



A Smokefree Future

A Comprehensive Tobacco Control Strategy for England

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Our vision is of a smokefree future: a future where our communities are free from the harms of tobacco use and where people lead healthier and longer lives.

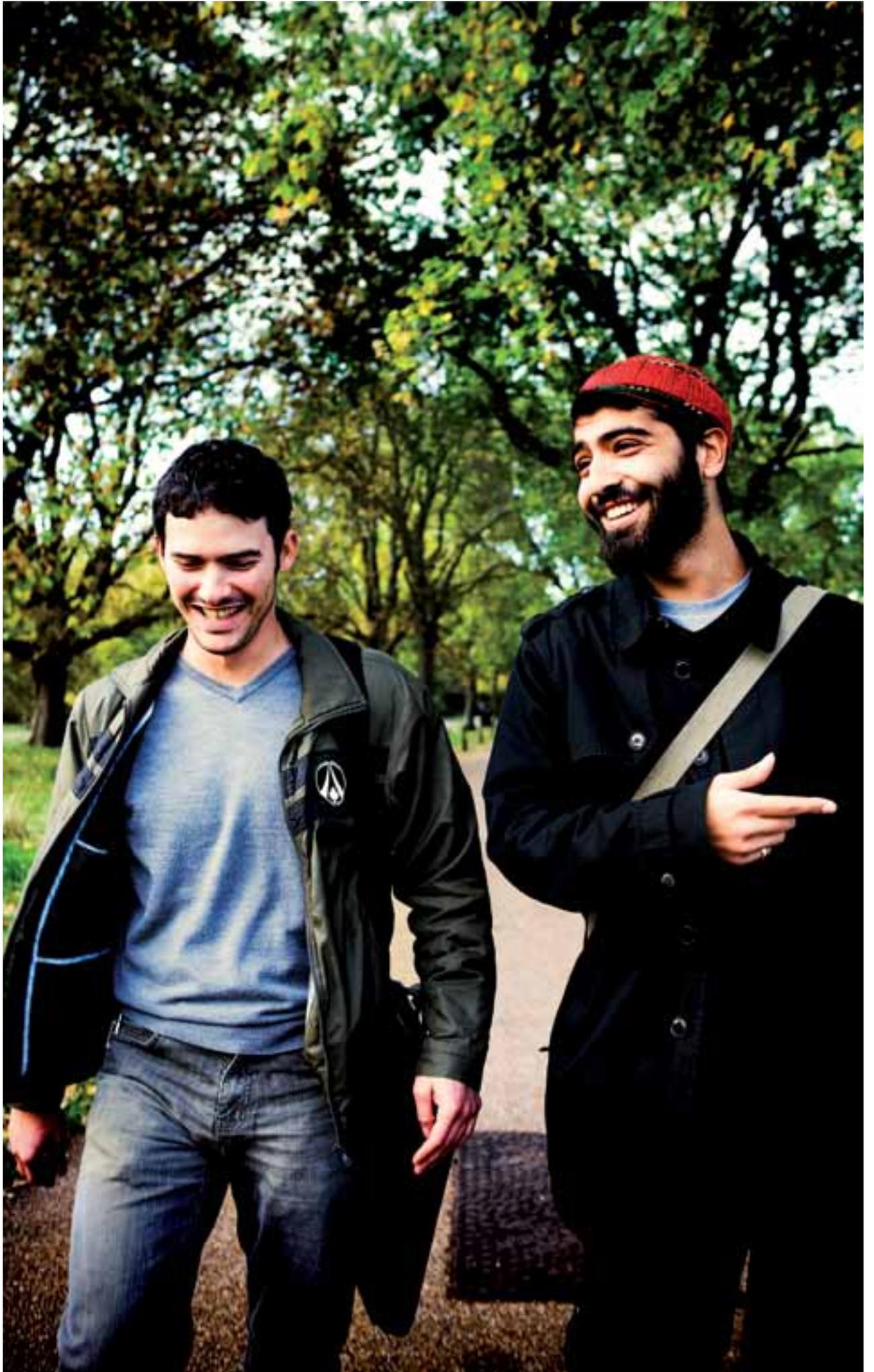
Smoking kills half of all long-term users and is the biggest single cause of inequalities in death rates between rich and poor in the UK.

A future free from tobacco use will mean our children will not die early and unnecessarily from smoking-related illnesses.

Contents

Foreword by the Secretary of State for Health and Minister of State for Public Health	5
Introduction by the Chief Medical Officer for England	7
Executive summary	9
1. Rationale for going further	15
Progress so far	15
The impact on health	18
Costs to society	22
Impact on health inequalities and children	23
Industry action and global trends	26
2. A new vision for tobacco control in England	31
A new vision for tobacco control	31
2020 aspirations	31
Measuring success	31
Economic benefits	33
3. Stopping the inflow of young people recruited as smokers	35
Reducing affordability	35
Reducing availability to children	37
Reducing the attractiveness of tobacco products	39
Increasing awareness of the harms of tobacco	40

4. Motivating and assisting every smoker to quit	43
Assisting smokers to quit	43
Motivating smokers to quit	44
Improving current NHS support and treatment	45
Introducing more routes to quit	48
A new NHS service	50
5. Protecting our families and communities from tobacco-related harm	53
Smokefree environments	53
Tackling high smoking rates in vulnerable and disadvantaged communities	55
Identifying and treating smoking in pregnancy	56
6. Delivering a smokefree future	59
Ensuring effective delivery	59
Accountability for delivery	63
Investing in our knowledge	66
References	67



Foreword by the Secretary of State for Health and Minister of State for Public Health



In 1998, the Government published *Smoking Kills*, this country's first ever public health strategy. Thanks to the policies that this strategy put

in place, action by the Government and NHS has reduced the numbers of adult smokers by a fifth to one in five and more than halved the number of children taking up smoking to under one in fifteen. These efforts have made us number one in Europe and one of the world leaders in tobacco control.

Yet it is too soon to claim victory. Smoking still causes over 80,000 deaths every year, it is the leading cause of health inequalities, and in the current financial climate we cannot be complacent about the annual costs to the NHS of £2.7 billion from smoking-related diseases.

We know that we must do more, and the public support further action – the nearly 100,000 responses to the consultation on the future of tobacco control in 2008 are testament to this.

This strategy responds to that demand. It sets a compelling vision of a future where society is free from the harms caused by tobacco, and describes aspirations for achieving this in which we have halved the number of adult smokers to just one in ten and reduced the number of children taking up smoking to negligible levels. In effect 'turning off the tap' that fuels high smoking rates.

This is about protecting children and young people. Half of the hundreds of thousands of children who take up smoking each year will die prematurely from a smoking-related disease if they continue to smoke. This strategy sets out our commitment to take tobacco out of sight

of children in shops, and to stop the sale of cigarettes from vending machines.

We cannot ignore those who already smoke, the majority of whom want to quit. NHS Stop Smoking Services are world leading but with over 8 million people in England still smoking we must be innovative in the support we provide. This strategy proposes a radical new approach to supporting smokers to quit, with more options available to help those smokers who are more addicted and find it harder to quit.

This strategy also sets out how we can protect and support the most disadvantaged and vulnerable in our communities. These groups continue to smoke at very high rates and smoking is one of the most significant causes of the difference in health and life expectancy between the richest and poorest.

Great progress has been made over the last decade and thousands of lives have been saved by the efforts of partners at all levels. We must build on this progress and aim to save thousands more lives, and protect our children, by creating a smokefree future.

A handwritten signature in dark ink, appearing to read 'Andy Burnham', written in a cursive style.

Andy Burnham
Secretary of State for Health

A handwritten signature in dark ink, appearing to read 'Gillian Merron', written in a cursive style.

Gillian Merron
Minister of State for Public Health





Introduction by the Chief Medical Officer for England

Tobacco has been used by humankind for centuries but it was the introduction of ready-made cigarettes in about 1884 that led to a global explosion in tobacco use. The estimated global toll from tobacco smoking in the 20th century is 100 million lives.

The enormous detrimental effect of tobacco on health is why I have always been a staunch advocate of tobacco control throughout my time as the Chief Medical Officer. My 2002 annual report called for public places to be made smokefree.¹ In 2004, I made a clear case for further action on tobacco smuggling.²

The Government has acted on the evidence and has put in place a comprehensive range of policies, including the introduction of smokefree legislation in July 2007. These policies have had a real impact and, over the last decade, the number of adults who smoke has fallen by a fifth, and the number of children taking up the habit has halved. In England today, there are over 2 million fewer adult smokers than there were a decade ago.³

However, we cannot afford to rest on our laurels. Today, there are still over 8 million people in England who smoke; half of them may be expected to die prematurely if they do not quit.⁴ In 2008, over 80,000 people died from a smoking-related illness.⁵ The case for further action is clear.

This new tobacco control strategy establishes a vision of eradicating tobacco harms, describing aspirations and evidence-based policies under three objectives to deliver the vision:

- 1. To stop the inflow of young people recruited as smokers.**
- 2. To motivate and assist every smoker to quit.**
- 3. To protect families and communities from tobacco-related harm.**

Delivering these objectives will create a smokefree future where people live healthier and longer lives, and I look forward to my successors as Chief Medical Officer writing about tobacco as a historical success, not a current problem.

Liam Donaldson
Chief Medical Officer for England



Executive summary

1 Our vision is of a 'smokefree future': a future where our communities are free from the harms of tobacco use and where people lead healthier and longer lives. Smoking kills half of all long-term users and is the biggest single cause of inequalities in the death rates of rich and poor. A future free from tobacco use will mean our children will not die early and unnecessarily from smoking-related illnesses.

2 There is a high price to be paid for the use of tobacco – for individuals, families, communities, the National Health Service and society at large. Helping people not to use or to stop using tobacco improves lives and saves money. The NHS alone already saves £380 million each year thanks to the decline in smoking rates over the past decade.

3 The Government's 1998 *Smoking Kills* White Paper was a landmark public health strategy, which set out a clear agenda for action. Since its publication, significant progress has been made in partnership with the private, public and voluntary sectors, the NHS and local government to reduce the harms from tobacco use. Today, tobacco advertising is no longer permitted; thousands of smokers have been helped to quit by our world-leading NHS Stop Smoking Services; and enclosed work and public places are free of the harm of secondhand smoke.

4 Our efforts to support smokers to quit are working. Today there are over 2 million fewer smokers in England than a decade ago. Yet tobacco use is still the leading cause of

preventable death and of health inequalities. In 2008, more than 80,000 premature deaths in England were caused by smoking. And although the numbers are going down each year as smoking rates decline, tobacco will remain the major preventable cause of premature death and disease for many years to come. Alongside the enormous human cost of tobacco use, there are hundreds of thousands of avoidable hospital admissions for smoking-related illness, and these cost the NHS billions of pounds every year.

Alongside the enormous human cost of tobacco use, there are hundreds of thousands of avoidable hospital admissions for smoking-related illness, and these cost the NHS billions of pounds every year.

5 This new tobacco control strategy sets out an ambitious vision for a society in which the burden of tobacco harm is significantly reduced. The strategy will build on the success of *Smoking Kills* and will strengthen our reputation as a world leader in tobacco control by acting on the clear public support for protecting our young people from tobacco and helping smokers to quit.

6 Although we have achieved much over the past decade, we must continue to focus on tobacco control, in order to improve public health and reduce health inequalities. To achieve this, we will work with communities, businesses, the private and voluntary sectors, local government and the NHS.

7 We have three overarching objectives to make significant progress towards a smokefree society. Against each objective, we have also set an aspiration for what could be achieved by 2020 if all our partners across the public, the private and the voluntary sectors were to continue to prioritise tobacco control and implement the evidence-based policies set out in this strategy.

- **To stop the inflow of young people recruited as smokers:** aspiring to reduce the smoking rate among 11–15-year-olds to 1% or less, and the rate among 16–17-year-olds to 8% by 2020.
- **To motivate and assist every smoker to quit:** aspiring to reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and in the most disadvantaged areas by 2020.
- **To protect our families and communities from tobacco-related harm:** aspiring to increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020.

Stopping the inflow of young people recruited as smokers

8 Each year in England, an estimated 200,000 children and young people start smoking; and most adult smokers say they started smoking regularly before they turned 18. We need to focus on preventing young people from taking up smoking in the first place. The home environment is very important: young people are much more likely to smoke if they live with smokers. For this reason, supporting adult smokers to quit is a key aspect in encouraging young people not to take up smoking.

9 By placing a greater emphasis on preventing young people from taking up smoking, we have

the opportunity to break the intergenerational cycle of initiation and addiction to tobacco. The perpetuation of tobacco use through the generations is one of the major reasons for the difference in quality of life and life expectancy between the richest and the poorest.

The perpetuation of tobacco use through the generations is one of the major reasons for the difference in quality of life and life expectancy between the richest and the poorest.

10 Action already taken to reduce the appeal and the supply of tobacco to young people has included a ban on most forms of tobacco advertising, the inclusion of pictorial warnings on tobacco packs to raise awareness of the risks of smoking, and an increase in the age at which young people can be sold tobacco products – from 16 to 18 years.

11 The affordability of tobacco products affects youth uptake and adult consumption alike. We have worked to reduce the affordability of such products by increasing the tax on them and maintaining the downward pressure on the illicit tobacco market. Despite these efforts, the evidence shows that young people are continuing to take up smoking for a number of reasons, including the way tobacco products are promoted.

12 In pursuit of our first objective, we will:

- Make tobacco less affordable by continuing to consider the case for real increases in duty on tobacco on a Budget-by-Budget basis, and by additional investment in overseas Fiscal Crime Liaison Officers, whom we expect to prevent over 200 million illicit cigarettes from being smuggled into the UK each year. More broadly we will

continue to bear down on the market for illicit cigarettes, which has fallen from 21% in 2000 to 10% in 2007/08 (midpoint estimates), and achieve similar success in reducing the illicit market for hand-rolled tobacco.

- Remove tobacco products from display in shops.
- Prohibit the sale of tobacco from vending machines, a significant source of tobacco for young people, subject to Parliamentary consideration of regulations.
- Take action to ensure that the advertising of tobacco accessories is not being used to encourage the use of tobacco products of any type.
- Encourage research to further our understanding of the possible links between tobacco packaging and smoking behaviours.
- Restrict tobacco availability to children by reviewing the current restrictions on the retail of tobacco and enforcement of tobacco retail regulations. Alongside this, we will launch a review within the first three months of this year into the purchase for and supply of tobacco to young people. This review will assess what more can be done to limit these sources, including examining the current legislation around the confiscation of tobacco that children are found to have in their possession.
- Continue to engage with young people to raise awareness about the dangers of smoking and develop skills that will encourage them to play a role in building our smokefree future.

Motivating and assisting every smoker to quit

13 Nearly all smokers started smoking regularly before they turned 18. While we recognise that adults remain free to make their own lifestyle decisions, we also know that smoking is highly addictive, and that the addiction can take hold in children after just a few cigarettes.^{6,7} Almost

three-quarters of all smokers say they would like to quit, but fewer than half actually go on to make a quit attempt and only a small fraction (less than 3%) actually successfully quit each year.

14 Those who are most successful in quitting use a combination of behavioural and medicinal support. We want to make the most effective forms of support easily and inexpensively available to everyone. Smokers who stop smoking with NHS support are up to four times more likely to stop successfully compared with smokers who stop without any form of support. In particular, smokers in routine and manual groups and lower socio-economic groups are much less successful in their quit attempts and are often more addicted to smoking.

15 Current action to support smokers to stop includes marketing and the provision of NHS Stop Smoking Services to encourage smokers to make a quit attempt, using support that will maximise their success.

16 Going further, we will:

- Continue to deliver marketing campaigns to encourage more quit attempts, particularly targeted at smokers from more disadvantaged backgrounds.
- Support primary care trusts (PCTs) to increase the percentage of smokers successfully supported by NHS Stop Smoking Services to quit.
- Introduce a radical approach to quitting smoking, producing more routes to quitting that we believe will help thousands more smokers quit successfully, particularly among disadvantaged communities where evidence suggests that smokers are more addicted. Although always encouraging smokers to break their

nicotine dependence entirely, the new routes will support those smokers who are unable to quit abruptly to:

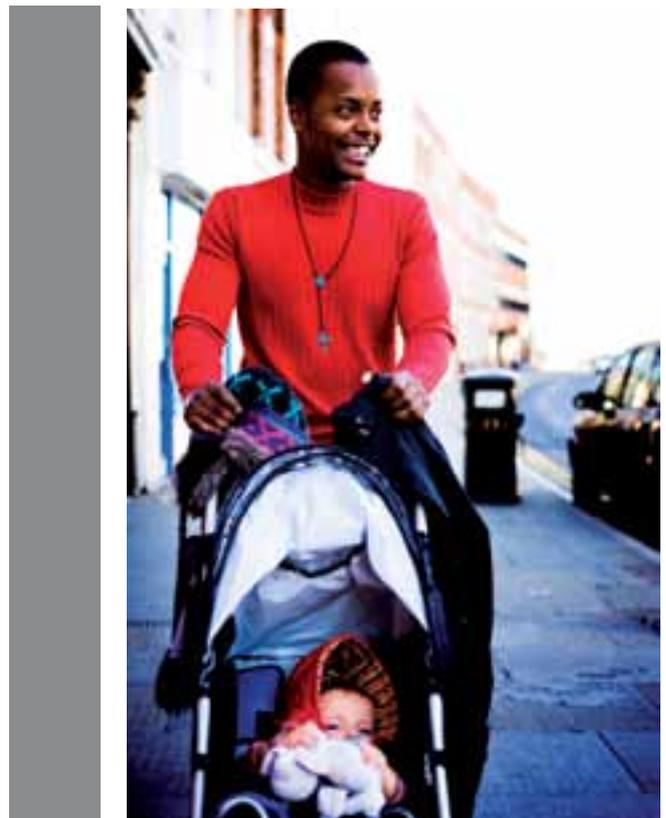
- cut down their levels of smoking as a precursor to completely quitting;
 - manage their nicotine addiction, using a safer alternative product, when they are unable to smoke (e.g. at work); and
 - dramatically reduce the damage to their health, and the harms to those around them, by using a safer alternative to smoking.
- Deliver this new approach with the Medicines and Healthcare products Regulatory Agency (MHRA) encouraging the development, marketing and wide availability of nicotine delivery medicines. To create a level playing field the MHRA will consult on regulating all nicotine-containing products (with the exception of tobacco products, which are governed through specific legislation), and a consultation on how this level playing field should be created is being launched alongside this strategy.
 - Support the creation of new routes to quitting by working with PCTs to develop a model for a new type of NHS smoking-cessation service that will support smokers who use the new routes to quitting.

Protecting our families and communities from tobacco-related harm

17 Smoking can have a serious impact on the health and wellbeing of other people. Secondhand smoke is a serious health hazard, and there is no safe level of exposure. Secondhand smoke consists of over 4,000 chemicals, including over 50 known carcinogens. Medical and scientific evidence shows that exposure to secondhand smoke increases the risk of serious medical conditions, such as lung cancer, heart disease, asthma attacks, childhood respiratory disease, sudden infant death syndrome and reduced lung function.

18 The introduction of smokefree legislation in England in July 2007 (and in other UK countries earlier) has been popular and has effectively removed secondhand smoke from virtually all enclosed work and public places. However, many people are still exposed to secondhand smoke in the home and in cars, and each year thousands of children are admitted to hospital for conditions related to exposure to secondhand smoke.

19 Many routine and manual workers as well as disadvantaged and vulnerable communities, including particular minority and ethnic groups, have high rates of tobacco use. There is a very marked social trend associated with smoking: smoking rates are considerably higher among poorer people than among those who are better off. While the overall prevalence of smoking in England has been declining steadily over the past 30 years, the decline in smoking rates among lower-income groups has been much slower.



20 Babies from deprived backgrounds are more likely to be born to mothers who smoke, and to have much greater exposure to secondhand smoke in childhood. Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality.

21 Local authorities and PCTs can jointly lead the local implementation of comprehensive tobacco control policies. They have had particular success working with Local Authority Coordinators of Regulatory Services (LACORS), Trading Standards and environmental health officers in enforcing smokefree and age-of-sale legislation.

22 Going further, we will:

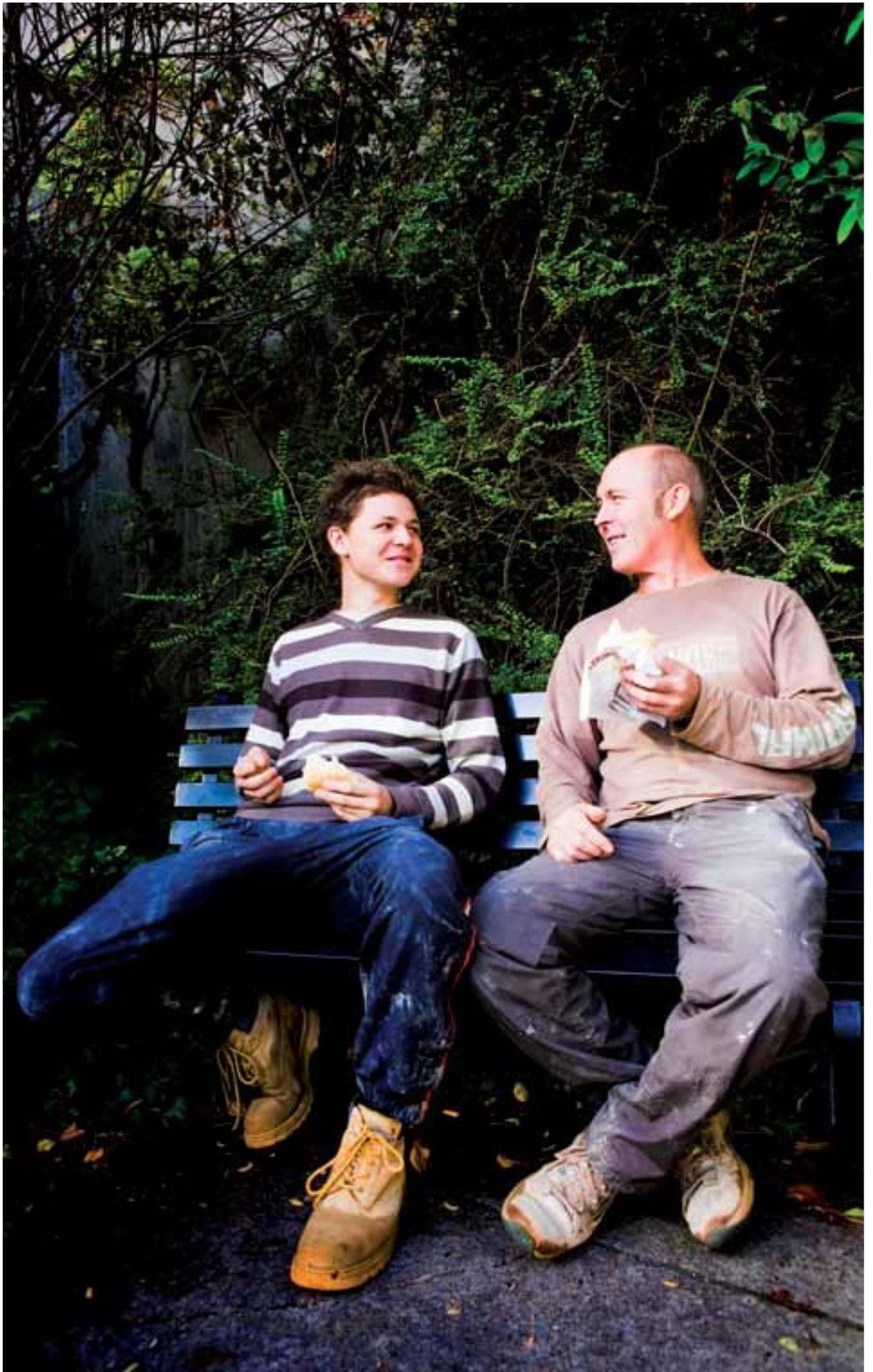
- Promote 'smokefree communities' through awareness campaigns and projects focused on the most disadvantaged communities that highlight the benefits of smokefree homes and cars. We will do this working in alliance with public sector and voluntary organisations, private businesses, civil society and local government to protect children from secondhand smoke.
- Consider as part of a review of the Health Act 2006 what further action is needed to protect people, including support for the extension of smokefree around doorways and protection for children from secondhand smoke exposure.
- Encourage and celebrate a tobacco-free London 2012 Olympics without the use or sale of tobacco at Olympic venues.
- Improve local data to more accurately guide local tobacco control activities.

- Support PCTs to work through local partnerships to develop public health interventions that consider lifestyle factors in the whole and consider the social, economic and cultural factors that influence smoking rates.
- Develop more effective methods of identifying and preventing smoking in pregnancy.

23 By delivering the policies and programmes set out above, over the next decade we will stop thousands of young people from starting to smoke and will support thousands of smokers to take action to stop. In the process, we will substantially improve health and quality of life.

24 There will also be benefits for the NHS, with a dramatic reduction in hospital admissions and stays. Savings will grow over time as smoking-related illness is averted. By 2020, if all partners prioritise the policies set out in this strategy, it will allow the NHS to have made cumulative net savings of between £1.5 billion and £2.4 billion; savings to society as a whole – for example through increased productivity – are estimated to reach between £13.7 billion and £15 billion.

25 The year 2010 will be a landmark one for tobacco control in England. All partners will be focusing on delivering the current 2010 Public Service Agreement, but will also be laying the groundwork for delivering this strategy in earnest from 2011 onwards. PCTs in particular will be expected to continue to prioritise tobacco control and to set their own local goals that meet local needs.



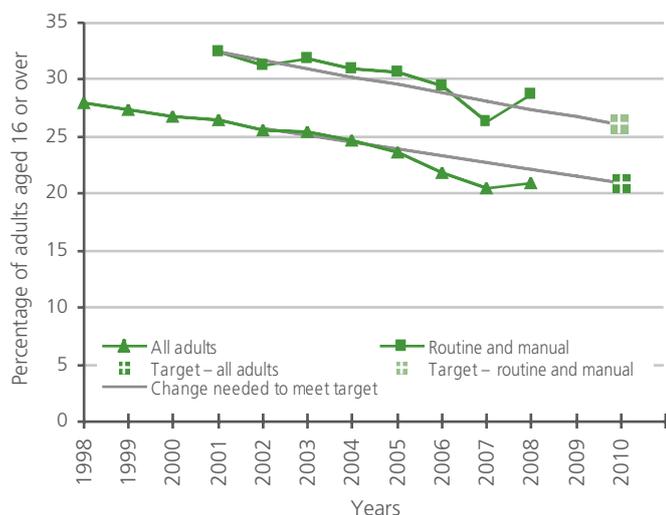
1. Rationale for going further

Progress so far

1.1 The Government's 1998 White Paper – *Smoking Kills* – was a landmark public health strategy and set out a clear agenda for action on tobacco control. At the time, more than 120,000 people were dying in the UK every year from smoking-related illness.⁸ *Smoking Kills* launched a comprehensive package of tobacco control measures to tackle this major public health issue.

1.2 The action that followed in the wake of *Smoking Kills* led to a fall in all adult smoking rates in England from 28% to 21%, and in smoking rates among routine and manual workers from 31% to 29% between 1998 and 2008.⁵ In the space of a decade, the number of smokers fell by a fifth. Today, there are over 2 million fewer adult smokers in England than there were a decade ago.³

FIGURE 1: SMOKING RATES IN ENGLAND FROM 1998 TO 2008^{3,4}



Today, there are 2.1 million fewer adult smokers in England than there were a decade ago.

1.3 The Department of Health appears to be on track to achieve delivery of the challenging 2010 Public Service Agreement on smoking:

“reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less.”

1.4 The approach to tobacco control within *Smoking Kills* was to implement the World Bank's six strands. This approach has been instrumental in reducing smoking rates across all age groups.⁹ The six strands are:

1. Reducing exposure to secondhand smoke.
2. Communications and education.
3. Reducing the availability and supply of cheap tobacco.
4. Support for smoking cessation.
5. Reducing tobacco promotion.
6. Tobacco regulation.

1.5 In 2007, based on implementation of the World Bank's six-strand strategy, the United Kingdom was considered to be the European leader in tobacco control (Table 1, page 19).

Summary of tobacco control milestones

Since *Smoking Kills*, there have been significant advances in various areas of tobacco control. Of these, the following are the most notable.

Preventing uptake:

- Most forms of tobacco advertising and sponsorship in print, on billboards and on the internet were banned (2003/04).
- The age at which people could be sold tobacco was raised to 18 years (2007).
- Hard-hitting pictorial health warnings were introduced on cigarette packets (2008).
- A law was introduced that gave judges the power to ban a retailer from selling tobacco for up to a year, if that retailer is found guilty of persistently selling tobacco to persons under the age of 18 (2008).
- Her Majesty's Revenue & Customs (HMRC) and the United Kingdom Border Agency (UKBA) joined forces to design an international-level strategy for reducing cross-border tobacco smuggling (2008), which refreshed previous strategy in 2000 and 2006.

Motivating and assisting every smoker to quit:

- World-class marketing and communication programmes were launched that reached out to millions of people (1998 onwards).
- Stop-smoking medicines became widely available over the counter and on prescription from the NHS (2001).
- Local NHS Stop Smoking Services were made available (1999).
- Public Service Agreements (PSAs) (for the Department of Health) were established to reduce smoking prevalence among all adult and routine and manual (R&M) groups (2004).
- A Quality and Outcomes Framework was implemented, with a points system for GPs and health practitioners, to encourage identification of patients who smoke (2004).
- Value Added Tax (VAT) was cut to 5% for nicotine replacement therapy (NRT) medications bought over the counter (2007).

Protecting families and communities:

- A law was introduced that made all enclosed public places and workplaces smokefree from 1 July 2007, to protect people from the harm caused by exposure to secondhand smoke.

Delivery:

- A regional tobacco policy programme was established in every region of England (2003).
- Additional resources were made available to Local Authority Coordinators of Regulatory Services (LACORS) to monitor and take action against under-age sales (2009).
- The World Health Organization (WHO) Framework Convention on Tobacco Control was ratified by the UK (2006).

TABLE 1: EUROPEAN TOBACCO CONTROL SCORECARD, 2007¹⁰

Rank	2007 score	Country
1	93	UK
2	74	Ireland
3	74	Iceland
4	66	Norway
5	62	Malta
6	61	Sweden
7	59	France
8	58	Finland
9	58	Belgium
10	57	Italy
11	56	Estonia
12	55	Spain
13	54	Bulgaria
14	50	Netherlands
15	50	Romania
16	50	Poland
17	48	Slovakia
18	47	Switzerland
19	46	Cyprus
20	45	Denmark
21	44	Lithuania
22	43	Hungary
23	42	Portugal
24	41	Latvia
25	40	Czech Republic
26	40	Slovenia
27	37	Germany
28	36	Greece
29	36	Luxembourg
30	35	Austria

1.6 Action to motivate and help adult smokers to quit reduces the uptake of smoking among teenagers by changing adult smoking role models, as well as young people's perceptions of smoking. This is demonstrated by experience in other jurisdictions, such as California: "lasting change in youth behavior regarding tobacco can only be secured by first changing the adult world in which youth grow up".⁴²

1.7 Adult cessation work is contributing to the achievement of our *Smoking Kills* ambition to reduce smoking among pregnant women from 23% (1995) to 18% by 2005 and 15% by 2010.

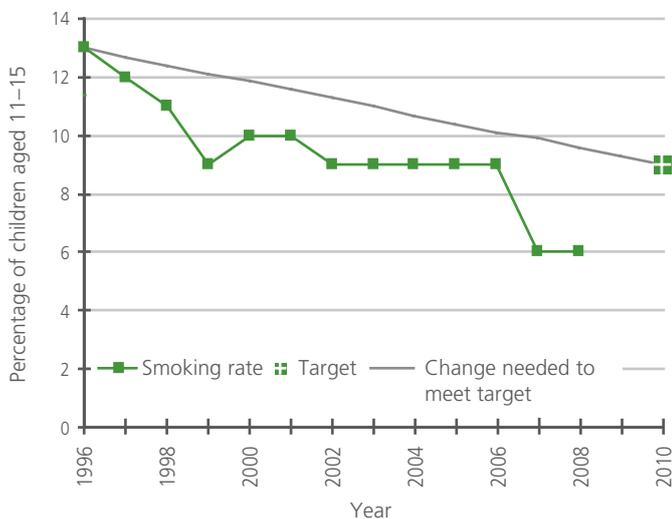
1.8 However, in 2008 some 14% of women still smoked at the time of delivery, as measured by women's self-reporting of their smoking status.¹¹

1.9 With the progress on tobacco control that has been made in the past decade – not least the raising of the age at which young people may be sold tobacco products from 16 to 18 years – we have seen a significant decline in the smoking rate among young people aged 11–15: from 11% in 1998 to 6% in 2008.

We have seen a significant decline in the smoking rate among young people aged 11–15: from 11% in 1998 to 6% in 2008.

1.10 We have achieved the ambition set out in *Smoking Kills* to reduce smoking among 11–15 year-olds from 13% (1996) to 11% by 2005 and 9% by 2010.

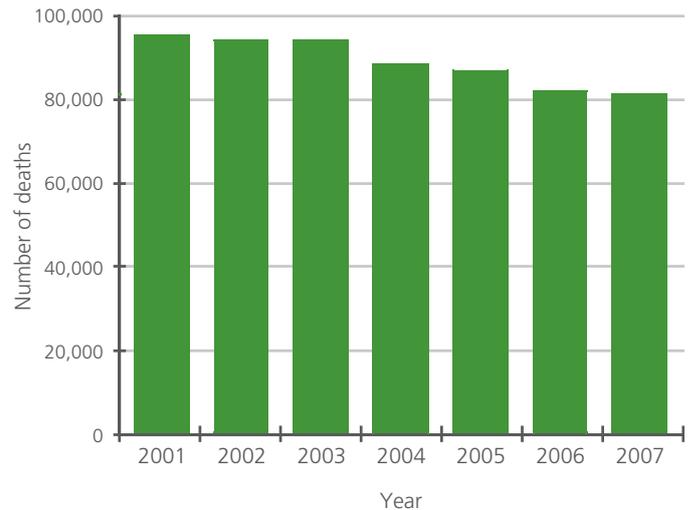
FIGURE 2: YOUTH SMOKING RATES, 1998 TO 2008⁷



1.11 Smokefree legislation is proving popular and effective, and has achieved high rates of compliance. Smokefree legislation protects millions of workers from the harms of secondhand smoke, and has created an environment that has motivated around an additional 300,000 successful quit attempts.^{12,13} This suggests that the law will prevent up to 40,000 premature deaths over the next 10 years.

1.12 The overall impact of our action is that there has been a decline in the number of deaths from smoking-related illness (see Figure 3).

FIGURE 3: DEATHS FROM SMOKING BY YEAR IN ENGLAND⁴



1.13 However, more can and must be done. The remainder of this chapter sets out why.

The impact on health

1.14 Despite the progress in tobacco control that has been made over the past decade, tens of thousands of smokers and ex-smokers continue to die every year from smoking-related disease. And smoking-related illness will affect the quality of life of thousands more.

1.15 In England today, over a fifth of the adult population smokes – over 8 million people.⁴ Smoking is one of the most significant factors underlying the differences to be found in the health and life expectancy of the wealthiest and the poorest in our society.^{14,15}

In England today, over a fifth of the adult population smokes – 8.8 million people.



1.16 In 2010, around 250,000 people in England will start smoking.¹⁶ The vast majority of them will be below the age of 18.¹⁷

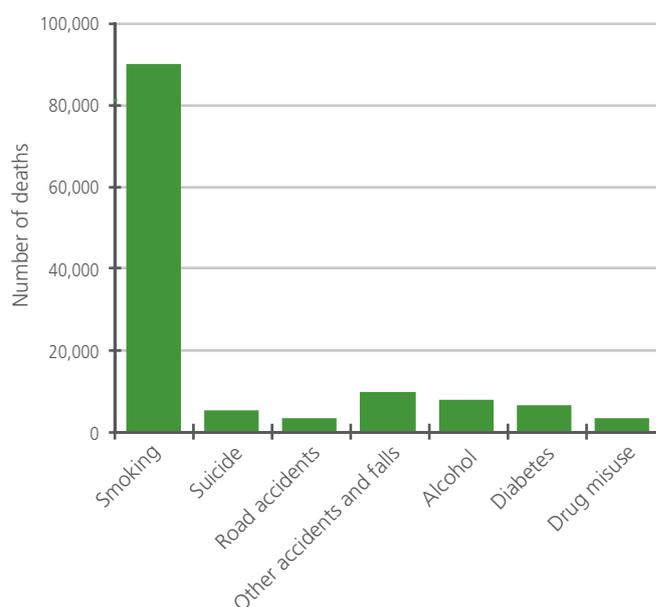
Deaths from smoking

1.17 In 2008, over 80,000 people in England died prematurely from a smoking-related disease.⁵ And, if they do not quit, half of England's smokers can expect to die prematurely from such a disease. Approximately a fifth of all deaths in middle age are attributable to smoking.¹⁸

1.18 Tobacco use is a risk factor in six of the eight leading causes of death in the world. Deaths from smoking are more numerous than the next six most common causes of preventable death combined: drug misuse, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse (see Figure 4).

Deaths from smoking are more numerous than the next six most common causes of preventable death put together: drug misuse, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse.

FIGURE 4: CAUSES OF PREVENTABLE DEATHS¹⁹



Disease and tobacco

1.19 Some of the impact of smoking on health was recognised as far back as the 1950s, and since then our knowledge has grown. Smoking is the single largest preventable cause of cancer. Over one in four of all cancers are attributable to tobacco use, and 90% of lung cancer is directly attributable to smoking.²⁰ Figure 5 shows the main types of disease attributable to smoking and what proportion of total deaths from each disease is directly related to smoking.

1.20 The three most common causes of death from smoking are lung cancer, chronic obstructive pulmonary disease (COPD) and cardiovascular disease (heart and circulatory disease) (see Figure 5). While someone who has never smoked or been chronically exposed to secondhand smoke is unlikely to get COPD, the majority of cases of COPD occur in smokers.

FIGURE 5: DISEASE ATTRIBUTABLE TO SMOKING⁵

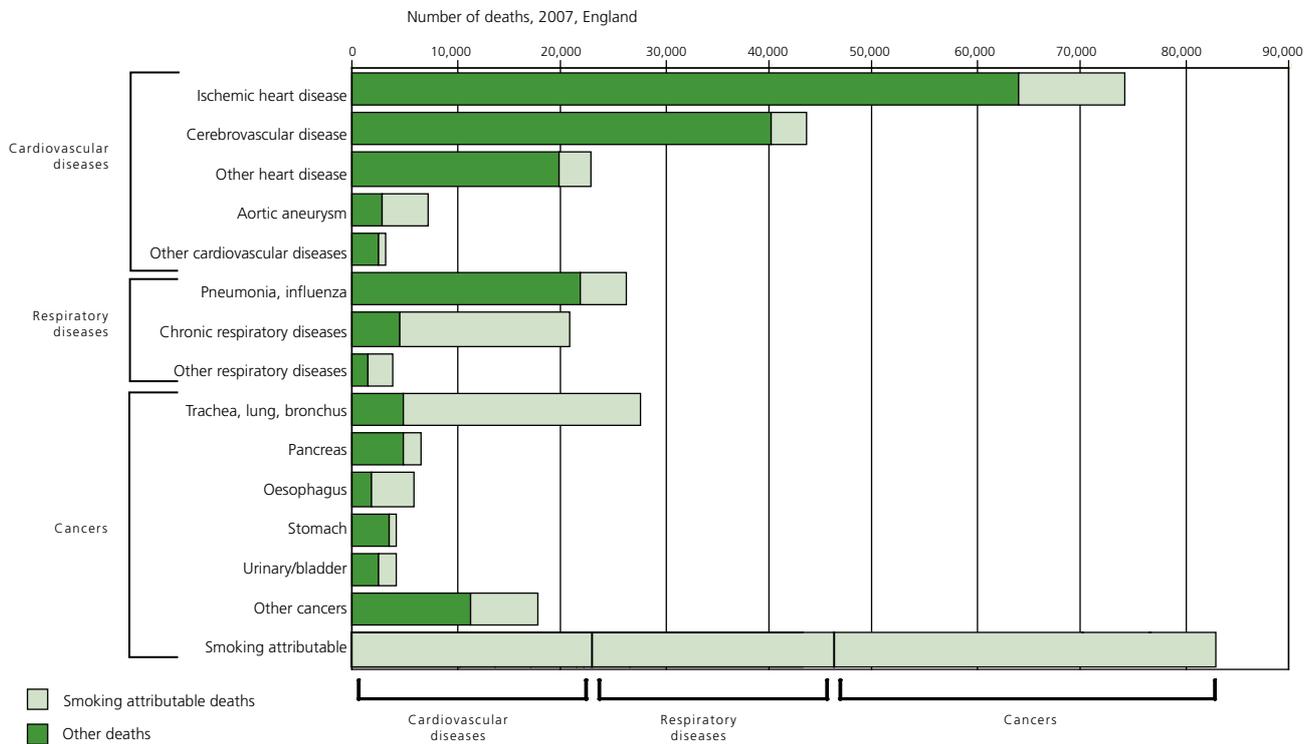
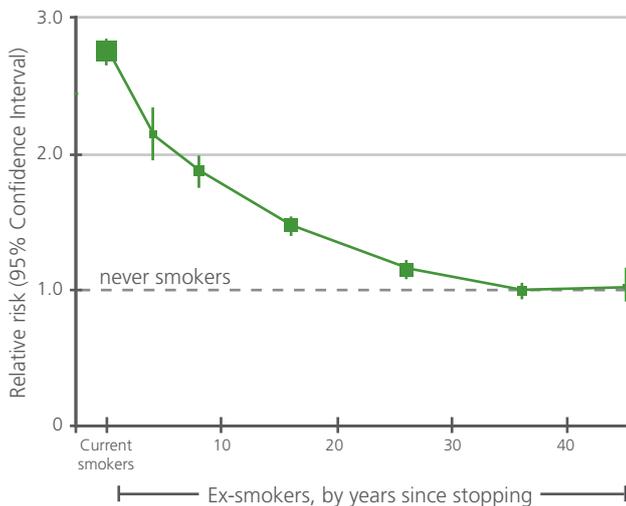


FIGURE 6: ALL-CAUSE MORTALITY BY TIME SINCE STOPPING SMOKING²¹



Over a period of time, an ex-smoker’s risk of suffering from heart disease can fall to the level of someone who has never smoked.

1.21 All the main smoking-related diseases are responsive to stopping smoking. For example, over a period of time, an ex-smoker’s risk of suffering from heart disease can fall to the level of someone who has never smoked (see Figure 6).

1.22 As well as increasing the risk of ill health and premature death, there is evidence that smoking reduces the benefits of other medical treatment. Smokers present for surgery at a younger age than their non-smoking counterparts, and smoking preoperatively affects postoperative recovery.²² The increased amounts in the blood of carbon monoxide and other chemicals from cigarette smoking have harmful effects on heart function and circulation.

1.23 After surgery, compared with ex-smokers and non-smokers, smokers are more likely to:

- have pulmonary, circulatory and infectious complications;
- have reduced bone fusion and impaired wound healing;
- be admitted to an intensive care unit;
- have increased risk of in-hospital mortality; and
- need to stay in hospital longer as a consequence.

1.24 By stopping smoking, people can avoid smoking-related disease and live longer. On average, a lifelong smoker loses 10 years of life (see Table 2).

On average, a lifelong smoker loses 10 years of life.

TABLE 2: YEARS OF LIFE GAINED BY STOPPING SMOKING AT DIFFERENT AGES, 30 TO 60¹⁸

Age at which stopped smoking	Years of life gained
30	10
40	9
50	6
60	3



1.25 While it is the nicotine within the tobacco that the smoker is addicted to, the tar and the carbon monoxide in smoked tobacco are the primary causes of smoking-related disease and death. Tobacco smoke contains over 4,000 different chemicals, including more than 50 known carcinogens. Nicotine (in the doses obtained from smoked and smokeless tobacco) is not a significant contributor to disease.

1.26 Although smokeless tobacco – chewing tobacco, snuff and ‘paan’ (a mixture of tobacco and betel nut, which is placed in the side of the mouth and sucked) – is less harmful than smoked tobacco, it is still a cause of diseases such as oral cancer.²³

1.27 Exposure to secondhand smoke is also harmful to health, particularly for children. While smokefree legislation has removed secondhand smoke from enclosed work and public places, people can still be exposed to it at home or in private cars.

1.28 The number of people who choose to make their homes smokefree has been rising since the introduction of smokefree legislation in 2007.²⁴

1.29 Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems for both the mother and her baby. In 2008/09, 14% of mothers in England are recorded as having smoked throughout pregnancy (although this is widely thought to be an underestimate, since there is evidence of significant under-reporting).¹¹

Costs to society

1.30 The current level of tobacco use is estimated to cost the NHS around £2.7 billion every year.²⁵ The NHS Information Centre calculates that in England in 2007/08 there were approximately 440,000 hospital admissions of adults aged 35 and over with a primary diagnosis of a disease that was caused by smoking (about 1,200 admissions per day on average). Recent research estimates that the decline in the number of smokers over the past

decade has led to current annual savings to the NHS of around £380 million.²⁵

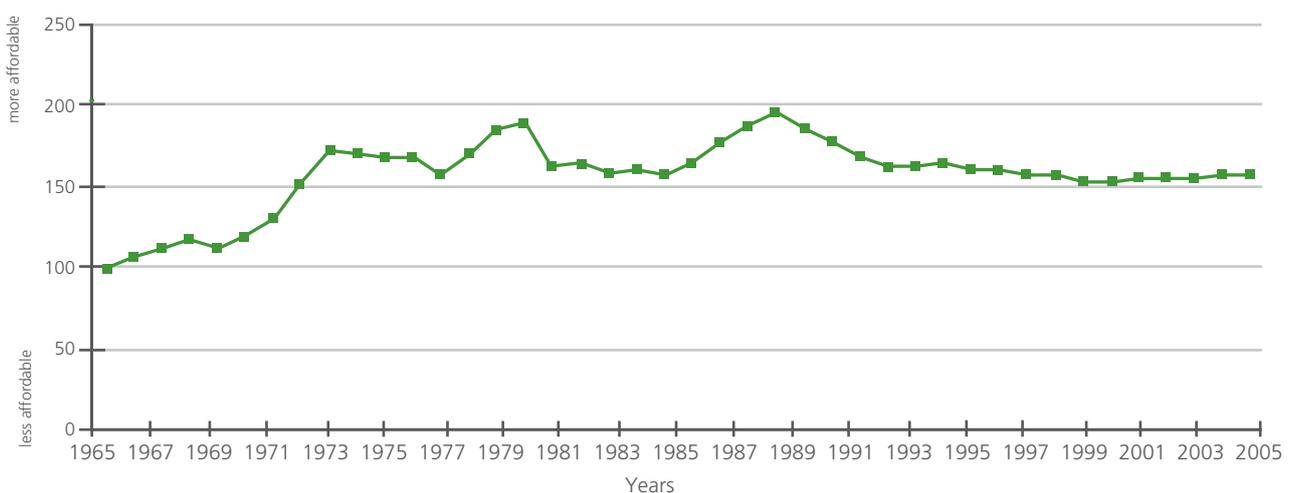
1.31 Tobacco use also has a significant impact on the wider economy – through lost productivity and other costs. Smokers take an average of eight days a year more sick leave than do non-smokers,²⁶ and the current level of smoking costs the economy about £2.5 billion each year in terms of sick leave and lost productivity alone.²⁷

1.32 In 2006, UK households spent approximately £16.1 billion on tobacco⁵ and, over the same period, about £3 billion in revenue was lost to HM Treasury due to smuggled and counterfeit tobacco products.²⁸

In 2006 about £3 billion in revenue was lost to HM Treasury due to smuggled and counterfeit tobacco products.

1.33 Based on the cost of 20 cigarettes (about £5), somebody who smokes a pack a day will spend over £1,800 a year. Lower-income groups are disproportionately affected by the cost of

FIGURE 7: AFFORDABILITY OF TOBACCO IN ENGLAND, 1965–2005²⁹



smoking, as more people in those groups tend to smoke at higher rates and smoke on average more cigarettes each day.⁴

1.34 As disposable income has increased, the affordability of cigarettes has increased considerably since the 1950s; however, over the past decade, duty increases have kept pace with inflation (see Figure 7).



Impact on health inequalities and children

Smoking and health inequalities

1.35 Health inequalities start early in life and persist into old age – and even into subsequent generations. Closing the health inequality gap is a priority for this Government. Reducing smoking rates in disadvantaged groups and areas is a critical factor in reducing the health inequalities gap.

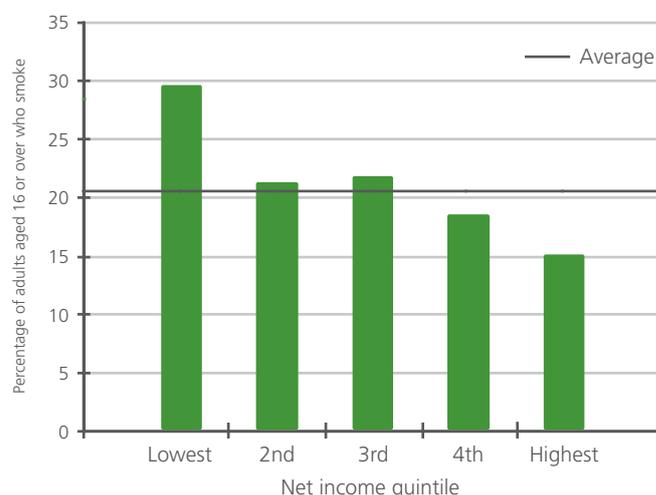
Reducing smoking rates in disadvantaged groups and areas is a critical factor in reducing the health inequalities gap.

1.36 In the UK of the mid-1950s, socio-economic groups smoked at similarly high rates. Since then, however, we have seen the development of a marked social trend: from

the 1960s onwards, the more advantaged socio-economic groups responded to emerging evidence about the harmful effects of tobacco use, and a higher proportion of people from those groups stopped smoking than from the more disadvantaged groups. Historically, the decline in smoking rates among higher-income groups has been much steeper than among lower-income groups, and this has contributed substantially to the widening of health inequalities. Evidence suggests that tobacco use is the primary reason for the gap in healthy life expectancy between rich and poor.¹⁴

Evidence suggests that tobacco use is the primary reason for the gap in healthy life expectancy between rich and poor.

FIGURE 8: SMOKING PREVALENCE BY NET INCOME QUINTILE IN ENGLAND, 2008⁴



1.37 Smoking rates are highest in the routine and manual group, lower socio-economic groups and certain minority and vulnerable groups (see Figure 8). There are significant differences between the genders and from one ethnic group to another: around 5% of Bangladeshi women smoke, compared to 25% of Irish women and

over 40% of Bangladeshi men. There tends to be a high rate of smoking among people with mental illness.³⁰

1.38 Disadvantaged groups who have high rates of smoking may also exhibit other unhealthy behaviours, and it is apparent that what is required is a broad approach to reducing health inequalities.³¹

1.39 The association between smoking and social disadvantage begins from the early stages of life. Children from disadvantaged backgrounds are much more likely to be born to mothers who smoke, and to suffer greater exposure to secondhand smoke as they grow up. They are also more likely to grow up with family members and friends who smoke.⁷ Smoking is a social norm in many disadvantaged communities.

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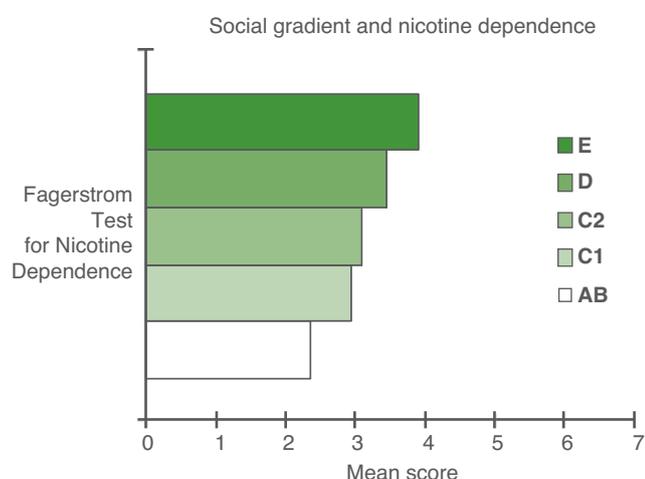
1.40 The desire to quit is relatively stable across all socio-economic groups, and access to NHS Stop Smoking Services (the most effective method of smoking cessation) is equitable across the socio-economic groups. However, the success of attempts to quit is not equal across the different groups. People from the most disadvantaged groups are less likely to quit (and to stay off tobacco) than those from more

advantaged groups. There is also evidence to show that poorer smokers are more physically addicted to nicotine, and are therefore less likely to succeed in their quit attempts.^{31,32}



1.41 The most affluent are nearly twice as likely to keep off tobacco over the long term than are those people from groups who show a greater physical dependence on tobacco, and for whom tobacco is more ingrained in the social aspects of their lives.

1.42 The difference between social groups in terms of the rate of decline of smoking prevalence over the past 60 years is due primarily to the differences in the success rates of quit attempts (see Figure 9).³²

FIGURE 9: TEST FOR ADDICTION TO SMOKING TOBACCO AND QUIT ATTEMPT¹⁷

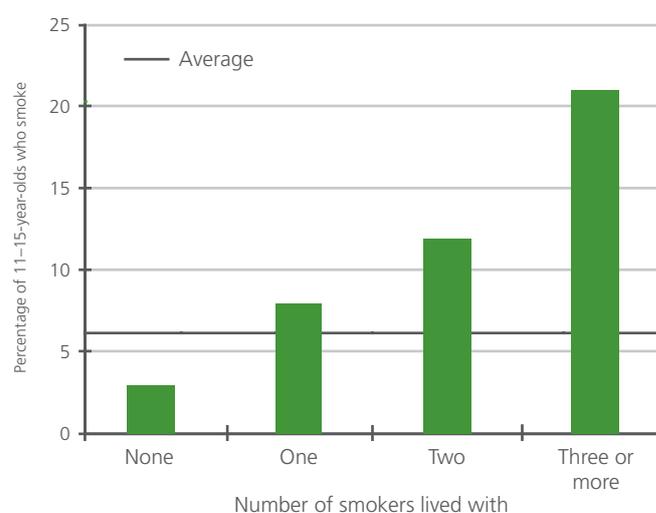
Smoking and children

1.43 A focus on reducing tobacco use among young people is vital, since children can very rapidly develop an addiction to, and dependence on, tobacco. The smoking prevalence among 11–15-year-olds is down from 13% in 1996 to 6% in 2008. This is the lowest level since records began. However, each year some 250,000 people in England take up smoking, and the vast majority of them are under the age of 18.¹⁶ Approximately 100,000 16-year-olds smoke (17%). Before the age of 11, very few children smoke, and most (if asked) are anti-smoking.³⁴

The smoking prevalence among 11–15-year-olds is down from 13% in 1996 to 6% in 2008.

1.44 We know that the tobacco industry needs to recruit over 100,000 smokers each year to replace those who die or quit. Since very few adults over the age of 21 take up smoking, young people continue to represent a key market for the tobacco industry.

1.45 Children who live with smokers suffer from exposure to secondhand smoke and are much more likely to become smokers themselves, perpetuating health inequalities (see Figure 10).

FIGURE 10: SMOKING AMONG CHILDREN IN ENGLAND AGED 11–15, BY NUMBER OF SMOKERS THEY LIVE WITH, 2008⁷

1.46 Children in lower social classes take up smoking in greater numbers and at an earlier age than those in higher social classes (see Figure 11).

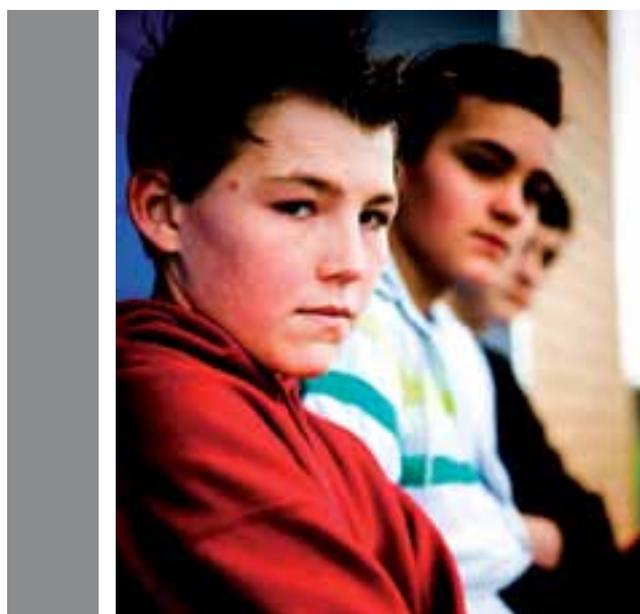
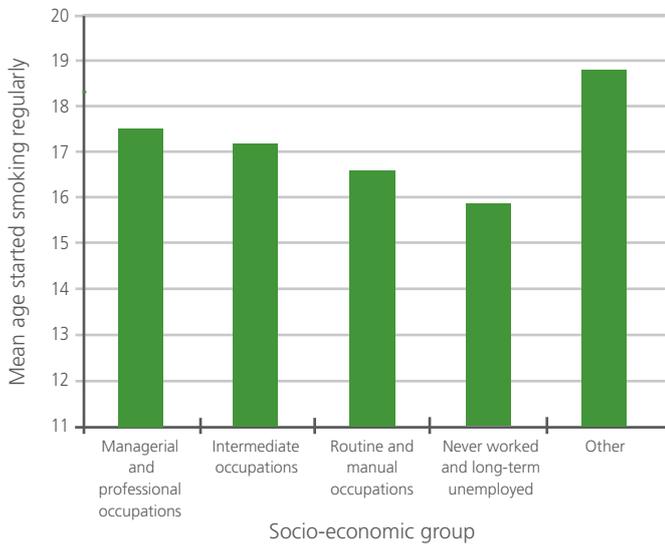


FIGURE 11: AGE AT WHICH PEOPLE START SMOKING REGULARLY, BY SOCIO-ECONOMIC CLASSIFICATION, IN GREAT BRITAIN, 2007⁴



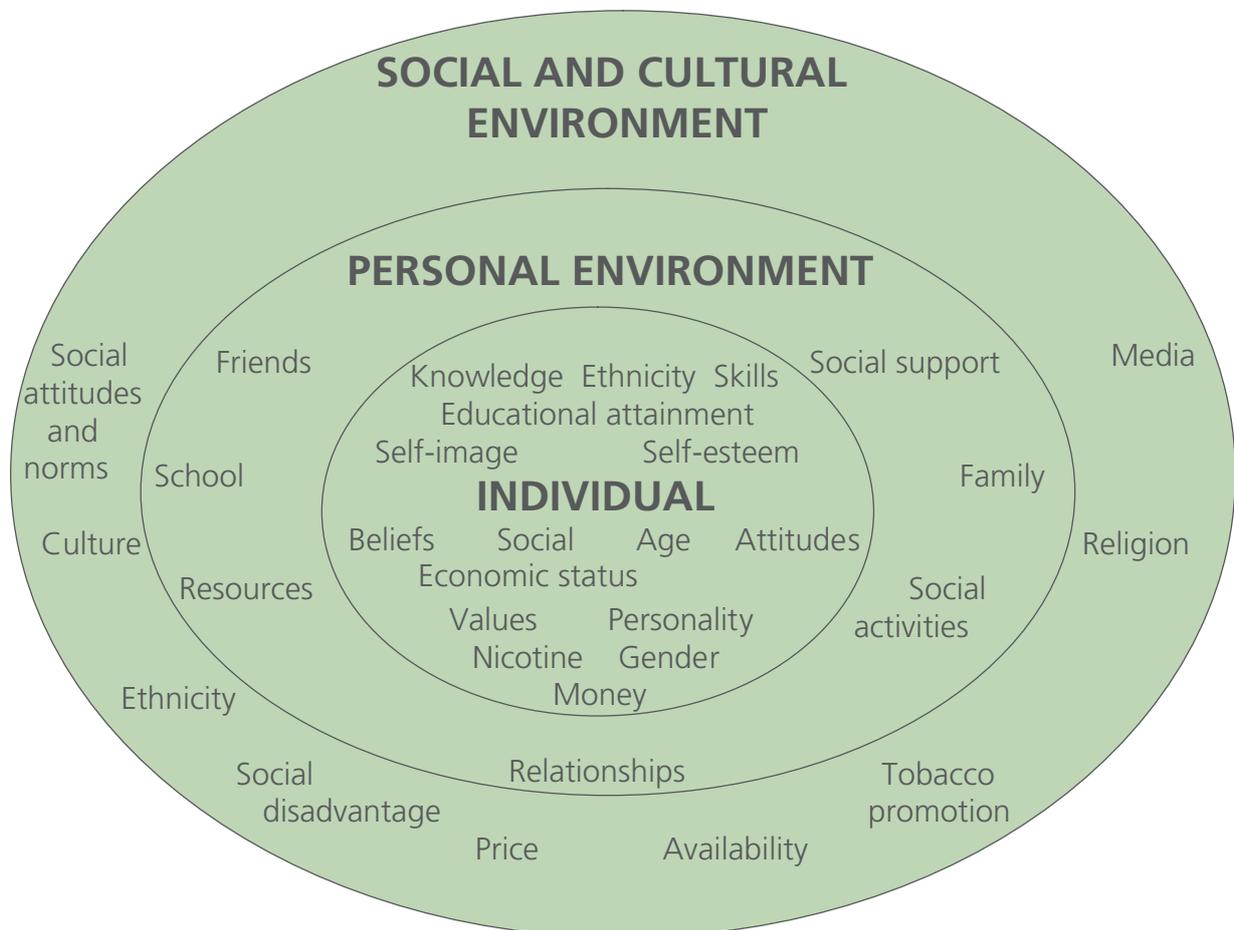
1.47 Young people are more likely to smoke if their family and friends smoke.⁷ Young people are also more likely than adults to exhibit greater ambivalence about the present health dangers of using tobacco.³⁴ See Figure 12 for an overview of the factors associated with smoking.

We can estimate that, if the Government, the NHS and its partners were to cease all tobacco control efforts, smoking prevalence could rise by over 200,000 smokers a year.

Industry action and global trends

1.48 Based on an analysis of the inflows and outflows of smokers over a calendar year, and what we know about the impact of tobacco

FIGURE 12: FACTORS ASSOCIATED WITH STARTING SMOKING³⁴



control policy, we can estimate that, if the Government, the NHS and its partners were to cease all tobacco control efforts, smoking prevalence could rise by over 200,000 smokers a year.¹⁶

Tobacco products and the tobacco industry

1.49 The upward pressure on smoking rates can partly be attributed to the continuing promotion and ready availability of tobacco products in areas not covered by current restrictions.

1.50 The UK tobacco industry has shown a capacity to evolve in order to meet the challenges that tougher tobacco control has brought. For instance, the past decade has seen a proliferation of cheaper brands that are most popular among poorer smokers, as well as increasing use of 'roll your own' tobacco.

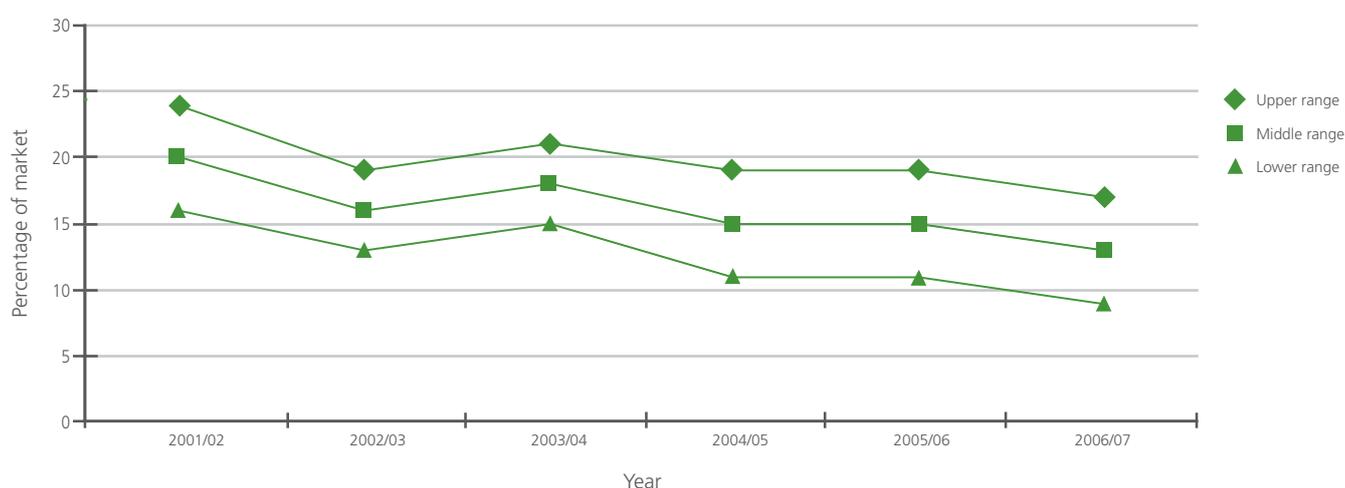
1.51 Despite prominent health warnings, packaging is still the 'silent salesman' for tobacco brands. Tobacco companies acknowledge the power of packaging as a marketing tool, and have invested significant resources in making packaging alluring and

eye-catching. Evidence suggests that, although such misleading descriptions as 'light' and 'mild' have been removed from packs, certain pack colours (whites, silvers and light blues) and other features falsely imply that the brands are less harmful. The figures for tar, nicotine and carbon monoxide yield that are printed on the pack can also wrongly suggest that some brands are safer than others.³⁵

Smuggled and counterfeit tobacco

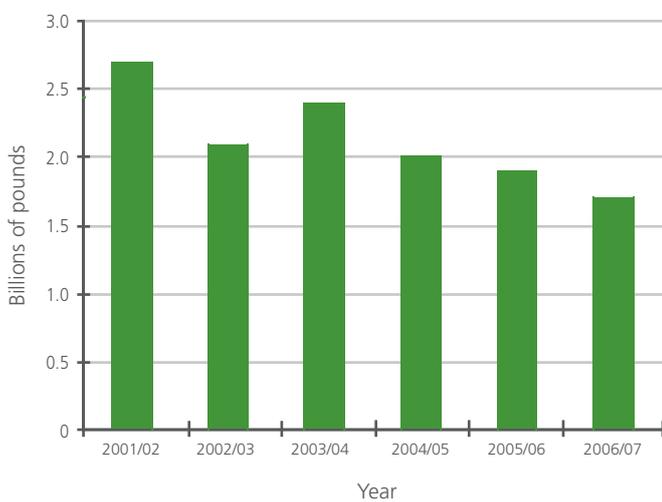
1.52 The illicit market for smuggled and counterfeit cigarettes has fallen considerably since the start of the decade – from 21% to 10% in 2007/08 (mid-point estimates) (see Figure 13). However, across the UK, a significant amount of tobacco is still sold illegally, avoiding tax and duty altogether: the market share of illicit hand-rolled tobacco is 47%.

FIGURE 13: ILLICIT TOBACCO MARKET 2000–07 AS A PERCENTAGE OF THE OVERALL MARKET²⁸



1.53 The result is a continuing supply of cheap cigarettes (see Figure 14), which hampers the attempts to reduce affordability by increasing duty. This particularly affects youth uptake, since young people are very sensitive to price.³⁴ As well as making tobacco more affordable, illicit tobacco undermines other tobacco control measures (such as age-of-sale restrictions) and often does not display health warnings.

FIGURE 14: VALUE OF THE ILLICIT TOBACCO MARKET 2000–07²⁸



1.54 The UK has some of the most expensive cigarettes in the world, but the presence of illicit tobacco increases affordability, as illicit cigarettes sell at roughly half the price of duty-paid premium brands. This is significant, because it is estimated that a 10% increase in the true price would reduce consumption by between 4% and 7%. Recent research has suggested that reducing the illicit tobacco market by 80% would save the economy £5.7 billion over 50 years (at net present value).³⁸

1.55 The sale of illicit tobacco fuels serious organised crime, and there is evidence that some criminals are finding the sale of such tobacco increasingly attractive. Smuggling and trading

in illicit tobacco is potentially a highly profitable activity, and carries less severe penalties than trading in other contraband, such as illicit drugs.

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1.56 As well as undermining attempts to reduce smoking rates, the availability of illicit tobacco harms legitimate businesses. It also encourages young people to take up smoking, and, since the tobacco is used more in disadvantaged communities, it perpetuates smoking and health inequalities.

1.57 Illicit tobacco is available in various places in our communities: the workplace, private homes, pubs, markets, car boot sales and on the street. The distribution network is thus totally unregulated, and tobacco is easily accessible to children and young people.²⁸

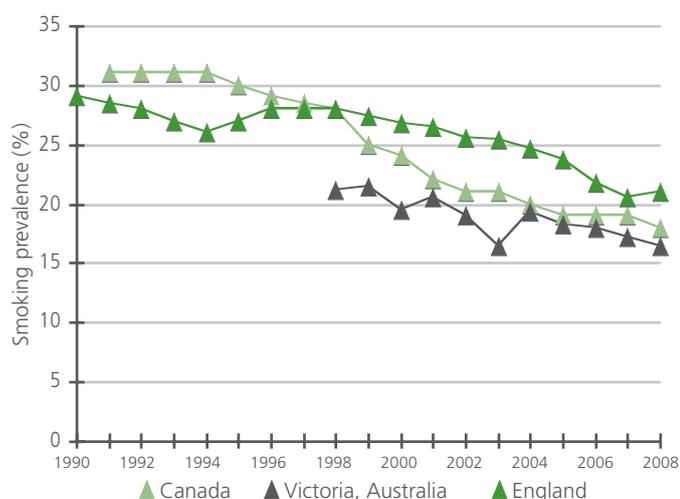
International smoking trends

1.58 While a smoking rate of 21% in England is the lowest ever seen, it remains high by comparison with other jurisdictions that have had comprehensive tobacco control strategies in place for longer.

1.59 Because of the different historic smoking rates, differences in sample questions and variations in methods used, the figures for other countries are not necessarily directly comparable. Nevertheless, the prevalence of smoking in other jurisdictions is significantly lower and demonstrates that it is possible for England to reduce its smoking prevalence much

further. For example, adult smoking prevalence in Canada is 18%, and in Victoria, Australia it is 14%. Canada has had a comprehensive tobacco control programme in place for longer than England (see Figure 15).

FIGURE 15: SMOKING PREVALENCE IN ENGLAND, CANADA AND VICTORIA, AUSTRALIA^{3,4,39,40}



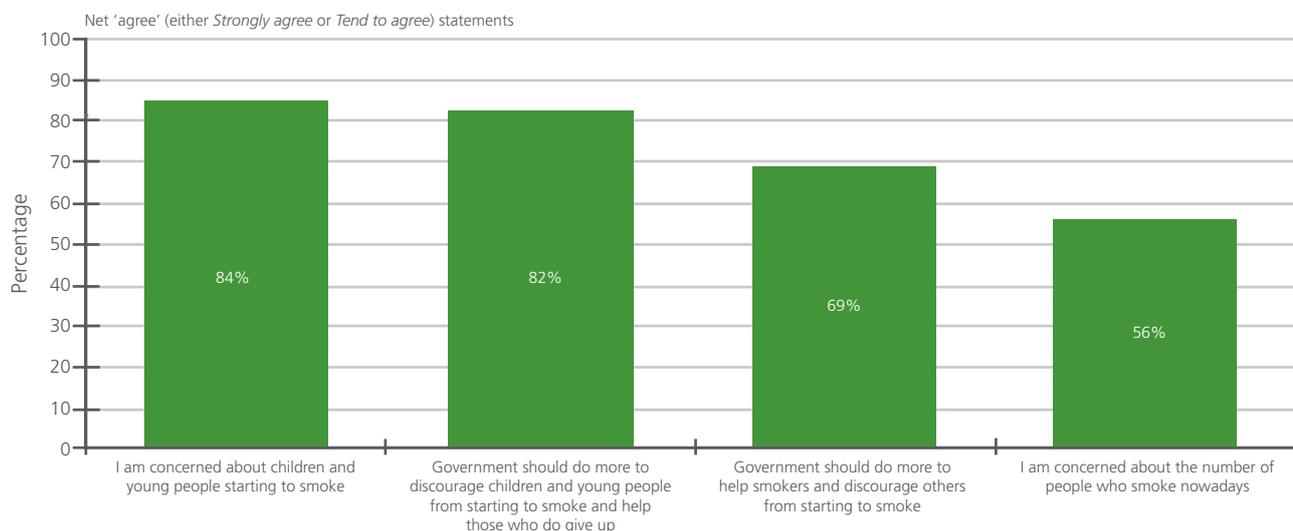
1.60 In 2003, the World Health Assembly explicitly recognised that the global nature of the tobacco epidemic requires a global response. Accordingly, it adopted the WHO Framework Convention on Tobacco Control (of which the UK is a party). The UK actively supports the work of the Convention.

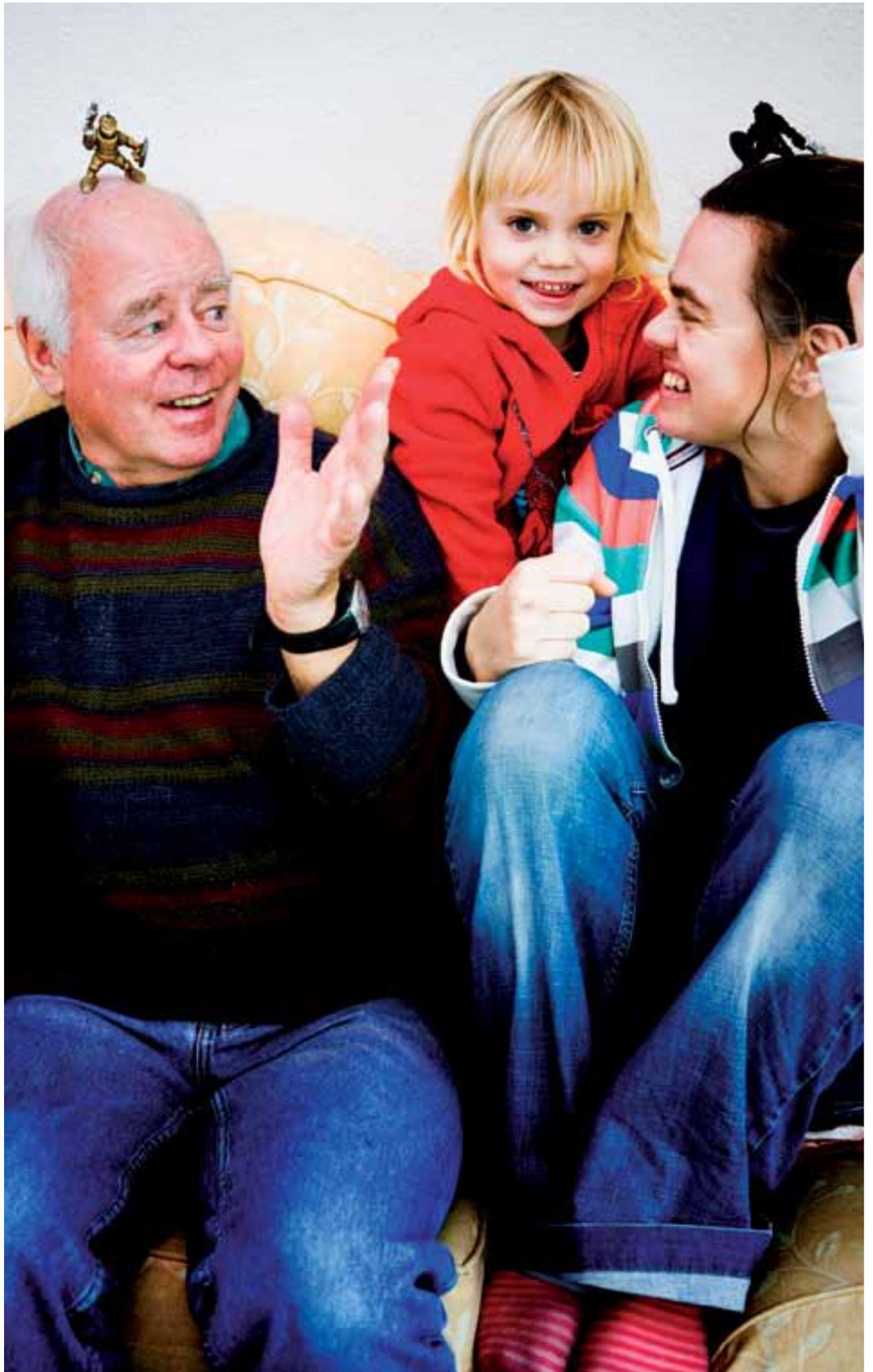
Public opinion and tobacco use

1.61 Finally, this new strategy is needed because public opinion is firmly behind further tobacco control efforts – not just to prevent youth uptake, but also to encourage and help smokers to quit (see Figure 16).

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FIGURE 16: ATTITUDES TO TOBACCO CONTROL IN 2008⁴¹





2. A new vision for tobacco control in England

A new vision for tobacco control

2.1 We seek to build on the success of *Smoking Kills*, by setting the end game for tobacco use in England and laying out our vision for a smokefree future.

2.2 The *Smoking Kills* White Paper was a landmark public health strategy. We believe that publication of a new tobacco control strategy presents the opportunity to set an equally ambitious vision for a society in which the health and social harms from tobacco use are eventually rendered negligible. This new strategy will be complemented and supported by the National Institute for Health and Clinical Excellence's own strategic review of comprehensive tobacco control interventions.

2.3 A smokefree future will enable people to lead healthier and longer lives. A future free from tobacco use will mean that our children do not die early and unnecessarily from smoking-related illnesses. There will be great human and financial savings to our families, communities and the NHS, as smoking kills half of all long-term smokers.

A smokefree future will enable people to lead healthier and longer lives. A future free from tobacco use will mean that our children do not die early and unnecessarily from smoking-related illnesses.

2.4 In order to deliver our vision, we have established three overarching objectives:

- To stop the inflow of young people recruited as smokers.
- To motivate and assist every smoker to quit.
- To protect our families and communities from tobacco-related harm.

2020 aspirations

2.5 To deliver our vision and the three objectives we are also setting aspirations of what could be achieved by 2020 if all partners across the public, private and voluntary sectors prioritise tobacco control and implement the evidence-based policies set out in this strategy.

Measuring success

2.6 The year 2010 will be a landmark one for tobacco control in England. All partners will be focusing on delivering the current 2010 Public Service Agreement, but will also be laying the groundwork for delivering this strategy in earnest from 2011 onwards. Primary care trusts (PCTs) in particular will be expected to continue to prioritise tobacco control and to set their own local goals that meet local needs.

2020 aspirations

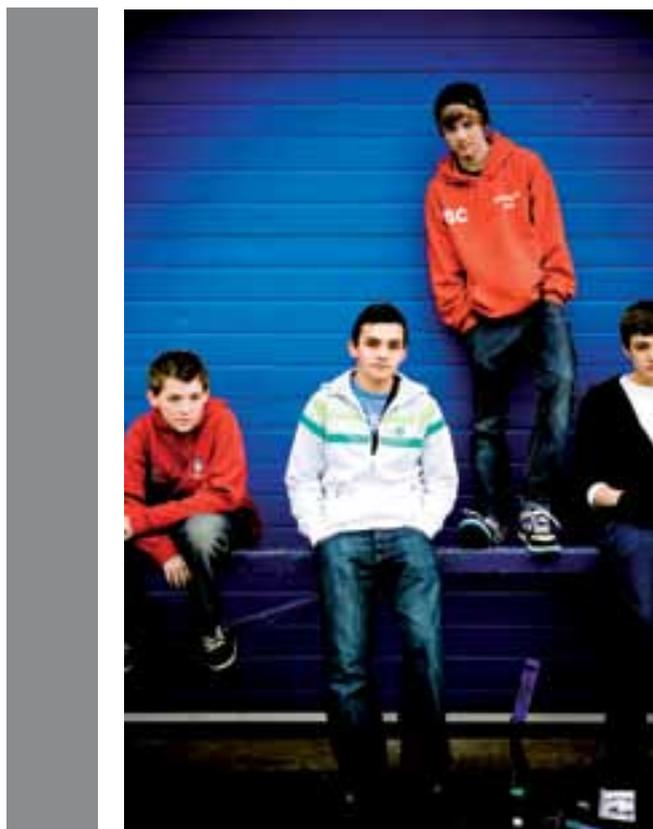
Stopping the inflow of young people recruited as smokers: *aspiring to reduce the 11–15-year-old smoking rate to 1% or less, and the rate among 16 and 17-year-olds to 8% by 2020.*

Motivating and assisting every smoker to quit: *aspiring to reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and within the most disadvantaged areas by 2020.*

Protecting our families and communities from tobacco-related harm: *aspiring to increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020.*

Preventing uptake

2.7 Meeting the 2020 aspiration of preventing youth uptake would require a 5 percentage point decline in smoking rates among 11–15-year-olds. This will be measured by the NHS Information Centre’s annual Smoking, Drinking and Drug Use among Young People Survey.



Motivating and assisting every smoker to quit

2.8 Meeting the aspiration of helping every smoker to quit would require an annual 1 percentage point decline in smoking rates – among the best in the world. If, by prioritising tobacco control, all partners can achieve this, then hospital admissions would be reduced by over 50,000 each year, and over 400,000 lives could be saved. We will measure smoking prevalence rates through the Office for National Statistics annual Integrated Household Survey.

Meeting the aspiration of helping every smoker to quit would require an annual 1 percentage point decline in smoking rates – among the best in the world.

Protecting families and communities

2.9 Increasing to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020 is consistent with the aspirations set out in the other two objectives. The effect this has in reducing children's secondhand smoke exposure will be validated by assessing cotinine levels in children, as in the annual Health Survey for England.

Economic benefits

2.10 Achievement of our ambitions will mean substantial savings for the NHS and the wider economy.

2.11 We estimate that, if all partners implement the evidence-based policies set out in this strategy, then the NHS would start to make net savings by 2015, and by 2020 cumulative net savings for the period 2011–20 will be between £1.5 billion and £2.4 billion. There will also be benefits to society as a whole, with estimated net savings of between £13.7 billion and £15.0 billion over the period 2011–20.

We estimate that, over the lifetime of the strategy (2011–20), the NHS will see cumulative net savings of between £1.5 billion and £2.4 billion, and society as a whole (including the NHS) will see cumulative net savings of between £13.7 billion and £15.0 billion.



3. Stopping the inflow of young people recruited as smokers

3.1 Evidence and experience from abroad suggest that lasting change in youth behaviour towards tobacco use can only be secured by first changing the adult world in which the young grow up.⁴²

3.2 Previous government and NHS action (outlined in Chapter 1) has focused on reducing the appeal and the supply of tobacco to young people through legislation and by means of initiatives to reduce adult smoking.

3.3 We now set out actions that will build on this successful approach.

Reducing affordability

3.4 There is considerable evidence to show that making tobacco less affordable is an effective way of reducing the prevalence of smoking (and young people are particularly sensitive to price).³⁴ Reductions in affordability can be driven by taxation on tobacco products or profit on tobacco products. The availability of cheaper illicit tobacco products undermines the effectiveness of high prices and increases affordability, especially for more disadvantaged groups who are more likely to buy illicit tobacco.¹⁷

3.5 Maintaining or increasing the real value of tobacco duty will reduce the affordability of tobacco products, provided parallel action is taken to reduce the illicit tobacco market share.

Duty on tobacco products

3.6 Successive UK governments have followed a policy of setting and maintaining a high level of tax on cigarettes, in order to discourage people from taking up the habit and encourage those who already smoke to quit.

3.7 The Government continues to see a strong, ongoing role for tobacco duty in discouraging smoking. At the time of the 2008 Pre-Budget Report, when there was a temporary reduction in VAT, tobacco duties were increased so that the overall tax on tobacco products remained broadly unchanged. The Government left the higher rates of duty unchanged when VAT returned to 17.5%. At the 2009 Budget, the Government also increased tobacco duties by around 5% in real terms.

3.8 On a Budget-by-Budget basis the Government will continue to consider the scope for real increases in duty on cigarettes, hand-rolled tobacco and other tobacco products.

3.9 The Government supports the recent political agreement at EU level to harmonise tobacco taxation across member states. This also increases flexibility for member states to raise a higher proportion of tobacco duty from the specific element of the tax, and this will work against the profitability of cheaper brands. The directive will come into force in 2011.

Action on illicit tobacco

3.10 Joint action by the UK Border Agency overseas and HM Revenue & Customs (HMRC) at home continues to maintain downward pressure on the market for illicit tobacco, and HMRC has employed an additional 200 staff devoted to tackling hand-rolled tobacco.

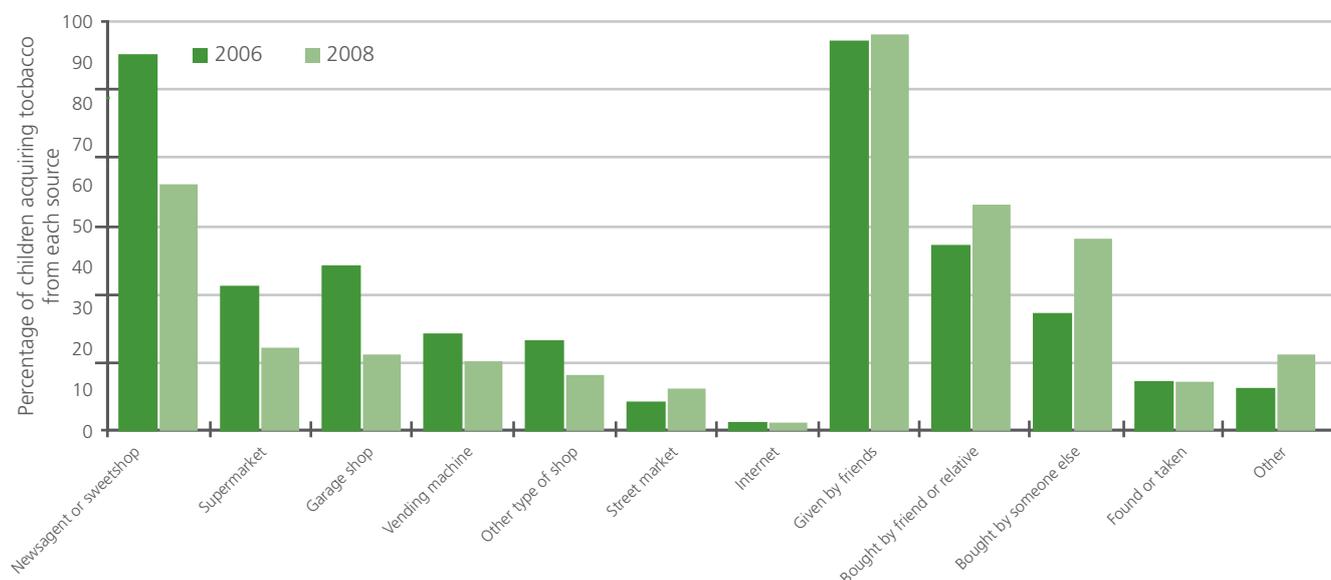
3.11 To complement this, the Government has developed a cross-departmental illicit tobacco marketing strategy to encourage reductions in demand for illicit tobacco. This will be fully implemented from 2011 as part of an updated strategy for tobacco control marketing.

3.12 Regionally, tobacco offices across England, working in partnership with HMRC, local authorities, the NHS, police and businesses, will all continue to play an important role in tackling the domestic trade in illicit tobacco (see case study below).

Case study: The North of England Action Plan on Illicit Tobacco⁴³

Work is under way in the North of England to tackle both supply of, and demand for, illicit tobacco in the region. Recent North of England research has found that a significant proportion of routine and manual smokers buy illicit tobacco and 64% say that doing so allows them to continue to smoke when they could otherwise not afford to do so. Smokefree North West, Fresh Smoke Free North East and Smokefree Yorkshire and the Humber have played a key role, alongside stakeholders including HMRC, regional trading standards groups and the police, in developing this world first pilot programme. It sets out to address the challenges of illicit tobacco across the three regions through eight key areas of activity, including enhanced enforcement action, marketing campaigns and direct engagement with communities where illicit tobacco is widely available. The success of the programme, which was launched in July 2009, will depend upon an unflinching commitment to coordinated partnership working at local, regional and national levels and recognition of the importance of European and international activity in this area.



FIGURE 17: USUAL SOURCES OF CIGARETTES FOR CHILDREN AGED 11–15 IN ENGLAND⁷

3.13 The illicit tobacco market is a global problem. The Government will continue working to support the development and adoption of a new international protocol to the World Health Organization (WHO) Framework Convention on Tobacco Control on illicit trade in tobacco. Key measures of the protocol currently under negotiation and due to be adopted at the conference of the parties in November 2011 include strengthened supply chain controls, including tracking and tracing of tobacco products.⁴⁴

3.14 We have boosted our intelligence gathering and sharing capacity on the illicit market both domestically and internationally. To take further action against the illicit market, the Government will invest in additional overseas Fiscal Crime Liaison Officers to tackle smuggling of illicit tobacco into England. These officers are expected to prevent 200 million illicit cigarettes from entering the UK every year.

3.15 We will continue to bear down on the market share for illicit cigarettes, which has

fallen from 21% in 2001 to 10% in 2007/08, and we will aim to achieve similar success in reducing the illicit market for hand-rolled tobacco. In addition we will continue to publish estimates of the size of the illicit tobacco market so that progress in tackling the illicit market is clear and visible. Overall, we will continue to keep downward pressure on the market share of illicit tobacco, and our aspiration is to achieve a lower market share for illicit cigarettes and illicit hand-rolled tobacco.

Reducing availability to children

3.16 Reducing the availability of tobacco to young people is a major challenge. The latest data on where young people get their tobacco shows that they acquire cigarettes from a wide variety of sources (see Figure 17). The Government will act to change this.

Vending machines

3.17 Since vending machines are self-service, they offer easy (and often unsupervised) access to tobacco, including for young people under

the legal age at which they may be sold tobacco (18 years). Although sales of tobacco products from vending machines represent just 1% of the overall tobacco market, a disproportionate number of purchases from vending machines are made by young people. In 2008, vending machines were the usual source of tobacco for 10% of those children aged 11–15 who said they smoked. Trading standards test purchasing has also shown that young people can easily access tobacco from vending machines.

3.18 We will prohibit the sale of tobacco from vending machines, subject to Parliamentary consideration of regulations.

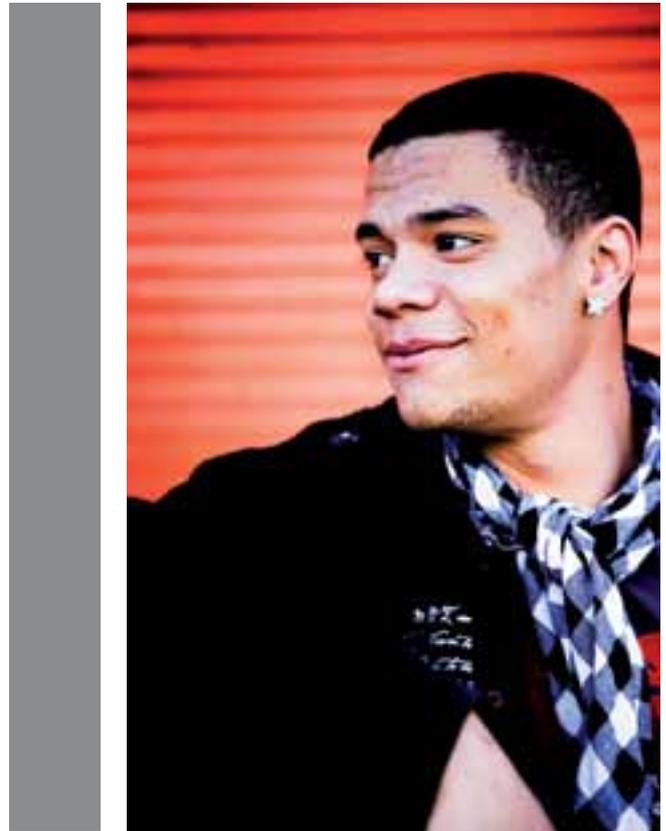
We will review the current regulations that govern the retail sale of tobacco, including current sanctions against retailers who break the law, once sufficient operational evidence is available.

Supply of tobacco to minors

3.19 The Government recognises that there are ways other than through vending machines that under-age smokers get cigarettes, such as through proxy purchasing by adults, under-age sales through retailers, or direct supply from sources other than conventional retailers, and we want to tackle all these sources.

3.20 We will review the current regulations governing the retail sale of tobacco, including current retail sanctions for breaking the law, no earlier than October 2016, once planned changes to existing regulations have bedded in. The review will specifically examine whether a registration scheme will be better for the retail of tobacco or whether a scheme more akin

to that regulating the retail of alcohol is more appropriate. For retailers who persistently sell tobacco to minors we could consider removing their ability to sell other age-related products.



3.21 While the current law around tobacco and children focuses on sales by retailers, we know that young people are increasingly getting tobacco from other sources. We will consider what more can be done to stop these sources of tobacco for children. Within the first three months of 2010 we will launch a review into the purchase for and supply of tobacco to young people and assess what more can be done to limit these sources, including examining the current legislation around the confiscation of tobacco that children are found to have in their possession.

3.22 In addition, a marketing campaign will highlight the harms of supplying illicit tobacco to young people.

Reducing the attractiveness of tobacco products

3.23 Even though tobacco advertising is no longer permitted, we remain concerned about the promotion of tobacco products and their use. For instance, evidence shows that tobacco branding is today still influencing youth smoking. The key remaining sources of promotion and branding include the display of tobacco in shops and tobacco packaging.⁴⁵

Removal of the display of tobacco products by retailers

3.24 The Health Act 2009 requires tobacco products to be removed from display in shops. The Government will implement the new law for large retailers in October 2011 and small retailers in October 2013.

Reducing the promotion of tobacco

3.25 Smoking is a major public health issue. The Government has already taken very significant steps to reduce tobacco use and the impact of smoking in our communities. Following the ban on advertising and the controls on displays, the most important part of brand marketing is the packet, and a number of studies published recently focus on the impact of tobacco packaging in stimulating tobacco use, rather than simply promoting particular brands. This is particularly the case for children and young people, for whom there is evidence to suggest that introducing 'plain packaging' could increase the effectiveness of health warnings

and reduce false views about the relative risks of different brands.

3.26 The Government believes that the evidence base regarding 'plain packaging' needs to be carefully examined. Therefore, the Government will encourage research to further our understanding of the links between packaging and consumption, especially by young people. The Government will also seek views on, and give weight to, the legal implications of restrictions on packaging for intellectual property rights and freedom of trade.

Limiting exposure to tobacco use in the media

3.27 Smoking is often depicted in glamorous ways in films, TV programmes and computer games. There is emerging evidence that children who are exposed to images of smoking in films are at increased risk of taking up smoking themselves. In recognition of this, the communications regulator Ofcom has already established clear guidelines, which state that smoking:

"must not be featured in programmes made primarily for children [defined as under 15 years of age] unless there is strong editorial justification"

and

"must not be condoned, encouraged or glamorised in other programmes likely to be widely seen or heard by under-eighteens unless there is editorial justification".⁴⁶

3.28 However, because the guidelines are not always heeded, the Government and Ofcom will work with the British Board of Film Classification

to ensure that their own guidance reflects Ofcom's position.

Reducing the promotion of tobacco through tobacco accessories

3.29 The 'roll your own' tobacco sector continues to show growth in sales, and there is emerging evidence that the promotion and marketing of some tobacco-associated products – particularly cigarette rolling papers – offers companies a way to promote tobacco use, particularly to young people, and to create a positive image of smoking. Where evidence suggests that such proxy promotion exists, the Government will take action to prevent it.

Increasing awareness of the harms of tobacco

3.30 While we will maintain our focus on reducing tobacco use among adults, as the foundation for reducing smoking among young people, we will also look at new possibilities to communicate with young people about tobacco. We will examine the potential for new technology and media to create fresh methods of passing on information about the harm of taking up smoking and the benefits of creating a smokefree future.

Peer-led and school-based initiatives

3.31 The Government will continue to integrate advice on smoking and tobacco use into the National Curriculum for schools, through the voluntary National Healthy Schools Programme, which aims to improve the health and wellbeing of children and young people. To date, nearly 4 million children have attended schools that participate in comprehensive personal, social and health education. We will

also work with the further education sector to encourage learners to embrace healthy lifestyles.

3.32 The National Institute for Health and Clinical Excellence (NICE) is currently reviewing the evidence on peer-led and school-based youth-focused initiatives, and is set to publish public health guidance shortly. The Government will await publication of this guidance before developing further plans in this area.

Product characteristics and health warnings

3.33 We will make the case strongly at EU level for improved labelling of all tobacco products. In the case of smoked tobacco, we will work to improve the salience and impact of the European picture warning library, and support future efforts to make pictorial warnings as prominent on the pack as possible.

3.34 Cigarette packets are currently required to include figures for the amounts of tar, nicotine and carbon monoxide that are emitted from a cigarette when it is smoked. The Government will work with its European partners to replace tar, nicotine and carbon monoxide data on the pack with a more meaningful statement about the harms of tobacco use, including contact details for NHS Stop Smoking Services.

The Government will work with its European partners to replace tar, nicotine and carbon monoxide data on the pack with a more meaningful statement about the harms of tobacco use.

3.35 We will continue to work with our EU and international partners and to monitor developments around regulation of the

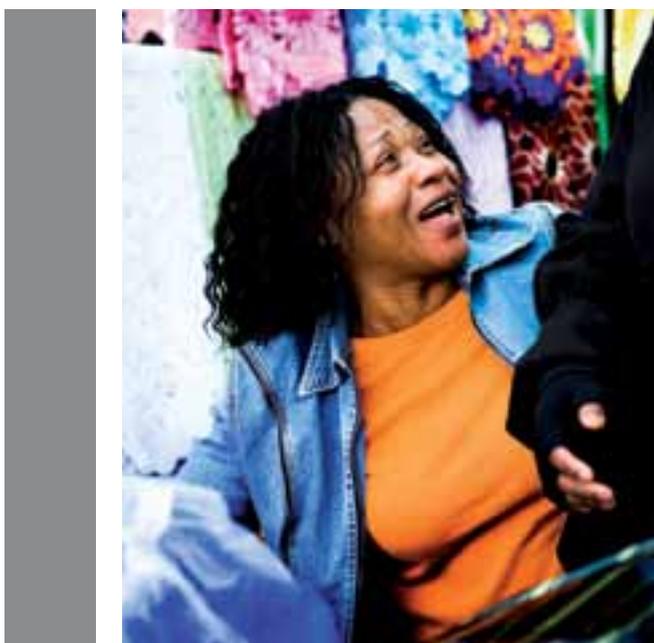
ingredients and emissions of tobacco products, in order to ensure that we meet our obligations under the WHO Framework Convention on Tobacco Control.

Regulations on use of smokeless tobacco

3.36 Despite the well-documented impact on health of smokeless tobacco products, under EU law they are not currently obliged to display pictorial health warnings. In response to the current review of the directive on product warnings, the Government will make the case that European tobacco legislation on pictorial health warnings should extend to smokeless tobacco, and that non-smoked tobacco products should be clearly labelled as tobacco products.

we will work to build up a picture of the current market.

3.38 Given the ongoing concerns about the health impacts of using snus (an oral smokeless tobacco which is illegal to sell in the UK), the UK continues to support the current European prohibition on the sale of this type of tobacco.



3.37 In addition, we will work with our local partners both to ensure that legislation on the labelling, display and sale of smokeless tobacco is enforced and to combat the evasion of duty. We currently have no accurate information on the illicit market in smokeless tobacco, and so



4. Motivating and assisting every smoker to quit

4.1 Stopping smoking improves health and wellbeing. There are immediate, short- and long-term benefits to be gained for the smoker, their family and their community. On average, each smoker who manages to stay off tobacco for the rest of their life gains 3.6 life years. Smoking cessation is the single most cost-effective life-saving intervention provided by the NHS.⁴⁷

Assisting smokers to quit

4.2 Half of all quit attempts are 'assisted quits' – they are made by people with support from NHS Stop Smoking Services or primary care, or using over-the-counter medication. This means that the other half are 'unassisted (cold turkey) quits', which have the lowest chance of success.¹⁶ New approaches are needed for those who find it most difficult to quit, to help them with quitting and to reduce tobacco-related health risks.

Marketing to encourage smokers to quit

4.3 The Government has encouraged people to stop smoking through its award-winning mass media campaigns, including the 'Get Unhooked' campaign (which won *Marketing Week's* Campaign of the Year award in 2008) and the 'Wanna Be Like You' campaign (which won the Thinkbox TV Brilliance award in June 2008 and the IPC Media Planning Award for Best Use of Consumer Insight in June 2009). These mass media campaigns have been supported through a national freephone telephone helpline and

web presence, which have emphasised the campaign messages while at the same time providing signposting mechanisms to help people access support to stop smoking.

Availability of smoking-cessation medicines

4.4 We have also introduced more readily available, effective smoking-cessation medicines delivered through the NHS, and nicotine replacement therapy (NRT) is available in various formats, both on prescription from the NHS and on general sale in a range of different retail settings. Bupropion (Zyban) and varenicline (Champix) are both available from the NHS on prescription.

NHS Stop Smoking Services

4.5 The most effective way of stopping smoking is provided by NHS Stop Smoking Services. Quitting with support from NHS Stop Smoking Services is up to four times more likely to result in prolonged abstinence from smoking than quitting without any assistance.⁴⁸

4.6 NHS Stop Smoking Services were set up in 1999 to provide evidence-based behavioural and medical support for people to stop smoking. Over the past 10 years, over 4 million quit dates have been set with local NHS Stop Smoking Services, and there have been over 2 million successful quit attempts (measured at four weeks). In this time, an estimated 1.4 million life years have been gained by smokers stopping

through the services, which equates to 70,000 lives being saved over the 10 years.⁴⁹

4.7 We need to develop more effective and inviting treatment and medicinal support for smokers who wish to quit or at least reduce the harm they suffer from using tobacco. We have three aims:

- to encourage more tobacco users to make a quit attempt;
- to improve and expand current NHS Stop Smoking Services; and
- to provide more options for effective quitting and improve the effectiveness of all quit attempts.

Motivating smokers to quit



4.8 Over the past decade, marketing communications have played a key role in motivating people to quit smoking. Today there are fresh opportunities to continue the effectiveness of our marketing efforts. While almost 7 smokers in 10 say they would like to quit, only half actually make a quit attempt.

Of this group, around half make unassisted quit attempts, which are the most likely to lead to relapse.^{15,16}

4.9 We want to help people maximise their chances of success when they try to stop smoking. We need to increase the numbers of assisted quit attempts by providing clear information about the benefits of support for quitting and about where support is to be found.

We need to increase the numbers of assisted quit attempts by providing clear information about the benefits of support for quitting and about where support is to be found.

A new marketing strategy for smoking cessation

4.10 A new marketing strategy to motivate smokers to make a quit attempt will be developed following publication of this document. The strategy will continue to target people from those groups that have the highest rate of smoking, including routine and manual workers (the largest group of smokers). We will also continue the successful strategy of using marketing techniques to generate 'leads'. The details of smokers will be captured, so that they can be contacted and helped to find their local support options. This will also make it easier to follow them up and maximise their motivation to quit. Furthermore, the strategy will consider new approaches, including exploiting the new media to communicate with young people about the harmful effects of taking up smoking and the benefits of creating a smokefree future.

The strategy will continue to target people from those groups that have the highest rate of smoking, including routine and manual workers (the largest group of smokers).

4.11 We will develop new 'quit kits' for smokers who do not wish to use conventional NHS smoking-cessation services. The quit kits will provide an easily accessible 'self-help' option for smokers that incorporates the experience gained by NHS Stop Smoking Services over the past decade.

Workplace marketing initiatives

4.12 We will support primary care trusts (PCTs) to make NHS Stop Smoking Services support available to all public sector employees, including military personnel and staff in social services, health and education. We will also expand our workplace quitting programme to make NHS Stop Smoking Services available at work to a wide range of employment groups.

4.13 In addition, we will continue our partnership work with employers with large numbers of routine and manual workers. We will also aim to work with trade unions to promote the economic benefits of smoking cessation and a healthy workforce.

NHS Stop Smoking Services are effective and we want to encourage greater use of them by smokers, even if they have tried to quit with NHS support in the past, and have not been successful.

Improving current NHS support and treatment

4.14 It is vital to expand the reach, appropriateness and effectiveness of NHS support for all smokers. NHS Stop Smoking Services are effective and we want to encourage greater use of them by smokers, even if they have tried to quit with NHS support in the past, and have not been successful. Currently, only about 6% of smokers access NHS Stop Smoking Services each year.⁵

Expanding the reach of NHS Stop Smoking Services

4.15 Most NHS Stop Smoking Services offer support in locations across the community, in order to provide high levels of reach. We want to help identify 'cold spots' in communities, where services such as 'stop shops' are needed in local high streets or shopping centres to boost both the visibility and the reach of NHS services.

4.16 We will also provide guidance to help cessation services embed their services – and tailored plans to achieve long-term cessation – in high-prevalence health and social care settings such as prisons and mental health services.

We also need to support training opportunities to make sure that all doctors, nurses, pharmacists and other healthcare professionals understand the importance to health of smoking cessation.

Improved referrals from health and social care settings

4.17 We need to ensure that all healthcare professionals know about local NHS Stop Smoking Services and how to refer patients to them. We also need to support training opportunities to make sure that all doctors, nurses, pharmacists and other healthcare professionals understand the importance to health of smoking cessation. We will continue to work with primary and secondary care

providers to achieve this, and with professional bodies to encourage all health professionals to discuss smoking cessation with their patients in a proactive way.

We will work together with our colleagues in primary and secondary care to develop integrated care pathways for those with long-term conditions and lifestyle diseases, so as to ensure robust systems for the identification and referral of at-risk patients who smoke.

Case study: Berkshire NHS Stop Smoking Services

Overview

In the Government's Index of Multiple Deprivation 2007, Reading is ranked 151 out of 354 local authorities. Although smoking prevalence has decreased year on year, rates of smoking remain above both the local and the national average. In 2008, fresh ideas of how to raise the stop-smoking profile among the local population started to emerge within Berkshire NHS Stop Smoking Services. Many options were considered, such as opening up a stop-smoking shop in the middle of the town or hiring a bus to facilitate work with hard-to-reach communities.

Work in practice

Berkshire NHS Stop Smoking Services has opened a stop-smoking shop, known as 'the Pod'. In September 2008, the Broad Street Mall in Reading town centre was chosen as the location for the new initiative on account of the high level of client 'footfall' at the time. In October 2008, the service started to offer free one-to-one stop-smoking advice. As an initiative, the Pod is unique in the area: for the first time, smokers are being offered support seven days a week (50 hours a week) and have easy access to NRT, as well as ongoing support from a team of approachable and non-judgmental advisers.

Results

From its launch up until the end of March 2009, 921 smokers registered with the service through the Pod, and 614 set a quit date with advice and help from the team. Overall, 260 smokers successfully quit smoking between October 2008 and March 2009. Since the launch of the Pod, Berkshire NHS Stop Smoking Services have attracted increased interest from local newspapers and radio stations. The service offered at the Pod is also highly valued by its customers, who have supplied testimonials that express their positive experiences of stopping smoking.

4.18 We will work with our colleagues in primary and secondary care to develop integrated care pathways for those with long-term conditions and lifestyle diseases, so as to ensure robust systems for the identification and referral of at-risk patients who smoke. There should also be guidance available to support these patients to quit if they want to. Where appropriate, we will encourage patients whose conditions are caused or exacerbated by exposure to secondhand smoke to consider referring the smokers in their household to NHS Stop Smoking Services.

4.19 The Department of Health will work with NICE to encourage alignment of the Quality and Outcomes Framework, so as to encourage more smokers to use NHS Stop Smoking Services.

Smoking has a high impact on morbidity and mortality rates among older people, but older people are more likely to be successful in stopping smoking than younger people.

4.20 Referrals from secondary and primary care will be encouraged for smokers of all ages, including older people. Smoking has a high impact on morbidity and mortality rates among older people, but older people are more likely to be successful in stopping smoking than younger people. The evidence that much of the harm from smoking can be halted or even reversed challenges the view that is commonly held by older smokers that the damage that has been done is irreparable.

Improving the quality of the services

4.21 We will provide systems and training to support core competencies in staff delivering

smoking-cessation interventions, and support the organisations delivering services to assure the quality of their service delivery for all service users. We will continue to support the development and implementation of the NHS Centre for Smoking Cessation and Training (NCSCT) as the benchmarking organisation for clinical competence and standards for NHS Stop Smoking Services advisers.

The evidence that much of the harm from smoking can be halted or even reversed challenges the view that is commonly held by older smokers that the damage has been done and is irreparable.

4.22 Treatment effectiveness rates are variable across the country and this is not only due to variations in levels of addiction or deprivation. Access rates also vary across the country, often due to local demographics of different socio-economic and black and minority ethnic groups. The work of the NCSCT and other partners will help PCTs ensure that this variation is only due to clinical need. We will monitor this through the quarterly and annual data provided by NHS Stop Smoking Services.

Most smokers have to try several times before they successfully quit, and so PCTs will be encouraged to ensure that their local NHS Stop Smoking Services re-engage with smokers who have used the service previously but have not been successful.

4.23 Most smokers have to try several times before they successfully quit, and so PCTs will be encouraged to ensure that their local NHS Stop Smoking Services re-engage with smokers who

have used the service previously but have not been successful.

4.24 Overall, by improving the quality of the services, we expect this support to enable PCTs and the services to increase the number of successful quit attempts made in their area.

Support and advice for users of smokeless tobacco

4.25 There is evidence that the use of smokeless tobacco products on sale in this country (e.g. chewing tobacco, 'paan' and 'zarda' similar to snus) can have adverse effects on health, and carry an increased risk of oral cancer.²³ There is also some evidence that the people who use these products want to stop just as much as people who smoke tobacco.⁵⁰

4.26 We will work with the NCSCT to develop and implement cessation packages and care pathways for smokeless tobacco users, and will find sustainable mechanisms to embed these pathways in communities.

4.27 These pathways will be complemented by the development of a communication strategy for users of smokeless tobacco and other niche products (and for the health and social care professionals who work with them) to highlight the health risks of using such products and the available methods of support to stop. This will form part of the wider tobacco control marketing strategy.

Introducing more routes to quit



4.28 It is important to recognise that millions of smokers who want to quit – despite efforts to persuade them to seek support – will choose to go 'cold turkey', the least successful approach to quitting. We also know that many tobacco users are keen to find safer alternatives to cigarettes, either to help manage their addiction or as a route to quitting.

This strategy introduces a radical approach to quitting smoking and suggests more routes to quitting, which, we believe, will help thousands more smokers to quit successfully.

4.29 To meet this demand, this strategy introduces a radical approach to quitting smoking and opens more routes to quitting, which, we believe, will help thousands more smokers to quit successfully. The new routes will encourage smokers to break their dependence entirely and will support smokers to:

- cut their levels of smoking as a precursor to completely quitting;
- manage their nicotine addiction, using a safer alternative product, when they are unable to smoke (e.g. at work); and
- dramatically reduce the harmful effects to their health, and the harmful effects to those around them, by using a safer alternative to smoking.

4.30 Delivering this new approach will require innovation in the regulation of nicotine delivery medicines and in NHS services. The Government will also maintain reduced VAT on NRT to the minimum 5% level allowed under current rules.

Innovation in the use, design and regulation of nicotine delivery medicines

4.31 The Medicines and Healthcare products Regulatory Agency (MHRA) regulates nicotine delivery medicines, and so will invite applications for licences to cover the new routes to quitting.

Nearly a fifth of smokers use NRT, bought from a retail outlet, to assist their quit attempt.

4.32 Nearly a fifth of smokers use NRT, bought from a retail outlet, to assist their quit attempt by cutting down in certain situations. However, feedback from smokers suggests that NRT is not easily accessible (unlike tobacco) and can be expensive (which introduces a disincentive to use it).¹⁶

4.33 The MHRA will encourage manufacturers to develop and market new and improved products. At the same time, the Government will work with the pharmaceutical industry and retailers to encourage the development of improved pack information, guidance and training packages for retailers on the use of nicotine delivery medicines, so that smokers can be better informed and retailers feel more confident in talking to their customers about the products.

4.34 The Government will also work with the pharmaceutical industry and other partners to dispel the myths surrounding the harms from nicotine. While it is the nicotine within the tobacco that the smoker craves and is addicted to, it is the tar and the carbon monoxide in smoked tobacco that are the causes of smoking-related disease and death.

4.35 We believe that these actions will encourage innovation in the use, design and marketing of nicotine delivery medicines. However, over the past year, we have already seen the emergence of many different forms of nicotine delivery systems, including e-cigarettes and nicotine hand gels. These products are unregulated and their safety remains undetermined.

Given the pharmacological action of nicotine, the Government will create a level playing field by seeking to regulate all products that contain nicotine (apart from tobacco, which is regulated by specific tobacco legislation) under medicines safety legislation.

4.36 Given the pharmacological action of nicotine, the Government will create a level playing field by regulating all products that contain nicotine (apart from tobacco, which is regulated by specific tobacco legislation) under medicines safety legislation. This will mean that any producer of a nicotine-containing product or nicotine delivery medicine will need to meet certain requirements for safety, quality and efficacy, in order to protect the public. The first step towards the creation of this new regulatory scheme for nicotine-containing products will be a public consultation, to be undertaken by the MHRA and launched alongside this strategy.

4.37 The Government will ensure that no nicotine-containing products or nicotine delivery medicines can be marketed in a way that promotes or encourages tobacco use. We will also keep nicotine delivery medicines under review. In particular, we will monitor the impact of the medicines' availability on quit rates at a national level, the safety implications of long-term use of the medicines and the potential for their abuse.

A new NHS service

4.38 The NHS already supports smokers in making quit attempts, so we can expect a demand for the NHS to support smokers in the new routes to quit.



4.39 Currently, NHS Stop Smoking Services work specifically with an 8–12-week 'withdrawal-oriented model', where smokers are assisted in setting a quit date within the following week or two and in reaching that date, and are then supported to manage their withdrawal symptoms. This may involve both behavioural support (to manage the situational cravings for nicotine) and medication (to manage the physical cravings). Many smokers are unable to quit abruptly and should be encouraged to use one of the new routes to quitting. We want to make individually tailored options available to smokers – options that meet their individual needs and their levels of tobacco dependence.

The Government will lead the development of a new type of NHS smoking-cessation service that provides a longer course of behavioural and pharmacological support, including the use of new forms of nicotine delivery medicines.

4.40 The Government will therefore support PCTs to develop a new type of NHS smoking-cessation service that provides a longer course of behavioural and pharmacological support, including the use of new forms of nicotine delivery medicines.

4.41 All NHS Stop Smoking Services will want to consider how they could develop this tailored approach. To aid this thinking, template care plans will be provided nationally. NHS commissioners will then be able to monitor the situation locally through the provision of data, including the number of service users who abstain continuously for an extended period.



5. Protecting our families and communities from tobacco-related harm

5.1 The implementation of smokefree legislation means that virtually all enclosed workplaces and public places are now free of the hazard of secondhand smoke.

5.2 Smokefree laws have been introduced in many parts of the world. There is clear evidence that smokefree laws can result in reductions in acute myocardial infarction (heart attacks).⁵¹ And there is evidence that many more families are voluntarily making their homes and private cars smokefree.

5.3 The burden of smoking rests most heavily on those from the most disadvantaged and vulnerable populations in our communities, and this perpetuates the inequalities faced by those groups. In order to tackle the high smoking rates among these groups, the Government has targeted smoking-cessation interventions in 'Spearhead' areas (areas of high health inequalities).

The burden of smoking rests most heavily on those from the most disadvantaged and vulnerable populations in our communities, and this perpetuates the inequalities faced by those groups.

5.4 Smoking remains one of the few modifiable risk factors in pregnancy. It can be the cause of a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality. To date,

we have targeted marketing campaigns and smoking-cessation interventions at pregnant women, but there is much more that can be done.

Smokefree environments

5.5 Smokefree legislation, introduced in 2007, continues to see high levels of compliance and public support. We have undertaken to review the impact of smokefree legislation in 2010. That review will provide an opportunity to examine whether the legislation is working and where it can be improved, and will also enable assessment of what more can be done to extend protection. Particularly, we will look to promote and support smokefree prisons and examine the case for extending smokefree requirements around building entrances. We will also review how 'smokefree environments' are implemented and managed in other countries.

5.6 Those schools that have the most rigorous policies on tobacco and a strong anti-smoking ethos have significantly lower levels of smoking than other schools, even allowing for socio-cultural factors.⁵² We will work to encourage all schools and colleges to adopt smokefree policies across their whole site, and to provide support and encouragement to learners not to start smoking. During the review of smokefree we will also consider the merits of establishing smokefree requirements for all children's play areas.

Working in partnership to achieve 'smokefree communities'

5.7 The levels of compliance and public support for smokefree legislation demonstrate that people are keen to reduce their exposure to secondhand smoke.



5.8 By increasing the level of awareness of the harms of secondhand smoke, particularly to children, we will encourage people to voluntarily make their homes and private cars completely smokefree.

Protecting children from secondhand smoke

5.9 We will continue to raise awareness about the harms of secondhand smoke, and will encourage the development of collaboration between local community stakeholders to support people in making their homes and cars smokefree – potentially under the banner of 'smokefree communities'. We will specifically focus our efforts on communities with the highest smoking rates in order to have the greatest impact on children's exposure to secondhand smoke.

We will encourage the development of collaboration between local community stakeholders to support people in making their homes and cars smokefree – potentially under the banner of 'smokefree communities'.

5.10 We will also encourage health professionals to talk to smokers about the impact that smoking has on their children.

5.11 If evaluation after the implementation of these measures shows that children continue to be exposed to unacceptably high levels of secondhand smoke, we will examine the available legislative routes to protect their health.

Smokefree Olympics

5.12 We will encourage and celebrate a tobacco-free London 2012 Olympics: tobacco products will be neither on sale nor in use at the Olympic venues, indoors or out. This will show our children what a tobacco-free future will be like.

'Reduced ignition propensity' cigarettes

5.13 Nearly a third of all fire deaths are attributable to smoking. 'Reduced ignition propensity' (RIP) cigarettes are designed to be self-extinguishing once they have been left unattended for a short period. The Government is committed to supporting the current development and implementation of a European RIP standard to reduce fire deaths and injuries attributable to smoking-related fires, and will also use safety as another means of promoting smokefree homes.

Tackling high smoking rates in vulnerable and disadvantaged communities

5.14 Working across government and within the public health community, we will develop an integrated approach at the local level to target health inequalities caused by smoking.

The Government will support local areas in developing targeted interventions such as integrated public healthcare packages.

Integrated public healthcare pathways

5.15 Tobacco dependence is often only one of several competing health and social care issues that individuals deal with. Sometimes different health and social care services act in isolation, without considering the overall wellbeing of the service user. The Government will support local areas in developing targeted interventions such as integrated public healthcare packages. These would be tailored to the individual and would support a wide range of interventions to improve general health and wellbeing and to empower communities to take action against tobacco use. These care pathways will help those individuals who stop smoking to access other public health services as a direct result of their interaction with NHS Stop Smoking Services. For example, a service user who is worried about putting on weight and who would like more opportunity to exercise could be referred by their NHS Stop Smoking Service to a local weight-management service or an 'exercise on prescription' scheme.

Improved local data to target smoking-related health inequalities

5.16 We will improve the health intelligence that is used to inform action. Often the data

gathered on smoking is at a relatively high level (such as across a whole primary care trust (PCT) area), and as a result pockets of high prevalence may be lost. We will, thanks to the Office for National Statistics' new Integrated Household Survey, be able to produce better estimates of smoking prevalence for areas within regions, and these can be used locally to target interventions.

Targeted workforce initiatives for community leaders

5.17 Trusted community professionals, such as teachers, nurses, GPs, pharmacists and the police, often act as the leaders of a community. We will continue to support PCTs to provide targeted workforce initiatives both for community professionals and for workers within the community. NHS Stop Smoking Services will be taken to the workforce, at times and in locations that are accessible and acceptable to routine and manual workers and their employers.

Tackling high smoking rates within mental health and prison settings

5.18 It is important that there should be effective referral and service provision for people with mental illness who use tobacco, so that they have equal access to NHS Stop Smoking Services. We will work with mental health service providers to offer consistent and clear information on tobacco use. We will pilot and evaluate innovative programmes within primary and secondary mental healthcare services to find acceptable and accessible service pathways, and the learning gleaned from such programmes will be shared with all mental health service providers.

It is important that there should be robust referral and service provision for people with mental illness who use tobacco, so that they have equal access to NHS Stop Smoking Services.

5.19 Moreover, PCTs will want to draw on examples of good practice – such as in Doncaster, where prisoners who use tobacco are assured of help in stopping, should they so wish (see the case study on page 59). Several pilots are in progress across the country, and we will ensure that the guidance and support offered to PCTs reflects the most effective models of practice.

Tackling high smoking rates within minority and ethnic groups

5.20 Smoking is highly prevalent among some ethnic groups, particularly Bangladeshi and Irish men. In addition, certain minority groups (such as lesbian, gay, bisexual and transgender people) also have high rates of smoking.⁵³ We will help local NHS Stop Smoking Services to work with representatives from those minority and ethnic groups that have high rates of tobacco use to develop good practice in reaching out to and supporting quit attempts.

Identifying and treating smoking in pregnancy



5.21 The rate of smoking in pregnancy is measured on the basis of self-reported smoking status at the time of delivery. But the earlier in pregnancy a mother can stop smoking, the better the health outcomes for both her and her baby. Smoking in pregnancy is best identified by the midwife at the time of the first booking-in visit, using biochemical screening. Although they have the chance to opt out, smokers thus identified can then be referred for support to quit. At this point a tailored quit plan is designed for them, to try to ensure that they quit as early in their pregnancy as possible.

5.22 We will work with health and social care providers to support each pregnant smoker (and her partner or any relatives in the household who smoke) to quit. We will improve the identification of pregnant smokers by piloting and testing different approaches towards identifying those women, in order to see which are the most effective and acceptable. We will then pilot different intervention approaches, to ensure that the most effective stop-smoking support is made available. NICE is currently reviewing the evidence on smoking-cessation interventions for women

Case study: Doncaster NHS Stop Smoking Service

Overview

The Doncaster NHS Stop Smoking Service has been offering a service to the 2,000 prisoners in Doncaster's four prisons since January 2004. Given that 80% of prisoners smoke, the tobacco-associated risks are very high in prisons. Intervention gives prisoners an opportunity, often for the first time, to invest in their own health.

Work in practice

Over the years, the service has been runner-up at the regional health and social care awards and was in the running for the trust's own award for best practice. The service was originally based on the Department of Health 'Acquitted' programme of best practice for prisons (as a hard-to-influence area). Started by a single stop-smoking specialist, the service now has a team of three, with a full-time and a part-time adviser alongside the original specialist.

Since January 2009, the service has worked with the commissioners and the prison service to increase the volume of prisoners seen and to reduce waiting times by introducing a new system, which involves prisoners being given individual appointments via a local NHS Stop Smoking Service.

Results

This small, dedicated team has built up a working partnership with the prison service and is now accepted as part of the framework of healthcare and stop-smoking promotion. Waiting times in each prison have been cut to two weeks or less, and the service sees over 100 prisoners every week. The quit rate has consistently been between 50% and 60%. The service is involved in health-promotion events within the prison for both prisoners and staff, and also runs in-house workplace groups for staff.

who are pregnant or have recently given birth and who smoke, and when this is available we will base our work on its conclusions.

The earlier in pregnancy a mother can stop smoking, the better the health outcomes for both her and her baby.

5.23 To bring all these different elements together, we will develop care pathways for use in pregnancy and with smokers who have young children in the household. We will also develop

ways of providing NHS support through NHS Stop Smoking Services that are acceptable and accessible to the particular needs of these groups. The evidence base needs to be expanded, so that PCTs can be offered pragmatic and evidence-based support solutions that are both clinically effective and cost-effective. This will include guidance on how to implement the most cost-effective means of using financial incentives for PCTs who wish to take advantage of the emerging evidence.



6. Delivering a smokefree future

Ensuring effective delivery

6.1 For tobacco control to be delivered effectively, a broad range of partners need to work together. Creating a partnership approach to delivering a smokefree future is key to this strategy.

Local public sector delivery partners

6.2 The backbone in delivering any successful health improvement strategy is the local public sector partnership between the NHS and local government. The commitment, effort and innovation to be found at the local level are essential ingredients in the success we have seen in tobacco control over the past decade.

6.3 To ensure delivery of a smokefree future, we will encourage effective local partnerships. And although the strategy sets out national-level policy, regions and local areas will be encouraged to innovate and set local ambitions that may go beyond the aspirations of this strategy. In many cases, the maximum impact and the greatest efficacy can be secured by jointly commissioning interventions both within and across local area boundaries.

Although the strategy sets out national-level policy, regions and local areas will be encouraged to innovate and set local ambitions that may go beyond the aspirations of this document.

NHS and public health practitioners

6.4 NHS and public health practitioners are central to delivering our aspirations for smoking prevention and cessation, and for the promotion of smokefree homes. In particular, they are vital to the establishment of new NHS services that can support smokers in the new routes to quitting.

6.5 Moreover, NHS staff can act as ambassadors for a smokefree future, which is why it is important for their health and wellbeing to be taken as seriously as the health and wellbeing of the population as a whole.

6.6 The Boorman Review of NHS staff health and wellbeing recommended that all NHS organisations provide staff with health and wellbeing assessments which are centred on prevention and aligned with wider public health policies. The Government has accepted this recommendation and one of the steps that all NHS organisations can take is to support any of their staff who smoke to use the NHS Stop Smoking Services to quit.

NHS staff can act as ambassadors for a smokefree future, which is why it is important for their health and wellbeing to be taken as seriously as the health and wellbeing of the population as a whole.

Social care providers

6.7 Social care settings provide an ideal opportunity to motivate and support quit

attempts among vulnerable and disadvantaged groups that have high rates of smoking.

Smokefree alliances

6.8 Local 'smokefree alliances' are made up of members of PCTs and trusts, the council, local voluntary and community groups and local businesses. The alliances can raise the profile of tobacco control and champion local implementation of a smokefree future.

Local government and local government national organisations

6.9 Local authorities, the Local Authority Coordinators of Regulatory Services (LACORS), Trading Standards and the Chartered Institute of Environmental Health are essential delivery partners in the implementation and enforcement of regulations governing all aspects of tobacco control – from smokefree legislation and action on illicit tobacco, to enforcement of age-of-sale legislation.

6.10 Local authorities are key delivery agents for reducing local smoking rates through the framework of local area agreements. The Local Government Association and the Improvement and Development Agency for local government are important partners in encouraging innovation, contributing to the development of best practice in tobacco control and disseminating good practice.

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Regional level

6.11 Regional structures have played a vital role in supporting local delivery of tobacco control, and today they play a key role in agreeing and monitoring local priorities. The regional directors of public health are part of the Department of Health and are co-located with each of England's nine Government Offices for the Regions and the 10 strategic health authorities. They and their teams work alongside public health colleagues in the NHS, local authorities and other agencies to improve and protect their local population. This involves addressing all determinants of health (including tobacco control) and factors that create health inequalities within their region. The main way in which they influence and collaborate with local government is through the negotiation and review of local area agreements. Regional directors of public health and their teams are responsible for ensuring that opportunities offered by these agreements for health gain are capitalised upon. Their support is also important in the development of strong and active local alliances for tobacco control.

6.12 Each regional director of public health will publish a programme that defines that region's contribution to the goals set out in this strategy, and will oversee its implementation. The regional director of public health will work to integrate the objectives of tobacco control into the wider public health regional strategies.

Case study: Regional tobacco offices

The 'Fresh, Smoke Free North East' regional tobacco office was established in 2005 to reduce smoking rates in the North East and to tackle health inequalities that are attributable to smoking. In the first two years of its existence, the North East witnessed the biggest regional decline in smoking rates compared with other regions – from 29% in 2005 to 21% in 2008.

The success of Fresh in making the case for (and then securing) additional regional funding to implement comprehensive tobacco control measures, together with the subsequent impact on regional smoking rates, created a template for regional action on tobacco control. A regional tobacco office in the North West followed soon after, and the South West became the latest English region to establish a regional tobacco control office – Smokefree South West – in March 2009.

The regional statistics on tobacco use clearly provided a compelling rationale for stronger action across the South West. The latest survey data available shows that while regional adult smoking prevalence, at 21%, is the national average, prevalence among young people aged 16–24 is the worst in England.

The point of establishing a regional office for tobacco control is to bolster national action, promote greater local collaboration and create a social climate in which tobacco becomes increasingly less desirable, less acceptable and less accessible.

The success of Fresh and evidence from abroad suggest that making and sustaining a significant investment will markedly accelerate the rate of progress in reducing smoking prevalence. All 14 South West PCTs agreed to collectively commission a boosted tobacco control programme at a rate of 50p per capita. This, together with Department of Health regional funding, creates a significant regional fighting fund of £3 million, administered by Smokefree South West. The new regional organisation has been running for just over six months and is already working to establish strong partnership action on a range of tobacco control issues, including illicit tobacco, improving the delivery and commissioning of NHS Stop Smoking Services, and a regional multimedia campaign to raise awareness of children's exposure to secondhand smoke. Further information about Fresh, Smoke Free North East, Smokefree North West and Smokefree South West can be found at www.freshne.com, www.smokefreenorthwest.org and www.smokefreesouthwest.org.uk

National government

6.13 As well as leading on national strategy and policy development, the UK Government takes the lead on raising taxes, developing and implementing national policy and legislation, and planning and implementing national marketing communications strategies.

International organisations

6.14 The World Health Organization and the Framework Convention on Tobacco Control (FCTC) are critical in reversing the global tobacco epidemic. Particularly important for tobacco control efforts in this country is the implementation of a protocol curtailing the trade in illicit tobacco. The UK has already been involved in the development of a range of guidelines under the FCTC to assist parties in implementing effective tobacco control measures.

6.15 We are also playing a role in the development of FCTC guidelines for product regulation and smoking cessation. Successful collaboration with the EU is essential to our aims of better regulating ingredients and emissions, developing new health warnings, improving regulation of smokeless tobacco and implementing reduced ignition propensity standards to reduce smoking-related fire deaths.

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Private sector organisations

6.16 Retailers already play a major role in the support of tobacco control, ensuring compliance with the legislation that governs the age at which people may be sold tobacco, as well as with other smokefree legislation. New legislation to remove tobacco from displays in shops will further protect young people from the harms of tobacco.



6.17 Looking to the future, retailers will be important partners in creating smokefree communities and in making effective medicines more readily available, particularly in small shops that are at the heart of our communities. We will therefore continue to work closely with retailers particularly through representative bodies such as the Association of Convenience Stores.

6.18 The pharmaceutical industry is another important partner. We will work with the industry to encourage the development of new stop smoking medicines for consumers at prices that are at least competitive with tobacco products.

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Non-governmental and academic organisations

6.19 As a party to the FCTC, the UK has a responsibility to ensure that civil society is involved in the development of its tobacco control strategies. The non-governmental and academic sectors have played an important role in the development of this strategy, and these organisations (for example Action on Smoking and Health) will continue to be invited to contribute to shaping the national and international tobacco control agenda. Medical bodies such as the Royal College of Physicians and the British Medical Association keep tobacco control at the forefront of the public health agenda. Academic bodies, including the UK Centre for Tobacco Control Studies, generate evidence and further our understanding, as well as encouraging young researchers to get involved in tobacco control.

Supporting effective delivery

6.20 The Government already produces a range of supporting documents and tools to ensure that local areas have the skills and capabilities they need to delivery comprehensive local tobacco control measures. The NHS Centre for Smoking Cessation and Training (NCSCT), launched in 2009, provides direct support to the areas that most need it.

6.21 The Government will continue its work in support of delivering this strategy, working with NICE and other relevant bodies to produce

timely and practical guidance, and ensuring that the NCSCT supports local areas and NHS staff in delivering tobacco control effectively.

6.22 The details of this support will be set out in a delivery plan, to be published by the Department of Health in 2010.

A comprehensive marketing programme

6.23 Over the past decade, tobacco control efforts have been supported by a number of award-winning marketing campaigns. Such efforts must continue, so that smokers continue to be motivated to quit and are directed to NHS Stop Smoking Services as the most effective route towards quitting.

6.24 A new marketing strategy, setting out the details of our marketing approach for the first three years of the strategy, will be published in 2010.

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Accountability for delivery

Accountability for the 2010 Public Service Agreement

6.25 At present, indicators of smoking prevalence are taken from the General Household Survey. This will continue to be the case for assessing progress against the 2010 Public Service Agreement (PSA).

6.26 However, the General Household Survey sample size is insufficient to provide measures

of prevalence at PCT or local authority level. Therefore, performance management of the 2010 smoking prevalence PSA is achieved through use of the indicator: “the number of people attending NHS Stop Smoking Services who had quit smoking at the four-week follow-up per 100,000 population”. The ‘four-week quit’ indicator is one of the NHS Vital Signs and is part of the local authority National Indicator set (NI 123).

Issues with the current system

6.27 Although the notion of successful four-week quits is useful in focusing the NHS on service delivery, it cannot be used to measure local smoking prevalence.

6.28 Provision of local NHS Stop Smoking Services is just one of several local tobacco control measures that reduce smoking prevalence. By using successful four-week quits as a proxy indicator, there is a risk – particularly within local area agreements – that NHS Stop Smoking Services are seen as the only tobacco control measure that can reduce local smoking rates.

6.29 The current indicator is also unpopular with local PCTs, which sometimes struggle with target setting and with the pressure to deliver a high volume of four-week quits (which can also interfere with improving treatment effectiveness and delivering a harm reduction strategy). Furthermore, data quality issues have complicated service provision, so that not all the problems connected with using successful four-week quits can be attributed to the choice of indicator.

6.30 An indicator based on local smoking prevalence is preferable, since it relates directly to the new prevalence targets and allows the NHS and local authorities to plan commissioning of comprehensive tobacco control measures to reduce local smoking rates.

6.31 However, there is also a risk that removing the current indicator could reduce the incentive for PCTs to invest in NHS Stop Smoking Services. The current four-week quit indicator has merit, in that it focuses the NHS on delivering its core contribution to the smoking prevalence local targets – while each year only 6% of smokers use NHS Stop Smoking Services, 25% of all successful 12-month quit attempts are made through these services.

6.32 The availability of the indicator has enabled the development of an essential data collection, which allows the Department of Health to monitor service provision across socio-economic class – a vital tool in the drive to reduce health inequalities.



Future performance monitoring

6.33 The Government has listened to the feedback it has received from its local partners. To address issues raised, a local smoking prevalence indicator is currently being developed. Transition to this indicator will take place once Integrated Household Survey data is available.

The Government has listened to the feedback it has received from its local partners. To address issues raised, a local smoking prevalence indicator is currently being developed.

6.34 This indicator could be used from 2011 to measure progress against aspirations contained in this strategy. We believe it will encourage all delivery partners to take broader action on comprehensive tobacco control.

6.35 Alongside this, we will seek to develop a more effective set of indicators to measure NHS Stop Smoking Services' performance that could provide clinical quality outcomes and cover services that support the new routes to quitting. For example, services could monitor outcomes at 4 weeks and 12 weeks, and validate self-reported status in at least 85% of cases.

6.36 To underpin this work, a national database will be created (subject to Review of Central Returns' approval) to support the future data-entry requirements for service providers.

6.37 Progress against the third objective of the strategy (protecting families and communities) will be measured using the annual Health Survey for England. By testing cotinine levels in children, the survey validates the proportion of homes where both parents are smokers but where the home itself has been declared 'smokefree'. (Cotinine is what nicotine becomes as it is processed in the body; its presence indicates exposure to tobacco smoke.)

Funding flows to support local NHS Stop Smoking Services

6.38 To ensure that effective NHS Stop Smoking Services are funded, we will seek to introduce nationally the kind of stop-smoking contract currently being developed by West Midlands Strategic Health Authority. The West Midlands, operating as a 'payment by results' development site, has produced proposals under which services would be paid for each smoker who has quit at 4 weeks and at 12 weeks.

6.39 This approach has three key benefits. First, it rewards outcomes, so NHS commissioners are only paying for successful interventions. Second, it provides an incentive for new services to develop, knowing that, if they are effective, they will receive funding. Third, the payment can be graded to give greater rewards for successful outcomes among particular groups (e.g. pregnant women).

6.40 All NHS Stop Smoking Services should move towards reimbursement along the lines of the West Midlands example. In addition, once national levels for service delivery are uniformly adopted, we will consider the merits of having national prices (or tariffs) for successful quitters.

Wider accountability

6.41 In order to provide leadership across Whitehall, the Cabinet's Sub-Committee on Health and Wellbeing will ultimately be responsible for driving and monitoring progress against the objectives set out in this strategy.

6.42 To ensure further transparency the Government commits itself to publishing the details of all policy-related meetings between the tobacco industry and any government official. This excludes meetings to discuss operational matters to reduce the illicit trade in tobacco and bilateral meetings between tobacco manufacturers and HM Revenue & Customs which relate to the administration of their tax affairs. The published details will include the titles of government officials and tobacco industry representatives who attended, the date and the issue discussed.

Investing in our knowledge

6.43 The evidence base for tobacco control is already strong, but continued success depends on evaluation of current policy and on further research. As a leader in tobacco control, England has a particular obligation to develop the evidence base still further, and so we will continue to promote a comprehensive and high-quality research and evaluation programme designed to inform policy and practice.

6.44 In particular, this will be achieved through continued collaboration with other funders – for example, through the UK Clinical Research Collaboration (UKCRC) and its Public Health Research Centre of Excellence which focuses specifically on tobacco. The UKCRC Centre for Tobacco Control Studies has already provided expert advice across a broad spectrum of disciplines in the development of this strategy.

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