FOREWORD

Tobacco is a major public health issue in Hackney. Up to 18% of deaths in Hackney are attributed to smoking. 6% of all hospital admissions and 12% of emergency admissions in Hackney can be attributed to smoking.

As the Scrutiny Commission focussed on the health issues facing Hackney, we wanted to investigate how the prevalence of smoking in the borough might be tackled and develop practical recommendations for developing and strengthening the work of the Council and its NHS partners in the area of tobacco control.

We particularly wanted to focus on the lessons to be learnt from successful Tobacco Control Alliances in neighbouring boroughs, and to distil and pass these on so that they can be built into the ways of working of the new Hackney Tobacco Control Alliance.

This report is extremely timely as it comes just as Hackney’s Tobacco Control Alliance is being implemented. We hope the members of the Tobacco Control Alliance will find our recommendations helpful and will seek to implement them.

We are extremely grateful to the LBH and NHS professionals and experts in the field who gave us their time and insights into the work they do both as witnesses at hearings and on field visits, and to the community groups and potential service users such as young people whose views on the services needed were extremely useful.

Cllr Luke Akehurst  
Chair- Health in Hackney Scrutiny Commission
**SUMMARY OF CONTENTS:**

1. **FOREWORD** ............................................................................................................. 0
2. **INTRODUCTION** ....................................................................................................... 2
3. **SUMMARY, RECOMMENDATIONS AND OUTCOMES** ........................................... 4
4. **FINANCIAL COMMENTS** ........................................................................................ 11
5. **LEGAL COMMENTS** .............................................................................................. 11
6. **FINDINGS** ............................................................................................................... 12
   - Witness Evidence Sessions .................................................................................. 13
   - Voluntary Sector .................................................................................................... 26
   - Site Visits ............................................................................................................... 33
   - Local Data and Intelligence .................................................................................. 38
   - Partnership Working .............................................................................................. 40
   - Communication ....................................................................................................... 42
   - Alliance Models and Work Streams ....................................................................... 46
   - Employers ............................................................................................................... 52
7. **CONCLUSION** ......................................................................................................... 55
8. **CONTRIBUTORS – Meetings and Site Visits** ........................................................ 56
9. **MEMBERS OF THE SCRUTINY COMMISSION** ...................................................... 57
10. **BACKGROUND PAPERS** ...................................................................................... 57
11. **REFERENCES & GLOSSARY** ............................................................................... 57
2 INTRODUCTION

2.1 The problems created by smoking are truly shocking. For public health, social inequalities, and cost to the taxpayer, all the data shows that smoking is a menace. More so in deprived areas such as Hackney. This review has gathered information about how best to reduce the prevalence of smoking and makes recommendations to help the borough achieve that aim.

2.2 Smoking is by far the most common, preventable cause of premature death in the UK. It kills more people each year than obesity, alcohol, road accidents and illegal drug use put together. Yet still over a fifth UK adults are smokers. In Hackney, that figure is closer to a third.

2.3 Up to 18% of deaths in Hackney can be attributed to smoking. 6% of all hospital admissions and 12% of emergency admissions in Hackney can be attributed to smoking. With a higher proportion of males (39%) smoking than females (26%), smokers in Hackney are mainly young (under 35 yrs) or older people (over 55 yrs) rather than middle aged. Statistically there is a clear socio-economic gradient which shows that if you are poor you are more likely to smoke.

2.4 Smoking is the biggest single cause of inequality in death rates of both the rich and the poor. Despite an overall drop in the number of people who smoke, the deep health inequalities it causes have barely shifted. The more deprived you are, the more likely you are to smoke. Almost every social indicator of social deprivation, (e.g. income, socio-economic status, education and housing tenure) independently predicts smoking behaviour.

2.5 People living in deprived areas like Hackney are more likely to take up smoking, and at a younger age. They are more likely to smoke heavily and are less likely to quit smoking, increasing the burden of smoking-related disease on local health services.

2.6 Legislation introduced in recent years has started to address the problem of smoking, and results are beginning to show. "Smoking Kills", a white paper published by the Department of Health in 1998, was the first document produced by a UK Government to confront the scale of harm caused by tobacco. Since then progress has been made in reducing the prevalence of smoking. Over the last ten years this has been driven down in England from 28% to 22%, with a decline in smoking among 11–15 year olds from 11% to 6% between 1998-2007.

2.7 This fall is estimated to have delivered net annual revenue benefits of £1.7 billion, in addition to health improvements. The total cost of tobacco control measures in the UK is currently around £300 million per year. A one percentage point drop in the prevalence of smoking is estimated to produce a net revenue gain of around £240 million per year through NHS

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cost savings, increased tax revenue (due to extra years of working life), less workplace absenteeism, and fewer payments of disability benefits.³

2.8 Comprehensive action on tobacco control, including the introduction of smoke free legislation and an increase in the age of sale, has helped to protect people who work indoors and in public places from the health risks of second hand tobacco smoke. It has also challenged the perception of smoking as a normal behaviour. However, there is a long way to go to achieve a society that is free from the harms of tobacco for future generations.

2.9 Establishing a tobacco control alliance in Hackney will help to achieve the aim, noted in our Sustainable Community Strategy, to promote health and well being for all, and to support independent living. Evidence considered by this Commission also suggests that the work of such an alliance would reduce the prevalence of smoking locally and thus reduce health inequalities for the borough.

2.10 Creating and enforcing a social and legal climate in which tobacco becomes less desirable, less acceptable and less accessible should be the aim of this alliance and of us all.

2.11 TERMS OF REFERENCE

The following term of reference for the review was agreed by the Health in Hackney Scrutiny Commission and the Overview and Scrutiny Board.

1. evaluate the models and structures for a tobacco control alliance
2. identify and recommend a structure and potential work streams for a local tobacco control alliance in Hackney
3. identify if a communication plan has been developed and implemented that reaches the most vulnerable communities and target groups for smoking cessation and tobacco control, and make appropriate recommendations for enhancing such communications
4. evaluate the current level of involvement and contribution of employers to the promotion of smoking cessation and prevention services for staff.

³ All Party Parliamentary Group on Smoking and Health, (October 2010), "Inquiry into the effectiveness and cost-effectiveness of tobacco control", (UK Parliament)
3 SUMMARY, RECOMMENDATIONS AND OUTCOMES

3.1 After hearing the evidence outlined in this report, the Commission makes the following recommendations, the findings for which are elaborated in Section 6 of the report, below.

3.2 Smoking is a major problem for public health and public services both nationally and locally. Within Hackney it is estimated to be the cause of up to 18% of deaths, and accounts for a significant proportion of inequalities for life expectancy. There are also thousands of avoidable hospital admissions for smoking-related illnesses every year, which cost the NHS billions of pounds.

3.3 Comprehensive action on tobacco control has helped to protect people in public places from the health risks of second hand tobacco smoke and challenged the perception that smoking is a normal behaviour. This action has included the introduction of smoke-free legislation, NHS Stop Smoking services, bans on advertising, and an increase in the age of sale. However, there is a long way to go for us achieve a society that is free from the harms of tobacco for future generations.

Recommendation One - Tobacco control work

Asking residents to attend stop-smoking clinics at central locations does not increase the likelihood of attendance. They should be community based wherever possible. The NHS stop-smoking service is successful but only reaches a small part of the smoking population. Access issue needs to be addressed proactively given the diverse community we have in Hackney. Therefore the Commission recommends that tobacco control activity takes place within the community to increase accessibility and use. In addition to different communities there are other groups using the service that required particular attention.

It is estimated that up to 75% of mental health service users smoke. Since 2008, mental health facilities have been smoke-free but a high smoking prevalence among this group has posed challenges to implementing the law. This contributes to their ongoing health inequalities. Attempts to help people with a mental illness quit smoking are made at in-patient settings but are less likely to be provided at primary care settings. Also, little of the in-patient work is carried forward into community settings at later dates. The Commission is of the view there should be a particular focus on mental health service users as this is a significant health inequality issue.

Consulting with local black and minority ethnic (BME) communities can improve the design of interventions and services, helping to make them accessible and culturally relevant. Reaching these smokers often means delivering services in different ways, and so the first step is to explore the best methods for reaching target groups.

Young people have told us that Personal Social Health Education (PSHE) lessons in school are not delivering a strong message about tobacco control. Schools are not the main influence on young people when it comes to smoking, and efforts should be made to engage young people in other ways, such as health fairs organised by The Learning Trust (TLT) in
school holidays, special events, etc. In light of funding cuts for the Healthy Schools Programme, this is an opportunity to review how tobacco control is delivered in schools and for the local authority to decide how to support local schools in doing so. Continuation of a programme in some form would be beneficial.

The National Tobacco Control Strategy states “the merits of establishing smoke free areas for all children’s play areas”\(^4\) will be considered. Efforts now need to be undertaken to further denormalise tobacco use, for example by having children’s play areas promote smoke free awareness. We would like the Tobacco Alliance to develop a policy on smoke-free children’s areas ahead of any national decision being taken.

The Commission recommends that:

a) tobacco control methods should be integrated with community health services, be community based and tailored for different community groups by finding out:
   1. what is important to them
   2. what would encourage them to quit
   3. appropriate methods of communication to educate smokers about the harmful effects of smoking to their health

b) the Tobacco Control Alliance should explore and establish a programme of support tailored for mental health service users, helping them to quit smoking.

c) the Tobacco Control Alliance should include and advise community champion’s from particular ethnic groups that have been identified as high risk, e.g. the Turkish and Kurdish community.

d) The Learning Trust should review how tobacco control education is delivered in schools and consult with the Hackney Youth Parliament on development of an improved programme. We believe there may be potential for this to form part of The Learning Trust Traded Services to schools in the future.

e) the Tobacco Control Alliance should explore how children’s play areas can promote smoke free awareness, to denormalise smoking for children.

Recommendation Two - Local Data and Intelligence

A tobacco control alliance needs reliable local data about smoking prevalence to inform its work. Identifying community groups with high smoking prevalence is important, particularly if tobacco control activity is to be targeted for best effect. We are pleased to note that this work has already begun in preparation for the Tobacco Alliance.

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\(^4\) Department of Health (1 February 2010), “A Smokefree Future”, (HM Government)
The availability, affordability and perceived attractiveness of tobacco products can undermine progress in reducing smoking prevalence among young people. Local tobacco alliances should build upon national initiatives that denormalise tobacco use. For example, targeting retailers that fail underage sales tests could be a good way to build up local knowledge of smoking trends among young people.

There is a gap in the national evidence base for tobacco control work: we do not know for a fact what works, and what doesn’t. We do know, however, that it is important to build-up knowledge about local smoking prevalence and the needs or preferences of different communities.

The Commission recommends further collation and analysis of local data. In particular we recommend that the Tobacco Control Alliance:

a) works with local GPs and NHS City & Hackney to improve and increase recording of their patients’ smoking status, so that it reaches a percentage level sufficient to make analysis worthwhile. These data could then be used to assess smoking prevalence in the community.

b) identifies the kind of services most likely to be used by smokers from different communities and which services would be most successful.

c) identifies the long term quit rate for pregnant women following the birth of their child and the relapse rate for mothers after pregnancy. The research should identify common reasons for failure to quit in the long-term, where relapses occur.

d) builds-up knowledge of areas with a high prevalence of smoking among young people. This knowledge should be set alongside data about retailers who fail underage sales tests so that enforcement action can be targeted to tackle underage sales of tobacco.

e) explores and promotes the best, evidence-based methods of providing tobacco control education to young people outside of schools.

f) supports small local shops and gives advice on how potential loss of income from declining tobacco sales can be mitigated.

g) explores what consultation surveys are conducted locally and considers how data on smoking prevalence can be captured in current planned consultations.

Recommendation Three – Partnership and partners

Creating a Tobacco Control Alliance will mean that expertise from different organisations can be focused on reducing the prevalence of smoking in Hackney. From the enforcement of trading standards, to education in
schools, a single, concerted approach has been a proven way of accelerating improvement in other boroughs. Working together more closely can also reduce the competition for limited funds that sometimes exists between organisations. Some local services are already working together effectively on tobacco control issues but we think that now is the time for this to go a step further through the creation of a dedicated Alliance.

Local authorities are set to have a leading role in public health services according to recent Government policy proposals. In this light, the Commission suggests that Hackney’s Tobacco Control Alliance be led by the Council. Raising the profile of tobacco control should be encouraged within the local authority by appointing a lead member to champion the issue; secure council-wide support; raise awareness among partners and in the community; and to keep tobacco control at the forefront of the health and wellbeing agenda.

Given this role in public health, the Council is likely to make more referrals to smoking cessation services. There is also great potential for other Hackney Council services to contribute to tobacco control activities, helping to reach the wider population in Hackney, especially socially excluded individuals. These services might include the customer services single front office, libraries, leisure services, etc. This would build on positive examples at the local Homerton Hospital Trust, which has already incorporated interventions and referrals to smoking cessation services for patients having an operation.

The Commission recommends that:

a) the local NHS Public Health Team and the Council’s Trading Standards and Environmental Health services review areas where enforcement and educational activity can be combined. (An example would be that, when conducting compliance duties, officers identify an opportunity to refer, educate or advise about accessing support services for smoking).

b) training to be provided for frontline staff undertaking statutory / enforcement duty ideally smoking advisor level 1 to ensure delivery of a consistent tobacco control message across the borough.

c) A local champion for London Borough of Hackney is identified to raise the profile of tobacco control across local organisations and partnerships.

d) Hackney Council explores how its social services, libraries, customer services and leisure services can assist with the promotion of smoking cessation. We recommend that training is provided for frontline staff to smoking advisor level 1 to make referrals to smoking cessation services.

e) the Homerton Hospital Trust removes all smoking areas from its grounds to encourage smokers to quit.

Department of Health (July 2010), “Equity and Excellence: Liberating the NHS”, (HM Government)
**Recommendation Four - Communication**

There is no communication strategy for tobacco control in Hackney at present. Developing one will be a role for the Tobacco Control Alliance, thus we were encouraged to hear that both the PCT and Council communication teams will be represented on it.

The Commission recommends:

a) creating a brand identity, like the Council’s ‘I love Hackney’, that distinguishes work on tobacco control from the individual organisations that deliver it. This branding should be used by all local organisations and service providers to promote the tobacco control message.

b) that message communicated about tobacco control should not be preachy but informative, so that smokers and non-smokers can make an informed decision about their healthy lifestyle.

c) A suggestion was added by the Overview and Scrutiny Board that the Tobacco Control Alliance promotes communication channels for Members of the public to whistleblow when encountering instances of underage cigarette sales.

**Recommendation Five - Tobacco Control Alliance Structure**

The Tobacco Control Alliance will bring together agencies from different sectors to promote tobacco control and improve public health. A strong tobacco control agenda requires a structure that supports strategic decision-making and clear accountability as well as allowing partners with different expertise and interests to engage at different levels. Ensuring that the right activities are identified and implemented requires a Tobacco Alliance with strong governance and lines of accountability.

The alliance needs to have a clear governance structure and general guidelines for how resources will be distributed, where decision-making powers lie, and who will act in an advisory capacity. The alliance needs membership that can increase the impact of a national tobacco control campaign by ensuring that the goals and practices established nationally are tailored to fit the local context. This will include taking into account the ethnic diversity and cultural requirements of Hackney’s population. We suggest that regular updates are provided to this Commission and relevant Team Hackney Partnership Boards, notably the Children’s Trust, the Safer Cleaner Partnership and Economic Development Partnership.

The Chair is a really important role. That individual will steer the Alliance locally, represent it in relation to other organisations, and advocate at a senior level. The post holder will advise on the purpose and work of the group. The Commission offers as a suggestion this could be a Councillor performing a champion role.

The success of the Alliance will depend, in part, on the networks it is able to build. Early groundwork is needed to establish these networks and
support structures before the Alliance starts implementing tobacco control activities. Ideally the Alliance should cultivate a network that encompasses community workers, policy writers, and decision makers from across different sectors such as the retailers, the leisure industry, education, etc.

The Commission makes the following recommendations:

a) national guidance offers three models for a Tobacco Control Alliance. We recommend that the parliamentary model is adopted in Hackney. We further suggest that Hackney’s Tobacco Control Alliance is accountable to the Thriving Healthy Partnership Board until the new Health and Well being Board is established.

b) that the Tobacco Control Alliance agrees Terms of Reference that include: desired outcomes, a clear set of priorities, approaches to partnership, reporting requirements, and publishing an updated programme of activity.

c) that the Tobacco Alliance appoints a Chair independent of service delivery, who would not be affected by any aspect of the tobacco control strategy.

d) that the Tobacco Alliance keeps a record of, updates and publishes a list of its membership. We further encourage the Tobacco Alliance to build networks that have multiple contacts within organisations, to safeguard against links being broken if an individual leaves.

Recommendation Six - Employer

There remains some uncertainty about stop-smoking services being offered to staff at The Learning Trust. The Commission feels it is important that staffs are sign-posted to support and receive information about smoking cessation.

The Commission makes the following recommends:

a) that The Learning Trust demonstrates how it promotes smoking cessation services to staff and provides support services to staff, especially teachers.

b) that other local employers (the Council, PCT, Homerton Hospital and East London Foundation Trust) regularly advise staff about the smoking cessation services and support they offer to quit, using the brand of the Tobacco Control Alliance once established

Recommendation Seven - General

Continued investment in activities that reduce smoking prevalence and increase cessation is crucial, especially in deprived areas like Hackney where smoking is the largest determinant of inequality in life expectancy.
The Commission hopes the Government will take the bold step and follow through with publishing and enacting the Health Act 2009 regulations\textsuperscript{6}.

The Health in Hackney Scrutiny Commission recommends that OSB ask it to write to the Government in support of implementation the Health Act 2009 regulations that will prohibit point of sale display of tobacco products and sale of tobacco from vending machines.

\textbf{OUTCOMES}

Since the review began the following actions arising from it have already been addressed.

1) Smokefree Hackney Tobacco Alliance has been established with membership.

2) Hackney Council has provided smoking cessation clinics for staff, which were commissioned from NHS City and Hackney.

3) “Integration, Respect, Inclusion and Empowerment (IRIE) Mind, a multicultural drop in service for vulnerable adults with mental health issues, has made contact with NHS City and Hackney Tobacco Control Team and is in discussion about how to work in partnership to provide smoking cessation support for its service users.

4 FINANCIAL COMMENTS

4.1 This report outlines findings to date on tobacco reduction and control within the London Borough of Hackney, and outlines further options for accelerating this reduction.

4.2 Implementation of at least some of the recommendations will have financial implications (e.g. training costs) for the Council and its partners, however at this juncture, it is not possible to quantify these costs.

4.3 All implementation plans will need to be fully costed and considered through the Council’s budget development and financial planning process prior to implementation, to ensure that they are workable within the Council’s existing cash limits.

4.4 Implementing these recommendations may involve incurring additional training costs for the Council and its partners.

4.5 In relation to Environmental Health and Trading Standards there may be potential training costs involved in training staff to implement Tobacco Control activities.

4.6 All implementation plans will need to be fully costed and considered as part of the Council’s budget development and financial planning process prior to implementation.

5 LEGAL COMMENTS

5.1 The Health Act 2009 came into force to strengthen tobacco control to protect children and young people from the health harms caused by tobacco.

5.2 The legislation permits the sale of tobacco from vending machines from 1 October 2011 and
• Prohibits the display of tobacco products in large shops from 1 October 2011 and in small shops from 1 October 2012.

5.3 The Act regulates the format of tobacco price lists and labels displayed in large shops from 1 October 2011 and in other places from 1 October 2013.

5.4 The Act also required that from 1 October 2013 specialist tobacconist may only advertise and display tobacco products inside their stores out of general public view.

5.5 Furthermore the Act requires that from 1 October 2013 retailers selling tobacco products in large quantities such a duty free and cash and carry businesses display tobacco and prices only in an area of the shop selling only tobacco and outside of which the tobacco products and prices cannot be seen.
6 FINDINGS

6.1 Background

6.1.1 Smoking is an addiction usually formed in childhood and adolescence. It is not an adult choice. Two out of three lifelong smokers are hooked before they are old enough to smoke legally.

6.1.2 There are nearly 9 million smokers in England. More than 80,000 people die each year from active smoking and possibly up to 10,000 from second hand smoke. This addiction kills more people than alcohol, obesity, road accidents and drugs misuse put together. It is estimated that one in two regular cigarette smokers will eventually be killed by their tobacco habit and approximately 50% of these deaths will occur before the age of 70. That is 12 years of life expectancy lost.

6.1.3 There are hundreds of thousands of avoidable hospital admissions for smoking-related illness, and these cost the NHS billions of pounds every year. Every percentage point reduction in smoking prevalence in England can be expected to prevent some 2,900 deaths per year.

6.1.4 Smoking is still a major public health concern nationally and within Hackney and is estimated to be the cause of up to 18% of deaths in Hackney. Smoking not only causes premature death but impacts on a person’s wellbeing and hinders their ability to be economically active. Tobacco consumption is recognised as the UK’s single greatest cause of preventable illness and early death.

6.1.5 The more deprived you are, the more likely you are to smoke. Almost every indicator of social deprivation, (including income, socio-economic status, education and housing tenure) independently predicts smoking as a behaviour. Children growing up in a household where one or more adults smoke are likely to be smokers themselves. More recently the Marmot Review has highlighted the importance of investing in evidence-based smoking cessation services and targeting them at smokers from disadvantaged groups.

6.1.6 The Government’s 1998 Smoking Kills White Paper was a landmark public health strategy, which set out a clear agenda for action. Since its publication, significant progress has been made to reduce the harms from tobacco use through partnership working between the private, public and voluntary sectors, as well as the NHS and local government.

6.1.7 Today, tobacco advertising is no longer permitted; thousands of smokers have been helped to quit by our NHS Stop Smoking services; and enclosed work and public places are free of the harm of second hand smoke. Experience of the benefits of smoke free public places appears to have increased public enthusiasm for new initiatives in tobacco control.

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7 All Party Parliamentary Group on Smoking and Health, (October 2010), Inquiry into the effectiveness and cost-effectiveness of tobacco control, (UK Parliament)
8 Ibid. 6
10 Ibid. 1
6.1.8 Reducing the harm caused by tobacco is best achieved by reducing smoking prevalence and reducing non-smokers’ exposure to tobacco smoke. Smoking prevalence is reduced by reducing the take-up of smoking and increasing the rate of permanent cessation.

6.1.9 Smoking accounts for a significant proportion of inequalities in life expectancy at birth in the UK and Hackney. Taking comprehensive action on tobacco control can help protect people in public places from the health risks of second hand tobacco smoke and challenge the perception of smoking as a normal behaviour.

Witness Evidence Sessions

The Commission wanted to get the views and opinions of experts about evidence-base tobacco control interventions that are used locally. It was also important to understand how access to support services for stopping smoking was communicated.

6.2 NHS City and Hackney

6.2.1 NHS City and Hackney (our local PCT) is responsible for commissioning health services in the primary and secondary care sector (i.e. GPs, community health services, hospital services, etc) for the local population of City and Hackney.

6.2.2 NHS City and Hackney’s Public Health service is responsible for monitoring, education, raising awareness and reducing preventable diseases within City and Hackney. It has a dedicated Tobacco Control Team which helps people who smoke to quit and delivers prevention work in the form of tobacco control activities. In 2009/10 the focus for the Tobacco Control Team was to improve smoking cessation services locally and raise awareness about the support available.

6.2.3 Raising demand for stop smoking services is an ongoing challenge in Hackney. Not many people in the borough place a premium on stopping smoking, in part due to the high levels of deprivation. As mentioned above, smoking prevalence is linked closely to inequality, hence quitting is hindered by issues such as poor housing and high unemployment.

6.2.4 National indicators for smoking cessation measure the number of people who have quit for four weeks. City and Hackney’s target for this indicator in 2009/10 was the second highest in London, at 2020 people. Despite the odds, this was exceeded with a total of 6920 people accessing smoking cessation services across Hackney and the City, and 2453 going on to quit successfully for four weeks.

6.2.5 A number of smoking cessation interventions are recommended by the National Institute of Clinical Excellence (NICE). In accordance with its guidance the NHS City and Hackney has commissioned the following:

- **Brief interventions** – opportunistic advice, discussion, negotiation or encouragement and, where necessary, referral to more intensive treatment. This is delivered by a range of professionals in less than 10 minutes
- **Individual behavioural counselling** – one-to-one meetings with a trained counsellor
- **Group behaviour therapy** – weekly meetings led by a trained therapist
- **Pharmacotherapies** – trained smoking cessation advisors may recommend and prescribe therapies including nicotine replacement therapy, varenicline or bupropion.

6.2.6 These services are delivered by a range of providers, including:
- City and Hackney Community Health Services (brief interventions only)
- Primary Care Enhanced Local Service
- Pharmacy Enhanced Local Service
- Homerton Hospital – In-patient and pregnancy service
- Queen Mary University Level III Specialist Service
- Shoreditch Spa – Priority Communities Service.

6.2.7 In addition, the PCT has commissioned a number of bi-lingual services to serve Hackney’s diverse communities and the Homerton Hospital has piloted a Sunday drop-in for Turkish and Kurdish smokers. The latter has proved popular and funding is being sought to mainstream the service.

6.2.8 Initial outreach by Halkevi, a local community group, to the Turkish and Kurdish communities has recently been decommissioned and replaced by Shoreditch Spa, a regeneration agency, in order to connect with a wider range of BME community groups including Somalian and Vietnamese groups. As part of this service the Shoreditch Spa will provide bi-lingual services for a range of BME communities with high smoking prevalence that do not access mainstream smoking cessation services. The service recruits community members from the priority groups into smoking cessation training at level 1 (training provides training to enable people a brief intervention following the 5 As model), 2 (training to provide 1 2 1 support over a period of 6 weeks) and 3 (training to become a specialist stop smoking advisor – providing group service and more intensive support) and supports them to provide stop smoking information and advice as part of a volunteer and skills development pathway.

6.2.9 There is believed to be a direct correlation between smoking prevalence and income but there is no reliable local data on smoking prevalence by socio-economic group. National assessments 11 from 2001 – 2007 have shown that smoking prevalence amongst routine and manual groups fell from 33% to 26% compared to prevalence amongst managerial and professional households which fell from 21% to 16%. It is estimated that routine and manual groups make up 44% of the national smoking population. So it was encouraging that 27% of clients accessing stop smoking services locally were from routine and manual occupations.

6.2.10 Supporting pregnant women to stop smoking remains a high priority for the PCT. 6.3% of mothers were known to be smoking at the time of delivery in 2009/10. This is considerably lower than the national average of 14.1%.

6.2.11 The Homerton Hospital piloted an incentive scheme for all pregnant women towards the end of 2009/10. The incentive scheme increased referrals into the service initially but anecdotal evidence suggests that the overriding motivation for stopping smoking in the long term remained the impact of smoking on the mother's unborn child. The scheme is, however, potentially a useful way of motivating women to take the first step towards stopping smoking. This Commission would like to see an evidence base built on the long term reasons for quitting amongst pregnant women after the child is born. This would help to establish the relapse rate and whether motivation for quitting was still related to the child.

6.2.12 With limited local and national data on smoking prevalence, the PCT wanted to build its data about local smoking prevalence from the GP registers and would be targeting the young people.

Recommendation Two - Local Data and Intelligence:

c) identifies the long term quit rate for pregnant women following the birth of their child and the relapse rate for mothers after pregnancy. The research should identify common reasons for failure to quit in the long-term, where relapses occur.

6.2.13 The PCT has a strong communication plan in operation for smoking cessation services, but an over-arching communication strategy is required if tobacco control activities are to achieve a reduction in smoking prevalence locally. At present the PCT makes use of local media to promote and gain support for the smoking cessation service. Using media such as the Hackney Gazette, Hackney Today and local non-English language newspapers to regularly feature their stories.

6.2.14 A reduction in smoking prevalence cannot be achieved by smoking cessation services alone. A partnership approach is essential to truly achieve a reduction in tobacco use, involving a range of partners working together to deliver an effective tobacco control programme across Hackney. This partnership would be called a Tobacco Control Alliance. In order for such an Alliance to be effective a number of key components would require implementation such as: identification of membership, structure and strong governance and accountability arrangements.

6.2.15 The size and makeup of the membership should be appropriate to Hackney. In order for an Alliance to function effectively having a dedicated co-ordinator would also be essential. The role of the Tobacco Control Alliance Co-ordinator would be to establish the local Tobacco Control Alliance by engaging organisations at a senior level and then providing ongoing support.

6.2.16 At the time the evidence was provided no Tobacco Control Alliance in Hackney was established but we are pleased to report that by the time this
review was drawing to a conclusion NHS City and Hackney had recruited a Tobacco Control Alliance Coordinator to take this work forward and a local tobacco alliance group had been established and conducted its first meeting.

6.2.17 It is vital for the Alliance to expand the reach, appropriateness and effectiveness of NHS support for all smokers. NHS Stop Smoking Services are effective and if we want to encourage greater use of them by smokers in Hackney it is even more important to provide the support in the community for those community groups with the highest prevalence, often not accessing traditional points for NHS Stop smoking services.

6.2.18 The NHS services, though successful, only reach a small part of the smoking population and with the diverse community we have in Hackney there appears to be access issues. Therefore the Commission recommends tobacco control activity should be embed in locations within the community which people are already familiar with to increase accessibility and use. The Commission would like consideration to be given to structuring services to be integrated within the community as far as possible with service providers not expecting services users to come to them.

**Recommendation One - Tobacco Control Work**

a) tobacco control methods should be integrated with community health services, be community based and tailored for different community groups by finding out:

1. what is important to them
2. what would encourage them to quit
3. appropriate methods of communication to educate smokers about the harmful effects of smoking to their health

6.3 Hackney Council

6.3.1 London Borough of Hackney Trading Standards service makes sure that there is fair and safe trading in Hackney and protects the interests of consumers and businesses. Trading standards enforces a wide range of consumer legislation, and provides advice to Hackney residents and businesses.

6.3.2 London Borough of Hackney Environmental Health services are responsible for making sure food businesses comply with food hygiene and food standards law to protect customers from the risks of poor food hygiene. They ensure commercial businesses such as shops, offices, warehouses, catering and leisure activities comply with Health and Safety law to prevent work-related accidents and ill-health. They are also responsible for the control of public health issues within commercial premises and/or land, and the control of infectious diseases within the borough.
6.3.3 Trading Standards Officers informed the Commission about the work they conduct in relation to tobacco control activities. These were:
- Enforcement of the smoke free legislation in Hackney (alongside Environmental Health)
- Test purchases for underage sales: from shop floor and vending machines
- Illicit tobacco – counterfeit products
- Point of sale (tobacco advertising – only permitted to have A5 size advertising).

6.3.4 At the time of the review enforcement action undertaken was:
- 2009/10: visits: 58 sales: 4 (approx. 6%)
- 2010/11: visits: 18 sales: 0.

6.3.5 The number of prosecutions in 2009/10 was 3 for underage sales all were successful convictions with an average fine of £500 per defendant.

6.3.6 At the time of the review enforcement action under taken in relation to smoke free premises was:
- 2009/10 visits: 42
- 2010/11 visits: 9.

6.3.7 The number of prosecutions for smoke-free premises in 2009/10 was 2.

6.3.8 The Council applies a strong line to enforcement of smoke-free rules and these activities were reported to be:
- Implementing fixed penalty notices (£50)

6.3.9 258 premises in the borough were permitted to sell tobacco at the time of this review. It is the responsibility of the Council to educate shop owners about the legal age for sales of tobacco and an education pack was given to traders before every test purchase operation.

6.3.10 Trading Standards Officers aim to conduct one session of underage sales per quarter despite there being no statutory requirement to visit a certain number of premises. Hackney Council Officers aim to visit all premises in the Borough and operate a rolling programme that prioritises premises in receipt of complaints or that have failed underage sales tests. It would require additional resources to allow for a dedicated officer in Trading Standards to be able to deliver a comprehensive tobacco control action plan for illicit tobacco sales, shisha (hookah pipes) and underage sales.

6.3.11 The work of Hackney Council services is more reactive and statutory-based. It is less focused on education or prevention work related to tobacco control. More could be done in this regard but it would affect resources and require a dedicated officer to conduct tobacco control work, in addition to the other duties currently required to be undertaken in the service. Therefore the Commission is conscious that making a recommendation to undertake more prevention work (i.e. tobacco control activities) would have resource implications. Instead we encourage the Council to explore how it can improve or do more partnership working to increase tobacco control activities and referrals to the smoking cessation care pathway.
6.4 Homerton University Hospital NHS Foundation Trust

6.4.1 Homerton Hospital is the local secondary acute care trust for the residents of Hackney. It provides a range of general hospital services to Hackney and the City of London and specialist care in obstetrics, neonatology, fetal medicine, laparoscopic surgery, fertility, bariatric surgery, obesity surgery and neurorehabilitation across east London.

6.4.2 Hospital admissions are an ideal opportunity to target smokers, especially if the admission was smoking related. Hackney has one of the highest prevalence of smoking in London along with a large BME population that is more prone to developing smoking related illnesses.

6.4.3 Evidence from the Trust shows that smokers increase their risk of cardiovascular and respiratory problems, and that smoking post operatively increases the risk of infection, wound healing time, length of stay in hospital, and risk of death in hospital. So there are significant health gains from stopping smoking preoperatively and the longer the length of abstinence before surgery, the fewer the risk of complications.

6.4.4 Patients cannot smoke while in hospital and this is viewed as a window of opportunity to offer smoking cessation interventions to patients who are often motivated to quit. Indeed, patients seemed more receptive to the information if coming from a health professional in a hospital context. To this end, a clear and systematic referral system has been set up between the service and clinical staff at the pre-assessment clinic. Patients are contacted pre-operatively and given advice, and supported in establishing a cessation attempt.

6.4.5 In future the trust sees Stop Smoking referral and advice being embedded within the elective surgery pathway, with all key health professionals trained in Brief Intervention Techniques.

6.4.6 Department of Health has expressed a wish to see Stop Smoking advice and support routinely provided in secondary care. The Department is also conducting a pilot in hospitals to establish ways of identifying every smoker admitted and making sure they are offered support to quit. This would be done by using care pathways for brief interventions and referrals to NHS Stop Smoking Services. The Department has also requested that the piloting Trusts appoint a 'hospital champion' to act as a link for all stop smoking activity.

6.4.7 The Commission commends the Homerton Hospital’s work to date embedding referrals to Stop Smoking services in the elective surgery pathway. We are also acutely aware of the NHS recommendation not to permit any smoking on a NHS site. Baring this in mind the Commission strongly recommends that the Homerton Hospital removes all smoking shelters from the hospital site and explores how it could expand its referral system for stop smoking to all patients admitted.

Recommendation Three - Partnership

e) the Homerton Hospital Trust removes all smoking areas from its grounds to encourage smokers to quit.
6.5 East London NHS Foundation Trust

6.5.1 East London NHS Foundation Trust (ELNFT) is the local provider of community and in-patient mental health services for both children and adults in Hackney. This Trust delivers services to four London Boroughs: Hackney, Newham, Tower Hamlets and City of London. It is commissioned by each of the Borough’s PCTs to provide these services to their local residents.

6.5.2 Smoking prevalence is much higher for mental health service users than the wider community. For instance, up to 90% of people with schizophrenia regularly smoke cigarettes and up to 75% of service users with a mental illness are likely to smoke.

6.5.3 The smoking status of patients is captured during a nurse’s assessment where Nicotine Replacement Therapy (NRT) is offered. It is estimated that 10% of patients opted to use this method of support.

6.5.4 The Trust supports service users who wanted to quit smoking more than people who do not, as mental illness and smoking often going hand in hand. Although the Smoke Free legislation came into force in 2007, mental health trusts were given an extended period of time to implement it. Since 2008, mental health facilities have been smoke free but effective implementation remains a challenge.

6.5.5 Soon after the introduction of the new policy, a significant number of service users at the forensic mental health unit signed a petition in protest at the restrictions on smoking. Feedback from some service users remains negative because there is a minority view amongst that the ban is an infringement on their human rights. Despite this negative feedback, however, many people have made positive remarks on the improvements to the ward environment and the ready availability of smoking cessation support. Negative comments have been made in relation to the limited access to outdoor smoking areas and the difficulty of cutting down or quitting during a hospital admission.

6.5.6 The Commission is concerned that this could become a big issue for ELNFT if the proposed new premises at St Leonards do not proceed. It was believed this could have resolved the issues regarding access to outside space for longer stay inpatient service users.

6.5.7 ELNFT has recognised and acknowledged that monitoring systems need to improve to track the success of quitters, especially when a service user has left inpatient care. The Trust estimated that it achieved a small number of quitters but highlighted that mental illness often made it hard for service users to give up smoking. It was noted the Trust was in the process of developing an overarching strategy for both in-patient and community services.

6.5.8 DOH evidence shows that high smoking rates amongst people with poor mental health will contribute to health inequalities. People with a mental illness have been less likely to receive stop smoking interventions in primary care, which is a key contact point for the majority of patients who are treated in the community. An increasing amount of research indicates
that long term smoking is associated with the onset and worsening of depression and anxiety disorders.\textsuperscript{12}

6.5.9 During the review we have noted that people with a mental illness seemed less likely to receive stop smoking interventions in primary care. Attempts to support people to quit are made at inpatient settings but little is carried forward into the community settings. The Commission is of the view there should be a particular focus on mental health service users: this is an important health inequality issue, especially as a high number of local residents suffer with some form of mental illness.

\textit{Recommendation One: Tobacco Control Work}

\begin{itemize}
\item[b)] the Tobacco Alliance should explore and establish a programme of support tailored for mental health service users, helping them to quit smoking.
\end{itemize}

6.6 Department of Health Regional Public Health

6.6.1 The Department of Health is responsible for health protection, health improvement and health inequalities issues in England. The Regional Public Health Group for London presented information to this Commission about the national picture of smoking prevalence and gave advice about the type of tobacco control activities that should be undertaken.

6.6.2 Tobacco use is the primary reason for the gap in healthy life expectancy between the rich and poor and evidence shows that if a child lives in a house with smokers they are more likely to smoke themselves. Previously the number was estimated to be 10,000 deaths from smoking per year but recent data showed deaths from smoking had declined to:

\textbf{Figure 1}

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>London</td>
<td>8481</td>
</tr>
<tr>
<td>Hackney</td>
<td>216</td>
</tr>
<tr>
<td>\textbf{Per 100 000 (over 35)}</td>
<td></td>
</tr>
<tr>
<td>London</td>
<td>200.4</td>
</tr>
<tr>
<td>Hackney</td>
<td>254.7</td>
</tr>
<tr>
<td>England (average)</td>
<td>206.8</td>
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<tr>
<td>England (worse)</td>
<td>360.3</td>
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\textit{Source: Health Profile 2010, www.healthprofiles.info}

It was advised the downward trend noted in figure 1 is believed to be higher amongst men than women yet smoking prevalence is still increasing among young women.

\textsuperscript{12} Ibid. 2
6.6.3 The Department recommends targeting young people with prevention activity. Evidence suggests that people do not start smoking once they are over the age of 20 because, despite an advertising ban, there are still loop holes in the system that make it easy to purchase tobacco using the internet. Advertisements on websites like Facebook are still reaching young people.

6.6.4 Tobacco advertising and branding encourage children and young people to smoke and young people are sensitive to the glamorization of smoking in films, on TV and on the internet. Stop Smoking services in local areas should work in partnership with their schools to ensure access young people.

6.6.5 Reducing the prevalence of adult smoking not only dramatically improves the health prospects of adult (ex) smokers, it is also the single best way of reducing harm to children and young people because it eliminates secondhand smoke and the normative, tacit support for smoking.

6.6.6 Working in partnership with Her Majesty’s Revenues and Customs (HMRC), local authorities, the NHS, police and businesses, must play an important role in tackling the domestic trade in illicit tobacco for their area.

6.6.7 Local areas could undertake the following tobacco control activities to reduce smoking prevalence in their area:

- Ensure local compliance on current and future legislation
- Support national marketing efforts through local social marketing to de-normalise tobacco use
- Work with local customs and borders agency partners to reduce the sale of illicit tobacco
- Continue delivering world class stop smoking services – and reach more people
- Highlight the harms of smoking in communities and help them to become smoke free
- Build local coalitions to help promote smoke free communities that take greater account of lifestyle factors and social, economic and cultural factors that influence smoking rates. This needs to be supported by an alliance coordinator
- Help to develop more tailored services for a wide range of groups.

6.6.8 The Department’s Regional Public Health Group recommends that local areas should set up a Tobacco Control Alliance. This should be a partnership that meets regularly to take a strategic overview of tobacco control activity and co-ordinates delivery across key delivery streams. Delivery should be adapted to fit local tobacco control priorities, implying that it may not be necessary to address each delivery stream as recommended in the “Tobacco Control Alliance – A Toolkit for London”\(^\text{13}\). The partnership should comprise senior level officers who are responsible for raising the profile of tobacco control across local organisations. The

\(^{13}\) Ibid. 11
Department recommends that it be led by either the PCT or the Local Authority, or jointly led by both organisations. It should have an accountability structure with the core group being accountable to a Local Strategic Partnership (LSP), for example via the Health and Wellbeing partnership. A Tobacco Control Alliance should ensure that other relevant thematic partnerships are kept informed and engaged with tobacco control, e.g. the Children’s Trust Board and Safer Communities Partnership.

6.6.9 Along with tobacco control work the Regional Public Health Group advised that it is imperative to have local champions, one from the PCT and one from the local authority, working in partnership as a team.

6.6.10 Taking into consideration proposals in the NHS White Paper “Equity and Excellence” the Commission is of the view the local Tobacco Control Alliance should be led by the Council and should provide regular updates to inform and engage others about tobacco control, notably the Children’s Trust Board and Safer Cleaner Partnership Board.

Recommendation Three: Partnership

c) A local champion for London Borough of Hackney is identified to raise the profile of tobacco control across local organisations and partnerships.

6.6.11 A citizen’s jury was conducted in Hackney (commissioned by ASH conducted by Dr Foster in February 2008) that outlined the views of local resident smokers. The citizens’ jury was made up of twenty local people, half of whom were smokers (twice the national average), around half were from Black and Minority Ethnic communities and the range of their incomes reflected the lower income of the community from which they were drawn.

6.6.12 Over three days the panel listened to expert evidence from politicians, academics and clinicians supporting and opposing a variety of tobacco control measures. The members had time to discuss the issues in some detail and come to their own conclusions and policy recommendations. The views expressed included:

6.6.13 They were willing to support government interventions that they thought:

- would work and would be enforceable (i.e. would prevent people smoking in the first place and would help people quit)
- would not be too costly to the public purse to enforce
- would not infringe adults’ civil liberties, (unless the health of children and young people was at risk) For example, they were sceptical that branding encouraged people to start smoking or to continue smoking and so did not believe that plain packaging would reduce the number of smokers significantly. Yet they had few objections in principle to regulating the tobacco manufacturers’ powers to market their products in this way.

6.6.14 The jurors were especially keen on measures to support smokers who wanted to quit. They wanted to see greater community involvement in the
design of Stop Smoking services in order that services met local needs. They thought low-income smokers might be reluctant to approach GP primary care teams for help and support, and might be more confident about attending a service in a local community centre or venue. Schools were suggested as a good place to deliver a Stop Smoking service to the whole community, especially smokers.

6.6.15 The jurors recognised that smoking around babies and children was bad for their health and that the children of smokers were significantly more likely to smoke themselves. They expressed a view that the government should do more to encourage people not to smoke around babies and children (e.g. through mass media campaigns). However they stressed that people should not be lectured about what to do in their own homes.

6.6.16 Shocked by the social inequalities in smoking and smoking related disease, the jurors gave priority to measures designed to tackle smoking in communities with high smoking prevalence. The jurors believed that high rates of smoking were driven by a variety of interrelated challenges faced by people living on very low incomes including social isolation, the stress and anxiety of making ends meet and the overall lack of opportunity within which they live. They wanted to encourage and support quitting among smokers from deprived backgrounds, especially among parents to break the cycle of smoking within low income families.

6.6.17 The following emerge as key concerns in the jurors’ decision-making:

- **Individual freedom** - they were passionate about individual liberty and needed to be confident that any restrictions on people were justified by the protection of the health of others, especially children.

- **Corporate culpability** - they wanted to minimise harm done by cigarettes and thought the chemicals in cigarettes should be listed on the packet. They expressed shock that there was no independent industry regulator and believed one should be established urgently. They also believed that the conduct of tobacco manufacturers should be scrutinised and their misconduct publicised.

- **Support for smokers** - they felt that the promotion of much safer alternatives to tobacco might help to reduce the impact of smoking among low income smokers who are more heavily addicted and find it harder to quit. They thought this could help to tackle health inequalities.

6.6.18 In their verdict the jurors prioritised tackling poverty, improving the lives of children in poverty, developing community-led stop smoking services and encouraging smokers not to smoke in front of children. They also expressed majority support for new tobacco control interventions.

6.6.19 The Commission noted how the views of this group mirrored the strong views coming through whilst it conducted this review.
6.7 Queen Mary University

6.7.1 The Tobacco Dependence, Research and Treatment Unit are part of the Wolfson Institute of Preventive Health, at Queen Mary University of London. This Unit conducts research into behavioural and pharmacological treatments for dependent smokers and has been involved in pioneering studies of several treatments now used worldwide. The Unit is also commissioned by NHS City and Hackney to provide intensive (level 3) stop smoking support.

6.7.2 According to their work, the aim of tobacco control is to limit the morbidity and mortality due to smoking by:

- preventing young people from starting to smoke
- help existing smokers to quit
- Reducing the harm associated with smoking.

6.7.3 Various methods of tobacco control interventions used were outlined by researchers from the Unit, including:

- school based programmes
- decreasing youth access to tobacco
- further work on health promotion
- warning labels on tobacco packaging
- mass media campaigns and media advocacy.

6.7.4 The Commission was advised that the most effective approaches, where there was good evidence to show change occurred, were warning labels, mass media campaigns and advocacy. The least beneficial from the list above was believed to be school based interventions which do not have a significant impact on the rate of smoking prevalence. The intervention believed most likely to reduce prevalence significantly would be an increase in price, hand in hand with tackling illicit and cheap tobacco.

6.7.5 The low volume of smokers accessing services is believed to be largely attributable to beliefs. Many smokers do not view smoking as a disease and view the NHS as a place where people who have diseases go. Therefore NHS support services were unlikely to be considered as their first port of call for support and help as often smokers would try to quit alone. Access rates would be likely to improve if Stop Smoking services were integrated with community health services.

6.7.6 The vast majority of people who choose to quit smoking do so with no support (the cold turkey approach). However evidence from the Unit indicates that only an estimated 3% of people who use this method would have still quit one year later. If more people accessed treatment to aid cessation this would increase the long-term quit rate by 5% because there was evidence to show that the best success rates are associated with people who access and used NHS stop smoking services.

6.7.7 An example of the cost saving resultant from reducing smoking prevalence were associated to a year of life saved:
- NHS Stop Smoking Services = £600 per life year saved
- Drugs (statins) for lowering cholesterol = £4,000 to £13,000
- It was thought over 80% of patients currently prescribed statins would not need these drugs if they stopped smoking

6.7.8 During the review we reflected on how much easier it is to buy a packet of cigarettes over the counter than it is to buy nicotine replacement products. There was deep debate as to whether providing incentives for retailers making the sale of tobacco difficult could be introduced and help reduce smoking prevalence - maybe leading to local newsagents becoming ambassadors for smoking prevention and advising about the harmful effects of tobacco.

6.7.9 Current nicotine replacement treatments have limited reach and efficacy but can be used. An example cited was Swedish snus (a less risky oral tobacco product) which though imperfect, is currently the front-runner. However it was anticipated that newer and novel products may have a role to play in the future, an example of which is below in figure 2.

Figure 2
The key aim is to get people to access services instead of going it alone and to integrate those services with existing community provision.

**Recommendation One: Tobacco Control Work**

a) tobacco control methods should be integrated with community health services, be community based and tailored for different community groups by finding out:

1. what is important to them
2. what would encourage them to quit
3. appropriate methods of communication to educate smokers about the harmful effects of smoking to their health.

**Recommendation Two: Local Data and Intelligence**

f) supports small local shops and gives advice on how potential loss of income from declining tobacco sales can be mitigated.

**Voluntary Sector**

The Commission sought to hear the views of different groups representing communities believed to have high smoking prevalence. An invitation was extended inviting groups or individuals to participate in the review. The evidence below is from those groups who attended the discussion and presented views of the communities and service users they represented.

6.8 Cancer Research UK

6.8.1 Cancer Research UK is the largest independent charity that funds cancer research in the UK and is dependent on the generosity of the public to fund its work, spending approximately £355m on research in 2009/10. Cancer Research UK carries out world-class research to improve understanding of cancer and to find out how to prevent, diagnose and treat different types of the disease.

6.8.2 Cancer Research UK explained that nicotine is as addictive as heroin or cocaine and can take an average of 12 to 14 attempts to quit smoking.\(^{14}\)

6.8.3 The World Health Organisation's Framework Convention on Tobacco Control (FCTC)\(^{15}\) is an international treaty signed by over 160 countries, including the entire EU (apart from the Czech Republic) to drive forward the work on tobacco control. This limits the interaction between government and industry organisations. Cancer Research UK has lobbied to exclude the tobacco industry from any scientific process as the industry has funded misinformed research to protect itself against liability claims


and to lobby against legislation. The World Health Organisation (WHO) says that there is a fundamental and irreconcilable conflict between the tobacco industry's interests and public health policy interests.

6.8.4 Tobacco advertising was banned in the UK in 2003 because of the evidence that it encouraged young people to take up smoking. The tobacco industry tried to get around the advertising ban by increasing the size and scale of tobacco displays in shops. So, in line with World Health Organisation recommendation (implemented by countries such as Iceland, Ireland, Norway, Thailand and all the Canadian provinces), UK legislation has been introduced to put tobacco out of sight in shops from 2011 onwards. However, the tobacco industry is challenging, and encouraging retailers to challenge, the regulations on point of sale display to try to get them revoked.

6.8.5 The advertising ban has reduced overall awareness of tobacco promotion and of brands among young people. Therefore shop displays are now the most important source of tobacco marketing to young people. Awareness of the new pack design and size had increased from 11% to 18%.\(^\text{16}\)

6.8.6 The tobacco industry still had two key ways in which to promote its product:

- tobacco displays in shops - point of sale displays have got larger with advertising restrictions
- attractive packaging.

6.8.7 Tobacco point of sale displays are reported to have three effects:

- they make smoking seem normal by being sold next to sweets and crisps in newsagents and corner shops
- they communicate cigarette brands – they are a form of advertising
- they add an extra difficulty to quitting by enticing purchase via the display.

6.8.8 Moving the point of sale display for tobacco in shops would not deter adults from purchasing their tobacco. It would, however, help to reduce the number of children smoking and enable tobacco to become less obvious to teenagers by not being presented as normality. Research also suggests that point of sale displays “undermine quitting intentions and behaviour among established smokers”\(^\text{17}\) by prompting unplanned purchases.

6.8.9 International evidence shows that youth smoking rates fell significantly when a tobacco point of sale display ban was implemented in Iceland in 2001. Iceland has had a national tobacco control strategy for many years but when the ban on point of sale displays was introduced, youth smoking rates (measured by a survey of all 10\(^{th}\) grade students) fell from 18.6% in 1999 to 13.6% in 2003.\(^\text{18}\)

\(^{16}\) Ibid. 13
\(^{17}\) Ibid. 13
\(^{18}\) Ibid. 13
6.8.10 Smoke free laws have continued to grow in popularity since they were implemented, to an even greater extent amongst smokers than non-smokers. Given the harm caused by smoking this legislation is proportionate and appropriate as well as popular with the public. By implementing this important, simple and cost-effective measure the Government would signal its commitment to the improvement of public health.

6.8.11 Evidence has shown that in the first year following implementation of smoke free legislation there was a statistically significant drop in the number of emergency admissions for heart attacks, resulting in 10,000 fewer bed days for emergency admissions saving the NHS £8.4 million. ¹⁹

6.8.12 Cancer Research UK urges Councils to have good enforcement of the underage sale restriction and to work across boundaries to tackle tobacco smuggling. Countries with high levels of tobacco taxation have lower rates of smuggling, averaging 9.8%, than low and middle income countries that have lower tobacco taxes but average smuggling rates of 11.8% and 16.8% respectively. ²⁰

6.8.13 Canada’s 2008 Contraband Tobacco Enforcement Strategy ²¹ lists the main drivers of tobacco smuggling, linked to pricing and organised crime, but does not cite the removal of point of sale displays as a factor. There was no evidence that the implementation of a point of sale ban has resulted in smuggling rates rising or that people have changed where they buy their tobacco.

6.8.14 In the UK, small shops have adapted to survive despite the long-term decline in smoking rates from 45% of the population in 1974 to 21% of the population today. ²²

6.8.15 Following consultation on the regulations in England, they have been adapted to minimise problems for retailers, with small retailers being given an additional two years until 2013 to comply with the display regulations, allowing ample time to explore a range of possible solutions.

6.8.16 Test purchasing by young people found that buying from vending machines was the most successful way for children to get hold of cigarettes and no attempt to create ‘child proof’ machines have been completely effective. It was reported in 2008 that 1 in 8 children and young people who were regular smokers usually bought their cigarettes from vending machines. By contrast, only 1 in 20 adult daily smokers said they had bought cigarettes from vending machines over the last six months. ²³ For Cancer Research UK it was inconceivable to imagine a situation where other age restricted goods such as fireworks or knives were available through a vending machine. Allowing tobacco to be sold through vending machines is an anomaly which should be tackled.

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¹⁹ Ibid. 13
²⁰ Ibid. 13
²¹ Royal Canadian Mounted Police (2008), “Contraband Tobacco Enforcement Strategy” (HMQ in right of Canada)
²² Ibid. 13
²³ Ibid. 13
6.8.17 Cancer Research UK suggests that the UK should argue for a protocol to:

- ensure tobacco companies take reasonable steps to prevent their products being smuggled by knowing who they are selling to
- include markings on packets so they can be tracked and traced
- direct cigarette machine manufacturers to put unique marks on their equipment to deter illicit use.

6.8.18 Given the overwhelming impact of smoking as the single largest determinant of inequality in life expectancy, it is clear that continued investment in reducing smoking prevalence and increasing cessation, especially in deprived areas like Hackney will be crucial to the reduction in smoking prevalence and health inequalities. This Commission hopes that the Government will take the bold step and follow through with publishing and enacting the Health Act 2009 regulation.

**Recommendation Seven: General**

The Health in Hackney Scrutiny Commission recommends that OSB ask it to write to the Government in support of implementing the Health Act 2009 regulations that will prohibit point of sale display of tobacco products and sale of tobacco from vending machines.

6.9 Derman

6.9.1 Derman is a local charity providing bilingual health advocacy to enable newly arrived community members to access urgently needed health services. Derman provides a range of health and well-being related services to Turkish, Turkish Cypriot and Kurdish people. Derman provided smoking cessation services directly in 2000-2003.

6.9.2 Over the past 15 years smoking prevalence among the Turkish and Kurdish community group has risen to approximately 65% for men and 44% for women. However recent research estimates the smoking prevalence to be even higher at 74% for males and 45% for women.

6.9.3 Cigarettes are cheaper in Turkey and often Turkish people purchase in bulk when visiting. It is estimated such trips could provide up to two months supply. Smoking prevalence was higher among the Turkish population in the UK, than it was in Turkey. Factors that contribute to this are believed to be linked to the pressures and complexity of life in the UK as well as language barriers.

6.9.4 Representatives of Derman indicated that generic smoking support services do not reach BME groups like the Turkish and Kurdish communities due to differing cultural specific needs. To reach this community group it was suggested that bilingual smoking advisors such as trained health advocates and community workers would be beneficial.

6.9.5 There is a low level of awareness of the health risks within the Turkish and Kurdish community, which could be raised through workshops, using videos or other visual materials, and also conducting an outreach approach to Turkish cafés for men and to the socially excluded within the community.
6.10 City and Hackney MIND: Integration, Respect, Inclusion and Empowerment (IRIE)

6.10.1 City and Hackney Mind IRIE provides a range of therapeutic activities with the aim of re-engaging service users with their own community. It also aims to open doors into healthy living lifestyles as well as a more satisfactory social life, avoiding social exclusion and isolation. Approximately 75% of its service users had mental health issues were highly likely to be smokers.

6.10.2 Officers from IRIE had not considered working with their service users in the area of tobacco control. However through participation in this review the Commission was informed that links had been made to consider how they could work in partnership with NHS City and Hackney Tobacco Control Team. It is our understanding that discussions are underway to look at how they could support and work with their service users to reduce smoking prevalence.

6.11 Shoreditch Spa

6.11.1 Shoreditch Spa is a healthy living element of the Shoreditch Trust that focuses on reducing health inequalities. Shoreditch Spa takes a whole person approach to supporting people to improve their health and wellbeing. The Spa delivers its services through four key programme areas: complementary therapies, healthy eating, peace of mind and health goals.

6.11.2 Shoreditch Spa is commissioned by NHS City and Hackney to provide a smoking cessation service to the general public as well as specifically identified priority communities. The priority communities selected are Vietnamese and Turkish/Kurdish, Polish, Somali communities and routine and manual workers.

6.11.3 Shoreditch Spa’s work ethos is to provide a holistic approach to health and wellbeing. A person-centred approach means that its staff meet people where they are psychologically (mentally) and geographically (physical location in their community). Shoreditch Spa brings this work ethos to its tobacco control work and is building partnerships with community organisations and employers through outreach services. This includes providing training to get people in the community trained to smoking advisor level 1 and 2.

- Level 1 – learning how to quit in a group
- Level 2 – community champions.

Recommendation One: Tobacco Control Work

c) the Tobacco Control Alliance should include and advise community champion’s from particular ethnic groups that have been identified as high risk, e.g. the Turkish and Kurdish community.
6.11.4 Shoreditch Spa reported some of the barriers to stop smoking services:

- not in the right language - not having the information in the right language. Although there was good national material this was available in limited languages and it was felt there should be a framework outlining what to use for different communities
- preachy – make you feel guilty and judged
- fear of medical practitioners
- fear of failure
- peer environments – need to tackle community culture and attitudes, working in groups and with communities not just individuals and aimed through peer pressure to give positive pressure to assist with changing behaviour and culture
- need to understand why people smoke and offer minimisation and alternate strategies to minimise stress.

6.11.5 Shoreditch Spa expressed the desire to see more web based resources for stop smoking material so it could be easily tailored to suit the needs of targeted community groups rather than having to print and store leaflets that may not be used.

6.12 The Learning Trust

6.12.1 The Learning trust is a not for profit organisation that provides education services in London Borough of Hackney. Education about smoking cessation and work on tobacco control is delivered through the Personal Social Health Education (PSHE) programme under the Healthy Schools Programme.

6.12.2 The Healthy Schools Programme operates four strands and currently within Hackney 82% of schools had achieved the healthy school status. The four strands were outlined to be:

i. Personal Social Health Education (PSHE)
ii. Healthy eating
iii. Physical activity
iv. Emotional wellbeing.

6.12.3 Participation in this programme is not compulsory for schools. It is funded nationally but that funding will cease in March 2011, after which local authorities will need to decide if they wished to continue supporting the programme.

6.12.4 Tobacco education is usually delivered in school to years 5, 6 and 7. It includes information about the impact on health, media influences and peer pressure. PSHE topics were not statutory so can be woven into other classes and schools can choose how to deliver the education for this via a full year programme or “drop days”. The latter are not recommended because absentees would miss that particular session. More pertinent was the need to explore personal attitudes and behaviour: experience shows
this is best delivered through a regular planned programme over a year. There was no formal evidence to assess the impact of this intervention and the only means was by staff and pupils noticing changes in behaviour.

6.12.5 TLT organised health fairs in 5 secondary schools during the summer term. These included workshops, a theatre production and a consultation to capture young people’s views on various health issues identified by schools. This consultation captured the views of approximately 1,000 years 7 and year 9 students. It was disappointing to note that questions about key issues such as tobacco, drug or alcohol use did not get asked. This Commission believes that it was a missed opportunity for partnership working between TLT and the PCT to raise awareness about key public health issues with young people. Nearly all smokers start young so deep, long term cuts in smoking prevalence will only be achieved by preventing children and young people from starting to smoke in the first place.

6.12.6 Key issues that remain are the exposure of children and families to second hand smoke in homes and cars. A review of smoke free issues, including an assessment of the merits of establishing smoke free requirements for all children’s play areas was proposed in the National Tobacco Control Strategy\(^24\). Efforts now need to be made to further denormalise tobacco use and extend smoke free environments where appropriate, for example by ensuring that schools maintain smoke free sites. We ask the Tobacco Alliance to explore the options of developing a policy locally, ahead of a national decision being taken.

6.12.7 In light of funding changes for the Healthy Schools Programme, this is an opportunity to review how tobacco control is delivered in schools and for the local authority to decide how to support schools at a local level. Continuation of some form of education programme to promote tobacco awareness in schools would be beneficial.

**Recommendation One: Tobacco Control Work**

- d) the Learning Trust should review how tobacco control education is delivered in schools and consult with the Hackney Youth Parliament on development of an improved programme. We believe there may be potential for this to form part of The Learning Trust Traded Services to schools in the future.

- e) the Tobacco Control Alliance should explore how children’s play areas can promote smoke free awareness, to denormalise smoking for children.

**Recommendation Two: Local Data and Intelligence**

- e) explores and promotes the best, evidence-based methods of providing tobacco control education to young people outside of schools.

\(^{24}\) Ibid. 4
6.13 Site Visits

6.13.1 Tower Hamlets Tobacco Control Alliance (Smokefree Tower Hamlets)

The Commission chose to visit Tower Hamlets Tobacco Control Alliance (branded ‘Smoke free Tower Hamlets’) because it was one of the first to be set up in 2008 and has since been highly commended for the work it has carried out, especially its work with the local Bangladeshi community. Its current tobacco control strategy for 2008-2011 has been implemented and, at the time of this review, was being evaluated along with the Tobacco Control Alliance group to assess its progress and the effectiveness of interventions deployed.

6.13.2 The Alliance was established was to develop a tobacco control strategy and implement it. The Council contributes by using its statutory role and duties, but mainly the tobacco control duties have been funded by the PCT, with the Council assisting the tobacco control work.

6.13.3 The Alliance has brought together different organisations who all had different ways of working. It has also brought people together who would not normally be in conversation. The Alliance needs core people to come together who are enthusiastic and can influence change in their organisations. Another key point made was the desire for Councillor involvement, which to date the Alliance struggled to achieve.

6.13.4 Smokefree Tower Hamlets was formed after the Tobacco Control Coordinator Post filled. To focus the work of the alliance, data and anecdotal evidence was used from:

- Complaints
- Community groups
- Contact through enforcement work.

6.13.5 Initially the Tobacco Control Alliance met every two months but now this had evolved to be quarterly.

6.13.6 Work has been conducted with local businesses to raise awareness of smoking cessation and tobacco control work. Officers have found that using compliance helped to get the message about softer issues like stop smoking and health effects across to businesses during visits. Smokefree Tower Hamlets also introduced Smoke free business award for businesses with employers looking after employees regarding smoking cessation and this had helped to get the message across to businesses too.

6.13.7 In regards to communication, the experience of officers from Smokefree Tower Hamlets suggests that using the main message from the national campaign works. They recommended an alliance finds the key message that can penetrate target groups and motivate people to take notice of the information, e.g. for a middle aged man they found highlighting they could miss out on being able to take their children out and play in the park. The work of the Smokefree Tower Hamlets was successful through having a website, word and mouth and a high profile in the borough.

6.13.8 Smokefree Tower Hamlets expressed the importance of health intelligence. There are gaps in the national evidence-base so locally an
alliance needs to build up data on smoking prevalence. Tower Hamlets PCT commissioned social marketing research to get information about cultural needs. Knowledge for the Smokefree Tower Hamlets was also collated from:

- GP register – new patients are asked about their smoking status and GPs are given incentives to ask the question (i.e. good registration rate)
- Annual healthy lifestyle survey - smoking prevalence measured by population survey
- 4 week quit rate – collect figures on the number of people using the stop smoking services.

6.13.9 With regards to young people, the Smokefree Tower Hamlets advised they had commissioned a stop smoking programme to go into schools because schools did not have the capacity to do this work alone through their PSHE programme. The PCT also commissioned a peer education programme for year 8 children and operated a separate specific website for young people.

6.13.10 A challenge for the Alliance was to ensure that services could be flexible and change with population needs, whilst staying focused on the priorities identified and what is known to works from evidence-base. Services should be individual and not based on rules, because different types of services with different levels of support are effective for different people with differing health needs.

6.13.11 Smokefree Tower Hamlets acknowledged there were service revolvers (those who try to quit more than once) but they were not deterred by this as it was expected. A key aim for Smokefree Tower Hamlets now is to drive more smokers through the services to obtain a more accurate picture of the changes in the borough’s smoking prevalence.

6.14 London Borough of Hackney Trading Standards and Environmental Health

6.14.1 To experience the work of frontline staff the Commission undertook a site visit to shadow Trading Standards Officers as they conducted tests on selected retail premises for underage tobacco sales. Members attended premises inspections related to the smoke free legislation with Environmental Health Officers.

6.14.2 Nationally since 1998, there has been a decline in smoking prevalence among 11–15 year olds, from 11% to 6% in 2007. From 1st October 2007 the purchase age for tobacco was raised from 16 to 18 years of age, along with new provisions to control retailers who repeatedly sell tobacco to young people.

25 Ibid. 2
Reducing the availability of tobacco to young people is a major challenge. The latest data on where young people get their tobacco shows that they acquire cigarettes from a wide variety of sources (see Figure 3, above).

It is an offence to sell tobacco products (which includes cigarette papers), to persons under the age of 18, even from a vending machine on a premises. This offence carries a maximum fine of £2500.

A high level of preparation and resources is required to conduct underage tobacco sales tests. On the occasion of our visit, two Trading Standards Officers, three Police Cadet Students and one Metropolitan Police Officer. A key points observed from the preparation process was that the young person should not look older than their age and steps were taken to demonstrate visually the difference and how they compared to an adult.

Information and education sessions are conducted approximately four weeks prior to the sales test, to ensure all shop keepers have been informed about the law, have the relevant notices to display, and know what is expected of them as business owners.

On this occasion the first premises on the list failed the test. Councillors were able to witness first hand the whole process when this happens. This highlighted how dangerous and intimidating a situation could be if the perpetrator did not co-operate and more importantly how hard it was to communicate with an individual when there was a language barrier. To this end, Hackney Council has now employed a Turkish speaking officer specifically to assist with the Turkish traders. The importance of having an officer employed with these skills was evident on the site visit.

Our second visit was to inspect three Turkish social clubs. These premises were selected for visits as a result of complaints being received about people smoking within the premises. From observations the difficulty was the time of day the visits were being conducted: there was very little activity within the premises so it was difficult to establish if the premises had been breaking the law. Again, on this occasion observations

Figure 3: Usual sources of cigarettes for children aged 11-15 in England

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26 Ibid. 4
revealed a language barrier: we noted that notices were not displayed in English, except for the no smoking sign, and were informed that this was because it is a legal requirement for this notice to be in English.

6.14.9 Under the new regulations introduced in 2009 a person convicted of making an illegal sale to anyone under the age of 18 years and, on at least two other occasions within a 2 year period, could result in a sanction being applied for by the Council. A Local Authority may apply to a Magistrates Court for a Restricted Premises Order or a Restricted Sale Order, or both. It was interesting to note even if the shop owner did not make the sale, as the business owner they were still liable for the actions of their staff.

6.14.10 A restricted premises prohibited the business from selling tobacco products for a period of up to 12 months (to be determined by the court). This means that no sales of tobacco or tobacco papers may take place from that business premises. This did not affect other businesses within the same group or chain. For example where a National company was the subject of a restrictive premises order, it would only apply to the specific location where the illegal sales had taken place.

6.14.11 A restricted sale order meant that a named person within a business was prohibited from selling tobacco or from having any management role in any premises relating to tobacco sales for a period of up to 12 months (to be determined by the court). This meant that the business premises may still sell tobacco products but that the named individual may not. The order would apply to the named individual regardless of where they were employed.

**Recommendation Two: Local Data and Intelligence**

d) builds-up knowledge of areas with a high prevalence of smoking among young people. This knowledge should be set alongside data about retailers who fail underage sales tests so that enforcement action can be targeted to tackle underage sales of tobacco.

6.15 Hackney Youth Parliament

6.15.1 The Department of Health recommends that tobacco control interventions should target young people because evidence suggests that people do not start smoking once they are over the age of 20. Working in partnership with schools to influence young people is a good way to get the message across. The Commission was keen to hear the views of young people directly so visited the Hackney Youth Parliament (HYP) to speak to them about tobacco control education in schools and to get a sense of whether the information being conveyed affects young people in Hackney.

6.15.2 We were surprised to learn that there was very little recognition that tobacco control education was delivered through PSHE. Members of the Hackney Youth Parliament indicated to the Commission that these lessons were viewed with very little interest, near avoidance, by students. But they
too agreed that delivering the tobacco control education via drop days was not effective for getting the information across.

6.15.3 HYP Members expressed strong views about the lack of guidance and offers of support services for students who were caught smoking. Students are also very aware of the tobacco control message being delivered by teachers who smoked and thought this was hypocritical.

6.15.4 The use of statistics has little effect on young people and it was suggested that consideration be given to using more visual material such as videos, or having people come into schools to talk to young people e.g. a person who’s life had been impacted by smoking taking about the harmful affects of tobacco was thought would get the message across more effectively and more likely to result in a behaviour change of young people. They felt younger secondary school pupils were more likely to listen to the message.

6.15.5 Suggestions of where tobacco control education could be incorporated into the school education programme were made, i.e. sports coaches could include discussion of the health affects of smoking in lessons, explaining how it would affect students’ health in relation to the sport they were doing.

6.15.6 HYP Members agreed that prevention is a key area and recommended that young people should be educated about the change in law for smoking and the penalties shop keepers faced if they did not adhere to the law. This way, young people would have a greater understanding of the implications for retailers.

6.15.7 One of the strongest messages that came across from HYP Members was for policy and decision makers to not view schools as the main influence in a young person life. Their surroundings and peers are a big influence and consideration should be given to conducting education programmes outside the school environments, i.e. in holiday time or at special events.

6.15.8 The key issue that undermines progress in reducing smoking prevalence among young people is the availability, affordability and perceived attractiveness of tobacco. The Commission is keen to see the Tobacco Control Alliance work with key partners to build upon national initiatives and communicate the tobacco control message locally to young people.

Recommendation Two: Local Data and Intelligence

e) explores and promotes the best, evidence-based methods of providing tobacco control education to young people outside of schools.
6.16 National current data used to measure smoking prevalence pre dates the 2007 smoking ban in England. The PCT informed the NHS Information Centre self reported smoking prevalence for Hackney and the City, using Health Survey for England data, between 2003 – 2005, this calculated that 1 in 4 adults (24.7%) in Hackney and the City smoke. However the London Health Observatory has recently published the results of additional research and that data was collected in 2006 and 2007 and estimate the overall smoking prevalence in Hackney and the City to be higher at 32.2% which puts Hackney and the City near the top of the prevalence table.

6.16.1 The universal measurement for smoking prevalence is the 4 week quit rate. However this can only give an accurate picture if the smoking population register and use the smoking support services. NICE recommend an area should aim to treat at least 5% of the estimated local population of people who smoke or use tobacco in any form each year and aim for a success rate of at least 35% at 4 weeks, (validated by carbon monoxide monitoring) and currently in Hackney the smoking cessation services is achieving 35%.

6.16.2 The PCT informed prevalence locally is measured through GP’s recording smoking status. Recording of this locally is high and potentially therefore presents a more accurate picture of overall prevalence at 19.5% this figure can vary dependant on the community group. It was advised the DOH have indicated a desire to move towards using GP recording smoking status as a proxy for measuring smoking prevalence. The PCT reported this measure would make sense baring in mind GPs do currently collect this data, however locally in Hackney we would need to achieve the 70% threshold to make this a reliable data source and the current rate is about 68%. The PCT were currently investigating the possibility of using GP data to carry out a local needs assessment and assess prevalence.

6.16.3 It was estimated that a higher proportion of men (39%) smoke than women (25.6%). Smokers in Hackney were mostly young (under 35yrs) or old (over 55 yrs) rather than middle aged and that smoking prevalence show a clear socioeconomic gradient - if you are poor you are more likely to smoke.

6.16.4 In 2007, 21% of all adults in England smoked but among men and women in routine and manual groups this prevalence was higher at 26%. 27

6.16.5 Smoking prevalence varies across different communities. Specific local research conducted recently estimated that smoking prevalence in our Turkish / Kurdish community could be as high as 68%. Though there is no research into other communities locally however other research conducted nationally estimates a high prevalence amongst other BME groups such as Vietnamese, Eastern European and Somali.

27 Ibid. 2
6.16.6 49% of four week quitters classify themselves as White British and the next largest group, at 17%, as White Other but this category includes communities such as Turkish and Kurdish, Orthodox Jewish and Eastern European. So it is hard to separate out these community groups to distinguish which has the highest smoking prevalence. 8% of clients accessing services have not stated their ethnicity and this may be due, in part, to the limitations of the census categories used to collect ethnic data and the categories not reflecting the diverse mix locally.

6.16.7 The NHS recognised there were service revolvers and estimated on average it could take up to 7-14 times for a person to quit smoking.

6.16.8 There is currently no agreed methodology for carrying out a needs assessment locally and assessing smoking prevalence for the above groups. Neighbouring boroughs, Newham and Tower Hamlets have used local surveys but in Hackney there currently is not a local survey that asks questions about smoking. The PCT commissioned to profile the smoking population but this was limited and only covered, City workers, Turkish and Kurdish and White British.

6.16.9 One of the pertinent points highlighted from discussion with Smokefree Tower Hamlets was the importance of local tobacco alliance groups to build up local knowledge on smoking prevalence and cultural needs for which they advised they used social marketing because there was a gap in national evidence base for tobacco control work.

6.16.10 The Commission was pleased to note in preparation for the work of the tobacco alliance efforts were being made to identify the community groups with high smoking prevalence to be able to target tobacco control activity to reduce prevalence. This is a key step to building the foundation of local knowledge about smoking prevalence and inform the work streams of the group and we commend this. During the review the Commission noted particular views and wished to suggest these be incorporated into the alliance action plan and strategy.

**Recommendation Two: Local Data and Intelligence**

a GPs work with NHS City and Hackney to improve smoking status recording for patients on their GP list with the aim of increasing it to the required percentage level to secure information as robust local data. Explore how this data could be used to assess the smoking prevalence for the community.

b What kind of services or support smokers from different communities would actually access and what they think would be successful.
Partnership Working

6.17 Upon commencing this review the Commission was keen to establish if partnership working existed between the Council and local partners. The Commission noted there was communication about tobacco control activities between the local NHS and LBH Trading Standards although partnership working was minimal.

6.17.1 Partnership working could prevent unnecessary duplication of effort and may in some circumstances reduce competition between organisations for limited funds. Working in partnership is important for enhancing the resources and altering the norms of the community and can often be the best means of reaching as many people as possible to create an environment that facilitates long-term and sustainable change in individual behaviour.

6.17.2 Some degree of partnership working existed between NHS City and Hackney Tobacco Control Team and London Borough of Hackney Trading Standards and Environmental Health but these we believed were more informal links. Although this partnership working is expected to enhance following the development of a local Tobacco Alliance and clear work streams.

6.17.3 We understand information is shared from both LBH Trading Standards and Environmental Health about their activities but is believed to be predominately enforcement based activities.

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6.17.4 In exploring this further with the PCT we were informed not many referrals were received from LBH staff to the smoking cessation care pathway and

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Recommendation Two: Local Data and Intelligence

c Identify the long term quit rate for pregnant women following the birth of their child and explore if there is a high relapse rate for Mothers after pregnancy or identify the reason for long term quit

g Explore what consultation surveys are conducted and consider how data on smoking prevalence can be capture in these consultations.
the view was there was potential for the Council staff to generate more referrals to the smoking cessation care pathway and feed into the tobacco alliance work streams.

6.17.5 This is an area the Commission recommends is explored for stronger partnership working. However it is recognised it can only be enhanced if supported by staff training especially frontline staff (in social care, leisure services single front office etc) to be smoking advisors e.g. to a minimum advisor level 1. It is our expectation that formation of the Tobacco Alliance will bring improved co-ordination of work which should be formally reported to the local Tobacco Alliance.

6.17.6 It is anticipated the newly established local Tobacco Alliance will address and develop partnership working with other key stakeholders such as Housing, local fire service and other voluntary sector groups.

6.17.7 One of the key points the Commission learned from its site visit to Smokefree Tower Hamlets was the close working relationship between their local PCT and Council Trading Standards department and we noted with interest the PCT did fund 4 posts within the local authority Trading Standards team to assist with tobacco control work. They explained from their experience they found wearing the compliance hat helped to disseminate information about softer issues such as stop smoking and health affects to businesses during visits.

6.17.8 Exploring if this existed in Hackney we learned a Tobacco Alliance Co-ordinator and Health Improvement Practitioner, was based in LBH Environmental Health. With responsibility for co-ordinating this work however it was our understanding this role did not have statutory powers and conducted visits with Environmental Health giving health improvement advice.

6.17.9 Another form of partnership working we heard about was the PCT Tobacco Control Team in collaboration with City and Hackney Young People Services Plus (CHYPS Plus). Developing a pilot youth tobacco control advocacy group involving preventative strategies. The advocacy group would have the aim of improving health outcomes for young people and empowering young people, offering to them the opportunity to contribute to issues which affect them and their peers, by:

- Involving young people in the development of the advocacy group and implementation process
- Giving young people an opportunity to air their views and concerns and to take action to de-normalise and de-glamorise smoking
- Contributing to the reduction of youth smoking prevalence in City and Hackney.

6.17.10 DOH Public Health emphasised the need for a tobacco alliance led to be appointed e.g. a PCT and/or Local Authority champion for tobacco control. Taking into consideration the proposals outlined in the NHS Equity and Excellence White Paper whereby it is proposed for local authorities to have an increased role in public health the Commission strongly suggests a
champion for London Borough of Hackney is identified and appointed to raise the profile of tobacco control in house to secure council wide support, raise awareness of tobacco control among its partners and in the community.

6.17.11 It is anticipated by forming stronger partnership working relationships the profile of prevention for tobacco control will be raised and kept at the forefront of the work agenda and local priorities.

**Recommendation Three: Partnership**

The Commission recommends that:

a) the local NHS Public Health Team and the Council’s Trading Standards and Environmental Health services review areas where enforcement and educational activity can be combined. An example would be that, when conducting compliance duties, officers identify an opportunity to refer, educate or advise about accessing support services for smoking).

b) training to be provided for frontline staff undertaking statutory / enforcement duty ideally smoking advisor level 1 to ensure delivery of a consistent tobacco control message across the borough.

d) Hackney Council explores how its social services, libraries, customer services and leisure services can assist with the promotion of smoking cessation. We recommend that training is provided for frontline staff to smoking advisor level 1 to make referrals to smoking cessation services.

**Communication**

6.18 There is currently no overarching strategy for tobacco control education although it was noted there is a communication strategy for the smoking cessation services which has been the PCTs focus to date. A broad smoking cessation communication plan was developed and a range of marketing campaigns were run throughout the year to raise awareness of and increase referrals into smoking cessation services.

6.18.1 NHS City and Hackney reported that, of the various campaigns tried, their local street recruitment and media campaigns had been significantly more cost effective than nationally run or regionally run campaigns. Including telecentre costs, with the average cost per quitter locally being £922, this compares very favourably with the estimated £2,333 for the national.

6.18.2 It is suggested at a local level, a tobacco alliance should work with key partners to build upon national initiatives and communicate messages locally. Research suggested that the impact of a national campaign including mass media advertising could be significantly increased by local
activities that built on and adapted campaign priorities to the needs and interests specific to the area.

6.18.3 The Commission understands it will be the role of the local Tobacco Alliance to lead on developing a tobacco control communication strategy and this will form part of a broader tobacco control strategy. The Commission was informed communication representation from both the PCT and LBH were expected to be on the local Tobacco Alliance and we strongly recommend this stance.

6.18.4 Establishing a communications strategy will be key to the conduct of tobacco control activities and any strategy should take into account internal and external communications to ensure all partners are on message and a clear and consistent message around tobacco control is being relayed to the general public regardless of which organisation is delivering the message.

6.18.5 Smokefree Tower Hamlets expressed their success was largely attributed to having a brand identity, website and building a high profile in the borough coupled with word and mouth through alliance partners and service users etc.

6.18.6 Mobilising alliances to promote health is acknowledged to be effective health promotion, but should be part of a broader strategy to enhance the well-being of the community. The diverse nature of Hackney creates additional complexities in terms of targeted communication and service provision.

6.18.7 We are pleased to note in preparation for the local tobacco alliance activities efforts were being made to identify the key target community groups with high smoking prevalence for tobacco control activity to reduce the prevalence. This is a key step in the work of an alliance to build up local knowledge and inform the work streams of the group.

6.18.8 To know how to communicate effectively to specific community groups you must first understand any cultural or specific reasons why people start to smoke. Research conducted by Customer Insight for London Social Marketing Unit (LSMU) looked at the Turkish / Kurdish, Somali and Polish community groups to understand why they smoked. It was reported to be:

- Turkish: a cultural norm (back home and in the UK)
- Polish: an intrinsic part of growing up and a key element in socialising
- Somali: an aspirational activity in Somalia

6.18.9 Other common key factors were stress, economic disadvantage and a sense of isolation often given as the rationale for continuing to smoke (and smoking more) in the UK.
6.18.10 The research highlighted for communication to be successful it was important to know the key influences that can play a role in changing behaviour. The research by Customer Insight revealed for all groups family was a key influence and specifically for each group the following:

6.18.11 Turkish / Kurdish
- GPs (from their community)
- Celebrities
- Community organisations already used for general advice (Halkevi was well known for their work in smoking cessation) but this was not motivation for Turkish / Kurdish women as they smoked behind closed doors and not on the street.

6.18.12 Polish / Somali
- Outreach and community workers, who were trusted, spoke their language and understood where they came from
- For Somali what they were not receptive too were community / religious leaders.

6.18.13 The research also identified overall there was a greater stigma attached to smoking in the UK than amongst the Turkish, Polish and Somalian Community groups.
- For many Turkish and Kurdish people it was part of everyday life
- For the Polish community if was part and parcel of growing up
- For Somali men smoking was a regular but often hidden activity back home often out of respect for their faith and elders. For Somali women it was taboo and Turkish women it was a shared activity with other women but often ‘behind closed doors’.

6.18.14 Consulting BME communities can add value to understand the communication methods the target groups need and should take into consideration the literacy level and language barriers. It was suggested for communication methods like television, radio, local community press could be used to get the tobacco control activity message across in addition to venues for events, exhibits and dissemination of leaflets / written communication. What type of method to use would depend upon knowledge being built of the day to day life of the community being targeted; therefore it would be imperative to understand where they may be most receptive to receive the message.

6.18.15 The Commissions urges service providers and communications to bear in mind for diverse communities like Hackney that face to face and word of mouth communication of health risks and cessation services whilst working in and with the community was key.

6.18.16 The Commission suggested the alliance looks into establishing a brand identity like “I love hackney” campaign to be used to promote the Tobacco Alliance brand, public health message and push education campaigns on
the effects on health and inequalities as a result of smoking. Development of a strong communication plan can:

- tie together a variety of tobacco control programme components
- to raise public awareness of tobacco issues
- build public support for tobacco control.

6.18.17 Tobacco advertising and brand is said to encourage children and young people to smoke seducing young people to perceive it to be glamorous through films, TV programmes and the internet. From the Commissions discussions with HYP it became evident that involving young people in the design of communications or advocacy campaigns can be powerful as they can bring their own perspective, and provide understanding of what works to decision-makers.

6.18.18 All mentioned the value of using ex smokers (from their communities for ethnic groups) to be a positive role model and could make the stop smoking communication more powerful.

6.18.19 It was encouraging to note both the PCT and Local Authority communication team will be represented on the tobacco alliance and we would urge within the communication strategy consideration is given to cultural specific factors, language barriers and use of visual aids as appropriate to communicate and highlight not only the tobacco control message, smoking cessation support services and health inequalities. Enlisting the support of the communications teams for both the local NHS and Council will help to bring this information to the alliance group.

**Recommendation Four: Communication**

The Commission recommends:

a) **creating a brand identity, like the Council’s ‘I love Hackney’, that distinguishes work on tobacco control from the individual organisations that deliver it. This branding should be used by all local organisations and service providers to promote the tobacco control message.**

b) **that message communicated about tobacco control should not be preachy but informative, so that smokers and non smokers can make an informed decision about their healthy lifestyle.**

c) **A suggested was added by the Overview and Scrutiny Board that the Tobacco Control Alliance promotes communication channels for Members of the public to whistleblow when encountering instances of underage cigarette sales**
An alliance is an organisation that brings together agencies from different sectors to target health promotion and in the initial stages the tobacco alliance will be instrumental in building the local knowledge and picture of prevalence.

This group is generally made up of senior level officers, who are responsible for raising the profile of tobacco control across local organisations and partnerships.

The tobacco alliance needs a membership that can increase the impact of a national tobacco control campaign by ensuring that the goals and practices established at the macro level are adapted to fit the local context, taking into account the diversity and cultural requirements of the local population.

When the Commission talked to Smokefree Tower Hamlets they advised from experience inclusion of seniority representatives in the tobacco control alliance membership was important to demonstrate commitment and ensure provision of necessary resources because of the need to have influence and decision making authority within their own organisation.

Core members, in this instance, consist of people who have a defined role in the tobacco alliance, regularly attend meetings and participate in the planning or implementation of more than one project. It is therefore important that the core members plan regular meetings and build into those meetings a discussion of potential conflicts of interest. For urban tobacco alliances in particular, open discussion of conflicts of interest is essential to promote teamwork and commitment.

The tobacco alliance needs to have clear governance structures that include general guidelines for how resources will be distributed, who will have final decision-making powers and who will act in an advisory capacity. They should also ensure that they keep other relevant thematic partnerships informed and engaged with tobacco control, notably the Children’s Trust Board and Safer Communities Partnership.

Recommendation nationally was in order for a tobacco alliance to function effectively having a dedicated co-ordinator was essential. The Tobacco Control Alliance Lead should ideally be a dedicated post working at a senior level to provide strategic leadership to partnership development and the delivery of tobacco control work programmes in the Borough. The post holder would be initially responsible for establishing a tobacco alliance locally engaging organisations at a senior level and then providing ongoing support.

Success of the alliance depends upon a balance between diversity and coherence in the membership. Research showed the need for groundwork to build networks and support structures before attempting to implement a program of tobacco control activities and the ability to form a strong
alliance network and achieve consensus on campaign content and strategy. Ideally an alliance should cultivate a network both vertically, (from community workers to policy decision makers), and horizontally (across different sectors such as the commercial sector, the leisure industry, education etc). The success an alliance will achieve depends upon the quality of the network it is able to build.

**Recommendation Five: Tobacco Alliance Structure**

The Commission makes the following recommendations:

**d)** that the Tobacco Alliance keeps a record of, updates and publishes a list of its membership. We further encourage the Tobacco Alliance to build networks that have multiple contacts within organisations, to safeguard against links being broken if an individual leaves.

6.19.8 The type of structure adopted by an alliance plays a vital role in ensuring that activities are implemented. Research identified three recommended structures for an alliance they were:

a) The mobile unit. Best suited: new alliances, urban alliances - This is an entrepreneurial model recommended for urban contexts where the opportunities for working across different sectors are multiple, and where many events might be happening that draw a mass audience, requiring a fast response from the alliance.

b) Parliamentary model. Best suited: alliances in mixed rural/urban settings - The parliamentary model is made up of a number of local partnerships or small alliances that send representatives to report to group. In this model, the power to make strategy and distribute resources is collectively held by all the delegates from the local areas. The coordinator has a more facilitative role, chairing the meetings, mediating disputes and ensuring that each representative has a say.

c) Three tier model best suited to alliances in single county areas with major city centre. The first tier composes a small body of executives who made the final decisions. In the second tier, representatives from a range of interest groups, such as community self-help groups or primary care teams, acted as advisors to the executive, making sure that the interests of their constituencies were met. The third tier comprised several working parties formed to implement programs and activities in particular sites, such as schools or the workplace.

6.19.9 A comprehensive tobacco control agenda requires a structure that supports clear accountability and strategic decision-making as well as allowing for a wide range of partners with different fields of expertise and interests to engage at different levels.
6.19.10 It is essentially made up of a core group of partners, who meet regularly to take a strategic overview and co-ordinate the successful implementation of the action plan.

6.19.11 It is recommended the local tobacco alliance has a structure similar to that outlined in the model below.

6.19.12 Considering the models above the Commission is minded to encourage the parliamentary model is adopted.

6.19.13 DOH recommended the core membership of an alliance should include the following (as detailed below) with membership altering to suit the needs of the work streams of the alliance to get the information it needs and experience as required.

- Tobacco Control Lead
- Head of Regulatory Services
- Public Health Consultant
- HM Revenue and Customs (HMRC)
- Local councillor (consider a member of the Health and Wellbeing thematic partnership) Children’s Trust
- Senior Trading Standards Officer
- Senior Environmental Health Officer
- Stop Smoking Service Manager
- Leisure and Children’s Services Healthy Schools representative
• Community Safety representative
• Fire Service representative.

6.19.14 The Commission was pleased to note since the review commenced an initial meeting of the local tobacco alliance group had taken place and membership was reported to consist of:

NHS City and Hackney representatives from Tobacco Control
• Public Health
• Communications,
• CHYPS Plus,
• CHS
• Children’s Services
• Children’s Centres

London Borough of Hackney members from:
• Trading Standards
• Environmental Health
• Councillors
• The Learning Trust
• Drug and Alcohol Team
• Communications
• Youth Services,
• Neighbourhoods and Regeneration
• Hackney Homes
• Community Services

Other members include:
• The Homerton University Hospital Trust
• East London NHS Foundation Trust
• Hackney Community Empowerment Network
• London Fire Brigade Borough Commander
• Regional Tobacco Policy Managers
• Principal of Hackney Community College.

6.19.15 The Commission is mindful of the proposals in the NHS White Paper Equity and Excellence and would strongly suggest post demise of the PCT if leadership is undertaken by the Council of the local tobacco alliance there should still be active at the core membership local NHS representative besides the Director of Public Health and GP consortia representative.

6.19.16 Hackney is unique and has a separate organisation called The Learning Trust who provides its children education services and the Commission strongly recommend a senior officer from TLT is active in the tobacco alliance group strategically and within the work streams.

6.19.17 A strong Terms of Reference for the group will be important so there is has clear guidance about aims, outcomes, partnership, reporting requirements, action plan etc and especially details of the decision making process.
6.19.18 The Chair of a tobacco alliance is a really important role which not only steers the partnership but will also represent the Alliance to other organisations and partnerships. The Chair of the Alliance should be a person who is able to advocate for tobacco control at a senior level and advice about the purpose and work of the group. Discussion with Smokefree Tower Hamlets informed they had a neutral Chair that had no responsibility for delivery of a strategy.

6.19.19 Tobacco control is about:
- Stopping the inflow of young people recruited as smokers
- Reducing affordability, availability and attractiveness of all tobacco products, and increasing awareness of the harms
- To motivate and assist every smoker to quit
- Improving support and treatment, including harm reduction
- To protect families and communities from tobacco-related harm
- Promoting smoke free environments, tackling high smoking rates in disadvantaged communities and reducing smoking in pregnancy.

6.19.20 Nationally recommended the work streams for tobacco control were noted to be and it was explained delivering of any of these areas in isolation would reduce the impact on smoking prevalence.
- Assisting and motivating smokers to quit
  - Very brief and brief interventions
  - Stop Smoking Services
  - Targeting specific groups
  - Training stop smoking advisors
- Stopping the inflow of young people recruited as smokers
  - Reducing underage sales
  - Denormalising tobacco and reducing availability
  - Delivering tobacco control interventions with children and young people
- Smoke free environments
  - Maintaining compliance with the requirements of Smoke free legislation
  - Promoting Smoke free homes and cars
- Action on illicit and niche tobacco
  - Tackling the supply of illicit tobacco
  - Increasing local knowledge and information about niche tobacco products
  - Ensuring these products comply with standards such as product safety and labelling
  - Enforcing point-of-sale regulations
- Communication and Education
  - To communicate tobacco control messages to raise awareness of the harms caused by tobacco within families and communities
  - Motivating smokers to quit.
6.19.21 During the review this was another area that had progressed and the Commission notes it is being proposed that Hackney’s local Tobacco Alliance would have a strategic group plus the following three work streams:

- Stopping the inflow of young people recruited as smokers
- Motivating and assisting every smoker to quit
- Protecting families and communities from tobacco related harm.

6.19.22 The Alliance will need to develop a local strategy. For tobacco control to succeed, a strategy requires a comparable breadth of vision and determination to pursue action in many different arenas at once. This will need to include an overview of where we are now, define the vision of the Alliance and the aims and objectives including work streams for achieving the vision and the milestones to indicate progress as well as a plan for monitoring success and evaluating outcomes. In order to be robust, the strategy should be underpinned by evidence, tested and developed by ongoing evaluation.

6.19.23 The new strategy should be rooted in current evidence of effectiveness but must also include a mechanism for evaluation that will deliver a richer understanding of the methods and outcomes of the interventions specified within it.

6.19.24 Particularly important will be to ensure that a consistent and complementary approach is taken across the borough.

6.19.25 However taking into consideration the proposals outlined in the NHS Equity and Excellence White Paper for local authorities to have an increased role in public health the Commission strongly suggests the Hackney’s Tobacco Alliance going forward should be led by the Council. We encourage the profile of tobacco control to be raised in-house and have a lead member to champion tobacco control to secure council-wide support, raise awareness of tobacco control among its partners and in the community and to keep tobacco control at the forefront of the health and wellbeing agenda.

***Recommendation Five: Tobacco Alliance Structure***

a) national guidance offers three models for a Tobacco Control Alliance. We recommend that the parliamentary model is adopted in Hackney. We further suggest that Hackney’s Tobacco Control Alliance is accountable to the Thriving Healthy Partnership Board until the new Health and Well being Board is established.

b) that the Tobacco Control Alliance agrees Terms of Reference that include: desired outcomes, a clear set of priorities, approaches to partnership, reporting requirements, and publishing an updated programme of activity.

c) that the Tobacco Alliance appoints a Chair independent of service delivery, who would not be affected by any aspect of the tobacco control strategy.
Employers

As part of the review the Commission wanted to explore if the main employers in the borough (public sector) were contributing to and supporting their employees in relation to tobacco control and smoking cessation.

6.20 The PCT Tobacco control team informed the Commission Queen Mary University were commissioned to deliver workplace clinics locally within City and Hackney and workplace clinics continue to offer an effective method of providing support to people wishing to stop smoking. However it appeared although workplace clinics in the City have proved popular this had not been the case in Hackney.

6.20.1 Public sector organisations are the largest employers in Hackney and Queen Mary University had approached the Learning Trust and Hackney Council about offering this service to their staff and the Commission was advised interest at the time of the presentation had been limited and was suggesting maybe they needed to consider a new approach to get them interested.

6.20.2 Each of the employers reported the following:

**PCT**

NHS City and Hackney’s Tobacco Control Team provided stop smoking support for PCT staff. A number of group clinics were advertised for staff but take up had been limited so a more flexible approach was now been implemented. Enabling staff to now contact the tobacco control team directly and make an individual appointment at a convenient time to themselves. This was promoted through regular updates in the staff bulletin. In addition staff drop-ins would be piloted this year allowing staff access to a regular smoking cessation clinic at their workplace.

**Homerton University Hospital NHS Foundation Trust**

The Homerton Hospital advised at present 11% of referrals to the service came from staff and the trust did a lot of publicity about the affects on health on the intranet for staff. The trust used opportunities like when a person becomes a new member of staff and attends an occupational health appointment to obtain their smoking status and if a smoker advise the staff member about smoking cessation services.

**East London NHS Foundation Trust**

The ELFNT advised they had recently commissioned a new contract provider for their Occupational Health Services. In this contract provision of support and advice and information about stop smoking services would be incorporated.

**London Borough of Hackney**

The Council informed it had run health fairs for employees in the past two years which proved very popular with staff and received positive feedback. As an alternative to a health fair, the Council has put on a range of health
programmes and events to maximise employees’ opportunities to attend some form of health event. These included diabetes testing, blood pressure and cholesterol checks and a 7 week stop smoking clinic and employee’s sports event. The Council has also adopted a strategy of integration with available NHS resources e.g. publishing the Borough’s NHS stop smoking programme in October 2010.

The Learning Trust

The Learning trust informed they run in partnership with The Royal London run some stop smoking session for staff in 2009. Staff feedback from their session in 2009 did not give a positive support for the programme and they noted the number of attendees dwindled over the period and those attending were not overly positive about the course or that the course itself would help them quit smoking. Therefore TLT decided not to offer further sessions.

6.20.3 The Commission is pleased to report since conducting the review the LBH had taken up the offer of clinics but TLT had refused.

6.20.4 The PCT responded to response provided by TLT and advised drop out during the period the smoking cessation operates is normal and can be up to a 50% drop and the number of people who then go on to quit usually drops by approximately another 50%. The PCT informed out of the 17 people who started the clinic they only received feedback from 5 people - which they felt was not representative of the whole group’s opinions

6.20.5 The PCT advised in response to the negative feedback comments the specialist who ran the sessions provided TLT with explanation or reasons for each of the comments. From their conversations with The Learning Trust some positive feedback was noted to be;

"The information provided during the sessions was overall found to be very informative",

"The group size and setting was good, with a smaller group size allowing discussion was generally very helpful",

"Generally everyone felt that the sense of support gained from the sessions as well as the sense of camaraderie that was made through peer support contributed to their ability/desire to stop smoking.

6.20.6 The Learning Trust HR also commented:

"Overall, the sessions would appear to have had a reasonable level of success and this was reflected in the feedback. At this time however, the possibility of holding future seminars would not be a possibility."

6.20.7 It was clear to the Commission there remains some uncertainty about the support or service being offered to TLT staff and the Commission wants to be certain all staff have access or are being offered support services for smoking cessation and received tobacco control education.
The Commission feels it is important that staffs are sign posted to support and received information about smoking cessation. Therefore the Commission wishes to see all employers (LBH, TLT, Homerton Hospital, NHS City and Hackney and ELNFT) regularly update staff about smoking cessation service and provide support or make referrals to services that offer quit support and use the local tobacco alliance brand (once established) to provide tobacco control education.

**Recommendation Six: Employer**

The Commission makes the following recommends:

a) that The Learning Trust demonstrates how it promotes smoking cessation services to staff and provides support services to staff, especially teachers.

b) that other local employers (the Council, PCT, Homerton Hospital and East London Foundation Trust) regularly advise staff about the smoking cessation services and support they offer to quit, using the brand of the Tobacco Control Alliance once established.
7 CONCLUSION

7.1 Smoking is the single largest determinant of inequality in life expectancy. Continued investment in reducing smoking prevalence and increasing cessation will be crucial if the vision to close the gap in health inequalities locally is to be realised.

7.2 A lot of firm views were expressed and resonating at the heart of this review was the call to see smoking support services based within the community and being flexible with the ability to change to meet the needs of the communities with the highest smoking prevalence. Improving the local knowledge about key community groups and smoking prevalence but also considering what incentives could be given to drive forward changes to deep rooted behaviours and challenge the current perceptions and thinking of tobacco use in our society being normal.

7.3 Overall, tobacco control policies are extremely cost-effective health interventions which deliver revenue benefits to the public finances as well as wider social benefits. Cutting back on tobacco control expenditure would almost certainly result in net revenue losses rather than gains to the public purse.
8 CONTRIBUTORS – Meetings and Site Visits

8.1 Attendance at Meetings

The following people gave evidence at Commission meetings or attended to contribute to the discussion panels:

6th September 2010 **Frances Schmocker**, Tobacco Control Programme Manager from NHS City and Hackney Primary Care Trust  
**Charlie Sheldon**, Chief Nurse and Director of Governance, from Homerton University Hospital NHS Foundation Trust  
**Dean Henderson**, Borough Director for City and Hackney from East London NHS Foundation Trust (ELNFT)  
**Audrey Lee**, Principal Commercial Standards Officer from London Borough of Hackney (LBH)  
**Victoria Honeyghan**, Health Improvement Advisor, from LBH Environmental Health & NHS City and Hackney

13th October 2010 **Dr Hayden McRobbie**, Senior Clinical Research Fellow from Queen Mary University London  
**Andrew Hayes**, Tobacco Policy Manager for London from Department of Health Regional Public Health Group

9th November 2010 **Robin Hewings**, Tobacco Control Policy Manager from Cancer Research UK  
**Dave Millard**, Healthy Schools Co-Ordinator from The Learning Trust  
**Nursel Tas**, Chief Executive from Derman  
**Mitchell Mullen**, Interim Deputy Manager of Operational Services from City and Hackney Mind I.R.I.E.

8.2 Site Visits completed as part of the Review

**Smokefree Tower Hamlets**  
The Commission is grateful to Jill Goddard Smokefree Tower Hamlets and Alan Richards London Borough of Tower Hamlets Trading Standards for talking to us about Tower Hamlets experiences from setting up the tobacco alliance in Tower Hamlets and advice about the lessons learned.

**London Borough Hackney - Neighbourhoods and Regeneration**  
The Commission is grateful to Officers Audrey Lee and James Grier from LBH Trading Standards, PC Dan Window from Clapton Police Station, Victoria Honeyghan and James Sharples from LBH Environmental Health and NHS City and Hackney Public Health for permitting the Commission to shadow officers as they performed their duties for tests of underage tobacco sales and inspections of premises for compliance with the smoke free legislation.

**Hackney Youth Parliament**  
The Commission is grateful to all the Members of Hackney Youth Parliament and support officers Mandy Richards, Nazia Gofur, Michael Connors from Hackney Youth Service hosting us at their meeting and providing views about tobacco education in schools and how improvements could be made to influence young people.
9 MEMBERS OF THE SCRUTINY COMMISSION

9.1 Members of the Health in Hackney Scrutiny Commission

- Councillor Luke Akehurst (Chair)
- Councillor Daniel Kemp (Vice Chair)
- Councillor Katie Hanson
- Councillor Ann Munn
- Councillor Wendy Mitchell
- Councillor Benzion Papier
- Councillor Jessica Webb

- Overview and Scrutiny Officer: Tracey Anderson

Legal by Comments: Joan Jones ☎ 020 8356 4813

Financial by Comments: Mark Player ☎ 020 8356 6894
Financial by Comments: James Newman ☎ 020 8356 5154

10 BACKGROUND PAPERS

10.1 The following documents have been relied upon in the preparation of this report or were presented to the Scrutiny Commission as part of the investigation.

- LBH Hackney, Agenda and Minutes of the meeting of the Health in Hackney Scrutiny Commission held on 6th September 2010, 13th October 2010 and 9th November 2010.

11 REFERENCES & GLOSSARY

11.1 The following publications were consulted by the Commission in its research for this review.

- Chartered Institute of Environmental Health, Tobacco Control Alliance – A Toolkit for London

- Department of Health, A Smokefree Future, Comprehensive Tobacco Control Strategy, February 2010

- NHS Health Development Agency, Tackling smoking through Partnerships – Lessons learned from the national alliance scheme, 11th November 2003
• Communities and Local Government, Working with Black and Minority Ethnic Communities – A guide for stop smoking service managers, May 2008
• ASH, Beyond Smoking Kills: protecting children, reducing inequalities, October 2008
  www.ash.org.uk/beyonddsmokingkills
• ASH, All Party Parliamentary Group on Smoking and Health – Inquiry into the effectiveness and cost effectiveness of tobacco control: submission to the 2010 spending review and Public Health White Paper consultation process, October 2010
  www.ash.org.uk/APPGoct2010
• Durham University, Durham Research Online – the Evolution of a UK regional tobacco control office in its early years: social contexts and policy dynamics, 03 June 2010
• Smokefree Tower Hamlets Tobacco Control Strategy 2008-2011 document
• London Social Marketing Unit \ COI, Smoking Cessation and Ethnic Minority Communities, April 2009 (Slide presentation)

GLOSSARY

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<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
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<td>City and Hackney Young People Services</td>
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<td>DOH</td>
<td>Department of Health</td>
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<td>ELNFT</td>
<td>East London NHS Foundation Trust</td>
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<td>General Practitioner</td>
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<td>Her Majesty Revenue and Customs</td>
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