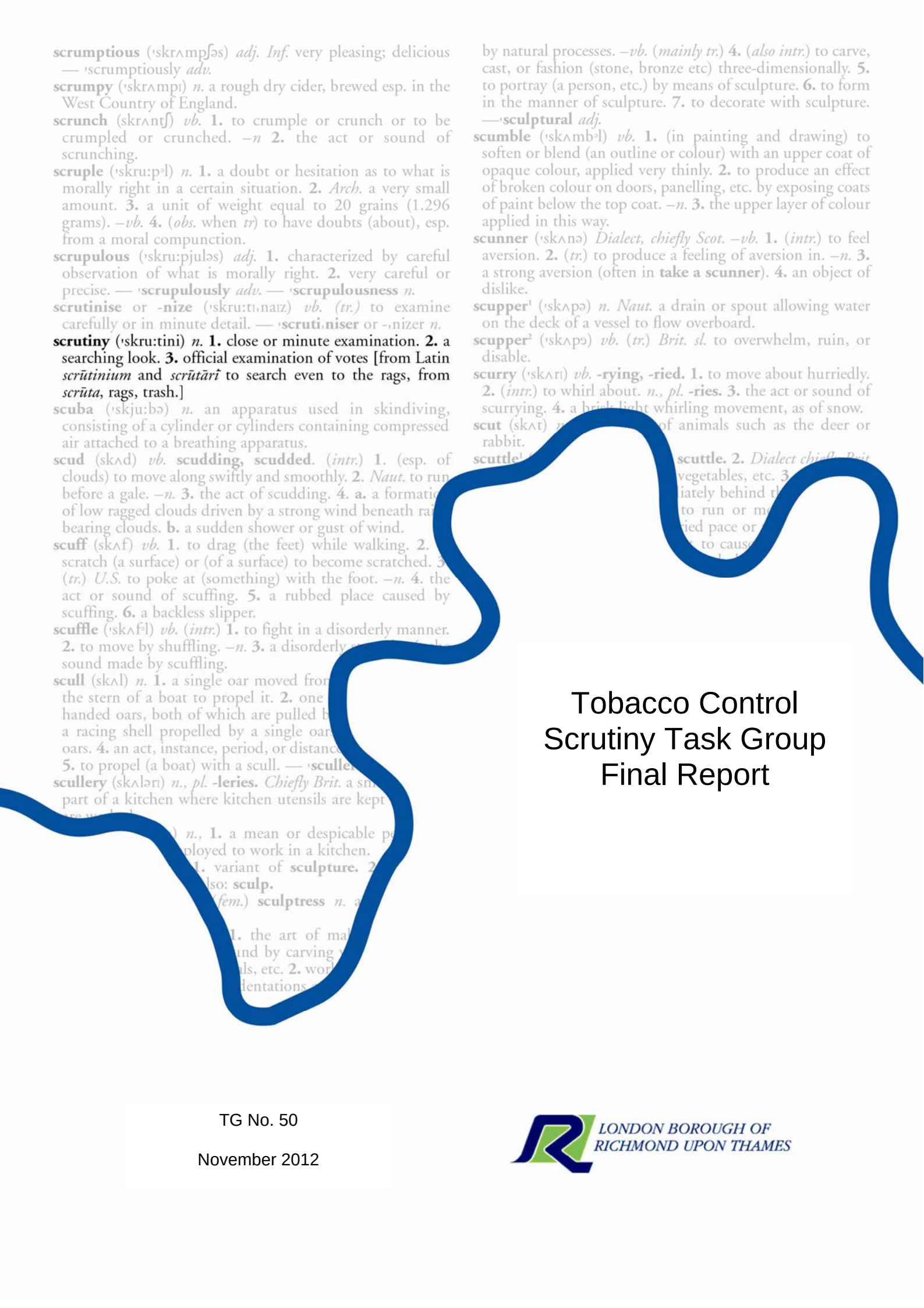

Tobacco Control Scrutiny Task Group Final Report

TG No. 50

November 2012

LONDON BOROUGH OF RICHMOND UPON THAMES

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INTRODUCTION

It is very timely that this detailed study of tobacco control is now available. In April 2013 public health transfers from the local NHS to the Council, so tobacco control with be a new local council responsibility, and the new Health and Wellbeing Board, chaired by the Leader of the Council, will be a key part of improving all our lives.

Anyone studying tobacco control in any depth is struck by three things.

First of all the horrendous statistics – half of regular smokers die from a smoking related disease, 10% of cigarettes and 40% of rolled tobacco sold are illegally imported, smokers have on average eight days more off work every year than non-smokers, and so on. For me personally, giving up smoking at age 26 increased my life expectancy by ten years.

Secondly, huge amounts of public money can be saved if people smoked less – in the health service and adult social care, for the fire service through fewer fires, even for street cleaning because of less litter.

Thirdly, every public service has something to gain from less smoking. Money saved can be used better elsewhere.

The Task Group has been fortunate in having the input of Health, Social Care Trading Standards and Fire Service professionals from Richmond and Kingston, from Richmond Youth Council as well as a number of Schools. We have gathered a significant amount of evidence over the course of the review. We are indebted to all those who gave up their time to contribute to this review.

We were lucky to have a talk from Professor Gerard Hastings, a leading expert on tobacco control and much wider. He delayed his return to the University of Stirling to come to Twickenham for the evening.

On behalf of the Task Group I would like to give particular thanks to the members of Richmond Youth Council, Michael Connor, Youth Engagement Lead, LBRuT and Louise Duffy, Health Improvement Lead**,** Richmond Borough Team, NHS South West London who have conducted invaluable research into ascertaining the views of Young People within the borough including hard to reach groups on the issue of tobacco control.

Most of all I wish to thank Ofordi Nabokei, who organised our work, clerked our meetings, and wrote this report. Without her hard work, persistence and expertise we would never have been the successful task group that we were.

It is not often that the Council has the opportunity to improve people's lives, save a lot of money, and run a popular campaign. But tobacco control can do all those things!

Sir David Williams

Chairman of the Tobacco Control Task Group.

LIST OF ABBREVIATIONS

COPD	Chronic obstructive pulmonary disease
CQUIN	Commissioning for Quality and Innovation.
CYP	Children and Young People
DH	Department of Health
ECM	Every Child Matters
EU	European Union
FCTC	World Health Organization Framework Convention on Tobacco Control
GP	General Practitioner
HFSV	Home Fire Safety Visits
HMRC	Her Majesty's Revenue and Customs
HWBB	Health and Well Being Board
JSNA	Joint Strategic Needs Assessment
LAA	Local Area Agreement
LACORS	Local Authorities Coordinators of Regulatory Services
LBRUT	London Borough of Richmond upon Thames
LSPI	Local Strategic Plan
NICE	National institute for Clinical Excellence
NRT	Nicotine Replacement Therapy
PCT	Primary Care Trust
PDGs	Patient Group Directives
PoS	Point of Sale
QOF	Quality Outcome Framework
QUIPP	Quality, Improvement, Productivity and Prevention
RBK	Royal Borough of Kingston upon Thames
RCDAT	Richmond Community Drug & Alcohol Team
RHITC	Reducing Health Inequalities through Tobacco Control
RIP	Reduced Ignition Propensity
RuT	Richmond upon Thames
SSS	Stop Smoking Service
SWLSGT	South West London and St. Georges Trust
TAPA	Tobacco Advertising and Promotion Act 2002
TCA	Tobacco Control Alliance
TOR	Terms of Reference
WHO	World Health Organisation.

EXECUTIVE SUMMARY AND RECOMMENDATIONS

Smoking represents one of the biggest public health challenges. As well as being the biggest single cause of preventable death and killing half of all long-term users in England[1], smoking costs the economy billions of pounds every year in NHS costs, reduced productivity, lost revenue and higher welfare payments. Tobacco control is an evidence-based approach to tackling the harm caused by tobacco. It includes strategies that reduce the demand for, and supply of, tobacco in communities.

Despite a number of national and local initiatives to tackle tobacco control and smoking cessation, concerns were expressed that some elements had not been addressed fully by existing activity within LBRuT. On the 9th March 2011 the government published *Healthy Lives, Healthy People - A Tobacco Control Plan for England* which set out how tobacco control will be delivered in the context of the new public health system.

The task group observed Kingston and Richmond's Tobacco Control Alliance, interviewed Health, Fire Services, Education and Trading Standards professionals and took the innovative step to commission Richmond Youth Council to conduct Peer Research into the causes and potentially effective deterrents for young people and smoking.

Through out the course of the review, the task group found that on an individual basis a lot of good work is being done with regards to tobacco control, however, the most effective way to deal with this issue is by taking a holistic approach - the sum *should* be greater than its constituent parts.

The review's other major findings are as follows:

i. Whilst many partners are doing good work individually, the most effective way to deal with tobacco control is holistically.

ii. TCA tends to focus mainly on the smoking cessation service and not the other areas of tobacco control – more attention needs to be given to the other issues not just the Stop Smoking Service so that it will effect a real change. There should be a more holistic approach with a wider programme than is currently the case and its focus should be more proactive in looking at local solutions not just legislation

iii. It would be beneficial to have Councillors from both boroughs on the TCA as they give a differing local perspective and political clout to the alliance.

iv. There needs to be a consistent, sustainable long term approach to smoking cessation for young people

[1] Department of Health (2010). A Smokefree Future. A comprehensive tobacco control strategy for England

Suggestions for change have been put forward in all areas and it is hoped that they will be taken forward by all stakeholders. The Task Group believe that the following recommendations should be given priority status:

Recommendation 10 - Tobacco control to be considered as a priority in the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy, the Corporate Plan and for the new Health and Wellbeing Board and for the Richmond upon Thames Partnership.

Recommendation 2 - Greater presence by LBRuT and non health partners at the Tobacco Control Alliance.

Recommendation 4 - Accountability of the Tobacco Control Alliance to be strengthened by clear reporting lines to the LSP or the *appropriate body*'.

Recommendation 11 - To investigate the feasibility of a holistic Future Generation Programme which targets children and young people from families where one or both parents smoke

Recommendation 17 - More effective campaigns to promote existing provision and raise awareness of resources which are currently available so that those who need them / are entitled to them are able to access them.

Recommendation 18 - The feasibility of a family smoking cessation strategy to be looked into.

PART I – ROLE AND FUNCTION OF THE TASK GROUP

BACKGROUND TO THE TASK GROUP

1. On 5 April 2011 a motions was proposed, seconded and carried to ask the Health Housing and Adult Services Overview and Scrutiny Committee to consider setting up a task group to consider all relevant aspects of smoking and tobacco control in Richmond upon Thames. At its meeting on 14 September 2011 concerns were expressed by the Health Housing and Adult Services Overview and Scrutiny Committee that despite a number of national and local initiatives to tackle tobacco control and smoking cessation, some elements had not been addressed fully by existing activity within LBRuT.

2. On the 9th March 2011 the government published *Healthy Lives, Healthy People -A Tobacco Control Plan for England* which set out how tobacco control will be delivered in the context of the new public health system, focusing in particular on the action that the Government will take nationally to drive down the prevalence of smoking and to support comprehensive tobacco control in local areas. The plan cited Local Authorities as being central to this work.

3. This review was commissioned to enable Members to investigate and make recommendations on tobacco control ((including illegal sales) in LBRuT and deterrents for young people. A cross-party cross-committee scrutiny task group was, therefore, set up comprising of:

TASK GROUP MEMBERSHIP

- Sir David Williams – Chair (Liberal Democrat)
- Cllr Butler (Conservative) - Health Housing and Adult Services Overview and Scrutiny Committee
- Margaret Dangoor (Co-opted member) - Health Housing and Adult Services Overview and Scrutiny Committee
- Cllr Elloy (Liberal Democrat) - Environment, Sustainability and Community Overview and Scrutiny Committee
- Cllr Jones (Liberal Democrat) - Health Housing and Adult Services Overview and Scrutiny Committee
- Cllr Coombs (Liberal Democrat)- Health Housing and Adult Services Overview and Scrutiny Committee
- Cllr Nicholson (Liberal Democrat) - Education and Children's Services Overview and Scrutiny Committee

4. The Group first met on 11 January 2012 where the scope and draft terms of reference were formulated. The terms of reference, were subsequently agreed by committee at a meeting on 31 January 2012.

TERMS OF REFERENCE

I. To review the Tobacco Alliance's Tobacco Control Strategy in relation to various guidance including the Government's *Healthy Lives, Healthy People*: A Tobacco Control plan for England.

II. Review the effectiveness of controls and actions for tobacco control currently used in Richmond upon Thames.

III. To investigate other controls and actions that could be used in Richmond upon Thames to help minimise the up-take, the prevalence, health and other related harms associated with tobacco use.

IV. To commission the Youth Council to conduct research and write a report on the reasons why Children and Young People smoke; the relationship between cannabis, alcohol and tobacco; and effective measures to disincentivise Children and Young People from using Tobacco. This report will feed into the final report of the task group.

V. To make recommendations to Cabinet, Health Partners and other stakeholders, to aid in the development of an effective, efficient and joined up Tobacco Control Strategy.

VI. To report back to the Health, Adult Social Care and Housing Overview and Scrutiny Committee on the progress of the Task Group on a regular basis.

VII. To produce a final report for the Health, Adult Social Care and Housing Overview and Scrutiny Committee.

VARIATIONS TO SCOPE

5. It has not been possible to fulfil all the aspects of the scope; in particular I as the Tobacco Control Alliance has already completed a refresh of its new strategy at the time of drafting this report. The task group hopes, however, that the Alliance takes on board and moves forward with the recommendations and findings contained within the report and amends its plan if and where appropriate to reflect and include them. The task group recognises that dentists have an important role to play as there are a number of smoking related diseases and conditions, such as oral cancer which can be identified by dentists at early stages. Given the resource and time constraints it was not possible to include them. In addition it was, not possible for Cllr Coombs to attend any of the meetings of the task group due to a conflict with prior commitments. Cllr Coombs therefore offered to remove himself from the task group as he was unable to contribute.

METHODOLGY

6. In order to conduct the review, the task group agreed that it was important to gather evidence from a wide range of sources. Members also decided it would be best to split the review up into sections in accordance with the areas of focus contained in the terms of reference. The list of meetings and witnesses who gave evidence is set out fully in **Appendix B.**

7. The task group used a mixture of methodologies including primary research via meeting and observing The Tobacco Control Alliance and meeting with professionals (including Health, Fire Services, Education professionals and Trading Standards).

8. The task group took the innovative step to commission Richmond Youth Council to conduct Peer Research via qualitative interviews, focus groups and self-completion surveys regarding Tobacco Control, the reasons why Young People take up smoking, the relationship between cannabis, alcohol and tobacco; and effective measures to disincentivise Tobacco use by Young People. The full peer research report, presentation and methodology is set out in **Appendix D.** The rationale was that as young people themselves, they would be able to gain a more in-depth and accurate picture as to the reasons why, as young people are more likely to be open and honest with their peers.

9. Desktop research was also used to provide context and to evidence approaches, issues, and best practice regarding various aspects of Tobacco Control. This was done via the use of policy documentation, previous surveys, benchmarking data and online resources. The provenance of all submissions received is listed in **Appendix C**

PART II – CONTEXT

WHAT IS TOBACCO CONTROL?

10. Tobacco control is an evidence-based approach to tackling the harm caused by tobacco. It includes strategies that reduce the demand for, and supply of, tobacco in communities. World Health Organization (WHO) Framework Convention on Tobacco Control (FCTC) adopted by the 56th World Health Assembly on May 21, 2003. seeks "*to protect present and future generations from the devastating health, social, environmental and economic consequences of tobacco consumption and exposure to tobacco smoke*" by enacting a set of universal standards stating the dangers of tobacco and limiting its use in all forms worldwide. To this end, the treaty's provisions include rules that govern the production, sale, distribution, advertisement and taxation of tobacco. FCTC standards are, however, minimum requirements. Significant provisions include:

    - Obligation to protect all people from exposure to tobacco smoke in indoor work and public places and public transport.
    - The contents and emissions of tobacco products are to be regulated and ingredients are to be disclosed.
    - Large health warning (at least 30% of the packet cover); deceptive labels are prohibited.
    - Public awareness for the consequences of smoking.
    - Action is required to eliminate illicit trade of tobacco products.

11. WHO subsequently produced an internationally-applicable and now widely recognised summary of the essential elements of tobacco control strategy, publicised as the mnemonic 'MPOWER'[2].

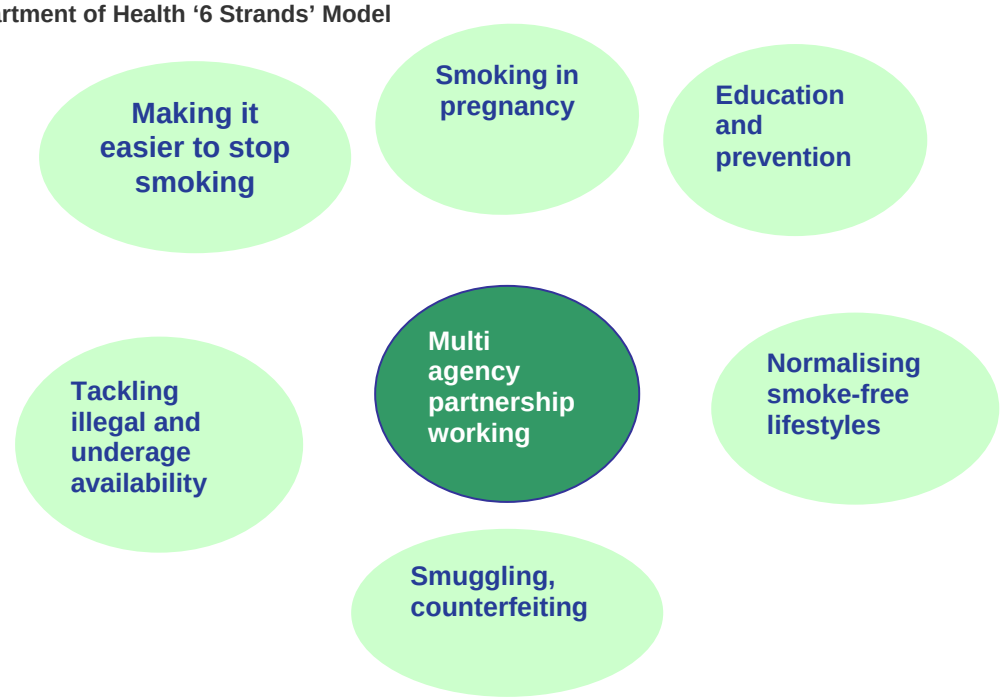
12. Tobacco control is not just a health issue and can be also be classified as "*any initiative which aims to reduce the demand for tobacco products*[3]". In order to cover this wide remit, it is therefore important that councils work strategically with a wide range of partners in the form of a Tobacco Control Alliance which works synergistically to develop, supervise and implement a comprehensive programme where the various strands are interrelated with the aim to de-normalise smoking in communities by: enforcing the minimum price of tobacco; ensuring non-price measures such as advertising restrictions, smokefree laws and health warnings are in place locally; providing information and advocacy; providing effective stop smoking programmes; restricting access to minors and controlling the illicit trade.

13. A holistic summary of the essential elements of tobacco control is detailed in figure 1 below (which is based on the DH '6 strands' model):

[2] http://www.who.int/tobacco/mpower/en/ The six components are: **M**onitor tobacco use and prevention policies, **P**rotect people from tobacco smoke, **O**ffer help to quit tobacco use, **W**arn about the dangers of tobacco, **E**nforce bans on tobacco advertising, promotion and sponsorship, **R**aise taxes on tobacco

[3] ESSTA Tobacco Control Toolkit Funded by the Department of Health, 2009

Figure 1 – Department of Health '6 Strands' Model

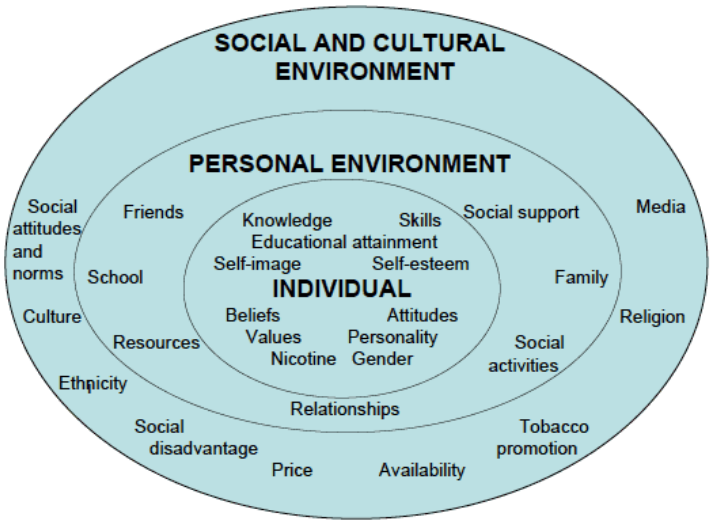


14. In order for the Alliance to be successful, it needs to be equitable, multiagency, accountable and have a shared goal and a clear delivery plan. It is very important that all partners are dedicated to the Alliance to ensure that it is successful. Alliances provide an opportunity to increase the effectiveness of smoking prevention and cessation activities by co-ordinating the work of those organizations, thereby gaining maximum impact.

15. No two alliances will be the same but most Alliances will include all or some of the following:
    - Trading Standards
    - Environmental Health
    - NHS including representatives
    - Children and Young People
    - HM Revenue and Customs
    - Schools or Education Representatives
    - Police
    - Fire Services
    - Smoke Free Co-ordinators
    - Locally Elected Members
    - Local Retailers

Why is Tobacco Control important?[4]

16. As well as being the biggest single cause of preventable death and killing half of all long-term users in England[5]. Smoking, smoking costs the economy billions of pounds every year in NHS costs, reduced productivity, lost revenue and higher welfare payments. Tobacco use is a highly complex behaviour that is particularly resistant to change. It is determined by a wide range of personal, social and environmental influences (see figure 2) and therefore must be approached simultaneously from every angles and on a number of levels.



Source: Reducing health inequalities through tobacco control: a guide for councils.

17. The continued importance of Tobacco Control is reflected in the Coalition Government's (Dec 2010) proposals to monitor tobacco control indicators as part of its public health outcomes framework.

18. The Marmot Review published in 2010 recognises that 'tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.'[6] With the decline in smoking rates among lower-income groups much slower than the decline amongst higher-income groups and tobacco usage perpetuating through generations, this social trend will become more pronounced without intervention.

19. Insofar as tobacco control is a public health issue, it has always been a council issue. Councils are being encouraged to work with the relevant health bodies and other organisations on tobacco control issues that go beyond statutory enforcement working in partnership, councils are taking on a community leadership role and targeted action to improve the wellbeing and life chances of their citizens. This makes councils better

[4] See Reducing health inequalities through tobacco control: a guide for councils Local government group : http://www.idea.gov.uk/idk/aio/25455753
[5] Department of Health (2010). A Smokefree Future. A comprehensive tobacco control strategy for England
[6] The Marmot Review, 'Fair Society, Healthy Lives' (2010)

[7].

THE NATIONAL PICTURE

20. It is estimated that 8,365,559 people smoke in England[8]. Each year, it is estimated that smokers spend approximately £14.8 billion on tobacco products which contributes roughly £11.3 billion in duty to the Exchequer and costs society approximately £13.8 billion per year. £4,100 million is estimated to be lost in terms of out puts due to early deaths, £2,900 million is the estimated cost of lost productivity from smoking breaks in England, £2,500 million is the estimated cost of lost productivity from smoking related sick days. The total cost to the NHS of smoking in England is £2,700 million, the estimated cost of cleaning smoking materials litter is £342million and the cost of smoking related fires in homes is £507 million.

21. In 2010/11 total expenditure on NHS Stop Smoking Services in England (excluding Nicotine Replacement Therapy (NRT), Bupropion (Zyban) and Varenicline (Champix) prescriptions) was £84.3 million. The overall economic burden of tobacco use to society estimated at £13.8 billion a year and these costs comprise not only treatment of smoking-related illness by the NHS but also the loss in productivity from smoking breaks and increased absenteeism, the cost of cleaning up cigarette butts, the cost of smoking-related house fires and the loss in economic output from people who die from diseases related to smoking or exposure to second-hand smoke[9]. A further £713million is the cost of lost productivity due to early death from passive smoking.

22. Although the level of exposure to second-hand smoke among children has declined in recent years, it remains a significant health issue. As it causes: over 20,000 cases of lower respiratory tract infection (in children under 3 years); 120,000 cases of middle ear disease; at least 22,000 new cases of wheeze and asthma; 200 cases of bacterial meningitis; and 40 sudden infant deaths (one in five of all sudden infant deaths are caused by smoking)[10] each year. Second-hand smoke in the home also presents a substantial health risk for adults. Over 12,000 deaths among people over 20 years of age each year are estimated to be attributable to second-hand smoke. These deaths are concentrated in groups where smoking rates are the highest[11].

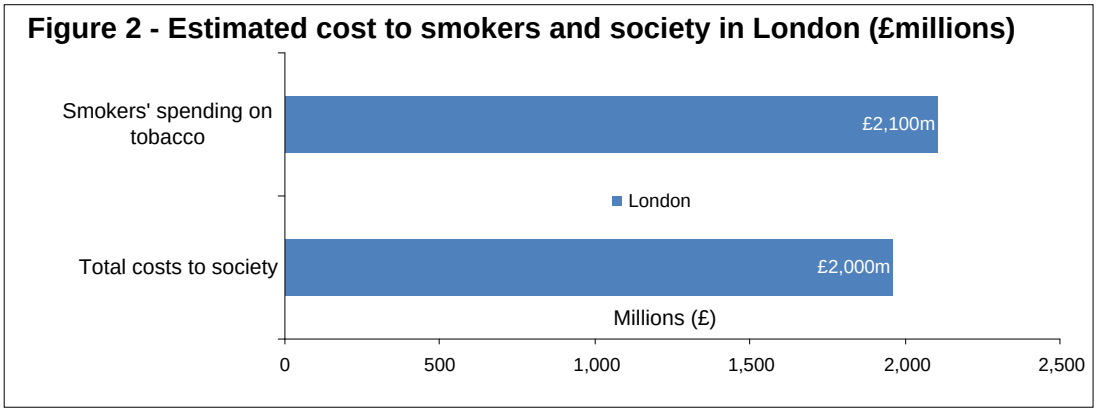
23. Smoking is the primary cause of preventable morbidity and premature death, accounting for around 81,700 deaths (18% of all deaths of adults aged 35 and over) were estimated to be caused by smoking. In England, deaths from smoking are more numerous than the next six most common causes of preventable death combined (i.e. drug use, road

[7] Social marketing approach to tobacco control: a practical guide for local authorities, LGID: http://www.idea.gov.uk/idk/aio/21028178
[8] Reckoner toolkit http://www.ash.org.uk/localtoolkit/docs/Reckoner.xls
[9] Nash, R. and Featherstone, H. (2010). *Cough up: Balancing tobacco income and costs in society*. Policy Exchange, London.
[10] Royal College of Physicians (2010). Passive Smoking and Children. Royal College of Physicians, London
[11] Royal College of Physicians (2005). Going smoke-free: the medical case for clean air in the home, at work and in public places: A report on passive smoking by the Tobacco Advisory Group of the Royal College of Physicians. Royal College of Physicians, London.

accidents, other accidents and falls, preventable diabetes, suicide and alcohol abuse).There were approximately 1.5 million hospital admissions in England in 2009/10 among adults aged 35 and over with a primary diagnosis of a disease that can be caused by smoking.

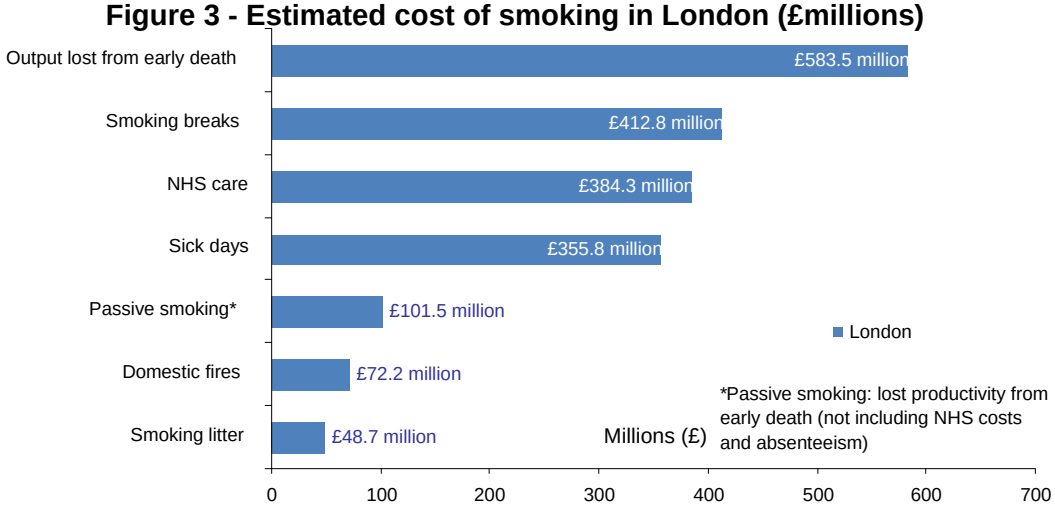
For London the figures are displayed below:

Figure 2 - Estimated cost to smokers and society in London (£millions)



24. The total cost to the NHS of smoking in London is 384.3 million, COPD costs London more than £100m per year[12]. Of the 5 most costly drugs to the NHS, 3 are for COPD. The estimated cost of cleaning smoking materials litter is £48.7 million and the cost of smoking related fires in homes is £72.3 million.

Figure 3 - Estimated cost of smoking in London (£millions)



25. There are approximately 800 fires a year in London that are started by smoking materials. Between January 2005 and November 2011 there were 90 fire related fire deaths where smoking materials have been the source of ignition. A new safety standard for cigarettes[13] which should reduce the number of fires started by smoking materials was agreed on 18 November 2010. It came into force across the EU on 17 November 2011. Fire safer cigarettes, also called 'reduced ignition propensity or 'RIP' cigarettes,

[12] NHS London Respiratory Team: Case for Change in London respiratory services using a right care approach August 2011 See: http://www.london.nhs.uk/webfiles/London%20Respiratory%20Team/LRT%20Case%20for%20Change%20FINAL.pdf

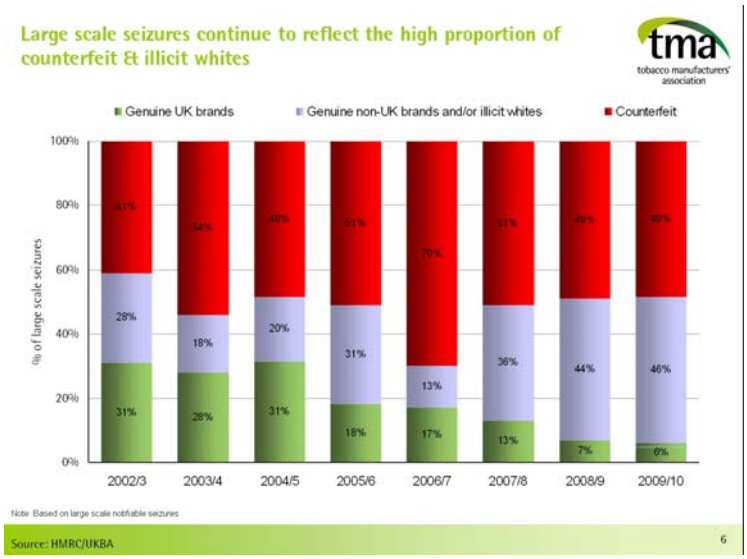
[13] Data taken from a document entitled 'Cigarettes' and 'Fire safer cigarette note for CSC members' from the London Fire Brigade.

have ultra-thin bands at intervals down the length of the cigarette. These cause the cigarette to go out if not puffed by the smoker. A fire safer standard is already in force on cigarettes sold in Canada, Australia, Finland, and some US states. Although a voluntary standard, manufacturers have a strong incentive to comply. If a cigarette does not comply, member state authorities (in the UK, this is Trading Standards) are able to withdraw it from the market (including directly from retailers) and prosecute the party that introduced the products into the UK market. In December 2011 DCLG reported that UK tobacco manufacturers had confirmed that all cigarettes being produced for the UK market were compliant with the new safety standard. With all cigarettes in the EU fulfilling this fire safety requirement, the European Commission estimates that one to two lives could be saved every day.

26. *Impact of illicit Tobacco*[14]*:* Tobacco smuggling costs the UK taxpayer an estimated £2.2 billion per annum (1.4 billion per annum in lost revenue for cigarettes and £0.8 billion per annum for hand-rolling tobacco). Tobacco duties contributed £8.8 billion to public finances in 2009/10. In 2000, the Government launched a £200 million initiative to tackle tobacco smuggling. As a result, the illicit cigarette market has reduced from 21% to 11% since 2000, and from 61% to 49% for hand-rolling tobacco over the same period.

27. HMRC spent almost £1.5m (excluding VAT) on targeted media campaigns to support its anti-tobacco smuggling strategy between 2003 and 2008 and £170,000 in 2009/10. There has been a £917 million additional investment to tackle organised crime, tax evasion and avoidance through the Government's Spending Review which is being used to achieve further sustainable downward pressure on the illicit market in cigarettes and hand-rolling tobacco through to 2015.

Figure 4 - **The proportion of counterfeit Illicit Whites between 2002/03 and 2009/10.**



[14] ASH Briefing: UK Tobacco Control Policy and Expenditure Updated May 2012 and Tackling Tobacco Smuggling– building on our success: A renewed strategy for HM Revenue & Customs and the UK Border Agency (2011)

28. In April 2011 HMRC and the UK Border Agency launched a new plan to tackle tobacco smuggling, building on their 2008 strategy[15]. 18 Key elements of the plan include increasing criminal intelligence and investigation resources deployed on tobacco fraud by 20% to prosecute more of those involved in smuggling at all levels; introducing new technology, intelligence and detection capability; pursuing proceeds of crime and applying new powers of assessment and penalties bringing the UK into line with all other EU Member States. In 2012, the Coalition Government increased tobacco duty by 5% above inflation.

29. The Role of Marketing[16]: Most conspicuous forms of tobacco advertising and promotion in the UK were banned following the implementation of the Tobacco Advertising and Promotion Act 2002 (TAPA)[17]. TAPA did not, however, regulate the display of tobacco products. Tobacco advertising on broadcast media (television and radio) is prohibited by the Broadcasting Acts of 1990 and 1996 as well as the EU Audiovisual Media Services Directive. Article 13 of the FCTC requires parties to implement and enforce a comprehensive ban on tobacco advertising within five years of ratifying the FCTC. As a party, the UK is bound by this agreement.

30. A Government commissioned review found that *"The balance of evidence supports the conclusion that advertising does have a positive impact on consumption"* (i.e. it increases consumption). The same review also found that in countries that had banned tobacco advertising the ban *"was followed by a fall in smoking on a scale which cannot reasonably be attributed to other factors"*[18].

31. There is also evidence that children and young people are more receptive than adults to tobacco advertising and that young people exposed to tobacco advertising and promotion are more likely to take up smoking[19]. Research suggests that very young children understand that tobacco promotion is promoting smoking rather than a particular brand and as they get older they can differentiate the brand messages[20]. The authors suggest the same process occurs in point of sale displays. Many studies from the UK and elsewhere have shown that adolescents who smoke are more likely to be aware of and appreciate tobacco advertising than their non-smoking peers[21].

32. Research shows that Point of Sale (PoS) display has a direct impact on young people's smoking[22]. Similarly research in Australia [23] and the USA[24] has shown that PoS display

[15] Tackling Tobacco Smuggling – building on our success: A renewed strategy for HM Revenue & Customs and the UK Border Agency
[16] http://ash.org.uk/files/documents/ASH_124.pdf
[17] www.opsi.gov.uk/acts/acts2002/ukpga_20020036_en_1
[18] Effect of tobacco advertising on tobacco consumption: A discussion document reviewing the evidence. Economics & Operational Research Division. Department of Health, 1992 (The Smee report)
[19] Pierce J et al. Tobacco industry promotion of cigarettes and adolescent smoking. JAMA 1998; 279: 511-515; &. Lovato, C et al. Cochrane Review: Impact of tobacco advertising and promotion on increasing adolescent smoking behaviours. The Cochrane Library. Issue 2, 2004.
[20] Freeman, D et al Youths' understandings of cigarette advertisements. Addictive Behaviours 2008 doi:10.1016/j.addbeh.2008.08.007
[21] Point of sale display of tobacco products. The Centre for Tobacco Control Research, 2008. **info.cancerresearchuk.org/images/pdfs/tobcon_pointofsalereport1**
[22] Point of sale display of tobacco products. The Centre for Tobacco Control Research, 2008. info.cancerresearchuk.org/images/pdfs/tobcon_pointofsalereport1

advertising of cigarettes normalises tobacco use for children and creates a perception that tobacco is easily obtainable. According to a 2006 survey of smoking among children in England, 14% of 11 to 15 year olds who smoked reported that vending machines were their usual source of cigarettes[25]. However, vending machines accounted for less than 1% market share of all cigarettes sales, suggesting that child smokers were more likely than adult smokers to purchase cigarettes from vending machines. The sale of tobacco products from vending machines became illegal in England on 1 October 2011.[26] Prohibition of the sale of tobacco products from vending machines was included as part of the Health Act 2009, following a consultation on the future of tobacco control.

33. In England, since 6 April 2012, it is illegal to display tobacco products at the point of sale in large stores (defined by the Sunday Trading Act 1994 as a relevant floor area exceeding 280 square meters). The ban will apply to small stores from 6 April 2015. It is estimated that the measure will affect 6,834 large stores and 49,099 small stores in England.

34. Tobacco control is a behaviour change issue and smoking behaviours are particularly resistant to change. The desire to smoke is driven by a mix of physical addiction, ingrained personal habits and strong social and cultural norms. Communications and advertising campaigns can contribute to a shift in behaviour, but in isolation cannot bring about lasting, sustainable change. As a result, more than just raising awareness and influencing attitudes and beliefs to focus specifically and directly on the more complex challenge of behaviour change needs to be done[27]. '*Social marketing*' has been developed to respond specifically to this challenge and is focused on achieving behaviour change objectives. With a growing evidence base for its effectiveness in tackling tobacco use, social marketing is already being used extensively at local, regional and national levels[28]. For example, through Smokefree partnerships at a regional level and locally through PCTs across the UK.

GOVERNMENT ACTION: Healthy Lives, Healthy People – A Tobacco Control Plan for England.

35. On 9 March 2011 the Government published its White Paper *Healthy Lives, Healthy People – A Tobacco Control plan for England.* The Tobacco Control Plan sets out how tobacco control will be delivered in the context of the new public health system over the next 5 years[29] focusing on the action that the Government will take nationally to drive down the prevalence of smoking and further comprehensive tobacco control, including

[23] Wakefield M, Germain D, Durkin S and Henriksen L. An experimental study of effects on schoolchildren of exposure to point-of-sale cigarette advertising and pack displays. Health Educ. Res. 2006; 21: 338-347
[24] Henriksen L et al. Effects on youth of exposure to retail advertising. J Appl Soc Psychol. 2002;32:1771-89
[25] Smoking, drinking and drug use among young people in England in 2006. The Information Centre for Health & Social Care, 2007
[26] The Protection from Tobacco (Sales from Vending Machines (England) Regulations 2010 http://www.legislation.gov.uk/uksi/2010/864/contents/made
[27] See Reducing health inequalities through tobacco control: a guide for councils Local government group : http://www.idea.gov.uk/idk/aio/25455753
[28] Department of Health (2010). A Smokefree Future. A comprehensive tobacco control strategy for England.
[29] White Paper *Healthy Lives, Healthy People – A Tobacco Control plan for England* (2011). Executive summary.

tackling the wider social determinants of health, in local areas. The paper holds that the most effective tobacco control strategies involve a multi-faceted comprehensive approach at both national and local levels. According to the White Paper, whilst the Public Health Outcomes Framework provides the key source of information about governmental progress on reducing tobacco use, there are three national ambitions to focus tobacco control work across the whole system:

- **Reduce smoking prevalence among adults in England:** To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015, meaning around 210,000 fewer smokers a year.
- **Reduce smoking prevalence among young people in England:** To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015.
- **Reduce smoking during pregnancy in England:** To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (measured at time of giving birth).

36. The paper clearly states that these national ambitions will not translate into centrally driven targets for local authorities. They represent, instead, an assessment of what *could* be delivered as a result of national actions described in the plan in conjunction with local authority areas deciding on their own priorities and methods in line with evidence-based best practice and local circumstances. The main government commitments set out in the White Paper are:
    - Implementing legislation to end tobacco displays in shops;
    - Looking at whether the plain packaging of tobacco products could be an effective way to reduce the number of young people who take up smoking and to support adult smokers who want to quit, and consult on options by the end of the year;
    - Continuing to defend tobacco legislation against legal challenges by the tobacco industry, including legislation to stop tobacco sales from vending machines from October 2011;
    - Continuing to follow a policy of using tax to maintain the high price of tobacco products at levels that impact on smoking prevalence;
    - Promoting effective local enforcement of tobacco legislation, particularly on the age of sale of tobacco;
    - Encouraging more smokers to quit by using the most effective forms of support, through local stop smoking services; and
    - Publishing a three-year marketing strategy for tobacco control.

THE SITUATION IN RuT

37. In RuT [30], it is estimated that 28,764 people smoke. Each year, it is estimated that smokers spend approximately £50.9 million on tobacco products - which contributes

[30] This amount is based on the ash. Reckoner toolkit http://www.ash.org.uk/localtoolkit/docs/Reckoner.xls

roughly £38.8 million in duty to the Exchequer - and smoking costs RuT approximately £47.3 million per year. £14.1 million is estimated to be lost in terms of out puts due to early deaths, £9 million is the estimated cost of lost productivity from smoking breaks and £8.6 million is the estimated cost of lost productivity from smoking relate sick days in RuT. The total cost to the NHS of smoking is £9.3 million, the estimated cost of cleaning smoking materials litter is £1.2 million and the cost of smoking related fires in homes is £1.7 million. A further £2.5 million is the cost of lost productivity due to early death from passive smoking.

38. LBRuT as a borough has significantly better figures that the national average in terms of deaths attributed to smoking (including heart disease), death from Chronic Obstructive Pulmonary Disease (COPD), smoking attributable hospital admissions, lung cancer registrations; the rate of smoking in pregnancy and prevalence in adults' aged 18 years and over. LBRuT is similar to the national average in terms of deaths from a stroke that are attributed to smoking, the number of people who are registered with oral cancer and the prevalence of smoking in adults aged 18 and over who are in a routine or manual occupation. These figures are displayed in the table below[31]:

Table 1: Local Tobacco Profile for London Borough of Richmond upon Thames[32].

Indicator	RAG Rating♦	Indicator Value	Regional Average	England Average	England Worst	England Best
Smoking attributable deaths 2007-09	🟢	173.8	207.9	216.0	361.5	131.9
Smoking attributable deaths from heart disease 2007-09	🟢	23.5	30.6	32.1	60.7	16.7
Smoking attributable deaths from stroke 2007-09	🟡	8.7	9.8	10.1	18.4	5.0
Deaths from lung cancer 2007-09	🟢	29.8	37.3	38.2	69.4	18.4
Deaths from chronic obstructive pulmonary disease 2007-09	🟢	17.4	25.4	26.2	48.7	11.9
Smoking attributable hospital admissions 2009/10	🟢	1029.9	1,342.1	1417.2	2538.6	760.6
Cost per capita of smoking attributable admissions, 2009/10	⚪	30.5	38.8	37.9	60.3	23.6
Lung cancer registrations 2006-08	🟢	39.1	47.9	48.3	87.3	24.4
Oral cancer registrations 2006-08	🟡	9.2	9.8	8.9	16.0	2.7
18+ smoking prevalence Apr 10 - Mar 11	🟢	17.2	19.8	20.7	33.5	8.9
18+ smoking prevalence-routine & manual Jan 10 - Dec 10	🟡	27.7	26.9	30.0	43.3	11.6

[31] http://www.lho.org.uk/LHO_Topics/Analytic_Tools/TobaccoControlProfiles/profile.aspx?

[32] See http://www.lho.org.uk/LHO_Topics/Analytic_Tools/TobaccoControlProfiles/indchart.aspx?inid=1&areatype=LA&region=H&shacode=H&areacode=00BD

♦ RAG rating refers to whether a local value is significantly better, worse, or similar to the England average. Red means that the indicator for the area is significantly worse than the England average; Amber means that the area's indicator value is similar to the England average, and Green means that the indicator for the area is significantly better than the England average. White indicates that statistical significance was not calculated.

Smoking in pregnancy 2009/10		4.6	7.4	14.0	31.4	4.5

Note: Where there are no values shown, this is because the data are not available or suppressed.

39. Overall, around 6,800 *primary fires*[33] occur in London and 3,100 in other buildings, of which around 10% have smoking related ignition sources. The London Borough of Richmond upon Thames has a similar proportion of smoking related fires (7%). Around 1% of the fires in London occur in LBRuT.

40. The figures detailed in the tables below highlight the levels of fires and smoking related fires/ injuries. It is however, important to be mindful that an increase of one incident can distort the figures. Furthermore, the figures (for the number of fires) do not indicate *secondary fires* or include careless disposal of cigarettes.

Tables 2-11: *Primary Fires* in London and LBRuT including smoking related primary fires- Data for the three calendar years 2009 to 2011[34]

Table 2 All Primary fires in London				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	6,914	6,815	6,631	20,360
Other Building	3,198	3,170	3,031	9,399
Grand Total	10,112	9,985	9,662	29,759

Table 3 All Primary fires in Richmond				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	84	97	92	273
Other Building	52	50	57	159
Grand Total	136	147	149	432

Table 4 Smoking related primary fires in London				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	586	641	678	1,905
Other Building	350	382	408	1,140
Grand Total	936	1,023	1,086	3,045

Table 5 Smoking related primary fires in Richmond				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	6	9	6	21
Other Building	2	3	5	10
Grand Total	8	12	11	31

In London, approximately 30% of all fire deaths in London are due to smoking related fires. By contrast, in Richmond over the last 3 years, no deaths (at primary fires) have been recorded.

Table 6 Fire deaths in London				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	52	62	48	162
Other Building	4	8	1	13
Grand Total	56	70	49	175

Table 7 Smoking related fire deaths in London				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	20	18	8	46
Other Building	2	3	0	5
Grand Total	22	21	8	51

[33] **"Primary"** fires include all fires in buildings, vehicles and outdoor structures or any fire involving casualties, rescues, or fires attended by five or more appliances.
"Secondary" fires are the majority of outdoor fires including grassland and refuse fires unless they involve casualties or rescues, property loss or five or more appliances attend. They include fires in single derelict buildings. Taken from CLG: Fire Statistics Great Britain 2010-2011:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/6762/568234.pdf

[34] Data taken from a document entitled 'Cigarettes' from the London Fire Brigade.

In London, 13% of all injuries due to fire were smoking-related. Richmond exhibits a similar pattern: 19% of all fire injuries over the three years were smoking related.

Table 8 Fire injuries in London				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	1,227	1,220	1,234	3,681
Other Building	177	155	169	501
Grand Total	1,404	1,375	1,403	4,182
Table 9 Fire injuries in Richmond				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	13	12	15	40
Other Building	3	2	2	7
Grand Total	16	14	17	47
Table 10 Smoking related fire injuries in London				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	157	158	138	453
Other Building	27	31	34	92
Grand Total	184	189	172	545
Table 11 Smoking related fire injuries in Richmond				
Property Type	**2009**	**2010**	**2011**	**3yr Tot**
Dwelling	3	4	1	8
Other Building	0	1	0	1
Grand Total	3	5	1	9

41. Richmond and Kingston have a joint stop smoking service[35], which is a free and confidential service that offers support and advice to any smoker who is registered with a GP in either LBRuT or RBK or who works in either borough and would like to give up.

42. A team of trained 'stop smoking' advisors provides both one-to-one support and group sessions. The service can also give information on stop smoking support offered by nurses and pharmacists in the borough. There are services located all over LBRuT where advice, information and access to treatment is available. Telephone support is also available for those who not wish to attend regular appointments. Services are available most days of the week and include evenings and weekends. The service offers practical help including access to nicotine replacement therapy, Zyban and Champix. This service is also advertised on the LBRuT's website[36]

PART III – FINDINGS

THE MULTI-AGENCY APPROACH: The Tobacco Control Alliance

43. The Richmond and Kingston TCA which meets on a quarterly basis, was set up to champion Tobacco Control and the Smokefree agenda. The TCA's aim is to:
    - Provide overall support and direction for the effective implementation of the tobacco control strategy which includes smoking prevention
    - Provide a high quality responsive stop smoking service in Kingston and Richmond
    - Support and develop a programme for tobacco control which will include: -
        - Reducing smoking prevalence, including young people and pregnant smokers
        - Reducing staff prevalence of smoking
        - Working with the local authorities in relation to tobacco use and control

[35] http://www.smokefreekingstonandrichmond.nhs.uk/
[36] http://www.richmond.gov.uk/help_to_stop_smoking

- Championing the tobacco control agenda and benefits of becoming smoke-free
- Reducing the availability of tobacco by ensuring that there is an effective tobacco control programme agreed for the boroughs of Kingston & Richmond
- To act in an advisory and supportive capacity and suggest changes or updates to the tobacco control programme
- Receiving progress reports on the tobacco control programme, to make recommendations for action accordingly within respective organisations and to contribute to delivery; and
- Taking responsibility report back and action to the various alliance partners.

44. The members of the task group met with the TCA on 2 occasions. The task group found that two things were apparent from attending the TCA meetings. Firstly that smoking cessation was a small part of people's jobs not their full-time job and secondly, there did not appear to be a strategic focus. The task group found the TCA to be very health focused and felt it would benefit from a broader more inclusive membership outside of health. The task group recognises that there are non-health members who attend the TCA however the task group observed on both occasion that this number was much smaller than the number of health professionals in attendance. From discussions with health witnesses, the task group heard that there was no specific programme covering or targeting young people and smoking cessation. Witnesses told the task group that they are aware this is a gap in provision and both the RYC and research shows that tobacco companies target young people[37]. The task group found that:

Finding 1: Whilst many partners are doing good work individually, the most effective way to deal with tobacco control is holistically.
Finding 2: Tobacco Control Alliance is health heavy in its membership.
Finding 3: There are a number of core players who attend but there are also many alliance members who do not engage in the meeting or with the alliance.
Finding 4: TCA tends to focus mainly on the smoking cessation service and not the other areas of tobacco control – more attention needs to be given to the other issues not just the Stop Smoking Service so that it will effect a real change. There should be a more holistic approach with a wider programme than there currently is and be more proactive in looking at local solutions not just legislation.
Finding 5: It would be beneficial to have Councillors from both boroughs on the TCA as they give a differing local perspective and political clout to the alliance.
Recommendation 1: Two elected members (in order to ensure political balance) to be nominated with agreement of either the council or by leaders of both political parties to join Kingston and Richmond Tobacco Control Alliance.
Finding 6 Children are not really covered in the alliance other than in the substance misuse service. As this is the area tobacco marketing companies are targeting an

[37] Viz. http://ash.org.uk/files/documents/ASH_124.pdf and at the talk provided by Professor Hastings to LBRUT 28 May 2012.

opportunity is being missed.
Recommendation 2: Greater presence by existing LBRuT and non health partners at the Tobacco Control Alliance meetings.
Recommendation 3: An officer from LBRuT Youth Service to be nominated sit on and attend the Kingston and Richmond Tobacco Control Alliance.
Recommendation 4 Accountability of the Tobacco Control Alliance to be strengthened by clear reporting lines to the LSP or the *appropriate body*'.

THE INDIVIDUAL APPROACH:

The Police and Safer Neighbourhoods team:

45. A written submission was provided by Borough Licensing Officer (Police) who explained that their remit is enforcement of the Licensing Trade which covers Alcohol-Public Houses, clubs & off-licences, fast food establishments open after 11pm, betting shops and any other licensed premises. It went on to explain that there is little involvement with cigarettes other than the rigid enforcement around shops who sell Tobacco to underage persons. The Police directed the task group to trading standards who they felt would be best placed to answer questions on tobacco control.

46. Evidence submitted by the Safer Neighbourhood Team was in a similar vein to that of the Police. The Safer Neighbourhoods Team stated that they engage with local stores and proactively target those suspected of wrongdoing. It made mention of an operation due to be run aimed at enforcing licensing responsibility (including sales of Tobacco). In addition, each Safer Neighbourhood Team works closely with local schools and under the *Every Child Matters* Framework: any child suspected of smoking is reported to the schools welfare officer.

47. Both the Police and the Safer Neighbourhoods Team were asked to discuss their involvement with the TCA. Neither submission made mention of this. When the task group attended the meeting of the TCA on 21 May, police from Kingston attended the meeting but there was no attendance from RuT's Police or Safer Neighbourhoods Team. The task group was informed that there had not been regular or frequent attendance by Richmond's Police and no attendance by the Safer Neighbourhoods Team.

Trading Standards and Environmental Health:

48. LBRuT's Trading Standards Team Plan has, for the last 5 years, looked at under age tobacco sales. The first active case was in the 1990s where there were 5 sales out of 5 attempts. Children and young people (CYP) under the legal age to buy tobacco are still able to obtain it through 'proxy sales[38]'. Unlike proxy sales to minors of alcohol, which is illegal this is not the case for tobacco: only the trader can commit an offence. Where there has been a flagrant abuse of the rules the trader will be prosecuted. There is scope for education programmes to raise this matter as proxy sales cannot be regulated.

[38] A proxy sale is defined as a person over 18 years of age who purchases tobacco in this instance on behalf of a minor.

49. The task group discovered that Trading Standards prefers to work *with* traders, maintain good relationships and speak to them about age restricted sales and other legislation concerning tobacco products for example promotion and labelling as this has meant traders tend to remain compliant and want to work with LBRuT. The majority success Trading Standards has had regarding underage sales is due to its' continuing good relationship with traders in the borough.

50. Levels of illicit tobacco sales in LBRuT are fairly low and illicit tobacco is dealt with effectively in LBRuT. According to Trading Standards this is sustained by maintaining good relationships with traders, asserting and reinforcing policies, and by the frequency of visits. Trading standards undertake 4 sessions, each session includes test purchasing - any children used in targeted under age sales had to clearly look underage and could not be concealed by use of things such as make up or hoods - per year, a session includes visiting 8 establishments. In addition, there are approximately 40 spot checks per year. LBRuT Shops have been asked to remove niche tobacco products such as *snuff*[39]: which is illegal in the UK and most of Europe (excluding Sweden).

51. The task group heard that as a borough, LBRuT is a fairly compliant but witnesses felt that more could be done to better regulate underage sales.

52. Whilst the use of Shisha pipes is not as prevalent in LBRuT as it is in neighbouring RBK, from a Trading Standards perspective there are concerns about what is being sold once the items are removed from the packaging as it is not possible /easy to tell if the product has had duty paid or is counterfeit and whether or not it contains tobacco[40]. In terms of Environmental Health, Shisha places do not need to be licensed unless they are conducting some other activity that requires a licence.

53. The task group heard that at present there is little / no co-ordination with the Safer Neighbourhoods Team and little co-ordination with the police. Increased and better co-ordination, it was felt, would be beneficial in terms of gathering intelligence of underage sales. This in turn would benefit the TCA as a whole. Trading Standards' work is intelligence-work led: Trading Standards monitor the Consumer Direct national database to see which traders generate the most complaints in their area and there is a memorandum of understanding with HMRC about the seizure of counterfeit and non-duty paid tobacco.

Recommendation 5: Safer Neighbourhoods Team and the Police to work more closely / form a strong working relationship with Trading Standards in supplying intelligence regarding tobacco related issues such as under age sales.

54. Trading Standards feel that the co-ordination of the Tobacco Control Alliance (TCA) has been very good with a great deal of work being done with other South West London Local Authorities and London-wide. The TCA is considered to be a good vehicle because

[39] Snuff is a product made from tobacco leaves *either powdered and taken into the nostrils by inhalation or ground and placed between the cheek and gum*. It is an example of smokeless tobacco.
[40] There are also herbal Shishas which do not contain tobacco

there are many agencies who shared the same aims who can work together and it has helped to make the outcomes more measureable. In addition the DH has funded a Tobacco Control Newsletter sent to tobacco retailers across London. Distribution was co-ordinated by Southwark on receipt of data supplied by individual Boroughs including Richmond. Trading Standards Officers are happy with the powers that currently exist but since the closure of LACORS much of the national expertise which has informed Trading Standards work has been lost.

55. As the smoking ban has pushed smoking outdoors, there has been a rise in the number of complaints and Environmental Health usually applies nuisance legislation to deal with the issue, even though penalty notices can also be used. Environmental Health is also responsible for enforcing smoke free legislation. When environmental health officers undertake food or hygiene inspections they also look at the smoke free aspects and discuss this with the licencee. Trading Standards and Environmental Health have a key role to play in tobacco control. The task group felt that:

Finding 7: More resources should be invested into Trading Standards and Environmental health to undertake their work.
Recommendation 6: Feasibility of increased resources to be looked at in order for: • Trading Standards to undertake more 'test purchasing' for underage and proxy sales; • more visits/inspections of cigarette sellers; • more trader education/training regarding underage and proxy sales.

Fire Service:

56. In RuT, the Fire Service actively targets areas of high deprivation and specific areas where fires are most likely to occur rather than relying on referrals from requests for home fire safety visits (HFSV). The Fire Service told the task group it was their belief that reliance on referrals would not steer resources where needed and that those most at risk from fire also often tended to smoke.

57. In LBRuT certain postcodes and 'Priority 1 people' - older people, for example, are considered to be a Priority 1 Group as many do not have much family support, require care/medical support or suffer fuel poverty. These groups are specifically targeted using a number of tools and receive fire safety advice. As a result the Fire Service are has a fairly clear picture of those most at risk of fire and is able to effectively target them. Due to the profile information, those who smoke may well be in target groups. The task group was told, however, that smokers cannot be targeted specifically.

58. In the case of housing partnerships its remit is slightly different: the Fire Service conducts an assessment and provides smoke alarm advice. The Fire Service works closely with the Fire Safety Regulatory Group which deals with multiple occupancy dwellings. The Fire Service is also working with Social Services to provide false alarm prevention work. The result of the approach as outlined above is that there are fewer calls reporting a fire.

59. In terms of tobacco control, the Fire Service has been pushing for the use of '*safer cigarettes*[41]' as normal cigarettes that are not properly extinguished can cause fires more easily. Careless disposal of cigarettes in open spaces such as parks or railways can also lead to fires, road and rail disruptions. RIP cigarettes are an EU-wide problem. NON RIP cigarettes affect Richmond because these cigarettes are smuggled into the country and into LBRuT. This however, is an issue for HMRC and the police.

60. The Fire Service told the task group that their main focus is on reducing the number of deaths resulting from home fires. They noted that for other agencies who may be involved, this is a secondary issue. The Fire Service felt that more could be done to deepen and expand working relationships for example, linked-up working with the smoking cessation service and the provision of Fire Service information/ advice on fire safety to smoking cessation clinics; and that there is a need for more effective multiagency working to educate and provide information about fire prevention successfully. The Fire Service viewed smoking as an issue best tackled holistically. The task group was told that the Fire Service have not undergone smoking cessation intervention training.

Recommendation 7 - The Fire Service to look into the provision of smoking cessation intervention training for its staff.
Recommendation 8 – Public Health and the Fire Service to explore more collaborative / 'linked-up' working in relation to tobacco control.

Health:

61. *Public Health:* Public Health told the task group that smoking prevalence data in general practice is dependent on the number of people GPs have asked about their smoking over the course of a year; it may not be wholly representative as they may not have checked the smoking status of every single patient aged 16+ years. GP data also includes people who reside out of the borough, but who are registered with a Richmond GP. Unless surgery information is revisited regularly, historical data may be included. As a result, the data does not provide a wholly accurate picture of smoking in the borough: Furthermore, due to the shifting population of the borough, general practice prevalence data is unlikely to give an accurate snapshot. It does, however, provide an indication of who to target. It is therefore important to note that the data gives an *indication* of prevalence only. The task group was told that GPs are expected to ask patients about their smoking status at least annually, as part of the GP contract,

62. GP data is one tool that enables Public Health to target resources. The issue of prevalence data was raised a number of times by professionals.

[41] This are RIP or Reduced Ignition Propensity cigarettes - A simple change in the design of cigarettes (two narrow bands of slightly thicker paper) greatly reduces the likelihood of unattended cigarettes continuing to burn, dramatically cutting the risk of fire.

Finding 8: There is a need for quality of local health data on smoking to be improved.

63. The Department of Health has stipulated that 5% of the smoking population should be accessing services. Richmond and Kingston were just under this level. The task group heard that the amount of resource and effort put into getting a person to make a quit attempt is dependent on the person. Some people are ready and want to attempt straight away whilst others need 3-4 meetings before they feel able to attempt. Being asked if a person would like to stop smoking and to make the attempt. Asking a person whether they would like to stop smoking is a separate matter from establishing whether they are ready to make a quit attempt can be long. In addition, many people say they would like to quit but are not ready to. Many prefer to attempt to quit on their own rather than using the smoking cessation service; and some are not aware of the services that are provided.

64. Public Health takes a proactive approach to smoking cessation: they go out and speak to people; provide information and actively recruit smokers. A large number of people who attend the service are also referred by others including GPs. Pharmacists are trained in order to reach wider sections of society and it is considered to be a good setting to raise the issue. Public health told the task group that GPs do refer onto pharmacies who offer the service, especially when they do not provide the service themselves.

65. The challenge for smoking cessation services is that national smoking cessation advertising has stopped. This has reduced people's exposure and awareness of the services available and the benefits of stopping smoking.

66. In Richmond, the core smoking cessation team sits within the NHS[42] and there is a network of community advisors including Youth Services, Health Visitors, Pharmacists and GPs. All are trained to provide one-to-one interventions. All community advisors undertake accredited training and are required to follow set procedures. At present there are no referrals from dentists but the NHS would be very keen to see this. Optometrists are also used in some areas for generating referrals but this is not the case in Richmond and Public Health said they would like to see this happen.

Recommendation 9: LBRuT and Health Partners to explore the viability of training dentists and optometrists to identify smokers and the relevant referral pathway.

67. The task group were informed that parents have been known to contact the cessation service on behalf of their children. Nationally, there is little evidence around supporting young people to quit, but that what has been shown to be effective is a whole systems approach to tackling tobacco.

68. From a Public Health perspective, it is often the case that the use of tobacco is linked to the likelihood of a young person being engaged in a whole a range of 'risky behaviours', which may include cannabis use. The task group heard that there may be cases where cannabis has led to young people using tobacco, but it is more likely to be the other way

[42] **NB:** This service has recently been commissioned from an external provider from 1 October 2012 and is now called **'Kick It**'

round. CYP do not see smoking as a long term threat, the borough is now focusing on risky behaviour in general and that a '*Risky Behaviour Strategy'* is being developed. Furthermore, a new service is being procured which would enable CYPs undertaking *risky behaviours* to be identified early and a range of issues / behaviours tackled together rather than in isolation.

69. Public Health told the task group that there is input into primary schools about smoking. Smoking is often tackled as part of the curriculum when the children do work around 'being healthy'. It is frequently the case that primary school children say they will never smoke. However, during the transition between primary and secondary school, views change and many take up smoking. CYP as with other vulnerable groups do not see themselves as being such. In order to change their views on smoking and other risky behaviours, campaigns are needed to reinforce the messages. One such initiative is Operation Smoke Storm, which commenced in September 2011. It is, however, dependent upon a school agreeing to participate/

70. **Public health stressed their wish for smoking to be seen as *everybody's* business and that a 'whole systems' / holistic approach to tackling tobacco is *the most* effective way to produce better outcomes in terms of smoking cessation and tobacco control.**

Finding 9: Tobacco control to be viewed as a priority in the Joint Strategic Needs Assessment and the new Health and Wellbeing Board.
Recommendation 10: Tobacco control to be considered as a priority in the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy, the Corporate Plan and for the new Health and Wellbeing Board and for the Richmond upon Thames Partnership.
Recommendation 11: In the course of its duties the HWWB to investigate how the second-hand smoke agenda is given greater attention and publicity than it currently receives.

71. Public Health told the task group that the NHS has always focused on prevention as it is very important, particularly in relation to tobacco use and that this will remain a focus. Smoking, it is believed, will remain a high priority for the government as its Public Health Outcomes Framework states that public health outcomes (which include smoking prevalence) should be addressed. Whilst the London tobacco team has largely been disbanded, stop smoking service managers across London meet regularly to learn and discuss best practice, they receive regular email updates and opportunities exist to develop this further.

72. Public Health told the task group that the TCA was making positive progress and that whilst many agencies and partners had signed up to it, there were many players who did not attend or did not attend on a frequent basis and that momentum in pushing the agenda forward was beginning to wane.

GPs:

73. A number of GPs came to give evidence to the task group including one who is part of the Clinical Commissioning Group (CCG) but did not have a professional specialist interest in smoking.

74. The impact of smoking on GPs work is seeing / treating patients with COPD and other smoking related diseases. In terms of prevalence data the GPs were in accordance with Public Health: there is a great deal of variation in prevalence and the levels are dependent upon variables such as the size of the practice, how strict the practice is in enforcing the measures are carried out / updated, random background variation due to inaccurate data and that data does not give the full or at times accurate picture. In the GPs' opinion, it is more effective to work with information that is well known: there is a higher prevalence amongst certain age and socio-economic groups and to target those particular groups accordingly as the success rate would be higher.

75. There are, for GPs, financial incentives / performance related pay for smoking prevention and cessation (and other area(s)) via the QOF as it accounts for a substantial part of GP remuneration and smoking is part of this. If a patient has been recorded as a smoker this will appear on the doctor's screen along side a number of related prompts which seek to ascertain whether smoking cessation intervention work has been carried out. There is, increasingly, conflict between the patient's agenda and what a GP is required to ask and do.

76. Pharmacists and practice nurses were felt to be better placed to offer ongoing interventions as GPs have brief access to patients in terms of time spent and because practice nurses and pharmacists are trained in smoking cessation advice. Witnesses told the task group that patients are aware of the SSS and the impression was that the service is very successful.

77. Witnesses expressed the view that as people have been aware of smoking cessation and prevention for some time it has become, to a degree, a background issue. Nevertheless, it remains in the top 10 issues to be addressed as it is one of *the* most cost effective interventions. In light of this, witnesses felt that a 'blitz' on national advertising for smoking cessation tied into events such as the Olympic Games or the New Year would be the most effective way to get the message across as there is fresh input and drive as was the chase with sport and the Olympic games.

78. The task group found that there does not appear to be a uniformed view with regard to young people and smoking intervention: One GP told the task group they raise the issue with the 15-25 age group, particularly as this is the age group which is targeted by tobacco companies: this age group is asked about their smoking habits when they attend the surgery with acute chest problems and has found that females rather than males of this age group tend to smoke. It was acknowledged that it is not possible to see a young person under the age of 15 on their own and that they are unlikely to admit to smoking in front of their parents. Action after the age 15, it was felt, is too late in terms of the

prevention. Plain packaging is considered to be the most effective measure to date. Other effective ways to discourage young people from smoking from a GP perspective were to show the physical impact on their health by for example showing a 15 year old who smokes that they have the lungs of an older person – to young people, the thought of premature aging is undesirable but something they can identify with - and also the financial cost. The task group also discovered that one of the challenges with the smoking cessation service is that those who access the service do not tend to be from the younger age groups. GPs stressed the importance of educating young people and that making the information meaningful and relevant to them is the key. It was felt that more intervention and preventative work should be done with families to raise awareness and change attitudes. One way to do this was via a family smoking cessation strategy. *Healthy Lives Healthy People: a Tobacco Control Plan for England* is also seen as a positive step.

79. There was a wish amongst the witnesses for a more joined up holistic approach to tackling tobacco control across the board, ideally via a local enhanced service which would encourage the PCT to be more active in this area and particularly with Youth Services and Trading Standards. It was felt that the division between Health and Social Care is artificial as many of the issues are cross cutting. Having said that, the average general practitioner does not have any contact with Public Health.

80. In terms of the new health landscape and the impact this will have on tobacco control there is a QUIPP plan and except for Richmond CCGs priorities (reducing expenditure due unneeded hospital admissions, end of life care, delivery of the 111 service and the use of urgent care facilities during GP opening hours), the rest of the budget will roll forward and be apportioned to areas as needed. In terms of the Health and Well Being Board and the CCGs ability to pick the issue of smoking cessation up and give it prominence, it was thought that this would be the case as the focus will be on hospital services and reducing the use of secondary care where it is not needed and on care for the elderly.

Pharmacists:

81. The task group heard that there are 46 well distributed pharmacies throughout the borough with support products for smoking cessation that are already available on the shelves. The task group heard that there is a PCT voucher scheme. People who decide to quit can access the pharmacy service, often without an appointment and following a consultation. When appropriate the Nicotine Replacement Therapy (NRT) can be issued there and then. Witness opinion is that this works well.

82. Witnesses told the task group that pharmacies have played an active role in tobacco control for a number of years. When NRT / smoking cessation began, implementation was performed mainly through pharmacies with GPs referring their patients to the appropriate pharmacist. Patient Group Directives (PGDs) provide the pharmacists with

delegated responsibility from GPs to undertake certain tasks: at present there are 2 PGDs for pharmacy in place in Richmond (and nationally) one of those is for NRT the other for Levonelle[43]. A PGD can mean either a document or a process, which should define what is included or excluded in its remit. PGDs allow pharmacists to prescribe NRT without the person needing to go to the GP to obtain a prescription.

83. Where the patient makes an appointment to see the GP for smoking cessation, the GP usually prescribes for 4 weeks whereas pharmacists prescribe on a weekly basis; when the patient returns for their next prescription their Carbon Monoxide level is taken. Witnesses told the task group that it is now more common for GPs to make in-house referrals to the smoking cessation services or interventions - to the practice nurse - rather than to pharmacists. As a result, fewer referrals are made to pharmacy. Many pharmacists feel that they can contribute more fully within the wider public health agenda but do not feel they are not considered or seen as a valuable asset alongside their the GP colleagues as they are seen as 'dispensers', are dependent on the decisions of GPs. This is not specific to Richmond but the case at the national level.

84. They highlighted the following examples: In Surrey all the pharmacies within East Surrey ran six, two monthly Pharmacy Information Campaigns on a number of issues including Domestic Violence, Healthy Eating, Alcohol Abuse and Diabetes. This was an excellent example of collaborative working in partnership with the PCT, the GPs and Social Services. The service was evaluated and was seen to be very successful. The pharmacists and their staff were trained in each topic, and thus able to discuss and sign post the customers to the appropriate support. Pharmacists also highlighted Healthy Living Pharmacies (HLPs) - Healthy Living Pharmacies have a healthy living champion who, as well as delivering services, keeps up to date with health services in the community and can sign-post people to further help and share this information with other healthcare professionals. At present, there are over 100 of these operating in the UK[44]. The best known is the one in Portsmouth[45].

85. The task group heard that pharmacies are the heart of the community, see both the well and unwell, and are open longer hours than GP surgeries. People who go to pharmacies often feel more at ease talking to pharmacists as they do not feel judged which many do with doctors. As a result pharmacists are privy to more information because of their perceived non-threatening nature. Moreover, pharmacists are able to access people who do not visit their GPs, or who are not registered with one. This accessibility is a pharmacy's key asset, which they feel is being over looked.

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[43] Commonly referred to the 'Morning after' pill.

[44] Viz. http://www.npa.co.uk/resources/press-releases/government-and-public-affairs/pathfinder-support-group-exceed-100th-healthy-living-pharmacy-target and http://www.npa.co.uk/resources/press-releases/government-and-public-affairs/pharmacy-minister-visits-100th-healthy-living-pharmacy-to-be-accredited-in-england and http://www.npa.co.uk/resources/press-releases/about-the-association/healthy-living-pharmacies-in-shropshire-recognised-at-awards-ceremony

[45] For a description of how the initiative was set up: http://www.nhsalliance.org/fileadmin/files/pdf/Pharma%2001.pdf for more on how this is working and for HLP newsletters see http://www.portsmouth.nhs.uk/services/guide-to-services/healthy-living-pharmacy.htm

86. The view among pharmacists is that National Government and HWBBs would reap greater benefits if there was a stronger and more effective model of co-operation with pharmacists than that which currently exists.

Finding 10: It would be beneficial for Richmond residents and Public Health as a whole if pharmacists are considered to be a public service that has the ability to offer more than it currently does.

87. Witnesses highlighted just how effective a tool pharmacies can be in relation to smoking cessation. According to pharmacist's figures the quit rate at 4 weeks in a pharmacy in Richmond is 42%.

88. Under contractual arrangements, pharmacies are under an obligation to publicise 6 public health campaigns per year, smoking is often one of them. Due to a lack of funding, these have decreased in the last few years. Moreover, smoking is now included as one of the issues in the NHS Health Checks and smoking issues are identified by pharmacists undertaking this service. Pharmacists were found be more than happy, where necessary, to sign-post members of the public to the appropriate services. Concerns were expressed that there have, over a number of years, been logistical issues with campaigns where a campaign has been launched but the distribution of associated information and leaflets has not coincided with the launch of the campaign and that there is a need for more better co-ordination. To further illustrate this, task group were informed that no smoking day was on the 14th March pharmacists had not received information and leaflets from the DH and PCT. As a result, many people were unaware it was national non-smoking day. Witnesses were of the view that active campaigns that reach a very wide audience would help to spread awareness and a proven successful method of doing this is by advertising the issue on the side of a bus for example. They added that when dealing with smoking cessation and adults, the issue boils down to behaviour change campaigns can only *raise* awareness but there needs to be more follow through after awareness has been raised**.**

Finding 11: Given the accessibility of pharmacies it would be beneficial for more campaigns regarding smoking cessation to be held in pharmacies.

89. Witnesses felt that the TCA is reactive to issues but that its focus should be about driving the agenda forward. Historically and to date smoking prevalence in LBRuT is lower than the national average. Nevertheless, whilst this is the case the overall levels of lower prevalence within LBRuT mask the high levels within certain groups: Eastern Europeans, young people and those in social housing. Witnesses said they felt the most effective way to deal with smoking cessation would be to look at the issue holistically as part of the overall *risky behaviours* agenda and to make the most of the non-threatening easily accessible nature of pharmacies. They stressed the importance of linked-up working and delivery of services.

Finding 12: Pharmacists are very passionate about the issue of tobacco control and the

benefits of their access to larger and wider groups within the community.

Richmond Community Drug & Alcohol Team (RCDAT):

90. in Richmond, RCDAT deals with between 130-150 cases and approximately 90-99% of clients smoke. A large number of referrals come from GPs whilst a small proportion comes from the criminal justice system. Recently, a good proportion of those referrals are alcohol related. The majority of service users tend to be in their 30s to 40s but young people also access the service.

91. The task group heard that given the complexity and issues of each case, smoking is low down the list of priorities for the service user. It is very difficult to get the smoking cessation message across as many clients do not wish to discuss the issue and do not want to stop because they feel that they are giving up everything else. Service users have reported smoking as the one 'pleasure' they are allowed and they do not wish to sacrifice this in addition to the other drugs and / or alcohol they use. Once, however, a rapport has been established with the client and they are in treatment, it is then possible to discuss the issue of smoking cessation further and potentially refer them on to the smoking cessation service. The witness told the task group that there are 8 smoking cessation groups at SWLSGT, 1-2-1 courses and a lot of support for service users once they consent and are referred to the smoking cessation service.

92. The task group heard it is often the case that service users do not engage with the smoking cessation service and do not attend the meetings/ groups. Even when they are made aware of the monetary benefits of stopping, the physical health risks and that smoking is just as harmful as other substances it is not taken on board. It was stressed that for this group, stopping smoking is not always the clients' primary focus as they are giving up other substances, which can be a difficult/traumatic process.

93. The task group heard that many service users know where they can access cheap tobacco. They smoke due to boredom, anxiety and because of psycho-social reasons. When education / training and other opportunities with Jobcentre Plus to help them relieve boredom (one of the reasons they say they smoke) have been suggested, service users remain unmotivated to utilise the opportunities. In the witness's opinion this is due to the fact that this group is riddled with an internal conflict: on the one hand they are in denial - it is difficult for them to admit they have an addiction and on the other, they are aware of their situation but if they admit this they will have to take responsibility for their actions which leads to self-guilt. Witnesses informed the task group that the majority of service users have been misusing substances for a number of years and may have had hard and traumatic experiences during this time – this is a group with complex issues who already smoke. The witness made the point that **no matter how publicised this issue is, if people do not want to take notice of it they will not.**

94. In addition, some service users have reported that smoking a cigarette gives them an extra 'buzz' in conjunction with the use of illicit substances. Challenges to smoking tend

to result in the service users disengaging and becoming less open as they feel they are being reprimanded. The witness told the task group that in the 3 years they have worked in the community setting not one of their clients has given up smoking.

95. The task group heard that there is a strong connection between recreational drug use and alcohol and that there is also a link between alcohol and cannabis use but less so than the link between cannabis and cocaine. Service users have reported they will take one substance to get a '*high*' for example crack or cocaine, heroin is then taken to bring them 'down' and cannabis is used in order to '*chill out*'. Some have referred to cannabis as '*dessert*'.

96. In the witness's professional opinion, any (preventative) targeting would need to be aimed at a younger age group. Their personal opinion was that it could take years for messages to be absorbed and processed by the psyche but if done from an earlier age there is perhaps a greater chance of success. The importance of a good education was also stressed. Whilst it was recognised that it would be much harder to target children at primary school level the need to start from an early age was emphasised because even from that point patterns of dysfunctional behaviour and addictive tendencies *may* be seen.

97. The task group heard that where families have a history of drug and alcohol misuse it is more likely that the children will exhibit this type of behaviour. Whilst it was important to target young people it was also important to target the older generation as in their experience, by the approximate age of 40, most service users have reached maturity and do not wish to continue with this lifestyle.

Recommendation 12: The feasibility of a holistic Future Generation Programme which targets children and young people from families where one or both parents smoke be investigated. The programme should be a holistic family programme which includes older generations so that they can positively influence young people not to smoke. This programme can be part of a wider programme to tackle Risky Behaviours but should be given equal importance and resources to all other risky behaviours if included.

98. RCDAT staff have undergone smoking cessation training and SWLSGT are keen on making staff aware of training and intervention opportunities and within the trust there is a good level of awareness of smoking and preventative work. SWLSGT also have CQUIN[46] targets on smoking cessation (including referrals to smoking cessation) they are required to meet.

99. The witness told the task group that ideally, a one-stop-shop type set-up where a client could see their GP and then see a specialist Drugs and Alcohol Nurse with access to social workers in the same place as this would help anonomyse issues so that people do not worry about stigma or their family knowing. Furthermore, if this resource was set within the community it may help to minimise other issues. A holistic approach could be taken effectively and would reach whole levels of people who are not targeted due to

[46] This is a system introduced in 2009 to make a proportion of healthcare providers' income conditional on demonstrating improvements in quality and innovation in specified areas of care.

resource constraints and because they are not considered to be 'extreme' enough to fit the criteria to be dealt with by certain services.

Young People and Tobacco:

100. It is estimated that each year in England around 340,000 children under the age of 16 who have never smoked before try smoking cigarettes[47]. Every year, around 200,000 children and young people start smoking regularly[48]. Of these 67% start before the age of 18 and 84% by age 19. Previously, girls had been more likely than boys to have ever smoked and to be regular smokers. However, in 2011, a similar proportion of boys and girls said they had tried smoking (25% and 26% respectively.) The prevalence of regular smoking increases with age, from less than 0.5% of 11 year olds to 11% of 15-year olds[49].

Table 12 - Percentage of regular smokers aged 11-15 by sex: 1982 – 2011, England

Years	1982	1986	1990	1994	1998	2002	2006	2008	2010	2011
Boys	11	7	9	10	9	9	7	5	4	4
Girls	11	12	11	13	12	11	10	8	6	5
Total	11	10	10	12	11	10	9	6	5	5

Note: ONS estimates that in 2010 around 140,000 children aged 11-15 were regular smokers10,000 fewer than in 2010.

101. Smoking initiation is associated with a wide range of risk factors including: parental and sibling smoking, the ease of obtaining cigarettes, smoking by friends and peer group members, socio-economic status, exposure to tobacco marketing, and depictions of smoking in films, television and other media[50].

102. Children who live with parents or siblings who smoke are up to 3 times more likely to become smokers themselves than children of non-smoking households[51]. It is estimated that, each year, at least 23,000 young people in England and Wales start smoking by the age of 15 as a result of exposure to smoking in the home[52].

103. In order to gain a more robust picture of young people and tobacco control in LBRuT the task group, in addition to speaking to a number of professionals, commissioned *Richmond Youth Council* (RYC) to conduct peer research focusing specifically on identifying the reasons why CYP do or do not smoke, what may stop a young person from quitting smoking, how CYP view local provision and education around smoking and what young people think they should know about the issues of smoking. The RYC worked in partnership with NHS Richmond to deliver this research. The evidence collected by the RYC is summarised below. The full research findings and methodology are set out in **Appendix D**.

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47 Impact Assessments for the Health Bill. Department of Health, January 2009 page 18 para 54

48 A Smokefree Future. A comprehensive tobacco control strategy for England. HM Government, 2010. (p10)

49 Smoking drinking and drug use among young people in England in 2011. The Information Centre for Health and Social Care, 2012

50 Passive smoking and children. Royal College of Physicians, London, 2010 (pdf)

51 Leonardi-Bee J, Jere ML, Britton J. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and metaanalysis. Thorax 15 Feb 2011 doi:10.1136/thx.2010.153379

52 Passive smoking and children. Royal College of Physicians, London, 2010 (pdf)

RYC Peer Research[53]:

104. The RYC collected data using three main data collection methods:

- Smoking survey conducted by peer researchers,
- Self completion survey distributed to secondary schools and youth clubs across the borough,
- Qualitative interviews on tobacco, cannabis and alcohol consumption.

A total of 911 questionnaires were received. Qualitative Interviews were carried out separately with young people who were known to smoke cannabis and drink alcohol.

105. 48% of respondents said smoking is a problem amongst young people in Richmond. 25% said it wasn't a problem; 27% said they did not know. 83% reported that they currently do not smoke. A total of 18% of young people reported that they smoke occasionally or regularly. 23% of young people aged 16+ years smoke regularly or occasionally compared to 4% who are 13 years old. A total of 4% indicated that they smoke regularly and would like to give it up.

106. Addiction to tobacco as a reason for not giving up was also acknowledged. A high proportion of young people cited parents as being responsible for helping young people to stop smoking. This response was more likely to be selected by young people who do not smoke. Young people who smoked occasionally or regularly felt it was their own responsibility. 48% of young people did not know where to go if they wanted advice about quitting smoking compared to 25% who did. There is demand for peer support and stop smoking advisers to help young people to quit. Young people who smoked occasionally or regularly were found to be more likely to suggest this as a solution.

107. Friendship groups play a large role in shaping perceptions of what is considered to be attractive and role models play an important part in forming views on smoking. Siblings and other family members have the most influence on young people starting to smoke and choosing to quit. Peer pressure is a much stronger motivation than 'rebellion'. The promotion of activities such as exercise would give young people access to a new social group and peer group who did not smoke and this in turn would bring about a reduction in smoking and take up rates. Advertising and the media also played a large role in shaping perception. Plain packaging is considered unappealing to young people and removes the impulse to buy cigarettes.

108. Education on the topic was rated least favourably by the young people who smoke. 72% of young people, who smoke occasionally or regularly rated education they have received as 'okay' or 'poor', compared to 24% of young people who do not smoke. In spite of the research findings, the RCY stressed the importance of educating children about the dangers of smoking at an early age, from Year 5 or Year 6, and being continually reinforced throughout a young person's school career. Peer research found that '*real life examples'* of the effects of smoking have a far greater impact on young

[53] This also includes discussions had by the task group and RYC when the RYC presented their findings to the task group on 18th April 2011.

people than seeing images in abstraction. Computer applications similar to mobile phone applications which show how a person's appearance might change and deteriorate over a number of years if they kept smoking were suggested as preventative tools to bring home the seriousness of the issue.

Peer Research Finding 1: The myths about smoking need to be dispelled in the same way myths about sexual health are.
Peer Research Finding 2: Young people only concern themselves with short term impacts. In light of this, smoking cessation should be promoted as the beginning of the journey rather than the end ('Quitting').

109. Increasing the price of tobacco is currently seen to be the most effective deterrent to encouraging young people to quit smoking. This was closely followed by education of the health risks and banning smoking in public places/workplace.

110. Interviews with young people who use cannabis revealed that there were no strict patterns of usage and initiation. All but one of the respondents smoked both tobacco and cannabis. Some respondents started smoking cannabis first and then moved to standard cigarettes because they could no longer afford cannabis or opted to smoke cigarettes more frequently. Others said they started smoking first and then tried cannabis, which they now smoke more regularly.

111. The perception of cannabis amongst users was that it is not as harmful or addictive as other drugs. The ease of access and price was also a reason why they engaged in this substance as opposed to others. Respondents who smoked cannabis indicated it was easily accessible. One respondent described how his local estate had a lot of people that smoked and sold cannabis and that exposure to it in this way may have contributed to him starting. Some interviewees felt that alcohol produced different effects to cannabis and that the situation or occasion determined their choice of substance use

Recommendation 13: Public Health and Youth Services in conjunction with LBRuT's Children and Young people to explore alternative way for CYP to reduce pressures they face via improved sign-posting, provision and marketing drive of recreational activities to ensure more CYP are involved in them.
Recommendation 13a: The feasibility of smoke-free parks or areas within parks where there are recreational facilities for children and young people to be investigated.

Youth Services:

112. The task group sought evidence from LBRuT's Youth Service and in particular Youth Work Leads who have day to day interaction with young people. Much of the evidence provided to the committee was consistent with many of the findings contained in the RYC's peer research:

113. Peer pressure *is* an influencing factor as to whether young people smoke however, the pressure is to conform and to 'fit in' rather then being *forced* to smoke. Another

contributing factor to whether or not a young person smokes is their background. Those who come from a culture or an area where smoking is prevalent and considered normal (for example in Castleneau there are a large number of families and young people who smoke) the result is that young people are more likely to smoke. Whereas in Hampton, where there is a sporting culture, ¾ of those who attend the provision do not smoke and not smoking is considered to be 'the norm'. Nevertheless, smoking is still seen as being 'cool' by many. In contrast to the evidence provided by RYC, role models were not deemed to be influential in terms of encouraging young people to smoke.

Finding 13: In order to effectively embed the non-smoking message and reduce prevalence there needs to be a cultural shift amongst various groups of young people and their families about de-normalising smoking.

114. The task group heard that for youth workers smoking and tobacco control is a lower priority to other 'risky behaviours' such as drugs and alcohol and issues such as teenage pregnancy and self harm. The task group heard that this is also the case with the police, the Safer Neighbourhood Team and the DAT when they attend to give talks - they tend to focus on issues such as crime and other drugs and alcohol. Witnesses said that in their experience, less resource and time was put into smoking cessation than into other issues.

115. Witnesses felt that developing a closer relationship with schools is beneficial as it would provide a holistic approach to dealing with a number of issues and is a way to ensure consistent and detailed information / signposting regarding smoking, drugs and sexual health are provided to all young people rather than just those who attend the youth club provision. Whilst some relationship building between youth workers and schools has taken place witnesses said that this has, at times, been challenging.

Recommendation 14: Closer working relationships to be built between Schools and LBRuT Youth Workers to enable the better delivery of consistent information to students on a range of issues including smoking and sexual health.

116. Witnesses in line with **Peer Research Finding 2**, said that young people do not think about the long or short term impact of smoking on their health unless smoking will impact on their ability to play sport or music for example.

117. In terms of education, practical learning based on real life examples were considered to be more effective than taking an intellectual approach to smoking cessation. Anecdotal evidence provided suggested that whilst an intellectual approach may work on younger children up to the age of 11, by 14 years of age this no longer works and some would have started to smoke despite being anti-smoking at a younger age. Furthermore, for anti-smoking education to successfully reach children and young people there would need to be a constant 'drip-feeing' of a mixture of resources (including leaflets, training, health interventions, and real life examples). The message should be clear but young people should be *given the choice to make the decision*, not be told what to do. For such

smoking cessation interventions to be successful for CYP, witnesses stated that the person delivering the intervention would need to have already built up a relationship with the young person in order to be able to encourage them to stop.

As the result of this the task group found that:

Finding 14: There needs to be a consistent, sustainable long term approach to smoking cessation for young people.
Recommendation 15: The feasibility of smoking cessation advice and support services specifically designed for young people to be looked into. Any development should ensure advice is easy to obtain, is non-judgmental and includes access to counseling for young people who smoke cannabis.
Recommendation 16: The feasibility of either: • training youth workers in smoking cessation; or • training dedicated smoking cessation workers for young people including counselling and advice in relation to cannabis use should be explored.
Recommendation 16: The feasibility of training young people to provide peer to peer education programmes within their schools i.e. School Councils to be looked into and where possible rolled out.

118. In line with the peer research and throughout discussions with a number of witnesses, it was a common theme that young people and youth workers did not know where to access information or advice about smoking cessation specifically targeted to young people.

Finding 15: There does not appear to be sufficient / effective communication tailored particularly for young people about smoking cessation services that exists.
Recommendation 18: More effective campaigns to promote existing provision and raise awareness of resources which are currently available so that those who need them / are entitled to them are able to access them. As part of this, LBRUT, Schools and Health partners to be encouraged to review their promotion of advice to ensure that there is specific information and advice available for CYP in the formats they find most accessible. The information should include where CYP can go to access support and advice.

119. Whilst increasing the price of tobacco was considered to be an effective deterrent that other deterrents needed to be considered as some CYP obtain tobacco products from home, are lent to them by friends, some barter for it whilst others obtain it from illicit or cheap sources.

Education and School Health Professionals:

Early Years

120. *:* Prior to 2011 the government's national Healthy Schools Programme was in place and came under the Every Child Matters (ECM) Agenda. At that time Healthy Schools was very high on the national education agenda but in recent years, education has increasing

become focused on attainment. LBRuT's Children's Services take a holistic and ECM approach for all its children no matter where they are from and whether they are in a state, independent or voluntary settings.

The *Healthy Schools Programme*[54]

121. involves the whole school community i.e. pupils, parents, governors and school staff. Healthy Schools provides support, training, resources and guidance for all schools. The aim of the Healthy Schools was to deliver real benefits for children and young people, specifically:

- To support CYP in developing healthy behaviours
- To help raise the achievement of CYP
- To help reduce health inequalities
- To help promote social inclusion

122. As part of the Healthy Schools programme, Tobacco Education is provided through structured PSHE lessons. This is carried out across the whole school community and is supported with information, resources and training to aid with the tobacco education which covers the many issues around tobacco and smoking.

123. As Healthy Schools came to a close, LBRuT put a Service Level Agreement in place for it to continue to be provided. LBRuT has commissioned a consultant to provide this. Nevertheless, it is up to schools to decide whether or not to buy the service. All Richmond Schools would be advised to have a non-smoking policy and the local authority has a smoking policy which is used as a model policy for them to follow[55]. Nationally, Local Authority influence on schools is waning. LBRuT, however, is fortunate as its Free Schools are keen to be part of the Richmond family which in turn means that LBRuT has a level of influence they would not normally have.

124. Government research shows that from the age of 3 a child's life is already mapped out: a child from a middle class family will have heard approx 33 m words whereas a child from a more deprived background will have heard 10 m words. Therefore Early Years intervention is a vital component in any effective approach. LBRuT's Lead Inspector for Curriculum and Learning told the task group that with regards to tobacco control and more generally, there needs to be a focus on family and peer influences. Moreover, parent's associations have a role to play in bringing hard to reach families into the discussion. Work is increasingly being done with Youth Services who are looking at lowering the age of engagement from 12 or 13 years old to 9 or 10 years old. The Lead Inspector for Curriculum and Learning stated that in her professional opinion the only way to change the dominant cultural attitude to smoking was for CYP who smoke to be absorbed into a non-smoking culture and the most effective way to do this is to push this message from an early age, again at year 6 and then

[54] Healthy Schools also applies to Academies if they choose to undertake it. More information on is available at: http://www.education.gov.uk/schools/pupilsupport/pastoralcare/a0075278/healthy-schools

[55] The policy is available here: http://rio/hsu0017smokefreepolicy.doc (NB. this is intranet not available on external website).

reinforced at the major transitions[56] stages of a young person's life. The witness said that in their professional opinion, in an Early Years setting the most effective method would be a multi-agency approach starting in children's centres - as is the case with Meadlands and the Ham Children's Centre, and the quindrat work is increasing being integrated with the work done in children's centres - and continually reinforced throughout a young persons' educational career.

Recommendation 19: The feasibility of a family smoking cessation strategy to be investigated.

Primary School[57]:

125. Evidence submitted stated that smoking was not considered to be an issue but that it has a significant impact on some families. For example; where parents smoke it can often be smelt on children's clothes in school suggesting parents are smoking in close proximity to children.

126. Whilst not aware of children who attend who are smokers, it is acknowledge that once pupils have greater freedom when joining secondary school in year 7, the pressure to smoke increases. Anecdotal evidence from witnesses told of a Head Teacher who had seen 14 year old former pupils with cigarettes. In their opinion, many of the children that do smoke are those who are exposed to cigarettes within the home environment.

127. Smoke Free policies in schools' embrace both the school and its grounds. Schools reported that children often asked questions about how they can stop their parents from smoking. All questions were answered honestly and reassuringly and children are encouraged to talk to their parents about their concerns.

128. A number of witnesses felt that all schools should have a clear approach to drugs and alcohol education supported by parents and outside agencies such as the police and the NHS. Schools deliver this through PSHE and science lessons relevant to the pupil's age. In their opinion all of the best work of this nature is done when agencies work together e.g. a planned programme.

129. However, witnesses highlighted a number of challenges for example time pressures on curriculum and teaching and fewer financial resources. The lack of available funding for a PSHE advisor / Healthy Schools Advisor was also cited as a challenge. When asked what the most effective ways to prevent children and young people taking up smoking were, the response was for them to understand the significant health effects and impacts and to work with parents / getting parents to quit. If resources were available, the witnesses would like to see a Local Authority Drug and Alcohol Advisory Teacher provided

Recommendation 20: Health Partners, the RCDAT and Children's Services to explore the

[56] Transitions are taken to mean from primary school to secondary school, from secondary school to 6th form – wherever a major change occurs as opposed to the traditional meaning associated with transitions.

[57] A number of Primary Schools were contacted: Heathfied Juniors, Meadlands and Lowther- a response was only received from Meadlands. Whilst the Tasks Group recognises this view does not necessarily represent the views of ***all*** primary schools we are nonetheless grateful to Meadleands for their response and it provides a point of view.

feasibility of employing a Local Authority Drug & Alcohol Advisory Teacher whose remit includes smoking.

Secondary School[58]*:*

130. Witnesses told the task group that in their opinion smoking is an age habit: many start as teenagers but then give up. Peer pressure is a huge influencing factor on whether a young person smokes and that peer pressure had no regard for socio-economic status. In a number of witnesses' opinion, whilst lifelong smokers tend to be from more deprived backgrounds there are plenty from non-deprived backgrounds who smoke and it is only those who are 'sporty' who do not smoke. Therefore, caution should be exercised when ascribing behaviours to certain socio-economic groups.

131. Witnesses felt that cannabis was more of an issue for the middle-class pupils with some no longer smoking tobacco and only smoking cannabis. Concerns have been expressed about the level of cannabis use as there has been an increase.

132. Witnesses told the task group that in 30 years of teaching, prevention work can be a double edged sword: On the one hand it re-enforces the anti-smoking message for those who do not smoke. Witnesses found that health advice delivered educationally through science is more effective than PHSE and that it is important to encourage sport and recreation as a form of avoidance / prevention strategy as many young people start smoking out of boredom and continue because of it. On the other, it alienates those who smoke. In their opinion it is possible to make a distinction between the 3 types of smokers:

- **Social smoker** – These are transient group who do not smoke other than in social settings (therefore if the setting was non-smoking they would stop / not smoke).
- **Peripheral smoker** – They are smokers but recognise the law and hence do not smoke at or near the school.
- **Hardcore smoker** – Will smoke on school grounds, regardless of the rules which indicates a lack of boundaries.

133. It was suggested to the task group that smoking is linked to dysfunction, self-esteem and low achievement which can in turn lead to drug misuse. The lack of self-esteem and dysfunction leads to low achievement which compounds smoking. At Christ's all the *hardcore smokers* receive a great deal of support to deal with these issues.

134. Smoking is not tolerated at any school within LBRuT. Some schools are conscious of a student's background and use internal exclusion, community service and detention. In these schools governors and parents do not tolerate smoking. Some schools have found that the most effective sanction has proven to be fixed term exclusions and governors and parents are happy with (fixed term) exclusion where warranted.

135. Witnesses stressed that the non-smoking policy should also apply to teaching staff otherwise there is a sense of double standards and resentment if a students sees a

[58] As with Primary Schools a number of secondary schools were contacted these include Christ's School, Hampton Academy and Greycourt School. Not all responded to the request to provide information however we are grateful to Hampton Academy and Christ's Schools who did as this gives a useful insight into Young People's behaviour regarding smoking.

member of staff smoking. Hampton Academy is an example of best practice within the borough as it has, through a major culture shift, managed to bring the number of staff who smoke down to 5 out of 103.

136. Witnesses felt that smoking is not given as high a priority as drugs, alcohol or crime and that this sends mixed messages about smoking. Another challenge for half of the schools in the borough is cross-boarder smoking: a large proportion of students are out of borough residents. Witnesses felt that there needs to be better cross-borough working by schools in this area. Witnesses, in line with previous submissions, felt that the most effective way to tackle the issue is holistically and consistently and reiterated **Recommendation 11**.

137. Witnesses reinforced the point made by other witnesses throughout the review, it is only with the formation of strong consistent relationships that smoking cessation and intervention will work. The UTurn project[59] was referred to.

138. Witnesses also reinforced the view expressed by the RYC and other witnesses - **there should be significant resources invested into Year 6 and Year 7 because <u>all</u> schools have the ability to identify those most likely to smoke by that age group and more targeted work could be done at an earlier stage.** It was suggested that in accordance with the views expressed by the Early Years professional, it would be beneficial to start targeting at primary school level (Year 5) and for the message to be regularly reinforced. Witnesses thought that Early Years could have a role to play in identifying the groups by looking at parenting skills, levels of dysfunction in the family setting and whether or not the parents are known smokers, and then target those groups and raise aspirations and esteem in order to get them to quit. Furthermore, any intervention or programme should be tailor made to each school as each school knows their students best and what measures would work most effectively for them.

School nurses:

139. The task group approached school nurses about their role and whether or not they provided any advice or intervention to young people about smoking cessation. The task group were informed that school nurses are not, at present, specifically commissioned to deliver a stop smoking service, but signpost young people onto the local SSS.

CONCLUSION:

140. Through out the course of the review, the task group has found that on an individual basis a lot of good work is being done with regards to tobacco control, however, the most effective way to deal with this issue is by taking a holistic approach- with all involved working together - the sum *should* be greater than its constituent parts.

141. Whilst we, the task group, found the individual approaches to be good there is room for further development and improvement of the joint-working approach and the approach of

[59] LBRuT's new free pilot to schools for the academic year January 2012 to July 2012, tackling risky behaviour causes and developing protective factors – as a way of effectively educating young people See: http://www.richmond.gov.uk/home/education_and_learning/youth/uturn.htm

the alliance as a whole. Whilst the task group understands the constraints of the current economic climate it is also clear that for many the alliance is not the main focus of their role and as a result some of the focus is lost. We believe that the alliance would benefit from a more strategic, holistic and co-ordinated approach where the focus is not mainly centred in the health aspect of this.

142. The task group would also like to encourage better linked up working between partners be it in the provision of intelligence or in the co-ordination of specific services. Finally, the task group wishes to stress that our observations are not meant as criticisms but hopefully as comments that will help support the ongoing development of tobacco control provision. Where we have made suggestions for a more robust process to be put in place, we hope they are helpful.

SELECTED READING:

- Role of Marketing tobacco on Adolescents: http://cancercontrol.cancer.gov/tcrb/monographs/19/m19_7.pdf
- Passive smoking and children. Royal College of Physicians, London, 2010 (pdf)
- Healthy Lives, Healthy People - a Tobacco Control Plan for England: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf
- Reducing health inequalities through tobacco control - a guide for councils: http://www.idea.gov.uk/idk/aio/25455753
- Ash briefing Tobacco Advertising and Promotion in the UK : http://ash.org.uk/files/documents/ASH_124.pdf
- A Smokefree Future. A comprehensive tobacco control strategy for England. HM Government, 2010.
- Tackling Tobacco Smuggling – building on our success: A renewed strategy for HM Revenue & Customs and the UK Border Agency
- NHS Information Centre's Statistics on Smoking 2011 visit: http://www.ic.nhs.uk/webfiles/publications/003_Health_Lifestyles/Statistics%20on%20Smoking%202011/Statistics_on_Smoking_2011.pdf
- The Marmot Review, 'Fair Society, Healthy Lives' (2010)
- Tackling tobacco Lessons from the Reducing Health Inequalities through Tobacco Control Programme, LGID: http://www.idea.gov.uk/idk/aio/30982561

TABLE OF FINDINGS

Finding Number	Finding
1	Whilst many partners are doing good work individually, the most effective way to deal with tobacco control is holistically.
2	Tobacco Control Alliance is health heavy in its membership.
3	There are a number of core players who attend but there are also many alliance members who do not engage in the meeting or with the alliance.
4	TCA tends to focus mainly on the smoking cessation service and not the other areas of tobacco control – more attention needs to be

	given to the other issues not just the Stop Smoking Service so that it will effect a real change. There should be a more holistic approach with a wider programme than there currently is and be more proactive in looking at local solutions not just legislation
5	It would be beneficial to have Councillors from both boroughs on the TCA as they give a differing local perspective and political clout to the alliance.
6	Children are not really covered in the alliance other than in the substance misuse service and as this is the area tobacco marketing companies are targeting an opportunity is being missed.
7	More resources should be invested into Trading Standards and Environmental health to undertake their work.
8	There is a need for quality of local health data on smoking to be improved.
9	Tobacco control to be a priority in the Joint Strategic Needs Assessment and the new Health and Wellbeing Board.
10	It would be beneficial for Richmond residents and Public Health as a whole if pharmacists are considered to be a public service that has the ability to offer more than it currently does.
11	Given the accessibility of pharmacies it would be beneficial for more campaigns regarding smoking cessation to be held in pharmacies.
12	Pharmacists are very passionate about the issue of tobacco control and the benefits of their access to larger and wider groups within the community.
13	In order to effectively embed the non-smoking message and reduce prevalence there needs to be a cultural shift amongst various groups of young people and their families about de-normalising smoking.
14	There needs to be a consistent, sustainable long term approach to smoking cessation for young people.
15	There does not appear to be sufficient / effective communication tailored particularly for young people about smoking cessation services that exists.
Peer Research Finding 1: The myths about smoking need to be dispelled in the same way myths about sexual health are.	
Peer Research Finding 2: Young people only concern themselves with short term impacts. In light of this, smoking cessation should be promoted as the beginning of the journey rather than the end ('Quitting').	

TABLE OF RECOMMENDATIONS:

Recommendation Number	Recommendation
1	Two elected members (in order to ensure political balance) to be nominated with agreement of either the council or by leaders of

	both political parties to join Kingston and Richmond Tobacco Control Alliance.
2	Greater presence by existing LBRuT and non health partners at the Tobacco Control Alliance meetings.
3	An officer from LBRuT Youth Service be nominated to sit on and attend the Kingston and Richmond Tobacco Control Alliance.
4	Accountability of the Tobacco Control Alliance to be strengthened by clear reporting lines to the LSP or the *appropriate body*'
5	Safer Neighbourhoods Team and the Police to work more closely / form a strong working relationship with Trading Standards in supplying intelligence regarding tobacco related issues such as under age sales
6	Feasibility of increased resources to be looked at in order for: • Trading Standards to undertake more 'test purchasing' for underage and proxy sales; • more visits/inspections of cigarette sellers; • more trader education/training regarding underage and proxy sales; and project work to be undertaken on Shisha pipes particularly lack of frequent changing of water in the pipes from a health promotion perspective.
7	The Fire Service to look into the provision of smoking cessation intervention training for its staff
8	Public Health and the Fire Service to explore more collaborative / 'linked-up' working in relation to tobacco control
9	LBRuT and Health Partners to explore the viability of training dentists and optometrists to identify smokers and the relevant referral pathway.
10	Tobacco control to be considered as a priority in the Joint Strategic Needs Assessment, the Health and Wellbeing Strategy, the Corporate Plan and for the new Health and Wellbeing Board and for the Richmond upon Thames Partnership.
11	In the course of its duties the HWWB to investigate how the second-hand smoke agenda is given greater attention and publicity than it currently receives.
12	The feasibility of a holistic Future Generation Programme which targets children and young people from families where one or both parents smoke. The programme should be a holistic family programme which includes older generations so that they can positively influence young people not to smoke. This programme can be part of a wider programme to tackle Risky Behaviours but should be given equal importance and resources to all other risky behaviours if included.
13	Public Health and Youth Services in conjunction with LBRuT's Children and Young people to explore alternative way for CYP to reduce stress via improved sign-posting, provision and marketing

	drive of recreational activities to ensure more CYP are involved in them.
13a	The feasibility of smoke-free parks or areas within parks where there are recreational facilities for children and young people to be looked into and consulted upon.
14	Closer working relationships to be built between Schools and LBRuT Youth Workers to enable the better delivery of consistent information to students on a range of issues including smoking and sexual health.
15	The feasibility of smoking cessation advice and support services specifically designed for young people to be looked into. Any development should ensure advice is easy to obtain, is non-judgmental and includes access to counseling for young people who smoke cannabis.
16	The feasibility of either: • training youth workers in smoking cessation; or • training dedicated smoking cessation workers for young people including counselling and advice in relation to cannabis use should be explored.
17	The feasibility of training young people to provide peer to peer education programmes within their schools i.e. School Councils to be looked into and where possible rolled out.
18	More effective campaigns to promote existing provision and raise awareness of resources which are currently available so that those who need them / are entitled to them are able to access them. As part of this, LBRUT, Schools and Health partners to review their promotion of advice to ensure that there is specific information and advice available for CYP in the formats they find most accessible. The information should include where CYP can go to access support and advice.
19	The feasibility of a family smoking cessation strategy to be looked into and drawn up if practicable.
20	Health Partners, the RCDAT and Children's Services to explore the feasibility of employing a Local Authority Drug & Alcohol Advisory Teacher which includes smoking.