
Appendices

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Appendix A: Key sources

1. Sources used in this report

1.1 Action on Smoking and Health (ASH), YouGov survey, 2015
ASH produce a range of statistical factsheets and one on smoking in cars is used in this report.

1.2 Adult smoking habits in Great Britain, 2014
The data in this report were collected on the Opinions and Lifestyle Survey (OPN) – an omnibus survey run by the Office for National Statistics. The survey is run monthly and is open for both government and non-government organisations to run questions.

The OPN is the only randomised probability sample omnibus survey in Great Britain and provides a fast, reliable and flexible service to customers.

1.3 Office for National Statistics: Affordability and expenditure
Additional information can be found at:
- Focus on Consumer Price Indices, Office for National Statistics
  http://www.ons.gov.uk/ons/publications/all-releases.html?definition=tcm_per_cent3A77-22465
- Economic and Labour Market Review, Office for National Statistics.
- Final Mid-Year Population Estimates (based on 2011 census), Office for National Statistics

1.4 HM Revenue & Customs (HMRC): Availability of tobacco
The availability of tobacco, shown as the volume of tobacco released for home consumption, is taken from HMRC statistical fact sheets. Graphs, tables and charts are used to present a variety of data and to communicate information to the user. In places, commentary is provided to support the data. Fact sheets are not National Statistics.
www hmrc gov uk/

Data sets can be obtained from the internet at:
www.uktradeinfo.com
1.5 Health at a glance

The Health at a Glance Europe edition is a biennial publication that presents a set of key indicators of health status, determinants of health, health care resources and activities, quality of care, health expenditure and financing in European countries. The selection of indicators is based largely on the European Community Health Indicators (ECHI) shortlist, a set of indicators that has been developed to guide the reporting of health statistics in the European Union. It is complemented by additional indicators on health expenditure and quality of care, building on the OECD expertise in these areas.

Every other year, Health at a Glance provides the latest comparable data on different aspects of the performance of health systems in all other OECD countries as well as Europe. It looks at variations across countries in the costs, activities and results of health systems. Key indicators provide information on health status, the determinants of health, health care activities and health expenditure and financing in OECD countries.

Each indicator in these publications is presented in a user-friendly format, consisting of charts illustrating variations across countries and over time, brief descriptive analyses highlighting the major findings conveyed by the data, and a methodological box on the definition of the indicator and any limitations in data comparability.

http://www.oecd.org/health/health-systems/health-at-a-glance.htm

1.6 Health Survey for England

The Health Survey for England (HSE) comprises of a series of annual surveys commissioned by the Health and Social Care Information Centre. All of the surveys cover the adult population aged 16 and over living in private households in England. Since 1991, the HSE has included questions related to smoking.

Each survey consists of core questions and measurements gathered during a nurse visit (e.g. blood pressure and analysis of blood samples) plus modules of questions on specific issues that change periodically such as cardiovascular disease or on specific population groups such as older people or ethnic minorities.

HSE publications from 2004 onwards are available on the Health and Social Care Information Centre website.

Earlier HSE publications are available on the Department of Health (DH) website.

The Health Survey for England is a National Statistic.


Publications prior to 2004 for the Health Survey for England can be found on the Department of Health website

https://www.gov.uk/government/publications
1.7 Hospital Episode Statistics

Hospital Episode Statistics (HES) is a data warehouse which includes details of all admissions to NHS hospitals in England since April 1987. It includes private patients treated in NHS hospitals, patients who were resident outside of England and care delivered by treatment centres (including those in the independent sector) funded by the NHS. HES also contains details of all NHS outpatient appointments in England as well as detailed records of attendances at major A&E departments, single specialty A&E departments, minor injury units and walk-in centres in England.

HES data are classified using the International Classification of Diseases (ICD) (http://www.who.int/classifications/icd/en/). Details of ICD-10 codes used are included in Tables 3.2 and 3.4. The statistics on hospital activity in England are derived from data collected on NHS hospital in-patient care. Thus, they may not fully reflect hospital treatment of patients with smoking-related diagnoses or conditions, as local choice might favour outpatient treatment, for which detailed information is not available.

http://www.hscic.gov.uk/hes

1.8 Integrated Household Survey

The Integrated Household Survey (HIS) was previously formed from “core” questions asked by a number of our household surveys. This year the HIS is based solely upon the Annual Population Survey (APS), following the removal of HIS questions on the Living Costs and Food (LCF) survey in January 2014.

Data for this bulletin were obtained from the APS for the survey months January to December 2014.

These data have been prepared using the established HIS approach of imputing and calculating weights using HIS specific methodologies. This will be the last independent HIS dataset to be released.

HIS variables will be added to the APS dataset from January – December 2015. For this dataset HIS variables will be subjected to the APS processing methodology.

http://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/sexuality/bulletins/integratedhouseholdsurvey/previousReleases

1.9 NHS Stop Smoking Services

NHS Stop Smoking Services (formerly known as Smoking Cessation Services) provide counseling and support to smokers wanting to quit, complementing the use of stop smoking aids Nicotine Replacement Therapy (NRT), Bupropion (Zyban) and Varenicline (Champix).

The establishment and development of Stop Smoking Services in the NHS is an important element of the government’s strategy to tackle smoking. Monitoring of the NHS Stop Smoking Services is carried out via quarterly monitoring returns. The quarterly reports present
provisional results from the monitoring of the NHS Stop Smoking Services, until the release of
the annual bulletin when all quarterly figures are confirmed.

Prior to October 2005, *Statistics on NHS Stop Smoking Services* were collected and published by
The Department of Health.

https://www.gov.uk/government/publications

This is now the responsibility of the Health and Social Care Information Centre.

http://www.hscic.gov.uk/stopsmoking

1.10 Mortality Statistics [NS]

The Office for National Statistics (ONS) produce an annual extract of mortality statistics to the
Health and Social Care Information Centre detailing the numbers of deaths by cause in
England. Registered deaths in England are classified using ICD-9 to 2000 and by ICD-10 for
both 1999, and from 2001 onwards.

ONS mortality data are shown in Tables 3.3 and 3.4 of this report.

https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths

1.11 Opinions and Lifestyle Survey [NS]

The Opinions and Lifestyle Survey (OPN) provides information on smoking rates, average
number of cigarettes smoked and smoking during pregnancy in Great Britain. This continues
the series of releases on smoking; previously provided by the General Household Survey
(GHS) and the General Lifestyle Survey (GLF).

GLF was discontinued at the end of 2011, following consultation with users. Some of the
questions on smoking were included in the new ONS Opinions and Lifestyles Survey.

1.12 PHE – Local Tobacco Control Profiles for England

The Local Tobacco Control Profiles for England provides a snapshot of the extent of tobacco
use, tobacco related harm, and measures being taken to reduce this harm at a local level.
These profiles have been designed to help local government and health services to assess the
effect of tobacco use on their local populations. They will inform commissioning and planning
decisions to tackle tobacco use and improve the health of local communities.

The tool allows you to compare your local authority against other local authorities in the region
and benchmark your local authority against the England or regional average.

http://www.tobaccoprofiles.info/

1.13 Prescription data

Information on prescription items prescribed in primary care settings in England is produced
using Prescribing Analysis and Cost Tool (ePACT). The ePACT system covers prescriptions
prescribed by GPs, nurses, pharmacists and others in England and dispensed in the
community in the UK. Prescriptions written in England but dispensed outside England are
included. Prescriptions written in hospitals/clinics that are dispensed in the community,
prescriptions dispensed in hospitals and private prescriptions are not included in PACT data.
Hospital prescription information is taken from the Prescription Cost Analysis (PCA) system, and is based on a full analysis of all prescriptions dispensed in the community i.e. by community pharmacists and appliance contractors, dispensing doctors, and prescriptions submitted by prescribing doctors for items personally administered in England. Also included are prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England. The data do not cover drugs dispensed in hospitals, including mental health trusts, or private prescriptions.

The differences between PCA and ePACT are that

1. PCA includes prescriptions prescribed by dentists.
   ePACT does not include prescriptions prescribed by dentists.

2. PCA includes prescriptions written in Wales, Scotland, Northern Ireland and the Isle of Man but dispensed in England.
   ePACT includes prescriptions written in England but dispensed in England and those dispensed outside England.

Prescriptions are written on a prescription form known as a FP10 and each single item on the form is counted as a prescription item. Net Ingredient Cost (NIC) is the basic cost of a drug. It does not take account of discounts, dispensing costs, fees or prescription charges income.

The prescription data included in this report are not routinely available. Sub-national or primary care data may be available on request from Prescription Services. National data with a wider coverage is available from the Health and Social Care Information Centre.

http://www.hscic.gov.uk/primary-care

1.14 Smoking at the Time of Delivery

Smoking during pregnancy can cause serious pregnancy-related health problems. These include complications during labour and an increased risk of miscarriage, premature birth, still birth, low birth-weight and sudden unexpected death in infancy.

Reducing smoking during pregnancy is one of the three national ambitions in the Tobacco Control Plan published in March 2011, which is “to reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth)”.

This data collection is designed to provide a measure of the prevalence of smoking among women at the time of giving birth at a local level.

http://www.hscic.gov.uk/datacollections/ssatod

1.15 Smoking, drinking and drug use among young people in England, 2014

Smoking, Drinking and Drug Use Survey among Young People in England in 2014 (SDD14) is the latest in the series of surveys of secondary school children in England which provides the national estimates of the proportions of young people in school years 7 to 11 (who are mostly aged 11 to 15) who smoke, drink alcohol or take illegal drugs.

The first survey in the series, carried out in 1982 and since 1998 survey has included questions on drinking and drug use as well as smoking.
As well as these core measures, questionnaires since 2000 have included more detailed questions, with the focus alternating between smoking and drinking in one year and drug use the next.

There was no survey in 2015.


1.16 What about YOUth survey

What About YOUth? (WAY) is a newly-established survey designed to collect robust local authority (LA) level data on a range of health behaviours amongst 15 year-olds.

The Health and Social Care Information Centre (HSCIC) was commissioned by the Department of Health to run the survey in direct response to the Children and Young People’s Health Outcomes Forum. This Forum identified gaps in the Public Health Outcomes Framework (PHOF) and other key health behaviour measures relating to young people. HSCIC contracted Ipsos MORI to carry out the survey.

WAY is the first survey to be conducted of its kind and it is hoped that the survey will be repeated in order to form a time series of comparable data on a range of indicators for 15 year-olds across England. Data has been collected on general health, diet, use of free time, physical activity, smoking, drinking, emotional wellbeing, drugs and bullying.

http://www.hscic.gov.uk/article/3742/What-About-Youth-Study

2. Other resources related to smoking

Readers may also find the following organisations and publications useful resources for further information on smoking:

2.1 Healthy Lives, Healthy People: A Tobacco Control Plan for England


The Tobacco Control Plan sets out what the Government will do to support efforts to reduce tobacco use over the next five years, within the context of the new public health system. It aims to promote comprehensive and evidence-based tobacco control in local communities. The plan is built around the six strands of comprehensive tobacco control that are recognised internationally.


2.2 Home Office Research, Development and Statistics Directorate (RDS)

Further information and other RDS Home Office publications can be found on the internet at:
2.3 Infant Feeding Survey

The Infant Feeding Survey (IFS) was last carried out in 2010 and was published by the Health and Social Care Information Centre in September 2012. The survey provided statistics on smoking and drinking behaviour among women before and during pregnancy. It is now discontinued.

http://www.hscic.gov.uk/searchcatalogue?productid=9569&q=title%3a%22Infant+Feeding+Survey%22&sort=Relevance&size=10&page=1#top

2.4 National Institute for Health and Clinical Excellence (NICE)

The NICE has taken on the functions of the Health Development Agency to create a single excellence-in-practice organisation responsible for providing national guidance on the promotion of good health and the prevention and treatment of ill health:

http://www.nice.org.uk/

2.5 NHS Smoking Helpline

Information and help on quitting smoking is available from the NHS Smoking Helpline: 0800 169 0 169.

http://www.nhs.uk/smokefree

2.6 Smoking-Related Behaviour and Attitudes from the Omnibus Survey [NS]

The Omnibus Survey is a multi-purpose continuous survey carried out by the Office for National Statistics (ONS) on behalf of a range of government departments and other bodies.

This survey is currently not being continued. The latest report on the smoking module was in 2008/09 and presents results on smoking behaviour and habits, views and experiences of giving up smoking, awareness of health issues linked with smoking and attitudes towards smoking.


2.7 Summary of Public Health Indicators Using Electronic Data from Primary Care

This report was published by the Health and Social Care Information Centre (HSCIC) in September 2008. The purpose of the project was to report trends over recent years (2001-2007) in the completeness of recording of selected public health indicators (obesity, smoking, blood pressures and cholesterol) within primary care electronic health care records, and to report on estimated population levels of obesity, smoking, blood pressure and cholesterol.

The project was jointly funded by the HSCIC and the Health Improvement and Protection Directorate (Department of Health); the work was undertaken by QRESEARCH.
2.8 Scientific Committee on Tobacco and Health (SCOTH)

The report of the SCOTH drew conclusions on the adverse health risks of smoking during and after pregnancy. Continuing to smoke during pregnancy was reported to increase the chance of miscarriage, reduced birth weight and prenatal death of the child. If mothers smoke after birth, the risk of sudden infant death syndrome is increased.

www.archive.official-documents.co.uk/document/doh/tobacco/contents.htm

2.9 Smoke-free Action

Provides various information relating to the smoke-free legislation.

http://www.smokefreeaction.org.uk/

2.10 The World Health Organization (WHO) Framework Convention Alliance for Tobacco Control (FCTC)

In May 2003, the member countries of the World Health Organization adopted an historic tobacco control treaty, the Framework Convention on Tobacco Control (FCTC), to set internationally agreed minimum standards on tobacco control and to ensure international cooperation on matters such as the illegal trade of tobacco.

www.fctc.org

2.11 Chartered Trading Standards Institute (CTSI)

CTSI has produced various reports relating to its activities around tobacco sales, often in conjunction with Public Health England and/or the Department of Health.

http://www.tradingstandards.uk/policy/Improvingthehealthofsociety.cfm
Appendix B: Technical notes

1 Estimating smoking-attributable deaths and hospital admissions

1.1 Introduction

Estimates of smoking-attributable NHS hospital admissions and deaths given in Tables 3.1 to 3.4 are based on three pieces of information:

1. Estimates of smoking prevalence for both smokers and ex-smokers
2. Relative risks for deaths and non-fatal diseases for both smokers and ex-smokers for those diseases known to be associated with smoking
3. Observed numbers of hospital admissions or deaths caused by those diseases which can be caused by smoking.

1.2 Smoking Prevalence

Estimates of the prevalence in England of current and ex-smokers by gender and age are taken from the results of Opinions and Lifestyle Survey (OPN). These estimates are used in order to estimate the number of smoking-attributable admissions and deaths.

The latest smoking prevalence information used in this report is presented in Table B.1.

1.3 Relative Risks

Fatal diseases

In 2007 a review of the existing methodologies was undertaken by the Department of Health (DH) which resulted in a revised list of diseases for which there was an excess risk of death for current and ex-smokers compared to those people who have never smoked. This was then used to estimate numbers of smoking attributable fatalities in the Health Profile for England (HPE)\(^1\). This revised approach has been adopted for this report.

The methodology employed in this report is identical to that used by the DH in the HPE 2008 and HPE 2009. The method differs slightly from the HPE 2007 as it does not reduce the deaths figure to take account of those diseases for which smoking decreases the relative risk, specifically Parkinson’s disease and cancer of the uterus.

The values presented in Table B.2 represent the risk of a person who smokes or is an ex-smoker, dying from that disease (unless listed as a non-fatal disease, see below) compared to someone who has never smoked. That is, a value greater than 1 represents an increased risk of death. The risks are only applicable to people aged 35 and over and therefore only deaths of people aged 35 and over have been used in calculating the estimates.

Non-fatal diseases

The relative risks for non-fatal diseases (Crohn’s disease; Periodontal disease/Periodontitis; Age-related cataract; Hip fracture and Spontaneous abortion) are also presented in Table B.2 to estimate the numbers of smoking-attributable hospital admissions in England. These risks have been taken from diseases used by Hughes and Atkinson in the report Choosing Health in the South East: Smoking\(^4\) which was based on an update of a 1996 epidemiological study. These diseases have not since been reclassified by the DH review as fatal.
The risks for these non-fatal diseases are presented in the same way as those for fatal disease, however they are not gender-specific (with the exception of hip fracture among the 75+ age group) and so the same risks are used to calculate the attributable proportions for both men and women. In the case of spontaneous abortion, the risk is only given for current female smokers.

In order to be consistent with the methodology for fatal diseases, the risks for non-fatal conditions were only applied for hospital admissions of people aged 35 and over.

For fatal diseases, the risks of death were also applied to calculate smoking-related hospital admissions in England. There are some drawbacks to using mortality risks for health outcomes and these are discussed by Callum and White in *Tobacco in London: The Preventable burden*.

### 1.4 Deaths and admissions

The number of deaths for men and women in each of the specified age groups are taken from an annual extract of Office for National Statistics (ONS) mortality statistics by cause and by registrations (V53). The data used refer to the number of registered deaths in England.

Figures on hospital admissions are from Hospital Episode Statistics (HES) supplied by the Health and Social Care Information Centre (HSCIC). The data refer to hospital admissions of people who are resident in England for the specified period.

The tenth revision of the International Classification of Diseases (ICD) was used to identify hospital admissions and deaths from the diseases of interest. Tables B.2 list the ICD-10 codes used in Tables 3.1 to 3.4.

In January 2011 ONS introduced a new version of ICD-10 (version 2010) which replaced version 2001.2. This means that some figures for the number of deaths for 2011 onwards will not be directly comparable to figures for 2001 to 2010.

Further details are available from ONS:


### 1.5 Calculation of Smoking-Attributable Deaths and Admissions

For each of the diseases or groups of diseases shown in Tables B.2, the attributable proportion is calculated as follows:

$$ a = \frac{p_{cur}(r_{cur} - 1) + p_{ex}(r_{ex} - 1)}{1 + p_{cur}(r_{cur} - 1) + p_{ex}(r_{ex} - 1)} $$

where:

- $a$ = attributable proportion for each disease
- $p_{cur}$ = proportion of current smokers
- $p_{ex}$ = proportion of ex-smokers
- $r_{cur}$ = relative risk of current smokers
- $r_{ex}$ = relative risk of ex-smokers.
The equation is reduced where the risks are only given for ‘all smokers’ or ‘current smokers’ (as is the case for some non-fatal conditions).

The estimated number of smoking-attributable hospital admissions or deaths in England is found by multiplying the observed number by the attributable proportion.

2 Affordability of tobacco index

The Real Households’ Disposable Income (RHDI) index exclusively tracks changes in real disposable income per capita and is then carried forward to produce an adjusted affordability of tobacco index.

The tobacco price index as seen in Table 1.1 of this bulletin shows how much the average price of tobacco has changed compared with the base price (1980).

The Retail Prices Index (RPI) shows by how much the prices of all items have changed compared with the base price (1980).

The relative tobacco price index is calculated as follows:

\[ rtpi = \frac{tpi}{rpi} \times 100 \]

\( rtpi \) = relative tobacco price index
\( tpi \) = tobacco price index
\( rpi \) = retail prices index

This shows how the average price of tobacco has changed since the base (1980) compared with prices of all other items. A value greater than 100 shows that the price of tobacco has increased by more than inflation, during that period.

Adjusted real households’ disposable income is an index of total households’ income, minus payments of income tax and other taxes, social contributions and other current transfers, converted to real terms (i.e. after dividing by a general price index to remove the effect of inflation) which tracks, exclusively, changes in real disposable income per capita.

The adjusted real households’ disposable income index is calculated by dividing the real households’ disposable income index by total number of UK adults (aged 18 and over). The resulting series was rebased, so that 1980 equals 100 per cent.

Affordability of tobacco gives a measure of the relative affordability of tobacco, by comparing the relative changes in the price of tobacco, with changes in households’ disposable income per capita over the same period (with both allowing for inflation).

The Relative Affordability of tobacco is calculated as follows:

\[ rat = \frac{arhdi}{rtpi} \times 100 \]

\( rat \) = relative affordability of tobacco
\( arhdi \) = adjusted real households’ disposable income index
\( rtpi \) = relative tobacco price index

If the affordability index is above 100, then tobacco is relatively more affordable than in the base year, 1980.
3 **Availability of tobacco: Forestalling**

Forestalling is a tax avoidance practice, whereby excessive quantities of goods are removed for home-use on payment of duty because an increase in the rate of duty is expected. (HMRC 2014).

Receipts were high in December 1998 following the November Budget and associated forestalling. The next Budget took place in March 1999 but as stocks were still available from the November forestalling, no further forestalling took place. The next Budget took place in March 2000. Manufacturers forestalled against this affecting April receipts. There was therefore no forestalling in the financial year 1999/00.

**Notes**

1. Work by Callum and White in *Tobacco in London: The Preventable burden*², and further work done by Twigg, Moon and Walker in the report *The Smoking epidemic: Deaths in 1995*³ use a correction to the estimates for the smoking-attributable proportion of unspecified site cancer deaths to account for the fact that only a proportion of the unspecified site cancers will be smoking-related. Callum and White states that this correction is arbitrary and this has not been adopted by the Department of Health in the Health Profile for England and has not been adopted here to ensure that our results are easily reproducible. Therefore, the number of unspecified cancer deaths attributed to smoking in this report may be an overestimate.

2. The risk for spontaneous abortion is for those women who were current smokers during their pregnancy. Data on smoking during pregnancy is not available from the Opinions and Lifestyle Survey and so smoking prevalence in the general population was used to calculate the smoking-attributable proportion of admissions in England with this condition.

**References**


   [Link](http://www.lho.org.uk/viewResource.aspx?id=8716)

   [Link](http://www.nice.org.uk/niceMedia/documents/smoking_epidemic.pdf)

   [Link](www.sepho.org.uk/Download/Public/9593/1/SmokingInSE-Aug2005.pdf)
Appendix C: Government policy and targets

Introduction
Tobacco use remains one of the government’s most significant public health challenges, causing nearly 80,000 premature deaths in England each year.

Targets

The subsequent Tobacco Control Plan, Healthy lives, Healthy people: A Tobacco Control Plan for England\(^2\) was published on 9 March 2011. An academic review of the evidence of the impact of the smoke-free legislation in England\(^3\) was also published alongside this document.

This Tobacco Control Plan for England, set out how tobacco control was to be delivered in the context of the new public health system, and the plan set out three national ambitions to reduce smoking rates in England by the end of 2015:

- From 21.2 per cent to 18.5 per cent or less among adults aged 18 and over;
- From 15 per cent to 12 per cent or less among 15 year olds; and
- From 14 per cent to 11 per cent or less among pregnant mothers (measured at the time they give birth).

Each of these ambitions has been met and the Government has committed to a new tobacco control plan for England expected to be published in 2016.

Regulation
The Tobacco and Related Products Regulations 2016 came into force on 20 May 2016, implementing the rules set out in the revised Tobacco Products Directive (TPD), which was published in April 2014\(^4\), and cover tobacco and smokeless tobacco products, herbal products and for the first time regulate e-cigarettes. The Regulations establish new specific product standards and rules for the safety and quality of ingredients, presentation and advertising of consumer e-cigarettes and refill containers.

E-cigarettes that contain more than 20 mg/ml of nicotine and/or make medicinal claims, such as “This product helps you to quit smoking”, will be regulated under existing medicines legislation, for which the Medicines and Healthcare products Regulatory Agency (MHRA) is responsible. Such products would be considered medicinal and manufacturers must obtain a license from the MHRA before placing on the market.

Those e-cigarettes not captured by medicines regulation will be regulated as consumer products with additional safeguards. These requirements include six month prior notification of a range of information before e-cigarettes or refills are placed on the market; a size limit for e-liquids of 10ml for dedicated refill containers and 2ml for disposable e-cigarettes, cartridges and tanks; the inclusion of health warnings and an information leaflet; child and tamper resistant packaging; and restrictions on the advertisement or promotion of e-cigarettes and refill containers on a number of media platforms.

The Government has adopted regulations to require standardised (plain) packaging of tobacco products for cigarettes and hand rolling tobacco. These new packs will also feature larger
graphic warnings and will be sold in a minimum pack size for cigarettes at 20 sticks and for hand rolling tobacco at 30g weight.

New legislation came into force in England and Wales on 1 October 2015, introducing a minimum age of sale of 18 for e-cigarettes and prohibiting the purchase of these products and tobacco products on behalf of someone under the age of 18.

In addition, legislation to protect children from second-hand smoke by ending smoking in private vehicles carrying children also came into force on 1 October 2015.

**Local Stop Smoking Services**

Stop Smoking Services were first set up in 1999/2000 and rolled out across England from 2000/2001. Services provide free, tailored support to all smokers wishing to stop offering a combination of recommended stop smoking pharmacotherapies and behavioural support.

Following a change in the guidance in December 2005, Nicotine Replacement Therapy (NRT) was made available for the first time to adolescents over 12 years, pregnant or breast feeding women and patients with heart, liver and kidney disease. In September 2006, the European Commission approved Champix, generic name Varenicline, as a new pharmacotherapy to help adults quit smoking. The National Institute for Health and Clinical Excellence (NICE) issued guidance in, recommending the use of Champix as an aid to stopping smoking in the NHS\(^5\).

NICE has since published a range of guidance to support the commissioning and delivery of stop smoking services and this is available on their website [www.nice.org.uk](http://www.nice.org.uk).

The National Centre for Smoking Cessation and Training (NCSCT) was established by the Department of Health in 2008 to standardise training for those providing support for and delivering stop smoking services. The full range of training can be accessed at [www.ncsct.co.uk/pub_training.php](http://www.ncsct.co.uk/pub_training.php).

The service and delivery Guidance for local stop smoking services was updated in 2014 and is available on the NCSCT website – [www.ncsct.co.uk](http://www.ncsct.co.uk).

In addition the local stop smoking services return now includes the use of unlicensed nicotine containing products, such as e-cigarettes, and these have shown to be effective, in combination with behavioural support, in helping people to stop smoking.
References


Appendix D: How are the statistics used?

Users and uses of the report

From our engagement with customers, we know that there are many users of the Smoking in England statistics report. There are also many users of these statistics who we do not know about. We are continually aiming to improve our understanding of who our users are in order to enhance our knowledge on how they use our data. This is carried out via consultations and feedback forms available online.

Following last year’s publication, a consultation was implemented to gain feedback on how to make the report more user-friendly and accessible while also producing it in the most cost-effective way. The results of this consultation can be found at the below link.
http://www.hscic.gov.uk/article/6770/Consultation-on-Lifestyles-Compendia-Reports

Below is listed our current understanding of the known users and uses of these statistics. Also included are the methods we use to attempt to engage with the current unknown users.

Known Users and Uses

Department of Health (DH) - frequently use these statistics to inform policy and planning. The Public Health Outcomes Framework was published in January 2012 which sets out the desired outcomes for public health and how these will be measured. The Department of Health publishes policies such as Reducing Smoking (25 March 2013) and can be found via this link: https://www.gov.uk/government/policies/reducing-smoking

Public Health Observatories - frequently use these data for secondary analysis.

Media - these data are used to underpin articles in newspapers, journals, etc. For example, the following articles appeared in response to the 2015 version of this report:

- The Guardian – “Fewer adults dying because of smoking, figures for England suggest”

- Nursing Times – “Hospital admissions linked to smoking higher for men”
  http://www.nursingtimes.net/clinical-archive/public-health/hospital-admissions-linked-to-smoking-higher-for-men/5085403.fullarticle

Public - all information is accessible for general public use for any particular purpose.

Academia and Researchers - a number of academics cite the Smoking data in their research papers.

NHS - frequently use the reports and tables for analyses, benchmarking and to inform decision making.

Public Health Campaign Groups - data are used to inform policy and decision making and to examine trends and behaviours.

Ad-hoc requests – the statistics are used by the Health and Social care Information Centre (HSCIC) to answer Parliamentary Questions (PQs), Freedom of Information (FOI) request and ad-hoc queries. Ad-hoc requests are received from health professionals; research companies; public sector organisations; and members of the public, showing the statistics are widely used and not solely within the profession.
**Unknown Users**

This publication is free to access via the HSCIC website [http://www.hscic.gov.uk/lifestyles](http://www.hscic.gov.uk/lifestyles) and consequently the majority of users will access the report without being known to the HSCIC. Therefore, it is important to put mechanisms in place to try to understand how these additional users are using the statistics and also to gain feedback on how we can make these data more useful to them. On the webpage where the publication appears there is a link on the right-hand side to a feedback form which the HSCIC uses to capture feedback for all its reports. The specific questions asked on the form are:

- How useful did you find the content in this publication?
- How did you find out about this publication?
- What type of organisation do you work for?
- What did you use the report for?
- What information was the most useful?
- Were you happy with the data quality?
- To help us improve our publications, what changes would you like to see (for instance content or timing)?
- Would you like to take part in future consultations on our publications?

Any responses via this form are passed to the team responsible for the report to consider. We also capture information on the number of web hits the reports receive, although we are unable to capture who the users are from this. Statistics on Smoking 2015 generated approximately 4,899 unique web hits between 29 May 2015 when it was published and 9 May 2016.