

**Doncaster Smokefree
Tobacco Control Strategy
2010 to 2015**

DRAFT

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1. INTRODUCTION

Tobacco use is a significant problem that affects us all. It affects our health, our wealth and our safety.

1.1 Health

Smoking kills¹. It is the single biggest cause of preventable illness and premature death particularly through cancer, circulatory and respiratory diseases. The effects begin even before birth. Women who smoke during pregnancy are three times more likely to have a low birth-weight baby and are more likely to suffer a miscarriage or premature birth or other complications². If parents continue to smoke then their children, raised in smoking homes, are more likely to have respiratory problems – quadruple the risk in infancy, be admitted to hospital with ear and respiratory problems and to become smokers themselves starting over the whole cycle.^{2,3}

1.2 Wealth and productivity

This effect on health impacts on the economy. Through the additional healthcare costs of treating smoking related disease, providing social care to people with disabilities as a result of their smoking and benefits to those who become too ill to work through diseases such as COPD. It impacts businesses through the number of additional days lost due to illness – on average eight more days a year than a non-smoker costing the economy about £2.5 billion a year in terms of lost productivity and sick leave⁴.

For the individual, smoking which is already linked to poverty perpetuates poverty. The poorest 10% spend 2.43% of income on smoking compared to 0.52% of the richest,⁵. And it is estimated that lone parents on benefit will spend around a seventh of their income on tobacco depriving children of both clothing and food⁶.

1.3 Fire

The Arson Control Forum, Social Exclusion and the Risk of Fire reported in 2004 that there is a correlation between poverty, smoking, fires and not having a smoke alarm. As a consequence of this lethal combination nationally 4 out of every 10 fire deaths are due to smoking.⁷

1.4 Crime

Crime and tobacco are linked. As prices for legitimate tobacco products are increased to deter smokers so the market in cheap and counterfeit cigarettes grows. In some cases the profits support more serious crime - weapons, drug and alcohol trafficking.

WHO estimates that for each 10% price rise in tobacco smoking consumption can be reduced by 4% but these measures are undermined by illicit tobacco⁸. The North of England is a hotspot for illicit tobacco which is used more widely by the poor and the young. It is estimated that around 1 in 3 cigarettes smoked is illicit counteracting the price-deterrent and age-of-sale measures and maintaining poorer smokers in their habit.⁹

1.5 Education.

Anecdotally it has been reported that school children addicted to nicotine are more irritable with poorer concentration as the need to take a cigarette break increases throughout the day. Whilst there appear to be no studies carried out to support this it is quite probable as these are well known symptoms of nicotine withdrawal

1.6 Our environment

A smokefree environment is a better environment for us all. Passive smoking or second-hand smoke is harmful to health.¹⁰ It can cause heart disease, stroke and lung cancer in adults. Being exposed to second-hand smoke even for a short time can cause eye irritation, headache, cough, sore throat, dizziness and nausea. In the year following the ban on smoking in enclosed public places in England there were 1,200 fewer emergency heart attack hospital admissions - a 2.4 percent decrease. Findings that have been seen in other countries following similar bans.

Second-hand smoke within the home however remains an issue, especially for children. In addition to the direct health impact we know that having a parent or sibling who smokes is strongly associated with the likelihood that a child will be a smoker themselves¹¹.

And lastly, smoking creates litter. The annual Local Environmental Quality Survey of England identified smoking related litter as one of the most prevalent types of litter.¹³ Due to its nature – small size – it is expensive to clear. Since Smoke Free legislation there is a visible issue with smoking litter outside some business premises.

2. THE SIZE OF THE PROBLEM IN DONCASTER

We know that smoking, tobacco prevalence is high in Doncaster around 29.1% giving us between 67,000 to 68,100 smokers over 16 years of age. This is higher than the England average of 25%. Whilst the new prevalence monitoring won't begin until December of this year, all the indicators and previous surveys support this because:

- There is a clear link between areas of deprivation and smoking prevalence⁵. The JSNA identifies that around 21% of the population in Doncaster are within 10% of the most deprived in England, 37% within the 20% most deprived, see Appendix 3
- Compared to national levels, Doncaster has higher rates of premature cancer mortality including lung cancer, and respiratory disease mortality.
- Tobacco prevalence figures are already available for the Doncaster NDC. These figures show a prevalence of 43% in 2008 (England 22%) and there is a statistically significant gap between this and the NDC aggregate which is 35%
- In contrast to the rest of England the rate of smoking in pregnancy in Yorkshire and Humber is increasing from 21.9 to 22.1%. In Doncaster the rate stayed at around 25% during 2008/09 and has shown no downward trend over the last 2 years.
- The flat rate of smoking in pregnancy is also reflected in the overall prevalence of smoking seen within Yorkshire and Humber which has seen no decrease from 2005 to 2008.
- Overall the JSNA estimates a prevalence of 29.1% in Doncaster but it may well be higher.

2.1 In June 2010 we know that:

- Between 2001 – 2005 there were 3,026 smoking related deaths – nearly 20 out of every 100
- There were 6.5 deaths infant deaths per 1,000 live births compared to the England rate of 4.8.
- There are 14,661 people with diagnosed COPD, cardio vascular disease and other chronic diseases who smoke.
- Twenty-five out of every 100 pregnant women are still smoking at delivery.
- We spend around 90 million in Doncaster a year on treating the results of smoking

- Five out of ten people in Doncaster who smoke say they want to quit compared to 7 out of 10 - England average.
- Across South Yorkshire smoking was responsible for 40% of deaths in accidental house fires in the last 5 years. In Doncaster over the last 3 years the number of house fires where smoking is the cause has remained level between 18 and 22 a year. Two people have died in this period and 22 people had to be rescued from their homes.
- Figures for underage sales and test purchase show a failure rate of around 14% in Doncaster. For under-age test purchases from vending machines 54.4% resulted in a sale. Around 21% of smokers in Yorkshire and Humber surveyed reported that they bought cheap illicit tobacco and just under 70% reported that illicit tobacco made it possible for them to smoke when they couldn't otherwise afford to. Other tobacco related crime – thefts, burglaries of tobacco products is on a small scale, of low value and considered opportunistic rather than planned and organised crime.

3.0 OUR VISION

Is a smokefree Doncaster.

Where smoking is the exception rather than the norm, where children grow up in homes and environments free from smoke and where the disease and premature death associated with tobacco is reduced to a minimum.

We will achieve our vision by addressing a number of key areas:

3.1 We want to reduce the number of people who smoke by motivating and assisting every smoker to quit.

WHY?

- **To reduce health inequalities.**
Half the difference in life expectancy between the most affluent and the most deprived is due to smoking⁵
Premature deaths from lung cancer are five times higher among men in unskilled manual labour than those in professional work¹⁴
People in routine and manual jobs, living in rented housing or overcrowded accommodation, receiving welfare benefits, suffering from mental health conditions, with no educational qualifications are all more likely to smoke⁵
- **To reduce the incidence of smoking related disease and premature death**
The primary cause of chronic obstructive pulmonary disease (COPD) is tobacco smoke (including second-hand or passive exposure).¹⁵
Smoking is one of the major causes of, and smokers are almost twice as likely to have a heart attack as people who have never smoked.¹⁶
Smoking is the single biggest cause of cancer in the world, and accounts for one in four UK cancer deaths.¹⁴
Smoking causes 9 out of 10 cases of lung cancer¹⁴

- **To reduce infant mortality rates**

Maternal smoking during pregnancy is a major cause of sudden infant death syndrome (SIDS)²

Infant exposure to ETS may contribute to the risk of SIDS.¹⁷

3.2 We want to reduce exposure to secondhand smoke, increasing the number of areas that are smokefree

WHY?

- **To reduce childhood illness and emergency admissions associated with passive smoking**

Infant exposure secondhand smoke may contribute to the risk of sudden infant death syndrome.²

In children exposure to secondhand smoke causes lower respiratory tract infections such as pneumonia and bronchitis, coughing and wheezing, worsening of asthma, and middle ear disease.^{2,17}

- **To reduce disease amongst adults associated with passive smoking**

Exposure to secondhand smoke can increase a non-smoker's risk of getting lung cancer by 24% and the risk of getting heart disease by 25%.¹⁰ There is no risk-free level of exposure to secondhand smoke. After just thirty minutes, breathing in secondhand smoke can make blood platelets become stickier, which means a higher risk of having a heart attack or developing other heart problems.¹⁸

- **To change the perception within Doncaster that smoking is a normal activity**

Interventions having the greatest, quickest and most sustainable impact on smoking prevalence are those aimed at changing social norms. The UK Government has highlighted social norms as key to changing health behaviours.²¹

- **To reduce the incidence of fires and fire-fatalities**

We know that our most vulnerable communities are where the combination of smoking and absence of a smoke alarm is the most prevalent.

3.3 We want to regulate tobacco products, stamping out cheap and illicit tobacco

Why?

- To make smoking less-affordable driving more people to quit
- To make smoking less affordable making ex-smokers less likely to relapse
- To make smoking less affordable thereby make it harder for children to start smoking
- To reduce the crime and antisocial behaviour associated with cheap and illicit tobacco

Current estimates are that one in three cigarettes smoked in the UK are smuggled.

Criminal activity targets areas of deprivation⁹

Price increases in tobacco reduce demand for tobacco products but this is undermined by the availability of cheap and illicit tobacco⁸.

3.4 To support our plans we want an effective, coordinated communication and education strategy.

Why?

- To understand why our residents smoke and how best to help them to quit
- To use all media resources to communicate our vision around tobacco control to our residents in the most effective way

- To ensure that everyone working in our partner agencies understands what we are trying to achieve and why and how they can help

Clear and consistent messages around tobacco control are a vital part of tackling tobacco prevalence⁶.

There is a clear link between mass media campaigns and significant reductions in tobacco use.⁶

Public campaigns have been shown to be cost effective and most likely to succeed if developed following social marketing principles.⁶

3.5 We want to do these things in the most efficient and effective way managing the Tobacco Programme within the resources that we have available.

Appendix 3 shows a recent audit of estimated tobacco control spend within Doncaster for the Strategic Health Authority. This audit did not capture the resources put into tobacco control by the fire, police and voluntary agencies.

The case for effective tobacco control measures and their cost effectiveness have been demonstrated in a number of documents including WHO World Health Report 2002, Reducing Risks, Promoting Healthy Life²⁰. Stop smoking services are the most cost effective health intervention provided by the NHS in England.⁶

We do not have evidence or local data as yet to show if the balance of spend across our tobacco control programme is right.

3.6 We will achieve our vision through our multi-agency Tobacco Control Alliance.

The preceding pages document how tobacco affects many areas of life and many agencies.

The Healthcare Commission in the 2007 No ifs, no buts: Improving services for tobacco control reported that PCTs with the highest rates of quitters also scored high in the area looking at partnership working.¹⁹

Experience and opinion from the US is also that partnership working is essential for successful tobacco control.⁶

4. TOBACCO CONTROL STRATEGY OBJECTIVES

i. PROGRAMME MANAGEMENT: DELIVER A REDUCTION IN TOBACCO PREVALENCE

Objectives	Action	Groups/Lead	Monitoring	Performance Measures/Indicators
A. Resources are used across the tobacco control programme to ensure value for money services with the best possible health outcomes and patient experience	<ul style="list-style-type: none"> • Robust programme management to ensure that resources invested achieve technical & allocative efficiency • Agree prioritisation criteria across tobacco control programme for evaluation of new developments • Develop systems to performance manage services and link specifications to KPIs and quality and health outcomes 	<p>Core Tobacco Control Alliance, R Suckling</p> <p>Core Tobacco Control Alliance, R Suckling</p> <p>K Warhurst</p>	<ul style="list-style-type: none"> • Programme profile completed • Technical and allocative efficiencies across all programme identified • Optimal economics of provision identified • Tobacco control services have an agreed specifications 100% agreed KPIs are reported quarterly to PHPB 	<ul style="list-style-type: none"> • Total cost of programme and cost per head identified and benchmarked against similar SHAs and PCTs • Premature smoking related mortality • Programme specific performance measures
B. Work streams deliver on their objectives	<ul style="list-style-type: none"> • Ensure each work strand has an annual dated action plan or strategy with accountable agencies /leads identified 	As per working group/Tobacco Control Alliance R Suckling	<ul style="list-style-type: none"> • Plans provided • Quarterly report on progress and performance 	% of objectives achieved Reduction in tobacco prevalence

ii. SUPPORT SMOKERS TO QUIT :MOTIVATE AND ASSIST EVERY SMOKER TO QUIT

Objectives	Action	Groups/Leads	Monitoring	Performance Measures/Indicators
A. Increase the % of smokers who report they are dissatisfied with their smoking habit	Industrialise brief interventions and roll-out to key partners/agencies. Tailor messages for fire, police, LA etc. Maximise potential with appropriate tailored messages Develop champions within voluntary sector –teenage peer groups, parents etc. Develop targeted media campaign to deliver key messages Gather relevant patient stories to illustrate success Enforce smokefree polices	Short term: Task and Finish Group – link with Communications Group after social marketing Medium term: ongoing monitoring via Tobacco Control Alliance	Lifestyle survey Referral rates by areas	Increased number of referrals Increased number of quits Reduced prevalence Increased report of smokers wanting to quit
B. Increase the % of smokers who quit with NHS support	LSSS Support: Raise profile of SSS with targeted and positive media campaign Streamline access to services Ensure easy access to repeat/further support	Via Communications Group IC Link with LSSS to streamline access & QIPP Ian Carpenter/Andrew Brankin/Kerry Warhurst	IHS Tobacco Prevalence DH Monitoring Returns	Increase in number of quits via the service Decrease in tobacco prevalence
C. Increase the success rate of those who try and quit independently	Map services to ensure no gaps in provision for those who want structured support Use social marketing to Identify support requirements for individuals who do not want to access structured support Link with Life checks	A Brankin//K Warhurst link with Communications Group	IHS Survey of tobacco prevalence Feedback option via website	Decrease in tobacco prevalence

ii. SUPPORT SMOKERS TO QUIT :MOTIVATE AND ASSIST EVERY SMOKER TO QUIT

Objectives	Action	Groups/Leads	Monitoring	Performance Measures/Indicators
D. Reduce the prevalence of smoking in pregnancy by half by 2020	Introduce a CO monitoring programme for all pregnant women Opt- out referral system for all pregnant women exposed to smoke to LSSS/SFH	Via Smoking in pregnancy subgroup, KW	% pregnant women smoking % setting quit date No. relapsed No. quit	Smoking prevalence in pregnancy Infant Mortality Maternal complications attributed to smoking
E. Reduce the prevalence of smoking in targeted groups: mental health, long term conditions – COPD, vascular	Brief Intervention AAA Training SSA and relevant clinicians Develop pathways to maximise referrals inc. explore opt-out system	Mental Health – AB LTC Pathways – Task and Finish Group	QoF registers Number referrals from MH No. quit No. relapsed Emergency Admissions for LTC	Reduction in smoking prevalence in LTC Reduction in emergency admissions
F. Reduce by half the level of smoking amongst routine and manual workers	Target Business Excellence Award to employers of routine and manual workers Shared success stories Develop business pack to facilitate expansion of smokefree business polices	Paul Williams A Brankin lead Workplace Group	DH Monitoring returns No of businesses with complete smokefree premises Number of businesses with Business Excellence Award	Reduction in tobacco prevalence Reduction in sickness rates
G. Reduce by half the levels of smoking in the most deprived and hard to access communities/groups	Map access and referrals against identified groups inc: Traveller and Roma communities Newly released offenders NDC area	Smokefree services	Referrals by communities	

iii. REDUCE EXPOSURE TO SECOND HAND SMOKE

Objectives	Action	Group/Leads	Monitoring	Performance Measures/Indicators
A. Ensure that no more than 1/3 rd of smoking parents smoke in the home or car by 2020	<p>Make smokefree part of brief advice Pathways for smoking parents of children admitted with possible smoking related illness</p> <p>Seek to extend smokefree environments - play areas, outdoors spaces accessed by children</p> <p>Link fire safety checks and smokefree homes particularly targeting the high risk families</p>	C&YP Group	<p>No of children living in smokefree homes</p> <p>No of children living in homes where parents smoke but not in the home or car</p>	Decreased paediatric admissions due to smoking related illness – respiratory disease
B. Reduce the incidence of house fires caused by smoking	<p>Provide smokefree advice to all smokers whether they want to quit or not.</p> <p>Link smokefree services and fire safety checks through Hot Spots</p>	Hot Spots	<p>No. of smoking related fires</p> <p>No of injuries/fatalities caused by smoking –related fires</p>	<p>Reduction in fires de to smoking</p> <p>Reduction in injuries/fatalities due smoking related fires</p>
C. Denormalise smoking through the extension of smokefree spaces	<p>Review workplace polices and identify where they can be strengthened to lead by example</p> <p>Look at common themes for smokefree places across key organisations e.g. fire, police, NHS etc.</p> <p>Publicise and recruit to the Smokefree Business Excellence Scheme</p>	<p>PH – NHS Doncaster</p> <p>Tobacco Control Alliance Core Group</p>	<p>No. businesses with totally smokefree premises</p> <p>No of businesses achieving Smokefree Business Excellence Award</p>	Increased number of totally smokefree business premises

iv. REDUCE EXPOSURE TO SECOND HAND SMOKE

D. Lead a systematic and coordinated approach to smokefree across all agencies.	Identify a senior level champion Enforcement of smokefree at a senior level	Senior champion – Annette Laban		
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v. REDUCE THE UPTAKE OF SMOKING AMONGST YOUNG PEOPLE

Objectives	Action	Group/Leads	Monitoring	Performance Measures/Indicators
<p>A. Reduce the prevalence of smoking in: 11 – 15 yrs to 1% by 2020 16 - 17 yrs to 8% by 2020</p>	<p>Audit of existing activity vs. NICE & PH Guidance 23</p> <p>Investigate peer-led approaches within schools</p> <p>Develop coordinated strategy for C&YP linking with communications strategy</p> <p>See also Objectives: iii, v and vi.</p>	<p>KW</p> <p>C&YP Group</p> <p>C&YP Group</p>	<p>No of schools achieving National Healthy School Status & No. with Smokefree Excellence award</p>	<p>Decrease in smoking prevalence</p> <p>Decrease in number of young people who report they have tried smoking</p>

vi. RUN EFFECTIVE COMMUNICATIONS AND EDUCATION CAMPAIGNS

Objectives	Action	Group/Leads	Monitoring	Performance Measures/Indicators
A. Develop a vision for a smokefree Doncaster which is understood and supported by our residents	Develop a communications strategy to support our vision and Tobacco Strategy Ensure strategy enables Tobacco Control Alliance to respond promptly to media enquiries/ provide local perspective on any key national initiatives Local lobbying of key influencers in support of our vision	Communications Group –IC	IHS Tobacco Prevalence Survey Public feedback Website response	Reduction in tobacco prevalence Increase in number of people who know what the key messages are Increase in number of people who know where to get help – stop smoking, smokefree workplaces
B. Denormalise smoking through creation of an “Everyone’s Quitting” environment	Through development of communications strategy and targeted key messages	Communications Group –IC	IHS Tobacco Prevalence Survey Public feedback Website response	
C. Use available resources to best advantage by maximising opportunities across all partners	Set up Communications Sub Group Identify small number of relevant messages for each partner agency Identify & develop champion within each partner agency Develop a Stop Smoking Matters checklist for partner agencies Identify new and more effective ways of communicating with key target groups: Blue-tooth Social Networking Sites, Twitter Use Regionally/nationally developed Campaigns and materials to minimise local costs Link local communications group with Regional Subgroup	Communications Group –IC Communications Group - IC	IHS Tobacco Prevalence Survey Public feedback Website response	

v. RUN EFFECTIVE COMMUNICATIONS AND EDUCATION CAMPAIGNS

Objectives	Action	Group/Leads	Monitoring	Performance Measures/Indicators
D. Reduce by half tobacco prevalence in key target groups	Identify priority groups and develop communications strategy and key messages inc. through brief intervention.	Via Communications Sub Group - IC		

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vi. REGULATE TOBACCO PRODUCTS

Objectives	Action	Group/Leads	Monitoring	Performance Measures/Indicators
<p>A. Maintain real price of tobacco through reduction in supply of illicit tobacco.</p>	<p>Focused enforcement action</p> <p>Increase intelligence followed up with targeted enforcement Adopt regional programme of communications to raise profile and generate intelligence.</p> <p>Develop a business case for a dedicated tobacco control officer</p> <p>Raise profile with Elected members and other key stakeholders Develop a joined up strategy to meet objectives which are of mutual interest</p> <p>Develop partnership working with target communities – e.g. NDC</p> <p>Stakeholder analysis to identify key individuals /organisations /communities</p>	<p>Tobacco Regulation and Enforcement Group DMcM</p>	<p>Regional benchmarking of intelligence reports</p>	<p>No of intelligence reports No of test sales carried out Increase in no. of test sales where under-age sales refused Increase no. retailers signing up for responsible retailer scheme</p>
<p>B. Reduce the uptake of smoking amongst young people</p>	<p>Evaluate responsible retailer programme Coordinated action - test sales, illicit tobacco and communications campaigns to ensure maximum impact</p> <p>Communications campaign to highlight link between cheap and illicit tobacco and childhood smoking</p> <p>Educate and support police/enforcement bodies of legal provisions when they identify young people smoking</p>	<p>Tobacco Regulation and Enforcement Group DMcM</p>		

vi. REGULATE TOBACCO PRODUCTS

C. Promote an equal opportunities policy in all tobacco control activities	Include BME communities in mapping illicit tobacco hotspots Tailor education/media messages appropriately Ensure all compliance/enforcement activities address legal requirements in relation to sales of niche tobacco products	Tobacco Regulation and Enforcement Group DMcM		
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APPENDIX 1: TOBACCO REFERENCE GROUP MEMBERSHIP

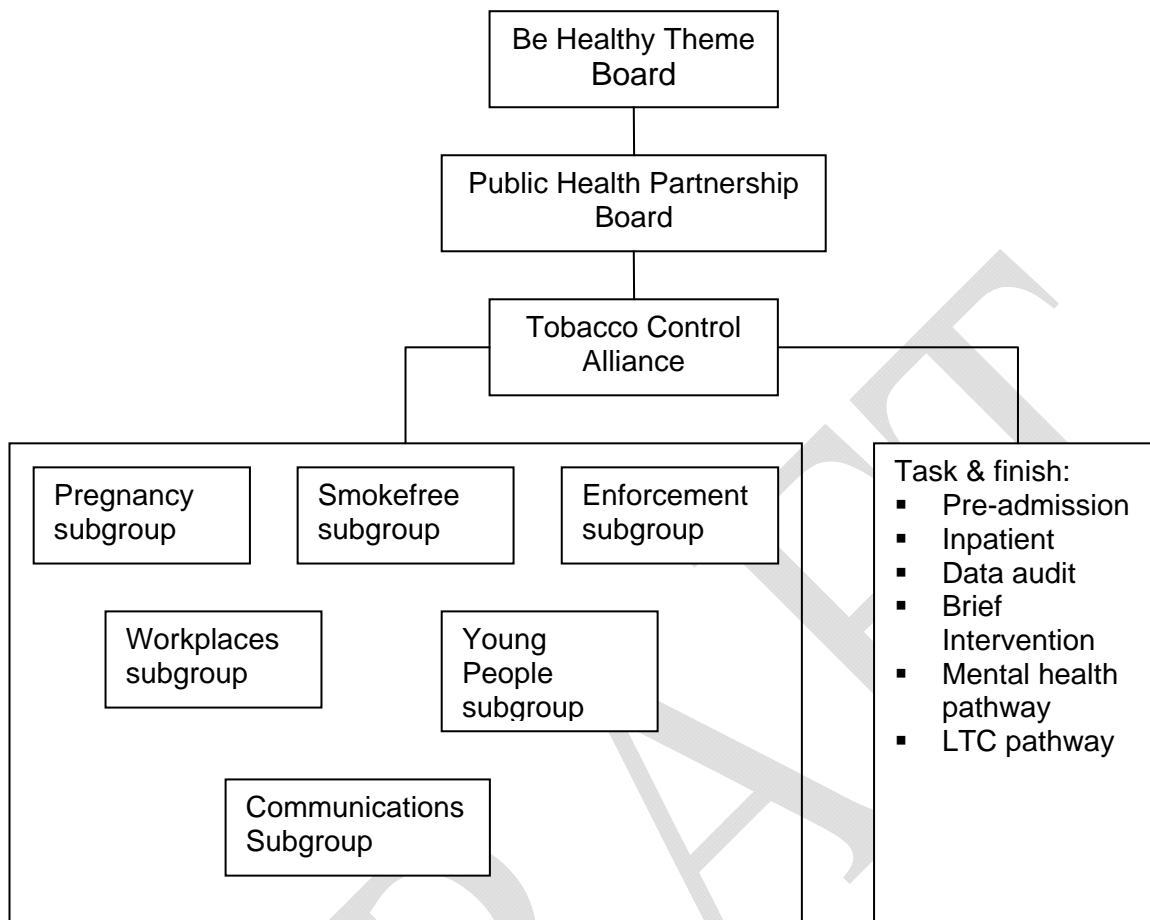
This strategy was the result of 2 workshops with participation from:

Dennis Ager, Y&H Trading Standards
Sofina Akhtar, Children, Young People & Families Stop Smoking Service
Andrew Brankin, Doncaster Stop Smoking Services Manager
Tony Carlin, South Yorkshire Fire Service
Ian Carpenter, NHS Doncaster Communications
Farai Chibansa, Children, Young People & Families Stop Smoking Service
Suzannah Cookson, NHS Doncaster Children, Young People & Families
Scott Crosby, Y&H Government Office, Communications
Clair Harris, DH Tobacco Control Team
Jan Greaves, Smoke Free Homes Coordinator
Caroline Greenough, RDaSH
Nandan Haldipur, DBHFT Vascular Surgeon
Clare Henry, DMBC, Leisure
Susan Hampshaw, NDC Evaluation
Rebecca Heyes, Children, Young People & Families Stop Smoking Service
Denise Hinds, Doncaster Stop Smoking Service
Pat Hodgson, Y&H Government Office, Tobacco Control
Nick Hunter, LPC Secretary
Pete Jones, South Yorkshire Fire Services
Pam Ley, DCH Children & Young People's service
Debby McKnight, DBHFT, Midwifery Services
Dave McMurdo, DMBC Trading Standards
Keri Newton, Children, Young People & Families Stop Smoking Service
Pat Nobbs, Healthy Schools
Helen Oldknow, RDaSH
Dale Rickett, DH Tobacco Control Team
Andy Rydel, Doncaster Stop Smoking Service
Angela Scott, NHS Doncaster, Public Health
Bronwyn Slater, NHS Doncaster Children & Young People
Rupert Suckling, NHS Doncaster & Chair of Tobacco Alliance
Neil Thomas, South Yorkshire Police
Kerry Warhurst, NHS Doncaster, Tobacco Control
Paul Williams, DMBC Environmental Health
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Vascular Surgery Department, Doncaster and Bassetlaw Hospitals Foundation Trust
Laurie Mott, Public Health Intelligence Unit
Anthony Howard, Public Health Intelligence Unit
Angela Dutton, Public Health
Abid Mumtaz, Public Health

APPENDIX 2: TOBACCO CONTROL ALLIANCE STRUCTURE



APPENDIX 3: DEMOGRAPHICS, HIGH RISK COMMUNITIES AND GROUPS

1. Doncaster's population is around 291,600 as of summer 2008 and there are 237,300 aged 16 years and older. Whilst the population of young people is expected to remain constant the over 65 population is expected to rise by 25% by 2020. (ONS)

2. Deprivation

Overall, Doncaster has an Index of Multiple Deprivation (IMD) score of 30.84 making it the 41st most deprived district in England. (Out of 345) For comparisons purposes (ONS) it is classed as a manufacturing town.

Given the links between deprivation and smoking, the highest tobacco prevalence will be found in the most deprived communities within Doncaster:

- Denaby Main
- Clay Lane
- Highfields
- Stainforth
- Carcroft
- Askern
- Hyde Park
- New Rossington
- Toll Bar & Almholme
- Woodlands
- Mexborough
- Hexthorpe
- Thorne
- Moorends
- Edlington

Within the NDC area - Balby Bridge, Hexthorpe, Hyde Park, Netherhall and Woodfield, the smoking prevalence in 2008 was 43% from the IHS

3. Pregnancy

In 2008-09 there were 3870 maternities and the number of maternities has been rising for the last 5 years. Smoking in pregnancy rates measured at delivery have remained static around 25%

4. Mental Health

The ONS estimates that 1 in 7 adults experience mental distress at any one time and smoking prevalence is significantly higher in people with mental health problems than amongst the general population. Up to 80% of people with schizophrenia smoke, people with depression are also more likely to smoke and find it harder to give up.

Using figures based on rates for Yorkshire and Humber we estimate the following for males and females 16 years plus:

- For all neurotic disorders (mixed anxiety and depressive disorder, generalised anxiety disorder, depressive episode, all phobias, obsessive compulsive disorder, panic disorder): 18,442 males and 21,722 females
- Mixed anxiety and depressive disorder: 8,990 males, 11,464 females
- Probable psychotic disorder: 1,037 males, females 965

5. Traveller and Roma community

Doncaster has one of the largest settled traveller communities. Figures vary significantly but numbers are estimated to be over 5,000. We don't have any accurate figures around smoking prevalence but we do know that people from these communities are less likely to choose to access health services and to find it harder to do so when they try.

6. Minority Ethnic Groups

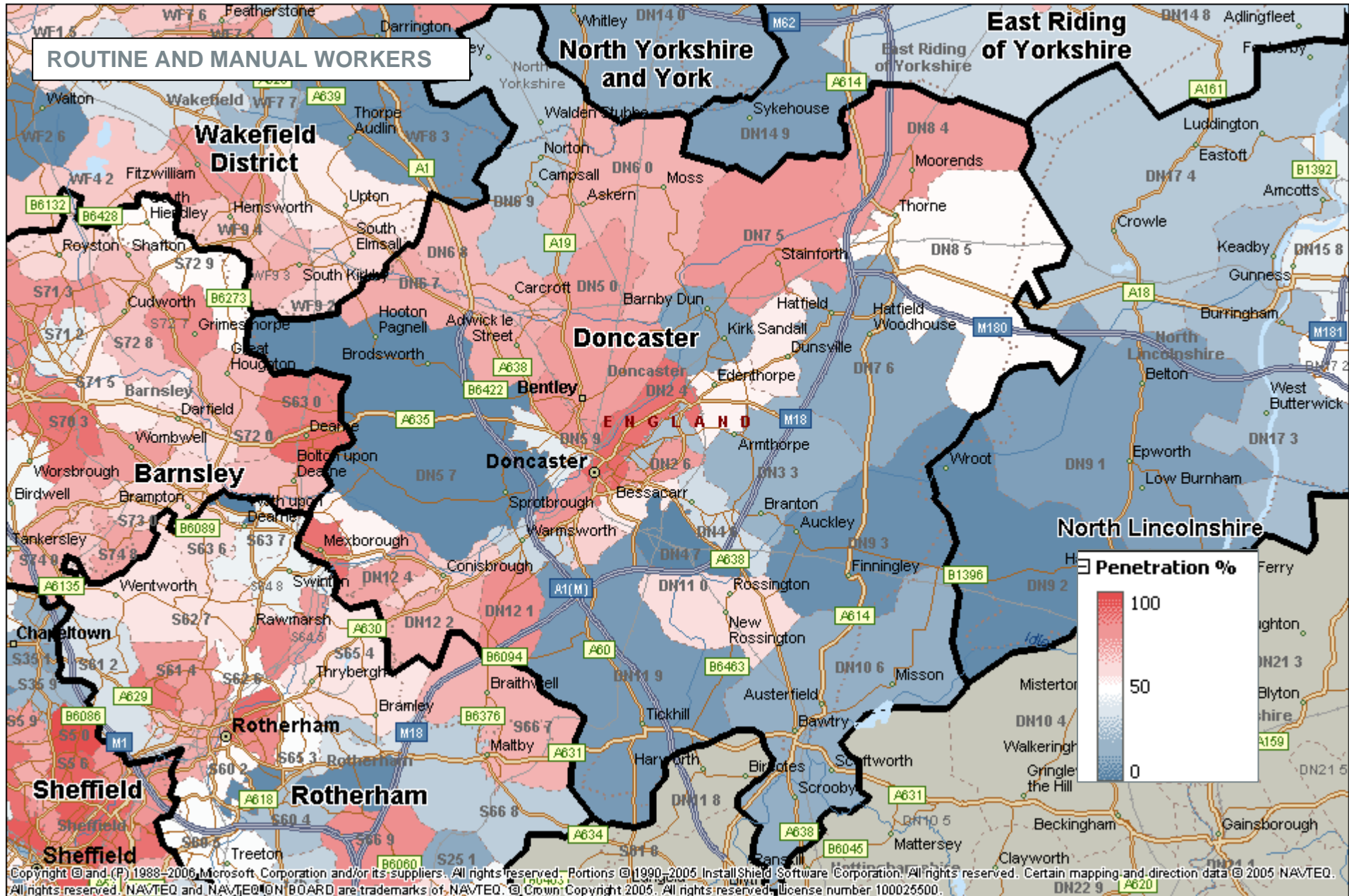
Smoking rates vary considerably and in some groups oral tobacco products, rather than smoking, are more prevalent

In Doncaster, over 95% of the population describe themselves as white – 93 % as white British. Asian or Asian British is the next largest group - 5,612 or 1.9% followed by black or black British – 2,605 or 0.9%.

Within the NDC area the percentage of people describing themselves as white is lower – 83%, 10% are Asian or Asian British.

7. Prison population – based on operational capacity

Doncaster has four prisons and one immigration removal centre with a total capacity of around 3,330. Smoking prevalence in prisons is known to be much higher than the general population - 80% and there are also higher levels of mental health problems. Despite high levels of smoking the initial quit rate for prisoners is good at around 62%. Relapse rates are not known



DH Occupation Classifications for stop smoking services activity returns.

Home carers - i.e. looking after children, family or home.

Managerial and professional occupations examples include: Accountant, artist, civil/mechanical engineer, medical practitioner, musician, nurse, police officer (sergeant or above), physiotherapist, scientist, social worker, software engineer, solicitor, teacher, welfare officer. Those usually responsible for planning, organising and co-ordinating work for finance.

Intermediate occupations, examples include: Call centre agent, clerical worker, nursery auxiliary, office clerk, secretary.

Routine and Manual occupations, examples include: Electrician, fitter, gardener, inspector, plumber, printer, train driver, tool maker, bar staff, caretaker, catering assistant, cleaner, farm worker, HGV driver, labourer, machine operative, messenger, packer, porter, postal worker, receptionist, sales assistant, security guard, sewing machinist, van driver, waiter/waitress.

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APPENDIX 4: FINANCIAL AUDIT

Optimising strategies to reduce smoking prevalence: Local spend on tobacco control

Please itemise 2009/10 approximate local spend on tobacco control by PCT, local authority and others. Indicate NA (not applicable if spend is nil). Please send report to paul.johnstone@yorksandhumber.nhs.uk by 6 May.

PCT: Doncaster Date of completion: May 5th 2010

Completed by Kerry Warhurst Remit: Tobacco Control, NHS Doncaster

	PCT	LA	Other funding; source
PREVENTION			
Young people activities			
o Pay	£23,210	£1000 2 poster competitions	n/a
o Non-pay	£13,000	£1,000	
o Publicity/social marketing	£2,500	n/a	
2. Underage sales			
o Trading Standard funding	n/a	£5000 proportion of responsible authority work spent on uas advice	DH Funding £8000 to trading standards for uas enforcement
o Publicity/social marketing	n/a	n/a	n/a
Total (prevention) £51,712			
PROTECTION			
Smokefree homes/cars			
o Pay	£11,878	£2100	Proportion of funding from NHS in 2008
o Non-pay	£7,788	n/a	n/a
o Publicity/social marketing	£5,000	n/a	n/a
Smoke free businesses Excellence Scheme	£15,000	n/a	n/a
Illicit tobacco			
o Pay	n/a	n/a	DH Funding £4,500 to trading standards for cit enforcement
o Non-pay	n/a	n/a	DH Funding £5000 from funding for translation in cit prosecution
o Publicity/social marketing	n/a	n/a	n/a
Total (protection) £51,266			

CESSATION			
o Pay (specialist service)	£368,423	n/a	n/a
o Non-pay	£141,397		
o LES- GP	£40,961		
o LES - Pharmacy	£32,600		
o NRT voucher scheme			
o Medication (NRT, Varenicline, Zyban)	£510,000		
o Incentive schemes			
o GP QOF payments (smoking)	£432,046.42		
o Pregnancy	£149,000		
o Secondary care	Inc in specialist		
o Dental	0		
o Pharmacy	0		
o Prisons, young offenders	£20,000		
o Voluntary sector	0		
o Training for brief intervention and advisors	£40,000		
o Publicity/social marketing	£12,727		
o Smokeless tobacco			
Total (cessation) £1,747,154			
ALLIANCE INFRASTRUCTURE			
Pay, e.g. coordinator, admin inc data analysis, central monitoring	£47,000	n/a	n/a
Non-pay e.g. spend on TC activities not captured above	n/a		
Total (infrastructure) £47,000			
OVERALL TOTAL	£1,897,132		