SmokeFree London
Lambeth

Lambeth NHS
Primary Care Trust

Consultation Response: The National Tobacco Control Strategy

1. Tobacco Control in the London Borough of Lambeth

The Lambeth Tobacco Alliance (SmokeFree London Lambeth) represents a partnership of organisations committed to reducing smoking prevalence in Lambeth and addressing health inequalities. Established since 2006, the partnership has assisted in the work of driving the Lambeth Tobacco Control Strategy forward through ownership, commitment, advocacy, networking, dissemination, monitoring and dedication. The Health and Wellbeing Partnership (a sub committee of the Local Strategic Partnership) are the overall champions for Smoking Prevalence in Lambeth and have pledged their strategic support to the work of the alliance.

The alliance also functions to:

1. Agree actions to improve the health of Lambeth residents through a comprehensive approach.

2. Review actions taken to address the impact of tobacco use on the health and economy of Lambeth residents

3. Provide tobacco control advice & expertise to the Health and Wellbeing (HSCP), the Local Strategic Partnership (LSP) and other agencies in the borough.

4. Commit to embracing best practice and evidence base for the purpose of reducing smoking prevalence in Lambeth.

A Lambeth Tobacco Control Strategy was first developed in 2006 covering a three year period, 2006 to 2009. This was achieved through the partnership efforts of the Lambeth Tobacco Alliance. The overall aim of the strategy was/is to contribute to a reduction in health inequalities in Lambeth through a measured and strategic response as demonstrated through its action plans. Smoking prevalence in Lambeth is currently estimated to stand at 28.1% (HSE, 2003-2005).

The Tobacco Control Action Plans contained within the strategy document are refreshed annually in response to national and local priorities.
Six priority areas have been identified for 2008/09, based on national and local priorities:

- Minimising harm from second hand smoke, by making enclosed public spaces smoke free.
- Encouraging abstinence through the provision of local stop smoking services.
- Preventing young people from taking up smoking
    - Enforcing existing tobacco control laws
- Media Campaigns
- Data Quality & Validation

1a. Our Positional Statement

The Lambeth Tobacco Alliance welcomes the government's consultation on a new tobacco strategy. Steady progress has been made by the UK government since 1998 in tackling Tobacco. Ten years on from the white paper *Smoking Kills,* this consultation represents as a fitting opportunity to really hone in on the inequalities that persisted in this area over the years despite consistent efforts.
The Lambeth Tobacco Alliance believe that increased investment, strategies to stop young people from starting and increased support for disadvantaged smokers need to be at the core of the National Tobacco Strategy.

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on behalf of the Lambeth Tobacco Alliance

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2. Responses to the questions listed in the document

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?
Moreover, what else should the government and public services do to deliver these rates?

We congratulate the government on its commitment to developing a new national tobacco control strategy. On the basis of a comprehensive new strategy, which is monitored, evaluated and regularly updated and includes a harm reduction approach, ambitious new targets should be achievable. The aim should be to reduce smoking prevalence rates for England by 2015 to 11% for the general population and 17% amongst routine and manual workers. Such stringent targets are supported by the significant decline in smoking prevalence in England following implementation of smokefree legislation, [1] recent rates of decline in the proportion of children smoking in England [2] and evidence of rates of decline achieved over a number of years in other jurisdictions with comprehensive tobacco control strategies [3] (e.g. Canada, Norway and California). Progress should be reviewed in 2012 to determine whether any revision of the tobacco control strategy is required in order to achieve these targets and again in 2015 to set new targets for 2020 and 2025.

Eroding the differential in smoking between the socio economic groups 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

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[1] Smoking ban triggered the biggest fall in smoking ever seen in England. Cancer Research UK press release, 30 June 2008. Research presented by Prof Robert West at the UK National Smoking Cessation Conference (30 June-1 July 2008).

[2] Drug use, smoking and drinking among young people in England in 2007. The Information Centre for Health and Social Care, 2008

[3] Health Canada. Long-term trends in the prevalence of current smokers. http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/_ctums-esutc_prevalence/chart_image_2005-eng.php
http://www.hc-sc.gc.ca/hl-vs/tobac-tabac/research-recherche/stat/index-eng.php
Statistics Norway: Smoking prevalence and social surveys http://www.ssb.no/royk_en/main.html
CDC Behavioural Risk Factor Surveillance System http://www.cdc.gov/brfss/

and manual groups. It is too soon to set targets for 2030 but by then smoking should be uncommon right across the socio economic groups.

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.

A partnership approach needs to be taken at a local level embracing such targets. Local Tobacco Alliances (including PCT's and local government) accountable to Local Strategic Partnerships should be the fore runners of this. The Department of Health must ensure that the 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.

Targets should also be set for exposure to secondhand smoke, by asking smokers whether they smoke in the home or in private vehicles backed up by measurement of cotinine levels amongst both children and adults.

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

High tobacco prices due to sustained increases in taxation are the best way of reducing smoking. However this is undermined by smuggled tobacco, mainly bought by poorer smokers.[4] Tougher action is needed to stop smuggling [see answers to Qs 4 & 5 below.]

Disadvantaged smokers also tend to be more heavily addicted [5] and need greater support to quit successfully. The introduction of a harm reduction strategy including

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[4] A YouGov poll commissioned by ASH found that 1 in 5 poorer smokers buy smuggled tobacco compared to only 1 in 20 of the most affluent smokers. (Fieldwork undertaken 20-25 Feb 2008. Total sample size was 3,329 adults, weighted to represent all GB adults aged 18+.)

[5] Jarvis, M. and Wardle J. Social patterning of health behaviours: the case of cigarette smoking. In: Marmot, M and Wilkinson, R.(eds) Social Determinants of Health (2nd ed). Oxford, OUP, 2005.

[15] *Department of Health (2007) Reducing* ***smoking pre-conception, during pregnancy and postpartum***

dedicated financial resources would be particularly helpful to poorer smokers who are unable to quit. [See answers to questions 13-17]
Women who smoke during pregnancy are likely to be young and or disadvantaged [15] Based on the findings from a local Antenatal Cessation Care Pathway Review, *it was* noted that despite offering support to support to pregnant smoker's uptake was low due to barriers perpetrated by both health care professionals and service users. This is a sensitive area for all parties involved and would benefit from government assistance through Public Education, Media Campaigns, a Review of Best practice treatment models for pregnant smokers and best practice training guidelines for supporting pregnant smokers and partners to quit.

It is crucial that the smoking status in women is identified before, during and after pregnancy with relevant support at all three stages [15]. Equally an Opt out referral systems to Stop Smoking Services should be adopted for pregnant smokers.

Social marketing campaigns targeting poorer smokers from BME, Routine and manual groups pregnant women 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 [para 2.23] 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.]

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.

We support the proposals as set out in paragraphs 2.38 – 2.39. However, 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.

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?

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’ identified above, 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 questions 7,8,10]

b) Banning sales of tobacco from vending machines, increasing price through taxation and stronger measures to curb smuggling will reduce the availability of tobacco products to young people.

Licensing of 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 or car boot sales).

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 or lighters can act as a prompt and reminder about smoking.

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?

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. [6] 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. [7]

A ban on the display of tobacco products also removes the temptation for adults who are trying to quit to make an impulse purchase.[8]

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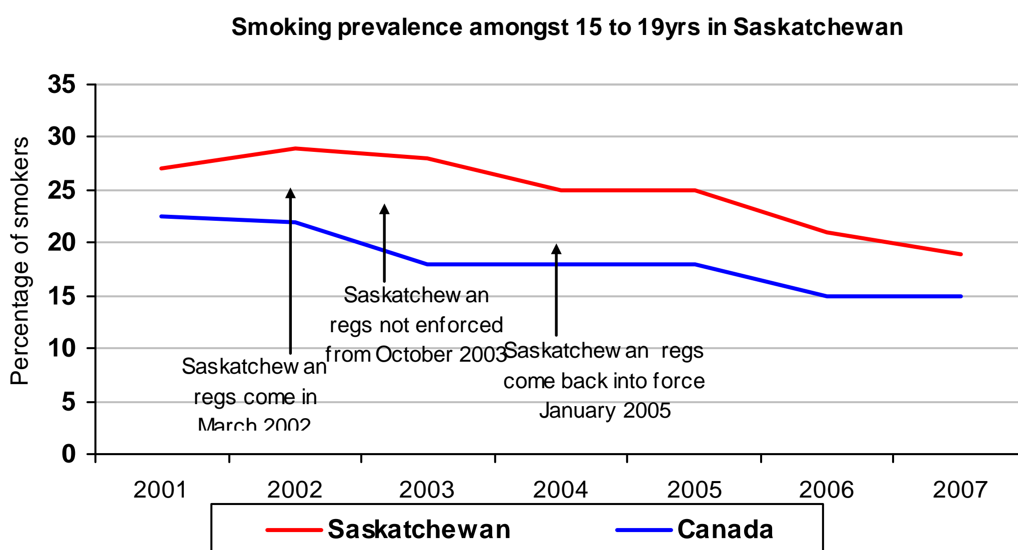
[6] Pierce J et al. Does tobacco advertising target young people to start smoking? Evidence from California. JAMA 1991; 266(2): 3154-3158

[7] The European School Survey Project on Alcohol and Other Drugs (ESPAD). www.espad.org/sa/node.asp?node=730

[8] Wakefield, M. The effect of retail cigarette pack displays on

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. [9]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. The latest survey conducted when the legal age for purchasing tobacco was 16, found that 17% of 11-15 year old smokers reported that vending machines are their usual source of cigarettes.

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impulse purchase. Addiction Nov 2007
http://www.addictionjournal.org/viewpressrelease.asp?pr=69
[9] Anti-tobacco troopers won't butt in - The Gazette (Montreal), 19 May 2008

[10] However, following the rise in age of sale to 18, unsupervised vending machines could become a more significant source of under age sales.

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. [11]

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)

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. ASH recommends that the policy is kept under review and that further research be conducted. The Government may wish to consider taking reserve powers to determine permitted pack sizes by Regulation in future.

[10] Fuller, E. Smoking, drinking and drug use among young people in England 2006. NHS Information Centre, Leeds, 2007.
[11] Cunnigham, R. & Kyle K. The case for plain packaging. Tobacco Control 1995; 4: 80-86

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 do 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.

Part C: Supporting smokers to quit

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

- 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
- Studies to examine the efficacy of different prevention 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?

Stop smoking services are very cost effective and combined with the use of pharmacotherapies can increase a smoker's chances of quitting four-fold compared to using willpower alone. However, take up by smokers wanting to quit is still low with only 3% to 6% of smokers making use of the services per year. If attendance was raised to 10% of smokers, it is estimated that the population long-term quit rate could be increased by 0.5%. [12] Therefore, there is huge scope for improving the services and making them more attractive to people seeking help in stopping smoking.

Hospitals should be required to monitor smoking rates of patients and to give all smokers brief advice to quit, access to stop smoking medicines and referral to stop smoking services. Smoking rates of people leaving hospital should also be monitored. In addition, smoking cessation should be included in the Standards for Better Health set by the Healthcare Commission.

The cost of purchasing stop smoking aids can be a barrier to use, as can the limited availability of these products. Although some versions of NRT are now on general sale, availability is still largely limited to pharmacies and supermarkets. Meanwhile tobacco products are widely available from many outlets such as corner shops, garage forecourts, supermarkets, pubs, vending machines in licensed premises, and specialist tobacconists. In order to help smokers who want to quit without NHS support, stop smoking aids should be accessible in all the places where tobacco products are currently sold. There is widespread public support for such as policy. According to a YouGov poll, 76% of adult smokers in England said they supported making NRT easier to access. [4]

Research should be conducted to examine the effectiveness and cost-effectiveness of strategies to increase the uptake of the smoking cessation services.

Social marketing campaigns targeted at particular social groups should be used to assist those who find it most difficult to quit.

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

[12] West, R. The Smokers Toolkit Study. www.smokinginengland.info

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, training quality standards and high quality administrative support for services.

Mass media health campaigns should be complemented by community-based initiatives to promote local 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, e.g. Faith Groups and local Tobacco Alliances.

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. [13] 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.

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[13] Siahpush M, McNeill A, Hammond D, and Fong GT. Socioeconomic and country variations in knowledge of health risks of tobacco smoking and toxic constituents of smoke: results from the 2002 International Tobacco Control (ITC) Four Country Survey. Tobacco Control 2006; 15: iii65 - iii70.