NHS Warrington Clinical Commissioning Group

WARRINGTON Health & Wellbeing Board

WARRINGTON Borough Council

# Warrington

# Joint Strategic Needs Assessment (JSNA)

# Tobacco Control

# March 2018

**Executive Summary**

Smoking continues to be the biggest cause of preventable death in the UK killing 1 in 2 users, approx. and 80,000 annually (Department of Health, 2017). Public Health England published a paper in 2017 'Cost of smoking to the NHS in England: 2015' which estimated that the total estimated smoking-related cost to the NHS was £2.6 billion in one year. There are also additional costs the economy related to lost days of productivity, increased social care and other public services. It is estimated that the annual cost of tobacco harm in Warrington is £53.6million.

However, smoking prevalence has decreased dramatically in recent years now, the lowest level since records began. Nationally it reduced from 19.3% in 2012 down to 15.5% in 2016. In Warrington approximately 18% of adults reported that they smoked in 2012, during 2016 this reduced to 12.6%.

This achievement has been reached through the comprehensive and wide reaching Tobacco Control Plan the UK has benefited from over the last 20 years. The UK has a comprehensive tobacco control legislation which is not matched anywhere else in the world, achieved through wide ranging public health measures. The UK has introduced and implemented a complex mix of measures that aim to influence the production, promotion, supply and use of tobacco products.

However, there are still 9 million smokers in UK and over 21,000 smokers living in Warrington, with the majority of these smokers living in low income households (Department of Health, 2017). Smoking rates have remained stubbornly higher amongst those in society who already suffer from poorer health and other disadvantages. Groups who are most at risk from tobacco harm include people living in more deprived areas, children & young people, LGBT groups, low income and unskilled workers, and people with mental health disorders. Helping disadvantaged smokers quit is the best way to reduce health and social health inequalities.

The new national plan 'Towards a Smokefree Generation' encourages local areas to use build upon the comprehensive tobacco control legislation that has been introduce since the last national strategy. The vision is ambitious and presents a challenge to local services - local councils, the NHS and civic society to continue to reduce smoking prevalence, targeting those communities where smoking rates are highest, and providing people who smoke with the tools that they need to quit.

An updated Local Tobacco Control plan based on the findings of this JSNA will be produced summer 2018. The main focus of the local plan will be to narrow the gap between the groups where there is high prevalence of smoking and the rest of the town. There will be targets to reduce the smoking in the more deprived wards to a rate of no more that 20% and also to reduce the rate among routine and manual workers to no more than 20% by 2020. The updated plan will be delivered via a newly formed local Tobacco Control Alliance who will begin quarterly meetings from September 2018.

## Key findings, issues and gaps

Smoking prevalence among adults has been steadily reducing in Warrington, the percentage of smokers (12.6%) is the lowest ever reported for Warrington and is significantly lower than England and the North West.

However, data shows an increasing smoking prevalence in adults in routine and manual occupations. The redesigned Smokefree Warrington Service will use a much more targeted approach to ensure stop smoking support is reaching the target groups most likely to smoke. Part of this is a focussed approach in workplace settings, particularly routine and manual occupations and care settings where smoking is still prevalent among both staff and patients/clients. Workplaces will be offered support to write and implement smokefree policies, while employees will be offered support to quit while at work, when this is an appropriate option. There will also be an offer of training for staff in brief intervention methods, where there is an opportunity to help people in their care quit smoking.

The data also highlighted that over a quarter of 15 year olds had used e-cigarettes, this is much higher than the national average. However, the rate for current smokers at 15 years is 9% which is statistically similar to the national average of 8.2%. It is not currently clear if the rate of e-cigarette use among young people is due to young people using e-cigarettes to quit or cut down smoking. The Smokefree Warrington Service are well briefed via national guidance and training from The National Centre for Smoking Cessation Training (NCSCT) about how to advise and support people who choose to use an e-cigarette to quit. The team will start regular drop-in's at the Youth Café from April 2018. The Youth Café already has an existing health offer where young people, aged between 11 and 19 years, are engaged with in a trusted location with support from youth workers. There also continues to be an active Smokefree Schools Award initiative, that requires all schools to have a comprehensive smokefree policy that is backed up by classroom sessions and support for national campaigns, this is coordinated by the Public Health Team in partnership with school health and Smokefree Warrington Team. The School Health Team also, continue to offer smoking support for students who access the appointments they offer in all high schools.

The overall rate of Smoking at Time of delivery (SATOD) in Warrington at 8.3% is below the national average of 10.7% and the regional average of 13.4%. However, within this rate there exists a large inequality gap where the vast majority of women who continue to smoke in pregnancy live in the more deprived areas of the town. The Stop Smoking Midwife is aware of this inequality and focusses one-to-one support of this targeted group, however as a part-time role this resource is limited, even when supported by the Smokefree Warrington Team. To ensure that all pregnant women who smoke, or if they live with smokers, receive information and support to stop smoking or reduce the risk of second hand smoke a wide range of staff have been trained to give stop smoking brief-advice to women. This means that CO monitoring is part of the initial health checks given at the first booking-in appointment and is discussed and any subsequent appointments, there is also a new initiative where sonographers will be trained and be giving brief-advice as part of the ultrasound appointments.

During 2016/17 there were 1,213 Warrington smokers setting a quit date with the local Stop Smoking Service (SSS), the number setting a quit date during 2016/17 was the highest recorded over the previous four time periods (2013/14 to 2016/17). The rate of smokers setting a quit date in Warrington (5,691 per 100,000 smokers) was higher than both England (4,434 per 100,000) and the North West (4,673 per 100,000). Of the 1,213 smokers who set a quit date, 871 reported that they had successfully quit at four weeks. The number of successful quitters increased during 2016/17 when compared to 2014/15 (852 quits) and 2015/16 (855 quits), the trend of increasing quitters is not reflected nationally or regionally.

## Opportunities for improvement and/or commissioning

There is a need for there to be a more focussed and targeted approach to help the most deprived groups more effectively to stop smoking and reduce the associated health inequalities.

The overall smoking prevalence of smokers in Warrington is currently 12.6%, while the last local lifestyle survey by Public Health in 2013 showed that on a ward level the highest rate of smoking was 28% found in Latchford East an area of deprivation while the rate was only 6% in affluent Appleton. As a town the ambition is to reduce this inequality gap by ensuring that smoking rates in all individual wards are reduced to 20% or less. It is proposed that as part of the redesign of the Smokefree Warrington team that their performance targets from 2019/20 reflect this ambition.

The current rate of smoking for Routine and Manual workers at 26.4% is more than double the rate across the general population. As a town the ambition to reduce this inequality gap by reducing the rate to 20% by 2020. It is proposed that as part of the redesign of the Smokefree Warrington team that their performance targets from 2019/20 reflect this ambition.

Warrington would benefit from having an active Tobacco Control Alliance, however at present there has not been a partnership group for several years. It is proposed that the local partners will be invited to take part in the CLEAR 2.0 process which allows local authorities to assess how effective their tobacco control plan is. CLEAR 2.0 is a Public Health England tool that is completed in two stages; firstly an in-house assessment followed by a peer assessment from the national team. This process will help spotlight where there are local successes and also highlight where there may be gaps, this in turn will generate a local plan for a refreshed Tobacco Alliance to work towards. The internal CLEAR assessment will happen in April 2018, with the peer assessment happening summer 2018. A new alliance will be in place in October 2018.

The Smokefree Warrington Team will continue to work in partnership with the hospital in their ambition to become a completely smokefree environment. The team currently link with the cardiac and respiratory departments as well as supporting the tobacco harm CQUIN implementation team. The vision is to for all staff and visitors to be smokefree on site while ensuring that patients have access to behavioural support and nicotine replacement therapies while in hospital or pre-surgery.

## Introduction

Smoking prevalence has decreased dramatically in recent years; however there are still 9 million smokers in UK, with the majority of these smokers living in low income households (Department of Health, 2017). Smoking continues to be the biggest cause of preventable death in the UK killing 1 in 2 users, approx. 80,000 annually (Department of Health, 2017).

Since the previous Tobacco Control Plan (Healthy Lives, Health People, 2011), smoking prevalence has substantially reduced; from 20.2% of adults smoking at the start of the plan to just 15.5% now, the lowest level since records began (Department of Health, 2017).

This achievement has been reached through the comprehensive and wide reaching Tobacco Control Plan the UK has benefited from over the last 20 years. Great strides have been made in the last five

years with a flurry of new legislation which has curbed advertising, established smokefree places, introduced new measures such as standardised cigarette packs with larger and more prominent graphic health warnings, banned smoking in cars with children; and made it illegal for a person over the age of 18 years buys tobacco products on behalf of someone underage, known as proxy buying.

However, smoking rates have remained stubbornly higher amongst those in society who already suffer from poorer health and other disadvantages. Smoking rates are almost three times higher amongst the lowest earners, compared to the highest earners (Department of Health 2017).

The new national plan 'Towards a Smokefree Generation' encourages local areas to use build upon the comprehensive tobacco control legislation that has been introduce since the last national strategy. The vision is ambitious and presents a challenge to local services - local councils, the NHS and civic society to continue to reduce smoking prevalence, targeting those communities where smoking rates are highest, and providing people who smoke with the tools that they need to quit.

## National Context

Smoking continues to kill 79,000 people in England every year and is the number one cause of preventable death in the country, resulting in more deaths than the next six causes combined. Tobacco use is also a powerful driver of health inequalities and is perhaps the most significant public health challenge we face today (Public Health England, 2017a).

Smoking rates are much higher within certain groups and deprived communities. Smoking is around twice as common among people with mental health disorders, and more so in those with more severe mental illnesses (estimates vary between 37% and 56%). Lesbian, gay and bisexual communities are also significantly more likely to smoke, as are the long-term unemployed, and some minority ethnic groups, which also have gender disparities. Helping disadvantaged smokers quit is the best way to reduce health inequalities (Public Health England, 2017a).

### National Strategy

The new national strategy 'Towards a Smokefree Generation – A Tobacco Control Plan for England' was released in July 2017 (Department of Health, 2017). The last national tobacco control plan ran from 2011-2015 with all the ambitions set in the previous plan being exceeded. A large part of this success can be attributed to the Government introducing a significant amount of legislation over the course of the plan including:

- 2011: Ban on tobacco sales using vending machines;
- 2015: Minimum age of sale of e-cigarettes, proxy-purchasing, ban on smoking in cars containing children;
- 2015: standardised packaging regulations (came into force 2016).

The new 2017 Tobacco Control Plan aims to build on these achievements. The national strategy has four main themes to help focus efforts where they will make the most difference.

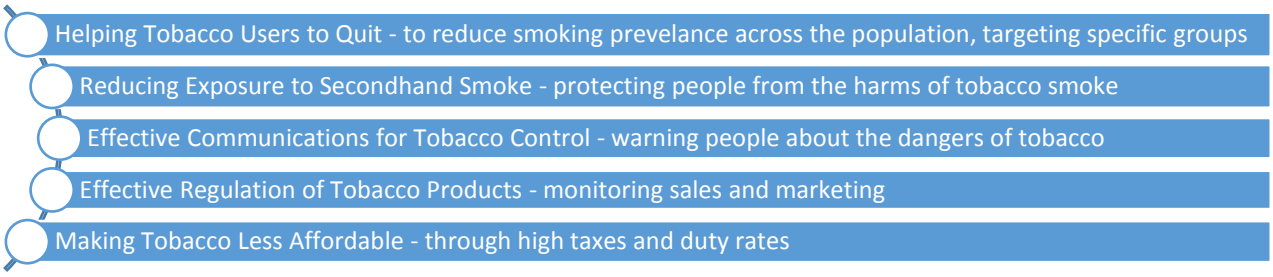
1. The first smokefree generation, primarily by supporting people not to start smoking, so by the end of 2022 to reduce:
   - Adult smoking prevalence from 15.5% to 12%;
   - Young people smoking prevalence from 8% to 3%;
   - Inequality gap in smoking prevalence between those in routine and manual occupations and the general population.

2. A smokefree pregnancy for all, every child deserves the best start in life, so the aim by the end of 2022 is to:
   - Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.

3. Mental health: parity of esteem, people with mental ill health should be given equal priority to those with physical ill health, so the aim is to:
   - Make all mental health inpatient services sites smokefree by 2018;
   - Improve data collected on smoking and mental health to help us to support people with mental health conditions to quit smoking.

4. Innovations to support quitting, the new strategy is committed to evidence-based policy making, so there is an aim to:
   - Help people to quit smoking by permitting innovative technologies that minimise the risk of harm, specifically vaping products;
   - Maximise the availability of safer alternatives to smoking.

There will also continue to be a framework of recognised tobacco control measures that support the implementation of the new ambitions.




**Tobacco Related Legislation**

The UK has a comprehensive tobacco control legislation which is not matched anywhere else in the world, achieved through wide ranging public health measures. This includes banning of smoking in public places; raising legal age of purchase; taxation to make tobacco products less affordable; make tobacco less available, especially to young people, via banning of vending and packs of ten; wide ranging restrictions on advertising and sponsorship and the banning of novelty products such as menthol flavours or lipstick packs. Over the period of the last national strategy (2011-2015), new legislation which curbed advertising further and established more smokefree public places as well as introducing new measures such as larger and more prominent graphic health warnings, a ban on both proxy purchasing and smoking in cars with children, and standardised packaging.

The UK has introduced and implemented a complex mix of measures that aim to influence the production, promotion, supply and use of tobacco products. As part of this the UK government supports international tobacco control work, primarily the World Health Organisation's Framework Convention on Tobacco Control (FCTC) and is committed to implementing the policies contained within the treaty. Amongst these policies is an obligation under Article 5.3 of the treaty to ensure that health policy is protected from the vested and commercial interests of the tobacco industry.

A detailed breakdown of the UK Tobacco Control measures offers the opportunity for both professionals and the public to understand better the complicated nature of the tobacco industry and its effect on the health and wellbeing of individuals and communities.

**Figure 1: Detailed breakdown of the UK Tobacco Control measures**

| Background of Measure, Legislation or Policy | Rationale | How it impacted on Smokers and the industry |
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| The House of Commons and the House of Lords took nine months to carefully consider and consult on the Health Bill, which turned the idea of a Smoke Free law into an actual law. After the Bill was passed the Health Act 2006 was born, part one of which set out the official plans for Smoke Free law (Smokefree England, 2018). | In July 2007 it became illegal for anyone to smoke in an enclosed public place and within the workplace. This ensured that everyone could use the train station, eat in a restaurant or shop without suffering the negative effects of second-hand smoke. | As well as protecting non-smokers from the harm of second-hand smoke this law significantly reduced the opportunity for smoking and interrupted entrenched habits such as smoking in pubs and restaurants.<br>It was predicted by many commenters that this would be the end of the UK pub and restaurant trade, this has not been the case. |
| Since 1 October 2007 it has been illegal to sell tobacco products to anyone under the age of 18 previously the legal age of sale was 16 years. In 2015 it also became illegal to buy tobacco for under 18's (ASH, 2017a). | Research shows that the majority of smokers start around the age of 15, this means they become addicted before they can fully understand the long term impact of smoking (Department of Health 2017). | This greatly reduced the opportunity for young people to smoke by banning legal access to tobacco. It also helped reduce peer pressure among younger teens to start smoking. As an adult 18 year olds should be able to make a more informed decision about smoking (Department of Health 2017). |
| In 2015 it became illegal for retailers to sell vaping products to anyone under 18 years. It is also an offence to buy vaping products for anyone under 18 years (ASH, 2017a). | There was an unanticipated rapid increase in the use of use of e-cigarettes and vaping around 2011. This meant there were very few controls in place with regards to the promotion, sale and quality of the products. While it's now recognised that vaping has played an important role in helping many smokers quit, long-term consequences are not known, and so they should not be promoted as a harmless pastime. | Many of the organisations who produce and sell vaping products are part of the tobacco industry, and so have an interest in people becoming or remaining addicted to nicotine (Tobacco Tactics, 2018). Many of the early adverts used old tobacco tactics such as glamorous and sexual imagery to attract new users. While a host of devices using colours and flavours appeared to appeal directly to teenagers. |
| In 2011 sale of tobacco products in vending machines was banned (ASH, 2017a). | Tobacco vending machines were once a common sight in public places around the UK. However, there were a small number of remaining vending machines operating. | Vending machines by their very nature offered very little governance in terms of when and who used them. By removing them it reduced the opportunity for smokers to buy tobacco, particularly young people as research showed they were the most likely to use them. |
| Tobacco advertising is banned by law throughout the United Kingdom. The Tobacco Advertising and Promotion Act 2002 prohibits tobacco advertising on billboards, in print media, by direct mail and through sponsorship. Tobacco advertising on television and radio is prohibited under the Broadcasting Act (ASH, 2017a). | All forms of tobacco advertising and promotion are banned in the UK including the display of tobacco products at the point of sale after research found that it has 'a positive impact on consumption'. Evidence from countries that had already introduced a ban found a fall in smoking on such a scale that it could not be attributed to other causes. There was also evidence that children | Advertising was a powerful tool for attracting and maintaining a customer base, the adverts sold a certain identity and lifestyle for users, or used clever psychology to communicate ideals such as luxury or relaxation. Since the ban on advertising tobacco companies now target wholesalers and retailers with discounts, public relations such as competitions and other incentives. |

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| | and young people were more receptive to advertising than adults, and the more they are exposed to promotion the more likely they are to take up smoking. | |
| Since 2012 (2015 for small stores) there has been a ban on point of sale promotion. Shops now cannot have any advertising materials on show and must keep products behind a plain shutter. | After the ban on general advertising the industry did focus more resources to advertising at point of sale (POS). Research also found that young people were most likely to recall brands from POS (Stead et al, 2016). | Banning POS promotions also helps to de-normalise smoking by making it seem less obtainable, less attractive and less affordable (no price promotions). |
| The UK government introduced picture warnings on cigarette packs in October 2008 (2010 on other smoked tobacco products). A new EU Tobacco Products Directive took effect in 2016. This requires picture warnings covering 65% of both sides, placed at the top of the pack. The 2001 EU Tobacco Products Directive set a maximum upper limit of tar, nicotine and carbon monoxide for cigarettes sold in the European Union, it also banned such words as 'light' or 'mild' as part of a brand name (ASH, 2017a). | Tobacco is a legal product that when used as directed will harm health. It is important that consumer including smokers understand the risks associated with any products they are buying and using. In the past tobacco manufacturers have been able to promote their product with little focus on negative impact smoking can have. | Although descriptors such as "light" and "mild" are prohibited under EU law manufacturers substituted these terms with words such as 'smooth' and had used colours to distinguish one brand variant from another. Research commissioned by ASH found that both adult and young people were more likely to rate packs with the terms 'smooth' 'gold' or 'silver' as lower tar and with lower health risks than 'regular' varieties of the same brands (ASH, 2009). |
| The Tobacco Products Directive was amended in 2014 in effect from 2016 includes a ban on distinguishable flavours, including menthol. And novel packs such as lipstick packs are all banned (ASH, 2017a). | All marketing tactics that did not reflect the true risk associated and made some products more desirable have been removed. | In the past marketing of certain brands or products gave the impression they were less harmful. This included menthol flavour described as cool and refreshing, and packs marketed to females such as slim packs and cocktail cigarettes. |
| Standardised packaging entered into force on 20th May 2016 at the same time as the EU Tobacco Products Directive. This means that the appearance of all tobacco packs will be where the attractive, promotional aspects, including logos and graphics are removed and the appearance of all tobacco packs on the market is standardised. This includes the shape and colour of the packaging and the typeface and colour of all text (ASH, 2017a). | Tobacco packaging was the most ubiquitous form of tobacco advertising. Smokers display the product branding every time they take out their pack to smoke. The tobacco companies invest considerable resources in making the packs as attractive as possible and frequently change the designs, often producing 'limited editions' to coincide with anniversaries or other events. They also remove potentially misleading information on cigarette packaging. | Standardised packaging should therefore increase the effectiveness of health warnings and reduce misconceptions about the risks of smoking. The colour of standardised packs, a drab dark brown, was market tested among smokers who found it to both 'minimise appeal' and 'maximise perceived harm' (Parr et al, 2011). |
| In 1993, Kenneth Clarke MP was the first Chancellor to explicitly state that he intended to raise the tax on tobacco for health reasons, noting that it was "the most effective way to reduce smoking". Since then, apart from | Raising the price of tobacco through taxation encourages people to stop smoking or dissuades them from starting. Tobacco tax raises revenue for the Treasury for the direct Medical costs of treating tobacco-induced illnesses there | Raising the tax on tobacco products in a large part is about making smoking less affordable, and reducing the opportunity, the desirability and the motivation to smoke. This is particularly relevant to young people. |

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| the period 2001-2008, successive UK governments have increased tobacco duties above the rate of inflation. At the current time, there is a commitment in place for an escalator of 2% above inflation until the end of this Parliament in 2020. | are other indirect costs including loss of productivity, fire damage and environmental harm from cigarette litter. In 2015 tobacco was 27% less affordable than in 2005 (NHS Digital, 2016) | Cigarettes are now to be sold only in packs containing a minimum of 20 sticks as part of this. |
| Smoking in the media. Despite guidelines issued by the British Board of Film Classification (BBFC) designed to limit children's exposure to smoking on screen, smoking in films is a major source of tobacco imagery and along with television, particularly reality TV still promotes smoking. | In response to the global spread of tobacco advertising bans the tobacco industry has found ever more innovative ways of promoting its products. One way is via the internet and You Tube which is largely unregulated and therefore provides the tobacco industry with promotional opportunities (ASH, 2015). | Despite lots of work to ban smoking imagery in film and on TV it still appears in subtle but powerful ways.<br>Of some concern is that smoking is reappearing on TV in particular reality shows that are popular with young people. These shows depict young attractive and healthy young people smoking as a norm, with fears they may become role models for others. |

## Who's at risk and why

Smoking rates are much higher within certain groups and deprived communities. Lesbian, gay and bisexual communities are also significantly more likely to smoke, as are the long-term unemployed, and some minority ethnic groups, which also have gender disparities (Public Health England, 2017a).

Health inequalities are preventable differences in health outcomes between different population groups. Reducing health inequalities remains a key goal of public policy in England, and a central function of public health teams. Because smoking is so harmful, differences in smoking prevalence across the population translate into major differences in death rates and illness, with smoking being the single most important driver of health inequalities (National Centre for Smoking Cessation, 2013).

**Lesbian, gay, bisexual and transgender communities**

Whilst there is a lack of research on smoking among bisexual and transgender people, surveys do show both bisexual and transgender people are more likely to smoke (Stonewall, 2012; Rooney, 2012 cited by NHS England, 2016). Young LGB people are also more likely to smoke, to start smoking at a younger age and smoke more heavily (Corliss et al, 2013 cited by NHS England, 2016).

**Unskilled and low income workers**

Smoking is far more common among unskilled and low income workers than among professional high earners. The more disadvantaged someone is, the more likely they are to smoke and to suffer from smoking-related disease and premature death. The specific drivers of smoking uptake and tobacco addiction must also be addressed. The reasons people smoke are complex; smoking is transmitted across the generations in a cycle underpinned by social norms, familiarisation and addiction. In poorer communities, young people are more exposed to smoking behaviour, more likely to try smoking and, once hooked, they find it harder to quit. Smoking is so corrosive to individual, family and community health that any success in reducing smoking in disadvantaged groups has knock on benefits for the wider determinants of health, above all through reductions in poverty. Helping disadvantaged smokers quit is the best way to reduce health inequalities (Public Health England, 2017a).

**Mental Health**

Smoking is around twice as common among people with mental health disorders, and more so in those with more severe mental illnesses (estimates vary between 37% and 56%) (Public Health England, 2017a). People with mental health conditions die on average 10-20 years earlier than the general population and smoking is the single largest factor accounting for this difference. Around one third of adult tobacco consumption is by people with a current mental health condition with smoking rates more than double that of the general population. Smoking rates among people with mental health conditions have barely changed at all over the last 20 years during a time when rates have been steadily falling in the general population (Ash, 2016).

Treating smoking-related illnesses in people with mental health problems has been estimated to cost the NHS £720 million a year in primary and secondary care. Given that smoking can reduce their effect, smoking increases psychotropic drug costs in the UK by up to £40 million (Royal College of

Physicians 2013). People with a mental health condition are just as likely to want to stop smoking as other smokers but they face more barriers to quitting and are more likely to be dependant and therefore need more support. Quitting smoking does not exacerbate poor mental health; in fact the positive impact of smoking cessation on anxiety and depression appears to be at least as large as antidepressants (Ash, 2016).

**Children and young people**

Tobacco Smoking impacts children in many and complex ways. The risks of smoking during pregnancy are serious, from premature delivery to increased risk of miscarriage, stillbirth or sudden infant death (Public Health England, 2018a). While, children who are born into smoking households, or who are exposed to smoky environments are at risk of harm from second-hand smoke, the consequences of this risk include higher risk of respiratory infections, asthma, bacterial meningitis and cot death. Second-hand smoke has been linked to around 165,000 new cases of disease among children in the UK each year (Cancer Research UK, 2016).

Smoking remains an addiction which is largely taken up in childhood, with the majority of smokers starting as teenagers. A study in 2014 found that 77% of smokers aged 16 to 24 began smoking before the age of 18, with 32% of smokers (current and ex-smokers) starting when they are 16 or 17 (Public Health England, 2017a).

The prevention of new smokers continues to be a main concern for the tobacco control agenda. There are several risk factors associated with increased likelihood of smoking initiation among young people. The following are associated with higher odds of youth smoking: exposure to parent, carer, sibling and peer smoking, lower socio-economic status, higher levels of truancy and substance misuse. Smoking prevention is therefore not achieved by youth targeted interventions alone (Department of Health, 2017).

**People living in Poverty**

Tobacco and poverty are inextricably linked. Many studies have shown that in the poorest households in many low-income countries, spending on tobacco products often represent more than 10% of total household expenditure. As a result, these families have less expendable income for necessities such as food, education and health care (World Health Organisation, 2018).

In 2011/12 approximately 2.3 million children, 17% of children in the UK, were estimated to be in relative poverty. Cigarette smoking is expensive and places an additional burden on household budgets, and is strongly associated with socioeconomic deprivation. A 2015 study aimed to provide an illustrative first estimate of the extent to which parental smoking exacerbates child poverty in the UK, it found 1.1 million children - almost half of all children in poverty - were estimated to be living in poverty with at least one parent who smokes; and a further 400,000 would be classed as being in poverty if parental tobacco expenditure were subtracted from household income. It concluded that smoking exacerbates poverty for a large proportion of children in the UK, and tobacco control interventions which effectively enable low income smokers to quit can play an important role in reducing the financial burden of child poverty (Belvin et al, 2015).

**Illicit tobacco**

In the UK, during the 1990's illicit tobacco rose to a very high level: Customs & Excise (now HM Revenue and Customs) (mid-range) estimates were that in 2000 21% of cigarettes in the UK market were illicit and 63% of hand rolled tobacco was illicit. However, following co-ordinated enforcement action in the UK and at European level, the level of illicit trade in the UK has subsequently fallen sharply. HM Revenue & Customs (mid-range) estimates for 2015/16 were that 13% of cigarettes in the UK market were illicit, and 32% of hand-rolled tobacco in the UK market was illicit. The tobacco tax gap is made up of the illicit markets in cigarettes and hand-rolling tobacco and was estimated to be £2.4 billion in 2015-16. Of this £1.9 billion was lost in tobacco duties and a further £0.5 billion in VAT. The cigarette tax gap was estimated to be £1.6 billion and the hand-rolling tobacco tax gap was estimated to be £0.8 billion. Meanwhile, tobacco tax revenues have stabilised at around £9.5 billion a year (ASH, 2017b).

Illicit tobacco reduces the public health impact of tobacco tax rises and increases demand for tobacco products. As illicit tobacco products are sold at a significantly lower price than those legally bought it works to counteract the impact of raised taxes by making tobacco affordable and so more obtainable allowing the heavily addicted will smoke more and giving young people access to tobacco (ASH, 2017b).

The illicit tobacco trade not only undermines legitimate business and controls to limit smoking but it is dominated by internationally organised criminal groups often involved in other crimes such as drug smuggling and people trafficking (HM Revenue and Customs, 2015). This criminal element is then often present in communities by local people who will sell illicit products via small shops or from back-doors. There is a perception that it is a victimless activity. Even when consumers of illicit product suspect duty evasion has affected the price, they might not understand the extent of criminality beyond that both on an international scale but also by the seller, or how the profits they are contributing to may be used (HM Revenue and Customs, 2015).

It is of particular concern that young people who are given or who buy cigarettes from local illicit tobacco sellers become vulnerable to grooming or future exploitation, either to become involved in criminal activity or sexual abuse.

These issues can form the foundation for valuable conversations with communities to help change their perceptions of the illicit trade. In the past many communications had been focussed on the belief that illicit tobacco was of a lower grade and so more harmful. However, the fact is that all tobacco is harmful with a longitudinal study finding it kills one in two users and so this gives an unhelpful message that legal tobacco is somehow safer (Doll et al, 1994).

The sale of illicit tobacco undermines public health policy by offering a cheaper option for those who might otherwise not be able to smoke; specifically it makes tobacco more accessible to children. In some communities people selling illegal tobacco are seen as 'local heroes' helping out smokers on a low budget. However in reality children and young people who buy illegal products are likely to come into contact with criminal individuals making them more vulnerable to harm, with addiction to tobacco being implicated in cases of coercion and exploitation (Department of Health, 2017).

**Controls on Retailers**

Tobacco is the deadliest commercially available product in England, with tobacco regulations serving to safeguard people, particularly children and young people from the avoidable disease and premature death it causes. Comprehensive enforcement is crucial and, across England, smokers, local councils, businesses, particularly tobacco retailers, play a vital role in protecting people from the harms of tobacco. This is a responsibility that most people take seriously and research shows high rates of compliance with the majority of tobacco regulations across England (Department of Health, 2017).

Despite the controls on the sale of tobacco many young people can still access tobacco in shops. Often these are repeat offenders whose actions facilitate children trying and becoming addicted to smoking. Non-compliance with tobacco regulations seriously undermines public health and damages legitimate local business. Government will review sanctions to ensure enforcement officers can act quickly and effectively, with a focus on tobacco retailers who repeatedly break the law (Department of Health, 2017).

**Health and Social Care Services**

In 2013, 78,200 people aged over 35 died from smoking-related causes in England, 17 per cent of all deaths in this age group, which equates to over 200 people every day (Health and Social Care Information Centre, 2015). Likewise the impact of smoking on ill health is huge: in 2013/14 an estimated 4% of all the hospital admissions in England in the 35+ age group were attributable to smoking.

**Figure 2: Burden of disease attributable to 20 leading risk factors, UK 2010**

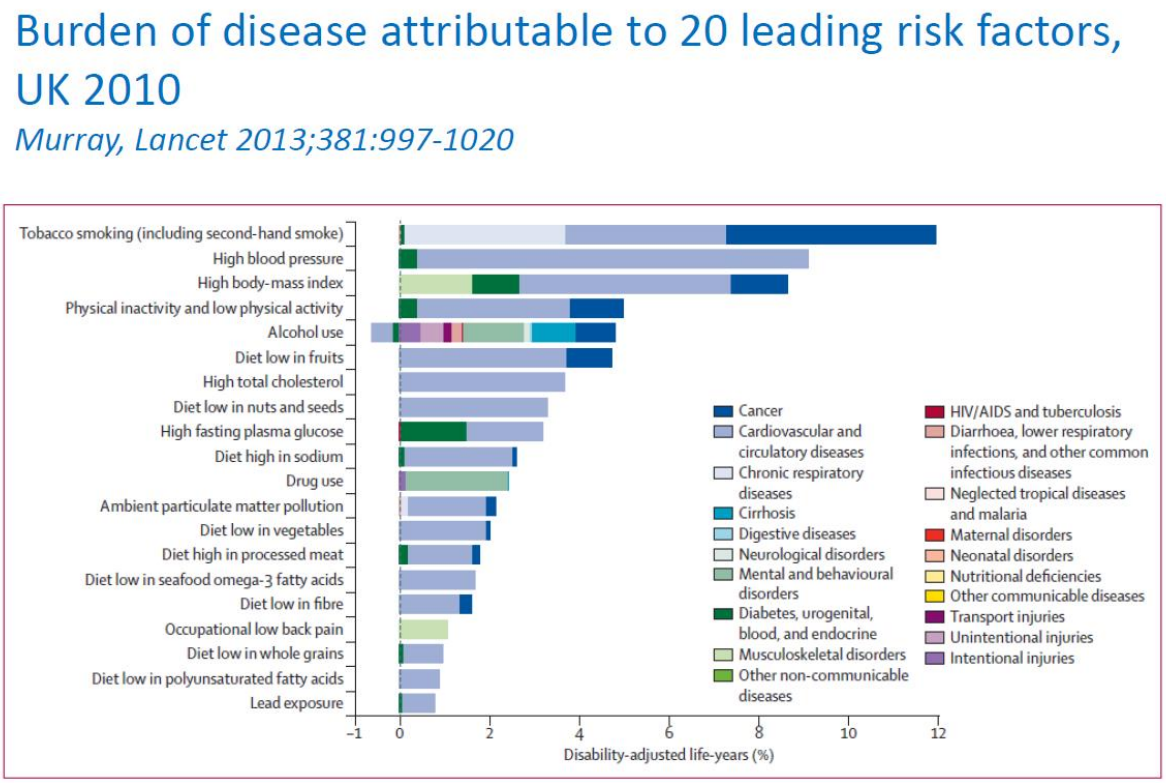



*Figure 7:* **Burden of disease attributable to 20 leading risk factors for both sexes in 2010, expressed as a percentage of UK disability-adjusted life-years**
The negative percentage for alcohol is the protective effect of mild alcohol use on ischaemic heart disease and diabetes.

Public Health England published a paper in 2017 'Cost of smoking to the NHS in England: 2015' which estimated that the total estimated smoking-related cost to the NHS was £2.6 billion in one year (Public Health England, 2017b).

Current and former smokers are more likely to require primary care services than those who have never smoked. Excess primary care events (the difference between usage of services between current smokers and never smokers; and former smokers and never smokers) were taken from the 2006 General Lifestyle Survey (GLS). Unit costs were applied to the smoking-related excess events. The total smoking related costs to primary care was estimated to be £1.1 billion (Public Health England, 2017b).

The GLS also provided estimates of excess outpatient visits in hospitals which amount to an estimated £696.6 million nationally in 2015. In 2015 to 2016, there were approximately 520,000 smoking attributable hospital admissions in people aged 35 and over in England. The total costs of these admissions are estimated to be £851.6million (Public Health England, 2017b).

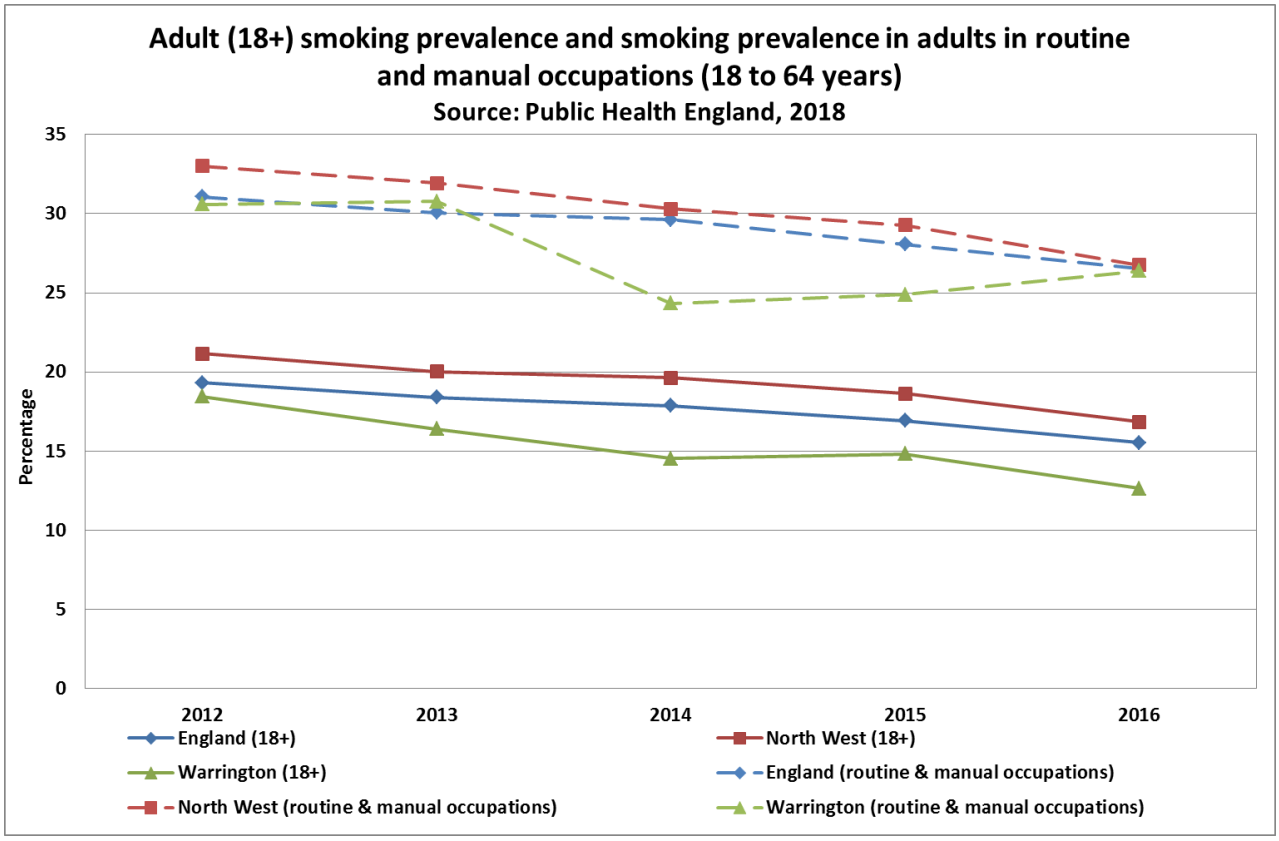
## Level of need in the local population

### Smoking prevalence

The percentage of adults (aged 18 and above) who report that they are a current smoker (as reported through the Annual Population Survey) has reduced in Warrington. During 2012 approximately 18% of adults reported that they smoked, during 2016 this reduced to 12.6%. The percentage of current smokers in Warrington is significantly lower than both England (15.5%) and the North West (16.8%) (Public Health England, 2018b).

For those adults (aged 18 to 64) who reported that they worked in routine and manual occupations, over a quarter (26.4%) reported that they currently smoked; this percentage was very similar to England (26.5%) and the North West (26.8%) (Public Health England, 2018b). However, the trend in the percentage of adults in routine and manual occupations who reported that they currently smoked has been increasing in Warrington; this pattern is not seen regionally or nationally as there has been a continued reduction in the smoking prevalence, as presented in the following chart.

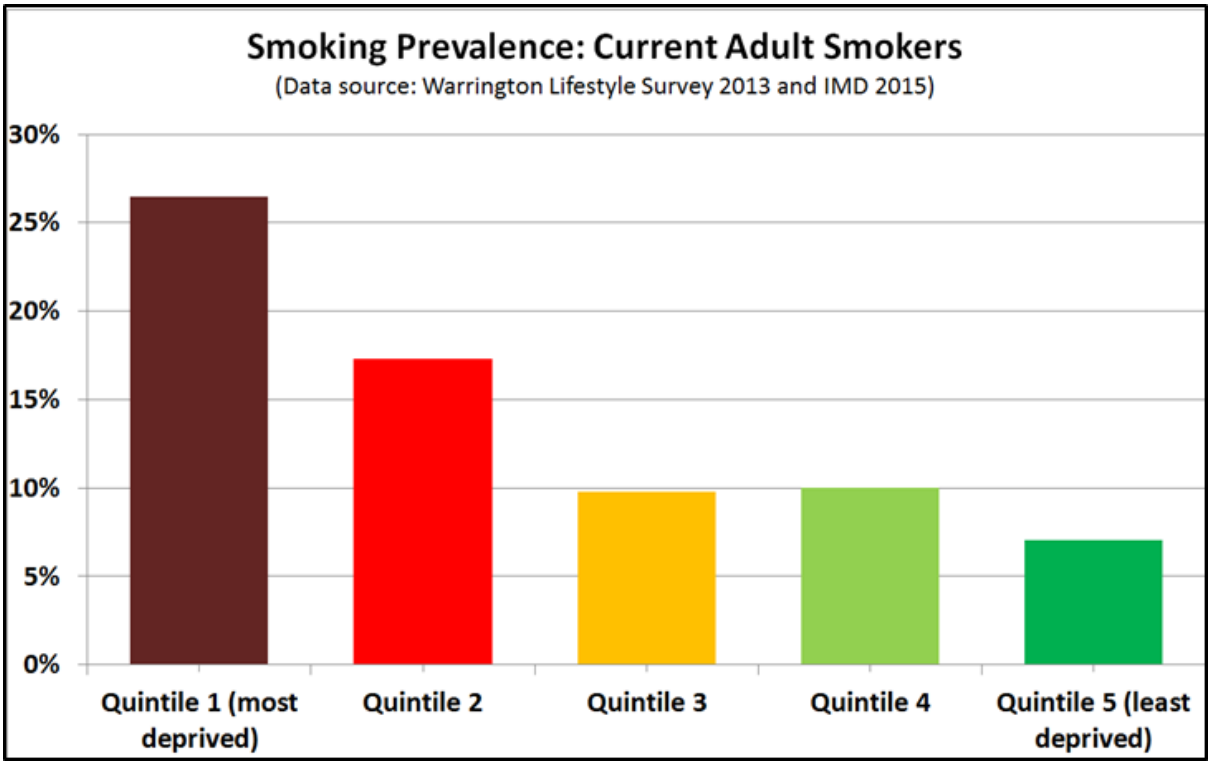
**Figure 3: Smoking prevalence in adults**




Results from the Warrington Health and Wellbeing Survey 2013 suggest that smoking prevalence amongst adults reduced from 21.3% in 2001, to 20.4% in 2006, to 13.0% in 2013. A prevalence of 13.0%, applied to the 18+ population of Warrington for mid-2015 suggests that approximately 21,200 adults in Warrington smoke (assuming that prevalence has not changed much since 2013). Increased use of e-cigarettes is likely to have contributed to the reduction in cigarette smoking over recent years.

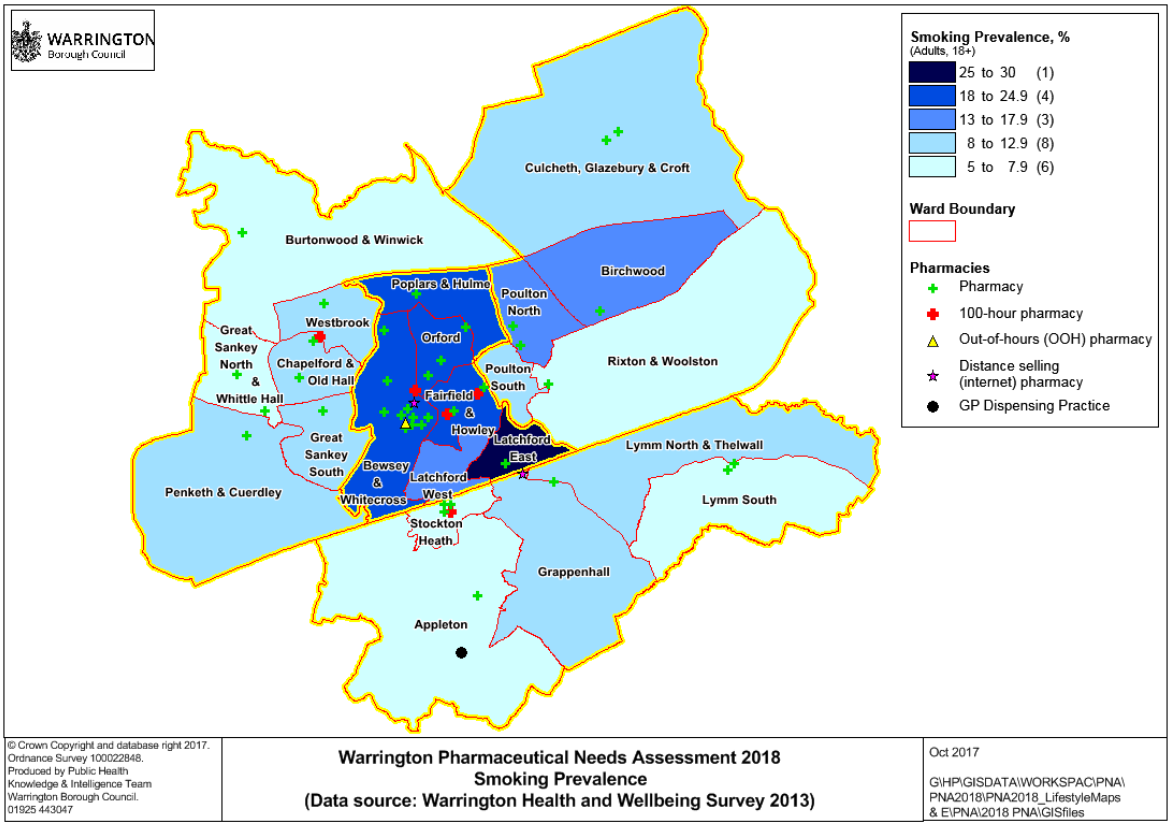
Prevalence varied between men (14%) and women (11%), and varied by age: 16.0% of 18-39 year-olds, 12.9% of 40-64 year-olds, and 8.2% of those aged 65+ said they smoked. It strongly followed the pattern of socio-economic deprivation, ranging from 26% in the most deprived quintile, to 7% in the least deprived quintile (see Figure 3).

**Figure 4: Smoking prevalence by socio-economic deprivation**




Map 1 shows smoking prevalence by ward. Highest rates were found in the Central ward grouping. Latchford East had by far the highest prevalence at 28%.

**Map 1: Smoking Prevalence by Warrington Ward 2013 with pharmacy locations**



Young people's smoking prevalence is estimated in the WAY (What About Youth) survey. In the 2014/15 survey, smoking prevalence at age 15 (current smokers) in Warrington was 9.0%, higher than 8.2% in England and 8.0% in the North West. The same survey also reported that a quarter (25.5%) of Warrington respondents stated that they had used e-cigarettes, significantly higher than England (18.4%) and slightly higher than the North West (24.5%) (Public Health England, 2018b).

Smoking in pregnancy rates have been reducing both locally and nationally. The smoking in pregnancy rate in Warrington is 8.3% (2016/17)[1]; significantly lower than England (10.7%) and the North West (13.4%) (Public Health England, 2018b). However, rates are substantially higher in the most deprived quintile (15.5% in 2016/17 compared to 4.3% in the rest of Warrington). This is in-keeping with the pattern in the general population of higher prevalence in more deprived areas.

The Health and Social Care Information Centre (HSCIC, now known as NHS Digital) produced analysis based on information collected at GP Practices which presented the smoking prevalence in adults with serious mental illness (SMI). Based on information collected during 2014/15, it was estimated that 43.8% of all adults with a SMI registered at a Warrington GP Practice were a current smoker, significantly higher than England (40.5%) and slightly lower than the North West (45.0%) (Public Health England, 2018b).

**Smoking related ill health**

There is substantial evidence that smoking during pregnancy and exposure to second-hand-smoke can lead to premature birth among many other adverse health effects including complications during labour, low birth-weight at full term and increased risk of miscarriage and stillbirth (Public Health England, 2018b). The rate of premature births (less than 37 weeks gestation) in Warrington is significantly lower (67.9 per 1,000) than both England (79.5 per 1,000) and the North West (84.7 per 1,000) whilst the percentage of babies born at term (equal to or greater than 37 weeks gestation) who were of low birth weight (less than 2,500g) is very similar to the England average (2.7% and 2.8% respectively).

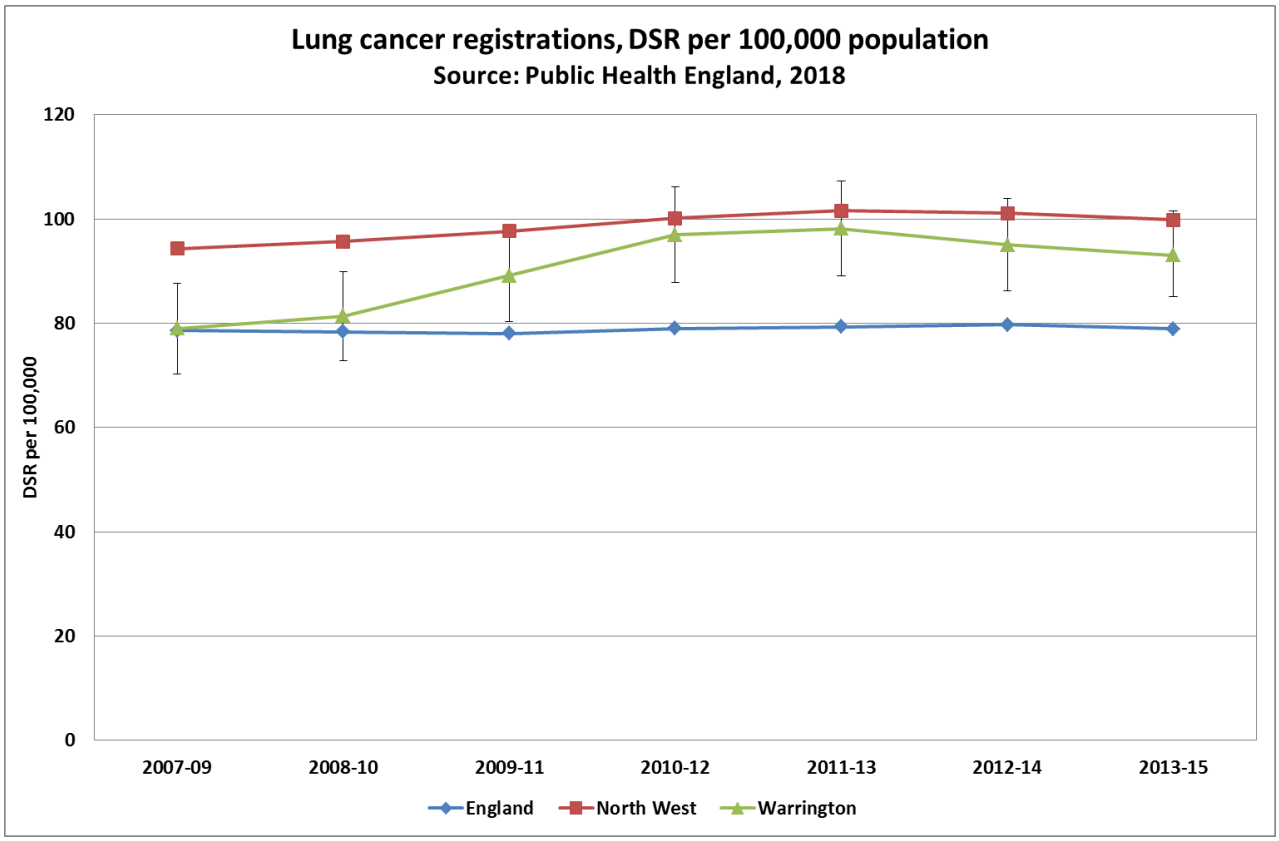
Hospital admissions due to asthma in children and young people aged 0 to 19 years is significantly lower in Warrington (144.7 per 100,000 or 68 admissions during 2016/17) when compared to both the North West (286.4 per 100,000) and England (202.8 per 100,000). Hospital admissions for those aged 35 years and above that are attributable to smoking are low in Warrington when compared to England. During 2016/17 there were 1,629 smoking attributable hospital admissions in Warrington, resulting in a rate of 1,390 per 100,000; this rate of admission was significantly lower than both England (1,685 per 100,000) and the North West (1,926 per 100,000).

Between 2013 and 2015 the number of lung cancer registrations in Warrington was 509. The rate of lung cancer registration in Warrington is significantly higher than England and has been for each time period since 2009-11 (see the following chart). However, since a steady increase in the rate of registrations between 2008-10 and 2011-13, the rate of registrations has started to reduce. The registration rate for oral cancer in Warrington has remained fairly similar to the England rate for registration between 2007-09 and 2013-15. However, over this time period there has been a steady

[1] Data quality issues have been identified with data submitted during 2016/17

increase in the registration rate, especially between 2008-10 and 2011-13, since 2012-14 the rate has remained steady.

**Figure 5: Lung cancer registrations**




**Smoking related mortality**

There has been a steady reduction in the number and rate of smoking attributable deaths in Warrington (all deaths attributable to smoking, smoking attributable deaths from heart disease and smoking attributable deaths from stroke). Between 2007-09 and 2013-15 Warrington had significantly higher rates of smoking attributable mortality when compared to England; however, during 2014 to 2016 the rate of mortality reduced substantially and was slightly higher than England. There were 953 smoking attributable deaths in Warrington between 2014 and 2016.

Warrington has consistently had a higher rate of mortality from lung cancer when compared to England, whether the rate of mortality was significantly higher than England has varied each year. Between 2009-11 and 2013-15 the rate of deaths in Warrington was significantly higher than England with a peak during 2011-13 resulting in 414 deaths and a rate of 78.8 per 100,000 (the England rate was 60.2 per 100,000). However, during 2014-16 the number and rate of deaths in Warrington reduced, resulting in a rate just slightly above England (62.2 and 57.7 per 100,000 respectively).

The number and rate of stillbirths in Warrington has steadily been reducing; during 2014 to 2016 the stillbirth rate (2.6 per 1,000 live births) was significantly lower than England (4.5 per 1,000 live births).

**Figure 6: Local cost of tobacco**

<table>
<tr><th colspan="4">The Local Cost of Tobacco ASH Ready Reckoner (version 5, Jan 2017)<br>Results for Warrington Unitary Authority</th></tr>
<tr><td rowspan="3">The cost of smoking across the local system<br><br>Each in Warrington UA year it is estimated that smoking costs society<br>£53.6m<br><br>That is £2,131 per smoker per year</td><td>Every year early deaths due to smoking results in 956 years of lost productivity<br>This costs the local economy approx. £18.7m</td><td>It is estimated the smoking breaks costs businesses a further £19.9 million every year</td><td rowspan="2">Local businesses also lose approx. 33,400 days of productivity every year due to smoking related sick days.<br><br>This costs about £3m</td></tr>
<tr><td colspan="2">The annual cost to the NHS in Warrington is about £6.4 million<br>£6.1 million is a result of treating smoking-related ill health.<br>£365,115 is due to treating the effects of passive smoking</td></tr>
<tr><td colspan="3">Current and ex-smokers who require social care in later life as a result of smoking-related illnesses cost society an additional £4.9 million per year<br>This represents £2.6 million in costs to the local authority and £2.3 million in costs to individuals who self-fund their care</td></tr>
<tr><td rowspan="2">In 2014 / 2015 Warrington smokers paid £27.9m in duty. Despite this contribution to the Exchequer tobacco still costs the economy roughly twice as much. This leaves a shortfall of £26 million each year</td><td colspan="3">Smoking is still a major cause of house fires, each year there are about 7 tobacco related house fires in the area<br><br>This impacts on the local economy approx. £697.2k each year</td></tr>
<tr><td colspan="3">The majority of cigarette filters are non-biodegradable and must be disposed of in landfill sites.<br><br>In Warrington around 100m filtered cigarettes are smoked each year. This results in 17 tonnes of waste annually.<br>Of this 4 tonnes is street waste that must be cleared by council staff.</td></tr>
</table>

## Current Services in relation to need

Smoking prevalence is declining but not fast enough. Too few people successfully quit every year and too many people start smoking. Each Local Authority has a duty to ensure that there is an active Tobacco Control Alliance working towards achieving the ambitions outlined in the national strategy. This alliance should include a range of professionals and stakeholders who together can devise practical ways to address the impact tobacco has on the locality.

CLeaR is a Public Health England evidence-based approach to tobacco control designed to be used by Local Authorities to maximise the impact of local work (Public Health England, 2017c). It uses a self-assessment tool followed by an outside peer assessment for measuring the success of local action to address harm from tobacco. This is an opportunity to bring local partners together to discuss the range of local tobacco control efforts and reinforce efforts and priorities, it is also a chance to benchmark work on tobacco control over time and against others. Warrington Borough Council (WBC) first completed this process in 2014, since then there have been many changes both with internal reorganisation and changes within the tobacco control agenda. WBC will complete the CLeaR assessment again in 2018 with a view to establish a strong and focussed Tobacco Control Alliance to meet the challenges set out in the national recommendations. Although Stop Smoking Services form a pivotal role in this renewed impetus, it is not their sole responsibility.

In the past Local Stop Smoking Services (LSSS) have used an NHS model designed to meet the needs of the smoking population as identified in 1998, this model was designed to meet the needs of a much larger smoking population. Since the creation of these services in the year 2000 they have played a large part in the large reductions in prevalence that can be seen nationally. The effectiveness of local stop smoking services to help people to quit smoking is well documented; a smoker is four times more likely to be successful if they receive support from a smoking advisor (Public Health England, 2017d).

However, this means that over time as the numbers of smokers have decreased, the local stop smoking service are now trying to attract and engage those long-term smokers that are most resistant to behaviour change. It is also likely that these hard to reach smokers will have already tried the local stop smoking service and had an unsuccessful quit attempt, and are unlikely to try them again unless they believe that the service has something new to offer. Nationally and locally this has been reflected in the big reduction in numbers going through local stop smoking services (NHS Digital, 2016).

There is national evidence that shows improved outcomes where LSSS have offered new or innovative interventions and services. For example, it is known that some people are not ready or able to quit smoking in one step, there is guidance from National Institute for Clinical Excellence (NICE) around a number of harm reduction methods that can be used to engage with long term smokers. On this basis the local stop smoking service will be re-designed and re-launched as ‘Warrington Smokefree’ from April 2018. This updated approach will offer more targeted and wide reaching tobacco support across communities particularly targeting groups where evidence shows high levels of smoking.

The service will be able to offer advice and guidance on the use of vaping products to minimise the harm from tobacco smoke. There is a body of evidence that popularity of e-cigarettes and vaping has helped large number of long-term smokers either to cut-down or quit smoking. E-cigarettes and other vaping products combine a rapid and effective release of nicotine, maintain the hand to mouth behaviours, and are easily bought, meaning they has revolutionised the success of people who try to quit. While acknowledging the many concerns health professionals have, the benefits e-cigarettes can bring in terms as a quitting aid cannot be ignored by stop smoking advisors. Following national guidance the advice the LSSS will offer is that while it is definitely better to vape than smoke in the short-term, the long-term health impacts are not yet known.

In terms of using vaping as a quitting aid, it will be discussed as another Nicotine Replacement Therapy (NRT) product (the evidence is that vaping is most effective for heavy smokers). However, the long-term aim would always to be support someone to become completely addiction free. On this basis the LSSS will work alongside those local vape retailers who wish to become partners in supporting tobacco quits. Theses retailers will demonstrate that they follow good standard practice such as having all their products licenced by the Medicines and Healthcare products Regulatory Agency (MHRA), and offer assessments to clients to assess the level of nicotine needed to meet their initial cravings and advice about reducing nicotine levels over time. The Warrington Smokefree Team and the retailers will work together to support national initiatives such as Stoptober. A large part of this updated service will be the continuation of the work that has already begun with NHS partners to support the implementation of the NICE guidance PH48 (for further details see the evidence section).

In terms of mental health services the LSSS has been working in partnership with Hollins Park Hospital for a number of years to train staff and support a smokefree policy, this support will be ongoing to maintain and build upon progress made. The Smokefree Warrington Team have also made good progress at Warrington Hospital where a number of good working relationships have been established. There is a Specialist Stop Smoking Midwife based in the maternity unit, who supported by the local service, offer a hospital based clinic and outreach support to the most vulnerable pregnant women. There have also been links with both respiratory and cardiology departments to offer stop smoking support as an integral part of a patients care package.

Links to wider health and social care providers will be made, including drug & alcohol services, private care providers and military veteran charities.

Innovative outreach into the more deprived areas of the town will use new ways of discussing issues around tobacco and the impact it has. Closer working with GP practices will allow the identification of smokers with long term health conditions that are both caused and exacerbated by smoking.
Industry and employers are also affected by tobacco use and they bear a significant financial burden resulting from the ill-health and sickness caused by smoking. The economic case for employers to promote smoking cessation across their workforce is strong and the national tobacco control plan calls for all employers to take responsibility for their workplace. Locally, Smokefree Warrington Service will target manual & routine workplaces offering support to develop and implement effective policies to create a smokefree and healthier workforce.

Partnerships with organisations that work directly with families will be strengthened so that a wide variety of workers understand and can communicate the benefits for a family by stopping to smoke. Smokefree schools and youth clubs will continue and develop in line with changing perceptions among young people. And, the creation of new smokefree environments will be a priority, building on the growing public support for clean air in public spaces (particularly locations used by families).

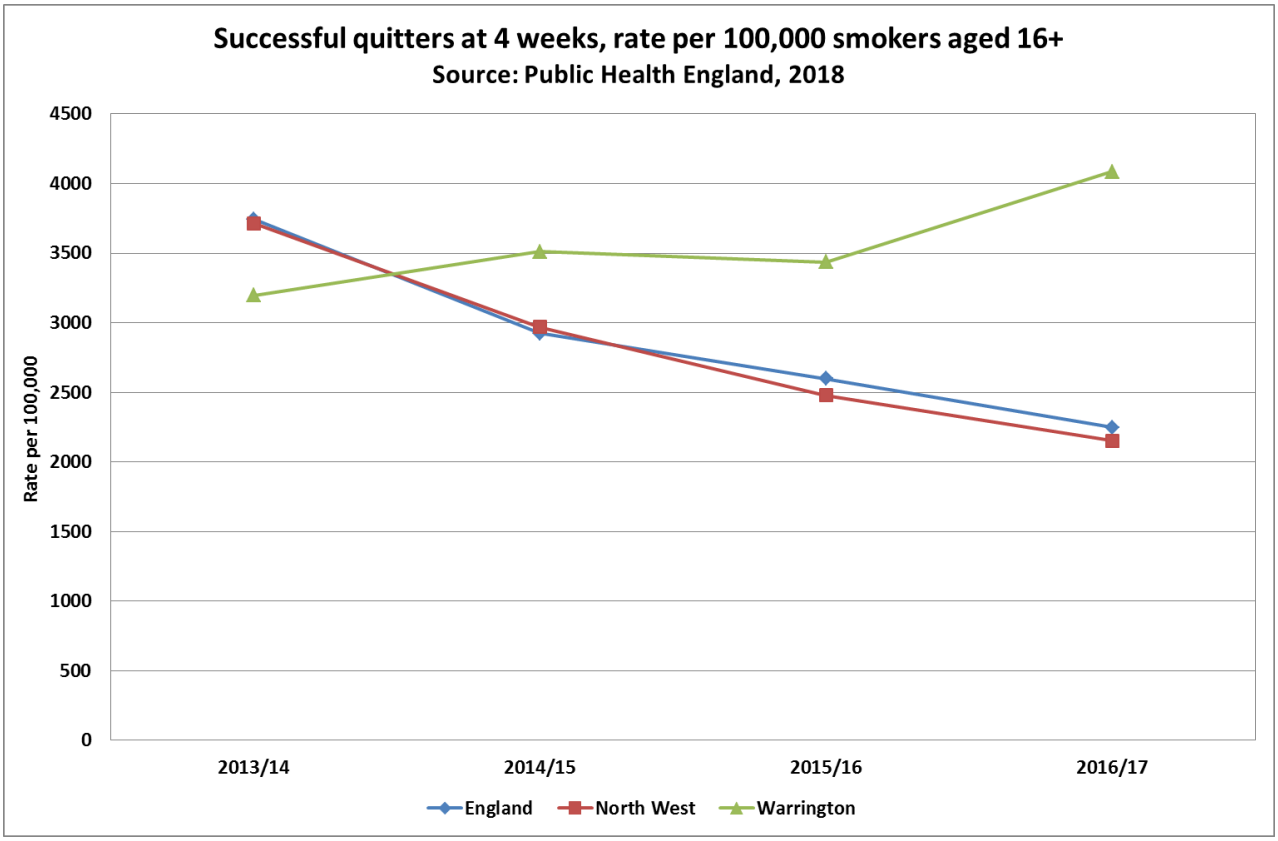
The stop smoking service has worked with the local mental health provider in recent years to begin to address the difference in smoking rates among those with a mental health condition compared to the general population. However, there is no single measure that will transform outcomes but a whole systems approach is needed that involves staff across mental health, physical health and social care, and empowers individuals to realise their goals of being smokefree.

## Stop Smoking Service Activity

During 2016/17 there were 1,213 Warrington smokers setting a quite date with the local SSS, the number setting a quit date during 2016/17 was the highest recorded over the previous four time periods (2013/14 to 2016/17) as published by Public Health England (PHE, 2018b). The rate of smokers setting a quit date in Warrington (5,691 per 100,000 smokers) was higher than both England (4,434 per 100,000) and the North West (4,673 per 100,000).

Of the 1,213 smokers who set a quit date, 871 reported that they had successfully quit at four weeks. The number of successful quitters increased during 2016/17 when compared to 2014/15 (852 quits) and 2015/16 (855 quits), the trend of increasing quitters is not reflected nationally or regionally as presented in the following chart.

**Figure 7: Successful quitters at 4 weeks**



The number and rate of successful quitters is based on the number of people who self-report that they have successfully quit at their four-week follow-up. However, it is possible that a client may report that they had quit when they have not. CO validated smoking quits provide an objective measure in addition to self-reported quits. The number of CO validated quits reduced substantially between 2013/14 (498 CO validated quits) and 2015/16 (316 CO validated quits), an increase was observed during 2016/17 (381 CO validated quits). The rate of CO validated quits in Warrington has consistently been below the England rate, however during 2016/17 the rate increased (1,788 per 100,000 smokers) to slightly higher than England (1,627 per 100,000 smokers) (Public Health England, 2018b).

## Evidence of what works

**National Institute for Health and Care Excellence (NICE)**

**Public Health Guideline 48 (2013):** The NICE Guidance PH48 covers helping people to stop smoking in acute, maternity and mental health services. It promotes smokefree policies and services and recommends effective ways to help people stop smoking or to abstain from smoking while using or working in NHS settings. The strong association between smoking and both physical and mental ill-health means that many people who access the NHS are smokers which give a valuable opportunity to use interventions of proven effectiveness and cost effectiveness to initiate and support stop smoking. However, some people find it difficult to tell healthcare professionals that they smoke for fear of disapproval. This is particularly true of pregnant women or people who know or suspect that their illness is related to smoking. This means that appropriate smokefree training and stop smoking support for healthcare staff is important in its own right, particularly as they may find it difficult to admit they smoke or to get support to quit. NHS staff who continue to smoke may also find it difficult to act as a health champion or to advise people to stop, and there is evidence that staff who do not smoke are more likely to support hospital smokefree strategies.

**Public Health Guideline 14 (2014):** NICE guidance for smoking prevention suggests that school based interventions, mass media interventions and enforcement to restrict illegal access to tobacco among young people are effective. The impact of these interventions are considered more effective when delivered as a package of multi-component interventions in family and community settings, particularly where there is an increased emphasis on reducing adult smoking through stop smoking support (NICE, 2014).

**E-cigarettes, vaping and other Nicotine Inhaling Products**

Public health England and other leading stop smoking organisations such as ASH (Action on Smoking and Health) promote the body of evidence that shows that e-cigarettes are significantly less harmful to health than smoking tobacco. Stopping smoking is hard and many smokers are turning to e-cigarettes as an effective way to help them in their attempts. In 2016 it was estimated that 2 million consumers in England had used these products and completely stopped smoking and a further 470,056 were using them as an aid to stop smoking.

A review of the evidence commissioned by Public Health England (PHE) in 2014 found that the hazard associated with electronic cigarette products currently on the market “is likely to be extremely low, and certainly much lower than smoking”. Other reviews have drawn similar

conclusions with one putting the risks of vaping at less than 5% of the risks of smoking and another review concluding that "Electronic cigarette [EC] aerosol can contain some of the toxicants present in tobacco smoke but at levels which are much lower. Long term health effects of EC use are unknown but compared with cigarettes, EC are likely to be much less, if at all, harmful to users or bystanders." (Hajek. P et al , 2014)

A recent review of the impact of electronic cigarettes noted that passive exposure to the aerosol can expose non-users to nicotine but at concentrations that are unlikely to have any significant health impact. The 2015 PHE review also reported that the amount of nicotine released into the ambient air poses no identifiable risk to bystanders. While electronic cigarette vapour can contain some of the toxicants present in tobacco smoke these are at much lower levels. One preliminary study found that the concentration of particles in electronic cigarette vapour was about 100-fold lower than from tobacco smoke (McNeill et al, 2015).

The Tobacco Products Directive 2014/14/EU (TPD) introduced new rules for nicotine-containing electronic cigarettes and refill containers (Article 20) from May 2016. The Medicines and Healthcare Regulatory Agency (MHRA) is the competent authority for the notification scheme for e-cigarettes and refill containers in the UK and is responsible for implementing the majority of provisions under Article 20. The TPD introduced new rules which ensure:

- Minimum standards for the safety and quality of all e-cigarettes and refill containers (otherwise known as e-liquids);
- That information is provided to consumers so that they can make informed choices;
- An environment that protects children from starting to use these products.

From 20 May 2017, the new requirements were:

- Restrict e-cigarette tanks to a capacity of no more than 2ml;
- Restrict the maximum volume of nicotine-containing e-liquid for sale in one refill container to 10ml;
- Restrict e-liquids to a nicotine strength of no more than 20mg/ml;
- Require nicotine-containing products or their packaging to be child-resistant and tamper evident;
- Ban certain ingredients including colourings, caffeine and taurine;
- Include new labelling requirements and warnings;
- Require all e-cigarettes and e-liquids be notified to MHRA before they can be sold.

Consumers and healthcare professionals can report side effects and safety concerns with e-cigarettes or refill containers to MHRA through the Yellow Card reporting system. You can also report products suspected to be defective or non-compliant to your local Trading Standards or to TPDsafety@mhra.gov.uk (HM Government, 2016).

The national guidance will continue to support consumers in stopping smoking by adopting the use of less harmful nicotine products, primarily the range of e-cigarettes and vaping products on the market. In addition there has been the development and very recent introduction of novel tobacco products that claim to reduce the harm of smoking; these include devices that heat rather than burn tobacco. The government has made assurances that there will be ongoing monitoring and

evaluation on vaping and novel products and the role they play in reducing the risk of harm to smokers. The government will therefore continue to critically evaluate the evidence on nicotine delivery products, providing clear communication about what is known and unknown about the short and long term risks of using different products relative to smoking and the absolute risk to children, non-smokers and bystanders.

Both Scotland and Northern Ireland have code of conduct schemes for retailers. The Tobacco Retailers Act (Northern Ireland) 2014 requires tobacco retailers across Northern Ireland to join the register by 1st July 2016. After this date it was illegal to sell tobacco products if not registered to do so. The new registration requirement is just one of a range of measures being introduced by the legislation to reduce smoking among children and young people. From 1st July 2016, enforcement officers had power to issue fixed penalty notices for failing to register as a tobacco retailer and retailers may also face prosecution through the court system where it is considered appropriate to do so (Tobacco Retailers Act (Northern Ireland), 2014).

Tobacco and Primary Medical Services (Scotland) Act 2010 (which came into force in 2011) the aim of these regulations was to make tobacco products less available to children and young people under 18, whilst minimising the impact on business. The Act establishes a tobacco sales registration scheme. This scheme allows retailers to be clearly identified, enabling trading standards officers and others to offer advice and support to them to avoid illegal sales. The Act sets out information required on any application to be on the Register of Tobacco Retailers. Under section 11 retailers are required to provide their name and address and the address of all premises at which they propose to carry out a tobacco business. Scottish Ministers can prescribe other information which must also be contained in the application (Tobacco and Primary Medical Services (Scotland) Act 2010).

The Public Health Bill in Wales was not passed in 2016, leading to concerns that the tobacco control measures contained in the proposed legislation might be lost. The Bill would have led to the creation of a national register of retailers of tobacco products and it would have restricted smoking in public playgrounds, school grounds and hospital grounds.

The English Government is seeking evidence and information on the supply chains currently used to distribute tobacco products in the UK, such as the number of links in the chain and the number of businesses affected. There was a consultation where the government welcomed initial views on a new initiative that tracked and traced products using security markings. Under the draft regulations, retailers would have to register to receive both an ‘economic operator identifier code’ for their business and a ‘facility identifier code’ for each store.

The tobacco industry focussed on the structure of the UK distribution network and how the process of distribution differs significantly from other European countries such as Spain or France, where a single distributor/wholesaler manages the supply of products from manufacturers. Due to this complexity it was expected that there will be a higher number of tracking events through the UK supply chain, and, therefore, costs of the proposed traceability system to both the industry and the distributive supply chain could be significant.

However, health related organisations opposed the use of 'Codentify', on the basis that it is a system developed by the tobacco industry. They considered that any track and trace system should be independent of the industry. Respondents also cited there has also been no assessment of Codentify's efficacy as a track and trace system and that an industry developed system is not compatible with the Framework Convention on Tobacco Control (FCTC).

Track and Trace was universally welcomed by enforcement officers within Local Authorities, with respondents expressing positive expectations regarding the effects on crime, the community, and on ensuring the supply of authentic tobacco products. Retailers were supportive of measures to tackle the supply and sale of illicit tobacco, but larger businesses – wholesalers and retail chains, expressed concerns that any future system should be practical and manageable and not impede the speed of distribution or significantly increase costs.

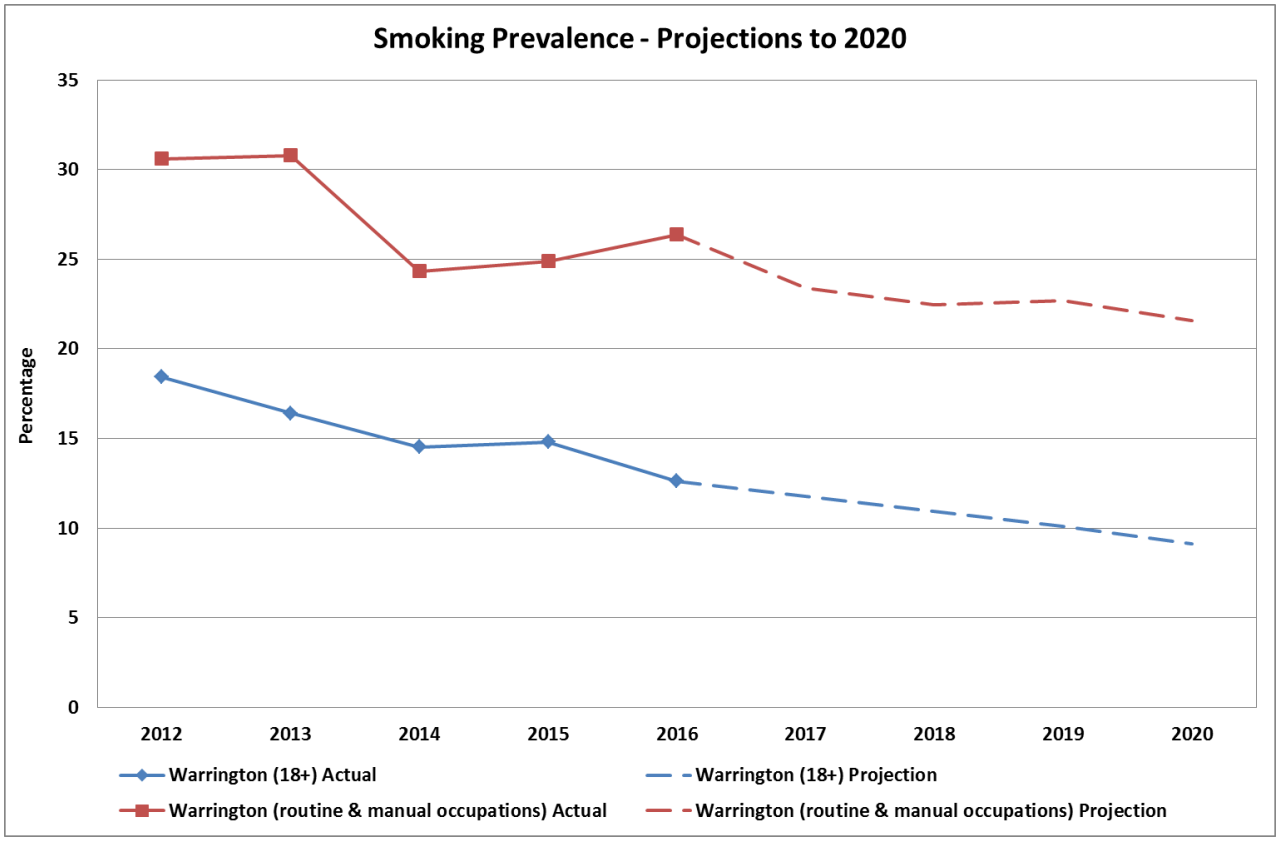
Views expressed by the public were mixed. Some welcomed tighter controls to prevent illicit trade of tobacco. Others noted that track and trace might have implications with regards to consumer choice and would further increase prices on imported goods, suggesting such an increase would likely encourage an increase in illicit trade of tobacco products.

Proposals for tertiary legislation on track and trace and security features are being developed by the European Commission and were due to be adopted in the first half of 2017. The Government is fully considering the information provided and will continue to listen to all businesses involved in the supply of tobacco products in the development of EU proposals in this area. HMRC is leading on this aspect of the TPD2 and will be transposing TPD2 Articles 15 and 16 in separate UK legislation, to apply to cigarettes and hand-rolling tobacco from 20 May 2019 and to all other tobacco products from 20 May 2024. Legislative proposals will be accompanied by an assessment of the estimated impact on businesses (Department of Health, 2016).

## Projected service use

The following chart presents the projected percentage of adult smokers and projected percentage of adult smokers in routine and manual occupations up to 2020. If the current trend in the prevalence smoking for these two groups continues, it is projected that the prevalence of smoking will reduce (assuming that there are no changes in national or local policy regarding tobacco control). If current trends were to continue, by 2020 approximately 9.1% of adults will be current smokers whilst 21.6% of adults in routine and manual occupations will be current smokers.

**Figure 8: Projected smoking prevalence**




## User Views

### Smokefree Environments

There are important lessons to be learned from the development of public opinion over tobacco control measures including smokefree legislation.

On the eve of the public consultation on plain packaging, a YouGov survey of 10,000 adults showed that 62% of the public supported plain packaging while only 11% opposed it. In addition, the survey revealed that only 6% believed the tobacco industry could be trusted to "tell the truth" (Doward and Legge, 2012).

When the Office for National Statistics first asked a question about smokefree provision in autumn 2003, only 20% of people wanted no smoking allowed anywhere. When it asked the same question in autumn 2004 this had risen to 31%. In a YouGov poll commissioned by ASH and conducted in August 2005, 41% wanted pubs to be smoke free. Respondents were then given peer reviewed scientific evidence about the harm caused by second-hand smoke and asked the question again. This time a clear majority, 52%, did not want smoking allowed anywhere in pubs. In June 2008 the one year report on smokefree legislation from the Department of Health showed that 80% of the public now agree with the legislation.

Public opinion on tobacco control is a dynamic phenomenon. Decisive and effective steps by Government create public approval: there is no need and no good reason to wait for overwhelming public backing before taking action (Department of Health, 2008).

**Figure 9: Public opinion in the North West**

<table>
<tr><th colspan="3">Public Opinion in the North West – the Smokefree Britain Survey 2015*<br>*ASH/YouGov Smokefree Britain Survey 2014</th></tr>
<tr><td colspan="2">The public does not trust the tobacco industry<br>Only 5% of adults in the North West agree that tobacco companies can be trusted to tell the truth (73% disagree)<br><br>Only 4% of adults in the North West agree that tobacco companies behave ethically (68% disagree)</td><td>The public supports Government action to tackle tobacco75% of adults in the North West support that all government health policy should be protected from the influence of the tobacco industry and its representatives (3% oppose)<br><br>78% think that political parties should not accept financial or in kind donations from the tobacco industry. Just 7% think political parties should accept them.</td></tr>
<tr><td colspan="2">A clear majority of adults in the North West believe that the Government is not doing enough or has got tobacco policy about right.<br><br>In addition, 62% of adults in the North West support adding an additional 25 pence on a packet of cigarettes, with the money being used to help smokers quit and discourage young people from taking up smoking.</td><td>Support for recent measures to tackle the harm caused by tobacco is very high in the North West.<br>Support for the ban on smoking in cars carrying children younger than 18 years of age is particularly high at 84%.</td></tr>
<tr><td colspan="3">Smoking in the home. Over 8 in 10 adults in the North West (82%) said that they do not allow smoking anywhere in their home<br>Or only in places that are not enclosed (such as in the garden or on a balcony). Only a minority (9%) stated that they would allow smoking anywhere in their house, or only in some rooms (9%).</td></tr>
<tr><td>78% of respondents in the North West said they were not purchasing tobacco through illicit channels, with 12% making some illicit purchases.</td><td colspan="2">There is very strong public support for measures to curb the illicit trade.<br><br>Only 4% of respondents in the North West opposed measures to crack down on tobacco smuggling.</td></tr>
</table>

**Figure 10: Local opinion**

| Local Opinion – Feedback from Warrington Residents | |
|---|---|
| **Support for a Smokefree Town Centre October 2016 –**<br>People were asked if they would support a total ban of smoking in the town centre. 197 were surveyed of these -<br>**130 supported a total ban** | **Comments from resident about smokefree town centre**<br>*'Smoking should be banned anywhere there are children about and anywhere near where people are eating and drinking'*<br>*Fair enough – I smoke but I would quit if I could'.*<br>*'A ban would be beneficial to everyone'* |
| **Smokefree School Gates**<br>In 2017 children at four primary schools teamed up to ask adults not to smoke near school gates. This resulted in a banner designed by the children attached to gates.<br><br>This story was covered by the Warrington Guardian who polled readers about if they supported the initiative, a total of 330 readers responded **and 90% thought banning parents from smoking outside school gates was a good idea.** | |

Sources: Street survey by Public Health Team in October 2016 and Warrington Guardian online survey in November 2017

## Unmet needs and service gaps

Local data shows an increasing smoking prevalence in adults in routine and manual occupations. The redesigned Smokefree Warrington Service will use a much more targeted approach to ensure stop smoking support is reaching the target groups most likely to smoke. Part of this is a focussed approach in workplace settings, particularly routine and manual occupations and care settings where smoking is still prevalent among both staff and patients/clients. Workplaces will be offered support to write and implement Smokefree Policies, while employees will be offered support to quit while at work, when this is an appropriate option. There will also be an offer of training for staff in brief intervention methods, where there is an opportunity to help people in their care quit smoking.

The data also highlighted that over a quarter of 15 year olds had used e-cigarettes, this is much higher than the national average. However, the rate for current smokers at 15 years is 9% which is statistically similar to the national average of 8.2%. It is not currently clear if the rate of e-cigarette use among young people is due to young people using e-cigarettes to quit or cut down smoking. The Smokefree Warrington Service are well briefed via national guidance and training from The National Centre for Smoking Cessation Training (NCSCT) about how to advise and support people who choose to use an e-cigarette to quit. The team will start regular drop-in's at the Youth Café from April 2018. The Youth Café already has an existing health offer where young people, aged between 11 and 19 years, are engaged with in a trusted location with support from youth workers. There also continues to be an active Smokefree Schools Award initiative, that requires all schools to have a comprehensive smokefree policy that is backed up by classroom sessions and support for national campaigns, this is coordinated by the Public Health Team in partnership with school health and

Smokefree Warrington Team. The School Health Team also, continue to offer smoking support for students who access the appointments they offer in all high schools.

The overall rate of Smoking at Time of delivery (SATOD) in Warrington at 8.3% is below the national average of 10.7% and the regional average of 13.4%. However, within this rate there exists a large inequality gap where the vast majority of women who continue to smoke in pregnancy live in the more deprived areas of the town. The Stop Smoking Midwife is aware of this inequality and focusses one-to-one support on this targets group, however as a part-time role this resource is limited, even when supported by the Smokefree Warrington Team. To ensure that all pregnant women who smoke, or if they live with smokers, receive information and support to stop smoking or reduce the risk of second –hand smoke a wide range of staff have been trained to give stop smoking brief-advice to women. This means that CO monitoring is part of the initial health checks given at the first booking-in appointment and is discussed ant any subsequent appointments, there is also a new initiative where sonographers will be trained and be giving brief-advice as part of the scan appointment.

## Opportunities for improvement and/or commissioning

There is a need for there to be a more focussed and targeted approach to help the most deprived groups more effectively to stop smoking and reduce the associated health inequalities.

Warrington would benefit from having an active Tobacco Control Alliance that would regularly bring a wide range of partners together to ensure a joined up approach to the agenda. Warrington Borough Council will use the Public Health England review process CLEAR 2.0 to assess which areas of the agenda we currently perform well on as a town and where improvements can be made. The process has two parts an internal; review followed up by a peer review where outside assessors speak to a number of local partners. This will leave an action plan that the newly formed alliance can work towards.

The overall smoking prevalence of smokers in Warrington is currently 12.6%, while the last local lifestyle survey by Public Health in 2013 showed that on a ward level the highest rate of smoking was 28% found in Latchford East an area of deprivation while the rate was only 6% in affluent Appleton. As a town the ambition is to reduce this inequality gap by ensuring that smoking rates in all individual wards are reduced to 20% or less. It is proposed that as part of the redesign of the Smokefree Warrington team that their performance targets from 2019/20 reflect this ambition.

The current rate of smoking for Routine and Manual workers at 26.4% is more than double the rate across the general population. As a town the ambition to reduce this inequality gap by reducing the rate to 18% by 2020. This will be a challenging target to meet as current projections estimate the percentage of smokers in routine and manual roles will be 21.6% by 2020 if current trends are to continue. It is proposed that as part of the redesign of the Smokefree Warrington team that their performance targets from 2019/20 reflect this ambition.

Data shows that young people in Warrington are much more likely to try an e-cigarette than in others of the country. Public Health England cigarette review in 2018 showed that very few non-smoking young people will use an e-cigarette. However, local data and anecdotal evidence suggest

that this is not the case. Public Health will lead on a project to explore the motivations, behaviours and risks associated with young people e-cigarette use and develop a plan to help raise awareness of the issues and minimise any risks.

Much or the focus of the new national plan 'Towards a Smokefree Generation' is related to de-normalising smoking behaviours limiting access to tobacco products and the creation of smokefree environments. There will be an ongoing enforcement programme carried out by the Public Protection team in relation to illicit products and underage sales. The Smokefree Schools agenda will now be rolled out over all the Children Centres. Public Health and the Smokefree Warrington Service will continue to develop smokefree environments in workplaces, third sector spaces and open public places.

The Smokefree Warrington Service will continue to work at Warrington Hospital to help it to become a completely smokefree environment, in terms of staff, patients and visitors. The team will do this by working in partnership with PH48 CQUIN implementation team to support all patients to quit or abstain while in hospital.

## Key Contact

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