Smokefree Bristol as part of the Bristol Partnership's response to the Department of Health Consultation on the future of tobacco control

Introduction:

Bristol, with a population of 410,500 people is the largest city in the South West and one of the eight 'core' cities in England (excluding London). The current trend is one of an increasing population, which is projected to reach 458,000 people by 2026. The Black and Minority Ethnic population in Bristol is estimated to have increased to 10.7%, including substantial growth in Polish, Somalian, Indian and Chinese populations.

Bristol has been a port for a thousand years and was made a city in 1542. It boomed in the late 17th and 18th centuries as new colonies were founded in the West Indies and North America with whom Bristol traded. Tobacco, sugar, rum and cocoa were all imported. In 1833 Isambard Kingdom Brunel was appointed chief engineer of the Great Western Railway and became one of the world's leading engineers, and helped shape the face of modern Bristol. At this time ship building, tobacco, chocolate and soap making industries all boomed in Bristol.

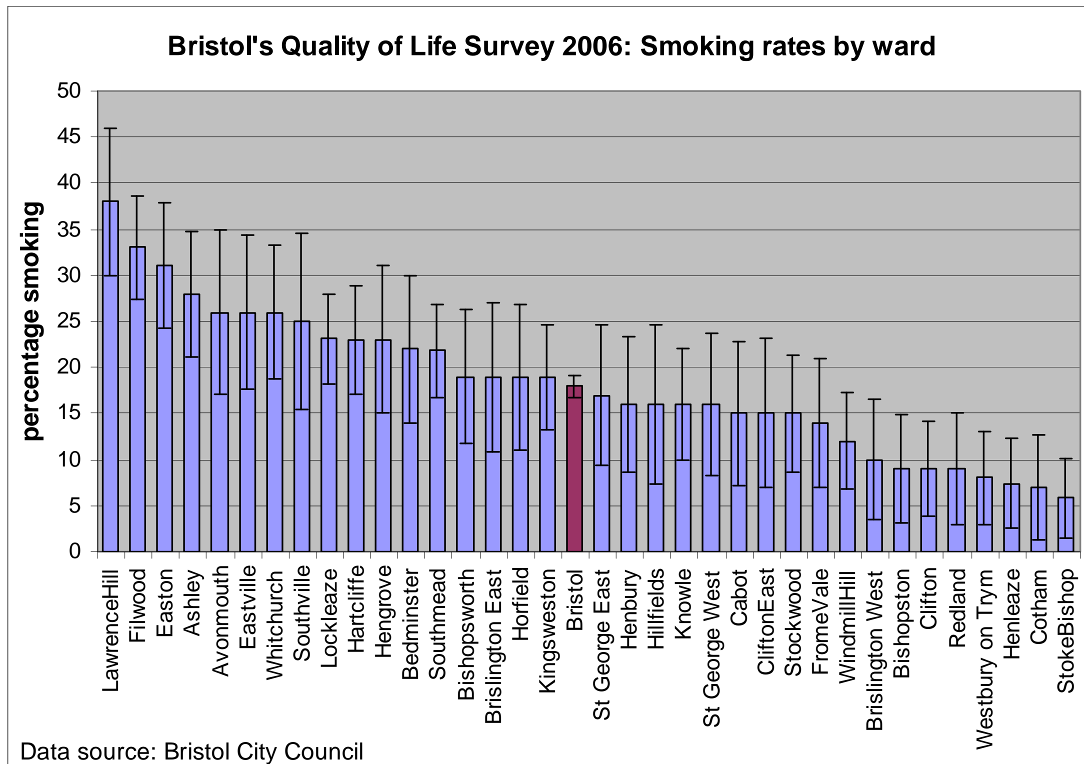
In the 20th century the aerospace industry came to Bristol, and Concorde was built and tested at Filton. Other industries that continued to flourish in Bristol were tobacco, chocolate, engineering, chemicals, zinc, furniture and pottery; and Bristol continued to be an important port.

Today, Imperial Tobacco is the fourth largest international tobacco manufacturer and still retains their UK headquarters in Bristol, although the cigarette manufacturing side has closed. It has, however, left a legacy of a cultural heritage of smoking; where in the past free cigarettes were given as part payment for employment and pensions, making it easy for generations of families to take up smoking. In the south of the City smoking prevalence is highest in wards most closely associated with the Tobacco industry.

As a consequence of the of the location of the Imperial Tobacco Head Office in Bristol, Bristol City Council Trading Standards Department has the role of acting as the UK Home Authority for the Company, meaning that the company has a high level relationship with the Lead Officer for Tobacco Controls in the service in order to seek advice regarding compliance with the Tobacco Advertising and Promotion Act 2002 (TAPA 2002) and related legislation regarding marketing and sale of their products and to act as a central point of referral for queries from other local authority enforcement services around the country. As a consequence of this role Bristol Trading Standards Lead Officer sits on the DH/LACORS Tobacco Enforcement group.

As a port and with an international airport, Bristol will be a main entry point for smuggled and counterfeit cigarettes, some of which will be destined for further afield, but a large proportion of which may be sold locally.

The smoking prevalence in the South West region is 22.4% (Gen Household survey), within Bristol this figure is 24.6%.



Compared to the rest of the South West region, the population profile of Bristol is relatively young, with more children aged under 20 than people aged over 60. For this reason our main focus for reducing prevalence of smoking is with young people.

In 2005, the Bristol Partnership (made up of Bristol City Council, the Primary Care Trust and over 30 organisations across Bristol) signed a ‘Smokefree Bristol’ charter and adopted a five year plan ‘Towards a smokefree Bristol’. The legislation for smokefree public places enabled rapid progression of the Bristol smokefree strategy, although we still face the challenge of maintaining, coordinating and expanding all aspects of tobacco-related work across many organisational boundaries. This is taken forward by the Smokefree Bristol Steering group which links across the South West region through SW Environment, Revenue & Customs Operations and Trading Standards (SWERCOTS) and SW Tobacco Alliance Network (SWTAN), working together to reduce the prevalence of smoking.

Within Bristol there has been an ongoing awareness raising campaign across the Neighbourhood renewal areas to highlight the dangers of secondhand smoke and the importance of maintaining a smokefree home. Latest figures show that this has had some effect on the number of people keeping their homes smokefree. Our smokefree strategy continues this work through a programme of embedding the smokefree messages into the work of healthcare professionals, Bristol City Council employees, the fire service and many other organisations and businesses.

Bristol's Quality of Life Surveys in 2006 and 2007 for Bristol and for the seven wards where smoking prevalence is highest.

	Percent of respondents answering 'yes' to the following questions:					
	'I smoke'		'Someone in my household smokes'		'Someone smokes regularly indoors'	
Year	Bristol	Seven wards	Bristol	Seven wards	Bristol	Seven wards
2006	18.0 (16.8-19.2)	24.2 (21.7-26.7)	30.1 (28.7-31.6)	38.6 (35.7-41.5)	15.9 (14.8-17.1)	22.3 (19.9-24.8)
2007	16.2 (15.2-17.2)	23.0 (21.0-25.0)	27.2 (25.9-28.4)	34.4 (32.1-36.8)	13.9 (12.9-14.9)	20.8 (18.8-22.8)

Source: Bristol Quality of Life Survey 2006 and 2007

It should be recognised that the UK has shown significant progress on Tobacco Control through successful implementation of legislation in recent years:

- TAPA 2002 which introduced a ban on most forms of tobacco advertising including on the Internet, brand sharing and sponsorship. The Home Authority responsibility for Imperial Tobacco meant that Bristol City Council Trading Standards had to engage significantly with this legislation and reach conclusions about what was and was not permitted under the legislation, supported where need be by counsel's opinion.
- Ban on smoking in public places and vehicles through the smokefree legislation in July 2007.
- Raising the age of sale of tobacco to 18 to bring in line with other age restricted products which cause harm such as alcohol in Oct 2007
- Introduction of picture health warnings on tobacco products which highlight the harmful effects of smoking, in Oct 2008.
- Imposition of stricter sanctions for persistent sales of tobacco products to under 18's to be introduced in Spring 2009.

However there is further progress to be made to build on these successes and the consultation document offers an excellent opportunity for a further major step forwards in reducing the harm and health inequalities caused by smoking. .

Set out below are the responses to the DH document 'Consultation on the future of tobacco control' by the Smokefree Bristol steering group on behalf of the Bristol Partnership.

Part A: Reducing smoking rates and health inequalities caused by smoking.

Question 1: What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030 and on what basis do you make these suggestions?
Moreover, what else should the government and public services do to deliver these rates?

We congratulate the government on its commitment to developing a new national tobacco control strategy. On the basis of a comprehensive new strategy, which is monitored, evaluated and regularly updated and includes a harm reduction approach, ambitious new targets should be achievable. The aim should be to reduce smoking

prevalence rates for England by 2015 to 11% for the general population and 17% amongst routine and manual workers. Such stringent targets are supported by the significant decline in smoking prevalence in England following implementation of smokefree legislation, [1] recent rates of decline in the proportion of children smoking in England [2] and evidence of rates of decline achieved over a number of years in other jurisdictions with comprehensive tobacco control strategies [3] (e.g. Canada, Norway and California). Progress should be reviewed in 2012 to determine whether any revision of the tobacco control strategy is required in order to achieve these targets and again in 2015 to set new targets for 2020 and 2025.

It may also be appropriate to look at setting regional rates taking into account local prevalence rates and weighting these against the size of the population groups within the region. These rates would then determine the prevalence rate for England. If prevalence rates are to be set, existing targets for 4 week quitters should cease.

Eroding the differential in smoking between the groups will be slow but achievable in the longer-term. By 2020 it should be possible to reduce smoking prevalence to around 1 in 20 in the general population, and around 1 in 10 in routine and manual groups. It is too soon to set targets for 2030 but by then smoking should be uncommon across all groups.

Given that smoking uptake amongst children (11-15 year olds) is concentrated amongst 14 and 15 year olds we would suggest setting targets for these specific age groups for 2015 of 5% for 14 year olds and 10% for 15 year olds (compared to 9% and 15% in 2007 respectively). This would give a smoking prevalence rate amongst 11-15 year olds of 4% by 2015, compared to 6% in 2007.

It is also crucial that PCTs and local authorities are required to set appropriate local targets for smoking prevalence reductions and that these targets are adopted by Local Strategic Partnerships. The DH must ensure that monitoring of smoking prevalence at PCT and local authority level is carried out consistently and comprehensively to enable PCTs and local authorities to measure their effectiveness in meeting their targets.

Targets should also be set for exposure to secondhand smoke, by asking smokers whether they smoke in the home or in private vehicles. These targets should feed into the overall smoking prevalence targets, and not be seen as separate.

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[1] Smoking ban triggered the biggest fall in smoking ever seen in England. Cancer Research UK press release, 30 June 2008. Research presented by Prof Robert West at the UK National Smoking Cessation Conference (30 June-1 July 2008).

[2] Drug use, smoking and drinking among young people in England in 2007. The Information Centre for Health and Social Care, 2008

[3] Health Canada. Long-term trends in the prevalence of current smokers.
http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/_ctums-esutc_prevalence/chart_image_2005-eng.php
http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/index-eng.php
Statistics Norway: Smoking prevalence and social surveys http://www.ssb.no/royk_en/main.html
CDC Behavioural Risk Factor Surveillance System http://www.cdc.gov/brfss/

Question 2: What more do you think could be done to reduce inequalities caused by tobacco use?

High tobacco prices due to sustained increases in taxation are the best way of reducing smoking. However this is undermined by smuggled tobacco, mainly bought by poorer smokers.[4] Tougher action is needed to stop smuggling [see answers to Qs 4 & 5 below.] Currently there is no effective price regulation mechanism through taxation as the flow of illicit tobacco remains unchecked.

Poorer, more disadvantaged smokers also tend to be more heavily addicted [5] and need greater support to quit successfully. The introduction of a harm reduction strategy would be particularly helpful to poorer smokers who are unable to quit. [See answers to questions 13-17]

Illicit trade and inequalities-
The Government's latest estimate is that the illicit share of tobacco market in UK is between 8% and 18%.This means that today of all cigarettes smoked in the UK, 1 in 6 is either counterfeit or smuggled.[6]

A cheap and unregulated source of tobacco undermines the benefits of high taxation in reducing tobacco use. Poorer communities with high prevalence rates are known to have easy access to smuggled or counterfeit tobacco, making it easily available and cheap for young people.

The policy development of illicit tobacco needs to clearly acknowledge additional risks in terms of the quality of the product but does not detract from the message that all tobacco products are harmful.

Any awareness raising and education campaign to highlight the dangers of illicit tobacco on health and well being of communities should make the link between illicit trade and organised crime. It is important to highlight the conditions in which such products are manufactured and which are contrary to our ethical obligations and fair trade.

We need effective tobacco control measures and enforcement that allow us to target differentials in health inequalities between social groups that are caused by smoking which is also linked to other causes, such as, alcohol and drugs.

Social marketing campaigns targeted more effectively at poorer smokers could also help reduce health inequalities.

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[4] A YouGov poll commissioned by ASH found that 1 in 5 poorer smokers buy smuggled tobacco compared to only 1 in 20 of the most affluent smokers. (Fieldwork undertaken 20-25 Feb 2008. Total sample size was 3,329 adults, weighted to represent all GB adults aged 18+.)
[5] Jarvis, M. and Wardle J. Social patterning of health behaviours: the case of cigarette smoking. In: Marmot, M and Wilkinson, R.(eds) Social Determinants of Health (2nd ed). Oxford, OUP, 2005.
[6] Department of Health Consultation on the future of tobacco control. May 2008.

Question 3: Do you think the six strand strategy should continue to form the basis of the Government's approach to tobacco control into the future? Are there other areas that you believe should be added?

Yes. There is good evidence that each of the six strands of tobacco control [para 2.23] is effective in reducing smoking rates. The United Kingdom has achieved a great deal, particularly with respect to:

- helping people who want to quit,
- reducing exposure to secondhand smoke

However, more could be achieved in the following strands:

- running effective communications and education campaigns by using greater investment in sustained media campaigns using social marketing techniques, and enabling local influence on campaigns to fit with local priorities.

- reducing tobacco advertising, marketing and promotion should be changed to '**Eliminating tobacco advertising, marketing and promotion.'** TAPA 2002 is not effective in controlling some forms of tobacco advertising and promotion such as display and packaging. This needs to be addressed to ensure effective enforcement of the legislation and to create a level playing field for businesses.

- greater regulation of tobacco products by linking these products with other regulated products and prohibiting illicit tobacco. This will present policing challenges.

- reducing the availability and supply of tobacco products should be split into 2 strands:
  - Reducing the availability supply of tobacco products through licensing
  - Prohibiting and preventing access to illicit tobacco products.

In addition, a harm reduction strategy would help those smokers who are either reluctant to quit or find it particularly hard to do so, and would help reduce health inequalities. [See answer to Q17.] This strategy should be linked to a harm reduction strategy for both alcohol and drugs.

Question 4: How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?

An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled by criminal gangs, with new tougher targets for a continued reduction in the market share of smuggled cigarettes and hand-rolled tobacco. The new Borders Agency must work closely with HMRC and the Treasury to develop a new and improved anti-smuggling strategy and ensure that cracking down on smuggling remains a priority for the Government.

We support the proposals as set out in paragraphs 2.38 – 2.39. However, the UK Government should also lobby for, and sign up to, a strong illicit trade protocol as part of the international treaty on tobacco – the Framework Convention on Tobacco Control. The UK should also sign the EU anti-smuggling agreements, in line with all other EU Member States.

HM Revenue & Customs (HMRC) have stated that in 2006/07 counterfeit cigarettes accounted for 70% of all large seizures, with tobacco smuggling and fraud including counterfeit tobacco products, costing nearly £3billion per year in lost revenue.

Integrated action between the relevant agencies to tackling illicit tobacco should be a priority for the National Tobacco Control Strategy. There are strong links between illicit tobacco and availability of tobacco products to young people which contributes to the high prevalence rates in Bristol, particularly in the socially deprived areas. This in turn undermines the effect of high taxation on cigarettes to reduce tobacco use.

At national level, effective action to tackle illicit tobacco requires co ordination between Government Departments and agencies, for example, the Treasury needs to ensure that HMRC continues to set, publish and monitor targets under its Departmental Strategic Objectives for reducing the market share of smuggled cigarettes and hand rolled tobacco in the UK. Provide HMRC the resources necessary to improve their impact on the top levels of the import and supply chain of illicit tobacco. There also needs to be coordinated work between HMRC and the new Borders Agency.

More needs to be done regionally and locally to tackle the local supply of illicit tobacco and discourage demand. A good example of how this may be delivered is illustrated through the North of England cheap and illicit tobacco Health Action Plan which is currently a draft for consultation.

Other issues included in the North of England Action plan call for a proactive media campaign to alert people to the dangers of illicit tobacco, better informed magistrates, more police involvement, better joint working between agencies and a protocol for information sharing.

We consider that the new Regional Trading Standards Scambuster Teams, funded until 2011 by BERR to target a wide range of consumer fraud that crosses local authority boundaries, coupled with the enhanced Regional Intelligence Capability, would provide a logical vehicle to target counterfeit tobacco in partnership with HMRC, Police and other agencies and would suggest that DH gives serious consideration to funding dedicated officers for this purpose within these regional enforcement teams.

Question 5: What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

There should be more investment in mass media campaigns to encourage the public to report illegal tobacco sales and to show how the availability of cheap smuggled tobacco undermines other tobacco control measures. There should also be greater transparency of information about the scale of smuggling to allow civil society to monitor the anti-smuggling strategy and lobby for change where necessary.

See points raised in Q2 and Q4. In Bristol we feel very strongly that an awareness raising campaign is needed to undermine the public's acceptance of cheap illicit tobacco by linking it to organised crime and the ethical issues surrounding the manufacture of illicit cigarettes to change perceptions. We need to work more closely with the Humanitarian Organisations who are currently trying to prevent development of illegal counterfeit cigarette manufacturing. There is a major challenge to get a media campaign to spell out the dangers of counterfeit cigarettes without deterring from the general health messages for tobacco smoke. The Government needs to be more transparent in tackling this issue.

Part B: Protecting children and young people from smoking.

Question 6: What more do you think the Government could do to:
a. reduce demand for tobacco products among young people?
b. reduce the availability of tobacco products to young people?

There is wide support for measures to reduce youth smoking but there is little evidence to show that measures targeted specifically at young people have much benefit. Indeed, youth smoking prevention campaigns (particularly those initiated by the tobacco industry) can be counter-productive. [7] [8]

Bristol is introducing an evidence based peer-led smoking intervention programme (ASSIST) in schools. The ASSIST programme encourages new norms of smoking behaviour by training influential students to work as 'peer supporters', and to have informal conversations with other students about the risks of smoking and the benefits of being smokefree and disseminate new norms of behaviour through their established networks. This programme was developed and evaluated by the Universities of Bristol and Cardiff, with Wales and Bristol being the first areas nationally to roll out to schools in a year on year programme. This programme should be considered by the Government as evidence based approach to reducing demand for tobacco products among young people.

Reduce demand for tobacco products among young people.

There is good evidence to show that a comprehensive tobacco control strategy aimed at the whole population is the best way to reduce demand for tobacco products among young people. In addition to the 'six strands' identified above, there is widespread and growing support for measures to restrict tobacco marketing such as removing tobacco from view at the point of sale and plain packaging [see answers to questions 7,8,10] Local authority enforcement would be greatly assisted in this if a holistic approach was taken so that all age restricted products were included. This would make it simpler for the retailer too.

The Government should work towards eliminating smoking on TV, film, music videos and computer games as this makes smoking glamorous and socially acceptable, particularly to young people. More research needs to be done to find out why young people believe smoking is a normal behaviour, safe and socially acceptable

Local Authority enforcement would be much better assisted by recognition of the value of a holistic or integrated approach to age restricted sales. Local priorities and funding determine where LA's prioritise resources in tackling sales of age restricted products. Sustained funding from the Government to enable standing capacity/ team to effectively tackle sales of all age restricted goods such as tobacco, alcohol, knives, fireworks would provide a more effective strategy.
Parity in legislation across the range of age restricted products regarding offences, powers, sanctions and process would make enforcement easier. It would also make things simpler for traders and would assist with compliance.

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[7] Landman, A., Ling, P., & Glantz, S. Tobacco industry youth smoking prevention programs: Protecting the industry and hurting tobacco control. Am J Public Health 2002; 92 (6): 917-930.
[8] Wakefield, M. et al. Youth responses to anti-smoking advertisements from tobacco-control agencies, tobacco companies, and pharmaceutical companies. J Applied Social Psychol 2005; 35 (9): 1894-1911.

Reduce the availability of tobacco products to young people

Banning sales of tobacco from vending machines, increasing price through taxation with stronger measures to curb smuggling will restrict the availability of tobacco products to young people.

Licensing of the sale of all age restricted products should be reintroduced with a penalty for anyone who sells these products illegally to have their licence removed. This would not just strengthen control of underage sales but would also help retailers by enabling unlicensed sales of age restricted products, including tobacco, to be tackled more effectively (for example in street markets or car boot sales).

Bristol would support tougher controls generally, including:

- **a.** The licensing of retailers as a means of reducing availability and number of retail outlets which can sell tobacco products.
- **b.** Removal of tobacco vending machines.
- **c.** Tackling illicit trade (as discussed above).
- **d.** Parity for tobacco legislation with that controlling the sale of alcohol would benefit enforcement
    - i) Proxy Sales- the creation of an offence of buying tobacco products on behalf of under 18s
    - ii) Restricting/controlling sales of tobacco products by staff under age of 18
    - iii) Introduction of fixed penalty notices would mean that offences by sales staff could be dealt with more promptly and efficiently.

Question 7: Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers?

Yes. The advertising of tobacco accessories such as cigarette papers, matches or lighters can act as a prompt and reminder about smoking and should be outlawed. Age restriction in lighters/matches should be consistent with butane fuel. The sale of cigarette papers to young people is restricted by the Children's and Young Persons Act 1933(as amended) and is therefore another argument for restricting advertising of cigarette accessories. In recent years there has been a rise in the proportion of smokers using hand-rolled tobacco: from 12% in 1996 to 22% in 2006.[9] It is noteworthy that when the Tobacco Advertising and Promotion Act were implemented Imperial Tobacco chose to place advertisements for Rizla cigarette-rolling papers at the point of sale since they were not covered by the controls on tobacco advertising and promotion. Imperial has also used the Rizla brand to sponsor motor racing, thereby maintaining a link between sport and smoking, despite UK and European law which has outlawed tobacco sponsorship of sport.[10] Tobacco accessories should come under the same legislation as tobacco since they are inextricably linked with and normalise tobacco smoking. The Government should enhance one of the six strands of tobacco control to 'eliminate' tobacco (including tobacco accessories) advertising, marketing and promotion.

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[9] Smoking-related Behaviour and Attitudes, 2006. Office for National Statistics, 2007

[10] Good, G. Presentation at UBS Tobacco conference. 1 December 2006 http://www.imperial-tobacco.com/files/financial/presentation/011206/ubs_transcript.pdf

Question 8: Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option? [We are particularly interested in hearing from small retailers and in receiving information on the potential cost impact of further restrictions on display. What impact would further controls on the display of tobacco have on your business, and what might the cost be of implementing such changes?]

Option 3: Require retailers to remove tobacco products from display.

There is strong evidence to show that tobacco advertising and promotion encourages children to smoke and this evidence underpinned the UK law which banned most forms of tobacco advertising. [11] Tobacco packaging is now the principal means by which tobacco companies promote their brands and point of sale displays are a form of tobacco advertising. Removing tobacco products from public view will not affect adult smokers' ability to buy them but it will remove the temptation of children to try to purchase them. It is noteworthy that in Iceland, where point of sale displays were made unlawful in 2001, the proportion of 16 and 17 year olds who reported that they had ever smoked fell from 61% in 1995 to 46% in 2003. [12]

A ban on the display of tobacco products also removes the temptation for adults who are trying to quit making an impulse purchase.[13] In terms of enforcement, it is harder to control displays effectively; therefore it would be easier to remove from sight. If displays were to remain there would need to be very clear guidelines as to what a minimal display would look like.

There has been considerable speculation in the retail trade press about the cost to the retail trade of this measure. However, evidence from Canada shows that the tobacco industry paid for cigarette displays and, once they were banned, the companies continued to pay retailers for the tobacco storage units. [14]The tobacco industry has the means and resources to assist tobacco retailers in managing similar changes in the UK. Moreover, we believe that the tobacco industry should be required to disclose to the Government the amount of money it spends on marketing its products, as is the case in Canada.

TAPA 2002 introduced a wide ranging ban on tobacco advertising and promotion. It also restricts advertising at point of sale to a maximum equivalent to A5 in size by virtue of Point of Sale Regulations. Display of tobacco products, however, to this date remains uncontrolled and provides an effective means by which tobacco products can be advertised and promoted. As noted in 3.21 of the consultation document a report from LACORS in 2006 noted increasingly frequent use in the retail environment of counter-top devices such as clocks and counter mats to draw attention to tobacco products. In addition, many retailers were found to be stacking multi packs of cigarettes in a way that creates large virtual advertisements that contravene the spirit if not the letter of the point of sale restrictions.

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[11] Pierce J et al. Does tobacco advertising target young people to start smoking? Evidence from California. JAMA 1991; 266(2): 3154-3158

[12] The European School Survey Project on Alcohol and Other Drugs (ESPAD). www.espad.org/sa/node.asp?node=730

[13] Wakefield, M. The effect of retail cigarette pack displays on impulse purchase. Addiction Nov 2007 http://www.addictionjournal.org/viewpressrelease.asp?pr=69

[14] Anti-tobacco troopers won't butt in - The Gazette (Montreal), 19 May 2008

There is evidence that Point of Sale tobacco advertising has a direct effect on young people's smoking. The odds of a young person professing an intention to smoke may increase by 35% with every brand that they can name as having seen advertised[14]

The legislation introduced for option 3 must be drafted such that there are no issues relating to interpretation or enforcement and it has the effect of completely removing tobacco products from display in retail environments.

Question 9: Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?

Option 3: A total ban on the sale of tobacco products from vending machines.

Although vending machines account for a small proportion of overall cigarette sales, a disproportionate number of young people under the legal minimum age for the sale of tobacco obtain cigarettes from this source. This is because the machines are not properly supervised and children can access them relatively easily. The latest survey conducted when the legal age for purchasing tobacco was 16, found that 17% of 11-15 year old smokers reported that vending machines are their usual source of cigarettes. [15] However, following the rise in age of sale to 18, unsupervised vending machines could become a more significant source of under age sales.

Currently estimates suggest there are around 70,000 vending machines across England and Wales. In particular, a survey by LACORS showed that young people have been able to buy cigarettes from coin operated vending machines on more than 4 in 10 occasions with some LA's reporting 100% failure rates in enforcement. Age restriction mechanism on vending machines will not eliminate problem of access by young people and therefore the only method of preventing this is to remove them.

Banning the sale of tobacco products from vending machines would make it harder for children to purchase cigarettes. Many countries already prohibit the sale of tobacco from vending machines (or have never allowed it) and a total ban on tobacco sales from vending machines has been recommended by the World Health Organisation. Implementing tighter controls is not only impractical, but would be hard to enforce.

Question 10: Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?

Yes. Although no jurisdiction has yet implemented a law requiring plain packaging, research suggests that it would help deter young people from taking up smoking because smoking would lose its appeal. [16]

There is evidence from around the world to show that the tobacco industry uses branding in general and pack design in particular to:

- Target young people

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[14] Henricksen et al. 2004. Association of retail tobacco marketing with adolescent smoking. Am J Pub Health, 94(12):2081-2083

[15] Fuller, E. Smoking, drinking and drug use among young people in England 2006. NHS Information Centre, Leeds, 2007.

[16] Cunnigham, R. & Kyle K. The case for plain packaging. Tobacco Control 1995; 4: 80-86

- Maximise display space (some members of brand families are virtually indistinguishable on taste alone yet the number of variants has increased dramatically in recent years).
- Communicate misleading messages (it would be illegal for manufacturers to claim products were "low tar" "light" or less harmful yet all these are communicated by the colour of sub-brand packaging)

Packaging is the last remaining and most ubiquitous form of tobacco advertisement. Since TAPA 2002 ended general tobacco advertising, pack design has become increasingly sophisticated and appealing with clever use of imagery, colours and design.

Tobacco companies invests considerable resources in making tobacco packaging alluring and eye-catching, as this is now one of the few methods currently available to the industry to market its products to new and existing smokers. [17] Industry analysts believe that plain packaging would have a significant negative impact on cigarette sales, radically reduce brand appeal to young people and children, and have an important role in de-normalising smoking. [18]

In order to avoid displacement of smokers towards illicit tobacco, which could also readily be produced in plain packaging, the introduction of plain packaging needs to be accompanied by a range of counter measures against illegal sales such as making scanner devices for detection of counterfeit products more widely available to Trading Standard Officers to monitor the retail supply of tobacco.

Question 11: Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?

Currently there is insufficient evidence to show whether a requirement for minimum pack sizes would have a significant impact on youth smoking. ASH recommends that the policy is kept under review and that further research be conducted. The Government may wish to consider taking reserve powers to determine permitted pack sizes by Regulation in future.

Question 12: Do you believe that more should be done by the Government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

Yes, more could be done by both Government and individuals to reduce children's exposure to secondhand smoke. For example, the Government should

- Run more National mass media campaigns targeted at parents/carers about the health effects of secondhand smoke, particularly in enclosed places such as the home and motor vehicles.
- Commission research into effective ways of helping parents to stop smoking and to prevent children's exposure to smoke if parents do not stop smoking. (This links to the harm reduction approach outlined in question 17.)

[17] Wakefield, M. The cigarette pack as image: new evidence from tobacco industry documents. Tobacco Control 2002; 11:i73-i80 http://tobaccocontrol.bmj.com/cgi/content/full/11/suppl_1/i73
[18] Material new risk appears: UK government suggests plain packaging. Citigroup, 2 June 2008

- Ensure that the stop smoking services are adequately funded and continue to be targeted towards disadvantaged smokers and other groups such as parents.
- Consider extending the smokefree regulations to cover private cars, although this action brings with it concerns over the ability of environmental health officers to adequately enforce the new regulations.

Part C: Supporting smokers to quit

Question 13: What do you believe the Government's priorities for research into smoking should be?

NB: You may wish to add your own ideas here but some of the key areas which warrant further research include:

- Research to further understand and overcome the barriers to using medicinal nicotine or other pharmacotherapies
- Research to improve the identification, referral and retention in treatment of pregnant smokers
- Studies to examine the impact of interventions and policies on different social groups.
- The use of tobacco amongst ethnic minority groups
- Studies to examine the efficacy of different prevention approaches including mass media interventions on young people
- Qualitative research with smokers to identify barriers to attending NHS Stop Smoking Services
- Study to scope regional variations in smoking behaviours particularly related to social groups

Question 14: What can be done to provide more effective NHS Stop Smoking Services for:
• smokers who try to quit but do not access NHS support?
• routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?

Stop smoking services are very cost effective and combined with the use of pharmacotherapies can increase a smoker's chances of quitting four-fold compared to using willpower alone. However, take up by smokers wanting to quit is still low with only 3% to 6% of smokers making use of the services per year. If attendance was raised to 10% of smokers, it is estimated that the population long-term quit rate could be increased by 0.5%. [19] Therefore, there is huge scope for improving the services and making them more attractive to people seeking help in stopping smoking.

The 4 week quit targets set by the Government detract from opportunities to be proactive in reducing smoking prevalence, which would encourage more smokers to consider quitting. Trusts are now at a stage where they are working with the 'hard core' smokers, and whilst it is important to continue to offer them support more time and effort needs to be placed in prevention particularly with young people. It is important for stop smoking services to continue, but more integrated into the wider tobacco control strategy. In Bristol we are attempting to do this with the ASSIST

[19] West, R. The Smokers Toolkit Study. www.smokinginengland.info

programme in schools and linking this into stop smoking programmes for young people.

Hospitals should be required to monitor smoking rates of patients and to give all smokers brief advice to quit, access to stop smoking medicines and referral to stop smoking services. Smoking rates of people leaving hospital should also be monitored. In addition, stop smoking should be included in the Standards for Better Health set by the Healthcare Commission.

The cost of purchasing stop smoking aids can be a barrier to use, as can the limited availability of these products. Although some versions of NRT are now on general sale, availability is still largely limited to pharmacies and supermarkets. Meanwhile tobacco products are widely available from many outlets such as corner shops, garage forecourts, supermarkets, pubs, vending machines in licensed premises, and specialist tobacconists. In order to help smokers who want to quit without NHS support, stop smoking aids should be accessible in all the places where tobacco products are currently sold. There is widespread public support for such a policy. According to a YouGov poll, 76% of adult smokers in England said they supported making NRT easier to access. [4]

Research should be conducted to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of the smoking cessation services.

Social marketing campaigns targeted at particular social groups should be used to assist those who find it most difficult to quit. National media campaigns should enable as much local focus as possible, or be delivered at a regional level so attention can be given to local priorities.

Question 15: How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?

Clearly much more needs to be done to make the services attractive to people who want to stop smoking. This could be achieved by improving the selection, training, assessment and supervision of specialists; the implementation of treatment protocols, but with recognition of the need to provide innovative services and treatment options, and high quality administrative support for services. A nationally recognised accredited training should be available for all stop smoking advisors.

Mass media health campaigns should be complemented by community-based initiatives to promote local services. In Bristol we feel strongly that the national campaigns should stop competing with locally based services in getting people signed up to stop smoking. Campaigns should be agreed nationally, but delivered at a regional level to allow for a more local focus and locally directed contact details. This enables a much quicker response rate to queries about stop smoking from the public.

Question 16: How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?

All health professionals should be trained to offer opportunistic stop smoking advice and referral to the stop smoking services, particularly to disadvantaged smokers who are likely to be in most need of help and ongoing support.

Stop Smoking training as brief advice and brief intervention should be included as part of the training for all healthcare professionals, with stop smoking training available as an additional module.

There should be more outreach with services being set up in places where people are likely to see them, such as in workplaces, shopping centres and schools.

Better use could be made of existing social networks including faith groups to reduce smoking prevalence.

The local NHS stop smoking services contact details should be on display at every retail outlet that sells tobacco.

Part D: Helping those who cannot quit.

Question 17: Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?

Yes. People are free to smoke but it is important to find ways of reducing the harm caused by smoking whilst allowing people to use nicotine in a way that will not endanger their health. Nicotine is relatively safe but little has been done to promote longer term use of nicotine replacement therapy as an alternative to smoking for those who are unable to quit. Although the Medicines and Healthcare Regulatory Agency (MRHA) has taken steps to increase the accessibility of NRT much more needs to be done.

The Government should take a lead in encouraging the development and promotion of pure nicotine products (which like the current medicinal products on the market only contain nicotine and not any other tobacco products) as an alternative to smoking. This should include educational campaigns to raise awareness of the relative safety of nicotine, as currently a significant proportion of smokers and health professionals believe that nicotine can cause smoking-related diseases such as cancer. [20] Such an approach will be particularly attractive to more deprived smokers who tend to be more heavily addicted to nicotine and so find it harder to quit, thereby helping to reduce health inequalities.

A harm reduction strategy should be extended to cover activities related to tobacco smoking such as, alcohol and drug use. It is also important to ensure that the message ‘there is no safe level of exposure to tobacco smoke’ remains clear.

END

These responses to the Consultation on the future of tobacco control have been sent on behalf of Smokefree Bristol, part of the Bristol Partnership, by Bristol Primary Care Trust and Bristol City Council. In the event of a query please contact:
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Stephen Meale, Trading Standards Manager, Bristol City Council
Hansha Reed, Senior Trading Standards Officer, Bristol City Council

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[20] Siahpush M, McNeill A, Hammond D, and Fong GT. Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. Tobacco Control 2006; 15: iii65 - iii70.