Wandsworth Tobacco Control Strategy

Needs Assessment

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Prepared by

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**Tobacco Control Background**

Tobacco control refers to a co-ordinated and comprehensive approach to reducing the prevalence of tobacco use.

A Tobacco Control Alliance has been recognised as the organisational tool to deliver effective tobacco control in localities. The Alliance brings together experts from different fields to work together to achieve the common goals.

The Department of Health has this month launched ‘Healthy Lives, Healthy People: a Tobacco Control Plan for England’. This sets out how tobacco control will be delivered in the context of the new public health system, focusing in particular on the action that the Government will take nationally over the next five years to drive down the prevalence of smoking and to support comprehensive tobacco control in local areas.

Pillars of the new plan are:

*To promote health and wellbeing, we will work to encourage communities across England to reshape social norms, so that tobacco becomes less desirable, less acceptable and less accessible. We want all communities to see a tobacco-free world as the norm and we aim to stop the perpetuation of smoking from one generation to the next. To reduce smoking uptake by young people, we all need to influence the adult world in which they grow up.*

*Under the leadership of local authorities, we want to encourage the development of partnerships in tobacco control where anyone who can make a contribution is encouraged to get involved. In implementing comprehensive tobacco control in their communities, we encourage local authorities to maximise local involvement by building tobacco control alliances that include civil society.[[1]](#footnote-1)*

The plan includes commitments to:

1. implement legislation to end tobacco displays in shops;
2. look at whether the plain packaging of tobacco products could be an effective way to reduce the number of young people who take up smoking and to support adult smokers who want to quit, and consult on options by the end of the year;
3. continue to defend tobacco legislation against legal challenges by the tobacco industry, including legislation to stop tobacco sales from vending machines from October 2011;
4. continue to follow a policy of using tax to maintain the high price of tobacco products at levels that impact on smoking prevalence;
5. promote effective local enforcement of tobacco legislation, particularly on the age of sale of tobacco;
6. encourage more smokers to quit by using the most effective forms of support, through local stop smoking services; and
7. publish a three-year marketing strategy for tobacco control.

Through the comprehensive action described in this plan, the Government want to reduce smoking rates faster in the next five years than has been achieved in the past five years.   The plan sets out national ambitions:

* to reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015 (from 21.2 per cent), meaning around 210,000 fewer smokers a year.
* to reduce rates of regular smoking among 15 year olds in England to 12 per cent or less (from 15 per cent) by the end of 2015.
* to reduce rates of smoking throughout pregnancy to 11 per cent or less (from 14 per cent) by the end of 2015 (measured at time of giving birth).

**Smoking is a global disaster**

Global tobacco control work streams are stated in World Health Organisation Framework Convention on Tobacco Control 2005.[[2]](#footnote-2)

The principles of this global charter can be actioned at international, national and local level. Tobacco control recognises that a number of tools are needed, working together, to reduce tobacco use - there is no one silver bullet.

Some tobacco control levers are more effectively leveraged at a national level, such as tax increases to reduce the affordability of tobacco. Other levers are more efficiently delivered at a local level, such as delivering compliance with age of sale or smokefree legislation and supplying an appropriate NHS Stop Smoking Service.

Smoking is a tragic accident of the 20th century: as millions of people became addicted before the full health consequences were recognised. It is up to the governments, local authorities and advocates of the 21st century to make smoking history.

**Fig 1.The Relationship between smoking incidence and smoking related diseases[[3]](#footnote-3)**



**The case for Tobacco Control in England**

**It is estimated that smoking costs the economy £13.74 billion per annum**.[[4]](#footnote-4)

This covers:

* + £2.7bn treating smokers in NHS
	+ £2.9bn lost productivity in smoking breaks
	+ £2.5bn increased absenteeism
	+ £342m cleaning up cigarette butts
	+ £507m the cost of fires
	+ £4.1bn loss of economic output due to early death
	+ £713m treating the victims of passive smoking

 Over the past few years an average of £300million per annum has been spent nationally on tobacco control.[[5]](#footnote-5)

The enormous cost burden of smoking means that interventions are exceptionally cost effective. The NHS Stop Smoking Services are cited as the most cost effective of all health interventions by the NHS in England.[[6]](#footnote-6)

All Party Parliamentary Group on Smoking and Health[[7]](#footnote-7) in 2010 concluded:

*‘The most significant finding for the Spending Review from this Inquiry is that Government expenditure on tobacco control is excellent value for money and provides a net annual revenue benefit of £1.7 billion.’*

 Over a three-year period, it is estimated that the department of Health’s marketing communications have returned £4.58 in savings for every pound spent to the NHS alone.[[8]](#footnote-8)

**There is a strong evidence base for tobacco control interventions** and England is one of the leading nations in reducing the prevalence of smoking.

**Fig.2. Decline in smoking prevalence in England compared to other Western nations[[9]](#footnote-9)**

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**Smoking is still the single biggest cause of preventable death and ill health in this country**

Further reducing the prevalence of tobacco use remains one of the most important interventions in improving and protecting the public’s health, as smoking causes an estimated 81,000 deaths in England every year[[10]](#footnote-10).

Deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).[[11]](#footnote-11)

It is still a fact that many smokers underestimate the dangers of smoking. To them, it is such a normal thing, something that surrounds them every day that they can’t see it for the killer that it is.

Tobacco is the only product you can buy in a shop that if used as expected, may result in death. And yet this very real danger is undermined by the fact that tobacco is so widely and obviously available. How can something that people can buy so easily be so dangerous? It is normal to see cigarettes on sale. Denormalising tobacco is the process of making everything to do with tobacco seem not normal. For example, the removal of tobacco displays is one way in which tobacco can be repositioned as the dangerous product it really is.

Often we hear smokers say ‘if it was that bad the government would ban it’. But when asked to think through the likely consequences to society of banning a substance that has over 8 million addicts, then they begin to understand the need for voluntary quitting.[[12]](#footnote-12)

**Smoking Patterns**

The latest data for England (2009) reports that 21% of all adults in England smoke[[13]](#footnote-13), but prevalence of smoking increases with levels of deprivation. Almost every indicator of social deprivation, including income, socio economic status, education and housing tenure, independently predicts smoking behaviour and therefore poorer health outcomes. Smoking accounts for half the difference in life expectancy between classes 1 and V.[[14]](#footnote-14)

Smokers in higher socio economic groups have been more successful in stopping smoking than other groups so today nearly half of all smokers are in the Routine and Manual economic groups.[[15]](#footnote-15)

Some Black and Minority Ethnic (BME) communities living in England have high smoking prevalence rates compared to the general population, notably Bangladeshi, Irish and Pakistani men. The use of smokeless tobacco is also popular among some BME groups, increasing the risk of oral cancers.[[16]](#footnote-16)

Shisha use has also become more apparent in England in recent years. It is essentially a water pipe used for smoking purposes, originating in the Middle East about 500 years ago. It is popular in Middle Eastern communities and increasingly amongst young people. Many young people mistakenly believe it to be less dangerous than smoking cigarettes.

Smoking during pregnancy endangers the health of the mother, the baby and the foetus. It is strongly linked with low birth weight which in turn is one of the main risk factors associated with infant mortality and also with problems later in life such as coronary heart disease, diabetes types I and II, obesity, a low IQ as a result of poor cognitive development and behavioural problems.[[17]](#footnote-17) Only a small minority of women now smoke during pregnancy, those most likely to smoke are single mums under the age of twenty.

**Children are the innocent victims of smoking**

Two million children in England are still exposed to toxic secondhand smoke in their home and during car journeys[[18]](#footnote-18).

Children are particularly affected by the poisons in tobacco smoke because their bodies are still developing. Their bronchial tubes and lungs are smaller and immune systems less developed, making them more vulnerable to infection. [[19]](#footnote-19) Also they breathe faster than adults, taking in proportionally more chemicals than an adult per kg body weight.[[20]](#footnote-20)

Babies and children exposed to a smoky atmosphere are more likely to need hospital care in

the first year of life.[[21]](#footnote-21) and are also off sick from school more often due to coughs, colds and

wheezes.[[22]](#footnote-22)

Smoking near children is a cause of cot death. Cot death is twice as likely for babies whose

mothers smoke.[[23]](#footnote-23)

Smoking near children is a cause of serious respiratory illnesses such as bronchitis and

pneumonia. In households where mothers smoke, for example, young children have a 72%

increased risk of respiratory illnesses.[[24]](#footnote-24)

Smoking near children increases the chance of asthma attacks and increases the risk of

other breathing problems such as wheezing, coughing, phlegm & breathlessness.[[25]](#footnote-25)

Secondhand smoke from parents is also causally linked to contracting asthma itself; there is a 50% increase in risk.[[26]](#footnote-26)

However the greatest threat to a child’s health is the increased likelihood of becoming a smoker.[[27]](#footnote-27) The children of smokers are up to three times more likely to smoke than those of non smokers.

The most effective way to stop children and young people smoking is to help parents and carers to stop smoking.

**The case for tobacco control in Wandsworth**

Overall Wandsworth is a relatively prosperous community and compares well with other London borough in terms of poverty. However there is 6-7 year difference in life expectancy between those living in the most deprived communities and those living in the most affluent.[[28]](#footnote-28)

The wards of Latchmere, Roehampton, Queenstown and Tooting are the most deprived communities, all exhibit disadvantages across many of the measures of deprivation.[[29]](#footnote-29)

The largest causes of years of life lost are coronary heart disease, other cardiovascular disease, lung cancer and other cancers. See diagram below.

**Fig.3. Breakdown of life expectancy gap between the Most Deprived Quintile in Wandsworth and the least deprived quintile in Wandsworth by cause of death[[30]](#footnote-30)**



All these diseases are related to smoking tobacco. In fact tobacco use is the single biggest driver of health inequality. Therefore to meet the borough’s ambitions in reducing health inequalities will require a reduction in the prevalence of smoking.

The burden of ill health caused by smoking is estimated to cost the NHS in Wandsworth over £20 million per annum.[[31]](#footnote-31)

And the total cost to the local economy of smoking is estimated to cost Wandsworth over £100 million per annum.[[32]](#footnote-32)

**Wandsworth has a good record in tobacco control**

Notable actions include:

Successful introduction and continued compliance with Smokefree legislation delivered by Environmental Services.

Continued monitoring and compliance with Age of Sale legislation delivered by Trading Standards.

A successful NHS Stop Smoking Service helping over 1000 smokers in the borough to stop each year delivered by the Primary Care Trust.

Local GP; Dr Alex Bobak, is a world recognised expert in smoking cessation and his practice in Wandsworth demonstrates best practice in assisting patients to stop smoking.

However it is believed that continued progress in reducing smoking rates can be made by working more effectively and more efficiently. The new organisational structures offer a good prompt to start these new ways of working.

Examples of new ways of working could be:

Partnership with the Fire and Housing Services to deliver smokefree homes.

GP consortia commissioning stop smoking support in new locations or using new technologies.

Partnership with Youth services to provide intelligence on suppliers of illegal tobacco to children.

New patient pathways to enable quick referral of smokers from St George’s Healthcare NHS Trust into the Wandsworth NHS Stop Smoking Service.

Local authority PR department promoting involvement in public consultation on plain packaging for tobacco products.

Tobacco control alliance members supporting Trading Standards in delivering compliance with all new legislation.

**A Tobacco Control Alliance is the organisational tool to deliver effective tobacco control in localities.**

**The Wandsworth Tobacco Control Alliance**

This is the structure that allows a wide range of stakeholders from different fields of expertise to contribute to reducing prevalence of tobacco use. The Alliance will report into the Health and Wellbeing Board at the Local Authority.

It is recommended that the group is led by a full time Tobacco Control Manager who is responsible for the development and delivery of the strategy as well as the smooth administration of the Alliance.

Stakeholders take responsibility for delivering programmes that fall into their areas of expertise. It is recommended that the group of stakeholders meet at least quarterly to develop the strategy and lead implementation of the plan.

The proposed stakeholder groups to be represented on the Wandsworth Tobacco Control Alliance are:

The Local Authority Health team

Public Health

Professional Executive Committee (PEC)

Environmental Services

Trading Standards

GP Consortia

St George’s Hospital

NHS Stop Smoking Service Manager

Children’s Services

Healthy Schools

Housing

Fire Service

Pharmacy

Local Civil Society

Communications

It is envisaged that there will be one representative for each stakeholder group.

An initial meeting of stakeholders was held at Wandsworth Town Hall on March 22nd 2011.

**Smoking in Wandsworth Insights**

Overall the estimated prevalence of smoking in Wandsworth is 20%, this is similar to London as a whole and lower than the national average prevalence of 21%.[[33]](#footnote-33)

**Smoking in England is most prevalent amongst young adults in routine and manual socio economic groups.**

Wandsworth has a high percentage of young adults in the borough but also a high percentage of young professionals with a lower propensity to smoke, so the population ‘bulge’ of young adults does **not** translate into high smoking prevalence.

*‘Wandsworth is the most populous Inner London borough and around 132,000[[34]](#footnote-34) dwellings are home to a population of over 290,000[[35]](#footnote-35) residents. The age structure of residents is skewed and differs significantly from both the national and the Greater London average. The 20-39 year old age group represents 48% of the population (Figure 14) compared to 27% nationally and 36% in Greater London[[36]](#footnote-36).’*

**Fig. 4 Wandsworth Age-Sex Pyramid**

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**There are pockets of high smoking prevalence in Wandsworth**

However within the average smoking prevalence of 20% there are pockets of high prevalence. Local GP data records the greatest numbers of smokers recorded in Latchmere, St Mary’s Park, Queenstown, Shaftesbury, West Hill, Fairfield, Roehampton and Earlsfield. However there are significant numbers of smokers in most of the wards.

The low levels of smoking prevalence in Graveney and Tooting are believed to be due to the relatively large number of Muslims and elderly people who live in these wards, as typically, these population groups have a low prevalence of smoking.

In order to consider ward level prevalence we have looked at GP data.

**Fig. 5 Patterns of smoking in Wandsworth compared to multiple deprivation index[[37]](#footnote-37)**

|  |  |  |  |
| --- | --- | --- | --- |
| Ward  | No of smokers in GP Population | Prevalence of smoking in GP population % | Index of multiple deprivation 2007 |
| Latchmere | **5032** | **29** | 36.9 **1** |
| St Mary’s Park | **4682** | **30** | 22.3 **7** |
| Queenstown | **4615** | **35** | 28.9 **3** |
| Shaftesbury | **4451** | **30** | 20.7 **9** |
| West Hill | **4322** | **24** | 21.6 **8**  |
| Fairfield | **4035** | **26** | 16.5  **13** |
| Roehampton | **3878** | **23** | 31.7 **2** |
| Earlsfield | **3692** | **24** | 19.4 **11** |
| Southfields | 3603 | 20 | 14.1 **18** |
| East Putney | 3382 | 19 | 14.9 **16** |
| West Putney  | 3204 | 19 | 18.8 **12** |
| Northcote | 3046 | 19 | 13.8 **19** |
| Wandsworth Common | 2994 | 21 | 14.8 **17** |
| Bedford | 2980 | 22 | 20.1 **10** |
| Thamesfield | 2720 | 16 | 10.4  **20** |
| Furzedown | 2639 | 19 | 22.8 **6** |
| Nightingale | 2604 | 16 | 16.4 **14** |
| Balham | 2085 | 14 | 15.3 **15** |
| Graveney | 1834 | 21 | 24.3 **5** |
| Tooting | 1396 | 16 | 24.9 **4** |
| Total | **67194** | **20** |  |

**Smoking amongst young people**

We have no evidence to suggest that smoking amongst young people is higher in Wandsworth than any other borough. The national average is a prevalence of 15% amongst 15year olds. [[38]](#footnote-38) However as Wandsworth has a young population and the number of teenagers is expected to grow over the coming two decades, actions to prevent the uptake of smoking amongst young people must remain a priority for the borough.

*‘Significant increases in the number of children in the borough are also projected, reflecting the continuing upward trend in the number of births. In 2009 there were 5,335 live births[[39]](#footnote-39), an increase of 31% since 2002 and the highest level for at least 20 years. Projection methodology ‘ages on’ these births to increase the number of children in age groups 5-9, 10-14 and 15-19 by 2030.’[[40]](#footnote-40)*

We have to be mindful that the tobacco companies would need to recruit more than 80,000 young people each year in England, to replace their customers who have died of their smoking habit.

**Smoking In pregnancy**

Wandsworth records very low levels of smoking in pregnancy with rates less than half the national average and declining year on year. This low level will be in part a reflection of the relative affluence of the mothers in Wandsworth as smoking at time of birth is lowest amongst the highest socio economic groups and highest amongst single teenage mothers. However as smoking pregnancy has considerable impact of the health of the mother, foetus and the child, every effort should be made to encourage every pregnant woman to stop smoking.

**Fig. 6 Wandsworth has low smoking in pregnancy rates[[41]](#footnote-41)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 2008/09 | 2009/10 | 2010/11 to Q3 | England 2009[[42]](#footnote-42) |
| Number of new mothers known to be smoking at time of delivery | 297 | 200 | 159 |  |
| % | 6.5 | 4.5 | 4.2 | 11 |

**Smoking amongst BME groups**

Wandsworth is home to a diverse range of communities and 20% of the borough’s population is non-white, compared with 31% in Greater London and 12% nationally.[[43]](#footnote-43)

 *‘In 2007, Wandsworth had the 27th largest non-white population of the 33 London boroughs. Although the overall non-white population in the borough has changed little since 2001, there has been a significant percentage increase in the number of residents of Asian or Asian British ethnicity, particularly Bangladeshi with an estimated increase in population size of 92% to 2,300 from 2001 to 2007. In contrast, a decrease of more than 20% has been observed in residents from Black or Black British Caribbean (-2,900), African (-2,100) and White Irish (-1,800) ethnic groups.’[[44]](#footnote-44)*

Some BME groups show a higher propensity to smoke cigarettes, such as Irish, Bangladeshi men, Chinese men, and people of Afro – Caribbean decent. Women of Asian decent have a higher propensity to chew Paan and men of Middle Eastern decent have a higher propensity to use a Shisha ( or Water Pipe).

In Wandsworth it is likely that within the smokers recognised above a disproportionate number (for the size of their total population) will be of Afro – Caribbean or Irish decent and Bangladeshi men. Absolute numbers of smokers in these groups, and where they live, will have to be identified to assess whether specific actions will be cost effective to encourage these smokers to stop.

 Trading Standards are aware of three Shisha bars and will be monitoring them to ensure compliance with all regulatory requirements.

**Fig .7 Wandsworth Population – Ethnicity Profile[[45]](#footnote-45)**

|  |  |  |
| --- | --- | --- |
| Ethnic Group | Number residents in Wandsworth | % of Wandsworth Population |
| White –British | 168665 | 65 |
| White – Irish | 8151 | 3 |
| White – other white | 26162 | 10 |
| Mixed – White and Black Caribbean | 2893 | 1 |
| Mixed – White and Black African | 1252 | 0.5 |
| Mixed - White and Asian | 2247 | 0.9 |
| Mixed – Other mixed  | 2336 | 0.9 |
| Indian | 7412 | 2.85 |
| Pakistani | 5449 | 2 |
| Bangladeshi | 1099 | 0.4 |
| Other Asian | 4084 | 1.6 |
| Caribbean | 12665 | 4.9 |
| African | 10013 | 3.8 |
| Other Black | 2388 | 0.9 |
| Chinese | 2227 | 0.9 |
| Other Ethnic | 3337 | 1.28 |
| Total Population | 260038 |  |

**Smoking in Wandsworth Prison**

It is not untypical for up to 80% of prisoners to smoke. The smoking prevalence at Wandsworth Prison is not known. Historically the local NHS Stop Smoking Service has trained prison staff to deliver evidence based cessation support. However the current status of the support offered and the number of successful quits is not known. This is an area for further scoping in 2011 with a view to further actions in 2012 and beyond**.**

**Smoking in Mental Health**

Again, historically mental health patients record a high incidence of smoking; equally healthcare professionals that work with mental health patients have also recorded a high level of smoking prevalence for health workers. This is an area for further scoping in 2011 with a view to further actions in 2012 and beyond.

**Stopping Smoking in Wandsworth**

The Wandsworth NHS Stop Smoking Service has over time seen increases in the number of smokers it has helped to stop. There was a decrease in those helped in 2008/9, but this was seen in many services across the country post the 2007 introduction of smokefree legislation.

**Fig. 8 Performance of Wandsworth NHS Stop Smoking Service[[46]](#footnote-46)**

|  |  |  |
| --- | --- | --- |
| Year | Number setting quit date | Number successfully quitting at 4 weeks (Self Reported) |
| 2006/7 | 2170 | 1211 |
| 2007/8 | 2306  | 1244 |
| 2008/9 | 2014 | 1015 |
| 2009/10 | 2644 | 1287 |

The Wandsworth NHS Stop Smoking Service has also delivered the required number of 4 week quitters. Although it has not delivered the desired number of quitters per 100,000 of population. [[47]](#footnote-47)

However it can also be seen that the number of smokers accessing the service is a very small percent the population of smokers in Wandsworth: less than 3000 of a universe of over 67000 smokers. Whilst reaching about 2% of the smoking population is a norm for a NHS Stop Smoking Service, it also identifies that there are still tens of thousands of smokers in the community that could be helped by the local service.

It should also be noted that of all the smokers that access the service about 20% will be quit after 12 months (as not all 4 week quitters remain quit) and that the service will account about 10 – 20 % of all smokers that successfully stop smoking. This is because many smokers successfully quit without the support of the service.[[48]](#footnote-48)

It can also be seen below, that the number of smokers accessing the service does not relate to the population of smokers. This suggests some localised systems are more effective than others and there is a real opportunity for all locations to work as effectively as the best.

A new Local Enhanced Service (LES) is being developed to encourage all local pharmacies in Wandsworth to offer a NHS Stop Smoking Service plus the most effective pharmacotherapy. This should improve the reach of the service and offer the opportunity to recruit smokers reluctant to go to other health settings for support to stop.

**Fig 9. A small percentage of Wandsworth smokers access the NHS Stop Smoking Service**

|  |  |  |  |
| --- | --- | --- | --- |
| Ward  | No of smokers in GP Population | No of smokers accessing NHS Stop Smoking Service | % of smokers accessing NHS Stop Smoking Service  |
| Latchmere | 5032 | 115 | 2.3 |
| St Mary’s Park | 4682 | 51 | 1 |
| Queenstown | 4615 | 20 | 0.4 |
| Shaftesbury | 4451 | 84 | 1.9 |
| West Hill | 4322 | 154 | 3.6 |
| Fairfield | 4035 | 73 | 1.8 |
| Roehampton | 3878 | 147 | 3.8 |
| Earlsfield | 3692 | 124 | 3.3 |
| Southfields | 3603 | 89 | 2.5 |
| East Putney | 3382 | 90 | 2.7 |
| West Putney  | 3204 | 121 | 3.8 |
| Northcote | 3046 | 25 | 0.8 |
| Wandsworth Common | 2994 | 84 | 2.8 |
| Bedford | 2980 | 75 | 2.5 |
| Thamesfield | 2720 | 67 | 2.5 |
| Furzedown | 2639 | 83 | 3.1 |
| Nightingale | 2604 | 81 | 3.1 |
| Balham | 2085 | 51 | 2.4 |
| Graveney | 1834 | 108 | 5.9 |
| Tooting | 1396 | 153 | 11 |
| Total | **67194** | **2477** |  |

**There is great scope to improve referrals to stop smoking at St Georges Healthcare NHS Trust**

The secondary care setting offers a significantly underplayed opportunity to engage, refer and support smokers to quit. The large footfall through this setting provides thousands of clinical and non-clinical interactions which represent what Professor Robert West terms ‘teachable moments’ when smokers are more likely to respond to offers of support to quit if we can step up the frequency, volume and quality of brief and more intensive interventions in this setting. Some acute trusts refer around 200 patients a year into their local NHS Stop Smoking Service [[49]](#footnote-49) St George’s Hospital sees hundreds of thousands of patients each year and its is likely that around 30% of these patients smoke.

Last year at St George's Healthcare[[50]](#footnote-50):

* 104,118 patients treated in A&E
* 4,755 babies delivered
* 460,714 outpatient appointments
* 26,340 day case procedures
* 65,141 inpatients admitted

Many thousands of smokers could be started on their journey to quitting by a brief intervention whilst at St George’s Hospital.

**Insights to support the Wandsworth tobacco control strategy**

**Strand 1: Stopping the promotion of tobacco in Wandsworth 2011**

|  |
| --- |
| Key strategies Implement the legislation to stop tobacco sales from vending machines from October 2011Implement the tobacco display provisions in the Health Act 2009 for large shops from April 2012Contribute to the consultation on options to reduce the promotional impact of tobacco packaging, including plain packaging, before the end of 2011  |

**Insight**

While the Tobacco Advertising and Promotion Act 2002 prohibits tobacco advertising, the tobacco industry can still promote its products in every supermarket, pub, corner shop and festival in the country through packaging, point of sale displays and event sponsorship by associated products.

Hence smoking is still perceived as a normal and everyday behaviour. In fact most people think, most people smoke![[51]](#footnote-51) And yet in reality less than 20% of the population smoke.

It is the strategies above that will align the perception with the reality.

**Strand 2: Making tobacco less affordable in Wandsworth 2011**

|  |
| --- |
| Key StrategiesWork with HM Revenue & Customs (HMRC) to tackle illicit tobaccoIdentify niche products to ensure that appropriate duty is paid on these productsConsider the use of evidence based marketing campaigns should funding become available  |

**Insight**

The incidence of using hand rolled tobacco (HRT) has been increasing since 2003. It appears the initial reason for this increasing incidence was price: hand rolled tobacco is the cheapest way to smoke tobacco. Legally purchased HRT is cheaper than manufactured cigarettes and it is believed that much HRT is illicit, making the cost to the user even cheaper still.

Recent quantitative research in South West of England found that

60 % of smokers claim to use hand rolled tobacco[[52]](#footnote-52) and 25% of smokers in the South West admitted to using illicit tobacco.[[53]](#footnote-53)

The availability of illegal tobacco and particularly illegal hand rolling tobacco therefore currently can undermine price as a lever to prompt quitting, it is therefore important to undertake a comprehensive strategy to prevent illegal tobacco being available in Wandsworth. To date there is little intelligence about the sources of illegal tobacco in the borough and so this needs to the priority for 2011.

**Strand 3: Effective Regulation of Tobacco products in Wandsworth 2011**

|  |
| --- |
| Key StrategiesLocal enforcement of tobacco legislation, particularly on the age of sale of tobacco products Consider where children obtain tobacco products and explore what action is needed to tackle the main sources |

**Insight**

**Reducing Underage sales**

Test purchasing uses local cadet volunteers to attempt to purchase tobacco in order to monitor the compliance of local retailers with the Age of Sale legislation. This work is led by Trading Standards. Retailers who make underage sales can be issued a warning an ultimately a fine of up to £2500.The provision of guidance to local retailers to inform of the law and consequences can prevent underage sales taking place.[[54]](#footnote-54)Authorities are also encouraged to publicise the age of sale legislation and encourage local media to provide coverage of successful prosecutions.

 The Criminal Justice and Immigration Act 2008 adds new sections to the Children and Young Persons Act 1933 to tackle the persistent sales of tobacco to persons under the age of 18 years. Local authorities may, under this legislation, apply to a Magistrates Court for a Restricted Premises Order. This can be done in cases where a person has already been convicted of a tobacco offence and permits other tobacco offences in the same premises on at least two occasions within a 2 year period.

A Restricted Premises Order prohibits the sale of tobacco or cigarette papers by any person or automatic machine within the premises. The summary conviction maximum fine is £20,000.A Restricted Sale Order prohibits a named person from selling tobacco or cigarette papers from a premise, from having any management functions in respect of the sale of tobacco or cigarette papers, or from keeping a vending machine. The summary conviction maximum fine is £20,000.

**Proxy sales and adults supplying to children**

A proxy sale is when a child gives money to an adult to buy an age restricted product on their behalf. Retailers can spot proxy sales by watching out for the following behaviours:

Groups of youths congregating outside a shop and approaching members of the public as they approach the shop

If an adult asks for the same product as a recently refused sale

If the adult pays separately for the product and keeps the change separate

If the age restricted product is kept separately from the other shopping

If the purchase is completely out of character for the shopper

If the shopper re- enters the store just to buy an age restricted product

In these circumstances, retailers are advised to remind the shopper that it is an offence to ‘proxy’ purchase.[[55]](#footnote-55) At present a proxy sale is only an offence for alcohol under Section 149 of the Licensing Act 2003, but best practice procedures are recommended for all age restricted products. Currently it is the person making, or attempting to make, the purchase who is responsible for the sale.

**Unofficial suppliers**

Qualitative research undertaken in the South West of England found that teenagers were available to buy single hand rolled cigarettes from older teens for a little as 10 pence. This was found to be the ‘starter’ product for many teen smokers.[[56]](#footnote-56)

**Strand 4: Helping tobacco users to quit in Wandsworth 2011**

|  |
| --- |
| Key StrategiesMotivate tobacco users to think about quitting, and guide them to the most effective support availableProvide local stop smoking services that are tailored to the needs of our communities and reach out to people from high smoking prevalence groups, in particular, people with routine and manual jobsScope the provision of a greater range of options for smokers who want to quit, based on evidence of clinical effectiveness and value for money Provide clinical guidance and training standards for local commissioners and providers of local stop smoking services  |

**Insight**

**Motivating every smoker to stop**

Different smokers are prompted to quit by different interventions. An intervention can be advice from a health professional or friend, an incident, such as illness or death of a loved one or something seen on TV or advertising. All these interventions can prompt a quit attempt and behavioural theory suggests that the more prompts that are delivered the more likely the desired behaviour is to occur.

The two most effective, and controllable motivators are Health Professionals and advertising.

It is recommended that Health professionals be the key motivators commissioned in Wandsworth and that advertising be used if additional funds become available.

**NICE Guidance for Healthcare professionals**

NICE[[57]](#footnote-57) recommend that all healthcare practitioners give brief stop smoking advice to all smokers (unless exceptional circumstances make it inappropriate). A typical brief intervention takes about 5 – 10 minutes and includes:

-Simple opportunistic advice to stop (takes 30 seconds)

-An assessment of the patients commitment to stop

-An offer of pharmacotherapy and/or behavioural

-Provision of self help material and referral to an NHS Stop Smoking Service

Very brief interventions typically last less than a minute and include

 ASK and record smoking status

ADVISE patient of the personal health benefits

 ACT on the patients response ,including referral to the NHS Stop Smoking Service

A combination of hard hitting ‘Why to quit’ advertising messages about the dangers of smoking plus clear ‘how to quit’ messages has proven effective in the past.

**Assisting every smoker to stop**

The NHS Stop Smoking Service provides the most effective method of stopping smoking: smokers are up to 4 times more likely to stop using this method than trying to stop without any type of help.[[58]](#footnote-58)

Unfortunately the most effective way of quitting would appear to be the least popular way to try and quit. There is a consistent picture across England, where we see over 30% of all smokers making a quit attempt each year but only about 2% of smokers using the NHS Stop Smoking Service![[59]](#footnote-59)

Of all those setting a quit date at an NHS Stop Smoking Service we can expect about 50% to be quit at 4 weeks and 20% to be quit at 12 months. Typically a good service will currently contribute about 20% of all quitters. These are the key conversions that should be remembered when calculating the contribution the local service will make to overall drops in prevalence.

Health professionals in primary and secondary care could dramatically change the smoking prevalence by encouraging smokers to attend their local service. These health settings see many thousands of smokers each day and the more quit attempts that are made the more successful quits there are.[[60]](#footnote-60)

Currently many secondary and primary care appointments with smokers do not involve a recommendation to stop smoking and these appointments offer a key opportunity to make a step change in smoking prevalence.

**The NHS Stop Smoking Service**

The NHS Stop Smoking Service Monitoring Guidance 2010/11 outlines the criteria for a successful service.[[61]](#footnote-61) The criteria are;

 The service should aim to treat at least 5% of their smoking population each year

 The service should be delivered by appropriately trained staff.

The service should target smokers in routine and manual groups and other groups with high smoking rates

The quit rate amongst those setting a quit rate should be 35 - 70%

CO testing should be carried out amongst all adult smokers where ever possible to provide both a pre quit base level and a post quit validation level. It is expected that a minimum of 85% of self reported 4 week quitters undertake expired CO validation.

All NICE approved pharmacotherapy should be offered as first line treatment in order to optimise success.

**Training**

The new NHS Centre for Smoking Cessation and Training (NCSCT) now offers a national standard for training. The training is developed in 2 stages. Stage 1 covers knowledge is assessed on an online resource. Stage 2 covers skill based competencies and is assessed face to face assessments. All staff should now be competent to these new standards.www.ncsct.co.uk

**Helping pregnant woman to stop smoking**

Smoking in pregnancy places the health of both mother and baby at risk and so this group should be a priority, yet evidence suggests that there are many barriers to recruiting pregnant women into the NHS Stop Smoking Service. One problem is that pregnant smokers often do not disclose their true smoking status. Another barrier is that healthcare professionals are often unwilling to raise the issue of smoking based on an unfounded fear that it will jeopardise the relationship with the client.

Much success has been seen by:

Training midwives through role play exercises to be confident in delivering smoking interventions[[62]](#footnote-62)

Introducing opt out protocols, hence making it more likely that clients will attend an NHS Stop Smoking Service [[63]](#footnote-63)

**Attracting young smokers to the NHS Stop Smoking Service**

The Department of Health provide a framework for commissioners and service providers called ‘Your Welcome’. This framework recognises that for services to be attractive to young people they need to offer:

 Accessibility -by public transport and at appropriate times

 Confidentiality and consent - Protocols to be displayed for all to see

 Staff trained in working with young people

 Joined up working so that other helpful services can be easily accessed

 A good reputation

 Monitoring and evaluation of performance

**Strand 5: Reducing Exposure to Secondhand smoke in Wandsworth 2011**

|  |
| --- |
| Key StrategiesEncourage smokers to change their behaviour so that they do not smoke in their homes or family cars |

**Insight**

**Secondhand smoke (SHS) is a killer**

SHS is dangerous to non smoking adults: evidence suggests exposure causes a 25% increase in risk of heart disease and 24% increased risk of lung disease. However this risk is avoidable: the Department of Health reported 10% fewer heart attacks in England in the first 12 months after the introduction of the smokefree legislation.

SHS is even more dangerous to the underdeveloped organs of children causing: cot death, respiratory illnesses, asthma and infections of the middle ear.

Response to the 2007 Smokefree legislation has been very positive with almost 100% compliance with the law. However many smokers continue to smoke in their homes and cars making innocent victims vulnerable to the poisons in their cigarette smoke.

Most recent data suggests 2 million British children are exposed to cigarette smoke in the home.[[64]](#footnote-64)Each year, the costs of treatment by primary care services for these children have been estimated at around £10 million, while hospital admissions cost a further £13.6 million.[[65]](#footnote-65)i These figures do not include the impact on the health of adults who are exposed to secondhand smoke.

In developing strategies to protect non smokers from SHS it is imperative that thoroughly researched interventions, rooted in the evidence base, are utilised. Many localities have introduced programmes that use ‘pledges’ or allow for smokefree rooms: - such programmes do not deliver health benefits and should be avoided. Strategies that communicate the impact of SHS on children and offer clear guidance to ‘Always smoke outside’ have been identified as the most effective.

Housing and Fire Departments also have an interest in delivering smokefree homes because cigarettes are the single biggest cause of fatalities from house fires. The opportunities to work in partnership with these departments should be explored in Wandsworth.

**Strand 6: Effective Communications for Tobacco control in Wandsworth 2011**

|  |
| --- |
| Key StrategiesEducate people about the risks of using tobaccoMotivate tobacco users to think about quittingEncourage tobacco users to make quit attempts, and to quit in the most effective waysEncourage communities to see not smoking as the norm  |

**Insight**

National mass media campaigns have proven to be very effective at prompting quitting behaviour and prompting compliance with new legislation.

*‘Over a three-year period, it is estimated that the department of Health’s marketing communications have returned £4.58 in savings for every pound spent to the NHS alone.’[[66]](#footnote-66)*

Mass media campaigns are difficult to deliver at a local authority level as popular TV and radio channels cannot be bought at a local level. However the benefits of national campaigns can be leveraged locally by promoting key messages in local media and throughout the local authority estate.

In addition, it is recommended that Wandsworth leverage those communication channels it can access and that are proven to deliver results: face to face interventions by health care professionals and other advocates.

It is proposed that should funds become available to fund marketing materials campaigns proven to be effective in other local areas should be assessed for use in Wandsworth ie Campaigns that challenge

* Use of hand rolled tobacco (Developed by Smokefree South West)
* Availability and acceptability of illegal tobacco (Developed by Smokefree North East)
* Smoking in the home ( Campaigns are available from Smokefree North West and Smokefree South West)

Media campaigns in particular benefit from economies of scale and therefore it is worth considering delivery of some programmes at a ‘cluster’ level; working with neighbouring boroughs.

**Delivering tobacco control interventions to young people**

The delivery of tobacco control interventions with young people requires professionals working in health, education and youth settings to deliver key communications.

Nice[[67]](#footnote-67)guidance recommends

 Development of a smokefree site policy (this is a criteria for Healthy Schools status)

 Integrate messages about tobacco into the wider curriculum

Support tobacco education in the school by booster activities such as health fairs and external speakers

Providing training for all staff that will undertake smoking prevention work

Ensure smoking prevention interventions delivered in education settings are evidenced based

**PSHE**

Education about the danger of tobacco use is a key theme of the PSHE core theme that includes Sex and Relationship Education (SRE) and Drug Education (covering tobacco, alcohol and volatile substance abuse).

The Alliance can assist by

 Providing additional training and resources to staff

Raising the profile of tobacco control to ensure the subject gets appropriate attention

Topics to be covered in PSHE are

 The real impact of smoking on health

 The impact of secondhand smoke on non smokers

 The impact of smokefree places on improved health

 Briefing on illegal tobacco

 How the tobacco companies conduct their business

 The success of NHS Stop Smoking Services

**Monitoring and Evaluation**

It is proposed that SMART[[68]](#footnote-68) targets will be agreed by the Alliance for each activity and appropriate measurement tools agreed.

Key quarterly milestones will be set and monitored by the Tobacco Control lead.

It is intended that regular progress reports on achievements against these SMART targets be reported regularly to the Health and Wellbeing Board.

**Risks to Delivery**

* Tobacco control is not prioritised for all Alliance members and associated departments and so the six strand programme is compromised.
* Financial constraints mean manpower is not available to deliver statutory requirements.
* New GP commissioning opportunities are missed and so delivery of stop smoking interventions in primary and secondary care do not improve.
* A specialist is not appointed to deliver the Tobacco Control strategy and so the programme loses efficiency and momentum.
* A specialist or specialist organisation is not appointed to manage the NHS Stop Smoking Service and so the service lacks efficiency.

**Funding**

It is envisaged that this strategy can be delivered from current resources, if tobacco control is clearly prioritised.

However there is evidence from the North East of England and the South West of England that demonstrates that increased investment in tobacco control can accelerate the rate of smoking decline.[[69]](#footnote-69) For example in the South West region (across the current 14 PCTs) a fund equivalent to 50p per capita per annum has been allocated to enhanced tobacco control activities over the past 3 years. The South West has seen prevalence drop by 3 percentage points in that period and now has the lowest prevalence in England at 18%.

Should extra funding become available then priority activities would be:

On the street recruitment of smokers into the NHS Stop Smoking Service

Focused recruitment of smokers in secondary care

Media campaigns highlighting

Why to stop smoking

Illegal tobacco funding crime/recruiting child smokers

The dangers of secondhand smoke to children

Where to get help to stop

Media campaigns in particular benefit from economies of scale and therefore it is worth considering delivery of some programmes at a ‘cluster’ level; working with neighbouring boroughs.

**Jane Webb**

**March 2011**

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