Smoking is the biggest single preventable cause of disease and premature death in Glasgow. It is estimated that more than 2,200 Glaswegians die from smoking related illnesses every year.

Although significant progress has been made, smoking levels amongst adults in Glasgow are still significantly higher than the Scottish average. The negative impact of smoking is considerable and particularly felt in areas of social deprivation.

The updated strategy aims to address this serious public health challenge through a range of approaches. These include regulation of tobacco products, reducing availability of tobacco to young people, education and communications campaigns, reducing exposure to secondhand smoke and provision of stop-smoking services.

We must continue to develop and evaluate our approaches and services to make sure that we reduce the significant health inequalities linked to smoking and improve the health of the people of Glasgow.

Dr Linda de Caestecker
Director of Public Health,
NHS Greater Glasgow and Clyde

The Glasgow Tobacco Strategy has been updated to take account of a number of key changes that have taken place since the strategy was first published in 2005.

The strategy sets the direction for tobacco work in Glasgow for 2009 - 2014. It has been aligned to Glasgow’s Single Outcome Agreement and will be the city’s approach to trying to achieve the Scottish Government target to reduce the percentage of the adult population who smoke.

Glasgow Community Planning Partnership has endorsed the strategy. Structures will be identified and plans developed to coordinate work at a local level. Contributions from a range of key partners across sectors will be essential to achieve success. Local groups and individuals will have the opportunity to get involved and take action to achieve positive changes in Glasgow’s communities.

The ban on smoking in public places is welcome but it does not mean that the challenge has gone away. We must maintain our focus and our efforts on tackling tobacco. Too many Glaswegians are harmed by this product. This strategy is a statement of our collective resolve to create a healthier smoke free Glasgow.

Councillor James Coleman
Glasgow Community Planning Partnership

1 Health Scotland 2007
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SECTION 1: BACKGROUND

Introduction

1. The initial Glasgow Tobacco Strategy was published by the Glasgow Alliance in 2005 with the overarching aim of “Promoting the health of people living and working in the city of Glasgow by reducing the health impact of tobacco, particularly targeting those of greatest need.” It set out the direction for future tobacco work in Glasgow. However, since then a number of key changes have taken place, which means that many sections of the strategy require updating. This new document takes these into account.

The impact of tobacco in Glasgow

2. Significant progress has been made in addressing the health impact of smoking. However, the City of Glasgow still has the highest smoking rates amongst adults in Scotland with 34% of the adult population smoking compared to a national average of 25%. Health inequalities are clearly evident with smoking prevalence in the poorest communities substantially higher than this - Shettleston (40.1%), Springburn (39%), Maryhill (37.3%) and Baillieston (36.2%) (NHS Health Scotland 2007).

3. The negative impact of smoking is considerable and particularly felt in areas of social deprivation. Smoking in pregnancy causes harm to both the mother and the unborn child and is more prevalent in the more deprived areas of Glasgow. Other population groups of particular concern include minority ethnic groups, those with mental health problems and young people, in particular young girls.

4. Secondhand smoke poses a risk of harm to health for children in particular.

5. Smoking imposes large costs both to individuals and the economy.

Progress in Glasgow

6. Although still high, there has been a steady decline in smoking prevalence rates since the 1970s. This is due to a continued programme of tobacco work comprising of effective stop smoking services, programmes of health education and promotion to reduce uptake of smoking, initiatives to reduce exposure to secondhand smoke and work to reduce the availability of tobacco products to young people.

National and local policy and organisational context

7. Recent changes in relation to policy and structure affecting the delivery of tobacco programmes in Glasgow include the following:

- It is now illegal to smoke in virtually all enclosed public places and workplaces and to sell tobacco products to those less than 18 years of age.

- The Government has recently produced a new national Smoking Prevention Action Plan providing direction for tobacco work in Scotland for the next 5 years.

- Structurally, Community Planning Partnerships and Community Health Care Partnerships have been created to direct planning and services at a local level and Glasgow City Council Services have undergone restructuring.

- The strategy required updating to take into account recent equality and diversity legislation.

Evidence based approaches

8. The evidence base for preventing harm from tobacco use identifies that a combination of key activities is most effective. These include protection and control measures, prevention and education, provision of stop smoking services and reducing exposure to secondhand smoke, alongside broader measures to address poverty.
Development of the updated Glasgow Tobacco Strategy

9. The updated Glasgow Tobacco Strategy has been developed through a review of the original documents and an assessment of evidence and strategies published since 2005. The objectives from the original strategy remain largely the same but have been revised and framed alongside new objectives, grouped under outcomes.

10. The Tobacco Strategy is regarded as a long-term strategy and sets the direction for tobacco work in Glasgow for 2009 - 2014.

Contribution to the Community Plan and Single Outcome Agreement

11. Implementation of Glasgow’s Tobacco Strategy is crucial for achieving the aims of a number of Glasgow’s plans and strategic documents including the Community Plan and the Single Outcome Agreement. The Tobacco Strategy has been aligned to Glasgow’s Single Outcome Agreement and will be the city’s approach to trying to achieve the Scottish Government target to reduce the percentage of the adult population who smoke to 22% by 2010. In addition, within the SOA specific tobacco targets for Glasgow have been set for 2009 - 2014.

Core principles of the Glasgow Tobacco Strategy

12. The updated strategy adopts the following principles:

- Tackling health inequalities is key to reducing smoking prevalence.
- Resources should be targeted at the most disadvantaged areas and groups.
- The needs of different populations should be taken into consideration.
- Locally relevant activity should be developed through effective community engagement.
- Tobacco control activities should be anti-smoking not anti-smoker.
- Non-smoking should be promoted as the social norm.
- All non-smokers have the right to not be involuntarily exposed to secondhand smoke.
- Children have the right to be free from any form of tobacco advertising and promotion.
- The tobacco industry should be challenged and its tactics exposed.
- All smokers should have the right to receive stop smoking advice and support through the NHS, with strategic planning areas tailoring the agreed service model to meet the needs of their diverse populations including minority ethnic communities, those with mental health problems and other key priority groups.

Vision of the strategy

13. The Glasgow Tobacco Strategy will result in long term, concerted and co-ordinated partnership action on tobacco in Glasgow, leading to an eventual reduction in smoking prevalence and exposure to secondhand smoke in the city, overall improvement in the health and well being of Glaswegians, a reduction in health inequalities, and improved economic and environmental status.
Aim and objectives of the strategy

14. The Glasgow Tobacco Strategy aims to promote the health of people living and working in the city of Glasgow by reducing the health impact of tobacco, particularly targeting areas and populations of greatest need.

15. To support the achievement of the aim the strategy has the following objectives.
   - Smoking prevention: reduce initiation and uptake of smoking in young people.
   - Stop smoking services: reduce rates and frequency of active smoking in adults and young people.
   - Health protection: reducing exposure to secondhand smoke (SHS) and the wider harm associated with smoking.

16. In line with the Council’s Single Outcome Agreement, the targets of the Glasgow Tobacco Strategy are to:
   - reduce prevalence of smoking in Glasgow in adults from 39% (2005)* to 32% (2011) and to 28% by 2014.
   - reduce prevalence of smoking in deprived communities from 47% (2005)* to 38% (2011) and to 34% by 2014.
   - reduce prevalence of smoking in the 16 - 24 age group from 39% (2005)* to 31% (2011) and to 28% in 2014.

* Figures from the local Health and Wellbeing Survey 2008

The tobacco strategy will also help to achieve the following national targets:
   - To reduce level of smoking in the adult population to 22% by 2010.
   - To reduce level of smoking in pregnancy from 29% to 20% by 2010.
   - To reduce the level of smoking amongst:
     - 13 year old girls from 5% in 2006 to 3% in 2014.
     - 13 year old boys from 3% in 2006 to 2% in 2014.
     - 15 year old girls from 18% in 2006 to 14% in 2014.
     - 15 year old boys from 12% in 2006 to 9% in 2014.
     - 16 - 24 year olds from 26.5% in 2006 to 22.8% in 2014.
   - NHS Boards to provide targeted services to support 8% of the smoking population to quit successfully at 4 weeks by the end of 2011.

Implementing the strategy

17. Glasgow City Council, NHS Greater Glasgow and Clyde, and the Glasgow Community Planning Partnership support this strategy, creating a positive environment in Glasgow that will enable action on tobacco to be taken forward at both a citywide and local level. Contributions from a range of key partners across sectors will be essential to achieve coordination and success.

Planning and reporting structures

18. Reports on progress against actions in the strategy will be made to the Glasgow City Council Joint Health Improvement Officer Group (JHIOG) and the NHS Greater Glasgow & Clyde Tobacco Planning and Implementation Group (PIG).

19. In addition, local structures will be developed or identified to coordinate tobacco work within each Strategic Planning Area. These structures will be the primary mechanism by which community engagement on specific actions on tobacco is carried out. Involving communities in decisions that affect them ensures that diversity of their needs is considered. Local structures may wish to link to local Community Reference Groups and Public Partnership Forums. It is important that these groups reflect diversity within their local population, ensuring that appropriate tobacco plans are developed.
Monitoring and evaluation

20. It is essential that the impact of the strategy is assessed. Evaluation will be used to inform future planning and resource allocation. This will require coordination and communication between the different structures involved in delivering the actions associated with the strategy.

21. A report compiled from information from all partners delivering actions in the plans (section 4) will be delivered to the JHIQG on a six-monthly basis. These six-monthly reports will then be submitted to the Tobacco PIG and to Community Planning at a citywide level.

22. Strategic Planning Areas will be encouraged and supported to produce local tobacco action plans linked to the Glasgow Tobacco Strategy (either a stand-alone document or incorporated into existing plans) and will report on activity on a six monthly basis, as indicated above. Outcome data in relation to the targets and indicators listed above will be collated and presented where possible, on an annual basis. Local plans should incorporate Equality and Diversity issues to ensure that plans address diverse needs of the local population.

Resources

23. Implementation and evaluation of the strategic plans will require funding, both for actions that relate directly to an organisation’s own remit and workplaces as well as actions requiring partnership with others. The level of funding required will depend on the range and timescales of the agreed actions within and across agencies.

24. The Scottish Government has allocated additional funding to NHS Boards from 2008/09 to 2010/11 to enable local coordination of action to deliver the measures outlined in the National Smoking Prevention Action Plan, and contained within the action plans of the Glasgow Tobacco Strategy.

Workforce development

25. Resources will also need to be identified for workforce development to support NHS and other staff to focus on tackling inequalities, to adopt evidence-based approaches and to work in a coordinated and sustained way across agencies.
SECTION 1: BACKGROUND

1.1 Introduction

The original Glasgow Tobacco Strategy was published by the Glasgow Alliance in January 2005. The overarching aim was to:

"Promote the health of people living and working in the city of Glasgow by reducing the health impact of tobacco, particularly targeting areas of greatest need."

The document was the result of a comprehensive consultation process (see Appendix One), which began in 2000, and was intended to set out the direction for tobacco work in Glasgow for a 5-10 year period. Since 2005, a number of key changes have taken place, to both policy and structures, with the result that many sections of the strategy are now out of date. This update to the strategy takes account of these key changes.

The level of tobacco use within the City of Glasgow continues to be a serious concern. The City of Glasgow has the highest smoking rates amongst adults (34%) in the country (Health Scotland 2007). Tobacco remains the number one cause of preventable death and ill health in the city and is the major contributor to inequalities in health. Focussing on health inequalities, this tobacco strategy outlines how tobacco affects the health of the population of Glasgow, reviews relevant developments at a local and national level, and describes the work that we need to undertake to ensure that "Glasgow’s future is smoke-free".

The reasons for smoking are many and varied; however, there is a clear association between smoking and deprivation, with a two fold difference in smoking between our most affluent and most deprived areas (Health Scotland 2007). The correlation between managing difficult life circumstances and smoking is further confirmed by the high smoking rates exhibited by people with mental health problems, prisoners, homeless people and young women.

Research shows that no single approach to tackling smoking will be successful. Instead, we need a comprehensive approach focusing on a combination of tactics including prevention, stop smoking support, legislation and protection, targeted to meet areas and population groups with greatest need. This has long been recognised as most likely to have the greatest long-term, population impact.

Tobacco companies employ significant resources and wide ranging tactics to encourage people to take up smoking and they have been very effective. We must adopt similar approaches if we are to truly reduce the impact of tobacco on the health of the people of Glasgow.

There is commitment from a range of organisations and agencies across Glasgow to work together to reduce the impact of tobacco on the city. This strategy proposes to build on the significant progress we have already made in Glasgow on tobacco.

This updated version of the strategy includes action plans for the first time - identifying action to be taken, by when and by whom with links to national priorities and activities. In line with best practice and national policy as identified below, it involves action in the areas of prevention, stop smoking support and legislation.

The plans set out in this strategy are ambitious and comprehensive and will require action from a range of organisations and agencies working in partnership. By creating a supportive environment, we can work together to tackle the issue of tobacco and make a major contribution to improving the health of people in Glasgow, particularly of those in greatest need. Glasgow’s future can be smoke-free.

1.2 The impact of smoking in Glasgow

1.2.1 Health impact of smoking

Smoking is the biggest single preventable cause of disease and premature death in Scotland, killing half of its long-term users. There are about 1.1 million adult people in Scotland who smoke (27% of the population). Between 1950 and 2000, 374,000 Scots aged 35-69 died prematurely from smoking-attributable causes - 34% of all deaths in this age group (44% of male and 19% of female deaths) and smoking still results in over 13,000 deaths per year in Scotland (Peto et al, 2007).

Nationally, it is estimated that around 17% of all deaths from heart disease, almost 90% of deaths from lung cancer and around 80% of deaths from obstructive lung disease are attributable to smoking (ASH, 2007). Tobacco use is also the key risk factor in oral cancer, the incidence rate of which is increasing in Scotland.
Smokers are at increased risk of developing a range of illnesses, from angina and cataract to depression and pneumonia. There is also evidence that smoking lowers fertility and reduces the immune system’s capacity to fight disease. Symptoms of ill-health such as asthma are more common and the impact of diseases is more severe among smokers (ScotPHO 2008). Many medical conditions associated with smoking, while they may not be fatal, may cause years of debilitating illness or other problems.

In comparison to national figures, smoking levels amongst adults in Glasgow are significantly higher than the average with 34% of the adult population identified as smokers (approximately 160,000 smokers) (Health Scotland, 2007). These figures are higher than for any other council area.

The Health and Wellbeing study (2005) in Glasgow showed levels higher than this at 39%. These figures are thought to be more accurate that those quoted above, as the sample size for Glasgow is much greater. Therefore the Health and Wellbeing Study figures have been used to set the local target associated with the Single Outcome Agreement, even though nationally the figures used are those from the Scottish Household Survey quoted above. On a positive note, there has been a decline in smoking prevalence since the Health and Wellbeing study in 2005 with prevalence amongst adults in 2008 at 35%.

Not surprisingly, therefore, NHS Greater Glasgow and Clyde also has the highest number and proportion of deaths from smoking in all age/sex groups. Over a five year period (2000 - 2004) it is estimated that there were more than 20,000 deaths attributed to smoking in Greater Glasgow and Clyde, equating to 29% of deaths at all ages (Health Scotland, 2007). The total annual inpatient costs to the NHS in Greater Glasgow of illnesses due to smoking are estimated as being £14.44 million.

1.2.2 Smoking and social deprivation
Social deprivation and health inequalities are the result of many interrelated factors. However, smoking has increasingly come to be linked with poverty. Although the overall prevalence of smoking has decreased markedly, little change has occurred among those living in low income. In the most deprived groups smoking prevalence can be very high, reaching 90% among the homeless (Coleman 2004).

This disparity in smoking prevalence between the most and least advantaged members of our communities is the single most important factor contributing to the gap in “healthy life expectancy” between these groups. Death rates are now two to three times higher in disadvantaged social groups than the more affluent, and poorer people can also expect to experience more illness and disability problems.

Graph One shows the incidence of lung cancer (90% of which is caused by smoking) against quintiles with quintile one being the most deprived section of the population and quintile 5 being the least deprived. The relationship between lung cancer incidence and deprivation is clearly visible.
Half the difference in survival to 70 years of age between professional classes and unskilled classes can be attributed to higher rates of smoking in the unskilled groups (Wanless 2003). Smoking also accounts for an estimated 30% of life years lost due to cancer (ScotPHO 2008).

Glasgow City contains the top five constituencies for worst smoking prevalence in the country - Shettleston (40.1%), Springburn (39%), Maryhill (37.3%), Baillieston (36.2%) and Pollok (33.6%). Within small areas (intermediate zones) in CHCPs there is two-threefold variation in smoking levels e.g. within North Glasgow there is 50% smoking prevalence in Roystonhill, Blochairn and Provanmill compared to 16% in Kelvindale (Health Scotland 2007). Not surprisingly, these communities are also the most deprived. Graph two shows smoking prevalence across CHCPs in Glasgow and that smoking prevalence is highest in the two most deprived localities - East and North CHCP.

1.2.3 Smoking in pregnancy
Smoking in pregnancy is harmful to the mother and to the unborn child. Smoking is the single, largest preventable cause of disease and death to the foetus and infants and accounts for a third of perinatal deaths (Health Scotland 2004). Smoking in pregnancy also increases the risk of diseases such as diabetes in later life and is being linked with behavioural and cognitive problems in childhood. Despite this, a significant number of women smoke during pregnancy.

Smoking in pregnancy is closely associated with disadvantage, with women in more deprived areas more likely to smoke than those in more affluent areas. Nationally, at the antenatal ‘booking’ visit in 2005, 6.3% of women living in the least deprived quintile smoked compared with 35.8% of those in the most deprived quintile. These figures may underestimate smoking in pregnancy, since smoking status of the mother was missing in around 1 in 20 cases in 2005 (ScotPHO 2008).

Smoking in pregnancy is more common in Glasgow than in some other areas of the country reflecting the challenges that Glasgow faces in terms of inequalities and poor health. For example, two deprived areas of the city - Ruchazie and Haghill - have smoking rates in pregnancy at 38% and 46% respectively (Bauld et al 2007). This is despite the Government target to reduce smoking in pregnancy from 29% nationally to 20% by 2010. The report by Bauld and colleagues highlights the persistent and complex relationship between disadvantage, smoking and pregnancy.

1.2.4 Smoking in minority ethnic communities
The largest single ethnic group in Glasgow are people from Pakistani (and other South Asian) backgrounds, followed by Indian and Chinese. With the arrival of over 10,000 asylum seekers and refugees Glasgow has become a diverse multicultural society.

Whilst there is no statistically reliable nationwide surveys of the prevalence of smoking among minority ethnic communities in Scotland, local research as well as information from elsewhere has provided information on tobacco use, stopping smoking and health knowledge among some minority ethnic groups.

In Glasgow as elsewhere, smoking levels are generally highest within Bangladeshi and Pakistani communities, particularly amongst men. The results from the Health and Wellbeing study (2005) below indicate a smoking prevalence of 22% in Pakistani people.
However other studies suggest much higher prevalence levels within this and the Bangladeshi population (White et al. 2009). Smoking is seen as socially acceptable among Pakistani and Bangladeshi men, but is associated with a sense of cultural taboo amongst women from these communities.

South Asians appears to be at greater risk of developing coronary heart disease and some cancers than white people and have higher rates of stroke, hypertension and diabetes. Knowledge of the links between smoking and disease however are often poor, in particular in relation to the health effects of chewing tobacco, commonly used within the South Asian Communities (Balarajan and Raleigh 1993).

A study in Glasgow in 2000 by Ashghar and Hampton found that minority ethnic communities were less likely to successfully quit smoking because of lack of awareness of stop smoking methods, including NRT, and services, lack of suitable literature and information and cultural and language issues that act as a barrier to accessing effective services.

The more recent study by White and colleagues in 2006 highlighted similar barriers, emphasising that Bangladeshi and Pakistani smokers had low levels of awareness of, and contact with formal stop smoking services and little acceptance of their value. This study also found that Islam in general, and particularly the holy month of Ramadan were important incentives to quit but because most smokers use willpower alone to quit, few quit attempts were successful.

There is a need for significantly more research in this area to allow better understanding of smoking prevalence and behaviour in all minority ethnic communities in Glasgow and the role of culture and religion in their smoking. Greater understanding would then allow the development of more effective tobacco control programmes and stop smoking interventions for these communities.

1.2.5 Smoking and disability

Smoking and mental health - A review of smoking and mental health was undertaken by McNeill at al in 2007 for Health Scotland and some of the key findings are noted below:

- Smoking is more prevalent among people with mental health problems that in the general population. This relationship is apparent among people with mental health problems living in the community but is more marked among people living in mental health settings. Smokers with mental health problems are also more likely to smoke more heavily with the heaviness of their smoking related to the severity of their illness. There is also considerable evidence to show high rates of smoking among health professionals who work in mental health settings.
- Surveys have revealed that people with all categories of mental health problems have higher levels of smoking. However, much higher rates of smoking have been observed among those living in mental health institutions with nearly three quarters reporting smoking.
- People having a mental health problem often are stigmatized because of a lack of understanding of their illness and are therefore frequently marginalized in society. It is important to tackle their high levels of smoking as this will exacerbate this stigma particularly as smoking rates continue to decline in Scotland.
- Many smokers with mental health problems want to stop smoking. However, there is some evidence that smokers with mental health problems are not being routinely, or even frequently, advised to stop.
- Studies have shown that stop smoking services treatments used with the general population of smokers can be used successfully with those having a diagnosis of depression, although tailoring to the illness may be needed. There is little evidence that symptoms of psychiatric illness worsen on stopping smoking, but it is recommended smokers with mental health problems are monitored more closely than usual when making quit attempts.

<table>
<thead>
<tr>
<th>Current smokers (smoke on at least some days)</th>
<th>Sample size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pakistani</td>
<td>22%</td>
</tr>
<tr>
<td>Indian</td>
<td>10%</td>
</tr>
<tr>
<td>African &amp; Caribbean</td>
<td>10%</td>
</tr>
</tbody>
</table>

Table One

NHSGG health & wellbeing of people from Pakistani, Indian and African & Caribbean backgrounds in Greater Glasgow, 2005

Adults aged 16 plus
**Smoking, physical disability and sensory impairment** -
There is very limited research on smoking in relation to physical disability and sensory impairment, with most studies amalgamating data relating to physical, sensory and learning disabilities. US research has indicated higher levels of smoking in people with disability but also notes a lack of studies in this area and also lack of knowledge in relation to stop smoking advice provided by health professionals (Armour et al 2004).

Clearly there are a range of potential barriers that can inhibit participation in stop smoking services - transportation difficulties are a major problem for many individuals with disabilities and may impede participation, whilst sensory limitations may hinder access to written information or to telephone helplines. To be effective stop smoking interventions should be tailored to the disabling condition of the different targets groups.

**Smoking and learning disabilities** - Most people with learning disabilities do not smoke (estimated 10.2% of people with learning disabilities in NHS GGC smoke). Nonetheless some people with learning disabilities do smoke particularly those living with the least support. Studies have highlighted unmet health needs in people with learning disabilities in relation to a range of issues including stop smoking support, an issue that needs to be addressed. In addition, tackling some of the wider determinants of health will also contribute to improvements in health within this population (NHS Health Scotland 2004).

### Glasgow City schools health & wellbeing survey, 2007 to 2008

#### Smoking prevalence: S1 to S4 pupils

<table>
<thead>
<tr>
<th>CHCP</th>
<th>Current Smokers</th>
<th>Tried Once or Twice</th>
<th>Never Tried Smoking</th>
<th>Used to Smoke</th>
<th>Total Sample Size</th>
</tr>
</thead>
<tbody>
<tr>
<td>East CHCP</td>
<td>9%</td>
<td>23%</td>
<td>62%</td>
<td>6%</td>
<td>2309</td>
</tr>
<tr>
<td>North CHCP</td>
<td>9%</td>
<td>23%</td>
<td>62%</td>
<td>6%</td>
<td>1692</td>
</tr>
<tr>
<td>West CHCP</td>
<td>10%</td>
<td>22%</td>
<td>61%</td>
<td>7%</td>
<td>2013</td>
</tr>
<tr>
<td>South East CHCP</td>
<td>10%</td>
<td>25%</td>
<td>58%</td>
<td>7%</td>
<td>1475</td>
</tr>
<tr>
<td>South West CHCP</td>
<td>10%</td>
<td>22%</td>
<td>60%</td>
<td>8%</td>
<td>1757</td>
</tr>
<tr>
<td>Glasgow City</td>
<td>10%</td>
<td>21%</td>
<td>63%</td>
<td>7%</td>
<td>9246</td>
</tr>
</tbody>
</table>

Table Two
Recent research has identified high levels of smoking within the 16 - 24 year age group (ScotPHO 2008). In 2006, an estimated 166,000 young adults (aged 16-24) in Scotland smoked regularly. Reducing this figure is now a priority and in the Smoking Prevention Action Plan, the government set a target to reduce smoking rates among those aged 16-24 to 22.9% by 2012 (from 30% in 2007). Meeting this target will require a clearer understanding of which young people smoke, how they spend the major part of their time and where they can be found, so that effective strategies can be developed and appropriately targeted.

Youth smokers are aware of the health risks of smoking and most would like to stop, but their attitudes towards their habit are more changeable than those of adult smokers.

**Older smokers** - Older people are less likely to smoke than younger people, but around a quarter of the 65-74 age group smokes regularly (Scottish Executive 2002).

Smoking later in life has been associated with a range of health issues including higher rates of physical disability, poorer self-perceived health status, higher levels of depressive symptoms and lower levels of physical function, bone mineral density, pulmonary function and muscle strength (Winstanley M., et al 2005). However, older people may feel that as they have smoked for many years, the health benefits of quitting will be lost to them.

A recent report from the BMA emphasises the need for older people to be given access to stop smoking services treatment. There is substantial medical evidence that quitting smoking increases life expectancy in older smokers, and amongst those who are already suffering from ill health, including those who have survived heart attacks, and people with existing cancers, chronic conditions, including diabetes and chronic obstructive pulmonary disease.

To successfully help this group to stop smoking, further research is needed to identify aspects of older peoples lives that sustain smoking. This will help inform development of appropriate strategies and services.

Smoking and smoking materials are a significant cause of fires and this is particularly an issue for the elderly smoking population. The introduction of Reduced Ignition Propensity cigarettes across Europe in 2011 should help to address this issue. In addition the fire service offer free fire home safety visits in Glasgow to help to reduce the risk of fires within the home.

1.2.7 Smoking and women
Smoking is the single most preventable cause of early death and disease in women, accounting for a third of all deaths in those aged 35-69. Research shows that there are both physiological and sociological differences impacting upon women and smoking which makes them more vulnerable to the effects of tobacco. Women who smoke have a higher risk of lung cancer, heart disease, chronic bronchitis and emphysema, cervical cancer, reproductive problems, and an increased risk of stroke if they also use oral contraceptives (ASH Scotland 2008).

Uptake and use amongst teenage girls is higher than that of boys (see 1.2.6), whilst lone parents (93% of these being women) are heavier users of tobacco as a coping mechanism. Research has shown that women are more emotionally attached to smoking, feeling more dependent than men on cigarettes to help them cope, to socialise and to keep weight down. For men, however, the relationship is much more about the physical pleasure they derive from smoking (ASH Scotland 2008).

Awareness of gender differences in relation to smoking is important if we are to effectively implement prevention and stop smoking support programmes in the city.

1.2.8 Smoking and the lesbian, gay, bisexual and transgender (LGBT) population

“LGBT people are estimated to make up around 5% of the population of Scotland, around 250,000 people across all parts of society. There is evidence showing that LGBT people are more likely to drink, smoke and use illegal substances than the general population” (Scottish Government 2008).

Whilst Scottish figures in relation to levels of smoking within the LGBT population is lacking, research from States has shown that smoking levels were 70% higher in the LGBT community compared to the heterosexual population (Tang et al 2004).
More information is required to establish levels of smoking within LGBT communities in Scotland and Glasgow and to establish effective ways for health services to support people to stop smoking.

Though not specific to smoking, research on alcohol suggests that LGBT people may be reluctant to enter treatment services because of prior experiences of or anticipation of alienation, discrimination, misunderstanding and mistreatment from or by staff or other service users. Anecdotal evidence suggests they may be more amenable to treatment by LGBT staff or LGBT-sensitive services (Stonewall Scotland and Health Scotland 2003). Given this information stop smoking services and health promotion initiatives on smoking need to consider how they target the needs of LGBT people.

1.2.9 Secondhand smoke

There is conclusive evidence that exposure to secondhand tobacco smoke causes death and disease. The Scientific Committee on Tobacco and Health (SCOTH) report 2004 concludes that exposure to secondhand smoke increases the risk of lung cancer and heart disease by 24% and 25% respectively.

Children are especially susceptible to harm from secondhand smoke. The risks associated with secondhand smoke exposure - from asthma to cot death - have been proven through robust international research (ASH 2006).

According to the World Health Organisation (2001) children exposed to secondhand smoke are at risk of bronchitis, pneumonia, asthma attacks, middle ear infection and cot death. In 2003, over 80% of children aged 8 - 15 years in Scotland reported being exposed to secondhand smoke and around 40% lived in a home with at least one smoker (Philips et al 2007). In addition, children from smoking households are much more likely to become smokers themselves in later life.

In terms of children in the Glasgow City Schools Health & Wellbeing Survey (2007-08):

- 59% of school children said that they had someone at home who smoked.
- Pupils at schools in areas of higher deprivation were more likely than those in schools in areas of lower deprivation to say that someone in their home smoked (74% higher deprivation; 44% lower deprivation).
- Those who lived with someone who smoked were more likely to be a current smoker in the East CHCP. Amongst those living with a smoker, 12% (162 pupils) were current smokers compared with 5% (38 pupils) of those who did not live with a smoker.

In response to health risks and growing public concern, the Scottish Executive (now Scottish Government) introduced smoke free legislation in March 2006, prohibiting smoking in most enclosed public places. In September 2007 outcomes of the national evaluation of the impact of Scotland’s smoke-free legislation were presented and showed that the legislation had had an overwhelmingly positive effect.

The evaluation found that after the legislation came into force there was:

- A 17% reduction in heart attack admissions to nine Scottish hospitals. This compares with an annual reduction in Scottish admissions for heart attack of 3% per year in the decade before the ban.
- A 39% reduction in secondhand smoke exposure in 11-year-olds and in adult non-smokers (Akhtar et al 2007).
- An 86% reduction in secondhand smoke in bars (Semple et al 2007).
- An increase in the proportion of homes with smoking restrictions (Philips et al 2007).
- No evidence of smoking shifting from public places into the home (Philips et al 2007).
- High public support for the legislation even among smokers, whose support increased once the legislation was in place.
Children’s exposure to secondhand smoke at home and in the car is now a major concern. The smoke free legislation has reduced overall exposure to secondhand smoke in young people in Scotland, particularly among groups with lower exposure in the home (Akhtar et al 2007). Children, however, still experience significant exposure in the home and car, and action is needed to ensure that every child is able to grow up in an environment free of tobacco smoke.

1.2.10 The economic impact of smoking
At a societal level, smoking costs the Scottish economy £837m each year, through the direct costs of treating smoking-related diseases, lost output and productivity to employers, and reduced consumer expenditure through premature deaths (Scotland’s Public Health Observatory 2008). This is equivalent to 1% of the total Scottish economic output in 2005.

Whilst no study has been conducted on the economic impact of smoking in Glasgow we can surmise that there would be a significant benefit to the economy if smoking rates decreased. Reviewing the economic impact of smoking on Manchester gives some indications of potential savings. A report in 2005 suggested that smoking costs the Greater Manchester economy £630 million, some 75% of this borne by businesses. A one percentage point decrease in smoking rates could be expected to lead to a net saving of £34.4 million for Greater Manchester’s economy (West Midlands Public Health Group 2004).

At an individual level, in 2003 the poorest 10% of households spent 2.4% of income in cigarettes per week, whilst the richest 10% spent 0.5% (ONS 2004). Smoking costs poorer households a larger proportion of smaller incomes; buying 20 cigarettes a day (at 2007 average pack prices) will cost almost £2,000 per year.

Smoking thus imposes large costs on both individuals and society as a whole.

1.2.11 Impact of smoking in Glasgow - conclusion
In conclusion, the high level of smoking within Glasgow significantly affects the health and well being of the population. In particular, smoking is most evident within and therefore has greatest impact upon, the poorest communities in Glasgow. Consequently, given this close relationship, reducing poverty amongst Glaswegians would be expected to reduce smoking prevalence and therefore reduce the impact of smoking on health. Tobacco use should be tackled within the context of wider health initiatives, taking consideration of the links between smoking and coping and other lifestyle choices that people make. Action on tobacco must be sensitive to exclusion and life circumstances, and specifically designed programmes need to be developed with and for socially excluded groups.

1.3 Tackling tobacco use - evidence based Approaches
When considering the approaches to adopt and what interventions to implement to reduce the impact of tobacco and improve health inequalities we must look at the evidence base to determine what constitutes effective tobacco control.

1.3.1 A comprehensive approach
As the reasons for smoking are many and varied, research shows that no single approach to tackling smoking will be successful. Impressive evidence that smoking rates can be substantially reduced by public health interventions comes from the US where a number of states have introduced comprehensive tobacco control programmes. These include a range of interventions such as education programmes, professional education, stop smoking services, regulation and economic strategies.

The aim of these programmes is to change the social climate around smoking, discourage people from starting to smoke, helping smokers to stop and creating an environment that is increasingly free of tobacco smoke. Policymakers at European, UK and Scottish level acknowledge the effectiveness of this approach.
The Framework Convention for Tobacco Control is an international treaty developed by the World Health Organisation and is supported by the UK and Scottish Governments. It binds its signatories to the process of regulating the tobacco industry via tobacco advertising and sponsorship, controls on labelling of products, tackling smuggling and measures to reduce availability and promotion of tobacco to young people. The report from the Scottish Public Health Observatory (2008) highlights the impact of the different strands of tobacco control activity, as below.

**Protection and controls** - Both supply (e.g. the trade in smuggled tobacco) and demand (the prohibition of advertising at the point of sales) interventions play a role. In terms of price, the World Bank estimates that a 10% ‘sustained and real’ increase in price would reduce tobacco consumption by around 4% in the general population, and by around 6% in the under-25s age group. Such increases should therefore form part of a package of interventions and be sensitive to context. There is, however, new evidence that higher prices disproportionately discourage young smokers from more affluent backgrounds, who have less access to tobacco from family, friends and local ‘grey’ markets.

**Prevention and education** - Because young people’s smoking has increased in recent years, it is tempting to focus tobacco control efforts primarily on them. However, in keeping with the social norm change model, young people cannot be prevented from taking up smoking without changing the smoking behaviour of adults. Youth smoking will decline when more adults stop smoking and when adults take action to:

- De-glamorise tobacco use.
- Establish well funded, comprehensive tobacco control programmes that de-normalise tobacco use (making non-smoking the norm).
- Have regular tobacco tax increases.

Research reviews show that information alone is not effective in preventing initiation into smoking and that even the most well developed schools programmes will at best delay onset of smoking.

The National Smoking Prevention Action Plan (2008) emphasises the importance of a holistic approach to tobacco programmes in schools, involving young people in programme development and highlights that tobacco education should be part of a wider programme that addresses tobacco, alcohol and other drugs.

**Stop smoking services** - There is good evidence on interventions to support stop smoking services. These include behavioural and pharmaceutical interventions, such as brief advice and counselling, intensive support and the administration of nicotine replacement therapy (NRT), bupropion and varenicline. In addition, helping smokers to quit has been shown as an extremely cost-effective intervention.

We need to recognise, however, that NHS stop smoking services can at best deliver a prevalence fall of 0.33%-0.50%. Focusing on stopping people smoking is not enough to deliver the national smoking prevalence targets of reducing prevalence to 22%. A more comprehensive approach, incorporating legislation, will be more effective.

Developing stop smoking services programmes targeting young people has been an area of interest for sometime but there is relatively little research evidence on which to base services. NHS Health Scotland and ASH Scotland funded a major programme of pilot stop smoking projects for young people over three years. From a total of 470 young people using the services, 11 (2.4%) were confirmed quitters with CO validation at 12 months (Platt et al. 2007). However despite the disappointing results there were wider benefits from the programmes such as improved self-esteem and confidence. Key learning points included the challenges of working and engaging with young people, the time required to establish such programmes and the need to address a range of issues not just smoking.

**Secondhand smoke** - Since the introduction of legislation prohibiting smoking in enclosed public spaces in Scotland in March 2006, there has been a reduction in exposure of both adults and children to secondhand smoke. In addition, international studies have shown that effective legislation on secondhand smoke will reduce smoking prevalence by approximately 4 - 6%.

**Broader determinants** - The de-motivating effects of poverty, the prevalence of smokers in particular areas and the socially differing effects of consumer culture make smoking more likely in the most deprived areas of Glasgow. Broader measures addressing issues of poverty are more likely over the longer term to impact on smoking rates in these communities and therefore such measures must form part of any comprehensive approach to tackling tobacco issues.
On a positive note, much of the evidence-based approach needed to combat the smoking epidemic has been initiated within Europe and the UK and the steady progress towards the goal of eliminating tobacco smoking is likely to continue. The challenge still remains however, to address the issue within our more deprived populations in Glasgow.

The importance of funding - Despite the enormous cost of tobacco use to our city, funding for tobacco control programmes has been relatively limited in comparison with the funds used to promote and market tobacco products. Evaluation research has shown that any reduction in smoking prevalence is commensurate with the resources dedicated to tobacco control programmes. In summary, the more money available to support a well managed, comprehensive tobacco control programme, the greater the reduction in tobacco use.
1.4 Tackling tobacco use in Glasgow

Though smoking prevalence in Glasgow is high, smoking rates have been declining steadily since the 1970s, further emphasised in the comparison of the 2005 and 2008 Health and Wellbeing studies. This is the result of a combination of factors at a national level including legislation, tobacco tax and national campaigns. In addition, a considerable amount of work on tobacco control has been delivered for many years in Glasgow, providing a solid foundation for the future delivery of the Glasgow tobacco strategy.

A wide range of evidence-based, effective tobacco control initiatives have and are being delivered across Glasgow by NHS Greater Glasgow and Clyde, Community Health and Care Partnerships (CHCPs), Glasgow City Council and other partners. These initiatives include stop smoking services, monitoring and enforcement of tobacco legislation, prevention initiatives, and training and resource development, highlights of which are detailed below.

1.4.1 Co-ordinated programme of tobacco work

In 1983 the tobacco control project Glasgow 2000 was launched, with the ambitious aim of making Glasgow smoke free by the year 2000, supported by the local authority, health board and the then Scottish Health Education Group. Whilst it might not have achieved its overall aim, Glasgow 2000 was an innovative, multidisciplinary project which achieved much during its 17 years of existence including supporting the implementation of smoke free policies within workplaces, campaigning to raise the profile of tobacco issues, delivering a Smokebusters prevention programme to 10,000 children, delivering a training programme on tobacco issues and undertaking stop smoking work.

In response to the publication of Smoking Kills, the national Tobacco White Paper in 1999, Glasgow 2000 was re-launched as Smoking Concerns, a Health Board funded initiative focusing on the development of comprehensive stop smoking services across Greater Glasgow, in partnership with other organisations. This has now evolved in to a comprehensive tobacco control programme - NHS Greater Glasgow and Clyde Smokefree Services - addressing all aspects of tobacco work in partnership with a range of agencies and organisations.

Such a co-ordinated programme of work over time has had a significant impact contributing to reducing smoking prevalence rates, raising the profile of tobacco as a health issue, ensuring that tobacco is recognised as a cross cutting issue addressed through partnership working, increasing the availability of smoke free workplaces, and widespread provision of comprehensive stop smoking services.

1.4.2 Provision of effective stop smoking services

Since Smoking Kills, support for smokers who want to stop has increased dramatically across Glasgow City and NHS Greater Glasgow and Clyde as a whole. We now have a comprehensive integrated stop smoking service across a range of settings including maternity, mental health, community, pharmacy and acute sectors. Smokers can access stop smoking support locally including pharmacological aids such as Nicotine Replacement Therapy (NRT), bupropion and varenicline.

In 2008, national statistics on the stop smoking services (ISD Scotland) showed that in NHS Greater Glasgow and Clyde:

- 15,903 people had set a quit date through the stop smoking services (6% of the total number of smokers in Glasgow and Clyde), an increase of 500 smokers on 2007 figures.
- East Glasgow and South East Glasgow had the highest stop smoking service uptake rates of CH(C)Ps in Scotland at 7.0% and 7.5% respectively.
- 5082 people using the stop smoking services had successfully quit smoking at 1 month (1.9% of the smoking population).
- 2058 people were still not smoking at 3 months
- 594 quit attempts were made by pregnant women (25% of pregnant smokers).
- 55% of people making quit attempts using the stop smoking services were from SIMD deprivation deciles 9 and 10.

Services compared well with those from other board areas. Concerns across Scotland however are that the majority (90%) of those attending the stop smoking services classify themselves as “White-British, the services attract considerably more women than men and that despite those in the 16 - 24yr age group having the highest smoking prevalence levels, they are the least likely to use the stop smoking services.
1.4.3 A programme of health education and promotion to reduce uptake
Education on tobacco is delivered through the Personal and Social Health Education programme within each school in Glasgow as part of the Curriculum for Excellence.

In addition, NHS Greater Glasgow and Clyde Smokefree Services, in conjunction with Glasgow City Council, offer a tobacco prevention programme to all primary and secondary schools in Glasgow, aiming to prevent or at least delay the onset of youth smoking.

“Smoke-Free Me” is a tobacco education initiative aimed at children in primaries 5, 6, and 7. The programme is designed to link into the National Curriculum Guidelines and comprises four lesson plans, with learning reinforced by an interactive drama delivered in the spring term.

“Smokefree Class” is a programme offered to S1 pupils over a five month period. It uses a social influences approach where pupils’ non-smoking behaviour is rewarded with regular prizes, reinforcing and recognising this as worthwhile behaviour. The programme is based on the Smokefree Class model developed through the European Network of Young People against Tobacco (ENYPAT), and evaluation has shown that the programme is effective in reducing smoking uptake in the target population.

A “Tobacco and Young People” training course is delivered on a regular basis by NHS GGC Smokefree Services, looking at smoking issues in relation to younger people.

A range of other initiatives addressing tobacco are delivered at a local level, for example Kool Kids in the Pollok area, training and support in the East CHCP schools and youth settings.

1.4.4 Reducing exposure to secondhand smoke
Given the acceptance that secondhand smoke is a serious health risk, action to reduce exposure to secondhand smoke is a key area of activity within Glasgow. Glasgow City Council is responsible for the enforcement of the smoke free legislation, which is well adhered to and ensures that all workers are now protected from the health effects of inhaling secondhand smoke.

Given the success of the smoke free legislation in protecting workers from secondhand smoke, a key area of concern now relates to children’s exposure to secondhand smoke, particularly in more deprived areas. In partnership with Glasgow City Council Social Work Services and other service providers, NHS Greater Glasgow and Clyde set up a two year project in 2007 to establish a supportive smoke free environment for all Looked After and Accommodated Children and to develop specialist stop smoking services for this vulnerable group.

A programme to address the issue of children’s exposure to secondhand smoke is currently being rolled out across NHS GGC and involves training health professionals on raising the issue of secondhand smoke and the development of resources to support the programme. In addition, both the North and East CHCPs are implementing Smokefree Homes programmes in an effort to reduce children’s exposure to secondhand smoke within their areas.

1.4.5 Reducing attractiveness and availability of tobacco products
Glasgow City Council enforces the legislation relating to the purchase of tobacco by children under the age of 18, undertaking a test purchasing programme to ensure compliance. The Council also widely promotes the Young Scot card as a “proof of age” card, increasing its attractiveness by linking it with a range of promotions and entitlements for young people.
1.5 National and local policy and organisational context

1.5.1 UK and Scottish Government tobacco policies

Over recent years action to address tobacco has been a high priority for both the UK and Scottish Governments and a number of policies have dealt with the issue of tobacco control. Some of the most significant are listed below:

The UK Government’s first tobacco control strategy Smoking Kills (Department of Health 1998) set national targets for reducing smoking rates. Key objectives were to reduce smoking among children and young people, to help adults - particularly the most disadvantaged - to give up and to offer particular help to pregnant women who smoke.

Towards a Healthier Scotland - a White Paper on Health 1999 acknowledged the importance of social inequalities as a backdrop to health problems and confirmed that action to tackle smoking would be a priority. The document also identified new tobacco targets for Scotland.

The Scottish Executive announced in Our National Health: A plan for action, a plan for change 2000 that Scotland’s resources from tobacco tax should be invested in a national Health Improvement Fund which included support for people who want to stop smoking.

The Tobacco Product Regulations 2001 requires tobacco products to carry ‘UK Duty Paid’ markings and any retailers failing to comply are liable to a fine of up to £5000. This legislation was implemented amidst concern for the rise in tobacco smuggling.

The Tobacco Advertising and Promotion Act 2002 comprehensively bans the advertising and promotion of tobacco products including the use of brand sharing and sponsorship of cultural and sport events.

The Tobacco Products (Manufacture, Presentation and Sale) Regulations 2002 is concerned with setting ceilings on the yields of tar, nicotine and carbon monoxide for all cigarettes, a significant increase in the size of health warnings on cigarette packs, and a ban on misleading terms such as “light” and “ultra light”. Further regulations in 2007 deemed that from October 2008 all cigarette products manufactured must carry picture warnings.

The Scottish Executive focused on smoking as one of the key health improvement programmes within Improving Health in Scotland - The Challenge 2003, setting out targets for reducing health inequalities.

In A Breath of Fresh Air for Scotland 2004 the Scottish Executive made a commitment to making Scotland “a society in which everyone aspires to live a healthy smoke free life and has access to support that can help them realise that ambition”. The tobacco action plan committed an additional £4 million per year to stop smoking services from 2005/6, made a commitment to prevention work, and outlined plans for a public consultation on smoking in public places.

The Smoking, Health and Social Care (Scotland) Act 2005. In March 2006, Scotland introduced a new law to make virtually all enclosed public places and workplaces in Scotland smoke free. England enacted similar legislation in July 2007. In October 2007 the age for sale of tobacco was raised from 16 years to 18 years in England, Scotland and Wales.

The Scottish Government’s Better Health, Better Care: Action Plan (2007) sets out to “help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care” and confirms the Government’s commitment to stepping up the efforts to reduce smoking across Scotland. The Action Plan sets out measurable targets - that stop smoking services would support 8% of each NHS Board’s smoking population in successfully quitting (at one month post quit) over the period 2008 - 2011.

Most recently The National Smoking Prevention Action Plan 2008 sets out a programme of measures designed specifically to dissuade children and young people from smoking. It builds upon and responds to the report, ‘Towards a Future without Tobacco’ (2006) which considered a wide range of evidence from national and international research. The consultations undertaken on the recommendations also provide a clear mandate for the action proposed.
1.5.2 Organisational changes

**Scottish Government** - Since the change of administration in May 2007, tackling smoking related harm, formerly the domain of the Scottish Executive Health Department (SEHD) has remained at the heart of the Scottish Government’s health improvement and inequalities drive. This is now organised through the Health and Wellbeing Directorates.

**Community planning** - The *Local Government in Scotland Act 2003* set out guidance to local authorities to facilitate the creation of Community Planning Partnerships, bringing together the public sector, partners and the community to agree priorities on the planning and provision of services. Glasgow Community Planning Partnership was formed in February 2004 and has 10 local Community Planning Partnerships operating across 5 areas. The Community Plan outlines action for change under the identified key themes of **Working Glasgow, Learning Glasgow, Healthy Glasgow, Safe Glasgow and Vibrant Glasgow**.

**Community health and care partnerships** - The 5 Community Planning Area boundaries are coterminous with the 5 Community Health and Care Partnerships (CHCPs) for Glasgow City, the new organisations which have been developed to manage a wide range of community based health and social care services.

**Glasgow City Council** - Glasgow City Council Services have been restructured, including bringing together education and social work, changing boundaries for service departments to reflect Community Planning Partnership and CHCP boundaries and the formation of Culture and Sport Glasgow and Glasgow Community and Safety Services. The Scottish Government COSLA Concordat, Single Outcome Agreement and HEAT (Health, Efficiency, Access and Treatment) targets are covered in Section 2.
2.1 Development of the updated Glasgow Tobacco Strategy

The Updated Glasgow Tobacco Strategy has been developed through a process of review of the original documents and an assessment and consideration of evidence and strategies published since 2005.

The aim of the original strategy was “to promote the health of people living and working in the city of Glasgow by reducing the health impact of tobacco, particularly targeting those in greatest need”. This aim remains the same in the updated strategy.

The strategic objectives of the original strategy were as follows:

• To ensure that lead organisations in the private, public and voluntary sector in Glasgow engage fully with tobacco control.
• To undertake a programme of activity specifically targeted at young people aimed at reducing the impact of tobacco.
• To encourage and deliver sustainable community led work on tobacco.
• To ensure that the Health Service in Glasgow fulfils its exemplar role and fully capitalises on its unique opportunities for effective action against tobacco.
• To make smoke-free public places the norm and to work towards a situation where all employees are protected from secondhand smoke.
• To use a variety of media effectively to ensure tobacco issues have due prominence as a public concern.

These objectives remain largely the same in the new strategy but have been revised and framed alongside new objectives, grouped under outcomes.

2.2 The Strategy’s Contribution to the Community Plan and Single Outcome Agreement

Implementation of the Glasgow Tobacco Strategy is crucial for achieving the aims of a number of Glasgow plans and strategic documents including the Community Plan and the Single Outcome Agreement.

**Community Plan** - This updated Glasgow Tobacco Strategy contributes to the priority themes of Glasgow’s Community Plan for 2005-2010

- Healthy Glasgow.
- Learning Glasgow.
- Safe Glasgow.
- Vibrant Glasgow.
- Working Glasgow.

Some examples of these contributions are described below:

**Healthy Glasgow** - Reducing the harm associated with smoking is one of the key aims of the Healthy Glasgow theme. Reduced tobacco consumption results in better overall health and has the potential to reduce health inequalities. Restricting areas where people can smoke leads to less harm from secondhand tobacco smoke. The plan adopts the national target of reducing adult smoking prevalence to 22% by 2010 within Glasgow.

**Learning Glasgow** - Improved health due to a reduction in smoking among young people and reduced exposure to secondhand smoke should result in less absenteeism from school, further or higher education. The strategy’s emphasis on life skills, decision-making, and innovative education about tobacco will result in greater awareness of related health, economic and international issues.

**Safe Glasgow** - Reduced tobacco consumption will lead to reduced air pollution, litter and fire hazard.

**Vibrant Glasgow** - Smoke-free areas offer more attractive environments for tourists and citizens. A healthier population participates more in cultural and leisure activities.

**Working Glasgow** - Reduced tobacco consumption will result in a healthier workforce, a reduction in absenteeism and improved productivity. There is evidence that a reduction in spending on tobacco in the city will result in spending where more of the money will remain in the local economy. Less spending on tobacco will result in households having more disposable income.
Single Outcome Agreement (SOA) – The Scottish Government National Performance Framework Outcome and Indicators (as stated in the Scottish Government COSLA Concordat) clearly states the indicator “to reduce the proportion of the adult population who smoke to 22% by 2010”. The Glasgow SOA identifies smoking as a priority. The targets have been updated to reflect the local targets in this strategy and are outlined in section 2.6.

In addition, as well as supporting us to “live longer healthier lives”, improved health resulting from reduced smoking rates has the potential to contribute to many of the other National Outcomes including:

- Our children have the best start in life and are ready to succeed.
- We have tackled the significant inequalities in Scottish society.
- We have improved life chances for children, young people and families at risk.
- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.

2.3 Core principles of the Glasgow Tobacco Strategy

The updated strategy adopts the following principles:

- Tobacco control activities should be anti-smoking not anti-smoker.
- Tobacco control activities should promote non-smoking as the social norm.
- All non-smokers have the right not to be involuntarily exposed to secondhand smoke. Where this conflicts with the rights of smokers, the rights of non-smokers should prevail.
- Children have the right to be free from any form of tobacco advertising and promotion.
- The tobacco industry should be challenged and its tactics exposed.
- All smokers should have the right to receive stop smoking advice and support through the NHS, with strategic planning areas tailoring the agreed service model, where appropriate, to meet the needs of their diverse populations including minority ethnic communities, those with disabilities and other key priority groups.
2.4 Vision

The Glasgow Tobacco Strategy will result in long term, concerted and co-ordinated partnership action on tobacco in Glasgow, leading to an eventual reduction in smoking prevalence and exposure to secondhand smoke in the city, overall improvement in the health and well being of Glaswegians, a reduction in health inequalities, and improved economic and environmental status.

2.5 Aim and objectives

Aim

To promote the health of people living and working in Glasgow city by reducing the impact of tobacco, particularly targeting areas and populations of greatest need.

Objectives of the strategy

Three key objectives have been identified, based upon those contained within the National Smoking Prevention Action Plan “Scotland’s Future is Smoke Free” and the National Tobacco Control Action Plan “A Breath of Fresh Air” ensuring clear links between local and national activity on tobacco. The updated objectives also incorporate those from the previous strategy (see 2.1). The objectives are:

2. Stop smoking services: reduce rates and frequency of active smoking in adults and young people.
3. Health protection: reducing exposure to secondhand smoke and the wider harm associated with smoking.

2.6 Target and indicators

National targets

The tobacco strategy will contribute to the achievement of the national tobacco targets:

- To reduce the level of smoking in the adult population to 22% by 2010 (Scottish Government COSLA Concordat).
- To reduce the level of smoking in pregnancy from 29% to 20% by 2010.
- To reduce the level of smoking amongst:
  - 13 year old girls from 5% in 2006 to 3% in 2014.
  - 13 year old boys from 3% in 2006 to 2% in 2014.
  - 15 year old girls from 18% in 2006 to 14% in 2014.
  - 15 year old boys from 12% in 2006 to 9% in 2014.
  - 16 - 24 year olds from 26.5% in 2006 to 22.8% in 2014 (Smoking Prevention Action Plan, 2008).
- New HEAT (Health Efficiency, Activity and Treatment) target: NHS Boards to provide targeted services to support 8% of the smoking population to quit successfully (at one month post quit) by the end of 2011 (see appendix two for more details).

Local Tobacco Strategy targets

The targets for the Glasgow Tobacco Strategy are to:

- Reduce the proportion of adults who smoke to 28% by 2014 (from a baseline of 39% in 2005).*
- Reduce smoking rates among young adults aged 16 - 24 years to 28% by 2014 (from a baseline of 39% in 2005).*
- Reduce smoking rates among people living in the city’s most deprived areas (bottom 15% SIMD) from 47% in 2005 to 34% by 2014.*

* (Prevalence figures from the Health and Wellbeing study 2005)

- Reduce smoking rates among 13 year olds from 3% in 2006 to 2% by 2010.*
- Reduce smoking rates among 15 year olds from 13% in 2006 to 12 % by 2010*

* (Prevalence figures from SALSUS)
Indicators
The progress and success of the strategy will be determined through several performance measures including:

- Smoking prevalence rates (adults, young people, pregnant women, areas).
- Attitudes to smoking and smoke free legislation.
- Exposure to secondhand smoke.
- Lung cancer rates.
- Performance of stop smoking services.
- Compliance with the smoke free legislation.

Duration
The Tobacco Strategy is regarded as a long-term strategy and sets the direction for tobacco work in Glasgow for 2009 - 2014.
SECTION 3: IMPLEMENTATION, MONITORING, RESOURCES & WORKFORCE DEVELOPMENT

3.1 Implementing the strategy
To create a favourable climate for tobacco control in Glasgow it is important that, as a first step, lead agencies in the city fully commit, individually and collectively to the strategy and establish appropriate structures to ensure the effective co-ordination and delivery of tobacco control activity.

This includes action to:

- Embed appropriate evidence-based tobacco control activity within the relevant plans and structures.
- Contribute to the delivery of national tobacco related targets and plans, and to the delivery of the Glasgow Tobacco Strategy, through activity and through appropriate representation at the Tobacco Planning and Implementation Group and the Joint Health Improvement Officers Group.
- Adopt a lead role in influencing and encouraging key local organisations to raise the profile of tobacco control work and to ensure co-ordinated and integrated effective action on tobacco, through local tobacco structures.
- Take a lead role in influencing and responding to local, national and international tobacco policy issues.

Glasgow City Council, NHS Greater Glasgow and Clyde, and the Glasgow Community Planning Partnership support this strategy. This commitment will create a positive environment in Glasgow, which will enable action on tobacco to be taken forward at a both a citywide and a more local level.

3.2 Planning and reporting structures

3.2.1 NHS Greater Glasgow & Clyde Tobacco Planning and Implementation Group (PIG)

The Tobacco PIG is the strategic group within NHS Greater Glasgow and Clyde responsible for co-ordinating a strategic plan for tobacco control within the NHS, informing the design of programmes to prevent uptake of smoking and provide stop smoking support, and influencing the work of wider partners to help to ensure that tobacco is embedded within relevant strategic plans.

As the Tobacco PIG is an NHS structure, membership is drawn primarily from the NHS including CHCPs and the acute sector. The Director of Public Health for NHS Greater Glasgow and Clyde chairs the group. Progress in relation to the tobacco strategy will be reported to this group, particularly focusing on the actions for the NHS.

3.2.2 Glasgow City Council Joint Health Improvement Officer Group

The Joint Health Improvement Officer Group will be the main structure overseeing the delivery of the tobacco strategy. This group brings together staff from a range of departments across Glasgow City Council and arms length companies (e.g. Culture and Sport Glasgow) as well as associated bodies such as Glasgow Community Planning and CHCPs. The remit of the group includes raising awareness of the Council’s role in improving health and ensuring that all policies and plans take account of their impact on health inequalities and link to Community Planning. The Director of Public Health chairs the group, as this is a joint appointment by Glasgow City Council and NHS Greater Glasgow and Clyde.

3.2.3 Local structures

Local structures should be established or identified to coordinate and monitor tobacco work at a strategic area planning level, as part of the Glasgow Tobacco Strategy. These may be existing structures (e.g. thematic health groups) or new structures (e.g. local tobacco alliance). These structures should involve appropriate representatives from relevant organisations.

In addition, these local structures should be the primary mechanism by which community engagement is carried out in relation to specific actions on tobacco. Meaningful community engagement is essential for sustainable action and is in line with the principles of Community Planning. Involving communities in the decisions that affect them ensures that diversity of needs will be taken into account. Therefore the identified local coordination structures for the tobacco strategy may wish to link to local Community Reference Groups or Public Partnership Forum for this purpose. It is important to ensure that the groups are consulted on local tobacco plans to reflect the diversity of the local population.

Local structures will be linked to the JHIOG through the CHCP representative on the group, to help to ensure co-ordination of activity and effective communication at a local and a citywide level.
3.3 Monitoring and evaluation

It is essential to evaluate the implementation of this strategy to assess its impact. The effectiveness of a co-ordinated and sustained approach using a wealth of activity will only become apparent if robust monitoring and evaluation mechanisms are put in place. Resources, both financial and “in kind” will be required to undertake a strategic level evaluation. Evaluation will be used to inform future planning and resource allocation. This will require coordination and communication between the different structures involved. NHS Greater Glasgow and Clyde will host a web based communication hub to support sharing of good practice in relation to tobacco control and tackling smoking related harm.

3.3.1 Activity monitoring

Local structures will be encouraged and supported to produce local tobacco action plans linked to the Glasgow Tobacco Strategy and to report on activity for specific geographies, making these available to local Community Planning Partnerships. Decisions should be made locally as to whether local tobacco action plans are incorporated into existing local plans or whether a stand-alone local tobacco plan is developed. Each Strategic Planning Area will be contacted on a six monthly basis by the Health Policy Team and asked for a report on progress on activity (outputs).

A report compiled from information all partners delivering actions in the plans (section 4) will be delivered to the Joint Health Improvement Officer Group on a six-monthly basis. These six-monthly reports will then be submitted to the Tobacco PIG and to Community Planning at a citywide level.

3.3.2 Outcome and impact monitoring

Outcome data in relation to the targets and indicators listed in section 2 will be collated and presented, where possible, on an annual basis.

3.4 Resources

Implementation and evaluation of the strategic plans will require funding, both for actions that relate directly to an organisation’s own remit and workplaces as well as actions requiring partnership with others. The level of funding required to progress the strategy will depend on the range and timescales of the agreed actions within and across agencies. It is, however, acknowledged that all agencies signing up to the Glasgow Tobacco Strategy will wish to promote joint ownership by contributing to its implementation either financially, or in kind, or both.

The Scottish Government has allocated additional funding to NHS Boards from 2008/09 to 2010/11 to enable local delivery of the Smoking Prevention Action Plan. CHCPs across Glasgow and Clyde have been asked to submit tobacco control proposals to the Tobacco PIG in order to access a share of the funds. In addition, Glasgow City Council also received an allocation to enable them to enforce new legislation relating to the sale of tobacco products.

3.5 Workforce development

Resources will need to be identified for workforce development to support NHS and other staff to focus on tackling inequalities, to adopt evidence-based approaches, to deal with barriers within the workforce in relation to addressing smoking with some population groups and to work in a coordinated and sustained way across agencies.

3.6 Summary

The development and implementation of Glasgow’s Tobacco Strategy is vital to improving the health of people of the city. Action needs to be undertaken on a range of fronts, not only by the large organisations within the city, but by smaller agencies, communities and individuals working in partnership to deliver concerted and co-ordinated action on tobacco.

This strategy does not stand-alone but is integral to other city wide strategies aimed at improving the circumstances of people in Glasgow. In a situation where smoking kills 1 in 5 Glaswegians, the social and economic regeneration of the city will be compromised unless we tackle the harm caused by tobacco.
SECTION 4: LOGIC MODELS AND ACTION PLANS

OBJECTIVE 1: Smoking prevention

- We give children the best start in life
- We have improved the life chances of children at risk
- We have tackled health inequalities in Scotland

OBJECTIVE 2: Stop Smoking Services

- We live longer, healthier lives
- Reduced risk of cancer
- Reduced cardiovascular disease (NIS, HEAT)

OBJECTIVE 3: Health Protection

- We have tackled health inequalities in Scotland
- Reduced cardiovascular disease (NIS, HEAT)
- Reduced risk of cancer

4.1 Logic models (adapted from Health Scotland, 2009)
Section 4: Logic Models And Action Plans

Objective 1: Smoking Prevention
Reduced initiation into and uptake of smoking among young people

**Outcomes**

- **Short-term**
  - Increased understanding of smoking-related risks/harm
  - More negative attitudes towards smoking & SHS exposure (CDC6)
  - Less positive media images of tobacco & smoking
  - Smoking seen as less appealing
  - Improved knowledge & skills in how to access help & support
  - Messages reached & understood by parents & young people.

- **Intermediate**
  - Social Environment
    - Non-smoking & smoke-free become the norm
    - Increased public support for tobacco control policies & measures
    - Reduced susceptibility to experimentation with tobacco (CDC10)
    - Maintained compliance with existing & new laws (CDC8)
    - Reduced initiation into, & uptake of, smoking by young people (CDC 13)
  - Economic Environment
    - Real price of tobacco products increased/or remain stable (CDC12)
    - Decrease impact of illicit sales of tobacco products

- **Long-term**
  - Reduced tobacco-related morbidity & mortality & reduced inequalities

**Activities / Outputs**

**Inputs**

- Local authorities
- Schools
- Youth work & community settings
- Public agencies in contact with young people
- Universities, Colleges, Further Education
- Employers
- Scottish Govt.
- Scottish Health Scotland
- UK Govt.
- Local authority trading standards

**Reduced smoking rates & frequency (adults & young people) (CDC 14)**

**Reduced influence of tobacco industry (CDC9)**

**Reduced economic impact on retail sector**

**Decrease impact of illicit sales of tobacco products**

**Reduced physical & mental health problems related to smoking & SHS exposure (CDC7)**

**Reduction in uptake of smoking among young people (CDC 12)**

**Reduced engagement & uptake of smoking among young people (CDC 13)**

**Reduced susceptibility to experimentation with tobacco (CDC10)**

**Reduced influence of tobacco industry (CDC9)**

**Maintained compliance with existing & new laws (CDC8)**

**Reduced initiation into, & uptake of, smoking by young people (CDC 13)**

**Reduced tobacco-related morbidity & mortality & reduced inequalities**

**Objective 2: Tobacco Control**
Reduced influence of tobacco industry on young people

**Activities / Outputs**

**Inputs**

- Local authorities
- Schools
- Youth work & community settings
- Public agencies in contact with young people
- Universities, Colleges, Further Education
- Employers
- Scottish Govt.
- Scottish Health Scotland
- UK Govt.
- Local authority trading standards

**Reduced influence of tobacco industry (CDC9)**

**Reduced economic impact on retail sector**

**Decrease impact of illicit sales of tobacco products**

**Reduced physical & mental health problems related to smoking & SHS exposure (CDC7)**

**Reduction in uptake of smoking among young people (CDC 12)**

**Reduced susceptibility to experimentation with tobacco (CDC10)**

**Reduced influence of tobacco industry (CDC9)**

**Maintained compliance with existing & new laws (CDC8)**

**Reduced initiation into, & uptake of, smoking by young people (CDC 13)**

**Reduced tobacco-related morbidity & mortality & reduced inequalities**
Objective 2: Stop Smoking Services

Reduced rates & frequency of active smoking in adults & young people

Inputs

- NHS Health Scotland
- NHS Boards & local partners
- Retail Sector
- ASH Scotland & PATH

Activities / Outputs

1.7) Develop a young people pilot intervention
2.7) Increase uptake of Pregnancy Service
2.9) Monitor performance
2.10) Contribute to debate on tobacco and harm reduction

Information/Marketing

1.2) Effective promotion of stop smoking services
2.2) Enhance referrals via health & other professionals
2.3) Ensure that stop smoking support is included in the implementation policies
2.4) Deliver stop smoking services
2.5) Enhance performance of services through training
2.6) Monitor performance
2.8) Develop accessible services
2.9) Coordinate interventions which encourage stopping smoking in young people

Provide NRT products

Telephone helpline (CDC2)

NHS Boards & local partners NHS Health Scotland, ASH Scotland & PATH

Outputs

Short-term

- Increased understanding of smoking-related risk/harm: Improved knowledge & skills in how to access help & support (CDC8): Intention to quit & support for policies to support quitting.
- Increased availability of NRT
- Increased quit attempts & use of proven methods (CDC11)
- Social environment
- Non-smoking & smoke-free become the norm
- Physical environment
- Reduced exposure to SHS
- Economic environments
- Reduced costs to NHS

Intermediate

- Increased quit rate (adults & young people) (NEAT & Menu indicators on quitting)
- Inc. availability of, referrals to, demand for and uptake of stop smoking services (CDC7)
- Reduced smoking rates & frequency (adults & young people) (CDC12 & 14)

Long term

- Reduced tobacco-related morbidity & mortality & reduced inequalities

Reduced smoking rates & frequency (adults & young people) (CDC 13 & 14)
Objective 3: Health Protection
Reducing exposure to secondhand smoking (SHS) & risk of home fires

Inputs

Scottish Govt
NHS Health Scotland

NHS Boards & local partners

Employers

Scottish Government

Local authority environmental health officers
Social Care Services

All partners

Activities / Outputs

3.1) Campaign to raise awareness of the impact of SHS on children's health

3.2) Implement workplace smoking policies

3.3) Through Health at Work Team promote the Healthy Working Lives initiative within workplaces in Glasgow.

3.4) Enforce ban on smoking in enclosed public places (CDC4&5)

3.5) Enforce smoking policies within residential care units and foster care

3.6) Support the introduction of reduced ignition propensity (RIP) cigarettes

3.7) Expand range of fire prevention measures

3.8) Implement workplace smoking policies

3.9) Through Health at Work Team promote the Healthy Working Lives initiative within workplaces in Glasgow.

3.10) Develop and monitor the ban on smoking in enclosed public places (CDC4&5)

3.11) Enforce ban on smoking in enclosed public places

3.12) Enforce smoking policies within residential care units and foster care

3.13) Support the introduction of reduced ignition propensity (RIP) cigarettes

3.14) Expand range of fire prevention measures

Outcomes

Short-term

Increased awareness & understanding of risks/harm associated with SHS (including homes & cars)
More negative attitudes towards SHS exposure (CDC3)

Campaigns reach public & messages understood

Intermediate

Reduced number of home fires

Maintain compliance with smoke free legislation (CDC6) (IO)

Reduced rates and frequency of smoking

Long term

Reduced tobacco-related mortality & morbidity & reduced inequalities

Social environment

Changes in smoking cultures

Non-smoking & smoke-free become the norm

Increased public support for smoking ban (CDC3)

Physical environment

Fewer opportunities to smoke

Extension of smoke free environment

Reduced exposure to SHS (CDC7) (inc. in homes and vehicles)

Economic environment

Variable economic impacts on hospitality & retail sector

Reduced costs to NHS

Reduced number of home fires

Reduced rates and frequency of smoking
4.2 Action plans

Key
The “↩” symbol is used to denote actions that have come from the Smoking Prevention Action Plan and the relevant number is referenced.

Some monitoring information will be gathered locally (at Strategic Planning Area) and some will only be gathered on a citywide basis.

• The “★” symbol denotes that the information will be collected for each Strategic Planning Area.
• The “○” symbol denotes that the information will be collected only on a citywide (Glasgow) basis.

Objective 1: Smoking prevention
Reduced initiation and uptake of smoking among young people

<table>
<thead>
<tr>
<th>Action - What will we do?</th>
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<tr>
<td><strong>Smoking prevention</strong></td>
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<tr>
<td>1.1 Adopt a holistic approach to health and well-being in Glasgow schools in line with the Schools (Health Promotion and Nutrition) (Scotland) Act 2007, ensuring that the school ethos, policies, services and extra-curricular activities all foster the health and wellbeing of all pupils</td>
<td>Schools improvement planning, including health promotion ○</td>
<td>Number of Health Promoting Schools. ○</td>
<td>Glasgow City Council Education Services</td>
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<tr>
<td>1.2 Support the delivery of effective tobacco education in primary, secondary schools and ASL schools in Glasgow through review of the Health and Wellbeing curriculum (in line with Curriculum for Excellence) and ensuring that appropriate teaching materials are available and used</td>
<td>Scoping of updated tobacco curriculum resources completed by 2010 ○</td>
<td>Updated tobacco curriculum resources made available to all Primary and Secondary schools ○</td>
<td>Glasgow City Council Education Services</td>
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NHS Greater Glasgow & Clyde Smokefree Youth Service, CHCPs.
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<tr>
<td><strong>1.3</strong> Deliver Smoke Free Me drama in primary schools and Smoke Free Class Competition in secondary schools</td>
<td>• Increased annual uptake of Smoke Free Me 〇 &lt;br&gt; • Increased annual uptake of Smoke Free Class 〇</td>
<td><strong>Smoke Free Me</strong>&lt;br&gt; • Increased awareness and knowledge of lesson plan tobacco topics 〇 &lt;br&gt; • Reduced acceptance of smoking among others / peers 〇 &lt;br&gt; • Increased ability to resist peer pressure to smoke 〇 &lt;br&gt; • Higher average age for first cigarette 〇</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Youth Service&lt;br&gt;Glasgow City Council Education Services, CHCPs</td>
</tr>
<tr>
<td><strong>1.4</strong> Develop an approach to discourage and support students and trainees (post school) from starting to smoke as part of wider substance misuse and other risk-taking behaviour programmes</td>
<td>• Partnership developed between relevant agencies by March 2010 ★〇 &lt;br&gt; • Review of need for 16-24 year olds completed by March 2010 ★〇 &lt;br&gt; • Pilot in Stow college completed ★〇 &lt;br&gt; • Focused strategy developed and joint working commitment across Further Education and Higher Education settings agreed by December 2010 ★〇</td>
<td>• Decrease in % of young people aged 16-24 smoking / experimenting 〇 &lt;br&gt; • Increased numbers with intention not to smoke in the future 〇 &lt;br&gt; • Reduced numbers viewing smoking as the norm 〇 &lt;br&gt; • Reduced acceptance of smoking 〇 &lt;br&gt; • Increased numbers with negative attitudes to smoking 〇 &lt;br&gt; • Increased knowledge about harmful effects of smoking 〇</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services, CHCPs&lt;br&gt;Further Education Colleges, Higher Education Institutions, NUS/student associations, training providers</td>
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For Staff Training see 1.10
### Smoking prevention

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<td>1.5 Explore with relevant agencies steps to engage with harder to reach groups in Glasgow - those who are not in employment, education or training or who are in occupations, settings or minority groups with higher than average smoking levels</td>
<td>• Relevant organisations and opportunities for joint working identified by March 2010</td>
<td>• Coordinated and consistent messages targeted at harder to reach groups and young people who are not in employment, education or training or who are in occupations or settings with higher than average smoking levels</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services Training providers, Scottish Prison Service, HM Forces, CHCPs</td>
</tr>
<tr>
<td>1.6 Actively involve children and young people in the planning and delivery of tobacco services and programmes to ensure their perspective is fully reflected in the approaches adopted and to encourage active citizenship</td>
<td>• Youth Advocacy Group and Youth Reference Group established to direct and inform youth related tobacco</td>
<td>• Smoking seen as being less appealing by young people involved</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services, CHCPs, Glasgow City Council Education Services</td>
</tr>
<tr>
<td>1.7 Encourage all organisations and agencies who come into contact with children and young people in Glasgow to have a health leadership role by: • adopting and enforcing clear no smoking policies • reinforcing messages concerning the addictiveness and health risks associated with smoking and second hand smoke</td>
<td>• Proposals developed and actions taken to raise awareness and enhance implementation of existing policies</td>
<td>• Numbers of facilities and community / youth work settings demonstrating through Health &amp; Safety audit process that effective policies are adopted and fully implemented</td>
<td>Culture and Sport Glasgow, Glasgow City Council Social Work Services NHS Greater Glasgow &amp; Clyde Smokefree Services, CHCPs, Voluntary Sector Youth Service Providers</td>
</tr>
<tr>
<td>1.8 Work to change smoking cultures by introducing and enforcing smoke-free policies in external areas frequented by children and young people such as playgrounds with fixed equipment</td>
<td>• Mapping of children’s playgrounds and relevant smoking policies by March 2010</td>
<td>• Number of children’s playgrounds where smoking policies are in place</td>
<td>Glasgow City Council Environmental, Health and Trading Standards, Land and Environmental Services Culture and Sport Glasgow, Glasgow City Council Education Services, Glasgow City Council Social Work Services</td>
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### Smoking prevention

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<td><strong>1.9</strong> Develop a pilot intervention designed to discourage the uptake of smoking in young people, particularly those living in disadvantaged circumstances; evaluate the effectiveness and if appropriate support roll out across Glasgow</td>
<td>• Youth advocacy initiative delivered and evaluated in partnership with relevant organisations, ongoing ★★★</td>
<td>• Reach of WEST brand and campaigns across Glasgow City - young people aware of the brand ★★★</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services CHCPs, ASH Scotland</td>
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<td>• Number of young people joining W-West ★★★</td>
<td>• Increased number of youth enquiries to youth cessation service ★★★</td>
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<td>• Increased number of visits on WWest website each month O</td>
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<td><strong>1.10</strong> Promote and facilitate training on tobacco for staff working with young people most at risk from taking up smoking</td>
<td>• Review of tobacco training programme by end of 2009</td>
<td>• Increased number of staff able to deliver tobacco messages ★★★</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services CHCPs, ASH Scotland, Culture and Sport Glasgow, Glasgow Community and Safety Services</td>
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<td></td>
<td>• Number of tobacco training O</td>
<td>• Consistent messages to young people across the board ★★★</td>
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<td>• Programmes delivered for those working with young people ★★★</td>
<td>• Lower smoking rates for young people in Scotland, especially in socially deprived areas O</td>
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<td></td>
<td>• Number of people trained ★★★</td>
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### Social marketing

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<td><strong>1.11</strong> Develop co-ordinated marketing and promotional activity on tobacco in Glasgow and link with national campaign where appropriate, using social marketing techniques and ensuring increased coverage of tobacco issues in media, including minority ethnic media</td>
<td>• Tobacco communications working group set up as sub-group of the Tobacco Planning and Implementation Group by June 2009 O</td>
<td>(See 2.1) • Source of enquiry data for new referrals ★★★</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services CHCPs, Health Scotland, Smokeline</td>
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<td></td>
<td>• Tobacco communications strategy for NHS Greater Glasgow &amp; Clyde developed and established by October 2009 O</td>
<td>• Improved attitudes and perceptions of services ★★★</td>
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<td>• Local delivery of communications activity, relevant to the needs of local people and specific populations</td>
<td>• Increased coverage of tobacco issues in media ★★★</td>
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<td>• Increased understanding of smoking-related risks/harm O</td>
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<td>• More negative attitudes towards smoking (H&amp;WB Survey) O</td>
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<td>• Messages reached &amp; understood by parents &amp; young people (focus groups) O</td>
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<td><strong>1.12</strong> Through relevant partners/ local structures, lobby the Scottish and UK Government, to take further action to reduce positive images of smoking in the media</td>
<td>• Glasgow wide responses to national consultations produced and proactive communication on the issue achieved ★★★</td>
<td>• Increased awareness of the issues amongst health professionals and politicians ★★★</td>
<td>Local tobacco structures</td>
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<td><strong>Protection and control</strong></td>
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<td><strong>Outcome measures/indicators</strong> - What will we monitor to show that we have done this?</td>
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<td>1.13 Support the introduction of legislative controls to further restrict the display of tobacco products at points of sale, and to work with retailers in Glasgow on the implementation of these measures</td>
<td>• Appropriate and timely responses to consultation on the issue of restriction of point of sale promotion produced</td>
<td>• Compliance with legislation is maintained</td>
<td>Glasgow City Council Environmental, Health and Trading Standards, Land and Environmental Services Local tobacco structures</td>
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<td>• Measures to restrict point of sale promotion implemented effectively (number of visits)</td>
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<td>1.14 Ensure rigorous enforcement of tobacco sales law relating to young people under the age of 18</td>
<td>• Programme of tobacco enforcement activity relating to sale of tobacco to young persons reviewed annually</td>
<td>• Percentage of retailers willing to sell cigarettes to persons under 18 reduced (reduce sales by 50% by 2011 from 26% in 2007 to 13%)</td>
<td>Glasgow City Council Environmental, Health and Trading Standards, Land and Environmental Services</td>
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<td>• Enforcement officers recruited</td>
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<td>Trade Associations, NHS Greater Glasgow and Clyde Smokefree Services, schools, local tobacco structures, Culture and Sport Glasgow (Glasgow Young Scot)</td>
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<td>• Test purchasing volunteers recruited</td>
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<td>• Targeted enforcement activity at retail level increased (minimum of 10% per annum of tobacco retailers subject to test purchase)</td>
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<td>1.15 Promote and embed a “no proof, no sale” culture in Glasgow, leading to including increased use and awareness of Glasgow Young Scot card under Proof of Age Standards Scheme (PASS)</td>
<td>• Advice and support to tobacco retailers increased (minimum of 20% retailers visited per annum)</td>
<td>• Awareness of Glasgow Young Scot Card as accredited by PASS ID amongst retailers increased</td>
<td>Glasgow City Council Environmental, Health and Trading Standards, Land and Environmental Services</td>
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<td>• Actions taken to promote uptake of Glasgow Young Scot card amongst young people.</td>
<td>• Uptake of Glasgow Young Scot Card amongst young people increased</td>
<td>Culture and Sport Glasgow (Glasgow Young Scot), schools, local tobacco structures, voluntary sector youth groups, Glasgow City Chamber of Commerce</td>
</tr>
<tr>
<td>1.16 Take action to reduce the extent and impact of illicit sales of tobacco products in Glasgow</td>
<td>• Programme of awareness raising delivered to encourage communities to provide information on illicit sales</td>
<td>• Information and intelligence provided by local communities increased</td>
<td>Glasgow City Council Environmental, Health and Trading Standards, Land and Environmental Services</td>
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<td></td>
<td>• Joint working with HM Revenue and Customs increased (seven operations by 2010 - 2011)*</td>
<td>• Reduction in illicit sales of tobacco products in Glasgow (amount of illicit tobacco seized)</td>
<td>Strathclyde Police, NHS Greater Glasgow &amp; Clyde Smokefree Services, Community Planning Partnerships, HM Revenue and Customs, Local tobacco structures</td>
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<td>* subject to agreement</td>
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<tr>
<td>1.17 Contribute to pressure on the UK Government to ensure duty on tobacco products is sufficiently high to keep prices in line with the cost of living</td>
<td>• Timely and appropriate communications produced by organisations and structures in Glasgow pressurising for duty on tobacco to be in line with the cost of living</td>
<td>• Increased awareness of the issues amongst health professionals and politicians</td>
<td>Local tobacco structures</td>
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<td><strong>1.18</strong> Contribute to the debate on the sale of cigarettes in packets of less than 20, as part of the planned legislative review proposed in the National Smoking Prevention Action Plan</td>
<td>• Glasgow response to consultation on packs of 10 produced as appropriate ★ ○</td>
<td>• Increased awareness of the issues amongst health professionals and politicians ★ ○</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services</td>
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<td>Glasgow City Council, Community Planning Partnerships, local tobacco structures, CHCPs</td>
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<tr>
<td><strong>1.19</strong> Through relevant partners/ local structures, lobby for a move to plain packaging of tobacco products</td>
<td>• Glasgow wide responses to national consultations produced ★ ○</td>
<td>• Increased awareness of the issues amongst health professionals and politicians ★ ○</td>
<td>Local tobacco structures</td>
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<tr>
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<td>• Proactive communication on the issue produced where appropriate ★ ○</td>
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- ★: High relevance
- ○: Moderate relevance
- ▲: Low relevance
**Objective 2: Stop smoking**  
**Reduced rates & frequency of active smoking in adults and young people**

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| 2.1 Effectively promote all strands of the stop smoking services (Smokefree community services, pregnancy services, hospital services and pharmacy services) through awareness raising with both the public and health professionals | • NHS Greater Glasgow & Clyde Smokefree Services Communications Strategy in place (October 2009) and Communications subgroup established by June 2009 ○  
• Standardised approach to promotion of the Smokefree Services developed ★★★  
• Smokefree Services materials widely available including the display of materials in all CHCP and Glasgow City Council waiting areas ★★★  
• Materials available in languages and formats to meet needs of minority groups | • Increased awareness of stop smoking services ★★★  
• Calls to Smokeline increased from baseline in 2007 associated with promotional campaigns. Calls monitored on a monthly basis ○  
• Increased number of appropriate referrals to stop smoking services ★★★  
• Increased uptake of stop smoking support ★★★  
• Increased referrals to workplace stop smoking support is provided for staff and, where appropriate and possible, time allowed within work time ○  
• Increased uptake of NRT for patients not wishing to quit (whilst in hospital to comply with smoke free policy) ○  | NHS Greater Glasgow & Clyde Smokefree Services, Smokefree Community Services, Smokefree Pharmacy Services, Smokefree Hospital Services, Smokefree Pregnancy Services, CHCPs, Glasgow City Council, NHS Health Scotland, Smokeline |
| 2.2 Enhance referrals to the service via health professionals (GPs, practice nurses, midwives, dentists, pharmacists, health visitors) and other professionals by increasing the delivery of brief interventions | • Effective CHCP referral process in place ★★★  
• Smokefree Services Brief Intervention training promoted and delivered (minimum of 4 per year) ○  
• When available, widespread promotion of the PATH e-learning brief intervention training (early 2009) ★★★ | • Increased uptake of NRT for patients not wishing to quit (whilst in hospital to comply with smoke free policy) ○  | NHS Greater Glasgow & Clyde Smokefree Services, Smokefree Community Services, Smokefree Pharmacy Services, Smokefree Hospital Services, Smokefree Pregnancy Services, CHCPs, Partnership Action on Tobacco and Health |
| 2.3 Ensure that stop smoking support is included and provided as a key component of smoking policies | • Number of policies reviewed and implemented as part of Healthy Working Lives Award ○  
• NHS Smokefree Services stop smoking support provided within Healthy Working Lives programme ★★★  
• Increased staff and patient awareness and increased provision of NRT to support patients not wishing to quit (whilst in hospital to comply with smokefree policy) ★★★ | | NHS Greater Glasgow and Clyde Smokefree Services, Scotland’s Health at Work, CHCPs, Smokefree Hospital Services, Workplaces |
## Action - What will we do?

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.4</td>
<td><strong>Continue provision and development of a comprehensive, integrated intensive stop smoking services based on the evidence of effectiveness and targeted to the needs of relevant populations</strong></td>
</tr>
<tr>
<td>2.5</td>
<td><strong>Enhance performance of stop smoking services through implementation of national recommendations in relation to training</strong></td>
</tr>
<tr>
<td>2.6</td>
<td><strong>Monitor and review the performance of local stop smoking services including collecting data in line with national requirements (National Minimum Dataset) and within the required time frame to inform targeting of service delivery</strong></td>
</tr>
<tr>
<td>2.7</td>
<td><strong>Increase uptake of the Smokefree Pregnancy Service and improving performance</strong></td>
</tr>
</tbody>
</table>

## Output measures/indicators - What will we monitor to show that we have done this?

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
</table>
| 2.4    | - Number of one-to-one and group stop smoking interventions delivered ★★★
|        | - Number of people accessing evidence based, effective stop smoking services delivered to agreed standard across Glasgow ★
|        | - Pilot cessation approaches in relation to equality strands ★★★
| 2.5    | - PATH training standards adopted within NHS Greater Glasgow & Clyde when finalised in 2009, ensuring appropriateness and effectiveness of training ★★★
|        | - Number of training courses delivered (either locally or nationally) that address the relationship between poverty, gender, ethnicity and smoking made available March 2011 ★★★
|        | - Number of tobacco awareness update sessions delivered and numbers of people attending ★★★
| 2.6    | - Data definitions and data collection systems agreed and implemented in all Smokefree Services ★★★
|        | - Data returned within agreed time frame ★★★
|        | - Reports on progress produced quarterly ★★★
|        | - New stop smoking database developed to ensure effective monitoring of services, linked to national stop smoking services database by October 2009 ★★★
| 2.7    | - 97% carbon monoxide monitoring of all pregnant women at booking achieved by 2011 ★★★
|        | - Increased awareness of Smokefree Pregnancy Service ★★★
|        | - Improved referral processes by effective promotion to pregnant women and primary care staff - ongoing ★★★

## Outcome measures/indicators - What will this achieve and what will we monitor to demonstrate this?

<table>
<thead>
<tr>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
</table>
| 2.4    | - Stop smoking targets (number of people setting quit date) for Smokefree Hospital by 2011 achieved ★★★
|        | - Associated annual increase in stop smoking activity levels indicated by increase in the number of smokers setting quit dates within CHCPs ★★★
|        | - 8% 4 week quit rates within CHCPs achieved by 2011 (2.7% per annum). Progress towards target indicated within quarterly performance focus reports circulated to CHCPs ★★★
|        | - Stop smoking services comply with national guidance ★★★
|        | - Data collected in line with Information Services Division recommendations ★★★
|        | - Increased number of referrals to Smokefree Pregnancy Service ★★★
|        | - Achieve HEAT target for pregnancy services (35% successful quitting at 4 weeks) ★★★
| 2.5    | - NHS Greater Glasgow and Clyde Smokefree Services, all Smokefree Services providers - hospital, maternity, mental health, pharmacy, CHCPs |
|        | - NHS Greater Glasgow and Clyde Smokefree Services, Smokefree Community Services, Smokefree Pharmacy Services, Smokefree Hospital Services, Smokefree Pregnancy Services, CHCPs |
|        | - Partnership Action on Tobacco and Health (PATH) |
| 2.6    | - NHS Greater Glasgow & Clyde Smokefree Services |
|        | - Smokefree Community Services, Smokefree Pharmacy Services, Smokefree Hospital Services, Smokefree Pregnancy Services, ISD Scotland (Information Services Division) |
| 2.7    | - NHS Greater Glasgow & Clyde Smokefree Services |
|        | - Smokefree Pregnancy Service, CHCPs |
### Pilot interventions and new approaches

<table>
<thead>
<tr>
<th>Action - What will we do?</th>
<th>Output measures/indicators - What will we monitor to show that we have done this?</th>
<th>Outcome measures/indicators - What will this achieve and what will we monitor to demonstrate this?</th>
<th>Lead and partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2.8</strong> Take action to embed stop smoking services within other services (e.g. debt counselling, housing, social work, etc.) which tackle the broader social issues that contribute to smoking behaviour and create barriers to stopping smoking</td>
<td>• Number of tobacco awareness raising targeting local key voluntary groups programme in place ★ ○</td>
<td>• Increase in the uptake of stop smoking services by people from Glasgow’s most deprived areas ★ ○</td>
<td>CHCPs, relevant community and voluntary services NHS Greater Glasgow &amp; Clyde Smokefree Services</td>
</tr>
<tr>
<td></td>
<td>• Increased number of local links between stop smoking services and relevant organisations enhanced on an ongoing basis ★ ○</td>
<td>• Increase in the number of people from Glasgow’s most deprived areas setting a quit date ★ ○</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of services developed to be accessible and sympathetic to those in the most deprived areas of our City. ★ ○</td>
<td>• Increased 4-week quit rate for people from Glasgow’s most deprived areas ★ ○</td>
<td></td>
</tr>
<tr>
<td><strong>2.9</strong> Develop a proposal to coordinate interventions which encourage young people across Glasgow to stop smoking, particularly those living in disadvantaged circumstances; and to evaluate the effectiveness of intervention(s)</td>
<td>• Local referral pathways and stop smoking support agreed based on best practice across NHS Greater Glasgow &amp; Clyde by March 2009 ★ ○</td>
<td>• Increased uptake of stop smoking services by young people ★ ○</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services CHCPs, youth organisations, schools</td>
</tr>
<tr>
<td></td>
<td>• Links established between practitioners throughout Glasgow ★ ○</td>
<td>• Increase in the number of young people setting a quit date ★ ○</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased 4-week quit rate for young people ★ ○</td>
<td></td>
</tr>
<tr>
<td><strong>2.10</strong> Contribute to the debate in relation to tobacco and harm reduction i.e. reduced harm cigarettes and the use of long term NRT for those addicted to nicotine</td>
<td>• Glasgow wide contribution to the debate on tobacco and harm reduction produced ★ ○</td>
<td>• Increased awareness of the issues amongst health professionals and politicians ★ ○</td>
<td>NHS Greater Glasgow &amp; Clyde Smokefree Services, local tobacco structures, CHCPs</td>
</tr>
</tbody>
</table>
### Objective 3: Health protection

**Reducing exposure to secondhand smoke and the wider harm associated with smoking**

<table>
<thead>
<tr>
<th>Action - What will we do?</th>
<th>Output measures/indicators - What will we monitor to show that we have done this?</th>
<th>Outcome measures/indicators - What will this achieve and what will we monitor to demonstrate this?</th>
<th>Lead and partners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social marketing and culture change</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| 3.1 Develop a Glasgow wide campaign targeted at parents, to raise awareness of the impact of secondhand smoke on their children's health, to promote smoke-free homes and family vehicles | - Steering group established and plan for campaign ongoing ★ O | - For training participants:  
  - Increased knowledge of risks of secondhand smoke ★ O  
  - Increased knowledge of effective ways to protect children from secondhand smoke O  
  - Increased awareness of opportunities to talk about secondhand smoke O  
  - Increased confidence in talking about secondhand smoke O  
  - Improved skills in brief intervention in relation to secondhand smoke ★ O  
Longer term:  
- More parents and carers restricting where they smoke O  
- Increased knowledge among parents and carers on how to protect children for secondhand smoke O  
- Increased knowledge amongst parents and carers of the health risks of secondhand smoke O | NHS Greater Glasgow & Clyde Smokefree Services, CHCPs  
Glasgow City Council, Strathclyde Fire and Rescue Services,  
schools, primary care, community groups, maternity services,  
Yorkhill Children’s Hospital, voluntary organisations |
| **Employers** |                                                                                   |                                                                                   |                   |
| 3.2 Through the Health at Work Team, promote workplace tobacco policies within organisations in Glasgow both generally and as part of Healthy Working Lives initiative ensuring that policies are highlighted in induction for all new staff ★ O | - Number of workplaces engaged in Healthy Working Lives initiative increased (annually) O  
- Number of new workplace policies in place and implemented O | - Increased awareness & understanding of risks/harm associated with secondhand smoke (including homes & cars) O  
- More negative attitudes towards secondhand smoke exposure O  
- Smoking seen as being less appealing O  
- Employees and the public are not exposed to secondhand smoke in the workplace or enclosed public spaces O | Health at work team  
NHS Greater Glasgow and Clyde, workplaces, CHCPs, local tobacco structures, Glasgow City Council Environmental, Health and Trading Standards, Land and Environmental Services, voluntary sector, Culture and Sport Glasgow |
## Action - What will we do?

### Enforcement of smoke free legislation

<table>
<thead>
<tr>
<th>Action</th>
<th>Output measures/indicators - What will we monitor to show that we have done this?</th>
<th>Outcome measures/indicators - What will this achieve and what will we monitor to demonstrate this?</th>
<th>Lead and partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.3</td>
<td>• Number of visits to premises carried out</td>
<td>• Number of written warnings issued</td>
<td>Glasgow City Council land and environmental services</td>
</tr>
<tr>
<td></td>
<td>• Number of written warnings issued</td>
<td>• Number of fixed penalties issued</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of visits to premises carried out</td>
<td>• Number of fixed penalties issued</td>
<td></td>
</tr>
<tr>
<td>3.4</td>
<td>• New comprehensive policy in Glasgow relating to smoking within care placements put in place in line with recommendations from BAAF. Consultation until December 2008 with policy launched by the end of 2009 ⭐️</td>
<td>• Increased awareness &amp; understanding of risks/harm associated with secondhand smoke (including homes &amp; cars)</td>
<td>Looked After and Accommodated Children’s Health Team, Glasgow City Council Social Work Services, NHS Greater Glasgow &amp; Clyde Smokefree Services</td>
</tr>
<tr>
<td></td>
<td>• Number of tobacco awareness sessions and stop smoking support services provided for LAAC staff and foster carers ⭐️</td>
<td>• More negative attitudes towards secondhand smoke exposure</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Number of tobacco awareness sessions and stop smoking support services provided for LAAC staff and foster carers ⭐️</td>
<td>• Smoking seen as being less appealing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• New comprehensive policy in Glasgow relating to smoking within care placements put in place in line with recommendations from BAAF. Consultation until December 2008 with policy launched by the end of 2009 ⭐️</td>
<td>• Smoking prevalence and carbon monoxide level within LAAC young people.</td>
<td></td>
</tr>
</tbody>
</table>

### Fire prevention

<table>
<thead>
<tr>
<th>Action</th>
<th>Output measures/indicators - What will we monitor to show that we have done this?</th>
<th>Outcome measures/indicators - What will this achieve and what will we monitor to demonstrate this?</th>
<th>Lead and partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5</td>
<td>• Enforcement activity monitored during introduction of RIP cigarettes across Glasgow (2011) ⭐️</td>
<td>• Reduced number of home fires caused by cigarettes ⭐️</td>
<td>Glasgow City Council Environmental, Health and Trading Standards, Land and Environmental Services</td>
</tr>
<tr>
<td>3.6</td>
<td>• Number of home fire safety visits carried out (annually) ⭐️</td>
<td>• Number of fire blankets and fire retardant bedding items distributed through Cordia ⭐️</td>
<td>Strathclyde Fire and Rescue</td>
</tr>
<tr>
<td></td>
<td>• Number of home fire safety visits carried out (annually) ⭐️</td>
<td>• Number of fire blankets and fire retardant bedding items distributed through Cordia ⭐️</td>
<td></td>
</tr>
</tbody>
</table>


6.1 Appendix One: Consultation report on previous tobacco strategy

The report below on the consultation process in relation to the original tobacco strategy was presented to the Glasgow Alliance Board in May 2003 and highlights the extensive consultation that was conducted on the tobacco strategy.

Introduction

1. This paper reports on the consultation exercise on the draft Tobacco Strategy for Glasgow and makes recommendations for changes to be made to the draft document. A copy of the draft strategy is attached.

The consultation process

2. The draft Tobacco Strategy for Glasgow, which was approved by the Glasgow Alliance Board on 13 December 2002, was widely distributed for consultation from mid January - 18 April 2003.

3. Two thousand copies were printed and distributed mainly through the combined databases of the Glasgow Alliance, Glasgow Healthy Cities Partnership and Greater Glasgow NHS Board. The strategy was translated into the 3 main black and ethnic minority languages (Urdu, Punjabi and Cantonese) and audiotapes were made available for people with visual impairment.

4. The general public were advised of the strategy through media articles in the Evening Times, the NHS Health News and Mosaic (a black and ethnic minority community newsletter).

5. It was considered vital to engage with groups who are least likely to respond to written communication, and direct engagement was carried out through a series of supported workshops (with local community groups in Social Inclusion Partnerships SIPS, young people and users of mental health services).

Consultation feedback

6. A summary of all the written responses in information gathered through the consultation workshops has been produced.

General issues raised

7. All respondents welcomed the strategy and agreed with the vision it sets out to achieve. There was generally strong support for the principles and approaches proposed in the strategy. However it was emphasised that while agreeing with the sentiment expressed in the strategy that non-smokers have the ‘right’ to a smoke free environment, such a right does not currently exist in law and at present conflicts with the rights of smokers to smoke.

8. A recurring theme was the need for action by the UK government and Scottish Executive to take action to tackle tobacco (especially in terms of enacting legislation to increase and enforce smoke free public places) and the exemplar role of all Alliance partners individually and collectively.

9. Some respondents highlighted the use of some jargon and abbreviations in the document and suggested that the inclusion of tables and graphs would make the document more understandable.

Specific issues

Environmental tobacco smoke

10. Many responses asked that the section on environmental tobacco smoke be strengthened and include more hard-hitting information. There was support for much more stringent no smoking policies in public places and workplaces. The provision of smoke free areas in respite care facilities was raised as an important issue. It was considered that the NHS in particular had a key role to play in this respect and should make all its premises smoke free.

11. The enforcement of smoke free policies was recognised as difficult but important, with some respondents highlighting that such policies are currently flouted (e.g. on public transport).

12. Young mothers participating in one of the community workshop raised issues regarding the lack of smoke free shopping areas in their local community and the dangers of burns to young children, when people are holding cigarettes at what is eye level for a child and reported instances where burning cigarette ends have landed in children’s buggies.
Stop smoking services support
13. The majority of respondents considered that more resources should be provided for cessation services to help smokers quit. Suggestions were made about the need to provide cessation services specially designed to meet the needs of young people and black and ethnic minority communities.

Prevention
14. There was strong support for the need to continue and increase efforts to prevent young people smoking.

Controlling sales of tobacco
15. It was considered that more action needs to be taken to restrict the sales of tobacco and many respondents raised the issue of the widespread availability of contraband in poorer areas.

The links between poverty and tobacco
16. A number of respondents from Social Inclusion Partnerships considered that the strategy needed to highlight wider poverty related issues.

Gaps identified
17. The following areas were identified as having been omitted/not having been given sufficient emphasis in the draft strategy:
   - The specific needs of black and ethnic minority communities for cessation services.
   - Tobacco and oral health (especially the links with oral cancer) and the potential for dentists to provide cessation support.
   - The need for a change in culture in relation to the use of tobacco for users of Mental Health Services.
   - The links between tobacco and cannabis use.
   - The needs of elderly should not be ignored while priority is given to young people.
   - The strategy should highlight the needs of children and young people (not just young people).

Conclusion and recommendations
18. The Board is asked to:
   a) consider the issues raised.
   b) agree that the strategy should be finalised taking account of the issues set out in paragraphs 7-17 of this report.
   c) individually and collectively as members of Glasgow Alliance commit their organisations to supporting the implementation of the strategy.
6.2 Appendix Two: NHS HEAT targets

Final H.E.A.T. targets for individual CH(C)Ps stop smoking services
Based on Cumulative Number of Successful Quits to reach 8% (21,240) in the Years 2008 - 2011

<table>
<thead>
<tr>
<th>Name of CH(C)P</th>
<th>Total population of smokers</th>
<th>8% of total population smokers</th>
<th>Level Of activity to achieve target (based on 30% quit @ 4 weeks)</th>
<th>Target for year 1 30%of total target</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Dunbartonshire</td>
<td>12687</td>
<td>1015</td>
<td>1017</td>
<td>305</td>
</tr>
<tr>
<td>East Glasgow</td>
<td>30375</td>
<td>2430</td>
<td>2430</td>
<td>729</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>10617</td>
<td>849</td>
<td>850</td>
<td>255</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>16377</td>
<td>1310</td>
<td>1310</td>
<td>393</td>
</tr>
<tr>
<td>North Glasgow</td>
<td>23927</td>
<td>1914</td>
<td>1913</td>
<td>574</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>29209</td>
<td>2337</td>
<td>2337</td>
<td>701</td>
</tr>
<tr>
<td>S. E. Glasgow</td>
<td>20394</td>
<td>1632</td>
<td>1632</td>
<td>490</td>
</tr>
<tr>
<td>S. W. Glasgow</td>
<td>24704</td>
<td>1976</td>
<td>1976</td>
<td>593</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>19654</td>
<td>1572</td>
<td>1572</td>
<td>472</td>
</tr>
<tr>
<td>West Glasgow</td>
<td>27253</td>
<td>2180</td>
<td>2180</td>
<td>654</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>50242</td>
<td>4019</td>
<td>4019</td>
<td>1206</td>
</tr>
<tr>
<td>Total</td>
<td>265,439</td>
<td>21235</td>
<td>21236</td>
<td>6372</td>
</tr>
<tr>
<td>NHSGGC Trajectory</td>
<td>265,498</td>
<td>21240</td>
<td>21240</td>
<td>6372</td>
</tr>
</tbody>
</table>
### Table 16: Estimated Smoking Population figures adjusted down by 21%. Excludes Maternity, Acute, and Mental Health

<table>
<thead>
<tr>
<th>Name of CH(C)P</th>
<th>Level of activity to achieve target years 2&amp;3 (30% quit @ 4 weeks)</th>
<th>Target year 2 &amp; 3 35% of total target</th>
<th>Current activity 2007</th>
<th>Current quit 2007</th>
<th>% increase quit: year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Dunbartonshire</td>
<td>1183</td>
<td>355</td>
<td>971</td>
<td>338</td>
<td>-10%</td>
</tr>
<tr>
<td>East Glasgow</td>
<td>2834</td>
<td>850</td>
<td>1937</td>
<td>535</td>
<td>27%</td>
</tr>
<tr>
<td>East Renfrewshire</td>
<td>990</td>
<td>297</td>
<td>337</td>
<td>148</td>
<td>42%</td>
</tr>
<tr>
<td>Inverclyde</td>
<td>1530</td>
<td>459</td>
<td>347</td>
<td>151</td>
<td>62%</td>
</tr>
<tr>
<td>North Glasgow</td>
<td>2233</td>
<td>670</td>
<td>1236</td>
<td>359</td>
<td>37%</td>
</tr>
<tr>
<td>Renfrewshire</td>
<td>2727</td>
<td>818</td>
<td>784</td>
<td>424</td>
<td>40%</td>
</tr>
<tr>
<td>S. E. Glasgow</td>
<td>1903</td>
<td>571</td>
<td>1409</td>
<td>472</td>
<td>4%</td>
</tr>
<tr>
<td>S. W. Glasgow</td>
<td>2307</td>
<td>692</td>
<td>1846</td>
<td>526</td>
<td>11%</td>
</tr>
<tr>
<td>West Dunbartonshire</td>
<td>1833</td>
<td>550</td>
<td>644</td>
<td>235</td>
<td>50%</td>
</tr>
<tr>
<td>West Glasgow</td>
<td>2543</td>
<td>763</td>
<td>1586</td>
<td>454</td>
<td>31%</td>
</tr>
<tr>
<td>South Lanarkshire</td>
<td>4690</td>
<td>1407</td>
<td>588</td>
<td>179</td>
<td>85%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24773</strong></td>
<td><strong>7432</strong></td>
<td><strong>11685</strong></td>
<td><strong>3821</strong></td>
<td><strong>40%</strong></td>
</tr>
<tr>
<td>NHSGGC Trajectory</td>
<td>24780</td>
<td>7434</td>
<td>13865</td>
<td>3032</td>
<td>38%</td>
</tr>
</tbody>
</table>

**HEAT target - Baseline smokers: 265,498**
(Source: An Atlas of Tobacco Smoking in Scotland)

Table 16: Estimated Smoking Population figures adjusted down by 21%. Excludes Maternity, Acute, and Mental Health