ASH Briefing for local authorities: Pavement licences and smoking

September 2020

Introduction

1. The Business and Planning Act 2020 received Royal Assent on 22 July 2020 and came into effect immediately to help hospitality premises during the COVID-19 pandemic. It sets out a fast track process for pavement licences, allowing licence-holders to place removable furniture over certain highways adjacent to the premises.

2. The purpose is to allow businesses to secure these licences in time for the summer. Local authorities will be receiving applications, and the timescale for determination is limited to 10 working days (see Appendix 1 for more detail).

3. There are two options on smoking, to implement the national condition to provide some smokefree seating; or to go further and make 100% smokefree seating a condition of licences at local level.

4. Arguments are being put forward that smokefree pavement licences will wreck the chances of the cafes, pubs and restaurants recovering from lockdown and could lead to thousands of job losses. In fact, smoking bans are popular with the public, leading to high levels of compliance, and have not been shown to cause a decrease in revenues. Therefore, there is no reason that unemployment may rise due to a requirement for pavement licences to be smokefree.

5. 100% smokefree seating is clear and simple: easy to understand, easy to implement and easy to enforce. Making seating entirely smokefree meets the test for 'reasonable justification' because it is needed, wanted and workable.

6. This briefing sets out the legal (paras 7 to 10), public health (paras 11 – 28), and economic (paras 29 – 37) rationale for local authorities who want to impose a local 100% smokefree seating condition when determining pavement licences under the Business and Planning Act 2020[1] (see Appendix 1 for more detail).

Legal Justification for smokefree pavement licences

7. A legal opinion for ASH has confirmed that a 100% council-wide prohibition on smoking is allowable under the legislation and the guidance in principle (as are 100% prohibitions on individual premises). Liverpool,[2] Manchester,[3] Newcastle[4] and North Tyneside[5] Councils have implemented this, and others are considering doing so.

8. The guidance says (confirming what the Act implies) that local authorities can impose local conditions which are different from the national conditions, and that where the local authority does impose local conditions they take precedence where there is reasonable justification to do so.

9. However, councils need to provide "reasonable justification" where they set their own conditions. Therefore, in imposing a local condition which is different from a national condition, a local authority ought to set out the justification for doing so in its decision making process; for example, in the officer's report to the licensing committee.

10. Such a report should include evidenced public health justification making the link between the harm caused by smoking, why tackling this is a priority for the council and the harm

that could arise from smoking in licensed pavement areas. The public health evidence is set out below.

Needed: The public health justification

Supporting reductions in smoking prevalence (see Appendix 2 for further information)

11. The UK is a party to the WHO Framework Convention on Tobacco Control and its obligations apply to all parts of government including local authorities.[6] [7]
    - Article 3 sets out the objective of the Treaty which is: *"to reduce continually and substantially the prevalence of tobacco use and exposure to tobacco smoke."*
    - Article 2 states that *"In order to better protect human health, Parties are encouraged to implement measures beyond those required by this Convention and its protocols".*
    - Article 4, sets out the guiding principles which include:
        - *2(a) the need to take measures to protect all persons from exposure to tobacco smoke;*
        - *2(b) the need to take measures to prevent the initiation, to promote and support cessation, and to decrease the consumption of tobacco products in any form;*

12. The Prevention Green paper, published in July 2019, lines up with our FCTC obligations in setting out the Government's ambition for England to be smokefree by 2030.[8] It recognised that delivering on this ambition would be *"extremely challenging",* and require *"bold action to both discourage people from starting in the first place, and to support smokers to quit".* It goes on to say: *"It will mean the government, both local and national, working with the health and care system, to put prevention at the centre of all our decision-making."*

13. Following the passing of the Health and Social Care Act 2012, local authorities have, since 1 April 2013, been responsible for improving the health of their local population. Reducing smoking prevalence, both in preventing people starting smoking and supporting smokers to quit, is recognised as essential to improving population health and reducing health inequalities.

14. For those who smoke, smoking is the main modifiable risk to their health, reducing life expectancy and quality of life. 78,000 people die a year from smoking in England, with an estimated thirty times as many suffering from serious smoking-related diseases.[9] [10] Smoking is also responsible for half the difference in life expectancy between the richest and poorest in society.[11] Local data is provided by Public Health England at: https://fingertips.phe.org.uk/profile/tobacco-control

15. Reducing smoking prevalence has immediate benefits to population health, as well as helping to build resilience in health systems, which will prove essential as we head towards winter and the risk of a disastrous co-circulation of COVID-19 and flu.[12] Public Health England guidance states that:[13]
    "On the available evidence, we advise:
    - *if you smoke, you generally have an increased risk of contracting respiratory infection and of more severe symptoms once infected. COVID-19 symptoms may, therefore, be more severe if you smoke*

- *stopping smoking will bring immediate benefits to your health, including if you have an existing smoking-related disease. This is particularly important for both you and for our NHS at a time of intense pressure on the health service."*

16. Stopping smoking leads to immediate improvements in respiratory and cardiovascular health. Current smokers are:[14] [15]
    - More than five times as likely as non-smokers to have microbiologically confirmed influenza, and twice as likely to develop pneumonia; major factors in the winter bed crisis.
    - Twice as likely to suffer acute coronary events, and when they do, twice as likely to die from them.
    - Significantly more likely to be admitted to hospital than non-smokers, spend (on average) a longer time in hospital and then more likely to be re-admitted within 30 days of leaving hospital.

Creating family-friendly spaces that denormalise smoking

17. If smoking is not prohibited, these pavement areas will not be family-friendly spaces. Not only customers and staff, but neighbouring premises — particularly in cramped inner-city areas — will be exposed to the unpleasant smell of second-hand smoke, and the litter left behind.[16]

18. Furthermore, children exposed to adults smoking around them are more likely to start smoking,[17] with two thirds of those who experiment with smoking going on to become daily smokers.[18]

Helping smokers quit and stay quit

19. Local authorities provide stop smoking services to help smokers quit, and they also work to support smokers in staying quit. It is estimated that a million smokers have quit in the last four months because of coronavirus, with those under 30 more than twice as likely to have quit.[19] But relapse is common, with many smokers taking as many as 30 attempts before they successfully quit long-term.[20]

20. Designating pavement licences as smokefree can provide a more supportive environment for smokers trying to quit and stay quit. A population-representative longitudinal cohort study in Canada found that exposure to smoking on patios of a bar or restaurant was associated with a lower likelihood of success in a quit attempt. The conclusion was that instituting smokefree patio regulations may help smokers to avoid relapsing after quitting.[21]

21. If smoking is allowed, passers-by, customers and above all staff, who have no choice, will be exposed to significant amounts of tobacco smoke:
    - Where patio smoking bans (very similar to pavement licences) were implemented in Canada secondhand smoke exposure went down by up to a quarter, while where there was no ban, it went up.[22]
    - Hospitality workers in places where smoking was allowed on patios in Canada were found to be exposed to significant levels of toxic chemicals associated with vascular injury.[23]

Preventing harm caused by secondhand smoke

22. The scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke.[24] Associated health effects include stroke, lung cancer, coronary heart disease,

low birth weight, nasal irritation, middle ear disease, respiratory symptoms, impaired lung function, lower respiratory illness, and sudden infant death syndrome.[25]

23. Significant decreases in hospital admissions for worsening of chronic obstructive pulmonary disease (COPD) and for acute coronary syndrome have been found in numerous jurisdictions following the implementation of smoke-free policies.[26] [27] [28] This evidence supports eliminating exposure to secondhand smoke as a public health priority.

24. Previously those wishing to avoid exposure to second-hand smoke could stay inside, but indoor access to hospitality venues is both more restricted as we emerge from COVID-19 lockdown, and riskier in terms of potential infection.[29]

25. Air quality studies have shown that where smoking is allowed in areas adjoining hospitality venues, exposure outdoors can be significant, and that smoke can, and does, migrate through the outdoor area as well as indoors.[30]

26. Just as with smoking indoors, the level of exposure is highly dependent on the number of cigarettes smoked. However, average outdoor tobacco smoke particle levels near active sources, over the course of one or more cigarettes, can be comparable with average indoor SHS particle levels observed to occur in living rooms or bedrooms during smoking.[31]

27. Another study of bars in Toronto with outdoor smoking patios tested levels of particulate polycyclic aromatic hydrocarbons (PPAH). Mixed model analysis showed that PPAH levels increased significantly with number of lit cigarettes per patio area. High levels of PPAH on patios may be associated with sustained vascular injury. The authors concluded that complete smoking bans including outdoor workspaces are needed to adequately protect hospitality workers from secondhand smoke.[32]

28. Where patio smoking bans (very similar to pavement licences) were implemented in Canada, secondhand smoke exposure went down by up to a quarter, demonstrating that prohibiting smoking on patios was an effective public health measure.[22]

Wanted and workable

<u>UK evidence</u>

29. A 2012 survey of over 4,800 pub customers in Britain found one in five said they visited the pub more often after the legislation was introduced, with 70% saying they were more likely to take their children. More than one in three said they actively avoided pubs with crowds of people smoking near the entrance.[33]

30. Fewer than one in seven adults smoke,[34] and people dislike being exposed to tobacco smoke. When Greater Manchester surveyed its population, over 70% wanted the areas immediately outside public buildings to be smokefree environments.[35]

31. Pavement licences will exacerbate the problem as by definition they are designed to make it easier for bars, restaurants and pubs to serve food and drink to customers on the pavement immediately outside their premises.[36]

32. Smokefree laws were introduced in England in July 2007, and government statistics show that the number of premises with licenses to sell alcohol increased (rather than decreased) by 4,200 during that year.[37] [38] While Forest, the tobacco industry funded lobby group, still asserts that the legislation *"was a significant factor in thousands of pubs closing after it was introduced in 2007",* the data show that there was an increase in licensed premises

serving food, and the only decline was in the number of pubs that were drinking only establishments.[39]

International evidence

33. A New South Wales Health survey found that 38% of males and 43% of females would frequent a venue 'more often' if it banned smoking in outdoor dining areas. Only 6% of males and 5% of females stated they would visit 'less often', the remainder of the respondents indicated it would have no effect on their attendance.[40]

34. The evidence from Canada, where 9 out of 13 provinces plus major cities like Vancouver have 'patio smoking bans' which cover the same areas as pavement licences, is that they are supported by the public.[41]

35. An international review, across 56 studies, of the financial impact of indoor smokefree policies for hospitality businesses found that: "An increase in the share of bar and restaurant sector sales in total retail sales was associated with smoking bans." [42] A subsequent analysis of the impact on bars, cafes and restaurants in Europe concluded that smokefree laws had "improved public health without a corresponding negative impact on revenues and employment in the hospitality industry".[43]

36. A survey of the impact of implementation of patio smoking bans across Canada found that:
    - Compliance was high and enforcement was not an issue (as measured by complaints and charges).[41] [44] In Ontario, where 100% smoke-patios outside restaurants and bars were introduced in 2015, compliance based on inspections was 96% from the outset, higher than for enclosed workplaces and public places.[44]
    - There was no evidence of an adverse impact on business after the law came into effect. Fears some businesses had in advance of implementation that they would lose out, "turned out to be unfounded".[41]

37. The hospitality trade has not been harmed by smoking bans to date, in either the UK or any other country.

Appendix 1: Detail on pavement licences

38. The detail is included in the Act and the Guidance, both available online and summarised below.

39. A pavement licence is a licence granted by the local authority which allows the licence-holder to place removable furniture over certain highways adjacent to the premises.

40. Pavement licences are presently granted primarily under Part 7A of the Highways Act 1980. The Business and Planning Act 2020 provides a cheaper, easier and quicker way for businesses to obtain a licence. The purpose of this streamlined process is to allow businesses to secure these licences in time for the summer and, where they are deemed to have been granted, allow these licences to remain in place for a year but not beyond 30 September 2021.

41. The fee for applying for a licence under the new process, is capped at £100 and the consultation period is 5 working days (excluding public holidays) starting the day after the application is sent electronically to the authority. It is currently a minimum of 28 calendar days under Part 7A.

42. The fee for applying for a licence under the new process, is capped at £100 and the consultation period is 5 working days (excluding public holidays) starting the day after the application is sent electronically to the authority.

43. If the local authority does not determine the application before the end of the determination period (which is 5 working days beginning with the first day after the end of the public consultation period, excluding public holidays), the licence is deemed to have been granted for a year (but not beyond 30 September 2021) and the business can place the proposed furniture such as tables and chairs within the area set out in the application for the purpose or purposes proposed.

44. The 2020 Act sets out two conditions which apply to pavement licences which are granted or deemed to be granted these are: a no-obstruction condition and a smoke-free seating condition. These apply only to licences granted under the Business and Planning Act 2020, not existing licences permitted under Part 7A of the Highways Act 1980, or other relevant legislation.

45. The smokefree seating condition in the legislation requires a licence-holder to make 'reasonable provision for seating where smoking is not permitted'. Guidance published by MHCLG[45] requires local authorities to assess whether the 'reasonable provision' test has been met. See below for relevant extracts from the guidance, which lacks specificity:
    - Reasonable provision means that where businesses provide for smokers, customers will also have the option of sitting in a non-smoking area.
    - Ways of meeting this condition could include:
        - Clear 'smoking' and 'non-smoking' areas, with 'no smoking' signage displayed in designated 'smoke-free' zones in accordance with Smoke-free (signs) regulations 2012 which can be viewed here.
        - No ash trays or similar receptacles to be provided or permitted to be left on furniture where smoke-free seating is identified.
        - Licence holders should provide a minimum 2M distance between non-smoking and smoking areas, wherever possible.

46. Therefore, at a minimum, smoke-free seating must be provided; but councils can go further and require that seating be entirely smoke-free. Where a local authority sets a local condition that covers the same matter as set out in national conditions, then the locally set condition would take precedence over the national condition where there is reasonable justification to do so.[46]

Appendix 2: Smokefree 2030 ambition and smoking prevalence

47. Major public health benefits, including for workers, have been secured from banning smoking in enclosed public places.[47] [48] In particular:
    - There was 98% smoke-free compliance from the outset and strong support for the legislation from the business community, with 87% of businesses saying implementation had gone well, and 40% reporting a positive impact and only 3% reporting a negative impact.
    - Public perceptions of the personal, health and environmental benefits of being smoke-free grew, and the proportion of the public prohibiting smoking in their home grew. Approximately two-thirds (67%) said that smoking was not allowed at all in their home in 2007, compared to 61% in 2006.
    - An additional 300,000 smokers in England tried to quit as a result of the legislation, with the Stop Smoking Services reporting an increase of 22% in the number of successful quitters at 4 weeks.

- Support for the legislation grew after implementation, particularly for pubs and restaurants. In 2005, before the legislation was passed, two thirds of the public supported the inclusion of pubs and restaurants. One year after the legislation was implemented, 96% supported smoke-free restaurants and 75% smoke-free pubs.

48. However, banning smoking inside public places has displaced SHS exposure to adjacent outdoor areas. [49] This exposes passers-by and those going into plumes of smoke, with staff worst affected.[50]

49. Last summer the Government announced its ambition for England to be smoke-free by 2030, with a commitment to bringing forward further proposals to deliver this ambition, recognising that it would require 'bold action' to achieve its vision.[8] By setting such a condition the Government would demonstrate its commitment to delivering the 'bold action' needed to achieve its smoke-free ambition.[8] A year later, there are still no such proposals.

50. Smoking rates have declined but smoking remains the leading cause of preventable premature death, killing 77,800 adults in England and 96,000 in the UK every year.[51] That's more than 200 every day in England and 250 every day in the UK, year in and year out.

51. Although most recent data for 2019**Error! Bookmark not defined.** show that smoking r ates are declining year-on-year, still more than one in ten of the adult population smokes. The figure is 13.9% for England, amounting to around 6 million adults and 14.1% for the UK, amounting to around 7 million.

52. Smoking rates in children under 16 have declined significantly since the millennium as tobacco and smoking has been regulated to a greater and greater extent. In the year 2000, 19% of 11-15 year olds smoked — by 2018 it was only 5%.[52] However, this still amounts to over 280 children starting smoking every day in England. On Monday 13th July 2020, the total number of children who had started smoking since the Government announced its ambition for England to be smokefree by 2030 topped 100,000.[53]

References

1 HM Government. Business and Planning Act 2020. 2020.

2 Liverpool City Council. Pavement Licences. Online. Accessed August 2020.

3 Manchester City Council. Terms and conditions of a pavement licence. Online. Accessed August 2020.

4 Newcastle City Council. Pavement Licences. Online. Accessed August 2020.

5 North Tyneside Council. Conditions to place items of furniture on the highway. Online. Accessed August 2020.

66 World Health Organization. WHO Framework Convention on Tobacco Control. 2003.

7 World Health Organization. Guidelines for implementation of Article 5.3 of the WHO Framework Convention on Tobacco Control. 2008.

8 Cabinet Office and DHSC. Advancing our health: prevention in the 2020s – consultation document. July 2019.

9 Public Health England (PHE). Smoking and tobacco: applying all our health. Online. Accessed July 2020.

10 Centers for Disease Control and Prevention (CDC). Smoking & Tobacco Use. May 2020. Accessed June 2020.

11 Jha P, Peto R, Zatonski W, et al. Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America. The Lancet 2006; 36: 367–370.

12 NHS England, the Department of Health and Social Care (DHSC) and Public Health England (PHE). The national flu immunisation programme 2020/21. Online. Accessed 20 August 2020.

13 Public Health England Guidance. COVID-19: advice for smokers and vapers. 29 May 2020.

14 Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. London: RCP, 2018.

15 Mullen KA, Manuel DG, Hawken SJ, et al. Effectiveness of a hospital-initiated smoking cessation programme: 2-year health and healthcare outcomes. Tobacco Control 2017;26:293-299.

16 Keep Britain Tidy. #BinTheButt. Online. Accessed August 2020.

17 Royal College of Physicians. Passive smoking and children. A report by the Tobacco Advisory Group. London: RCP, 2010.

18 Birge M, Duffy S, Miler JA, Hajek P. What Proportion of People Who Try One Cigarette Become Daily Smokers? A Meta-Analysis of Representative Surveys. *Nicotine Tob Res.* November 2018. doi:10.1093/ntr/ntx243

19 ASH. A million people have stopped smoking since the COVID pandemic hit Britain. 15 July 2020. Analysis based on an online survey conducted by YouGov between 15th April and 20th June 2020 with 10251 respondents. Additional analysis was undertaken by Action on Smoking and Health and University College London using ONS population data mid-year 2019 estimates. The central estimate is 1095409, with a 95% confidence interval of 947,096 to 1,259,014 people. This is a rate for short-term quit success and it remains to be seen if this translates into longer term quit success.
20 Chaiton M, Diemert L, Cohen JE, et al. Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers. BMJ Open 2016;6:e011045. doi: 10.1136/bmjopen-2016-011045
21 Chaiton M, Diemert L, Zhang B, et al. Exposure to smoking on patios and quitting: a population representative longitudinal cohort study. Tobacco Control 2016;25:83-88.
22 Azagba S. Effect of smoke-free patio policy of restaurants and bars on exposure to second-hand smoke. Preventative Medicine 76 (2015) 74-78. https://doi.org/10.1016/j.ypmed.2015.04.012
23 Zhang B. Bondy S. Ferrence R. Do indoor smoke-free laws provide bar workers with adequate protection from secondhand smoke? Prev Med. Aug-Sep 2009;49(2-3):245-7. doi: 10.1016/j.ypmed.2009.06.024. Epub 2009 Jul 6.
24 U.S. Department of Health and Human Services. The Health Consequences of Involuntary Exposure to Tobacco Smoke: A Report of the Surgeon General. Atlanta, GA. 2006.
25 US Department of Health and Human Services. The health consequences of smoking—50 years of progress: a report of the surgeon general. Atlanta, GA, 2014.
26 Naiman A, Glazier RH, Moineddin R. Association of anti-smoking legislation with rates of hospital admission for cardiovascular and respiratory conditions. CMAJ 2010;182:761–7.
27 Sims M., Maxwell R., Bauld L., Gilmore A. Short term impact of smoke-free legislation in England: retrospective analysis of hospital admissions for myocardial infarction. BMJ 2010; 340 :c2161
28 Meyers DG, Neuberger JS, He J. Cardiovascular effect of bans on smoking in public places: a systematic review and meta-analysis. J Am Coll Cardiol 2009;54:1249–55
29 Department of Culture Media and Sport. Department for Business, Energy, and Industrial Strategy. Working safely during coronavirus (COVID-19). Online. Accessed August 2020.
30 Mulcahy M, Evans DS, Hammond SK, et al. Secondhand smoke exposure and risk following the Irish smoking ban: an assessment of salivary cotinine concentrations in hotel workers and air nicotine levels in bars. Tobacco Control 2005;14:384-388.
31 Neil E. Klepeis, Wayne R. Ott & Paul Switzer. Real–Time Measurement of Outdoor Tobacco Smoke Particles. Journal of the Air & Waste Management Association, 57:5, 522-534, DOI: 10.3155/1047-3289.57.5.522
32 Zhang B, Bondy S, Ferrence R. Do indoor smoke-free laws provide bar workers with adequate protection from secondhand smoke? Prev Med. 2009;49(2-3):245-247. doi:10.1016/j.ypmed.2009.06.024
33 Harrington J. One in five visit pubs more often after smoking ban. Morning Advertiser. 2012.
34 Office of National Statistics. Adult smoking habits in the UK: Statistical bulletins. 2020.
35 Greater Manchester Health & Social Care Partnership. Representative sample of 8085 adults. Asked which, if any, of the following public places would you like to see as smoke-free environments highest rated were children's playgrounds (93%) and school and nursery entrances (92%), but 72% wanted the areas outside public buildings and 79% entrances and exits to be smoke free.
36 Ministry of Housing, Communities and Local Government. Guidance: pavement licences (outdoor seating proposal). July 2020.
37 DCMS, DCMS Statistical Bulletin - Alcohol, Entertainment and Late Night Refreshment Licensing, England and Wales, April 2007 – March 2008, 30th October 2008.
38 Mark Easton, Pubs aren't dying – they are evolving, BBC, July 2009.
39 Forest Press release. Forest condemns move to ban smoking outside pubs and cafes. 13th July 2020.
40 NSW Health. Impact of total smoking ban on outdoor dining areas, adults aged 16 years and over, NSW, 2008 Sydney: 2008.
41 City of Winnipeg. Council Minutes – 25 January 2018. Accessed August 2020.
42 Cornelsen L, McGowan Y, Currie-Murphy LM, et al. Systematic review and metaanalysis of the economic impact of smoking bans in restaurants and bars. Addiction 2014;109:720-7.
43 Pieroni L., Salmasi L., The Economic Impact of Smoke-Free Policies on Restaurants, Cafés, and Bars: Panel Data Estimates From European Countries. J Policy Anal Manage. 2017;36(4):853-79. doi: 10.1002/pam.22016.
44 Ontario Tobacco Research Unit. Smoke-Free Ontario Strategy Monitoring Report: Protection. 2018.
45 Ministry of Housing, Communities and Local Government. Guidance: pavement licences (outdoor seating proposal). 22 July 2020 (accessed 23rd July 2020)
46 Ministry of Housing, Communities and Local Government. Guidance: pavement licences (outdoor seating proposal). 22 July 2020 (accessed 23rd July 2020)
47 Bauld L. The Impact of Smoking in England: Evidence Review. 2015.
48 Department of Health. Smokefree England – one year on. 2008.
49 Lopez M., Fernandez E., Gorini G., Moshammer H., Polanska K., Clancy L., Dautzenberg B., et al. Exposure to Secondhand Smoke in Terraces and Other Outdoor Areas of Hospitality Venues in Eight European Countries. PLoS One. 2012; 7(8): e42130.
50 Licht A., Hyland A, Travers M, Chapman S. Secondhand Smoke Exposure Levels in Outdoor Hospitality Venues: A Qualitative and Quantitative Review of the Research Literature. Tob Control. 2013 May; 22(3): 172–179. doi: 10.1136/tobaccocontrol-2012-050493
51 ONS. Adult smoking habits in the UK: 2019. July 2020.
52 NHS Digital. Smoking, drinking and drug use among young people in England 2018. 2019.

53 Methodology: Calculated by the Cancer Intelligence Team at Cancer Research UK, December 2019, using Smoking, Drinking and Drug Use in Young People in England 2016 and 2018 data. Figures represent the average number of children per year between 2016 and 2018. Percentage of new smokers was calculated for each single-year age band, and 'smoker' was defined as 'regular', 'occasional' or 'used to smoke'. For example, percentage of new smokers aged 13 in 2018, was calculated by subtracting the percentage of smokers aged 12 in 2017, from the percentage of smokers aged 13 in 2018. This calculation was used for ages 12, 13, 14 and 15; for age 11 all smokers were considered new smokers. 2017 figures were estimated as the average of 2016 and 2018, as no 2017 survey was carried out. Percentage of new smokers in England was applied to UK population estimates to obtain the number of new UK smokers. The 2014-18 trend in estimated number of new child smokers in the UK each year was projected forward to obtain estimates for 2019-21. Yearly figures were divided by 365 to obtain daily figures.