States of Jersey

Tobacco Strategy 2017-2022

Creating a generation of non-smokers

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Title	Tobacco Strategy for Jersey: creating a generation of non-smokers
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Purpose of the Document	The purpose of this policy document is to provide a direction for preventing the uptake of smoking in young people, protecting families and communities from tobacco related harm and supporting smokers to quit in order to reduce the Island's smoking rate.
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Foreword

Smoking is now very much a minority activity in Jersey. This is thanks to many years of concerted strategic efforts from the States of Jersey alongside an increasing widespread awareness among our community of the harms to health. Previous Tobacco Strategy led to successes including: restriction on smoking in enclosed public work places; removal of sale of tobacco from vending machines; advertising, promotion and display restrictions; the introduction of the Stop Smoking Services in community pharmacies; peer based schools programs; the implementation of Smokefree Health and Social Services and the regulations restricting smoking in motor vehicles.

So, why are we still talking about tobacco? Simply put, smoking still kills. Despite our successes, we cannot say that the job of tobacco control is done when around 140 people in Jersey die prematurely every year from tobacco related disease and many more face the risks of smoking-related illness. Our aim is for the people of Jersey to live as well as possible for as long as possible. However, almost one in five adults still smoke. The personal costs to individuals and families from smoking related disease and death have a significant impact. In addition the current social costs of ill health through smoking are significant for the States of Jersey, both in terms of the cost of treatment and care, with 1000 hospital admissions every year estimated to be directly related to smoking, and also in terms of the economic consequences such as loss of productivity. Yet a huge part of the burden of ill health is avoidable through reduced smoking.

Survey data shows that smoking is becoming less popular amongst young people, although sadly some, albeit a minority, still choose to start smoking. We have a duty to our children to protect them from an addiction that takes hold of most smokers when they are young. To achieve our goals, we need to continue to reshape social norms around tobacco use so that choosing not to smoke is the normal thing to do no matter who you are or where you live. An important part of this is continuing to reduce the attractiveness of smoking, particularly to young children. We have therefore made children and young people the focus of this strategy by setting the long term aspiration of creating a smoke free generation.

The States of Jersey Strategic Plan (2015a) and the Island Vision consultation document (States of Jersey, 2016a), outline the need to focus on reducing the burden of ill health by focusing on prevention. Enabling healthier lifestyles has been identified as one of the priority areas for development in the Medium Term Financial Plan. We need to help people stay healthy rather than just treating illness so by focusing on prevention we acknowledge that our health is shaped by where and how we live: by our jobs, families and homes. The biggest beneficiaries of preventing smoking are individuals who are disadvantaged, marginalised or have mental health problems (Royal College of Physicians, 2016). Escalating efforts to prevent more smoking will serve to further improve our Islands health and make better health more equal across our community.

We continue to be committed to helping those who wish to stop smoking, particularly those who face specific challenges in quitting. The need to address health inequalities in our community underpins the

rationale for many of the actions within the strategy in recognition that smoking rates are much higher in some social groups, including those with the lowest incomes. These groups suffer the highest burden of smoking-related illness and death so tackling tobacco use is central to realising the States of Jersey's commitment to reduce health inequalities in our community.

The breadth of actions outlined within this document demonstrate that tobacco is not just an issue for Health and Social Services. Everyone has a role to play and our plan requires commitment across government departments. We know from experience elsewhere in the world that when governments become complacent and take the pressure off tobacco control measures, smoking prevalence rises. As Medical Officer for Health, I am proud to introduce our Tobacco Strategy. It builds on the achievements of the previous strategy and sets out what the States of Jersey will commit to in supporting efforts to reduce tobacco use over the next five years, on our way towards a new tobacco free generation.

Signed

Dr Susan Turnbull
Medical Officer of Health

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Executive Summary

Tobacco use has health and social consequences borne by individuals, their families and the wider community. This strategy sets out the direction and evidence based actions that will help us work towards a generation of children and young people who choose not to smoke. This approach will help to create a Jersey where families and communities are free from smoke and smoking and the harm that it causes.

Evidence shows that the younger an individual starts to smoke the more likely they are to be an adult smoker, the heavier they are likely to smoke in adulthood and the more likely they are to fall ill and die early as a result of smoking (Tobacco Advisory Group of Royal College of Physicians, 2010). Nearly all smokers start young so any meaningful reduction in smoking rates will only be achieved by preventing children and young people from taking up smoking. Every effort should be made to reduce the attractiveness of smoking and the accessibility of tobacco products to young people. If we are to create a smoke free generation, we need to shift social attitudes amongst young people and adults so that choosing not to smoke is increasingly the normal thing to do no matter what your social circumstances are.

Our planned approach will involve a range of interventions incorporating legislation where appropriate, education, harm reduction approaches and the development of specialist services to support smokers to quit, specifically those who face particular challenges in tackling this addiction. Extending smokefree environments and developing 'Smokefree' policies and voluntary codes will be a new focus within our strategy. We will also take account of the emerging evidence base around the use of e-cigarettes, also known as electronic nicotine delivery systems (ENDS), and where appropriate to introduce proportionate legislation and provide advice and guidance to the public and businesses.

The actions for the next five years have been developed by drawing on local health intelligence and the international evidence base for tobacco control and cessation regarding what works to reduce tobacco related harm. The themes that will guide our work are:

- Prevention: creating an environment where non-smoking is the norm
- Protection: protecting families and communities from tobacco related harm
- Cessation: provision of quality services to smokers who want to quit

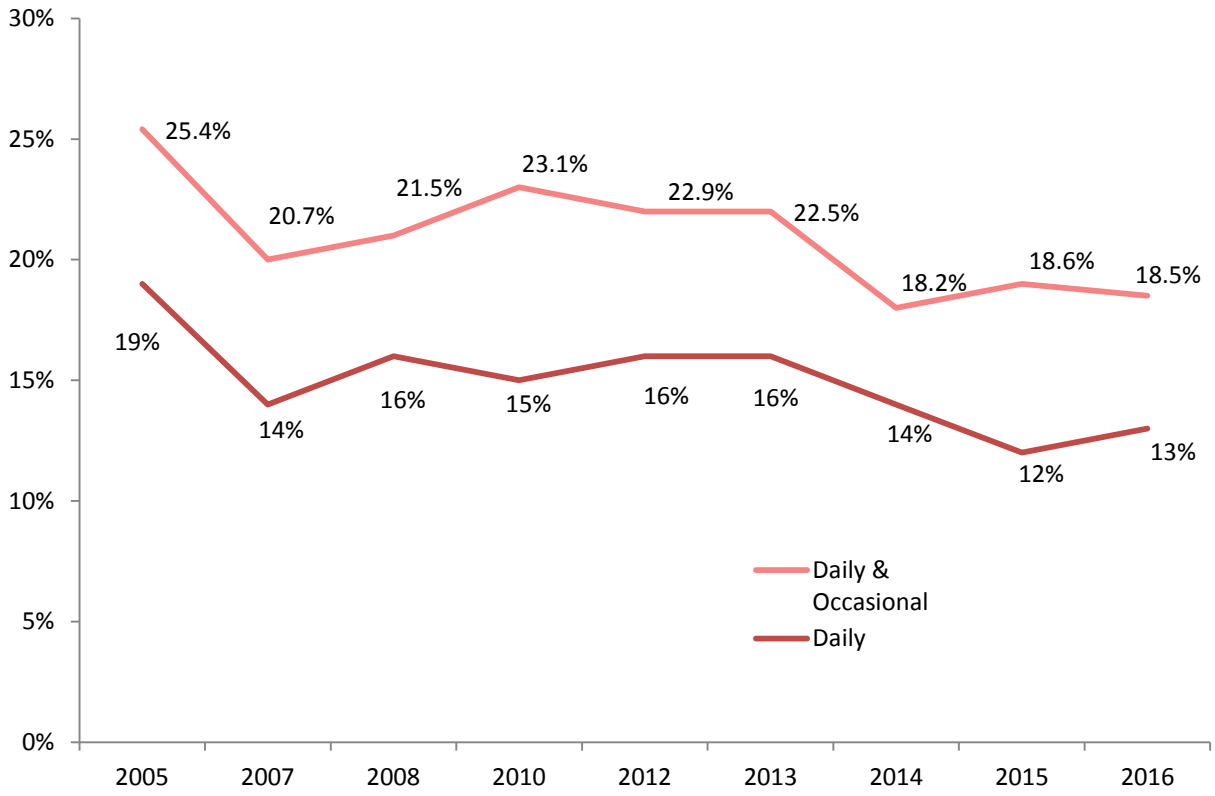
As an Island, we should continue to work hard to prevent the harm that tobacco causes in our community. Promoting non-smoking as the norm among adults and young people, together with supporting existing smokers to quit, will have long term health benefits for individuals, the health service and our Island community.

This programme of work will require the development of partnerships and commitment across States Departments in recognition that working towards a community free from tobacco related harms is a social issue as well as a health issue. Health is everyone's business. Everyone representing the States of Jersey must work together now to build even further on the successes of our previous Tobacco Strategies.

Introduction: Building on success

Action to reduce the smoking of tobacco in Jersey has been highlighted as a priority for reducing preventable deaths in the local population. Local data tell us that interventions from the previous strategy are having an effect. The adult smoking rate in 2015 was 19% compared to 25% a decade earlier in 2005 (Figure 1, States of Jersey 2016b). However, although the most recent rate is slightly less than in 2012 & 2013, the figure has remained largely unchanged in recent years, and so it is time to start increasing our efforts.

Figure 1. Prevalence of cigarette daily and occasional smoking among adults aged 16 and over in Jersey, 2005 and 2015 (States of Jersey 2016b)



Smoking remains the biggest cause of preventable illness and premature death on our Island with tobacco killing around half of its users. Smoking causes 1 in 5 of all deaths amongst those aged 35 or over, and lung cancer still accounts for a high proportion of working life lost. This amounts to around 140 individuals dying annually from smoking attributable causes in Jersey (States of Jersey, 2016c). Non-smokers are also at risk as exposure to second hand smoke contributes to a range of serious and fatal diseases.

In 2014, there were over 2,500 admissions to Jersey General Hospital for adults aged 35 and over with a primary diagnosis of a disease that can be caused by smoking. Around 1,000 admissions are estimated to be directly attributable to smoking. This is 4% of all hospital admissions in this age group (States of Jersey, 2016b).

Additionally, although the most recent survey of young people (States of Jersey, 2015b) tells us the overall trend in smoking continues to be downward, with fewer occasional and regular smokers, 7% of 14-15 year olds reported regular smoking with an average of 34 cigarettes smoked per week.

Building on the achievements of Jersey's previous Tobacco Strategy, a multi-disciplinary co-ordinating group has developed this new plan that will guide our priorities and work for the next five years. In this strategy we will see a shift in the decision making process to be inclusive of wider government policy. We have consulted with senior officers and Ministers across government departments to ensure that these priorities have broader support and engagement.

What will success look like in 2022?

- Even more young people will have never smoked at age 15.
- Even more children and young people will breathe air free from tobacco smoke.
- Adult smoking rates will continue to fall.
- People experiencing particular challenges in quitting will have easier access to effective stop smoking services.

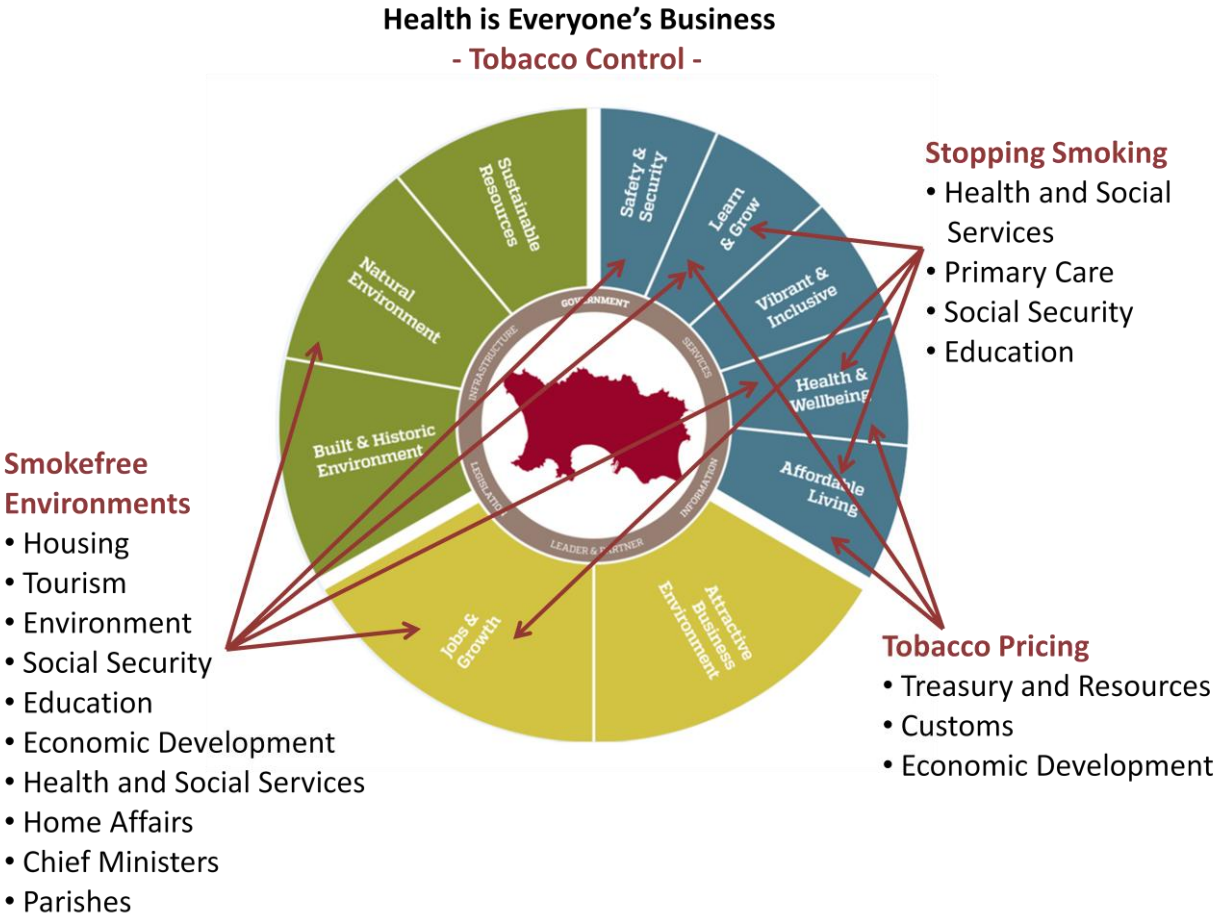
Guiding principles

Our actions will be guided by four overarching principles;

1. We are aiming to creating an island culture where future generations consider that it is normal to be a non-smoker.
2. There is a need to reduce health inequalities by using population level interventions and targeted interventions for groups with specific challenges to quit.
3. We will use international evidence around what works in tobacco control applied to the local context.
4. We will create new partnerships for action in recognition that joint working across departments and organisations will be more likely to achieve an overall reduction in smoking prevalence.

The States of Jersey Island Vision Framework (States of Jersey 2016a) is helpful in demonstrating the importance of bringing together interdependent government policies. Figure 2 gives a visual representation of how areas of tobacco control work across and support wider government policy priorities rather than being solely focused on health and wellbeing.

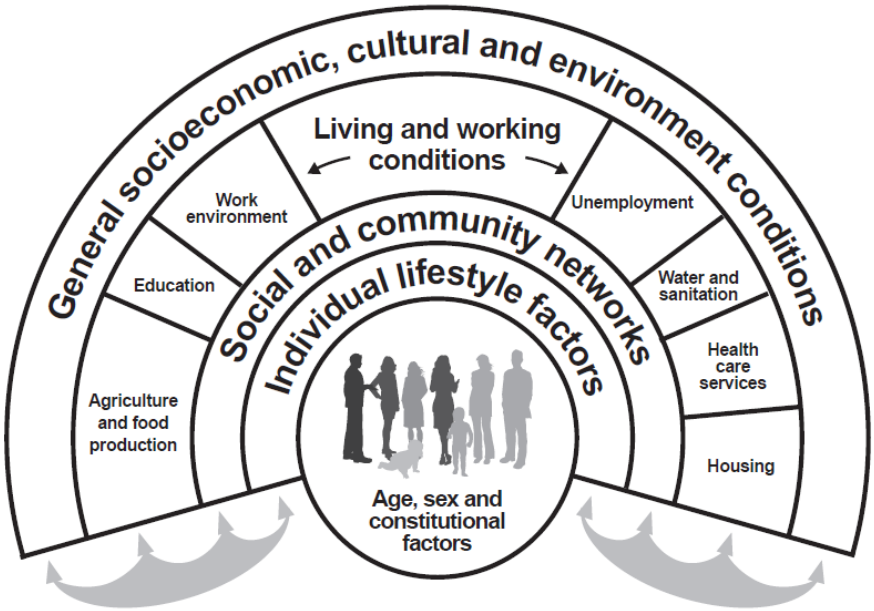
Figure 2: Cross departmental working for Tobacco Control (Island Vision 2016a)



A smoke free generation is a long term aspiration and will not be achieved within the five year lifetime of this strategy. However, the Island Vision (States of Jersey 2016a) and government wide approach to tobacco control will support us in reaching beyond 2021 in recognition that health and wellbeing, a priority in the current States of Jersey Strategic plan, is central to the future of our Islands prosperity. We know that tackling tobacco is key to achieving our aspirations for a healthier Jersey and is essential in delivering the legacy of longer healthier lives for all Islanders.

This cross government approach acknowledges that our health behaviours are shaped by the environment in which we are born, grow, live and work. Health, ill-health and health inequalities are the consequence of a wide range of factors that operate at a number of different levels, illustrated in Figure 3. Factors that influence our health include those that are fixed, such as age, sex and genetic makeup and a set of potentially modifiable factors expressed as a series of layers of influence including: personal lifestyle, the physical and social environment and wider socio-economic, cultural and environment conditions. The causes of health and health inequality are complex but they do not arise by chance. The social, economic and environment conditions in which we live strongly influence health. These conditions are known as the social determinants of health, and are largely influenced by public policy.

Figure 3: The Wider Determinants of Health (Dahlgren and Whitehead 1992)



Policy context

Tobacco control remains a global priority with tobacco being described by the World Health Organisation (WHO) as one of the biggest public health threats the world has ever faced (WHO, 2015a). The WHO Framework Convention on Tobacco Control (FCTC), (WHO, 2015b) is the first global public health treaty. It is an evidence-based treaty that was developed in response to the globalisation of the tobacco epidemic and aims to tackle some of the causes of that epidemic, including tobacco advertising, promotion, sponsorship and illicit trade in tobacco products. As a crown dependency, the Island of Jersey has recently been offered the opportunity to join the UK as a signatory to the Treaty. We are working with the Department of Health and our colleagues in Guernsey to explore this further.

Action:

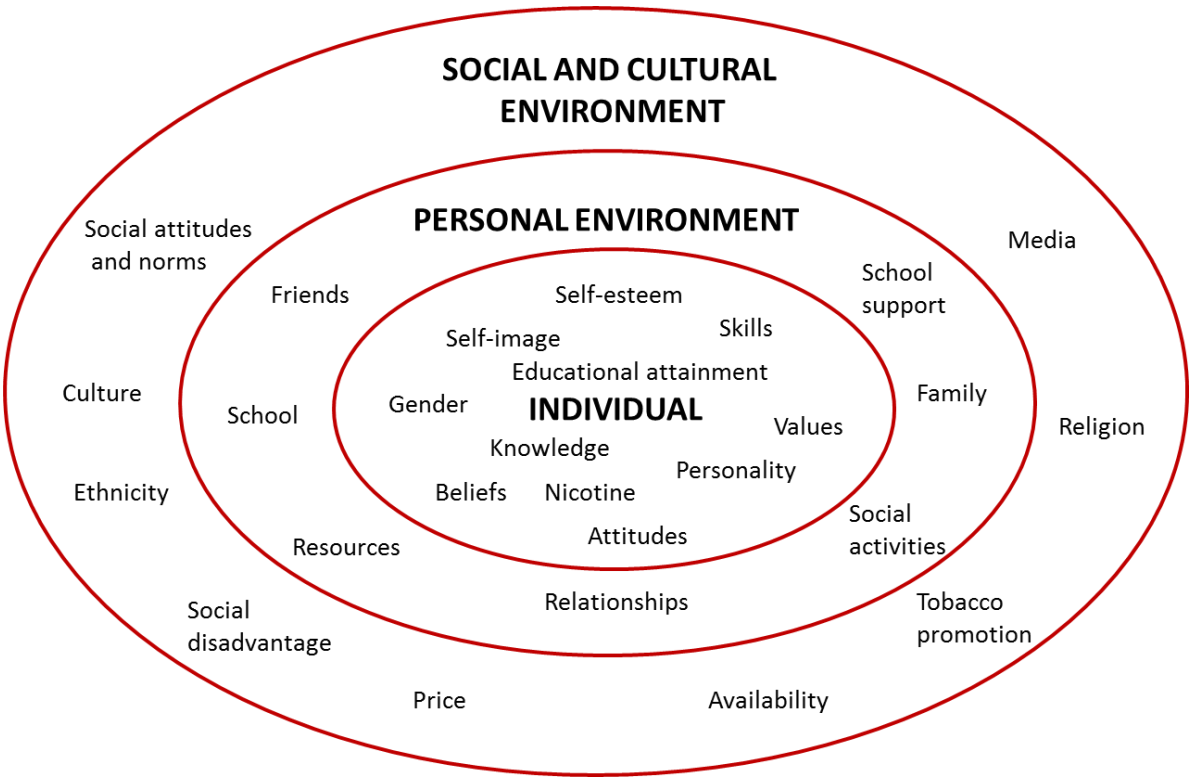
- Link with Department of Health and the States of Guernsey in seeking to join the UK as signatories to the FCTC.

The States of Jersey Tobacco Strategy has drawn on both the global and national evidence base around what works to reduce tobacco consumption together with local health intelligence to inform relevant action at a local level. Our priority areas for action are also consistent with the States of Jersey strategic priority to improve health and wellbeing with a focus on preventing disease and also the Health and Social Services Department (HSSD) Business Plan (States of Jersey, 2015b) to improve health outcomes by reducing the incidence of mortality, disease and injury in the population.

Theme 1. Prevention: creating an environment where young people do not want to smoke

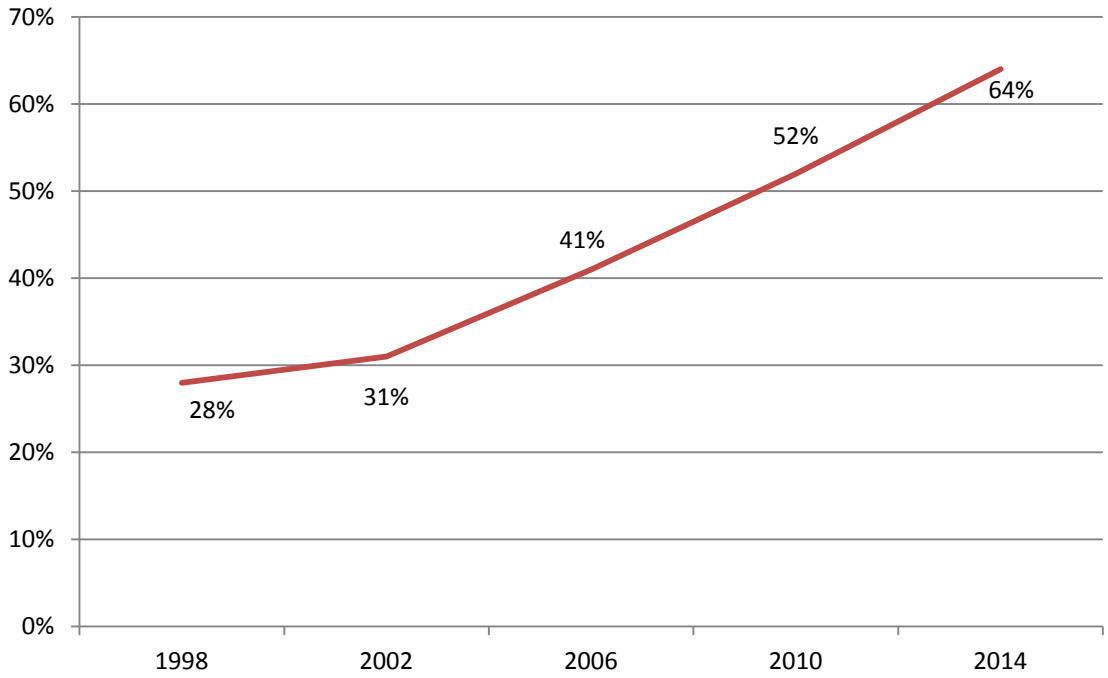
Almost 90% of regular smokers begin at or before the age of 20 (Ash, 2015a). If we are to be successful in preventing young people from becoming smokers, we need to understand why they start smoking in the first place and why they continue. Figure 4 provides a diagrammatic view of a range of factors thought to contribute to whether or not young people become and remain smokers (Public Health Research Consortium, 2009). It divides these factors into three domains: individuals and their knowledge, attitudes and state of mind; their immediate circle of family and friends; and the wider social and cultural environment in which they live. Effective smoking prevention must address all of these. The social and environmental interventions listed under themes 2 & 3 will also play a role in prevention. However, under this theme, we aim to address the prevention of smoking at an individual and personal environmental level in addition to investigating measures aimed at reducing the attractiveness of smoking to children.

Figure 4. Levels of influence associated with young people smoking (Public Health Research Consortium, 2009)



In Jersey, self-reporting of smoking has reduced considerably since 2000. Reducing the uptake of smoking is key to the success of reducing tobacco related harm at population level and we must continue to build on this success. Measuring 'never smoking' amongst 14-15 year olds will therefore be a key measure of this strategy in creating a generation of non-smokers.

Figure 5. Percentage of young people who have never smoked 1998-2014 (States of Jersey 2015b).



There is little value in trying to change the attitudes of young people about smoking without making changes in the adult population. Young people aspire to be more adult, and freedom is a key feature of being an adult. Messages about smoking targeted at youth through youth specific channels of communication will have minimal impact if the adult environment is one where smoking is viewed as an expression of personal freedom and choice. Therefore, our actions within this theme are focused on changing the social norms amongst adults whilst addressing the importance of youth engagement and voice. To enable us to do that, we are framing our evidence based interventions to be consistent with the FCTC (WHO, 2015b).

1.1. Engaging young people to develop the work of the strategy

If we are to create a generation of non-smokers, we need to involve young people in the development of policies, interventions and services designed to address tobacco use. Young people need to be given the opportunity to play an active role in tobacco control and policy makers and service providers need to listen to their views about what actions might be helpful to support young people not to smoke.

Action: Develop a youth forum in order to:

- Engage young people in policy and strategy decisions around smoking prevention, protection and cessation that will impact on them.
- Identify what matters to them when working towards a generation of non-smokers.

1.2. Introducing standardised packaging for tobacco products

It has long been recognised that marketing and promotion of tobacco products undermine public health messages about the dangers of smoking (ASH, 2015a). New smokers are nearly always children or young people. Now that tobacco advertising and sponsorship are prohibited, tobacco packaging has become one of the tobacco industry's only remaining promotional tools. An independent review (Chantler, 2014) considered evidence from both tobacco control experts and the tobacco industry and concluded that branded packaging plays an important role in encouraging young people to smoke and in consolidating the habit irrespective of the intentions of the industry. Branding drives teen smoking and awareness of packaging and new pack design is a key element on ongoing marketing (Moodie & Hastings, 2010).

A growing body of research suggests that standardised packaging (e.g. packaging that has had the 'attractive' promotional aspects of products removed) when compared to branded cigarettes is less attractive to young people who are more susceptible to branding imagery (Moodie et al, 2012). A systematic review concluded that standardised packaging has the potential to improve the effectiveness of health warnings, reduce false and misleading messages that one type of cigarette is less harmful than another and reduce the attractiveness of smoking to young people (Moodie et al, 2012).

Action:

- In partnership with Guernsey, introduce Regulations under the Restriction on Smoking (Jersey) Law 1973 that require tobacco companies to produce their products in standardised packaging without the attractive promotional aspects of the product.

Theme 2. Protection: protecting families and communities from tobacco related harm

2.1. Extending 'Smokefree' Environments

We want every child in Jersey to have the best start in life. Growing up in a smoke free environment is an important part of that. While previous legislation goes some way towards achieving this, other spaces such as homes remain significant sources of exposure to second-hand smoke, particularly for children as they have less control over their environment. In 2013 the Public Health Directorate conducted a public consultation on protecting children from second-hand smoke (States of Jersey, 2014b). The purpose of this Island wide consultation was to gauge public opinion and explore Islanders' views about protecting children from second-hand smoke in public places and homes. This comprised viewpoints about smoking in cars carrying children, in family homes where children are present and in outside spaces where children play.

The findings of this consultation suggested a readiness within our community to consider approaches towards extending 'Smokefree' environments where children are present. We responded by bringing in

legislation to restrict smoking in cars where children are present. The other most supported area for action amongst both smokers and non-smokers (82%) is to stop smoking in children's playgrounds. Smoking in family friendly places such as playgrounds creates the impression that it is a harmless activity and something normal that adults do.

Stopping smoking in playgrounds has benefits beyond those of denormalisation of smoking. It would reduce smoking related litter (boxes, cellophane, lighters, matches, paper or pouches that cost money to clean up) and the environmental threat of cigarette butts which are non-biodegradable. It could also potentially increase the use of parks and recreation areas.

The findings also told us that 83% of non-smokers and 61% of smokers under 18 years support encouraging families to create 'Smokefree' homes. The most recent survey of lifestyles in Jersey tells us that 12% of homes reported having somebody that regularly smokes within the home and 10% of homes with children living or being looked after have somebody that regularly smokes within the home (States of Jersey, 2016d). We know that 1 in 6 babies are living in homes where they are at risk from passive smoking (States of Jersey, 2016d) and some children are still exposed to smoke in the home (States of Jersey, 2016b) so we would like to encourage families to ensure that their children are protected.

Actions:

- Introduction of voluntary codes for 'Smokefree' playgrounds
- Protect children from second hand smoke in the home through partnership approaches that support families to keep their homes smoke free.
- Extend 'Smokefree' policies to all States of Jersey departments
- Explore partnership working with 'Visit Jersey' to support local businesses in developing voluntary codes for smoke free venues

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2.2. Regulations for controls on electronic nicotine delivery systems (ENDS)

ENDS are not cigarettes. They do not contain tobacco leaf and using them is not smoking. They do however, deliver nicotine but in a vapour rather than smoke. Evidence concerning the harms and benefits of ENDS is evolving but there is a concern that as well as potentially creating nicotine addiction in new users, they might lead to tobacco use and could cause problems in the enforcement of 'Smokefree' legislation. However, there is also some emerging evidence that, if products became properly regulated they could have a part to play as nicotine replacement products in helping existing smokers to quit and reduce rates of tobacco thus reducing harm in identified groups (Hartmann-Boyce et al, 2016). The challenge of governments is to find the appropriate balance between appropriate and proportionate regulatory approaches and harm reduction messages. At this time, in the absence of robust evidence and

regulation, our position is one of advising caution in the use of these products whilst continuing to monitor the emerging scientific evidence.

Currently ENDS are regulated as general consumer products but sales to under 18's in Jersey have been restricted since September 2016. ENDS are not regulated under our smoking legislation meaning they can be legally used in public places including restaurants and bars although in most cases they are generally restricted to outdoor use by policy. The current availability of thousands of unregulated products alongside the emerging evidence supports a need for enhanced regulation to ensure the safety and reliability of ENDS and in order to prevent their promotion to non-smokers or children.

Actions:

- Careful monitoring of the evolving evidence base to produce accurate information concerning potential harms/benefits arising from ENDS for the public.
- Make legislative recommendation for the introduction of appropriate and proportionate regulations to improve the safety, efficacy and quality of ENDS sold in Jersey.

2.3. Reduce the affordability of tobacco products

Smokers are no different to other consumers when spending money: price dominates decision-making. Consequently, increasing the price of tobacco through taxation remains the single most effective way of reducing smoking rates (Wilson et al, 2012). Economic models show that a 10% increase in price leads to a 4% drop in smoking prevalence across the population with higher quit rates among lower income smokers and younger smokers (Jha & Chaloupka, 2009).

Higher tobacco taxes reduce smoking and smoking-related disease and early death as people cut down, stop smoking, or never start because of the high cost. As effective tobacco taxes lead to lower smoking rates this contributes to the reduction of governments' expenditures for the health care costs associated with preventable illness caused by tobacco consumption. Increasing tobacco taxes is particularly important and effective for protecting young people from initiating or continuing tobacco consumption (WHO, 2015c).

However, if smokers respond to price rises by switching to cheaper products, the effect of the price rise is lost. This is most obvious when smokers switch from cigarettes to hand-rolled tobacco. Since rolling tobacco is less expensive than cigarettes, previous year on year percentage increases have opened up the cost differential between cigarettes and rolling and other forms of tobacco, resulting in many young people using 'cheap tobacco' (loose rolling tobacco) (ASH, 2015a).

The influence of tobacco price on numbers of cigarettes smoked and stopping smoking is also likely to be influenced by the accessibility of duty free tobacco on the Island. This differs from other jurisdictions where counterfeit tobacco can be more cheaply available.

We intend to take action that strikes a balance between making tobacco products more expensive whilst reducing the availability of duty free tobacco to deter people from starting to smoke, and to encourage adults and children to stop.

Actions

- Agree with the Treasury and Resources Department an appropriate minimum annual above inflation price/tax escalator over the next five years.
- Make rolling tobacco proportionately more expensive, reducing the differential by increasing the RPI by a greater degree than tobacco over the next five years.
- Investigate the costs and benefits of hypothecation of tobacco taxes to support a range of tobacco control programmes.
- Explore the costs and benefits of reducing the amount of duty free allowances both outbound and inbound at Jersey's borders.
- In partnership with States of Guernsey, investigate options for restricting the tobacco duty allowance between Channel Islands.

Theme 3. Cessation: provision of quality services to smokers who want to quit

Although much of the proposed work is focused on prevention and protection, we are also committed to providing accessible services for those who wish to stop smoking. Evidence shows that the introduction of increasing numbers of smokefree environments and the increase in prices of tobacco products as described in the previous sections will encourage more smokers to attempt to go smoke free. Supporting smokers to quit also has a direct influence in smoking uptake in young people by removing smoking role modelling and so contributes towards the vision of the future of a generation of non-smokers.

High quality evidenced based Stop Smoking Services include four core elements (National Centre for Smoking Cessation Treatment and Training and Public Health England, 2014):

- Pharmacotherapy
- Specialist behavioural support
- Targeting those that need most support
- Outcome measurement and audit monitoring

Stop Smoking Services play a central role in the long term effort to reduce smoking rates in the Island because they offer smokers the best chance of quitting. There is clear evidence that the combination of personal support and effective treatment offered by these services is the most effective and cost-effective way for smokers to successfully quit and remain smoke free (Bauld et al, 2010). Local community services will continue to offer behavioural support and pharmacotherapy and monitor success benchmarked against the UK Department of Health four week quit rates.

The Community Pharmacy Service assists those who wish to quit from a number of local pharmacies, however they do not have the capacity to offer a specialist service. Specialist services offer intensive behavioural support in addition to medication and advice. They have a particularly important role to play in tackling health inequalities by targeting disadvantaged groups (West et al, 2013). At a time of financial pressure, it is vital that these services are sustained and better targeted to reach disadvantaged groups.

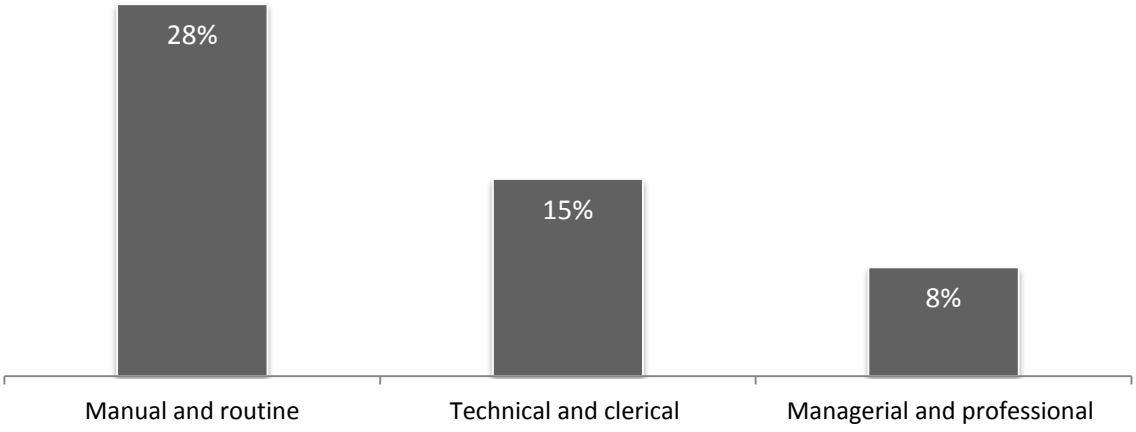
Action:

- Improve access to all evidence based first line treatments to maximise the opportunities to quit.

3.1. Developing the specialist service

People and families on low incomes: The more deprived you are, the more likely you are to smoke (Office for National Statistics, 2016). If you have a routine or manual job, you are more likely to smoke than someone with a professional or managerial occupation (Figure 6). If you live in rented housing, you are more likely to smoke than someone who owns their own home. If you receive States benefits you are more likely to smoke than someone who does not. The list goes on in terms of disadvantage and this translates into major inequalities in both illness and mortality. Smokers in lower socio economic groups are just as likely to try to quit as affluent smokers but are less likely to succeed.

Figure 6: Proportion of daily smoking in Jersey, by occupation, 2015 (States of Jersey, 2016b)



People with chronic physical health problems: The higher prevalence of smoking in poor and disadvantaged populations increases their risk of tobacco-related disease and is the key factor explaining the well recognised serious health inequality that exists between those on higher and lower incomes. Local data tells us that 37% of all deaths due to respiratory diseases and 31% of all cancer deaths, in Jersey, were attributable to smoking. In addition, an estimated 14% of deaths from circulatory diseases and 6% of deaths from diseases of the digestive system were attributable to smoking (States of Jersey, 2016b). All of these proportions are similar to those reported for England. However Jersey has significantly higher rates than England of smoking-related cancers (lung cancer and cancers of the head and neck), our legacy of much higher smoking rates in the past. In addition to the devastating health consequences, there are enormous economic costs, partly due to the costs of treating people with chronic diseases and also as a result of the loss of productivity from people dying prematurely.

Smoking in pregnancy: Reducing smoking in pregnancy is not always easy. Many women will quit as soon as they discover they are pregnant. For others, their understanding of the risk posed to their unborn baby may not be sufficient to motivate them to quit; or they may face significant barriers that prevent them from stopping. Specialist Stop Smoking Services should be more available and accessible to pregnant women and innovative ways of encouraging quitting in pregnancy are also needed (NCSCTT & Public Health, 2014).

People with mental health problems: Smoking prevalence is significantly higher in people with mental health problems than among the general population (ASH, 2015b). As a result of high smoking rates, people with a mental health disorder also have high mortality rates compared to the general population. People admitted to hospital with a mental health problem should have the same rights to a smoke free environment, treatment and advice as those admitted to hospital with a medical issue.

Prisoners: People whose control over their daily lives is highly constrained and who do not have the resources and opportunities to thrive are most likely to be smokers and least likely to successfully quit (ASH, 2015a). In 2015, four fifths of admissions to HM La Moye prison were recorded as being smokers (States of Jersey, 2016b). Prisoners who want to quit smoking should be supported to do so both during their time in prison and at the time of their release.

Actions

- When designing and targeting campaigns and interventions, specialist services will use the evidence base to prioritise marginalised groups of smokers and improve accessibility to specialist support.
- Specialist services will target approaches and interventions for groups with specific challenges to quit as described above.
- Develop data sets that measure the impact of smoking on disadvantaged groups.

3.2. Making every contact count

Although smoking cessation services lie at the heart of the effort to help smokers quit, many smokers never get anywhere near them. People use our Health and Social Services for reasons other than their smoking behaviour so opportunities ought to be taken wherever possible to engage with them. Many individuals are advised to stop smoking, but this may not lead to a change in behaviour. The evidence shows that offering assistance is more effective in encouraging individuals to make a quit attempt than only advising people to quit. Offering assistance to stop smoking should be provided to all smokers and not only those who express an interest in quitting.

However, there are other ways of reducing the harm from smoking which may involve continued use of nicotine. NICE (2013) recommends harm-reduction approaches which may or may not include temporary or long-term use of licensed nicotine-containing products and the WHO FCTC recognises 'harm reduction' as a key strategy in tobacco control. Harm reduction approaches can potentially support those who are highly dependent on nicotine, who may not be able (or do not want) to stop smoking in one step

Actions

- The specialist service will support staff within HSSD to fully implement the 'Smokefree' Health and Social Services policy.
- The specialist service will investigate different models for brief intervention training for health professionals.
- Harm reduction approaches will be utilised where appropriate to engage smokers.

Evaluation and monitoring

Success will not be achieved by any single measure. Many of the actions within the strategy will have long term impacts but short, medium and long term outcomes will be identified within the strategy to measure progress. In addition, we will seek to improve the availability of information to better support measures that show progress towards the health and wellbeing of children and young people.

We want to focus on achieving outcomes and ensuring that tobacco control is a priority across government. We will adopt the CLeaR model of evaluation recommended by Public Health England (2014) specifically for tobacco work across government. The CLeaR model includes reporting on three domains underpinned by local priorities:

- Challenge – ensuring our actions are based on evidence of the most effective components of comprehensive tobacco control.
- Leadership – have we got the appropriate cross governmental leadership to tackle tobacco.
- Results – a focus on outcomes.

Completing the process requires taking time out to review the work on tobacco control by key stakeholders carrying out a comprehensive self assessment process to identify successes and areas for further work. (Public Health England, 2014) (Appendix 1) The Strategy Steering Group will be responsible for ensuring a strong focus on delivering outcomes that are best linked to the States of Jersey Island Vision framework to support Islanders in living longer healthier lives.

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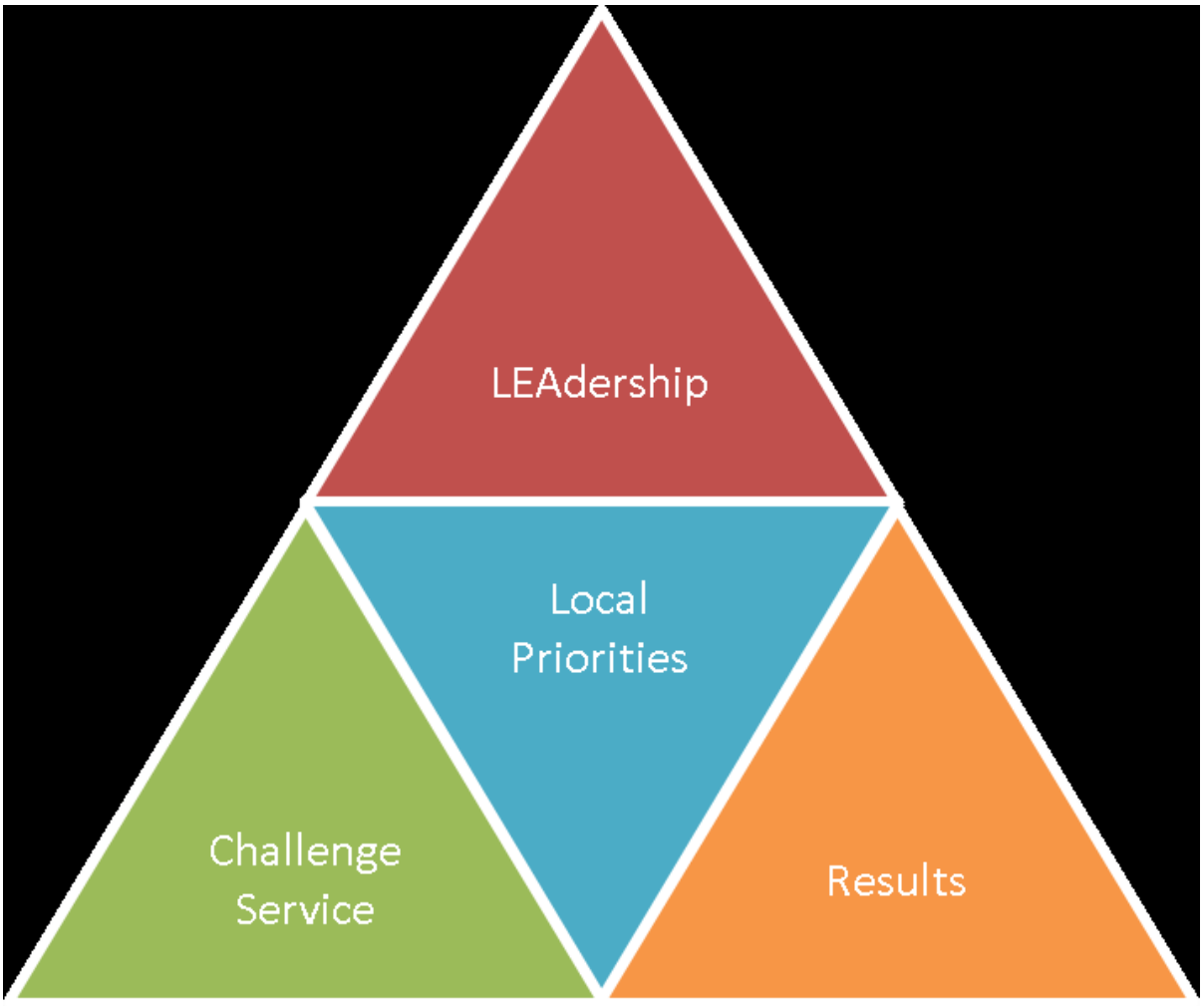
Appendix 1. CLeaR model of tobacco control



CLeaR stands for the three linked domains of the model:

Challenge for your existing tobacco control services – based on evidence of the most effective components of comprehensive tobacco control

Leadership for comprehensive action to tackle tobacco.

Results demonstrated by the outcomes you have delivered against national and local priorities.

These three domains are underpinned by the central core of **local priorities**, which encourages local partnerships to consider how the broader aims of central government complement and support the strategy to tackle tobacco.