



| | |
|----------|---|
| Subject: | Consultation on the future of tobacco control |
| Author: | Rosalind Watson Co-ordinator, Smokefree Lincs Alliance |

RECOMMENDATION

To submit the following as the formal response of Smokefree Lincs Alliance to the consultation exercise.

Signature: Date: 8th September 2008

**Mr Mike Harrison, FCIEH,
Chairman, Smokefree Lincs Alliance**

Tobacco Consultation
Department of Health
Room 712, Wellington House
135 – 155 Waterloo Road
London SE1 8UG

Response from Smokefree Lincs Alliance – Future of tobacco control

Introduction

The Smokefree Lincolnshire Alliance is a multi-agency group that has been established since 1995. Some of the many key partners include; Lincolnshire Primary Care Trust, The seven District Councils and the County Council, Lincolnshire Fire Service, the Prison Service, Phoenix stop smoking service and other smoking related organisations and charities. We press for concerted action on a broad range of health, economic and social costs arising from tobacco use.

The Alliance broadly welcomes and supports the Government's consultation on the future of tobacco control and the commitment to a new national tobacco control strategy. For this to be successful, the Alliance is urging the government to ensure that the new national strategy;

- ❑ Has the scope and ambition needed to tackle the full range of harm caused by tobacco.
- ❑ Is funded sufficiently to succeed.
- ❑ Is monitored, evaluated and updated regularly.
- ❑ Enlists help from across civil society.

Smoking is still the major preventable cause of death and disease and inequalities in health, killing nearly 90,000 people in England each year. Two thirds of smokers start before reaching 18. There is wide popular support for action to;

- ❑ Protect young people from smoking and secondhand smoke.
- ❑ Reduce the inequalities in tobacco-related death and disease, a burden that weighs heaviest on the most disadvantaged in society who smoke most.
- ❑ Give greater help to those smokers who want to quit.
- ❑ Find ways of helping those smokers who cannot quit.

The Alliance also believes that a comprehensive, adequately funded tobacco control strategy is needed which is properly monitored, evaluated and regularly updated and which makes appropriate links with international tobacco control measures at EU and WHO level.

The Alliance supports further action to reduce smoking rates and health inequalities caused by smoking. High tobacco prices due to taxation are the single most effective intervention to prevent smoking. Unfortunately this is undermined by access to cheap, smuggled tobacco, which also exacerbates

health inequalities as its use is concentrated among poorer smokers. An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled by criminal gangs. Further action must include signing up to a strong WHO FCTC illicit trade protocol and the existing EU anti-smuggling Agreements.

The Alliance believes that protecting children and young people from smoking and secondhand smoke is paramount. Children need protection from tobacco marketing through concerted government effort including taking tobacco out of sight at point of sale, prohibiting tobacco sales from vending machines, removing all brand descriptors and misleading information on tar and nicotine yields, tackling visibility of smoking in the media and sustained social marketing campaigns to prevent uptake and encourage quitting.

The Alliance stresses the importance of the strategy further supporting smokers to quit. Smokers who want to quit need the Government to increase support for NHS stop smoking services, making them more widely available and easy to access particularly for disadvantaged and pregnant smokers. Smokers already suffering the harmful effects of smoking need effective stop smoking services in hospitals. Also needed is free nicotine replacement therapy and other stop smoking medications for all smokers. Better training support is needed for stop smoking counsellors (Advisors) and training is needed for all healthcare professionals and community workers in the importance of referring smokers to stop smoking services.

The Alliance also stresses the importance of helping those who cannot quit. The Government should support the development of pure nicotine products (which like the current medicinal products on the market contain only nicotine and not any other tobacco products) which will be attractive to heavily addicted smokers by relieving their cravings without the harmful effects of smoking. These new, more efficient medicinal quality nicotine products need to be promoted as a safer alternative to tobacco and be available wherever tobacco is sold.

Smokefree Lincs Alliance
8th September 2008

Part A: Reducing smoking rates and health inequalities caused by smoking

Question 1: What smoking prevalence rates for all groups (children, pregnant women, routine and manual workers and all adults) could we aspire to reach in England by 2015, 2020, and 2030, and on what basis do you make these suggestions? What else should the Government and public services do to deliver these rates?

A comprehensive adequately funded tobacco control strategy is needed which is properly monitored, evaluated and regularly updated and which makes appropriate links with international tobacco control measures at EU and WHO level. This should include ambitious new targets to reduce smoking prevalence by 2015 to 17% in the general population and 21% amongst routine and manual workers. These targets are significantly challenging considering the incoming of

ethnic populations into areas of Lincolnshire where smoking prevalence is much higher than our own. Eroding the differential in smoking between the classes will be slow but achievable in the longer-term. By 2020 it should be possible to reduce smoking prevalence to around 1 in 20 in the general population, and around 1 in 10 in routine and manual groups. It is too soon to set targets for 2030 but by then smoking should be uncommon right across the classes.

Given that smoking uptake amongst children (11-15 year olds) is concentrated amongst 14 and 15 year olds we would suggest setting targets for these specific age groups for 2015 of 5% for 14 year olds and 10% for 15 year olds (compared to 9% and 15% in 2007 respectively). This would give a smoking prevalence rate amongst 11-15 year olds of 4% by 2015, compared to 6% in 2007. In order to achieve these targets government need to encourage PCT's to develop specific young people services. Services should look broader than simply quitting smoking looking at the whole lifestyle of the child, incorporating links to sport and healthy lifestyle projects should be encouraged.

With regard pregnant smokers we should focus on relapse prevention as a target it is our ambition to influence a change from 'market & target' to prevalence, stopping them starting means you don't have to deal with them again and again.

It is crucial that PCTs and local authorities are required to set appropriate local targets for smoking prevalence reductions and that these targets are adopted by Local Strategic Partnerships. The DH must ensure that monitoring of smoking prevalence at PCT and local authority level is carried out consistently and comprehensively to enable PCTs and local authorities to measure their effectiveness in meeting their targets.

Question 2: What more do you think could be done to reduce inequalities caused by tobacco use?

High tobacco prices due to taxation are the single most effective intervention to prevent smoking. Unfortunately this is undermined by access to cheap, smuggled tobacco, which also exacerbates health inequalities as its use is concentrated among poorer smokers. [See answer to Q4]. This is confirmed by local opinion for when asked Lincolnshire residents suggested that "There should be more publicity in community areas, that target hard to reach places, because these places are where the majority of tobacco is smoked and smuggled" also "They should target the poor who can't afford to buy cigarettes from shops."

Nationally there must be an adequate level of sustained investment for tackling smuggling and counterfeit tobacco with the commitment of HMRC and the Police to prioritise this locally through their local service plans, committing to working collectively with partners in Trading Standards and local Tobacco Alliances.

Poorer, more disadvantaged smokers also tend to be more heavily addicted and need greater support to quit successfully. The introduction of a harm reduction strategy would be particularly helpful to poorer smokers who are unable to quit but are willing to cut down to stop and would encourage them to engage with local cessation services. [See answers to Q's 13-17] more research is also needed to determine that 'cut down to stop', harm reduction strategies actually work.

Social marketing campaigns targeted more effectively at poorer smokers could also help reduce health inequalities.

Question 3: Do you think the six-strand strategy should continue to form the basis of the Government's approach to tobacco control into the future? Are there other areas that you believe should be added?

Yes. There is good evidence that each of the six strands of tobacco control is effective in reducing smoking rates. The United Kingdom has achieved a great deal, particularly with respect to: helping people who want to quit, banning tobacco advertising and promotion, and reducing exposure to secondhand smoke. However, more could be achieved by: greater investment in sustained mass media education campaigns and investment in social marketing of the stop smoking services; by further reducing tobacco industry promotional opportunities; by greater regulation of tobacco products and by reducing the availability and supply of tobacco products.

In addition, a harm reduction strategy would help those smokers who are either reluctant to quit or find it particularly hard to do so, and would help reduce health inequalities. [See answer to Q17.] There needs to be a shift on emphasis from targets to quality with more support being offered to heavily dependant smokers. Increasing the amount of support offered from 6 contacts to 12 contacts.

Question 4: How can collaboration between agencies be enhanced to contribute to the inland enforcement against illicit tobacco?

An improved strategy to tackle smuggling at national, regional and local level is needed to stop the flow of tobacco smuggled by criminal gangs, with new tougher targets for a continued reduction in the market share of smuggled cigarettes and hand-rolled tobacco. The new Borders Agency must work closely with HMRC and the Treasury to develop a new and improved anti-smuggling strategy and ensure that cracking down on smuggling remains a priority for the Government. [See answer to Q2.]

The UK Government should also lobby for, and sign up to, a strong illicit trade protocol as part of the international treaty on tobacco – the Framework Convention on Tobacco Control. The UK should also sign the EU anti-smuggling agreements, in line with all other EU Member States.

Question 5: What more can the Government do to increase understanding about the wider risks to our communities from smuggled tobacco products?

There should be more investment in mass media campaigns to encourage the public to report illegal tobacco sales and to show how the availability of cheap smuggled tobacco undermines other tobacco control measures. There should also be greater transparency of information about the scale of smuggling to allow civil society to monitor the anti-smuggling strategy and lobby for change where necessary.

During the consultation period, Lincolnshire undertook a public survey where we asked specific questions to gauge the public's knowledge of the UK market on smuggled and counterfeit tobacco. Unsurprisingly 59% of the surveys completed knew that the smuggled UK market was 16%, however what was concerning was that only 28% of the same returns knew that the Counterfeit UK market was above 50%, with 63% of the public thinking it was below 30% and 9% admitting to not being sure.

When asked to comment on what the government could do to raise awareness of risks to the community from counterfeit and smuggled tobacco one respondent said - "I don't feel smuggled tobacco is a threat to the community".

The government need to ensure that the public understand the difference between smuggled and counterfeit and also dispel some of the myths around it simply being a 'Robin Hood Crime'. As with all previous successful tobacco control messages we need to get the public on-side to help us tackle the problem. The same survey recorded that 82% of the public think the government should reduce the availability of counterfeit and smuggled tobacco products. Other suggestions made by the public to raise awareness of the trade were to undertake media campaigns in particular TV advertising showing how counterfeit affects the body compared with regulated tobacco, contents of counterfeit products, criminal involvement and case studies. Also targeted work in illicit trade hotspots ie areas of deprivation and specific education in schools.

Part B: Protecting children and young people from smoking

Question 6: What more do you think the Government could do to:

- a. reduce demand for tobacco products among young people?**
- b. reduce the availability of tobacco products to young people?**

There is wide support for measures to reduce youth smoking but there is little evidence to show that measures targeted specifically at young people have much benefit. Indeed, youth smoking prevention campaigns (particularly those initiated by the tobacco industry) can be counter-productive. Strengthening young persons ability to make healthier lifestyle choices in general through the PHSE programme will have more impact not just on tobacco consumption but on other unhealthy choices made by young people.

- a) There is good evidence to show that a comprehensive tobacco control strategy aimed at the whole population is the best way to reduce demand for tobacco products among young people. In addition to the 'six strands', there is widespread and growing support for measures to reduce tobacco marketing such as removing tobacco from view at the point of sale and plain packaging [see answers to Q's 7,8,10]. Sixty three percent of young smokers questioned in Lincolnshire reported buying cigarettes on impulse opposed to only 14% of the adult smokers questioned.

When asked the above questions our survey recorded the following results:

- 74% said the government should increase restrictions on secondhand smoke in homes and vehicles.
- 84% think the government should increase education on smoking in schools and other youth environments.

- 82% asked for the removal of tobacco displays in retail environments.
 - 50% supported plain packaging on all tobacco products.
 - 84% asked for increased restrictions on advertising/promotion of tobacco accessories.
 - 86% suggested restricting access/removing vending machines.
- b) Banning sales of tobacco from vending machines is long overdue our survey recorded 38% of under 18's purchasing their tobacco from vending machines opposed to 11% of adults. This was matched with 38% accessing their cigarettes through family/friends. Increasing tobacco price through taxation and stronger measures to curb smuggling will reduce the availability of tobacco products to young people [see answers to Q9). In addition 33% of respondents to our survey reported buying the brand of tobacco they do because of the price.

It is important for the government to tighten up those areas that operate below the normal radar, licensing the sale of tobacco should be reintroduced with a penalty for anyone who sells tobacco illegally to have their licence removed. This would not just strengthen control of underage sales but would also help retailers by enabling unlicensed sales of tobacco to be tackled more effectively (for example in street markets, car boot sales or from private residences).

Question 7: Do you believe that there should be restrictions on the advertising and promotion of tobacco accessories, such as cigarette papers

Yes. The advertising of tobacco accessories such as cigarette papers matches and lighters can act as a prompt and reminder about smoking. Restricting the advertising and sale may also contribute to the work of Fire and Rescue Services across the country in reducing anti social behaviour associated with fire and also a reduction in the incidents of recorded arson. There may also be another knock on effects in the reduction of the number and type of injuries attributed to fire play and the lack of awareness of the dangers of fire. In recent years there has been a rise in the proportion of smokers using hand-rolled tobacco: from 12% in 1996 to 22% in 2006. It is noteworthy that when the Tobacco Advertising and Promotion Act was implemented Imperial Tobacco chose to place advertisements for Rizla cigarette-rolling papers at the point of sale since they did not require health warnings. Imperial has also used the Rizla brand to sponsor motor racing, thereby maintaining a link between sport and smoking, despite UK and European law which has outlawed tobacco sponsorship of sport.

Question 8: Do you believe that there should be further controls on the display of tobacco products in retail environments? If so, what is your preferred option? We are particularly interested in hearing from small retailers and in receiving information on the potential cost impact of further restrictions on display. What impact would further controls on the display of tobacco have on your business, and what might the cost be of implementing such changes?

Option 3: Require retailers to remove tobacco products from display.

There is strong evidence to show that tobacco advertising and promotion encourages children to smoke and this evidence underpinned the UK law which banned most forms of tobacco advertising. Tobacco packaging is now the principal means by which tobacco companies promote their brands and point of sale displays are a form of tobacco advertising. Removing tobacco products from public view will not affect adult smokers' ability to buy them but it will remove the temptation of children to try to purchase them. It is noteworthy that in Iceland, where point of sale displays were made unlawful in 2001, the proportion of 16 and 17 year olds who reported that they had ever smoked fell from 61% in 1995 to 46% in 2003.

A ban on the display of tobacco products also removes the temptation for adults who are trying to quit to make an impulse purchase.

There has been considerable speculation in the retail trade press about the cost to the retail trade of this measure. However, evidence from Canada shows that the tobacco industry paid for cigarette displays and, once they were banned, the companies continued to pay retailers for the tobacco storage units. The tobacco industry has the means and resources to assist tobacco retailers in managing similar changes in the UK. Moreover, we believe that the tobacco industry should be required to disclose to the Government the amount of money it spends on marketing its products, as is the case in Canada.

Question 9: Do you believe that there should be further controls on the sale of tobacco from vending machines to restrict access by young people? If so, what is your preferred option?

Option 3: A total ban on the sale of tobacco products from vending machines.

Although vending machines account for a small proportion of overall cigarette sales, a disproportionate number of young people under the legal minimum age for the sale of tobacco obtain cigarettes from this source. This is because the machines are not properly supervised and children can access them relatively easily. [see answers to Q6b].

In Lincolnshire during the last financial year 07/08, Trading Standards carried out revisits at premises which had previously sold tobacco to underage children by way of a vending machine. Subsequently, three of them sold again. Since the previous sales, the following actions had been taken at the premises concerned:

- 1) Public House - this premise had put in a token system, which meant that the underage volunteers had to physically go up to the bar and request a token to activate the machine. Our volunteers simply walked up the bar, spoke to a lady working there who then handed them a token. No questions were asked of their age. They were then able to go over to the machine, buy the cigarettes and walk out of the pub, unchallenged.
- 2) Bowling Alley - this premise had moved the vending machine away from general public use and put it behind the counter. The underage volunteers had to ask for the cigarettes. The assistant took the money off our

volunteers and dispensed the cigarettes to give to them. Again, no questions were asked of their age.

- 3) Public House - this third premise had done nothing at all since the previous sale.

Banning the sale of tobacco products from vending machines would make it harder for children to purchase cigarettes. Many countries already prohibit the sale of tobacco from vending machines (or have never allowed it) and a total ban on tobacco sales from vending machines has been recommended by the World Health Organisation.

Question 10: Do you believe that plain packaging of tobacco products has merit as an initiative to reduce smoking uptake by young people?

Yes. Although no jurisdiction has yet implemented a law requiring plain packaging, research suggests that it would help deter young people from taking up smoking because smoking would lose its appeal.

There is evidence from around the world to show that the tobacco industry uses branding in general and pack design in particular to:

- Target young people
- Maximise display space (some members of brand families are virtually indistinguishable on taste alone yet the number of variants has increased dramatically in recent years).
- Communicate misleading messages (it would be illegal for manufacturers to claim products were "low tar" "light" or less harmful yet all these are communicated by the colour of sub-brand packaging). The results of our survey prove that pack colour and design still influence our smokers with 14% stating that they buy a particular brand because it is identified as low tar or light.

Tobacco companies invest considerable resources in making tobacco packaging alluring and eye-catching, as this is now one of the few methods currently available to the industry to market its products to new and existing smokers. We would also urge the government to consider expanding any packaging restriction to include different shape, forms of packaging and different opening styles of packs as there are already reports of packs appearing on shelves with sliding openings and spring loaded pop-ups.

To avoid infiltration of the market by counterfeiters the tobacco industry need to expand their current work with government departments to ensure that there is a sophisticated bar code and chip system in place, with readers available to all border controls officials and as important trading standard officials.

Question 11: Do you believe that increasing the minimum size of cigarette packs has merit as an initiative to reduce smoking uptake by young people?

Currently there is insufficient evidence to show whether a requirement for minimum pack sizes would have a significant impact on youth smoking. On one

hand it may be reasonable to assume that packets containing ten cigarettes may appeal to younger smokers as the cost is cheaper, however, adult smokers may use packets of ten cigarettes as part of their quit process. Our survey showed that there was an equal proportion 42%, of young people that purchased packs of 10s as 20s, so we would advocate that further research be carried out.

Question 12: Do you believe that more should be done by the Government to reduce exposure to secondhand smoke within private dwellings or in vehicles used primarily for private purposes? If so, what do you think could be done? Where possible, please provide reference to any relevant information or evidence to accompany your response.

Yes, more could be done by both Government and individuals to reduce children's exposure to secondhand smoke. For example, the Government should

- Run further mass media campaigns targeted at parents/carers about the health effects of secondhand smoke, particularly in enclosed places such as the home and motor vehicles.
- Commission research into effective ways of helping parents to stop smoking and to prevent children's exposure to smoke if parents can not stop smoking. (This links to the harm reduction approach outlined in question 17.)
- Ensure that the stop smoking services are adequately funded and continue to be targeted towards disadvantaged smokers and other groups such as parents.
- Consider extending the smokefree regulations to cover private cars.
- Ensure that Smoke Free Homes programmes are promoted and supported with sustained funding.

Lincolnshire has successfully run a Smoke Free homes project since 2004, targeting areas of highest deprivation and in particular Sure Start families. The evidence of the health benefits to the children growing up in a smokefree home are well documented, but local evidence gathered showed a significant decrease in the number of children under 5 admitted into hospital for lower respiratory conditions in the areas that our project targeted compared to the rest of Lincolnshire, where numbers were continuing to rise.

Part C: Supporting smokers to quit

Question 13: What do you believe the Government's priorities for research into smoking should be?

In addition to those already identified earlier in this response we would recommend the following:

- Research to further understand and overcome the barriers to using medicinal nicotine or other pharmacotherapies
- Research to improve the identification, referral and retention in treatment of pregnant smokers

- Studies to examine the impact of interventions and policies on different social groups.
- The use of tobacco amongst ethnic minority groups
- The impact on smokers and on society of contraband tobacco products.
- Motivation factors for young people, why some smoke and others don't.
- Studies to examine the efficacy of different prevention and cessation approaches including mass media interventions on young people.

Question 14: What can be done to provide more effective NHS Stop Smoking Services for:

- **smokers who try to quit but do not access NHS support?**
- **routine and manual workers, young people and pregnant women – all groups that require tailored quitting support in appropriate settings?**

Protection of NHS stop smoking services:

Stop smoking services are a highly effective, cost effective addition to the NHS and measures need to be taken to ensure these services are protected and sustained, particularly as there is likely to be a growth in competitive commercial sector services over the next 5 years.

Both Darzi and Wanless recommend that strong stop smoking services are essential, and that to achieve the necessary health improvements required nationally to sustain the NHS, we must "industrialize" the scale of existing services currently offered.

NHS based stop smoking services must remain at the heart of any future developments, in order to oversee and maintain the quality of service provision, ensure consistency and expertise in the long term.

- Introduce measures / national strategies that protect and sustain existing NHS stop smoking services over the next 5-10 years.
- Encourage "industrialization" of stop smoking services as recommended by Wanless and Darzi, whilst maintaining a hub & spoke structure (NST recommendations, 2008), with Specialist services maintaining responsibility for training, delivery of intensive treatment services, and monitoring.
- Facilitate growth of stop smoking services in commercial sector (eg national supermarket and Pharmacy chains) through, for example, establishing national service level agreement tariffs for Pharmacy. Take measures to encourage the set up of commercial stop smoking services as part of existing NHS structures rather than as "competitive services" parallel to NHS services.
- Standardise professional training requirements for individuals wanting to work in the stop smoking profession. Introduce professional registration in order to "professionalize" and increase status of stop smoking specialists (equivalent to Specialist nurses, dieticians etc).
- Introduce national training for Service Managers and commissioners of stop smoking services.

Stop Smoking targets: Recommendations

- Replace 4-week quitter target with NICE recommended PCT target of 5% (or greater) of all smokers supported through specialist services.

- Set quality indicator targets for service delivery around CO validation rates, 52 week quit rates, and to reach groups requiring specific, tailored and more intensive approaches. In addition they provide professional expertise and training, and strategic leadership on smoking within PCTs.

The Commissioning / Provider split within PCTs potentially places many current NHS stop smoking services at risk in the short to long-term, as they become distanced from specialist Public Health expertise and Service Managers become more distanced from the decision making process.

With the potential loss in specific expertise in tobacco control and smoking cessation there is a strong risk that much of the excellent work developed over the past 8 years could be lost. Based on a simplistic assessment of cost per quitter comparisons for example, over zealous commissioners may place NHS stop smoking services in direct competition with potential mass market providers such as Tesco or Lloyds Pharmacy, viewing stop smoking services simply as front-line services rather than as more holistic services providing development and public health expertise also.

Whilst the commercial sector has much to offer in maximising the number of smokers the NHS can reach, this must not be at the expense of existing PCT services, but rather as an addition to them (hub and spoke model). Whilst large commercial providers could offer good value for money services and increasing the range of services available, they are unlikely to deliver true "Specialist" services, and will fundamentally be motivated by volume and NRT sales (in the Pharmacy sector).

- This can perhaps be addressed by reducing the high volume targets set for PCT stop smoking services. This will allow existing services to focus on the most addicted patients, specific targets for support of Routine & Manual workers and pregnant smokers.

High volume stop smoking targets for PCTs have achieved their aim in establishing largely successful services nationwide over the past 8 years, but could now be used in a more sophisticated manner to protect services and generally improve quality of services.

Existing stop smoking services not only provide front line services, but are leading the way in developing new and innovative approaches to managing nicotine addiction and reaching those at greatest health risk, those not being served by other services (ethnic minorities, prisoners, socially excluded etc). Commercial providers can then be commissioned to provide the high volume, less intensive treatments required by the majority of smokers.

Current "high volume" targets do little to encourage PCT commissioners to protect existing services and act as a driver for low quality, high volume activity. We need to introduce quality based targets to protect specialist services (as these are the only providers likely to be able to achieve these) in addition to maintaining (or slowly increasing) the number of patients supported. NICE Recommends a minimum of 5% of all smokers being seen by services meeting national minimum standards and this could be increased over time as services are "industrialized"

Targeting hard to reach groups (rural counties)

Whilst It is important that spearhead PCTs receive extra funding to address high smoking prevalence rates in high deprivation areas, this should not be at the exclusion of other localities. For example stop smoking services based in geographically large rural county PCTs (Leicestershire, Lincolnshire, Derbyshire etc) have the challenging task of delivering population level services to very thinly dispersed communities and face high travel costs, and need to establish perhaps 2-3 times the number of stop smoking clinics to meet the same support the same number of people as an inner city PCT. No account is taken in terms of PCT targets for such challenges, and therefore many rural services are effectively penalised and struggle to meet unrealistic targets.

Rural deprivation and isolation is also a serious public health problem and efforts could be made to recognise and support services working with these communities.

GP's should be encouraged not to prescribe without behavioural support as evidence demonstrates poor outcomes.

Question 15: How can communication and referral be improved between nationally provided quit support (such as the website and helplines) and local services?

Clearly much more needs to be done to make the services attractive to people who want to stop smoking. This could be achieved by improving the selection, training, assessment and supervision of specialists; the implementation of treatment protocols, and high quality administrative support for services.

Mass media health campaigns should be complemented by community-based initiatives to promote local services.

National quit line support should strongly emphasise the better outcomes seen when smoker accesses local stop smoking services.

Question 16: How else can we support smoking cessation, particularly among high-prevalence or hard-to-reach groups?

All health professionals should be trained to offer opportunistic stop smoking advice and referral to the stop smoking services, particularly to disadvantaged smokers who are likely to be in most need of help and ongoing support.

Smoking cessation should be included as part of the medical training for all healthcare professionals.

There should be more outreach with services being set up in places where people are likely to see them, such as in workplaces, shopping centres and schools.

Better use could be made of existing social networks including faith groups to reduce smoking prevalence.

The NHS smoking quitline should appear on all tobacco packaging.

Part D: Helping those who cannot quit

Question 17: Do you support a harm reduction approach and if so can you suggest how it should be developed and implemented?

Yes. People are free to smoke but it is important to find ways of reducing the harm caused by smoking whilst allowing people to use nicotine in a way that will not endanger their health. Nicotine is relatively safe but little has been done to promote longer term use of nicotine replacement therapy as an alternative to smoking for those who are unable to quit. Although the Medicines and Healthcare Regulatory Agency (MRHA) has taken steps to increase the accessibility of NRT much more needs to be done.

The Government should take a lead in encouraging the development and promotion of pure nicotine products (which like the current medicinal products on the market only contain nicotine and not any other tobacco products) as an alternative to smoking. This should include educational campaigns to raise awareness of the relative safety of nicotine, as currently a significant proportion of smokers and health professionals believe that nicotine can cause smoking-related diseases such as cancer. Such an approach will be particularly attractive to more deprived smokers who tend to be more heavily addicted to nicotine and so find it harder to quit, thereby helping to reduce health inequalities. We would however add a caution that although extended use of nicotine for heavily addicted smokers may be one way to support long term cessation and relatively safe, there is a need to recognise that some categories of smoker need to avoid prolonged use of nicotine ie pregnant smokers and those with Buerger's disease, so alternatives methods of harm reduction will be necessary to support these groups.