SMOKEFREE DEVON ALLIANCE

TOBACCO CONTROL STRATEGY 2012-15

Foreword

Smoking is the biggest single preventable cause of disease and premature death in Devon. It is estimated that 1,225 people die from smoking related illness every year in the Devon County Council area. Over the last few years we have made impressive progress in reducing the proportion of people smoking in Devon, but we still need to do more to stop people being harmed or killed by tobacco. I am confident that our updated strategy will continue to address this major public health challenge.

Dr Virginia Pearson
Director of Public Health, Devon County Council

As we move towards hosting public health within local authorities in April 2013, this revised tobacco control strategy continues to be of paramount importance, particularly in addressing health inequalities. There will be new opportunities to seize as stronger links are made with key partners in the Alliance. The first Smokefree Devon Alliance strategy was launched in 2009 but was swiftly followed by a change to a coalition government in 2010. It is notable that the new government recognised the social and economic burden of smoking on individuals and communities and swiftly developed their own Tobacco Plan in 2011. I look forward to driving smoking prevalence in Devon even further downwards.

Dr Phil Norrey
Chief Executive, Devon County Council

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Introduction

This document sets out a tobacco strategy for Devon.

The harmful effects of tobacco on health, both on the individual and on those around them, are widely accepted. Lesser known, however, are the significant costs to the economy which further exacerbate the burden imposed by tobacco. Section 1 of this document sets out the statistical evidence for the widespread harm caused by tobacco in Devon. It will be a useful basis for identifying the local need and designing a collaborative approach to tackle the issue.

A multiple agency approach, working across organisational divides, together with a correct balance between clinical and social policies/interventions is the most effective way to prevent and stop people from smoking. The Smokefree Devon Alliance is a partnership of organisations committed to reducing the prevalence of smoking in Devon. Section 2 of this document sets out the approach being used in Devon to reduce smoking prevalence in the local authority area.

This strategy is led by the Smokefree Devon Alliance Steering Group which agrees and reviews an action plan each year. In addition to the steering group, there is a wider membership of partners and individuals in the Alliance that are able to uplift and communicate key messages when needed. The Alliance has a reporting link to the Health and Wellbeing Board (HWBB).

The Devon HWBB has developed its first Joint Health and Wellbeing Strategy 2013-16 (JHWBS) which states the importance of lifestyle choices in improving health and reducing health inequalities; smoking cessation is a priority for 2013/14.[1]

The tobacco control strategy and the work of the Alliance will support a reduction in smoking prevalence, discouraging young people from smoking and reduce exposure to secondhand smoke which will contribute to improving the health of Devon's population.

[1] Available online at www.devonhealthandwellbeing.org.uk/strategies

SECTION 1

1. The Burden of Smoking

1.1.1 The impact of smoking

Smoking is the largest single preventable cause of death, killing over 80,000 people annually in England alone. This totals more than suicide, diabetes, alcohol and drug related deaths, road traffic and other accidents put together.[2] Tobacco is linked to more than 200 diseases and is the primary cause of lung cancer and chronic obstructive pulmonary disease (COPD). Moreover, it is the primary reason for the gap in healthy life expectancy between rich and poor as identified by Marmot in his review of health inequalities.[3]

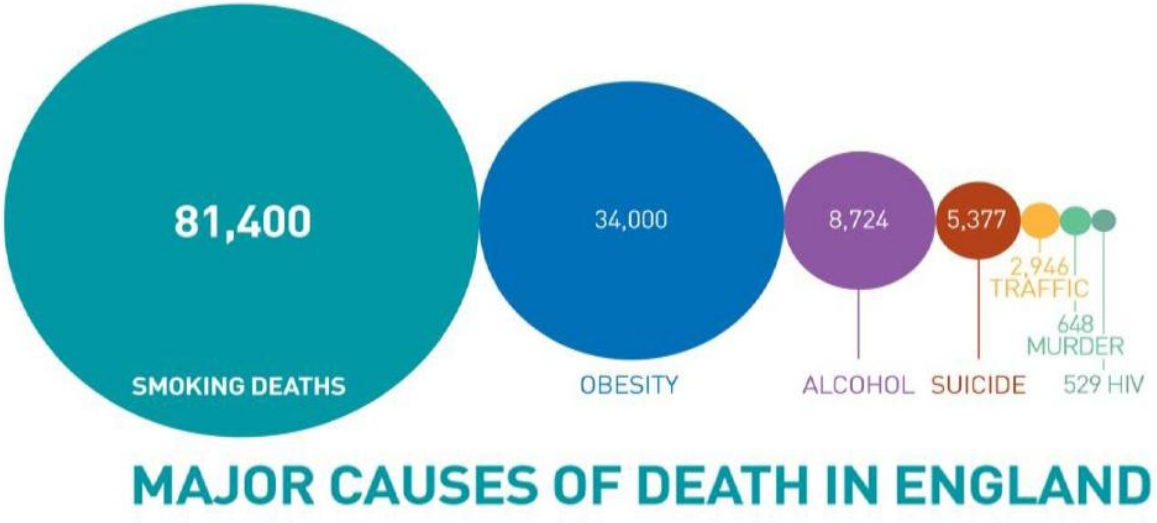

Figure 1: Source ASH Factsheet: Smoking statistics, illness and death, June 2011

Total annual deaths in Devon caused by smoking are 1,225 but levels do vary greatly across local authority areas.[4] Mortality statistics for Devon are shown in Table 1 on the next page.

[2] Smoking Statistics: Illness and Death. http://ash.org.uk/files/documents/ASH_107.pdf.

[3] Post-2010 strategic review of health inequalities (the Marmot Review).

[4] Actual per year in period 2008-10. Health Profile 2012 Devon. APHO.

Local Authority Area	Smoking related deaths
East Devon	243
Exeter	151
Mid Devon	108
North Devon	168
South Hams	133
Torridge	104
Teignbridge	234

Table 1: Smoking attributable mortality in Devon (Health Profiles 2012)

Smoking is the greatest single factor in the different life expectancy between social classes. Figure 2 over the page shows the distribution of mortality rates across Devon in 2010. Mortality rates have improved in all areas since the 1950s, the greatest shifts were in rural parts of North Devon, and the weakest shifts are in Ilfracombe, Dawlish, Newton Abbot and West Devon.[5]

[5] Devon Annual Public Health Report 2011-12, available online at www.devonhealthandwellbeing.org.uk/aphr/2011-12

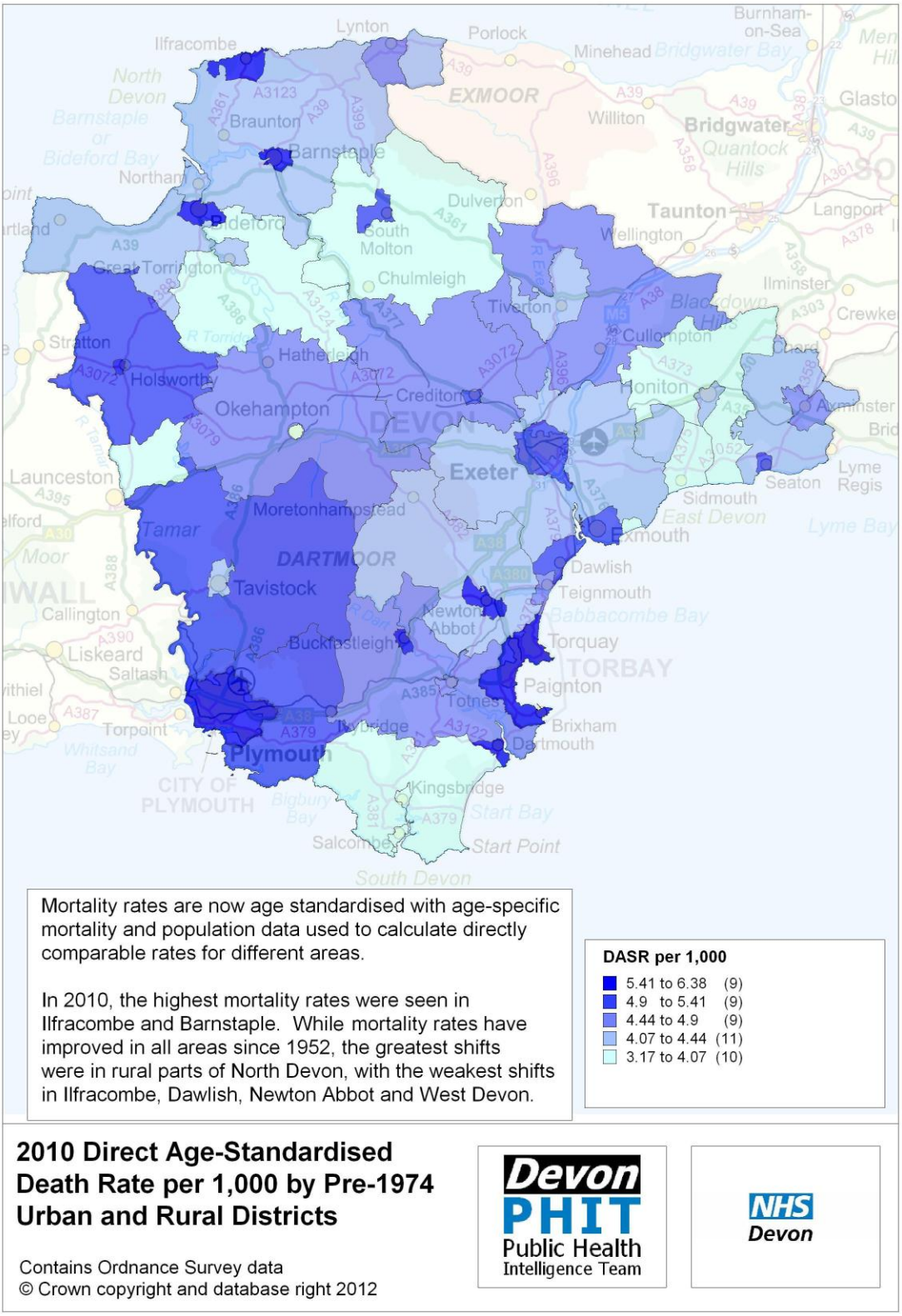

Figure 2: The pattern of health inequalities across Devon in 2010

Almost half of smoking-related diseases are cancers, 25% are respiratory and 27% are cardiovascular (figure 3). More than one in four cancers are attributable to tobacco, whilst one in five deaths from cardiovascular disease are caused by smoking.

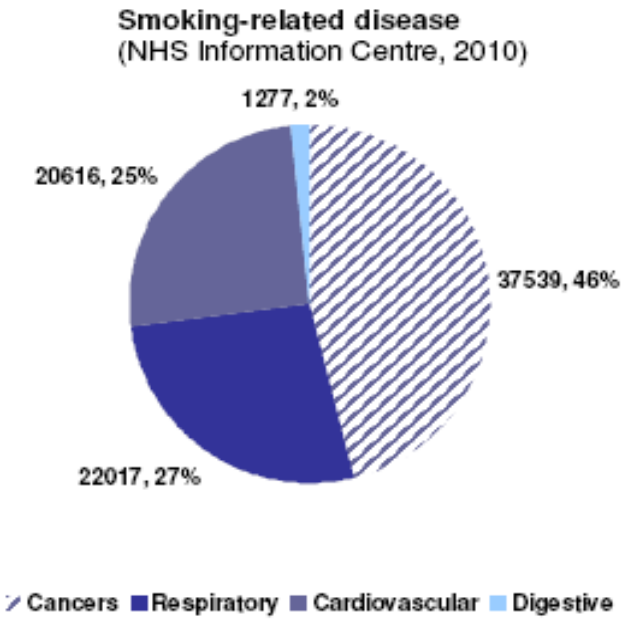

Figure 3: Comparison of disease

The local picture for deaths from heart disease, stroke, lung cancer and respiratory disease is shown in Table 2 below. While Devon fares better than the England average, other primary care trusts in England have even lower rates, as shown by the England best column.

Indicator	Devon value	England Average	England Worst	England Best
Smoking attributable deaths 2007-09	164.8	216.0	361.5	138.4
Smoking attributable deaths from heart disease 2007-09	27.7	32.1	59.9	18.7
Smoking attributable deaths from stroke 2007-09	7.3	10.1	18.4	5.7
Deaths from lung cancer 2007-09	26.2	38.2	69.4	21.8
Deaths from chronic obstructive pulmonary disease 2007-09	16.9	26.2	48.7	14.7

Table 2: Mortality in Devon

(Local Tobacco Control Profiles for England 2011. London Health Observatory. Data shown is the age-standarised rate per 100,000 population)

1.1.2 Hospital Admissions

There are over 5,700 admissions to NHS Devon hospitals each year which are due to smoking. This is estimated to cost the NHS around £15.9 million each year, or £33.40 for every person in Devon aged over 35.

Indicator	Devon value	England Average	England Worst	England Best
Smoking attributable hospital admissions 2009/10	**1219.9**	**1417.2**	**2508.1**	**797.3**
Cost per capita of smoking attributable admissions, 2009/10	**£33.6**	**£37.9**	**£57.7**	**£28.7**

Table 3: Hospital Admissions in Devon
(Local Tobacco Control Profiles for England 2011. London Health Observatory. Data shown is the age-standardised rate per 100,000)

1.1.3 Risk Pyramid

Risk pyramids illustrate both the scale of an issue, and the distribution of different health-related outcomes and behaviours. The risk pyramid for smoking below shows the number of smokers in Devon, the number of interactions they have with the Stop Smoking Service, the smoking related hospital admissions and the number of annual smoking related deaths.

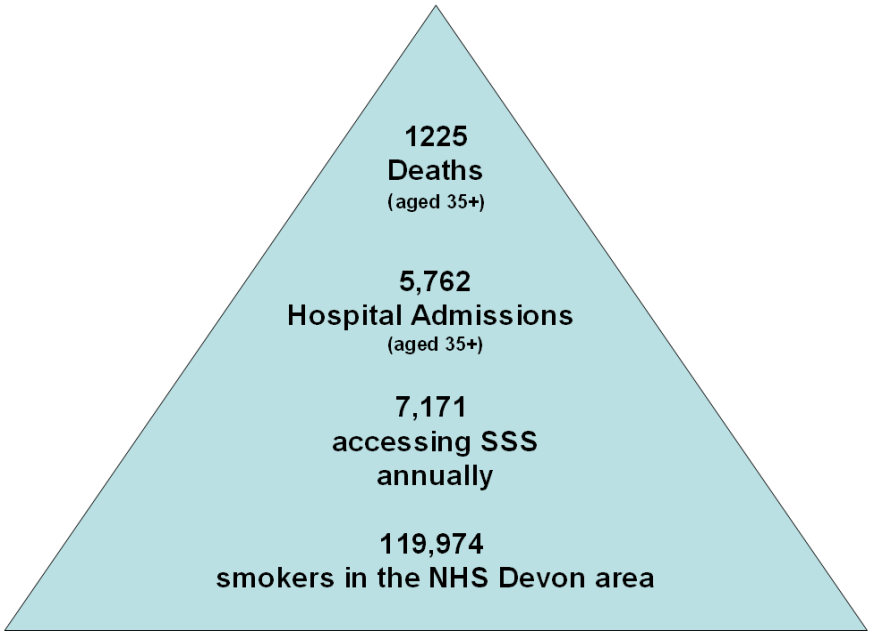

Figure 4: Risk pyramid; smoking in Devon

1.1.4 Secondhand smoke

The harm caused by smoking is not just to the individual. Exposure to smoke is harmful and this is particularly a problem for children. Tobacco smoke contains over 4,000 chemicals, 60 of which are known to be carcinogenic. In 2004 the Scientific Committee on Tobacco and Health (SCOTH) report found that secondhand smoke is a cause of lung cancer and ischaemic heart disease in adult non-smokers, and a cause of respiratory disease, cot death, middle ear infections and asthma attacks in children.[6] The Committee reported a "causal effect of exposure to secondhand smoke on the risks of lung cancer, ischaemic heart disease and a strong link to adverse effects in children", and found that secondhand smoke "represents a substantial public health hazard."

In 2010 The Royal College of Physicians published a landmark report entitled "Passive Smoking and Children". The report acknowledges the importance of smokefree legislation in reducing exposure to secondhand smoke in the workplace but points out that the principle source of exposure for non-smokers is in the home and that children are especially at risk.[7]

It has been estimated that domestic exposure to secondhand smoke in the UK causes around 2,700 deaths in people aged 20-63 and a further 8,000 deaths a year among people aged 65 years and older.[8]

1.1.5 Prisoners

A 1998 study showed approximately 80% of all prisoners smoke.[9] The prevalence is even higher amongst those who are dependent on drugs and/or alcohol and/or who have mental illness. Quit rates for prisoners and staff are consistent with those of the community, with some individual prisons out-performing local community settings.

Based on Office for National Statistics studies on the general prison population, an estimated 43% of prisoners would like help to quit smoking.

Research carried out for the Youth Justice Board among children and young people in the secure estate (aged 12 to 18) found that their rates of smoking before entering custody were substantially higher than among young people who do not offend. Over 83 per cent were regular smokers.

The JHWBS has prioritised the health needs of prisoners due to the high smoking prevalence and the health inequality this causes.

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[6] Secondhand smoke: Review of evidence since 1998. Scientific Committee on Tobacco and Health (SCOTH). Department of Health, 2004.
[7] Passive smoking and children. A report of the Tobacco Advisory Group of the Royal College of Physicians. London, RCP, 2010.
[8] Jamrozik,K Estimate of deaths among adults in the United Kingdom attributable to passive smoking. BMJ 2005, published online 1 March 2005.
[9] Office for National Statistics 1998.

1.1.6 Smoking in pregnancy

Smoking in pregnancy can cause increased risk of miscarriage, stillbirth, preterm birth and low birth weight.[10] It has been found to increase infant mortality by about 40%. Women in the routine and manual workers group are 1.5 times more likely to smoke than women in the general population. Smoking in pregnancy is three times higher in mothers aged under 20 compared with rates for all pregnant women.[11]

1.1.7 Smoking and fires

A 2003 report for the Office of the Deputy Prime Minister found that smokers' households were 50% more likely to have experienced a fire in the previous year than tobacco-free households. While there may be other social or environmental factors to this statistic, local data shows that cigarette fires are more dangerous than other fires. The relative risk of dying in a fire caused by smoking is five times that of dying in a fire caused by another source. Known risk factors include smoking in bed and smoking while drinking alcohol.

In the south west in 2008-12, at least 16 fatalities were caused by fires started by "smokers' materials" which is about 22% of the overall total. A further eight died in additional accidental fires started by matches or lighters. Two of these deaths were in the Devon local authority area.

1.2 The Economy

1.2.1 National costs of smoking

Smoking imposes a huge burden on NHS resources. It is the single most significant drain on the NHS, accounting for 23% of the NHS spend on five common diseases.[12] In 2005, smoking cost the NHS £5.2bn per year compared to a £3bn spend on overweight and obesity. Therefore, reducing the prevalence of smoking could significantly reduce the future costs in treating cancer, COPD and cardiovascular disease.

The total cost of smoking to the economy is substantial and, contrary to popular belief, is not outweighed by tax revenue on tobacco. The Policy Exchange, in their 2010 report 'Cough Up', estimate that the annual cost to the economy is as much as £13.74bn. Tax revenue contributes £10bn annually. The report states:-

[10] Board of Science and Education. Smoking and reproductive life. The impact of smoking on sexual, reproductive and child health.
[11] http://www.nottinghamshire.gov.uk/smoking_in_pregnancy.doc [accessed 27.5.10].
[12] Allender S, Balakrishnan et al. The burden of smoking related ill health in the UK, Tobacco Control 2009; 18: 262-267.

> "These societal costs comprise not only the cost of treating smokers on the NHS (£2.7 billion) but also the loss in productivity from smoking breaks (£2.9 billion) and increased absenteeism (£2.5 billion); the cost of cleaning up cigarette butts (£342 million); the cost of smoking related house fires (£507 million), and also the loss in economic output from the deaths of smokers (£4.1 billion) and passive smokers (£713 million)."

Two recent attempts have been made to estimate the financial burden of tobacco use. The first is a toolkit developed by researchers at Brunel University, with input from the London Health Observatory and Nottingham University, which was commissioned by smokefree networks in the North West, North East and South West and is a tool aimed at commissioners of health services.[13] The second is a reckoner of the social costs of smoking developed by ASH which attempts to provide high-level estimates of the costs of tobacco use to the health service and the economy more generally.[14] This tool is aimed at policy-makers and statistics from the tool are used in this document. A recently developed 'return on investment' tool has been developed by the National Institute for Clinical Effectiveness and will be used by the Alliance in future commissioning.

1.2.2 Devon costs of smoking

In Devon it is estimated that smoking related health costs to the NHS alone are approximately £37.5m annually. There are over 5,700 admissions to NHS Devon hospitals each year which are due to smoking. This is estimated to cost the NHS around £15.9 million each year, or £33.40 for every person in Devon aged over 35. Each year, smokers in Devon spend an estimated £205.6m on tobacco related products. The cost of smoking to society in Devon (including smoking related lost productivity, absenteeism, litter cleaning, fires etc.) and the NHS, is estimated to be £191.3m. The cost of smoking related fires can be divided into the response costs to the fire service in dealing with an incident, and the consequential costs, such as cost to insurers and property owners, and the physical, employment and emotional costs of injuries and death.

Figures 5 and 6 below illustrate these statistics and have been taken from the ASH 'Local Costs of Smoking Reckoner'. They are estimates based on national surveys and research. They provide an important and useful signifier of the scale and cost of smoking in Devon. It should be noted that whilst these 'cost of smoking' figures are rough estimates, they do represent a degree of intelligence and knowledge that is difficult to obtain for other 'lifestyle behaviours' and do provide a strong economic argument supporting the commissioning of policies to reduce tobacco use.

[13] 'Building the economic case for tobacco control', available at http://www.brunel.ac.uk/herg/research-programme/building-the-economic-case-for-tobacco-control
[14] Available at www.**ash**.org.uk/**local**toolkit/docs/Reckoner.xls

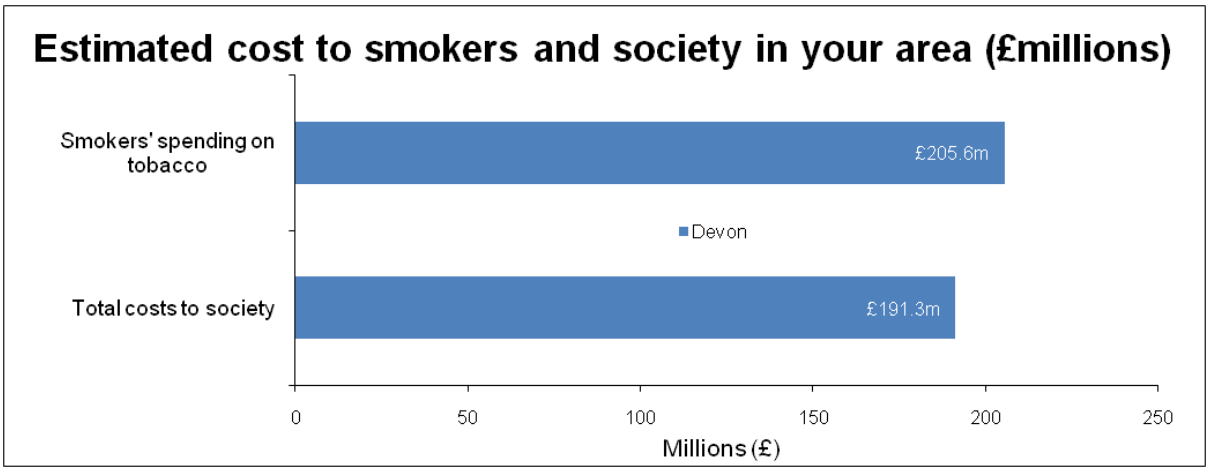

Figure 5: Estimated costs of smoking in Devon 2012

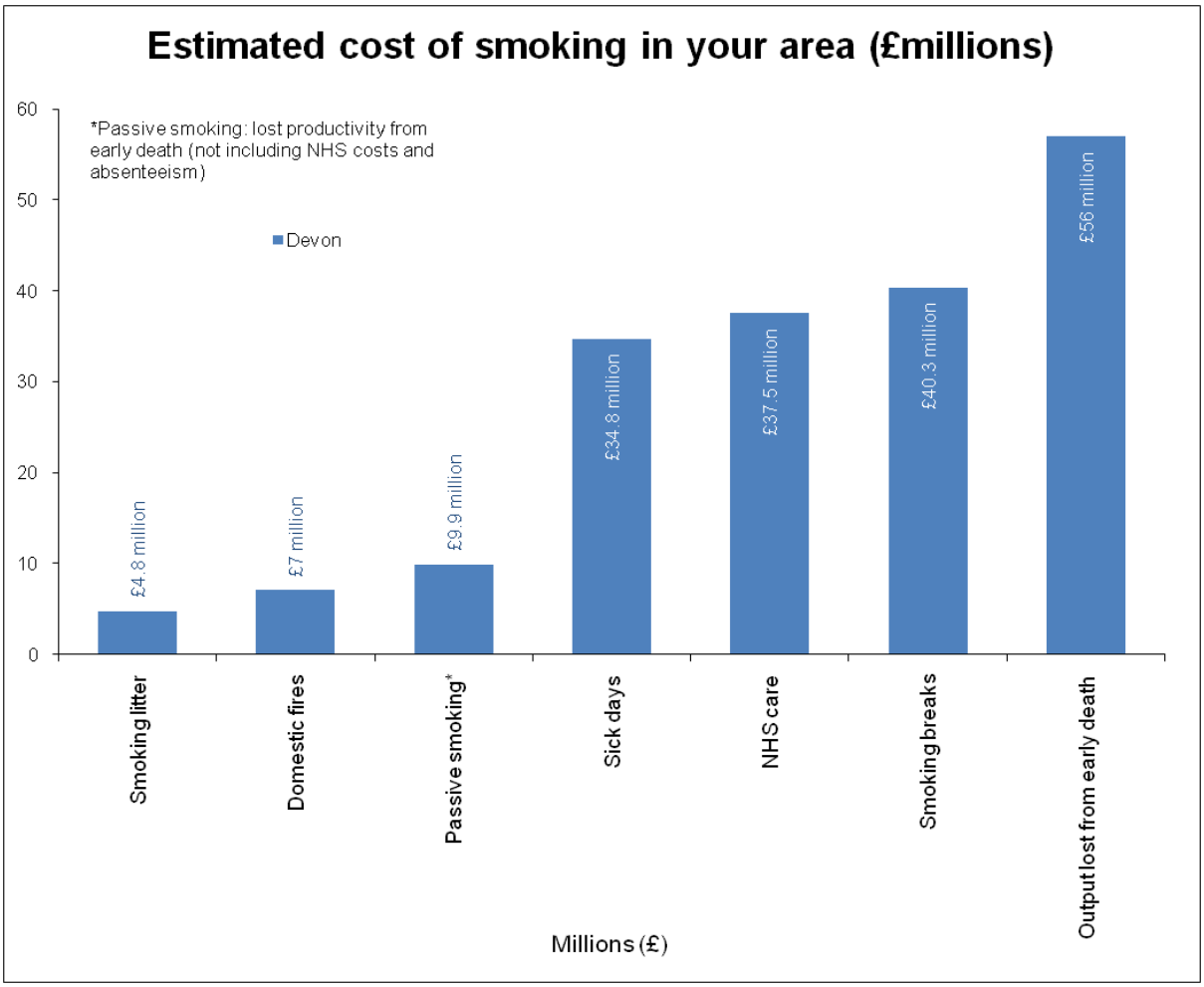

Figure 6: Estimated breakdown of societal costs in Devon 2012
Source: Available at www.**ash**.org.uk/**local**toolkit/docs/Reckoner.xls

Fires

Whilst fatalities in Devon from smoking-related fires are not great in number they are tragic and unnecessary. The costs of fire below are drawn from in the Economic Costs of Fire (CLG, 2006).

Cost of fire death	£1,357,000
Cost of serious injury	£155,000
Cost of slight injury	£12,000

2. The Present Picture
The Prevalence of Smoking in Devon

2.1 Adults

There have been huge strides made in reducing prevalence over the last ten years. A significant impact was made by the Health Act 2006 which introduced a ban on smoking in public places and workplaces in July 2007. The public have been extremely compliant with this legislation and it has prompted quit attempts and helped smokers stay quit. The prevalence of smoking in Devon has fallen from 24.1% in 2007 to 18.1% in 2012 – a significant drop of 1% per year.

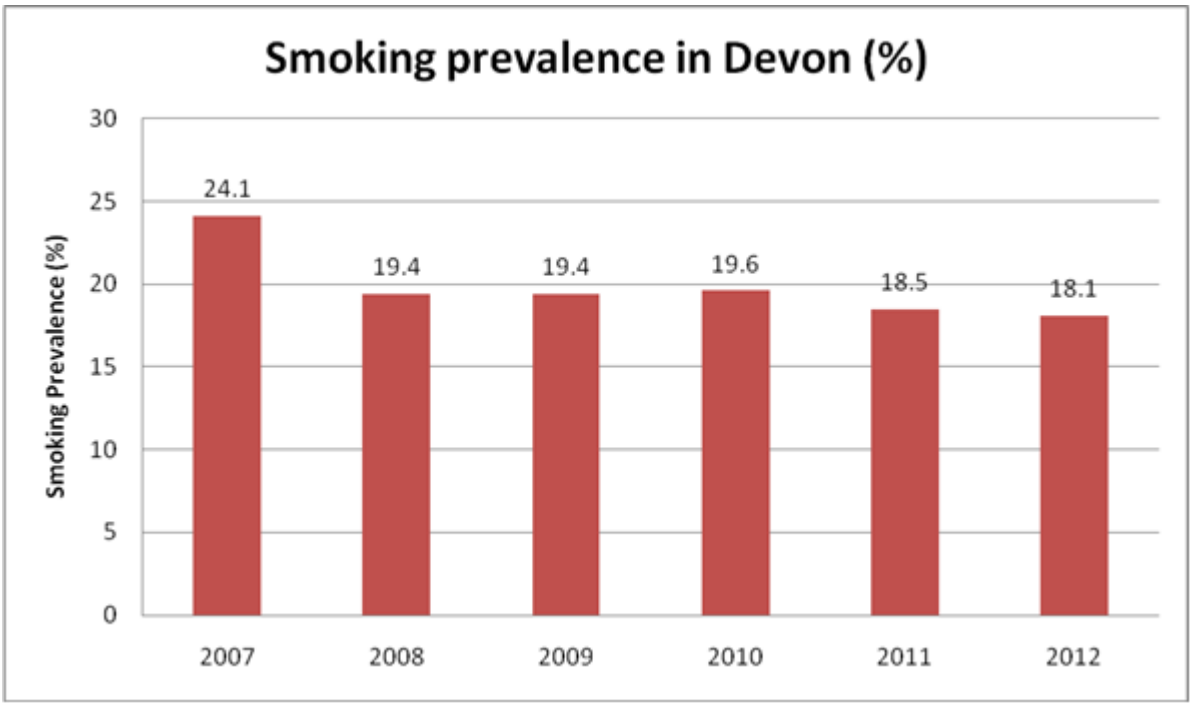

Figure 7: Smoking prevalence in Devon County Council
Source: Health Profiles for England (APHO)2012

Current smoking rates in England are 21% generally and 28% for routine and manual groups (R/M).[15] Across Devon (excluding Plymouth and Torbay), the most recent estimated smoking rate generally is 18.1%.[16] However, there is variation between local authority areas as can be seen in Figure 6 below, with Torridge and Exeter showing the highest smoking rates.

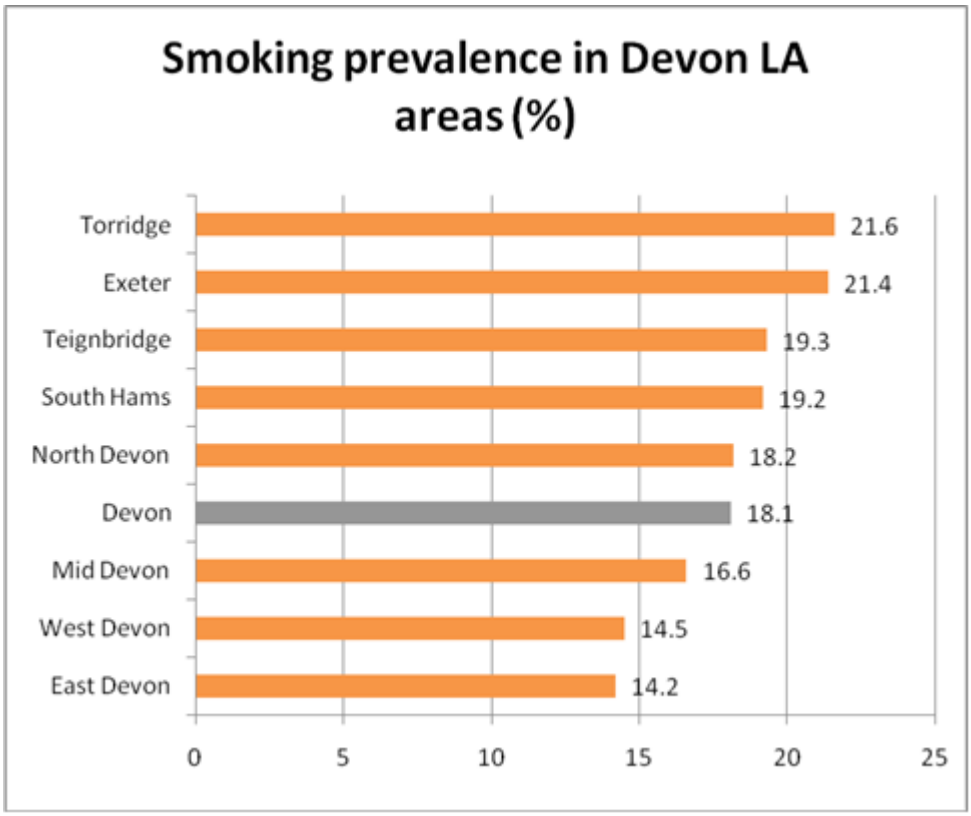

Figure 8: Smoking prevalence in Devon.
Source: Health Profiles 2012

Most smokers are found in the routine and manual occupational groups (figure 9) and stop smoking services have directed their efforts at this group. Smoking is the leading cause of health inequalities as the poorer you are, the more likely you are to smoke. Smokers with mental health problems are heavier and more dependent smokers than those in the general population. For example one study found that 51% of those with schizophrenia and half of those with bipolar affective disorder, smoked more than 20 cigarettes a day compared to only 8% in the general population (ONS, 2002).[17] Life expectancy generally is 5.4 years lower for men and 2.8 years lower for women in the most deprived areas of Devon than in the least deprived areas.[18]

[15] Office for National Statistics. Statistics on Smoking, England 2011.
[16] Health Profiles 2012.
[17] Coultard, M., Farrell, M., Singleton, N. and Meltzer, H. (2000). *Tobacco, alcohol and drug use and mental health.* London: Stationery Office.
[18] APHO Health Profiles 2012.

The Joint Health and Wellbeing Strategy has identified the significant contribution that smoking cessation in certain population groups will make to reducing health inequalities.

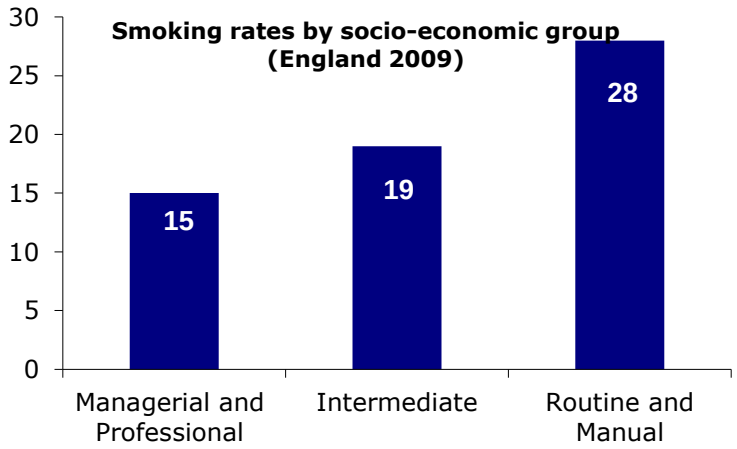

Figure 9: Source: General Lifestyle Survey, ONS 2010

2.2 Prisoners

Devon has three prisons; Exeter, Channings Wood and Dartmoor. The Devon Prisons Health Needs Assessment 2011 shows that the percentage of prisoners that smoke is considerably higher than the prevalence in the general population, with around 70% of prisoners smoking in all three prisons. This is however slightly lower than the expected prevalence of smokers based on Office for National Statistics studies on the general prison population, 1998, which suggests around 80% of prisoners smoke. The prison setting provides an opportunity to target smokers and reduce health inequalities.

2.3 Pregnant women

In 2010/11, 13.7% of women smoked at the time of delivery in England. However, this figure is considered to be underreported. In Devon, the prevalence of smoking in pregnancy is 9.4%.[19] While this figure is lower than the national average, it should be noted that the lowest prevalence in England is as low as 3.1%. Smoking is more common in younger pregnant women.

[19] Health Profiles 2012, Association of Public Health Observatories.

2.4 Young people

It is estimated that each year in England around 340,000 children under the age of 16 who have never smoked before try cigarettes.[20] Every year, around 200,000 children and young people start smoking regularly.[21] Of these 67% start before the age of 18 and 84% by age 19 making smoking a decision of childhood.[22]

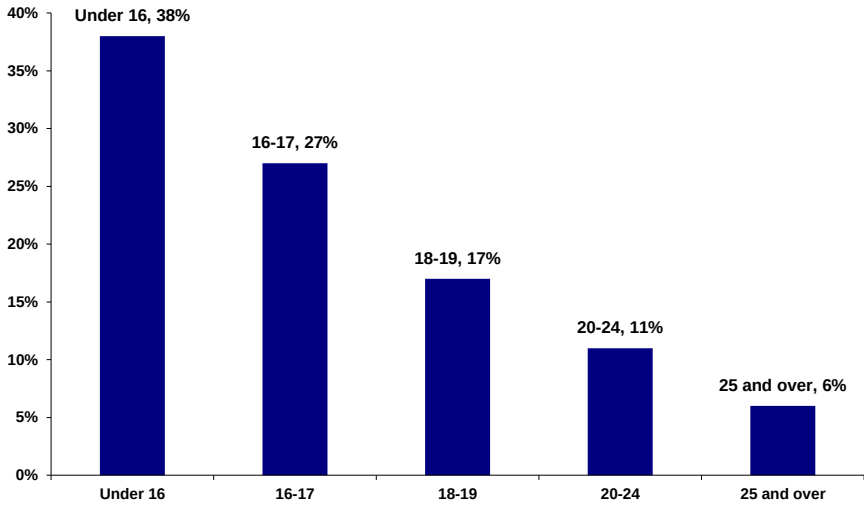

Figure 10: Age of starting smoking (General Lifestyle Survey 2009)

Regular smoking varies by sex and age. Girls are more likely than boys to smoke regularly (6% of girls and 4% of boys). The prevalence of regular smoking increases with age from less than 0.5% of 11 year olds to 12% of 15 year olds. This prevalence continues to increase to even higher rates in the 16-24 year old age group. The onset of smoking is a function of three combined factors: individual, family and community. As an individual factor smoking is considered part of the construction of a young person's self-image.[23] Research has shown that young people perceive smoking to be more common than it is and it is used as a social tool, particularly in transition periods. They also feel that smoking helps people relax and cope with life. If others smoke in the household it increases the likelihood of children taking up smoking.

Regular smoking among 11 to 15 year olds has halved since its peak in the mid 1990s – 13% in 1996. Whilst overall prevalence has been falling since 1996, it has remained static since 2007 and the average consumption of cigarettes in a week by a regular smoker (aged 11-15) is over 38 per week.[24]

[20] Impact Assessments for the Health Bill. Department of Health, January 2009 page 18 para 54.
[21] A Smokefree Future. A comprehensive tobacco control strategy for England. HM Government, 2010 (p10).
[22] Robinson S & Bugler C. Smoking and drinking among adults, General Lifestyle Survey 2008. ONS, 2010.
[23] Public Health Research Consortium, (2009) A Review of Young People and Smoking in England. Final Report. Preface.
[24] Smoking, Drugs and Alcohol Survey 2010.

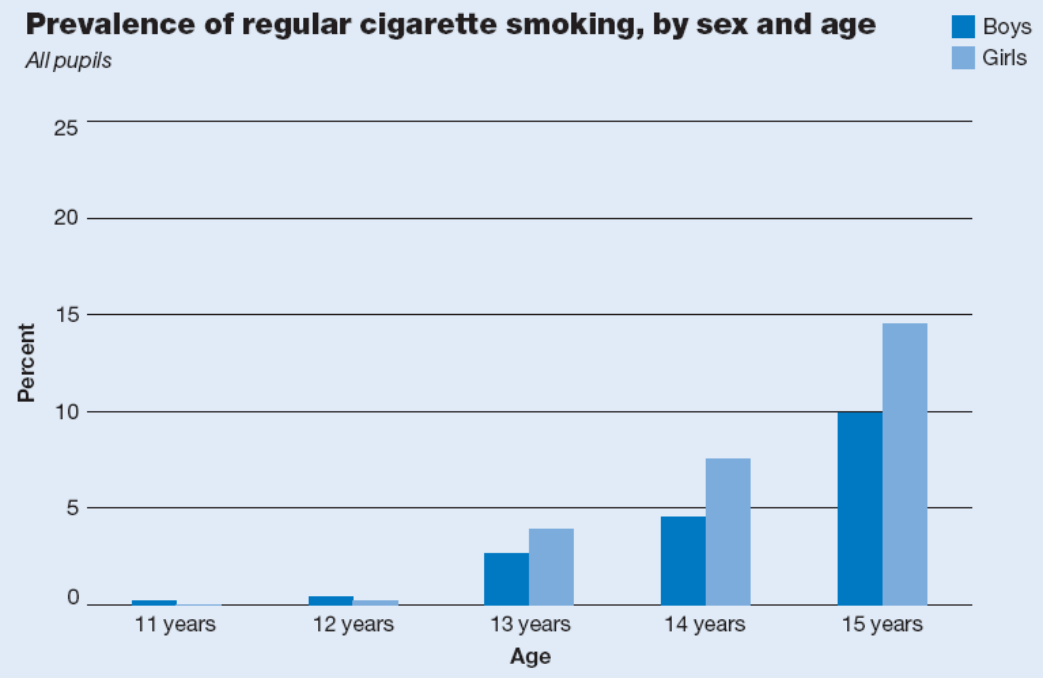

Figure 10: Source: Smoking, Drinking and Drug Use among Young People 2010. The NHS Information Centre 2010

The Devon Public Health Intelligence Team (PHIT) using national data from the "Smoking, Drinking and Drug use Among Young People in England in 2010", and the current difference between national and Devon rates in adults, estimate the prevalence of children currently smoking regularly in Devon aged 15 years old as 10.5%. This means that, in Devon, approximately 1,350 15 year olds are smokers.

3. How is the problem addressed?

3.1 Tobacco control

Tobacco control consists of three key principles that underpin efforts to tackle the tobacco epidemic:–

- a strategic approach to tobacco control
- effective partnership working
- a focus on denormalising smoking.[25]

[25] Excellence in tobacco control: 10 High Impact Changes to achieve tobacco control. Department of Health 2008.

Excellent progress has been made in reducing smoking prevalence through legislation on smoking in public places and strengthening regulations on the sale of tobacco. However, the Irish experience shows that such measures only have a short term impact and prevalence can return to pre-legislation levels without sustained action. Moreover, it should be noted that whilst we have seen reductions in tobacco use among the general population, slower progress has been made in reducing tobacco use among routine and manual groups and deprived populations.

Without further action to control tobacco use, the prevalence of smoking is likely to remain similar to what it is now. Smoking related inequalities in health would also persist and could even worsen. The Marmot Review made a strong case for prioritising upstream, preventative approaches to tackle health inequalities. One of its six policy objectives is to directly address health behaviours by strengthening the role and impact of ill health prevention.

As the reasons behind smoking are diverse, it is generally accepted that no single approach to tackling smoking will be successful. Concerted, sustained, and co-ordinated action on a number of issues by a wide range of agencies and individuals is required. Tobacco Alliances have a major role to play here as they co-ordinate a multi-faceted response.

Tobacco control activity is guided by the Department of Health's six strand approach developed by the World Bank. These six strands are:-

- supporting smokers to quit
- reducing exposure to secondhand smoke
- running effective communications and education campaigns
- reducing tobacco advertising, marketing and promotion
- regulating tobacco products
- reducing the availability and supply of tobacco products.

Some actions can only be taken at a national level but there is much to be done at the local level and this is recognised in Healthy Lives, Healthy People: A Tobacco Plan for England (2011). The plan sets out three ambitions which are:-

- to reduce smoking prevalence among adults to 18.5% or less (from 21.2%) by the end of 2015
- to reduce smoking prevalence among 15 year olds to 12% or less (from 15%) by the end of 2015
- to reduce smoking during pregnancy to 11% or less (from 14%) by the end of 2015.

Andrew Lansley, then Secretary of State for Health, in his introduction, states:-

> "The Government recognises that tobacco control forms a crucial component of our efforts to improve public health, and everyone has a role to play. My ambition is for national and local government to work in close collaboration with civil society, with public and private sector organisations and with communities to implement effective tobacco control and reduce the prevalence of smoking."

It recognises the value of collective commissioning arrangements, particularly around communications and illegal tobacco.

The Public Health Outcomes Framework for England, 2013-16 has two outcomes:-

- Increased healthy life expectancy
- Reduce differences in life expectancy and healthy life expectancy between communities.

Tobacco control is a key element in achieving both these outcomes. Specifically, the framework will measure smoking prevalence of adults, 15 year olds and pregnant women. Other indicators that smoking can influence are low birth weight in babies, infant mortality, mortality from cardiovascular, respiratory disease and cancer, sickness absence and hospital readmissions within 30 days of discharge.

Tobacco control work in Devon has a strong evidence base and a performance framework including the three main public health indicators above will be reported to the Health & Wellbeing Board as part of its implementation of the Joint Health & Wellbeing Strategy for 2013-16. This will track the trajectory for reduced prevalence and the inequality gap between the least and most deprived areas in Devon.

4. Modelling the future

4.1 The Pipe Model

The Alliance has recently modelled potential outcomes using The Smoking Pipe Model: A model of the inflow and outflow of smokers (West R).[26] It models numbers joining the smoking 'pool' (young people, immigration) and those leaving the 'pool' (deaths, quitters, emigration). This model can be used to estimate future outcomes.

Figure 11 below shows the number of incoming Devon smokers to the pool and highlights the significance of young people taking up smoking.

[26] Available at www.smokinginengland.info.

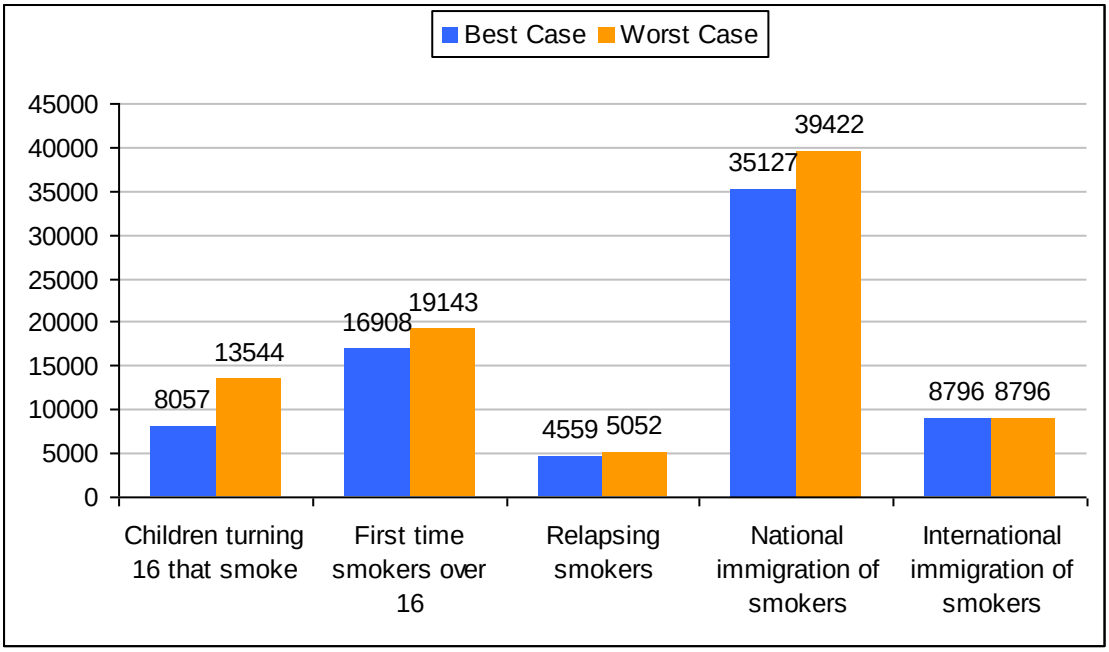

Figure 11: Sources of new smokers to the 16+ population of Devon – between 2010 and 2016 (7 year period)

Figure 12 below shows the number of Devon smokers leaving the pool and highlights the importance of successful stop smoking service provision.

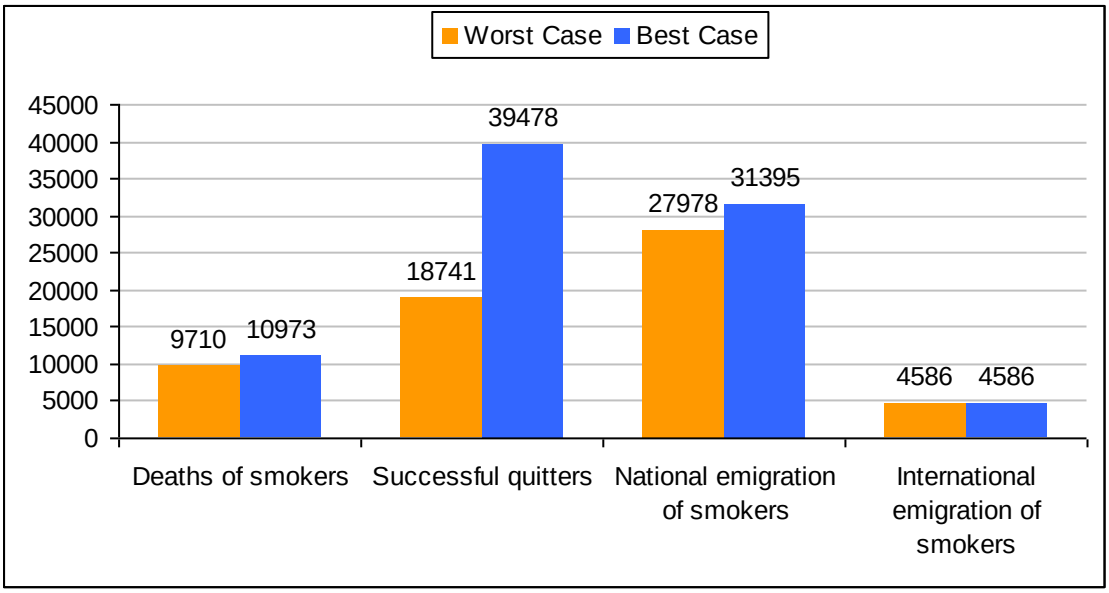

Figure 12: Reductions to smokers in the 16+ population of Devon – between 2010 and 2016 (7 year period)

Figure 13 shows a worrying trend of smokers becoming less inclined to quit smoking as time goes on. The Smoking in England Toolkit Survey was updated in April 2012 and states that success in quitting is higher in older smokers, lighter smokers and in

non-routine and manual populations.[27] This would indicate that the smoking population is becoming a group of more dependent smokers located in more deprived communities. These smokers find it harder to quit and often require more intense support.

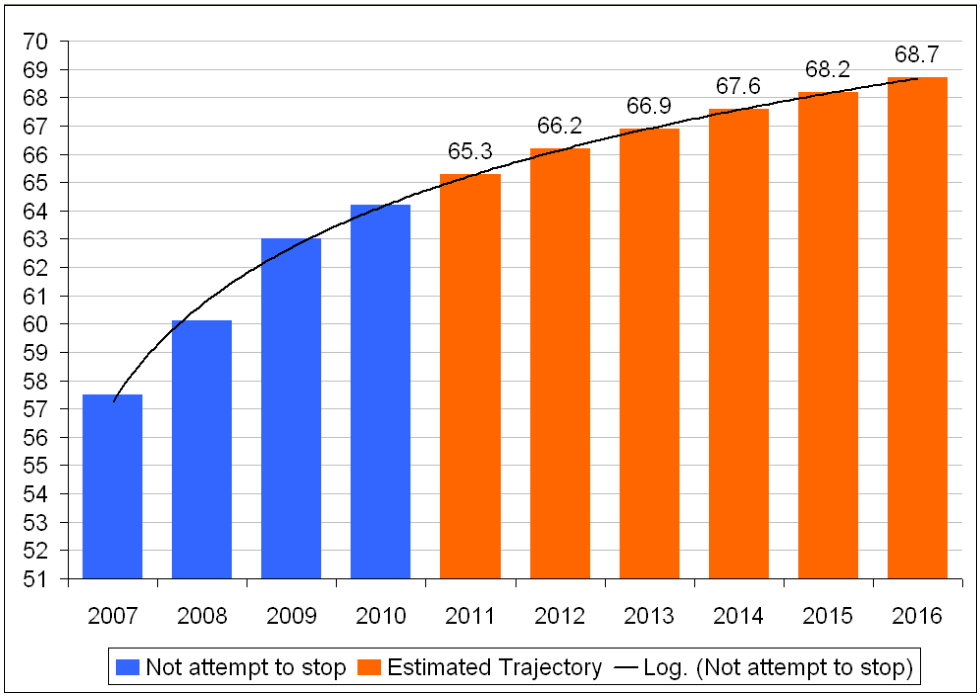

Figure 13: Modelled trajectory of smokers not attempting to quit in Devon 2007 – 2016 (from The Smoking Pipe Model: A model of the inflow and outflow of smokers. R West)

More information on the Pipe Model is available on the Devon Joint Strategic Needs Assessment website topic page on smoking.[28] The move of Public Health into local authorities in 2013 gives a new and growing role for tobacco control. There are new opportunities to strengthen and build on partnership work, particularly around age of sale activities, smokefree environments, smuggled and counterfeit tobacco and commissioning stop smoking services.

[27] West R, Brown J (2012) Smoking and Smoking Cessation in England 2011. London. www.smokinginengland.info) updated April 2012.
[28] Available at www.devonhealthandwellbeing.org.uk.

SECTION 2

5. The Strategy

5.1 Vision

Our vision is that by the end of 2015 smoking prevalence for the adult population of Devon will be 15%. This means achieving a fall in smoking prevalence of 1% per year.

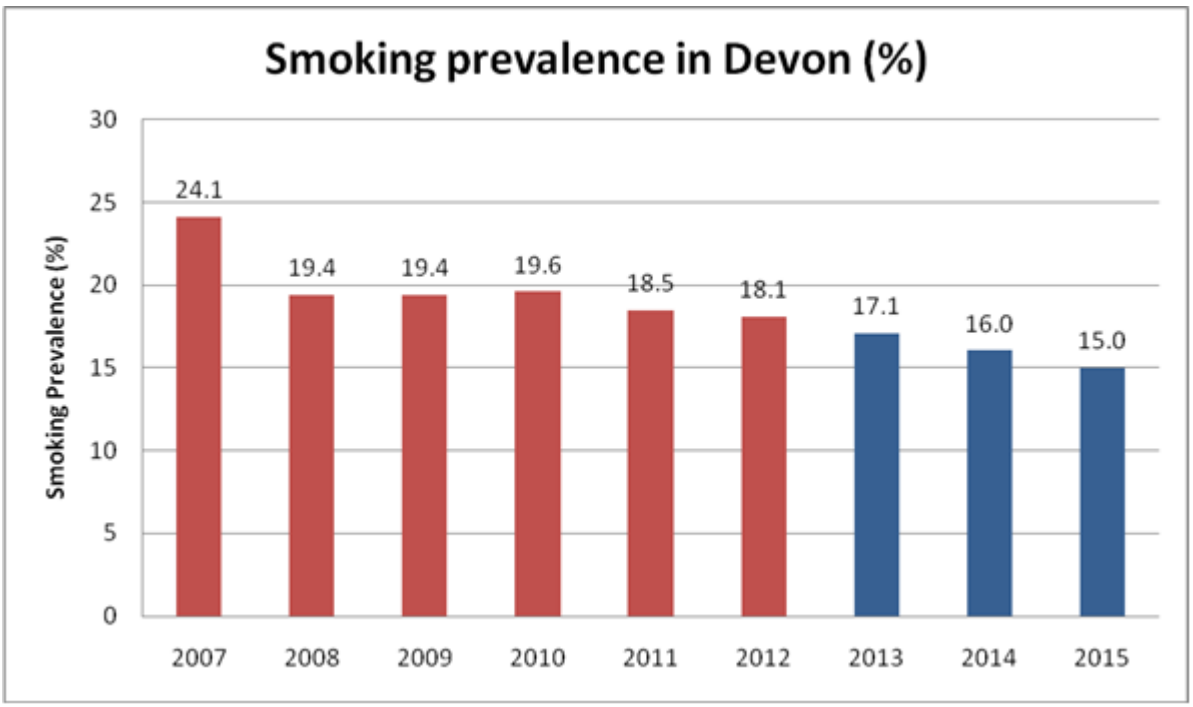

Figure 14: Projected decline in smoking prevalence in Devon

5.2 Aims

The aims of this tobacco control strategy are as follows:

- To improve the health of the population of Devon by reducing the smoking prevalence rate and exposure to secondhand smoke
- To reduce health inequalities in Devon in the longer term by reducing the number of smoking-related illnesses suffered by the population.

We have identified seven priorities for tobacco control in Devon:

1. Reduce health inequalities caused by smoking
2. Reduce illegal tobacco in the community

3. Protect children and young people from smoking
4. Reduce smoking in pregnancy
5. Normalise a smokefree lifestyle
6. Support smokers to quit
7. Carry out marketing and communication programmes.

5.4 PRIORITIES

5.4.1 PRIORITY 1
Reduce health inequalities caused by smoking

Objective: Reduce the number of people that smoke by at least 1% a year

Stopping smoking is the strongest action we can take to improve the health of our population. The Marmot Review, Fair Society, Healthy Lives: A Strategic Review of Health Inequalities in England Post-2010 (2010) identifies strengthening the role and impact of ill-health prevention as one of its six policy objectives. The review stressed that tackling health inequalities was a matter of social justice, with real economic benefits and savings. The review recognises that the losses from illness associated with health inequalities account for productivity losses including reduced tax revenue, higher welfare payments and increased treatment costs. It recommends action across the social gradient of health – not just on the health of the most disadvantaged – across the social determinants of health.

For tobacco control work, this means efforts need to be targeted towards helping smokers from routine and manual groups as they make up the largest group of smokers. Ultimately by reducing smoking rates in this group we are likely to make the biggest difference to our overall smoking cessation rates.[29] Stop smoking services should also target very deprived smokers, but the biggest gains are to be made in the routine and manual population. The Alliance has developed profiles of where these populations live and how they are influenced.[30]

Reducing smoking rates in disadvantaged groups and areas is a critical factor in reducing the health inequalities gap as evidence suggests that tobacco use is the

[29] Tackling Health Inequalities, Targeting routine and manual smokers in support of the PSA smoking prevalence and health inequality targets. Department of Health 2009.
[30] Available online at www.devonpct.nhs.uk/Smokefree_Devon_Alliance/Smokefree_Devon_Alliance_Information.aspx

primary reason for the gap in healthy life expectancy between rich and poor.[31] 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[32] [33].
The availability of illegal tobacco makes tobacco more affordable. The Alliance supports strengthening resources and partnership working to tackle illegal tobacco in our community.

The Alliance recognises that higher taxation on tobacco is an effective tobacco control measure. However, it can increase poverty for those who buy legal cigarettes and are very addicted with limited incomes. The Alliance supports exploring other options to support these members of the community for example financial advice, tobacco harm reduction programmes, and more intensive stop smoking support.

The Alliance recognises that smoking prevalence is very high in vulnerable groups such as drug and alcohol users, mental health and offender institutions. The Marmot Review recommends effective participatory decision making at a local level by empowering individuals and communities. The Alliance will use all opportunities to take this approach.

Key areas of work in this priority include:-

- Identifying areas of routine and manual (R/M) workers and high deprivation to ensure local stop smoking services are provided in the right place and targeting community work in these areas.
- Strong engagement with mental health services. High smoking prevalence exists in mental health settings and smokers in this category are sometimes neglected in mainstream services. Evidence indicates that mental health services users wish to and can quit, given adequate support.
- Strong engagement with prisons. The Devon Prisons Health Needs Assessment 2012 has identified that around 70% of prisoners smoke.[34]
- Promoting smokefree places so that tobacco is further denormalised (see Priority 5).
- Targeting geographical areas of high smoking prevalence through community partnerships.
- Ensuring that tobacco control objectives are included in a wide range of strategies and commissioning arrangements.

5.4.2 PRIORITY 2
Reduce illegal tobacco in the community

Objective: Reduce the supply of and demand for illegal tobacco

[31] Department of Health (2009). Health Profile for England 2008.
[32] Jarvis M J and Wardle J (2006). Social patterning of individual health behaviours: the case of cigarette smoking. In Marmot M and Wilkinson RG (eds). Social Determinants of Health. Second Edition. Oxford University Press, pp 224-37.
[33] Kotz D and West R (2009). Exploring the social gradient in smoking cessation: it's not in the trying, but in the succeeding. Tobacco Control 18: 43-6
[34] http://www.devonhealthandwellbeing.org.uk/library/health-needs-assessments/

Cheap illegal tobacco undercuts the national taxation policy and is linked to funding serious, organised crime such as human trafficking and drugs. Working together in partnership will be our most effective way of tackling this problem. Illegal tobacco is more accessible in areas of deprivation and supports the cycle of ill health and poverty. Central to the Alliance objectives is to reduce availability of this kind of tobacco in our communities.

The Alliance commits to working together and providing the public with safe means to share information with the authorities about the availability of illegal tobacco and is committed to working in partnership to make a difference in this area. Key partners that work in this field include HMRC, Trading Standards, Devon & Cornwall Police, community safety partnerships, health practitioners, the local stop smoking service, the local community, local business, Devon & Somerset Fire and Rescue and Environmental Health. Together they can commit a solid approach to tackling this issue. Key to the partnership will be creating local intelligence and a full range of information about illegal activity and its effect on the community. The Alliance will also enable agencies to be clear about our communication with the public through effective and consistent messages to be shared across the whole Alliance.

This is a key area for SWERCOTS (South West trading standards partnership) activity which for this priority is based around:-

- Detection and disruption of illegal/counterfeit tobacco products
- Niche products (e.g. snuff, e-cigarettes)
- Monitoring the display of products at point of sale.

From November 2011 all cigarettes sold throughout the EU must conform to 'reduced ignition propensity' standards, which should help to reduce the risk. This is another reason to make illegal tobacco a priority, as illegal tobacco is less likely to conform to the new standards and is therefore more likely to cause fires.

5.4.3 PRIORITY 3
Protect children and young people from smoking

Objectives:

- **Reduce the number of young people smoking to below that of the national average**
- **Reduce the number of underage sales of tobacco to children and young people**
- **Reduce the number of homes where children are exposed to secondhand smoke**

The Alliance recognises that starting to smoke is a decision of childhood as 84% of smokers start before the age of 19 years. The Alliance supports initiatives to help stop children and young people from starting to smoke and to find ways to help them stop as soon as possible if they have started. Starting young can lead to a lifetime of tobacco addiction and a three times increased likelihood of dying young due to their smoking behaviour. Millions of children and young people are exposed to tobacco smoke in homes and cars every day.

The Alliance supports government action to tackle this agenda. The Alliance will explore initiatives to improve knowledge and understanding about this issue locally. Empowering children to make an informed choice will be central to the approach. The Alliance especially supports encouraging the young to be advocates on this subject, and will pursue local initiatives to support our children and young people to be involved.

Smokefree homes and cars are messages needed in our community to protect children, young people and babies and infants. Gold standard school smokefree policies promote a smokefree lifestyle for children and their families.

There is little evidence to support smoking cessation initiatives amongst young people and it is agreed that prevention strategies are more successful. Efforts to stop children taking up smoking are less effective for children living in a smoking environment. Therefore reducing adult prevalence has a direct effect on children. However, there are a limited number of evidence-based prevention interventions to draw on and these are cited in NICE Guidance PH23: School-based interventions to prevent the uptake of smoking among children.

The Alliance wishes to engage the voices of young people in shaping and taking forward the strategy and notes there is a lack of local information on smoking prevalence of young people.

The Alliance supports the Plain Packs Protect national campaign.[35]

This is a key area for SWERCOTS (SW Trading Standards Partnership) activity which, for this priority, is based around:-

- Test purchasing activity
- No proof of age, no sale.

Other interventions include 'whole school approaches' and peer-led prevention programmes in schools, such as the Assist programme.

5.4.4 PRIORITY 4
Reduce smoking in pregnancy

Objective: Reduce the number of pregnant women smoking

[35] www.plainpacksprotect.co.uk.

As stated in section 1, smoking in pregnancy can cause increased risk of miscarriage, stillbirth, preterm birth and low birth weight.[36] It has been found to increase infant mortality by about 40% and is 1.5 times higher in women in the manual workers group than the population as a whole.[37] It is nearly three times higher among mothers aged under 20 compared with rates for all pregnant women.[38]

Key areas for development to reduce inequalities around smoking in pregnancy are as follows:-

- Accurate data capture mechanisms to record smoking prevalence at delivery must be in place. Current data capture systems should be assessed and improved where needed.

- Training programmes around brief intervention need to be developed and steered through strategic groups so that all midwives can carry out brief interventions with all pregnant smokers.

- Systems to record and performance monitor the proportion of pregnant smokers that have been offered smoking cessation advice (brief intervention) need to be developed to ensure evidence of effectiveness.

- Maternity services should work towards achieving compliance with NICE guidance.

- All professionals coming into contact with pregnant women that smoke should use that opportunity to give brief advice and refer to stop smoking services.

5.4.5 PRIORITY 5
Normalise a smokefree lifestyle

Objective:
Increase the number of smokefree places and promote why and how to quit smoking

Smokefree legislation has made public places smokefree. It is important that the public sector leads by example, displaying to others the best of policy and implementation of policy. The Alliance fully supports the smokefree message in the NHS and other public sector areas. The Alliance understands the irony of allowing smoking in areas, especially health associated environments, when it is known to do so much harm to health and cause so many illnesses. The Alliance is working towards all NHS acute trusts in Devon implementing a gold standard 'whole

[36] Board of Science and Education. Smoking and reproductive life. The impact of smoking on sexual, reproductive and child health.
[37] Levels of excess infant deaths attributable to maternal smoking during pregnancy in the United States. Salihu HM, Aliyu MH, Pierre-Louis BJ, Alexander GR, 2003.
[38] http://www.nottinghamshire.gov.uk/smoking_in_pregnancy.doc [accessed 27.5.10]

organisation' smokefree policy, supported with systems such as referrals to stop smoking and availability of nicotine replacement therapy. It will also support extending this approach to other organisations such as children's centres and housing associations. It will promote the smokefree agenda to district councils and continue to lobby for further national smokefree regulations.

Key areas of work that progress this priority are:-

- smokefree homes
- smokefree cars
- smokefree leisure site areas e.g., playparks, beaches, local tourist attractions
- widening the scope of workplace smokefree policies to include whole-site bans and a whole organisation approach.

5.4.6 PRIORITY 6
Support smokers to quit

Objective: Increase the number of smokers using the local stop smoking services

The Alliance strongly supports the work of the local NHS Stop Smoking Service and the help they can give to people wanting to stop smoking. It recognises that nationally less than 6% of the smoking population access NHS stop smoking services. Quitters using NHS services are four times more likely to succeed than without support. No other method of quitting can match this success rate. Moreover, stop smoking services offer value for money. The All Party Parliamentary Group on Smoking and Health (2010) concluded that commissioning of stop smoking services should be a priority.

The Alliance seeks to support the success of the stop smoking service in the following key areas:

- Ensuring that promotion of referral to smoking cessation is included in a wide range of strategies and commissioning arrangements.
- Developing a robust and systematic smoking cessation referral system at acute trusts.
- Introducing referral mechanisms in a wide number of organisations.
- Providing brief intervention training opportunities across a wide audience including health organisations, voluntary sector and service provider organisations.

5.4.7 PRIORITY 7
Carry out marketing and communication programmes

Objective: Raise the profile of smoking and its dangers so every smoker understands the dangers of smoking and secondhand smoke and also knows how to access the local NHS stop smoking service

The Alliance seeks to take advantage of government campaigns and developments led by Smokefree South West. Locally all initiatives will follow these themes. This will create a consistent, coherent and coordinated communications strategy. Research undertaken and campaigns run by Smokefree South West will help develop local campaign work.

The Alliance has developed a communications strategy to support its work.

Key areas of work for this priority are:-

- Promoting stop smoking attempts according to national and regional branded campaigns
- Promoting the dangers of secondhand smoke
- Using all partners and a social marketing approach to communicate the key messages in the strategy to their stakeholders and members around smokefree policies, secondhand smoke and smokefree environments
- Using all partners to promote the NHS stop smoking support available in Devon
- Reaching the routine and manual population through effective communications.

SECTION 3

6 Accountability

The Smokefree Devon Alliance Steering Group will meet at least every four months.

The Steering Group has a reporting link to Health and Wellbeing Board where performance indicators are tracked on adult smoking prevalence and smoking in pregnancy.

Conclusion

The implementation of the Smokefree Devon Alliance Strategy is vital to improving the health and economics of Devon. Action needs to be undertaken on a range of fronts, not only by large or public organisations but by smaller agencies, communities and individuals working in partnership to deliver concerted and co-ordinated action on tobacco. This strategy does not stand alone but is integral to other county and district strategies. It is a key contributor to Devon's Health and Wellbeing Strategy. Devon has made significant progress in tobacco control but must continue to take sustained and comprehensive action to ensure that tobacco is less attractive, less available and less accessible.

APPENDIX 1

Partners for local tobacco control activity

The Tobacco Control National Support Team High Impact Changes document highlights the importance of effective partnerships. These are some of the agencies, groups and individuals that could provide support to this agenda:

- Health promotion units
- Health and Safety representatives from the Local Authority
- Health professionals
- Respiratory specialists
- Cancer specialists
- Midwives – both hospital and community based
- Health visitors
- Pharmacists
- School nurses
- Dentists
- Local Authority Public Health Department
- Trading Standards
- Environmental Health Officers
- HM Revenue and Customs
- Council members
- Leisure and Children's Services
- Council housing and planning departments
- Council community health and social care departments
- Education Department at County Council
- Individual city councillors
- Business leaders
- Chamber of Commerce
- Small business associations
- Hospitality sector representatives
- Lawyers
- Economists
- Business Link
- TUC/individual unions
- Schools and further education colleges
- Healthy School schemes
- Sure Start
- Teachers
- Students
- Parents' organisations
- Youth clubs
- The media
- Non-governmental organisations
- Women's and children's groups
- Environmental groups
- Consumer organisations
- Regional Tobacco Policy Managers
- Department of Health
- Children's Centres

APPENDIX 2

MEMBERSHIP OF THE SMOKEFREE DEVON ALLIANCE STEERING GROUP (As at March 2013)

Name	Organisation	Representing
Dr Phil Norrey (Chair)	Chief Executive Devon County Council	Devon County Council
Dr Virginia Pearson (Vice Chair)	Director of Public Health Devon County Council	Devon County Council
Lesley Thomas (Co-ordinator)	Tobacco Control Manager	Alliance
Jon Ellwood	Trading Standards Officer Devon County Council	Trading Standards
Bob Sturtivant	Devon & Somerset Fire & Rescue Service	Fire Service
Greg Ward	IDTS Project Manager Exeter Prison	Prison Service
John Calvert	Service & Development Manager Devon County Council	Youth service
Bob Gaiger	Media Relations Manager	Her Majesty's Customs & Excise
Lynne Jeary	Modern Matron Devon Partnership Trust	Mental Health Services
Nicola Glassbrook	Health Inequalities Programme Manager Devon County Council	Devon County Council
Paul Nicholls	Environment and Safety Service Teignbridge District Council	Environmental Health
Colin Flanagan	Lead in Oral Health Promotion Northern Devon Healthcare Trust	Oral Health Services
Tania Skinner	Childrens Centre Advisor, South and West Locality	Early Years & Childcare Service
Greg Price	Stop Smoking Service Manager Northern Devon Healthcare Trust	Stop Smoking Service
Tina Henry	Health Improvement Lead Devon County Council	Health improvement/health inequalities
Mike Slot	GP Sid Valley Medical Practice	GPs
Sam Hill	Marketing & Communications Manager Devon County Council	Local communications
Dr David Halpin	Consultant, Respiratory Medicine Royal Devon & Exeter Hospital	Secondary Care
Sarah Bird	Tobacco Control Project Officer Devon County Council	Devon County Council
Melissa Cullum	Campaigns & Communications Manager Smokefree South West	Smokefree South West, regional communications