking Bus Campaign and Mobile Stop Smoking Service have provided stop smoking support in convenient geographical locations.	Limited evidence to support continuation of this approach however service locations across the Region have been reviewed in terms of convenience as well as alternative delivery models, for example, a shared service model harnessing community partners and community pharmacists is under consideration.
Ensuring effective referral systems across the HSC to smoking cessation services.	Care pathways and electronic care: a smoking cessation referral pathway has been incorporated into the Northern Ireland Electronic Care Record (NIECR) which will enable seamless referral to smoking cessation services. This is now available across all HSC Trusts.	NIECR referral pathway is now available within all HSCTs. **Example – South Eastern HSCT** Percentage of referrals received via ECR (average per month) Financial year 2020/21……25% 2021/22……41% 2022/23……48% Referral numbers in acute settings, for this area, have increased by 120% over the same period. PHA has engaged with encompass and HSCT providers in relation to stop smoking service care pathways and will review any impact on referral rates as encompass is rolled out across all HSCTs.

Strategic Priority	Action	Evaluation, Evidence, and Impact
	The PHA support dentists to refer to cessation services or to provide in-house stop smoking services.	PHA offer advice and support to the Oral Medicine Department in Belfast Health and Social Care Trust (BHSCT), including brief intervention training via BHSCT and support for onward referrals across the region. The current web-based monitoring platform does not allow for accurate tracking of referral source to service provider at present.
Expansion of Brief Intervention training to other professionals.	Brief intervention training is aimed at triggering a quit attempt regardless of an individual's current quitting intention. It is particularly recommended for professionals in regular contact with the Strategy's priority groups.	The PHA commission HSC Trusts to deliver this training and the annual training target of 2080 participants is usually exceeded.
Target Group: Disadvantaged Adults		
Increasing cessation rates amongst manual workers and those with mental health issues, taking into consideration the particular needs of these groups.	A workplace settings approach has been used to encourage and support quit attempts amongst manual workers for whom prevalence rates remain high.	Workplace setting support is provided by Cancer Focus NI (CFNI) in the Belfast/ South Eastern areas and by HSCTs regionally where capacity allows. An example of this work from 2019-2023 includes services provided across industries such as Health, Food, and Agriculture, along with Retail and Manufacturing. CFNI provided a stop smoking service in over 50 workplaces, with 475 people setting a quit date and 352 had successfully quit at 4 weeks (74%). In 2021/22 a third (31%) of the 8,014 adults who set a quit date were from the most deprived quintile while a further quarter (25%) were from the second most deprived quintile. This compares with around one in ten (8%) from the least deprived quintile[24].

Strategic Priority	Action	Evaluation, Evidence, and Impact
		Smoking rates amongst manual workers have declined from 35% in 2010 to 26% in 2019/20.
	The PHA provide funding to assist HSC Trusts to further develop stop smoking services within maternity services, mental health services, for patients receiving treatment for long term conditions or cancer, and pre-operative patients.	In total, PHA invest in the region of £1.2m annually in HSCTs for services related to tobacco control. This is a combination of stop smoking service provision, including for general population needs, including those with long term health conditions, mental-health service users, and also pregnant women and their partners. In 2021/22 over 2300 people received a service input from a member of staff in HSCT, over 66% of those people had successfully quit at 4 weeks and at 52-week follow-up (of those who were contactable) 22% remained quit.
Target Group: Pregnant women and their partners who smoke		
Increased signposting to cessation services for pregnant women and their partners who smoke.	All pregnant women have their carbon monoxide levels measured in their booking clinic/ante natal care (with opt out possible). Everyone with a reading of 4 ppm or above will be referred to the stop smoking midwife. *ppm = parts per million	**Sample Year 2021/22**: of the 644 women who were recorded as being pregnant, 34% were from the most deprived quintile compared with 9% from the least deprived quintile. At the 4-week follow-up, 63% of pregnant women reported to have successfully quit, 20% had not quit, and 17% were not able to be contacted[25]. **Since it was introduced, 69% of all antenatal bookings included a CO test.**
	PHA along with Queen's University Belfast, contributed to a new nationwide UK	Pregnancy incentive research results are now being considered in development of pilot with a view to Northern Ireland application.

Strategic Priority	Action	Evaluation, Evidence, and Impact
	study, led by the University of Glasgow, and published in the BMJ, in relation to incentivised quitting in pregnancy.	

OBJECTIVE TWO - REMAINING CHALLENGES

Reduced numbers accessing smoking cessation services

- Footfall to cessation services continues to decline and the COVID-19 pandemic resulted in a particularly significant drop in access and slowed recovery.

Table 2 – Number of people setting a quit date at smoking cessation services.

Year	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Number setting a quit date	**39,204**	**32,714**	**26,870**	**21,779**	**21,285**	**18,637**	**15,461**	**14,214**	**14.342**	**6,907**	**8,039**
% of all smokers accessing services	**10.9**	**9.5**	**8.4**	**6.8**	**6.3**	**6.2**	**6.1**	**5.3**	**5.6**	**2.7**	**3.1**

NB: Reach of Service figures have been calculated using the revised Mid-Year Population Estimates for NI published on 29/6/23 therefore these will vary from figures published in previous reports. Due to changed data collection mode for the 2020/21 Health Survey NI, 2019/20 prevalence rate was used in calculations for 2020/21 to allow findings to be comparable with previous years.

- Low levels of children and young people (aged 11-16) who smoke access cessation services (0.3% of young smokers in 2021/22 – a decrease since 2018/19 when 3.1% accessed services).

Addressing the continued inequalities in smoking prevalence

- 31% of the 8,014 adults who set a quit date in 2021/22 were from the most deprived quintile compared to 8% from the least deprived quintile. However, the 4-week success rate was 55% for those in the most deprived quintile compared with 62% in the least deprived quintile.
- Continued challenges in mental-health in-patient settings and prisons where smoking rates are high.
- Feedback suggests that the delivery of Brief Interventions in HSC settings is challenging due to staffing pressures and a lack of opportunity for delivery.
- Enrolment on workplace programmes is typically low.
- In 2021, within the most deprived areas the proportion of births where the mother reported smoking during pregnancy was almost five and a half times the rate in the least deprived areas.
- In the 2021/22 Health Survey, respondents with a high GHQ12 score (which indicates a possible psychiatric disorder) were more likely to report being a current smoker (28%) than those with a low score (12%).

OBJECTIVE 3: Protecting People from Tobacco Smoke

Strategic Priority	Action	Evaluation, Evidence, and Impact
Target Group: General Population		
Further awareness raising around harm caused by exposure to second-hand smoke in areas not covered by smoke-free legislation.	From March 2016 smoking was not permitted in the grounds of any HSC Trust facility in Northern Ireland, sending a clear message about the health implications of second-hand smoke.	PHA invested over £25,000 in supporting the development of HSC Trusts 'Smoke Free' policies. This included funding enforcement roles (smoke-free wardens) however, compliance levels remain unclear. **Feedback**: "*The hospital itself does not need any improvements but I think patients from A&E smoking at entrance doors are unacceptable. My wife was leaving in a package for me and she choked on the smoke of at least 20 people smoking at front doors."* *Patient smoking | Care Opinion*
	Vehicles: An extensive multimedia campaign accompanied the introduction of The Smoke-Free (Private Vehicles) Regulations (Northern Ireland) in February 2022. Enforcement of smoking in workplace vehicles.	The evaluation of the campaign that accompanied the ban on smoking in private vehicles with children present showed that of the sample of 1,000 adults involved, over four in five (82.4%) said the advertising encourages them to support the new legislation. Compliance with smoke-free legislation and has been reported on through a series of separate reviews[26] and in the University of Stirling report that accompanies this review.

Strategic Priority	Action	Evaluation, Evidence, and Impact
Encouraging organisations to voluntarily expand their smoke-free areas.	Some councils have been preparing to move towards smoke-free parks and smoke-free grounds of leisure centres.	**Example**: Mid and East Antrim – Since 2018 all 68 play parks have been smoke-free. Signage is displayed at each play park detailing the park rules and this signage includes a no smoking symbol. Lisburn and Castlereagh – all playparks and leisure centres are smoke-free.
	Smoke-Free School Gates – to encourage parents and guardians to refrain from smoking and protect their children from the harmful effects of smoking – offered to all primary schools across Northern Ireland.	Scheme was run in 2018/19 and reporting showed that 440+ primary schools were benefitting from smoke-free school gates, protecting parents, carers, siblings, pupils, and staff from exposure to second-hand smoke. A further 207 primary schools had indicated that they also wanted to join the scheme. The scheme was relaunched in 2023 with region wide interest.
	Work continues to be taken forward by the Northern Ireland Prison Service with the aim of implementing smoke-free prisons.	Ongoing.

OBJECTIVE THREE – REMAINING CHALLENGES

Homes and private settings

- Whilst numbers reporting regular exposure to second hand smoke (SHS) in their own home dropped (9% in 2015/16 to 6% in 19/20), inequalities remain around smoke-free exposure in homes – in 2019 YPBAS children that lived with smoking adults: 36% in the most deprived areas reported that those smokers smoked inside the house versus 23% in the least deprived areas. (ref. University of Stirling Report). In the 2018-19 Health Survey Northern Ireland (HSNI), the proportion of respondents saying that smoking is not allowed in their home remained lower for respondents living in the most deprived areas than for those living in all other deprivation quintiles.
- In addition, the 2018/19 HSNI showed smoking in a family car is twice as likely to be allowed in the most deprived areas as the least deprived areas.

Workplaces

- 2019/20 HSNI showed 7% of adults still experience some degree of exposure to SHS at work. The University of Stirling Report notes that some of this is likely to occur in work vehicles.
- Anecdotal concerns regarding hospitality settings with increasingly elaborate “outdoor” structures and resulting potential for increased SHS exposure.
- The University of Stirling report highlights challenges for those providing domiciliary care in the homes of smokers.

Enforcement

- Compliance levels in Health and Social Care settings remain unclear.

4. Structure and Implementation

Tobacco Strategy Implementation Group (TSISG)

4.1 The Public Health Agency (PHA) lead on the implementation of the Strategy. To facilitate this role the PHA set up a multi-sectorial steering group and five work streams. Together they produced, and have continued to develop, a comprehensive action plan to work towards achieving the Strategy objectives. This group is chaired by the PHA and meet four times a year. The group is responsible for overseeing and co-ordinating the implementation of the Strategy and for sharing progress made with the Department through regular reporting mechanisms.

4.2 The overall aim of the TSISG is the implementation of the Strategy within the agreed timeframe and the specific objectives are:

- To provide advice and strategic direction to the PHA to assist with the development of an implementation plan for the Tobacco Strategy.
- To monitor progress in implementation and identify any areas needing specific attention.
- To agree the content of progress reports for submission to the Department of Health.

Action Plan

4.3 The action plan has been developed in line with the MPOWER model[27]. The MPOWER model is a policy package that builds on the measures of the WHO Framework Convention on Tobacco Control[28].

4.4 This package has been proven to reduce smoking prevalence (WHO 2008)[29].

4.5 The MPOWER package is an integral part of the WHO Action Plan for the Prevention and Control of Non-communicable Diseases[30]

4.6 There are six main components of the MPOWER model package:

- **M**onitor tobacco use.
- **P**rotect people from tobacco smoke.
- **O**ffer help to stop smoking.
- **W**arn about the dangers of smoking.
- **E**nforce bans on tobacco advertising and promotion.
- **R**aise taxes on tobacco products.

Work Streams

4.7 The five work streams as identified at the outset of the Strategy were:

(i) Research & Information
(ii) Protection & Enforcement
(iii) Services & Brief Intervention
(iv) Communication & Education
(v) Policy & Legislation

4.8 Each work stream is chaired by a member of the implementation group, and seeks advice, support or expertise from other individuals and organisations as required.

Roles

4.9 While TSISG is responsible for overseeing and co-ordinating the implementation of the Strategy the PHA works closely with the work stream chairs to monitor progress of the group against the activities in the action plan. Regular updates are provided to the PHA co-ordinator who subsequently presents a status assessment to the group using RAG designations; Red, Amber, or Green. Progress against the action plan is discussed at each steering group meeting.

4.10 Members of the implementation group serve as the nominated representative for their respective organisations and are responsible for taking forward actions within their organisations as required.

Reporting and monitoring

4.11 TSISG reports to the Agency Management Team in the PHA via the Director of Public Health. The action plan is reviewed at every implementation group meeting for progress against key milestones. Any issues or areas of concern are reported back to senior management as they arise on an ad-hoc basis. Reporting to the Department of Health is by way of annual progress reports.

Development of TSISG structure and membership following Mid-Term Review

4.12 TSISG includes representation from the Department as well as other Northern Ireland Civil Service departments and district councils. It also includes representation from the health, education, and voluntary sectors with a particular interest or role in tobacco control.

4.13 Following the completion of the Mid-Term Review of the Strategy in 2020, several recommendations were made in respect of TSISG structure and

membership. Alongside this, some of the strategic recommendations meant that additional representation was desirable. Following a restructure in early 2023, TSISG membership expanded to take account of key organisations across Northern Ireland who are aligned to the outcomes and overall aim of the Strategy. Mostly notably this saw the inclusion of representation from the Department of Health's Strategic Planning and Performance Group (formerly the Health and Social Care Board), Health and Social Care Trusts, Community Development Health Network, Healthy Living Centre Alliance, Cancer Research UK, Chest Heart and Stroke Northern Ireland (NICHS), Community Pharmacy Northern Ireland, Council for Curriculum Examinations and Assessment (CCEA) and ASH Northern Ireland.

4.14 Taking account of the recommendations of the Mid-Term Review, TSISG members agreed to a workstream review that realigned the 'education' remit to a newly established 'Children and Young People' workstream. The TSISG chair role was again taken up by the Director of Public Health, PHA.

4.15 As of 2023 the five TSISG work streams are:

(i) Health Intelligence
(ii) Policy, Legislation & Enforcement
(iii) Service Development
(iv) Communication
(v) Children and Young People – Prevention

Funding

4.16 The PHA funds the implementation of the Strategy through their budget allocation from the Department of Health. The funding covers the costs of:

- Stop smoking services across Pharmacy, GP, Community and Voluntary settings.
- The purchase of Nicotine Replacement Therapy (NRT), Carbon Monoxide (CO) monitors etc.
- Training of stop smoking specialists and the development of training resources.
- The implementation of brief interventions across all sectors.
- The monitoring of tobacco enforcement.
- The purchase and development of resources.
- Carbon Monoxide monitoring of all pregnant women at booking appointment in all 5 HSCTs.
- Regional Primary school education programme delivered in schools for P6 and P7 pupils re: dangers of smoking.

- A web-based monitoring system which includes reporting and monitoring data from stop smoking services in Northern Ireland.
- In the current financial year, a small amount of funding has been spent on vaping specific training for professionals and early-stage development of a schools' cessation programme.

Table 3 – Approximate tobacco spend per financial year.

Financial Year*	Total Tobacco Control Spend	Cessation Services**	Nicotine Replacement Therapy –(NRT)	Associated Tobacco Control Costs ***	Campaigns and associated costs****
2011-2012	£4,121,122.55	£1,596,282.96	£1,347,463.08	£737,467.55	£439,908.96
2012-2013	£4,489,251.78	£1,596,282.96	£1,899,017.27	£737,467.55	£256,484.00
2013-2014	£4,336,786.17	£1,596,282.96	£1,611,593.66	£737,467.55	£391,442.00
2014-2015	£3,182,981.36	£855,111.84	£1,271,171.06	£828,352.69	£228,345.77
2015-2016	£4,097,020.92	£1,639,054.97	£1,436,068.60	£760,247.90	£261,649.45
2016-2017	£4,288,899.84	£1,772,760.51	£1,403,253.51	£715,072.06	£397,813.76
2017-2018	£4,006,249.43	£1,765,418.65	£1,342,002.62	£800,208.45	£98,619.71
2018-2019	£3,932,856.76	£1,782,492.48	£1,264,921.70	£742,814.82	£142,627.76
2019-2020	£4,272,982.08	£1,769,901.24	£1,562,725.78	£641,467.40	£298,887.66
2020-2021	£3,169,399.90	£1,758,442.97	£726,686.51	£684,270.42	£0.00
2021-2022	£3,234,290.95	£1,427,081.01	£957,190.13	£727,306.65	£122,713.16

**NB: Some of the early figures (2011-2014) have been based on average spend due to gaps in the level of detail available at this time.*

***Smoking Cessation Services and the associated NRT expenditure is demand led therefore variable from year to year based on the number of people accessing services.*

****Associated Tobacco Control costs include, specialist training, enforcement of tobacco regulations in Northern Ireland, preventative education programmes, resources, and materials. Please note this list of items is for example purposes only and not exhaustive.*

***** Note that spend in relation to campaigns is from the PHA Communications Campaigns Budget.*

Smoking Cessation Services

4.17 Smoking cessation services are provided through Health & Social Care Trusts, Community Pharmacies, GP Practices and Community and Voluntary sector partners.

4.18 These services aim to help smokers to quit and are provided free of charge to the public. Service users receive support over a 12-week period including one-to-one support and Nicotine Replacement Therapy as required.

4.19 The PHA oversees a Stop Smoking Northern Ireland website which has been co-designed with ex-smokers and service providers and is targeted at smokers wishing to quit and others seeking support and information on the services available across Northern Ireland. The website includes a service finder function

and has case studies from ex-smokers in Northern Ireland who have successfully quit using the Department of Health funded services co-ordinated through the PHA.

4.20 In order to meet the varying needs of the population services are provided in a range of settings and tailored to meet needs. For example, pregnant smokers and their partners receive support through specialist midwifery services, prisoners received direct support through prison-based services, and areas where there are more smokers per head of population receive additional support through organisations such as Healthy Living Centres.

4.21 Smoking Cessation services also include promotional materials, NRT (where appropriate), training for individuals delivering the cessation services and signposting to services.

4.22 These services helped 8,039 people set a quit date through the smoking cessation services in 2021/22, an increase on the previous year (6,907 in 2020/21 when the COVID-19 pandemic impacted most on services) however a decrease from the numbers (in the region of 14,000) in 2019/20[31]. Prior to this, the number of people accessing smoking cessation services had been in decline.

Value for Money

4.23 Smoking cessation services account for most of the expenditure on tobacco control. A report by The National Centre for Smoking Cessation and Training (NCSCT) in 2015[32] noted that "the evidence shows that specialist stop smoking services, offering evidence-based behavioural support alongside effective pharmacotherapy, provide smokers with highly effective treatment for tobacco dependence. These services are not only effective in supporting smokers to quit but highly cost effective as well." Other smoking cessation and prevention initiatives in Northern Ireland, including mass media campaigns, school-based prevention, and carbon monoxide testing, are largely based on National Institute of Clinical Excellence recommendations which in turn are supported by cost-benefit considerations and evidence of effectiveness.

By way of financial context, hospital treatment for smoking-related conditions in Northern Ireland in 2019/20 was in the region of £218 million.

Impact of COVID-19 Pandemic on smoking habits and cessation services

4.24 A review of studies by public health experts convened by the World Health Organisation on 29 April 2020 found that smokers are more likely to develop severe disease with COVID-19, compared to non-smokers[33].

4.25 A YouGov survey was conducted between 15th April and 20th June 2020[34]. Subsequent analysis by ASH and UCL found that over a million people in the UK had stopped smoking since the COVID-19 pandemic hit the country. A further 440,000 smokers tried to quit during this period[35]. Elsewhere, there were reports of increased uptake of smoking. A study from Cancer Research UK, published in August 2021[36], found that the number of young adults taking up smoking in England rose during the first coronavirus lockdown. The research found that the number of 18 to 34-year-olds who classed themselves as smokers increased by a quarter from 21.5% to 26.8% (an extra 652,000 young adults). The research did however find that the number of existing smokers successfully quitting smoking also rose during the lockdown.

4.26 Northern Ireland official figures on smoking prevalence are obtained from the Northern Ireland Health Survey. The 2020/21 Health Survey[37], which was published with several caveats regarding revised methodology and reduced sample size, showed a smoking prevalence rate of 12%. Whilst this was lower than expected, it corresponded with similar findings from NISRA COVID-19 Opinion Surveys. However, the 2021/22 Health Survey[38], which had an increased sample size, showed a return to the 2019/20[39] prevalence rate of 17%.

4.27 The 2021/22 Health Survey provided a mixed picture regarding smoking behaviour. Almost a quarter (23%) reported that they had tried to reduce the number of cigarettes they smoked while 13% reported that they had tried e-cigarettes and 13% tried to quit smoking. More than half (54%) of smokers reported that since the outbreak of the Coronavirus pandemic they had made no change to their smoking behaviour.

4.28 As a result of the pandemic services were remodelled moving from face to face to virtual engagement. Carbon Monoxide monitoring was stood down due to infection control concerns and Community Pharmacy stop smoking services stood down for new patients due to competing pressures. Some Trusts Stop Smoking service providers were redeployed, and Community and Voluntary partners were impacted as their school and workplace audiences were not accessible to them. Services returned to a blended approach to service delivery by October 2021 and this remains the current model with face to face (where risk assessment permits) and/or telephone/video contact, group facilitation and/ or one-to-one engagement available depending on service user needs.

Regulation

4.29 Over the lifetime of the Strategy, there have been numerous regulatory developments at local and UK level. Key legislation is outlined below.

Legislation	Purpose
The Protection from Tobacco (Sales from Vending Machines) Regulations (NI) 2012	Banned tobacco sales from vending machines, introduced on 1st March 2012.
Tobacco Advertising and Promotion (Display) Regulations (Northern Ireland) 2012	Introduced a ban on the display of tobacco products at point of sale in retail premises. Introduced for large shops and supermarkets from 30 October 2012. The ban was extended to cover all retail premises from 6 April 2015.
The Tobacco Advertising and Promotion (Display of Prices) Regulations (Northern Ireland) 2012	Imposed requirements in relation to the display of prices of tobacco products. 31 October 2012 for large shops, and on 6 April 2015 for all other purposes.
Tobacco Retailers Act (Northern Ireland) 2014	The Tobacco Retailers Act (Northern Ireland) 2014 was introduced to the Assembly in April 2013 and was granted Royal Assent on 26 March. The main provisions of the Act (and regulations that followed): • Required all tobacco retailers to register. • Prohibited registration for 5 years following a conviction for a serious illicit tobacco offence. • Allowed for the application of banning orders by enforcement officers following 3 relevant tobacco offences within 5 years. • Allowed period for banning order to range from 28 days to 3 years. • Created a number of new offences, including those relating to the register and the offence of proxy purchasing. • Allowed for the application of fixed penalty notices for a number of offences.
The Standardised Packaging of Tobacco Products Regulations 2015	On 4 February 2014, the Assembly agreed, through a Legislative Consent Motion, to the extension of certain provisions in the Westminster Children and Families Bill to Northern Ireland. The provisions related to the standardised packaging of tobacco products and provided a Secretary of State with regulation-making powers on a UK wide basis. Subsequent regulations commenced throughout the UK from 20 May 2016.
The Tobacco and Related Products Regulations 2016	Effective from 20th May 2016 and transposed Tobacco Products Directive 2014/40/EU (Tobacco Products

	Directive) rules on the manufacture, presentation and sale of tobacco and related products, including herbal products for smoking, e-cigarettes and refill containers, as well as smokeless and novel tobacco products.
The Smoke-Free (Private Vehicles) Regulations (Northern Ireland) 2021	Extended 2007 smoke-free provisions to enclosed private vehicles carrying children from 1st February 2022.
The Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations (NI) 2021	Banned the sale of nicotine containing e-cigarettes to under 18s (and proxy purchase of such products on behalf of under 18s) from 1st February 2022.

Enforcement

4.30 Domestic tobacco legislation in Northern Ireland is primarily enforced by District Councils. The Mid-Term Review reported on enforcement activity, but subsequently much enforcement activity was paused during the COVID-19 pandemic. However, two new enforcement regimes were introduced in February 2022. An update on the enforcement activity in relation to those new regulations is set out below.

4.31 The Smoke-Free (Private Vehicles) Regulations (Northern Ireland) 2021[40] extended current smoke-free provisions to private vehicles carrying children. The Police Service of Northern Ireland were introduced as an additional enforcement body in respect of smoke-free vehicles. Two new offences were introduced: smoking in a smoke-free private vehicle and failure to prevent smoking in a smoke-free private vehicle.

4.32 In addition, The Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regulations (Northern Ireland) 2021[41] introduced a minimum age of sale of 18 years for nicotine inhaling products, commonly known as electronic cigarettes, and certain related parts of such devices. Furthermore, the regulations made it an offence for an adult to purchase a nicotine inhaling product on behalf of a child (proxy purchasing).

Table 4 - Smoke-free Vehicles Fixed Penalty Notices (February 2022-June 2023)

OFFENCE	NUMBER OF FPNs ISSUED	OTHER ENFORCEMENT ACTION
Smoking in smoke-free private vehicle	12	0
Failure to prevent smoking in a smoke-free vehicle (driver offence)	1	0

Table 5 - Nicotine inhaling Products Fixed Penalty Notices (April 2022-March 2023)

OFFENCE	TEST PURCHASES	NUMBER OF FPNs ISSUED	OTHER ENFORCEMENT ACTION
Sales to under 18s	273	45	Written warnings:24 Prosecutions: 0 Restricted Premises Order: 1 Formal cautions: 0
Proxy Purchasing	N/A	0	0

5. New developments during lifetime of the Strategy

E-cigarettes

Use in smoking cessation

5.1 The Mid-Term Review highlighted the varying opinions on e-cigarettes across the world and it remains the position that opinion on benefits and potential harms is divided. However, since the Mid-Term Review, the National Institute for Clinical Excellence (NICE) guidelines[42] have been updated to incorporate the use of e-cigarettes as a smoking cessation tool. The guidelines, published 30 November 2021, recommend that those giving stop smoking support or advice should give clear, consistent, and up-to-date information about nicotine-containing e-cigarettes to adults who are interested in using them to stop smoking and advice on how to use them. It should be noted that this advice should be alongside information on other forms of pharmacological support and the offer of behavioural support. The Department has endorsed the guidelines and the PHA is working to incorporate them into local services.

5.2 Northern Ireland does not currently provide e-cigarettes through smoking cessation services in contrast to England where there are plans to introduce a "Swap to Stop" scheme, whereby free e-cigarette starter packs will be made available to millions of smokers.

5.3 Despite considerable evidence in support of e-cigarettes as a smoking cessation tool, it is widely acknowledged that e-cigarettes are not harmless. Whilst they have a role in supporting smoking cessation for some people, there remains a lack of evidence about the health impacts of prolonged use. NICE recommends that cessation services make clients aware that there is not enough evidence to know whether there are long-term harms from e-cigarette use, and that cessation services should support clients when they are ready to stop using them. Meanwhile the use of e-cigarettes by non-smokers and young people is discouraged.

E-cigarette use in Northern Ireland

5.4 The 2019 Young Persons Behaviours and Attitudes Survey[43] figures showed 6% of 11–16-year-olds currently use e-cigarettes compared with 5% in 2016. However, the numbers who have ever used e-cigarettes increased significantly with age, ranging from 4% in year 8 to 38% in year 12.

5.5 The 2019/20 Health Survey[44] showed that 6% of adults use e-cigarettes, and that 57% of those currently using e-cigarettes were ex-smokers (up from 48% in 18/19). In 2019/20 only 6% of e-cigarette users reported that they had never smoked.

5.6 Whilst most adult e-cigarette users are either ex-smokers or current smokers, there is growing concern about the recreational use of e-cigarettes by non-smokers and young people. Of particular concern is the apparent growth in the use of disposable e-cigarette products which are low cost, attractively packaged, available in a range of flavours, convenient, and appear to have appeal to young people. Recent reports are suggestive of a surge in youth use of these products in other parts of the UK. In parallel, there are mounting pressures throughout the UK for regulatory measures to address the environmental concerns in relation to the disposal of these products.

5.7 Whilst the current Strategy has focused primarily on tobacco use, in recognition of the potential for e-cigarette use to act as a gateway to smoking and the harms nicotine can cause to adolescent cognitive development, the Department introduced regulations in 2022 which banned the sale of e-cigarettes to under 18's. Despite these measures, the PHA continue to respond to concerns raised about youth vaping, particularly from schools. The current tobacco action plan includes several activities relating to vaping including development of education materials on vaping, communications on vaping harms, research in schools, and consideration of a pilot vaping/smoking cessation service for young people**.**

Reason for Concern

5.8 Much of the current evidence in respect of potential e-cigarettes-related health harms is based on academic studies. In the Office for Health Improvement and Disparities *Nicotine vaping in England: 2022 evidence update summary*[45], some of the limitations of the current evidence base were highlighted and it was noted that *good quality studies in humans are needed that investigate the effects of vaping on a wider range of physical and mental health outcomes. They should also explore the progression of various health disorders in people who vape compared with people who smoke or do not vape nor smoke.* In recognition of the need for timely information, the Department has asked the Institute of Public Health to take forward a further review of the evidence relating to health harms caused by e-cigarettes, which will be used to inform our strategic response and communications.

5.9 The Medicines and Healthcare Products Regulatory Agency's (MHRA) Yellow Card scheme[46] collects and monitors information on safety concerns or incidents involving medicines or medical devices in the UK. Anyone can report an adverse reaction that they suspect to be related to e-cigarettes use. The reports are therefore not evidence of a proven side effect nor of a causal link between vaping and the suspected adverse reaction. MHRA identified that as of 13 January 2022 (since the Yellow Card scheme was put in place for vaping products on 20 May 2016) it had received 257 Yellow Card adverse reaction reports (covering 720 adverse reactions)[47].

5.10 Service level data in Northern Ireland shows that in a sample year of 2021/22 there were less than 10 admissions to hospital as a result of vaping-related disorders (none of which were children). It is important to acknowledge that the distinction between vaping nicotine and vaping other harmful substances (and unregulated e-cigarettes) is not always clear.

5.11 Whilst many health professionals are already expressing concerns about vaping-related harms, the evidence may take time to fully emerge. In the meantime, there is no room for complacency. Some of the immediate concerns around youth vaping extend beyond physical health and relate to social and educational implications of nicotine addiction. There have been reports of local schools being forced to take disciplinary action (including suspensions) to address the problem. However, in developing our strategic response to e-cigarette use, we must also ensure that we do not lose sight of the extensive health harms that continue to be caused by tobacco use.

5.12 Non-nicotine containing e-cigarettes are also a cause for concern given the potential for other harmful contents and for undeclared addition of nicotine. These products are currently regulated as consumer products under General Products Safety Regulations 2005. Those UK wide regulations provide the basis for ensuring the safety of consumer goods by setting requirements and providing a range of provisions to secure compliance and enforcement with the requirements. There is no age of sale requirement for these products in Northern Ireland. This is also the position in England and the issue is currently under review by The Department of Health and Social Care. Northern Ireland officials will continue to liaise with their counterparts across the UK to determine any future legislative approaches to these products and local implications.

Emerging Nicotine-containing Products

5.13 In recent months we have seen increased media reports of use of Snus and nicotine pouches amongst footballers. Snus is a type of powdered tobacco, typically held in the mouth between the lips and gum and is illegal to sell in the UK. Nicotine pouches are tobacco-free and are widely available. In addition, the EU recently announced changes to the Tobacco Products Directive which will see flavourings banned for heated tobacco products due to an increase in the market share of such products across EU member states (these changes will apply in Northern Ireland). Whilst reported use of these products in Northern Ireland remains low[48], it is important that we continue to monitor use of novel tobacco and nicotine products in Northern Ireland to inform appropriate and timely policy responses.

6. Mental ill-health and Smoking

6.1 The Department of Health's Mental Health Strategy[49] notes that in Northern Ireland, people with severe and enduring mental illness have a reduced life expectancy of 15 to 20 years because of poor physical health. The Mental Health Strategy acknowledges that, *"addressing this requires a cultural change and systematic approach across our communities, primary care, secondary care, and specialist acute services. Every part of the mental health system should take all appropriate opportunities to support people with mental health problems where they have difficulties with smoking, weight, alcohol or drug use, and exercise – the physical healthcare of people with mental health problems is everybody's responsibility."* Under the theme of physical health and mental illness, the Strategy aims for a specific outcome of a reduction in the percentage of mental health patients who are smoking.

6.2 The Mid-Term Review of the Tobacco Control Strategy in 2020 highlighted the high smoking prevalence amongst those with mental ill-health and recommended the formulation of a plan for the development of actions and targets in relation to people with mental health issues who smoke. It was recommended that this should consider both short term actions and scope for the inclusion of people with mental health issues as an additional priority group in any new strategy.

6.3 In the 2021/22 Health Survey, respondents with a high GHQ12 score (which indicates a possible psychiatric disorder) were more likely to report being a current smoker (28%) than those with a low score (12%). The proportions are similar to the position in 2019/20 (i.e., no significant changes)[50].

6.4 As a result of the delays in fully implementing the Mid-Term Review recommendations, IPH were tasked with a follow-up quantitative analysis of survey data on mental ill-health and tobacco use in Northern Ireland, along with a document analysis of tobacco control policy documents in England, Scotland, Wales, Northern Ireland, and Republic of Ireland to help us better understand the relationship between mental ill health and tobacco use and inform an appropriate policy response.

6.5 The conclusions of this analysis, completes the suite of evidence on smoking and mental health captured for the Mid-Term Review of the Strategy and will support decision making on further actions and the potential inclusion of people with mental health issues as a priority group in any new strategy.

Summary of (and extracts from) IPH report: Smoking and Mental Health - An exploration of data in Northern Ireland and scan of policy approaches in the UK and Ireland.

6.6 The full IPH report can be found on the IPH Website[51]. Extracts from that report are set out below. The agreed aims of the IPH report were to:

- Describe the relationship between smoking and mental ill-health in Northern Ireland based on representative government survey data.
- Explore policy development in relation to smoking and mental ill-health in the UK and Ireland.
- Provide insights based on these analyses and propose considerations for policy on tobacco and mental health in Northern Ireland.

Insights from data (and extracts from IPH report)

6.7 Data from the Health Survey Northern Ireland 2018-2019 dataset were analysed to assess the relationship between smoking status and mental ill-health. Variables indicating/relating to mental ill-health included General Health Questionnaire score (a high score is classified as a respondent with a possible psychiatric disorder), Warwick Edinburgh Mental Wellbeing Scale (where score in range 41-44 is indicative of possible/mild depression and a score less than 41 is indicative of probable clinical depression), self-reported levels of anxiety and use of anxiety medications. The key findings were:

MENTAL HEALTH AND SMOKING IPH REPORT
KEY FINDINGS (FROM DATA):

- Possible psychiatric disorder was twice as common among those who currently smoke compared to those who never smoked (33% vs 14%, $p<0.001$) or those who used to smoke regularly (33% vs 15%, $p<0.001$).

- Probable clinical depression was twice as common among those who currently smoke than among those who used to smoke regularly (24% vs 12%, $p<0.001$).

- Probable clinical depression was four times more common among people who currently smoke than among people who have never smoked (24% vs 6%, $p<0.001$).

- The proportions of people who had ever tried to quit smoking were comparable between those with a possible psychiatric disorder, possible/mild, or probable clinical depression and those without (small numbers in analysis).

MENTAL HEALTH AND SMOKING IPH REPORT
KEY FINDINGS (FROM DATA) continued:

- The proportions of those wanting to quit smoking were also comparable between those with scores indicating a possible psychiatric disorder and those without a possible psychiatric disorder (small numbers noted in analysis).

- Fewer people with probable clinical depression who smoke want to quit smoking compared to those without probable clinical depression (57% vs 70%, $p<0.01$).

Observations from IPH report on smoking and mental health (extracts from IPH report)

Current knowledge on mental ill health and smoking in Northern Ireland

In keeping with studies throughout the UK and Europe, there was evidence of a strong relationship between mental ill health and tobacco use in Northern Ireland. This relationship existed for self-reported symptoms of mental ill health using thresholds on validated scales and appears to be broadly similar to patterns observed in similar data in Ireland (Department of Health, 2021b).

Mental ill-health might be considered a valid target group or might be considered a cross-cutting issue in need of attention in order to better meet the needs of the existing policy target groups.

A lower proportion of 'never smokers' was observed among people with mental ill health across the variables studied. This could be interpreted as:

- Mental ill health being a pre-disposing or risk factor to being a smoker.
- Smoking being a pre-disposing or risk factor for development of mental illness.
- Common risk factors for the development of smoking and mental ill health.

In any case, the data on 'never smokers' has implications for how mental ill health might be understood in the context of efforts to prevent smoking as well as to respond to the needs of people with combined mental ill health and tobacco dependence.

Problem emergence – 'what's the problem?'

Higher smoking prevalence among people with mental ill-health is universally recognised in tobacco control policy across the UK. In general, more recent policy documents tend to afford a higher level of recognition and a broader understanding of the relationship - these frame the issue as a population health and health equity issue and not just an issue for attention within the health service. This is best evidenced in specific recommendations in the English Khan review, the Irish State of Tobacco Control 2022 report, and the 2018 Mid-Term Review of Tobacco Strategy in Northern Ireland. In general, the core policy problem is understood as 'too many people with mental ill health smoke and this negatively affects their physical health'. However, some 'unpacking' of components of the relationship, and its complexities, were evident including:

*Mental ill health as a risk factor for becoming a smoker.

*Smoking negatively affecting effectiveness of psychiatric medications.

*Misunderstandings about the likely mental health outcomes from smoking cessation.

*Barriers to inclusivity and accessibility of stop smoking support for people with mental ill health including in public messaging, campaigns, support materials and in terms of lower health literacy.

*Barriers to health service engagement with mental health service users on smoking cessation.

Agenda setting – evidence, advocacy and engagement with people experiencing mental ill-health

The joint report of the Royal College of Physicians and the Royal College of Psychiatrists and reports by ASH appear particularly influential to policy development. Evidence reviews and high-quality intervention studies were also influential in challenging false assumptions about smoking cessation and mental health outcomes. NICE guidance specific to mental health services has also been significant in agenda setting within mental health services. Structured engagement with mental health service users within policy and programme development has grown but is not universally or consistently applied.

Engaging the health service with offering stop smoking support to people with mental ill-health

A focus on training of mental health service providers in delivering best practice stop smoking support is evident across all jurisdictions. Beyond this, policy actions vary considerably. This is consistently presented as the 'solution' to the 'problem' (perceived or otherwise) of people with mental ill health not being engaged in stop smoking attempts. However, some jurisdictions adopt additional measures targeted to enhance stop smoking support in mental health services including financial incentives for service users and service level inducements such as funding/awards /bursaries for service development. There was some evidence of specific interventions seeking to decouple smoking and mental ill health. Ireland reported on the use of bespoke training and modules and Scottish policy endorsed the roll out of a specific IMPACT advice and training programme.

Addressing gaps in knowledge and understanding 'what works'

Identifying and addressing gaps in data and research on smoking and mental health emerges as a priority activity in English and Welsh policy, with England making specific reference to the value of qualitative research. However, none of the jurisdictions commit to a defined research programme or further development of indicator sets specific to tobacco and mental health nor any dedicated resource to support pilot/change management or feasibility testing of new programmes.

Priority groups, target populations and target setting

Neither Ireland nor any region in the UK has set a specific target to reduce smoking prevalence among people with mental ill health. Some jurisdictions report on relevant indicators, with the inclusion of mental illness within England's local tobacco profiles potentially being a highly significant development. Indicators used across the UK and Ireland are diverse and not comparable. They relate to both different populations and information systems (mental wellbeing scores, probable mental health conditions, disabling/serious mental illness, and use of mental health services). Despite policy targets for full compliance with smoke-free mental health services, the true extent of compliance remains a little unclear. None of the jurisdictions appear to provide indicators on smoking and mental ill health among children or in relation to the policies priority/target groups (e.g., pregnant women, lower socio-economic groups).

Integration in policy, across the health system and through intersectoral partnerships

There was no real evidence of integration between tobacco policy and mental health policy at national level in any jurisdiction with no shared policy agenda, common actions, or joint priorities. However, reviewing tobacco issues within mental health policy was beyond the scope of this work. Integration and shifts to local planning and commissioning emerges as a significant theme in Wales, Scotland, and England but it is not clear how addressing smoking and mental ill health will be enhanced within the new configurations. English policy commits to partnership approaches with ASH and the clinical/psychiatry bodies and Irish policy commits to partnership with the largest national mental health charity and recovery colleges.

Communication, messaging, and literacy

The Khan review is the only policy document to make a specific recommendation on public communication and focusses on presenting accurate information that smoking does not relieve stress or anxiety and that smoking cessation does not cause a deterioration in mental health outcomes. Scottish policy acknowledges challenges in health literacy and the capacity of socially disadvantaged people to understand the harms caused by smoking. This policy seeks an improvement in the inclusivity and accessibility of stop smoking supports for mental health service users.

Summary of policy positions across UK and Ireland

In summary of the policies considered, the IPH analysis showed that:

- Most recognised that there was a relationship between smoking and mental ill-health.
- They used evidence to help understand the link between smoking and mental ill-health.
- This evidence showed that people with mental ill-health were not always getting the same support to stop smoking.
- None of the policies set a target for reducing smoking among people with mental ill-health.
- Only some of these policies recognised that people with mental ill-health need to receive additional priority.

Key policy considerations for Northern Ireland (extracts below are further elaborated on in the IPH report):

- **Better understand the relationship between smoking and mental health.**
- **Effectively focus attention and resource at policy level to reduce smoking-related harms among people with mental ill-health.**
- **Build partnerships with mental health advocacy organisations and professional organisations leading on delivering mental health services.**
- **Assess 'best buys' for investment in training of service providers building on existing good practice.**
- **Modify public awareness and messaging to engage people who smoke with mental ill-health and facilitate access to support.**
- **Enhancing assessment of risk from tobacco-related harms among people with mental illness.**

7. Stakeholder Engagement and Views

7.1 The stakeholder engagement exercise, facilitated by the IPH, highlighted many similar themes to the exercise taken forward for the Mid-Term Review. The full report, and the Mid-Term Review stakeholder report, can be accessed through the IPH website[52]. Perspectives were sought on:

- The achievements of the Strategy.
- The changes delivered for priority groups.
- What could have been done differently.
- The goals and ambitions of a future strategy.
- The components of the current Strategy that should remain and those that should change.

7.2 Key findings of the stakeholder engagement are summarised in the following textboxes and extracts from the IPH report *End of Term Review of the Ten-Year Tobacco Control Strategy for Northern Ireland (2012-2022) Findings from a stakeholder engagement workshop: A report prepared by the Institute of Public Health for the Department of Health Northern Ireland*.

Stakeholders recognised positive changes delivered through the Strategy, including:

Smoking rates declined at population level, particularly among children and young people, and pregnant women.

Stop smoking services had developed and there were good quit rates, roll-out of carbon monoxide testing in antenatal care, and regional and local outreach innovations.

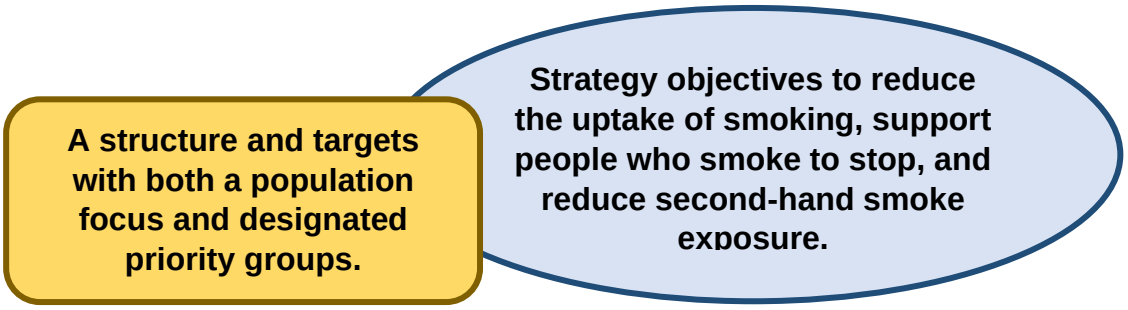
High impact legislation introduced including the ban on sale of tobacco from vending machines, ban on point-of-sale advertising, standardised cigarette packaging, and the ban on smoking in private vehicles where children are present.

New forms of social marketing had been delivered to engage smokers with stop smoking supports, and to denormalise smoking.

Stakeholders identified some deficits in delivery of the Strategy, including:

- Delays in passage of some legislation due to lack of sitting Assembly.
- Lack of sufficient resources meaning social marketing campaigns and service development were underpowered.
- Failure to reduce socio-economic inequalities in smoking and the absence of a sufficiently clear strategy or operational model to meet the target for this priority group.
- A decline in levels of engagement with stop smoking supports and a service model which struggled to adapt to rise in the use of e-cigarettes.
- Underdeveloped information systems for monitoring the journey of people through stop smoking services and referral pathways.
- Inconsistent progress on fully integrating stop smoking best practice within primary and secondary care.
- No pandemic preparedness component to the strategy leaving implementations vulnerable to redeployment of resources as part of the pandemic response.

Stakeholders proposed that the following components of the Strategy should be retained:



Stakeholders proposed that the following components of the Strategy should be changed:

A new commitment to tobacco endgame with a target date rather than incremental targets for reducing smoking, and a consideration of the scope for adopting components of the New Zealand endgame strategy in Northern Ireland, and measures like Tobacco 21.

A research programme aligned with any new strategy to inform implementation in the Northern Ireland context, and enhanced health information systems to describe stop smoking journeys.

Extended list of priority groups to include people living with mental ill- health, and people in prisons.

Continued focus on manual workers and disadvantaged groups with additional data disaggregation needs to support community outreach.

Additional support for expansion of smoke-free environments including regulatory and legislative changes.

A more agile and responsive form of strategy governance with better planning around implementation challenges, including pandemic preparedness, and responses to changes in tobacco and nicotine products.

A firmer commitment to integrate management of tobacco dependence of the health and social care service through focused investment in training, leadership, structures, reporting, and service performance.

A clear communications strategy on the use of e-cigarettes by children and young people, and a direction of travel in relation to addressing e-cigarette use in difference population groups.

A new focus on reducing harms for people who continue to smoke, including a decision on the roll-out of lung cancer screening.

8. Protection from Second-hand Smoke

8.1 'Protecting People from Tobacco Smoke' is one of the three key objectives of the current Strategy. However, measures to reduce exposure to second-hand smoke (SHS) pre-date the current Strategy. The Smoking (Northern Ireland) Order 2006 came into operation on 30 April 2007, introducing measures to protect the public and employees from exposure to second-hand smoke. This was a major step forward in helping create a climate where non-smoking is becoming the norm in society. In 2022, regulations were introduced extending smoke-free provision in work and public vehicles, to private vehicles when children are present.

8.2 Other smoke-free measures have largely been through organisational policy initiatives. One such measure was the introduction of smoke-free Health and Social Care sites in March 2016, which extended smoke-free requirements to outdoor areas. Whilst this policy position was a positive development, enforcement and compliance have remained challenging.

8.3 In order to assess the overall progress made and to identify priorities for a successor strategy, the IPH agreed to facilitate a review by the University of Stirling. The full report (An overview of progress in reducing second-hand smoke exposure in Northern Ireland and policy options for the future: A report to inform the end of term review of the Northern Ireland Tobacco Control Strategy 2012-2022) is available on the IPH website[53], and a summary of the conclusions reached is set out in the extracts below.

An overview of progress on reducing second-hand smoke exposure in Northern Ireland and policy options for the future. A report to inform the end of term review of the Northern Ireland Tobacco Control Strategy 2012-2022 – Executive Summary. University of Stirling

Second-hand cigarette smoke (SHS) is known to cause a wide range of ill health and disease. The burden is likely to be greatest among our most vulnerable including those with pre-existing illness such as respiratory and heart disease. SHS can also cause acute and long-term consequences for children. Northern Ireland has been on a long journey to protect the population from the dangers of SHS exposure. Gone are the days of smoky pubs, cinemas, and offices. The *Ten-Year Tobacco Control Strategy For Northern Ireland* looked to continue this journey with one of the three key aims of that policy being "protecting people from tobacco smoke". The University of Stirling's report examines progress towards that aim over the past decade. It reviews evidence from policy documents, reports, survey data and primary research, in order to provide an overview of how exposure to SHS in different settings and among different populations has changed since 2012.

There has been progress in introducing policy and regulation to reduce the number of settings where non-smokers are exposed to SHS. Legislation to prohibit smoking in vehicles carrying children came into force in February 2022, while measures to ban

smoking across all Health and Social Care (HSC) Trust sites were introduced in 2016. Awareness raising through national campaigns have focused on smoking cessation or prevention of initiation, with some local measures targeting smoking at school entrances and parks.

Compliance with the public space restrictions introduced in 2007 continues to be high and most exposure in the workplace and leisure settings has been reduced to passing or incidental SHS. There are a small number of exceptions, including workplace vehicles, outdoor hospitality settings where definitions of enclosed spaces continue to be stretched, and health care workers who visit patients at home. There is a need for a future strategy to continue to tackle these settings and work towards protecting the workforce from exposure to SHS. No-one should have to breathe SHS while at work.

Northern Ireland gathers world-leading, longitudinal survey data on smoking and smoking-related behaviours through the Health Survey Northern Ireland (HSNI) and the Young Persons' Behaviour and Attitudes Survey (YPBAS). These data show some marked changes in population level exposure to SHS. Over the past decade the proportion of homes where smoking is permitted indoors has fallen from 28% in 2011/12 to 14% in 2018/19. This is a significant achievement that should be celebrated. It represents approximately 114,000 homes where smoking is no longer viewed as the social norm within the space of just 7 years. However, these changes have disproportionately benefited those living in wealthier areas: children living in poorer areas are less likely to have experienced reductions in SHS exposure at home.

In terms of future focus, it is important that the next strategy recognises the need to continue to tackle smoking in the home. Those living in the remaining 1 in 7 smoking-permitted homes across Northern Ireland will breathe concentrations of SHS often much higher than those measured in the smoky pubs of a bygone era. They will do so for many hours of their day and, as a result, be at much higher risk of cancer, stroke, respiratory disease, and heart disease. Future strategy should commit to setting bold targets to drive down both the prevalence of smoking and the proportion of children and adults who live in smoking-permitted homes. These include consideration of a tobacco endgame with policies that further restrict smoking in indoor spaces as well as investment in mass media campaigns to continue to shift social norms and support people who smoke to make their homes smoke-free. Further objective measures of SHS exposure such as collecting salivary cotinine in an annual nationally representative survey will bolster SHS data collection and policy evaluation data by establishing a monitoring system to track population levels of SHS exposure.

8.4 In reaching their conclusions regarding future focus, the authors specifically considered whether our approach to addressing SHS exposure should continue to be based upon an incremental approach with measures aimed at reducing population prevalence of smoking, increasing awareness of SHS harms among both smokers and non-smokers, along with policy measures to reduce the number of (public space) microenvironments where non-smokers are likely to be exposed to SHS. Whilst they recognised benefits in such an approach, they also noted that there:

…is a risk that smoking behaviour is restricted in so many outdoor settings that the proportion of cigarettes smoked within the (unrestricted) home setting increases and therefore, there is a high risk that continuing with this approach sees further increases in socio-economic inequalities in relation to SHS exposure with those living in more deprived circumstances experiencing less benefit than those in wealthier areas.

8.5 The authors note that risk from exposure to many harmful substances is a product of two factors: duration and concentration. These two factors form the basis of the 'dose' of SHS that a person inhales, and while the WHO declare that there is 'no safe limit for SHS' there is also clear evidence that increasing concentrations cause increasing harm. The report concludes that...

…those living with smokers in smoking-permitted households suffer most of the exposure burden: a child living with a parent who smokes in the home will, over the course of a week, inhale much more SHS than a child who is only incidentally exposed to SHS by a smoker in a park, playground or at a building entrance.

8.6 The recommendation of the University of Stirling report is therefore for a population-dose centred approach, which aims to tackle the settings where the greatest numbers of the population are exposed to the highest concentrations for the longest durations, ***since this offers the potential for greatest population benefit and is more likely to align with a tobacco endgame strategy that produces a tobacco-free generation in the lifetime of the next strategy document. Such an approach is also more likely to reduce socio-economic inequalities in relation to SHS exposure.***

8.7 Further recommendations made by the University of Stirling for the successor strategy include:

Policy Targets

Set a target for Northern Ireland to become a tobacco-free generation (<5% prevalence) by 2035.

Create measures to protect home health care workers who are exposed to SHS when visiting patients' homes.

Smoking Cessation Programmes

Continue investment in provision and delivery of smoking cessation services, with targeting of support to smokers within socio-economically deprived communities, pregnant women, and parents of children.

Generate local research capacity to develop and test interventions including NRT provision, very brief advice, and financial incentives to help create smoke-free homes.

Data & Evidence

Continue to gather data on SHS exposure and public opinion related to possible control measures via longitudinal surveys (HSNI and YPBAS).

Develop a new, cross-sectional annual survey of children's salivary cotinine levels to provide objective measurement of SHS exposure.

Set targets (aligned with #2) for measured reductions in children's salivary cotinine (e.g., <1% of children with measurable cotinine by 2035).

Public Awareness Campaigns

Invest in mass media campaigns to educate, encourage, and empower smokers and non-smokers to create a smoke-free home and to make smoking indoors socially unacceptable.

9. Conclusions and Next Steps

9.1 The combined findings of this report of the End Review of the NI Tobacco Control Strategy, and the Mid-Term Review of 2020, clearly demonstrate the vast amount of work undertaken to deliver tobacco control initiatives in Northern Ireland over the lifetime of the Strategy. Despite the difficulties in progressing the Mid-Term Review recommendations during the COVID-19 pandemic, the commitment of the Department, and of delivery partners, to tobacco control has remained. This was evidenced by the work to adapt smoking cessation services to remote provision, and the implementation of two important pieces of legislation aimed at protecting children from second hand smoke and nicotine addiction, during a period of unprecedented pressures.

9.2 Progress in relation to tobacco control has been significant over the lifetime of the Strategy. Reductions in smoking prevalence have not been at a rate to meet the 2020 targets but have shown an overall downward trajectory (see Annex 1). This has been achieved through comprehensive smoking cessation services and campaigns, alongside work to prevent smoking uptake amongst young people.

9.3 The University of Stirling report (*An overview of progress in reducing second-hand smoke exposure in Northern Ireland and policy options for the future: A report to inform the end of term review of the Northern Ireland Tobacco Control Strategy 2012-2022*) confirms the significant progress made in reducing exposure to second-hand smoke in public places, and more recently in private vehicles carrying children. The report helpfully identifies areas for potential future attention, in particular the exposure in home settings. Whilst that report notes the potential risk in focusing our efforts on further restricting smoking in public outdoor places, it is important that the benefits of such measures in de-normalising smoking behaviours are also considered in our strategy development discussions.

9.4 The issues identified in the Mid-Term Review have again been highlighted as the primary remaining challenges. Socio-economic inequalities remain a key concern across a wide range of indicators including smoking prevalence, smoking in pregnancy, children reporting ever having smoked, successful quit attempts, and exposure to second-hand smoke. The work undertaken by the IPH as part of this End Review has also further defined the links between smoking and poor mental health, summarised the policy position in other nations, and set out a range of considerations for the next strategy.

9.5 The COVID-19 pandemic has brought additional challenges for smoking cessation services where services have had to adapt to remote provision and numbers accessing services have significantly reduced. The current blended approach (remote and face-to-face provision of services) broadens accessibility and means services are better prepared for any future disruption. However

further consideration needs to be given to means of bolstering the numbers accessing services, whether remotely or in person.

9.6 The 2020 Mid-Term Review found that Northern Ireland's legislative approaches to tobacco control were in keeping with best practice and some have been at the forefront of international developments on tobacco control. Activity in relation to the action plan continues to be extensive, and the Department is grateful for the resolve and commitment of all our delivery partners.

The Future

9.7 Since the development of the 2012 Strategy, new challenges in relation to tobacco and nicotine products have emerged. Whilst Northern Ireland's smoking prevalence rates remain higher than the targets set for 2020, the number of children and young people smoking appears to be steadily declining. However, apparent increases in youth vaping raise new generational concerns. As highlighted by stakeholders**, in the development of our next tobacco control strategy, we will need to identify our remit in relation to emerging nicotine products along with the strategic response that is required in relation to e-cigarettes**. Stakeholders also highlighted the need for flexibility moving forward, with a strategy that can respond to new and emerging nicotine products during its lifetime.

9.8 Whilst population level smoking cessation services are a central component of tobacco control, the Mid-Term Review pointed to the need for specific actions in relation to groups where smoking rates are highest. The inequality gaps in smoking prevalence continue to keep our overall smoking rates high and enhanced targeting of cessation services at high-risk groups is justified and supported. However, the relationship between smoking and social disadvantage is complex and multi-layered. Addressing this correlation effectively will require collaborative working across government, health services, community organisations and the voluntary sector.

9.9 The following table provides a summary of the key recommendations and issues identified for consideration in the development of the next strategy. These should be considered alongside recommendations from the Mid-Term Review (Annex 2) and the full reports referenced at sections 6, 7, and 8. Since further stakeholder input will be an integral part of the strategy development process, this list is not exhaustive.

9.10 Prior to his departure in 2022, the Health Minister approved the commencement of work on a new tobacco control strategy which we will now progress. Unfortunately, we commence the development of a successor strategy at a time of considerable pressures on public funds. It is important to acknowledge that, at least in the short term, prioritisation will be inevitable.

9.11 The Department of Health continues to work closely with counterparts in UK Government in relation to reserved tobacco matters and regulatory requirements for Northern Ireland resulting from changes to Directive 2014/40/EU (The Tobacco Products Directive)[54].

9.12 In development of the successor strategy, the Department of Health will work collaboratively and constructively with stakeholders to identify where our time and resources are best spent. The End Review process has highlighted the need for robust evidence in support of our investments. Whilst our key activities are based on NICE recommendations, there is also a need to enhance the mechanisms in place to cost, review, and evaluate our investments at a local level. Going forward, we also need a clearer understanding of the impact of our longer-term strategic approach on health outcomes.

9.13 In recent years, we have seen a shift in the narrative. Many nations are now referring to end-game approaches and smoke-free target dates have been set across Great Britain and the Republic of Ireland. Such targets are strongly supported by stakeholders, and the Department has committed to consider the setting of such targets in a Northern Ireland context.

9.14 Efforts to de-normalise smoking pre-date the current Strategy and have resulted in many highly influential public health initiatives, but the tobacco industry are persistent, and tobacco still kills up to half of its users[55]. New smokers continue to be recruited and new novel nicotine products continue to emerge, and our response needs to be equally uncompromising. Northern Ireland's tobacco control activities cannot stand still if we are to achieve a tobacco-free society. Our future strategic approach will need to develop and enhance existing successful approaches, but also be ambitious, inventive, and open to new ideas.

Considerations for successor strategy

Addressing the harms caused by second-hand smoke	
1.	Consider the policy recommendations put forward by the University of Stirling in their report [An overview of progress in reducing second-hand smoke exposure in Northern Ireland and policy options for the future: A report to inform the end of term review of the Northern Ireland Tobacco Control Strategy 2012-2022. January 2023], in particular with a view to: (a) Addressing second-hand smoke exposure within homes – particularly amongst children. (b) Developing measures to help protect workers, in particular those who provide care in community settings and those within the hospitality sector. (c) Identifying data collection and research opportunities to objectively test interventions and measure progress. (d) Considering ways to target cessation messaging at those living with children or with people who have health conditions that make them particularly vulnerable to the harms of second-hand smoke.
2.	Reflect on the experiences of Scotland and Wales in introducing regulations for smoke-free hospitals and assess the benefits for replication in Northern Ireland.
3.	Consider means of encouraging and supporting the voluntary development of smoke-free public places and ways of ensuring compliance.
4.	Consider the advantages and disadvantages of further expansion of smoke-free public places.
5.	Support and encourage cross-departmental working to develop smoke-free prison policy, along with support for those in prison who wish to quit smoking.
Addressing smoking prevalence and inequalities	
6.	Seek to ensure commitment to continued investment in the re-building, provision, and delivery of population level smoking cessation services.
7.	Target and modify smoking cessation services to support groups where smoking prevalence is highest, including socio-economically deprived communities, amongst smokers who are pregnant, and smokers with mental ill-health.
8.	Seek to secure investment in mass media campaigns to educate, encourage and empower smokers and non-smokers to quit and build on the messaging that smoking indoors is socially unacceptable.

9.	Ensure information and campaigns are accessible and effective for groups with high smoking prevalence.
10.	Consider setting a target date for Northern Ireland to become smoke/tobacco-free and identify the measures that would be needed to achieve such a target.
11.	Identify opportunities for smoking prevention research and activity in relation to children and young people.
12.	Identify clear goals in respect of smoking cessation services in acute and secondary care settings.
13.	Pilot and evaluate an incentives scheme in relation to smoking cessation in pregnancy with a view to wider implementation.
14.	Continue to highlight the importance of investment in enforcement of tobacco legislation and identify opportunities for enhanced partnership working with other law enforcement agencies.
15.	Assess the potential benefits of a raised age of sale in relation to tobacco.
16.	Consider further measures to support smoking/vaping cessation in young people.
17.	Consider IPH report on mental health and smoking with a view to: (a) Identifying qualitative and quantitative research needs to help understand the relationship between smoking and mental health. (b) Effectively focusing attention and resource at policy level to reduce smoking-related harms among people with mental ill-health (including consideration of identifying those with mental ill-health as a target group). (c) Building partnerships with mental health advocacy organisations and professional organisations leading on delivering mental health services. (d) Assessing 'best buys' for investment in training of service providers building on existing good practice. (e) Modifying public awareness and messaging to engage people who smoke with mental ill-health and facilitate access to support. (f) Enhancing assessment of risk from tobacco-related harms among people with mental illness through collaborative working with colleagues across health service delivery and policy development.

18.	Identify opportunities for collaborative working with mental health policy colleagues in respect of shared objectives.
Nicotine-containing Products	
19.	Identify the strategy's remit and role in relation to novel tobacco and nicotine products.
20.	Consider the most appropriate and effective strategic response to concerns about youth and recreational vaping.
21.	Consider how the strategy can be best future-proofed to enable a timely response to new and emerging products.
Regulation and Enforcement	
22.	Identify measures to further support enforcement activity and consider a structured approach to: (a) Maximise potential of existing regulation and identify best practice. (b) Review priorities across tobacco and nicotine inhaling products enforcement activity.
23.	Consider further regulatory levers required to achieve the future strategic goals identified.
Information and Evidence	
24.	Consider development of a framework for research, data, and information needs.
25.	Ensure future action plan includes clear plans for review, evaluation, and costing mechanisms.
26.	Identify appropriate indicators and outcomes by which we can measure success.
Collaborative Working	
27.	Identify opportunities to work together with colleagues across Great Britain, the Republic of Ireland, and across the NI Government, to address smoking-related harms.
28.	Embrace and seek opportunities for international networking and shared learning.

Annex 1

Smoking-related trends over the lifetime of the Strategy

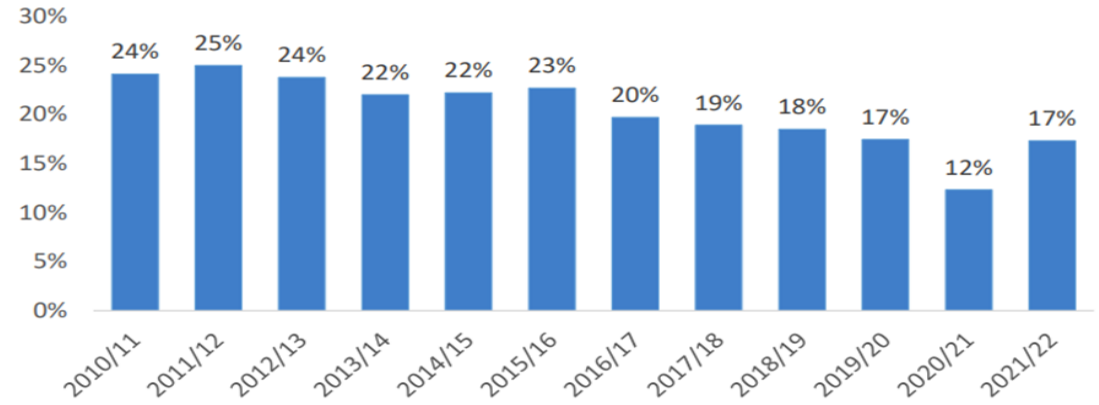
See Department of Health: Health Inequalities Annual Report 2023 and Department of Health: Health Survey (NI) Smoking in Northern Ireland 2010/11 to 2019/20 for further trend information.

Trends by priority groups

Adult population

In 2021/22, **17%** of adults smoked cigarettes; this is an increase compared with the 2020/21 finding of 12%, however it is similar to the 2019/20 rate. Smoking prevalence has decreased from **24%** in 2010/11[56].

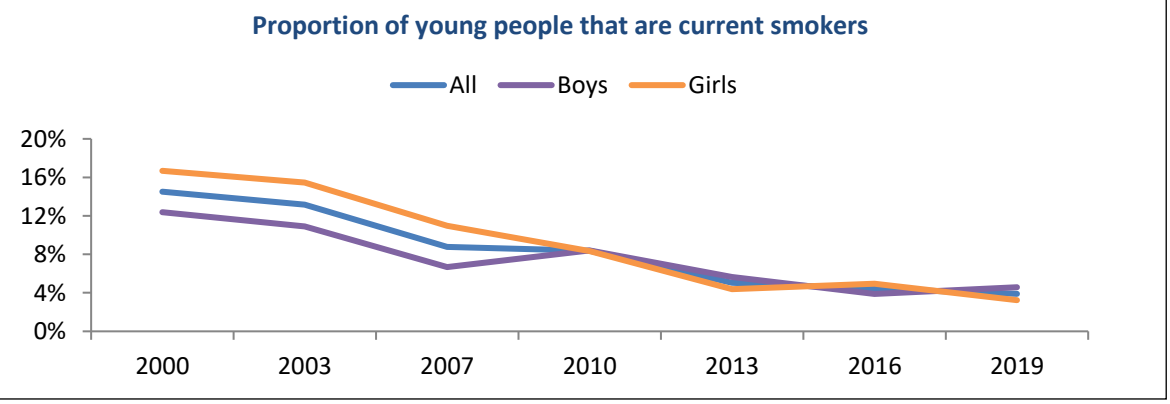
Figure 5 – Adult smoking prevalence by year.



Children and young people

Smoking prevalence among 11–16 year-olds has reduced from **8%** in 2010 to **4%** in 2019.

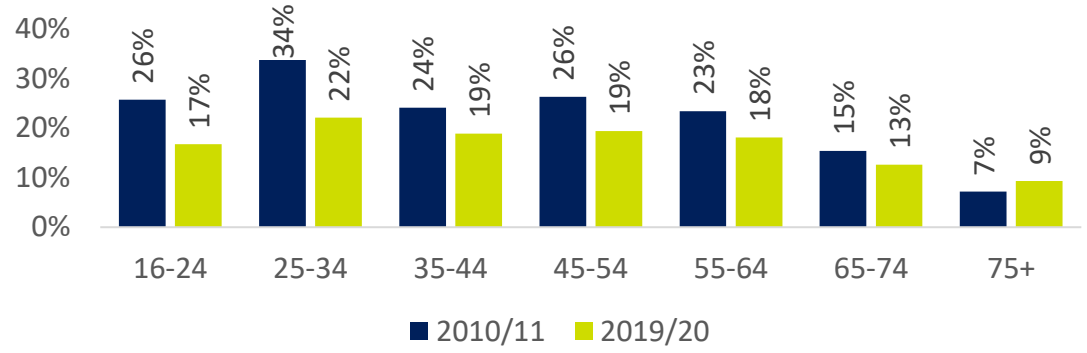
Figure 6 – 11-16 year old smoking prevalence by year.



Age

Between 2010/11 and 2019/20, the proportion of those aged 16-24 and 25-34 that smoked fell by around a third (from 26% to 17% for age 16-24 and from 34% to 22% for age 25-34), whilst the proportion of those aged 35-64 that smoked fell by around a quarter. The proportion of those aged 65+ that smoked remained at a similar level over this time period.

Figure 7 - Smoking prevalence by age-group (2010/11 and 2019/20 compared).

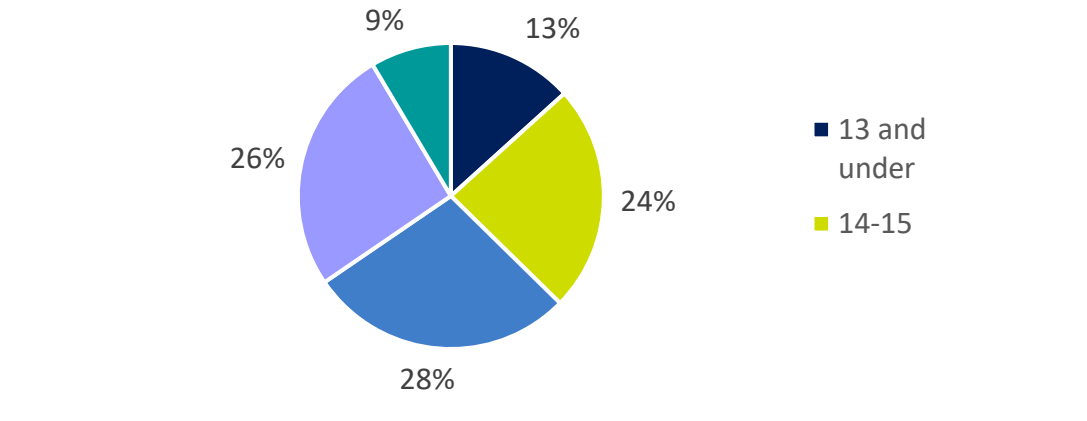


Age first started smoking

The age that smokers have started smoking regularly has remained relatively unchanged over the ten years between 2010/11 and 2019/20, with approximately two-thirds of those who ever regularly smoked cigarettes having started smoking regularly before the age of 18.

In 2019/20, more than a quarter (28%) of those who had ever smoked regularly had started at the age of 16 or 17, while 37% started smoking regularly aged 15 or under.

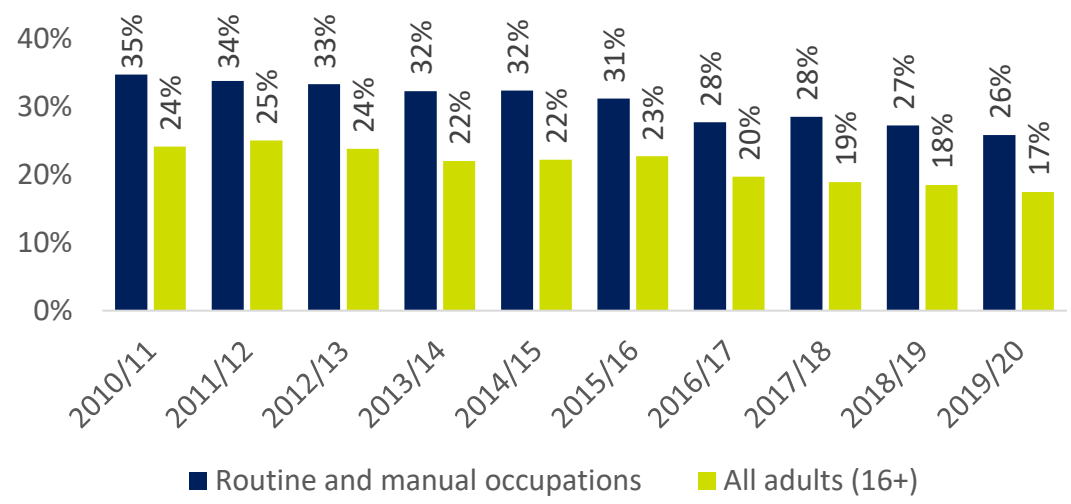
Figure 8 - Age first started smoking regularly (All smokers and ex-smokers in 2019/20).



Manual occupations

Smoking prevalence amongst the routine and manual occupations has fallen from **35%** in 2010/11 to **26%** in 2019/20.

Figure 9 - Smoking prevalence (All adults and routine and manual occupations compared).

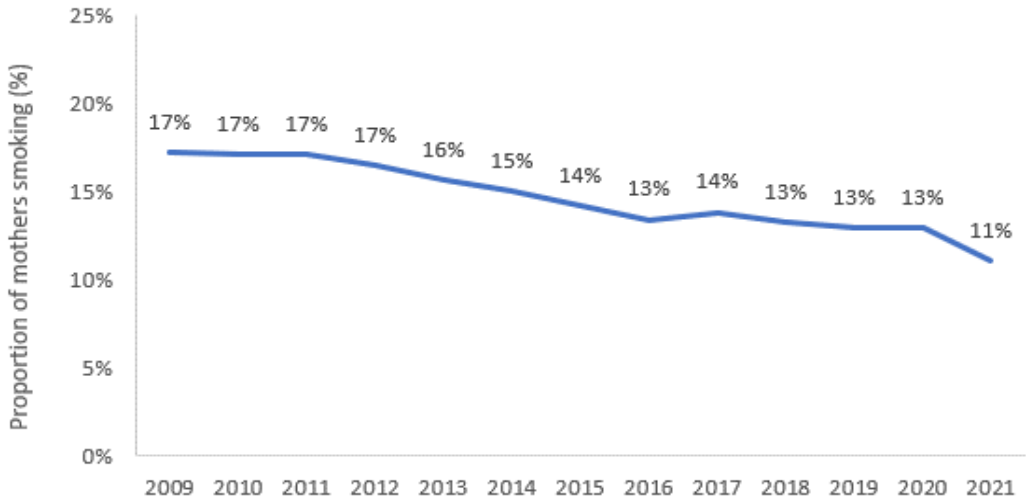


Please note that a change in classification methodology for National Statistics Socio-Economic Classification (NSSEC) applied from 2014/15. The 2010/11 baseline of 31% used in the original strategy (which referred to the old classification of manual workers) does not directly equate in relation to the newer classification of routine and manual workers. The new classification methodology for NSSEC has been applied to all years for this new graph.

Pregnant women

The proportion of all live births to mothers that reported smoking during pregnancy has decreased in Northern Ireland from **17%** in 2009 to **11%** in 2021. This reduction has been consistent year-on-year, with the exception of 2017 which showed a slight increase.

Figure 10 - Proportion of all live births to mothers that reported smoking during pregnancy.

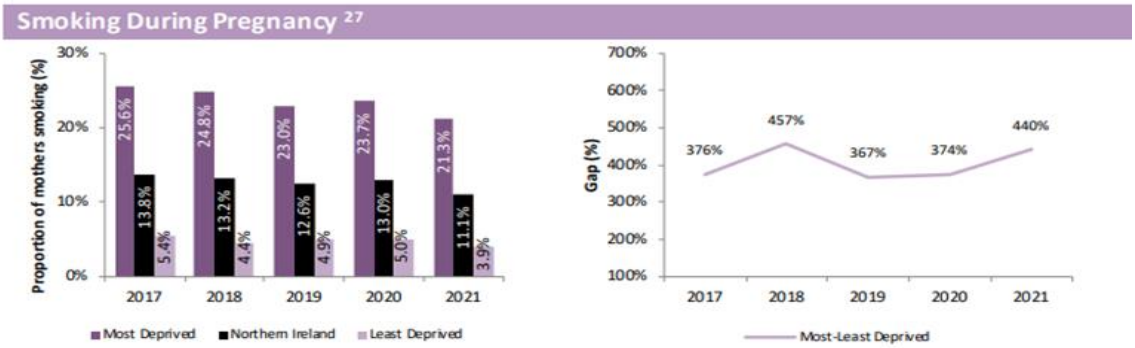


Note: figures from 2018 onwards have been revised from those previously reported due to a change in how data is recorded on the NI Maternity System.

Deprivation and smoking in pregnancy

The proportion of births where the mother reported smoking during pregnancy in the most deprived areas was more than five times the rate in the least deprived areas.

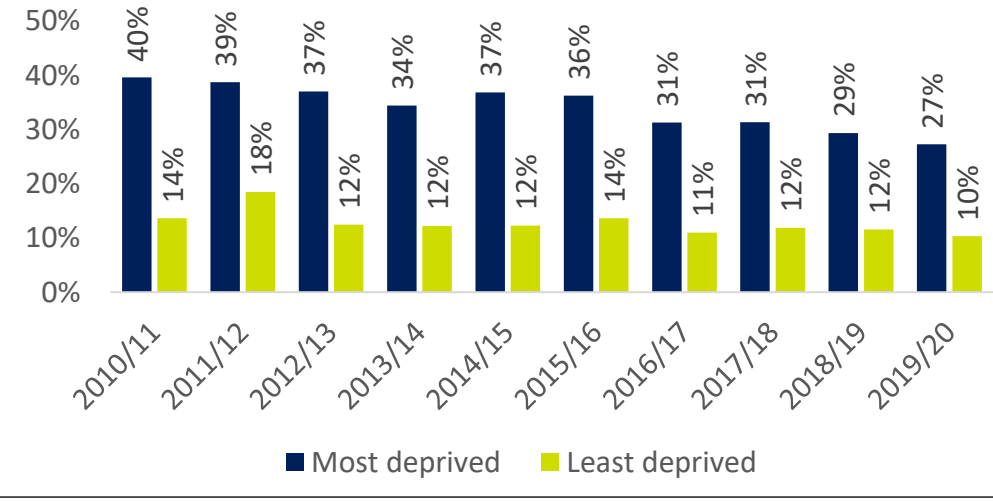
Figure 11 – Smoking during pregnancy 2017-2021[57].



Deprivation

Those living in the most deprived areas have consistently been between two and three times as likely to smoke as those living in the least deprived areas, however, smoking prevalence has fallen from 40% to 27% in the most deprived quintile over the last ten years.

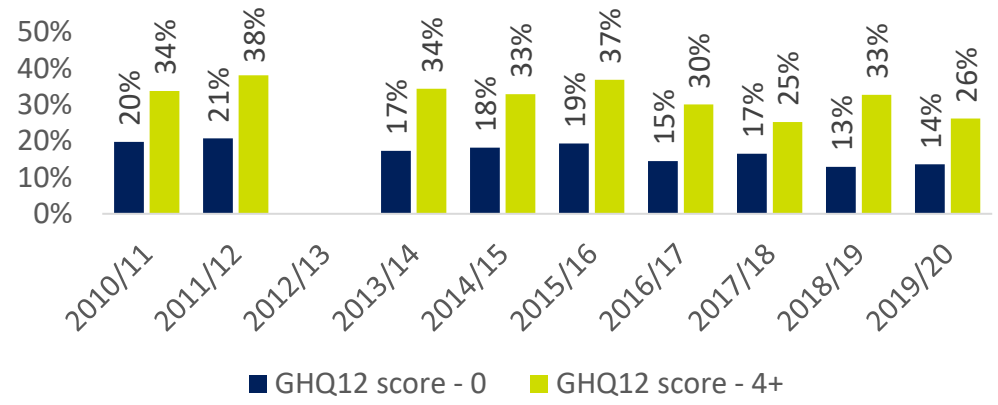
Figure 12 - Smoking prevalence by most and least deprived quintile and year.



Mental Health

The Health Survey NI captures information on the GHQ12[58], which is a measurement tool designed to detect the possibility of psychiatric morbidity in the general population. A score of 4 or more is classified as a respondent with a possible psychiatric disorder and referred to as a 'high GHQ12 score'. In 2019/20, respondents with a high GHQ12 score were more likely to report being a current smoker (26%) than those with a low score (14%). Whilst those with mental ill-health were not identified as a priority group in the Strategy, the Mid-Term Review of the Strategy made specific recommendations in relation to this group.

Figure 13 - Smoking prevalence (0 GHQ12 score and 4+ GHQ12 score compared).



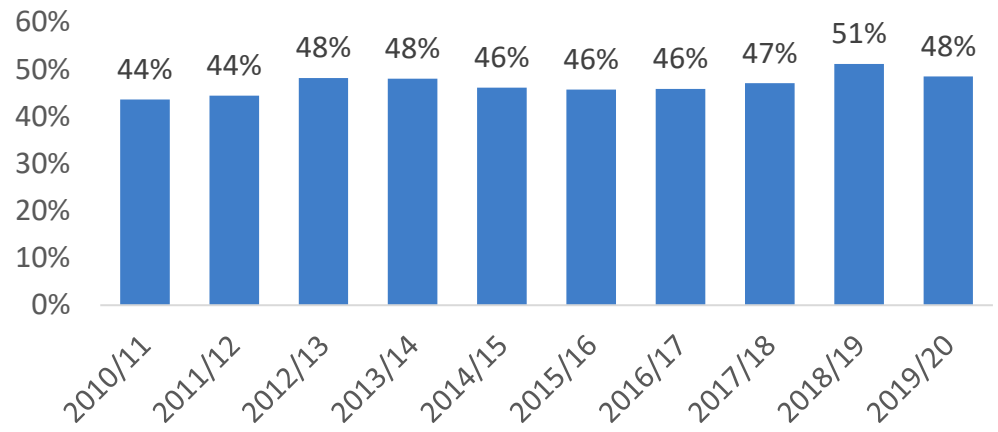
Trends by strategic objectives

Fewer People starting to smoke

Never smoked

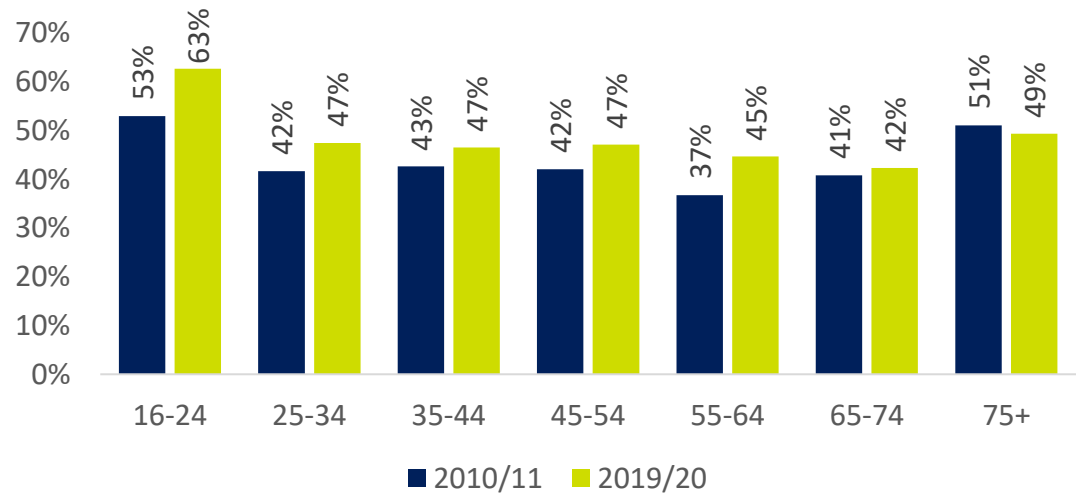
The proportion of those that had never smoked rose from 44% in 2010/11 to 48% in 2019/20.

Figure 14 - Never smoked by year.



Between 2010/11 and 2019/20, the proportion of those aged 16-24 that had never smoked increased from 53% to 63%.

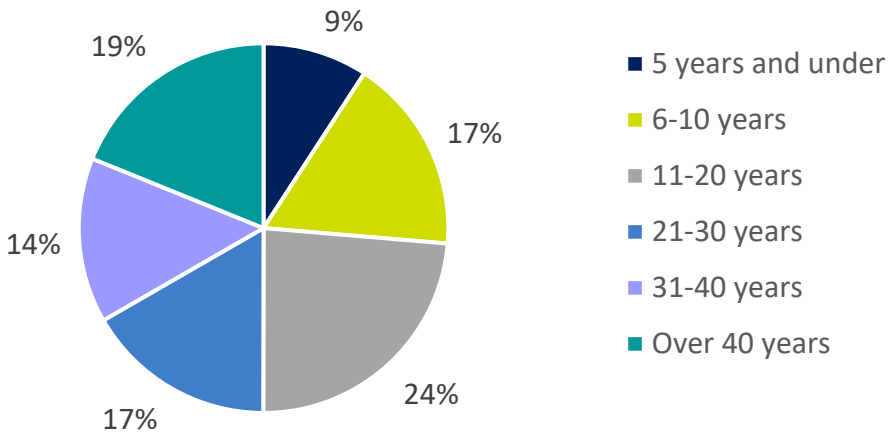
Figure 15 - Never smoked by age-group (2010/11 and 2019/20 compared).



Number of years smoked

In 2019/20, half of all current smokers had been smoking for more than 20 years, with 24% of smokers having smoked for between 11 and 20 years.

Figure 16 – Number of years smoking by Current smoker.

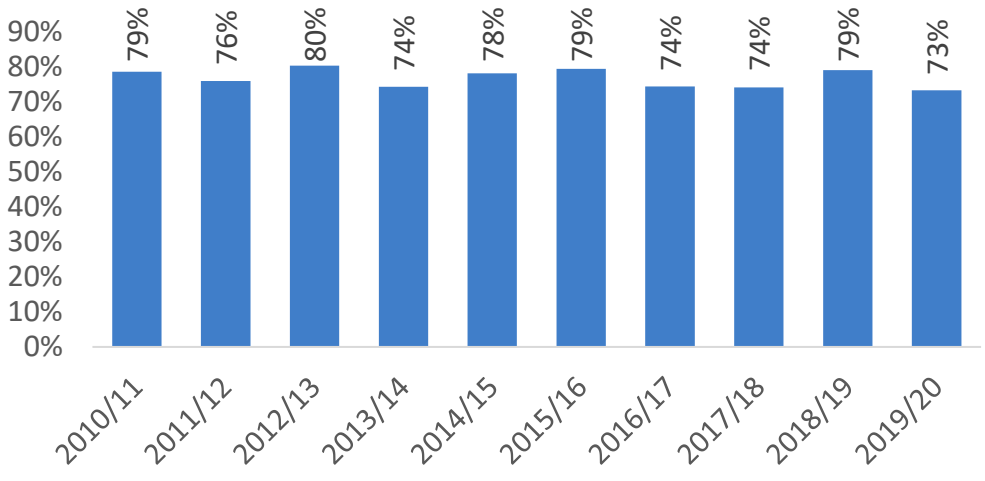


More smokers quitting

Tried to quit smoking

Since 2010, the proportion of smokers that have tried to quit smoking has remained around the three-quarters level (73% in 2019/20).

Figure 17 - Proportion of smokers who had tried to quit smoking by year.

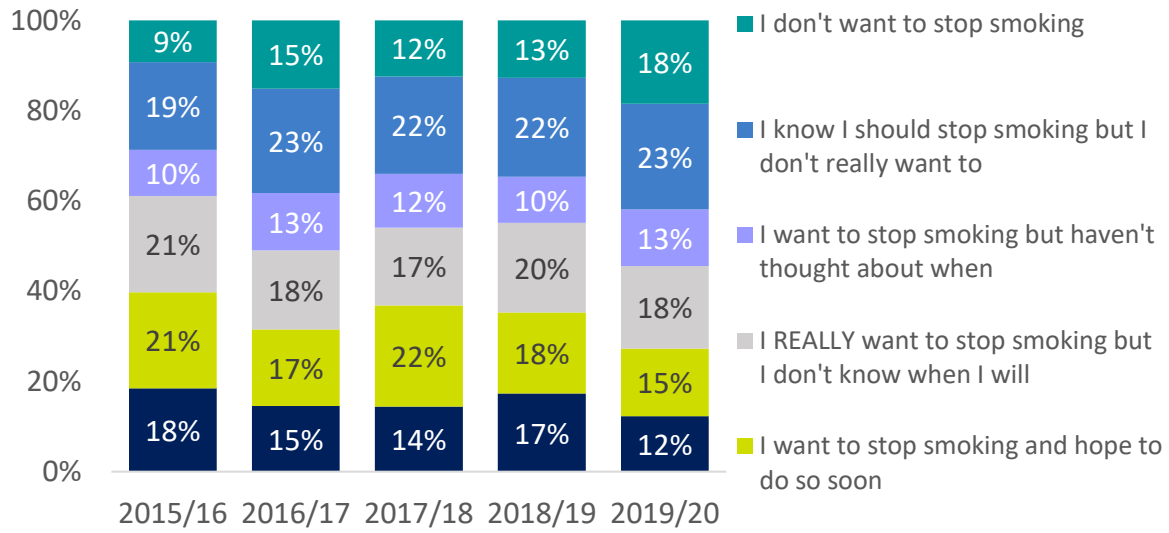


Intentions to quit

From 2015/16 to 2019/20, current smokers were asked about their intentions to quit smoking. Over this time the proportion of current smokers who said they wanted to stop smoking and intended to do so in a set time period decreased, while the

proportion of current smokers who said they "*don't want to stop smoking*" doubled from 9% in 2015/16 to 18% in 2019/20.

Figure 18 - Intentions to quit smoking for current smokers by year.

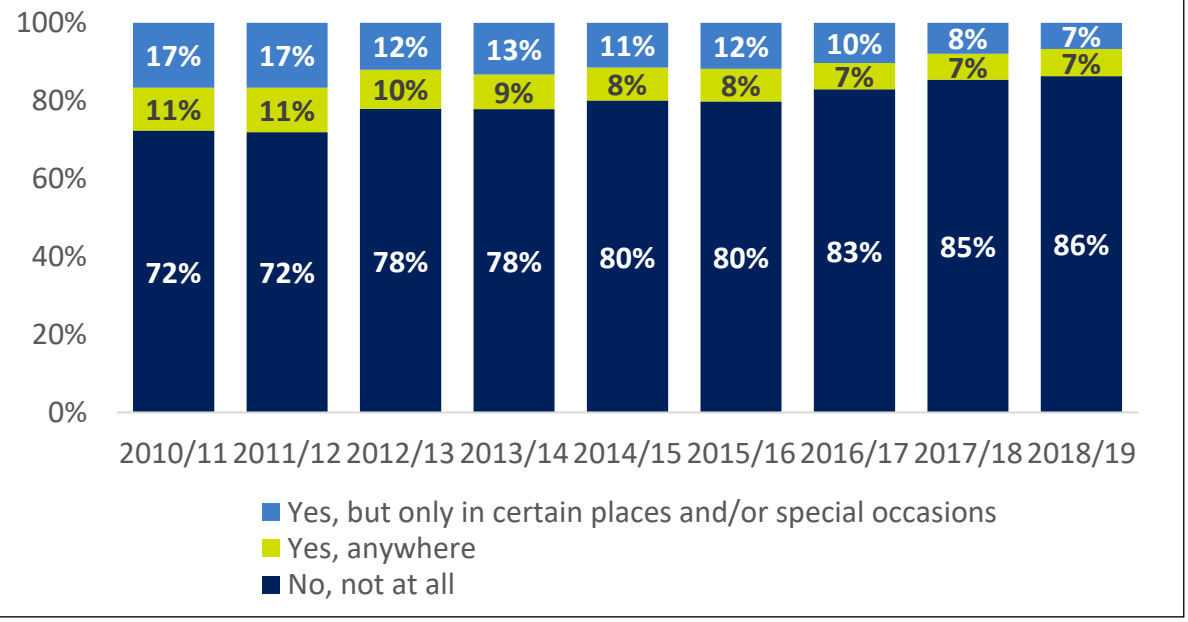


Protecting people from tobacco smoke

Smoking in the home

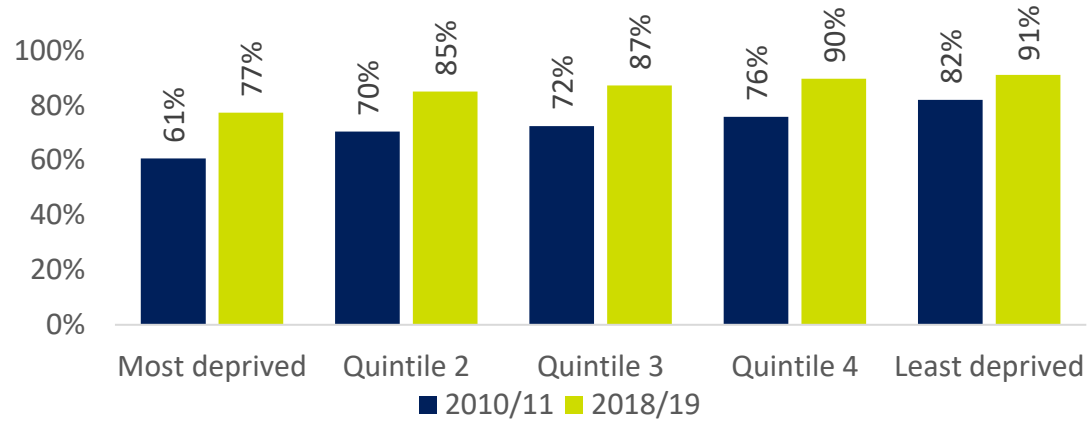
In 2018/19, the majority (86%) of respondents said that smoking was not allowed in their home (up from 72% in 2010/11). In this time, the proportion of respondents indicating that smoking was allowed anywhere in their home fell from 11% in 2010/11 to 7% in 2018/19, while the proportion of respondents indicating that smoking was allowed but only in certain places and/or special occasions fell from 17% in 2010/11 to 7% in 2018/19.

Figure 19 - "Is smoking allowed in your house?" by year.



The proportion of respondents indicating that smoking is not allowed in their home increased in all deprivation areas between 2010/11 and 2018/19. However, the proportion of respondents saying that smoking is not allowed in their home remained lower for respondents living in the most deprived areas than for those living in all other deprivation quintiles.

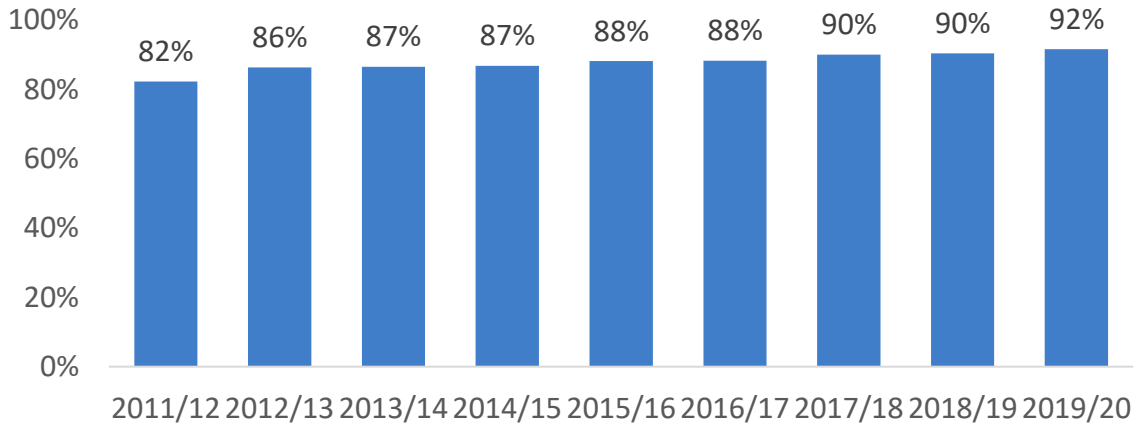
Figure 20 - "Smoking not allowed in home" by deprivation (2010/11 and 2018/19 compared).



Smoking in the family car

In 2019/20, the majority (92%) of respondents that had a family car said that smoking was not allowed in the family car while children were travelling in it (up from 82% in 2011/12). **It should be noted that this indication of high compliance pre-dates the 2022 change in the law which banned smoking in enclosed private vehicles when someone under 18 is present.**

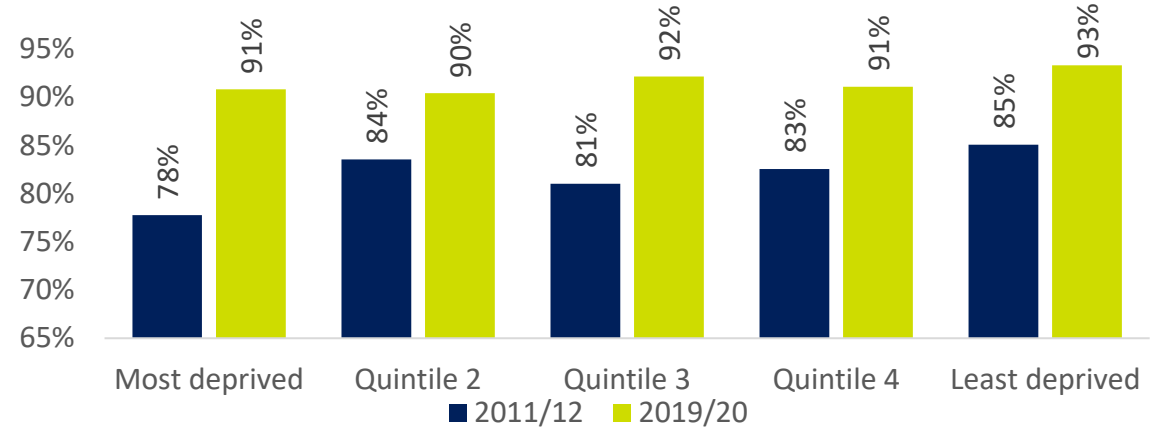
Figure 21 - Smoking not allowed in family car while children are travelling in car (of those that have a family car) by year.



Note that throughout this section the term *"smoking not allowed in the family car while children travelling in it"* includes those that indicated smoking is never allowed in their car and those that prohibit smoking when children are present in the car.

The proportion of respondents that had a family car that said that smoking was not allowed in the family car while children travelling in it increased in all deprivation quintiles between 2011/12 and 2019/20. In 2011/12, those living in the least deprived areas were more likely than those who lived in the most deprived areas to not allow smoking in the family car while children were travelling in it. In 2019/20, there was no difference by deprivation area.

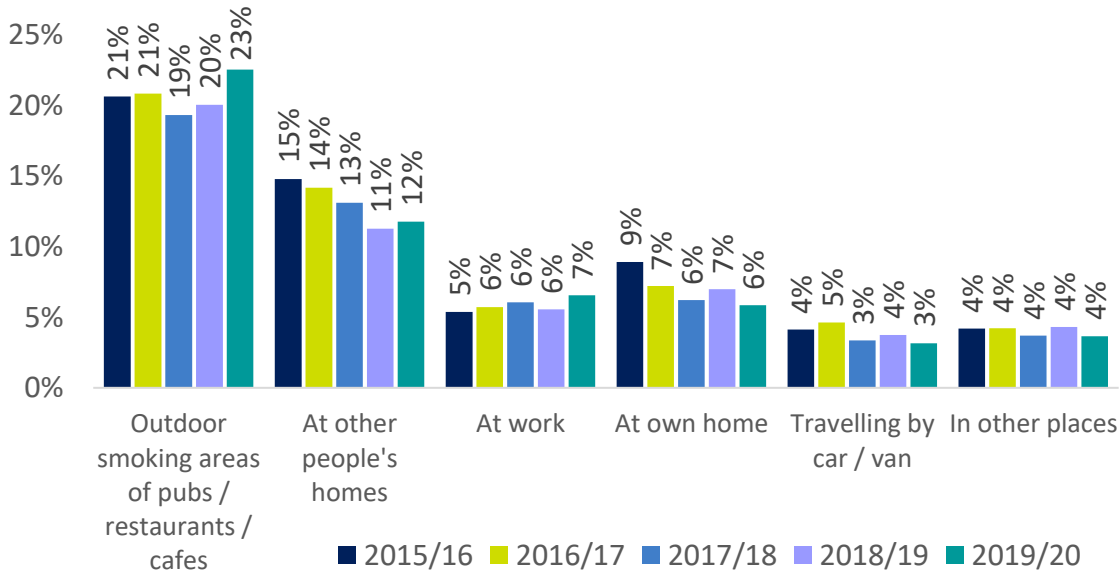
Figure 22 - Smoking not allowed in family car while children are travelling in car (of those that have a family car) by deprivation quintile (2011/12 & 2019/20 compared).



Exposure to other people's tobacco smoke

In 2019/20, over a third (37%) of respondents stated that they were regularly exposed to other people's tobacco smoke (similar to 2015/16 – 38%). Almost a quarter of respondents (23%) said that they were regularly exposed to other people's tobacco smoke in outdoor smoking areas of pubs, restaurants, or cafes (up from 21% in 2015/16) while 12% experienced this at other people's homes (down from 15% in 2015/16).

Figure 23 – Places that respondents were regularly exposed to other's tobacco smoke by year.



Annex 2

Recommendations from the Tobacco Strategy Mid-Term Review

Recommendation		Evidence
PRIORITY GROUPS		
1	TSISG to formulate a plan for the development of actions and targets in relation to people with mental health issues who smoke. This should consider short-term actions and scope the inclusion of people with mental health issues as an additional priority group in any new strategy.	Smoking prevalence is high in relation to people reporting a possible psychiatric disorder. In particular those with severe mental illness are more likely to die prematurely as a result of modifiable health-risk behaviours such as tobacco smoking.
FEWER PEOPLE STARTING TO SMOKE		
2	TSISG to explore possibilities and develop appropriate actions to maximise the prevention opportunities in relation to health and social care providers interfacing with children.	The evidence review supports the extension of family and community-based programmes and healthcare-based programmes as approaches to smoking prevention. In addition, it would be beneficial to consider the evidence in relation to effectiveness of school-based programmes and approaches to communications with children (in particular peer- led initiatives and media). The need to explore new media in relation to children and young people was also a consideration identified by stakeholders.
3	TSISG to explore opportunities and identify appropriate actions to maximise prevention opportunities through family and community programmes.	
4	TSISG to consider actions to refresh the design and delivery of school-based programmes, along with a communications strategy for young people in relation to both prevention and cessation.	
5	TSISG to consider and identify most appropriate mechanisms for engagement with HMRC on challenges relating to illicit tobacco.	The availability of illicit tobacco continues to cause concern. Work is underway at a UK inter-departmental level to address issues such as demand and communications. However, supply issues are primarily a matter for HMRC and Border Force. A better understanding of local challenges and

Recommendation		Evidence
		enforcement activities would be beneficial in understanding the challenges.
MORE SMOKERS QUITTING		
6	Reflecting on the evidence review and current successful approaches in health care settings, TSISG to consider feasibility of expanding stop smoking interventions and support in such settings and develop appropriate actions. Where such services and interventions already exist, the group should consider whether expansion is feasible, or beneficial, and develop new or amended actions as appropriate.	The existing focus in the Strategy on integration of stop smoking approaches across a range of services, including chronic disease management, is supported by the evidence. The evidence review suggests it would be beneficial to explore the feasibility of expansion of such approaches to both substance misuse and HIV/AIDS health and social service settings. Additionally, in relation to young people, it is suggested that it would be beneficial to integrate stop smoking support into sexual and reproductive health services for young people. Similarly, cessation interventions prior to surgery are shown to be effective and the evidence supports the further development of this service.
7	TSISG to consider and discuss progression of work-based programmes taking account of experiences from recent programmes as well as the evidence presented in relation to the design, delivery, and monitoring of such approaches.	The evidence review supports the effectiveness of work-based approaches to smoking cessation.
8	TSISG/PHA to consider the evidence relating to medicine compliance and NRT dosage, alongside updated NICE guidance, in service development, monitoring, and quality management of cessation services.	Medication compliance and the use of sufficiently high doses of NRT are important success factors for quit attempts.
9	TSISG to continue to identify and progress actions relating to training and skills development in relation to smoking cessation interventions, reflecting on effective practice across UK and Republic of Ireland, particularly in primary care.	Investment in training and skills development deliver results, particularly in primary care settings.

Recommendation		Evidence
10	TSISG to consider the options in terms of financial incentives in line with evidence and assess the viability of progressing this specifically in relation to pregnant women.	Financial incentives enhance the effectiveness of stop smoking services, including amongst pregnant women, principally in terms of attracting people to make and sustain a quit attempt.
11	TSISG to consider practices in Scotland in relation to disadvantaged communities and those recommended in UK-wide equity impact analysis of stop smoking services. New actions to target areas of high deprivation to be developed.	Disadvantaged people who smoke were considered in the context of health inequalities. The continued high prevalence rates are a clear indication of a need to look specifically at this group. Feedback from stakeholder engagement confirmed the view that targeting smoking cessation services to areas of disadvantage and within the priority group populations is needed. Scotland has reduced inequalities in smoking mainly through a strategy of intensive targeting coupled with a service-based equity target and reporting mechanism. Stakeholder feedback also suggests that an increased focus on health inequalities could be achieved through targeted co-production of services and community-based approaches to services.
12	TSISG Research and Information work stream to continue to provide updates from UK e-cigarette forum. TSISG to develop further actions to provide for the monitoring of developments in relation to e-cigarettes, which take account of consensus/position statements across the UK and ROI along with recommendations of professional and non-statutory organisations.	The evidence review did not specifically consider e-cigarettes (or other novel tobacco and nicotine-containing products) in relation to smoking cessation. However, this is an evolving area of evidence and has implications across all the Strategy objectives. The impending updated NICE guidelines, research to be taken forward by the Health Research Board in the Republic of Ireland, and the ongoing research by Public Health England (and Cancer Research UK) will all be relevant considerations.
PROTECTING PEOPLE FROM TOBACCO SMOKE		
13	TSISG to consider and develop actions to explore the possibilities of third level educational establishments adopting a smoke free policy position. Actions to be developed reflecting work with NI	Evidence supports the expansion of smoke-free bans and policies in university settings. There is also evidence that smoke-free prisons achieve reduced mortality from smoking-related illness. Stakeholders also raised

Recommendation		Evidence
	Prison Service in relation to smoke free prisons.	the need for progression in relation to NI smoke-free prisons.
14	The Department of Health and TSISG to continue to consider the developing evidence relating to expansion of smoke-free policy and regulations (including developments elsewhere in the UK and Republic of Ireland), along with learning from current smoke-free legislation, with a view to assessing implications and applicability to NI.	
15	Subject to the necessary approvals, the Department of Health to work towards implementation of legislation restricting smoking in cars when children are present at the earliest opportunity.	There is little evidence yet on the benefits of legislation aimed at preventing smoking in cars with children present. However, the benefits of this legislation also extend to de-normalising smoking.
STRUCTURE AND IMPLEMENTATION		
16	TSISG to make provision for an annual event bringing together all members of main group and work streams with a view to improving connectivity between the members.	There was some feeling that connectivity between the work streams could be improved (most respondents described it as poor or ok). The suggestion of a periodic meeting of all TSISG, and associated work stream members, would appear to be a positive suggestion in terms of increasing that connectivity. There were several comments made by TSISG members relating to current membership. For example, there was some feeling that membership was too rigid and could include guest speakers, and others suggested that the communication and education work stream be split into distinct work streams. There was a further suggestion that the research work stream would benefit from collaborative links with other research networks.

References

[1] https://www.health-ni.gov.uk/publications/ten-year-tobacco-control-strategy-northern-ireland
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