Thurrock

Tobacco Control Strategy

2014 – 2019

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"Public health is the science and art of preventing disease. Prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals"

(Winslow, 1920)

"Comprehensive tobacco control is more than just the provision of local stop smoking services or the enforcement of smokefree legislation. The effectiveness of tobacco control is dependent on strategies which implement a wide range of actions that complement and reinforce each other"

Tobacco Control Plan for England

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Document Control

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Appendices

Executive Summary

Smoking continues to be the single biggest cause of death in England. In 2013 Thurrock's smoking prevalence was 22.8% which was above the national and regional rates but broadly in line with its Chartered Institute of Public Finance & Accountancy (CIPFA) comparators. Nationally prevalence for 2013 reached 18.4%, its lowest rate since records began.

This strategy sets out our vision for a five year plan from 2015 to 2019 for prevention, treatment and enforcement utilising the 6-strand approach of a tobacco control programme.(see appendix 1) Targets within the strategy stretch to 2019 in order to lay the foundations needed to achieve our aspirations that:

- By 2020 we will reduce by half the smoking prevalence of our under 20 year olds
- Between 2013 – 2016 we will reduce the prevalence of smokers.

We know that 80% of smokers take up the smoking by the age of 20, with 40% starting before the age of 16, shifting the strategy away from treatment and weighting it towards prevention will yield measurable future outcomes for individuals, families, communities and businesses.

Therefore this strategy will focus on prevention, setting challenging targets to engage with our young people in our schools and colleges to raise awareness of the harms of smoking.

The management and responsibility of this strategy will be through the Tobacco Control Alliance which reports into adults and children's directorate management team meetings (DMTs) and the Health and Wellbeing Board (HWBB).

Introduction and Strategic context

The Health and Social Care Act 2012 introduced the establishment of a new public health system. All local authorities now have a duty to improve the health of the people in their area and have responsibility for commissioning appropriate public health services. Progress in public health is measured by the Public Health Outcomes Framework (PHOF). Public Health's key areas are:

- Health improvement
- Health protection
- Healthcare public health

The PHOF has domains relevant to addressing the topic of Tobacco Control and the following areas are relevant to the new duties of the local authority:

- Smoking prevalence – 15 year olds
- Smoking prevalence – Adults (over 18 years)
- Smoking status at the time of delivery
- Behavioural and lifestyle campaigns to prevent cancer and long-term conditions
- Local initiatives on workplace health

One of Thurrock Council's five corporate priorities is to 'Improve Health and Wellbeing', demonstrating the Council's commitment to this agenda. The council has established a Health and Wellbeing Board (HWBB) that brings partners together to lead the integration of

health and well-being services across the NHS and local government, to assess the community's assets and needs and develop a Health and Wellbeing Strategy (HWBS) to improve the health and well-being of the community and to reduce inequalities.

The HWBB priority to 'improve health and well-being' has three specific objectives:-

- Ensure people stay healthy longer
- Reduce inequalities in health and well-being
- Empower communities to take responsibility for their own health and well-being.

Its vision is to have 'resourceful and resilient people in resourceful and resilient communities'.

The Thurrock Health and Wellbeing Strategy for 2013 – 2016; health and wellbeing targets are to improve the physical health and wellbeing of the people of Thurrock, with initial focus on reducing the prevalence of smoking. This will be accomplished by:

- Identifying and implementing actions and initiatives to prevent young people from starting smoking
- ensuring a range of options to motivate and encourage current smokers to stop smoking
- protecting families and communities from the harm caused by smoking
- developing approaches that use prevention, treatment and enforcement – particularly in restricting the supply of tobacco products to minors

In November 2013 Thurrock Council became only the 22nd Local Authority to sign up to the Local Government Declaration on Tobacco Control. This committed us to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with our partners and local communities to address the causes and impacts of tobacco use, according to our local priorities and securing maximum benefit for our communities;
- Participate in local and regional networks for support; and
- Monitor the progress of our plans against our commitments and publish the results.

This strategy realises this commitment and provides a framework for its delivery alongside supporting the ambition set out in the vision.

Prevalence of smoking

Today smoking continues to be the leading preventable cause of death in England with over 8 million smokers. Tobacco is a uniquely dangerous product because when used as the manufactures intend it will kill half of all life-long users[1].

This diagram illustrates the number of deaths attributable to the following causes, as at October 2013

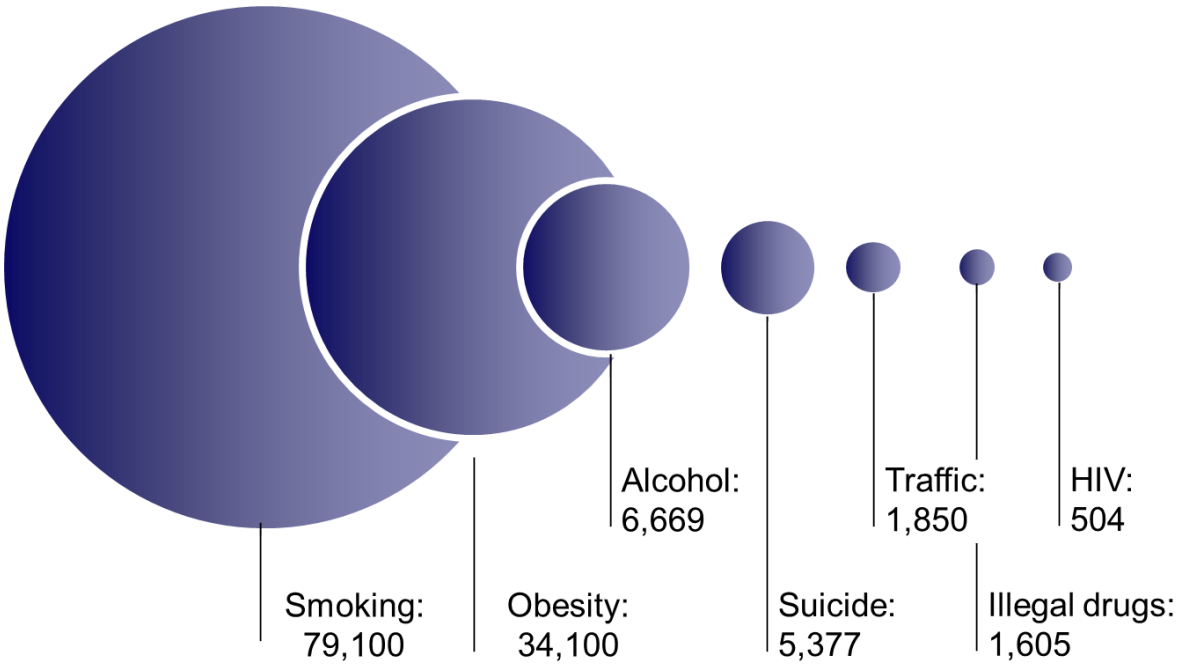


Figure 1, Source: ASH Factsheet, Smoking Statistics: illness & death, October 2013
http://ash.org.uk/files/documents/ASH_107.pdf

Local Profile

Over a fifth (22.8%) of Thurrock adults aged 18 years smoke. This is both an increase from the previous years (20.7%) and above the national average, the latter of which is currently the lowest figure since records began (18.4%)[2].

In 2013, Thurrock had the highest smoking prevalence out of its CIPFA (Chartered Institute of Public Finance and Accountancy) (nearest neighbours) comparator authorities. It was also significantly higher than the regional and national averages.

[1] Doll R, Peto R, Boreham J, Sutherland I. Mortality in relation to smoking: 50 years observations on male British doctors. BMJ 2004, 328: 1519 http://www.bmj.com/content/328/7455/1519
[2] http://www.tobaccoprofiles.info/profile/tobacco-control/data#gid/1000110/pat/6/ati/102/page/0/par/E12000006/are/E06000034

None of the CIPFA comparators were statistically better than the national average - of the 15 authorities, 8 were statistically similar and 7 were statistically worse.

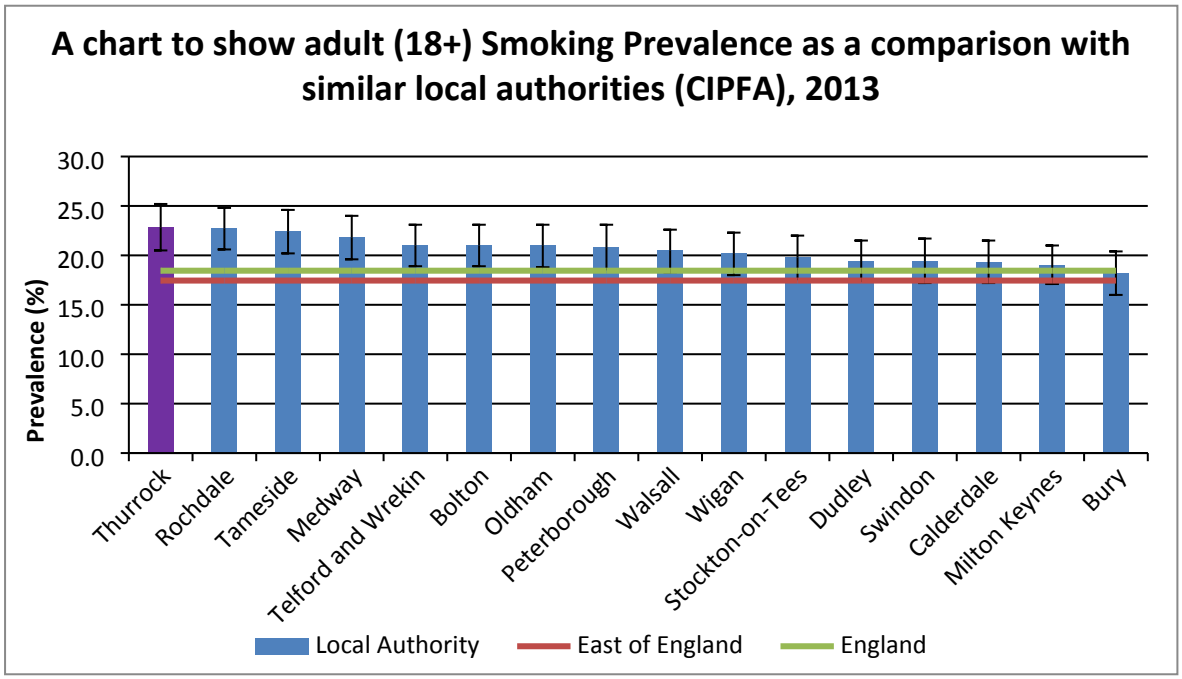
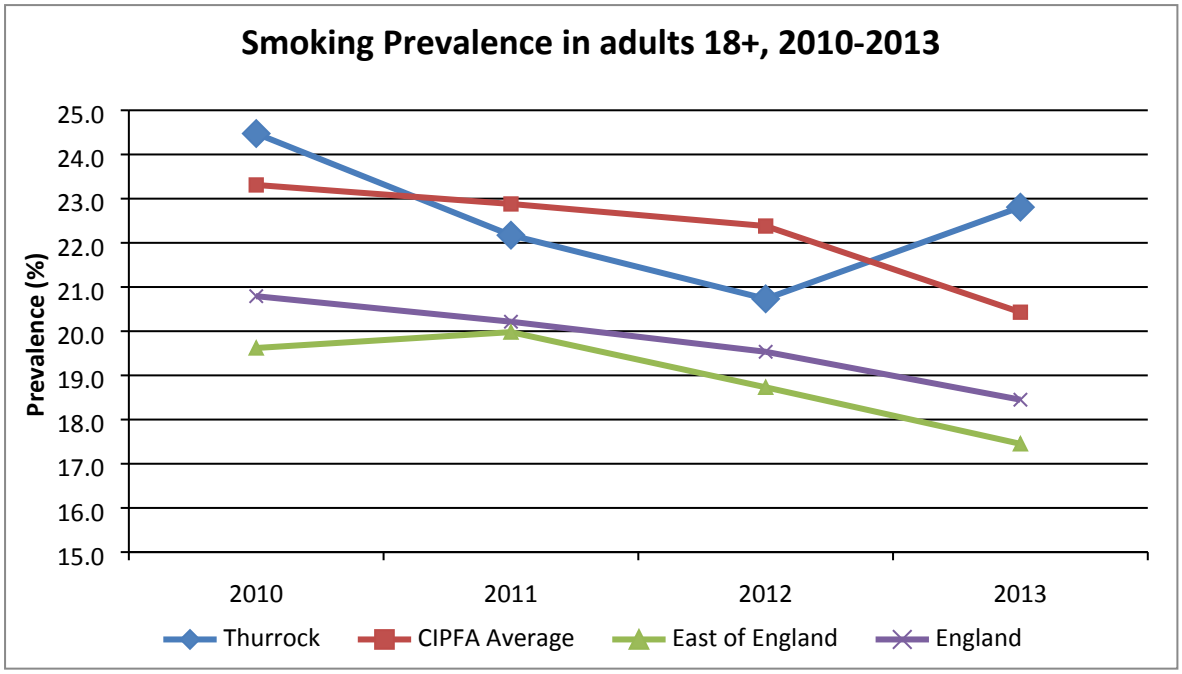


Figure 2, Source: Integrated Household Survey 2013.

Figure 3 illustrates how Thurrock outperformed the CIPFA comparator sites in reducing prevalence between 2010 and 2012, but in 2012/13 there is an increase of 2% where our comparator sites continue to reduce the smoking prevalence. Therefore a new approach is required. The cause in the 2% increase is currently unknown.



Research tells us that 80% of smokers take up the habit before the age of 20[3], with 40% starting before the age of 16 years. Young people smoking prevalence rates for 2013 are currently estimated at some 11.5% for all under 20 year olds in Thurrock, with prevalence amongst 15 year olds (regular smokers) estimated at some 8.2%, reaffirming our focus for early intervention and preventative work with young people[4].

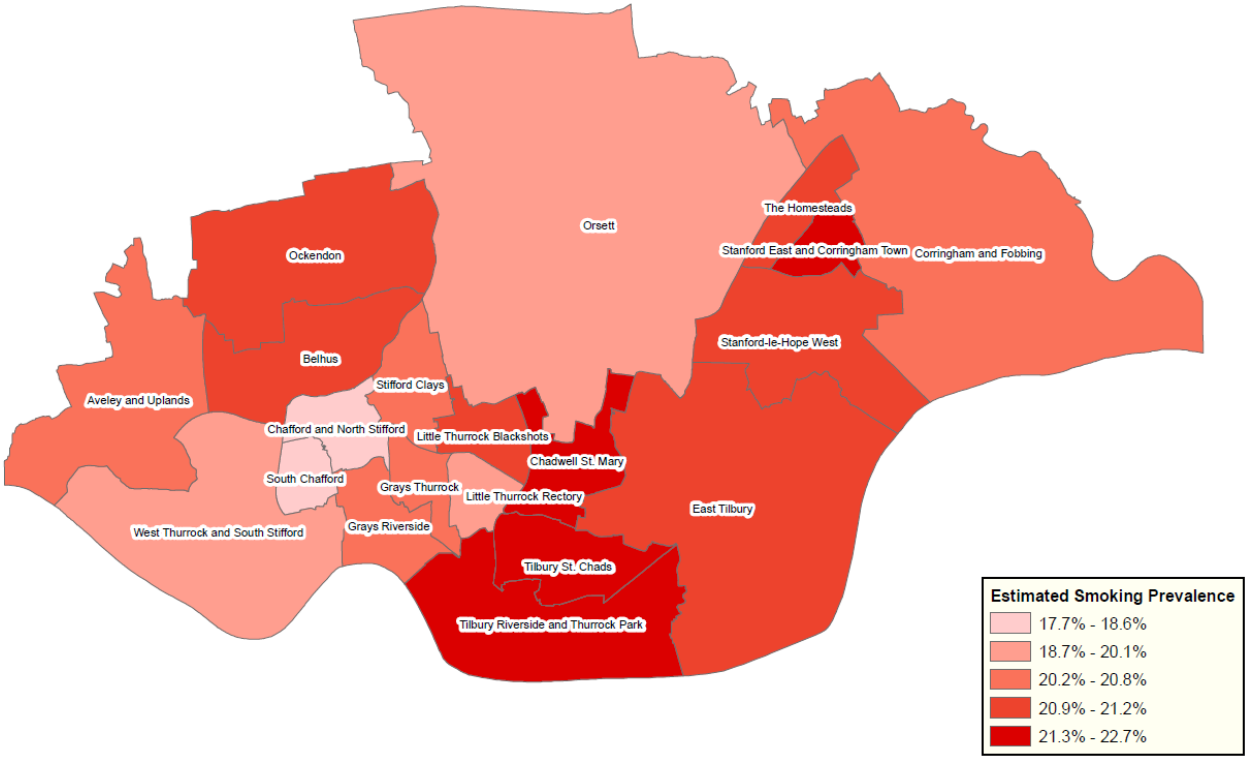
A level of caution needs to be applied to prevalence data as this based on self-reported evidence i.e. the Integrated Household Survey and GP records with the assumption that people and patients have been honest about their smoking status.

We are unsure if those who use e-cigarettes report themselves as a smoker or not which could have impact of prevalence figures.

If we can stop people from starting smoking this will make a measurable difference in future datasets, particularly if we target the young and those living in areas of deprivation; smoking is directly linked to health inequalities with prevalence significantly higher in areas of deprivation and vulnerable groups (see appendix 2).

The map in figure 4 below shows modelled synthetic estimates based on the 2012 Integrated Household Survey to illustrate smoking prevalence data in different wards in Thurrock. These data show a direct correlation with the more deprived areas of Thurrock demonstrating a clear health inequality.

Smoking Prevalence at ward level, 2012



[3] General Lifestyle Survey 2008

[4] Source: Children and Young People's Health Outcomes Framework http://fingertips.phe.org.uk/profile/cyphof (Accessed Feb 2015).

Figure 4

Thurrock's smoking prevalence in routine and manual occupational groups is higher than the overall smoking prevalence average for Thurrock.(25.6%) of adults aged 18+ within these groups smoke, which is just under the regional and national averages (28.4%, 28.6% respectively).

- The mortality rate attributed to smoking in Thurrock is 235.76 per 100,000 populations (2012/13). This is equivalent to 229 smoking-related deaths per year[5].
- Smoking status at time of delivery (for pregnant women) indicator (2012/13) for Thurrock is (11.4%) this remains below the East of England (12.4%) and England (12.7%) averages[6].
- Young people are more likely to smoke if their friends smoke and generally exhibit greater ambivalence about the present health dangers of their tobacco use than adults. 200,000 new smokers start each year and two thirds are under 18, the legal age of purchase in the UK[7]. See chart 5 below.

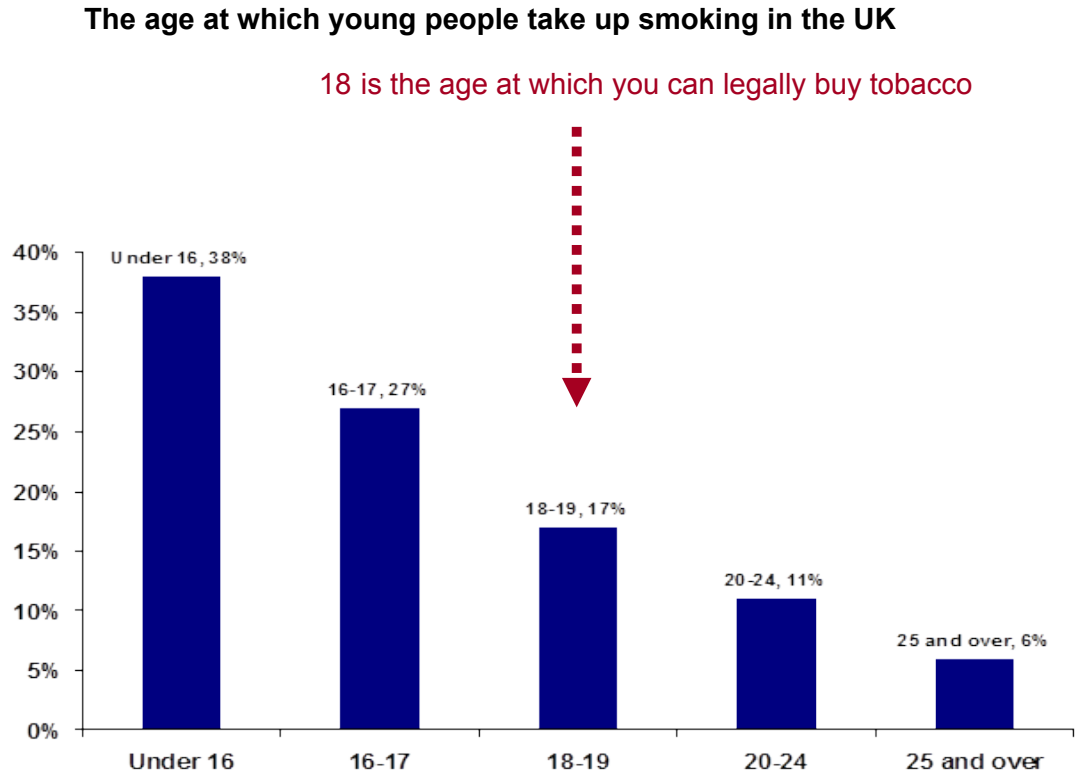


Chart 5. Source: Smoking Attitudes & Behaviours, ONS 2011

[5] Public Health England Thurrock Health Profile 2014, http://www.healthprofiles.info
[6] Public Health England Thurrock Health Profile 2014, http://www.healthprofiles.info
[7] Smoking Attitudes & Behaviours, ONS 2011

Estimated costs to our local economy

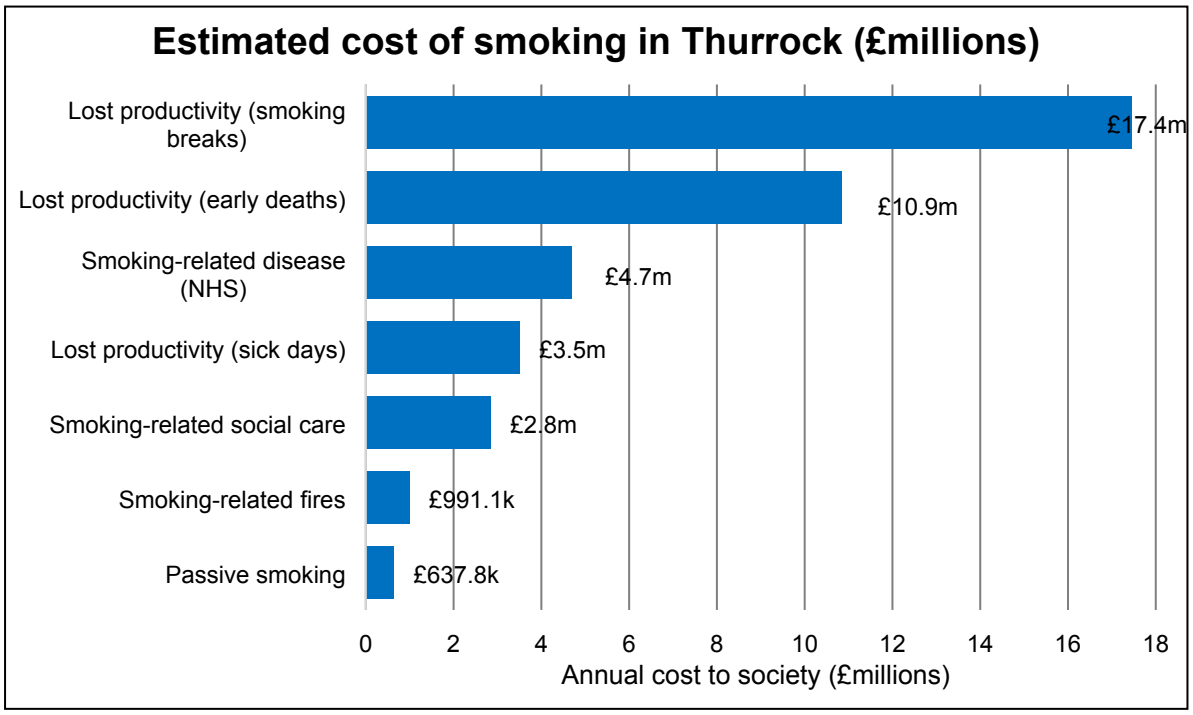


Figure 6, Source: The Local Cost of Tobacco, ASH Ready Reckoner 2014.

These costs can be broadly divided into two groups; costs to smokers and costs to society:

Costs to smokers

- In 2013, a 20 a day smoker of a premium cigarette brand will spend around £2,900 a year on cigarettes.
- Estimates for the total amount spent on tobacco in the UK in 2011 range from £15.3 billion to £18.3 billion[8] [9].
- The proportion of total household expenditure on tobacco has decreased from 3.6% 1980 to 1.9% in 2012[4]. In 2012, tobacco was 27.9% less affordable than in 1980[5].

Costs to society

- Contrary to popular belief smokers do not "bankroll the NHS". £9.5 billion is collected by the Treasury every year in tax, but the costs to society have been estimated to be £13.74 billion every year[10] [11].
- Costs to the NHS include the costs of hospital admissions, GP consultations and prescriptions. The government also pays for sickness/invalidity benefits, widows' pensions and other social security benefits for dependants.
- There are wider costs such as increased absenteeism, productivity lost due to smoking breaks etc. that tend to impact on the employer. The loss of economic output from the premature death of smokers costs £4.1 billion every year.

[8] AC Nielsen Market Track cited in The Grocer, 18 Feb. 2012.
[9] Statistics on smoking: England, 2012. The Health and Social Care Information Centre, 2012.
[10] Tobacco Bulletin. HM Revenue & Customs, Apr. 2014
[11] Nash, R & Featherstone H. Cough Up: Balancing tobacco income and costs in society. Policy Exchange, 2010

- Smoking-related diseases include illnesses such as lung cancer, heart disease, bronchitis and chronic obstructive pulmonary disease (COPD).
- Social care costs include those costs related to the wellbeing of smokers who on average need social care support such as home care nine years earlier than non-smokers.
- The national cost of cleaning up cigarette butts every year is estimated to be £342 million, with the cost of fires being £507 million every year. Cigarettes are the leading cause of fatal accidental fires in the home: in 2008 smokers' materials accounted for 113 deaths and 932 non-fatal casualties from fires in the home. Costs to society from house fires also include increased insurance premiums.

The Thurrock Approach

Our five year strategy sets out the priorities and actions for the council and our local partners, including statutory and voluntary agencies and local communities, we aim to achieve a coordinated reduction of smoking prevalence and the associated harm caused by tobacco in Thurrock. This will include looking at age-specific smoking issues and strategies.

Our Ambition

From 2013 Thurrock's multi-agency Smoke Free Work Stream has had some significant achievements including

- sign up to the Local Government Declaration for Tobacco Control
- refresh its own Smoke Free policy to include e-cigarettes and recognise their harm-reduction benefits.
- led a public consultation on tobacco
- delivered a multi-agency workshop to discuss the results of the consultation and explore the future for tobacco control in Thurrock. (see appendix 3 for the consultation summary report).

In 2015 the Smoke Free Work Stream will develop into a Tobacco Control Alliance with the responsibility of overseeing the implementation of this strategy.

The findings following the consultation and the workshop will now inform our commissioned services. From April 2015 a new preventative tobacco control model will be developed with the existing provider. We will still continue to commission interventions around stopping people smoking with a focus on targeted groups and targeted areas and we will continue to work with trading standards on enforcement

Shifting to a tobacco control programme will release the potential to affect the entire population of Thurrock including those who want to quit and also those who are passive smokers. including monitoring and enforcement of national legislations (e.g. smoke free, illicit tobacco sales, advertising bans), taking responsibilities for paid and unpaid mass media, evaluating and monitoring progress of the control programme and advocacy work to influence national and international actions.

Prevention

Prevalence refers to activity designed to stop people from smoking in the first place. Given that we know most smokers take up the habit before they are old enough to legally purchase cigarettes (18), we will focus our preventative work at schools, colleges, youth settings and other places where young people access; creating an environment where young people choose not to smoke.

A multi-agency approach with shared objectives is the key to success here

The offer can be a mixture of both universal (open to all) and targeted (aimed at certain groups/individuals). Evidence tells us that particular people are more likely to smoke, e.g. children from households where 1 or more adults already smokes. manual workers, people suffering with mental health and those using substances

Evidence Base:

Nicotine addiction plays a strong part in smoking, and most adult smokers become addicted to nicotine when they are children or young people during a time of their lives when they do not have the knowledge or experience to understand either the nature of addiction or the difficulty many smokers have in quitting smoking. Children who smoke become addicted to nicotine very quickly, and currently 200,000 young people in the UK take up the habit each year. That is 548 new young smokers every day (DECIPHer IMPACT 2011).

A randomised control trial of ASSIST (A Stop Smoking in Schools Trial) results suggest if implemented on a population basis, the ASSIST intervention could lead to a reduction in adolescent smoking prevalence of public-health importance[12].

Nationally, education regarding smoking forms part of the Science and the Personal, Social and Health Education (PSHE) curriculum in both primary and high schools. The curriculum focuses on educating children on the health effects of smoking.

- Key Stage 2 (age 7–11) pupils are taught that tobacco has harmful effects.
- Key Stage 3 (11-14) pupils are taught that tobacco will affect health including lung structure.
- Key Stage 4 (14-16) pupils are taught the effects of smoking on the body functions. Education regarding skills development, e.g. in resisting the pressure to smoke, can also form part of the PSHE programme.

Commissioning programmes that successfully prevent young people from starting smoking could have a much greater long term impact on smoking prevalence than commissioning services to help current smokers to quit. We will ensure that all our schools are meeting the targets at each key stage in Thurrock.

[12] Campbell R, et al, Lancet 2008, http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60692-3/abstract

Treatment

Despite the strategy having a bias towards prevention, it is still important that treatment is available for those smokers that wish to quit. The NICE best practice recommendations that service providers should aim to treat at least 5% of their local smoking population[13].

Quitting smoking can take a smoker an average of 7 attempts, but smokers are 5 times more likely to quit with support from a Local Stop Smoking Service (LSSS). This can include behavioural support from a trained professional, 1:1 support, group support and medications such as free Nicotine Replacement Therapy (NRT) more commonly known as nicotine patches, gums and sprays or medications such as Varenicline (Champix) or Buproprion (Zyban).

Currently smokers can access support via a dedicated LSSS or through their local pharmacist or GP; we will continue to commission treatment services with a focus on our hard to reach groups and areas

In Thurrock, older people who set quit dates were more likely to quit smoking, with almost 57% of those aged 60+ successfully quitting (self-reported) at 4 weeks[14].

Evidence Base:

Stopping smoking is arguably the single most effective thing a smoker can do to improve their health and it's never too late to quit.

Surveys show that at least 70% of adult smokers would like to stop smoking and of those who express a desire to quit, more than a third are very keen to stop[15]. Many smokers continue to smoke, not because they choose to, but because they are addicted to nicotine and are unable to beat the addiction.

Reducing smoking prevalence in our adults is also likely to have an effect on preventing young people from starting smoking, as there will be fewer adult smokers acting as role models to young people.

[13] Local Stop Smoking Services, Service and Delivery Guidance 2014, NCSCT, http://www.ncsct.co.uk
[14] HSCIC: http://www.hscic.gov.uk/article/2021/Website-Search?productid=15174&q=stop+smoking&sort=Relevance&size=10&page=1&area=both#top
[15] Smoking-related Behaviour and Attitudes, Lader and Goddard, ONS, 2004

Enforcement

Enforcement includes where tobacco is available for sale, we ensure that these are genuine products with UK duty paid and only sold to those old enough to purchase tobacco products working with agencies such as Trading Standards, Boarder Force and Her Majesty's Revenue and Customs (HMRC).

Within the last decade there has been significant achievements including the introduction of smoke free public buildings and businesses, bigger health warnings on cigarette packets, greater restrictions on cigarette advertising and the introduction of plain screens in front of tobacco cabinets.

There has been increased pressure on government to pass legislation that supports plain (standardised) cigarette packets, with the Chantler review[16] finding no evidence to support the tobacco industry's arguments that standardised packaging would increase the illicit trade in tobacco.

There has also been a call to introduce legislation to protect children from the effects of second-hand smoke by banning adults from smoking in cars that carry children. The regulations to prohibit smoking in cars when children are present were laid before Parliament on 17th December 2014 and were approved in February 2015. The law will take effect on 1 October 2015.[17]

Evidence Base:

The UK has the most expensive cigarettes in the EU and among the most expensive cigarettes in the world. Price increases have successfully helped people become non-smokers. UK budget changes to tobacco duty have saved lives and prevented serious illness.

Research has shown that four times more people die from the effects of smuggled tobacco than from all illicit drugs combined. Furthermore, other studies estimated that eliminating smuggling could lead to an overall fall in the number of cigarettes smoked by around 5 per cent, resulting in 4,000 fewer premature deaths[18]. It is essential that work should be continued to reduce illegal tobacco sales within Thurrock.

[16] https://www.gov.uk/government/speeches/chantler-report-on-standardised-packaging-of-tobacco-products
[17] http://www.smokefreeaction.org.uk/SmokeCars.html
[18] http://tobaccocontrol.bmj.com/content/17/4/230.short

Targets

The future targets are set against ambitions laid out in the Coalition Government's 2011 Tobacco Control Plan for England and national data provided by the Office for National Statistics. The ONS data for male and female prevalence rates have then been averaged. The Thurrock average takes account of the fact that deprivation is not evenly distributed across the local population.

***Table 1 - smoking prevalence milestones* by quintiles**

DATE	Quintile 5 *Most deprived*	Quintile 4	Quintile 3	Quintile 2	Quintile 1 *Most affluent*	THURROCK AVERAGE
2012 baseline	29.5	22.9	18.9	15.2	12.3	**22.8%**
2015	25	18	13	11	10	**21%**
2017	21	13	9	8	7	**19%**
2019	17	9	6	5	4	**14%**

Public Health England have modelled some local estimates for smoking prevalence in particular age groups, however, this doesn't exist for all young people under 20 years. Therefore, for table 2 we have calculated the baseline from the national prevalence rates for young people. A local measure is expected in 2016 from the What About YOUth survey[19], at which point table 2 may get amended.

Table 2 – young people prevalence milestones

DATE	THURROCK AVERAGE
2013 baseline	**11.5%**
2015	**10%**
2017	**9%**
2019	**8%**

[19] http://www.whataboutyouth.com/

Conclusion

The work of the tobacco control work stream over the last twelve months has informed this five year strategy which included completing a public consultation and holding a multiagency workshop. The findings have resulted in our vision and remodelling of the way we commission tobacco control in Thurrock.

Over the next five years we will focus on preventative services with the young people of Thurrock, we will work with targeted populations and target local hot spot areas Quintiles 4 and 5 on stop smoking services, and finally we will work in partnership with trading standards and enforcement agencies on the enforcement agenda.

We will ensure that our commissioned programmes are updated to reflect these findings.

We have developed a delivery plan which will monitor progress ongoing. The delivery plan will be managed through the work stream reporting into the PHSB and the HWBB. We will continue to refresh our approach following continued engagement and consultation with partners and our communities.

Delivery Plan

Action / KPI	How will we know it's made a positive impact?	Can it be done?	Responsible person	Completed by when
Specific	*Measurable*	*Achievable*	*Realistic*	*Time-bound*
Evolve the Smoke Free Work Stream in to a Tobacco Control Alliance	When activity reports are submitted to the Public Health Strategy Board that demonstrate a directly measurable improvement in the areas of Prevention, Treatment and Enforcement	Yes. The nucleus of the group already exists as a work stream	Kev Malone	Spring 2015
Prevention				
(Strand 2) Annual support of ASH and UKCTCS budget submission to the Chancellor of the Exchequer	Tobacco taxation increased above inflation in annual budget report. Tobacco is less affordable	Linked to Key Strand 2 of strategy. Submission to be reported to the TC Alliance	Kev Malone	End of financial year, each year
Support campaigns to lobby for the implementation of standardised (plain) packaging for cigarettes	Achieve a drop in youth smoking prevalence	The regulations were approved by the House of Lords on 16.03.15	Tobacco Control Alliance	May 2016
CLeaR / babyClear	When peer assessment	Preparatory work is	Jacqui Sweeney /	2015/16

	is completed	**being undertaken to ensure delivery in 2015**	**Kev Malone**	
(Strand 1 & 5) **Increase smoke free outdoor zones at pubs and restaurants via the Public Health Responsibility Deal**	**Patrons can dine alfresco at on-licenses and restaurants without having to breathe second hand smoke**	**Yes, provided businesses sign up to this and enforce the rule at their establishment**	**Tobacco Control Alliance**	**2018/19**
Promote to the public the risks of hand-rolled tobacco and niche tobacco products e.g. shisha	**Myths dispelled about these products being lower risk. Users of these products accessing LSSS for quit support**	**Via prevention programme in secondary schools and general campaigns e.g. Stoptober and Health Harms campaigns**	**QUIT / Vitality** **Public Health**	**2016/17**
Promote to the public the adverse effects of counterfeit tobacco	**Myths dispelled about these products being okay. Educate people about how tax evasion and organised crime impacts on communities and society**	**Via prevention programme in secondary schools and general campaigns e.g. Stoptober and Health Harms campaigns**	**QUIT / Vitality with Public Health and Trading Standards advice**	**2018/19**
Work with schools and colleges to promote local and national prevention campaigns	**Evaluation of programmes to assess the level of understanding gained and assess the likelihood of uptake of tobacco by young people following their intervention**	**A programme of interventions will be delivered by QUIT within schools to prevent the uptake of smoking and demonstrate the harm of tobacco smoking as outlined in NICE guidance (PH23)**	**QUIT/Vitality**	**2015/16**
Treatment				
(Strand 4) **Evaluation of new**	**Service is delivering against targets and**	**Yes**	**Kev Malone**	**2015/16**

service / Service Review	**demonstrating value for money**			
Value for Money benchmarking exercise	**Service compares favourable against CIPFA comparator sites**	**Underway**	**Kev Malone**	**2015/16**
Engage with more older people e.g. sheltered complexes & retirement homes to offer quit support	**Increase in number of over 65's engaging in quit attempts**	**Yes**	**Vitality / Housing / LACs**	**2015/16**
Hospitals: Implement Quit Manager onto desktops in hospitals for secondary care referrals at pre-op assessment including support for pregnant smokers via maternity services with an opt out policy **NICE PH48, PH22**	**Increase in stop smoking referrals from BTUH**	**Ensure relevant hospital staff are trained to deliver smoking cessation interventions to patients** **Support local hospitals to refer patients in to the stop smoking service**	**Vitality** **Vitality**	**2015-19** **2015/16**
Community Healthcare: Dentists, Optometrists, Mental Health and Substance misuse	**Increase in referrals for quit support from these partners**	**Train dental nurses and dental reception staff in level 2 smoking cessation brief intervention training.** **Train optometrist staff in level 2 smoking cessation brief intervention training.** **Ensure pharmacy staff are trained or refreshed in level 2 smoking cessation brief intervention training.** **Develop referral**	**Vitality / KCA / CRI** **Vitality** **Vitality**	**2015/16** **2015/16** **2015/16**

		pathways with all mental health services and providers within Thurrock. **Develop referral pathways and train staff in level 2 smoking cessation brief intervention training for adult and young person substance misuse services in Thurrock.**	**Vitality** **Vitality**	**2015/16** **2015/16**
Workplaces	**Increase in referrals for quit support from local businesses, especially routine and manual employers**	**Build relationships with businesses and their occupational health departments and offer the stop smoking services for their employees and volunteers**	**Vitality**	**2015/16**
(Strand 4 & 5) **Work with Housing to promote quit support for tenants**	**Increase in quitters from LSOA postcodes in quintile 4 & 5 and routine and manual quitters**	**Yes, via promotion of Local Stop Smoking Service by housing officers**	**Lynette Royal**	**2015/17**
Young people	**Increase in referrals for quit support from schools and colleges**	**Work with schools and colleges to offer cessation services to young people**	**Vitality / QUIT**	**2015/16**
E-cigarettes: **Local Stop Smoking Service to support quitters doing so via e-cigarettes**	**Increase in people engaging in a quit attempt but using their own e-cigarette**	**Yes**	**Vitality**	**2015/16**
Enforcement				
Reduce illegal	**Increase in number of seizures of illegal and**	**Work with Trading Standards to maximise**	**Border Force / HMRC / Trading**	**2018/19**

tobacco sales	**illicit tobacco from our borders and retailers**	**the inclusion of other agencies to reduce illegal sales to minors including, for example, the use of covert cameras with underage volunteers**	**Standards**	
Promote the Crimestoppers number to the public to report retailers, traders or members of the public who make illegal sales of counterfeit and smuggled products	**Increase in number of seizures of illegal and illicit tobacco from our retailers / traders**	**Yes**	**Trading Standards & Tobacco Control Alliance**	**2015/16**
Enforce point of sale regulations, for example, reduction of exposure to tobacco product advertising by enforcing the Tobacco Advertising and Promotion (Point of Sales) Regulations and associated legislation	**Regulations adhered to**	**Enforcement of tobacco display ban**	**Trading Standards**	**2015-19**
Ensure the 'Challenge 25' proof of age scheme is implemented and adhered to	**Scheme adhered to and evidenced via refusal books**	**Yes**	**Trading Standards**	**2015-19**
(Strand 5) **Support the ban on adults smoking in cars that carry children and promote pressure**	**Fewer adults witnessed smoking in their cars while carrying children** ***(The latter has since been achieved since the regulations were***	**Via Civil Enforcement Officers issuing fixed penalties where vehicles are stationary and via local marketing to raise awareness of the law change on**	**Tobacco Control Alliance**	**2015/16**

on MP's to support this	***approved by Parliament in February 2015)***	**01.10.15**		
Work with HM Revenue & Customs to maximise the inclusion of other agencies to reduce the supply of smuggled tobacco products including hand-rolled tobacco and niche tobacco products e.g. shisha	**Reduction in amount of illicit and illegal tobacco products available in Thurrock**	**Via information sharing of intelligence and coordinated resources to respond to intelligence**	**Tobacco Control Alliance**	**2015-19**
Work with Trading Standards to collate greater intelligence on illicit and illegal tobacco	**Successful operations with tobacco detection dogs**	**Cost implication regarding tobacco detection dogs**	**Tobacco Control Alliance**	**2015-19**

Appendices

Appendix 1

Glossary

ASH	Action on Smoking and Health
BME	Black and Minority Ethnic
CCG	Clinical Commissioning Group
CIPFA	Chartered Institute of Public Finance & Accountancy
CLeaR	Excellence in local tobacco control
DMT	Directorate Management Team
DOH	Department of Health
HMRC	Her Majesty's Revenue and Customs
HSCIC	Health and Social Care Information Centre
HWBB	Health and Wellbeing Board
LSSS	Local Stop Smoking Service
NCSCT	National Centre for Smoking Cessation and Training
NICE	National Institute for Health and Care Excellence
NRT	Nicotine Replacement Therapy
ONS	Office for National Statistics
PHOF	Public Health Outcomes Framework
UKCTCS	UK Centre for Tobacco Control Studies

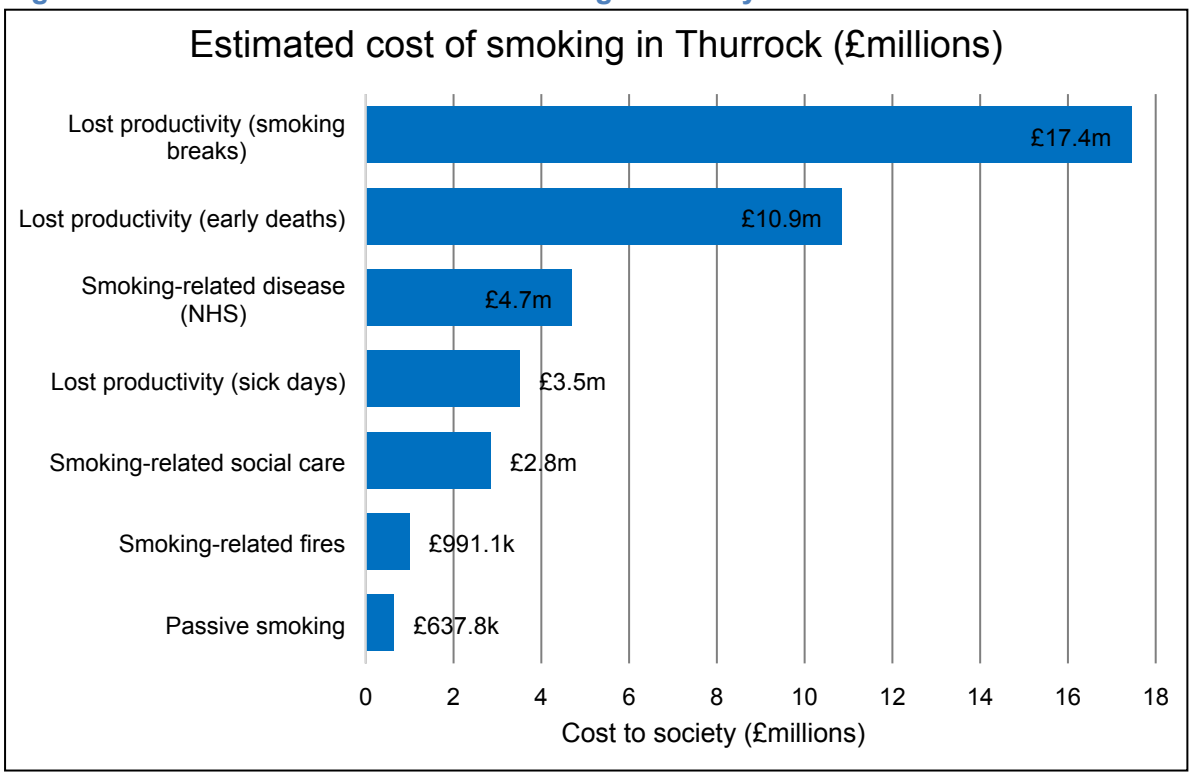
Appendix 2

JSNA section: Smoking - What do we know?

Economic Cost

There are a wide range of costs to society due to smoking. In Thurrock, it is estimated that smoking costs society approximately £41 million each year. Below is a breakdown of the estimated impact of smoking in Thurrock, and it can be seen that the largest cost is due to lost productivity from smoking breaks (£17.4 million), followed by lost productivity due to smoking-related deaths – an estimated 525 years of productivity is lost, at a cost of £10.9 million.

Figure 1: Estimated annual cost of smoking to society in Thurrock



Source: ASH and LeLan

Children and Young People

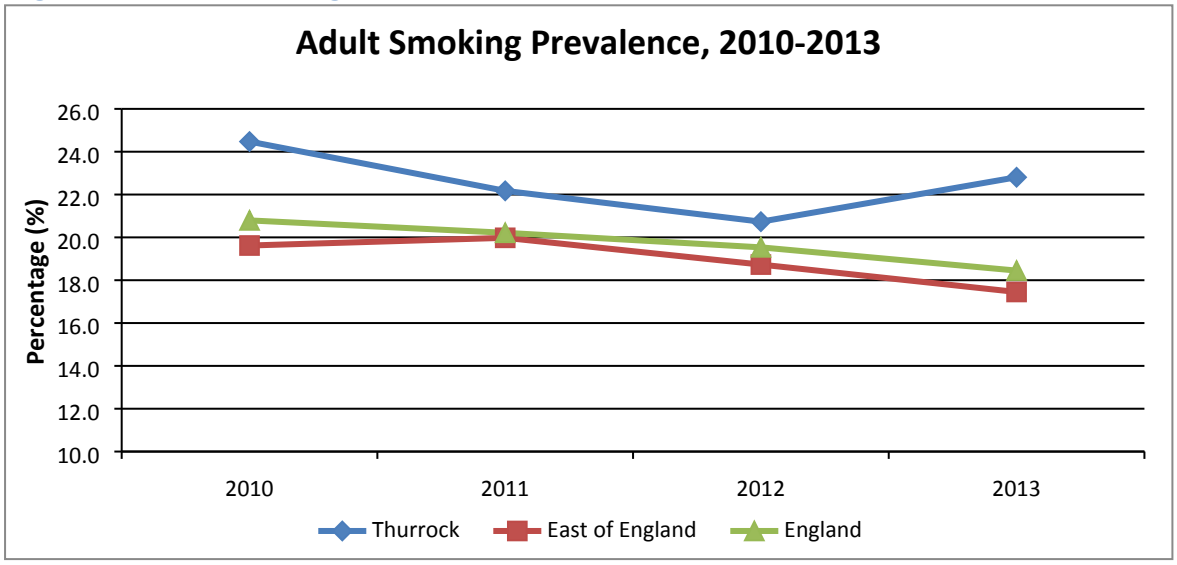
Data collected by the Health and Social Care Information Centre (2013) indicates that 3% of pupils in England reported that they smoked at least one cigarette per week. When results were broken down by age, it can be seen that the prevalence of smoking increased with age: less than 0.5% of 11 and 12 year olds said that they smoked at least one cigarette per week, compared with 4% of 14 year olds and 8% of 15 year olds.

Accurate local data is limited. The most recent data on smoking habits in children and young people originates from the TellUs4 survey (2009), which indicates that 4% of Thurrock children in years 6, 8 and 10 usually smoke at least one cigarette per week, which was the same as the national average but higher than the regional average (3.4%).

Adults

Data from the Integrated Household Survey in 2013 indicates that 22.8% of adults aged 18+ in Thurrock smoke, which is significantly higher than the regional and national averages. The prevalence of smokers in Thurrock has increased from 2012, where it was statistically similar to the national average.

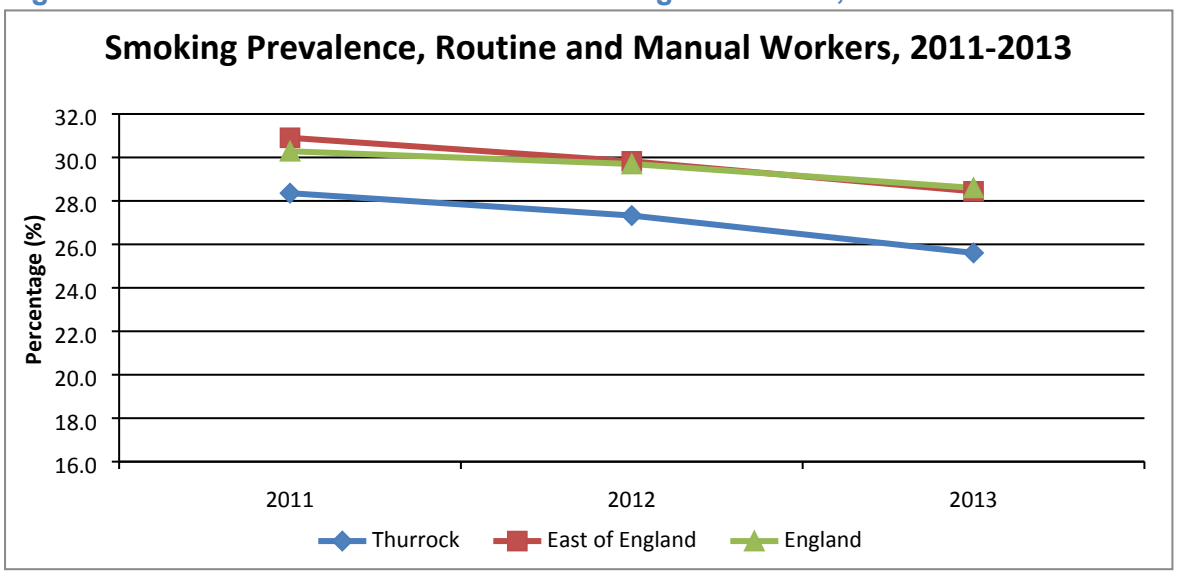
Figure 2: Adult Smoking Prevalence, 2010-2013



Source: Integrated Household Survey

Routine and manual workers are a key priority group whose smoking prevalence is monitored as it is an occupation group with a particularly high prevalence of smoking. In Thurrock, the latest data shows that smoking prevalence within this group is 25.6%, which is statistically similar to the regional and national averages. The prevalence in Thurrock for this population group has decreased slightly over the last three years.

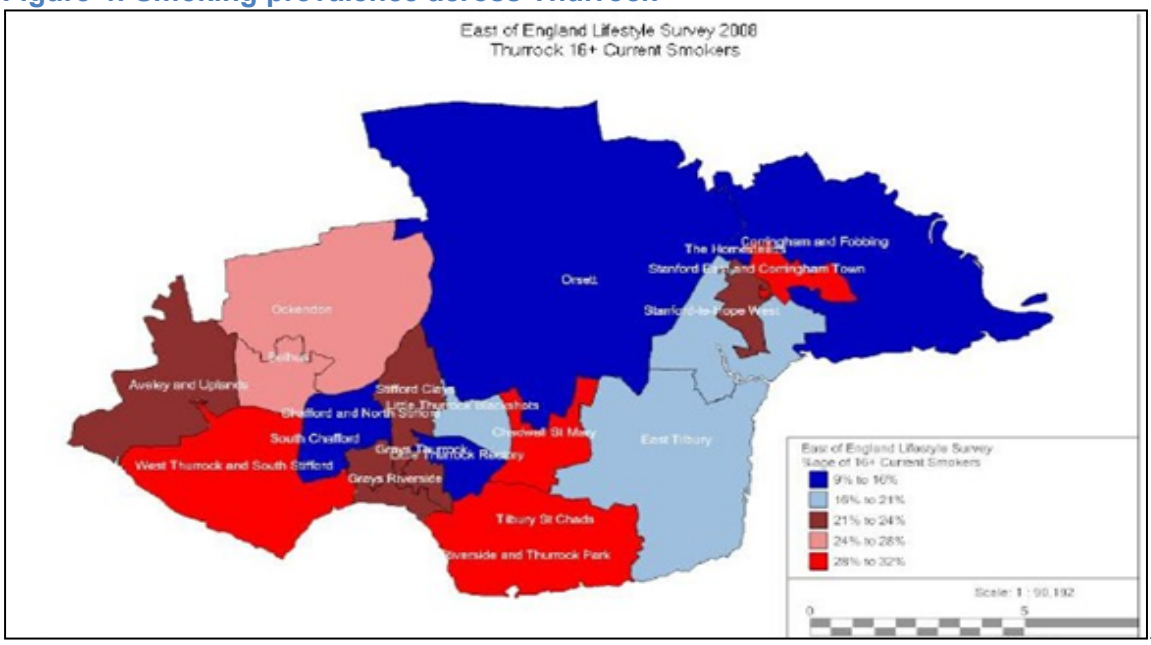
Figure 3: Routine and Manual Workers Smoking Prevalence, 2011-2013



Source: Integrated Household Survey

Smoking across the borough of Thurrock is not uniform. Modelled estimates from the 2008 East of England Lifestyle Survey indicate that areas such as Tilbury St Chads, Tilbury Riverside and Thurrock Park, West Thurrock and South Stifford, and parts of Stanford East and Corringham Town have higher prevalence of adults who smoke.

Figure 4: Smoking prevalence across Thurrock

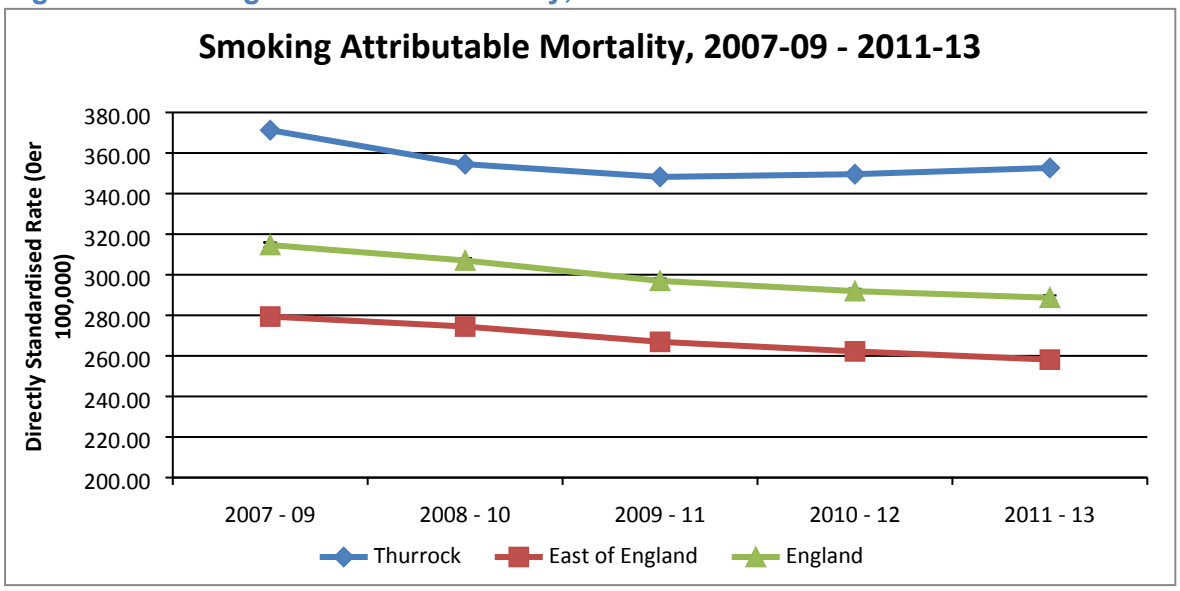


Source: East of England Lifestyle Survey, 2008

Smoking-Attributable Mortality

For many years the rate of deaths attributable to smoking has been significantly higher in Thurrock than the regional and national rates. The rate per 100,000 in Thurrock is 352.66 in 2011-13, compared with the regional rate of 258.15 and the national rate of 288.66.

Figure 5: Smoking Attributable Mortality, 2007-09 - 2011-13

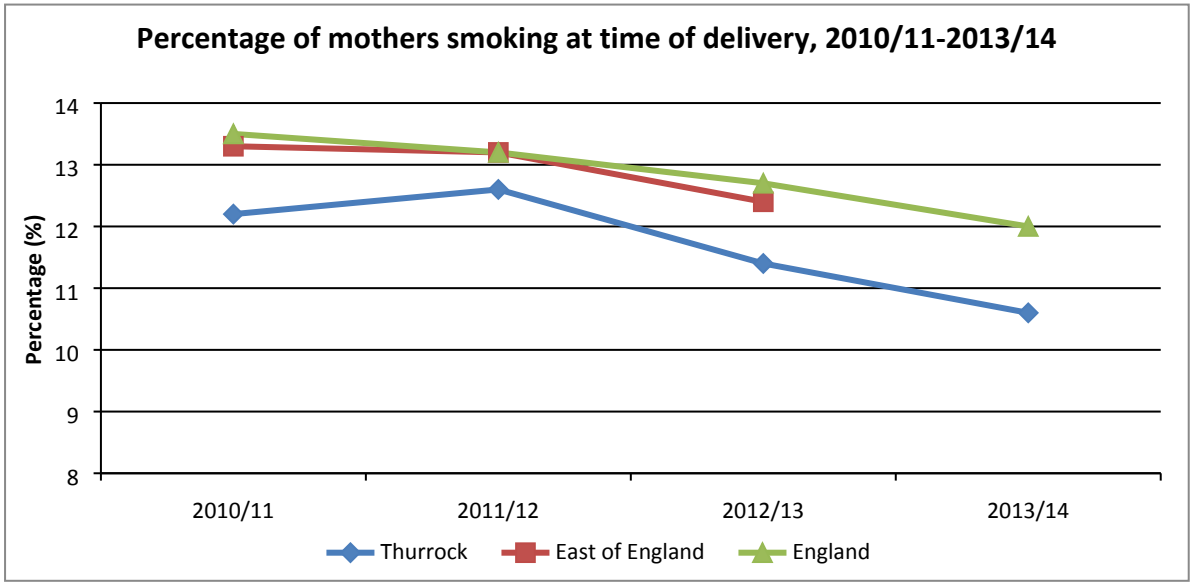


Source: Public Health England

Smoking in Pregnancy

The latest information shows that 10.6% of women were smoking at the time of delivery in 2013/14, which is lower than the previous two years. Comparing the data to East of England and England, Thurrock's figures do appear to be consistently lower; however confidence intervals mean that the authority is statistically similar to the national average.

Figure 6: Percentage of mothers smoking at time of delivery 2010/11-2013/14

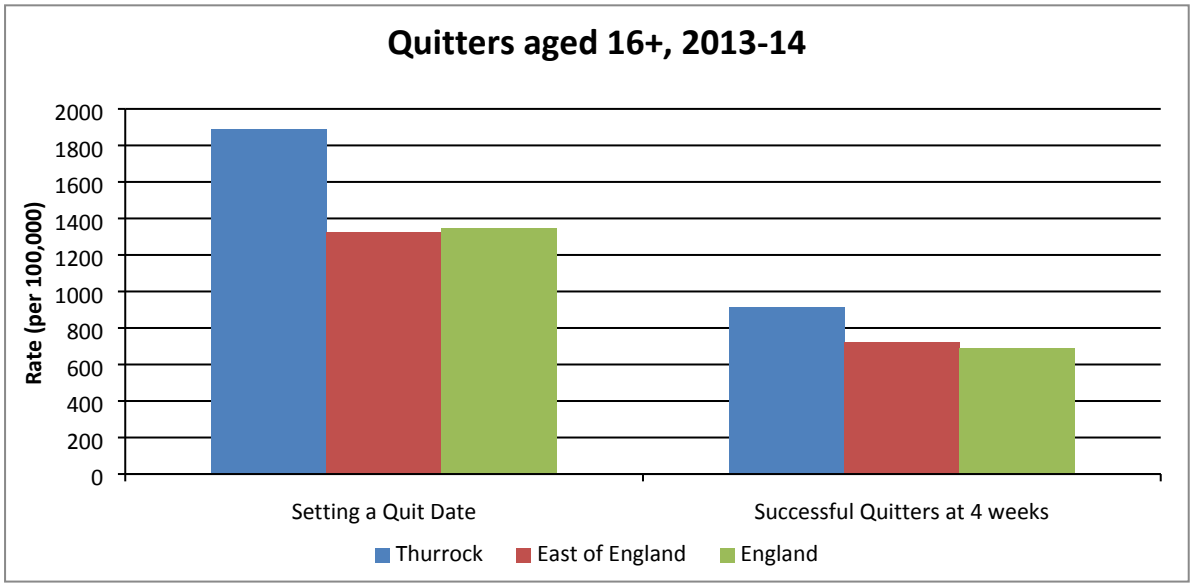


Source: Public Health England / Health and Social Care Information Centre

Smoking Quitters

In 2013-14, there were 2,372 people aged 16+ who set a quit date in Thurrock, of which 1,145 (48.1%) self-reported to have successfully quit at 4 weeks. To enable comparison to regional and national figures, rates per 100,000 population were calculated, and as below it can be seen that Thurrock had both a higher rate per 100,000 of smokers setting quit dates, and a higher rate per 100,000 of successful self-reported quitters.

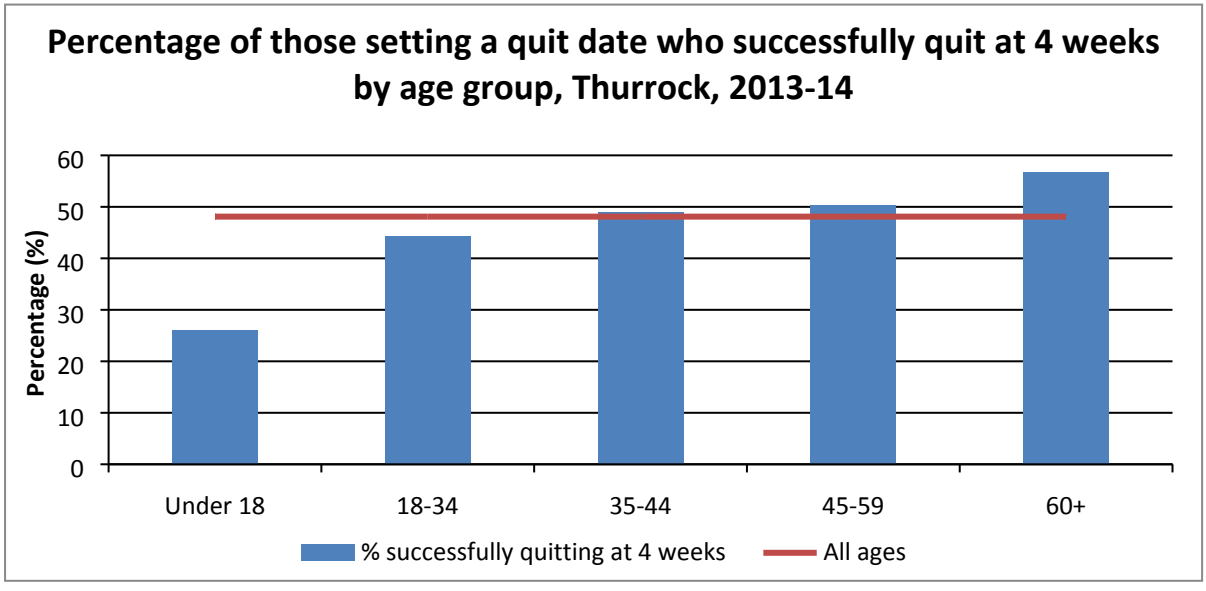
Figure 7: Smokers setting a quit date and successful quits at 4 weeks, 2013/14



Source: Health and Social Care Information Centre

In Thurrock, older people who set quit dates were more likely to quit smoking, with almost 57% of those aged 60+ successfully quitting at 4 weeks, compared to just 26% of those aged 16-18. The proportion for all age groups in Thurrock was 48.1%.

Figure 8: Successful quitters by age group, 2013-14



Source: Health and Social Care Information Centre

Appendix 3

Thurrock Smoke Free Workshop Survey Summer 2014

This Survey consisted of a Public online survey which generated 105 responses and was conducted by Thurrock Council Public Health Department.
The survey ran for 6 weeks across June and July and consisted of 12 main smoking related questions with further interrelated sections.

The aim of this public survey was to gain current views amongst local residents around specific national and local smoking issues in order to obtain an improved understanding of public perception within the borough.

Summary of findings

- The majority of respondents felt that peer pressure (47%) and stress (33%) were the main reasons why children and young people take up smoking. Other reasons were cited as learned behaviour from family members where smoking is considered normal rather than a bad habit or addiction. These reasons were also recognised as obstructions to quit smoking.
- Almost three quarters of respondents felt that smoking on television and in the media has an effect on how people view smoking and whether it influences people to start, compared to only a quarter who think it makes no difference.
- Smoke-free zones were largely supported with 70% of respondents in favour of this idea.
- Over 80% of respondents had heard of the Stoptober smoking campaign with 66% agreeing it helps people to quit smoking.
- 73% of respondents felt that standardised tobacco packaging will not have a positive effect on reducing smoking.

Review of Findings

Question 1& 2
Results suggest that young people are attracted to a perceived "cool image" that they feel smoking presents, and there is still a strong desire to "keep in" with friends that smoke. Smoking was also linked as a tool for weight management.
In families where parents smoke there is a danger children become desensitised to the health effects, and there is more likely to be a lack of positive guidance within these families.

Question 3
Responses to whether smoking on screen has an effect on how people view smoking and whether it may encourage smoking indicates that almost three quarters felt it did have an effect, compared to almost a quarter of respondents (24%) that think it makes no difference. It was largely agreed that smoking in films and soaps presents smoking as a normal and acceptable activity in our society.

Question 4
It was encouraging to note that almost three quarters of respondents (69%) were in favour of smoke free zones, although a further 78% thought these would be difficult to enforce and may not be adhered to.

Question 5
81% of respondents had heard of the NHS Stoptober challenge, recognised as a high profile campaign that is successful due to it being a group activity offering focussed support to people

wishing to give up smoking. Media communication and education around smoking – viewed by the World Health Organisation as the cornerstone of any successful tobacco control programme.

Question 6

Almost three quarters of respondents felt that standardised packaging on cigarettes will not influence consumption, posting comments such as "it doesn't change what's inside" and "we don't even look at the packaging anyway", this is contrary to scientific studies which shows a positive impact.

Question 7

25% of respondents thought the legal age to purchase cigarettes was 16. Some 41% of 15-year-olds who smoke say they usually buy their cigarettes from someone else rather than from a shop.[i] The new rules on adults buying cigarettes for under-18's could be in force by the autumn and may mean anyone caught buying cigarettes for a child could be given a £50 fixed penalty notice or a fine of up to £2,500. Further publicity around this will coincide with the launch of the new ruling.

Question 8 and 8a

Cigarettes will now have to be hidden under the counter or behind shutters in a bid to cut down on the number of smokers and deter young people from taking up the habit.

69% of respondents feel that plain screens when selling cigarettes will not help to quit smoking, while 32% feel it will discourage non-smokers to start smoking. This is in contrast to the Department of Health's view that said the move was in response to evidence that cigarette displays in shops can encourage young people to take-up the habit.

Question 9

90% of respondents felt that the sale of illegal tobacco in Thurrock was a bad thing. There are national concerns over an increase in illegal tobacco if the standardised packaging of cigarettes comes into force as people will attempt to bypass the product in favour of illegal imported cigarettes with branded packaging. Local trading standards and customs and excise are aware of the potential problem. The high percentage of opposition to illegal cigarettes in Thurrock was encouraging.

Question 10

93% agree that passive smoking in cars has an effect on child passengers.
90% agree that smoking while pregnant has an effect on unborn babies.
79% agree that passive smoking while pushing a pram/walking with a child has an effect.
88% agree that smoking in the home with children in the same room has an effect.
79% agree that smoking in the home but with children in a different room has an effect.
Results indicate a reassuring level of support within Thurrock.

Question 11

E-cigarettes generated a mixed response, only 12% of respondents saw them as a good stepping stone to quitting, 13% saying there is not enough evidence to support their use and 8% think they are good for your health.
An estimated 1.3m people in the UK use e-cigarettes which were designed to help smokers quit. Concerns have been raised that electronic cigarettes could be a gateway into smoking for young people. Although there is no evidence to suggest this it is recommended that e-cigarette use is closely monitored and make sure advertising and promotion does not glamorise their use. We do not yet know the harm that e-cigarettes can cause to adults or children, but we do know they are not risk free and that they currently remain unregulated in the UK.

Question 12

43% of respondents think public health should target its resources into education and prevention.
25% think public health should target greater enforcement in buying/accessing cigarettes.
31% think public health should target resources into treatment and helping more smokers to quit.
The results represent a mixed reaction to how public health should target its resources and is reflective of Thurrock's current multi-component approach to resources.

Conclusions and Recommendations

Children are very impressionable and the "smoking is cool image" still remains very much a problem. More focus should be given to Initiatives that improve self-confidence and self- esteem to empower children to make their own decisions and become more self-assured. Thurrock will strive to advocate a culture of well-being where children are empowered with the knowledge and the confidence to make rational decisions.

More focus could be given to stress reduction initiatives aimed specifically at children and young people to addresses more psychological issues. The introduction of specialised programs that teach coping mechanisms or yoga/relaxation classes in schools can help prevent some of the consequences of stressful behaviour, such as smoking, becoming apparent.

Smoking is sometimes perceived as an activity for young people to do with their friends to alleviate boredom. Offering alternative choices such as involvement with community groups, recreational facilities, clubs, hobbies and interests instead of smoking socially with friends should be promoted further.

The promotion of positive healthy role models and mentors in our borough that advocate regular exercise and healthy eating as a cool image should be more abundant and high profile.

A weight management message linked with the fundamental principles of healthy diet and regular exercise should be consistently reinforced at every opportunity which overshadows other less desirable mind-sets such as smoking as a tool to control weight.

It was encouraging to note that the majority of the respondents were in favour of smoke free zones and plans to expand on existing zones or the introduction of new smoke free areas e.g in play areas and parks could be considered in response to this.

The high recognition of Stoptober confirms that people are aware and responsive to national campaigns and find it helpful to quit as part of a supportive programme with other smokers. Thurrock Council need to ensure that advice on quitting remains high profile and there is plenty of access to group activities and stop smoking clubs throughout the year. National campaigns play an important role in raising profiles and encouraging people to quit and Thurrock will continue to work closely with these initiatives to support local quitters.

Reactions to e-cigarettes were mixed and respondents were unclear about the associated health risks. E-cigarettes are a relatively new phenomenon and although perceived as a better option than smoking and a helpful aid when quitting, it is important to remember they still contain nicotine and as such are as addictive as cigarettes. Not to smoke anything should still remain the ultimate goal.

Appendix 4

The Six Strands

1. **Stopping the promotion of tobacco**

   A reconfigured treatment service that looks more broadly at tobacco control will advocate work to highlight the need to tackle the broad range of tobacco harms, including, for example, lobbying for standardised (plain) packaging for cigarettes. Early evidence from Australia suggests that the measure is beginning to have an impact on smoking rates.

   The preventative work conducted with children and young people will include information from Public Health, supported by Trading Standards, to inform and educate people on key areas of enforcement, in particular how the illicit and illegal tobacco machine operates and how purchasing such products sustains this illegal industry and its activities.

2. **Making tobacco less affordable**

   The simplest way to make tobacco less affordable is to massively increase the duty, but we have no influence over tobacco pricing at a local level since their taxation is determined by central government. However, through mechanisms such as local and regional tobacco control alliances and in partnership with recognised organisations such as Action on Smoking and Health (ASH)[20] we can help exert pressure towards achieving such changes.

3. **Effective regulation of tobacco products**

   The effective regulation of tobacco products remains a high priority for Trading Standards who will be using intelligence to identify target areas to focus their efforts, particularly around underage sales.

   While it is accepted that niche tobacco products such as smokeless products and shisha may exist in Thurrock, intelligence and evidence of their use is currently very limited to a few isolated incidents. Nevertheless, future work should include making the public more aware of such products and their harms so that subsequent reported incidents can be responded to by Trading Standards.

4. **Helping tobacco users to quit**

   The service will work broadly across all organisations in Thurrock to ensure the benefits of quitting are promoted as widely as possible and that referral pathways exist for those that wish to quit. In addition it will develop better pathways to support mental health service users and people with long term conditions.

[20] Action on Smoking and Health (ASH) was established in 1971 by the Royal College of Physicians . It is a campaigning public health charity that works to eliminate the harm caused by tobacco. ASH provides the secretariat for the All Party Parliamentary Group on Smoking and Health.

In February 2015 NICE are scheduled to publish new guidance on reducing tobacco use in the community. This guidance will include mental health and behavioural conditions and therapeutic procedures[21], both of which will feature in the smoking cessation service redesign in 2015.

E-cigarettes re-normalising smoking is a complex issue for Public Health; on the one hand there is a current lack of evidence to support this concern, yet on the other hand their harm reduction possibilities for smokers appear to be enormous and some estimates suggest that if all 9 million UK smokers switched to using e-cigarettes tomorrow this would save 54,000 lives a year[22].

Nevertheless, the footfall of smokers entering their LSSS for quit support has reduced in recent years, particularly in 2014, which impacts on the subsequent 4-week quit targets that are also below trajectory. Anecdotally e-cigarettes are believed to be one cause of this phenomenon whereby smokers are independently switching to e-cigarettes in recognition of their harm-reduction benefits.

5. Reducing exposure to second hand smoke

This strand includes compliance monitoring of existing smokefree legislation and work around challenging compliance areas e.g. taxis and work vehicles; advocacy around smoking in cars with children; smokefree homes programmes; outdoor smokefree spaces programmes

The redesigned LSSS will develop policy and practice to embrace the harm reduction agenda, particularly the use of e-cigarettes. As the rise of e-cigarettes continues, so does the response to their use. We can expect to see e-cigarettes feature within the NICE Harm Reduction guidance scheduled for release in July 2015 [23].

The latest briefing released from the NCSCT on electronic cigarettes recommends that smoking cessation services provide behavioural support for clients who are using e-cigarettes and to include these clients in their national returns[24].

6. Effective communications for tobacco control

Work here will include supporting Public Health England campaigns such as Stoptober, providing year round PR on a range of tobacco issues, promoting local campaigns and the LSSS, developing local media campaigns on wider tobacco issues and working with others around regional media campaigns.

[21] http://www.nice.org.uk/Guidance/InDevelopment/GID-QSD83
[22] West, R, University College London, 5th September 2014, http://www.bbc.co.uk/news/health-29061169
[23] http://www.nice.org.uk/Guidance/InDevelopment/GID-QSD103
[24] http://www.ncsct.co.uk/usr/pub/e-cigarette_briefing.pdf

[i] Department of health