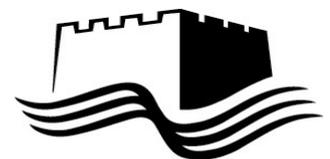


Report of the Health Scrutiny Panel

Review of Tobacco Cessation in Tower Hamlets

Tower Hamlets Council

March 2008



TOWER HAMLETS

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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 Support Officers, Shanara Matin and Michael Carr who worked tirelessly and with good humour to ensure this review was completed successfully

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, 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.

The Health Scrutiny Panel has 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'. We have encountered 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. We need to learn if this resistance is widespread and to understand why there can be a barrier to offering support for smoking cessation in the course of the delivery of other health care.

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.

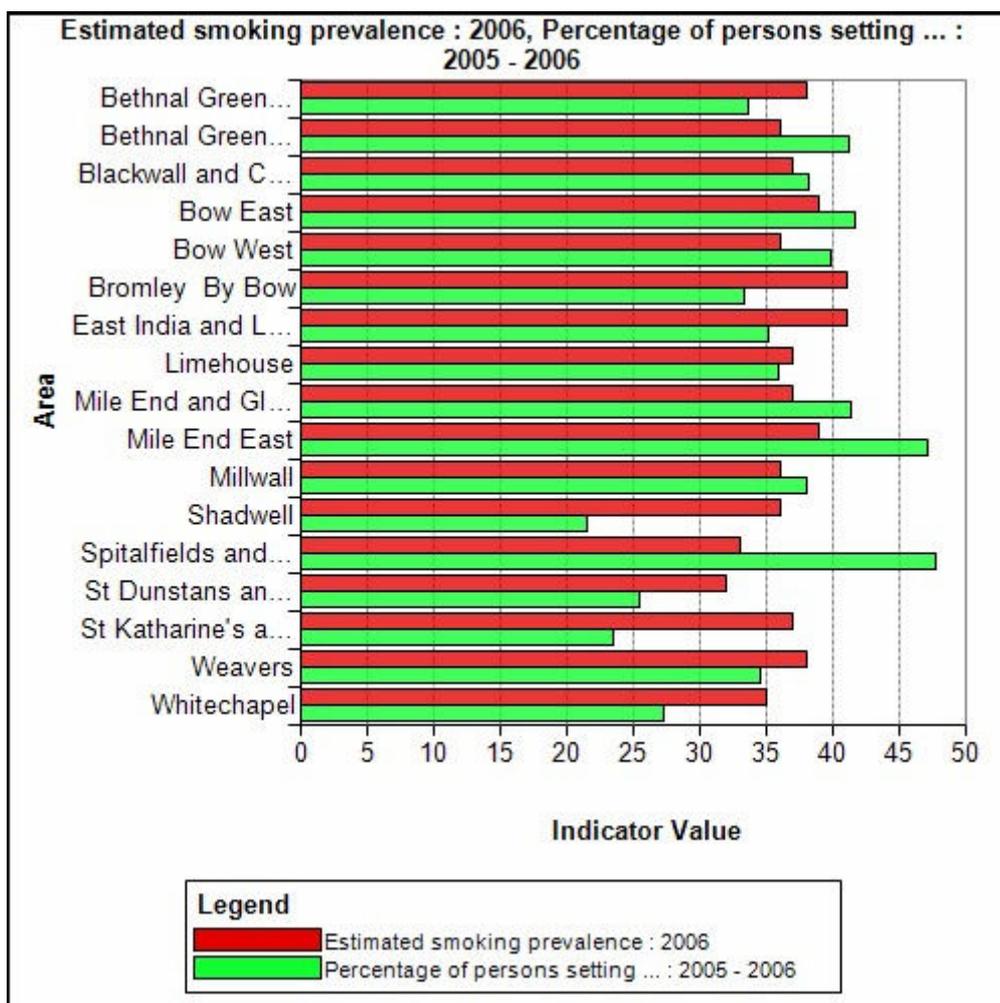
Councillor Stephanie Eaton
Chair

Chapter 1 – Introduction

Background

1. Smoking and tobacco related illness is preventable and smoking exacerbates a range of health problems. 86,500 people die prematurely each year from smoking related illnesses in the UK. Smoking is the major reason for the differences in death rates between rich and poor and deaths from tobacco use are two to three times higher amongst disadvantaged social groups than among the better off.
2. Our Borough's diverse and transient population experiences very different levels of access to health care services and differences in health outcomes. Levels of deprivation in the Borough can be high in some areas and this often translates into low life expectancy levels. Last year 36% of all deaths in the borough were linked to smoking related diseases - a very high level of preventable mortality.
3. Mortality from smoking related diseases (including cardiovascular disease, lung cancer, other cancers and chronic obstructive pulmonary disease) is higher than the UK 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 (Association of Public Health Observatories Health Inequalities Toolkit).
4. Smoking prevalence in Tower Hamlets is 37% compared with the England average of 24% and 22% for London. This means that in 2007 nearly 68, 000 people were smokers in Tower Hamlets. The smoking rate for men aged 25-44 years was reported as being the highest (43%) for all Primary Care Trusts (PCT) in England. Amongst the Bangladeshi male population it is believed that the percentage is even higher at 50%. Such high levels of smoking prevalence represent a heavy disease burden for our community.
5. Smoking and tobacco use is therefore one of the most important and urgent public health issues for the Borough. Every day in Tower Hamlets at least one resident dies prematurely because of smoking.

Figure 1. Estimated smoking prevalence (%) in 2006 and percentage of residents setting a quit date to stop smoking.



6. This year the England wide smoking ban in public places and the Tower Hamlets' Tobacco Control Strategy review offered an opportunity to raise the profile of the wider tobacco cessation campaign, for reviewing smoking cessation services and tobacco control measures to ensure they are making a difference to local health outcomes.
7. The establishment of a joint Tobacco Control Unit between Tower Hamlets Primary Care Trust (THPCT) and the Council will ensure that the Borough has co-ordinated services and a holistic approach to this important area of public health.

The review process

8. The Health Scrutiny Panel was established in 2004 and since then has carried out reviews on childhood obesity, diabetes and young people's access to sexual health services. Work on a four-year work programme commenced in 2006 when the panel reviewed access to general medical practitioner and dental services. This year's work on tobacco and smoking

cessation aims to continue the panel’s general concern to investigate access to services in order to tackle inequality in health care.

9. 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 specific parts of the community and social groups in the borough
- The preventability of disease related to and exacerbated by smoking
- To improve on the low life expectancy levels caused by tobacco use
- To maximize the opportunities coming out of the introduction of the Workplace Smoking Ban and the revised Tobacco Control Strategy.

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

11. 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, especially 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 to stop smoking and chewing 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.

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

Stage 1 (Sept07)	<ul style="list-style-type: none"> • Consideration of national and local policies; • Tobacco Control Strategy
Stage 2 (Oct 07 – Dec 07)	<p>Evidence Gathering from:</p> <ul style="list-style-type: none"> • Tower Hamlets Primary Care Trust • LBTH Tobacco Control Team • Voluntary and Community Sector Smoking Cessation and Prevention Services

Stage 3 (Dec 07 – Feb 08)	<ul style="list-style-type: none"> • Enforcement Visits • Mystery Shopping Exercise – Introduction of the higher age of sales legislation
Stage 4 (Mar 08)	<ul style="list-style-type: none"> • Draft report and consultation

Chapter 2 - National Policy Context

13. 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.
14. 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 to quit
 - increases in tobacco tax
15. Published at a time when smoking prevalence was increasing, the 1998 White Paper also set out specific targets to reduce smoking amongst young people and pregnant women.
16. 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 and other agencies and to begin the development of smoking cessation services. 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.
17. 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.

18. 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 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.
19. Alongside the focus on smoking in public, measures have been introduced 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. Black market sales reduce the impact of taxation on tobacco as a public health intervention to price out consumers. 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.
20. The Health Act 2006 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 legislation reflected mounting scientific evidence of the risk posed by passive smoking and mirrors the introduction of smoking bans across cities in Europe and North America.
21. There has been a growing body of evidence around the need for targeted interventions alongside national campaigns to help different groups of people quit and the challenges faced by smokers who are in difficult circumstances in turning a desire to give up into reality and the evolving legislation reflects this.

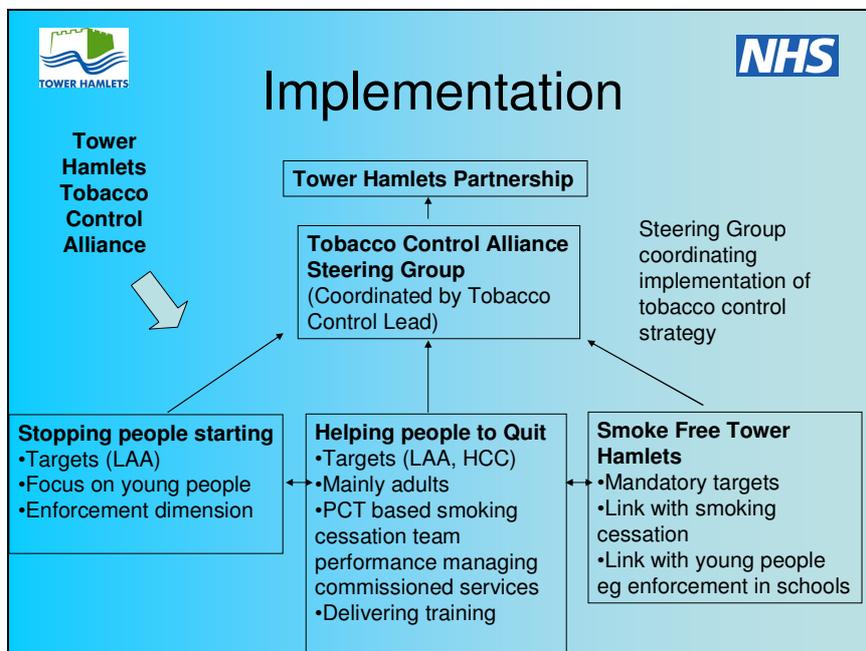
Chapter 3 - Local Policy Context

22. The 2006 Tower Hamlets Public Health Report which examines the causes and consequences of poor health in the people of Tower Hamlets cited 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 accounts for a quarter of early deaths in men.
23. Smoking rates in the borough are 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. There is also a high prevalence of chewing tobacco/pan which is linked to severe gum disease and mouth cancers.

24. 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.
25. There are large differences in smoking prevalence and consumption in the UK, varying by age sex, social class, employment status, and ethnicity. 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.
26. The 2006 Healthcare Commission review into PCT Tobacco Control & Smoking Cessation Services gave the THPCT an overall score of 3 which is equated to 'good' (1 being 'weak' and 4 being 'excellent'). Some of the innovative aspects of the Tobacco Control Programme in Tower Hamlets which were highlighted include the recruitment of smoking cessation advisors from the community (e.g. pharmacists and voluntary groups), projects targeted at ethnic minority groups, drop-in clinics, collaboration with environmental health and the Ramadan stop smoking campaign. In 2006/07 the borough helped 2151 people to quit smoking against a target of 1755.
27. There are some important areas for development 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.
28. The Tower Hamlets Tobacco Control Strategy is currently being reviewed. 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.
29. 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 is 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** i.e. smoking and oral tobacco use by teens and pre-teens. The theme 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 use of stop smoking services and increasing the supply of NHS accredited Stop Smoking services across a wide range 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 the 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.

30. 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 would like the steering group to include Councillor representation to reflect the health scrutiny role but also to raise the profile and endorse this work.

31. 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 different reasons for tobacco use across different parts of our community – and the resultant need for different types of services.
32. Communications work should also come under the remit of the Tobacco Control Alliance. The formation of the Tobacco Control Alliance is an opportunity for a Communications Strategy review. Since the Member discussion on the Tobacco Control Alliance a communications stream has been added to the Tobacco Control Alliance model.
33. Members also believed that while it was important to develop the arguments for going smokefree on health grounds, it is equally important to emphasise the wider economic benefits from having a healthier community.
34. The Panel would like to review progress monitored by the Tobacco Control Alliance as part of the recommendations coming out of this review.
35. Members also welcomed the information that quit targets for 2006/07 in the Local Area Agreement had been exceeded. Members felt it would be useful for the Tobacco Control Strategy to include more challenging targets to build on and reflect current success.

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.

36. 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 messages around tobacco and smoking cessation.
37. 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 annual No Smoking Day in March uses nationally produced materials and is sent to all GP practices and pharmacies. The New Year campaigns are much more locally relevant 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.

38. 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. 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. 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 saw a range of public health resources to promote smoking cessation used at public events, in schools and by community and voluntary sector organisations that deliver cessation services. Primary Care Trust officers discussed current communication plans which include sending out Smokefree branded leaflets and dispensers to 800 settings across the borough.



40. Members welcomed the 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.

41. Members enquired 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 a range of communication streams 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. **Members suggested greater analysis of the impact of materials by gauging user feedback through patient focus groups.**

42. Members 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. The Panel requested information on the calls made to quit help lines in the borough, which identified 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 in the Tower Hamlets Tobacco Control Strategy action plan.**

43. 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 included ideas 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 in Tower Hamlets.

44. 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 national tobacco tax and as a result harms health.
45. Smuggled cigarettes now account for up to 10% of the UK market. The effect on poorest households is an important concern. The national figures are that over 70% of two-parent households on Income Support buy cigarettes, spending about 15% of their disposable income on tobacco. The prevalence of smoking in the poorest 'unskilled manual' occupations is 38% compared to around 11% in the professional classes.
46. 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 had been paid.
47. 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.
48. Contraband tobacco is also a problem. It is thought that 1 in 6 cigarettes and almost half of rolling tobacco in this country is illicit. 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.
49. 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.
50. A mystery shopping exercise was arranged for the panel to investigate the extent of the issues identified above. Councillor Stephanie Eaton accompanied undercover officers from the Council to markets around Brick lane and spoke with the tobacco sellers. In many cases the sellers were

asylum seekers who are prohibited from obtaining work by their immigration status. They turn to black market sales of tobacco to supplement their income. This exercise showed the complexity of the social, economic and cultural conditions which lead to a black market in tobacco sales.

51. 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 but at time of publication the results were not available. Members are keen to see that the findings of the tests inform local tobacco control publicity 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

52. 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. 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.
53. The draft Tower Hamlets Tobacco Control Strategy recognises the increasing resource requirements that result from the new duties on enforcement officers and the wider trading standards teams. There are about 13, 500 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 activity possible by Tower Hamlets Council is dependant on available resources.
54. In 2007 all 404 premises selling tobacco products were visited in advance of the new sales legislation and 463 further visits were undertaken afterwards. 13 businesses were formally found to be non compliant because they were not displaying the "underage" statutory notice. One successful test purchase was obtained and the retailer undertook to comply with the legislation in future.
55. The Trading Standards Services plan to visit and test purchase 25% of tobacco retailers in 2008/9. This programme of work will combine enforcement with continued support to businesses.
56. If no additional resources are made available 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.

57. Public support for restricting smoking in public places is high with 91% of adults being in favour of restrictions in restaurants, 86% at work and 65% in pubs. The regulatory impact assessment estimated the effect of the recent ban would be to reduce the smoking prevalence by 1.7%. In Tower Hamlets this would mean approximately 3,200 fewer 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.
58. Levels of compliance with the smoking ban in the borough were encouragingly very high at 98.5%. To date, twenty seven complaints about illegal smoking have been received and investigated. 106 requests for advice have been received from businesses, 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.
59. 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 to introduce the smoking ban. The programme of activities outlined in the action plan have the potential to make a much wider impact on reducing smoking prevalence compared to reactive enforcement activity but only if this funding stream continues.
60. The Council's Trading Standards Service also have responsibility for enforcing a number of statutes that restrict the sale of certain products namely such as alcohol, cigarettes, knives, solvents, fireworks and gaming software to under 18's. 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 of smoking increases with age. Only 1% of 11 year olds smoke compared to 20% of 15 year olds.
61. 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 and enforcement 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.

62. Demand for tobacco is highly 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.
63. 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.
64. 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. In the company of a Trading Standards officer, Councillor Stephanie Eaton visited a number of premises including bars, restaurants, clothes shops and video outlets to ensure that the correct signs were in place and to encourage the placement of quit smoking advice leaflets. The vast majority of premises were fully compliant and, where they were not, informal information and advice was given with follow-up visits scheduled to ensure compliance.



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 and chewing of oral tobacco.

65. Tobacco use in Tower Hamlets exceeds the national average both in its smoked and oral forms. The Panel received a briefing on the potential of front line health care staff to more widely deliver smoking cessation messages.

Whilst 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 strategy.

66. The current smoking cessation services in Tower Hamlets follows an evidence based model operating on 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 Nicotine Replacement Therapy and other pharmacological aids).** This is provided in Tower Hamlets in a number of 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. Most smokers want to quit and an intervention by a health care professional increases a person's likelihood of quitting.

67. Some of the barriers identified as deterring front line health care providers from delivering tobacco cessation advice are outlined below.

- **Smoking cessation fatigue** – the use of old tired messages and traditional ways of relaying health information
- **Lack of skill/training deficit** - Staff lack of confidence 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.
 - **Fear that it will affect client relationship** – staff feel it may create a barrier between the health worker and patient.
68. 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.
69. There are also areas where there is only limited smoking cessation advice available. This includes the acute hospitals, out-patients and social service premises such as day centres, residential homes, learning disability services and youth programmes.
70. 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. These professionals have an important role to play in giving the kind of smoking cessation advice to match the specific needs of the patient accessing health services. Smokers need to be aware that those who know about health, advise them against smoking. **Members recommend 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.**
71. The Tobacco Control Unit also highlighted issues around inactivity of smoking cessation advisers for example of the 350 level 2 advisers only half are currently active. There is evidence of inconsistency of approach with some advisers 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.**

Review objective:

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.

72. 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.
73. 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.
74. 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.
75. 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.
76. Tower Hamlets PCT have also commissioned 4 community groups (one in each locality) 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.

77. 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.
78. The Panel were keen that the PCT capitalise on the success of voluntary and community groups in achieving successful number of quit attempts, as this is probably indicates greater knowledge and experience of the needs of specific groups within our community.
79. The November stakeholder event to review the draft Tobacco Control Strategy looked at how to identify and target difficult to reach groups. The groups in the borough were identified as Mental Health service users, teenagers and pre-teens, people who are housebound, elderly, who have disabilities or who do not go outside the home for cultural reasons. Other 'hard to reach' groups are Black and Minority Ethnic groups, Shisha 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.

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.

80. Smokeless tobacco includes many different types of tobacco that you can chew, suck or inhale. 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. The nicotine is absorbed more slowly and stays in the blood for a longer time.
81. There is little accurate information on the extent of use of oral tobacco products. There are also wide differences between the type of tobacco products used by different ethnic groups within the borough. It is known that Bangladeshi people are much more likely to both smoke and chew tobacco

and betel liquid, than the general population. This puts our Bangladeshi residents at a much higher risk of mouth cancer. The health risks of using Paan include the ingestion of tobacco (a carcinogen), and the consumption of areca nut which is a major cause of Oral Submucous Fibrosis (which causes oral stiffness and a problem opening and closing the mouth) and the development of precancerous lesions. Cancer Research UK have funded a pilot project in the borough to raise awareness of mouth cancer amongst the Bangladeshi part of the Community.

82. 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.
83. In reviewing the wider range of communication strategies, enforcement work and tobacco cessation services, **Members identified a gap across all work streams on tackling the issue of oral or smokeless tobacco consumption.**
84. The Panel also discussed a briefing on the legality of oral tobacco products. Although these products are legal they are subject to the same health warning and labelling regulations which cover all tobacco products.
85. Members recommended that the profile of health risks around non-cigarette tobacco products needs to be raised amongst the groups that use them. There is also greater potential for cultural tobacco products to be marketed at children because of their bright colours, shiny wrappers and cheap cost. These products often enter the UK without duty added because they are imported as food (spices) products and there are very serious issues around the listing of ingredients and appropriate labelling, with products claiming to be tobacco free when they are not.
86. The mystery shopping exercise carried out by trading standards officer and Councillor Stephanie Eaton revealed widespread failure of correct labelling on these products. Purchased products either had no or inadequate health warnings and/or limited or no information on the ingredients. **The Panel recommends that leaflets for both businesses and consumers be produced to highlight the risks of both selling and using oral tobacco products.** These products have also been sent for content analysis and Members are keen to see the findings inform the production of the leaflets.



Chapter 5 – Conclusion and Recommendations

87. 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 Tower Hamlets.

88. 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 and raise the profile of this work.

89. 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 overseen by the Tobacco Control Alliance.

90. 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, design of future campaigns and resources for tobacco cessation publicity reflect the community of Tower Hamlets and take account of the results of social marketing exercises commissioned by the Primary Care Trust.

Recommendation 4

That communications resources be developed to target the users of all types of tobacco consumption, including chewing tobacco, paan and sheesha pipe smoking.

91. 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 to help understand user's needs and to gauge the effectiveness of communications resources.

92. we are awaiting the outcome of the laboratory tests on tobacco products from the enforcement and mystery shopping visits during the review. Where appropriate we wish to see the results used in local tobacco cessation campaigns.
93. Members would like to endorse the proposals in the draft Tobacco Control Strategy and action plan and strongly 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 have agreed to fund the programme. Members welcome this outcome and would like to encourage 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 have a more strategic role.
94. The enforcement visits highlighted the benefits of a 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 develops a business plan to demonstrate the time and effort involved in enforcement, education and support activities.

95. The evidence is that health care professionals can play a pivotal role in delivering the stop tobacco use message to the patients they see and to offer advice and appropriate referrals. 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 that there should be a training programme for health care professionals to overcome these barriers and to encourage them to be more 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.

96. 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.

Recommendation 8

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

97. 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 deliver smoking cessation services.

Scrutiny in Tower Hamlets

To find out more about Scrutiny in Tower Hamlets

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