Acknowledgements: We are grateful to those colleagues and partners that have contributed to this report.

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Executive summary

Scope and purpose
This tobacco control needs assessment sets out the context of tobacco use in Plymouth and shows why tackling tobacco is fundamental to the continued healthy growth of the city. It makes a set of evidence based recommendations that will focus local efforts on the challenges of reducing prevalence of smoking and the associated health inequalities.

Key findings
- Smoking tobacco is the primary cause of preventable death, ill health and health inequalities in Plymouth.
- There are around 400 deaths every year in Plymouth that are attributable to smoking.
- Tobacco is currently costing Plymouth’s local economy around £77,000,000 every year; this includes £6,500,000 additional social care costs.
- There are around 47,000 adults who smoke in Plymouth (20.6%).
- Rates of smoking in Plymouth are showing a downward trend but remain around four percentage points above the national average.
- There are groups of people within the general population of Plymouth who experience higher than average rates of smoking and where needs are therefore greatest.
- These higher use groups are: people living in more deprived wards, people who work in routine and manual occupations and the unemployed, young adult men and people with mental health diagnoses.
- An additional group who also have greater needs, related to their use of tobacco, are pregnant women.
- People on low incomes are twice as likely to smoke than the more affluent. The rates of smoking in wards in Plymouth range from 4.3% to 37.1%.
- The rate of regular smoking among 15 year olds in Plymouth is 6%; the rate in England as a whole is 5.5%.
- Rates of smoking are determined by a combination of supply-side and demand led factors. Supply-side factors include: price and access (including the availability of cheap and illegal tobacco) and demand led factors are: age of trying tobacco and peer influence (social network effect).
- Local authorities are ideally placed to formulate broad reaching plans to tackle tobacco.
- The local strategy to tackle tobacco coordinates and combines a range of approaches to control the supply and drive down the demand. These approaches focus locally on tackling cheap and illegal tobacco, supporting smokers to stop smoking and early interventions to prevent the uptake of smoking among during childhood.
• Structured support to stop smoking is currently accessed by around 5% of people who smoke in Plymouth every year. When people use nicotine replacement therapy with structured behavioural support, such as that offered by the One You Plymouth team they are four times more likely to quit than those attempting without such support.

• Emerging use of e-cigarettes is changing smoking related behaviour and further work is required to identify and maximise the positive impacts of their use.

**Conclusion**

Whilst smoking prevalence has seen an overall long term decline amongst both young people and adults, this decline is less marked in some population groups. In order to address prevalence and reduce inequalities in rates of smoking among Plymouth’s population there is a need for local focus and action across a range of approaches.

Fundamental drivers behind the prevalence of smoking relate to supply and demand. They include: access, price paid, age of uptake, peer influence, and support to stop smoking.

Therefore it is recommended to ensure that resources are used most cost effectively by tackling these drivers and focussing activity with groups of people whose needs are greatest.
Recommendations
More specifically, the following recommendations are made:

Recommendation 1:
Local tobacco control interventions should be implemented to ensure that they focus on areas of greater need as identified in this needs assessment.

Recommendation 2:
The city should expand the brief intervention training programme to new front facing professionals who engage with those groups identified in this needs assessment.

Recommendation 3:
The city should focus efforts to tackle the uptake of smoking in electoral wards with higher rates.

Recommendation 4:
The Office of the Director of Public Health (ODPH) should maintain support for Plymouth’s Healthy Child Quality Mark to continue to build the whole school approach to tackling tobacco.

Recommendation 5:
The ODPH should embed tobacco control issues in the Continued Professional Development - Thrive Plymouth offer to teachers.

Recommendation 6:
The ODPH and One You Plymouth team should maintain the Decipher ASSIST peer supporter programme in targeted secondary schools.

Recommendation 7:
The Maternity and Early Years System Optimisation Group (MEYSOG) should review the pathway for pregnant mums who smoke and introduce service changes to ensure a consistent systematic and effective approach by related health professionals.

Recommendation 8:
The One You Plymouth team should consider a quitter incentive scheme for pregnant mums.

Recommendation 9:
The One You Plymouth team should continue to support smokefree sites in secondary care settings.

Recommendation 10:
It should remain a priority for the city’s enforcement bodies [Plymouth City Council, The Police Service and Her Majesty’s Revenue and Customs (HMRC)] to continue to work to disrupt the supply of cheap and illegal tobacco.
1. Scope and purpose

This tobacco control needs assessment describes the context of tobacco use in Plymouth and shows why tackling tobacco is fundamental to the continued healthy growth of the city. It shows the way that a coordinated strategic approach works to decrease the prevalence of smoking.

The introduction covers key facts and figures about tobacco, the harms it causes, the strategic and legal context, and the pattern of smoking in Plymouth. It identifies areas where tobacco-related need is greatest.

The report goes on to consider the fundamental factors that influence rates of smoking and describes impacts in greater detail.

It then describes the way that locally provided activities and services work to drive down the demand for tobacco and restrict the supply of tobacco.

Finally, the report concludes by recommending further developments that are required in order to more effectively focus our approach to reduce smoking prevalence and associated inequalities in our city.

1.1 Definitions

1.1.1 “Health needs assessment”

A health needs assessment allows the needs of a population to inform the use of resources and services. It can cover a particular condition or group of conditions or a particular population of people. A health needs assessment is:

“A systematic review of the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce health inequalities”

This needs assessment focuses on the needs of people who use tobacco in Plymouth.

1.1.2 “Tobacco control”

There is a broad based national and international consensus around tobacco control, which has been summarised as:

“a range of supply, demand and harm reduction strategies that aim to improve the health of a population by eliminating or reducing the consumption of tobacco products and exposure to tobacco smoke;”

Tackling tobacco provides an opportunity for Plymouth to continue to be healthier and wealthier as it grows over the coming years.

---

2. Introduction

2.1 Impact of tobacco

2.1.1 Smoking attributable mortality

Tobacco continues to have a major impact in Plymouth. Every year in Plymouth, it is associated with around 400 deaths, 244 premature births, 2,722 hospital admissions, and 208 new cases of lung cancer.

Figure 1: Smoking attributable mortality in Plymouth

![Graph showing smoking attributable mortality in Plymouth](image)

Source: Public Health England

Figure 1 shows the rate of deaths per 100,000 population in Plymouth that are attributable to smoking. The rate has remained stable since 2007.

2.1.2 Impact of tobacco within the healthcare system

Over a quarter of all hospital admissions are attributable to smoking. Direct costs to the NHS are estimated to be £2.5bn and costs to social care £1.1bn. Smoking causes cancers, circulatory disease, and respiratory disease, as well as impotence and infertility. Smokers that manage to quit reduce their cost to the NHS and social care providers by 48%. Greatest long-term savings would result from preventing people from ever smoking altogether, but the short-term opportunity lies in helping smokers who are in contact with the NHS to stop smoking.

In 2014, Plymouth’s rate of tobacco related hospital admissions was 1,953 per 100,000 whilst the annual cost of smoking attributable hospital admissions in Plymouth was £5,610,143 in 2011/12.

Long term conditions (LTCs) are those which cannot currently be cured, but can be controlled with medication and therapies. The prevalence of LTCs increases with age. LTCs

---

2 [www.tobaccoprofiles.info/tobacco-control](http://www.tobaccoprofiles.info/tobacco-control)
are a significant cause and consequence of health inequalities, with the poorest and most vulnerable affected the most.

The poorest and most vulnerable population group is a wide category that includes people with a range of different conditions and associated needs. It includes, for example, people with mental health disorders who have a much higher smoking prevalence than the general population and people with conditions such as chronic obstructive pulmonary disease (COPD), which may have been caused by, and will be exacerbated by smoking. In COPD, for example, 80% of cases are attributable to smoking, continuing to smoke speeds up the loss of lung function to around three times the normal rate. Other conditions where smoking is a factor include coronary heart disease, myocardial infarction, diabetes, asthma, and lung cancer. Smoking prevalence amongst GP patients recorded as having one or more LTCs is a key driver of emergency admissions.

Points on the patient pathways to and from hospital provide opportunities where discussions about stopping smoking and the offer of additional support are likely to have a more productive impact.

2.2 Tobacco facts and figures
Smoking tobacco remains the single greatest cause of preventable death both in England and Plymouth. Figure 2 shows that, despite long term falling rates, smoking causes more preventable deaths than the next six causes combined.

Figure 2: Causes of preventable death in England

![Figure 2: Causes of preventable death in England](image)

Source: Action on Smoking and Health

Smoking has been identified as the primary reason for the gap in life expectancy between the rich and poor. Tobacco control is therefore a vital element of strategies aimed at tackling health inequalities.

Thrive Plymouth’s 4-4-54 framework identifies smoking as one of the four key lifestyle behaviours associated with preventable death in the city. The city currently sees a gap in life

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expectancy of almost 10 years between the wards with the highest and lowest life expectancies.

Tobacco costs Plymouth more than £77m every year, made up of:
- £57.78m lost productivity due to smoking
- £10.46m smoking related disease
- £ 6.52m smoking associated social care costs
- £ 0.68m second hand smoke
- £ 1.90m smoking related fires

Research shows that people who smoke are likely to need care on average nine years earlier than those who don’t and that being a smoker doubled the chance of receiving care of any sort and increased the risk for ex-smokers by 25%. In addition, Plymouth spends an estimated £80m every year directly on the cost of buying tobacco.

The illegal market in hand rolled tobacco and cigarettes was responsible for an estimated national tax gap of £2.1bn in 2014/15. The ‘tax gap’ is the difference between the amount of tax that should, in theory, be collected by HMRC, against what is actually collected.

The World Bank states that no other area of public health expenditure provides the social and economic returns of the magnitude that result from investing in effectively tackling tobacco.

2.3 Strategic and legislative context of tobacco control

Since 1st April 2013, Plymouth City Council has been required to put in place plans to reduce health inequalities within their area. These include effective tobacco control measures to reduce rates of smoking.

2.3.1 National government tobacco control plan

The current national government strategy for tackling tobacco involves taking a multi-faceted and comprehensive approach at both national and local level. It states that tobacco control is more than just providing local stop smoking services or enforcing smokefree legislation. The effectiveness of tobacco control is dependent on the coordinated and focussed implementation of a wide range of actions that complement and reinforce each other.

The national plan emphasises the crucial role of tackling the underlying social and behavioural factors that drive uptake and make it harder for tobacco users to quit. It sets out the main aim of tobacco control as working to: “reshape social norms to support local areas to drive down rates of smoking by making tobacco less desirable, less acceptable, and less accessible.” The plan describes three national ambitions:
- Reduce smoking prevalence among adults in England to 18.5% or less by the end of 2015
- Reduce smoking prevalence of regular smoking among 15 year olds in England to 12% or less by the end of 2015
- Reduce rates of smoking throughout pregnancy to 11% or less by the end of 2015 (measured at time of giving birth)

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5 http://www.plymouth.gov.uk/documents/publichealthannualreport
6 http://ash.org.uk/download/reckoner-local-costs-of-smoking/
Local authorities are ideally placed to formulate local broad ranging, inclusive and effective partnerships – where anyone who can make a contribution is encouraged to get involved\(^8\).

The national plan provides a framework for tobacco control activity using the “Nuffield Council for Bioethics’ ladder of public health interventions”. This identifies different interventions along a scale of varying levels of intrusiveness and justification. This framework will be used to describe current and recommended tobacco control measures further on in the document.

2.3.2 Saving babies’ lives – a care bundle for reducing stillbirth
Reducing smoking in pregnancy has been identified as the only behavioural element of “Saving babies’ lives – a care bundle for reducing stillbirth guidance”. This is because smoking in pregnancy has well known detrimental effects for the growth and development of the baby and health of the mother. On average, smokers have more complications during pregnancy and labour. Encouraging pregnant women to stop smoking during pregnancy also helps them kick the habit for good, providing health benefits to both the mother and infant.

2.3.3 ASH Strategy – smoking still kills
Action on Smoking and Health (ASH) have produced a more recent strategy\(^9\) to inform the new national government strategy, due for release at the end of 2016. This also recognises the key role of local authorities and aims to support tobacco control teams in local authorities to use all of the opportunities provided by the local government setting.

The report makes the case that, while tobacco control has a successful history, the job is not yet complete; millions of smokers in England still face the risks of smoking-related illness and premature death, hundreds of young people start smoking every day, and smoking remains the principal cause of health inequalities.

The strategy describes the fundamental challenge for tobacco control as addressing the high prevalence rates in lower socio-economic groups and other groups including people with mental health problems and people with long-term conditions.

2.3.4 Thrive Plymouth and 4-4-54\(^10\)
Thrive Plymouth is a 10 year plan which aims to improve health and wellbeing in Plymouth and narrow the gap in health status between people in the city. Its objective is to generate collective action for social change around the main lifestyle choices that determine health and wellbeing in Plymouth. The plan encourages and enables partners to support positive lifestyle choices.

In Plymouth, four lifestyle behaviours (including smoking) lead to four chronic diseases (cancer, heart disease, stroke, and respiratory disease) which account for approximately 54% of deaths. This has been called the the "4-4-54 framework" and forms the backbone of Thrive Plymouth.

The local strategy to tackle tobacco is to deliver and coordinate a range of actions that drive down rates of smoking by reducing the demand for tobacco and restricting its supply.

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\(^{8}\) https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england

\(^{9}\) http://ash.org.uk/information-and-resources/reports-submissions/reports/smoking-still-kills/

\(^{10}\) http://web.plymouth.gov.uk/thrive
2.3.5 Plymouth Plan
The Plymouth Plan is the city’s sustainable development plan for the next 15 years. It draws together all the strategic plans for the city and attempts to set a direction of travel which will result in Plymouth becoming a city where an outstanding quality of life is enjoyed by all. In order to achieve this, the policies (particularly Policy 8) contained within the plan outline the city’s ambitions with regard to tobacco use.

Policy 8 prioritises the promotion of health-enabling lifestyle choices and early detection of the health conditions most strongly related to health inequalities. This includes encouraging a smoke-free Plymouth where future generations are protected from tobacco related harm and live longer and healthier lives through reducing the demand for, and restricting the supply of, illegal tobacco.\(^{11}\)

2.3.6 Legislation
Tobacco is a unique product among those that are legally available because of the scale of harm that is causes. There are areas of its marketing and use, therefore, which require legal control in order to reduce and restrict its impact.

The introduction of smoke free laws in 2007 has had a positive impact on hospital admissions, for example it is associated with a fall in hospital admissions for heart attacks (Sims et al. 2010). In addition, an estimated 6,802 fewer children were admitted to hospital in England with asthma symptoms in the first three years following its implementation. This is a reversal of what was a steady annual increase\(^{12}\).

Table 1 provides an outline of laws that involve local regulatory services working to build compliance.

Table 1: Current tobacco control laws

<table>
<thead>
<tr>
<th>Impact and focus</th>
<th>Legislation</th>
<th>Start date</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Second hand smoke:</strong>) banned smoking in workplaces and public places</td>
<td>Health Act 2006</td>
<td>July 2007</td>
</tr>
<tr>
<td><strong>Second hand smoke:</strong>) introduced smoke free cars with children in</td>
<td>Smoke-free (Private Vehicles) Regs 2015</td>
<td>Oct 2015</td>
</tr>
<tr>
<td><strong>Age of sale:</strong> Increasing the minimum age of purchasing tobacco products to 18</td>
<td>Children and Young Persons (Protection from Tobacco) Act 1991</td>
<td>Oct 2007</td>
</tr>
<tr>
<td><strong>Age of sale:</strong> Offence of purchasing tobacco, cigarette papers or a relevant nicotine product on behalf of person under the age of 18</td>
<td>Proxy Purchasing of Tobacco, Nicotine Products etc. (Fixed Penalty Amount) Regs 2015</td>
<td>Oct 2015</td>
</tr>
<tr>
<td><strong>Age of sale:</strong> Prohibits sale (and proxy sale) of e-cigs to children under 18</td>
<td>Nicotine Inhaling Products (Age of Sale and Proxy Purchasing) Regs 2015</td>
<td>Oct 2015</td>
</tr>
<tr>
<td><strong>Marketing of tobacco:</strong> banned sale of tobacco from vending machines</td>
<td>Protection from Tobacco (Sales from Vending Machines (England) Regulations 2010</td>
<td>Oct 2011</td>
</tr>
<tr>
<td><strong>Marketing of tobacco:</strong> banned display of tobacco for sale</td>
<td>Tobacco Advertising and Promotion (Display) (England) Regs 2010</td>
<td>Oct 2013</td>
</tr>
<tr>
<td><strong>Marketing of tobacco:</strong> Introduction of standardised packaging for cigarettes and hand rolling tobacco</td>
<td>Standardised Packaging of Tobacco Products Regulations 2015</td>
<td>May 2016</td>
</tr>
</tbody>
</table>

\(^{11}\) [www.ThePlymouthplan.co.uk](http://www.ThePlymouthplan.co.uk)

\(^{12}\) Millett et al. (2013)
2.4 Patterns of smoking in Plymouth

2.4.1 Adult prevalence

Figure 3 shows that in England, most people do not smoke and rates show a long term declining trend. Rates of smoking are now at their lowest level since recording started in the 1940s, when the national smoking rate was around 45% of the adult population. Nearly one in five adults (19%) aged 16 and over were smokers in 2013, a rate that although slightly less than 2012 has remained largely unchanged in recent years.

Figure 3: Smoking prevalence in adults, 2014

![Smoking prevalence in adults](image)

Source: Health and social care information centre\(^\text{13}\)

Figure 4 shows that recent patterns of smoking in Plymouth are similar to England, in that the rate shows a year on year decline, although the rate is typically around four percentage points greater in Plymouth. The current smoking rate in Plymouth is around 20.6% compared to 16.9% in England.

Average figures often mask a more complex picture and this is the case with patterns of smoking. There are groups of people who show significantly higher average rates of smoking both nationally and within Plymouth. As will be described in more detail below, smoking rates and associated needs are closely aligned to geography, occupational status, gender, age, and mental health status. An additional group of people, for whom smoking presents a greater need than the general population, is pregnant women.

When compared with other local authorities with a similar demographic structure, Plymouth’s adult smoking rate is 13\textsuperscript{th} highest out of 15\textsuperscript{14}.

**Recommendation 1:**

Local tobacco control interventions should be implemented to ensure that they focus on areas of greater need identified in this needs assessment.

### 2.4.2 Age and gender (adults)

Figure 5 shows that since 2001, rates of smoking have dropped among adult men and women, although during this period rates among men are consistently around 2-3 percentage points higher than women. This gap has increased over recent years because of a more rapid drop in smoking among women and a levelling out of the rate among men.

\textsuperscript{14} [www.tobaccoprofiles.info/]
Figure 5: Smoking prevalence in Great Britain by gender, 2001 to 2013


Figure 6 shows that rates are higher among men than women for all adult age brackets. The only increase in rate during adulthood is between the 16-24 year and 25-34 year age brackets for men. After age 34, rates gradually decline due to the combined effect of people quitting as adults and people who smoke passing away at a higher rate than the general population.

Source: Opinions and Lifestyle Survey, Smoking Habits Amongst Adults, 2013. 15

Statistics on Smoking England 2015
Figure 6: Adult smoking behaviour, by sex and age, Great Britain, 2013

When rates of smoking are analysed by age and gender, the age bracket with the highest rate of smoking for men and women is 25-34 years whilst the rate across all age brackets is higher for men than for women.

**Recommendation 2:**
The city should expand the brief intervention training programme to new front facing professionals who engage with those groups identified in this needs assessment.

2.4.3 Deprivation

People on low incomes are twice as likely to smoke as more affluent people, more likely to have started to smoke earlier in their lives, and be more addicted to tobacco. People who smoke in lower income groups are also likely to experience behavioural re-enforcement because they will know more people who also smoke. The direct financial cost of tobacco to a person who smokes therefore affects both individuals and families in lower income groups disproportionately.

Figure 7 shows that that the prevalence among Plymouth’s routine and manual workers (RMWs) is broadly similar to the RMW rate in England and is showing a gradual decline over time. Figure 7 compared to Figure 4, shows that the rate of smoking among RMWs is consistently higher than the average rate in England by around five percentage points.

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Figure 7: Smoking prevalence in adults in routine and manual occupations, current smokers in Plymouth, 2012 to 2015

![Smoking Prevalence Graph]

Source: Public Health England

Figure 8 shows that Plymouth has a rate of smoking among RMWs that is 7th lowest out of 15 other local authorities with a similar socio-demographic structure.

Figure 9 shows the prevalence rates in wards in Plymouth and compares these to relative levels of deprivation. It shows that generally the more deprived wards have a higher rate of smoking and a higher rate of children who report that they have tried smoking.

When rates of smoking are analysed by occupation, the population with the highest rate is RMWs. (n.b. the definition of RMWs includes people who have been unemployed for up to two years).

When analysed on a ward basis, the three wards in Plymouth with the highest rates of smoking (and therefore greater need) are: Devonport, Honicknowle, and St Budeaux.

17 [www.tobaccoprofiles.info/tobacco-control](http://www.tobaccoprofiles.info/tobacco-control)
Figure 8: Smoking prevalence in adults in routine and manual occupations in Plymouth and local authorities with a similar demographic, 2015

<table>
<thead>
<tr>
<th>Area</th>
<th>Recent Trend</th>
<th>Rank</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>--</td>
<td>-</td>
<td>-</td>
<td>26.5</td>
<td>26.1</td>
<td>26.9</td>
</tr>
<tr>
<td>Plymouth</td>
<td>--</td>
<td>-</td>
<td>-</td>
<td>26.0</td>
<td>23.9</td>
<td>25.3</td>
</tr>
<tr>
<td>North Tyneside</td>
<td>--</td>
<td>1</td>
<td>-</td>
<td>26.5</td>
<td>21.3</td>
<td>21.9</td>
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<tr>
<td>Wirral</td>
<td>--</td>
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<td>-</td>
<td>30.5</td>
<td>24.8</td>
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<tr>
<td>Sunderland</td>
<td>--</td>
<td>3</td>
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<td>29.4</td>
<td>24.4</td>
<td>34.3</td>
</tr>
<tr>
<td>Southampton</td>
<td>--</td>
<td>4</td>
<td>-</td>
<td>28.1</td>
<td>23.2</td>
<td>33.0</td>
</tr>
<tr>
<td>Bristol</td>
<td>--</td>
<td>5</td>
<td>-</td>
<td>31.2</td>
<td>25.4</td>
<td>36.9</td>
</tr>
<tr>
<td>Redcar and Cleveland</td>
<td>--</td>
<td>6</td>
<td>-</td>
<td>25.5</td>
<td>20.9</td>
<td>30.1</td>
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<tr>
<td>Derby</td>
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<td>-</td>
<td>31.1</td>
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<td>24.5</td>
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</tr>
<tr>
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Source: Public Health England 18

18 www.tobaccoprofiles.info/
Figure 9: Adult ward level smoking prevalence in Plymouth (version 4)

<table>
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<tr>
<th>Plymouth wards - Ranked by overall deprivation from IMD 2010</th>
<th>IMD (overall deprivation) rank</th>
<th>Ward-level deprivation and health / determinant indicator comparison tables</th>
<th>DASR Rank</th>
<th>% Rank 2009-13</th>
<th>Adult smoking prevalence 2014</th>
<th>% Rank 2013/2014</th>
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</table>

Source: Plymouth City Council¹⁹

2.4.4 Young people

Figure 10 shows the decline in the rate of regular smoking among 15 year olds in England since 2004.

Figure 10: Smoking prevalence at age 15 years, regular smokers, England, 2004 to 2014

Source: Public Health England

Figure 11 shows that Plymouth’s rate of regular smoking at 15 years old is 5th lowest out of 15, when compared with other local authorities of a similar demographic structure, and 0.5 percentage points above the England average.

20 www.tobaccoprofiles.info/tobacco-control
2.4.5 Age and gender (children)

Figure 12 shows the rate of current smokers from aged 11 years onwards by gender. Boys are more likely than girls to be current smokers at aged 11 whilst girls have a higher rate between ages 13-15.

This tendency among boys to try smoking and become current smokers at an earlier age may explain the higher rate of males who smoke as adults compared to females – as age of starting to smoke is a predictive risk factor for level of adult addiction (see section 3.2).

Source: Public Health England\textsuperscript{21}

\begin{table}[h]
\centering
\begin{tabular}{|c|c|c|c|c|c|}
\hline
Area & Recent Trend & Rank & Count & Value & 95\% CI & 95\% CI \\
\hline
England & - & - & - & 5.5 & 5.4 & 5.6 \\
Gateshead & - & 13 & - & 9.8 & 7.3 & 10.5 \\
Tameside & - & 15 & - & 8.9 & 7.1 & 10.7 \\
Sunderland & - & 3 & - & 9.9 & 6.7 & 9.9 \\
Southampton & - & 4 & - & 8.3 & 6.1 & 9.5 \\
Bristol & - & 5 & - & 7.8 & 6.1 & 9.3 \\
North East Lincolnshire & - & 10 & - & 7.7 & 6.0 & 9.0 \\
North Tyneside & - & 1 & - & 7.5 & 5.4 & 8.4 \\
Bolton & - & 14 & - & 6.9 & 5.2 & 8.4 \\
Darlington & - & 8 & - & 6.8 & 4.8 & 7.6 \\
St. Helens & - & 9 & - & 6.2 & 4.6 & 7.4 \\
Plymouth & - & - & - & 6.0 & 4.5 & 7.5 \\
Redcar and Cleveland & - & 6 & - & 6.0 & 3.9 & 6.7 \\
Selton & - & 11 & - & 5.3 & 3.8 & 6.4 \\
Derby & - & 7 & - & 5.1 & 3.6 & 6.2 \\
Dudley & - & 12 & - & 4.9 & 3.6 & 6.2 \\
Wirral & - & 2 & - & 4.9 & 3.6 & 6.2 \\
\hline
\end{tabular}
\caption{Smoking prevalence at age 15 - regular smokers (WAY survey) 2014/15}
\end{table}

\textsuperscript{21} \url{www.tobaccoprofiles.info/tobacco-control}
Figure 12: Smoking behaviour, by age and gender

![Graph showing smoking behaviour by age and gender](image)

Source: Smoking, Drinking and drug use survey (2014)\(^{22}\), and Health Survey for England (2013)\(^{23}\)

Figure 13 shows the rate of current smoking among Year 8 and Year 10 pupils in Plymouth. The three wards with the highest prevalence are: St Budeaux, Honicknowle, and Ham.

**Recommendation 3:**
The city should focus efforts to tackle the uptake of smoking on wards with higher rates.

**Recommendation 4:**
The ODPH should maintain support for Plymouth’s Healthy Child Quality Mark to continue to build the whole school approach to tackling tobacco.

**Recommendation 5:**
The ODPH should embed tobacco control issues in the Continued Professional Development - Thrive Plymouth offer to teachers.

**Recommendation 6:**
The ODPH and One You Plymouth team should maintain the Decipher ASSIST peer supporter programme in targeted secondary schools.

\(^{22}\) [http://www.hscic.gov.uk/catalogue/PUB17879](http://www.hscic.gov.uk/catalogue/PUB17879)

\(^{23}\) [http://content.digital.nhs.uk/catalogue/PUB16076](http://content.digital.nhs.uk/catalogue/PUB16076)
Figure 13: Geographical analysis of smoking rates among Year 8 and Year 10 pupils in Plymouth 2014/15 and 2015/16

<table>
<thead>
<tr>
<th>Plymouth wards - ranked by overall deprivation (from IMD 2015)</th>
<th>Most deprived</th>
<th>Least deprived</th>
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<td>Sutton and Mount Gould</td>
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Data period 2016

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</table>

Source: Plymouth City Council\(^24\)

\(^{24}\) Plymouth Schoolchildren’s Health Related Behaviour Survey, Plymouth 2014 and 2016
2.4.5 Maternity
Figure 14 shows that the rate of smoking at time of delivery (SATOD) in Plymouth was 15% in 2015. This was around five percentage points below the rate among Plymouth’s adult population but above the national target rate (11%).

Pregnant women are a subgroup of the population with greater needs associated with their use of tobacco because of links to conditions associated with pregnancy.

Recommendation 7:
The Maternity and Early Years System Optimisation Group (MEYSOG) should review the pathway for pregnant mums and introduce service changes to ensure a consistent systematic and effective approach by related health professionals.

Recommendation 8:
The One You Plymouth team should consider a quitter incentive scheme for pregnant mums.

Figure 14: Smoking at time of delivery Plymouth and England, 2005 to 2015

Source: Public Health England\(^{25}\) and Plymouth Hospital Trust data

2.4.6 Mental health
People with mental health problems smoke significantly more and are more dependent on nicotine than the population as a whole. Levels of smoking in this group are about three times higher than in the general population. It is recognised that admission to a secure mental health unit can be an opportunity to intervene to reduce smoking and that interventions are welcomed and effective. Supporting individuals to stop smoking while receiving NHS care represents a significant opportunity to close the gap in morbidity and

\(^{25}\) [www.tobaccoprofiles.info/tobacco-control](http://www.tobaccoprofiles.info/tobacco-control)
mortality between those people experiencing mental health conditions and the general population.

Figure 15 shows that the rate of smoking among people with long standing mental illness has been consistently higher than the general population since 1993 and that the decline in rate shown by the general population has not been experienced by this group.

A third of people with mental health problems, and more than two-thirds of people in psychiatric units, smoke tobacco. Some 42% of all tobacco smoked is by people with mental health problems.

Smoking is also more common among young people with mental health problems. According to the Child and Adolescent Mental Health Survey of Great Britain (2004), young people aged 11-16 years with an emotional, hyperkinetic, or conduct disorder were much more likely to be smokers (19%, 15%, and 30% respectively) than other young people (6%)\(^{28}\).

Recent studies show that people with mental health problems are just as likely to want to stop as the general population and are able to stop when offered evidence-based support\(^{29}\). However, research also shows that effective stop smoking treatment is not always offered to them\(^{30}\).

Figure 15: Smoking prevalence in England 1993 to 2013

Analysis of smoking by a person’s mental health status shows that groups of people with long standing mental illness have higher rates of smoking than the general population, both among adults and children.

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\(^{26}\) McManus et al. (2010); Royal College of Physicians (2013)

\(^{27}\) Jochelson and Majrowski (2006)

\(^{28}\) Green et al. (2005)

\(^{29}\) Jochelson and Majrowski 2006; Siru et al 2009; Royal College of Physicians 2013.

\(^{30}\) Ratschen et al. 2009.

\(^{31}\) http://ash.org.uk/information-and-resources/reports-submissions/reports/the-stolen-years/
Recommendation 9:
The One You Plymouth team should continue to support smokefree sites in secondary care settings

3. Risk and protective factors
The fundamental factors that influence rates of smoking are:
- Price
- Age
- Access
- Peer influence (social network effect)
- Income/ deprivation

3.1 Price
Evidence shows that the financial cost of tobacco to the consumer has a direct impact on the consumption rate and prevalence of smoking. Price paid is, therefore, a protective factor for consumption and prevalence of tobacco use. It acts to prevent initiation and uptake by young people, promotes cessation among current users, and lowers consumption among continuing smokers.32

National government use this factor as a disincentive to guide choice by using tax to maintain the high price of tobacco products.

The availability of illegal tobacco undermines these supply side tax measures by providing an alternative, non-taxed, cheaper supply.33

Local market research, carried out in Plymouth supports these findings and indicates that access to cheap and illegal tobacco is a significant factor in local rates of smoking. Illegal tobacco provides an easy and cheap source of tobacco to children, available at pocket money prices, with a lack of legal diligence in terms of age of sale restrictions.

Illegal tobacco products make tobacco more accessible to children and young people, and those from socioeconomic groups already experiencing significant health inequalities. They are often available at half or a third of the price of duty-paid products and can be accessed from a wide range of unregulated suppliers.

Figure 16 shows that, while the trend in the market share of illicit tobacco is reducing over time, it remains at 13% of cigarette and 32% of hand rolling tobacco markets.

Figure 17 suggests that, while this downward trend is also reflected in Plymouth, 28% of people asked in 2014, did not pay the full price for tobacco and nearly half thought they had bought counterfeit tobacco. This suggests that the availability of illegal tobacco continues to drive up the prevalence of smoking in Plymouth by enabling people to smoke, and smoke more, when they would otherwise have stopped smoking altogether or cut down.

32 http://tobaccocontrol.bmj.com/content/20/3/235/T1.expansion.html
33 http://tobaccocontrol.bmj.com/content/23/e1/e44.full?sid=91530992-fb96-4bb0-a885-3bd73c019ca3
Recommendation 10:
It should remain a priority for the city’s enforcement bodies (Plymouth City Council, The Police Service and Her Majesty’s Revenue and Customs (HMRC) to continue to work to disrupt the supply of cheap and illegal tobacco.

Figure 16: Illicit tobacco market share in UK, 2009/10 to 2015/16

![Graph showing illicit tobacco market share with data points for 2009-10 to 2015-16 indicating trends for Cigarettes and Hand rolling tobacco.]

Source: HM Revenue and Customs

Figure 17: Reported use of illegal tobacco among One You Plymouth team new clients, 2014

![Bar chart showing the percentage of clients who did not pay full price for tobacco in 2010, 2011, and 2012.]

Source: Livewell South West Wellbeing Stop Smoking Service – Sources of Tobacco Survey, 2014

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3.2 Age

Section 2.4.4 described the age profile of young people who are current smokers. This is important because age of starting to smoke is a risk factor for level of adult addiction. The earlier a person first tries tobacco, the heavier their level of addiction is likely to be as an adult. For example, if someone tries smoking before they are 15 years old they will have a much higher chance of being a regular smoker at some time during their life than those who try smoking later in life.

Figure 18 shows that among children who have smoked at age 15, boys tend to try smoking earlier than girls, but that at age 14 and 15, girls try smoking at a higher rate than boys. This is also reflected locally, as the rate of regular smoking in Year 10 (14 year olds) in Plymouth in 2015 was 5% for boys and 9% for girls³⁵.

The greatest increase in rate of trying smoking occurs between the ages of 10 and 13 years.

Figure 18: Age first tried smoking by gender, England (2014)

3.3 Peer influence and social networks

As we grow up, we learn and develop our own sense of behaviour from the people around us, our peers. Peer influence emerges from the social interactions we have in social networks and acts to shape our perceptions of a range of risk taking behaviours, including smoking. Social groups tend to define themselves and others in relation to these behaviours and smoking behaviour clearly demonstrates a person’s position in their own social world.

³⁵ Plymouth Schoolchildren’s Health Related Behaviour Survey (2016)
³⁶ http://www.hscic.gov.uk/catalogue/PUB17879
Figure 19: The role of social networks

Source: Public Health England, Health matters: smoking and quitting in England

This is important because peer influence can have a fundamental impact on the smoking behaviour of groups of people.

3.4 Access
Access to tobacco is a supply side factor that affects the uptake of smoking among children and therefore the prevalence. Among children, the most common source of cigarettes has been found to be those given to them by other people and friends. Other significant sources involve payment and originate directly from shops or via other people, friends, or relatives. Of those bought from shops, the most common type of shop has consistently been newsagents.

Other key points from the smoking, drinking, and drug use survey of children:
- Only 25% of children who smoke said they found it difficult to buy cigarettes from shops.
- The percentage of all children who tried to buy cigarettes from shops has declined to 4% in 2014. The greatest drop was seen in 2008 when the age at which children could be sold cigarettes was raised to 18.
- Among those children who had attempted to buy cigarettes from a shop, over 40% said they were always successful when they tried.
- The majority of current smokers had asked someone else to buy them cigarettes from a shop (87% of regular smokers and 49% of occasional smokers).
- In 2014, 91% of pupils who had asked someone else to buy them cigarettes from a shop in the last year had been successful at least once.

Key points from Plymouth’s health related behaviour survey:

- 16% of Year 10 girls in Plymouth obtained their cigarettes from a friend;
- 8% of Year 10 pupils reported that they have bought cigarettes or tobacco at a price cheaper than usual in the shops.

Figure 20 shows that locally, friends are the most common supply of cigarettes, with other sources being directly from shops and other people and parents.

The most common source of cigarettes for children is being given them by friends. This suggests a social network element of obtaining tobacco for children.

When they do attempt to buy cigarettes, children say that it is not difficult and report local newsagents as being the type of shop most commonly used.

Figure 20: Locations pupils reported obtaining cigarettes (%), 2014

Source: Plymouth City Council

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39 Plymouth Schoolchildren’s Health Related Behaviour Survey (2014)
4. Services and activity

Tobacco control is an internationally recognised, evidence based discipline that seeks to reduce harm caused by tobacco by coordinating a range of successful, evidence based approaches. Measures that have successfully combined to reduce rates of smoking in England have included smoke free public places, standard packs, and the offer of free NHS services to help people quit. The local plan coordinates local actions and works in sync with nationally adopted measures to sustain and increase the beneficial impacts of the range of tobacco control measures.

The broad range of factors that influence use of tobacco (see section 3, above) necessitates a strategy combining a range of evidence based approaches in order to be effective. These approaches have been identified by the national tobacco control plan in relation to the degree to which they involve regulatory control. For example, the supply of tobacco to children and illegal, non-duty paid tobacco are key areas that are heavily regulated and controlled through strict enforcement of relevant laws. Other elements involve less emphasis on control and focus more on influence through working with individuals and groups of people to inform their choices. Both approaches are needed, in combination, to make long term population wide shifts in rates and take-up of smoking.

The goal is to reduce smoking overall with particular focus on groups of greater need identified in this needs assessment and preventing up-take among young people.

Approaches include supply side measures, for example the disruption of illegal tobacco and interventions at the demand side, such as the use of evidence based behavioural insights, enhancement of national marketing campaigns, and working with young influential peers to prevent the uptake of smoking.
4.1 The Nuffield ladder of interventions

Actions taken to improve health can be viewed as a range of interventions positioned on a spectrum, represented by a ladder. Each step upwards represents a shift from approaches at the foot of the ladder that focus more on enabling and empowering towards those at the top, which involve a greater degree of control.

Figure 21: Nationally delivered tobacco control approaches on the Nuffield ladder of public health interventions

- **Eliminate choice**: support enforcement of age of sale laws
- **Restrict choice**: promote enforcement of smoke free laws
- **Guide choice through disincentives**: use tax to maintain high price
- **Guide choice through incentives**: support local areas to use behavioural insights
- **Guide choice through changing the default policy**: work with professionals to help them engage with and refer smokers
- **Enable choice**: support extension of options available to help people stop smoking
- **Provide information**: signpost the help available
- **Monitor the current situation**: consider further action on advertising of smoking accessories

Figure 22: Locally delivered tobacco control approaches on the Nuffield ladder of interventions

**Eliminate choice:** ensure compliance with age of sale laws.

**Restrict choice:** disrupt the supply of cheap and illegal tobacco; ensure compliance with Smoke Free laws.

**Guide choice through changing the default policy:** Deliver brief interventions via health and social care professionals.

**Enable choice:** Provide peer support programme to young people to enable them to maintain smoke free social networks.

**Provide information:** provide balanced risk based information on vaping; use behavioural insights in our communications and marketing strategies.

**Monitor the current situation:** Review regular updates to Tobacco Control Profile, tobacco elements of PCC dashboard; repeat the local health behaviours in schools survey.

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4.1.1 Trading Standards Service

**Nuffield ladder rung: eliminate choice**

**Local level action:** secure compliance with age of sale laws. The Trading Standards team undertake a range of different activities in this area in close partnership with Devon and Cornwall Police and the regional Trading Standards body SWERCOTS. Work includes delivering test purchase operations with associated follow up action. Table 2 details the test purchase operations carried out since April 2009.

Table 2: Under Age Sales Test Purchase programme 2009 to 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Premises tested (n)</th>
<th>Sales (n)</th>
<th>Rate of sale (%)</th>
<th>Regulatory outcome</th>
<th>Publicity (media coverage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>April 2009 – Mar 2010</td>
<td>84</td>
<td>10</td>
<td>12%</td>
<td>Revisits + training</td>
<td>Press release</td>
</tr>
<tr>
<td>April 2010 – Mar 2011</td>
<td>69</td>
<td>15</td>
<td>22%</td>
<td>Warnings + training</td>
<td>Press release</td>
</tr>
<tr>
<td>April 2011 – Mar 2012</td>
<td>25</td>
<td>4</td>
<td>16%</td>
<td>4 cautions</td>
<td></td>
</tr>
<tr>
<td>April 2012 – Mar 2013</td>
<td>34</td>
<td>4</td>
<td>12%</td>
<td>2 warnings 2 cautions</td>
<td></td>
</tr>
<tr>
<td>April 2013 – Mar 2014</td>
<td>17</td>
<td>8</td>
<td>44%</td>
<td>5 warnings 2 cautions 1 prosecution</td>
<td>Press release for prosecution</td>
</tr>
<tr>
<td>April 2014 – Mar 2015</td>
<td>50</td>
<td>7</td>
<td>14%</td>
<td>2 warnings 5 cautions</td>
<td></td>
</tr>
<tr>
<td>April 2015 – Mar 2016</td>
<td>15</td>
<td>3</td>
<td>20%</td>
<td>1 warning 2 cautions</td>
<td></td>
</tr>
<tr>
<td>E-cigs – Feb 2016</td>
<td>15</td>
<td>9</td>
<td>60%</td>
<td>Re-visits for advice</td>
<td>Press release</td>
</tr>
</tbody>
</table>

**Nuffield ladder rung: restrict choice**

**Local level action:** these are measures principally aimed at disrupting the supply of cheap and illegal tobacco and reducing exposure to second-hand tobacco smoke. Restrictive legal controls also exist on the display of tobacco, the use of vending machines, packaging for tobacco products, and smoking in cars with children.

Plymouth City Council’s Trading Standards team are the enforcing authority for many of these laws and work to build compliance among local businesses by offering a combination of proactive educational and reactive enforcement work.

**Nuffield ladder rung: guide choice through disincentives**

Reducing the affordability of tobacco is known to reduce smoking prevalence and illegal tobacco is associated with organised crime, children and young people’s smoking, as well as losing significant amounts of revenue for the Treasury.

**Local level activity:** Trading Standards in Plymouth continue to work with HMRC to work to reduce the supply of illegal tobacco. Table 3 quantifies the amount of tobacco seized by the Trading Standards team. Over the last 6 years the team have seized the equivalent of over £100,000 of tobacco at today’s prices.
National Institute for Health and Care Excellence have confirmed the fundamental role that cheap and illegal tobacco has in influencing rates of smoking and acknowledged the need for further evidence based guidance to be developed.

Table 3: Plymouth Trading Standards Regulatory Services illegal tobacco operational job results 2010 to 2016

<table>
<thead>
<tr>
<th>Year</th>
<th>Counterfeit (kg)</th>
<th>Non-UKDP (kg)</th>
<th>Total</th>
<th>£</th>
<th>Counterfeit (tips)</th>
<th>Non-UKDP (tips)</th>
<th>Total</th>
<th>£</th>
</tr>
</thead>
<tbody>
<tr>
<td>2016</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>378</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.00</td>
</tr>
<tr>
<td>2015</td>
<td>5.15</td>
<td>20.15</td>
<td>25.3</td>
<td>9,563</td>
<td>0</td>
<td>1178</td>
<td>1,178</td>
<td>483</td>
</tr>
<tr>
<td>2014</td>
<td>0.15</td>
<td>18.25</td>
<td>18.4</td>
<td>6,955</td>
<td>10,960</td>
<td>45,460</td>
<td>56,420</td>
<td>23,132</td>
</tr>
<tr>
<td>2013</td>
<td>32.6</td>
<td>38.5</td>
<td>71.1</td>
<td>26,876</td>
<td>0</td>
<td>2,000</td>
<td>2,000</td>
<td>820</td>
</tr>
<tr>
<td>2012</td>
<td>0.85</td>
<td>20.65</td>
<td>21.5</td>
<td>8,127</td>
<td>0</td>
<td>50</td>
<td>50</td>
<td>21</td>
</tr>
<tr>
<td>2011</td>
<td>28.75</td>
<td>0</td>
<td>28.75</td>
<td>10,868</td>
<td>0</td>
<td>20,600</td>
<td>20,600</td>
<td>8,446</td>
</tr>
<tr>
<td>2010</td>
<td>11.4</td>
<td>12.825</td>
<td>24.225</td>
<td>9,157</td>
<td>320</td>
<td>297</td>
<td>617</td>
<td>253</td>
</tr>
</tbody>
</table>

UKDP = UK duty paid

Hand rolling tobacco and cigarettes total £105,079
Hand rolling tobacco and cigarettes / year £15,011
4.1.2 **Workplace Wellbeing Charter**  
**Nuffield ladder rung: guide choice through incentives**  
**Local level activity:** encourage employers to take a proactive approach to workplace health through the Workplace Wellbeing Charter. This provides incentives in the form of recognition for healthy criteria, including smoke free policies, being met.

4.1.3 **Brief interventions**  
**Nuffield ladder rung: guide choice through changing the default policy**  
**Local level activity:** One You Plymouth team provide training and guidance to a range of health professionals – including health visitors, midwives, children centre staff – on the use of brief intervention techniques to talk to people about smoking and signpost people towards support to stop.

4.1.4 **Stop smoking services**  
**Nuffield rung: enable choice**  
**Local level activity:** stop smoking services are a key component of highly cost-effective tobacco control strategies at local and national level. Targeted, high-quality stop smoking services are essential to the reduction of health inequalities for local populations. All health and social care services can play a key role in identifying smokers and referring people to stop smoking services. For those people who are not ready, willing, or able to stop in one step, harm reduction interventions can support them in moving closer to becoming smokefree. Specialist interventions provided by trained practitioners are the most effective way of quitting smoking successfully.

In Plymouth, NHS stop smoking services are provided by Livewell Southwest’s One You Plymouth team, pharmacies, and GP practices. Together, they support over 1,000 four-week quits each year although these numbers are showing a decrease year on year, both in Plymouth and nationally.

One You Plymouth team provide Level 3 support for people from priority groups who wish to quit, including pregnant women. They also support other local providers, monitor performance, provide training, and undertake marketing activity to recruit quitters. The pharmacies and practices which are signed up to the public health contract for smoking cessation provide Level 2 support delivered by registered advisors.

In addition the One You Plymouth team coordinate and deliver an evidence based peer supporter programme, called Decipher ASSIST, which aims to prevent the uptake of smoking during early teenage years.

Figure 23 shows the number of people setting a quit date with local stop smoking services and the numbers who successfully quit between 2007/08 and 2015/2016 in England. Both values show a decline in numbers. The quit rate remains fairly stable at around 50% of those setting a date.

Figure 24 shows the number of people setting a quit date and the numbers of successful quitters in Plymouth between 2011/12 and 2015/16. The trend in Plymouth is similar to that for the rest of England. The quit rate among people who have accessed local support has shown a gradual improvement and currently stands at 46% of those setting a date.
The decline in numbers of clients for the local stop smoking service shows a pattern that mirrors the national picture. The cost effectiveness of the local stop smoking service, at £463 per quitter is similar to other local authority areas with a similar demographic to Plymouth.\(^{42}\)\(^{43}\)

\(^{42}\) http://content.digital.nhs.uk/catalogue/PUB21162
\(^{43}\) http://www.tobaccoprofiles.info/
4.1.5 Cessation in secondary care settings
Savings to the NHS can be accelerated by treating tobacco dependence as an essential part of care plans for patients. This can be achieved by a whole hospital approach as per NICE PH48 guidance by: 1) screening and recording smoking status during every patient episode; 2) providing immediate access to nicotine replacement therapy (NRT) and or pharmacotherapies; 3) enabling smokers to access specialist in-situ support to quit; 4) implementing automatic e-referral for intensive behavioural support and other specialist treatment; 5) training of healthcare staff to deliver interventions; and 6) making secondary care settings smoke-free. Initiating treatment for tobacco dependency in hospital is critical but success will depend on continuing care after discharge. Patients who smoke should leave hospital with a clear treatment plan to address their tobacco dependence.

Stopping smoking at any time has considerable health benefits for people who smoke, and for those around them. For people using secondary care services, there are additional advantages, including shorter hospital stays, lower drug doses, fewer complications, higher survival rates, better wound healing, decreased infections, and fewer re-admissions after surgery.

Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among people who use, or work in, their services. This duty of care includes providing them with effective support to stop smoking or to abstain from smoking while using, or working in, their settings.

Hospitalisation presents an opportune time to encourage patients to stop smoking for four key reasons:
1. The time is often a “teachable moment” where patients are more receptive to intervention and are more motivated to quit.
2. The hospital’s no smoking environment creates an external force to support abstinence.
3. Patients are ideally placed to be given information about treatment options, support through withdrawal, and signposted to specialist services.
4. Abstaining from smoking at this time can lead to significant health benefits.

4.2 Client demographic profile

4.2.1 Ethnicity and gender
The ethnic and gender profile of people who access support to stop smoking in Plymouth broadly follows the profile of the total adult population of the city.

It should be noted that the ethnic background of 8% of users for the period 2011-2015 were recorded as “not stated”.

4.2.2 Age

Figure 25 shows the age bands of clients who have received support to stop smoking locally. Rates of take-up by age broadly follow a similar pattern to rates of smoking in the general population by age, with the graph showing a slight spike at age 18-34 and 45-59 years.

Figure 25: Number of people setting a quit date by age, Plymouth, 2011-2015

Source: HSCIC Monitoring return

4.3 Peer supporter programme

The One You Plymouth team are also commissioned to coordinate and deliver the Decipher ASSIST programme.

Decipher ASSIST is a smoking prevention programme which aims to reduce adolescent smoking prevalence. ASSIST encourages new norms of smoking behaviour by training influential Year 8 students to work as ‘peer supporters’. Peer supporters are trained and supported to have informal conversations with other Year 8 students about the risks of smoking and the benefits of being smoke-free.

ASSIST has been evaluated by a randomised controlled trial funded by the Medical Research Council. The trial found the ASSIST programme to be effective in reducing smoking prevalence over a two year period of follow-up. If implemented throughout the UK, it is estimated that the ASSIST programme would prevent 20,000 young people taking up smoking each year. It is estimated that the programme in Plymouth has prevented between 63-150 children from starting to smoke.

Internationally and in the UK no other schools-based smoking prevention programme has been found to be as effective in such a rigorously conducted large scale randomised trial.

45 http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(08)60692-3/fulltext
4.4 Marketing and communications
Nuffield rung: provide information
Local level actions: information is provided to local residents of Plymouth through amplification of nationally led marketing campaigns (One You, Stoptober, and illegal tobacco marketing campaigns), local PR activities, and awareness raising among stakeholder groups.

4.5 Plymouth City Council dashboard
Nuffield rung: monitor the current situation
Local level actions: tobacco control measures make a key contribution towards delivering Plymouth City Council’s corporate objectives. Table 4 describes the three tobacco related indicators that are included in the Plymouth City Council dashboard of indicators.

Table 4: Tobacco control indicators on the Plymouth City Council dashboard

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Dashboard</th>
<th>Source</th>
<th>Year</th>
<th>Current measure</th>
<th>RAG (England)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking prevalence in adults – current smokers (APS)</td>
<td>ISPIG</td>
<td>PHOF</td>
<td>2015</td>
<td>20.6%</td>
<td>Significantly worse than England</td>
</tr>
<tr>
<td>Smoking prevalence – 15 year olds</td>
<td>ODPH</td>
<td>PHOF</td>
<td>2014/15</td>
<td>9.2%</td>
<td>Similar to England</td>
</tr>
<tr>
<td>Smoking prevalence – adults</td>
<td>ODPH</td>
<td>PHOF</td>
<td>2015</td>
<td>20.6%</td>
<td>Significantly worse than England</td>
</tr>
<tr>
<td>Smoking status at time of delivery</td>
<td>ODPH</td>
<td>Local data</td>
<td>2014</td>
<td>15.6%</td>
<td>N/A</td>
</tr>
</tbody>
</table>
5. **Summary**

5.1 **Conclusions**

When rates of smoking are analysed by age and gender, the age bracket with the highest rate of smoking for men and women is 25-34 and the rate for men is higher than for women.

When rates of smoking are analysed by occupation, the population with the highest rate is RMWs. (NB the definition of RMWs includes people who have been unemployed for up to 2 years).

When analysed on a ward basis, the three wards in Plymouth with the highest rates of smoking (and therefore greater need) are: Devonport, Honicknowle, and St Budeaux.

The greatest increase in rate of trying smoking occurs between the ages of 10 and 13 years.

Pregnant women are a subgroup of the population with greater needs associated with their use of tobacco because of links to conditions associated with pregnancy.

Analysis of smoking by a person’s mental health status shows that groups of people with long standing mental illness have higher rates of smoking than the general population, both among adults and children.

Price, age, access, peer influence (social network effect,) and income/ deprivation can have a fundamental impact on the smoking behaviour of groups of people.

The most common source of cigarettes for children is being given them by friends. This suggests a social network element of obtaining tobacco for children.

When they do attempt to buy cigarettes, children say that it is not difficult and report local newsagents as being the type of shop most commonly used.

Points on the patient pathways to and from hospital provide opportunities where discussions about stopping smoking and the offer of additional support are likely to have a more productive impact.
5.2 Recommendations

5.2.1 Nice guidance recommendations

Figure 26: Evidence base of interventions on the Nuffield ladder of interventions

Eliminate choice:
Reduce uptake among children by effectively regulating age restricted sales

Restrict choice:
Disrupt the supply of cheap and illegal tobacco

Guide choice through changing the default policy:
Improve access to services through brief interventions and referral (PH1)
Develop school-based interventions to prevent smoking - SF policies, whole school approach (PH 23)

Enable choice:
Smoking cessation services (PH 10)
Identifying and supporting people most at risk of dying prematurely (PH 15)
Quitting smoking in pregnancy and following childbirth (PH 26)
School-based interventions to prevent smoking: peer support; curriculum enhancement (PH 23)
Smoking cessation in secondary care: acute, maternity and mental health services (PH 48)

Provide information:
Prevent the uptake of smoking by children and young people - marketing (PH 14)
5.2.2 Local provision RAG rated against NICE guidance

Table 5: Plymouths local level activity RAG rated against tobacco control NICE Guidance

<table>
<thead>
<tr>
<th>Evidence base recommendation</th>
<th>Do we already do it? (RAG rating)</th>
</tr>
</thead>
<tbody>
<tr>
<td>PH 14 Preventing the uptake of smoking by children and young people: age restricted sales and marketing</td>
<td>Test purchase programme, Amplify national campaigns</td>
</tr>
<tr>
<td>Illegal tobacco</td>
<td>Investigation and follow up legal action</td>
</tr>
<tr>
<td>PH1. Brief interventions and referral</td>
<td>Training for key groups</td>
</tr>
<tr>
<td>PH 10 Smoking cessation services</td>
<td>Provided by Livewell Southwest, GP and pharmacies</td>
</tr>
<tr>
<td>PH 26 Quitting smoking in pregnancy and following childbirth</td>
<td></td>
</tr>
<tr>
<td>PH 23 School-based interventions to prevent smoking: SF policies, whole school approach peer support; curriculum enhancement</td>
<td>Peer supporter programme; teacher CPD training offer</td>
</tr>
<tr>
<td>PH 48 Smoking cessation in secondary care: acute, maternity and mental health services</td>
<td>Stop smoking service available to secondary care, acute, maternity and mental health services</td>
</tr>
</tbody>
</table>
5.2.3 Local recommendations:
More specifically, the following recommendations are made:-

Recommendation 1:
Local tobacco control interventions should be implemented to ensure that they focus on areas of greater need as identified in this needs assessment.

Recommendation 2:
The city should expand the brief intervention training programme to new front facing professionals who engage with those groups identified in this needs assessment.

Recommendation 3:
The city should focus efforts to tackle the uptake of smoking in electoral wards with higher rates.

Recommendation 4:
The ODPH should maintain support for Plymouth’s Healthy Child Quality Mark to continue to build the whole school approach to tackling tobacco.

Recommendation 5:
The ODPH should embed tobacco control issues in the Continued Professional Development - Thrive Plymouth offer to teachers.

Recommendation 6:
The ODPH and One You Plymouth team should maintain the Decipher ASSIST peer supporter programme in targeted secondary schools.

Recommendation 7:
The Maternity and Early Years System Optimisation Group (MEYSOG) should review the pathway for pregnant mums who smoke and introduce service changes to ensure a consistent systematic and effective approach by related health professionals.

Recommendation 8:
The One You Plymouth team should consider a quitter incentive scheme for pregnant mums.

Recommendation 9:
The One You Plymouth team should continue to support smokefree sites in secondary care settings.

Recommendation 10:
It should remain a priority for the city’s enforcement bodies [Plymouth City Council, The Police Service and Her Majesty’s Revenue and Customs (HMRC)] to continue to work to disrupt the supply of cheap and illegal tobacco.
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