Bath & North East Somerset Council

Smoke Free
Bath & North East Somerset

Draft
Tobacco Control Strategy
2013 - 2018

B&NES Tobacco Action Network
August 2013

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Executive Summary

Smoking is still the single biggest cause of premature death and disease nationally and locally. Life expectancy varies in Bath &North East Somerset by up to 6.3 years for men in the most deprived areas and by 3.5 years for women. Smoking accounts for approximately half this difference in life expectancy.

Smoking related deaths and diseases in B&NES are lower than the English average and smoking prevalence is less than South West and England rates. However there are still over 23,000 smokers in B&NES, the majority from disadvantaged communities.

The Governments' Tobacco Control Plan (2011) sets targets for reducing smoking prevalence amongst pregnant women, young people and adults by 2015. This focus is reflected in the Public Health Outcomes framework which have become the responsibility of Local Authorities to deliver from April 2013.

There is strong local leadership and resourcing of tobacco control initiatives in B&NES and a comprehensive programme of evidence based work on tobacco control. The challenge locally is to deliver a co-ordinated population wide tobacco control programme whilst effectively targeting resources to reduce the significant inequalities in smoking prevalence within our communities.

This B&NES Tobacco Control Strategy aims to reduce health inequalities by:

- Preventing young people from starting to smoke
- Encouraging smokers to quit
- Reducing the harm from smoking through
    - exposure to toxins from second hand smoke and
    - harm to existing smokers

This will be achieved through a co-ordinated multiagency approach focussing on the following key strands of tobacco control:

- Multi agency partnership working
- Normalising smoke free lifestyles
- Reducing exposure to second hand smoke
- Restricting supply of tobacco
- Helping people to quit
- Ensuring effective communications and marketing

Recommendations for action (2013 – 2015) across all of these strands have been drawn up in consultation with a wide range of key stakeholders and will form the Tobacco Control Action Plan which will be overseen and monitored by the B&NES Tobacco Action Network.

Background

The World Health Organisation (WHO) Framework Convention on Tobacco Control is a treaty designed to reduce the health and economic impacts of tobacco globally. To date 175 countries have bound themselves to delivering on the Framework including the UK, which signed up in 2004.

The WHO Framework commits countries to a range of actions including reducing demand for tobacco through price and tax measures and non-price measures such as regulation of tobacco products and protection from exposure to tobacco smoke. It also includes actions to reduce supply of tobacco via illicit trade and sales to and by minors.

Specifically Article 5.3 of the WHO Framework aims to protect public health policies from the commercial and other vested interests of the tobacco industry. This applies to all levels of Government, national and local, and aims to encourage transparency and accountability amongst government officials and employees and avoid conflicts of interest.

The Marmot review (2010) states that tobacco control is central to any strategy to tackle health inequalities and to any prevention strategy[1]. It identified the driver of health inequalities as social inequalities created by differences in living standards, occupation and education for example. One of Marmot's key proposals linked to reducing cardiovascular disease and cancers is:

'Reduce smoking in the most marginalised groups by focusing on price and availability, while providing stop smoking services targeted to help the poorest groups quit'.

In March 2011 the coalition Government launched Healthy Lives, Healthy People: A Tobacco Control Plan for England with the aim of '*achieving a demonstrable reduction in inequalities by improving the health of the poorest fastest by prioritising smoking'.*[2] The Plan aligns with the key strands of the WHO Framework and references the findings of Marmot.

The Plan states that measures need to be active at local, regional, national and international level to be effective and sets out how the Plan fits with the localism agenda.

National targets have been set to reduce smoking levels amongst young people, pregnant women and the general population and are also part of the new Public Health Outcomes Framework from April 2013.

[1] Marmot (2010) Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010

[2] Department of Health (2011) Healthy Lives: Healthy People: A Tobacco Control Plan for England

National Targets

- To **reduce adult (aged 18 or over) smoking prevalence to 18.5% or less** by the end of 2015 (from 21.2%)

- To **reduce rates of regular smoking among 15 year olds to 12% or less** (from 15%) by the end of 2015

- To **reduce rates of smoking throughout pregnancy to 11% or less** (from 14%) by the end of 2015 (measured at time of giving birth)

From April 2013 local authorities have responsibility for achieving the public health outcomes for smoking. In order to ensure smoking prevalence continues to decline, a strategic multi layered approach is recommended which ensures all elements of the six internationally recognised strands of tobacco control are being addressed including:

- Making smoking less affordable
- Reducing exposure to second hand smoke
- Stopping the promotion of tobacco
- Regulating tobacco products more effectively
- Helping smokers to quit
- Producing effective communications for tobacco control

The Tobacco Control Plan identifies key opportunities with the move of public health to local authorities including improved compliance with regulations, tailoring services such as cessation support to local need and enhanced opportunities to engage local communities in the development and delivery of local initiatives. Equally there are significant opportunities to embed smoke free policies across the broad spectrum of local authority responsibilities.

The existing B&NES Tobacco Control Strategy *Breathing Free* was written in 2006. Significant progress has been made nationally, regionally and locally since then and it is appropriate now to review local strategy in the light of this and set priorities which are in line with the new opportunities for public health and the changing local landscape within public services.

Strategic Vision

Our vision is for a smoke free Bath and North East Somerset, where children and young people grow up free from the harms caused by tobacco.

This B&NES Tobacco Control Strategy aims to reduce health inequalities by:

- Preventing young people from starting to smoke
- Encouraging smokers to quit
- Reducing the harm from smoking through
    - exposure to toxins from second hand smoke and
    - harm to existing smokers

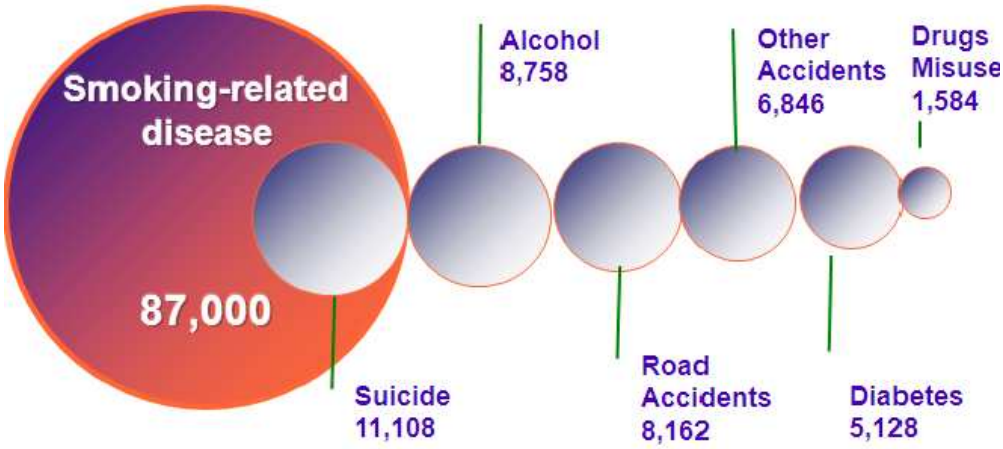
Local action will focus on achieving these aims through the following key strands of Tobacco Control:

- Multi agency partnership working
- Normalising smoke free lifestyles
- Reducing exposure to second hand smoke
- Restricting supply of tobacco
- Helping people to quit
- Ensuring effective communications and marketing

The current picture of smoking in B&NES

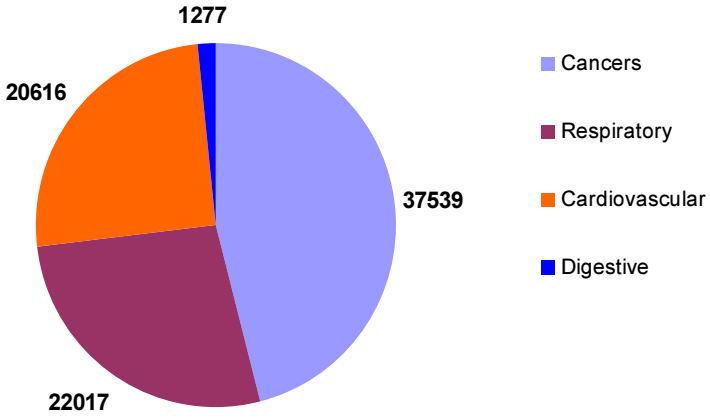
Smoking is still the single biggest cause of premature death and disease nationally and locally. Smoking related deaths are more numerous than the next 6 most common causes of preventable death combined (drug use, road accidents, preventable diabetes, suicide, other accidents and falls and alcohol abuse).[3]

Figure 1 Causes of preventable death annually



The top 3 causes of mortality in B&NES are diseases of the circulatory system (heart etc.), followed by neoplasms (Cancer), and respiratory diseases (lungs)[4]. These diseases (in particular, heart attack, stroke, lung cancer and chronic obstructive pulmonary disease (COPD)) are responsible for the majority of smoking related deaths (see figure 2).

Figure 2 Smoking attributable deaths from major causes (England 2009)[5]



Total deaths 87,000

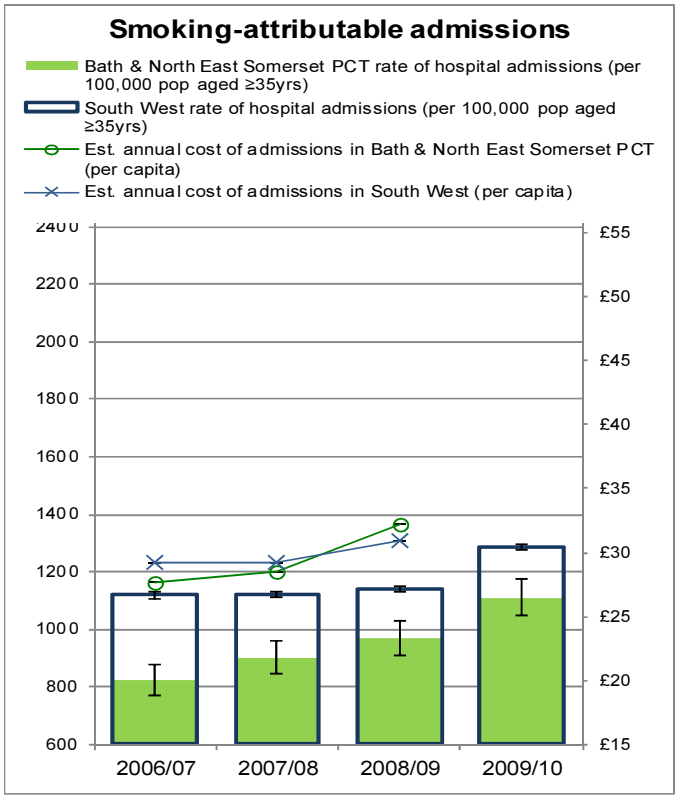
[3] Department of Health (2011) Healthy Lives Healthy People: A Tobacco Control Plan for England
[4] Joint Strategic Needs Assessment, Bath and North East Somerset Draft (March 2012)
[5] NHS Information Centre (2009), Statistics on smoking: England 2009 available at www.ic.nhs.uk/webfiles/publications/smoking09/statistics_on_smoking_england_2009.pdf

Life expectancy varies in B&NES by up to 6.3 years for men in the most deprived areas and by 3.5 years for women. Smoking accounts for approximately half the difference in life expectancy. Smoking related diseases such as cardiovascular disease and lung cancer are more prevalent in disadvantaged communities.

300 people die prematurely in B&NES due to smoking related diseases each year. One in two smokers will die from a smoking related cause and life time smokers will lose approximately 10 years of life.

Smoking related deaths and diseases in B&NES are lower than the English average, with the exception of stroke which is in line with England average[6]. Smoking attributable hospital admissions are rising, this is considered to be a consequence of people living longer with chronic conditions (see figure 3).

Figure 3 B&NES Smoking Attributable Hospital Admissions 2006/7 – 2009/10



Overall smoking prevalence amongst adults in B&NES is 16.4%, this equates to 23,308 smokers 18 years and over[7]. This is lower than national (21%) and South West prevalence (19%). Local data suggests 56% of B&NES smokers want to give up.[8]

[6] Local Tobacco Control Profiles for England (2011) www.lho.org.uk
[7] Integrated Household Survey ONS Smoking prevalence by region and local authority April 10 – March 11 www.lho.org.uk
[8] Bath and North East Somerset Council (2010) Voicebox 18 Survey, in-house analysis

Nationally smoking prevalence has been declining steadily since the 1960's. However the downward trend has stalled in recent years and now seems to be levelling out, with little change in prevalence rates since 2008. Experience from other countries indicates that smoking prevalence can be reduced even more. Australia, Sweden and parts of the USA have reduced smoking prevalence to 15%, 15% and 11.9% respectively. Australia has the lowest prevalence of smoking amongst 14 –17 year olds in the world at 2.5%.

Research has shown that the decline in smoking rates in the UK has slowed since the start of the economic recession. [9] Prevalence has reduced across all social gradients however the gap between the socio economic groups has stayed constant. Smoking is becoming more engrained in specific communities and there has been a shift in smoking behaviour with a rise in use of Hand Rolling Tobacco (HRT), 53% of smokers in the South West roll their own, the highest rate in the UK.

Smoking in pregnancy

Tobacco smoke contains over 4,000 chemicals many of which can cross the placental barrier and have a direct toxic effect on the foetus.[10] Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40%.[11]

Smoking amongst pregnant women in B&NES is currently 9.4% compared to a national level of 12.7%. However there are marked differences in levels of smoking amongst younger women who are pregnant and those who live in different areas of B&NES. For example, 35% of under 18's who are pregnant in B&NES smoke and there are much higher rates of smoking amongst pregnant women in the Radstock (32%) Twerton (22%) and Keynsham (15.4%) children centre catchment areas compared to other areas of B&NES.

Children and young people

Very few adults take up smoking for the first time. Two thirds of smokers say they began before they were legally old enough (18 years) to buy cigarettes and 9 out of 10 before the age of 19 [12]. Nicotine addiction starts in adolescence.

National surveys show that the proportion of secondary school pupils who have ever smoked continues to decline.[13] In 2010, 27% of 11 – 15 year olds

[9] West R, Brown J Fidler J (2012) Key findings from the Smoking Toolkit Study presentation www.smokinginengland.info
[10] Royal College of Physicians (March 2010) Passive Smoking in Children
[11] Department of Health: 2007 Implementation plan for reducing health inequalities in infant mortality
[12] http://ash.org.uk/localtoolkit/docs/cllr-briefings/Children.pdf
[13] NHS Information Centre; Smoking, drinking and drug use among young people in England in 2010. National Centre for Social Research

had smoked at least once, compared to 53% in 1982. Smoking increases with age, becoming more prevalent as children progress through secondary school, and more girls are smoking than boys.

Regular smoking is associated with other risky behaviours such as drinking alcohol and taking drugs. Cannabis, which is commonly smoked with tobacco, is the most commonly used drug amongst Year 10 pupils in B&NES, with 9% reporting using it within the last month.

Those young people who have truanted from school or been excluded at some point are more likely to be regular smokers. Children are three times more likely to smoke if their parents smoke and the vast majority of 16yr old regular smokers live in a household with at least one other smoker. The younger the age of uptake of smoking, the greater the harm is likely to be because early uptake is associated with subsequent heavier smoking, higher levels of dependency, a lower chance of quitting, and higher mortality.

The local Secondary School age survey (Yr 8 and 10) in B&NES[14] reported that:

- 24% of pupils said they have tried smoking in the past or are smoking now
- 8% said they smoke regularly or occasionally (compared to 9% in national sample)
- 6% smoked at least one cigarette during the last 7 days (compared with 9% of national sample)
- 12% of year 10 boys and 21% of year 10 girls said that they smoke 'occasionally' or 'regularly'
- 13% of B&NES primary school pupils think they may smoke when they are older compared to 10% of the national survey.

The two Further Education Colleges in Bath & North East Somerset have carried out similar surveys of health related behaviours amongst students, including smoking. A Bath City College survey in spring 2013 involving 325 students indicated that 28% of students smoke (80% of which is hand rolling tobacco) and 21% started smoking when they joined the College. The majority of smoker (65%) said they wanted to quit.

Second hand smoke

Second hand smoke is made up of the smoke emitted from the burning end of a cigarette or other tobacco product, in combination with smoke exhaled by the smoker. It contains a number of toxins and is carcinogenic to humans. Evidence shows that exposure to second hand smoke causes death, disease and disability in children and adults. A 2010 report from the Royal College of

[14] NHS B&NES (2011) Primary and Secondary Health Related Behaviour Survey: Bath & North East Somerset

Physicians estimates that exposure to second hand smoke impacts the health of children in the UK each year in the following ways[15]:

- around 20,500 new cases of lower respiratory tract infection in children under the age of 3 years
- 121,400 new cases of middle ear disease in children of all ages
- 22,600 new cases of wheeze and asthma
- at least 200 cases per year of bacterial meningitis
- 40 sudden infant deaths

This report also concludes that passive smoking is a significant contributor to the levels of health inequalities in terms of incidence of these diseases across socio economic gradients.

Local survey data tells us that 33% of B&NES 11 – 15 year olds say at least one person regularly smokes indoors in their home[16]. This is lower than the national comparator (40%) but still a significant number exposed to second hand smoke and smoking behaviours.

Routine and manual workers

The percentage of people in routine and manual jobs who smoke in B&NES is 26% (2011/12) compared to 30.2% regionally and 30.3% nationally and B&NES average of 16.4%.[17] Smokers from lower socio economic groups are no less likely to try to give up smoking, however they are less likely to succeed.[18] This suggests that some groups face social and economic barriers that may inhibit their ability to quit.

Mental health and smoking

Smoking rates are much higher amongst people with mental health problems than the general population. Research has found that people with depressive episodes, phobias or obsessive compulsive disorders were twice as likely as those without these conditions to smoke. Also smokers with mental health problems are heavier and more dependent smokers than the general population.[19] There is evidence to suggest that smoking is a factor in the onset and worsening of mental health conditions, specifically depression and anxiety related problems.[20]

[15] Royal College of Physicians: March 2010 Passive smoking in Children
[16] NHS B&NES (2011) Primary and Secondary Health Related Behaviour Survey: Bath & North East Somerset
[17] Local Tobacco Profile (2010) www.lho.org.uk
[18] Kotz D, West R. Explaining the social gradient in smoking cessation: it's not in the trying, but in the succeeding. *Tob Control.* Feb 2009;18(1):43-46.
[19] NHS Health Development Agency (2004) Smoking in patients with mental health problems
[20] McNally L (2009) Quitting in mind. A guide to implementing stop smoking support in Mental Health settings. London Development Centre

Smoking and ethnicity

Smoking rates amongst ethnic groups are generally lower than the population as a whole. However rates vary considerably between ethnic groups and amongst men and women within ethnic groups. Higher rates of smoking are found in men in Black Caribbean (37%) Bangladeshi (36%) Chinese (31%) and White Other (30%) populations. These differences could be explained by socio economic differences between groups. Smoking rates among women are low with the exception of Black Caribbean (24%) and White Irish (26%) populations.[21]

Bath and North East Somerset is less ethnically diverse than the UK as a whole but more so than the South West. 88% of residents are likely to define their ethnicity as White British. White Other (3.66%) is the most significant non White British ethnicity by volume which is likely to include EU Accession state residents (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia), followed by "Asian Indian" (1.97%), "Chinese/Other ethnic background" (0.96%), "Black African" (0.9%) and White Irish (0.7%).[22]

Evidence shows that minority ethnic groups in England are as ready to quit smoking as the general population, however fewer have made an attempt to stop through using professional support. Whilst the black and minority ethnic population in B&NES is 7.66% only 2.8% of people accessing cessation support services during 2011/12 were from these groups. Those from BME groups setting a quit date were also less likely to successfully quit (36% quit rate) compared to the other groups (52%).

Smoking related fire deaths and casualties

Nationally, smokers' materials (i.e. cigarettes, cigars or pipe tobacco) were the most frequent source of ignition causing accidental dwelling fire deaths, accounting for over a third of all accidental dwelling fire deaths in 2010-11. For every 1,000 accidental dwelling fires (where smokers' materials were the source of ignition), 35 people were killed in 2010-11. Since 2000-01, such deaths have become increasingly less common and there has been a downward trend in the figures for most of the decade.[23]

Avon Fire & Rescue reported a 13% reduction of primary fires in 2010/11 (2,295 reduced to 2,004) and a 12% reduction in fire related injuries. There were 12 primary fire deaths in the Avon area in 2010/11(1.1 per 100,000 population) this is higher than the South West rate (0.7 per 100,000). Of these deaths, 4 involved smoking materials. During 2011/12, there were 5 primary fire deaths in the Avon area, none of these were caused by smoking materials.

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[21] Millward D and Karlsen S Tobacco Use among Ethnic Minority populations and cessation intervention. A Race Equality Foundation Briefing Paper May 2011 www.better-health.org.uk
[22] B&NES JSNA Technical Summary Document 2012 www.bathnes.gov.uk/jsna
[23] Fire Statistics Great Britain 2010/11 Communities and Local Government http://www.communities.gov.uk/publications/corporate/statistics/firestatsgb201011

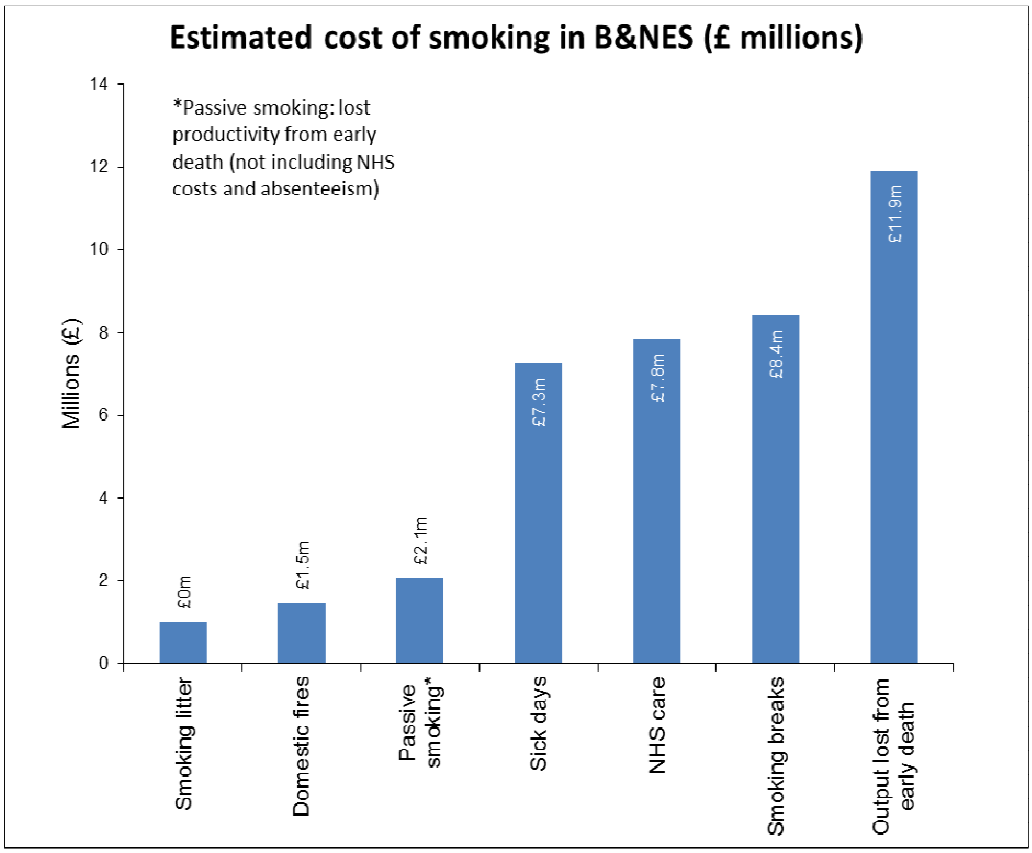
The financial costs of smoking

Whilst tax on tobacco contributes £10 billion annually to the Treasury, the true costs to society from smoking are far higher, at £13.74 billion.[24] This cost is made up of the cost of treating smokers on the NHS (£2.7 billion) but also the loss in productivity from smoking breaks (£2.9 billion) and increased absenteeism (£2.5 billion); the cost of cleaning up cigarette butts (£342 million); the cost of fires (£507 million), and also the loss in economic output from the deaths of smokers (£4.1 billion) and exposure to second hand smoke (£713 million).

Using the above figures the ASH (Action on Smoking and Health) Ready Reckoner was used to estimate the overall economic burden of smoking in B&NES (see figure 4). [25]

Each year in B&NES it is estimated that smoking costs society £39.9 million. Annually smokers in B&NES spend approximately £45.3 million on tobacco products, approximately £1,700 per smoker per year. This contributes roughly £34.5 million in duty to the exchequer leaving an estimated annual funding shortfall of £5.5million.

Figure 4 Estimated costs of smoking in B&NES



Note above figures based on 2011 estimated smoking population in B&NES of 25,600.

[24] Featherstone H & Nash R (2010) Cough Up; Balancing tobacco income and costs in society. Policy Exchange

[25] http://ash.org.uk/localtoolkit/R9-SW.html

Across the Avon area (Bristol, B&NES, South Gloucestershire, North Somerset) NHS Public Health departments invest over £3.8 million in tobacco control programmes annually, including specialist support to stop services[26]. See Appendix 1 for a breakdown of B&NES Tobacco Control investment for 12/13.

By comparison, the Avon Pension Fund currently invests £11.8 million in Imperial Tobacco and British American Tobacco.[27] This is one area where Local Authorities with their new responsibilities for Public Health have an opportunity to look strategically at how money is invested to effectively support public health policy.

What works in Tobacco Control?

There are six internationally recognised strands of tobacco control which have become the core of tobacco control policies worldwide:

- Making smoking less affordable
- Regulating tobacco products more effectively
- Reducing exposure to second hand smoke
- Stopping the promotion of tobacco
- Helping people to quit
- Producing effective communications for tobacco control

The most effective policies are those aimed at changing behaviour on a population level through regulation and enforcement, reinforced by co-ordinated local action and support for individuals in quitting.

Making smoking less affordable

Research has consistently shown that cigarette price increases, through taxation, reduce tobacco consumption. The UK now has the most expensive cigarettes in the EU apart from Ireland. The average cost of a pack is now £7.46. Even though the price is high, tobacco is still more affordable now that it was in the 1960's relative to income[28]. High prices can deter children from smoking, since young people do not possess a large disposable income and have been shown to be more price sensitive than adults.

Regulating tobacco products more effectively

Illegal tobacco

The public health benefits of taxation are undermined by illegal supply and in times of recession people are looking for cheaper alternatives, fuelling the market for illegal tobacco. It is estimated that 147 million packets of illegal

[26] Costs include Specialist Support to Stop Services, Medication, Smoke Free South West Programme, ASSIST programme costs and Tobacco Control co-ordinators.
[27] http://www.avonpensionfund.org.uk/financeandinvestments/faqs.htm#1
[28] Nash R, Featherstone H. Cough Up. Balancing tobacco income and costs in society Policy Exchange Research Note March 2010

cigarettes are smuggled into the South West every year and over half of all hand rolled tobacco is counterfeit.[29]

Whilst there has been a significant reduction in the illicit tobacco market in the UK since 2000, from 21% to 11% of the cigarette market and from 61% to 49% for hand rolling tobacco, illicit tobacco still represents a significant proportion of consumed tobacco especially within poorer communities.[30]

Around one fifth of the South West smoking population admit to purchasing illicit tobacco. Smokers buy from a wide variety of outlets. These range from independent shops to houses in local communities, pubs/clubs, markets and ice-cream vendors selling illicit tobacco to children. This illegal trade has a direct impact on the profits of legitimate retailers.

Routine and manual workers are more likely to use illicit tobacco and the majority of smokers from disadvantaged and poorer backgrounds agree that illegal tobacco makes it affordable for them to smoke. Smuggling therefore contributes to widening health inequalities. Smuggling is usually one part of wider organised crime and is used to fund other criminal activities.[31] The same channels previously used for dealing Class A drugs are now being used for illicit tobacco due to its profitability and relatively low risk in terms of punishment when caught.

The South West Region's coalition of Trading Standards (SWERCOTS) have identified an intelligence gap in relation to understanding the illicit tobacco trade in the region.

Under age sales

Legislation introduced in the UK in 2007 increased the legal age of purchase of tobacco products from 16 years to 18 years. This did contribute to a drop in the proportion of 11 – 15 year olds who said that they bought cigarettes in shops, however 2010 national data showed that a high proportion (58%) of 'regular' smokers in this age group still report purchasing cigarettes from shops.[32] In B&NES, 9% of those who smoke say they got them from a shop and 41% say they got them from friends.[33]

Proxy purchase, when someone else buys cigarettes on behalf of children, is commonly reported amongst 11-15 year olds. This is usually done by older friends or strangers. At present it is not illegal to buy cigarettes for children in this way.

Section 5 of the *Children and Young Persons (Protection from Tobacco) Act 1991*[34] requires every local authority to consider a programme of enforcement

[29] Smoke Free South West (2010) NEMS Market Research
[30] HMRC (2011) Tackling Tobacco Smuggling – building on our success
[31] LACORS 2010, Illicit Tobacco: An introductory guide for enforcement agencies. Local Government Association
[32] NHS Information Centre; Smoking, drinking and drug use among young people in England in 2010. National Centre for Social Research
[33] NHS B&NES (2011) Primary and Secondary Health Related Behaviour Survey: Bath & North East Somerset
[34] http://www.legislation.gov.uk/ukpga/1991/23/contents

at least every 12 months. Trading Standards officers carry out test purchases of cigarettes using young people 16 years of age or younger. On average 15% of test purchases lead to an illegal sale. Figure 5 below shows the type of premises where illegal sales occur.[35]

Figure 5 Test Purchases in retail premises leading to illegal sales by type

Test Purchases made in retail premises	
Type	% of illegal sales
Petrol Station Kiosk	23
Small retailer	18
Independent Newsagent	18
Off Licence	13
Large retailer	10
National newsagent	9

Fire safer cigarettes

In November 2011 European Union legislation was introduced requiring cigarette manufacturers to comply with a new fire safety standard BS EN 16156:2010. All cigarettes now sold in the EU must comply with this standard of reduced ignition propensity which means that, once lit, the cigarette goes out if it is not actively smoked. Cigarettes now have special bands at intervals down the length of the cigarette paper so that they extinguish themselves when they are not puffed on which dramatically cuts the risk of fire. It is estimated that this legislation could cut the number of smoking related fires and fire deaths by two thirds. In 2010, Finland became the first EU country to require fire safer cigarettes reducing the number of smoking related fire deaths by 40% in one year.[36] The trade in illicit tobacco could undermine these benefits as illegal cigarettes are unlikely to comply with EU product safety standards and therefore are a greater fire risk.

Reducing exposure to second hand smoke

Smoke Free legislation introduced in 2007 in England has been highly effective in reducing exposure to second hand smoke in work and public places. It has also resulted in significant reduction in the number of hospital admissions for heart attacks[37]. There has also been an increase in the number of homes with smoking restrictions since the Smoke Free legislation was introduced. Experience in other countries demonstrates that extension of the legislation to cars, parks, beaches and other public areas could prove popular and effective.

[35] Local Government Group (2011) Tobacco Control Survey 2010/11. A report of council trading standards service activity
[36] RIP Coalition; http://www.firesafercigarettes.org.uk
[37] Sims M, Maxwell R, Bauld L & Gilmore A. The short-term impact of smokefree legislation in England: a retrospective analysis on hospital admissions for myocardial infarction. BMJ 2010;340:2161

A recent survey showed wide spread public support in the South West for going completely smoke free on hospital grounds (62%), in play areas (76%) and in cars carrying children under 18 months (80%).[38]

Tobacco control activities are increasingly about the protection of children. Safeguarding children from exposure to tobacco is fundamental to preventing them becoming smokers in the long term and protecting their health. The best way to protect children from the harms of tobacco is to get those around them to quit. This protects them from second hand smoke at home and in the car and also reduces their exposure to smoking behaviour, which role models healthy lifestyles.

'Young people are more likely to smoke if their parents smoke. If you stop adults from smoking then more young people wouldn't want to smoke'

DAFBY member

Research suggests that knowledge about smoking is a necessary component of smoking campaigns but by itself does not affect smoking rates. It may result in a postponement of initiation as part of a whole school smoke free policy.

Stopping the promotion of tobacco

UK Legislation in 2002 (Tobacco Advertising and Promotions Act) has banned most direct and indirect advertising of cigarettes. Also a point of sale display ban in supermarkets came into force in April 2012 and will be enforced in small retailers from 2015. However there are still many areas of media where smoking imagery is still widely used and seen by young people specifically in TV programmes, films, on the internet, through video games and in music videos. Local feedback from members of Democratic Action for Youth in B&NES (DAFBY) confirms the power of the media in making smoking attractive.

'Films make smoking more noticeable than cigarette packets – they give smoking a good image. You see people smoking and think about doing it (especially when it's one of your) role models' DAFBY member

The packaging of cigarettes and other tobacco products is also key to communicating brand identity and favourable imagery to children about smoking. It is interesting to note that the tobacco industry have begun to specifically target the branding of hand rolling tobacco at young people.

The Government is currently considering whether or not to legislate for plain packaging of tobacco products in the UK, as is the case in Australia. Research suggests that plain packaging would increase the impact of health

[38] ASH (2011) Tackling Tobacco: Public Opinion in the South West http://ash.org.uk/localtoolkit/docs/R9-SW/PO-R9-SW.pdf

warnings, reduce false and misleading messages that one type of cigarette is less harmful than another, and reduce the attractiveness of products to young people.[39]

Helping people to quit smoking

Stop smoking services are one of the most cost effective interventions in public health care**,** and evidence shows that people are four times more likely to quit smoking if they have support.[40] Treating nicotine dependence produces a good return on investment compared to the cost of treating a wide range of smoking related chronic conditions.

Harm reduction for smokers

Smokers have an almost universal regret about having started smoking and the majority want to give up, and make many attempts to quit[41].

Whilst there are health harms associated with all tobacco use, smoking tobacco is by far the most hazardous to health. If people are unable to quit nicotine altogether it has been argued that they can reduce harm by stopping smoking to get nicotine and use a safe pharmaceutical nicotine product instead.[42] As those from disadvantaged communities are more likely to smoke, are heavier smokers and their children are more likely to be exposed to second hand smoke and start smoking younger, it can be argued that harm reduction approaches will contribute to reducing inequalities in health.

NICE has recently published guidance on tobacco harm reduction. While recognising that quitting smoking is always the best option for smokers, the NICE guidance supports the use of licensed nicotine containing products (NCPs) to help smokers not currently able to quit to cut down and as a substitute for smoking, where necessary indefinitely. This guidance does not cover tobacco containing products or E cigarettes as they are currently not licensed.

On 12th June 2013 the Medicines and Healthcare Products Regulatory Agency (MHRA) announced its intention to regulate nicotine containing products, such as E cigarettes, as medicines. Electronic cigarettes that are currently on the market will not be required to obtain a medicine license until the proposal in the European Commission's revised Tobacco Products Directive is agreed and transposed into law. The revised Directive is expected to be adopted in 2014 and to come into effect in 2016.

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[39] University of Stirling (2011) Plain Tobacco Packaging: A Systematic Review

[40] Godfrey et al (2005) The cost-effectiveness of the English smoking treatment services: evidence from practice. Addiction, Volume 100, Issue s2

[41] Chapman S Freeman B. Markers of the denormalisation of smoking and the tobacco industry. Tobacco Control 2008: 17 25 - 31

[42] Royal College of Physicians (2007) Harm reduction in nicotine addiction: Helping people who can't quit

Producing effective communications for tobacco control

In the context of a holistic tobacco control approach mass media campaigns have been shown to drive quit attempts both nationally and regionally. They educate about harms, set the agenda for discussion locally, change beliefs and attitudes and increase quit intentions and attempts. Television is the prime media for maximum audience penetration but this also needs to be backed up by local press and publicity to reinforce messages. Equally campaigns need to be on-going, sustained and of sufficient intensity and reach to be effective.

B&NES Tobacco Control Activity

Multi agency partnership working

The B&NES Tobacco Action Network is currently chaired by Public Health and has a membership representing the key stakeholders and service providers in the area. This includes Public Protection, Maternal and Child Health services, specialist cessation support providers, Fire & Rescue, school & youth services and mental health services. It has been in existence since 2002 however momentum and leadership has varied over this time.

The role of the TAN is to support workforce development, intelligence gathering, co-ordination of communications and marketing and the promotion of evidence based practice across the tobacco control community.

The TAN is currently meeting quarterly. Membership of the TAN has been static for the last 2 years and engagement from local authority councillors, leaders and local employers with this agenda has been opportunistic to date. The links with the wider Health and Wellbeing Strategy and reporting structure need to be clarified and formalised to ensure strategic engagement and support for the work of the group.

The B&NES Children & Young People's Plan has recently consulted on a number of 'narrowing the gap' indicators for children's health and wellbeing. Two smoking related indicators have been adopted for monitoring by the Children's Trust Board. These are smoking at time of delivery for young pregnant women compared with those over 25 years and the percentage of year 10 pupils who smoke by gender. These indicators will help to raise the profile of inequalities in these areas and track progress over time.

Action on Smoking and Health (ASH) developed a model for Peer Assessment of Excellence in Tobacco Control (CLeaR) during 2012/13 and the B&NES Tobacco Action Network decided to use this as a way to test assumptions and gain some objective feedback on our performance and future plans. The CLeaR model focuses on three areas; Vision and Leadership, Challenging your services and Results and provides a structured, evidenced based approach to achieving excellence in local tobacco control.

The Peer Assessment Day took place in June 2013. The assessment team included representation from Smoke Free South West, ASH and North Somerset Council.

The external CLeaR Report accorded closely with our self-assessment and made some recommendations for additional areas of improvement. These have been included in the relevant sections below:

Recommendations

- Clarify governance arrangements for Tobacco Control Strategy and Tobacco Action Network in line with the Health and Wellbeing Board structure.

- Council to consider an organisation wide policy in line with WHO Framework Convention on Tobacco Control to provide guidance for staff and members and protect work on Tobacco Control from the vested interests of the tobacco industry.

- Broaden engagement with the Tobacco Action Network to include Council members, clinical input, representation from the Clinical Commissioning Group/primary care and Universities.

- Increase capacity and skills development in tobacco control locally

- Develop, agree and monitor local targets for tobacco control that contribute to narrowing the gap in health inequalities locally.

- Increase the engagement and involvement of young people in activities of the Tobacco Action Network.

Normalising smoke free lifestyles

National Institute for Health & Clinical Excellence (NICE) recommended smoking prevention interventions within school settings are implemented in B&NES. Smoking education is provided to all pupils through the structured Personal Social and Health Education (PSHE) programme in schools and a whole school approach to tobacco control is supported as part of the Director of Public Health Award launched in May 2012 (previously Healthy Schools Award and Healthy Schools plus programme). The two further education colleges in Bath & North East Somerset are working towards becoming health promoting colleges through the Director of Public Health Award

NHS B&NES also commission an evidence based initiative to support children and young people to resist the temptation to take up smoking. ASSIST is a peer led programme in secondary schools (year 8) which has been shown to

prevent uptake of smoking up to 2 years after implementation[43]. This programme is currently in its third year of operation in B&NES, with the majority of schools having taken part at least once. The programme is not suitable for smaller schools and not adapted for special schools therefore an alternative is needed to ensure equity of access to this programme.

Recommendations:

- Ensure all secondary schools in B&NES undertake the ASSIST programme (or equivalent) annually including how the approach can be adapted so that smaller schools and special schools can participate.

- Carry out regular baseline surveys of health related behaviours in Schools and Further Education Colleges to inform local action and monitor progress

- Provide on-going support to Further Education Colleges in developing a whole college approach to becoming Smoke Free

- Incorporate the principles of a Smoke Free Environment into local authority Play Policy and other relevant policies

Reducing exposure to second hand smoke

Tobacco control services are commissioned via Sirona Care & Health to support implementation of the Smoke Free Homes, Play Areas and Hospital settings. Settings are supported through policy development, training, guidance and links to national and regional campaigns. Avon Fire and Rescue service also support implementation of the Smoke Free Homes campaign.

B&NES Council Public Protection teams support on going enforcement of Smoke Free legislation in local workplaces, public spaces and entertainment venues.

Recommendations:

- Implement further training for frontline staff in health and social care to deliver brief interventions on smoking and second hand smoke to support embedding of Smoke Free Homes Programme (including Family Nurse Partnership)

- Develop and evaluate the Smoke Free play areas project across B&NES

- Work with the Royal United Hospital to ensure effective implementation of Smoke Free policy and practice

[43] Campbell R et al. (2008) An informal school based peer-led intervention for smoking prevention in adolescence (ASSIST); A cluster randomised control trial Lancet 2008 371:1595 - 1602

- Undertake work with mental health service providers on the development of Smoke Free Policies

Restricting supply of tobacco

B&NES Trading Standards receive a low level of complaints about illegal sales of tobacco, either under age or illicit, compared to other products such as alcohol or knives. They run test purchasing and product testing in response to complaints within existing resources.

Very little information about illicit tobacco is passed on to trading standards by the public or other agencies and local trading standards are keen to work collectively with professionals and community members to improve intelligence to inform local action.

Recommendations

- Improve local professionals and community understanding of the illegal tobacco trade and its impact on communities

- Improve local intelligence from professionals and the community regarding the sale of illicit tobacco and under age sales

- Increase the awareness and engagement of young people in test purchasing process

- Increase engagement of local communities in tackling the issue of illegal tobacco and under age sales.

Helping people to quit

Smoking cessation services are currently provided across B&NES through a Specialist Support to Stop service and through GP surgeries, pharmacies, maternity services and mental health services. In total, over 120 professionals have been trained across B&NES to provide stop smoking support services.

Since 2009 in B&NES, over 2000 people each year access the smoking cessation support services and set a quit date. This is approximately 8% of the smoking population, above the Department of Health recommended 5% but still only a small proportion of those smoking. Numbers of people using cessation services are rising year on year however the quit rate has been declining year on year, falling from 62% to 52% in 2011/12. This is a trend mirrored across the South West region. Nationally the average quit rate is 49%.

B&NES local services are effective in reaching people across the social gradients however people from black and minority ethnic groups and young people are under-represented and those in the most deprived areas of

B&NES are less successful at quitting than other service users, suggesting further support is needed for some groups to access the service, and to improve outcomes for others.

Recommendations

- Target cessation services more effectively at disadvantaged groups including those with mental health conditions, young women who are pregnant, black and minority ethnic groups and those in routine and manual jobs.

- Ensure access to cessation services is widened via a wider range of settings including further education colleges, workplaces, dentists, pharmacists, secondary care and voluntary and community organisations

- Explore the feasibility of providing online and text based support for quitters

- Improve access to brief interventions in secondary care

- Increase availability of group based cessation support

- Develop a policy on approaches to harm reduction for smokers in line with NICE guidance.

Ensuring effective communications and marketing

Alongside local implementation of national campaigns, the 14 Local Authorities (previously PCT Public Health Departments) across the South West have collectively commissioned Smoke Free South West to deliver social marketing campaigns across the region. This collective commissioning arrangement has been in place since 2008/09 with the aim of delivering consistent and co-ordinated messages to change social norms and promote smoke free policies, whilst benefitting from economies of scale. This model of sub national service in combination with local tobacco control activity has been evaluated in the USA and shown to be effective in speeding up reductions in prevalence rates.[44] To date Smoke Free South West has focussed on key cross cutting issues which benefit from being co-ordinated over a larger footprint including illegal tobacco, smoke free policies, smoke free homes, hand rolling tobacco and plain packaging.

[44] Health Economics Research Group (Dec 2011) Building the case for Tobacco Control; The evidence base report. Commissioned by Smoke Free South West, Tobacco Free Futures, Fresh North West

Recommendations:

- Continue to commission a range of social marketing campaigns on key issues including smoke free homes and cars, hand rolling tobacco, illegal tobacco and plain packaging.

- Co-ordinate local communications work with national and regional campaigns to maximise impact

- Continue to promote opportunities to quit via National No Smoking Day, Stoptober and pharmacy health promotion campaigns

- Evaluate the impact of the Bath City College Social Marketing project and disseminate learning to other settings.

Summary of recommendations 2013 – 2018

Multi agency partnership working

- Clarify governance arrangements for Tobacco Control Strategy and Tobacco Action Network in line with the Health and Wellbeing Board structure.

- Council to consider an organisation wide policy in line with WHO Framework Convention on Tobacco Control to provide guidance for staff and members and protect work on Tobacco Control from the vested interests of the tobacco industry.

- Broaden engagement with the Tobacco Action Network to include Council members, clinical input, representation from the Clinical Commissioning Group/primary care and Universities.

- Increase capacity and skills development in tobacco control locally

- Develop, agree and monitor local targets for tobacco control that contribute to narrowing the gap in health inequalities locally.

- Increase the engagement and involvement of young people in activities of the Tobacco Action Network.

Normalising smoke free lifestyles

- Ensure all secondary schools in B&NES undertake the ASSIST programme (or equivalent) annually including how the approach can be adapted so that smaller schools and special schools can participate

- Carry out regular baseline surveys of health related behaviours in Further Education Colleges to inform local action and monitor progress

- Provide support to Further Education Colleges in developing a whole college approach to becoming Smoke Free

- Incorporate the principles of a Smoke Free Environment into local authority Play Policy and other relevant policies

Reducing exposure to second hand smoke

- Implement further training for frontline staff in health and social care to deliver brief interventions and Smoke Free Homes campaign (including Family Nurse Partnership)

- Develop and evaluate the smoke free play areas project across B&NES

- Work with the Royal United Hospital to ensure effective implementation of Smoke Free policy

- Undertake work with mental health service providers on the development of Smoke Free Policies.

Restricting supply

- Improve local professionals and community understanding of the illegal tobacco trade and its impact on communities

- Improve local intelligence from professionals and the community regarding the sale of illicit tobacco and under age sales

- Increase the awareness and engagement of young people in test purchasing process

- Increase engagement of local communities in tackling the issue of illegal tobacco and under age sales.

Helping people to quit:

- Improve access to brief interventions in secondary care

- Target cessation services more effectively at disadvantaged groups including those with mental health conditions, young women who are pregnant, black and minority ethnic groups and those in routine and manual jobs.

- Ensure access to cessation services is widened via a wider range of settings including further education colleges, workplaces, dentists, pharmacists, secondary care and voluntary and community organisations

- Explore the feasibility of providing online and text based support for quitters

- Increase availability of group based cessation support

- Develop a policy on approaches to harm reduction for smokers in line with NICE guidelines

Ensuring effective communications and marketing for tobacco control

- Co-ordinate local communications work with national and regional campaigns to maximise impact

- Continue to promote opportunities to quit via National No Smoking Day, Stoptober campaign and pharmacy health promotion campaigns

- Commission a range of social marketing campaigns on key issues including smoke free homes and cars, hand rolling tobacco, illegal tobacco and plain packaging.

- Evaluate the impact of the Bath City College Social Marketing project and disseminate learning to other settings.

Local structure for delivery, monitoring and reporting

The Tobacco Action Network will develop an Action Plan to take forward the recommendations within the Strategy and will oversee its monitoring and evaluation.

The TAN will monitor and report on progress on the following indicators on a quarterly basis:

- Smoking amongst pregnant women (smoking at time of delivery)
- Number of 4 week quitters – Target for 13/14 = 1049

The following indicators are reported annually or bi annually:

- Smoking prevalence amongst adults (Integrated Household Survey)
- % of smoking population accessing specialist support (Target 13/14 = 8%)
- Smoking prevalence amongst young people (B&NES School Health Education Unit Survey)

Two narrowing the gap indicators have been incorporated into the Children's Plan:

- smoking at time of delivery for pregnant women under 25 years compared with those over 25 years
- the percentage of year 10 pupils who smoke by gender

As B&NES is performing better than the England average for all of the above indicators our ambition will be to be in the top quartile in the South West and/or amongst the group of local authorities with similar deprivation profiles, where data is available at this level. Where data is not available at local authority or regional level national comparators will be used.

The TAN will report progress on the Action Plan annually to the Health and Wellbeing Board.

Link to other strategies

This Strategy supports and contributes to the overarching aims within the following B&NES Strategies:

B&NES Corporate Plan & Sustainable Communities Plan (2011- 2026)

Health and Wellbeing;

- To help individuals achieve their potential by improving health and wellbeing and reducing inequalities within our communities

Stronger communities

- Creating communities where everyone contributes and everyone takes responsibility

Safer Communities

- Building communities where people feel confident about carrying out their daily activities, inside and outside the home

Children and young people

- All children and young people will do better in life than they thought they could

B&NES Community Safety Plan (2009-2012)

- through reduction in criminal activity and cleaner streets.

B&NES Children and Young People's Plan (2011 – 2014)

- Providing children and young people with a safe environment, including empowering children and young people to recognise and manage risks
- Reducing health, education and social inequalities in specific groups of children and young people and specific geographical areas.
- Promoting healthy lifestyles for children and young people.

B&NES Health and Wellbeing Board – Strategy (2013)

The Board aims to:

- Reduce health inequalities and improve health and wellbeing in Bath and North East Somerset

Theme areas:

- Helping people to stay healthy (prevention)
- Improving the quality of people's lives (quality of life)
- Fairer life chances (health inequality/Life expectancy)

Glossary

Smuggling
The unlawful movement of genuine or fake products from one tax jurisdiction to another, without the payment of tax.

Boot legging
When individuals or small groups travel to the EU or Russia for example and buy cheap tobacco in lesser quantities and bring it back to the UK for resale.

Counterfeit (fake)
The manufacture of illegal tobacco products using the trademark of others. Tax is rarely paid on counterfeit products.

Illicit Whites
In recent years a novel type of large scale smuggling has emerged with cigarettes often termed 'illicit whites' or 'cheap whites'. These cigarettes are marketed on price and typically produced legally but intended for smuggling into countries where there is no prior legal market for them. An example of this is "Jin Ling", manufactured outside the EU but the second most seized illegal brand within the EU in 2008.

Quit rate
A smoker is considered to have quit if they have not smoked a cigarette in the four week period since setting a quit date (-3 to +14 days). This is validated by a Carbon Monoxide monitoring test.

Smokeless Tobacco
Smokeless tobacco is not a single product, but rather a summary term for a range of different tobacco products which deliver nicotine without combustion. Smokeless tobacco products differ substantially in their risk profile in approximate relation to the content of toxins in the tobacco.

Smoking prevalence

Local and regional smoking prevalence is generated from the Integrated Household Survey (IHS) April 2009 to March 2011. The IHS is a composite survey including questions from a number of Office for National Statistics (ONS) social surveys to produce a dataset of "Core" variables. The surveys are the General Lifestyle Survey (GLF), Living Cost and Food Survey (LCF), the Opinions Survey (OPN), Annual Population Survey (APS), English Housing Survey (EHS) and Life Opportunities Survey (LOS). Figures are the number of persons aged 18+ who are self-reported smokers in the sample covering the population of England, including a subset of the routine and manual group. Smoking status is defined as self-reported "current smoker", "ex-smoker" or "never smoked". Prevalence is also generated in the routine and manual group

Appendix 1

Tobacco Control Investment in Bath & North East Somerset 2012/13

Specialist Support to Stop Smoking services	375,138
Medication via GP's and Pharmacists	260,647
Smoke Free South West Regional Programme	79,032
Tobacco Control activity (inc. ASSIST programme)	72,000
Total £	**786,817**

The above investment is funded by Public Health Grant (£526,170) and B&NES Clinical Commissioning Group (£260,647).

Please note costs above do not include tobacco control activities carried out as part of frontline staff job roles e.g health visitors, midwives etc. Costs associated with enforcement activities carried out by Trading Standards officers are also not included in the above.

Benchmarking

The cost per 4 week quitter in B&NES for 2010/11 was £480 per person compared to a South West average of £548 (CO validated & self-reported, including medication). This figure does not include Tobacco Control Activity or Smoke Free South West costs but does include commissioning costs.[45]

[45] Willis N Options appraisal of Stop Smoking Service Delivery in South West. Commissioned by South West Directors of Public Health (March 2012)