SMOKEFREE DEVON ALLIANCE

TOBACCO CONTROL STRATEGY UPDATE 2016-17

Foreword

Smoking is the biggest single preventable cause of disease and premature death in Devon. It is estimated that 1,227 people die from smoking related illness every year in the Devon County Council area. Over the last few years we have made impressive progress in reducing the proportion of people smoking in Devon, but we still need to do more to stop people being harmed or killed by tobacco. I am confident that our updated strategy will continue to address this major public health challenge.

Dr Virginia Pearson
Director of Public Health, Devon County Council

This revised tobacco control strategy continues to be of paramount importance, particularly in addressing health inequalities. There will be new opportunities to seize as stronger links are made with key partners in the Alliance. The first Smokefree Devon Alliance strategy was launched in 2009 and then amended following the publication of the coalition government's Tobacco Plan in 2011. The current government plans to publish a new Tobacco Control Strategy for England this year and this will inform our strategic approach in the future. The social and economic burden of smoking on individuals and communities is significant and I look forward to driving smoking prevalence in Devon even further downwards.

Dr Phil Norrey
Chief Executive, Devon County Council

Contents

Introduction

This document sets out a tobacco strategy for Devon.

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

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

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

The Devon HWBB developed its first Joint Health and Wellbeing Strategy 2013-16 (JHWBS) which states the importance of lifestyle choices in improving health and reducing health inequalities; reducing the proportion of people in Devon who still smoke and preventing young people from starting smoking still remains a priority as stated in the most recent update in June 2015.

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

SECTION 1

1. The Burden of Smoking

1.1.1 The impact of smoking

Smoking is the largest single preventable cause of death, killing over 78,000 people annually in England alone. This totals more than obesity, diabetes, alcohol and drug related deaths and road traffic accidents put together.[1] Tobacco is linked to more than 200 diseases and is the primary cause of lung cancer and chronic obstructive pulmonary disease (COPD). Moreover, it is the primary reason for the gap in healthy life expectancy between rich and poor as identified by Marmot in his review of health inequalities.[2]

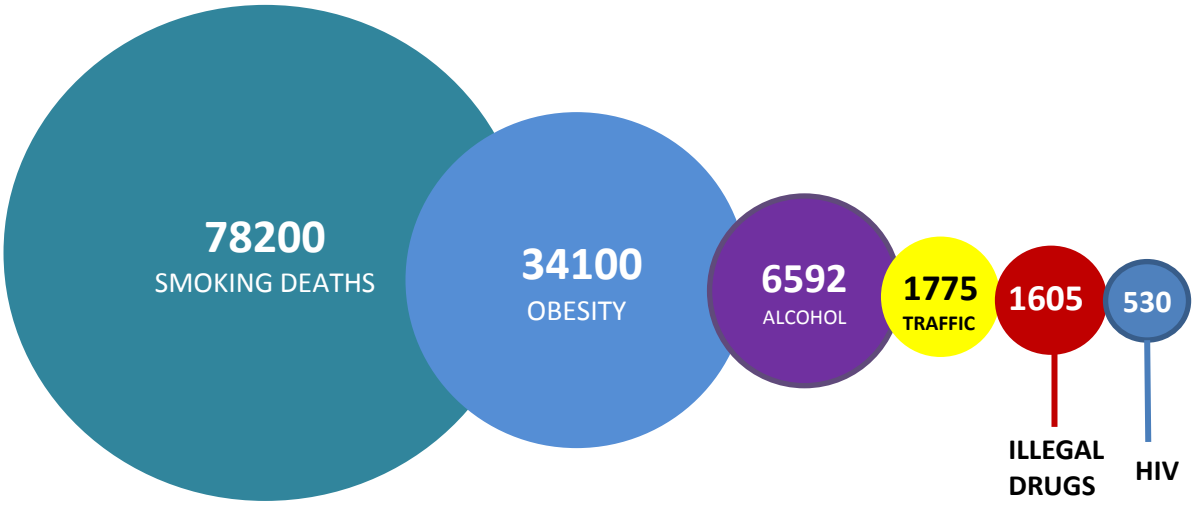

Figure 1: Source ASH Factsheet: Smoking statistics, illness and death, December 2015[1]

Total annual deaths in Devon caused by smoking are 1227 but levels do vary greatly across local authority areas.[3] Mortality statistics for Devon are shown in Table 1 on the next page.

[1] ASH (2015). *Smoking Statistics, Illness and Death.* London: ASH. Available from: www.ash.org.uk/files/documents/ASH_107.pdf [Accessed 21 March 2016].

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

[3] Actual per year in period 2012-14. Local Tobacco Control Profiles 2015, Devon, PHE.

Local Authority Area	Smoking related deaths (per 100,000)
East Devon	204
Exeter	237
Mid Devon	236
North Devon	261
South Hams	229
Torridge	243
Teignbridge	246
West Devon	220

Table 1: Smoking attributable mortality in Devon
Source: Health Profiles 2014[4]

Smoking is the greatest single factor in the different life expectancy between social classes. Figure 2 shows an estimate of smoking prevalence across Devon in 2016. There is a 3.5 fold difference between the lowest estimated smoking rate in Devon (9.36% in Cotaton, Sidmouth) and highest (34.7% in parts of Exeter City Centre). Areas with a younger age profile and a higher level of deprivation are particularly affected, which also includes areas with higher levels of rural deprivation.[5]

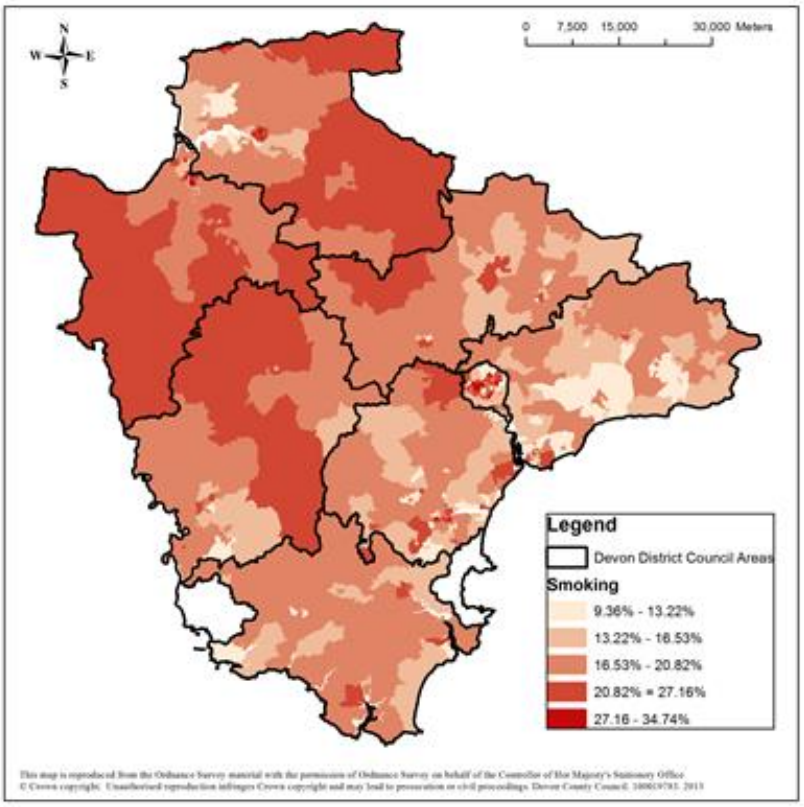

Figure 2: Estimated Smoking Prevalence Across Devon
Source: Public Health Devon Estimates 2016 (using 2014 population data)

[4] Public Health England, 2016. *Health Profiles (using 2014 population data).* Available from: fingertips.phe.org.uk/profile/health-profiles [Accessed 21 March 2016].
[5] Public Health Devon Estimates 2016 (using 2014 population data)

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

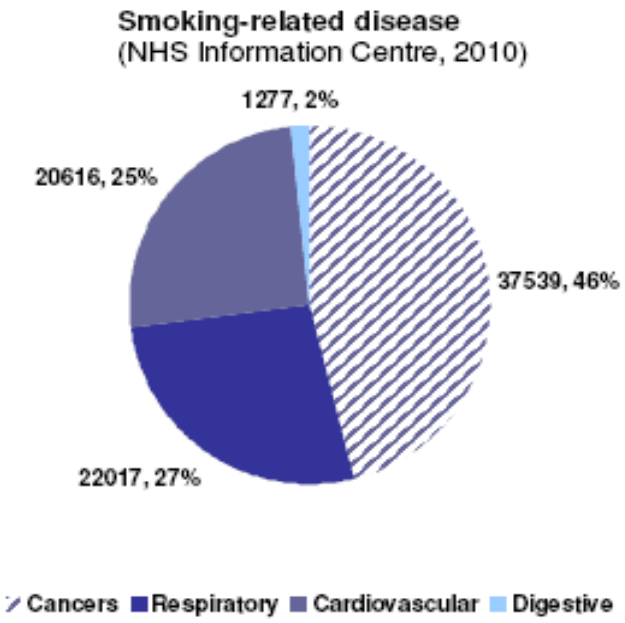

Figure 3: Comparison of disease

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

Indicator	Devon value	England Average	England Worst	England Best
Smoking attributable mortality 2012-14	220.2	274.8	458.1	184.9
Smoking attributable deaths from heart disease 2012-14	24.6	29.7	58.1	18.9
Smoking attributable deaths from stroke 2012-14	8	9.3	17.8	6.3
Deaths from lung cancer 2012-14	47.1	59.5	107.7	29.8
Deaths from chronic obstructive pulmonary disease 2012-14	33.1	51.7	103.6	28.1

Table 2: Mortality in Devon

(Local Tobacco Control Profiles for England 2015. London Health Observatory. Data shown is the age-standarised rate per 100,000 population)

1.1.2 Hospital Admissions

There are over 7900 admissions to NHS Devon hospitals each year which are due to smoking. This is estimated to cost the NHS around £16.8 million each year.

Indicator	Devon value	England Average	England Worst	England Best
Smoking attributable hospital admissions 2014/15	1489	1671	2835	1030
Cost per capita of smoking attributable admissions 2011/12	£35.6	£38	£59.3	£23

Table 3: Hospital Admissions in Devon
(Local Tobacco Control Profiles for England 2015. London Health Observatory. Data shown is the age-standardised rate per 100,000)

1.1.3 Risk Pyramid

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

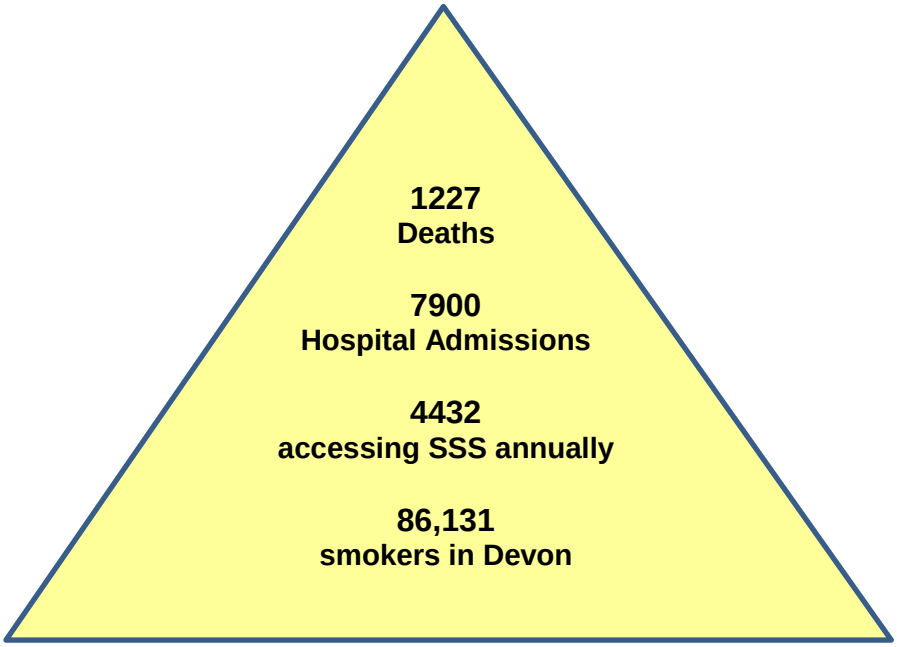

Figure 4: Risk pyramid; smoking in Devon

1.1.4 Secondhand smoke

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

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

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

1.1.5 Prisoners

Around four times as many people in prisons smoke than in the general population. The last national survey (1997) found between 78%-85% of sentenced and remand prisoners were smokers. A more recent survey of 6 prisons in 2014 reported smoking rates of between 62%-81%The prevalence is even higher amongst those who are dependent on drugs and/or alcohol and/or who have mental illness. Quit rates for prisoners and staff are consistent with those of the community, with some individual prisons out-performing local community settings.

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

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

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[6] Secondhand smoke: Review of evidence since 1998. Scientific Committee on Tobacco and Health (SCOTH). Department of Health, 2004.

[7] Passive smoking and children. A report of the Tobacco Advisory Group of the Royal College of Physicians. London, RCP, 2010.

[8] Jamrozik,K Estimate of deaths among adults in the United Kingdom attributable to passive smoking. BMJ 2005, published online 1 March 2005.

1.1.6 Smoking in pregnancy

Smoking in pregnancy can cause increased risk of miscarriage, stillbirth, preterm birth and low birth weight.[910]It has been found to increase infant mortality by about 40%. Pregnant women from unskilled occupation groups are five times more likely to smoke than professionals and teenagers in England are six times more likely to smoke than older mothers. [11]

1.1.7 Smoking and fires

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

In the south west in 2008-13, at least 20 fatalities were caused by fires started by "smokers' materials" which are still the most common source of ignition in household fires.

1.2 The Economy

1.2.1 National costs of smoking

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

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

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[9] Board of Science and Education. Smoking and reproductive life. The impact of smoking on sexual, reproductive and child health. 2014, British Medical Association.

[10] Castles, A. et al., Effects of smoking during pregnancy: five meta-analyses, American Journal of Preventive Medicine 16 (3), 1999: 208-215.

.Smoking Cessation in Pregnancy: a call to action; 2013, ASH

[12] Allender S, Balakrishnan et al. The burden of smoking related ill health in the UK, Tobacco Control 2009; 18: 262-267.

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

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

1.2.2 Devon costs of smoking

In Devon it is estimated that smoking related health costs to the NHS alone are approximately £28.2m annually. There are over 7900 admissions to NHS Devon hospitals each year which are due to smoking. This is estimated to cost the NHS around £16.8 million each year.

The cost of smoking to society in Devon (including smoking related lost productivity, absenteeism, litter cleaning, fires etc.) and the NHS, is estimated to be £162.5m. The cost of smoking related fires can be divided into the response costs to the fire service in dealing with an incident, and the consequential costs, such as cost to insurers and property owners, and the physical, employment and emotional costs of injuries and death.

In 2014/15. Smokers in Devon paid approximately £96.4m in duty on tobacco products. Despite this contribution there is still a shortfall, meaning that tobacco still costs the local Devon economy £66m each year.

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

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[13] 'Building the economic case for tobacco control', available at http://www.brunel.ac.uk/herg/research-programme/building-the-economic-case-for-tobacco-control

[14] Available at www.**ash**.org.uk/**local**toolkit/docs/Reckoner.xls

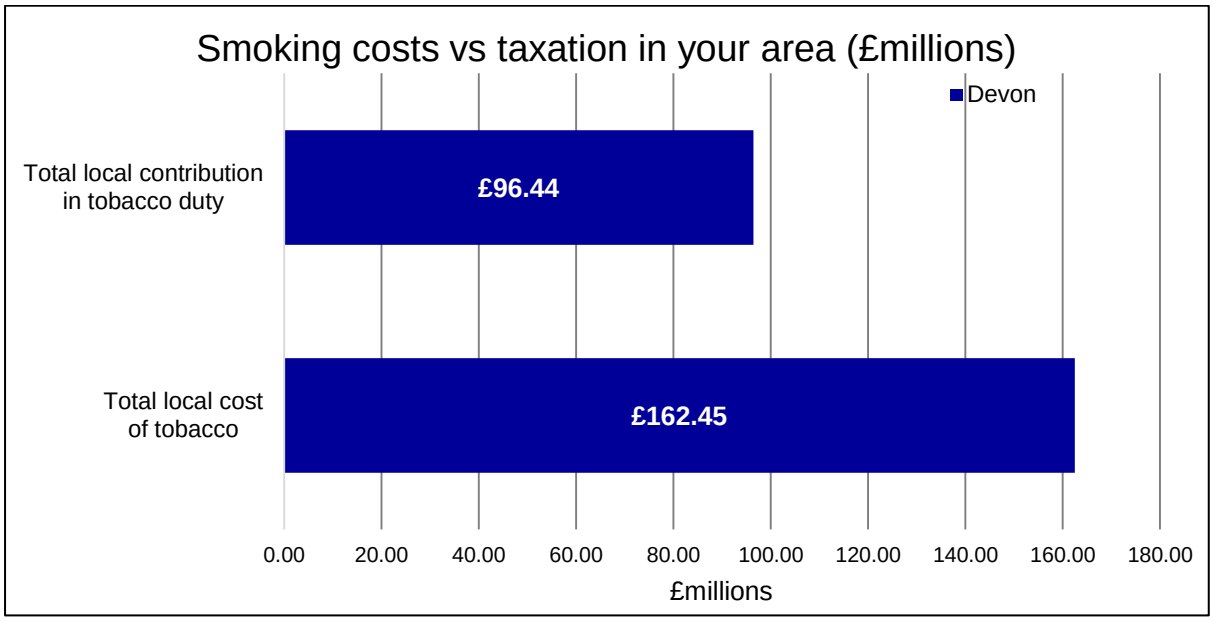

Figure 5: Cost of Smoking vs Contribution in Tobacco Duty in Devon 2015

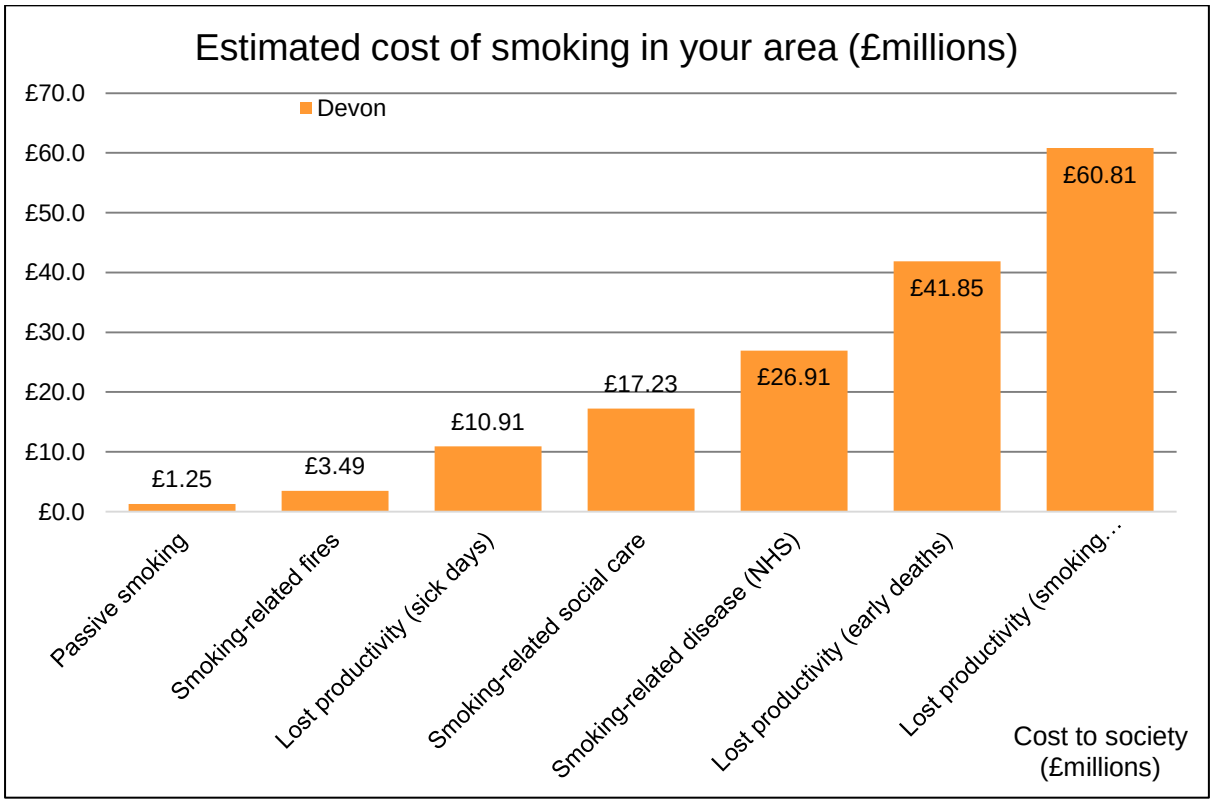

Figure 6: Estimated breakdown of societal costs in Devon 2015
Source: Available at www.**ash**.org.uk/localtoolkit/docs/**Reckoner**.xls

Fires

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

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

2. The Present Picture
The Prevalence of Smoking in Devon

2.1 Adults

There have been huge strides made in reducing prevalence over the last ten years. A significant impact was made by the Health Act 2006 which introduced a ban on smoking in public places and workplaces in July 2007. The public have been extremely compliant with this legislation and it has prompted quit attempts and helped ex-smokers maintain their behaviour. The prevalence of smoking in Devon fell from 24.1% in 2007 to 19.4% in 2008 after the ban. Since then, smoking prevalence dropped further to 13.8% in 2015 - a significant 10.3% reduction in eight years.

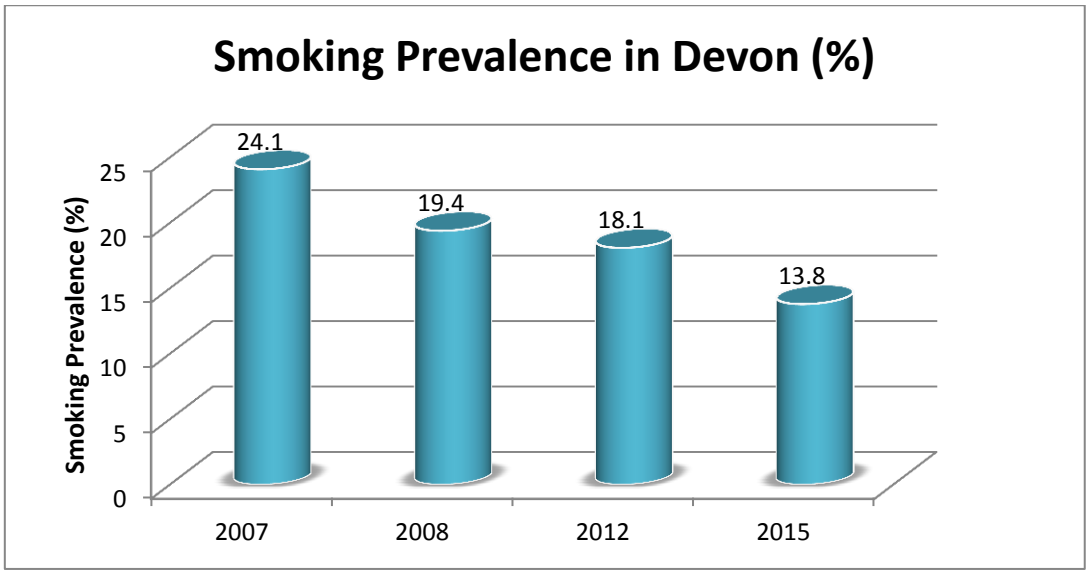

Figure 7: Smoking prevalence in Devon
Source: Health Profiles for England (APHO) 2015[15]

[15] Public Health England, 2016. *Health Profiles.* Available from: fingertips.phe.org.uk/profile/health-profiles [Accessed 21 March 2016].

Current smoking rates in England are 18% generally and 28% for routine and manual groups (R/M). Across Devon (excluding Plymouth and Torbay), the most recent estimated smoking rate is 13.8%.[16] However, there is variation between local authority areas as can be seen in Figure 6 below, with North Devon and Exeter having the highest smoking rates.

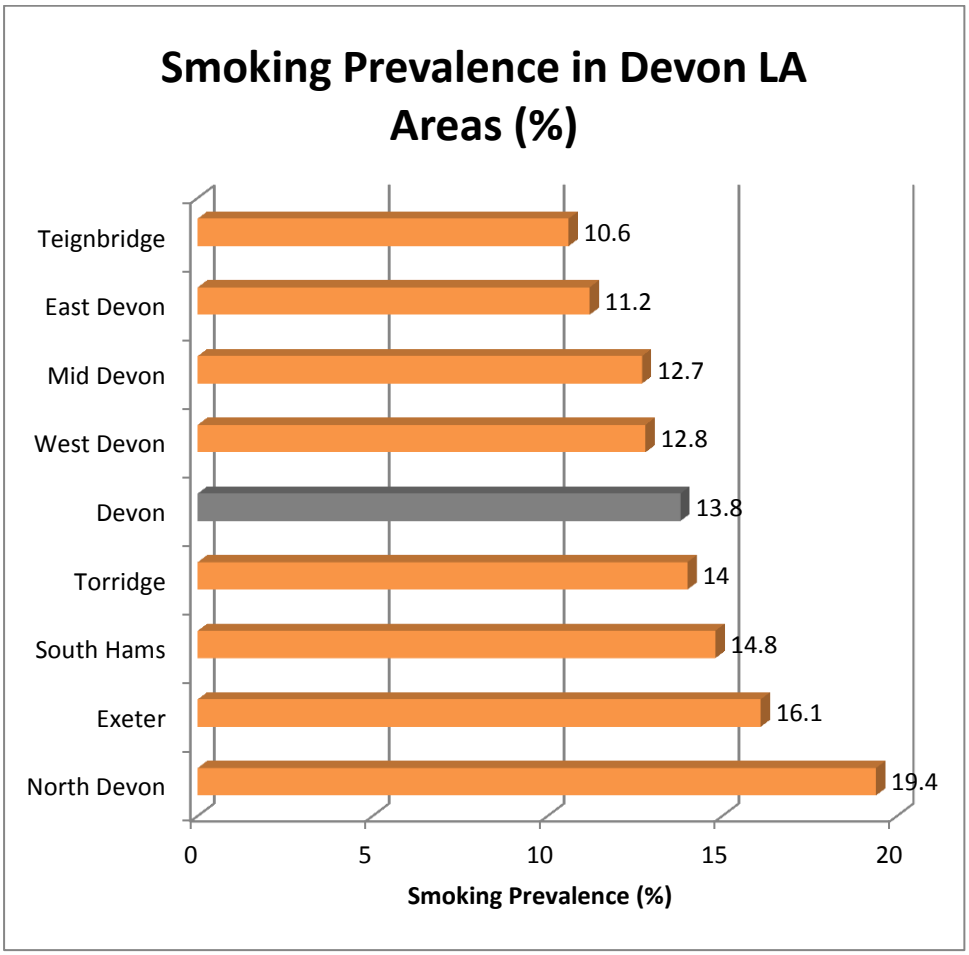

Figure 8: Smoking prevalence in Devon.
Source: Local Tobacco Control Profiles, 2015.

Most smokers are found in the routine and manual occupational groups (figure 9) and stop smoking services have directed their efforts at this group. Smoking is the leading cause of health inequalities as the poorer you are, the more likely you are to smoke. Smokers with mental health problems are heavier and more dependent smokers than those in the general population. For example one study found that 51% of those with schizophrenia and half of those with bipolar affective disorder, smoked more than 20 cigarettes a day compared to only 8% in the general population (ONS, 2002).[17] Life expectancy generally is 5.6 years lower for men and 3.1 years lower for women in the most deprived areas of Devon than in the least deprived areas.[18]

[16] Local Tobacco Control Profiles 2015
[17] Coultard, M., Farrell, M., Singleton, N. and Meltzer, H. (2000). *Tobacco, alcohol and drug use and mental health.* London: Stationery Office.
[18] Devon Health and Wellbeing Outcomes Report 2016

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

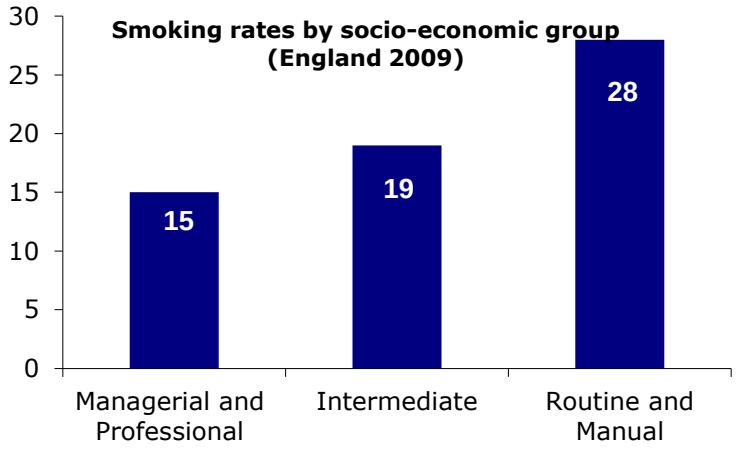

Figure 9: Source: General Lifestyle Survey, ONS 2010

2.2 Prisoners

Devon has three prisons; Exeter, Channings Wood and Dartmoor. The Devon Prisons Health Needs Assessment 2011 shows that the percentage of prisoners that smoke is considerably higher than the prevalence in the general population, with around 70% of prisoners smoking in all three prisons. This is however slightly lower than the expected prevalence of smokers based on Office for National Statistics studies on the general prison population, 1997, which suggests around 80% of prisoners smoke. The prison setting provides an opportunity to target smokers and reduce health inequalities.

As the South West has been working towards the Smokefree agenda within prisons for a number of years, HMPs Exeter, Channings Wood, Dartmoor and Erlestoke have all been chosen to be a part of the early adopter sites for a smokefree policy.

The Smokefree policy is set to go live in HMP Exeter during May 2016, to then be rolled out to the other three prisons throughout the year. This will have a significant effect on smoking prevalence in Devon and will be an important action towards addressing health inequalities.

2.3 Pregnant women

In 2014/15, 11.4% of women smoked at the time of delivery in England. However, this figure is considered to be underreported. In Devon, the prevalence of smoking in pregnancy was 11.2% in 2014/15.[19] This figure is similar to the national average, whereas the lowest prevalence in England is as low as 2.1%. Smoking is more common in younger pregnant women.

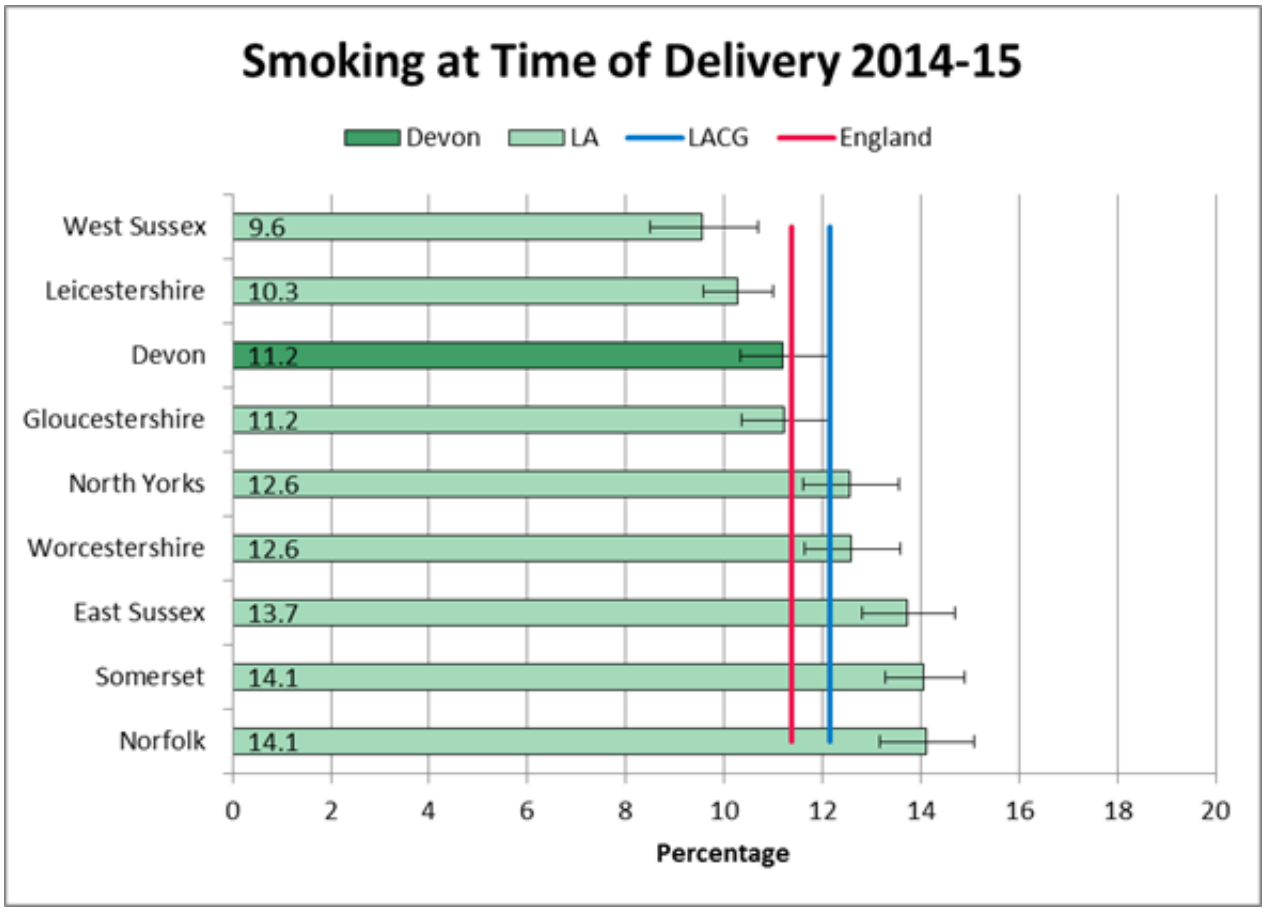

Figure 10: Smoking at Time of Delivery 2014-15 – Local Authority Comparator Group Chart
Source: Joint Health and Wellbeing Strategy Outcomes Framework[20]

[19] Local Tobacco Control Profiles 2015
[20] Joint Health and Wellbeing Strategy Outcomes Framework (www.devonhealthandwellbeing.org.uk)

2.4 Young people

It is estimated that each year in England around 340,000 children under the age of 16 who have never smoked before try cigarettes.[21] Every year, around 200,000 children and young people start smoking regularly.[22] Of these, 67% start before the age of 18 and 84% by age 19 making smoking a decision of childhood.[23]

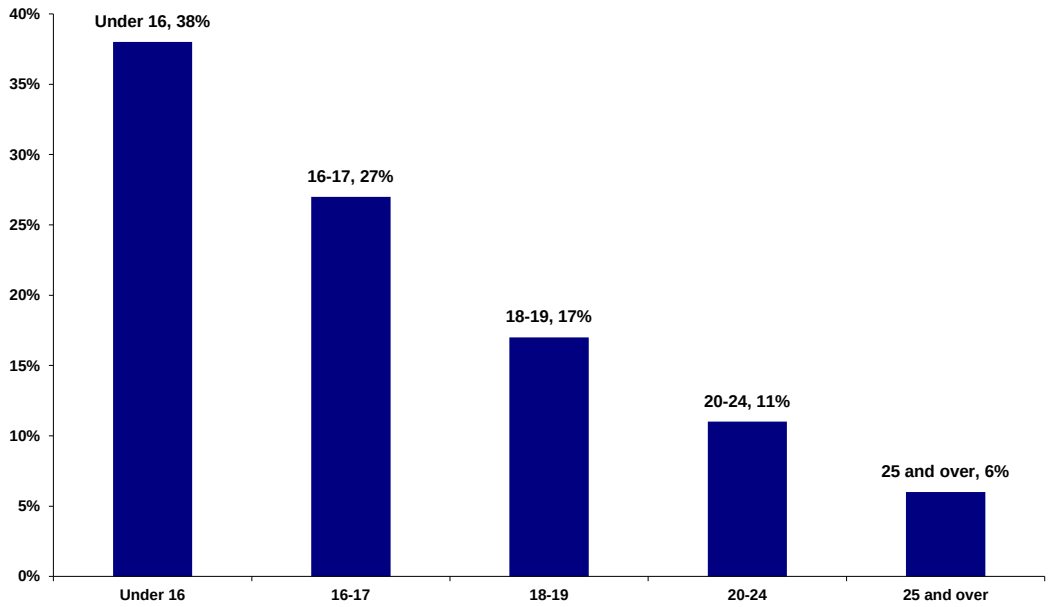

Figure 11: Age of starting smoking (General Lifestyle Survey 2009)

The Health and Social Care Information Centre 2014 survey 'Smoking, Drinking and Drug Use Among Young People in England in 2014' showed that 18% of 11 to 15 year olds had tried smoking, which is the lowest level recorded since the survey began; in 2003 42% had tried smoking. Additionally young people were much less likely to condone smoking, with 26% thinking it was okay to try smoking, compared with 48% in 2003[24].

Although smoking prevalence in children and young people in England continues to decline, it is important that tobacco control work is still focussed in this group. In Devon, smoking prevalence at age 15 is 10%, compared to 8.2% nationally.

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[21] Impact Assessments for the Health Bill. Department of Health, January 2009 page 18 para 54.
[22] A Smokefree Future. A comprehensive tobacco control strategy for England. HM Government, 2010 (p10).
[23] Robinson S & Bugler C. Smoking and drinking among adults, General Lifestyle Survey 2008. ONS, 2010.
[24] Health and Social Care Information Centre (2015). Smoking, drinking and drug use among young people in England in 2014. Available from: www.natcen.ac.uk/media/1006810/Smoking-drinking-drug-use-2014.pdf

Of young people who are regular smokers, 97% reported having either a family member or friend who smoked, compared to 46% in non-smokers. The onset of smoking is a function of three combined factors: individual, family and community. As an individual factor smoking is considered part of the construction of a young person's self-image.[25] Research has shown that young people perceive smoking to be more common than it is and it is used as a social tool, particularly in transition periods. They also feel that smoking helps people relax and cope with life. If others smoke in the household it increases the likelihood of children taking up smoking.

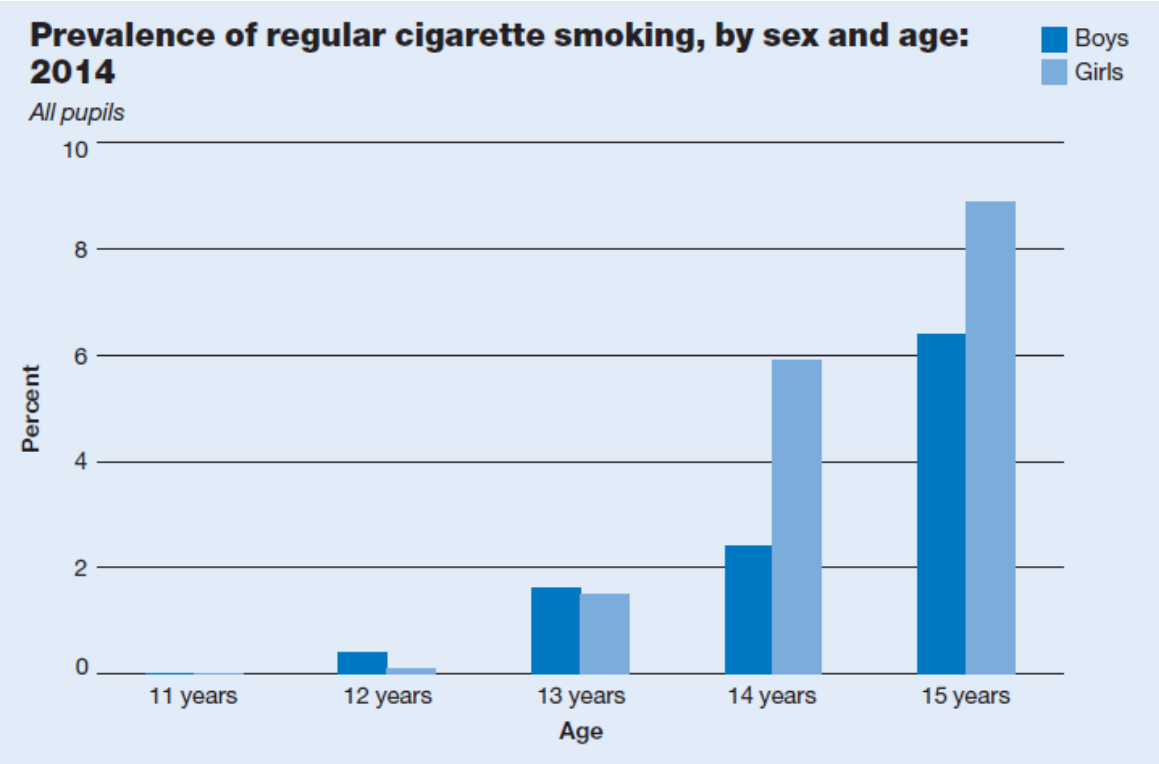

Figure 12: Prevalence of Regular Cigarette Smoking in 11-15 year olds. Source: Smoking, Drinking and Drug Use among Young People 2014

The estimated prevalence of children aged 15 years old in Devon currently smoking is 10.0%, with 6.2% being regular smokers[26]. This means that, in Devon, approximately 832 of 15 year olds are smokers.

[25] Public Health Research Consortium, (2009) A Review of Young People and Smoking in England. Final Report. Preface.
[26] Local Tobacco Control Profiles 2015

3. How is the problem addressed?

3.1 Tobacco control

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

- a strategic approach to tobacco control
- effective partnership working
- a focus on denormalising smoking.[27]

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

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

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

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

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

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

Some actions can only be taken at a national level but there is much to be done at the local level and this was recognised in Healthy Lives, Healthy People: A Tobacco Plan for England (2011). Andrew Lansley, then Secretary of State for Health, in his introduction in the Tobacco Plan, states:-

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

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

The plan set out three ambitions:-

- to reduce smoking prevalence among adults to 18.5% or less (from 21.2%) by the end of 2015

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

- to reduce smoking during pregnancy to 11% or less (from 14%) by the end of 2015.

These ambitions have almost all been met. In 2015 the smoking prevalence was 18% among adults and 8.2% among 15 year olds. Smoking prevalence at the time of delivery was 11.4% and therefore is the only one to not have quite reached the target set out in Healthy Lives, Healthy People.

A new government tobacco control plan is set to be released during Summer 2016. This document will be used to inform the new strategy for the Smokefree Devon Alliance in 2017.

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

- Increased healthy life expectancy

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

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

Tobacco control work in Devon has a strong evidence base and a performance framework including the three main public health indicators above which are reported to the Health & Wellbeing Board as part of its implementation of the Joint Health & Wellbeing Strategy for 2013-16. This will track the trajectory for reduced prevalence and the inequality gap between the least and most deprived areas in Devon. The *Update on the Joint Health and Wellbeing Strategy for 2013-2016: Year 3* was completed in June 2015[28].

4. Modelling the future

4.1 The Pipe Model

The Alliance has modelled potential outcomes using The Smoking Pipe Model: A model of the inflow and outflow of smokers (West R).[29] It models numbers joining the smoking 'pool' (young people, immigration) and those leaving the 'pool' (deaths, quitters, emigration). This model can be used to estimate future outcomes.

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

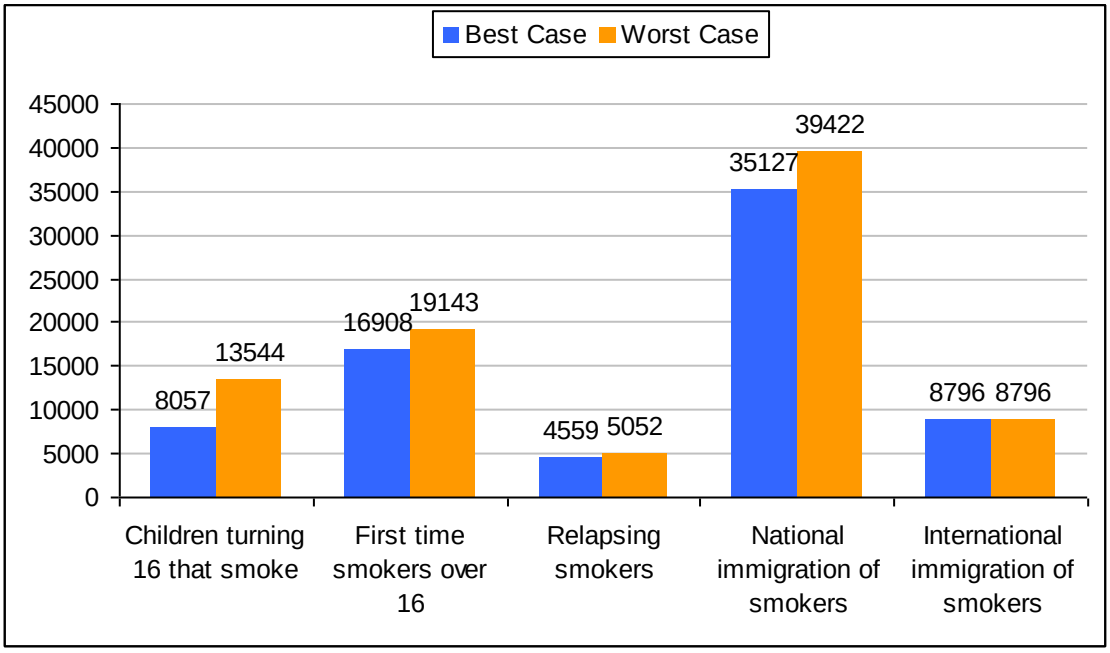

Figure 13: Sources of new smokers to the 16+ population of Devon – between 2010 and 2016 (7 year period)

[28] Devon Health and Wellbeing Board (2015).*Update on the Joint Health and Wellbeing Strategy for 2013-2016. Year 3: June 2015.* Available from: www.devonhealthandwellbeing.org.uk/wp-content/uploads/2015/06/Joint-Health-and-Wellbeing-Strategy-update-June-2015.pdf

[29] Available at www.smokinginengland.info.

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

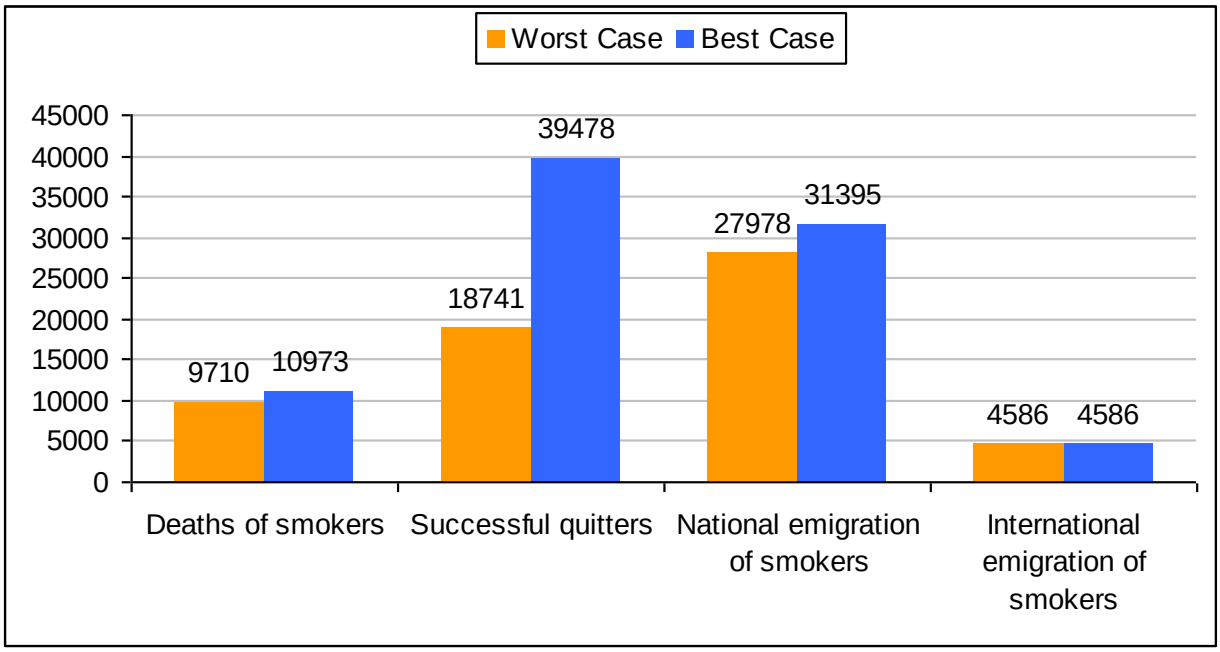

Figure 14: Reductions to smokers in the 16+ population of Devon – between 2010 and 2016 (7 year period)

Figure 13 shows a worrying trend of smokers becoming less inclined to quit smoking as time goes on. The Smoking in England Toolkit Survey was updated in April 2012 and states that success in quitting is higher in older smokers, lighter smokers and in non-routine and manual populations.[30] This would indicate that the smoking population is becoming a group of more dependent smokers located in more deprived communities. These smokers find it harder to quit and often require more intense support.

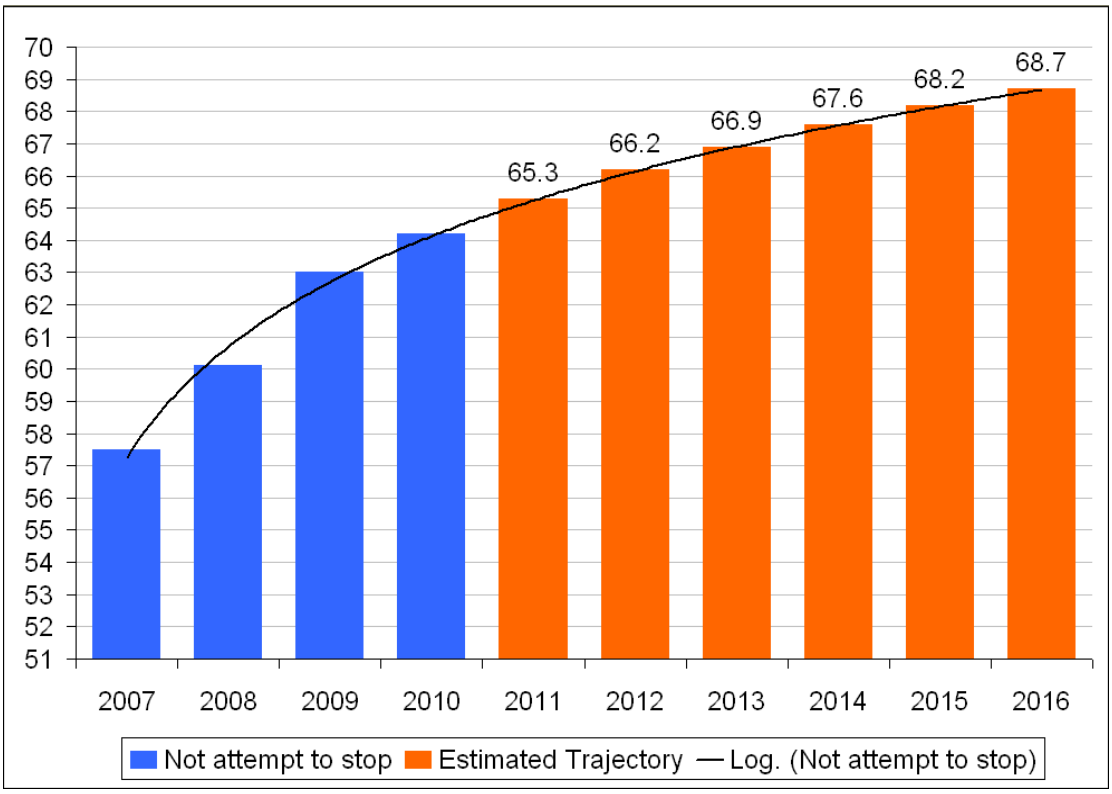

Figure 15: Modelled trajectory of smokers not attempting to quit in Devon 2007 – 2016 (from The Smoking Pipe Model: A model of the inflow and outflow of smokers. R West)

More information on the Pipe Model is available on the Devon Joint Strategic Needs Assessment website topic page on smoking.[31] The move of Public Health into local authorities in 2013 gave a new and growing role for tobacco control, including new opportunities to strengthen and build on partnership work, particularly around age of sale activities, smokefree environments, smuggled and counterfeit tobacco and commissioning stop smoking services.

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

SECTION 2

5. The Strategy

5.1 Vision

After the success of achieving 13.8% prevalence in 2015, an additional 1.2% reduction over the initial ambition of the Smokefree Devon Alliance, we hope to continue this decline. However, as the upcoming year brings several changes to tobacco control work in Devon, we hope to achieve a more modest reduction than seen over recent years.

Therefore for the year 2016/17 covered by this updated strategy, our vision is that smoking prevalence for the adult population of Devon will reach 13.3%.

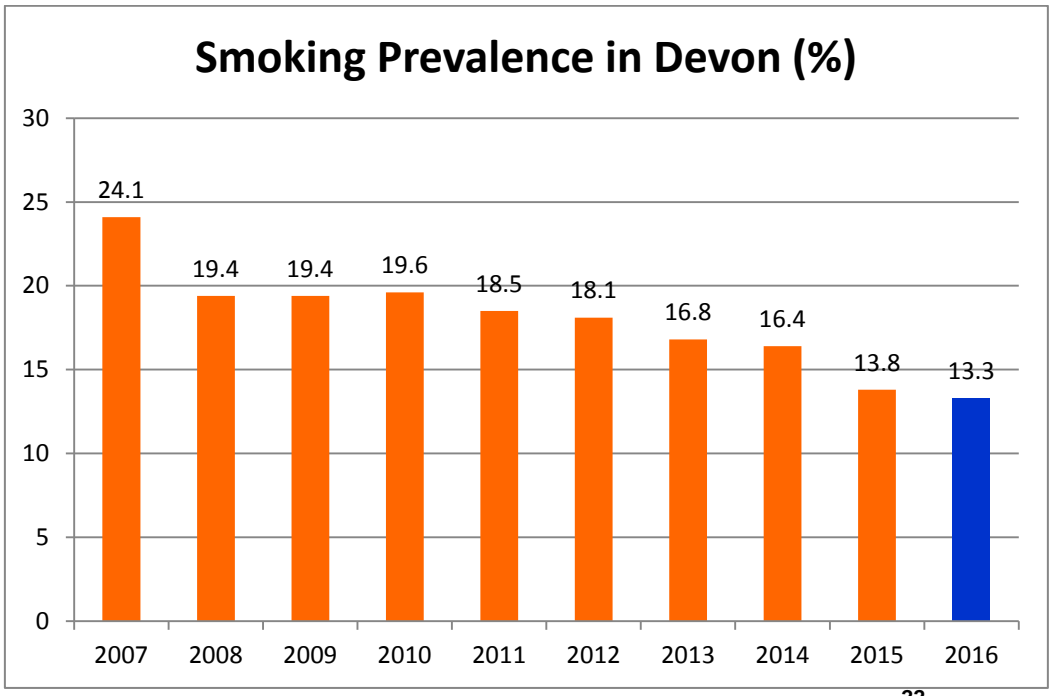

Figure 16: Predicted smoking prevalence in Devon[32]

5.2 Aims

The aims of this tobacco control strategy are as follows:

- To improve the health of the population of Devon by reducing the smoking prevalence rate and exposure to secondhand smoke

- To reduce health inequalities in Devon in the longer term by reducing the number of smoking-related illnesses suffered by the population.

[32] Local Tobacco Control Profiles

We have identified seven priorities for tobacco control in Devon:

1. Reduce health inequalities caused by smoking
2. Reduce illegal tobacco in the community
3. Protect children and young people from smoking
4. Reduce smoking in pregnancy
5. Normalise a smokefree lifestyle
6. Support smokers to quit
7. Carry out marketing and communication programmes.

5.4 PRIORITIES

5.4.1 PRIORITY 1
Reduce health inequalities caused by smoking

Objectives:

- **Reduce the smoking prevalence by 0.5% in the general population by 2017.**
- **Reduce the prevalence of smoking by 1%in routine and manual workers by 2017.**

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

For tobacco control work, this means efforts need to be targeted towards helping smokers from routine and manual groups as they make up the largest group of smokers. Ultimately by reducing smoking rates in this group we are likely to make the biggest difference to our overall smoking cessation rates.[33] Stop smoking services should also target very deprived smokers, but the biggest gains are to be made in the routine and manual population.

[33] Tackling Health Inequalities, Targeting routine and manual smokers in support of the PSA smoking prevalence and health inequality targets. Department of Health 2009.

Reducing smoking rates in disadvantaged groups and areas is a critical factor in reducing the health inequalities gap as evidence suggests that tobacco use is the primary reason for the gap in healthy life expectancy between rich and poor.[34] There is also evidence to show that poorer smokers are more physically addicted to nicotine, and are therefore less likely to succeed in their quit attempts[35] [36].
The availability of illegal tobacco makes tobacco more affordable. The Alliance supports strengthening resources and partnership working to tackle illegal tobacco in our community.

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

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

Key areas of work in this priority include:-

- Identifying areas of routine and manual (R/M) workers and high deprivation to ensure local stop smoking services are provided in the right place and targeting community work in these areas.

- Strong engagement with mental health services. High smoking prevalence exists in mental health settings and smokers in this category are sometimes neglected in mainstream services. Evidence indicates that mental health services users wish to and can quit, given adequate support.

- Continue to support and progress the Smokefree work in early adopter prisons, with a view for HMP Exeter to go Smokefree in May 2016.

- Promoting smokefree places so that tobacco is further denormalised (see Priority 5).

- Targeting geographical areas of high smoking prevalence through community partnerships.

- Ensuring that tobacco control objectives are included in a wide range of strategies and commissioning arrangements.

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

5.4.2 PRIORITY 2
Reduce illegal tobacco in the community

Objective: Reduce the supply of and demand for illegal tobacco

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

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

This is a key area for Trading Standards Partnership South West activity, which for this priority is based around:-

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

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

5.4.3 PRIORITY 3
Protect children and young people from smoking

Objectives:

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

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

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

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

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

Interventions that can be used include 'whole school approaches' and peer-led prevention programmes in schools, such as Operation Smokestorm. The Alliance will continue to support schools and academies with tobacco control work as part of this priority.

The Alliance supported the Plain Packs Protect national campaign[37] and will continue to support during the implementation of the standardised packaging of tobacco products in the UK from May 2016.

Protecting young people from smoking is a key area for Trading Standards Partnership South West activity which, for this priority, is based around:-

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

[37] www.plainpacksprotect.co.uk.

5.4.4 PRIORITY 4
Reduce smoking in pregnancy

Objective: Reduce the number of pregnant women smoking

As stated in section 1, smoking in pregnancy can cause increased risk of miscarriage, stillbirth, preterm birth and low birth weight.[38] It has been found to increase infant mortality by about 40%.[39] Pregnant women from unskilled occupation groups are five times more likely to smoke than professionals and teenagers in England are six times more likely to smoke than older mothers[40]. .

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

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

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

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

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

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

- The benefits of the investment in specialist stop smoking midwives must be realised and the good work continued through effective partnerships and communication.
    - Strong links between maternity units and the local stop smoking service/healthy lifestyle service must remain and develop.

[38] Board of Science and Education. Smoking and reproductive life. The impact of smoking on sexual, reproductive and child health (2014). British Medical Association.
[39] Levels of excess infant deaths attributable to maternal smoking during pregnancy in the United States. Salihu HM, Aliyu MH, Pierre-Louis BJ, Alexander GR, 2003.
[40] Smoking Cessation in Pregnancy: a call to action; 2013, ASH

5.4.5 PRIORITY 5
Normalise a smokefree lifestyle

Objectives:

- **Increase the number of smokefree places**
- **Promote why and how to quit smoking**

Changing social norms plays a large part in effective tobacco control.[41] Therefore actions towards normalising a smokefree lifestyle will be valuable to reduce uptake of smoking, as well as increase quit attempts. Consequently, important aspects that must go together with increasing smokefree places is good communication of the health consequences of smoking and effective promotion of stop smoking support available in Devon.

Smokefree legislation has made public places smokefree. There is a robust evidence base supporting the positive effect smoking bans have on health outcomes through a reduction in second hand smoke.[42] Additionally the local data shows a significant reduction in smoking prevalence after the smokefree legislation was introduced in 2007; prevalence reduced from 24.1% in 2007, to 19.4% in 2008 (see figure 7).[43]

It is important that the public sector leads by example, displaying to others the best of policy and implementation of policy. The Alliance fully supports the smokefree message in the NHS and other public sector areas. The Alliance understands the irony of allowing smoking in areas, especially health associated environments, when it is known to do so much harm to health and cause so many illnesses. The Alliance is working towards all NHS acute trusts in Devon implementing a gold standard 'whole organisation' smokefree policy, supported with systems such as referrals to stop smoking and availability of nicotine replacement therapy.

It will also support extending this approach to other organisations such as early years and housing associations. It will promote the smokefree agenda to district councils and continue to lobby for further national smokefree regulations.

Key areas of work that progress this priority are:-

- Smokefree Cars
- Smokefree Children Centres and Early Years Settings
- Smokefree Housing Associations
- Widening the scope of workplace smokefree policies to include whole-site bans and a whole organisation approach.
- Healthy New Towns programme – exploring the development of smokefree areas in Cranbrook
- Smokefree outside places, such as children's play parks and country parks
- Marketing and communication programmes (see priority 7).

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[41] Livingood et al., 2016. Culture Change from Tobacco Accommodation to Intolerance: Time to Connect the Dots. *Health Educ Behav,* 43(2), 133-138.
[42] Frazer et al., 2016. Legislative smoking bans for reducing harms from secondhand smoke exposure, smoking prevalence and tobacco consumption. *Cochrane Library.*
[43] Public Health England, 2016. *Health Profiles.* Available from: fingertips.phe.org.uk/profile/health-profiles [Accessed 21 March 2016].

5.4.6 PRIORITY 6
Support smokers to quit

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

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

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

- Ensuring that promotion of referral to smoking cessation is included in a wide range of strategies and commissioning arrangements.
- Developing a robust and systematic smoking cessation referral system at acute trusts.
- Introducing referral mechanisms in a wide number of organisations.
- 'Making Every Contact Count' – Providing training so NHS staff can deliver brief intervention at every opportunity.
- Continuing to extend these brief intervention training opportunities across a wider audience including voluntary sector and service provider organisations.
- Providing an e-cigarette friendly stop smoking service which will support individuals who choose to use an e-cigarette as a quitting aid.

5.4.7 PRIORITY 7
Carry out marketing and communication programmes

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

The Alliance seeks to take advantage of national campaigns and previous work led by Public Health Action.

The Alliance will be updating the communications plan to support its work, with a person-centred focus and more emphasis on digital communications. This will link in with the marketing plan for the new Healthy Lifestyle Service.

Key areas of work for this priority are:-

- Promoting stop smoking attempts according to national branded campaigns, in particular making use of PHE's One You branding and resources.

- Using all partners and a social marketing approach to communicate key messages to their stakeholders and members around smokefree policies, secondhand smoke and smokefree environments.

- Using all partners to promote the stop smoking support available in Devon.

- Reaching the routine and manual population through effective communications.

SECTION 3

6 Accountability

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

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

Conclusion

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

APPENDIX 1

Partners for local tobacco control activity

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

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

APPENDIX 2

MEMBERSHIP OF THE SMOKEFREE DEVON ALLIANCE STEERING GROUP (As at March 2016)

Name	Organisation/Role	Representing
Dr Phil Norrey (Chair)	Chief Executive Devon County Council	Devon County Council
Dr Virginia Pearson (Vice Chair)	Director of Public Health Devon County Council	Devon County Council
Sara Gibbs	Public Health Consultant Devon County Council	Devon County Council
Ruby King (Co-ordinator)	Advanced Public Health Practitioner Devon County Council	Devon County Council
Denise Deardon	Project Officer, Trading Standards, Devon County Council	Trading Standards
Lynne Jeary	Modern Matron Devon Partnership Trust	Mental Health Services
Nicola Glassbrook	Senior Public Health Officer (Health Inequalities) Devon County Council	Devon County Council
Paul Nicholls	Food, Health and Safety Manager, Teignbridge District Council	Environmental Health
Tania Skinner	Childrens Centre Advisor, South and West Locality	Early Years & Childcare Service
Greg Price	Stop Smoking Service Manager Northern Devon Healthcare Trust	Stop Smoking Service
Dr Mike Slot	GP Sid Valley Medical Practice	GPs
Julia Hulland	Marketing & Communications Manager Devon County Council	Local communications
Prof David Halpin	Consultant, Respiratory Medicine Royal Devon & Exeter Hospital	Secondary Care
Melissa Cullum	Campaigns & Communications Manager Smokefree South West	Smokefree South West, regional communications
Alan Coxon	Community Safety Prevention Manager, Devon & Somerset Fire & Rescue Service	Devon & Somerset Fire & Rescue Service
Darren Bolt	HIMP Exeter	Prison Service
Emma Herd	Senior Commissioning Manager	South Devon & Torbay CCG
Kevin Henman	Head of Youth Service Devon County Council	Youth Service
Therese Chapman	Lead Midwife, NDDH	Midwifery
Rachel Campbell	Public Health Specialist	Public Health England, Health & Justice
Justin Parsons	Service Development Manager, British Lung Foundation	Voluntary Services
Lucy Crystal	Young People's Project Delivery Manager, Public Health Action	Public Health Action, Comms & Marketing
Philip Sanders	Elected Member, Devon County Council	Members
Russ Moody	Health Improvement Manager, Public Health England	Public Health England
Peter Ashton	Federation of Small Businesses	Businesses
Martin White	Public Health Specialist Devon County Council	Devon County Council