Lifestyle factors:
Tobacco
The document describes the policy context, estimated prevalence, risk factors and sub-groups of need, current service provision and national best practice in relation to tobacco use in Halton. It considers the issue across the lifecourse.

Please quote the JSNA

We would like to know when and how the JSNA is being used. One way, is to ask people who use the JSNA when developing strategies, service reviews and other work to quote the JSNA as their source of information.
List of Abbreviations

ASH       Action on Smoking and Health
BME       Black & Minority Ethnic
CO        Carbon monoxide
DSR       Directly Standardised Rate
GP        General Practitioner
HSCIC     Health and Social Care Information Centre
HSE       Health Survey for England
IHS       Integrated Household Survey
IMD       Index of Multiple Deprivation
JSNA      Joint Strategic Needs Assessment
LGB       Lesbian, Gay and Bisexual
NHS       National Health Service
NICE      National Institute for Health and Clinical Excellence
NW        North West
ONS       Office for National Statistics
PCT       Primary Care Trust
PHE       Public Health England
PHOF      Public Health Outcomes Framework
RMW       Routine and Manual Workers
SHS       Second hand smoke
SIDS      Sudden Infant Death Syndrome
SUS       Secondary User Service (local hospital admissions database)
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<th>Goal</th>
<th>Description</th>
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<tr>
<td><strong>Intelligence</strong></td>
<td>A dataset that enables a full understanding of smoking prevalence and outcomes including inequalities</td>
<td>Data is available on a regular basis on both smoking prevalence and smoking cessation service outcomes. However, lack of locally driven data collection limits the ability to fully understand the varying smoking prevalence and needs of different groups within the borough.</td>
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| **Level of Need: Maternity and Early Years** | Reduce the level of smoking uptake and prevalence and reduce inequalities amongst different groups within the borough and between Halton and comparators | • There have been small incremental changes at both a national, regional and local level. However, Halton rates remain higher, probably reflections of the levels of deprivation and social complexity of the local population.  
• Admission rates due to asthma amongst 0-18s are higher in Halton than England and vary substantially across the borough. |
| **Level of Need: School-age children** | • Data from both national and regional surveys shows that the percentage of young people who start to smoke has been falling. The percentage in Halton who smoke is similar to the North West. However, modelled estimates suggest a slightly higher level than the Trading Standards NW survey. They also show prevalence amongst Halton YP is likely to be higher than the England rate.  
• The percentage of YP who purchase cigarettes from unlicensed vendors and ‘fake’ cigarettes is higher than the North West averages and has been one of the highest in the North West  
• Despite the low percentage of YP who smoke, there is a perception amongst YP that smoking is much more prevalent amongst their peers than is actually the case. Whilst only 7% indicated that they had used e-cigarettes, YP thought a third of their year group smoked them |
| **Level of Need: working age adults and older people** | • Adult smoking prevalence has been falling steadily over recent years. However, data from different sources provides variation in smoking prevalence within the borough. Whilst the 2013 Integrated Household Survey put the figure at 18.4%, the same as the England average, 2012/13 Merseyside Lifestyle survey put it at 30%. Differences in methodology and confidence intervals help to explain this but mean a ‘definitive’ prevalence is difficult to determine  
• Prevalence varies slightly by gender but more significantly with age. Prevalence is highest amongst the 25-34 age group and lowest amongst those aged 65+ |
| **Level of Need: Vulnerable groups** | • Deprivation plays a significant role in smoking prevalence. Both the HIS and Merseydie Lifestyle survey show that those is routine and manual groups or living in the most deprived quintile have higher smoking prevalence and those living in the least deprived areas had lower prevalence.  
• Rates varied from 49.1% in Norton South to 6.5% in Heath ward |
| **Service Provision: smoking cessation** | Ensure that Halton continues to provide services that meet people’s needs and produce recommended outcomes | • Analysis of Halton’s Specialist Smoking Cessation Service shows that whilst there is not a perfect match between need and outcomes (successful 4-week quit rates), there is a good match. However, there are a few areas within the borough with high prevalence where the quit rates appear relatively low. This needs further investigation.  
• Halton has comparable or slightly higher success rates (percentage of people who set a quit date and a successful at 4 week, either self-reported or carbon monoxide validated) compared to England and the North West.  
• Of note, Halton’s success rate amongst routine and manual workers is
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<td>• Higher than comparators.                                                                                               • However, the success rate per 100,000 population is lower than comparators, yet the smoking prevalence is at least comparable, if not higher. This would suggest an expected rate per 100,000 higher than comparators not lower. It suggests less people access the service per head of population but the higher success rates show that the service is effective in aiding quitting. The local model has historically been one of GP practices providing an intermediate level service and sharing quit data with the specialist service. However, since this has begun to wane success per head of population has fallen. This suggests the issue may be, in part at least, due to data sharing, as much as people being given support to quit.</td>
</tr>
<tr>
<td>Service</td>
<td>Provision: smoke-free environments</td>
<td>• Halton has been active in action to tackle tobacco from the petition to ensure smoke-free legislation to smoke-free playgrounds. Trading Standards are active in tackling illegal sales and counterfeit tobacco. Environmental Health and Trading Standards are part of the Public health team within Halton Borough Council, which offers further opportunities to integrate action on tobacco control</td>
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<tr>
<td>Impacts</td>
<td>Reduce the impact smoking has on morbidity, mortality and wider factors through continued action to reduce smoking prevalence</td>
<td>• Smoking continues to have a significant impact on morbidity and mortality locally. For example mortality rates attributable to smoking is higher in Halton than in the North West and England                                                                 • Income generated from taxation and duty on tobacco is less than the cost to the local economy and health &amp; social care system                                                                 • The legacy of high smoking prevalence is still having an effect due to log lag period between exposure and disease development. This can be seen for example in female lung cancer incidence and mortality rates which have been increasing recently, whilst rates amongst men continue to fall. The incidence rates has been converging and the mortality rate for females is now higher than for males.</td>
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1. Introduction

Tobacco use remains one of the most significant global public health challenges today and is a key government public health priority. Smoking is the most harmful form of tobacco use and continues to be the major cause of preventable morbidity and premature death, responsible for more than 80,000 deaths per year in England, 18% of all deaths of adults aged 35 and over. Most died from lung cancer, chronic obstructive pulmonary disease (bronchitis and emphysema) and coronary heart disease. It was also a major cause of ill health, leading to approximately 1.5 million hospital admissions nationally in 2010/11. With up to 10,000 dying from the effects of inhaling secondhand smoke, tobacco is killing more people per year than the next six most common causes of preventable deaths combined (i.e. drug use, road accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse). It is estimated to cost the NHS in the UK £5.2 billion a year. [1]

Smoking rates are much higher in some social groups, including those with the lowest incomes. Smoking is the single biggest cause of inequalities in death rates between the richest and poorest in our communities. In Halton, inequalities exist, in terms of tobacco use as well as health outcomes, between the affluent and the deprived.

The independent review into health inequalities in England undertaken by Professor Sir Michael Marmot[2] identified the most effective evidence-based strategies for reducing health inequalities in England. Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.

Nearly 7 out of 10 adults (66%) who had ever smoked regularly began before they were aged 18, with 40% of men and 38% of women starting before the age of 16. Those in routine and manual households were more likely to have started smoking before they were 16 than those in managerial and professional households (45% and 31% respectively).[3] Those who started smoking when they were young were three times more likely to die of a smoking-related disease. Having a low birth weight increases the risk of ill health and death for an infant and smoking in pregnancy increases the risk of having a low birth weight baby by 3.5 times. There is also a dose response relationship, i.e. the more cigarettes smoked, the lower the birth weight.[4]

Second-hand smoke is a major risk to the health of non-smokers, especially children. Family and household smoking increases the risk of sudden infant death, lower respiratory tract infections, middle ear infections and wheeze asthma. As smoking is higher in more deprived families, so most of the burden of disease falls on the most disadvantaged children and has an effect on development and behaviour, all of which is avoidable. [5]
2. Policy Context

2.1 National Policy

Smoking remains the leading cause of preventable death and disease in England, and is one of the most significant factors that impacts upon health inequalities and ill health, particularly cancer, coronary heart disease and respiratory disease. Treating smoking-related illness is estimated to cost the NHS £2.7bn a year, with the wider economic costs reaching over £13bn once factors such as lost productivity, tobacco litter and smoking-related house fires are taken into account. Reducing smoking prevalence therefore remains a key local public health priority and a national focus.

National policy and broader local tobacco control strategies are proven to be effective in reducing smoking prevalence and an effective way of reducing the rate of children and young people taking up smoking is to support adult smokers to stop.

There have been many national documents published aimed at reducing the prevalence of smoking in the population.

- Smoking Kills, (1998)
- BEYOND Smoking Kills (2008)

Major achievements over the last 10 years include:

- Smoke free legislation
- Graphic picture warnings on cigarette packets
- A rise in age from 16 – 18 for the legal sale of tobacco
- Removal of cigarettes from vending machines and at point of sale

Planned legislation on plain packaging:
The UK is set to become the second country in the world and the first in Europe to require cigarettes to be sold in plain, standardised packaging, following the lead of Australia which implemented the measure in December 2012. If the draft regulations are approved by a final vote in Parliament the measure could be in place by May 2016.
2.2 New Strategy Proposals


The Plan includes clear goals to reduce:

- adult smoking prevalence from 21% to 18.5% by 2015
- smoking rates among 15 year olds from 15% to 12% by 2015
- smoking in pregnancy from 14% to 11% by 2015.

These national ambitions will not translate into centrally driven targets for local authorities but represent an assessment of what could be delivered as a result of local areas implementing evidence-based best practice for comprehensive tobacco control.

Through this plan, the Government supports comprehensive tobacco control in England across the six internationally recognised strands, which are:

- stopping the promotion of tobacco
- making tobacco less affordable
- effective regulation of tobacco products
- helping tobacco users to quit
- reducing exposure to secondhand smoke
- effective communications for tobacco control

2.3 Regional Policy

Tobacco Free Futures is a partnership programme covering the Northwest which draws on evidence based research and valuable public insight to tackle tobacco harm, drive down smoking prevalence, and reduce childhood addiction within Local Authority areas. Smoking kills 13,000 people a year in the North West and over 24,000 children start smoking every year, which is 68 children a day or one every 20 minutes. In the UK this is 207,000 new smokers, aged 11-15 every year. In the North West alone smoking costs £2 billion every year. This includes direct costs to local smokers as well as the costs incurred by local NHS services and the wider community.

Tobacco Free Futures priorities are:

- Youth led and focussed action
- Protecting children from secondhand smoke
- Reducing the supply and demand of illicit tobacco
- Supporting stop smoking services
- Supporting smokefree pregnancy
2.4 Local Policy

Halton’s Strategic Partnership set out five priorities for the Borough, in its Sustainable Community Strategy 2011-2026, which will help to build a better future for Halton:

- A Healthy Halton
- Employment learning and skills in Halton
- A Safer Halton
- Children and Young people in Halton
- Environment and Regeneration in Halton

Tobacco Control contributes towards the Sustainable Communities Strategy priorities as demonstrated in Figure 1.

Figure 1: Tobacco Control initiatives contribution to the Sustainable Communities Strategy priorities

- **A Healthy Halton**
  - By reducing smoking prevalence, and thereby health inequalities, to improve the health and wellbeing of Halton people so they live longer, healthier and happier lives

- **Employment, Learning and Skills**
  - Providing information and training to health and social care professionals in order to deliver evidence-based smoking cessation support
  - Providing advice on Tobacco policy to workplaces and access to cessation

- **A Safer Halton**
  - Tackling illegal, illicit and counterfeit tobacco-related crime within communities

- **Children and Young People**
  - Reducing smoking prevalence in pregnant women
  - Reducing the harmful impact to children caused by secondhand smoke
  - Reducing the risk of children and young people taking up smoking
  - Providing Tobacco education in Halton’s schools
  - Providing policy guidance to schools

- **Environment and Regeneration**
  - Supporting national smokefree legislation to reduce the harmful impact of secondhand smoke
  - Promoting smokefree children’s play areas in Halton’s parks
3. Level of need in the population

3.1. Maternity and Early Years

3.1.1. Smoking during pregnancy

Smoking during pregnancy causes poorer outcomes because smoking harms both the mother and the baby. Research has shown that smoking during pregnancy increases the risk of pregnancy complications, premature delivery, low-birth-weight infants, stillbirth, and sudden infant death syndrome (SIDS). In the UK smoking is believed to be one of the main causes of low birth weight.

Smokers inhale nicotine and carbon monoxide, which reach the foetus via the placenta and prevent the baby from getting the nutrients and oxygen it needs to grow. Smoking detrimentally effects the babies heart, blood pressure, breathing and development. The impact of smoking on birth weight is believed to be particularly important in the final three months of pregnancy.

If a mother stops smoking during pregnancy she can reverse and reduce some of the risks.

Key messages: Smoking during pregnancy

- Women who smoke are at increased risk of ectopic pregnancy.
- Women who smoke during pregnancy may be at increased risk of having a miscarriage.
- Women who smoke are three times more likely to have a low birth-weight baby.
- Women who smoke during pregnancy are more likely to suffer a stillbirth.
- Babies born to women who smoke during pregnancy are more likely to die during the first four weeks of life.
- Women who smoke during pregnancy are at increased risk of certain complications of the placenta.
- Women who smoke during pregnancy may be at increased risk of giving birth prematurely.
- Smoking during pregnancy may increase the risk of certain foetal malformations.
- Stopping smoking before pregnancy avoids these risks.
- Stopping smoking in the first three months of pregnancy greatly reduces the risk of low birth-weight.
- Stopping smoking at any stage during pregnancy brings proportional health benefits.

Source: British Medical Association 2004

In Halton a specialist smoking cessation service is available to help pregnant women to stop smoking, there is also a midwife who specialises in this area. However evidence suggests that the majority of women who smoked at the beginning of pregnancy continued to smoke throughout their pregnancy.
Figure 2: Annual trend in smoking at time of delivery

The data in the chart above should be treated with a degree of caution since it is not clear whether smoking status is double checked at time of delivery. Nevertheless, supporting women and families of a child bearing age, and pregnant women to never smoke and to stop smoking needs to remain a high priority for Halton.

The percentage of full term babies born with a low birth weight in Halton is now below the North West and England average. Although the percentage has been subject to fluctuations, the overall trend is a downwards one.

Figure 3: Trend in percentage of full term babies that are a low birth weight

The data in the chart above should be treated with a degree of caution since it is not clear whether smoking status is double checked at time of delivery. Nevertheless, supporting women and families of a child bearing age, and pregnant women to never smoke and to stop smoking needs to remain a high priority for Halton.

The percentage of full term babies born with a low birth weight in Halton is now below the North West and England average. Although the percentage has been subject to fluctuations, the overall trend is a downwards one.
Halton’s crude rate of stillbirths is slightly higher than the England average but the difference is not statistically significant.

3.1.1. Impacts of exposure to smoke during early years and childhood

Exposure to smoke is not only important during pregnancy, but also once the child has been born. Smoking causes significant health risks for the child through breathing in second hand smoke (SHS), often referred to as passive smoking. Reviews of the research around poor health outcomes for children exposed to SHS have found:\[19\]

- SHS exposure in the home increases young infants’ risks of lower respiratory tract infections (including flu, bronchitis and pneumonia) by around 50%
- Exposure to pre or post-natal SHS is associated with between 30-70% increased risk of wheeze, and 21-85% increased risk in asthma in children
- A further review reported exposure to SHS was associated with a 30% increased risk of physician-diagnosed asthma in childhood
- Exposure to maternal smoking increases a child’s risk of middle ear infection by over 60%, and when exposed to both parents smoking children are significantly more at risk of needing surgery for middle ear infections
- Maternal smoking after birth is associated with a three-fold increased risk of SIDS. Having one or more smokers living in the household more than doubles the risk of SIDS
- In the UK around 2 million children are estimated to be regularly exposed to SHS in the home and many more are outside the home

Heart of Mersey estimated that in Cheshire and Merseyside 46,239 children are exposed to SHS each year. Illnesses related to exposure to SHS (in children and adults) are estimated to cost the NHS £32.9 million pounds a year.\[20\]

Bronchiolitis is a common lower respiratory tract infection that most commonly affects babies and young children under a year old. Most cases are mild and improve without specific treatment within about two weeks, although some children have severe symptoms and need treatment in hospital. However, there are several things that can increase the risk of developing the condition. These include:\[21\]
- being breastfed for less than two months or not at all
- being exposed to smoke, for example if parents smoke
- having brothers or sisters who attend school or nursery, as they are more likely to come into contact with a virus and pass it on

Between April 2010 and March 2014, there were 365 emergency admissions for Acute Bronchiolitis in babies under 1 year old; 110 of these were during 2013/14 with between 80-90 occurring in the other three years.

There was less than 5 cases of SIDS in Halton between 2006 and 2013. The national rate during 2012 was 0.22 per 1,000 births (158 total infant deaths).

Infants and children of parents who smoke are twice as likely to suffer from a serious respiratory infection as the children of non-smokers. Smoking during pregnancy can also increase the risk of asthma and wheezing in young children. Research suggests that the increased risk of asthma and respiratory infections may be due to changes in biological receptors in the baby’s immune system that are responsible for recognising and fighting infections and bacteria.\(^{22}\)

Asthma is the most common long-term condition among children. The UK has one of the highest rates in the world with around one in 11 children having the condition. Research by the Royal College of Paediatrics and Child Health published in 2009 revealed at least 209 per 100,000 children aged 0-17 have diabetes (any type)\(^ {23} \). Epilepsy is the most common serious neurological condition. The Joint Epilepsy Council estimates it affects 1 in 220 children under 18 in the UK. They also note that more than one in five people with epilepsy have learning or intellectual disabilities and that prevalence is 25% higher in the most socially deprived areas compared to the least socially deprived areas\(^ {24} \). Applying these prevalence rates to Halton’s population aged under-19 (in line with the NHS Outcomes Framework indicator for hospital admissions) suggests about 2,583 young people may have asthma.

**Figure 5: Asthma admission rate in 0-18 year olds, due to Asthma, Halton and comparators**

Source: Hospital Episode Statistics via CHIMAT (DHMT), 2014
Analysis of hospital admission shows that Halton’s rates rose between 2009/10 and 2011/12, then fell slightly. However, rates are now higher than all comparators, although the difference is not great except between Halton and England.

Rates also vary within the borough as Figure 6 shows.

Figure 6: Crude rate of admissions in 0-18 year olds, due to Asthma, 2011/12 to 2013/14
3.2. School-Age children

Individuals who start smoking at a young age have higher age-specific rates for all types of tobacco related cancers, linked primarily to their earlier exposure to the harmful toxin from cigarettes.\textsuperscript{25}

Smoking aggravates asthma symptoms in those already diagnosed, and increases the risk of asthma in young people with no history of the condition.\textsuperscript{26} It can also lead to impaired lung growth in children and young adults.\textsuperscript{27}

Smoking continues to be a public health concern, with an on-going focus on the protection of children and young people from its harmful effects. \textit{Healthy lives, healthy people}\textsuperscript{28} laid out policy for improving public health across England. It makes clear that tobacco consumption will continue to be a key public health priority.

The \textit{Smokefree} legislation, implemented in July 2007, prohibited smoking in enclosed public spaces, including the workplace. This was unlikely to have a direct effect on children and young people but there may have been indirect effects, for example through the influence of changes in smoking habits by other household members. In October 2007, it became illegal to sell tobacco products to anyone under the age of 18 (rather than 16), in England and Wales. The Health Act 2009\textsuperscript{29} prohibited the sale of tobacco products from vending machines from 2011, and the display of tobacco products at all points of sale by the end of 2015. Since 6\textsuperscript{th} April 2012 it is illegal for large shops, like supermarkets, to display tobacco products. This extends the overall ban on promoting tobacco products in public in ways that are believed to be particularly attractive to non-smokers and young potential smokers.

The White Paper \textit{Healthy lives, healthy people: a tobacco control plan for England}, published in 2011, set out a strategy for reducing tobacco use in the next five years, with the stated aim ‘to reshape social norms to make smoking less desirable, less acceptable, and less accessible’. The plan acknowledged that tobacco use amongst adults must be addressed in order to reduce the number of young people who take up smoking. It included a national ambition to reduce the proportion of 15 year olds who are regular smokers to 12% or less by the end of 2015.

National Picture

\textit{Smoking, Drinking and Drug Use among Young People in England} is an annual survey carried out by pupils in years 7-11 in participating schools across England to provide national estimates and information on the smoking, drinking and drug use behaviours of young people aged 11-15. The latest published findings are for the 2013 survey\textsuperscript{30}. Key findings include:

- In 2013, less than a quarter of pupils reported that they had tried smoking at least once. At 22%, this is the lowest level recorded since the survey began in 1982, and continues the decline since 2003, when 42% of pupils had tried smoking.
- 3% of pupils said that they smoked at least one cigarette a week, the survey definition of regular smoking. This is also at the lowest level measured since 1982, and considerably below the 9% who smoked regularly in 2003.
- The prevalence of regular smoking increased with age. Less than 0.5% of 11 year olds were regular smokers in 2013, and this increased to 8% amongst 15 year olds.
• 6% of pupils reported that they had smoked cigarettes in the last week. Older pupils were more likely than younger pupils to have smoked in the last week (13% of 15 year olds, compared with 1% of 11 year olds).

• Regular smokers consumed, on average (mean), 31.1 cigarettes a week. Occasional smokers consumed 3.4 cigarettes a week.

The 2012 survey covered issues pertaining to young people’s living and social circumstances in relation to smoking. It found:

• 67% of pupils reported being exposed to second-hand smoke in the last year.  
• 68% of pupils reported that members of their family smoked. About a third (32%) reported that one or both of their parents smoked.  
• Almost all smokers had at least one friend who smoked (97% of regular smokers and 98% of occasional smokers) compared with about half (51%) of non-smokers.  
• Pupils who lived with someone else who smoked were more likely to smoke themselves. Pupils who smoked were most likely to get cigarettes by being given them by other people (69%), typically by other friends (57%).

• The proportion of pupils who tried to buy cigarettes in shops in the past year has fallen in recent years, from 17% of pupils in 2006 to 5% in 2012. 51% of pupils who tried to buy cigarettes in a shop were refused at least once – in other words half (49%) were always successful.

• Most pupils (84%) believed that people smoked because they thought it made them look cool in front of their friends. Pupils were also very likely to agree that people of their age smoked because they were addicted to cigarettes (70%), or their friends pressure them into it (70%).

• Pupils were most likely to say that they got helpful information about smoking from their parents (73%), teachers (71%) and television (69%).

• Factors strongly associated with smoking include being female, being older, risky behaviours (drinking alcohol, drug use, truancy), and having friends and family who smoke.

For the first time the Health Survey for England conducted in 2013 examined a number of issues around children and smoking. It found similar influences to the 2012 young people’s survey detailed above. In particular:

• Among children aged 0-15, the mean reported number of hours per week exposed to others’ smoke decreased from 2.6 hours for boys and 2.7 hours for girls in 2007-2008 to 1.0 hour for boys and 1.2 hours for girls in 2011-2013.

• For both sexes, the average reported number of hours per week of exposure to other people’s smoke increased with age.

• Children from lower income households were more likely to be exposed to secondhand smoke.

• Cotinine levels were higher among non-smoking children with one or more parents who currently smoked cigarettes than those in households with neither parent smoking.

• Multinomial logistic regression was used to examine factors associated with levels of secondhand smoke exposure (objectively measured) in cotinine-validated non-smokers aged 4-15. Key influences on the saliva cotinine levels among non-smoking children were age, living in the most deprived IMD (Index of Multiple Deprivation) quintile, parental smoking,
whether people smoked inside the home on most days, and whether or not the child had smoked in the past.

- Only a very small proportion of children aged 13-15 reported current or previous use of any non-tobacco nicotine delivery product, including e-cigarettes.

**Regional and Halton Picture**

Results from the Trading Standards North West Alcohol and Tobacco survey 2014 (Figure 6) showed that as with the national pattern, the percentage of young people who say they smoke has reduced. Halton levels in 2014 was the same as the regional average at 10%. It has fallen each year the survey data is available for, from a high of 24% in 2007.

**Figure 7: Percentage of young people aged 14 to 17 years of age who say they smoke, 2015**

Trading Standards North West Survey

Most young smokers claimed to have started smoking at the ages of 13-14, 38% were 12 or under when they first started smoking. Results from the survey also showed a fall in the proportion of young people purchasing fake cigarettes (19% compared to 23% for the NW average).

Modelled data is now available at a local authority level as part of PHEs Tobacco Profiles. Using modelled estimates derived from the Understanding Society survey Waves 1-3 (2009-12), Census and IMD 2010, they estimate the number and percentage of young people aged 11-15, 15 and 16-17 who are regular and occasional smokers. It should be noted that the survey uses different definitions to that used in the *Smoking, Drinking and Drug Use amongst Young People in England* survey and so the results cannot be directly compared.
Table 1: modelled estimates of regular and occasional smoking prevalence amongst 11-17 year olds in Halton

<table>
<thead>
<tr>
<th></th>
<th>Halton</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>%</td>
<td>Number</td>
</tr>
<tr>
<td>Regular smoking 11-15 years</td>
<td>4.2%</td>
<td>322</td>
</tr>
<tr>
<td>Regular smoking 15 year olds</td>
<td>11.4%</td>
<td>183</td>
</tr>
<tr>
<td>Regular smoking 16-17 years</td>
<td>18.7%</td>
<td>601</td>
</tr>
<tr>
<td>Occasional smoking 11-15 years</td>
<td>1.4%</td>
<td>109</td>
</tr>
<tr>
<td>Occasional smoking 15 year olds</td>
<td>3.8%</td>
<td>62</td>
</tr>
<tr>
<td>Occasional smoking 16-17 years</td>
<td>5.7%</td>
<td>184</td>
</tr>
</tbody>
</table>

In the Trading Standards North West survey, in 2011 respondents were most likely to have purchased cigarettes with health warnings in different languages in Trafford, Liverpool and Rochdale (though the sample sizes for the latter two local authorities is low so the results should be treated with caution). The NW average was 50%, with 58% of Halton respondents stating they had purchased such cigarettes. However whilst the NW rate rose slightly between 2013 and 2015 the Halton rate continued to fall and for 2014 was below the NW average. Many local authorities saw a rise 2014 compared to 2013 with the highest rates in 2014 being in Stockport (67%) and Cheshire West (63% but small sample size). However, the overall sample size for 2015 was much smaller and so differences may not be statistically significant.

Figure 8: Purchasing non-English language cigarettes, 2015 survey

Halton appears to have a relatively high proportion of young people who buy their cigarettes from vendors other than newsagents/supermarkets/general shops (joint third highest, behind Knowsley and Cumbria, the same as Cheshire West, all of whom had small sample sizes and so results need to be read with caution). This together with the data in non-English cigarettes is indicative of a significant proportion of young people buying counterfeit and/or smuggled cigarettes.
For the first time in the 2013 survey respondents were also asked if they had ever tried shisha smoking or e-cigarettes. Rates across the North West were generally low apart from in Blackburn and Oldham. Halton’s levels were significantly lower than the NW rates, at 8% - 9% indicating they had ever tried shisha.
Although based on a small sample size, there would appear to be a substantial increase in the proportion of young people who have tried e-cigarettes, with 44% of Halton respondents stating they had used them within the last month, higher than the NW average of 41%.

**Figure 12: Any e-cigarette use, 2015 survey**

![Graph showing e-cigarette use in 2013 and 2015 across different areas.](image)

*Source: Trading Standards North West Alcohol and Tobacco survey 2015*

**Figure 13: E-cigarette use in the last month**

![Graph showing e-cigarette use in the last month across different areas.](image)

*Source: Trading Standards North West Alcohol and Tobacco survey 2015*

Further analysis of the North West Trading Standards Survey 2013 in relation to e-cigarettes has recently been published by the Centre for Public Health at Liverpool John Moores University. The report found that one in eight (12.7%) young people reported having accessed e-cigarettes:

- E-cigarette access was strongly associated with tobacco smoking. Two thirds (66.7%) of regular smokers reported having ever accessed cigarettes, compared to 40% of ex-smokers and 24% of those that had never smoked tobacco cigarettes.
- Students whose parents or guardians smoked were at significantly increased risk of having accessed e-cigarettes. Almost two thirds (60.2%) of children that had accessed e-cigarettes had a parent or guardian that smoked.
- E-cigarette access was strongly associated with alcohol use. Young people who drank alcohol were more likely to access e-cigarettes than non-drinkers. Of those that drink,
binge-drinkers were more likely to have accessed them than non-binge drinkers. One in three young people that reported drinking at least weekly and binge drinking had accessed e-cigarettes.

- Young people that used e-cigarettes were significantly more likely to agree with statements supporting drunkenness (e.g. I only drink to get drunk), drinking due to boredom, and indicating alcohol related harm such as forgetting things after drinking. They were less likely to worry about the long-term health effects of drinking alcohol.
- They were less likely to worry about the long term health effects of drinking alcohol.

Social Sense’s R U Different? project was commissioned by Halton Borough Council Public Health team to work with eleven secondary schools (one Pupil Referral Unit, one college and nine schools) commencing in October 2014. The main target area was year 9s (72% aged 13 and 28% aged 14), with 1264 students in total completing the baseline survey, 46% of which were male and 54% were female. This ‘social norms’ initiative aimed to explore young people’s attitudes and behaviours in relation to what they thought their peers were doing. It then designs interventions to promote positive behaviours and dispel myths that may have also become apparent from the data. It found:

- Whilst 95% of students indicated that they had never smoke cigarettes, they perceived others in their year group to smoke more frequently (perception is that only 57% don’t smoke at all)
- The perception of non-smoking friends (with whom an individual will have more contact) is 73%, which although closer, is still short of the reported figure.
- 80% of those questioned felt that tobacco use was never a good thing to do, whilst 12% thought it was ok occasionally. When asked about the attitudes of others, respondents believed that 47% would say that tobacco was never a good thing to do, indicating a belief that others have less healthy beliefs than themselves.
- About e-cigarettes, most (93%) said ‘I have never used them’, 4% said ‘I just smoke them’ and 2% said ‘I smoke both e-cigarettes and normal cigarettes’.
- The perception is that 31% of others in their year group smoke e-cigarettes.
3.3. Working age Adults and Older People

The 2013 Health Survey for England (HSE)\(^{[35]}\) found:

- About one in four men (24%) and one in six women (17%) reported they were current smokers.
- The average number of cigarettes smoked per day among current smokers was higher for men (12.5 per day) than women (10.8 per day); older smokers had higher consumption.
- Prevalence of current smoking varied considerably across regions; it was highest for men in the West Midlands and women in the North East and Yorkshire and the Humber.
- The proportion of current smokers in the lowest two income quintiles was double the proportion in the highest income quintiles (36%-40% for men in the lowest quintiles, 17%-18% in the highest: the equivalent figures for women were 22%-30% and 10%-14%). Similarly, those living in the most deprived areas had the highest proportion of current smokers.
- 31% of men and 24% of women who had a limiting longstanding illness were current smokers.
- Among women, there has been a steady decline in the proportion of current smokers since around 2003 (26% in 1993, 24% in 2003, 17% in 2013). Equivalent figures for men were 28%, 27%, and 24%; however, there have been fluctuations year on year for men since 2006 rather than a continuing downward trend.
- 3% of adults were currently using e-cigarettes (vapourisers); a further 2% of men and 1% of women were currently using other nicotine delivery products but not e-cigarettes.
- Among men, 29% of current smokers, 6% of ex-smokers and 1% of never smokers had ever used e-cigarettes. The proportions were similar for women.
- Self-reported exposure to secondhand smoke was highest among those aged 16-24; over half of this age group reported at least some exposure. Exposure was most likely to occur in outdoor smoking areas of pubs/restaurants/cafes or at home (including other people’s homes).

Regional and Halton Picture

The most regular data in tobacco use at a local authority level is that used in the Health Profiles. It uses data from the Integrated Household Survey (IHS). Using a combined dataset of three different surveys, one conducted face-to-face and two via telephone interviews, it found that Halton’s smoking prevalence has reduced substantially over the last four years from a point where it was higher than the North West and England averages to a point in 2013 where it is now at the England average.
In 2012/13 a Merseyside Lifestyles survey was carried out. Using face-to-face interviews amongst a random stratified sample is found much higher prevalence of smoking among Halton’s population. The England comparator is from the 2010 Health Survey for England.

As can be seen rates differed slightly amongst men and women which is the same as the national picture, although the difference was less in the Merseyside lifestyle survey than for the HSE. Prevalence reduced with age and much substantially lower amongst black and minority ethnic (BME) populations and those who were owner occupiers. This latter point probably reflects the socioeconomic characteristics of home owners compared to those living in rented accommodation.
The reasons for the difference between the IHS results and the lifestyle survey results were examined. Some of the difference can be explained by differences in methodology and sample size, with the lifestyle survey using a larger, representative sample and exclusively face-to-face interviews which is considered to provide a more robust result. However, when examined further, the confidence intervals, although not overlapping, are close.

Figure 16: smoking prevalence, Merseyside Lifestyle survey compared to Integrated Household survey: explanation of results

The North West Mental Wellbeing Survey 2012/13[^36] also used face-to-face interviews. The sample size was smaller than for the lifestyles survey. It found an adult smoking prevalence rate in Halton of 28.2%.

Table 2: Smoking prevalence in Halton, North West Mental Wellbeing Survey, 2012/13

<table>
<thead>
<tr>
<th></th>
<th>2012/13</th>
<th>North West</th>
<th>2009</th>
<th>North West</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td>38.4%</td>
<td>45.0%</td>
<td>52.9%</td>
<td>47.8%</td>
</tr>
<tr>
<td>Non-smoker</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker</td>
<td>28.2%</td>
<td>27.7%</td>
<td>28.4%</td>
<td>29.1%</td>
</tr>
<tr>
<td>Ex-smoker</td>
<td>33.3%</td>
<td>27.2%</td>
<td>15.4%</td>
<td>20.8%</td>
</tr>
</tbody>
</table>

*2009 data for Halton are unweighted and consequently not representative of the Halton population nor directly comparable with 2012/13 data

Source: McHale, Hughes and Jones 2014

Because of these different results, it is probably most accurate to state that prevalence is between 18% and 30%.

Prevalence also varies across the borough. Analysis of the 2012/13 lifestyles survey shows the rates being highest in Norton South (49.1%) and lowest in Heath ward (6.5%). There was no data from Hale.
3.4. Smoking Prevalence amongst Vulnerable Groups

3.4.1. Smoking and poverty
Tobacco use is highest in the poorest communities and among the most troubled families. Every penny spent on tobacco literally goes up in smoke. More money spent on tobacco – and less on families and children – puts enormous pressure on poorer families’ budgets already hit hard by cost of living pressures and welfare reform. Children whose parents smoke are much more likely to grow up to smoke themselves and so, in our poorest communities, there has been an inter-generational cycle of smoking, deprivation and increased child poverty. Yet about two thirds of people from the poorest communities want to quit.

A low-income family earning £21,000 a year, where both parents smoke 20 cigarettes a day, will spend a quarter of their total income on tobacco or around £5,600 a year. The proportion and amount spent on smoking is further detailed in Figure 17.
Figure 17: Proportion of household income smokers spend

<table>
<thead>
<tr>
<th>Income (net)</th>
<th>% of household income spent on cigarettes (net)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Both parents smoke: 20 cigs a day</td>
</tr>
<tr>
<td>£10,000</td>
<td>51%</td>
</tr>
<tr>
<td>£15,000</td>
<td>34%</td>
</tr>
<tr>
<td>£20,000</td>
<td>26%</td>
</tr>
<tr>
<td>£25,000</td>
<td>24%</td>
</tr>
<tr>
<td>£27,000</td>
<td>20%</td>
</tr>
<tr>
<td>£30,000</td>
<td>17%</td>
</tr>
<tr>
<td>£40,000</td>
<td>13%</td>
</tr>
<tr>
<td>£50,000</td>
<td>10%</td>
</tr>
<tr>
<td>£60,000</td>
<td>9%</td>
</tr>
</tbody>
</table>

Source: Tobacco Free Futures 2014

• The poorer and more disadvantaged you are, the more likely you are to smoke and suffer smoking-related disease and early death. Unemployed people are around twice as likely to smoke as people in employment while workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles.

• Smoking kills half of all long-term users and is the biggest single cause of inequalities in death rates between rich and poor in England.

• The poorer you are the more likely you are to smoke and continue to smoke during pregnancy leading to massive health implications including miscarriage, stillbirth, and cot death. Children born to mothers who smoke are much more likely to smoke themselves.

• Children from homes where smoking is the ‘norm’ indoors are harmed by exposure to secondhand smoke and miss important school days because of secondhand smoke related illness with impacts on educational attainment.

• Tobacco has a disproportionate effect on living standards of Britain’s poorest households, for whom expenditure on tobacco is a large proportion of disposable income (see chart).

• Poorer people who smoke tend to be more addicted but importantly are just as likely to want to quit smoking as more affluent smokers.

• For every cigarette pack bought with local money, only a fraction will stay in the local community. Most will go on tax or to the tobacco industry.

• Smoking also takes extra money out the family budget through parents’ inability to work due to sickness, a reduced property price from tobacco staining, damage due to house fires and even cleaning of clothes/upholstery and redecorating.

• Every penny spent on tobacco isn’t spent on improving a child’s quality of life including quality food, family holidays, sport, education and recreational activities.
The IHS data also provides a breakdown by socio-economic status and shows a significant difference between the overall population prevalence and that amongst routine and manual workers (RMW). Whilst prevalence has been reducing this gap has remained, albeit the gap is much narrower for Halton than it is for the NW or England.

Figure 18: Smoking prevalence amongst RMW

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Halton</td>
<td>30.7</td>
<td>28.1</td>
<td>21.9</td>
</tr>
<tr>
<td>NW</td>
<td>33.0</td>
<td>31.6</td>
<td>30.1</td>
</tr>
<tr>
<td>RMW</td>
<td>30.3</td>
<td>29.7</td>
<td>28.6</td>
</tr>
</tbody>
</table>

Source: Tobacco Profile, PHE 2014

However, analysis of the Merseyside Lifestyles Survey 2012/13 for Halton shows that there remains a substantial difference between smoking prevalence amongst those living in the most deprived areas of the borough compared to the least deprived. It showed smoking prevalence being 10% points higher than the average for those living in the most deprived quintile compared to prevalence being half that of the borough average amongst those living in the least deprived quintile.

Figure 19: Smoking prevalence by local deprivation quintiles, Halton

3.4.1. Mental Wellbeing
Positive mental health or mental well-being has recently emerged as an important predictor of overall health and longevity. Mental well-being is more than the absence of mental illness or
psychiatric pathology. It implies ‘feeling good’ and ‘functioning well’ and includes aspects such as optimism, happiness, self-esteem, resilience, agency autonomy and good relationships with others. Recent research suggesting the economic benefits of promoting positive mental health means that it now assumes an important place in mental health and public health policy. Yet epidemiological evidence on the behavioural correlates of mental well-being is sparse. A recent examination of the extent to which smoking, body mass index (obesity), fruit and vegetable consumption and physical activity levels correlates with high and low mental well-being was undertaken using the Health Survey for England. It showed a consistently and statistically significant relationship between smoking and mental wellbeing.\(^{37}\)

A greater proportion of those who had never smoked had high mental wellbeing than low mental wellbeing. Amongst all categories of smokers - light, moderate and heavy - a greater proportion had low mental wellbeing than high mental wellbeing and the difference became more marked as the level of smoking increased.

The North West Mental Wellbeing Survey 2012/13 found that, in Halton, although a greater percentage of smokers than non-smokers had low mental wellbeing and visa versa the results were not statistically significant. However, the NW level analysis showed that the difference was statistically significant.

### Table 3: Smoking prevalence in Halton and levels of mental wellbeing, North West Mental Wellbeing Survey 2012/13

<table>
<thead>
<tr>
<th>Mental Wellbeing Category</th>
<th>number</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>non-smoker</td>
<td>187</td>
<td>11.2%</td>
<td>59.9%</td>
<td>28.9%</td>
<td>NS</td>
</tr>
<tr>
<td>current smoker</td>
<td>137</td>
<td>17.5%</td>
<td>62.8%</td>
<td>19.7%</td>
<td></td>
</tr>
<tr>
<td>ex-smoker</td>
<td>161</td>
<td>12.4%</td>
<td>65.8%</td>
<td>21.7%</td>
<td></td>
</tr>
</tbody>
</table>

*Source: McHale, Hughes and Jones 2014*

#### 3.4.2. Smoking prevalence amongst those with mental illness

A recent joint report by the Royal College of Physicians and Royal College of Psychiatrists found that:\(^{38}\)

- Mental disorders are associated with increased rates of a range of health risk behaviours (such as smoking, alcohol and drug misuse, poor diet, less physical activity, self-harm), poor educational and employment outcomes, homelessness, social stigmatisation, marginalisation, and reduced uptake or delivery of health services including for health risk behaviour and physical illness
- Smoking is around twice as common among people with mental disorders, and more so in those with more severe disease
- Up to 3 million smokers in the UK, 30% of all smokers, have evidence of mental disorder and up to 1 million have longstanding disease
- A third of all cigarettes smoked in England are smoked by people with a mental disorder.
- In contrast to the marked decline in smoking prevalence in the general population, smoking among those with mental disorders has changed little, if at all, over the past 20 years
- Smokers with mental disorders are just as likely to want to quit as those without, but are more likely to be heavily addicted to smoking and to anticipate difficulty quitting smoking, and historically much less likely to succeed in any quit attempt
Over the course of a year, smokers with mental disorders are more likely to receive advice from their GP to quit smoking, and be prescribed cessation medications, but this reflects the increased frequency of their consultations. Overall, only a minority receive cessation pharmacotherapy.

Experimental evidence suggests that nicotine can relieve symptoms of anxiety, depression, schizophrenia and attention deficit hyperactivity disorder, although nicotine withdrawal symptoms may then exacerbate symptoms of mental disorders. Thus people with some mental disorders may use nicotine to ameliorate symptoms such as depression or anxiety (the self-medication model).

However, the symptoms of mental disorders can be confused with or exacerbated by those of nicotine withdrawal, hence resulting in false attribution of relief to effects on mental disorders.

Current smoking is associated with an increased risk of onset of depression, including postnatal depression, and anxiety disorders. People with depression and anxiety disorders are more likely to become smokers.

Former smokers are not at an increased risk of subsequent onset of depression.

Adolescents with eating disorders are more likely to become smokers.

Smoking is associated with an increased risk of dementia.

People with mental disorders appear to have higher risks of cardiovascular disease and stroke (after accounting for the effects of smoking); however, there is no consistent evidence regarding an increased risk of cancer.

Analysis of the HSE data shows the same variations in smoking prevalence amongst those with mental illness as those without, namely, prevalence being slightly higher amongst men than women, reducing prevalence by age and prevalence increasing across deprivation quintiles.

Whilst there is no routinely collected data in local prevalence of smoking amongst those with mental illness, there are 2496 people on GP registers with a diagnosis of depression and 381 with severe mental illness (Schizophrenia and Bipolar disorders). A variety of sources for estimating population prevalence of smoking amongst those with mental illness are available. Taking an average result of 34% - 37% for those with depression and anxiety and between 37% and 45% for those with schizophrenia and bipolar disorders and applying these to the numbers of GP registers would give a conservative estimate of 989.

3.4.3. Smoking prevalence amongst those who are homeless

People who are homeless have worse overall health than the general population. Health is worst amongst rough sleepers but levels of wellbeing and health problems of all homeless people are worse generally.

Smoking disproportionately affects homeless people as they are both more likely to smoke and less likely to quit than wealthier groups. The latest data from the Homeless Link’s Health Needs Audit 2014 (2,500 respondents) found smoking prevalence was 77% amongst homeless people. It also found that only 41% of respondents to their survey wanted to quit compared to 63% of the general population. Whilst no local data is available, the Liverpool Audit found that 77% of homeless clients were smokers, which was the same as the national figure and much higher than the 21% amongst the general population. Research from other countries show similar results. It is estimated that homeless people on average smoke approximately 18.3 cigarettes per day and
rates are also reported to be high in people who have mental health problems. Since 26% of homeless people have mental illness, this subgroup may be particularly at risk. Also, with poor general health and exposure to the cold weather, the detrimental short term effects of smoking such as chest infections, bronchitis, breathing problems and coughs are likely to be further exacerbated. This is seen in the self reported conditions homeless people suffer from with 15.2% reporting chest and breathing problems compared to 5.2% of the general population.\textsuperscript{[45]}

In 2012/13, 166 people in Halton applied for assistance under the Housing and Homelessness Acts. Of these, 86 (52%) were accepted as being statutorily homeless and in priority need (compared to 44% in Liverpool City Region). There were 280 single homeless people moving on from Supporting People services in 2012/13 (primary client group). There were 115 homeless families moving on from Supporting People services in 2012/13.

3.4.4. Learning Disabilities

Emerson et al\textsuperscript{[46]} carried out analysis of the Millennium cohort study, which tracks children born between 2000 and 2002. They found that some risk-taking behaviour was lower amongst adults with learning disability, such as smoking and drinking alcohol. However, they found that rates of smoking were considerably higher among adolescents with mild learning disabilities.

No local data is collected. However, a health needs assessment carried out in Knowsley for adults aged over 18 years with a learning disability registered with general practice\textsuperscript{[47]} found that one in ten adults with learning disability use tobacco. This is consistent with other research findings.

There are 714 (aged 18+) registered with Halton GPs with a diagnosis of learning disabilities.

3.4.5. Ethnicity

Data from the HSE shows that smoking prevalence rates vary between BME and religious groups, with rates above the national average for white and mixed ethnicity and amongst those citing they have no religion.

Figure 20: smoking prevalence by ethnicity and religion, England 2013

A 2014 tobacco survey of the Liverpool Chinese, Polish and Somali communities\textsuperscript{[48]} found that overall, 42% of Polish respondents smoke, compared to 21.3% from the Somali community and
15.8% of Chinese respondents. Of the 42% of Polish smokers 32.7% smoked everyday with a further 9.3% smoking regularly but not every day. Whilst this is not Halton data, it does support other research. It may be a useful proxy indicator of the smoking prevalence for Halton’s Polish population which constitutes the third largest single BME group, behind Irish and White and Black Caribbean (Chinese was the fifth largest single group). The top 12 ethnic groups make up 3,370 out of the 4,490 BME population living in Halton.

Table 4: Numbers living in Halton by ethnic group, top 12 groups, 2011 Census

<table>
<thead>
<tr>
<th>Ethnic group</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irish</td>
<td>662</td>
</tr>
<tr>
<td>White and Black Caribbean</td>
<td>467</td>
</tr>
<tr>
<td>Polish</td>
<td>371</td>
</tr>
<tr>
<td>White and Asian</td>
<td>332</td>
</tr>
<tr>
<td>Chinese</td>
<td>313</td>
</tr>
<tr>
<td>Indian or British Indian</td>
<td>286</td>
</tr>
<tr>
<td>White and Black African</td>
<td>253</td>
</tr>
<tr>
<td>Other White</td>
<td>154</td>
</tr>
<tr>
<td>Caribbean</td>
<td>149</td>
</tr>
<tr>
<td>Other Western European</td>
<td>138</td>
</tr>
<tr>
<td>African</td>
<td>134</td>
</tr>
<tr>
<td>European Mixed</td>
<td>111</td>
</tr>
</tbody>
</table>

Source: 2011 Census, ONS 2013

The Liverpool survey revealed that 46% of Polish smokers intended to give up smoking, 25% of them within the next year. In the Somali community, 30% of smokers stated that they intended to give up smoking, 13% of them within the next year, whereas among Chinese smokers the percentages of intending to quit were 55% overall and 20% within the next year.

The survey asked respondents who had attempted to make quit attempts without accessing stop smoking support services (n=102), the reason why they had not done so. The most common responses were:

- “I wanted to stop on my own” (31% of Polish, 50% of Somali and 42% Chinese respondents)
- “I did not know about the services available” (37% of Polish, 37% of Somali and 27% Chinese respondents)

3.4.6. Sexuality

Research suggests that Lesbian, Gay and Bisexual (LGB) people are more likely to smoke than heterosexual people, and lesbians and bisexual women are more likely to smoke (and are likely to smoke more) than heterosexual people, or gay men. The exact reasons for this difference have yet to be identified, yet it is likely that (like alcohol consumption) social pressures to smoke are likely to be prevalent amongst the LGB community. Gay women are also less likely to get pregnant (a trigger point for giving up smoking) and are more likely to continue to go out to pubs and clubs on a regular basis for more years than their heterosexual counterparts.
Like alcohol, one of the problems with smoking and stopping smoking is that the preventative health care messages are not targeted at LGB people. For example, stop smoking campaigns state that “smoking makes you unattractive to the opposite sex”. This does not communicate with LGB people. Messages on cigarette packages only make a reference to female sexuality in relation to pregnancy. This means that LGB people are less likely to be receptive to anti-smoking messages.\[50\]

National data available from the IHS shows that whilst smoking prevalence now stands at 18.4%, there is variation by sexual orientation

**Figure 21: Smoking prevalence by sexual orientation**

![Graph showing smoking prevalence by sexual orientation.](source: Tobacco Profiles, PHE 2015)
4. Service provision

4.1 Tobacco Control

Local Government Declaration on Tobacco Control

Halton Borough Council has signed up to the Local Government Declaration on Tobacco Control. This is a statement of the Council’s commitment to ensure tobacco control is part of mainstream, public health work and commits the Council to:

- Reduce smoking prevalence and health inequalities
- Develop plans with partners and local communities
- Participate in local and regional networks
- Support Government action at national level
- Protect tobacco control work from the commercial and vested interests of the tobacco industry
- Monitor the progress of our plans
- Join the Smokefree Action Coalition

4.2. Smoking cessation for pregnant women

BabyClear is a package created and delivered by the Tobacco Control Collaborating Centre to train Halton midwives and healthcare staff to deliver a local smoking cessation pathway for all pregnant women. The aim of BabyClear is to ensure that all women understand the dangers of smoking during pregnancy, and those that do smoke are identified early, referred to cessation services and receive ongoing support to quit smoking, and to stay quit throughout their pregnancy and beyond.

The baby clear pathway includes:

- Carbon monoxide screening for all pregnant women
- Opt out referral system
- Briefing sessions for midwifery staff and other relevant health professionals
- Protocols and care pathways reflecting the evidence base and NICE guidance
- Advanced skills training to support Stop Smoking Advisors to work effectively with pregnant women
- Ways to reach out to those pregnant smokers who currently do not engage with the Stop Smoking Services
- Administrative / call centre staff training to increase the number of women accepting appointments
- Awareness raising and engagement with all health professionals involved with pregnant smokers
- A performance management system
- Monitoring and evaluation of effectiveness
4.3. Smoking education and cessation for school aged children and young people

Through Halton Healthy Schools programme, tobacco education sessions are delivered as part of the Healthitude programme. The sessions aim to provide children and young people with a greater awareness of the issues related to smoking and tobacco, including the effects of smoking, chemicals in a cigarette, financial implications, legislation, and the impact of advertising on smoking behaviours.

School nurses and other members of staff working within schools are also offered training which is geared around equipping staff with the key health messages to be able to cascade to pupils.

All Halton primary and secondary schools have received an updated smokefree policy (which includes E-cigarettes) to refer to.

4.4. Smoking cessation for adults

4.4.1. Specialist Service

Halton Stop Smoking Service is a small team made up of 4 WTE adopting a hub and spoke approach to delivering Tobacco Control and cessation in Halton. The service offers 19 sessions per week in 14 venues including 2 evening sessions and more recently a Saturday morning session in Widnes Market to allow ‘out of hours’ access. The venues are in community and clinical settings across the borough ranging from GP practises to Walk In Centre, Community Centres, Children Centres, Widnes Library and Runcorn Halton Direct Link. The cessation sessions offer a choice of one to one appointments or ‘drop in’ depending on the clients preference. Home visits are also available on request for ‘Housebound’ clients. Texting and telephone counselling are also available as forms of support with clients consent. The team are National Centre for Smoking Cessation trained (NCSCT) and follow NICE and National Stop Smoking Service Guidelines to deliver a comprehensive service which includes behavioral and pharmacotherapy support. NRT pharmacotherapy support is delivered via a voucher scheme which allows clients easier and speedier access to NRT products. Methods of measuring the success of the service are via: CO2 validated quits at 4 week review. Other data collected include:

- Customer satisfaction
- Number of smokefree homes
- Number of referrals from whom
- Socio economic
- Gender
- Age
- Pregnancy status
- Pharmacotherapy used

As well as delivering cessation to clients the service offers Very Brief Advice and Intermediate Cessation training to target groups in order to increase referrals and maximise access to smoking cessation for the Halton population.

Target Groups training delivered to and planned delivery to include:

- Midwives
- Health Visitors
- Breast Feeding Coordinators
- Children Centre Staff
- Workplaces (via Occupational Health)
- Leisure Centre staff
Recently adopting a hub and spoke approach has allowed the team to target groups with the highest smoking prevalence and as such each Specialist has been allocated an area to lead on:

- Smoking and pregnancy
- Mental Health
- Substance Misuse

4.4.2. Intermediate Service

Provision at this level is via either GP practices or pharmacies

**GP provision**

Halton has a substantial history of GP practice engagement in smoking cessation support. Before NRT was available on subscription, Halton Health Promotion Service negotiated a significant budget with the North Cheshire Health Authority to enable them to purchase NRT on behalf of GP practices. In return for this being made available free of charge (it was only available as an over-the-counter paid for product at the time and not routinely available via an NHS prescription) all practices agreed to provide an intermediate level service. The Health Promotion Service trained their staff, usually practice nurses, to run 4 week cessation support on a one-to-one basis with their patients who wanted help to quit smoking. The practices supplied the Health promotion Service with data in numbers accessing the support and percentage quitters. When funding became available for the establishment of the Specialist Smoking Cessation Service, this provision continued, using NRT now available via the NHS free of charge. The support continues to this day. However, the recent changes to the NHS, have resulted in a reduction in the level of data being shared by the practices with the Specialist Service and this needs to be rectified as it is important all data on successful quitters is reflected in the data submissions which then appear in the official statistics.

**Smoking cessation services in community pharmacies**

Community pharmacies are ideally placed to support their customers who wish to give up smoking. Halton Borough Council commissions three stop smoking services in community pharmacies.

The NRT Voucher scheme enables users of Halton’s Stop Smoking Service and Intermediate services to exchange vouchers for NRT products in local pharmacies. Participating pharmacies are paid a dispensing fee for each dispensation and NRT products are paid for by the local authority (minus any applicable prescription charge).

The Intermediate Smoking cessation service enables pharmacy customers to receive one to one ongoing support to quit smoking at their local pharmacy. Participating pharmacies are trained and supported by Halton’s Stop Smoking Service and are remunerated for carrying out initial consultations, four week status reviews and for successful quits which have been verified using a carbon monoxide monitor.
The Varenicline service is a new service whereby customers can receive Varenicline (brand name Champix) from their local pharmacy rather than having to go to the GP for a prescription. Varenicline can only be given in accordance with a locally developed Patient Group Direction. Participating pharmacies are paid to undertake an initial PGD consultation and for follow on dispensing of Varenicline and drug costs are also met by the Council (minus any applicable prescription fees).

In order to deliver any of the Stop Smoking services staff involved in the delivery must undertake the National Centre for Smoking Cessation and Training (NCSCT) online training and assessment programme and must have completed a self declaration of competence for delivery of the service.

At the time of writing Halton Borough Council has recently undertaken a Provider Assessment Process to ensure that all pharmacies who wish to deliver services meet minimum standards and requirements. This has resulted in 19 pharmacies being accepted to deliver all three smoking cessation services. This represents double the number of pharmacies who were previously contracted to deliver Intermediate Smoking Cessation services in Halton.

### 4.4.3. Outcomes

The overall percentage of Halton clients who set a quit date and were successful quitters at 4 weeks was higher than both the England and North West averages. As a rate per 100,000 population however, it was lower. So, whilst a smaller proportion of Halton’s population entered the service, of those that did the impact of Halton’s service was greater.

#### Table 5: Smoking quitters 2013/14

<table>
<thead>
<tr>
<th></th>
<th>Number setting a quit date</th>
<th>Number of successful quitters (self-report)</th>
<th>Percentage who successfully quit</th>
<th>Number setting a quit date per 100,000 of population aged 16 and over</th>
<th>Number successfully quit (self-report) per 100,000 of population aged 16 and over</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>586,337</td>
<td>300,539</td>
<td>51</td>
<td>1,341</td>
<td>688</td>
</tr>
<tr>
<td>North West</td>
<td>98,967</td>
<td>42,879</td>
<td>43</td>
<td>1,716</td>
<td>743</td>
</tr>
<tr>
<td>Halton</td>
<td>1,235</td>
<td>643</td>
<td>52</td>
<td>1,224</td>
<td>637</td>
</tr>
</tbody>
</table>

Source: HSCIC 2014
Of note is that a higher proportion of Halton quitters are validated using carbon monoxide (CO) monitors, confirming that they have not smoked since setting a quit date. This proportion is substantially higher than the North West figure. It also shows that quit rates are similar for males and females (females slightly higher) and this follows the England and North West experience.

Halton has relatively small percentage of its population who from black or minority ethnic communities. This is reflected in the small numbers accessing the service. However, analysis does show that Halton’s success rates are at least comparable to results elsewhere.

**Figure 22: Successful quitters including CO validated quitters, total population and by gender, 2013/14**

<table>
<thead>
<tr>
<th>Total</th>
<th>Number who had successfully quit (self-report), confirmed by CO validation</th>
<th>Number of successful quitters (self-report), confirmed by CO validation</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>51.3</td>
<td>70.1</td>
</tr>
<tr>
<td>North West</td>
<td>48.3</td>
<td>52.1</td>
</tr>
<tr>
<td>Halton</td>
<td>52.1</td>
<td>77.9</td>
</tr>
</tbody>
</table>

Source: HSCIC 2014

**Figure 23: Successful quitters by ethnic group, 2013/14**

Source: HSCIC 2014
As described previously there is provision for pregnant women who wish to quit, both through trained midwives and via the specialist service. Whilst numbers are small for Halton, the percentage setting a quit date who were successful is comparable to England and the North West, albeit, marginally lower. The percentage setting a quit date who self reported that they had quit was higher in Halton than elsewhere but the percentage validated using CO monitors was the same as England and slightly higher than the North West.

**Table 6: Successful quitters, pregnant women**

<table>
<thead>
<tr>
<th></th>
<th>Number setting a quit date</th>
<th>Percentage of successful quitters (self-report)</th>
<th>Percentage who had not quit</th>
<th>Percentage not known/lost to follow up</th>
<th>CO validated quitters as a percentage of clients setting a quit date</th>
<th>CO validated quitters as a percentage of successful quitters (self-report)</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>19,805</td>
<td>47</td>
<td>29</td>
<td>23</td>
<td>27</td>
<td>56</td>
</tr>
<tr>
<td>North West</td>
<td>3,402</td>
<td>45</td>
<td>36</td>
<td>20</td>
<td>24</td>
<td>54</td>
</tr>
<tr>
<td>Halton</td>
<td>66</td>
<td>44</td>
<td>50</td>
<td>6</td>
<td>27</td>
<td>62</td>
</tr>
</tbody>
</table>

*Source: HSOC 2014*

**Map 2: successful quitters at 4 weeks, rate by electoral ward 2011/12 - 2013/14**

The relationship between socio-economic circumstances and smoking has been described earlier in this JSNA. It is therefore important that the Specialist Smoking Cessation Services monitors both access into and success rates by socio-economic groups.
This analysis shows that Halton’s success rates are comparable to the England and North West experience. However, of note, is that the success rate amongst routine and manual workers is higher in Halton than comparators.

Age is another important determining factor for smoking. Halton has very small numbers of people under age 18 access the service and only a few quit for 4 weeks. However, for all other age groups Halton’s success rate was higher than comparators and followed a similar pattern, with people in the older age groups having greater quit rates. This is likely to reflect the presence of long-term conditions amongst these groups and also that they may have had numerous quit attempts previously.

**Figure 24: Success rate by age group, 2013/14**

Most clients accessing smoking cessation support use some form of pharmacotherapy quit aid. Halton’s success rate was either comparable or better irrespective of quit aid and amongst those that did not use a pharmacotherapy, except for clients using Varenicline (Champix) and combined NRT and Bupropion (Zyban).
4.5. Enforcing Legislation: Tackling underage sales and counterfeit tobacco

4.5.1. Counterfeit and Illicit tobacco

Halton Trading Standards service enforces legislation in relation to illicit tobacco and cigarettes. Illicit product refers to counterfeit tobacco and cigarettes which are non-duty paid or not made for the UK market. Illicit cigarettes can pose a fire risk because they are not designed to extinguish when not actively smoked and can also facilitate the continued participation in smoking by Halton residents because they are cheaper than legitimate cigarettes. The illicit trade in tobacco and cigarettes also costs the UK economy about £3bn a year in unpaid duty.

The criminal enforcement of illicit tobacco and cigarettes applies to traditional sales mediums and outlets including independent retailers, public houses, markets, car boots and itinerants. Halton Trading Standards has established a covert investigation unit to assist with the investigation of the increasing phenomenon of online sales via social networking sites (e.g. Facebook) and online classified sites (e.g. Gumtree), which has increased exponentially during the past 2-3 years.

Essentially each case of illicit tobacco and cigarettes is considered on the evidence available, however, the Service generally adopts a ‘zero tolerance’ policy in relation to criminals involved in the sale of illicit tobacco and cigarettes (although see restorative justice approach below). Enforcement action may include: cease and desist warnings being issued; investigation/prosecution of individuals; and the seizure/voluntary surrender of any illicit product, facilitating the removal from the market place. In cases of high volume seizures the Service may consider offences of money laundering against the perpetrators and the consequential impact of the Proceeds of Crime Act.
2014-15 has resulted in the following seizures/enforcement action:

- **Amusement Arcade**: 40 x 50g pouches of counterfeit tobacco; and 89 x 20 packs of illicit cigarettes. The manageress and an employee were offered a smoking cessation course as a trial of restorative justice. Both were eventually issued with warnings after completion of the course.
- **Couple**: 24 x 50g pouches of counterfeit tobacco and 6 x 20 packs of illicit cigarettes were seized from a male and female. Along with a small selection of other counterfeit goods. Due to small quantities both were issued with a warning.
- **Individual**: 45 x 50g tobacco pouches and 60 x 20 packs of illicit cigarettes. Male was selling via a retail outlet. Currently under investigation.
- **Online**: current investigations into two traders selling illicit tobacco via Facebook accounts.

### 4.5.2. Under Age Sales

Trading Standards are responsible for preventing the sale of tobacco products to children. They advise businesses on how to put in place procedures to make sure that neither they nor their staff sell or supply tobacco product to under 18’s (The Children and Young Persons Act 1933 as amended makes it an offence for a person to sell tobacco to a person under 18).

During 2014/15 the service advised 10 businesses which sell tobacco on adopting a Challenge 25 policy. While no legislation in place at the moment, we have also encouraged businesses to adopt the same policy in relation to E cigarettes where it has been identified that E cigarettes are also being sold (this work is planned to continue for the year 2015/6).

**Table 8: Advice to local business on under age sales of tobacco products, 2014/15**

<table>
<thead>
<tr>
<th>COMPLAINTS/REQUEST FOR ADVICE</th>
<th>TEST PURCHASES*</th>
<th>FAIL</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>12</td>
<td>4</td>
<td>10 businesses advised and provided with Challenge 25 materials.</td>
</tr>
</tbody>
</table>

*The test purchases were conducted using an 18 year old volunteer the aim of which was to establish if the businesses had adopted an appropriate age verification policy. A failure indicated that they sold to the volunteer without asking for identification.*

In 2015/16 visits are planned to sellers of tobacco products to advise on their adopting a Challenge 25 policy, where previously Challenge 21 was in place.

Challenge 21 and Challenge 25 are part of a scheme in the United Kingdom, introduced by the British Beer and Pub Association, with the intention of preventing young people gaining access to age restricted products including cigarettes and alcoholic beverages. Under the scheme, customers attempting to buy age-restricted products are asked to prove their age if in the retailer’s opinion they look under 19, 21 or 25, even though the minimum age to buy alcohol and cigarettes in the UK is 18. The scheme was launched in 2005.

Further to advice being given, test purchase exercises are planned for the 2015/16 to establish whether the advice is being complied with.
4.6. Enforcing national legislation at a local level: Advertising and Promotion Displays

The Tobacco Advertising and Promotion (Display) (England) Regulations 2010 and the Tobacco Advertising and Promotion (Display of Prices) (England) Regulations 2010 came into force in 2012. Initially these regulations applied to larger shops such as supermarkets. However from 6th April 2015 these regulations will also apply to all retailers that sell tobacco products including off-licenses, newsagents, grocers and convenience stores. The regulations will prohibit the display of tobacco products except in limited circumstances. The regulations will also set out detailed rules on the price marking and advertising of tobacco products. The Trading Standards team have written to all small businesses to advise them of the new regulations and provide advice on compliance. This will then be followed up by a survey of businesses in May and June 2015 to monitor compliance.

4.7. Enforcing national legislation at a local level: smoking in vehicles with children

In addition it is anticipated new legislation on smoking in vehicles with children will come into force in October 2015. These new rules will be made under the existing smoke free provisions of the Health Act 2006. Currently the local authority is responsible for enforcing the smoke free provisions in public places and commercial vehicles. However it is anticipated that enforcement of the new provisions will be delegated to local police authorities. The environmental health department will liaise with the police to ensure effective enforcement of the new legislation.

4.8. Ensuring a smokefree environment: smokefree playgrounds

Childrens smokefree play areas in parks across Halton was a Halton Borough Council initiative and, supported by the Cheshire and Merseyside Tobacco Alliance, resulted in local authorities across Cheshire and Merseyside following suit. After consultation with Halton residents a voluntary code that discourages people from smoking in play areas designed for children was introduced.

In an attempt to denormalise tobacco, Environmental Health and Tobacco Control staff worked together on a pilot survey in Phoenix Park in Castlefields, to discover local smokers’ attitudes towards smoke-free parks for children. Park rangers distributed the questionnaire to smokers and non-smokers accessing their local park.

- 82% of respondents both smokers and non-smokers either “agreed” or “strongly agreed” with the statement; “It’s important not to smoke in front of young Children”.
- 82% of respondents (both smokers and non-smokers) also “agreed” or “strongly agreed” with the statement; “I would be in favour of a voluntary code of not smoking within the fenced playground area”
- 87% of non-smoking participants and 62% of the smoking respondents strongly agreed that they would be “…in favour of a voluntary code of not smoking within the fenced playground area”

Children from Oakfield primary school in Widnes designed the signs and slogans used for the smoke free play areas. Community Park Wardens have been trained to issue advice and guidance to the public to encourage them to support the scheme.
The smoke free requirement covers all children’s playgrounds and multi use games areas (e.g. football / basket ball courts and Skate board and BMX parks) There are 39 children’s playgrounds and 32 multi use games areas. The public are free to smoke in the park and open space areas outside the play areas. The survey revealed there was limited support for a voluntary smoke free code for entire parks – 38% strongly agreed with the proposal whilst 37% strongly disagreed. 62% of smokers were against a smoke free code covering entire parks.
5. Impacts of tobacco use

5.1. Health Impacts

Smokers are more likely than nonsmokers to develop heart disease, stroke, and lung cancer.

- Smoking is estimated to increase the risk\(^{51}\):
  - For coronary heart disease by 2 to 4 times
  - For stroke by 2 to 4 times
  - Of men developing lung cancer by 25 times
  - Of women developing lung cancer by 25.7 times

- Smoking causes diminished overall health, such as self-reported poor health, increased absenteeism from work, and increased health care utilization and cost.

Smoking also does significant harm to the musculoskeletal system, to bone density, is associated with bone fractures, back pain and rheumatoid arthritis. It also does progressive harm to the cognitive system, contributing to a decline in cognitive function as early as middle-age and is one of the main environmental risk factors for dementia, primarily through increasing vascular risk. It is detrimental to oral health, with current smokers have more than a three times greater risk of developing oral cancers and are three to four times more likely to have periodontal disease than non-smokers, as well as greater risk of developing periodontal disease and tooth decay. Quitting smoking reduces these risks. Current smokers are at increased risk of age-related macular degeneration (AMD) and ever smokers are at increased risk of age-related cataracts. Again quitting smoking decreases risk, with early quitting being more beneficial.\(^{52}\)
In Halton, during the 3 year period 2011 – 2013, 758 people over the age of 35 years died as a result of smoking. This represents a Directly Standardised Rate (DSR) of 416 deaths per 100,000 people aged 35 and over in Halton per year, this is considerably worse than both the North West (346.7 / 100,000) and the England (288.7 / 100,000) average death rates.

Figure 26: Main health impacts of smoking

Figure 27: DSR for male and female lung cancer incidence in Halton, 1995-2012

Source: HSCIC, 2015
5.2 Financial Impacts

Based on an estimated smoking prevalence of 22.6% (2012 estimate from IHS), there are 22,122 people in Halton who smoke. It is estimated that smoking costs the society of Halton approximately £35.3 million each year.

In 2013/14, smokers in Halton paid approximately £25.5 million in duty on tobacco products. Despite this contribution to the national purse from tax revenue, tobacco still costs Halton roughly 1.5 times as much than the duty raised. This results in a short fall of around £10 million each year, as Figure 29 shows. [53]

Figure 28: DSR for male and female lung cancer mortality in Halton, 1995-2013

Figure 29: Smoking costs vs taxation in Halton (£millions), 2013/14

Data in this section comes from ASH Local Cost of Smoking Toolkit unless otherwise indicated. See Ref 36
The majority of the cost is due to lost productivity (due to smoking breaks, deaths and sick days), with nearly £5m direct cost to the NHS in treating smoking related disease and £3m providing social care to people with smoking related conditions.

**Figure 30: Estimated cost of smoking in Halton (£millions), 2013/14**

![Cost of smoking in Halton graph](source: ASH, 2015)

### 5.1.1. NHS

Smoking related deaths are the biggest cause of premature death across England. Every year there are over 79,000 deaths as a result of smoking. Figure 31 shows how the numbers of deaths from smoking related to the next highest causes of death.

**Figure 31: Major causes of death in England**

![Major causes of death in England](Image courtesy of Tobacco Free Futures)
Halton bears a statistically higher burden of death due to smoking than the North West. Using population attributable fractions derived from national and international research\textsuperscript{55} Halton has higher mortality rates due to smoking.

**Figure 32:** Mortality attributable to smoking, directly standardised rate per 100,000 population aged 35+, 2007/09 to 2011/13

![Mortality graph](source: Tobacco Profiles, PHE 2014)

Smoking accounts for approximately 5.5% of the NHS budget and admissions to hospital due to smoking related conditions represent a large demand on NHS resources.

Using population attributable fractions shows that hospital admission rates in Halton are higher than England but fell below the North West level in 2011/12. Rates have been and remain statistically significantly higher than the England rates, in both Halton and for the North West.

**Figure 33:** Hospital admissions attributable to smoking, directly standardised rate per 100,000 population aged 35+, 2009/10 to 2012/13

![Hospital admissions graph](source: PHE Tobacco Profiles 2015)
Local, unverified analysis for 2013/14 shows the rate has increased slightly.

The total annual cost to NHS trusts as a direct result of smoking related ill health in Halton is approximately £5 million. The health effects on non-smokers as a result of passive smoking also results in a large additional burden on the local health care system, costing a further £578,000 every year.\[56\] The cost per capita in Halton is greater than that for the North West or England, £46.04, compared to £43.33 and £36.92 respectively.\[57\]

Halton Borough Council public health department spend £2.50 per head of population on smoking cessation services and interventions to encourage people to stop smoking. This represents over 3.5% of the total public health spend in Halton.\[58\]

5.2.2. Social Care

Current and ex-smokers who require care in later life as a result of smoking related conditions cost Halton an additional £3 million each year. This represents £1.7 million in costs to the local authority as a result of additional social care needs, and £1.3 million in the costs to individuals and families who self-fund their own care.

5.2.3. On employment and the economy

An estimated £14 million is lost to local businesses in Halton each year by people taking smoking breaks at work.

Local businesses in Halton also lose approximately 29,437 days of productivity every year as a result of smoking related sick days. This costs Halton businesses around £3 million each year. In addition, every year, smoking related early deaths in Halton result in 501 years of lost productivity. This costs the local economy approximately £9 million a year.

5.2.4. On individuals and families

Tobacco use is highest amongst our poorest communities. Money spent on smoking means less money is available for the families and children, putting enormous pressure on family budgets, particularly amongst lower income households.

A low income household, earning £21,000 a year, where both parents smoke 20 cigarettes a day, will spend around a quarter of their income on tobacco (around £5,600 a year). Children whose parents smoke are much more likely to grow up to smoke themselves. In our poorest communities there is a cycle of smoking across the generations, continuing the cycle of deprivation and increasing child poverty.

Cigarettes and smoking materials are a major contributor to accidental fires in Halton. Each year there are around 81 smoking related fires across the area covered by Cheshire Fire and Rescue Services, which results in around 2 deaths per year. The impacts of this cost the local economy approximately £904,000 each year. In Halton, this represents about £52,200 due to deaths; £141,100 due to injuries; and £241,100 due to the non-human costs of smoking related fires. The non economic costs as a result of family deaths and household losses is immeasurable.
5.2.5. On the environment

The majority of cigarette filters are non-biodegradable and must be disposed of in landfill sites. Halton smokers smoke around 101,000,000 filtered cigarettes (including filtered roll ups) each year which resulting in around 17 tonnes of waste. Of this, more than 4 tonnes of cigarette waste is discarded as street litter that must be collected by local street cleaning services.
6. Projected levels of need

Smoking prevalence amongst both young people and adults is falling. Lung cancer incidence rates have been fluctuating but generally decreasing for males but increasing for women. This is likely due to the long lag period between exposure and disease development for this condition and the increase in female smoking prevalence in 1960s and 1970s. Chronic Obstructive Pulmonary Disease continues to rise under the influence of an aging population and legacy of smoking together with continued level of adults who smoke. Cardiovascular Disease death rates have reduced by 40% over the last 20 years, in large part due to falling prevalence of smoking together with other risk factors and improvements in medical interventions/management.

Smoking during pregnancy rates continue to be resistant to change locally, although there are now indications that they are starting to fall, slowly but steadily. This should have a positive influence on child health outcomes and family finances. Parental smoking habits have a significant influence on a young person’s likelihood of smoking. Falling smoking prevalence amongst parents is likely therefore to be influencing falling rates amongst young people, together with smoking education in schools and the ban on smoking in public places.

Analysis of both health and social care shows that smoking continues to play a key role in the burden on local systems.
7. User views

Service User Feedback:

- “After nearly 32 years smoking I would not have been able to stop without the amazing support and help from the Quit Smoking Service” *Source: Talk 2 Us*

- “I was a 15 a day smoker not fully wanting to give up but really glad that I came along and got the help from the team. I now have lots of money saved up for a second holiday. If I can do it anyone can do it” *Source: Talk 2 Us*

An overwhelming majority of clients say they would not hesitate to recommend the service to friends or family and were very satisfied with the level of care and treatment they have received from the service. *Source: Bridgewater annual customer service results 2013*

A recent Mystery Shopper exercise took place within Widnes Market and as a result the service achieved 93% for providing an overall quality service to residents and has been invited to attend a ceremony in May 2015 to receive an award.

Consultations

Halton has previously taken part in national consultations in Tobacco Control which resulted in removal of cigarettes from vending machines and removal of tobacco from point of sale. The Northwest area obtained the largest response nationally to this consultation – over 62,000 of which Halton and St Helens achieved over 3,000 responses and were recognised for initiative by TobaccoFree Futures (formerly Smokefree North West) and showcased for best practise.

> “Halton and St Helens PCT did a great job of generating a fantastic response to the Consultation. They are a good example of how working collaboratively with key health professionals from both Local Authorities and the PCT can provide excellent results when working with members of the public. It’s meant that there is increased partnership working with colleagues in the PCT, both Local Authorities and also out in the community. They showed great initiative in thinking of ways to raise awareness of the consultation and generate a positive response.”

*Source: Vicky Mills, Editor Smokefree North West*

The *Local Health Services Survey* (which was distributed to a random sample of households during 2008) revealed that only 36% of residents in Halton and St Helens, stated that they were not given support to quit smoking by their local health professional, but also that they did not want any help or advice anyway.
In the last 12 months, have you been given advice or help from your GP practice/health centre on giving up smoking?

<table>
<thead>
<tr>
<th>Response</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have not smoked in the last 12 months</td>
<td>1,1721</td>
<td>51%</td>
</tr>
<tr>
<td>Yes definitely</td>
<td>1,303</td>
<td>6%</td>
</tr>
<tr>
<td>Yes to some extent</td>
<td>947</td>
<td>4%</td>
</tr>
<tr>
<td>No but I would have liked help/advice</td>
<td>795</td>
<td>3%</td>
</tr>
<tr>
<td>No but I did not want any help/advice</td>
<td>8,302</td>
<td>36%</td>
</tr>
</tbody>
</table>

Source: Listening to patients Halton and St Helens Primary Care Trust, Local Health Services Survey Results, 2008

Local Insight
Local Smoking in Pregnancy Research was carried out in 2011. The aim of the research was to explore and build an understanding of:

- The pregnancy journey
- The barriers to quitting
- The quit journey
- Views on existing service
- Views on existing creative

Findings from the research showed that local pregnant smokers were:

- hard to engage
- low confidence
- high stress levels

Stress is a central issue:
- drives smoking behaviour
- drives relapse
- acts as a key barrier to cessation attempts
- compounded by pregnancy

Knowledge of smoking harm is high but low in relation to harm to foetus

Audience are heavily influenced by others:
- Personal network (family, friends, partner)
- Midwives
- Wider partners who have contact with the audience and could raise the profile of SIP

Awareness of the Stop Smoking Service was low

Those who have accessed the service have had positive experiences

Barriers to Quitting:

- Stress
- Personal influencers who continue to smoke
- Habit / boredom
- Fear of judgement and therefore not accessing support
- Addicted
- Unaware of support available
- Don’t want to be told what to do / rebellion
- Side-effects of NRT
- Low confidence / destined to fail
8. Unmet need and service gaps

It is clear that levels of smoking have been reducing in Halton as they have across the UK. However, because they are a number of ways of estimating prevalence, it is less clear how close to England the Halton figures truly are. The most regular data, from the HIS, suggests Halton is now on a par with England and below the North West. However, results from two recent surveys, the Merseyside Lifestyles Survey and the North West Mental Wellbeing Survey, cast a doubt on the accuracy of the HIS figures for Halton, as both used the same methodology of face-to-face interviews, which is considered to produce more robust findings, than the mixed methods employed within the IHS.

Wherever, the true picture lies within the 18% - 30% prevalence range, it is nevertheless clear that there is a social gradient with prevalence being highest amongst the poorest, more deprived communities and occupational groups. Then are the ones spending the greatest proportion of their household income on smoking and the ones who often find it hardest to quit, having used smoking as a stress reliever for many years.

Despite this, figures for Halton show that once people have accessed the smoking cessation services, the local programme has a comparable success rate overall and a higher success rate amongst routine and manual workers. Halton needs to look at its throughput as the rate of quitters per 100,000 population is lower than the North West and England, despite a higher success rate. This suggests the issue is numbers accessing the service and setting a quit date. Recent changes within the NHS has resulted in the Specialist Smoking Cessation Service receiving much less data from the GP intermediate provision. The Specialist Service is responsible for submitting the official figures and this drop off is therefore reflected in Halton’s official outcomes data. It is not know at this stage if this is because less smoking cessation support is being offered within practices and so they have less data to submit or if the level of support has remained the same with less of this being reported and this needs to be investigated.

In terms of targeting cessation services, prevalence at ward level and successful quitters data at ward level suggests a fairly good match.
9. Best practice interventions

Table 4 lists all NICE guidance, quality standards and commissioners available for commissioners and providers to support the local delivery of best available practice across a range of types of tobacco control needs.

**Table 9: List of current NICE guidance**

<table>
<thead>
<tr>
<th>Type of Need</th>
<th>Guidance Title</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tobacco Control</strong></td>
<td>Workplace interventions to promote smoking cessation. NICE Public Health Guidance 5.</td>
</tr>
<tr>
<td></td>
<td>Identifying and supporting people most at risk of dying prematurely. NICE Public Health Guidance 15.</td>
</tr>
<tr>
<td></td>
<td>Tobacco: harm reduction approaches to smoking. NICE Public Health Guidance 45.</td>
</tr>
<tr>
<td></td>
<td>Smoking. NICE advice LGB1</td>
</tr>
<tr>
<td></td>
<td>Smoking. NICE advice (update) LGB24.</td>
</tr>
<tr>
<td><strong>Pregnancy</strong></td>
<td>Quitting smoking in pregnancy and following childbirth NICE Public Health Guidance 26.</td>
</tr>
<tr>
<td><strong>School age children</strong></td>
<td>Preventing the uptake of smoking by children and young people. NICE Public Health Guidance 14.</td>
</tr>
<tr>
<td></td>
<td>School based interventions to prevent smoking. NICE Public Health Guidance 23.</td>
</tr>
<tr>
<td><strong>Adult Smoking Cessation Services</strong></td>
<td>Brief interventions and referral for smoking cessation. NICE Public Health Guidance 1.</td>
</tr>
<tr>
<td></td>
<td>Smoking cessation services. NICE Public Health Guidance 10.</td>
</tr>
<tr>
<td></td>
<td>Smoking cessation in secondary care: acute, maternity and mental health services. NICE Public Health Guidance 48</td>
</tr>
<tr>
<td></td>
<td>Smoking cessation: supporting people to stop smoking. NICE quality standard 43.</td>
</tr>
<tr>
<td></td>
<td>Varenicline for smoking cessation. NICE technology appraisal guidance 123.</td>
</tr>
</tbody>
</table>

Additionally, there are a number of pieces of guidance due for publication, including reviews of existing guidance and quality standards.

**Table 10: forthcoming NICE guidance and quality standards**

<table>
<thead>
<tr>
<th>Title</th>
<th>Publication date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace policy and management practices to improve the health and wellbeing of employees</td>
<td>May 2015</td>
</tr>
<tr>
<td>School based interventions to prevent smoking (partial update)</td>
<td>TBC</td>
</tr>
<tr>
<td>Smoking cessation (update)</td>
<td>TBC</td>
</tr>
<tr>
<td>Smoking - harm reduction</td>
<td>In development</td>
</tr>
<tr>
<td>Smoking - reducing tobacco use in the community</td>
<td>In development</td>
</tr>
</tbody>
</table>
References


17. Adapted from Primary determining factors of low birth weight infants available from [http://www.stanford.edu/group/virus/herpes/2000/primaryf.htm](http://www.stanford.edu/group/virus/herpes/2000/primaryf.htm)


19. ASH (2014) *Factsheet on secondhand smoke*


22. ASH (2013) Factsheet on Smoking and Reproduction


38. Royal college report

40. [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)


45. [http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf](http://www.homeless.org.uk/sites/default/files/site-attachments/The%20unhealthy%20state%20of%20homelessness%20FINAL.pdf)


49. Res on smoking prevalence amongst eastern Europeans


56. Local Cost of Smoking Toolkit [http://ash.org.uk/localtoolkit/R2-NW.html]

   [http://www.tobaccoprofiles.info/profile/tobacco-control/Halton]

58. PHE Spend and Outcomes Tool