Smokefree West Sussex Operational Plan 2014 – 2017:

reducing smoking prevalence in our community

Smokefree West Sussex Partnership towards a tobacco free West Sussex

Content

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Acknowledgement

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Sussex Community NHS Trust
Solutions 4 Health
Respiratory Nurses, Worthing Hospital
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Executive summary

The aim of the Smokefree West Sussex Operational Plan 2014-2017 is to reduce smoking prevalence in West Sussex. The plan has been established using national guidance for local authorities to undertake tobacco control strategies at the local level as outlined in the 'Healthy Lives, Healthy People: A Tobacco Plan for England'.

The actions in the plan move West Sussex towards best practice in tobacco control and are aligned with the ten high impact changes developed by the Department of Health.

The challenges for West Sussex

- West Sussex has an estimated 125,000 adults over 18 years of age smoking on average around 12.7 cigarettes a day. While smoking prevalence in West Sussex is below the national average we experienced a 0.5% increase in 2012/13 to 19.1%, from 18.6% in the previous year.
- In 2012/13 the estimated cost of smoking in West Sussex was £196.8 million. The greatest cost to our community was through loss of output and productivity from early deaths, smoking breaks and sick days, totalling £135.7 million.
- 31.2% of smokers are from routine and manual occupations. This represents a significant proportion of the population and therefore more tailored approaches need to be in place to reach and support them.
- In West Sussex 70% of 14-15 year olds who smoked had their first cigarette between 12-13 years old. The earlier a young person starts smoking is a predictor of future smoking behaviour and they are more likely to remain regular smokers in their adult years.
- Smoking in young people in West Sussex is declining, however, continued early intervention programmes are key to prevent the uptake of smoking in young people.
- Equally important is to break the cycle of smoking at the earliest possible moment in life. This means helping pregnant mothers to quit smoking during pregnancy. Not only is this important to the health of the unborn baby and mother but young people are more likely to smoke themselves if they have a parent that smokes, than those who had non-smoking parents.

On the horizon – legislative changes

Tobacco control encompasses a variety of approaches (e.g. legislation and enforcement, social marketing, stop smoking services) in order to reduce smoking prevalence. In the last two decades we've seen a number of successful legislative changes to denormalise smoking behaviour across the UK including the smokefree legislation, advertising bans to tobacco products and the ban on selling tobacco products to anyone under the age of 18 years of age.

Plain packaging and electronic cigarettes (e-cigs) have been hotly debated nation-wide in recent years with polarised views on both these topics. It is now illegal to sell e-cigs to under 18s, and in 2016, e-cigs will be regulated by the Medicines and Healthcare Regulatory Authority (MHRA).

Following an independent review completed in March 2014, consultation on draft regulations to introduce plain packaging is underway.

Key themes to reduce smoking prevalence in West Sussex

An integrated tobacco control approach

Smokers are four times more likely to quit successfully with support. Stop smoking services (SSS) for West Sussex will continue to offer an evidence-based programme to support smokers to quit. We will continue to offer SSS county-wide in GP surgeries, pharmacies or at a specialist stop smoking service. More smoking advisors across the county means support is never far away for smokers.

We know that two thirds of people who smoke want to quit. Therefore, we need to enable the wider public health community to start a conversation about smoking with users of community services. Well established referral pathways into the SSS by organisations that have regular face-to-face contact with the community are paramount to helping people quit smoking and stay quit with the right support.

Training and sharing of information is integral to educating the wider public health community about why and how we can reduce smoking prevalence in West Sussex. This in turn will generate a natural advocacy for tobacco control and lead to a greater push at the grass roots level to influence and embed legislation. Policies stemming from this will bring about social change and denormalise smoking across the county.

Tackling health inequalities through tobacco control

West Sussex will provide specialist support to priority groups that are vulnerable to health inequalities. Priority groups for West Sussex are:

- routine and manual workers
- pregnant mothers and their partners
- black and minority ethnic (BME) groups
- young people (under 25)
- smokers with at least 5 unsuccessful quit attempts
- residents of deprived areas
- mental health service users in the community

Smokers in these priority groups are often the hardest to reach. We will work with community groups and organisations to target our most vulnerable in the community and deliver SSS to the heart of where people live and work. We will ensure that the services are accessible to all by visiting pregnant women at home, locating specialist clinics in the right areas and utilising mobile clinics. We will take the service into the workplace to capture routine and manual workers

and work with schools to equip our youth with the knowledge and skills to say no to cigarettes.

Tackling health inequality through tobacco control is as much about providing specialist support as it is about eradicating the sale of illicit cigarettes and tobacco from our community. Cheaper cigarettes undermine the impact of other tobacco control measures because they make smoking more affordable and encourage greater addiction to cigarettes for longer. Trading Standards will continue to educate retailers, stop the sale of tobacco to young people and continue raids to uncover recalcitrant retailers.

Working together in partnership

Central to this plan is tackling smoking prevalence as a unified community and working together in partnership. The Smokefree West Sussex Partnership membership includes organisations in the community that are committed to reducing the impact of smoking on health and health inequalities. The Smokefree West Sussex Partnership will provide leadership in tobacco control in West Sussex.

Sharing local data to identify where smoking prevalence is highest in our community and who is the most vulnerable to health inequality is important to keeping abreast of emerging trends in our community. Working together to collect and share local data will also improve our understanding of the attitudes and behaviours of smokers in our community so we can tailor our marketing strategies.

Only by working together can we ensure we reach the community to educate them on the benefits of reducing smoking prevalence for a healthier West Sussex. Taking a joined up approach at the local level to support national anti-smoking campaigns such as, Stoptober, Health Harms and No Smoking Day should provide the marketing platform to extend the reach of our messages about the benefits of quitting to every corner of the county.

Reducing smoking prevalence for a healthier West Sussex is a challenge, but it is not impossible, when we join forces. Tobacco control is everybody's business.

Monitoring and evaluation

This operational plan is a working document for the Smokefree West Sussex Partnership and the West Sussex community. We will monitor the performance of the actions outlined in the plan and report on progress quarterly to key stakeholders.

Introduction

Public Health is committed to promoting healthier lifestyles to the residents of West Sussex. Following the move of Public Health from NHS to local authorities in April 2013, there is now a shift from focusing primarily on encouraging smokers to quit to a more comprehensive approach incorporating preventative measures.

There is, therefore, an increased need for partners throughout the county to be involved in tobacco control as the responsibility to reduce smoking prevalence impacts on a large number of organisations. This may include front line social care staff working with residents and informing them on the harms of smoking, or it could be a school organising events and school lessons that challenge social norms on young people smoking.

The purpose of the Smokefree West Sussex Operational Plan 2014-2017 is to reduce smoking prevalence and health inequalities associated with smoking in West Sussex.

This report outlines ten high impact changes as identified by the Department of Health which reflects the view of the World Health Organisation (WHO). The central themes are:-

- Targeting the supply and demand of tobacco consumption including illicit supply.
- Addressing the perceptions of smoking.
- Relying on evidence and strong partnerships to deliver programmes.
- Preventing the uptake of smoking particularly among young people.

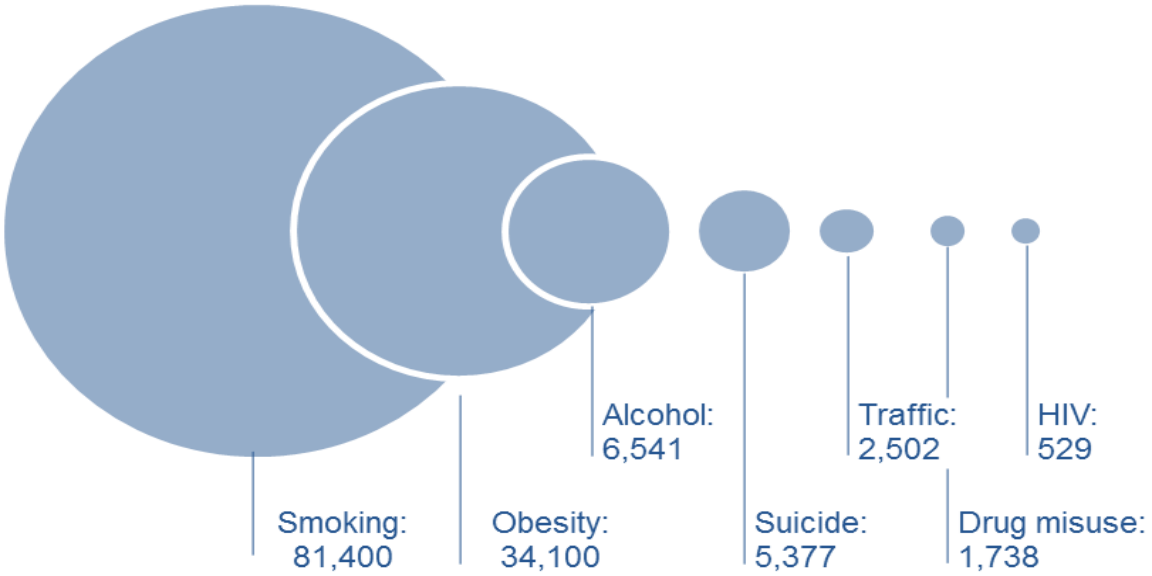
Behind each of the high impact changes are priorities and actions that set out how partners can work together towards meeting the aim. A detailed action plan that includes outcome measures to help reach these goals is on page 38.

Information in this report is based on current evidence. Where actions have been suggested as sufficient evidence was not available, best practice is applied. This report was developed in collaboration with partners and identifies areas where partnership working is possible.

Why is tobacco use a problem?

Smoking is the leading cause of premature morbidity and mortality, accounting for more than 80,000 deaths every year in England. This is higher than all other causes of preventable deaths combined[1]. Smoking is also central to tackling health inequalities as smoking-related death rates are two to three times higher in low-income groups than in wealthier groups. Reducing the smoking prevalence in disadvantaged groups will be the fastest way to increase life expectancy in the United Kingdom (UK).

Figure 1 Leading causes of premature morbidity in the UK, 2011.



Source: ASH Factsheet, Smoking Statistics: illness & death, October 2011

The national picture

It is currently estimated that 19.5% of people aged 18 and above smoke in England[2]. This is based on the Integrated Household Survey in 2012.

The 2013 Statistics on Smoking report for England[3] found that:

- In 2011, 20% of adults reported smoking, which is similar to 2010 but much lower than the 39% in 1980.
- Current smokers smoked an average of 12.7 cigarettes per day.
- There has been an increase in proportion of smokers who smoke mainly hand rolled tobacco.
- Around 462,900 hospital admissions in 2011/2012 were estimated to be attributable to smoking. This accounts for 5% of all hospital admissions in adults aged 35 and over.

Smoking and health inequalities

The link between smoking and health inequalities is well established. Health inequalities are differences between people or groups due to social, geographical, biological or other factors. These differences can have a big impact on people's health and result in shorter lives or people experiencing poorer health.

Addressing health inequality through tobacco is important because, for example, death rates from tobacco are two to three times higher among low-income groups than among those better off. Smoking may be a greater source of health inequalities than social position as it has been found that non-smokers have a much better survival rate than smokers in all social positions.[4]

Men in the most deprived areas were more than twice as likely to smoke (32.9%) compared to men who were in the least deprived areas (14.3%). Among those who have ever smoked, men and women from the most deprived areas were less likely to have given up smoking (46.5% and 48.5%) compared to those in the least deprived areas (74.0% and 76.0%).

The Marmot report on health inequalities identifies tobacco control as being central to any strategy to tackle health inequalities[5]. The scope for reducing health inequalities related to social position is limited unless smokers in lower social positions stop smoking. Guidance by the National Institute for Health and Care Excellence (NICE) stated that reducing tobacco consumption among minority groups would reduce health inequalities more than any other measure[6].

Smoking is a risk factor for several conditions including cardiovascular disease (CVD) and diabetes. The NICE guidelines on preventing CVD address smoking as one of the risk factors that can be targeted to reduce the likelihood of developing CVD[7].

Smoking in routine and manual occupations

The 2013 report on smoking[3] says prevalence of cigarette smoking in manual groups has been steadily declining since 1998 from 33% to 26% in 2010. The trend is comparable to the decline of smokers in non-manual groups from 22% in 1998 to 15% in 2010. Seven per cent of those in routine and manual groups reported heavy smoking (20 or more cigarettes a day) compared to 3% of those in managerial and professional groups. Routine and manual workers were also more likely to smoke hand rolled cigarettes (36% compared to 25%).

Smoking in pregnancy

Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risk of developing a number of long term conditions including attention and hyperactivity difficulties, learning difficulties and diabetes[8]. The highest levels of smoking before or during pregnancy were found among mothers in routine and

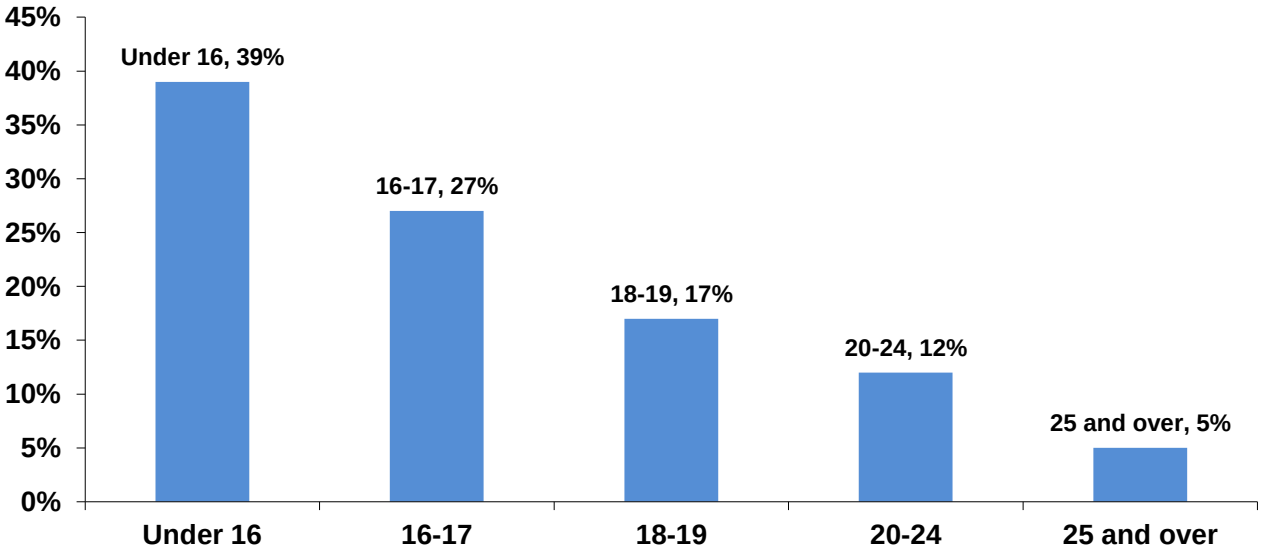
manual occupations (40%) and among those aged under twenty (57%). Mothers under twenty years of age were also the least likely to have given up smoking at some point before or during pregnancy (38%).

Most women who smoke quit soon after discovering they are pregnant. However, there are a number of obstacles to be overcome when reducing smoking in pregnancy for both the women and the professionals that support them. For some mothers, this could be a lack of understanding of the risk posed to their baby. For health professionals, the day to day challenges are having the confidence to identify if the woman smokes and provide very brief advice at ante-natal appointments.

Smoking in children and young people

More than 80% of smokers started before the age of 20[9]. The younger the age of uptake, the greater the risk of harm as early uptake is associated with subsequent heavy smoking, higher levels of dependency, a lower chance of quitting and higher mortality.

Figure 3 Age of smoking uptake among adult smokers



Source: Health Surveys for England 2013, Smoking Attitudes and Behaviours

In a survey conducted among secondary school pupils (11-15 years) smoking amongst this group has shown a long-term decline in the prevalence since the mid-1990s. The survey also found that[10]:

- less than a quarter (23%) of pupils had tried smoking at least once.
- The prevalence of regular smoking increased with age, from less than 0.5% of 11 year olds to 10% of 15 year olds. Being a regular smoker was associated with other risky behaviours, such as drinking alcohol, taking drugs and truancy.
- Two thirds (67%) of pupils reported that they had been exposed to second-hand smoke in the past year (Figure 4)
- Regular smokers were also more likely than occasional smokers or non-smokers to have family members who smoked (82% of regular smokers,

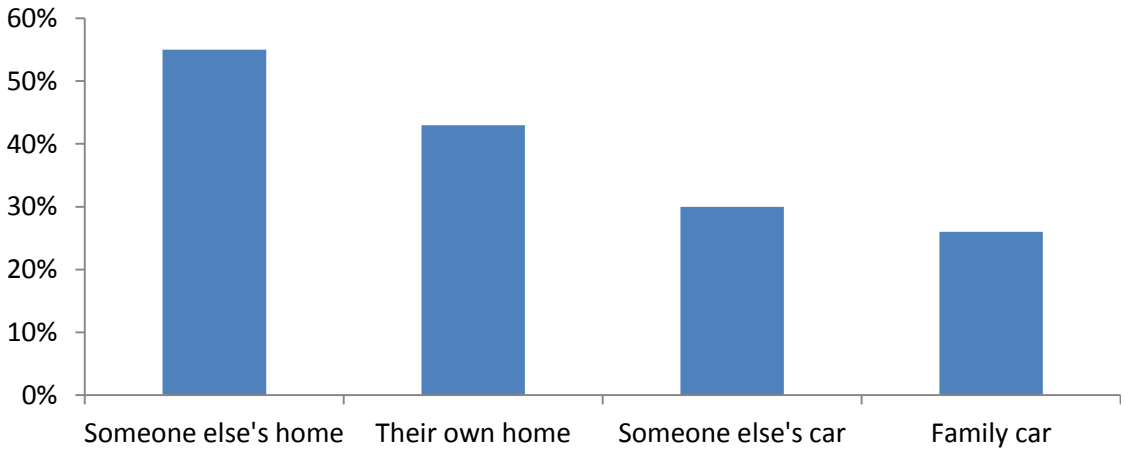
compared with 71% of occasional smokers and 68% of non-smokers). The higher the number of smokers in a household, the more likely a young person is to smoke. About 16% of regular smokers lived with three or more smokers compared to 2% who lived with non-smokers.

- Since 2007, when the minimum age at which pupils can be sold cigarettes was increased from 16 to 18, the proportion of pupils who have tried to buy cigarettes in a shop has fallen: from 17% in 2006 to 5% in 2012. However, half of pupils who have tried to buy cigarettes reported that they were never refused.

- Rather than trying to buy cigarettes in shops, pupils were more likely to have asked someone else to buy cigarettes for them and were more likely to get cigarettes as a result. In 2012, 8% of pupils had asked somebody to buy cigarettes on their behalf, and nine out of ten (88%) were successful at least once.

- Most pupils thought that people of their age smoked to look cool in front of their friends.

Figure 4 Exposure to second-hand smoke among 14-15 year old pupils in England in 2012



Source: Health and Social Care Information Centre Smoking, Drinking and Drug Use among young people in England in 2012, 2013

Smoking in black and minority ethnic groups

Black and minority ethnic (BME) groups are a priority group for tobacco control. Whilst smoking rates among this group is lower than the UK general population as a whole, there are huge variations in smoking prevalence between men and women within this group. In addition, risk of developing conditions such as strokes and diabetes among some BME groups is higher than the general population.

Analysis of the Health Surveys for England 2006, 2007 and 2008 found that among men, Black Caribbeans and Bangladeshis had the highest smoking rate (37% and 36% respectively). This was followed by Chinese (31%) and Other White (30%) while Indians (15%) and Other Black (12%) men had the lowest rate[11].

In addition, the higher prevalence of certain conditions within BME groups adds to the necessity of prioritising them for tobacco control. Prevalence of coronary heart disease (aged 55 and over) is highest in Indian (24%) and Pakistani (35%) men than the general population (18%)[12]. Among Black Caribbean men, they have the highest prevalence of stroke (11.5%) compared to other ethnic groups. In Black Caribbean and Indian men, the prevalence of Type 2 diabetes is more than twice that found in the general population (9.5% and 9.2% vs 3.8%)[12]. Uptake of smoking within these groups will further raise the likelihood of developing a condition that may have long-term implications on their health.

Poverty is higher among people from BME groups, which may explain the higher percentage of smoking within certain BME groups. Differences in smoking within Bangladeshi and Black Caribbean men compared with White English men could be explained by differences in socioeconomic position. However, differences in smoking prevalence within other BME groups are not explained by socioeconomic position.

World Development Indicators database[12] shows the smoking prevalence of males in Poland is up to 40%. Poles tend to be heavy smokers with 10% of men and 5% of women having more than 20 cigarettes a day. Work in Scotland[13] with focus groups has found that they smoke even more in the UK than in Poland. The primary reason reported is stress and working long hours. Many regard smoking as a social activity particularly the younger Eastern Europeans, and socialisation is the main reason for the majority of them not wanting to give up smoking. Cigarettes are much cheaper in Poland and many Poles go back regularly and bring back cigarettes with them.

The Brighton and Hove report[12] found that Eastern Europeans are not aware that there is free help and support for giving up smoking cigarettes available in the UK. Language difficulties mean that they are unlikely to access smoking cessation classes unless they are tailored to them.[14]

People with mental health difficulties

About 42% of cigarettes smoked by the general population are smoked by people with mental health disorders[15]. While smoking prevalence in the general population has been declining, smoking among people with a mental disorder has not changed much over the last 20 years[16]. Only a minority of people with a mental health condition receive effective smoking cessation intervention from the NHS[16].

There is a perception amongst smokers that smoking reduces some symptoms of mental ill health such as anxiety. A recent report found that smoking cessation is associated with reduced depression, anxiety, stress and improved mood and quality of life compared to people who continued to smoke.[17]

Smoking – cost to society

The estimated cost of tobacco sales in 2012 was £13 billion in the UK[18] with a total cost of smoking to society estimated at £13.7 billion[19]. Costs include loss of productivity at work, loss of economic output from the death of smokers, costs to the NHS and passive smoking among other factors. The cost to the NHS for treating diseases caused by smoking is approximately £2.7 billion.

UK market trends

Eighty-five per cent of the tobacco industry in the UK is dominated by two companies, Imperial Tobacco and Japan Tobacco International[19].

In 2012, overall sales of cigarettes fell by 6.4%, equivalent to an estimated £2.5 billion in cigarette sales. In recent years, there has been a decline in sales of premium cigarettes and corresponding growth in sales of economy-priced cigarettes, hand-rolled tobacco (HRT) and electronic cigarettes (e-cigarettes). Economy-priced cigarettes account for one in three cigarettes sold in the UK.

HRT sales have increased by 12% in 2012. Her Majesty's Revenue and Customs (HMRC) has estimated that 38% of all HRT smoked in the UK is smuggled, which is equivalent to £660 million in tax revenues lost. In the same year, the sales of e-cigarettes in the UK had increased from £2.5 million to £23.9 million.

The UK has some of the highest priced cigarettes and tobacco in the EU.

- Between 1980 and 2012 the retail prices of tobacco increased by more than 191%
- UK household expenditure on tobacco has more than trebled from £4.8 billion in 1980 to £18.7 billion in 2012[2].

Regulation of sales of tobacco product

Tobacco smuggling is a significant threat to UK tax revenues. HMRC collected £9.9 billion in duty from the sale of tobacco products in 2011-12[20]. HMRC estimates that duty was not paid on around 9% of cigarettes and around 38% of the hand-rolled tobacco smoked in the UK in 2010-11, with associated revenue losses of approximately £1.2 billion and £0.66 billion respectively[20].

About 80% of all councils had dealt with complaints and enquiries about illicit tobacco products. Of the 136 councils undertaking illicit tobacco work, 89% stated that some visits had resulted in the seizure of illicit tobacco products.

Trading Standards regularly carry out undercover operations involving a young person to check if premises sell tobacco to anyone under the age of 18. Any premises found to sell to young people are said to have failed. Of the 4,407 test purchase attempts made for tobacco nationally, sales were made at 506 premises. This equates to a failure rate of 12%, and continues a downward trend from 18% in 2008/09[20]. The largest proportion of visits resulting in under-age sales occurred at independent newsagents (16% of all) and the fewest at national newsagents (2% of all visits).

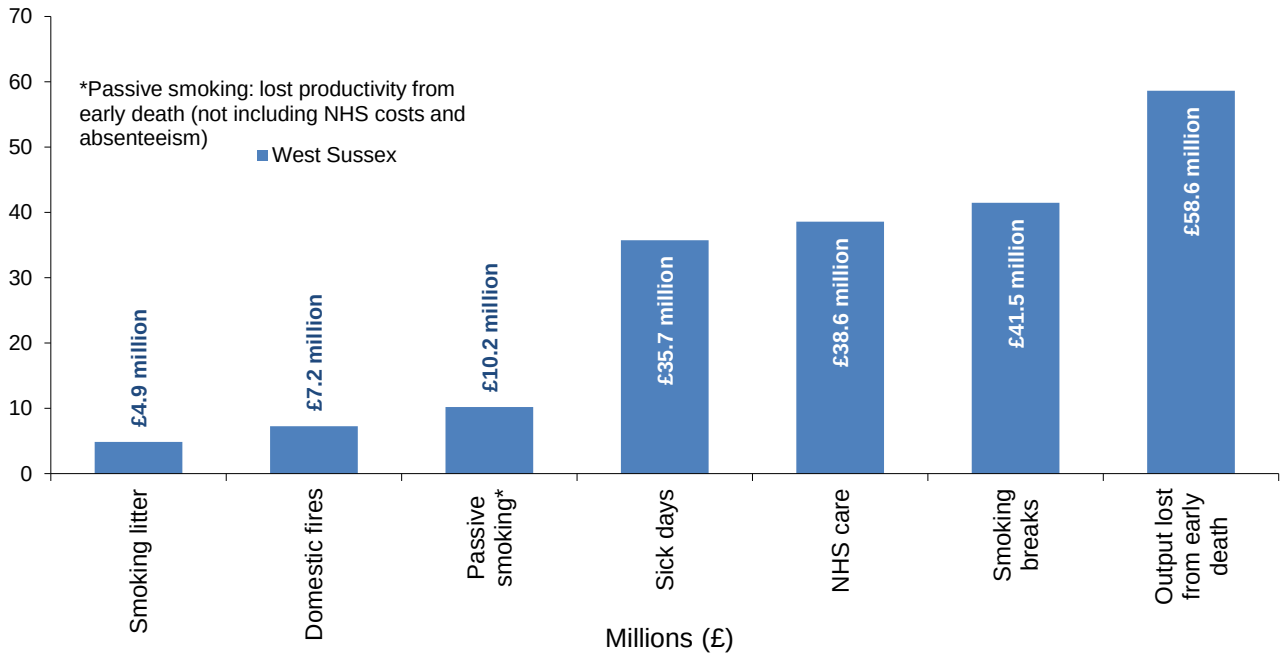
The West Sussex picture

Note: Smoking prevalence in West Sussex for the population and for people with routine and manual occupations are taken from the Integrated Household Survey (IHS). Results reported below should be viewed with caution as the data is based on small sample sizes and therefore volatile.

Smoking prevalence in West Sussex for 2012/13 in those aged 18 years and over is 19.1%. This is below the estimated national average of 19.5%[21] but higher than the previous year's estimate for West Sussex of 18.6%.

In West Sussex, smokers spent an estimated £210.8 million on tobacco[4] with an overall cost of smoking to society estimated to be £196.8 million.[4] Figure 5 shows the breakdown of cost. However, it is important to bear in mind that the financial implications from smoking are long-term in that cost resulting from morbidities is continuous and not included in the cost quoted above.

Figure 5 Estimated cost of smoking in West Sussex (£millions)



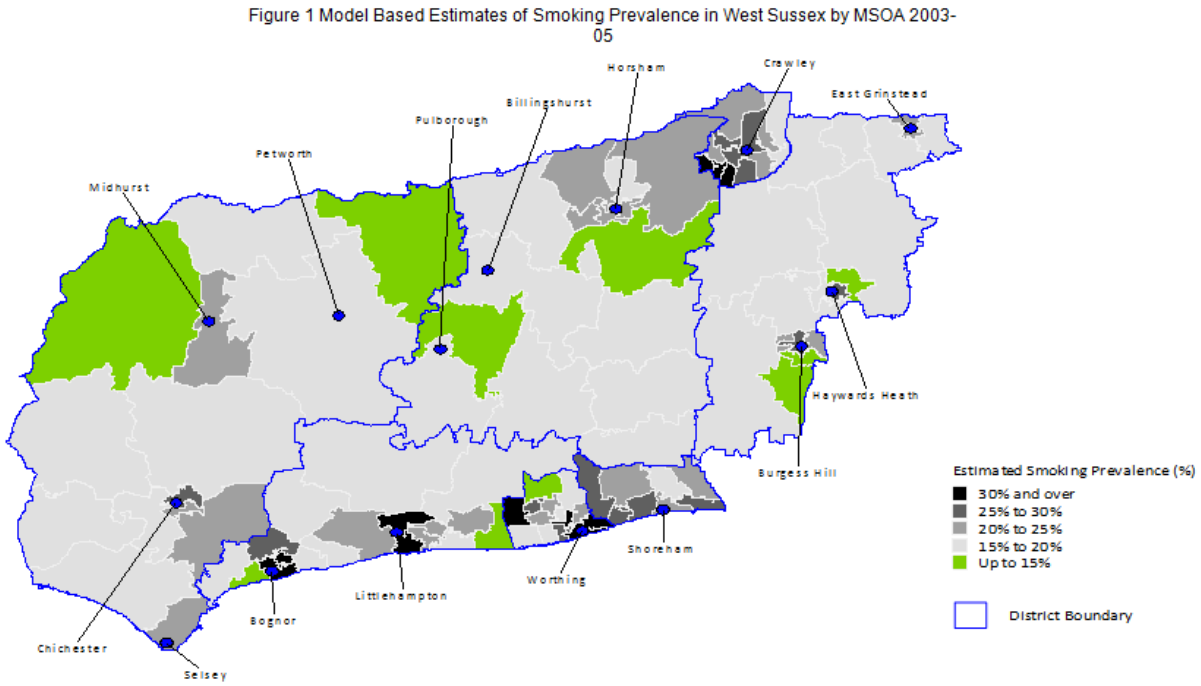
Source: ASH, The local cost of smoking 2013 Update, 2013

In 2010/11, the per capita cost of smoking attributable hospital admissions in those aged 35 and over is £32.50.[21]

The county wide smoking rate hides the considerable variation between areas across the county, with rates in some wards being as high as 34%[22]. Within Arun, Crawley and Worthing there are 12 middle super output areas (MSOAs), that have an estimated smoking prevalence of above 30%*

*MSOAs are a geographical boundary with a population within 5,000 to 15,000.

Figure 6 Smoking prevalence rate by MSOA



Source: ONS Neighbourhood Statistics Information on Healthy Lifestyle Behaviours: Model Based Estimates 2003-2005, 2008

Smoking in routine and manual workers

It is estimated that more than 22% of residents (aged 16 to 74) are in routine or semi-routine occupations[23]. Smoking prevalence in routine and manual workers in West Sussex has increased by 1.5 percentage points since 2009 up to 29.7%[21].

The high number of people in this occupation and who smoke indicate that smokers in these occupations are an important priority group. Between April 2012 and March 2013, 2,190 people with routine and manual occupations set a quit date in West Sussex. About 1,130 (51.6%) of these quit successfully[24]*.

** Quitting is defined as a smoker who has set a quit date and are recording as being off cigarettes at the 4-week follow up (either confirmed by carbon monoxide testing or self-reported)*

Smoking in pregnancy

At time of delivery (birth), 9.7% of mothers are smoking[21.] Between April 2012 and March 2013, 294 pregnant women set a quit date with 114 (38.8%) of them successfully quitting[24].

Table1 Outcome of pregnant women making a quit attempt between 2010/11 to 2012/13

	April 2010 March 2011		April 2011 - March 2012		April 2012 - March 2013	
	Number	**%**	**Number**	**%**	**Number**	**%**
Number who had successfully quit (self-report)	183	42.5%	188	46.4%	114	38.8%
Number not known/lost to follow-up	91	21.1%	99	24.4%	112	38.1%
Number who had not quit (self-report)	151	35.0%	118	29.1%	68	23.1%

Smoking in young people

The West Sussex lifestyle survey of 14-15 year olds[25] found that over 10% of girls and 8% of boys were regular smokers by the age of 15. This is a reduction since 2007[26]. Over 69% have never smoked. The survey found there were fewer young people smoking more than five cigarettes a day compared to three years earlier

About 16.8% of girls smoke occasionally and 10.1 % do so regularly. This compares to 12.9% of boys smoking occasionally and 7.8% smoking regularly.

Of the current smokers, over 70% had their first cigarette between the ages of 12 and 13. The age a young person starts smoking is a predictor of future smoking behaviour. The earlier a young person takes up smoking, the more likely they are to remain as regular smokers as adults. Of the eight year olds taking up smoking, 50% are thought to remain as regular smokers. This compares to 28% of 13 year olds remaining regular smokers as adults. However, numbers starting to smoke by age eight are much less than those starting to smoke at 13.

Parental smoking habits have a strong effect on smoking habits of their children. The West Sussex lifestyle survey shows a high prevalence of parental smoking with a third of all pupils reporting to have at least one parent/guardian who smokes. This is down from 2007 when 40% of those that smoked reported that at least one of their parents smoked[25,26]. Pupils who had a parent who smoked were over four times as likely to smoke regularly themselves as those who had non-smoking parents. Those whose parents do not smoke were 50% more likely to have never tried a cigarette.

Young people from a Local Neighbourhood Improvement Area (LNIA) were twice as likely to be a regular smoker compared with young people from other areas[25]. Appendix 2 shows the prevalence of 14-15 year old smokers by area (2010).

Smoking in black and minority ethnic groups

Census data, 2011, would suggest there are just over 16,500 smokers in the BME groups in West Sussex, but the numbers of them accessing the stop smoking service is below the nationally expected rate[27]. Smoking cessation activity for 2012/13 shows that only 601 people from BME groups in West Sussex approached the service and set a quit date. This represents 6.7% of the total number of people approaching the service[24]. This also represents 3.6% of smokers from BME groups accessing the service.

Illicit tobacco in West Sussex

In West Sussex, a total of 2,068 packets of cigarettes and 494 pouches of tobacco have been seized over a 6 month period in 2013/14[28].The estimated value of these seized products is £13,000.

**LNIAs were identified as part of the West Sussex Local Area Agreement (LAA) as areas where there needed to be targeted action to improve quality of life.*

Underage sales in West Sussex

Since April 1st 2012, Trading Standards have used 15 and 16 year old volunteers to attempt to purchase cigarettes at 62 premises. Of these, eight premises sold to the volunteers, which is a failure rate of 13%. This is close to the national figure of 12%.

In 2013/14, the largest number of underage sales was carried out in independent newsagents (16%) and the fewest at larger retailers (2%). However, the sales of underage tobacco have decreased particularly at petrol stations, small retailers and off licenses[28].

National and local policy

The Health and Social Care Act 2012[29] signalled the start of a new era for public health. The white paper "Healthy Lives, Healthy People"[30] outlines the new approach - empowering local communities to focus on the needs of the local population.

The "Healthy Lives, Healthy People: Tobacco Control Plan for England 2011"[31] sets out how tobacco control will be delivered under this approach. The three national priorities on tobacco control in which local authorities are encouraged to develop partnerships are:

1. **Reduce smoking prevalence among adults in England:** To reduce adult (aged 18 or over) smoking prevalence in England to 18.5% or less by the end of 2015, meaning around 210,000 fewer smokers a year.
2. **Reduce smoking prevalence among young people in England:** To reduce rates of regular smoking among 15 year olds in England to 12% or less by the end of 2015.
3. **Reduce smoking during pregnancy in England:** To reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth).

The Public Health Outcomes Framework[32] provides the key source of information to measure progress on reducing tobacco use. It sets the direction for public health and aims to promote better joint working with local organisations sharing common goals. Within this framework two high level outcomes have been set for local authorities:

- increased healthy life expectancy
- reduced difference in life expectancy and healthy life expectancy between communities.

A set of indicators to measure how we achieve the outcomes above have been grouped under four domains. Smoking and smoking related mortality plays a key role in two of these domains: health improvement and preventing premature mortality.

- Smoking is a major contributor to both high morbidity and mortality. Reducing adult smoking prevalence will contribute significantly to a reduction in this indicator [33].
- There is clear evidence for the disproportionate negative impact of tobacco use on poorer people. It is a major contributor to health inequalities.

Reducing smoking prevalence also impacts on a number of other indicators as outlined in Appendix 3. Smoking does not feature as an indicator in the NHS Outcomes Framework (NHSOF). However, smoking is featured as a contributor towards poor health. Under the NHSOF domain two – Preventing people dying prematurely comprises of two overarching indicators, which are potential years of life lost and life expectancy[34]. The NHSOF report looks at the contributors and drivers of premature mortality and notes that the continuing decline in smoking prevalence is likely to be one of the main drivers of gains in life expectancy over the next 50 years.

Recent developments

Advertising and promotion – standardised packaging of tobacco products

Following the Tobacco Advertising and Promotion Act 2002 virtually all forms of tobacco advertising in the UK are banned. This has led to tobacco companies relying on display of tobacco products in shops and on cigarette packs to attract customers.

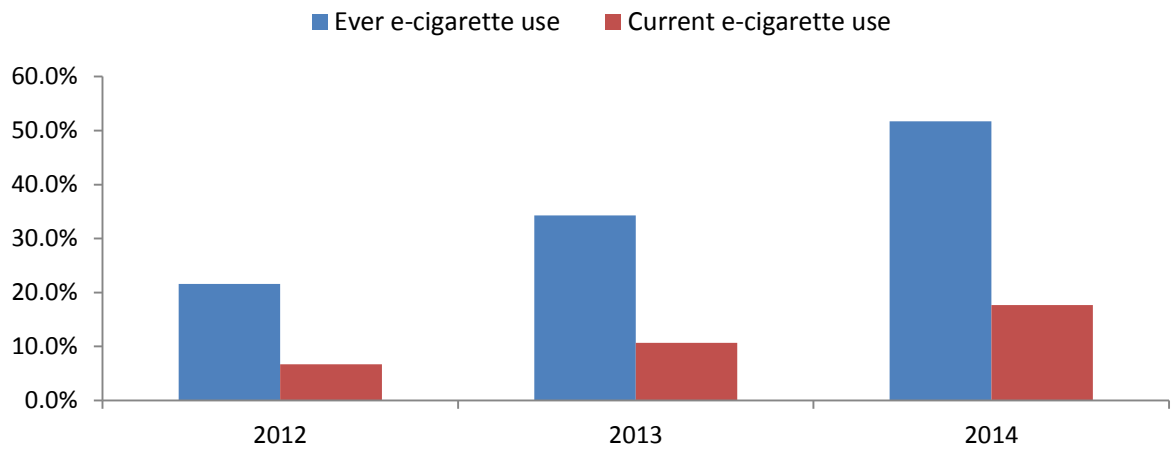
The current campaign for standardised packaging of cigarettes is another step in making cigarettes less attractive to children and young people. Standardised packaging refers to tobacco packages in unattractive packaging, devoid of branding and dominated by large health warnings. Exploring the options of standardised packaging is a key commitment under the 'Healthy Lives, Healthy People: A Tobacco Control Plan for England'.

An independent review by Sir Cyril Chantler was completed in March 2014. He found that plain packaging would result in a modest reduction in the uptake and prevalence of smoking and would have a positive effect on public health[35.] More recently, government published draft regulations for standardised packaging for consultation. Following feedback to the draft regulations, government will make a final decision on whether to go ahead with standardised packaging[36].

Electronic cigarettes

Electronic cigarettes, commonly known as e-cigarettes, are increasingly popular (Figure 7)[37]. E-cigarettes provide a hit of nicotine without the tar and toxins from tobacco found in conventional cigarettes. It comprises of a battery, atomiser and a cartridge suspended in a solution of propylene glycol. When the user inhales, the solution is vaporised and delivers nicotine.

Figure 7 Percentage of cigarette smokers using e-cigarettes between 2011 and 2014



Source: ASH, Use of electronic cigarettes in Great Britain, April 2014

Spending on e-cigarette promotion in the UK increased from £1.7 million in 2010 to £13.1 million in 2012[38]. While there are concerns that they are used by non-smokers and young people, a survey has found that users of e-cigarettes are mainly smokers and ex-smokers. About 0.5% of the population who use e-cigarettes are non-smokers. The majority use them as a way to quit while others use it as a way to reduce their tobacco consumption without stopping completely.

E-cigarettes have provoked mixed reactions on their usage for helping people quit. Although nicotine is addictive, the health harms associated with it are minimal. However, the long-term health impacts of inhaling nicotine and propylene glycol are still unclear. One of the other concerns is that as e-cigarettes can be advertised and can be inhaled indoors, it may undermine all the work done so far into smoke-free laws and advertising bans on tobacco products.

The NICE guidelines currently do not recommend the use of e-cigarettes as a nicotine product to stop smoking as they are currently unregulated with little evidence into their effectiveness.

There are also concerns over the safety of e-cigarettes as they are unregulated, particularly surrounding the ingredients used and nicotine content. However, as of 2016, e-cigarettes will be regulated by the Medicines and Healthcare Regulatory Authority (MHRA) as a medicine so that it can be quality controlled.

In January 2014, the government announced that under-18s will be banned from buying e-cigarettes. The law, which is being introduced as an amendment to the Children and Families Bill, will also ban adults from buying on behalf of under-18s.

Shisha

Waterpipes, also known as shisha, hookahs or hubble-bubble pipes are increasingly popular in the UK. There is little research into shisha use but evidence suggests that prevalence amongst university students lies between 7% and 11% while 12% of secondary students smoke, which is double the prevalence of cigarette use[39,40].According to a WHO report, smokers using waterpipes are exposed to more smoke over a longer period of time than occurs with cigarette smoking[41]

The common misconception is that smoke from waterpipes is safer than cigarettes. While research into waterpipes is limited, there is increasing evidence to suggest that waterpipes are associated with many of the same risks as cigarette smoking including lung cancer and respiratory illnesesses[42,43].

Waterpipe smoking is covered by the smokefree laws while packaging of waterpipe products are also subject to the same regulations as other tobacco products in the UK. However, most shisha tobacco in the UK is illicit and health warnings tend to cover less than 3% of the packaging rather than the recommended 30%.

A product that is increasingly becoming popular among young people is e-shisha. Like e-cigarettes, they are battery operated devises containing fruit flavourings and some devises do contain varying degrees of nicotine. They are unregulated and similar to e-cigarettes, there are concerns on the safety and health impacts of these products. There is very little evidence on e-shisha to support the use of these products.

Smokefree cars with children

It is estimated that the costs of treatment by primary care services for children suffering from conditions caused by exposure to other peoples smoke is around £10 million with hospital admissions costing a further £13.6 million[44]. This doesn't include impact on health of adults exposed to secondhand smoke.

Currently, the law prohibits smoking in vehicles used for work. From January 2014, following lobbying by members for parliament (MPs), the Children and Families Bill now includes a proposal to ban smoking in cars carrying children. In February 2014, MPs voted in favour of the ban. This empowers, but does not compel government to introduce legislation to ban smoking in cars carrying children.

Tobacco Control Declaration

Local councils across the country have been encouraged to sign up to the Tobacco Control Declaration. The declaration commits councils to take comprehensive action to address the harms from smoking. This includes action to reduce smoking prevalence, work with partners and protect tobacco control work from the tobacco industry. To date, 25 local councils have signed up to it. In addition, there is also a NHS Statement of Support, which will provide the health sector (including CCGs) the opportunity to demonstrate their commitment to tobacco control.

National campaigns

The information below outlines the Public Health England (PHE) national tobacco control campaigns that are supported in West Sussex with local promotional events and media:-

Stoptober – Stoptober is a national campaign to encourage people to stop smoking for 28 days. This is based on research findings that suggest those who quit smoking successfully for four weeks are five times more likely to remain smokefree. In 2013, the national campaign resulted in 250,000 signups to quit smoking over 28 days. Of the residents signing up to Stoptober 335 chose to be supported through the West Sussex Stop Smoking Service. This resulted in 167 residents (49.8%) successfully quitting as a result. However, this number will likely be an underestimation of the numbers quitting as there will be people quitting without the support of the service during Stoptober.

No Smoking Day – No Smoking Day is an annual national health awareness campaign held in March. Every year, over one million people in the UK will use No Smoking Day to try to quit.

Health harms campaign – This campaign commenced in December 2012 to increase awareness of the damage caused by every single cigarette. The campaign runs annually from December through to March with a particular emphasis on encouraging smokers to quit in the New Year. Smokers are encouraged to collect a quit kit from their local participating pharmacy. The first campaign (2012-2013) achieved 92% awareness, the highest of any Smokefree campaign in five years. Thirty-four per cent of those that saw the ads took some action either ordering the kit, stopping smoking or talking about it with family and friends. Four hundred and sixty thousand quit kits were distributed.

Smokefree homes and cars secondhand smoke campaign – This annual campaign launched in 2012 with the next campaign expected to commence in March 2015. The messages remind smokers about the dangers of secondhand smoking on their families and encourage smokers to order a Smokefree kit. The 2012 campaign achieved 84% awareness with 37% of people who saw the ads taking some action to order a kit, stop smoking or talk about it with family and friends. PHE distributed 84, 596 Smokefree kits. Overall 6% of people who saw the ads made a quit attempt[45].

How will we approach tobacco control in West Sussex?

The tobacco control plan for England released in 2011 supports action across the six internationally recognised strands established by the WHO in 2008[31]. The six strands are:

- Stopping the promotion of tobacco
- Making tobacco less affordable
- Effective regulation of tobacco products
- Helping tobacco users to quit
- Reducing exposure to second hand smoke
- Effective communications for tobacco control.

Achieving the percentage change set out in the plan (and other national/county level documents with tobacco control priorities) will require systematic programmes of action to implement interventions that are known to be effective. This will ensure that they are reaching as many people as possible who could benefit[30].

> *"The mission of comprehensive tobacco control programs is to reduce disease, disability and death related to tobacco use. A comprehensive approach _ one that optimizes synergy from applying a mix of educational, clinical, regulatory economic and social strategies has been established as the guiding principle for eliminating the health and economic burden of tobacco use "*
> *US Surgeon General cited in the Tobacco Control Plan.*

The driving ethical principle of tobacco control is that of fairness. A fairness for children and young people to grow up in an environment where smoking is not seen as the norm, for smokers to get help to quit (as the majority wish to do), and for people to live and work without being exposed to the hazards of second hand smoke[38].

Ten high impact changes for tobacco control

Ten high impact changes for tobacco control have been identified to support the six strands[38] .These strands are very closely linked and locally, they need to be developed to ensure that they work well together. The ten high impact changes are as follows:

1) Working in partnership is the building block for success
2) Gather and use the full range of data to inform tobacco control
3) Use tobacco control to tackle health inequalities
4) Deliver consistent, coherent and coordinated communication
5) An integrated stop smoking approach
6) Build and sustain capacity in tobacco control
7) Tackle cheap and illicit tobacco
8) Influence change through advocacy
9) Helping young people to be tobacco free
10) Maintain and promote smoke free environments

Delivery of tobacco control in West Sussex

The Smokefree West Sussex Partnership delivers work programmes and supports other partners in reducing smoking prevalence in West Sussex. The Smokefree West Sussex Partnership is a multi-agency group that includes Public Health, Wellbeing Hubs, Stop Smoking Services, Respiratory Nurses and Trading Standards that work together to implement this plan.

In order for the Smokefree West Sussex Partnership to be successful, all partners need to agree on local goals for tobacco control and work with different partners in a coordinated way.

Ten high impact changes for tobacco control in West Sussex

1) Working in partnership is the building block to success

A successful partnership is central to moving the tobacco control agenda forward. A comprehensive tobacco control programme involves multiple agencies and a clear commitment from senior officers at each partner organisation.

The aim of a Smokefree West Sussex Partnership is to have a range of partners across the local area that are committed and active in making their own contribution to reducing the impact of smoking on health and health inequalities.

Evidence from the North East[46] shows three key factors underlie an effective tobacco control partnerships:

- A clear but detailed purpose that enables each of the partners to identify the importance of their and their organisation's contribution.
- Coordination by a "neutral" officer. A neutral officer is not seen as entirely within the structure of any one member organisation. However, in all likelihood this person is unlikely to come from outside one of the member organisations, but the way they approach the work and partnership relations must portray neutrality.
- Dedication of managerial time and attention to developing effective working relationships and a shared sense of mission across Smokefree West Sussex Partnership members.

The 2007 Healthcare Commission on tobacco control services, cited in the high impact changes, revealed that the areas with the highest proportion of quitters compared with smokers achieved a score of "excellent" in the key review area of partnership working.

What West Sussex is doing already to address this priority

In West Sussex, we have a Smokefree West Sussex Partnership which is a multi-agency partnership. Terms of reference have been reviewed recently to ensure all partners are clear of their organisation's contribution towards the Smokefree West Sussex Partnership (Appendix 4). In 2014, membership increased and now includes partners from the wider public health community. Partners of the Smokefree West Sussex Partnership include:

- Solutions 4 Health (specialist smoking cessation provider for Smokefree West Sussex stop smoking service)
- Tobacco Control, Public Health, West Sussex County Council
- Healthy Schools, Public Health, West Sussex County Council
- Wellbeing Hubs from all districts
- Trading Standards, West Sussex County Council
- Respiratory Nurses from Worthing Hospital
- Workplace leads from District and Borough Councils
- West Sussex Fire and Rescue Service (joined 2014)
- Human Resources (HR), West Sussex County Council (joined 2014)
- Mental Health Services – Sussex Partnership NHS Foundation Trust (joined 2014)
- Midwifery, Western Sussex Hospitals NHS Foundation Trust (joined 2014)

2) Gather and use the full range of data to inform tobacco control

A systematic approach to identifying what data intelligence is needed to enable the Smokefree West Sussex Partnership to carry out their priorities is essential. However, it is about more than just data. It is about gathering intelligence and using innovative approaches to translate the available knowledge into informed planning, commissioning and tailored messages for the local population.

Collecting robust intelligence across organisations informs local tobacco control activity and helps to ensure that efforts are focused in the right parts of the county.

The full range of data available – international, national, regional as well as local should be used. Data is not all about quit rates, it must include data from surveys about behaviours and attitudes, feedback from local events and programmes, and that from the full range of partners.

Implementing this change will result in local data being available that will, in time, show how effectively local tobacco control plans are targeting the high risk, hard to reach groups. In 2014/15, we want to achieve 795 four week quits from our priority groups (excluding pregnant women) 100 four week quits from a pregnant woman and increase the number of quits by approximately 10% annually for both groups to 2017.

What West Sussex is doing already to address this priority

The table below outlines the data and information used in West Sussex.

Type of data/Information	**Use in West Sussex**
Smoking Prevalence	Data from national surveys such as the Integrated Household Survey are used to give an indication of smoking prevalence at district and county level.
National guidelines on tobacco control	Use of NICE, PHE and other national reports to inform tobacco control work in West Sussex. This includes current guidelines on behavioural change and e-cigarettes
Quit rates, demographic profile of people accessing the service, information on the provider the public used to access service i.e. GPs, pharmacies and the specialist service	Data, based on the PHE gold standard monitoring report, is collated by Solutions 4 Health across all West Sussex service providers and will be used to monitor progress of quit rates and improve the service provision such as ensuring the specialist clinics are accessible to the hard to reach and hardly reached service users.
Information on smoking behaviour and attitudes	1. Use of national reports and journals to keep up-to-date on smoking behaviour 2. The West Sussex Public Health Research Unit are publishing a 14-15 year old lifestyle report, which will highlight smoking behaviours among young people
Identifying local communities to target and to run promotional events	1. Use of 2011 census on demographic profile of the county including BME distribution 2. Using information from local networks and groups to identify local communities

3) Use tobacco control to tackle health inequalities

Addressing inequalities in health through tobacco remains a huge challenge. Tailoring tobacco control work according to the needs of these untapped groups will continue to be the most effective way of tackling health inequalities.

We also understand that young people with parents who smoke are over 4 times as likely to smoke themselves as those with non-smoking parents. Therefore, intervention at the earliest possible stage in life, like helping pregnant mothers to quit and through programmes like ASSIST-Decipher aimed at 12-13 year olds, and have a significant impact on reducing the uptake of smoking in young people.

It will be important that we identify those groups most susceptible to health inequality and tailor interventions to support them. Specialist stop smoking support will be a significant contributing factor to reducing health inequalities and remains a key intervention in reducing smoking in the untapped groups. Specialist support combined with a targeted social marketing approach provides the greatest opportunity to reach out to high smoking prevalence groups.

What West Sussex is doing already to address this priority

1. We have developed a population specific tobacco control programme directed at the hard to reach groups. Public Health have commissioned Solutions 4 Health to target these high risk groups including:
    a. routine and manual workers
    b. pregnant mothers and their partners
    c. black and minority ethnic (BME) groups
    d. young people (under 25)
    e. smokers with at least 5 unsuccessful quit attempts
    f. residents of deprived areas
    g. mental health service users in the community

    This will include identifying and providing support to these target groups. A mobile unit will also be utilised to bring the service to the local area particularly in deprived parts of the county and areas with high BME population to encourage residents to quit smoking.
2. Data from the 2011 census and reports have been used to identify areas that have high populations of target groups. The West Sussex 14-15 year old lifestyle survey 2010 has been used to understand attitudes and smoking behaviours among young people in the county with an updated report due by the end of 2014.
3. In addition to carrying out county-wide campaigns, we also target specific communities and organisations for local participation. For example, a local college and factory took part in the 2014 No Smoking Day campaign targeting young people and routine and manual workers.
4. The Council's Public Health unit have been contacting local partnership networks to request information on local communities to tailor the service accordingly through provision of new clinic venues and to arrange for the mobile unit to visit these communities.
5. Specialist smoking cessation services have initiated a programme to support mental health patients and staff to quit smoking. This is a pilot programme with an aim to identify the best way to support patients to quit smoking successfully.

4) Deliver consistent, coherent and coordinated communication

A coordinated and strategic approach to local communication is central to increasing the effectiveness of the national campaigns within West Sussex. It is vital for social marketing and tobacco control advocacy to play a central role in this (see section 8).

Effective communication about the harms of tobacco use is central to comprehensive tobacco control. There is a strong international evidence base[39] for the role of marketing communications and mass media in reducing smoking prevalence and so they remain important levers in influencing behaviour.

Marketing communications for tobacco control have centred on three key objectives:

- reinforcing the motivation of smokers to quit
- triggering quitting action
- making quitting more successful by signposting people to the most effective support available.

The Public Health England annual marketing plan[47] clearly states that their approach is based on social marketing principles. The expectation is that this is mirrored at a local level. It is important that communication reflects central messages and uses smoke free national branding.

> *"Social marketing is the systematic application of marketing concepts and techniques to achieve specific behavioural goals relevant to a social good. Health-related Social marketing is the systematic application of marketing concepts and techniques to achieve specific behavioural goals relevant to improving health and reducing health inequalities."*
> ***Department of Health definition***

Establishing a communications strand as part of a strategic approach to tobacco control is vital and should consider both internal and external communications.

- Internal communication to ensure that all partners are on message.
- External communication to ensure that clear and consistent messages around tobacco control are being relayed to the general public.

Our marketing strategies should consider the following approaches which have been proven to be effective in changing behaviour:

- develop marketing platforms not campaigns
- coach and motivate, not nanny or hector
- take an open source approach to developing and promoting high quality work
- utilising new technology and media opportunities to full potential
- maximising our impact on health inequalities.

Communication campaigns serve to link the elements of the tobacco control programme, raise public awareness of tobacco issues, and build public support for tobacco control as an appropriate response to the tobacco epidemic. Local

level communication needs to be clear and efficient and augment national campaigns.

What West Sussex is doing already to address this priority

- Marketing communications in West Sussex are centred on motivating smokers to quit, providing information on the effectiveness of the service and contact details of the service. This includes all press releases, information on the Smokefree West Sussex website, leaflets and campaigns.
- A suite of print resources have been developed to appeal to specific segments of the population including young people, pregnant mothers and older people that promote the benefits of quitting smoking and using the Stop Smoking Service.
- Regular contact with regional PHE staff and information from national strategies are used to ensure that the key messages we produce are in line with the national direction.
- A focus for 2014 will be to develop the Smokefree West Sussex social media tools and utilise this medium across our Smokefree West Sussex Partnership to extend the reach of our messages within the community and promote the service.
- The Smokefree West Sussex Partnership have commenced work on marketing and communication strategies to support the national Stoptober campaign.
- The Smokefree West Sussex Partnership are working to improve the way they communicate to the public by ensuring messages about smoking prevalence are consistent across all communications and meet with social marketing principles. The Public Health department within the Council is coordinating this effort.

5) An integrated stop smoking approach

The WHO Framework Convention on Tobacco Control outlines effective implementation of tobacco control measures that combine stop smoking services and wider tobacco control.

Stop smoking services that combine face-to-face behavioural support and pharmacological support (nicotine replacement therapy, Champix), as within the NICE guidelines have been found to be an effective health intervention, particularly with disadvantaged smokers[48].

Stop smoking services will be provided by professional stop smoking advisors from a specialist service provider, general practices and pharmacies. However, these services cannot be seen as the sole agency that can deliver tobacco control. Alone they will not be able to reduce prevalence on the scale that is required. Stop smoking services have the knowledge and expertise in smoking cessation practices and can advise and train other partners (health and non-health professionals) on the role they can play within the community in tobacco control. These partners of the local tobacco control programme need to support the service through promotion and referral.

Large scale collaboration across the wider public health community will be necessary to promote brief interventions and referral as widely as possible. An integrated stop smoking approach highlights the importance of embedding the idea that quitting smoking is not only achievable and desirable, but an outcome that should be encouraged and supported by all organisations.

Helping people to quit should be everyone's business. Non-health professionals working with community members on a daily basis should be educated about the benefits of quitting smoking and trained on giving very brief advice to smokers and carers so they are comfortable with starting the conversation and encouraging them to quit with support.

What West Sussex is doing already to address this priority

In West Sussex, Council have commissioned a specialist stop smoking service to target hard to reach groups identified in section three. The specialist provider has a greater role in leading tobacco control in West Sussex and working with partners. Council has also renewed the enhanced services agreement with general practices and pharmacies to provide stop smoking services.

We are also working with organisations to encourage very brief advice (VBA) at every possible opportunity with their service users and educate them of the referral pathway into the service. A number of initiatives are already in place including:

- Public Health and the specialist stop smoking service work with the Wellbeing Hubs for all districts refer people into the service and to work together in organising campaigns
- Public Health and the specialist stop smoking service collaborate with schools to deliver tobacco education. This includes integrating best practice for staff and students who are smokers
- We have developing information (referrals, supporting our campaigns as well as access to training and resources) for the voluntary sector to support their customers to quit.
- A dedicated helpline for Smokefree West Sussex has been moved to the specialist stop smoking service provider to streamline the user experience from the first point of contact with the service.
- Levels 1 and 2 smoking cessation training and bespoke training courses are offered to organisations by the specialist stop smoking service. Training is in line with National Centre for Smoking Cessation and Training (NCSCT) guidelines.

6) Build and sustain capacity in tobacco control

To maintain progress and momentum, capacity building is essential.

Capacity building is about developing people's skills and providing the right tools, building networks and training leaders, collaboration and collecting local data and knowledge to provide an understanding of the local community. Concentrating on how to expand the infrastructure of a local Smokefree West Sussex Partnership can only help efficient delivery of tobacco control in the area.

The key aim is to engage with the right people and to keep them interested in the tobacco control agenda by providing them with new information relevant to meeting their business objectives so as to ensure their interest translates to action at every opportunity. We should ensure:

- we target key decision makers to fulfil the role of trained and educated ambassadors and champions who can sell the whole tobacco control message from executive level to grass roots level
- The Smokefree West Sussex Partnership should ensure the NCSCT approved level 1 and level 2 training is a key organisational priority for their organisation and accessible to local staff

What West Sussex is doing already to address this priority

- Public Health presented to the Health and Wellbeing Partnership for Adur and Worthing as well as for Crawley to promote joint working by informing them of the impact successful tobacco control can have on their local area. Public Health is responding to a number of actions identified during the meeting that will support hubs with tobacco control such as information on how local district staff can encourage people to quit smoking and refer people into the service.
- The West Sussex specialist smoking service provider, Solutions 4 Health, offers level 1 and 2 NCSCT approved training throughout the calendar year to GP and pharmacy stop smoking advisors. This includes training for new advisors as well as refresher training. Level 1 and 2 training will be available to any healthcare and non-healthcare professionals wanting to provide very brief advice (VBA). The provider will also offer bespoke training for organisations and addressing smoking prevalence in some target groups.
- A dedicated GP and pharmacy coordinator provided by the specialist stop smoking service will be working to support GP and pharmacy staff in developing an efficient service.

7) Tackle cheap and illicit tobacco

Making tobacco less affordable is proven to be an effective way of reducing the prevalence of smoking. Young people, pregnant women and people from lower socio economic groups are particularly sensitive to price.

The health gain from high priced tobacco can be undermined if the illicit market in tobacco products is allowed to thrive at the expense of legal, duty paid products.

Tobacco smuggling and subsequent supply, undermines the impact of other tobacco control measures. It is a cross cutting issue that needs engagement from a range of partners. To maximise the impact of tackling cheap and illicit tobacco both supply and demand need to be addressed. Both elements have their challenges, but success in reducing the illicit share of the tobacco market helps reduce organised crime in local communities, reduce potential revenue loss to the Treasury and support legitimate retailers.

As mentioned previously, the primary source of tobacco for young people is changing. Young people tend to get other people to purchase tobacco for them. This is an area that needs to be addressed. There is a strong suggestion of a role for youth advocacy within local alliances.

Enforcement activities should also include these products such as shisha tobacco. From 2016, e-cigarettes will be regulated by the MHRA. There is ongoing debate about the role of these products in tobacco control.

Research on techniques about the best messages to give out locally includes focusing on reminding buyers that illicit tobacco is helping them to stay addicted to smoking for potentially much longer than if they were buying cigarettes legitimately. There is little point in driving home messages about breaking the law or cigarettes being harmful as they have little resonance with this group.

Social marketing, rather than mass media is a better approach as this group of smokers are sceptical that messages seen coming from the government represent the taxman. Marketing on illicit tobacco needs to be complemented by information on the support available for people who want to quit.

It is important to steer clear of the idea that genuine tobacco is "safer" than fake versions. Cigarettes kill half of all smokers whether they are legal or illegal and promotion of messages that illicit tobacco is more harmful could have serious repercussions for overall health messages about the impact of smoking. The fact is all tobacco is harmful to health.

What West Sussex is doing already to addressing this priority

Trading Standards in West Sussex is continuing to carry out raids on retailers selling illicit tobacco as well as test purchasing on underage sales of tobacco. They have also produced an online reporting form, which allows members of the public to report on risky retailers.

8) Influence change through advocacy

Tobacco control advocacy is about changing the political, economic and social conditions that encourage tobacco use. It seeks to gain public, political and media support for tobacco related issues.

An advocate is defined as someone who acts on behalf of a person, group or interest; advocacy is about winning support of key constituencies in order to influence policies and spending and bring about social change.

Advocacy can be used to inspire and generate growth in public support to bring about change. At its simplest level advocacy means making efforts to persuade others to take some type of action. But tobacco control advocacy is about more than getting stories in the media, although the media is probably the most influential advocacy vehicle that exists.

This includes changing the conditions that encourage tobacco use with the ultimate aim of denormalising tobacco use and changing social norms. Advocacy activity should be integrated into the overall communication campaign.

What West Sussex is doing already to addressing this priority

- Updating Smokefree West Sussex Partnership members with recent news on tobacco control both locally and nationally.
- Presentation to local Health and Wellbeing Partnerships to get their support on tobacco control.

9) Helping young people to be tobacco free

Tackling youth smoking as a stand-alone intervention will probably have little impact. Youth prevention should be part of all of the other strands of work in a comprehensive tobacco control programme based on denormalising smoking as a habit.

NICE guidance recommends five approaches including whole-school, adult-led and peer-led interventions[49]. PH Guidance 14[44] makes recommendations to prevent the uptake of smoking by children and young people through mass media and point of sales measures. Mass media campaigns for young people should be informed by research that understands the target audience and considers groups that have a higher than average or rising rate of smoking prevalence.

Campaigns should convey messages based on research with target audiences which could:

- elicit a strong, negative emotional reaction while providing sources of further information and support
- portray tobacco as a deadly product, not just as a drug that is inappropriate for children and young people to use
- use personal testimonials that children and young people can relate to
- be presented by celebrities to whom children and young people can relate to
- empower children and young people to refuse offers of cigarettes
- include graphic images portraying smoking's detrimental effect on health as well as appearance.

Campaigns should exploit the full range of media used by children and young people, including television advertising. For campaigns to be effective, a long-term approach that runs for 3 -5 years needs to be adopted. Campaigns should use process and outcome measures to ensure campaigns are being delivered correctly and effectively.

Young people tend to respond to social trends. They want the facts so that they can make up their own mind rather than being told the rights and wrongs. Social influence is probably the best intervention.

Young people start to smoke in spite of the best efforts of parents and health educators. By working to reduce adult and parental smoking the risk for children and young people may be reduced[50]. Decreasing the number of sources available to children will make it easier to focus on the areas where they can still buy tobacco.

The NICE Public Health Briefing Document of 2012 recommends that local authorities ensure environmental health and trading standards services prioritise tobacco control, and that they enforce legislation on tobacco in accordance with their statutory role and best practice. This includes conducting and auditing test purchases, providing training for retailers and prosecuting those who break the law.

What West Sussex is doing already to addressing this priority

ASSIST is a peer mentoring programme where Year 8 students are trained to speak to their peers on the harms of smoking. West Sussex has the largest number of schools participating in ASSIST in the country. In 2013/14, the ASSIST programme ran in ten schools with a further four schools expected to run the programme this year.

Some of these schools have expanded their tobacco education to include smoke-free policies in schools. In addition, we are working with schools to run PSHE lessons and activities as part of their Healthy School status.

Solutions 4 Health will be focusing on prevention as well as reducing the number of smokers. Parallel to the ASSIST programme, they will be developing and working with schools to offer tobacco education and run activities such as competitions and use of mediums familiar to young people (videos, social media) to engage with them.

The Smokefree West Sussex website (http://www.smokefreewestsussex.co.uk/) will contain content specifically for young people. It will serve as a youth-led platform to reveal the myths around smoking, challenge social norms and to provide an environment for them to share their thoughts on smoking.

10) *Maintain and promote smoke free environments*

The 2007 Smokefree legislation gave momentum to the profile of tobacco control. A concerted effort is required to sustain this if the significant benefit from de–normalising smoking is not going to be lost.

A comprehensive smokefree policy is the only approach that has been shown to be practical and effective in protecting people from harm from secondhand smoke exposure.

People are now most likely to be exposed to the harmful effects of secondhand smoke in their own homes and private motor vehicles. Exposure to second hand

smoke causes a range of diseases. Children are particularly vulnerable to the harms of secondhand smoke.
The Tobacco Control Plan for England[31] wants people to recognise the risks of secondhand smoke and decide voluntarily to make their homes and family cars smoke free. In addition, Public Health England marketing strategy[47] for tobacco control sets out details of how they will support efforts by local areas to encourage smokefree homes and family cars.

NHS organisations and local authorities may voluntarily wish to make non enclosed parts of their properties smokefree, particularly where people can't otherwise avoid being exposed to secondhand smoke such as around the entrances to buildings.

A recent NICE guideline recognises the health benefits of supporting smoking cessation and introducing smokefree policies for people using secondary care[44]. A growing number of hospitals are starting to adopt these recommendations.

Local communities may also want to go further than the smokefree law requirements in creating environments free from secondhand smoke such as playgrounds, outdoor parts of shopping centres and venues associated with sports and leisure activities. These types of activities can help shape positive social norms and discourage use of tobacco.

Amendments to the Children and Families Bill in January 2014 provided government with the power to introduce regulations banning smoking in private vehicles when a child is present. In February 2014, MPs voted in support of the amendment, which empowers ministers to introduce the ban.

What West Sussex is doing already to addressing this priority
Smokefree legislation like other parts of the country is well established in West Sussex with Environmental Health responsible for ensuring that organisations comply with the regulation.

The smoking ban in cars carrying children will be effective from 2015. Measures will need to be in place in West Sussex ahead of the new law. This will include public relations activities to inform the public. As part of the campaigns planned for 2014/15, we will also be supporting the national Smokefree Homes and Cars campaign to highlight the financial, safety and social benefits of having a smokefree environment. West Sussex has committed to having smokefree play areas and an evaluation is needed to be done on the effectiveness of it in deterring parents or adults from smoking in the play areas.

Monitoring and evaluation

The action plan on page 38 details how we will address the ten high impact changes at an operational level. The success of this plan will help West Sussex meet the key challenges identified in the "Public Health Plan 2012-2017". That is, to reduce smoking prevalence in young people and adults, including smokers during pregnancy.

Monitoring and evaluation of this plan will not be based solely on the reduction of smoking prevalence in our target groups and general population, or preventing the uptake of smoking in West Sussex. Our success will also be measured on how well we have implemented the actions/performance indicators outlined in the action plan and how they have met the objectives.

Public Health will report on the progress of the plan to the Cardio Vascular Disease Reduction Strategy Group who has oversight of the "Keeping Yourself Healthy" chapter.

Public Health will also report, via the public facing dashboard, our progress on targets set for adult and pregnant women four week quits and will continue to provide Public Health England with smoking cessation data which is also made publicly available.

The Smokefree West Sussex Partnership will collectively take responsibility for the monitoring and evaluation of this plan. The Smokefree West Sussex Partnership will regularly review the work they are doing and discuss what is working well at a local level. This involves regular monitoring of the progress of the actions/performance indicators as set out in the plan against the objectives so we can evaluate and benchmark our progress now and in future years.

Action Plan: September 2014 – September 2015

Work in Partnership			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**

Smokefree West Sussex Partnership (SWSP) membership reviewed to ensure appropriate membership	Contact organisations:- business representative organisations, environmental health, fire services, workplace HR lead, CFC, mental health organisations and voluntary organisations.	Public Health	October 2014
		All SWSP partners	October 2014
Clear objectives developed for the SWSP and roles defined for each of the SWSP member	Refresh terms of reference to include clear objectives for the SWSP. Define the roles of each of the SWSP members in the context of achieving the SWSP objectives. Discussion and write up of how organisations contribute towards SWSP objectives. Distribute so that each partner is aware of what other partners have committed to doing.	All SWSP partners All SWSP partners	October 2014

Gather data to inform tobacco control			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Local data sources identified	Work across SWSP partners and other agencies to identify the type of data they hold that could inform future tobacco control strategies and assist with evaluation of the plan.	Public Health	August 2014
	List data sources and date of release (if regular) for monitoring purposes. This includes PHOF, ASCOF, NHSOF, QoF data, Integrated Household Survey and 14-15 year old Lifestyle Survey – list to be used to monitor changes in smoking behaviour and prevalence in the county. Results to be shared with SWSP partners.	Public Health	September 2014 February 2015
Completion of Stop Smoking Services health equity audit	Identify hotspots, which are: 1. areas with high prevalence of smoking i.e. youth prevalence of smoking using data from the 14-15 year old Lifestyle Survey 2. exposure to sales of tobacco products i.e. map of premises selling tobacco products and schools	Public Health Stop Smoking Service	December 2014 Quarterly
SWSP members are kept up-to-date of SSS and other SWSP partner activities	Write-up of report to include demographics, analysis of smoking prevalence and any issues with the service. Use report to identify areas for improvements to the service and to plan towards tailoring workstreams towards identified target groups/areas SSS to present quarterly activity data analysis at each SWSP meeting SWSP members to present at SWSP meetings data that is relevant to influencing the actions of the Smokefree West Sussex Operational Plan or can assist with evaluation of the plan. This may include data from the wellbeing programmes, Fire and Rescue	Stop Smoking Services All SWSP partners	Ongoing

	Services and Trading Standards activity		

Use tobacco control to tackle health inequalities			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Number of people from targeted groups accessing SSS services increased – BME groups, pregnant mothers, people in routine/manual occupations, people living in deprived areas, people with mental health conditions and young people	Use Census and NHS data to identify areas of high concentration of target groups Identify networks and community groups specific to target groups SWSP to tailor awareness campaign to the specific groups. SSS to send mobile units to identified areas. All partner organisations in these areas actively signpost to SSS GP practice baby clinics and community ante-natal clinics to have smoking prevention events Develop links with BME communities and organise regular events within their religious groups/community venues to raise awareness of the harms of smoking and promote the service Work with mental health providers to support their staff and customers to quit smoking. Develop a support system that works around individual needs Work with Children and Family Centres to raise the profile of smoking cessation by training staff and encouraging staff to refer parents to the service Increase the number of community venues for drop-in/group sessions in deprived areas and areas of high smoking prevalence rates. Contact workplaces to	For all: All SWSP partners	All are ongoing actions

	organise workplace awareness events and increase the number of referrals into SSS Include specific activities for target groups as part of Stoptober. This includes mobile unit visits to deprived areas and BME community groups.		

Deliver consistent, coherent and co-ordinated communication			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Communication activities of all SWSP partners are consistent Resources to support partners developed and disseminated. Profile of Stop Smoking Services raised. Monitor referrals Number people accessing the Smokefree West Sussex website and social media sites as a result of partner promotion.	Agreed statement to be used by all SWSP members to publicise Stop Smoking Services at all media opportunities – effectiveness of service, experienced staff, tailored support and that it is free Include Smokefree West Sussex branding (including website and Smokefree West Sussex helpline phone number) on all promotional material – this will ensure that the website/helpline is the main way people are getting through to the service Regularly update websites to reflect any changes to services, respond to current trends in laws/sales of specific tobacco product Support non-SWSP partners in writing key messages to ensure consistent communication is provided to their collegues/client base Work with partners to have a link of the Smokefree West Sussex website on their respective organisation websites. Monitor and increase access to Smokefree West Sussex website. To do this:- 1. baseline of website traffic needs to be established first. i.e	Stop Smoking Services Stop Smoking Services Stop Smoking Services Stop Smoking Services and Public Health Stop Smoking Services Stop Smoking Services Stop Smoking Services	Ongoing Ongoing Ongoing September 2014 August 2015 Ongoing Ongoing

	number of people accessing website and identify popular pages accessed to know areas of interest.		Ongoing
Take a joined up approach to local events and promotion to support national anti-smoking campaigns	2. Collate information on how people found out about the service Increase the number of people accessing and following the facebook and twitter Smokefree West Sussex sites. This will be done by promoting the social media sites at all available opportunities and creating interactive and user-focused sites. Form communication working groups in which SWSP members can participate to form shared objectives, ensure our messages are consistent, and there is a collaborative approach to local promotions and events Distribute PHE communication toolkits and Smokefree West Sussex communication resources to be used at all events /campaigns An events calendar is published on the SWSP pages of the Smokefree West Sussex website for the purposes of alerting the general public and for SWSP members to identify possible opportunities to join forces Monitor the number of people accessing Smokefree West Sussex during campaigns to evaluate if it has raised awareness among the public	All SWSP members Stop Smoking Services Stop Smoking Services All SWSP partners Stop Smoking Services	Ongoing Ongoing

An integrated stop smoking approach			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Clear referral pathways into services established for all partners	Clear referral and treatment pathway developed with particular focus getting target groups into the service. Continue to monitor referral	All SWSP Partners Health and Wellbeing Board	July 2015

	numbers reported by the Stop Smoking Service to identify organisations, considered part of the Public Health workforce, and broaden the referral base.	VCS organisations Police Children and Family Centres	
Develop joint working on tobacco control with other organisations.	Identify areas where tobacco control will be relevant in meeting the priorities of other organisations Meet with leads of organisations/providers to develop how SWSP can work with them to achieve joint working on tobacco control. Include referral/signposting into SSS and promotion of smoking cessation as key priorities Identify risk factors for smoking and risky behaviours associated with smoking i.e. drug use. Work with partners to include smoking cessation as part of the recovery model.	Public Health Stop Smoking Services Public Health Stop Smoking Services	Ongoing Ongoing Ongoing

Build and sustain capacity in tobacco control			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
All staff members to have received up-to-date and relevant training (SSS, wellbeing hubs and LES providers)	Develop training programme for staff – meet with staff to identify needs All LES providers to be trained to level 2. Level 1 training to be rolled out to 240 people	Stop Smoking Services	Ongoing. Level 1 training target– completion date: March 2015
Improved awareness of tobacco control across West Sussex	Publish a quarterly newsletter on the SWSP pages of the Smokefree West Sussex and distribute to SWSP members and any organisations signing up to the distribution list from the website.	Public Health	Quaterly
Appropriate infrastructure (e.g. provider resources, training, clinic venues, monitors, mobile unit locations) of Stop Smoking Services in place	Carry out a needs assessment on Stop Smoking Services to evaluate it and assess infrastructure in place and what resources are needed.	Public Health Stop Smoking Services	September 2015

Tackle cheap and Illicit tobacco			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Reduced supply of illicit tobacco	Trading Standards to form subgroup with Police and HMRC. Subgroup to identify sources of illicit tobacco and decide on approaches for identifying and dealing with retailers who sell them.	Trading Standards Police HMRC	December 2014
Increased use of local intelligence to target activities	Publicise Trading Standard's online reporting form and link on all local smoking cessation websites	Trading Standards All SWSP partners	February 2015
Promoting the health harms of tobacco	Trading Standards to carry out health promotional activities with retailers	Trading Standards	Ongoing

Influence change through advocacy			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Tobacco control advocate identified	Ensure all SWSP partners and relevant organisations have the knowledge to become tobacco control advocates and aware of where tobacco control feeds into their organisation. This is done by providing regular updates to SWSP partners on tobacco control activity	All SWSP partners Fire services Police Public Health	Ongoing September 2015
West Sussex County Council sign up to the Tobacco Control Declaration	Presenting and informing decision making groups eg elected members to gain their support in becoming tobacco control campaigners. For year one of the action plan - present to all local Health and Wellbeing Partnerships The SWSP build a compelling case for Council to become a signatory of the declaration and take key stakeholders through the 5 steps to sign up to the to the Tobacco Control Declaration	SWSP	June 2015

Helping young people to be tobacco free			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Social media sites and website established targeted at	Identify effective social media site and website for reaching young people, particularly targeted at	Public Health Press and Communications	October 2014

young people, particularly young girls, are identified. Used as a way to communicate with young people the health harms of smoking	young girls – consider setting up a Facebook webpage, Facebook advertising and webpage on main Smokefree West Sussex website Use social media and website identified above to inform young people of the health harms of tobacco products particularly those that are popular among young people (shisha and e-cigarette).	Stop Smoking Service	Ongoing
Increased number of test purchasing being carried out	Increase the number of test purchasing being carried out in all retail environments where young people can access tobacco – an extra 3 test purchasing carried out	Trading Standards Business organisations	September 2015
ASSIST programmes established in 5 more schools	Contact all schools and arrange meetings to encourage them to adopt ASSIST for 2014/15 Evaluate the ASSIST program to determine the success of the programme to date	Stop Smoking Service Stop Smoking Service	Ongoing August 2014
Tobacco education established as part of the school curriculum	Using Healthy Schools as the setting schools are signposted to effective policy development, use of appropriate resources and where possible directed to training and support through the core offer from Public Health and the PSHE-CPD programme	Public Health Core School Group	Ongoing

Maintain and promote smokefree environments			
Objectives	**Action/Performance Indicators**	**Lead Partners**	**Completion date**
Increased publicity on smoking bans in cars with children in line with new legislation	Produce messages on smoking ban in cars – first launch to coincide with legislation. Publicise in key areas:- supermarkets, car parks, CFCs and all smoking cessation services (clinic/drop-in sessions)	Public Health Press and Communications Schools Hospitals	April 2015
Smoke-free areas adopted by more organisations	Develop workplaces to have designated smoking areas away from the main entrance as part of their policy Contact mental health providers and businesses to discuss how to roll out smoke-free policies in premises Provide training for frontline staff on smoke free issues to ensure all key staff are fully aware of the benefits of quitting smoking Support partners to develop smokefree policies for their organisation.	Public Health Public Health Stop Smoking Service Stop Smoking Service Public Health	Ongoing Ongoing Ongoing Ongoing

Appendices

Appendix 1

Table 1 Model Based Estimates of Smoking Prevalence by MSOA in West Sussex, 2003-05

MSOA	MSOA Population	Ward	Smoking Prevalence Estimate (%)
Crawley 013	8,565	Broadfield North	36
		Broadfield South	
Worthing 011	8,665	Central	35.3
		Heene	
		Selden	
Crawley 010	7,925	Bewbush	35.1
		Ifield	
Crawley 012	8,120	Bewbush	33.9
		Broadfield North	
Arun 016	7,229	Orchard	33.6
		Pevensey	
Arun 011	6,567	Beach	32.1
		Ham	
		River	
Arun 004	8,101	Ham	31.7
		Wick with Toddington	
Arun 017	10,455	Hotham	31.6
		Marine	
		Pevensey	
Arun 014	7,682	Bersted	31.5
		Hotham	
		Orchard	
Worthing 008	8,523	Central	31.4
		Gaisford	
		Tarring	
Worthing 006	7,523	Castle	31.2
		Northbrook	
Worthing 009	7,768	Broadwater	30.3
		Selden	
Adur 004	10,202	Eastbrook	29.5
		Southlands	
		Southwick Green	
		St Mary's	
Worthing 003	7,807	Durrington	29
		Northbrook	
		Salvington	
Worthing 010	8,170	Central	29
		Heene	
Adur 007	5,748	Mash Barn	28.4
		Widewater	
Adur 006	7,204	Cokeham	28.3
		Peverel	
Adur 008	7,477	Churchill	28
		Widewater	
Mid Sussex 014	8,834	Burgess Hill Leylands	27.8
		Burgess Hill Meeds	
		Burgess Hill Victoria	
Chichester 008	9,932	Chichester East	27.6
		Chichester North	
		Chichester West	
Crawley 003	7,949	Ifield	26.1
		West Green	
Crawley 007	8,488	Southgate	25.7
		West Green	
Mid Sussex 010	6,839	Haywards Heath Bentswood	25.5
		Haywards Heath Franklands	
Arun 012	7,376	Bersted	25.2
Crawley 011	8,087	Southgate	25.1
		Tilgate	
Crawley 004	8,792	Northgate	25
		Three Bridges	
Chichester 010	7,960	Chichester East	24.8
		Chichester South	
Mid Sussex 001	11,146	East Grinstead Ashplats	24.5
		East Grinstead Baldwins	
		East Grinstead Town	
Worthing 005	7,716	Broadwater	24.4
		Gaisford	
Adur 001	8,678	Eastbrook	23.6
		Hillside	
		Southlands	
		Southwick Green	
Arun 005	9,739	Angmering	23.5
		East Preston with Kingston	
		Rustington East	
Chichester 012	9,364	Chichester South	23.5
		North Mundham	
		Sidlesham	
		Tangmere	
Horsham 006	10,331	Denne	23.5
		Horsham Park	
		Trafalgar	
Crawley 001	8,321	Langley Green	23.4
Crawley 006	7,875	Gossops Green	22.8
		Ifield	
Horsham 001	7,603	Roffey South	22.8
		Rusper and Colgate	
Arun 007	9,546	Brookfield	22.6
		Rustington West	
Arun 009	9,556	Beach	22.2
		Brookfield	
		River	
		Rustington West	
		Wick with Toddington	
Crawley 005	7,962	Pound Hill North	22.2
		Pound Hill South and Worth	
		Three Bridges	
Arun 006	5,979	Yapton	22.1
Worthing 007	8,540	Castle	22.1
		Tarring	
Worthing 002	7,728	Offington	21.6
		Salvington	
		Tarring	
Mid Sussex 012	6,800	Burgess Hill Dunstall	21.3
		Burgess Hill Victoria	
Horsham 004	7,925	Horsham Park	21.1
		Roffey North	
		Roffey South	
Chichester 004	7,037	Easebourne	20.8
		Midhurst	
		Stedham	
Horsham 003	8,471	Broadbridge Heath	20.8
		Holbrook West	
		Itchingfield, Slinfold and Warnham	
		Trafalgar	
Mid Sussex 013	7,905	Burgess Hill Franklands	20.8
		Burgess Hill Leylands	
		Burgess Hill St Andrews	
Crawley 009	9,189	Furnace Green	20.7
		Maidenbower	
Horsham 007	6,557	Broadbridge Heath	20.6
		Denne	
		Trafalgar	
Adur 003	7,273	Cokeham	20.4
		Manor	
		Mash Barn	
Adur 005	8,349	Marine	20.4
		St Mary's	
		St Nicolas	
Chichester 014	11,121	Selsey North	20
		Selsey South	
Arun 003	10,170	Barnham	19.6
		Walberton	
Arun 002	5,710	Angmering	19.5
		Findon	
Horsham 010	9,311	Billingshurst and Shipley	19.4
Horsham 009	8,817	Southwater	19.1
Horsham 013	8,995	Chantry	19.1
		Pulborough and Coldwatham	
Worthing 012	7,810	Marine	19
Arun 019	9,303	Aldwick West	18.7
		Pagham and Rose Green	
Horsham 015	7,596	Chanctonbury	18.7
		Chantry	
Mid Sussex 003	7,865	Ashurst Wood	18.7
		East Grinstead Ashplats	
		East Grinstead Herontye	
Mid Sussex 016	7,675	Bolney	18.5
		Hurstpierpoint and Downs	
Mid Sussex 002	6,169	Copthorne and Worth	18.3
		Crawley Down and Turners Hill	
Horsham 002	11,422	Holbrook East	18.1
		Holbrook West	
		Roffey North	
Mid Sussex 009	9,390	Haywards Heath Ashenground	18.1
		Haywards Heath Heath	
		Haywards Heath Lucastes	
Mid Sussex 005	5,594	Crawley Down and Turners Hill	18

MSOA	MSOA Population	Ward	Smoking Prevalence Estimate (%)
Mid Sussex 011	9,477	Cuckfield	18
		Haywards Heath Ashenground	
		Haywards Heath Franklands	
		Haywards Heath Lucastes	
Crawley 002	8,323	Pound Hill North	17.8
		Pound Hill South and Worth	
Chichester 007	7,675	Funtington	17.7
		Southbourne	
		Westbourne	
Arun 013	6,910	Felpham East	17.6
		Middleton-on-Sea	
Adur 002	6,699	Buckingham	17.2
		St Mary's	
		St Nicolas	
Chichester 005	8,171	Bury	17.1
		Easebourne	
		Petworth	
Chichester 013	10,619	East Wittering	17.1
		Sidlesham	
		West Wittering	
Horsham 014	8,124	Bramber, Upper Beeding and Woodmancote	17.1
		Henfield	
		Steyning	
Arun 001	5,939	Arundel	16.8
		Walberton	
Mid Sussex 007	6,770	Ardingly and Balcombe	16.7
		Bolney	
		Cuckfield	
Horsham 016	8,790	Bramber, Upper Beeding and Woodmancote	16.6
		Steyning	
Chichester 011	7,586	Bosham	16.5
		Chichester West	
		Donnington	
		Fishbourne	
Arun 015	8,459	Felpham East	16.4
		Felpham West	
Worthing 004	7,085	Broadwater	16.3
		Gaisford	
		Offington	
Horsham 005	6,335	Itchingfield, Slinfold and Warnham	16.2
		Rudgwick	
Horsham 011	5,473	Cowfold, Shermanbury and West Grinstead	16.1
Crawley 008	7,966	Maidenbower	16
		Pound Hill South and Worth	
Mid Sussex 006	6,774	Ardingly and Balcombe	16
		High Weald	
Chichester 001	6,796	Fernhurst	15.7
		Plaistow	
Chichester 009	8,360	Bosham	15.5
		Southbourne	
Mid Sussex 004	6,991	East Grinstead Herontye	15.5
		East Grinstead Imberhorne	
Worthing 013	8,148	Goring	15.5
Arun 010	7,713	East Preston with Kingston	15.4
		Rustington East	
		Rustington West	
Chichester 006	7,529	Boxgrove	15.2
		Chichester North	
		Lavant	
Chichester 003	5,652	Harting	14.8
		Rogate	
		Stedham	
Chichester 002	5,701	Plaistow	14.6
		Wisborough Green	
Worthing 001	7,696	Durrington	14.5
		Offington	
		Salvington	
Mid Sussex 017	8,539	Hassocks	14.4
		Hurstpierpoint and Downs	
Arun 018	8,144	Aldwick East	13.1
		Aldwick West	
Mid Sussex 015	6,009	Burgess Hill Franklands	13
		Burgess Hill Meeds	
		Burgess Hill Victoria	
Mid Sussex 008	9,679	Haywards Heath Franklands	12.7
		Haywards Heath Heath	
		Lindfield	
Arun 008	5,983	East Preston with Kingston	12.4
		Ferring	
Horsham 008	8,153	Forest	12.1
		Nuthurst	
		Southwater	
Horsham 012	6,907	Chanctonbury	11.2
		Chantry	
		Pulborough and Coldwatham	

Source: ONS, Neighbourhood Statistics, Information on Healthy Lifestyle Behaviours: Model Based Estimates

Appendix 2

Smoking prevalence in 14 -15 year olds (percentage) by area, 2010

	Sex		Local Authority Area							LNIA	
	M	F	Adur	Arun	Chi	Crw	Hor	Mid	Wor	Yes	No
Never	73	66	70	69	78	85	72	74	68	67	73
Stopped	13	17	6	8	6	2	7	5	9	8	7
Occasionally	6	8	16	13	14	9	15	14	11	13	13
Regularly	8	10	8	11	2	4	6	7	12	13	7

Appendix 3

Additional indicators within the Public Health Outcomes Framework where reducing smoking prevalence significantly impacts on:-

1.9 Sickness absence rates
2.1 Low birth weight of term babies
4.1 Infant mortality
4.3 Mortality from causes considered preventable
4.4 Mortality from all cardiovascular diseases (including heart disease and stroke)
4.5 Mortality from cancer
4.7 Mortality from respiratory diseases
4.9 Excess under 75 mortality in adults with serious mental illness.

Appendix 4

Smokefree West Sussex Partnership - Terms of Reference

Purpose
The role of Smokefree West Sussex Partnership will be to provide strategic direction and leadership to drive the tobacco control agenda in West Sussex.
To own and address the priorities stated within the Smokefree West Sussex Operational Plan, which aims to reduce smoking prevalence and health inequalities associated with smoking.

Objectives
To support, implement and review progress on objectives outlined in the Smokefree West Sussex Operational Plan

To review and advice on national policies relating to tobacco control and their implications for West Sussex

To publicise the work of the Partnership and develop more partnerships across the county to progress the purpose of the group

To promote and ensure a co-ordinated approach to all work streams relating to tobacco control

To deliver consistent and co-ordinated communication for campaigns and on all tobacco-related issues

Roles and responsibilities
Solutions 4 Health – will be providing leadership on all campaigns and tobacco-related issues using their expertise and drawing on the skills and resources of partners

Public Health – will support all campaigns and tobacco control work streams. They will also review progress of the Stop Smoking Service and objectives of the operational plan

Wellbeing Hubs – will work with Solutions 4 Health in running events and in effectively referring clients into the service

Healthy School lead – will promote and support the delivery of tobacco control programmes in schools

Workplace leads District and Borough Councils and West Sussex County Council HR – will identify opportunities for raising awareness on the harms of smoking among employees. They will also be contacting and encouraging employers to agree to smoking advisor running events or clinic on employers premise.

Trading standards – will be working on reducing supply of illicit and cheap tobacco through raids and working with local districts in identifying risky businesses

Mental health services, respiratory nurses – will promote and support all campaigns in the context of their organisation. All partners will apply the 'Make every contact count' approach in identifying and referring people into the service.

West Sussex Fire and Rescue Service– will promote messages on the fire hazards of smoking and health harms of smoking during the campaigns they carry out.

Midwifery Unit – Western Sussex Hospitals NHS Foundation Trust – to identify pregnant mothers who are smokers and support or refer them to an advisor for smoking cessation support.

Membership
The Smokefree West Sussex Partnership will consist of the following members:-

Solutions 4 Health

Tobacco Control lead – WSCC Public Health

Healthy Schools lead – WSCC Public Health

West Sussex Wellbeing Hubs

Respiratory Nurses

Workplace Leads – Districts and Borough Councils

Trading Standards

West Sussex Fire and Rescue Service

Human Resources (HR) - WSCC

Mental Health Services – Sussex Partnership NHS Foundation Trust

Midwifery Unit – Western Sussex Hospitals NHS Foundation Trust

The Smokefree West Sussex Partnership will be led by Solutions 4 Health. The Public Health Tobacco Control lead or nominated representative will chair the meetings

Meetings
The Smokefree West Sussex Partnership will meet on a quarterly basis. Meetings will be chaired and organised by a tobacco control representative from Public Health. Public Health will also provide secretariat functions for the group. Meetings will be quorate if four members are present including the chair and lead for the group.

Governance
The group will consult, inform and update as appropriate with:-Cardiovascular Disease Programme Board, Health and Adult Social Care Committee via Public Health Plan, West Sussex Health and Wellbeing Board, local health and wellbeing boards, Wellbeing Hubs management meeting.

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