Consultation on the future of tobacco control

Consultation Report: December 2008

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Consultation report

Prepared by Department of Health Tobacco Programme

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Executive summary

The Department of Health published a consultation paper entitled C*onsultation on the future of tobacco control* on 31 May 2008*.* This consultation was the first step in developing a new national tobacco control strategy and covered four main areas:

- Reducing smoking rates and health inequalities caused by smoking;
- Protecting children and young people from smoking;
- Supporting smokers to quit; and
- Helping those who cannot quit.

The consultation closed on 8 September and this report summarises the responses which were received. It aims to provide a representative summary of all the responses, drawing out key themes and messages. The consultation report has been provided to Ministers to support their decision-making on future tobacco control policy.

Introduction

Background

Smoking remains the single greatest cause of preventable death and is one of the primary causes of health inequality in the United Kingdom. Smoking is responsible for 87,000 deaths in England each year.

The Government has an important responsibility to protect children and young people from smoking. We remain particularly concerned that in Great Britain, nearly seven in ten adults who have ever smoked regularly say that they started smoking regularly before they were 18 years old.

As a result of the Government's focused action on tobacco, overall adult smoking prevalence has been reduced in England over the past decade from 28 per cent in 1998 to 22 per cent in 2006. In England, tobacco control activity is led by the Department of Health. The Department is on target to reach the Public Service Agreement (PSA) Objective of reducing adult smoking rates to 21 per cent or less by 2010. Although we have seen reductions in tobacco use among the general population, slower progress has been made in reducing tobacco use among routine and manual groups, and the use of tobacco remains one of the single greatest contributors to health inequality.

Ten years after the publication of the *Smoking Kills* White Paper in 1998, the UK has developed a reputation as a leader in Europe and across the world in effective tobacco control. In 2007, an independent academic survey of tobacco control activity across 30 European countries ranked the UK as being most effective. Over the past decade, the Government has delivered an ambitious programme of tobacco control, with achievements including:

- introducing laws to provide protection from the harm caused by exposure to secondhand smoke in enclosed work and public places;
- comprehensively banning advertising of tobacco in print, on billboards and on the internet;
- limiting tobacco advertising at the point of sale to a maximum space of an A5 sheet of paper;
- raising the age of sale for tobacco products from 16 to 18 years;
- introducing legislation into Parliament to substantially increase sanctions for retailers who persistently sell tobacco to people under the age of 18;
- passing laws to require hard-hitting pictorial health warnings on all tobacco products produced for the UK market from October 2008;
- setting up an extensive network of local NHS Stop Smoking Services in communities across the country to support smokers who want to quit. Today, smokers who quit with the support of the NHS are up to four times more likely to quit long term than are smokers who try to quit by going 'cold turkey';
- continuing high levels of investment in the NHS Stop Smoking Services meaning that we have the most comprehensive and fully resourced smoking cessation support programme in the world;
- making pharmaceutical stop smoking aids more widely available, including on prescription from the NHS; and

- running a world class marketing and communications programme that has reached out to millions of smokers with information on and support in quitting.

The *Consultation on the future of tobacco control* is the first step in developing a new national tobacco control strategy, which will be brought forward in 2009. The Government's intention to consult on the next steps in tobacco control was set out in the *Cancer Reform Strategy*, published in December 2007. The Department of Health hopes that, through the consultation, stakeholders can play a key role in the development of our future strategy to control tobacco use. The Government recognises that reducing the impact of tobacco within our communities requires a multi-faceted approach at local, regional, national and international levels, and that a wide range of stakeholders from across local government, the NHS, industry and the third sector have valuable contributions to make in shaping the new strategy.

The purpose of the consultation was to provide a basis for discussion and to encourage feedback as the first step in developing the new strategy. In particular, the consultation:

- outlined progress over the past decade in tobacco control;
- set out challenges for the future;
- presented and analysed a number of specific options on tobacco display in retail environments and the sale of tobacco from vending machines; and
- sought feedback on a variety of questions about what more can be done to reduce smoking prevalence and the impact of tobacco use in our communities.

Purpose and methodology

The consultation ran from 31 May to 8 September 2008. Respondents were asked 17 questions.

Annex 1 lists the organisations that responded to the consultation. For the purpose of the analysis, we have defined "organisations" as public or third sector agencies, larger companies and other representative bodies. Responses from small retailers (including specialist tobacconists, newsagents and other tobacco outlets) have been counted separately. Responses from other small businesses that employ fewer than an estimated ten staff have been treated as individual responses.

Responses from individuals have been given the same consideration as those from organisations. The names of individual respondents are not given in this report.

Often respondents have responded to many different questions in their responses but for ease of reference, responses have been collated and considered under each of the 17 questions posed by the consultation.

Overview of consultation submissions

In total, more than 96,000 responses were received. The majority of these were pre-written postcards or e-mail campaigns. These included the following:

Campaign/Organisation	Submissions
Smokefree North West	**49,507**
Cancer Research UK	**9,200**
Dmyst	**10,757**
Smokefree Action	**1,562**
Smokefree North East	**8,128**
Tobacco Control Alliance Wales	**118**
FOREST	**2,121**
Independent Retail News (petition)	**581**

Most of the responses for each of these campaigns focus only on a few issues raised in the consultation, particularly on questions 7 (marketing tobacco accessories), 8 (displays), and 9 (vending machines). The phrasing was often generic, for example, *"I support measures to protect our children from tobacco marketing."*

Respondents

Respondents to the consultation fall into the following broad categories.

Category	Respondents
Third sector – voluntary and community groups	**45**
Public sector	
- Local authorities, including police and fire services	60
- NHS organisations (including PCTs, SHAs) and Smokefree partnerships	161
- other	11
Total public sector	**232**
Private sector	
- industry representative organisations, including trade associations	21
- leisure industry	3
- tobacco companies (including cigar manufacturers)	12
- vending machine operators/manufacturers	3
- retail (larger industries/employers)	11
- healthcare	3
- small, independent retailers, including specialist tobacconists	10,586
- private sector other	17
Total private sector	**10,656**
Professional bodies	**15**
Other stakeholders	**2**
Individuals	**85,565**
Total responses received	**96,515**

Responses to specific consultation questions

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? What else should the Government and public services do to deliver these rates?

Responses: 265

Around half of respondents regard a target of 17% in the general population, and 23% among routine and manual workers as achievable by 2015. The Smokefree Action Coalition proposed the following targets:

- By 2015, smoking prevalence at 15 per cent in the general population and 19 per cent amongst routine and manual workers;
- By 2020, fewer than one in ten people smoking; and
- By 2030, fewer than one in 20 people smoking.

Suggested ways of achieving target rates include:

- Better targeting of vulnerable populations (see question 2, below);
- Better enforcement of existing laws, particularly with respect to underage smoking and counterfeit and smuggled tobacco;
- Tackling underage smoking by linking social marketing campaigns with other issues affecting young people, including drinking, drug misuse and sexual health;
- Setting regional targets, with Primary Care Trusts (PCTs) and local authorities (LAs) being required to set local targets for each priority group; and
- Embedding referral and access to Stop Smoking Services within health services in general, including the Quality and Outcomes Framework (QOF) and *Standards for Better Health*.

The British Medical Association suggests that targets for smoking prevalence rates should be 11 per cent by 2015 in the general population and 17 per cent among routine and manual workers with the aim of making the UK tobacco free by 2035. This follows a lead from Australia where the aim is to reach a national tobacco free status by 2030. The most ambitious targets were suggested by the Royal College of Physicians (RCP) of 11 per cent prevalence across all adult groups by 2015, and the eradication of smoking between 2020 and 2030.

Action on Smoking and Health (ASH), Cancer Research UK and others suggest specific targets should be set for young people (4% by 2015) and pregnant women. They suggest that

targets for pregnant women should be established on the basis of anonymised monitoring of saliva cotinine. Several respondents also suggest gender-specific targets for 13-15 year olds and 16-24 year olds.

A popular suggestion is not to set firm targets for 2020 and 2030 until 2012 or 2015, by which time better information on rates of decline will be available. It is also noted by many respondents that the General Household Survey (GHS) figures are not robust enough a measure on which to base targets, particularly at local or regional level. Problems identified include that GHS figures can be two years out of date, and that they rely on self-reported smoking prevalence. One suggestions is to supplement the GHS with the Smoking Toolkit Study or Omnibus survey figures.

FOREST believes that targets should not be set at all, because people should be free to make an informed choice based on evidence-based health messages.

ASH and others recommend establishing a Tobacco Control Commission reporting to the Prime Minister to implement, monitor and review the new tobacco control strategy, evaluating progress against the evidence base and recommending improvement and change. Another proposal is to establish a Nicotine Regulatory Authority to ensure cheaper and more available nicotine replacement therapy (NRT). Many respondents note that NRT is expensive and difficult to obtain whereas more harmful smoked tobacco products are cheaper and widely available.

Many respondents call for targets on environmental tobacco smoke exposure among non-smokers, particularly children. However, NHS North of Tyne believes that these would be impracticable, difficult to measure and to achieve. It suggests that resources would be better focused on social marketing and health promotion rather than monitoring.

Incentive schemes offering cash or food vouchers in return for signing up for smoking cessation assistance were suggested by some stakeholders. NHS Walsall proposes more radical measures, for example, withholding welfare benefits for smokers who do not sign up for cessation support.

The Chartered Institute of Environmental Health has suggested to local authorities that they include smoking prevalence as one of their targets in national indicators under the new Performance Framework for Localities since:

- Smoking prevalence is an indicator of health inequalities not just smoking related disease; and
- Reducing smoking prevalence can have a positive effect on local economy.

Smoke free Essex Tobacco Control Alliance suggests that the government should not benefit from smoking. They suggest that all taxation revenues from smoking should be redirected to helping reduce prevalence among target groups.

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

Responses: 281

A concern among many respondents is that success in reducing smoking among the general population has not been reflected particularly well in certain areas and among certain groups. For example, Great Yarmouth and Waveney PCT largely attributes an 18-year gap in life expectancy across the best and worst wards in the PCT area to smoking. Sutton and Merton PCT recommends that Health Equity Audits be conducted to tackle health inequalities, followed up by social marketing targeted at vulnerable groups.

ASH notes that 89 out of 150 local areas in England have chosen reducing smoking rates as part of their Local Area Agreement (LAA) targets. ASH believes that all local authorities should set these targets and they should be supported by coordinated work nationally and locally and through the mainstreaming of local best practice.

Around two thirds of respondents to this question believe taxation of tobacco should be raised. The BMA, ASH, Cancer Research UK and others suggest that this would be a cost-effective public health measure. The BMA cites research from the World Bank estimating that a 10 per cent increase in price results in a four per cent reduction in demand. ASH also cites research which suggested that in 1998 cigarettes were 60 percent more affordable than in 1965, and that this situation has changed little since. The BMA also believes that the lower cost of hand rolling tobacco has permitted smokers to maintain their consumption by "trading down" to this product.

Tobacco companies are against any dramatic rise in price. Philip Morris Ltd, for instance, suggests that the price differential between UK and EU member states is too high and that the UK's tax level on tobacco is the highest in the world. It suggests continuing with only moderate increases in future years to allow convergence with EU member states. The Tobacco Manufacturers Association (TMA) calls for tax levels to be frozen.

Tobacco companies and many smoke-free campaigners believe that raising the price of tobacco may have the effect of driving smokers (particularly young people and those on low incomes) to sources of illicit tobacco. Instead, they recommend that better enforcement of existing legislation and control of the illicit trade is vital. ASH reflected research they conducted in 2008 that found:

- 20 per cent of smokers reported buying cigarettes from illicit sources;
- 10 per cent reported buying more than three quarters of their tobacco products this way; and
- Younger smokers were more likely to report buying cigarettes from illicit sources.

Many suggest inequalities could be addressed by setting targets and providing enhanced cessation support for vulnerable groups where tobacco prevalence is highest. These groups include:

- Routine and manual workers;

- People with mental health problems, who have a prevalence of about 40 per cent at the most conservative estimate;
- Drug users;
- Prisoners;
- Lesbian, Gay, Bisexual, and Transgender (LGBT) people; and
- Black and minority ethnic groups, including users of chewing tobacco and shisha.

The Association of Public Health Observatories believes that there should be more emphasis on inequalities in the tobacco strategy. This would include:

- Providing evidence on the impact of ethnicity and sex on health inequalities;
- Collating baseline data for smoking prevalence among ethnic groups at local level;
- Standardising and improving data collection; and
- Standardising good practice among PCTs, for example, with respect to carbon monoxide or cotinine testing.

Drugscope notes that the high prevalence of smoking among drug users. They suggest providing smoking cessation initiatives within drug treatment services and that combining stop smoking support with drug dependency treatment could contribute to reducing smoking-related health inequalities within this group.

The Nuffield Council on Bioethics suggests that public health policies should aim to reduce inequalities through public education and information. If these are unsuccessful, an 'intervention ladder' approach should be taken with progressive steps taken to enable choice through policy and incentives and disincentives, then finally restricting and eliminating choice altogether.[1]

Other suggestions for tackling inequality of access to stop smoking services are covered under Question 14.

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 any other areas that you believe should be added?

Responses: 281

Almost 90 per cent of respondents believe the current six strand strategy should continue. Other suggestions for framing the future strategic direction for tobacco control include:

- Preventing young people from starting to smoke (some respondents cite the BMA's report on this issue[2]);
- Harm reduction, through pure nicotine products;
- Further regulating or controlling the tobacco market by: tackling illicit supply; providing better infrastructure and resources for control of the tobacco market; reducing supply and

[1] Nuffield Council on Bioethics (2007) Public health: Ethical issues
[2] BMA (2008) Forever cool: The influence of smoking imagery on young people

availability of tobacco products (ASH); a Government agency to manage all marketing of tobacco products; and retailer education and awareness raising;
- Research, monitoring and evaluation, including data gathering at regional and local level to gain a better understanding of prevalence among local populations (Smokefree London); and
- Consider the recommendations of the US Board of Public Health report[3].

Several respondents favour adopting the strategic approach recommended by the World Health Organisation set out in the MPower report[4]. The report recommends that governments:

- **M**onitor tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit tobacco use
- **W**arn about the dangers of tobacco
- **E**nforce bans on tobacco advertising, promotion and sponsorship
- **R**aise taxes on tobacco

There were other suggestions from some respondents.

LACORS suggests that the six strand strategy could be improved by:

- Making explicit the roles of agencies with primary responsibility for the strategy, and highlighting the role that local authorities have in tobacco control;
- Clarifying the roles of trading standards and Her Majesty's Revenue and Customs (HMRC); and
- Linking the strategy into local authority key indicators.

ASH recommends the Government support the development of guidelines under Article 5.3 of WHO Framework Convention on Tobacco Control[5] to protect the development of public health policy in tobacco control from the influence of the tobacco industry. ASH also calls for the government to ensure that tobacco companies based in the UK meet minimum standards when selling tobacco in markets overseas.

FOREST does not support the old strategy or the bringing forward of a new strategy. They suggest there should only be evidence-based health messages about tobacco consumption, allowing people to make informed decisions about whether to take-up or quit smoking.

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

Responses: 297

[3] Board of Population Health and Public Health Practice (2007) Ending the tobacco problem: A blueprint for the nation, National Academies Press, Washington
[4] World Health Organisation (2008) MPower: Report on the global tobacco epidemic
[5] http://www.who.int/fctc/en/

Many respondents point out that illicit tobacco results in revenue loss to HMRC and undermines legitimate trade. Some respondents believe that counterfeit products are more harmful than legal tobacco products, though several, including Cancer Research UK, dispute this.

ASH calls for effective monitoring of the illicit market to assess and reduce its market share. The Tobacco Manufacturers Association estimates that three percent of all tobacco consumed in the UK is counterfeit. ASH and others call for new targets to reduce the market share of illicit cigarettes (8 per cent by 2010 and 3 per cent by 2015) and hand-rolled tobacco (45 per cent by 2010 and 33 per cent by 2015).

At national level, the most popular suggestion (216 respondents) is for a strategic partnership of all stakeholders, including HMRC, local government, the NHS and business. Most favour the new UK Borders Agency working with HMRC and HM Treasury to prioritise and implement an anti-smuggling strategy.

Smokefree Greater Manchester, and others, believe that the personal allowance for duty-free cigarettes should be reduced from its current 3,200. They suggest that duty free cigarettes are often brought into the UK and traded on cheaply and illicitly.

Smokefree East Lancashire suggests that the North of England action plan on cheap and illicit tobacco is a model which can be rolled out nationwide.

At national and international level, suggestions for tackling illicit tobacco include:

- Around 60 per cent of respondents suggest the Government sign up to the agreements between the EU and Philip Morris International and Japan Tobacco International and support the early introduction of the illicit trade protocol being developed under the Framework Convention on Tobacco Control;
- British American Tobacco (BAT) suggests the need for better oversight and enforcement in free trade zones which are used for storage and shipment of illicit cigarettes and the production of counterfeit products;
- The appointment of an Intellectual Property (IP) Coordinator to oversee a joint strategic plan for enforcing IP law, and/or a high profile coordinating officer to drive action against smuggling;
- The Trading Standards Institute suggests secure e-mail links are developed as intelligence on illicit tobacco is currently sent by post between the UK Intellectual Property Office and trading standards;
- BAT support a track and trace standard for legitimate tobacco products which is open and flexible rather than narrowly defined, to allow all tobacco companies to participate; and
- A national database for all agencies to input and check intelligence on illicit trade.

At regional and local level, suggestions include:

- Many trading standards groups and councils believe that current resources are inadequate to tackle counterfeit tobacco but that, with more ring-fenced resources for training and recruitment, trading standards officers would be able to perform more spot checks backed up by prosecutions;
- Engaging communities, including faith groups and community health and social workers;
- Making detectors more widely available to local authorities to check for counterfeit tobacco;

- Regional illicit tobacco teams to disrupt the lower level illicit supply chain, based on similar teams for illegal money lending;
- A widespread and confidential facility, perhaps electronic and based online, to report illegal trading; and
- A new national indicator on tackling smuggling for Local Strategy Partnerships.

LACORS and others note that cooperation between enforcement agencies is often ad hoc and relies on informal networks, and information is not always shared freely owing to fear of breaking data protection law. They suggest that cooperation needs to be formalised, with nationally standardised protocols for sharing information.

The Cardio Wellness Charity proposes regulating chewing tobacco imported from Asia, which they suggest is now being displayed and sold freely, without age restriction, in some grocery stores.

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

Responses: 212

Many of the responses repeat issues covered in Question 4 and are dealt with under that heading.

Popular measures suggested include:

- Stronger enforcement of existing legislation and tougher penalties for illicit traders (the RCP suggests penalties should be commensurate with those for dealing class A drugs);
- A clear "Counterfeit Kills" message directed at local communities, to emphasise the alleged dangers of counterfeit cigarettes[6]; and
- A requirement for registered social landlords to prohibit illegal trading from residents. In particular, Stockton PCT and Stockton Borough Council suggest tenancies of distributors of illicit tobacco should be revoked.

The UK Centre for Tobacco Control Studies notes the widespread perception that the Government is trying to prevent illicit trade because of concern about revenue loss rather than public health. The Centre notes that a strong message needs to be sent that the Government wants to eradicate smoking regardless of cost. Local authorities and Smokefree Alliances also acknowledge that many smokers regard illicit trade as a benign "Robin Hood" style venture and will continue to buy cheap cigarettes illicitly if this perception is not challenged.

The Trading Standard North West Smoking Survey (2007) cited by Warrington Borough Council indicates that 62% of 14-17 year olds in Warrington had bought "imported" cigarettes, with 34% saying they had bought them from illicit sellers. Fresh North East notes a survey by the British Market Research Bureau which found 68 of 391 smokers bought from illicit sources.

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[6] As noted above, however, Cancer Research UK and ASH believe that counterfeit tobacco is neither more nor less damaging to health that legally purchased tobacco. The Consultation Document itself also acknowledges this.

Derbyshire Action on Smoking submitted the results of a countywide survey showing that 78% of respondents favoured tougher sentences for smuggling or selling on smuggled tobacco. The survey also found evidence of public confusion about to whom they should report suspected breaches of the law. For example, 49 per cent did not know where to report sales of counterfeit or smuggled cigarettes, while 50 per cent did not know who to contact to report sales to children.[7]

[7] Details of how this survey was conducted, with how many respondents, were not included within the response.

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?

Responses: 437

Many respondents to this question advocate the measures suggested in the consultation, including plain packaging and display restrictions. These responses are covered under their respective question headings.

Some respondents (mainly small retailers) suggest combating proxy purchasing by prosecuting people who buy cigarettes for those underage. The Association of Convenience Stores, representing 33,000 independent retailers, claims that initiatives to stop young people buying tobacco have led to an increase in proxy purchasing and have encouraged young people to seek out illicit traders instead.

Other popular suggestions include:

- The minimum age of sale law should be strictly enforced, with severe penalties for contravention and prohibition of sales for those who offend repeatedly
- The greater use of proof of age schemes; and
- A positive licensing scheme for tobacco retailers (80 respondents);

Approximately 90 per cent of respondents in the Wirral Smokefree Consultation believe tobacco retailers should be licensed. Western Cheshire PCT cites Smoke Free North West's[8] telephone survey of 1,900 residents where 57 per cent supported licensing of retailers and 70 per cent advocated banning retailers from sale of tobacco for a number of years if convicted of selling to children.

The Trading Standards Institute suggests that licensing would reduce the number of retail outlets, and that a licensing scheme might encourage retailers where tobacco is small part of turnover to opt out of selling tobacco altogether. They suggest that a register would also help local authorities determine who was a legitimate trader and would help stamp out illicit trade.

Trading Standards North West believe that sentences are very inconsistent for those found to be selling to people underage. The Northern Ireland Independent Retailers Trading Association calls for tough sanctions for selling to the underage, on a par with penalties for category C drugs. They suggest that selling illegal smuggled tobacco to people underage should be an aggravated offence.

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[8] Social and Market Strategic Research (June 2008) Attitudes to smoking consultation 2008, Report commissioned for Smokefree North West

On the sale of tobacco, other suggestions include:

- New offences for those underage who try to buy tobacco, or who smoke in public, giving enforcement officers confiscation powers;
- Uniform powers for local authorities across all age restricted goods to ensure consistency and prevent confusion among traders;
- Raise the minimum age for purchasing tobacco to 21;
- Restrict sales of tobacco near schools; and
- More education in schools on awareness of tobacco harm and campaigns based on the Florida "Truth" campaign exposing the marketing tactics of the tobacco industry.

Smokefree County Durham reports a pilot of the "Truth" campaign in Newcastle, where students reported they were less likely to start smoking.

On reducing youth uptake of smoking, suggestions include:

- Youth-oriented marketing of the prevention message developing in consultation with young people (101 respondents);
- Limiting pro-smoking imagery in the entertainment media and other promotion and marketing opportunities directed at young people;
- Use aging software to demonstrate the negative effects of smoking health and attractiveness; and
- Levy tobacco companies based on the numbers of underage smokers and use the funds for youth prevention (Smoke Free North East).

Leeds Tobacco Control Group suggests that because many young people start smoking after leaving school, there should also be a commitment by universities and colleges of further education to explore how to encourage students to not take up smoking.

Warwickshire PCT worked with the local Youth Parliament to survey young people's views on this question. Suggestions included:

- Stopping parents smoking to help young people to give up or not start; and
- Raising the minimum age at which tobacco can be bought.

The Roy Castle Lung Cancer Foundation also submitted research that suggests that parents' smoking behaviour is a predictor of whether children will start smoking. Many organisations therefore suggest that the best way of tackling young people smoking is through "denormalisation" of smoking by reducing smoking among adults. For instance, according to Smokefree Newham, young people in the most deprived areas see smoking as the norm because it is so prevalent in those areas.

Cumbria Healthy Schools (CHS) suggests a holistic approach. Young people in Cumbria cite boredom as a factor in trying out smoking. CHS believe there is therefore a need for more youth centres and activities as well as adequate transport so that young people in rural areas can reach them.

The Cardiff Institute of Society, Health and Ethics developed the Assist programme whereby influential Year 8 peers are nominated as peer supporters in school. The programme was evaluated[9] and found to have positive effect on reducing smoking rates in schools. It has been implemented nationally in Wales and locally by the London Borough of Tower Hamlets and Bristol PCT.

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

Responses: 82,771

There was over 99 per cent agreement by respondents to this question that there should be further restrictions. It should be noted that most responses were from e-mail or postcard campaigns. In many cases the phrasing is generic and respondents are giving general support to the consultation document and may not necessarily be giving support to this measure specifically. If these pre-written responses are discounted, the total number of responses falls to around 10,000 with approximately 75 per cent in agreement with the measure. This is comparable with two surveys one of young people in Medway (75% in favour), and one in Wirral (83% in favour).

Of those who disagree and say why, many believe that there is no evidence or insufficient evidence that the measure will make any impact on smoking behaviour. The 2,121 respondents via FOREST postcard or e-card campaign believe the measure is unjustified because tobacco accessories present no threat to health.

Rethink suggests that messages about the risks to mental health through smoking cannabis with tobacco should be displayed on tobacco and the packaging of smoking accessories.

Several Fire Services believe that there should be age restrictions on purchase of matches and cigarette lighters.

Question 8: Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is you 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?

Responses: 95,488

Around 84 per cent of respondents to this question favour stricter controls, with the vast majority of these preferring option three: requiring retailers to remove tobacco products from display.

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[9] Starkey, F et al (2005) Rationale, design and conduct of a school-based peer-led antismoking intervention in the UK: the ASSIST cluster randomised trial. BMC Public Health, 5, 43

Among the 10,570 small retailers responding, virtually all are against the proposal. A number of reasons are given, the most common being:

- The perceived "unfair" burden on small retailers, as smokers who provide important foot-traffic for small businesses might go to supermarkets where it is suggested they can be more certain of getting their brand;
- Stimulation of the illicit market;
- Displays do not encourage purchases, therefore the lack of display will not discourage purchases;
- Health and safety, security and customer care concerns, for example, taking longer to serve customers and having to bend down or reach behind the collect cigarettes; and
- Removing display and setting up storage elsewhere in the shop will be expensive, with estimates ranging from £1,500 to £10,000 per shop, and could mean a day's loss of business while any refit is completed.

The Tobacco Manufacturers Association (TMA) and tobacco manufacturers also believe that display does not constitute advertising (citing TAPA 2002[10]). They believe that the proposed restrictions run counter to the right of freedom of commercial expression. They believe that the studies cited in the consultation paper are not reliable for the reasons including:

- Retail marketing, including point of sale advertising, is considered in its broadest sense without attempting to isolate the impact of display;
- There is a failure to study environments comparable to post-TAPA 2002; and
- The research relies on self-reported data, asking hypothetical and sometimes leading questions.

The TMA also question how effective display restrictions have been in Iceland and Canada. They also suggest that the current available data on smoking by young people in this country do not take account of recent legislation – including the raising of sale age to 18 in October 2007 and the restricted sales and premises orders under Criminal Justice and Immigration Act which do not come into force until April 2009. They believe that further restrictions should only be considered once the effectiveness of these measures has been evaluated.

The TMA do not accept that link between displays and impulse purchases. They believe that customers have made a pre-planned decision to buy tobacco and the display only acts to inform brand decisions.

FOREST also believes that display restrictions are intended to "denormalise" smoking which they suggest is an improper basis for regulation as the Government should not impose a code that stigmatises the use of legal products

Tobacco manufacturers would support option two (regulate point of sale display more strictly by further restricting permitted advertising space and/or restricting display space or ways in which tobacco products are displayed) if the following provisions were met:

- Communications about products and prices to customers permitted;
- Effective competition between manufacturers and new products permitted;

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[10] Tobacco Advertising and Promotions Act 2002

- Financial and other impacts on retailers mitigated; and
- Adverse unintended consequences minimised.

The Independent Retail News magazine conducted a survey of 780 retailers across England, Northern Ireland and Wales. The findings are given in the table below:

Question	Yes %	No %
Do you agree with the proposal to ban the display of tobacco products in stores?	**15**	**85**
If there is a display ban would you be concerned about the following:		
a) retail efficiency, more queues, longer time to serve customers?	**88**	**12**
b) security (fear of being attacked tending the counter, theft)?	**80**	**20**
c) cost of implementing a new display system?	**89**	**11**
d) loss of sales (tobacco and associated sales)?	**79**	**21**
e) health and safety	**75**	**25**
If the ban is enforced do you think it will increase the trade in illegal tobacco?	**78**	**22**
Will the proposed ban on display:		
a) have little or no impact on under-age smokers?	**80**	**20**
b) increase the number of under-age smokers?	**10**	**90**
c) decrease the number of under-age smokers	**10**	**90**
The government is also proposing a ban on packets of cigarettes smaller than 20. Do you agree with the proposal?	**18**	**82**
How much do you think changes to tobacco display will cost you		
a) up to £2,000	**77**	
b) £2,000 to £4,000 +	**23**	

The National Federation of Retail Newsagents suggests there is no connection between tobacco display and smoking, and calls for independent research to establish whether a link exists, before any action is taken.

One local independent retailer compared times for selling cigarettes directly from the gantry and from under the counter, estimating 230 minutes per week extra in serving customers in a shop that sells 3,096 tobacco items per week, 30 minutes extra for stock take and 140 minutes extra for replenishment of stocks – a total labour cost of £44.67 per week at £6.70 an hour.

Smoke Free campaigners and health groups take a different view on the impact of display. A Nottingham City NHS Stop Smoking Services survey of 48 clients showed that 63 per cent were tempted to start again because of displays with 75 per cent stating they would not be tempted if tobacco products were not displayed and 44 per cent stated they bought tobacco on impulse.

Cancer Research UK submitted research which suggests that point of sale displays are a well established retail and marketing function to influence pre-planned and impulsive behaviour and suggest that would-be quitters are influenced by displays to buy cigarettes. Cancer Research UK's research concludes that:

- Since the Tobacco Advertising and Promotion Act (TAPA) 2002 came into force, manufacturers have effectively used point of sale display as a marketing tool, encouraging purchase initially through promotion awareness;
- Gantries and tobacco packs are designed to look attractive thereby enhancing the appeal of tobacco and smoking;
- Prominent display distorts smoking norms; making smoking appear more common than it is;
- Young people are aware of and influenced by point of sale display; and
- If tobacco were out of sight, it would help to reduce smoking uptake and decrease the number of people who continue to smoke.

Cancer Research UK, ASH and others report that when displays were banned in Canadian provinces, tobacco manufacturers continued to pay retailers for tobacco storage units and they suggest that this should alleviate concerns about cost among small retailers in the UK. Heart of Mersey believes the tobacco industry should be legally required to disclose to the government how much it spends on marketing, as is the case in Canada.

Many specialist tobacconists believe that they should be exempt from display restrictions in line with TAPA 2002. Specialist tobacconists believe that display restrictions would be impracticable and would disrupt trade irreparably. Several responses detail the disadvantages of display restriction for shops which are solely devoted to the supply of tobacco products and accessories, including issues of refitting and security. Specialist tobacconists point out that their customer base is mature smokers (average age in the range 36-60 years), not young smokers.[11] One suggests that an alternative to display restrictions for specialist tobacconists might be to forbid anyone under the age of 18 from entering specialist tobacconist shops.

The Association of Independent Tobacco Specialists (AITS) submits a survey of its 71 members. Ninety-five percent of specialist tobacconists and all non-specialist shops surveyed suggested that display ban would lead to them being unable to carry on trading. Additionally, AITS suggests that the small number of specialist tobacconists is unlikely to make any impact on the numbers of those who want to give up smoking.[12]

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[11] The Imported Tobacco Products Advisory Council also points out that in the UK 83% of cigar smokers and 96% of pipe smokers are aged 35 and over.

[12] AITS also calls for reviewing the legal definition of specialist tobacconist – to reduce the proportion of sales of specialist tobacco products from 50% to 30%, which would ease pressure on small businesses without affecting the smoking habits of young people.

Duty free retailers at airport departure lounges point out that their customers all have passport or photographic ID and believe that purchases of the cartons they stock (200 cigarettes) are not impulse buys. If displays were removed, the majority of customers would believe tobacco was not stocked – particularly those who do not speak English. Since tobacco purchases drive sales this would dramatically reduce sales of other products.[13] Duty free retailers say that their competitors are not domestic retailers but other airports. The display restrictions would thereby skew sales to competitors in other countries.

The potential cost of implementing a display ban is addressed by a variety of respondents:

- Sainsbury's: redesign of kiosks in filling stations and convenience stores with a cost of up to £25,000 per kiosk;
- British Institute of Inn-keeping: one third of businesses surveyed believe that display restrictions would damage business – only 2 per cent think that it would be beneficial;
- UK Consumer Cooperative Movement: total costs of implementing option three (requiring retailers to remove tobacco products from display) would be approximately £3,500 per store – a total of nearly £6 million across the group, not counting loss of sales and additional labour costs;
- Thresher group: around £2,000 per store, a total of £3 million across the group; and
- Association of Convenience Stores (ACS): cost over £250 million across the UK

Retail trade organisations such as ACS, NIIRTA and the BRC suggested that TAPA point of sale regulations should be reviewed to prevent any form of 'avoidance' that may be permitted under existing regulations but which could be perceived as against the spirit of the regulations.

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?

Responses: 82,722

Those in favour of further controls totalled 80,501 respondents and approximately 90 per cent of these expressed a preference for option three (prohibit the sale of tobacco products from vending machines altogether).

For those against further controls, the most commonly expressed arguments are that:

- It restrict free trade, particularly harming the pub trade, and/or will drive sales to unlicensed premises;
- The costs of implementation outweigh the benefits; and
- It will have no impact on underage smoking.

The National Association of Cigarette Machine Operators (NACMO) points out that since tobacco vending machines account for only 1 per cent of tobacco sales in the UK, there exists

[13] Studies referenced show that purchasers of duty free tobacco spend 2.5 times more on other goods in the store.

an argument based on proportionality for option one (retain the status quo), given the impact on the livelihoods of cigarette machine operators and the possibility of the complete destruction of the industry. Additionally, the Association points to the declining numbers of young people who say that vending machines are their usual source of cigarettes. Further, NACMO point out that since 99 per cent of vending machines are in licensed premises this acts as a safeguard, current or potential, against young people getting cigarettes from this source.

The Association of Licensed Multiple Retailers (ALMR) question the reliability of figures quoted which show that 17 per cent of young people buy cigarettes from vending machines. ALMR's estimate is around 7 per cent – still higher than the 1 per cent of the total market accounted for by vending machines, but less dramatic than stated in the consultation document. ALMR suggests that additional controls could be limited to converting the existing voluntary code to a statutory one.

The British Institute of Inn-keeping surveyed its members finding that most would prefer a proof of age card (42 per cent as first choice) with a vending ban as the least preferred option (60.5 per cent against).

The Trading Standards Institute (TSI) reports that test purchases of tobacco from vending machines have had a failure rate which is far higher than retail premises. They have found that the NACMO voluntary code of practice on positioning of machines is not being adhered to, and many vending machine operators are not members of NACMO and therefore do not follow the voluntary code of practice. TSI suggest that, on occasion, staff have been found to help children obtain cigarettes from vending machines.

There is further evidence from other respondents concerning test purchases of tobacco from vending machines:

- Local Authority Coordinators of Regulatory Services (LACORS) conducted test purchases between October 2007 and April 2008, which failed (ie, sold to children) in 41 per cent of cases for vending machines, with several councils reporting 100 per cent failure;
- Smokefree Lincolnshire found that 38 per cent of underage people were able to purchase cigarettes from vending machines with evidence of repeat sales, tokens and behind the counter cigarettes being offered to children;
- East Midlands Trading Standards conducted 17 underage test purchases between April and September 2008, which resulted in 13 sales, with vending machines having the highest failure rate; and
- Smokefree Solihull found all five test purchases for under 16s failed.

London Trading Standards (LTS) report on an intensive programme of activities, including letters and personal visits, to premises where compliance with underage legislation was poor. The programme succeeded in gaining 100% success in test purchasing, but was highly resource intensive. Because of this, LTS believes option three (prohibit the sale of tobacco products from vending machines altogether) is a more cost effective measure.

Wales Heads of Trading Standards Group reports that traders are given advice on the citing of machines in order to permit supervision, and the trade has been compliant. The Group therefore favours option two (require mechanisms on all tobacco vending machines to restrict underage access by young people).

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

Responses: 82,818

Almost 98 per cent of respondents who answered this question (80,543 respondents) were in favour of plain packaging.

Approximately 2,000 respondents were against the measure, with most of these suggesting that such a requirement would stimulate counterfeit and illicit trade

Trading Standards South East favour an increase in the size of the health warning to consumers rather than removing the brand altogether.

The AITS survey of specialist tobacconists said that it would make their work impossible, and vending machine operators also point out that it would make products identification very difficult for staff and customers.

Tobacco product manufacturers suggest that packaging is part of intellectual property and believe a requirement for plain packaging would contravene EU regulations on trade marks and the World Trade Organisation's agreement on trade-related aspects of intellectual property rights. They also suggested that plain packaging would restrict free trade and prevent new entrants to the market

Several manufacturers have said they would seek compensation for loss of intellectual property if the measure were implemented, and have requested further consultation should specific proposals be considered by the Government.

Birmingham young people's health project found that most young people consulted would prefer plain packaging that detailed the effects of smoking and which took the glamour out of smoking. Lancashire County Council ran a focus group of young people who suggested plain packaging would make little difference to smoking behaviour.

The UK Centre for Tobacco Control Studies (UKCTCS) suggests that tobacco manufacturers are currently in breach of the law by using packaging to suggest that some cigarettes are safer than other, by using lighter colours and words such as 'smooth' and 'gold' instead of the banned terms 'light' and 'mild'. The UKCTCS, among others, suggest that generic packaging would result in brands being less attractive and would reduce misperceptions of risk between varieties. UKCTCS cites US research showing that plain packaging would maximise the impact of the health warning.[14]

Several organisations believe that information on tar yields misleads smokers into believing that some cigarettes are safer than others, and that this information should be removed.

[14] Goldberg ME et al (1999) The effect of plain packaging on response to health warnings. *American Journal of Public Health,* 89.

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?

Responses: 687

Two thirds of respondents who answered this question are against the proposal.

The most common reason cited against the proposal is that it could encourage smokers, particularly those who are giving up, to smoke more. The National Federation of Retail Newsagents, alongside many small retailers, claims that 10-packs are used by adults to regulate, or cut down their smoking. They also raise the issue of pricing in illicit trade as illicit 20-packs sell for the same price as a legitimate 10-pack.

Even among individuals and organisations who are generally in favour of the consultation's proposals, many do not support this proposal. Some believe that it could encourage people to smoke more and may not have any impact on young people's smoking. Cancer Research UK and around 60 other organisations believe that further research is needed to establish possible benefits before implementing the measure.

Many respondents warn that the measure would be worthless or even counterproductive unless the issue of the availability of cheap, illicit tobacco is addressed.

Wiltshire Tobacco Control Alliance calls for a limit on the number of cigarettes that can be purchased at any one time, similar to requirements in place for retail sales of certain drugs. They suggest that limited stocks at home may restrict access to young people and may help adults cut down on smoking.

Below are summarised the key points among the research cited:

- British Medical Association (BMA, *Breaking the cycle of children's exposure to tobacco smoke, 2007*): most children buy cigarettes in 10 packs;
- Medway (young people's focus group): 70 per cent believe the measure would make no difference to smoking behaviour;
- Lancashire County Council (survey of 686 people): 54 per cent believe the measure would make no difference to smoking behaviour;
- Wirral (survey): 64 per cent in favour of the measure; and
- Smokefree Nottinghamshire (survey of secondary school pupils, n=1,000): the majority of young people smoke less than 20 cigarettes per week and most pupils purchase 10 packs, therefore removing 10 packs would deter young smokers.

Several respondents recommend that if the measure should come into force, tobacco companies should not be permitted to sell Gemini packs (20 cigarettes sold as two sets of ten) as they were in Ireland.

Question 12: Do you believe that more should be done by the Government to educe exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done?

Responses: 687

Around two thirds of respondents believe that the government should take no further legislative action, either because it is impracticable or because it is an undue interference in people's private lives. For example, Hackney & City PCT surveyed 221 Stop Smoking Services customers and found that 69 per cent believed there should be no further legislation to control smoking in homes and private vehicles. Reasons cited included enforcement and personal freedom issues.

Among respondents who are in favour of the consultation proposals in general, 112 believe that there should be more activity to raise awareness of the dangers of secondhand smoke in the home. The BMA suggests that social marketing campaigns to denormalise smoking in the home can be effective in illustrating the dangers to children of secondhand smoke. The Royal College of Nursing (RCN) reports health visitors and paediatricians finding that many parents are unaware of the effects of their smoking on their children. The Nuffield Council on Bioethics suggests that in exceptional cases children with serious respiratory illness should be protected from smoking in the home through action taken by local authority's children's services. Newcastle City Council estimates that at least half the children in the city live in households with at least one smoker.

ASH would like to see further research into the dangers of smoking in cars. Fifty-three respondents support making smoking illegal in moving cars to be enforced in a similar manner to the law on use of mobile phones. Several respondents suggest that there should be no smoking in cars when children are present.

Several respondents also suggest that the term 'passive smoking' is an inaccurate description, and should be replaced with the term 'secondhand smoking'.

Additional points that were made include:

- Smoking could be classed as odour pollution and therefore controlled as a "statutory nuisance" under existing regulations;
- Bury described a Successful Smokefree Homes scheme, where certificates were issued to parents who agreed not to smoke in front of children; and
- The RCN described a similar scheme implemented in Sefton, where 365 homes signed up, 235 of which were within the most deprived areas.

PART C: Supporting smokers to quit

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

Responses: 208

Respondents suggested a variety of research priorities including:

- Preventing young people from starting to smoke;
- Prompting quit attempts among different communities;
- Improving the impact of health warnings;
- NHS Stop Smoking Services:
    - Accessibility and efficacy of NHS Stop Smoking Services;
    - Barriers to using services;
    - Barriers to using medicinal nicotine or other pharmacotherapies;
    - Motivation to quit;
    - What makes quitting difficult in different social groups;
    - Monitoring and evaluation of social marketing to prompt quit attempts;
    - Piloting and evaluation of different approaches to treatment and relapse prevention within different groups;
    - Using incentive schemes; and
    - Cost-benefit studies of cessation approaches.
- Supply, demand and use of tobacco products:
    - Young people and those living in disadvantaged communities using smuggled and imported tobacco;
    - Reducing availability of smuggled tobacco;
    - Understanding how tobacco marketing strategies evolve;
    - Measuring the impact of restricting access to tobacco; and
    - Use of chewing tobacco, shisha and other tobacco products, in particular among ethnic minorities.
- Harm reduction:
    - Monitoring trends in level of exposure of children to secondhand smoke and exploring the long-term impact on health of exposure to secondhand smoke;
    - Reducing exposure to secondhand smoke;
    - Assessing effects of long-term use of pure nicotine products;
    - Relative efficacy and cost-benefits of different harm reduction products; and
    - Impact of controls on contents, design and emissions of tobacco products.

Trading Standards Partnership North West suggests the tobacco industry should be compelled to release all the research it possesses on smoking.

ASH, Cancer Research UK and others suggest that the new tobacco control strategy should be continually monitored to assess the impact of policy measures and initiatives on smoking behaviour. Wolfson Research Institute suggests establishing a network of academic researchers on tobacco control.

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?**

Responses: 334

Many respondents suggest that resources for NHS cessation services need to be increased. They suggest this is needed to provide better training, assessment and supervision of stop smoking specialists, as well as implementing protocols for treatment and providing better administrative support for front-line services.

The UK Centre for Tobacco Control Studies notes that the availability and quality of support varies across local areas. There is a need for specialist guidance to draw on best practice, which, they suggest, could be produced by NICE. The Centre would also like to see more information collected on referral and success rates.

Many respondents believe that the four week quit target is inadequate and should be extended, as quitters are particularly vulnerable to relapse during the first three months to one year of stopping.

Most respondents believe that NHS cessation services are highly effective. However, Allen Carr Easyway (ACE) say that they believe the quit rate for NHS cessation services is the same as for use of Nicotine Replacement Therapy (NRT) alone, and that there is no evidence to suggest that the counselling element has any effect.

Several themes emerged from responses to this question, including:

- Access and accessibility – only four per cent of smokers make use of stop smoking services:
    - Stop smoking services need to be available in a variety of settings, including: the workplace; community pharmacies; schools and colleges; community resources; and health trainers;
    - Cessation information and resources should be widely available and provided in different languages with internet-based resources;
    - 'Smokefree families' initiatives should be available through schools and Children's Centres;
    - Outreach services should be made available through mobile units;
    - Services should operate extended hours;
    - A 24 hour helpline is needed, with integrated Choose & Book support; and
    - Stop smoking services should be open to smokers who have had an unsuccessful quit attempt as soon as they are ready to try again.

Several respondents note that there is a need to research why people the majority of those who attempt to quit each year are not accessing NHS stop smoking services. An evaluation of stop smoking service provision by Newcastle City Council showed a need for community outlets, local access and availability at a range of times. Service users responded well to advisors who did not present as typical, 'traditional health professionals.' A review by

Birmingham Young People's Health Project found that young smokers wanting to quit do not feel comfortable accessing a service from their GP. Smokefree Newham focus groups found that no participating smokers had heard of local stop smoking services. The Royal College of Nursing found low awareness of local cessation services among nurses, and poor availability of training for cessation support. Finally, Smokefree Wirral, in a survey of 29 clients of their local NHS Stop Smoking Service, found that clients believed NRT should be made widely available and that many wanted evening accessibility with one-to-one counselling the preferred model of treatment.

Several respondents refer to their own experience in providing outreach services and note their effectiveness. Knowsley PCT, with high smoking prevalence and some of most deprived wards in country, detailed their success in support local smoking cessation with over 1,300 quitters achieved between April and December 2007. They attribute their success to an extensive range of flexible support and social marketing. Bath and North East Somerset Tobacco Action Network report a Smokefree Families campaign to identify where children are exposed to secondhand smoke and provide health promotion messages and offer cessation support. They trained health visitors in brief intervention and support/referral and developed information resources for parents and children. Birmingham City Council produced a 'face2face' mobile resource.

Other suggestions include:

- Identifying and reaching smokers proactively:
    - Hospitals should record the smoking status of all patients;
    - Routine screening for tobacco use among pregnant women;
    - Clinical staff, including midwives and oral health professionals, should be able to provide brief interventions and referral to stop smoking advice and there should be training and protected time for this;
    - Referral to stop smoking services should be part of the GP's Quality and Outcomes Framework; and
    - Proactive contact of previous service users who failed to quit.

- Stop smoking aids:
    - Free NRT
    - Widespread availability of NRT

- Vulnerable groups and hard to engage groups:
    - Drugscope: smoking cessation should be embedded as part of a wider drive to improve general health and well-being promotion in services working with the most marginalised groups, including drug treatment services;
    - Rethink: GPs should ask patients with severe mental illness to be registered for annual physical health checks, using this as an opportunity to offer cessation support;
    - Rethink: Tailored smoking cessation programmes for people with mental health problems;
    - Centre for Tobacco Control Research: cessation services should be located in:
        - prisons as this would create an opportunity to reach target groups, among them disadvantaged young males, who are otherwise hard to reach;
        - deprived areas, where smoking prevalence is high; and
        - BME communities, where shisha and chewing tobacco is used.

Cardio Wellness cites a case study showing that two prisoners preferred to spend money on cigarettes rather than NRT since they were cheaper.

Roy Castle Lung Cancer Foundation said that although half of smokers with mental health problems want to stop smoking, quit rates are two to three times lower in this group compared to the general population.[15]

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

Responses: 173

Over half of respondents to this question believe there should be better communications between local and national services. There are several complaints about the current system of referrals from the national helpline, including:

- Leeds Tobacco Control Group: reported delays in forwarding caller details to local services, resulting in lost opportunities as motivation to quit declines over time, and suggested that referrals need to be sent immediately by e-mail;
- Smoke Free North East: prospective referrals are lost at the interface between national and local services;
- Islington PCT: Callers are asked for the same information by the national helpline and local services; and
- National helpline provides too few referrals.

The majority of respondents call for a rapid, seamless referral pathway, which operates consistently across the country.

There is also popular demand for advance warning of national publicity and promotion campaigns to local services so they can coordinate local campaigns to capitalise on increased motivation, and better handle increased demand.

Some respondents suggest that helpline services should be promoted and available in other languages in particular to address the high prevalence of smoking among migrant workers.

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

Responses: 174

Many suggestions are also covered under question 14. Common responses include:

- Outreach in community settings among employers, voluntary sector organisations and faith groups;

[15] Mental Health Foundation (2007) Taking a deep breath

- Training for health, social services, community workers and teachers to deliver cessation advice;
- Better resourced social marketing;
- Delivery of cessation advice embedded within mandatory training for all health professionals; and
- Brief interventions by all health professionals.

It is also suggested that all health professionals (including dentists, for example) should be able to prescribe NRT. Many suggest that the quit line number and website should be displayed on all tobacco packaging.

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?

Responses: 189

Around 80 per cent of respondents are in favour of a harm reduction approach based on medicinal nicotine replacement therapy (NRT). However, around half of these suggest that this should be as part of a structured approach leading to permanent smoking cessation. Many suggest that the phrasing of the consultation question be changed: “Helping those who cannot quit” could be replaced by: “helping those who have greatest difficulty stopping smoking’ or ‘those who cannot yet quit’ (Cancer Research UK), as this would underline the emphasis on using harm reduction as a temporary measure to wean smokers off tobacco products.

ASH and other respondents call for the Government to encourage pharmaceutical companies to develop new, more user-acceptable NRT products.

NHS Cambridgeshire believes that harm reduction should be clearly defined. It warns that there is a danger that NRT could otherwise become too consumer-friendly and lose power as a medical product.

Many stakeholders, in particular Fire Services, are in favour of the development of reduced ignition propensity “RIP” cigarettes. London Fire Brigade, for example, presents research to show that 30% of fatalities in London house fires are caused by smoking materials: a total of 34 deaths in London between 2005 and 2008.

Annex 1: Consultation Respondents

A G Parfett and Sons Ltd
Advertising Standards Authority
Aelia
Age Concern Durham
Age Concern England
Agio Cigars
Airport Operators Association
Alcan Packaging
All Party Parliamentary Group on Smoking and Health
Allen Carr's Easyway (International) Ltd
Alliance Party of Northern Ireland
Alpha Retail
Ards Borough Council (NI)
Armagh City & District Council (NI)
Arnold Andre
ASH
ASH Northern Ireland (NI)
ASH Scotland
ASH Wales (W)
Association of British Dispensing Opticians
Association of Convenience Stores
Association of Directors of Public Health
Association of Independent Tobacco Specialists
Association of Licensed Multiple Retailers
Association of North East Councils
Association of Public Health Observatories
Asthma UK
Auk Investments
Automatic Sales
BAA Ltd
Bainbridge District Council (NI)
Ballymoney Borough Council (NI)
Bath and North East Somerset Tobacco Action Network
Belfast International Airport
Berkshire East Stop Smoking Services
Bestway Holdings
BII
Birmingham City Council, Health Overview and Scrutiny Cttee
Birmingham City Council, Public Protection Cttee
Birmingham East and North PCT
Birmingham (School) Governor's Network
Birmingham Youth Service - Young People's Health Project
Blaby District Council
Black Country Tobacco Control Alliance
BMA Northern Ireland

BMA, BMA Northern Ireland
BME Community Development Easington
BME Community Development County Durham
Board of Community Health Councils in Wales (W)
Bolsover District Council
Booker
Bradford and Airedale PCT
Brighton and Sussex University Hospitals NHS Trust
Bristol International Airport Ltd
Bristol Partnership
British American Tobacco
British Beer and Pub Association
British Brands Group
British Dental Association
British Heart Foundation
British Lung Foundation
British Psychological Society
British Retail Consortium
British Thoracic Society, British Association for Stop Smoking Practitioners
Brobot Petroleum Ltd
Buckinghamshire PCT - Bucks Alliance for Action on Smoking
Buckinghamshire Stop Smoking Service
Bury PCT
Business Action to Stop Counterfeiting and Piracy
Cambridgeshire County Council
Cancer Research UK
Capper & co
Cardiff Institute of Society, Health and Ethics, Cardiff University (W)
Cardio Wellness
Carlisle Partnership
Cash Bases Ltd
Castle Rock Brewery
Castlereagh Borough Council (NI)
Centre for Tobacco Control Research - University of Sterling
Chamber of Commerce for Hull
Chartered Institute of Environmental Health
Cheshire and Merseyside Tobacco Alliance
Cheshire Fire and Rescue Service
Cheshire Health and Adult Social Care Scrutiny Select Committee
Chester-le-Street District Council
Chief Environmental Health Officers Group (NI)
Chief Fire Officers Association
Chief Police Officers in Wales
Child Accident Prevention Trust
Children in Wales (W)
Children's Rights Alliance for England
Christie Hospital NHS Foundation Trust
Cigars Unlimited
Citizencard
City and Hackney tPCT

Cleveland Fire Brigade
Cleveland Fire Brigade
Coleraine Borough Council (NI)
Community Action on Health
Community and Voluntary Organisations Sedgefield
Community Safety Partnership (Easington)
Cornwall and Isles of Scilly PCT
County Durham and Darlington Fire and Rescue Service
County Durham PCT - Easington PBC Group
County Durham PCT, Darlington PCT
Coventry NHS Stop Smoking Services
Croydon Tobacco Control Alliance
Cumbria County Council
Cumbria Fire and Rescue Service
Cumbria Healthy School
Cumbria PCT
Cumbria TCA
Cumbria Trading Standards
Dark Market Ltd
Darlington Borough Council
Denbighshire County Council - Trading Standards (W)
Derby City PCT
Derbyshire Action on Smoking
Derbyshire County PCT
Derwentside Health Improvement Group (LSP Subgroup)
Derwentside PBC Cluster, County Durham PCT
Devon PCT Trust
Dhamacha Group Ltd
Diabetes UK Cymru (W)
Directors of Public Protection Wales (W)
DISC (Easington and Sedgefield)
District of Easington Council
DrugScope
Duckworth (Blackpool) Ltd
Durham and Chester-le-Street Health Improvement Group (LSP subgroup)
Durham County Council
D-MYST
Ealing and Hounslow Stop Smoking Service
Easington PBC Group
East and Coastal Kent PCT
East Durham LSP
East Riding of Yorkshire Council - Food Services Team
East Sussex Fire & Rescue Service
East Tobacco Control Alliance
Eastern Health and Social Services Board (NI)
Enfield Council - Environmental Protection and Regulation
Essex County Council Trading Standards
European Cigar Manufacturers Association
European Communities Trade Mark Association
European Smoking Tobacco Association

Expert Patient Programme Darlington
Faculty of Public Health
Families Need Fathers
FECIBEL
Federation of Licensed Victuallers Association
Federation of Small Businesses
Federation of Wholesale Distributors
FOREST
Fox International
Freedom to Choose
Fresh - Smoke Free North East
Gallaher Ltd (Lisnafillan)
Gateshead NHS Trust
GlaxoSmithKline
Global Intellectual Property Centre
Gloucestershire Hospitals NHS Trust
Gloucestershire Public Health Directorate
Great Yarmouth and Waveney PCT
Greater Manchester Health Commission
Greenwich Stop Smoking Services
Greenwich tPCT
Group Against Smoking in Public
GT News Ltd
Gwynned Council - Administration and Public Protection Service (W)
Halton Borough Council
Hampshire PCT
Harlow Council
Hartlepool Borough Council
Hartlepool Health and Wellbeing Partnership
Hartlepool PCT
Hartlepool PSHE Healthy Schools
Hartlepool Smoke Free Alliance
Havant Borough Council
Havering Tobacco Control Alliance
Health and Wellbeing Partnership Board (Redcar & Cleveland)
Health Promoting Hospitals Group, Gloucestershire NHS Foundation Trust
Health Promotion Agency (NI)
Health Visiting Services (Wheatley Hill)
Healthier Communities (Nottinghamshire County Council)
Healthy Southwark
Heart of Birmingham TPCT
Heart of Mersey
Henri Wintermans UK Ltd, Henri Wintermans Cigars
Herefordshire Stop Smoking Service
Heywood, Middleton and Rochdale PCT
Horden and Easington Neighbourhood Management Pathfinders
Horden Youth and Community Centre
Humber Alliance on Tobacco
Hunters & Frankau
Imperial Tobacco Group plc, Imperial Tobacco UK

Imported Tobacco Products Advisory Council
Independent Retail News Magazine (Tobacco Survey)
Independent Scottish Specialist Tobacconists' Association
Institute of Public Health in Ireland
International Smokeless Tobacco Company
International Trademark Association
Islington PCT
Islington Trading Standards
J Cortes Cigars
Japan Tobacco International
John Hollingsworth & Son Ltd (Specialist tobacconist)
Keep Wales Tidy (W)
Kent Alliance on Smoking and Health
Knowsley Metropolitan Borough Council
Knowsley PCT
LACORS, LGA
Lancashire County Council
Lancashire County Council - Trading Standards Service
Lancashire Fire and Rescue Service
Leeds Tobacco Control Steering Group
Leicester County and Rutland NHS PCT
Leicester Tobacco Control Coordination Group
Lewisham PCT - Stop Smoking Service
Lichfield & District Citizens Advice Bureau
Liverpool PCT
London Borough of Redbridge
London Borough of Southwark
London Borough of Sutton
London Fire Brigade
London Luton Airport
London Trading Standards Authorities
L'Union des Fabricants
Manchester Airports Group
Manchester Health and Wellbeing Board
Marie Curie Cancer Care
Markenverband
McNeil Healthcare (UK) Ltd
Medway PCT
Middlesborough Council
Middlesborough, Hartlepool and Stockton on Tees tPCTs
Middlesborough Health and Social Care Partnership
Mills Group Ltd
Mind
Mitchells and Butler
MRH (GB) Ltd
Musgrave Retail Partners GB
National Association of Child Contact Centres
National Association of Cigarette Machine Operators
National Federation of Retail Newsagents
National Heart Forum

National NGO Forum
National Oral Health Promotion Group
National Public Health Services (Wales)
New Leaf (Nottinghamshire County Stop Smoking Service)
New Trade Publishing
Newcastle City Council, also Regulatory Service and Public Protection Directorate
Newcastle Healthy City
Newcastle Healthy Schools
Newcastle International (airport)
Newham Youth Council
NHS Cambridgeshire (Cambridgeshire PCT)
NHS East of England
NHS Health Scotland
NHS Manchester
NHS Norfolk (Norfolk PCT)
NHS North of Tyne - North of Tyne Primary Care Organisations
NHS North Staffordshire
NHS Sheffield
NHS South Central SHA
NHS South of Tyne and Wear
NHS Walsall
NHS Warwickshire
No Smoking Day
North East Essex PCT
North East Regional Pregnancy Network
North East Trading Standards Association
North of Tees Smoking in Pregnancy Steering Group
North Tyneside Council
North Tyneside Healthy Schools
Northamptonshire Smokefree Alliance
Northern Group Systems (NI)
Northern Health and Social Care Trust (NI)
Northern Health and Social Services Board (NI)
Northern Ireland Cancer Registry (NI)
Northern Ireland Commissioner for Children and Young People (NI)
Northern Ireland Independent Retail Trade Association (NI)
Northern Ireland Tobacco Task Group
Northumberland Care Trust
Northumberland County Council and Berwick-upon-Tweed Council
Northumberland Stop Smoking Service
Northumberland, Tyne and Wear NHS Trust
Nottingham City Council
Nottingham City PCT
Nottingham County tPCT
Nottinghamshire County Council
Novartis
Nuance Group
Nude Brand Consulting
Nuffield Council on Bioethics
Nuneaton and Bedworth Council

Opolka Ltd, Redorange Ltd
OWM (German Advertisers Association)
Oxford Alliance on Smoking Issues
Peterlee Town Council
Peterlee Neighbourhood Management Pathfinder
Pfizer
Pharmaceutical Society of Northern Ireland (NI)
Philip Morris Ltd
Pioneering Care Partnership (Spennymoor)
Plymouth SSS
Proudfoot Group
QUIT
Redcar and Cleveland PCT
Rethink
Ribble Valley LSP
RNIB
RNIB Cymru (W)
Rochdale Council
Rochdale Borough Multi-Agency Healthy Lifestyles Strategy Group
Rochdale Borough Tobacco Free Strategy Group
Rotherham PCT
Roy Castle Lung Cancer Foundation
Royal Borough of Kensington and Chelsea
Royal Borough of Kingston upon Thames
Royal College of General Practitioners
Royal College of Nursing
Royal College of Nursing (NI)
Royal College of Paediatrics and Child Health
Royal College of Physicians
Royal College of Physicians of Edinburgh
Royal College of Radiologists
Royal Pharmaceutical Society of Great Britain
Rural Shops Alliance
Salford PCT
Sainsbury's
Sandwell PCT
Secure Systems for the Control of Illicit Tobacco
Sedgefield Council
Sefton Public Health Partnership for tobacco
Sheffield PCT
Shropshire PCT
Sinclair Collis
Smoke Free Bristol (Steering Group)
Smoke Free Cambridgeshire and Peterborough
Smoke Free Coventry Alliance
Smoke Free Derwentside, Smoke Free Durham & Chester Le Street
Smoke Free Essex TCA
Smoke Free Gateshead Alliance
Smoke Free Hampshire and Isle of Wight
Smoke Free Hertfordshire

Smoke Free Middlesborough
Smoke Free Newcastle
Smoke Free North Lincolnshire Alliance
Smoke Free North Tyneside
Smoke Free Nottingham
Smoke Free Solihull
Smoke Free Warwickshire
Smoke Free Wirral
Smoke Free Youth Advocacy Group (Birmingham)
Smokefree Barnsley
Smokefree Bedfordshire and Luton Alliance
Smokefree Berkshire Alliance
Smokefree Camden
Smokefree County Durham and Darlington Tobacco Control Alliance
Smokefree East Lancashire
Smokefree Greater Manchester
Smokefree Lincs Alliance
Smokefree Liverpool
Smokefree London
Smokefree Medway
Smokefree Newham Alliance
Smokefree North West
Smokefree Plymouth Alliance
Smokefree Redcar and Cleveland
Smokefree Surrey Alliance
Smokefree Wakefield Tobacco Control Alliance Action
Smokefree Wiltshire - TCA
Smoking Control Network
Solihull Care Trust
Somerset PCT
South Asian Health Foundation
South Bedfordshire District Council
South Birmingham PCT
South East Coast SHA
South Essex Partnership NHS Foundation Trust
South Gloucestershire NHS Stop Smoking Team
South Gloucestershire PCT
South Gloucestershire Tobacco Action Network
South of Tyne and Ware PCT - Local safeguarding children board subgroup
South Somerset District Council
South Staffordshire PCT
South Tyneside PCT
South Tyneside PCT
South Tyneside Tobacco Control Alliance
South West Essex PCT
South Yorkshire Joint Trading
Southern Health and Social Care Trust (NI)
Southern Health and Social Services Board (NI)
Southwest Cancer Network
Spar (UK) Ltd

Staffordshire County Council
Stockport PCT
Stockport Public Health Partnership Board
Stockton and Tees tPCT
Stockton Borough Council
Stockton on Tees Tobacco Alliance
Stoke on Trent PCT
Sunderland City Council
Sunderland LPC, Gateshead & South Tyneside LPC
Sunderland PCT
Sunderland Voluntary Sector Youth Forum
Surrey PCT
Sutton and Merton PCT
Swedish Match Cigars
Swindon PCT
Swindon Trading Standards
T Wiseman Ltd
Talking About Cannabis
Tees, Esk and Wear Valleys NHS Foundation Trust
Telford and Wrekin PCT
The Co-operative Group
The Free Society
The Tobacconist
Thresher Group
Tobacco Control Accountability Initiative
Tobacco Control Collaborating Centre
Tobacco Manufacturers Association
Tobacco Retailers Alliance
Tor Imports Ltd
Torbay Stop Smoking Service
Tower Hamlets Tobacco Control Alliance
Trading Standards East Midlands
Trading Standards Institute
Trading Standards Northwest
Trading Standards Partnership (SWERCOTS)
Trading Standards South East Ltd
TransAtlantic Business Dialogue
Transform Drug Policy Foundation
Tyne and Wear Fire and Rescue Service
Tyneside Council
UK Centre for Tobacco Control Studies
UK Cooperative Consumer Movement
UK Lung Cancer Coalition
UK Travel Retail Forum
Ulster Cancer Foundation (NI)
Unite
Unite (NI)
US Chamber of Commerce
Verband Schweiz
Wakefield Council - Enviromental Health

Wakefield District PCT
Wakefield Tobacco Control Alliance
Wales Heads of Trading Standards Group (W)
Walkers Crisps
Walsall Metropolitan Borough Council - Environmental Division
Waltham Forest PCT
Warrington Borough Council - trading standards
Warrington PCT
Warwickshire PCT
Warwickshire Stop Smoking Services
Washington Legal Foundation
Waynes Foods Ltd
Welsh Association of Chief Police Officers
West Kent NHS Stop Smoking Service
West Midlands Fire Service
West Sussex Health
West Sussex PCT
Western Cheshire PCT
Western Cheshire Tobacco Control Alliance
Western Health and Social Care Trust(NI)
Western Health and Social Services Board (NI)
Western Investing for Health (NI)
Westminster Tobacco Control Alliance
Wolfson Research Institute, Durham University
World Duty Free
Yorkshire and Humber Tobacco Control Network
Yorkshire and Humber Trading Standards Group
Young People's Forum (Telford)