1. **Summary**
   1.1 This report submits the draft report of the Health Scrutiny Panel Review on Smoking and Tobacco Cessation

2. **Recommendations**
   It is recommended that the Health Scrutiny Panel:

   2.1 consider the draft report and comment on the recommendations of the review and suggest any further recommendations.

   2.2 delegate final approval of the report to the Acting Assistant Chief Executive after consultation with the Chair of the Health Scrutiny Panel.

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**LOCAL GOVERNMENT ACT, 2000 (SECTION 97)**

**LIST OF “BACKGROUND PAPERS” USED IN THE PREPARATION OF THIS REPORT**

| Background papers | Name and telephone number of and address where open to inspection |
Report of the Health Scrutiny Panel

Smoking & Tobacco Cessation

Tower Hamlets Council
March 2008
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Chair’s Foreword

There can hardly be any member of our community who is not aware of the health message around smoking. We are bombarded with images and words telling us that smoking kills, harms the unborn child, reduces fitness, leads to premature aging and makes most chronic diseases worse. Yet people still smoke and more people in our community smoke than elsewhere. Our poorest residents suffer the most from smoking related disease and they are also less likely to access support services to help them stop. Because of this a person living in our poorest areas dies on average 12 years earlier than someone living in a more affluent area of the Borough.

A great deal of research and activity has occurred to encourage people across the UK to stop smoking, to prevent smoking and to reduce people’s exposure to second hand smoke. However our Tower Hamlets’ community has some distinct and particular characteristics that require local examination and local solutions. To give one example, the use of chewing tobacco by some members of the Bangladeshi community is not well researched and there has been little or no action taken to advise sellers and users of paan of the dangers of this product and to support them in their efforts to cease.

In carrying out this review we have taken a distinctively local approach to the problems that arise in our community from the use of tobacco products. We have looked at the supply of cheap (and nasty) tobacco products through our street markets, and researched the availability of these to young people. We have considered the high smoking levels among Bangladeshi men and the use of paan more widely in Bangladeshi homes. We have considered the materials used to promote tobacco cessation, and we have been surprised at the lack of any comprehensive evaluation of ‘what works’. There is anecdotal evidence that health care workers such as midwives, occupational therapists and community mental health workers struggle to include smoking cessation advice with their other guidance and support to patients, which needs to be addressed urgently if we are to meet targets to reduce the gap in health inequalities amongst the residents of our borough.

This work has been undertaken with the support and assistance of colleagues from London Borough of Tower Hamlets, the Primary Care Trust and elsewhere. We are grateful for all their support but special mention should be made of the Scrutiny Policy Officers, Shanara Matin and Michael Carr who worked tirelessly and with good humour to ensure this review was completed successfully.
This report takes a fresh perspective on the problems that arise from the use of tobacco in Tower Hamlets. We have identified areas where the Primary Care Trust and the Council need to improve data collection, local engagement strategies, the evidence base, enforcement and advice to retailers. We hope that these recommendations will be implemented quickly and in full. The human and financial cost to our community of continued ill health and premature death demands we address the threat of tobacco with vigour and urgency.

Councillor Dr Stephanie Eaton
Chair
Chapter 1 – Introduction

Background

1. Smoking is the single most preventable cause of death and ill health in the UK and it is one of the most important factors in maintaining health inequalities in Tower Hamlets.

2. 86,500 people are estimated to die each year from smoking related illnesses in the UK. Smoking disproportionately affects the least well-off and is the major reason for the differences in death rates between rich and poor. The ratio of deaths from tobacco are two to three times higher amongst disadvantaged social groups than among the better off.

3. The borough’s diverse and transient population alongside high levels of deprivation contribute to very different levels of access to health care services and differences in health outcomes. This most significantly translates into low average life expectancy levels for local residents. The analogy of travelling eight stops on the Jubilee Line from Westminster to Canning Town equating to almost a year per stop lost in terms of life expectancy highlights the extent of health inequalities between neighbouring Boroughs.

4. Through an induction process looking at the borough’s health profile in 2006, the Health Scrutiny Panel agreed a four year work-programme with smoking being identified as one of the most important public health issues amongst local communities.

5. This is re-enforced by figures which put smoking prevalence at 37% in Tower Hamlets compared with the England average of 24% and 22% for London. This means in 2007 it is estimated that there were nearly 68 000 smokers in Tower Hamlets. The smoking rate for men aged 25-44 years was reported as being the highest (43%) for all English Primary Care Trusts (PCT). Amongst the Bangladeshi male population it is thought the percentage is higher at 50%. Such high levels of smoking prevalence represent a heavy disease burden. In 2005 this equated to 405 smoking related deaths - a rate of more than one a day.

6. Mortality from smoking related diseases (including cardiovascular disease, lung cancer, other cancers and chronic obstructive airways disease) is higher than average and is estimated to be responsible for about 70% of the gap in life expectancy between Tower Hamlets and the rest of the country for men and 59% for women. Last year 36% of all deaths in the borough were linked to smoking related diseases - a very challenging level of preventable morbidity.
7. This year the England wide smoking ban in public places and the Tower Hamlets Tobacco Control Strategy refresh also offered timely and significant opportunities for raising the profile of the wider tobacco cessation campaign and for reviewing smoking cessation services and tobacco control measures to ensure they are making a difference to local health outcomes.

8. The establishment of a joint Tobacco Control Unit between Tower Hamlets Primary Care Trust (THPCT) and the Council is also an important step in more co-ordinated services and a holistic approach to tackling an important area of public health.

The review process

9. The Health Scrutiny Panel was established in 2004 and has since then carried out reviews on Childhood Obesity, Diabetes and Young People’s Access to Sexual Health Services. In beginning work on a four-year work
programme in 2006, the Health Scrutiny Panel reviewed Access to GP and Dentistry Services. This year’s work on tobacco and smoking cessation aims to build on recommendations to improve access to primary care by considering how we can improve access to and take up of health promotion services.

10. Smoking is a challenging health issue linked to lifestyle, culture and deprivation in uniquely different ways to other health problems. Policy measures such as the smoking ban, though widely accepted and seen as successful do also still raise issues around infringement of civil liberties on both sides. Given this context the Panel agreed that it was important to narrow the focus of the review to concentrate on the Tower Hamlets Tobacco Control Strategy as the best means for delivering meaningful improvements in this wide area of public health concern.

11. The panel agreed that the reasons for undertaking the review were:

- The high prevalence of smoking in the borough
- The high prevalence of smoking in individual communities and social groups in the borough focusing particularly on the needs of hard to reach groups
- The preventability of diseases related to smoking
- To improve on the low life expectancy levels
- To maximize the opportunities coming out of the introduction of the Smoking Ban and the revised Tobacco Control Strategy.

12. The panel agreed that a review on smoking should include all types of tobacco consumption including passive smoking and chewing tobacco to take into account the high levels of oral tobacco use in the borough.

13. The objectives of the review were to:

a. To consider the composition and terms of reference of a tobacco control alliance.
b. To evaluate the effectiveness of current strategies of engagement with key community groups and organisations, including targeting of high risk and “hard to reach” groups for smoking and tobacco cessation, specifically Bangladeshi males.
c. To evaluate the extent of the availability of black market tobacco and the price and quality of products sold at street markets.
d. To evaluate available research on access to tobacco products by under 18s and the enforcement of breaches of trading standards relating to the selling of tobacco to under 18s.
e. To collate the available material for communicating the smoking cessation and tobacco control message, to examine evidence that the communications strategies work, and to identify possible gaps.
f. To investigate strategies to develop the capacity and skills of front line healthcare providers to support people in giving up smoking / oral tobacco.
g. To evaluate the time and resource implications for the enforcement of the workplace smoking ban on LBTH Trading Standards officers.
h. To consider the strategies in place for the regulation and cessation of chewing tobacco (including Paan) and whether these products carry the legal health notices to the required standard.

14. The Panel's work programme is outlined below:

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Chapter 2 - National Policy Context

15. The 1998 white paper, *Smoking Kills*, promoted a comprehensive strategy for tobacco control, which still underpins much of current policy initiatives aimed at reducing the number of people smoking. The legislation put tobacco control at the heart of the NHS policy agenda thereby building in a mechanism for accountability and placing tobacco control measures at the heart of health promotion and disease prevention work.

16. The wide-ranging proposals in the white paper included measures to abolish tobacco advertising and promotion, altering public attitudes, preventing tobacco smuggling, and supporting research to improve the design, delivery and impact of smoking cessation services. Some of the specific measures were:

- rules on the placement of cigarette vending machines
- the introduction of an approved code of practice on smoking in the workplace – (eventually to be replaced with a total ban on smoking in public places)
- mass media health promotion campaigns
- the prevention of under-age tobacco sales
- additional services to help smokers quit
- increases in tobacco tax

17. Published at a time when smoking prevalence was increasing, it also set out specific targets to reduce smoking amongst young people and pregnant women.

18. Part of the Department of Health response to the white paper included directing Health Authorities and Primary Care Groups to develop
comprehensive local strategies to tackle smoking as part of Health Improvement Programmes in partnership with local authorities. This was also the first time health agencies were explicitly directed to develop smoking cessation services in partnership with local groups and organisations. There has thus been an increasing focus on greater partnership working between tobacco control services traditionally delivered by local authorities and smoking cessation services which are in the main provided by the NHS.

19. The NHS Cancer Plan of 2000 set out the government’s vision for tackling the disease and for cancer prevention. It focused in particular on narrowing the gap in inequalities with the introduction of an additional target to reduce rates of smoking among people in ‘manual’ groups from 32% in 1998 to 26% by 2010.

20. The White Paper Choosing Health: Making Healthier Choices Easier (November 2004) set out how the Government will make it easier for people to make informed choices about their health by offering them practical help to adopt healthier lifestyles. Choosing Health signalled the Government’s intention to refocus the NHS into a service for improving health as well as one that treats sickness. Central to this approach is a focus on reducing smoking and protecting people from exposure to second hand smoke.

21. Alongside the focus on smoking in public health policy there have been measures to improve the enforcement of legislation prohibiting the sale and access to Tobacco by young people. These measures include work to prevent trade in black market cigarettes which reduces the impact of the Government’s use of taxation on tobacco as a public health intervention. The Government’s New responses to new challenges: Reinforcing the Tackling Tobacco Smuggling Strategy was published in 2006 detailing a comprehensive response to the new challenges emerging as the illicit market in tobacco adapts and develops.

22. The Health Act 2006 further raised the age at which tobacco can legally be bought and set out legislative provisions for making almost all public places and workplaces smoke free, from July 2007. This reflected the mounting scientific evidence of the risks posed by passive smoking and changes in wider public opinion leading to the introduction of bans across cities in Europe and North America.

23. National policies and legislation have continued to evolve since the 1998 white paper which is seen as a benchmark for tackling tobacco consumption in a more holistic way than before. This has meant an increasing focus on areas such as passive smoking, ensuring tobacco control and enforcement is more effective and a recognition of differences in needs of different smoking groups including the much bigger challenges around encouraging smoking cessation amongst more disadvantaged groups.
Chapter 3 - Local Policy Context

Smoking Prevalence

24. The 2006 Tower Hamlets Public Health Report which examines the causes and consequences of poor health in the people of Tower Hamlets cites smoking as the biggest threat to the health of local people. Smoking increases the risk of both lung cancer, the most common cause of death in the borough, and heart disease, which accounted for a quarter of early deaths in men in the previous year.

25. Smoking rates in the borough are still amongst the highest in the country at 37%, with 43% of men aged between 35-44 smoking cigarettes. Almost half of all men in Tower Hamlets over the age of 35 die from smoking-related causes. The UK average is 27% of men and 25% of women. People in deprived circumstances are not only more likely to take up smoking but generally start younger, smoke more heavily and are less likely to quit smoking, each of which increases the risk of smoking-related disease. There is also a high prevalence of chewing tobacco/pann which is linked to severe gum disease and mouth cancers.

26. Low average life expectancy figures means that the borough is a Government ‘spearhead’ area with specific targets to reduce health inequalities by 10 per cent by 2010. These targets are mirrored in the Local Area Agreement and Tower Hamlets Community Plan both of which include a priority to increase life expectancy and prevent premature loss of life due to smoking related diseases. Life expectancy is also a key measure for determining levels of health inequality.

Healthcare Commission Review

27. The 2006 Healthcare Commission review into PCT Tobacco Control & Smoking Cessation Services gave the THPCT an overall score of 3 or ‘good’ (1 being weak and 4 being excellent). Some of the innovative aspects of the Tobacco Control Programme in Tower Hamlets were highlighted as the recruitment of smoking cessation advisors from local communities (e.g. pharmacists and voluntary groups), projects targeted at ethnic minority groups, drop-in clinics, collaboration with environmental health and locally specific campaigns such as the one taking place during Ramadan, the Muslim month of fasting.

28. The review also set out some important areas for improvement such as strengthening partnership working, targeting specific groups such as pregnant women and young people, broadening the range of smoking cessation advisors and increasing the settings for tobacco control activities.

Tower Hamlets Tobacco Control Strategy Refresh

29. The Tower Hamlets Tobacco Control Strategy is currently being refreshed. It is a joint strategy between the Council and the Tower Hamlets Primary Care
Trust providing a comprehensive approach to tackling tobacco use by focusing on prevention, smoking cessation and effective enforcement of tobacco legislation.

30. One of the key aims of this review is to contribute to the revised Strategy and inform its action plan. The draft strategy currently has three themes (detailed below) and structured around work streams relating to each of these themes. The Strategy also makes provisions for a Tobacco Control Alliance which will be a multi agency steering group to oversee implementation of the action plan.

a. Theme 1: **To stop people starting to use tobacco** (smoking, oral tobacco use targeted particularly at teens and pre-teens. It focuses on both enforcement of tobacco control policies particularly affecting young people (under age sales, contraband/counterfeit tobacco, smoking ban) and sustained campaigns across a range of relevant settings such as families, schools, preschool, other youth settings.

b. Theme 2: **To encourage and help people to stop using tobacco** - focused on promoting demand for stop smoking services and increasing supply of NHS accredited Stop Smoking services across a wide ranges of settings. The work stream also recognises the need for targeted work with specific groups (pregnant women, Bangladeshi males, and people with mental health problems) and use of oral tobacco.

c. Theme 3: **To achieve a Smoke Free Tower Hamlets** – recognises the critical importance of the effective implementation of the smoking ban in Tower Hamlets in both protecting people from second hand smoke and also in providing motivation for people to stop smoking (linking to theme two). It also recognises the role of smoking as a significant contributor to accidental fires.

*Figure 2. Proposed structure for implementation of Tower Hamlets Tobacco Control Strategy as presented to the Health Scrutiny Panel in November 2007.*
Conclusions

Review objective:
To consider the composition and terms of reference of a tobacco control alliance.

31. The panel received a presentation on the draft Tobacco Control Strategy and were invited to comment on the proposed composition of the Tobacco Control Alliance. Members suggested that the steering group include a Councillor/ elected member representative to reflect the health scrutiny role of the Council but also to support profile raising and endorsement.

32. Members stressed the need to ensure a balance between representation and effectiveness. The panel also recommended that the strategy should be more explicit in taking into account the different reasons for smoking between different communities – thus requiring different types of services.

33. The formation of the Tobacco Control Alliance is an opportunity for a Communications Strategy refresh and Members suggested that Communications work should also come under the remit of the Tobacco Control Alliance. Since the initial discussion during the review, a communications work stream has been added to the Tobacco Control Alliance working model.

34. Members also believed that it was important to develop the arguments for going smokefree on health grounds and to emphasise the wider economic benefits from healthier communities.

35. The Panel would like to be kept updates of progress against the Tobacco Control Strategy as monitored by the Tobacco Control Alliance and for this to be included within the Action Plan for this review.
36. Members also welcomed the information that quit targets for 2006/07 in the Local Area Agreement had been exceeded, achieving 2151 quits against a target of 1755. Members felt it would be useful for the Tobacco Control Strategy to include greater stretch targets to build on and reflect current good practice.

Chapter 4 – Findings

Communications

**Review objective:**  
To collate the available material for communicating the smoking cessation and tobacco control message, to examine evidence that the communications strategies work, and to identify possible gaps.

37. Members received briefings from the Primary Care Trust, the Trading Standards and Environmental Health Team and visited the Tobacco Control Unit and its public health resource centre to review the range of communication strategies and resources and materials used to promote tobacco and smoking cessation.

38. The Primary Care Trust run a number of annual campaigns that tie in with national events, the New Year and a specific campaign during Ramadan targeting Muslim communities within the Borough. The development of a campaign specifically around Ramadan makes use of opportunities around the prohibition of smoking whilst fasting to target messages around the health benefits of giving up altogether. The campaign uses posters and leaflets translated into community languages and a series of adverts on Muslim Community Radio. Members welcomed the work targeted at communities where there is a high smoking prevalence and the local knowledge used in developing these campaigns.

39. The annual ‘No Smoking Day’ in March uses nationally produced materials which is sent to all GP practices and pharmacies. The New Year campaigns are much more locally specific and in January 2007 were used to introduce the ‘Fresh Start’ campaign leading up to the introduction of the Smoking Ban in July. A Bengali video advert was broadcast on Channel S as part of that campaign.

40. The PCT and Local Authority produced a joint strategy for delivering the smoking ban in Tower Hamlets which included information on smoking cessation services to complement the enforcement messages and general awareness raising of the new legislation.
41. Panel Members were able to see the range of branded materials that have been developed as part of the adoption of the national Smokefree brand through a visit to the Tobacco Control Unit. They also looked at a range of public health resources to promote smoking cessation used at public events, in schools and by community and voluntary sector organisations that promote tobacco cessation. Primary Care Trust officers discussed current communication plans which include sending out Smokefree branded leaflets and dispensers to 800 settings across the borough.

Pictues of visit to be inserted

42. The public health resource centre holds an extensive range of materials targeting the elderly, pregnant women, new dads and for people who have tried to quit smoking and not yet been successful. These materials reflected a range of approaches from using shock tactics to prevent uptake and motivate people to quit to practical mediums for promoting the availability of cessation services such as the quit help lines.

43. The Panel asked about how the impact of these resources were measured. There is currently limited information on the impact of individual resources which would be difficult to track and record. 70% of smokers are estimated as wanting to quit and the aim of the smoking cessation materials is to provide act as a continuous stream of communications that raise awareness of the risks and make it easy for potential quitters to access the appropriate services. There is anecdotal information on material that doesn’t work such as beer mats produced with the Freshstart logo as part of the campaign supporting the smoking ban. Members suggested it would be useful to carry out greater analysis of the impact of materials by gauging user feedback through patient focus groups.

44. The Panel also suggested that it would be useful to capture information from people accessing cessation services about what motivated them and where they had seen the information about the service they were contacting. Members requested information on the calls made to quit help lines in the borough, which identified that there were gaps in the way this information has been recorded to date. This is partly being addressed through the migration of the help lines to the customer access centre within Tower Hamlets Council. Members are keen to review the impact of this change on the type and level of information held and that this should be included in the Tower Hamlets Tobacco Control Strategy action plan.

45. The Panel were invited to a stakeholder event to consider the themes within the draft Tobacco Control Strategy in November 2007. Attendees generated a range of innovative ideas to help inform the strategy action plan including greater use of peer groups particularly amongst young people and to train them as smoking cessation ambassadors. Other communications gaps identified included the need to target young people and prevent uptake by making use of opportunities around the Olympics. Stakeholders also felt that there was a need for anti-smoking messages to be associated with activities that were ‘cool’, if they were to be successful with young people.
**Black Market Tobacco Products**

**Review objective:**
To evaluate the extent of the availability of black market tobacco and the price and quality of products sold at street markets.

46. It is estimated that one third of the world wide internationally traded cigarettes (355 billion per year) are sold illegally with the avoidance of duty. This reduces the price, increases demand, undermines tobacco taxation and as a result harms health. Smuggled cigarettes now account for up to 10% of the UK market.

47. The effect on poorest households is an important concern because the prevalence of smoking in the poorest 'unskilled manual' occupations is 38% compared to around 11% in the professional classes. The national figures are that over 70% of two-parent households on Income Support are estimated as spending 15% of disposable income on tobacco. Although how much of that is spent on illegal products compared to duty paid cigarettes is unknown, the impact of cheaper and widely available black market products is likely to encourage existing consumption and increase the uptake of smoking.

48. Since 2000, a number of central government initiatives have been implemented in an attempt to reduce smuggling. This involved increasing HM Revenue and Customs resourcing and technical infrastructure. Also changes have been made to the marking on tobacco products so that now there is an indication when duty has been paid.

49. A major problem in the illegal trading of cigarettes has been the involvement of the tobacco companies themselves. This is where UK made cigarettes are exported only to be smuggled back into the UK. As part of the anti-smuggling initiative Central Government are entering into agreements where the Tobacco companies have to ensure product and supply controls for themselves and their customers. Tobacco companies will have to comply with these agreements and risk being penalised if they do not.

50. Counterfeit tobacco is also a problem. It is thought that 1 in 6 cigarettes and almost half of rolling tobacco in this country is fake. Tests on counterfeit tobacco have shown that products contain up to 160% more tar, 80% more nicotine, 133% more carbon monoxide and 5 times the level of cadmium (a carcinogen linked to lung, kidney and digestive tract damage) than genuine cigarettes. Government toxicologists have found that counterfeit cigarettes have the potential to deliver consistently higher levels of heavy metals to the lungs. Moreover the lower price and easy access to contraband tobacco can act to encourage younger smokers.

51. There are other examples of low grade counterfeit products containing non tobacco bulk out products like sawdust and manure which pose an even higher health risk than genuinely branded cigarettes.
52. A mystery shopping exercise was arranged for the panel to investigate the extent of the issues identified above. As part of this exercise both contraband and counterfeit tobacco products were collected for the Panel to review. These have been sent to testing laboratories for content analysis. Members were keen to see that the findings of the tests inform local tobacco control campaigns.

Enforcing the new legislation

**Review Objectives:**
To evaluate the time and resource implications for the enforcement of the workplace smoking ban on LBTH Trading Standards officers.

To evaluate available research on access to tobacco products by under 18s and the enforcement of breaches of trading standards relating to the selling of tobacco to under 18s

Tobacco Sales Legislation

53. The introduction of the smoking ban and the raising of the legal age of sale for tobacco products to 18 are important tobacco control measures in the drive to reduce smoking prevalence and preventing young people from starting to smoke. It is the role of the Local Authority to enforce legislation locally. The council’s Trading Standards Services carry out surveys and undertake test purchases to ensure understanding of legislation and compliance.

54. The last major survey of young people and smoking took place in 2005. There are central government targets to reduce the number of children between the ages of 11 and 15 who smoke regularly from a base line in 1996 to 11% by 2005 and 9% by 2010. The prevalence has plateaued since 1999 at between 9 and 10%. Girls are more likely to smoke than boys with prevalence at 10% girls compared to 7% for boys and the prevalence increases with age 1% of 11 year olds compared to 20% of 15 year olds.

55. The 2006 Healthcare Commission of Smoking Cessation Services in the borough also found that the number of young people (under 18s) accessing the service is very low. Only 20 out of 103 schools in Tower Hamlets are recording as having a non smoking policy or working towards one (18 of which are primary schools).

56. Underage smokers when surveyed say they can acquire cigarettes easily. Most regular smokers aged 12-15 buy cigarettes from shops, although with more robust legislation they are increasingly likely to be refused service. Younger smokers, in particular, also buy cigarettes from relatives. School pupils exchange cigarettes with their peers, sometimes for money. Regular
smokers are also given cigarettes by friends and relatives; for occasional smokers, this is by far the most common source.

57. Demand for tobacco is price sensitive. A 10% increase in price is associated with an estimated 4% reduction in demand in higher income countries. Young people are at least as sensitive (perhaps two to three times more sensitive) to price as older adults. A recent systematic review of cross sectional studies from the United States found strong evidence for an association between cigarette prices and both the number of smokers aged 13 to 24 and the quantity each consumes.

58. Young people living in areas of the US with more stringent sales policies for underage customers are also less likely to smoke. Enforcing the minimum legal age for purchases can reduce illegal cigarette sales, but the evidence from controlled intervention studies is that the affect on actual smoking behaviour is weaker, presumably because underage smokers can acquire cigarettes from other sources. Unenforced voluntary agreements and educational interventions with retailers are less effective in reducing sales.

59. The draft Tower Hamlets Tobacco Control Strategy considers the increasing resourcing requirements as a result of the new duties on enforcement officers and the wider trading standards teams, for example there are about 13500 businesses and premises in the Borough where the smoking ban currently applies. The Tobacco Control Strategy is in the process of being refreshed for 2008/9 and beyond and the level of enforcement activity possible by the Council is dependant on available resources.

60. In 2007 all 404 premises selling tobacco products were visited in advance of the new tobacco sales legislation and 463 further visits were undertaken afterwards. 13 businesses were found to be non compliant because they were not displaying the “underage” statutory notice. One successful test purchase was obtained and the retailer formally undertook to comply in the future.

61. Based on a work programme which requires £230,000 of new funding, The Trading Standards Services plan to visit and test purchase 25% of tobacco retailers in 2008/9. This programme of work has combined enforcement with support to businesses as they loose revenue combined with education about the dangers of smoking and health risks for children.

62. If no additional resources are secured the level of activity possible will be largely reactive. Limited amounts of proactive work will be integrated into existing routine work streams. The levels of outreach and proactive work achieved in 2007/8 will not be possible in 2008/9. The Tobacco Control Strategy action plans provide options based on additional funding and in the scenario that no extra funds are secured.

63. A visit to investigate the enforcement of breaches of trading standards relating to the selling of tobacco to under 18s was arranged in November 2007.
Enforcing the Smoking Ban

64. Public support for smoking restrictions in public places is high with 91% of adults in favour of restrictions in restaurants, 86% at work and 65% in pubs. The regulatory impact assessment estimated the effect of the ban would be to reduce the smoking prevalence by 1.7 percentage points. In Tower Hamlets this would mean approximately 3,200 less smokers. A recent paper on the cost-effectiveness of English smoking cessation services estimates that the average life-years gained per quitter is 3.59 years. In Tower Hamlets the impact of the ban could be to gain an additional 11,500 life-years for the local population.

65. Levels of compliance in the borough were encouragingly very high at 98.5% which demonstrated that the levels and mechanism of engagement and support produced a smooth and successful introduction of the legislation. Twenty seven “smoke free” complaints about illegal smoking have been received and investigated. 106 requests for advice have been received from businesses and to date five written warnings have been given to businesses where smoking was illegally taking place and five written warnings have been given to premises that were not displaying the statutory signs.

66. Members would like to endorse the proposals in the draft Tobacco Control Strategy and action plan and support the request to maintain the level of funding at £230,000 which was the initial grant sum provided by the Government for 2007/08. The programme of activities outlined in the action plan have the potential to make a much wider impact on reducing smoking
prevalence compared to stand alone enforcement activity. Since the initial review of the Tobacco Control Strategy by the Health Scrutiny Panel, the Primary Care Trust have agreed to fund the full £230,000 for activities in 2008/09.

Widening Access to Smoking Cessation Advice & Services

**Review Objective:**

To investigate strategies to develop the capacity and skills of front line healthcare providers to support people in giving up smoking / oral tobacco.

67. Tobacco use in Tower Hamlets exceeds the national average both in its smoked and oral form. The Panel received a briefing on the potential of front line health care staff to more widely deliver smoking cessation messages. Whist there are some examples of effective practice there is huge potential for developing this area of work and for it to become a key component of the new Tobacco Control Strategy.

68. The current smoking cessation services in Tower Hamlets follows an evidence based model operating at three levels which relate to the individual’s dependency and need matched with the appropriate intervention. The model is described as follows;

- **Level 1 - Brief intervention from any front line health professional.** Essentially this involves assessing motivation to quit and signposting to quit services. It also reinforces to the individual that tobacco use is bad for your health and that there is effective treatment available to support you quit.

- **Level 2- Intensive 1-1 support and advice (and use of NRT and other pharmacological aids).** This is provided in Tower Hamlets in a number of innovative ways by commissioning health professionals such as community pharmacists, practice nurses and community staff as well as many organizations from the voluntary sector who provide a service to those who may not traditionally access mainstream services.

- **Level 3 – Intensive support either on a 1-1 basis or using other methods.** This is currently commissioned from the specialist smokers clinic who provide input to our local hospitals and for those people who need more intensive support, for example due to their level of addiction or complexity of their health needs, for example post heart attack or pregnant. Most smokers want to quit and a brief intervention by a health care professional will increase a person’s likelihood of quitting.

69. Some of the barriers identified as preventing front line health care providers from delivering smoking cessation advice are outlined below:

- **Smoking cessation fatigue** Old tired messages and traditional ways of relaying health information
- **Lack of skill/training deficit** - Staff lack confidence and skill in how to do it
- **Changing face of health care providers** - Health care is now commissioned in many different ways so front line health care providers now span many organizations.
- **Too many demands on time** - Staff feel burdened by their workload
- **Perception /belief that smoking is a “lifestyle choice”** - Staff feel uncomfortable discussing it as they perceive it as a “lifestyle issue” with choice and do not understand the nature of the addiction.

70. The Healthcare Commission Review 2006 found that the range of healthcare professionals delivering smoking cessation services is limited and could be expanded (e.g. currently no midwives, school nurses or dentists are trained to deliver level 2 services and few health visitors).

71. In response the PCT have proposed a programme of work to address these barriers including a range of mandatory and voluntary training for health care workers and extending these training options to a wider range of front line providers. These options also need to be marketed more effectively to front line staff to motivate them and make them believe in what they are doing and why it is important.

72. There are also areas where there is only limited smoking cessation advice given which needs some urgent action. This includes the acute hospitals, out-patients and social service premises such as day centres, residential homes, learning disability services and youth programmes.

73. Most people see their GP at least once a year, and other health professionals at other times during the year. But at the same time, less than half of smokers say they remember being given advice on smoking by a GP, practice nurse or other medical person at any point during the last five years. GPs, practice nurses, midwives, dentists, pharmacists, health visitors and other health professionals are key sources of advice for how to improve health. These professions have an important role to play in giving the kind of smoking cessation advice to match the needs of the patient or person accessing health services. This would also promote a consistency of the message being given to smokers who would be aware that those who know about health, advise against smoking. Members recommend that the Primary Care Trust introduce measure to ensure all health professionals working in hospital or community settings offer advice to change smoking habits and refer smokers to services to help them quit, whenever possible.

74. The Tobacco Control Unit also highlighted issues around inactivity of smoking cessation advisers for example of the 350 level 2 advisors only half are currently active. There is evidence of inconsistency of approach with some focussing on hard to reach groups and others working with larger more accessible groups. Around 350 people are trained to level 1 each year but there is a need to follow through on their activity and there is a need to make more use of spare capacity at the Level 2 and Specialist levels. Members welcomed plans to re-invigorate the pool of advisers available as well as plans to recruit and train more.
75. Tower Hamlets PCT commissions both generic and specialist smoking cessation services. The public can access these services directly by phone (free call number available) or in person (for example, through pharmacies), or by referral from primary care. All services are free of charge.

76. The generic services include:
- Smoking Cessation Clinic, Royal London Hospital – Staffed by psychologists, this service offers intensive support in the form of weekly group or individual sessions from two weeks prior to quitting to four weeks after quitting. Ongoing support is available for up to one year at weekly drop-in sessions. The clinic also provides a specialist service for pregnant women and their partners, and workplace-based sessions on a bespoke basis.
- Pharmacists and other health care professionals - Almost all pharmacists in the borough as well as hundreds of other health care professionals in numerous settings are trained and registered smoking cessation advisers and are able to provide one-to-one advice. In addition, the PCT has just commissioned a local enhanced service for smoking cessation to be delivered through GP surgeries.

77. Specialist services include:
- Bengali Tobacco Cessation Project – This specifically aimed at members of the Bangladeshi community in Tower Hamlets who smoke or chew tobacco with paan. The project workers speak Bengali and have both male and female workers to allow for cultural sensitivities. The PCT is also carrying out a pilot smoking cessation project in the East London Mosque, where the majority of worshippers are Bangladeshi it is anticipated this will be continued and expanded on completion of the pilot.
- Neighbours in Poplar – Poplar is one of the most deprived parts of the borough and contains some of the most deprived super output areas (small areas used by the census on average approximately 1500 people) in the country. The project is for vulnerable people living at home in the Poplar area of Tower Hamlets.
- Ocean Somali Community Association – This is specifically aimed at members of the Somali community in Tower Hamlets.
- Positive East – for people living with HIV and those who care for them.

78. The PCT’s current plans for improving access to smoking cessation services for hard to reach groups in 2007/08 is looking to address the weaknesses of previous campaigns and develop much more targeted interventions for groups of smokers. The PCT have commissioned two separate social
marketing interventions to increase uptake of smoking cessation services specifically for Bangladeshi men and an intervention focused on prevention of uptake amongst young people. There is also an ongoing peer education project being piloted in a secondary school which if successful will be rolled out across all the local authority secondary schools in the borough.

79. Tower Hamlets PCT have also commissioned 4 community groups in different localities to deliver the health trainer initiative. As the organisations develop they will have an increasing role in both delivering smoking cessation sessions and signposting people into other stop smoking services in the communities in which they are based.

80. An analysis of activity across the main providers of smoking cessation services in 2007 shows a contribution to quits of 37% by community providers, 23% from Pharmacists, 27% from the Specialist service and 11% by a range of primary care providers (GPs, Nurses and Counsellors) The quit rate is on average 36% and this varies quite considerably between service providers (in the range 60% to 20%). Similarly the cost per quit varies from around £500 per quit in the specialist unit to £250 per quit for community providers.

81. The Panel were keen that the PCT capitalise on the success of voluntary and community groups in achieving successful number of quit attempts, and that this is probably reflective of the greater knowledge and understanding of the community groups they are working with.

82. The November stakeholder event to review the draft Tobacco Control Strategy also looked at how to identify and target difficult to reach groups. The groups in the borough were identified as Mental health users, Teenagers and pre-teens, people who are housebound such as those with long term conditions, elderly, disabilities or who are housebound for cultural reasons. Other ‘hard to reach’ groups are Black and Minority Ethnic groups, Sheesha pipe smokers and users of other types of tobacco or smokeless tobacco. Some of the solutions suggested in the discussion included a greater emphasis on relationship building with smokers, health bars to provide diversionary activities, cash for quitting and the need for sustained interventions.

83. Members welcomed the fact that the Ramadan Campaign and Bangladeshi Stop Tobacco Project have been highlighted in a London Health Observatory Review on the Equity of smoking cessation services in London. Both projects are seen as achieving above average success rates in both improving knowledge of the health risks of smoking and in achieving validated quit rates, particularly the Bangladeshi Stop Tobacco Project.
Smokeless Tobacco

**Review Objective:**
To consider the strategies in place for the regulation and cessation of chewing tobacco (including Paan) and whether these products carry the legal health notices to the required standard.

84. Smokeless tobacco includes many different types of tobacco that you can chew, suck or inhale. It is known that almost all brands of smokeless tobacco cause mouth cancer. In the UK, chewing tobacco is most common amongst South Asian communities and chewing paan in particular is a very old cultural practice. Most types of smokeless tobacco contain at least 28 different chemicals that can cause cancer and contain as much, if not more nicotine as smoked tobacco products. People who use smokeless tobacco absorb three to four times as much nicotine as smokers do. The nicotine is also absorbed more slowly and stays in the blood for a longer time.

85. There is little accurate information on the full extent of use of oral tobacco products. There are also wide differences between the type of tobacco products used by different communities within the borough. It is known that Bangladeshis are much more likely to both smoke and chew tobacco and betel liquid, putting them at a much higher risk of mouth cancer than the general population. Health risks in using paan, include; Tobacco as a carcinogen, areca nut is implicated as a major cause of Oral Submucous Fibrosis (causes stiffness in being able to open and close the mouth) which can also become a precancerous lesion. Cancer Research UK have funded a pilot project in the borough to raise awareness of mouth cancer amongst the local Bangladeshi Community.

86. As part of this project four hundred adults who smoke or chew tobacco or betel liquid were surveyed. Less than half recognised chewing tobacco as a risk and only 64% knew that smoking can cause mouth cancer. Just 18% were aware that chewing betel quid without tobacco still increases mouth cancer risk.

87. In reviewing the wider range of communication strategies, enforcement work and tobacco cessation services, Members identified a gap across all these work streams on tackling the issue of oral or smokeless tobacco consumption.

88. The Panel also discussed a briefing on the legality of oral tobacco products which although legal were also subject to the same health warning and labelling regulations which cover all tobacco products.

89. Members recommended that the profile of health risks around cultural tobacco products needs to be raised amongst the communities that use them. There is also greater potential for some cultural tobacco products to be marketed at children because of their bright colours and shiny wrappers available at a cheap cost. These products are often entering the UK without
Chapter 5 – Conclusion and Recommendations

91. This section draws the key findings of the review together and makes a number of recommendations that we feel will contribute to improving Tobacco and Smoking Cessation in the borough.

92. The National Institute for Clinical Excellence recently concluded that reducing smoking prevalence among people in routine and manual groups, some minority ethnic groups and disadvantaged communities will help reduce health inequalities more than any other public health measure. It is therefore important that the new Tower Hamlets Tobacco Control Strategy includes challenging targets and delivers tangible improvements in health outcomes related to tobacco consumption.

**Recommendation 1**

That the Tobacco Control Alliance include an elected member to reflect the health scrutiny role but also around profile raising and endorsement.

93. In reviewing the composition and terms of reference of the Tobacco Control Alliance, Members were keen to see direct responsibility for the accompanying Communications Strategy to be added to the remit of the alliance.

**Recommendation 2**

That the Communications Strategy accompanying the Tobacco Control Strategy be added as a workstream to be overseen by the Tobacco Control Alliance.
94. The analysis of communications strategies covering the full range of tobacco control interventions in the borough highlighted both successful measures as well as gaps in communication work as did the outcomes from the November 2007 stakeholder event for the strategy. The adoption of the Smokefree brand has clear benefits in terms of resourcing these products, the consistency of the stop smoking message and building a recognisable brand. Members were keen however for communication materials to reflect local issues particularly when targeting hard to reach groups and that there should be better analysis of what works well. Smokefree also excludes messages about use of other types of tobacco.

**Recommendation 3**

That the Communications Strategy, and design of future campaigns and resources for tobacco cessation take account of the outcomes from the social marketing exercises commissioned by the Primary Care Trust.

**Recommendation 4**

That further communications resources be developed to cover the dangers of other types of tobacco consumption, including chewing tobacco/paan and sheesha pipe smoking.

95. There is a lack of up to date information on smoking prevalence as well as what helps to motivate people to quit. The Smoking cessation helplines are well used and much more needs to be done to capture information to help profile smokers, understand their needs and what worked to help them contact a cessation service. The migration of the helpline to the Council offers opportunities to improve the type and levels of data held on people accessing cessation services.

**Recommendation 5**

That the Tobacco Control Unit develop a service level agreement with the new helpline provider to capture information on users needs and to gauge the effectiveness of communication resources.

96. Pending the outcome of the laboratory tests on tobacco products from the enforcement and mystery shopping visits during the review, the results should be used in local tobacco cessation campaigns.

97. Members would like to endorse the proposals in the draft Tobacco Control Strategy and action plan and support the request to maintain the level of
funding at £230,000 which was the initial grant sum provided by the
Government for 2007/08. The programme of activities outlined in the action
plan have the potential to make a much wider impact on reducing smoking
prevalence compared to stand alone enforcement activity. During the course
of the review the Tower Hamlets Primary Care Trust agreed to fund the
programme. Members welcome this outcome and would like to see that
funding for future work to implement the strategy beyond 2009 to also be
secured through the Council or the Primary Care Trust. A longer term
funding solution would also enable the joint tobacco control partnership to
take a more strategic role.

98. The enforcement visits highlighted the light touch approach to enforcing the
smoking ban and in working with businesses that sell tobacco. Whilst this
reflects the Government guidance on implementing the new legislation in
2007 it is equally important that work carried out by enforcement officers is
recorded in a way that demonstrates the outputs and outcomes from that
work.

**Recommendation 6**

That the Trading Standards Team take measures to record enforcement work
to demonstrate the value added as part of the funding secured from the PCT
and to help develop a business case for future funding.

99. The evidence is that health care professionals can play a pivotal role in
delivering the stop-smoking message and refer smokers to the most
appropriate advice and services. This is currently an under utilised resource
and there are barriers both perceived and actual to healthcare workers taking
on this role. The panel agree with the Tobacco Control Unit proposals that
there should be a training programme for health care professionals to
overcome these barriers and be motivated about taking on this important
public health role.

**Recommendation 7**

That the Primary Care Trust introduce measures to ensure all health
professionals working in hospital or community settings offer advice to change
smoking habits and refer smokers to services to help them quit, whenever
possible.

100. The current range of smoking cessation services are good but there is
a need to improve the flexibility of these services and the way they are
provided. Members welcomed plans to re-invigorate the pool of advisers
available as well as plans to recruit and train more advisers.
**Recommendation 8**

That the PCT commission more Level 1 and Level 2 Smoking Cessation advisors and develop an action plan to re-energise currently inactive advisers.

101. A recent analysis of the role of local smoking cessation services in achieving quits highlighted the importance of community organisations accounting for 39% of quits in 2007. The Panel were keen that the PCT capitalise on the success of voluntary and community groups in achieving successful number of quit attempts.

**Recommendation 9**

That the PCT commission more voluntary and community sector organisations including exploring options through the Tower Hamlets Partnership to extend the way smoking cessation services are delivered.
Scrutiny in Tower Hamlets

To find out more about Scrutiny in Tower Hamlets

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