Department of Health

Towards a Smokefree Generation

A Tobacco Control Plan for England

July 2017

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Foreword

The UK has made great strides in reducing the harms caused by smoking, the leading cause of preventable illness and premature death in England[1].

Since the previous Tobacco Control Plan, smoking prevalence has substantially reduced; from 20.2% of adults smoking at the start of the plan[2] to just 15.5% now[3], the lowest level since records began.

This achievement has been reached through world-leading public health measures. During the period of the last plan, we built on the legislation which curbed advertising and established smokefree places to introduce 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 now has comprehensive tobacco control legislation which is the envy of the world.

But whilst we have made great strides in the right direction, there is more to do. Over 200 deaths every day are still caused by smoking[4].Though smoking rates among young people and pregnant women have dramatically reduced, 8% of 15 year olds[5] still smoke, risking a lifetime of ill health. Over 10% of pregnant women [6] still smoke, with all the attendant risks of miscarriage, premature birth, still birth and neonatal complications.

Smoking rates have remained stubbornly higher amongst those in our 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[7].

The Prime Minister has spoken about the burning injustice that sees some of the poorest in our society die on average nine years earlier than the richest.[8] [9] Smoking accounts for approximately half the difference in life expectancy between the richest and poorest in society[10]. This injustice in the variation in smoking prevalence can be seen across England; from places where adult smoking is as low as 5% to others where smoking remains above 25%[11]. The prevalence remains even higher in people with mental health conditions, where more than 40% of adults with a serious mental illness smoke[12].

We want to address this. Our vision is nothing less than to create a smokefree generation, To do this we need to shift emphasis from action at the national level - legislation and mandation of services to focused, local action, supporting smokers, particularly in disadvantaged groups, to quit.

This 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.

For its part, the government will provide leadership and guidance on the most effective interventions, ensure that the new legislation is implemented well and that organisations with national responsibilities are joined up and effective. I know that this ambition cannot be achieved without a collaborative effort.

I hope we can all rise to the challenge.

Steve Brine (Parliamentary Under Secretary of State for Public Health and Primary Care)

Our National Ambitions

Our vision is to create a smokefree generation. We will have achieved this when smoking prevalence is at 5% or below. To deliver this, the government sets out the following national ambitions which will help focus tobacco control across the whole system:

1. The first smokefree generation

People should be supported not to start smoking, so we aim, by the end of 2022 to:

- Reduce the prevalence of 15 year olds who regularly smoke from 8% to 3% or less.[13]
- Reduce smoking prevalence amongst adults in England from 15.5% to 12% or less.
- Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population.

  To do this we need all public services to work together, leading the way in helping people to stop smoking.

  After 2022, we will continue to reduce smoking prevalence further, on our way to a smokefree generation.

2. A smokefree pregnancy for all

Every child deserves the best start in life, so we aim, by the end of 2022 to:

- Reduce the prevalence of smoking in pregnancy from 10.7% to 6% or less.

3. Parity of esteem for those with mental health conditions

People with mental ill health should be given equal priority to those with physical ill health, so we aim to:

- Improve data collected on smoking and mental health to help us to support people with mental health conditions to quit smoking.
- Make all mental health inpatient services sites smokefree by 2018.

4. Backing evidence based innovations to support quitting

We are committed to evidence-based policy making, so we aim to:

- Help people to quit smoking by permitting innovative technologies that minimise the risk of harm.
- Maximise the availability of safer alternatives to smoking.

Action

To achieve these ambitions we have developed a new tobacco control plan, targeted around four main themes, with a range of actions for each. These actions include:

1. Prevention first

To achieve a smokefree generation we will:

- Ensure the effective operation of legislation such as proxy purchasing and standardised packaging designed to reduce the uptake of smoking by young people.
- Support pregnant smokers to quit. NICE has produced guidance on how pregnant smokers can be helped to quit. Public Health England and NHS England will work together on the implementation of this guidance.

2. Supporting smokers to quit

To achieve a smokefree generation we will:

- Provide access to training for all health professionals on how to help patients - especially patients in mental health services - to quit smoking.
- NHS Trusts will encourage smokers using, visiting and working in the NHS to quit, with the goal of creating a smokefree NHS by 2020 through the 5 Year Forward View mandate[14].

3. Eliminating variations in smoking rates

To reduce the regional and socio-economic variations in smoking rates, we need to achieve system-wide change and target our actions at the right groups so we will:

- Promote links to "stop smoking" services across the health and care system and full implementation of all relevant NICE guidelines by 2022.
- Support local councils to help people to quit by working with Directors of Public Health to identify local solutions, particularly where prevalence remains high.

4. Effective enforcement

To reduce the demand for tobacco and continue to develop an environment that protects young people and others from the harms of smoking we will:

- Maintain high duty rates for tobacco products to make tobacco less affordable.
- Ensure that sanctions in current legislation are effective and fit for purpose, using lessons from HMRC's work on sanctions to stop illicit tobacco.

The Evidence – and the Costs

Where we are now

Smoking remains the single largest cause of preventable deaths[1] and one of the largest causes of health inequalities[15] in England. There are still 7.3 million adult smokers[16] and more than 200 people a day die from smoking related illness which could have been prevented.

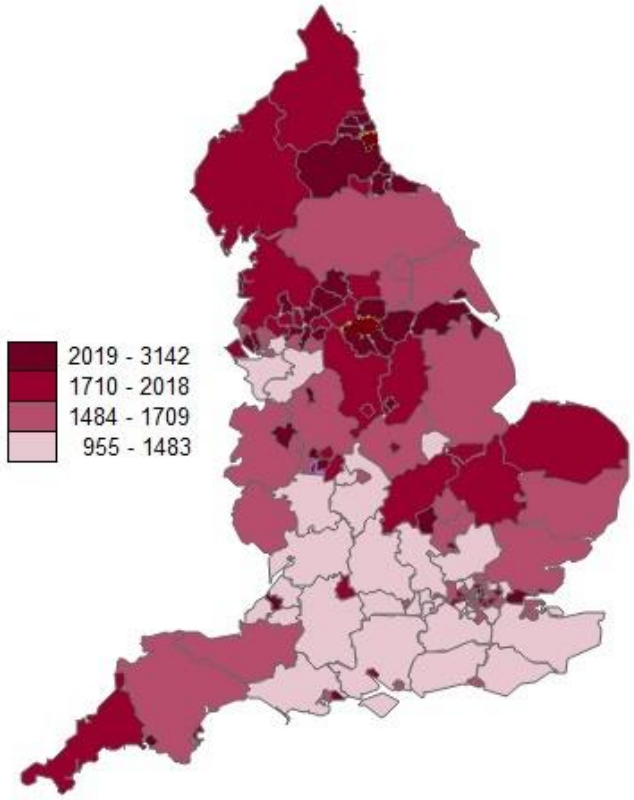
During the period covered by the last tobacco control plan (2011-15), prevalence across all target groups dropped. This is a huge achievement.

But these headline numbers disguise the fact that smoking and its associated harms continue to fall hardest on some of the poorest and most vulnerable people in our society. The difference in life expectancy between the poorest and the richest can be as much as nine years[9]. Smoking accounts for approximately half of this difference[10]. This is an injustice which must be addressed.

As well as dying prematurely, smokers also suffer many years in poor health. Many of the conditions caused by smoking are chronic illnesses which can be debilitating for the sufferer and make it difficult to carry out day to day tasks and engage with society and the economy. Smokers proportionately are less likely to be in work[17] .

From 2012 to 2015 smoking related mortality was around 50% greater in the north-east compared to the south-west[18]. But smoking blights poorer communities across the country. The local authority with the highest rate of smoking is Hastings which has a prevalence of 26% among adults.[19]

Figure 1: Smoking attributable hospital admissions per 100,000 people 2015/16



Data drawn from PHE Local Tobacco Control Profiles

The cost of smoking to society

Smoking causes around 79,000 preventable deaths in England[4] and is estimated to cost our economy in excess of £11 billion per year. Of this cost:

£2.5 billion fell to the NHS[20]

In 2015/16, there were approximately 474,000 smoking related hospital admissions[4] with smokers also seeing their GP 35% more than non-smokers.[21] These costs add a great burden to a system already dealing with growing demand.

£5.3 billion fell to employers

Smokers are, on average, absent from work 2.7 days more per year compared to ex and non-smokers[22]. In 2014 this is estimated to have led to a loss of economic output of around £1.7 billion[23]. Smoking breaks also result in lost output for employers estimated at around £3.6 billion a year[23].

£4.1 billion fell to wider society

Smoking results in the death or absence of people who would otherwise be working and contributing to the economy. Accounting for potential lifetime earnings, it is estimated that smoking-attributable deaths in 2014 resulted in a total output loss of around £3.1 billion[23]. Unemployment and economic inactivity due to smoking-attributable ill health also results in lost output to the economy, estimated at around £1.0 billion per year[24].

The further costs of tobacco

Smoking-related ill health also leads to increased costs for the adult social care system. One study estimates that local councils face a demand pressure of £760 million a year on domiciliary (home) care services, as a result of smoking-related health conditions. [25]

The true cost of tobacco use is likely to be higher than the figures provided here, with evidence now showing that smoking causes a greater range of diseases and death than accounted for in these costs. Every year additional costs are also incurred from smoking related fires and tobacco litter, as well as the wider costs associated with illicit tobacco and organised crime.

1. Prevention First

A smokefree generation

Work to eliminate smoking among under 18s and achieve the first smokefree generation.

Smoking remains an addiction which is largely taken up in childhood, with the majority of smokers starting as teenagers. 77% of smokers aged 16 to 24 in 2014 began smoking before the age of 18.[26] As a result many young people become addicted before they fully understand the health risks associated with smoking.

Discouraging young people from smoking remains a priority, which is why we want to reduce the prevalence of 15 year olds who regularly smoke to 3% or less by the end of 2022.

However, 32% of smokers (current and ex-smokers) aged 16-24 started when they are 16 or 17[26]. Therefore as smoking prevalence in 15 year olds continues to decline, we will also review the data on 16 and 17 year olds to help inform our understanding of the trends in smoking amongst young people.

One of the most effective ways to reduce the number of young people smoking is to reduce the number of adults who smoke. We know that children are heavily influenced by adult role models who smoke: in 2014, 82% of pupils who regularly smoked reported having a family member who smoked.[27] Continuing to encourage adult smokers to quit must therefore remain an important part of reducing prevalence amongst the young, and achieving a smokefree generation.

Research shows that in 2014, 46% of pupils aged 11 to 15 who were current (regular and occasional) smokers usually bought their cigarettes in shops, despite the law which prohibits the sale of cigarettes to those under the age of 18.[28] Breaking age of sale laws puts young people at risk and it is clear that we must more effectively enforce laws designed to protect young people.

At a national level the government will:

- Provide access to training for all health professionals on smoking cessation, particularly those working with mental health patients.
- Review the type and level of sanctions for tobacco retailers who repeatedly break laws designed to protect young people.

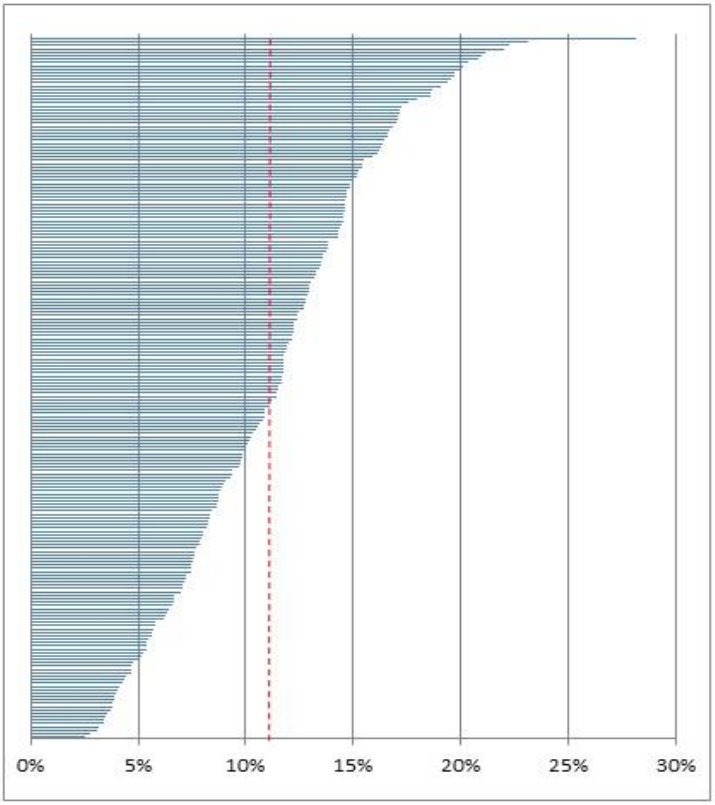
Stamping out inequality: smokefree pregnancy

Reduce the prevalence of smoking during pregnancy to improve life chances for children.

Smoking can have devastating consequences for expectant mothers and their babies. Smoking during pregnancy increases the risk of stillbirth, and babies born to mothers who smoke are more likely to be born underdeveloped and in poor health. Maternal smoking after birth is associated with a threefold increase in the risk of sudden infant death.[29]

Smoking during pregnancy is also a major health inequality, with prevalence varying significantly across communities and social groups. Smoking prevalence among pregnant women in more disadvantaged groups and those aged under 20 remains considerably higher than in older and more affluent groups. Mothers in routine and manual occupations are five times more likely to have smoked throughout pregnancy compared to women in managerial and professional occupations[30], meaning those from lower socio-economic groups are at a much greater risk of complications during and after pregnancy[31]. Children who grow up with a smoking parent are also more likely to become smokers themselves[32], further perpetuating the cycle of inequality and affecting their life chances.

Figure 2: Smoking at Time of Delivery by CCG in 2016/17



Building on the progress made in reducing rates of smoking during pregnancy over the course of the previous tobacco control plan, we have set ourselves an ambitious new goal of reducing smoking amongst pregnant women to 6% by the end of 2022. This is critical to our drive to ensure children have the best start in life. We know that smoking in pregnancy varies hugely, from 2.3% in West London to 28.1% in Blackpool. So to reach our ambition for all pregnant women, we must focus particular attention on disadvantaged groups and localities where prevalence remains much higher.

Achieving this requires sustained system wide action at both national and local level. NICE Guidance[33] [34] on smoking amongst pregnant women contains a range of evidenced based recommendations for local policy makers. These include regularly using Carbon Monoxide (CO) monitors to assess whether women are smoking, and requiring pregnant smokers to opt-out of stop smoking support[35]. The latter has been shown to double quit rates in pregnant women who smoke[36] [37]. Whilst progress has been made, particularly in relation to CO monitoring at antenatal appointments and referral to stop smoking services, the degree to which all of the NICE recommendations are implemented at local level is variable.

At a national level:

- PHE will analyse current practice in maternity services, to assess the use of CO monitoring and the implementation of smokefree policies across England.
- NHS England will work to reduce smoking in pregnancy through Carbon Monoxide testing at antenatal care and referral to stop smoking services through the Saving Babies' Lives Care Bundle[38].
- NHS England will include the recording of the outcome of Carbon Monoxide screening within the Maternity Services Dataset, which is the standard record of maternity care to accurately measure actual smoking behaviour beyond self-reporting bias.
- PHE and NHS England will develop a joint work plan setting out recommendations for how local areas can work together to achieve the government's ambition on reducing smoking in pregnancy.
- Through the Maternity Transformation Programme, an initiative within the 5 Year Forward View, which will modernise and enhance maternity care NHS England will work with PHE to reduce stillbirths, neonatal and maternal deaths, by consistently emphasising opportunities to achieve and sustain smokefree pregnancies.
- PHE will continue to work with the Smoking in Pregnancy Challenge Group, a partnership between the Royal College of Midwives, the Royal College of Paediatrics and Child Health, the third sector and academia, to improve smoking cessation in pregnancy.

We want to see:

- All CCGs, Trusts and local councils fully implementing NICE Guidance including Smoking: stopping in pregnancy and after childbirth (PH26) which recommends that all pregnant women are CO screened and those with elevated levels referred via an opt-out system for specialist support.
- Local areas - especially those with smoking in pregnancy prevalence above the national average - identifying local Smokefree Pregnancy Champions to consider how prevalence can be reduced in their locality and lead action to achieve this.

2. Supporting smokers to quit

Stop smoking services

Tobacco dependence is one of the hardest addictions to break. A smoker will typically have many failed quit attempts before they manage to successfully quit smoking[39].

Providing support to help smokers quit is highly cost-effective[40] and local stop smoking services continue to offer smokers the best chance of quitting. Smokers who use them are up to four times as likely to quit successfully as those who choose to quit without help or with over the counter nicotine replacement therapy products[41].

However, since 2011-12 attendance at local stop smoking services has been declining[42]. This has prompted some localities to look at new models of delivery which address a variety of unhealthy behaviours within a 'lifestyle service'. A recent review of models where a variety of risky behaviours are addressed in combination found that, whilst this approach may show promise for addressing behaviours such as poor diet and physical inactivity, they have not been effective at helping people to quit smoking, particularly among the most vulnerable smokers prioritised within this plan[43].

Comprehensive and effective local tobacco control strategies require joined up working and integrated commissioning between local government and the NHS. It is through these dedicated joint partnerships that local areas can demonstrate real strategic leadership and champion the importance of a collaborative 'whole system approach' in working towards a common goal.

At a national level:

- PHE will continue to monitor effectiveness of stop smoking services and support local authorities to refocus support to quit.
- PHE will ensure that local health professionals have access to the information and training they need to provide effective help for smokers to quit.

We want to see:

- Local areas developing their own tobacco control strategies, based on NICE evidence-based guidance.

Parity of esteem: supporting people with mental health conditions

Reduce the prevalence of smoking in people with mental health conditions.

Smoking prevalence may be declining year on year nationally, but in our journey towards a smokefree generation, we risk leaving some people behind. 40.5% of adults with a serious mental illness smoke[44] and people with a mental health condition die on average 10 to 20 years earlier than the general population[45] [46]. Smoking causes premature death, disability and poverty and if we do not reduce smoking prevalence among this group, we will have failed to reduce inequalities.

People with mental health conditions want to quit smoking as much as other smokers do [47], yet health professionals can be reluctant to offer them stop smoking support[48]. Some professionals mistakenly believe that stopping smoking could negatively affect their patients' mental health, when it can actually reduce symptoms of anxiety and depression[49].

People with mental health conditions have an equal right to be asked whether they smoke. They need to be offered effective methods to quit smoking or reduce harm as part of their care plan and there is an urgent clinical need to improve the support they receive. In some instances, healthcare staff will escort patients on and away from hospital grounds to smoke. This practice is outdated. It reduces the resources available to deliver clinical care[50] and causes direct harm to patients.

We are committed to implementing comprehensive smokefree policies, including integrated tobacco dependence treatment pathways, in all mental health services by 2018. For any hospital setting, becoming smokefree is more than simply telling patients, staff and visitors where they can and cannot smoke. It is about Trusts working to end cultures in which smoking is used as a way to build relationships with patients or whereby cigarettes and smoking breaks are used as incentives or rewards. It also includes increasing the availability of a full range of evidence-based treatment options to support quitting or temporary abstinence for patients and staff[34] [51] and encouraging staff to act as role models.

The majority of mental health provision takes place in the community and, if we are to achieve our ambition and reduce inequalities, urgent action is needed in these settings. Primary care and community care providers are fundamental in delivering an integrated tobacco dependence treatment pathway. This includes the systematic identification of smokers, provision of advice and access to effective support to quit or reduce harm. Shared ownership and responsibility in the local health and social care system is essential to ensure the continuity of care between primary, community and inpatient settings.

At a national level:

- PHE and NHS England will develop and disseminate materials to support staff in mental health trusts to implement NICE Guidance PH45[1] and PH48[2], which outline the recommendations for reducing the harm from smoking and for helping people stop smoking for people using maternity, mental health and acute services respectively.
- DH will explore how to integrate further stop smoking support with addiction services and services for people with mental health conditions.
- PHE will work with the Mental Health and Smoking Partnership of Royal Colleges, third sector organisations and academia to consider the evidence on how to reduce the prevalence of smoking among people with mental health conditions.
- DH and PHE will identify and rectify gaps in data on smoking and mental health which show prevalence, trends and the level of stop smoking support provided in order to have a comprehensive picture of the problem.
- NHS England and PHE will support the implementation of commissioning levers associated with Commissioning for Quality and Innovation and Sustainability and Transformation Partnerships: the "preventing ill health by risky behaviours – alcohol and tobacco CQUIN", which includes a requirement for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status.

We want to see:

- Commissioners and providers of the local health and social care system assessing the need of stop smoking support for people with mental health conditions and delivering targeted and effective interventions.
- NICE guidance PH48 and PH45 fully implemented in all mental health contexts. This will mean the full roll out of comprehensive smokefree policies in all mental health units by 2018, as recommended in the 2016 Independent Mental Health Taskforce Report *'The Five Year Forward View for Mental Health'* [52].

[1] PH45 - Smoking: harm reduction

[2] Smoking: acute, maternity and mental health services

Backing evidence based innovation

Develop a strong evidence base on the full spectrum of nicotine delivery products.

Two thirds of smokers say they want to stop smoking[53], however long term success rates are low. Despite the availability of effective medicines and treatments to support quit attempts, the majority of smokers choose to quit unassisted, by going 'cold turkey'. This has proved to be the least effective method[54]. Smokers who use a combination of medication and expert behavioural support are up to four times as likely to stop smoking successfully as those who attempt to quit unaided or with over the counter nicotine replacement therapy[41].

Stopping smoking is hard and many smokers are turning to e-cigarettes to help them in their attempts. In 2016 it was estimated that 2 million[55] consumers in England had used these products and completely stopped smoking and a further 470,000[56] were using them as an aid to stop smoking.

The best thing a smoker can do for their health is to quit smoking. However, the evidence is increasingly clear that e-cigarettes are significantly less harmful to health than smoking tobacco. The government will seek to support consumers in stopping smoking and adopting the use of less harmful nicotine products. Public Health England has produced guidance for employers and organisations looking to introduce policies around e-cigarettes and vaping in public and recommend such policies to be evidence-based[57]. PHE recommends that e-cigarette use is not covered by smokefree legislation and should not routinely be included in the requirements of an organisation's smokefree policy. In addition there has been the development and very recent introduction of novel tobacco products that claim to reduce the harm of smoking. We welcome innovation that will reduce the harms caused by smoking and will evaluate whether products such as novel tobacco products have a role to play in reducing the risk of harm to smokers.

The government will therefore continue to evaluate critically 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.

The Tobacco and Related Products Regulations which came into force in May 2016[58] introduced controls for tobacco, tobacco products and electronic cigarettes and herbal products used for smoking. These regulations require detailed information on both e-cigarettes and novel tobacco products, enabling us to monitor their sales and marketing and give careful consideration to their impact on smoking cessation and initiation. They will aid in developing the evidence base needed for innovation to stop smokers quit.

The challenge will remain to develop an environment that maximises reductions in smoking prevalence and improves public health, while providing accurate information to the public.

At a national level:

- DH will monitor the impact of regulation and policy on e-cigarettes and novel tobacco products in England, including evidence on safety, uptake, health impact and effectiveness of these products as smoking cessation aids to inform our actions on regulating their use.
- PHE will update their evidence report on e-cigarettes and other novel nicotine delivery systems annually until the end of the Parliament in 2022 and will include within quit smoking campaigns messages about the relative safety of e-cigarettes.
- PHE will continue to provide smokers and the public with clear, evidence based and accurate information on the relative harm of nicotine, e-cigarettes, other nicotine delivery systems and smoked tobacco, to enable informed decision-making. This will include the publication of an assessment of the risks of nicotine addiction.
- PHE will provide evidence based guidance for health professionals to support them in advising smokers who want to use e-cigarettes or other nicotine delivery systems to quit.
- The Medicines and Healthcare products Regulatory Agency (MHRA) will ensure that the route to medicinal regulation for e-cigarette products is fit for purpose so that a range of safe and effective products can potentially be made available for NHS prescription.
- DH will, based on the evidence reviews undertaken by PHE, review policy and regulation of nicotine delivery systems to provide an environment that facilitates smokers taking action to improve their health and the health of those around them, whilst minimising any risk of new nicotine addiction in children.

A smokefree NHS, leading by example

Create and enable working environments which encourage smokers to quit.

The economic burden caused by smoking results in a significant financial pressure which is felt throughout our society. Industry and employers are also affected by tobacco use and they too bear a significant financial burden resulting from the ill-health and sickness caused by smoking.

As smoking prevalence declines the financial burden of smoking for employers is also seen to reduce. The economic case for employers to promote smoking cessation across their workforce is strong and through this tobacco control plan the government calls upon all companies to champion this work and lead by example.

As a major employer in this country, NHS England will lead the way, supported by Public Health England, in creating an environment which encourages smokers working in the NHS to quit. This includes support to give these individuals the best chance of quitting successfully and working towards a completely smokefree NHS estate.

Public Health England welcomes the opportunity to work with other employers to pilot this initiative and develop advice for how employers across different industries can best support their workforce to stop smoking.

At the national level:

- PHE will support NHS England to help smokers using, visiting or working in the NHS to quit.
- PHE will support NHS Trusts and secondary care units to implement NICE guidance PH48 on stopping smoking for people using maternity, mental health and acute services.
- PHE will work with willing employers to develop advice for how employers across different industries can best support their workforces to stop smoking including the implementation of NICE guidance PH5 on workplace interventions to help people stop smoking.

We want to see:

- All employers making good use of information and momentum generated by national campaigns such as ‘Stoptober’ and regional campaigns to promote stopping smoking amongst their employees.

3. Eliminating variation in smoking rates

A whole system approach

Develop all opportunities within the health and care system to reach out to the large number of smokers engaged with healthcare services on a daily basis.

Helping smokers to quit is the job of the whole health and care system. As smokers experience a greater incidence of poor health and disease, the health system will already be regularly engaging with them. We must exploit these opportunities and make every contact count.

Promoting smoking cessation is the most effective thing a clinician can do to improve health outcomes for patients who smoke. It is also one of the most effective ways of triggering a quit attempt[59] and all smokers should be offered stop smoking advice and referral to evidenced based support at all relevant points in their journeys through the health system.

At a national level:

- DH and PHE will work with the Academy of Medical Royal Colleges, as well as charities and the research community, to develop guidance and messages for professionals across the health and care system on the delivery of stop smoking interventions.
- PHE will support the provision of training for health professionals to provide evidence based interventions that support patients to give up smoking.
- NICE will consider the need for including advice on smoking in all relevant new and updated guidelines.

We want to see:

- All health professionals engaging with smokers to promote quitting[60].
- All commissioners taking up the 2017-19 Commissioning for Quality and Innovation framework which includes tobacco as a national indicator for clinicians to undertake assessment and arrange for intervention where appropriate in relation to smoking status.
- All NHS hospitals fully implementing NICE PH48 guidance supporting cessation in secondary care.

Local inequalities

Eliminating health inequalities through targeting those populations where smoking rates remain high.

Although national smoking prevalence continues to decline, the picture is not so positive for all groups and communities across England. Smoking remains highest among populations who already suffer from poorer health and other disadvantages.

In 2015, there were almost three times as many smokers among the lowest earners in our society in comparison to the highest earners[7]. In 2016, the prevalence of smoking among people working in jobs classed as routine and manual was more than double that of people working in managerial and professional occupations.[61]

Smoking creates an inter-generational cycle of inequality in which the children of smokers frequently become tobacco dependent before they reach adulthood. Children who have a parent who smokes are also 2 to 3 times more likely to be smokers themselves[62] .

Smoking also varies greatly for some ethnic minority groups[63] and those from the Lesbian, Gay and Bisexual community who remain far more likely to smoke than the general population. [64]

If we are to achieve the first smokefree generation and break this cycle, we must support those populations where smoking rates remain high to quit.

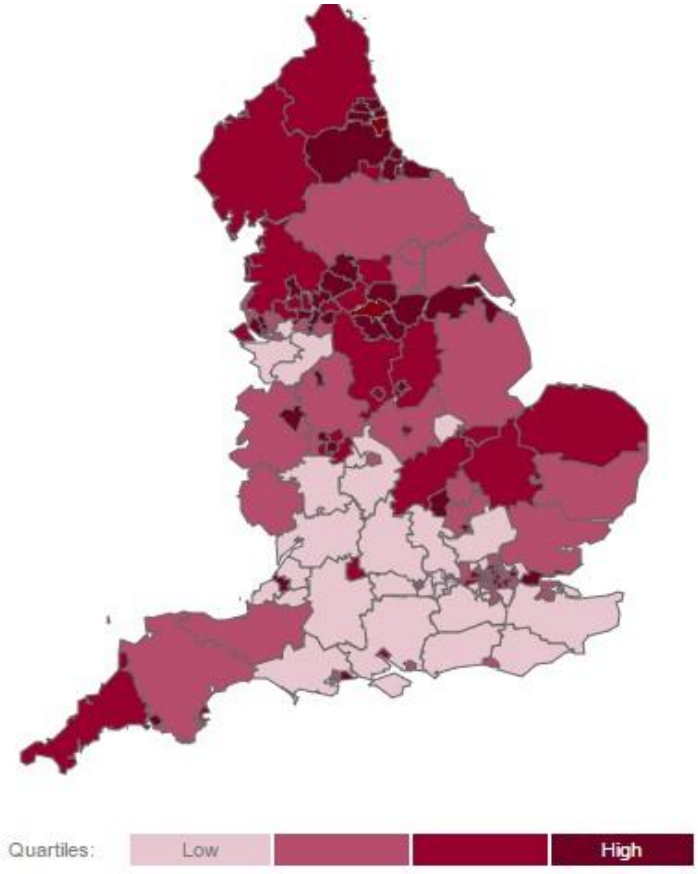
The populations most in need of support and with the highest rates of smoking will not be the same in all areas and it is natural that local councils look to ensure their services meet the needs of their particular communities.

However, all local areas will want to consider how to target their stop smoking service at those groups locally where prevalence remains high and it is clear that those in routine and manual occupations are likely to need this targeted support in all areas. Local councils will want to consider how to ensure that support is available to assist this group and other priority groups they have identified to quit smoking and break this cycle of inequality.

Regions and individual local councils are also encouraged to come together to agree local ambitions around which collective action can be organised.

Figure 3:

Adult smoking prevalence by local authority (2015/16)



Data drawn from PHE Local Tobacco Control Profiles

At a national level:

- PHE will support local councils in their evidence based local tobacco control plans through the development of work on sector-led improvement driven by the local councils working together to drive performance[65].
- PHE will publish an annual Joint Strategic Needs Assessment support pack to help local councils to commission comprehensive tobacco control interventions.
- PHE will target support at those areas with high levels of smokers advising on commissioning and delivery of stop smoking services.

We want to see:

- Regions and individual local councils coming together to agree local ambitions around which collective action can be organised.
- Local health and wellbeing partners participating in 'CLeaR'[66], an evidence based improvement model that can assist in promoting local tobacco control activities.
- Local councils identifying the groups and areas with the highest smoking prevalence within their local communities and taking focused action aimed at making reductions in health inequalities caused by smoking in their population.

Public awareness

Use mass media campaigns to promote smoking cessation and raise awareness of the harms of smoking.

Marketing remains a core pillar of tobacco control with evidence indicating that taking a population wide approach to encouraging quit attempts is the most effective approach[67]. The three primary strands of the national tobacco communications strategy are to boost motivation to quit, trigger quit attempts and provide support to make quit attempts successful.

Targeted mass media interventions, in the context of a comprehensive tobacco control programme, continue to be an extremely cost-effective way to decrease tobacco use, reframe social norms and cultural acceptance, increase quit attempts and promote the use of stop smoking tools and services[68]. As the popularity of social media continues to increase, we must also understand how to use these channels to better target those groups where smoking prevalence remains high.

Regional variation in smoking prevalence means we must consider how best to approach different audiences and explore innovative ways to reach them. Digital developments and the changing dynamics of a digitally engaged public mean that we must ensure our approaches have an evidence base to bring about the cost effective result of public behaviour change.

The most effective regional and local campaigns are those which deliver culturally appropriate messages which tie in well to other local tobacco control activity.

At the national level:

- PHE will continue to use mass media campaigns to promote smoking cessation and raise awareness of the harms of smoking. This will include the funding and delivery of Stoptober.
- PHE and DH will continue to review the effect of marketing campaigns in comprehensive action to reduce smoking and maintain an effective, evidence based approach towards behaviour change marketing.

We want to see:

- Local areas working together to explore if regional and cross-regional approaches could offer a greater return on investment for stop smoking campaigns.

Smokefree places

Explore further opportunities to protect people from the harm of secondhand smoke.

In 2007 Smokefree laws were introduced to protect people from the harms of secondhand smoke in public places, public transport and work vehicles. These laws have proven to be highly effective resulting in an immediate reduction in the number of children being admitted to hospital for asthma[69]. Compliance is also virtually universal[70]. To further protect children, the government extended legislation to cover private vehicles carrying children from October 2015[71]. There is no further legislative change planned.

Despite smokefree legislation, evidence shows that over a quarter of people are exposed to secondhand smoke, with over half of 16 to 24 year olds reporting exposure[72]. It is therefore still important to raise awareness of the risks of exposure to secondhand smoke, especially for those who may be smoking around children. Public Health England will continue to increase awareness of this as part of its social marketing strategy and we can expect NHS England to lead the way as NHS estates become increasingly smokefree.

Alongside our ambitions to achieve a completely smokefree NHS estate by 2020, we also aim to support prisons in implementing smokefree policies. With 80% of the prison population estimated to smoke,[73] the level of exposure to secondhand smoke in many prisons is significant. It is only right that prisoners and prison staff receive the same protection from secondhand smoke, as has been afforded to the general population and the government will implement a smokefree policy across the entire prisons estate in England.

Post implementation reviews of smokefree prisons in other countries have shown that the smoking bans result in better short and long term health outcomes for prisoners. For example, prisons in America which had implemented smoking bans experienced a 9% reduction in smoking related death[74].

At a national level:

- PHE will assess the evidence base around perception and role-modelling for smokefree outdoor places.
- PHE will support local areas looking to implement local smokefree policies differentiating the levels of harm caused by existing tobacco products including e-cigarettes and other novel products.
- The government will implement smokefree policies across all prisons in England.
- The government will support the implementation of smokefree policies across all hospitals in England.

Tobacco control intelligence

Ensure our strategies are effective and evidence based.

The government has a wide range of high quality data sources on smoking and tobacco which inform both national and local tobacco control strategies and enable the comprehensive evaluation of policies and services. Amongst other things, these data sources allow the government to track smoking and smoking related ill-health, product and support service use, as well as quitting behaviour and the illicit tobacco market. This information can often be filtered by geographical and demographic factors to show how smoking affects different people, across different places in England, as well as how this changes over time.

Good quality local information is required to support effective local commissioning and target support to those who need it. Public Health England collates and analyses a range of data for each local authority in the 'Local Tobacco Control Profiles for England'. This allows a local view of the extent of tobacco use and tobacco-related harm providing information on smoking prevalence, smoking related mortality and morbidity. This tool enables local government and health services to evaluate data at a local, regional and national level.

At a national level the government will:

- Continue to develop and monitor the evidence base to identify and respond to emerging issues.
- Evaluate and monitor the effect of substantive tobacco control measures implemented or taking effect over the course of this plan.
- Consider how tobacco control measures could be better embedded into existing NHS data collections.
- Explore how more frequent and reliable data could be collated to better inform tobacco control measures which aim to support people with mental health conditions.
- Review how the prevalence of young people who smoke is measured as well as their attitudes to smoking to inform policy on reducing smoking prevalence for young people.
- Continue to work to improve the reliability of data measures for smoking during pregnancy, by removing 'unknowns' from the calculation of Smoking Status at Time of Delivery[3] and reviewing the point at which smoking status is recorded for pregnant women.
- Continue to develop the evidence base by funding further tobacco control research.

[3] From 2017 NHS Digital will include pregnant women of unknown smoking status into the smoking prevalence measured at the time of delivery

4. Effective enforcement

Taxation

Maintain a robust tax regime for tobacco and reduce discrepancies in tobacco product prices.

Maintaining high duty rates on tobacco products is a proven and effective means through which to reduce smoking. As well as providing an incentive to quit for those who smoke, it provides a disincentive for young people to take up smoking in the first place.

Tax policy is a matter for HM Treasury and tobacco taxation will be kept under review as part of the usual Budget process. The government will continue its policy of maintaining high duty rates to meet the twin objectives of promoting public health objectives and raising revenue. To support a continuation in the reduction of smoking prevalence, Budget 2016 included measures to tackle cheap tobacco, including increasing the duty on hand-rolling tobacco by an additional 3%.

At a national level the government will:

- Continue its policy of maintaining high duty rates for tobacco products to improve public health.

Illicit tobacco

Implement the illicit tobacco strategy and reduce the market share of these products.

Dominated globally by organised criminals, the illicit trade in tobacco has a devastating effect on individuals and communities across the UK and abroad. The sale of illicit tobacco undermines public health policy by offering a cheaper option for those who might otherwise see price as a reason to stop smoking.

Illicit tobacco damages legitimate business and makes tobacco more accessible to children. Tobacco smuggling is serious organised crime and the proceeds made from it are used to fund further criminality, perpetuating the cycle of harm.

Considerable progress has been made in addressing tobacco smuggling and the reductions we have seen have been achieved through regulatory changes, new sanctions, detection technology and partnership working across government and internationally. The illicit tobacco market still however poses a significant challenge, estimated to cost £2.4 billion in lost revenue in 2015/2016[75].

The government will continue the implementation of its 2015 strategy 'Tackling Illicit Tobacco: From Leaf to Light'[76] to address duty evasion. A cross government ministerial group has been established to help champion co-operation across government and various agencies which have a role to play in tackling illicit tobacco.

The UK is a Party to the WHO Framework Convention on Tobacco Control (WHO FCTC), the world's only health related international treaty, and aims to ratify the FCTC Protocol on Illicit Tobacco as soon as the required legislation has been approved by Parliament.

At a national level the government will:

- Continue to work with other EU Member States on implementation of the track and trace and security marking requirements of the Tobacco Products Directive and the WHO FCTC Illicit Trade Protocol.
- Improve the use of sanctions to address tobacco fraud, in particular for repeat offenders.
- Continue engagement with the media to raise awareness of tobacco duty evasion, its effect on society and the consequences for those involved in the fraud.
- Ratify and implement the WHO FCTC Protocol on Illicit Tobacco as soon as the required legislation has been approved by Parliament.

Regulation and enforcement

Improve the use and effectiveness of sanctions and monitor the development of novel products.

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[70 77 78].

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[79]. 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.

Finally, there is a fundamental and irreconcilable conflict between public health and the interests of the tobacco industry. Under Article 5.3, the WHO FCTC includes an obligation for all countries that have ratified the treaty to protect public health policies from the commercial and other vested interests of the tobacco industry. The government will continue to uphold its obligations under the WHO FCTC. Local authorities are also responsible for meeting the treaty obligations set out in the WHO FCTC to protect their public health policies from the commercial and vested interests of the tobacco industry. The framework does not prevent them from discussing operational issues with the industry where that is necessary, for example around the issue of clearing up tobacco litter. However we recommend that such discussions are fully transparent – for example, by pro-actively publishing online any correspondence and minutes of meetings.

At a national level the government will:

- Offer magistrates reliable information about the severity and impact of tobacco crimes and explore options for sentencing guidelines.
- Meet its legal requirement to review the impact of new tobacco regulations including: the Tobacco and Related Products Regulations 2016 and the Standardised Packaging of Tobacco Products Regulations 2015.
- Continue to publish information on all meetings with the tobacco industry to further transparency. The exception is for commercially or operationally sensitive information.
- Limit direct contact with the tobacco industry to that necessary to discuss the implementation of regulatory provisions or operational matters, and more broadly encourage tobacco companies to engage with the government in writing rather than face to face, email or phone communications so as to maximise transparency.

Leaving the European Union

Review where the UK's exit from the EU offers us opportunities to further improve public health.

On the 23 June 2016, the UK voted to leave the European Union (EU). Until exit negotiations are concluded, the UK remains a full member of the EU and all the rights and obligations of EU membership remain in force.

During this period the government will continue to negotiate, implement and apply EU legislation. The outcome of the exit negotiations will determine what arrangements apply in relation to EU legislation in future once the UK has left the EU. Future tobacco control measures will need to reflect the new environment in which tobacco control will be delivered.

Over the course of this Tobacco Control Plan, the government will review where the UK's exit from the EU offers us opportunities to re-appraise current regulation to ensure this continues to protect the nation's health. We will look to identify where we can sensibly deregulate without harming public health or where EU regulations limit our ability to deal with tobacco.

In particular, the government will assess recent legislation such as the Tobacco Products Directive, including as it applies to e-cigarettes, and consider where the UK's exit provides opportunity to alter the legislative provisions to provide for improved health outcomes within the UK context.

The government will continue to embrace developments that have the potential to reduce the harm caused by tobacco use and as such we will consider if the current regulatory framework strikes the right balance, and whether there is more we can do to help people to stop smoking. We remain committed to a comprehensive and robust tobacco control strategy which protects the population of England.

At a national level the government will:

- Review measures and activities which are affected by the UK's exit from the EU, including the identification of de-regulatory measures that further health objectives.

References and Further Information

Data sources for national ambitions

Young people smoking prevalence

Measure: Prevalence of regular cigarette smoking (at least one cigarette a week) among 15 year olds, from NHS Digital's Smoking, Drinking and Drug Use Among Young People in England survey.

Baseline measure: 8 per cent (2014).

Adult smoking prevalence

Measure: Smoking prevalence among adults from Office for National Statistics' Annual Population Survey in 2020.

Baseline measure: 15.5 per cent (January 2016 to December 2016).

Relative inequality gap

Measure: Ratio of smoking prevalence among adults in the routine & manual category to adult smoking prevalence (above) from Office for National Statistics' Annual Population Survey in 2022.

Baseline measure: The ratio of 26.5 per cent (January 2016 to December 2016) to adult smoking prevalence of 15.5 per cent (above).

Smoking in pregnancy smoking prevalence

Measure: Percentage of expectant mothers recorded as being smokers at the time of giving birth, from NHS Digital's Statistics on Women's Smoking Status at Time of Delivery.

Baseline measure: 10.7 per cent (April 2016 to March 2017). This definition excludes women with unknown smoking status.

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