HM Government

Healthy Lives, Healthy People:

A Tobacco Control Plan for England

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FOREWORD

The Public Health White Paper *Healthy Lives, Healthy People: Our strategy for public health in England* sets out the Government's long-term vision for improving public health in England. The White Paper recognises the devastating impact that tobacco use has on public health in our communities and it sets out a commitment to publish this Tobacco Control Plan in order to maximise our efforts to reduce tobacco use.

Smoking is harmful not only to smokers but also to the people around them. Smoking rates have fallen considerably since the 1960s but over 8 million people in England still smoke. The decline in smoking rates in England has lost momentum in recent years.

The plan builds on the achievements in tobacco control policy made over many decades and sets out a comprehensive package of evidence-based action that will be implemented at national level to support local areas in driving down rates of tobacco use. We also set out how we will continue our work to reshape social norms around tobacco use to promote health and wellbeing. The plan includes national ambitions to reduce smoking prevalence among adults and young people, and to reduce smoking during pregnancy.

Smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Consequently, tackling tobacco use is central to realising the Government's commitment to improve the health of the poorest, fastest.

This Tobacco Control Plan sets out what the Government will do to support efforts to reduce tobacco use over the next five years, within the context of the new public health system. It aims to promote comprehensive and evidence-based tobacco control in local communities. The plan is built around the six strands of comprehensive tobacco control that are recognised internationally.

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.

Andrew Lansley CBE
Secretary of State for Health

EXECUTIVE SUMMARY

Tobacco use remains one of our most significant public health challenges. While rates of smoking have continued to decline over the past decades, around 21 per cent of adults in England still smoke. Smoking prevalence has fallen little since 2007 and we need to take new action to drive smoking rates down further.

Smoking is the primary cause of preventable morbidity and premature death, accounting for 81,400 deaths in England in 2009. In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).

Smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. Consequently, tackling tobacco use is central to realising the Government's commitment to improve the health of the poorest, fastest.

Treating smoking-related illnesses was estimated to have cost the NHS £2.7 billion in 2006/07, or over £50 million every week. In 2008/09, some 463,000 hospital admissions in England among adults aged 35 and over were attributable to smoking, or some 5 per cent of all hospital admissions for this age group. Clearly, the costs of tobacco use are much greater than just costs to the NHS, and the overall economic burden of tobacco use to society is estimated at £13.74 billion a year.

The Government is committed to improving public health in communities across England. The proposals set out in the White Paper *Healthy Lives, Healthy People* show that this is a new era for public health. It will have higher priority and dedicated resources. A radical new approach for delivering public health will empower local communities and provide professionals with greater freedom to focus on the needs of local populations.

This Tobacco Control Plan shows how tobacco control will be delivered in the context of this new public health system, focusing in particular on the action that the Government will take nationally to drive down the prevalence of smoking and to support comprehensive tobacco control in local areas. There is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local level.

We recognise that while nicotine keeps tobacco users physically dependent, there are a wide range of social and behavioural factors that encourage young people to take up smoking and that make it harder for tobacco users to quit. The Government's approach to improving public health includes tackling the wider

social determinants of health and it aims to build people's self-esteem, confidence and resilience, right from infancy. To promote health and wellbeing, we will work to encourage communities across England to reshape social norms, so that tobacco becomes less desirable, less acceptable and less accessible. We want all communities to see a tobacco-free world as the norm and we aim to stop the perpetuation of smoking from one generation to the next. To reduce smoking uptake by young people, we all need to influence the adult world in which they grow up. We must also remove the considerable social barriers that smokers face when they are trying to quit.

Under the leadership of local authorities, we want to encourage the development of partnerships in tobacco control where anyone who can make a contribution is encouraged to get involved. In implementing comprehensive tobacco control in their communities, we encourage local authorities to maximise local involvement by building tobacco control alliances that include civil society.

While the Public Health Outcomes Framework will provide the key source of information about our progress on reducing tobacco use, the Government is setting three national ambitions to focus tobacco control work across the whole system:

- **Reduce smoking prevalence among adults in England:** To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015, meaning around 210,000 fewer smokers a year.

- **Reduce smoking prevalence among young people in England:** To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015.

- **Reduce smoking during pregnancy in England:** To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).

These national ambitions will not translate into centrally driven targets for local authorities. Rather, they represent an assessment of what could be delivered as a result of the national actions described in this plan, together with local areas implementing evidence-based best practice for comprehensive tobacco control. The new approach to public health delivery in England means that local areas will decide on their own priorities and ways of improving health in their communities, in line with the evidence base and local circumstances.

Through this plan, the Government supports comprehensive tobacco control in England across the six internationally recognised strands, which are:

- stopping the promotion of tobacco;

- making tobacco less affordable;

- effective regulation of tobacco products;

- helping tobacco users to quit;

- reducing exposure to secondhand smoke; and

- effective communications for tobacco control.

This Tobacco Control Plan sets out the key actions under each strand that the Government will take in order to support efforts to reduce tobacco use over the next five years, within the context of the new public health system. These key actions are highlighted at the start of each chapter. The work we will undertake to maximise the use of information and intelligence to support comprehensive tobacco control, as well as the actions we will take to protect tobacco control from vested interests, is also set out.

1. A RADICAL NEW APPROACH FOR PUBLIC HEALTH

1.1 The Government is committed to improving public health in communities across England. The proposals set out in the White Paper *Healthy Lives, Healthy People* show that this is a new era for public health. It will have higher priority and dedicated resources. A radical new approach for delivering public health will empower local communities and provide professionals with greater freedom to focus on the needs of local populations. This Tobacco Control Plan shows how tobacco control will be delivered in the context of this new public health system, focusing in particular on the action that the Government will take nationally to drive down the prevalence of smoking, and to support comprehensive tobacco control in local areas.

1.2 The new Public Health Outcomes Framework will set the direction for public health. While not a tool for performance management, this new framework will promote accountability at all levels of the public health system and help to promote better joint working where local organisations share common goals. The framework will provide a consistent means of presenting the data so that we can measure the progress that is being made to improve health at both national and local levels.

1.3 Localism will be at the heart of the new public health system, with responsibilities and funding for public health devolved to local level. Ring-fenced funding for public health, drawn from the overall NHS budget, will go to upper-tier and unitary local authorities. These resources will be used to support local comprehensive tobacco control activity, as well as other public health activities, according to local need. A new health premium will reward progress made locally against elements of the proposed Public Health Outcomes Framework, including reductions in health inequalities.

1.4 Directors of Public Health will be the strategic leaders for public health and health inequalities in local communities, working in partnership with the local NHS and across the public, private and voluntary sectors. In the new system, improving public health will be the responsibility of local authorities, with action being taken at national level only where there is a clear rationale for this to support the work of local areas.

1.5 The NHS will continue to play a key role in health improvement. Public health will be part of the NHS Commissioning Board's mandate. There will be stronger incentives for GPs to play an active role in improving public health.

1.6   The Department of Health will put forward detailed proposals for the establishment of statutory health and wellbeing boards in every upper-tier local authority. These boards will also have the flexibility to bring in the local expertise of district councils. GP consortia and local authorities, including Directors of Public Health, will have an obligation to prepare the Joint Strategic Needs Assessment (JSNA) through arrangements made by the health and wellbeing board.

1.7   We envisage that health and wellbeing boards will develop joint health and wellbeing strategies, based on the assessment of need outlined in their JSNA, and include a consideration of how all the relevant commissioners can work together. It is expected that this local, joint health and wellbeing strategy will provide the overarching framework within which more detailed and specific commissioning plans for the NHS, social care, public health, and other services that the health and wellbeing board agrees to consider, are developed. Given the impact of tobacco use on health, it is likely that comprehensive tobacco control will be a feature of local health and wellbeing strategies.

1.8   There is already an extensive evidence base on effective tobacco control measures, which continues to develop. The Department of Health will encourage local areas to make use of evidence, especially to support behaviour change. A new National Institute for Health Research School for Public Health Research and a Policy Research Unit on Behaviour and Health will also be created.

1.9   Public health guidance published by the National Institute for Health and Clinical Excellence (NICE) will also assist local areas to take an evidence-based approach to their work to improve public health. NICE guidance includes costing tools to assist with financial planning. NICE has recently undertaken a project to develop potential new methods around the use of evidence on cost-effectiveness, cost impact and return on investment in order to inform local commissioning. Key NICE guidance documents on tobacco control are in the appendix.

Promoting comprehensive tobacco control

1.10   There is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local level. The actions set out in this plan will promote action across key areas. Comprehensive tobacco control is more than just providing local stop smoking services or enforcing smokefree legislation. The effectiveness of tobacco control is dependent on strategies which implement a wide range of actions that complement and reinforce each other, as explained by the US Surgeon General:

The mission of comprehensive tobacco control programs is to reduce disease, disability, and death related to tobacco

use. A comprehensive approach—one that optimizes synergy from applying a mix of educational, clinical, regulatory, economic, and social strategies—has been established as the guiding principle for eliminating the health and economic burden of tobacco use.[i]

1.11 We recognise that while nicotine keeps tobacco users physically dependent, there are a wide range of social and behavioural factors that encourage young people to take up smoking and that make it harder for tobacco users to quit. The Government's approach to improving public health will include tackling the wider social determinants of health and it aims to build people's self-esteem, confidence and resilience right from infancy. To promote health and wellbeing, we will work to encourage communities across England to reshape social norms, so that tobacco becomes less desirable, less acceptable and less accessible. We want all communities to see a tobacco-free world as the norm and we aim to stop the perpetuation

of smoking from one generation to the next. To reduce smoking uptake by young people, we all need to influence the adult world in which they grow up. We must also remove the considerable social barriers that smokers face when they are trying to quit.

1.12 Tobacco use is the major cause of preventable death in England and harms not just smokers but the people around them, through the damaging effects of secondhand smoke. Smoking is an addiction that takes hold largely in childhood and adolescence, with the vast majority of smokers starting to use tobacco regularly before the age of 18. Given the level of harm caused by tobacco, it is appropriate to use a range of behaviour change interventions. Tobacco control measures cover all of the public health interventions set out in the Nuffield Council on Bioethics' "intervention ladder", that shows the potential approaches that can be used to promote positive lifestyle changes. Examples from this plan are shown in Figure 1.

Figure 1: Tobacco control actions across the Nuffield Ladder of public health interventions

Eliminate choice: We will continue to support the enforcement of age of sale laws, building compliance so that young people cannot access tobacco products.

Restrict choice: We will continue to promote the enforcement of smokefree legislation in communities in order to remove the hazard of secondhand smoke from enclosed work and public places.

Guide choice through disincentives: We will continue to follow a policy of using tax to maintain the high price of tobacco products at levels that impact on smoking prevalence.

Guide choice through incentives: We will support local areas to use behavioural insights in order to develop incentives, such as positive recognition for smokers that take voluntary action to make their homes and family cars smokefree.

Guide choice through changing the default policy: We will work with health and social care professionals to help them to engage with smokers about quitting and to offer referrals to local stop smoking services, unless a smoker opts out.

Enable choice: We will support local stop smoking services to extend the range of services they offer so that tobacco users are presented with a range of choices about how to quit and can choose one that suits their needs and wishes.

Provide information: We will provide information to people about the risks of using tobacco and signpost the help available for smokers who want to quit.

Monitor the current situation: We will examine the impact that the advertising and promotion of smoking accessories, including cigarette papers, has on promoting the use of tobacco products and consider whether further action is needed.

1.13 Under the leadership of local authorities, we want to encourage the development of partnerships in tobacco control where anyone who can make a contribution is encouraged to get involved. In implementing comprehensive tobacco control in their communities, we encourage local authorities to maximise local involvement by building tobacco control alliances that include civil society. Many areas already have local tobacco alliances and these have proved effective in galvanising action by involving people and organisations including:

- local councils;

- local businesses;

- schools and colleges;

- children's and youth groups;

- local councillors and MPs;

- NHS services, including coronary care, respiratory and mental health services;

- Trading Standards Officers;

- Environmental Health Officers;

- HM Revenue & Customs;

- police;

- fire services; and

- civil society groups with an interest in tobacco control and public health.

1.14 In the future, local areas may wish to commission and deliver tobacco control initiatives over larger geographical areas, in order to achieve greater levels of effectiveness and efficiency. Tobacco control offices in the North West, North East and South West of England have demonstrated the value of such models of working for many years, particularly around marketing communications and tackling illicit tobacco.

Case study: Recommendations for local comprehensive tobacco control

Local authorities will take a leading role in improving tobacco control in their communities. The following recommendations for good practice in local tobacco control are informed by the experience that the Department of Health's National Support Team has gained by working with local areas:

- Address tobacco control through strategic multi-agency partnership working, senior level accountability and a dedicated, co-ordinating resource.

- Promote compliance with tobacco legislation, for example activities to stop underage sales of tobacco, to promote smokefree legislation and to reduce the availability of illicit tobacco.

- Develop and communicate a clear understanding of the harm caused by tobacco, and understanding of the benefits of supporting smokers to quit, particularly by frontline staff.

- Provide local stop smoking services in ways that maximise accessibility and outreach, particularly for groups with high rates of smoking prevalence. These services should be provided in a way that maximises value for money.

- Get the most out of commissioning by developing and supporting existing and potential markets. Build in processes to ensure robust performance monitoring and management of commissioned service providers.

- Use local data and intelligence to develop a local tobacco control strategy and action plan that has appropriate and measurable outcomes.

- Encourage community engagement and development so that local people can get involved and become advocates if they wish to.

- Develop a co-ordinated local communication strategy.

- Encourage local people to make their homes and cars smokefree.

National ambitions

1.15 While the Public Health Outcomes Framework will provide the key source of information about our progress on reducing tobacco use, the Government is setting three national ambitions to focus tobacco control work across the whole system:

- **Reduce smoking prevalence among adults in England**

  National ambition: To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015, meaning around 210,000 fewer smokers a year.

  Measure: Smoking prevalence among adults from Office for National Statistics' *Integrated Household Survey*.

  Baseline measure: 21.2 per cent (April 2009 to March 2010).

- **Reduce smoking prevalence among young people in England**

  National ambition: To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015.

  Measure: Prevalence of regular cigarette smoking among 15 year olds, from the NHS Information Centre's *Smoking, Drinking and Drug Use Among Young People in England* survey.

  Baseline measure: 15 per cent (2009).

- **Reduce smoking during pregnancy in England**

  National ambition: To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).

  Measure: Percentage of expectant mothers recorded as being smokers at the time of giving birth, from the Department of Health's *Smoking status at time of delivery* statistical collection.

  Baseline measure: 14 per cent (2009/10).

1.16 These national ambitions will not translate into centrally driven targets for local authorities. Rather, they represent an assessment of what could be delivered as a result of the national actions described in this plan, together with local areas implementing evidence-based best practice for comprehensive tobacco control. The new approach to public health delivery in England means that local areas will decide on their own priorities and ways of improving health in their communities in line with the evidence base and local circumstances.

Developing and implementing the Tobacco Control Plan

1.17 The Government will support comprehensive tobacco control in England across six strands that have been categorised by the World Bank, which are:

- stopping the promotion of tobacco;

- making tobacco less affordable;

- effective regulation of tobacco products;

- helping tobacco users to quit;

- reducing exposure to secondhand smoke; and

- effective communications for tobacco control.

1.18 The Tobacco Control Plan was developed in collaboration with local government representatives, public health advocacy groups, academics, clinicians, professional bodies and retailers. We will continue to work with key organisations such as the Local Government Group, NICE, the Royal College of Physicians, Action on Smoking and Health, the Chartered Institute of Environmental Health, the Trading Standards Institute and the UK Centre for Tobacco Control Studies in order to use evidence and best practice to guide the implementation of this plan.
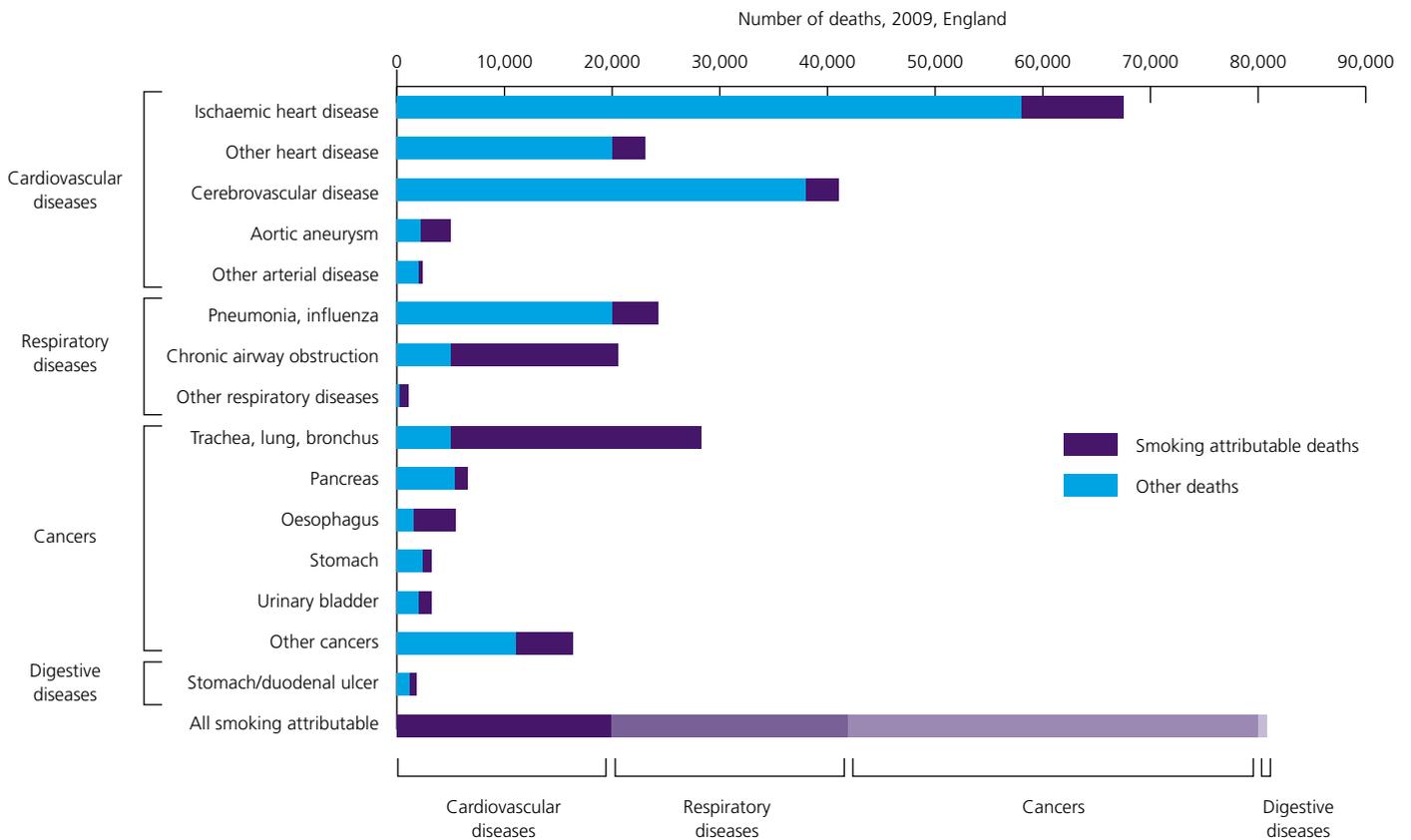
2. TOBACCO AND HEALTH IN ENGLAND

2.1 Tobacco use remains one of our most significant public health challenges. While rates of smoking have continued to decline over the past decades, 21 per cent of adults in England still smoke. Smoking prevalence has fallen little since 2007 and we need to take new action to drive prevalence down further.

2.2 While in the past more men than women smoked, today the prevalence of smoking is about the same for men and women.[ii] Smoking rates vary considerably between different social groups and it is most common among people who earn the least, and least common among people who earn the most. In recent times, smoking has become one of the most significant causes of health inequalities.

Smoking and health

2.3 Smoking is the primary cause of preventable morbidity and premature death, accounting for 81,400 deaths in England in 2009, some 18 per cent of all deaths of adults aged 35 and over.[ii] In 2009, a larger proportion of men than women died from smoking-related diseases, reflecting the higher rates of smoking by men in the past.[ii]

2.4 Smoking is a major cause of health inequalities. Although the number of deaths from smoking is declining, rates remain much higher in the north than in the south of England[iii] and among lower income groups. Reducing the prevalence of smoking in disadvantaged groups and areas is one of the fastest ways to increase life expectancy and to reduce smoking-related ill health.

2.5 Smoking is harmful not only to smokers but also to the people around them. Tobacco smoke contains thousands of chemicals, many of which are carcinogenic or toxic.

2.6 In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).

2.7 Smoking causes a range of illnesses, most of which only become apparent after many years of smoking. In 2009, around 35 per cent of all deaths in England from respiratory diseases and 29 per cent of all cancer deaths were attributable to smoking. Smoking also accounted for 14 per cent of deaths from circulatory diseases and 6 per cent of deaths from diseases of the digestive system. Mortality attributable to smoking in these disease areas is shown in Figure 2.[ii]

Figure 2: Mortality attributable to smoking by disease area in England, 2009

Number of deaths, 2009, England

Legend
■ Smoking attributable deaths
■ Other deaths

Cardiovascular diseases
- Ischaemic heart disease
- Other heart disease
- Cerebrovascular disease
- Aortic aneurysm
- Other arterial disease

Respiratory diseases
- Pneumonia, influenza
- Chronic airway obstruction
- Other respiratory diseases

Cancers
- Trachea, lung, bronchus
- Pancreas
- Oesophagus
- Stomach
- Urinary bladder
- Other cancers

Digestive diseases
- Stomach/duodenal ulcer

All smoking attributable

Source: Statistics on Smoking: England, 2010; NHS Information Centre for Health and Social Care

Smoking and addiction

2.8   Some two-thirds of current smokers in England say that they want to quit smoking, with three-quarters reporting that they have attempted to quit smoking at some point in the past.[ii] Around half of all regular smokers are eventually killed by a smoking-related illness. On average, smokers who die from a smoking-related illness lose around 16 years of life.[iv]

2.9   Nicotine is highly addictive and smoked tobacco delivers nicotine to the brain very efficiently[v] and so many people find quitting to be very challenging. Tobacco addiction is complex, having physical, psychological and social dimensions that manifest differently in different people. However, by successfully stopping smoking, people can avoid smoking-related diseases and live longer, whatever their age, and this means that there is a very strong case for delivering effective tobacco control. The years of life gained by stopping smoking are shown in Figure 3.

Figure 3: Years of life gained by stopping smoking at different ages[vi]

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

The economics of smoking

2.10 Treating smoking-related illnesses was estimated to have cost the NHS £2.7 billion in 2006/07, or over £50 million every week.[vii] In 2008/09, some 463,000 hospital admissions in England among adults aged 35 and over were attributable to smoking, or some 5 per cent of all hospital admissions for this age group.[ii] Illnesses among children caused by exposure to secondhand smoke lead to an estimated 300,000 general practice consultations and about 9,500 hospital admissions in the UK each year.[viii]

2.11 The costs of tobacco use are much greater than just costs to the NHS, with the overall economic burden of tobacco use to society estimated at £13.74 billion a year. These costs comprise not only treatment of smoking-related illness by the NHS but also the loss in productivity from smoking breaks and increased absenteeism, the cost of cleaning up cigarette butts, the cost of smoking-related house fires and the loss in economic output from people who die from diseases related to smoking or exposure to secondhand smoke.[ix] Reducing tobacco use will not only benefit NHS finances but also the wider local and national economy.

Smoking and health inequalities

2.12 The *Healthy Lives, Healthy People* White Paper sets out that one of the Government's key objectives is to improve the healthy life expectancy of the population, improving the health of the poorest, fastest.

2.13 The independent review into health inequalities in England undertaken by Professor Sir Michael Marmot culminated in the publication in 2010 of *Fair Society, Healthy Lives*. The review identified the most effective evidence-based strategies for reducing health inequalities in England and made the following recommendation:

Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.[x]

2.14 The strong relationship that exists today between tobacco use and health inequalities has developed since the late 1950s, when smoking rates were uniformly high across all social groups. From the 1960s onwards, more affluent groups increasingly responded to the evidence of the health harms by stopping smoking, but quit rates have remained lower in less affluent groups. Given the devastating impact of smoking on health, these differences in quitting rates have resulted in a substantial widening of health inequalities.

2.15 There is also a strong relationship between smoking and occupation. In 2009/10, smoking prevalence was twice as high among people in routine and manual occupations compared to those in managerial and professional occupations. Nearly half of all smokers in England, more than 4 million people, work in a job defined by the Office for National Statistics as routine or manual.

2.16 Smoking prevalence is also higher in certain ethnic groups (such as Bangladeshi and Pakistani men and Irish men and women), while the use of niche tobacco products (such as non-smoked tobacco) is also higher in certain ethnic groups. Smoking rates are high in certain other groups, such as among lesbian and gay people.

2.17 The difference in smoking between social groups widens throughout adulthood because greater numbers of people from more affluent groups are able to quit smoking. There are likely to be a number of reasons why people from less affluent backgrounds are less successful in quitting. Differences in motivation do not account for the different prevalence because desire to quit remains broadly the same. However, levels of nicotine dependence do vary, with smokers from less affluent backgrounds smoking more and taking in more nicotine from the tobacco they smoke. The socially reinforcing nature of smoking in peer groups and communities where smoking rates are high also creates significant social barriers to successful quitting.

Smoking in pregnancy

2.18 Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy. Smoking during pregnancy also increases the risk of infant mortality by an estimated 40 per cent.[xi]

2.19 Babies from less affluent backgrounds are more likely to be born to mothers who smoke. While 14 per cent of women who gave birth in England in 2009/10 said that they smoked during pregnancy, rates vary considerably across England. Smoking prevalence is particularly high among pregnant women under the age of 20.

Health effects of exposure to secondhand smoke

2.20 Children from less affluent backgrounds suffer greater levels of exposure to secondhand smoke when growing up. Infants of parents who smoke are more likely to suffer from serious respiratory infections (such as bronchitis and pneumonia), symptoms of asthma and problems of the ear, nose and throat (including glue ear). Exposure to smoke in the womb is also associated with psychological problems in childhood.[xi]

2.21 Although the level of exposure to smoking among children has declined in recent years, it remains a significant health issue. Among children in the UK each year, exposure to secondhand smoke causes:

- over 20,000 cases of lower respiratory tract infection (in children under 3 years);

- 120,000 cases of middle ear disease;

- at least 22,000 new cases of wheeze and asthma;

- 200 cases of bacterial meningitis; and

- 40 sudden infant deaths (one in five of all sudden infant deaths are caused by smoking).[viii]

2.22 Secondhand smoke in the home also presents a substantial health risk for adults. Over 12,000 deaths among people over 20 years of age each year are estimated to be attributable to exposure to secondhand smoke. These deaths will be concentrated in groups where smoking rates are the highest.[xii]

Uptake of smoking by young people

2.23 Smoking is an addiction largely taken up in childhood and adolescence, so it is crucial to reduce the number of young people taking up smoking in the first place.

2.24 If smoking is seen by young people as a normal part of everyday life, they are much more likely to become smokers themselves.[xiii] A 15 year old living with a parent who smokes is 80 per cent more likely to smoke than one living in a household where no one smokes.[xiv] About one-third of children under the age of 16 live with someone who smokes.[xv] The latest research in social psychology and behavioural economics suggests that reducing the uptake of smoking is best achieved by influencing the adult world in which young people grow up.

2.25 Across the population, the highest rates of smoking are among young people. Around 26 per cent of people aged 16–24 smoked in 2009. While the rates of smoking among young people have reduced considerably in recent years, the uptake of smoking by young people continues to be a serious problem. An estimated 330,000 young people under the age of 16 try smoking for the first time in England each year, and around 6 per cent of pupils aged 11–15 were regular smokers in 2009 (regular smoking for pupils being defined as at least one cigarette a week).[ii]

2.26 Young people can rapidly develop nicotine dependence and symptoms of dependence can develop soon after a young person's first puff on a cigarette.[xvi] The Government is particularly concerned about the early age at which people become regular smokers in England and that nicotine addiction for most people starts in adolescence. In England, almost two-thirds of current and ex-smokers say that they started smoking regularly before they were 18 years old, with 39 per cent saying that they were smoking regularly before the age of 16. Very few people start smoking

for the first time after the age of 25.[ii] Our efforts to stop the uptake of smoking must focus on teenagers.

Smoking and mental health

2.27 The Government is concerned about the substantial impact that smoking has on the health and wellbeing of people suffering from mental health problems. Overall smoking prevalence among people receiving psychiatric care is significantly higher than among the general population.

2.28 People suffering from mental health problems who also smoke have commonly been found to display patterns of heavy smoking and severe nicotine dependence. Many smokers with mental health problems want to stop smoking but often they do not receive the advice and support they need to do so. Smoking rates by young people with mental health problems are significantly higher than average.[xvii]

International comparisons

2.29 Comparisons of smoking prevalence between countries are complicated by the need to take account of the different definitions that are used to define smokers, different age groups covered, different survey methods used to collect the information and potential differences in the tendency of respondents to under (or over) report smoking. Figure 4 offers information for eight countries including England.

2.30 Even allowing for issues of comparability, there is strong evidence that the decrease in prevalence observed in England over the past decade has been at least on a par with other countries and that the current prevalence in England is among the lowest in this group.

Figure 4: Smoking prevalence in eight countries including England (from Department of Health analysis of latest available comparable national data)

3. STOPPING THE PROMOTION OF TOBACCO

3.1 Action to stop the promotion of tobacco products has been taken over many years. While the Tobacco Advertising and Promotion Act 2002 prohibits tobacco advertising, the tobacco industry continues to find ways of promoting tobacco products, for example through packaging, point of sale displays and through entertainment media, including the internet. Given the substantial health risks caused by tobacco use, the Government is committed to preventing the promotion of tobacco products to both young people and adults.

Key actions

The Government will:

- **implement the tobacco display provisions in the Health Act 2009 for large shops from April 2012 and for all other shops from April 2015;**

- **consult on options to reduce the promotional impact of tobacco packaging, including plain packaging, before the end of 2011;**

- **continue to defend tobacco legislation against legal challenges by the tobacco industry, including legislation to stop tobacco sales from vending machines from October 2011;**

- **examine the impact that the advertising and promotion of smoking accessories, including cigarette papers, has on promoting the use of tobacco products and consider whether further action is needed;**

- **work with media regulators and the entertainment industry around the portrayal of smoking in entertainment media;**

- **consider whether the internet is being used to promote tobacco to young people in the UK and, if so, examine what more can be done on a global level; and**

- **encourage local areas to consider action to further protect young people from exposure to smoking so they do not see it as a normal behaviour, reducing the likelihood of them becoming smokers.**

Helping shape perceptions of tobacco use by young people

3.2 The more that smoking is seen to be a normal part of everyday life, the more likely it is that young people will take it up. As the Cabinet Office Behavioural Insights Team suggests in *Applying behavioural insight to health*:

We generally do what we see or think others are doing but an important twist is that our estimate of what other people are doing is often distorted.[xviii]

3.3 We will encourage local authorities to examine what role they can play in helping to change social norms around smoking, particularly through using behavioural insights. Young people can often overestimate the number of people smoking among the peer group and in the wider community, and this can drive smoking behaviour.

Display of tobacco products in shops

3.4 There is evidence that the display of tobacco products in shops can promote smoking by young people and undermine the resolve of adult smokers who are trying to quit. The Health Act 2009 ends the display of tobacco in shops.

3.5 The tobacco display provisions in the Health Act 2009 and related regulation will be implemented for large shops from April 2012 and for all other shops from April 2015. We will amend the regulations on stopping the display of tobacco to make the arrangements more practical for shop keepers to comply with in the day-to-day running of their businesses. These changes to the legislation ending tobacco displays in shops will especially support small businesses, in line with the *Growth Review* announced by the Chancellor of the Exchequer in November 2010.

Plain packaging of tobacco products

3.6 The Government will look at whether the plain packaging of tobacco products could be effective in reducing the number of young people who take up smoking and in supporting adult smokers who want to quit. The Government wants to make it easier for people to make healthy choices but wants to understand whether there is evidence to demonstrate that plain packaging would have an additional public health benefit. We will explore the competition, trade and legal implications, and the likely impact on the illicit tobacco market of options around tobacco packaging.

3.7 We will consult on options to reduce the promotional impact of tobacco packaging, including plain packaging, before the end of 2011.

Sale of tobacco from vending machines

3.8 We are robustly defending the legislation to stop the sale of tobacco products from vending machines against two judicial review cases brought by the tobacco industry. From 1 October 2011, tobacco products will no longer be sold from

vending machines in England. As vending machines are self-service, they offer young people easy and poorly supervised access to tobacco. By ending this source of tobacco we will reduce the number of young people taking up smoking as well as extending a supportive environment for adult smokers who are trying to quit.

Advertising of smoking accessories

3.9 We are aware of the increasing prominence of the advertising and promotion of smoking accessories, such as cigarette papers, at large-scale public events such as music festivals. We will examine the impact that the advertising and promotion of smoking accessories has on promoting the use of tobacco and consider whether further action is needed.

Tobacco and the entertainment media

3.10 The portrayal of smoking in the entertainment media can create the false impression that tobacco use is a normal, or even glamorous, activity and it rarely shows the real life negative consequences of tobacco use. Smoking in the media can also give a false impression that tobacco use is more common than it actually is. We remain especially concerned about how these influences affect perceptions of social norms and how they encourage young people to take up smoking.

3.11 Guidelines on reducing images of smoking in television programmes and films directed towards children have been published by Ofcom, the UK communications industries regulator. We will continue to work to reduce the depiction of smoking in the media, including through bringing together media regulators and the entertainment industry to consider what more can be done.

3.12 We will also consider whether the internet is being used to promote tobacco to young people in the UK. If this is the case, we will need to examine what more can be done on a global level, potentially through the World Health Organization's Framework Convention on Tobacco Control.

3.13 We will also explore ways to provide young people with information about risky behaviours that can affect their health, including tobacco use, and to help them develop their ability to resist pressures to take up smoking. This work is likely to involve digital media, due to its reach and popularity among young people.

4. MAKING TOBACCO LESS AFFORDABLE

4.1 Making tobacco less affordable is proven to be an effective way of reducing the prevalence of smoking. Young people, pregnant women and people from lower socio-economic groups are particularly

Tax on tobacco

4.2 The UK has some of the highest-priced cigarettes and tobacco products in the EU and the Government continues to follow a policy of using tax to maintain the high

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Key actions

The Government will:

- **continue to follow a policy of using tax to maintain the high price of tobacco products at levels that impact on smoking prevalence;**

- **promote a revised joint working protocol between local authorities and HM Revenue & Customs (HMRC) to tackle illicit tobacco;**

- **continue to support the development of a protocol on illicit trade in tobacco products under the World Health Organization's Framework Convention on Tobacco Control (FCTC);**

- **support the development of evidence-based marketing campaigns by local authorities to reduce illicit tobacco use in their communities;**

- **promote local action to identify tobacco products, including niche products, on sale to ensure that appropriate duty is paid on these products;**

- **keep under review the evidence about the affordability and average price smokers pay for tobacco; and**

- **examine the feasibility and likely impact of restricting the amount of cheap tobacco products individuals can bring in to the UK from abroad.**

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sensitive to price.[xix] The health gain from high-priced tobacco, however, can be undermined if the illicit market in tobacco products is allowed to thrive at the expense of legal, duty-paid products.

price of tobacco products at levels that have an impact on smoking prevalence. Tax policy is a matter for HM Treasury and tobacco taxation will be kept under review as part of the usual Budget process.

Illicit tobacco

4.3 Success in reducing the illicit share of the tobacco market helps to reduce consumption, reduce organised crime in local communities, reduce potential revenue loss to the Treasury and support legitimate retailers. HMRC is responsible for tackling the illicit share of the tobacco market. However, the Department of Health, local authorities and others interested in tobacco control in local communities also have important roles to play. The Government is committed to tackling the illicit trade in tobacco products and will continue to take action as part of HMRC's strategy.

4.4 Groups of local authorities may wish to collaborate and co-operate around intelligence-gathering and analysis, enforcement, public education and engagement in the area of tackling illicit tobacco. Working across a wider geographical area is likely to be more cost-effective and have a greater impact.

4.5 There is a role for marketing communications in reducing illicit tobacco in our communities. Marketing campaigns can be more cost-effective when commissioned across wider geographical areas. As part of the North of England's Tackling Illicit Tobacco for Better Health programme, a marketing communications campaign was run in the North West and North East of England in 2010. The use of marketing communications to tackle illicit tobacco was also piloted in Portsmouth and Liverpool. Ongoing evaluation of these initiatives has shown that marketing communications can be effective in raising awareness about the dangers posed by the availability of illicit tobacco products in communities, in changing attitudes towards illicit tobacco use and in encouraging people to report illicit activity. We will disseminate the conclusions and recommendations from this work in order to guide other local areas that wish to undertake marketing activity to reduce illicit tobacco products in their communities.

Case study: Tackling illicit tobacco in the north of England

An innovative approach to tackling both the demand and supply of illegal tobacco in local communities is showing promising results. The *North of England Tackling Illicit Tobacco for Better Health Programme* has united the key agencies of HMRC, UK Border Agency, police, local authority trading standards departments and the NHS around a comprehensive action plan, covering eight key strands of work. The programme is focused on: building effective partnerships for delivery; increasing intelligence sharing and enforcement; training on illicit tobacco for a wide range of professionals, including local magistrates and local stop smoking service staff; and using well-tested media and marketing communications to shift public perceptions around illegal tobacco. In a recent stakeholder survey, over half of over 500 respondents said that tackling illicit tobacco had become a higher local priority since the programme was launched in the summer of 2009. Where this had happened, the overwhelming driving force had been the sharing of expertise and resources through the programme's work. Calls to Crimestoppers have increased significantly since the launch of the 'Get Some Answers' campaign and there has been some effective multi-agency enforcement activity in recent months.

The experience in the north of England is helping to shape similar programmes in other parts of the country. An independent evaluation is being carried out by the UK Centre for Tobacco Control Studies, and its interim report concluded:

The programme has provided the context for different players to come together, and catalysed a significant increase in partnership-working around illicit tobacco.

4.6 We will continue to support the work being carried out by local trading standards authorities to detect and take action on niche and novel tobacco products which currently breach pack labelling or health warning legislation, or which evade duty.

4.7 A joint working protocol on tobacco offences between HMRC officials and local authority trading standards officers is currently under revision. When finalised, the protocol will provide an operational framework for optimising the efforts of all those involved in the detection and seizure of illicit tobacco products. The protocol will encourage an effective, multi-agency approach to detecting illicit tobacco products and taking appropriate action.

4.8 HMRC will continue to support the development of a protocol under the FCTC to tackle illicit trade globally. It is anticipated that agreement of that protocol will be reached at the fifth FCTC Conference of the Parties in 2012.

Tobacco price and consumption

4.9 Cigarettes and other tobacco products vary considerably in price from premium brands to cheaper "lower-end" products. There is evidence that smokers are increasingly "downgrading" to cheaper brands. Levels of consumption of tobacco products available at various prices will vary between individuals and social groups. To explore the scope for new policy interventions

in this area, we will encourage research to examine the evidence on the average price that different groups usually pay for tobacco products and the pack sizes they usually purchase.

4.10 The Government will look at the feasibility and likely impact of introducing a restriction on the amount of tobacco products that an individual can bring in to the UK from abroad, on the grounds of protecting public health.

5. EFFECTIVE REGULATION OF TOBACCO PRODUCTS

5.1 The effective enforcement of tobacco control legislation is a key element of any comprehensive tobacco control strategy. Laws are already in place that regulate the way that tobacco products are presented for sale and ensure that tobacco is not sold

Effective local enforcement of tobacco legislation

5.2 We will continue to work closely with the professional bodies for local regulatory officers. Their work to educate and

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Key actions

The Government will:

- **encourage and support the effective local enforcement of tobacco legislation, particularly on the age of sale of tobacco products;**

- **support the continuing provision of guidance, education and best practice for the local enforcement of tobacco legislation;**

- **promote local action to identify niche tobacco products on sale in communities to ensure that these products meet the requirements of tobacco legislation;**

- **consider the evidence for where children obtain tobacco products and explore what action is needed to tackle the main sources;**

- **include a new EU standard for reduced ignition propensity (RIP) cigarettes in the British National Standards collection;**

- **contribute to the planned revision of the EU Tobacco Products Directive; and**

- **co-ordinate, through the Medicines and Healthcare Products Regulatory Agency (MHRA), scientific and market research on the use of nicotine-containing products, such as electronic cigarettes, to inform decisions about the most effective and proportionate form of regulation.**

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to people under the age of 18. We will encourage local areas to continue to focus on the enforcement of tobacco legislation, which will contribute to their efforts to drive down the rates of tobacco use in their communities.

promote the professional practice of local authority regulatory staff, and to produce and disseminate good practice guidance, has a valuable role to play in supporting effective tobacco control.

5.3 Local authorities have extensive experience in taking a proportionate approach to the enforcement of legislation. We will encourage local areas to continue to build compliance with tobacco legislation, including through provision of advice and information to businesses. The Government believes that enforcement action should only be needed in cases where the law is deliberately flouted, but where that happens, we support local authorities in taking strong action.

Reducing the availability of tobacco to young people

5.4 While the legal age of sale of tobacco products is 18, young people under this age say that they continue to find ways to circumvent the law, either by directly purchasing or getting tobacco through other sources. The Government recognises the efforts of retailers in recent years to ensure that tobacco sales are made only to adults. We will encourage the continued effort, particularly by retail representative bodies, to promote responsible retailing.

5.5 In recent years, evidence suggests that the primary sources of tobacco for young people are changing. The Department of Health has commissioned an academic review of the evidence in this area that will be completed in late-2011. We will examine the outcome of this review carefully to determine what further action is needed to reduce the availability of tobacco to young people under the age of 18.

Effective regulation of novel or niche tobacco products

5.6 Novel or niche tobacco products, including tobacco mixtures for use in waterpipes (such as shisha) and smokeless tobacco, are available for sale in communities throughout England. All tobacco products, especially those that are smoked, carry health risks and are subject to tobacco legislation, including the requirement not to sell these products to people under the age of 18.

5.7 We will support local enforcement activities relating to novel or niche tobacco products, and we have commissioned work to develop an online directory that will help enforcement officers to identify such products. Guidance to support the effective regulation of waterpipes, based on experience from local areas, has been produced by Local Government Regulation, the Chartered Institute of Environmental Health and the Trading Standards Institute. This guidance also covers how smokefree legislation applies to the use of waterpipes. Other projects are currently underway in local areas and we will promote the widespread dissemination of these recommendations and findings.

> **Case study: Raising awareness of the dangers of waterpipes**
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> The number of establishments offering waterpipes to smoke is increasing in England, and they are reported to be attracting young people who are seeking new social experiences. Some people incorrectly believe that smoking waterpipes is less harmful than smoking cigarettes. In response to this problem many local authorities, including the London Borough of Tower Hamlets and Coventry City Council, have implemented enforcement strategies that include the provision of information and advice on the health hazards from smoking waterpipes.
>
> The Tower Hamlets shisha campaign started in 2009, as part of a wider strategy to combat high tobacco use. The local council has worked collaboratively with local NHS organisations to produce information highlighting the dangers of waterpipe smoking. This information is distributed to businesses by officers of the Environmental Health Commercial Services team during their visits. The campaign has resulted in greater awareness of the health implications of smoking waterpipes and of the legal requirements regarding the sale of this form of tobacco.

RIP cigarettes

5.8   Smoking materials are a significant cause of house fires. In 2007, there were 2,354 smoking-related fires in England, resulting in 73 deaths and 789 injuries. The EU published a Safety Standard and Test Method for Reduced Ignition Propensity Cigarettes in November 2010, with referencing in the *Official Journal of the European Union* planned for 12 months later. This period will enable cigarette manufacturers to make necessary changes in their manufacturing processes to meet the new standard.

5.9   The Standard for Reduced Ignition Propensity Cigarettes was developed to find a technical solution to prevent cigarettes from burning through their whole length when not being actively smoked, because of the fire hazard

this represents. In December 2010, an equivalent British Standard (EN 16156) was included as a UK national standard. The introduction of RIP cigarettes could save between 800 and 900 lives per year in European countries.

Planned revision of the EU Tobacco Products Directive

5.10 The European Commission consulted in 2010 on options to inform its expected proposal for a revised Tobacco Products Directive. The Government will seek to play an active role in revising the Directive, and sees the following as areas of priority for revision:

• The removal of the current requirement for inclusion of tar, nicotine and carbon monoxide yields from cigarette packs, because this information can be misleading to consumers.

- The mandatory use of picture warnings for all tobacco products for sale in the EU (picture warnings are already required on the packaging of smoked tobacco for sale in the UK).

- The improved labelling and use of health warnings for smokeless tobacco products.

5.11 The sale of smokeless oral tobacco products such as snus is not permitted across the EU (with the exception of Sweden). Given that health risks are associated with the use of these types of smokeless tobacco products, the Government does not intend to support calls for oral tobacco products to be made available in the EU as part of any revision to the Tobacco Products Directive.

Regulation of nicotine-containing products

5.12 The MHRA conducted a public consultation in 2010 about the need for regulation of nicotine-containing products, such as electronic cigarettes. In response to the consultation, there was clear support for more effective regulation of such products as medicines from interested groups such as the Royal College of Physicians, Royal College of General Practitioners, Royal Pharmaceutical Society, British Medical Association, British Heart Foundation, Cancer Research UK, Trading Standards Institute, local authority representatives, NHS bodies and the pharmaceutical industry. Some importers of electronic cigarettes said that they are willing to work with the MHRA towards the development of licensed nicotine-containing products.

5.13 There is, however, concern that an immediate move to medicines regulation for nicotine-containing products could lead to potentially useful products, which could support quitting, cutting down and reducing the harms to smokers and those around them, being taken off the market temporarily or innovation in this area being stifled. Questions around the level of nicotine contained in such products and the possible impact of regulation were also raised.

5.14 To inform future decisions in this area, the MHRA will co-ordinate a period of scientific and market research looking, in particular, at the levels of nicotine that have physiological effects. We will use the information gained to develop a better understanding of the possible benefits and disadvantages of potential regulation, including how potential public health benefits can be promoted, safety considered and the impact that future regulation would have on business.

6. HELPING TOBACCO USERS TO QUIT

6.1 Over 8 million people in England are smokers. By helping people to quit smoking for good, we can significantly improve public health and reduce health inequalities. By quitting, tobacco users can improve their own and their family's health and wellbeing, and also reduce the likelihood that their children will become smokers.

6.2 England is seen as a global leader in helping smokers to quit and evidence shows that local stop smoking services provide the most effective type of support. We want to increase levels of motivation among tobacco users to quit, increase the referral of smokers to local stop smoking services and extend the support options available to tobacco users who want to quit. We will also develop a new approach to encourage tobacco users who cannot quit to substitute tobacco for safer sources of nicotine.

6.3 Despite over 6 in 10 smokers saying that they want to quit, less than half make a quit attempt in any given year. We want to encourage smokers to try to quit more often until they succeed, and for smokers to quit using an effective approach such as local stop smoking services, rather than quitting "cold turkey" without any help.

Key actions

The Government will:

- **use marketing communications to motivate tobacco users to think about quitting, and guide them to the most effective support available;**

- **encourage local areas to provide stop smoking services that are tailored to the needs of their communities and reach out to people from high smoking prevalence groups, in particular, people with routine and manual jobs;**

- **support the provision of a greater range of options for smokers who want to quit, based on evidence of clinical effectiveness and value for money;**

- **provide clinical guidance and training standards for local commissioners and providers of local stop smoking services;**

- **encourage local areas to commission stop smoking services that maximise value for money;**

- **ensure data on local stop smoking service activity and effectiveness informs national and local commissioning and enables measurement of cost effectiveness;**

- **work to increase the number of tobacco users who are offered advice about quitting and referral to local stop smoking services;**

- **support the development of guidance on helping users of smokeless tobacco to quit; and**

- **develop new approaches to encourage tobacco users who cannot quit to switch to safer sources of nicotine.**

Supporting provision of stop smoking services that meet local needs

6.4   Local stop smoking services have been helping tobacco users to quit in England for over 10 years and the services are proved to be the most effective way for tobacco users to quit. The new public health system presents new opportunities for stop smoking services to continue to develop in order to meet the needs of tobacco users in their communities. To assist local areas to make available stop smoking services that provide the highest quality evidence-based support, we will:

- encourage local commissioners to use local intelligence and data (including local tobacco profiles) to make stop smoking services available in ways that meet the needs of their community, especially for high smoking-prevalence groups and groups where smoking presents particular risks, such as pregnant women;

- regularly publish updated *Local Stop Smoking Services: Service and monitoring guidance* to support local commissioners and providers;

- continue to support the provision of training standards for stop smoking service professionals and providers;

- encourage local areas to commission stop smoking services that maximise value for money;

- ensure data on stop smoking services informs national and local commissioning, and enable monitoring of cost-effectiveness of services;

- continue to provide resources to local areas to help them promote their local stop smoking services and facilitate the sharing of conclusions from local marketing communications projects that have proved effective; and

- encourage stop smoking services to offer help to all tobacco users, including users of waterpipes and smokeless tobacco.

6.5   We support the introduction of a non-mandatory currency for smoking cessation services under the Payment by Results (PbR) framework in 2011/12, following the positive evaluation of the ongoing pilot of this approach in the West Midlands. The PbR system is used widely within the NHS as a mechanism to pay providers and is

designed to improve quality and efficiency, increase value for money and promote service innovation. In the PbR pilot for smoking cessation services, payment is made to providers on the basis of the outcomes that services achieve. A payment is received for each 4-week and 12-week quitter. To help organisations implement these arrangements, indicative prices used in the West Midlands have been published within the PbR framework. Moving forward, we will work with local authorities to explore whether they wish to make use of this tariff-based approach, once the budget for health improvement services is transferred from PCTs to local authorities.

Supporting local stop smoking services to extend the range of support options for smoking cessation

6.7   We will support the provision of a greater range of options for smokers who want to quit, based on evidence of clinical effectiveness and value for money. Presently, stop smoking services operate an "abrupt quit" model where a smoker sets a quit date and is expected to have stopped smoking completely from that date onwards. While this form of quitting support has proved effective, not all smokers want, or can, quit this way and other options could be made available.

Case study: Specialist support for pregnant women who smoke

At the Phoenix Stop Smoking Pregnancy Service, run by NHS Lincolnshire, pregnant women are given specialist support and advice to help them stop smoking. NHS Lincolnshire has facilitated a co-ordinated, multi-agency approach that works with the families of pregnant smokers to help them to quit together. The service also offers advice on how to make the baby's home smokefree even if some members of the household still smoke. Since the service started in 2005, over 3,500 pregnant women have quit smoking and the quit rate has steadily improved from 40 per cent in the first year to 62 per cent in 2010.

6.6   To assist local areas to provide services, the National Institute for Health and Clinical Excellence (NICE) will produce guidance for commissioners and providers on delivering cessation services for users of smokeless tobacco (to be published in autumn 2012) and on smoking cessation services provided by NHS secondary care providers (to be published in autumn 2013). The development of NICE guidance is informed by the best available evidence of effectiveness and cost-effectiveness. The interventions recommended in these guidance documents are considered to be an efficient use of resources and be good value for money.

6.8   We are currently supporting trials of a new "tailored quit plans" model that offer smokers a wider range of quit options, including gradual reduction in smoking and longer-term use of nicotine replacement therapies (NRT). Although research shows that these interventions may not be as effective as the "abrupt quit" model, they are more effective than a smoker trying to quit without any assistance. We will make the findings and recommendations of these trials available to local areas as soon as possible.

Increasing the number of tobacco users that are offered advice about quitting and are referred to local stop smoking services

6.9 We will also work to increase the opportunities for smokers to receive advice about quitting and referral to local stop smoking services. Advice can come from a range of sources but especially through the contact that smokers have with health and social care professionals. We will:

- maximise the potential within the Quality and Outcomes Framework (QOF) to provide incentives for GPs to identify smokers, to offer brief advice about quitting and to refer smokers to local stop smoking services;

- continue to encourage commissioners and providers of secondary care, mental health and maternity services to put in place local schemes, including Commissioning for Quality and Innovation (CQUIN), to create incentives for the identification of smokers and referral to local stop smoking services;

- through a proposed Quality, Innovation, Productivity and Prevention (QIPP) prevention workstream, support local commissioners and providers to work together in order to improve the quality and reach of local stop smoking services that maximise value for money and contribute to achieving efficiency savings for the NHS;

- continue to work with health and social care professionals and their representative bodies to improve advice for tobacco users on quitting and referral to local stop smoking services, with a focus on groups with a high prevalence of smoking;

- encourage the provision of advice to tobacco users about quitting and referral to local stop smoking services in a range of settings in workplaces and the community; and

- encourage local authorities and local NHS organisations to act as exemplars in supporting their staff to stop using tobacco.

Case study: QIPP

The QIPP agenda, included in the NHS White Paper published in 2010, aims to generate efficiency savings within the NHS of up to £20 billion by 2014/15 that will be reinvested into the health system to support the delivery of continued quality improvements. To support clinical teams and NHS organisations with QIPP, a programme of a number of national workstreams has been established, where the potential for large-scale savings has been identified.

The proposals for a national QIPP workstream, initially focused on tobacco and alcohol, aim to deliver high-impact interventions that will contribute to the efficiency savings to be realised through the QIPP programme. We will focus on those high-impact actions surrounding tobacco and alcohol for which strong evidence exists for the realisation of savings and efficiency gains within the current spending review period, drawing upon existing evidence.

The detail of the workstream is currently being scoped, but may include:

- **the further development and handing over of evidence;**

- **the provision of best practice briefings for commissioners for the established complement of high-impact interventions; and**

- **benchmarking of data on implementation to support further delivery of high-impact interventions.**

New approaches to help tobacco users who cannot quit to instead use safer sources of nicotine

6.10 Smokers are harmed by the tar and toxins in tobacco smoke, not necessarily by the nicotine to which they are addicted. There is no way of avoiding these deadly toxins if you inhale the smoke from burning tobacco. In recognition of this, the Medicines and Healthcare Products Regulatory Agency granted an extended indication in 2010 for NRT to be used for "harm reduction", to assist smokers who are unwilling or unable to quit, as a safer alternative to smoking and to reduce the health hazards from secondhand smoke.

6.11 We will work in collaboration with the public health community to consider what more can be done to help tobacco users who cannot quit, or who are unwilling to, to substitute alternative safer sources of nicotine, such as NRT, for tobacco. In support of this, NICE will produce public health guidance on the use of harm reduction approaches to smoking cessation (to be published in spring 2013). We will also encourage the manufacturers of safer sources of nicotine, such as NRT, to develop new types of nicotine products that are more affordable and that have increased acceptability for use in the longer term.

7. REDUCING EXPOSURE TO SECONDHAND SMOKE

7.1 Exposure to secondhand smoke is hazardous to health, especially for children. As a result of the high level of compliance with smokefree laws, smoking in enclosed work and public places is now largely a thing of the past. Everyone can now benefit from clean air at work, while travelling on public transport and in enclosed public places. Smokefree laws are proving to be effective, popular and compliance is virtually universal.

exposure to other people's smoke are substantial and avoidable. Each year, the costs of treatment by primary care services for these children has been estimated at around £10 million, while hospital admissions cost a further £13.6 million.[viii] These figures do not include the impact on the health of adults who are exposed to secondhand smoke. This burden of disease can be minimised by both encouraging smokers to quit, and by encouraging

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Key actions

The Government will:

- **publish an academic review of the impact of smokefree legislation in England;**

- **work with national media to raise awareness of the risks in exposing children to secondhand smoke;**

- **support local areas to encourage smokers to change their behaviour so that they do not smoke in their homes or family cars;**

- **continue progress to reduce secondhand smoke in prisons; and**

- **support other countries that want to introduce smokefree laws by sharing our experience.**

Health risks from secondhand smoke and costs to the NHS

7.2 Exposure to secondhand smoke causes a range of diseases, many of which can be fatal. Children are particularly vulnerable to the harms from secondhand smoke. The costs to the NHS of treating children who suffer from conditions caused by

responsible behaviour by smokers so that their smoking does not put the health of others at risk.

Smokefree legislation

7.3 Alongside this Tobacco Control Plan, we are publishing an academic review of the evidence of the impact of the smokefree legislation that was implemented in

England in 2007. The evidence is clear that smokefree legislation has had beneficial effects on health. We also know that levels of compliance and public support for the law are high. The Government believes that the aims of the legislation continue to be effectively achieved.

7.4 Evidence gathered has debunked concerns that the smokefree law would result in increased exposure of children to secondhand smoke in the home. In fact, the trend has been in the opposite direction, with the number of children being exposed to smoke in the home continuing to fall. The trend towards the adoption of smokefree homes by parents who smoke continued after smokefree legislation was implemented.

Smokefree homes and family cars

7.5 Nevertheless, people are today most likely to be exposed to the harmful effects of secondhand smoke in their own homes and private motor vehicles. Even though more people are making their own homes smokefree, far too many people continue to be exposed to secondhand smoke at home. We want to encourage people to create home environments where smokers no longer expose their families to secondhand smoke.

7.6 We will support local areas to work in partnership across their communities to encourage smokers to change their behaviour so that they do not smoke in their homes or family cars. Rather than extending smokefree legislation, we want people to recognise the risks of secondhand smoke and decide voluntarily to make their homes and family cars smokefree. We will encourage local areas to create networks of local smokefree ambassadors at a community level to encourage people to make their homes and family cars smokefree. We will support local efforts to raise awareness and use behavioural change insights, for example around building positive social norms and through positively recognising people who protect their families and other people from secondhand smoke in their homes and family cars.

7.7 To support local efforts, we will work with national media to raise awareness of the risks in exposing children to secondhand smoke. The Department of Health's new marketing strategy for tobacco control will set out further details of how we will support efforts by local areas to encourage smokefree homes and family cars.

Case study: Lincolnshire's Smokefree Alliance

Lincolnshire's Smokefree Alliance has developed a partnership with Lincolnshire Fire & Rescue through their Smoke Free Homes Project. The project aims to raise public awareness of the dangers of secondhand smoke for children and vulnerable adults both in the home and the car.

Since the project started in 2004, over 17,000 people have signed up. Over 1,000 smokers have been referred to local stop smoking services and around 5,000 homes have received a home safety fire check by the local fire service.

Case study: Smokefree families in Wythenshawe, Manchester

A local community engagement initiative in Wythenshawe, Manchester, led by Barnardo's and commissioned by NHS Manchester, promotes the message of Healthy Smokefree Families. During a one-year project in Wythenshawe, 1,151 households signed up and declared their homes smokefree. Over 400 families who previously smoked in the home pledged to keep their homes smokefree, protecting over 1,500 children from secondhand smoke exposure.

Tackling smoking in prisons

7.8 We recognise the substantial progress that has been made in prisons over the past decade to make common areas of prisons smokefree and to end smoking entirely in youth (15–18 years) establishments.

7.9 The National Offender Management Service is considering what further action can be taken to protect prison officers, prisoners and others in prisons from secondhand smoke and to create an environment which will be conducive to quitting tobacco use. Effective smoking cessation programmes in prisons can be established through partnership working with local authorities and the NHS.

Promoting the benefits of environments free from secondhand smoke

7.10 Much has already been achieved at the local level to make outdoor areas at NHS properties smokefree. In the future, NHS organisations and local authorities may voluntarily wish to make non-enclosed parts of their properties smokefree, particularly where people cannot otherwise avoid being exposed to secondhand smoke, such as around the entrances to buildings.

7.11 Local communities and organisations may also wish to go further than the requirements of smokefree laws in creating environments free from secondhand smoke, for example in children's

playgrounds, outdoor parts of shopping centres and venues associated with sports and leisure activities. Initiatives such as these can also help to shape positive social norms and discourage the use of tobacco.

Promoting smokefree environments around the world

7.12 Given the UK's success in implementing effective smokefree legislation, we will continue to share our experiences of implementing smokefree legislation with other countries, to encourage the creation of smokefree environments around the world.

8. EFFECTIVE COMMUNICATIONS FOR TOBACCO CONTROL

8.1 Effective communication about the harms of tobacco use is central to comprehensive tobacco control. We will support the delivery of local tobacco control though national communications and education activities aimed at a range of audiences.

behaviour. Econometric modelling has demonstrated a clear relationship between tobacco control marketing activity and people quitting smoking. In 2008 and 2009, tobacco control marketing activity in England directly stimulated over

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Key actions

The Government will:

- **publish a three-year marketing strategy for tobacco control;**

- **engage with young people to support them to make healthy lifestyle choices, including not taking up the use of tobacco;**

- **continue to educate people about the risks of using tobacco;**

- **motivate tobacco users to think about quitting;**

- **encourage tobacco users to make quit attempts, and to quit in the most effective ways;**

- **encourage communities to see not smoking as the norm;**

- **explore new roles for marketing communications in reducing young people's uptake of smoking, communicating the harms from secondhand smoke and in encouraging people to make their homes and family cars smokefree;**

- **provide guidance and benchmarks on cost-effective and evidence-based marketing communications initiatives for local commissioners, and resources that can be used locally; and**

- **work with health and social care professionals to help them engage with smokers about quitting and provide referrals to effective stop smoking support.**

8.2 There is a strong international evidence base for the role of marketing communications and mass media in reducing smoking prevalence. These remain important levers in influencing

1.5 million quit attempts (estimated to be around a third of the total annual number of quit attempts) and over 100,000 successful quits in each year.

8.3   Marketing communications for tobacco control over the last few years has centred on three key objectives: reinforcing the motivation of smokers to quit, triggering quitting action and making quitting more successful by signposting people to the most effective support available. The key target audience has been routine and manual workers, because of the significant number of smokers in this group. Over a three-year period, it is estimated that the Department of Health's marketing communications have returned £4.58 in savings for every pound spent to the NHS alone.

8.4   As part of marketing activity to encourage smokers to quit, the Department of Health launched a new Quit Kit in January 2010. Aimed particularly at people who attempt to quit without any help, the Quit Kit incorporates insights from research and behavioural economics to prompt quit attempts and to introduce the idea of using effective quitting support. We will carefully evaluate the outcomes of the new Quit Kit to inform our future marketing activity.

8.5   We will continue to take an insight-driven and evidence-based approach to developing communications and social marketing initiatives. We will also draw from emerging thinking, particularly around behavioural economics, to develop innovative approaches to influencing behaviour. Where the evidence base is still developing, we will take a "test, learn and refine" approach to trial ideas so that we can develop understanding about

what is most effective. Our emphasis will be on delivering the maximum efficiency and effectiveness from marketing communications at local and national level.

8.6   By mid-2011, we will publish a new three-year marketing strategy for tobacco control. The marketing strategy will set out the role for marketing communications in delivering this Tobacco Control Plan, particularly on: motivating tobacco users to quit; signposting tobacco users to the most effective cessation support; reducing uptake of smoking by young people; communicating the harms of secondhand smoke; and encouraging smokers to make their homes and cars smokefree.

8.7   Our communications activities will be aimed at supporting local areas by:

- providing clear and nationally consistent information to help smokers to quit and direct them to the most effective quitting options, through the communications channels that we own (such as the NHS Smokefree website and Facebook site) and through working with a wide range of partners across the public, private and third sectors, for example other government departments, local authorities, local stop smoking services, local tobacco control alliances, businesses, schools, civil society and employers;

- continuing to reach out to the groups with the highest smoking rates, in particular those people with routine and manual jobs;

- exploring ways to provide young people with information about risky behaviours that can affect their health, including tobacco use, and to help them to develop their ability to resist pressures to take up smoking. This work is likely to involve digital media due to its reach and popularity among young people;

- working with health and social care professionals to help them to engage with smokers, including pregnant smokers, about quitting and to provide referrals to effective stop smoking support;

- building on work to galvanise local social marketing efforts and ensuring that national and local initiatives work together to achieve maximum impact;

- minimising duplication and making the best use of resources by sharing messaging, research findings, evaluation, best practice guidance, "Smokefree" brand guidelines and other materials with local areas; and

- providing guidance on how behavioural insights can be used by local areas to shape positive social norms, discourage the use of tobacco and to encourage smokers to voluntarily make their homes and family cars smokefree.

9. INFORMATION AND INTELLIGENCE

9.1 The Public Health White Paper, *Healthy Lives, Healthy People*, sets out the role for Public Health England in developing an evidence-based approach to public health, promoting information-led, knowledge-driven public health interventions. We will continue to develop existing and new sources of evidence on tobacco control to form an increasingly coherent and comprehensive evidence base that is useful at national and local levels.

National and local data collection

9.2 Estimates of smoking prevalence among adults became available at local authority level for the first time in September 2010 through the Office for National Statistics *Integrated Household Survey* (IHS). This information is expected to form a central element of the proposed Public Health Outcomes Framework and health premium. Results from the IHS are available more frequently and quickly than the information that has previously been used to track smoking prevalence. This will enable local areas to plan tobacco control strategies based on data that is more current, and to monitor the effectiveness of their activities.

9.3 To complement the IHS, important data on smoking and health-related matters is available from the NHS Information Centre's *Health Survey for England*. The survey can be analysed across various strands of equality, which is vital given the role of smoking in perpetuating health inequalities. Information on cotinine levels, obtained through saliva samples from those aged 4 and over, is also collected. This provides an indication of personal tobacco use and exposure to secondhand smoke. The survey has been running since 1994, providing a valuable insight into changes in smoking behaviours over time.

9.4 Our understanding of smoking among children is informed by the NHS Information Centre's *Survey of Smoking, Drinking and Drug Use Among Young People* (SDD). SDD offers a wide range of information about children aged 11 to 15, encompassing smoking behaviour, family influences, where children get cigarettes, dependence on smoking, attitudes and beliefs, lessons about smoking, sources of helpful information about smoking, school policies on smoking and other factors associated with regular smoking.

9.5 SDD is a school-based survey and is, therefore, unable to cover those beyond the age of compulsory education. While the *Health Survey for England* obtains information about smoking behaviour from those aged 8 or over, the number of 16 and 17 year olds and young adults covered by the survey is limited to about 200 in each year group. This is a key age group for the uptake of smoking and the limited availability of information for this group is

a problem. We will examine the potential to collect information for this group through other surveys.

9.6 We are also interested in smoking among other particular groups of the population. Smoking rates among people with mental illness cause concern and we will continue to collect data through the NHS Information Centre's *Adult Psychiatric Morbidity Survey*. One of the objectives of *No Health Without Mental Health*, the Government's new mental health strategy, is to improve the physical health of people with mental health problems, and tackling high smoking rates is vital in achieving this.

9.7 Smoking during pregnancy causes a range of serious health problems for mothers and their babies. The Department of Health currently publishes quarterly information on the smoking status of pregnant women at the time of delivery in each Primary Care Trust area (*Smoking status at time of delivery*). We are working with the NHS Information Centre to obtain more detailed information on smoking in pregnancy. The results from the latest *Infant Feeding Survey* will be published in 2011 and these will provide current information about smoking before, during and after pregnancy.

9.8 We want to do more to make evidence available and easy to use. Results from each of these data sources are published on a routine basis. The underlying data is also made available to researchers through the UK Data Archive in order to enable as much value to be derived from the information as possible.

9.9 The Department of Health has commissioned the London Health Observatory to produce local tobacco control profiles to enable commissioners, providers and service users to compare tobacco-related outcomes for their areas. We will continue to support the provision of meaningful information to local areas to inform the delivery of their public health strategies.

9.10 We will look for further opportunities to maximise the opportunities around data on tobacco use as the central information and intelligence function of Public Health England evolves, working closely with public health and academic partners with an interest in surveillance, monitoring, evaluation and intelligence. In particular, we will include tobacco within the single, accessible and authoritative web-based evidence system for professionals set out in *Healthy Lives, Healthy People*.

Supporting commissioning of comprehensive tobacco control in local areas

9.11 Good-quality local information lies at the heart of effective local commissioning for comprehensive tobacco control. We will work to ensure that transparent data systems are made available for local areas to use. These systems will help commissioners and providers to know how effective their local services are, and will help to guide individuals towards which smoking cessation support they want to use.

9.12 We will support the provision of relevant local data sources to inform the development of Joint Strategic Needs

Assessments. This information will also be of use nationally to inform benchmarking and cost-effectiveness analysis.

9.13 We will encourage the development of modelling tools to enable local commissioners to select the tobacco control interventions that will best meet the needs of the local population. By encouraging the development and provision of cost-impact information through the publication of national costing templates, we will support the development of local tobacco control strategies.

9.14 To assist the commissioning and provision of local stop smoking services, we will support data collection and monitoring of people who use these services. We will continue to recommend that stop smoking service provision is evaluated against a number of measures, including the principles of service delivery described in the Department of Health's *Local Stop Smoking Services: Service and monitoring guidance*.

9.15 As a key aspect of monitoring the quality of provision of local stop smoking services, we will encourage local areas to monitor the numbers of people who achieve a "four-week" quit date that has been validated bio-chemically through expired carbon monoxide or cotinine measurement. This will enable commissioners to understand the likely impact of the services on local smoking prevalence rates.

Tobacco control research and policy development

9.16 The evidence base for comprehensive tobacco control is extensive, and the UK is a leader in tobacco control research and policy development. The Government will continue to use evidence to inform the development of tobacco control policy, as well as to guide its implementation. We will continue to encourage future research in the field of comprehensive tobacco control.

10. PROTECTING TOBACCO CONTROL FROM VESTED INTERESTS

10.1 The Government takes very seriously its obligations as a Party to the World Health Organization's Framework Convention on Tobacco Control (FCTC). The FCTC places obligations on Parties to protect the development of public health policy from the vested interests of the tobacco industry. As a result, the tobacco industry has not been involved in the development of this Tobacco Control Plan.

10.2 To ensure further transparency, the Government commits to publishing the details of all policy-related meetings between the tobacco industry and government departments. This excludes meetings to discuss operational matters to reduce the illicit trade in tobacco and bilateral meetings between tobacco manufacturers and HM Revenue & Customs. In the future, organisations engaging with the Department of Health on tobacco control, for example by responding to consultation exercises, will be asked to disclose any links with, or funding received from, the tobacco industry.

10.3 Local authorities are encouraged to follow the Government's lead in this area, and to take necessary action to protect their tobacco control strategies from vested interests. While we recognise that there may be legitimate operational reasons for local authorities to deal with the tobacco industry, we would encourage transparency in all dealings.

APPENDIX: RESOURCES FOR COMPREHENSIVE TOBACCO CONTROL

Public health in England:

Healthy Lives, Healthy People: Our strategy for public health in England (HM Government) White Paper and associated documents:
http://www.dh.gov.uk/en/publichealth/healthyliveshealthypeople

No Health Without Mental Health: A cross-Government mental health outcomes strategy for people of all ages (HM Government):
http://www.dh.gov.uk/en/Healthcare/Mentalhealth/MentalHealthStrategy/index.htm

Comprehensive tobacco control:

A Comprehensive Guide to Achieving Effective Local Tobacco Control: Evidence, support and publications developed by the Tobacco Control National Support Team, 2006–2011 (Department of Health National Support Team):
http://www.dh.gov.uk/nst

Excellence in Tobacco Control: 10 high impact changes to achieve tobacco control (Department of Health National Support Team):
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_084847

Tobacco Control: The story so far (Local Government Improvement and Development):
http://www.idea.gov.uk/idk/aio/21028759

Reducing Health Inequalities through Tobacco Control: A guide for councils (Local Government Group):
http://www.idea.gov.uk/idk/core/page.do?pageId=25455569

Tobacco Control Alliances: A toolkit for London (Department of Health and Chartered Institute of Environmental Health):
http://www.cieh.org/publication/tobacco_control_alliances.html

Infrastructure and Outcome Indicators of an Effective Tobacco Control Alliance: A toolkit
(Department of Health and Smokefree Yorkshire and Humber):
http://www.yorksandhumber.nhs.uk/document.php?o=4761

General tobacco resources:

Going smoke-free: the medical case for clean air in the home, at work and in public places:
A report on passive smoking by the Tobacco Advisory Group of the Royal College of Physicians
(Royal College of Physicians):
http://bookshop.rcplondon.ac.uk/contents/pub4-fc8ce703-7a85-4f1e-a579-1151971a5157.pdf

Harm reduction in nicotine addiction: Helping people who can't quit (Royal College of Physicians):
http://bookshop.rcplondon.ac.uk/contents/pub234-aafdfc2b-5c23-4ee3-8f1d-ea18f017edce.pdf

Passive smoking and children: A report by the Tobacco Advisory Group of the Royal College of
Physicians (Royal College of Physicians):
http://bookshop.rcplondon.ac.uk/contents/pub305-e37e88a5-4643-4402-9298-6936de103266.pdf

Cough up: Balancing tobacco income and costs in society (Policy Exchange):
http://www.policyexchange.org.uk/images/publications/pdfs/Cough_Up_-_March__10.pdf

Action on Smoking and Health website:
http://www.ash.org.uk

Smokefree Action Coalition website:
http://www.smokefreeaction.org.uk

Enforcement of tobacco legislation:

Essential Elements of Tobacco Control (East of England Trading Standards Association):
http://www.lacors.gov.uk/lacors/ContentDetails.aspx?id=23435

Implementation of smokefree legislation in England: Guidance for local council regulatory officers
(Local Government Regulation, Chartered Institute of Environmental Health and Trading
Standards Institute):
http://www.cieh.org/policy/smokefree_workplaces.html

Implementation of smokefree legislation in England: Associated issues (Local Government Regulation, Chartered Institute of Environmental Health and Trading Standards Institute):
http://www.cieh.org/policy/smokefree_workplaces.html

Implementation of smokefree legislation in England: Supplementary guidance for local authority regulatory officers on dealing with non-compliance in shisha bars (Local Government Regulation, Chartered Institute of Environmental Health and Trading Standards Institute):
http://www.lacors.com/lacors/ContentDetails.aspx?id=24860

Tobacco control survey England 2009–10: A report of council trading standards service activity (Local Government Regulation):
http://www.lacors.gov.uk/lacors/ContentDetails.aspx?authCode=34C4416&id=23992

Directory of niche tobacco products website:
http://www.ntpd.lacors.gov.uk

Tackling illicit tobacco:

Tackling Tobacco Smuggling Together (HM Revenue & Customs and UK Border Agency):
http://www.hmrc.gov.uk/pbr2008/tobacco-2800.pdf

Illicit Tobacco: An introductory guide for enforcement agencies (Local Government Improvement and Development):
http://www.lacors.gov.uk/lacors/ContentDetails.aspx?authCode=34C4416&id=23435

North of England Tackling Illicit Tobacco for Better Health programme website:
http://www.illicittobacconorth.org

Supporting tobacco users to quit:

Smoking cessation services (NICE public health guidance 10):
http://www.nice.org.uk/PH10

Varenicline for smoking cessation (NICE technology appraisal 123):
http://www.nice.org.uk/TA123

Workplace interventions to promote smoking cessation (NICE public health guidance 5):
http://www.nice.org.uk/PH5

Brief interventions and referral for smoking cessation in primary care and other settings
(NICE public health guidance 1):
http://www.nice.org.uk/PH1

Identifying and supporting people most at risk of dying prematurely (NICE public health guidance 15):
http://www.nice.org.uk/PH15

Stop Smoking Services: Service and monitoring guidance 2010/11 (Department of Health):
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_109696

Smokefree Resource Centre (Department of Health):
http://www.smokefree.nhs.uk/resources

Quitting smoking in pregnancy and following childbirth (NICE public health guidance 26):
http://www.nice.org.uk/PH26

*Reducing smoking pre-conception, during pregnancy and postpartum: Integrating high impact
actions into routine healthcare practice* (Department of Health and NHS Yorkshire and The Humber):
http://www.yorksandhumber.nhs.uk/document.php?o=1073

Delivering Healthy Ambitions, Better for Less: Smoking in pregnancy (NHS Yorkshire and The Humber):
http://www.yorksandhumber.nhs.uk/document.php?o=6682

Department of Health's Quality, Innovation, Productivity and Prevention website:
http://www.dh.gov.uk/qualityandproductivity

NHS Centre for Smoking Cessation and Training website:
http://www.ncsct.co.uk

Stop Smoking Services Needs Analysis: A Toolkit for Commissioners (NHS Centre for Smoking
Cessation and Training):
http://www.ncsct.co.uk/resources/downloads/NCSCT_needs_analysis_final.pdf

Smoking and young people:

Preventing the uptake of smoking by children and young people (NICE public health guidance 14):
http://www.nice.org.uk/PH14

School-based interventions to prevent smoking (NICE public health guidance 23):
http://www.nice.org.uk/PH23

Social marketing and tobacco control:

Social marketing approach to tobacco control: A practical guide for local authorities
(Local Government Improvement and Development):
http://www.idea.gov.uk/idk/aio/21028178

National Social Marketing Centre website:
http://www.thensmc.com

Behaviour change for public health:

Behaviour change at population, community and individual levels (NICE public health guidance 6):
http://www.nice.org.uk/PH6

Community engagement to improve health (NICE public health guidance 9):
http://www.nice.org.uk/PH9

Applying behavioural insight to health (Cabinet Office Behavioural Insights Team):
http://www.cabinetoffice.gov.uk/resource-library/applying-behavioural-insight-health

Smoking statistics:

Local Tobacco Control Profiles for England (London Public Health Observatory):
http://www.lho.org.uk/LHO_Topics/Analytic_Tools/TobaccoControlProfiles

Links to statistics on smoking:
http://www.lho.org.uk/LHO_Topics/National_Lead_Areas/NationalSmoking.aspx#Resources

Tobacco-related research:

UK Centre for tobacco control studies website:
http://www.ukctcs.org

International tobacco control:

World Health Organization Framework Convention on Tobacco Control:
http://www.who.int/fctc

World Health Organization Tobacco Free Initiative:
http://www.who.int/tobacco

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Sources and definitions for Figure 4: *Smoking prevalence in eight countries including England*

England: General Lifestyles Survey, Office for National Statistics: current smokers (those answering yes to the question "do you smoke at all nowadays?") aged 16 or over.

United States: CDC/NCHS, National Health Interview Survey, 1997–2009, Sample Adult Core component: Current smokers (those who had smoked more than 100 cigarettes in their lifetime and now smoke every day or some days) aged 18 or over.

Canada: Canadian Tobacco Use Monitoring Survey (CTUMS), Health Canada: Current smokers (daily and occasional) aged 15 or over.

France: Baromètre Santé, l'Institut National de Prévention et d'Education pour la Santé (Inpes): Current smokers (daily and occasional) aged 15 to 75 years old.

Germany: Mikrozensus, Statistisches Bundesamt: Current smokers (daily and occasional) aged 15 or over.

Ireland: Ipsos MRBI telephone omnipoll, Office of Tobacco Control: Current smokers (those answering yes to the question "Do you smoke one or more cigarettes each week, whether packaged or roll your own?") aged 15 or over.

Australia: National Health Survey, Australian Bureau of Statistics: Current smokers (daily and occasional) aged 15 or over.

New Zealand: Tobacco Trends 2008: A brief update of tobacco use in New Zealand, Ministry of Health: Current smokers (those who had smoked more than 100 cigarettes in their lifetime and currently smoke at least once a month) aged 15 or over.

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of Health