Brent Tobacco Control Strategy

2010-2013

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The Brent Tobacco Control Alliance

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Contents

	Executive Summary	
1.	**Introduction**	**9**
2.	**The National Context**	**10**
	2.1 *Preventable Death, Smoking Prevalence and Health Inequalities in England*	10
	2.2 *Costs to NHS*	12
	2.3 *Young People and Smoking in England*	12
	2.4 *Factors relating to tobacco use*	13
	2.5 *Niche Tobacco Products*	14
3.	**National Aspirations for 2020**	**16**
4.	**Brent Picture**	**17**
	4.1 *Vision, Aims and Strategic Objectives*	17
	4.2 *Preventable Death, Smoking Prevalence and Health Inequalities in Brent*	18
	4.3 *Linking Tobacco Use To Health Inequalities in Brent*	20
	4.4 *Cost of Tobacco Use in Brent*	21
	4.5 *Evidence for Tobacco Use Among Young People in Brent*	22
	4.6 *Shisha Tobacco in Brent*	22
	4.7 *Young People and Shisha in Brent*	23
	4.8 *Marketing of Shisha in Brent*	24
	4.9 *Tobacco Paan and Gutka*	24
5.	**Tackling Tobacco Use in Brent**	**24**
	5.1 *What have we been doing to tackle tobacco use in Brent?*	24
	5.2 *Roles of different agencies*	24
6.	**Brent Strategy**	**29**
	6.1 *Stopping the inflow of young people recruited as smokers*	29
	6.2 *Motivating and Assisting Every Smoker to Quit*	35
	6.3 *Protecting our families and communities from tobacco related harm*	36
	6.4 *Improving Partnership Working*	38
7.	**Delivery and Review**	**39**
	7.1 *Brent Tobacco Control Alliance Governance Structure*	39
	7.1 *Action Plan*	40
8.	**Appendices**	**49**
	Appendix 1 - Acknowledgements	49
	Appendix 2 - Shisha and Paan Fact Sheet	51
	Appendix 3 - Brent map detailing Accidental Dwelling Fires 2009/10	53
	Appendix 4 - NHS Brent Commissioning Strategy Plan (extract)	54
	Appendix 5 - Launch invitation	55

Executive Summary

Background

This tobacco control strategy for Brent has been developed to reduce smoking prevalence and other tobacco use in Brent.

The Brent Tobacco Control Alliance is chaired by Kostakis Christodoulou (NHS Brent) and Yogini Patel (Brent Council). This strategy was co-ordinated and edited by Amanda Wilson. It was developed by members of the Brent Tobacco Control Alliance (Appendix 1) which consists of a variety of relevant key stakeholders that are committed to reducing smoking prevalence and tobacco use through various avenues including:

- Advocacy
- Enforcement of tobacco regulations
- Prevention
- Reducing availability and supply of illicit tobacco
- Reducing exposure to second hand smoke
- Smoking cessation support

Input has also been sought from a number of additional tobacco control experts (Appendix 1).

Why is Tobacco Use a Problem?

- Although there are 2 million fewer smokers in England today than ten years ago, smoking remains the largest preventable cause of death and illness, responsible for over 80,000 deaths per year in England. It is also the single greatest cause of health inequalities both nationally and in Brent.
- Smoking kills half of all long term users and in 2009, 18% of all deaths of adults aged 35 and over in England were estimated to be caused by smoking.
- Smoking and tobacco use impact on quality of life, greatly increasing the risk of individuals developing cardiovascular diseases, cancers, respiratory diseases and low birth weight. Evidence also suggests that tobacco use impacts on reproductive health and other aspects of physical and mental health and well being.
- Smoking costs the NHS £2.7 billion per year nationally. In Brent alone it has been estimated that £1.3 million could be saved over five years from reducing smoking prevalence.
- Children and young people are the primary victims of tobacco in the 21st century. Targeted marketing toward young people has been identified as integral to the survival and growth of the tobacco industry which needs to recruit 100,000 new smokers every year in order to replace those who die or quit. *Two thirds of all new smokers are young people under the age of 18.*
- Smoking is a risk factor in six out of the eight leading causes of death world wide.

What factors are associated with uptake and maintenance of a tobacco habit?

A complex tapestry of personal, individual, physiological, social and cultural factors are likely to influence uptake and maintenance of a tobacco habit.

- Smoking is considered 'a lifestyle choice'. Personal beliefs about image, control/independence, stress relief, relaxation, weight control and freedom of choice influence uptake and maintenance of a tobacco habit.
- Smoking cigarettes and other tobacco use (for example smoking tobacco shisha or chewing tobacco paan) are often considered normal and are socially supported behaviours that lead quickly to addiction.
- Addiction is the reason why most people find it hard to stop. The power of addiction is grossly underestimated, especially by young people.
- The younger a person starts a tobacco habit the more likely they are to become more heavily addicted, for longer.
- Young people are three to five times more likely to smoke if they come from a household where either a parent or older sibling smokes.
- Clever marketing by the tobacco industry has attracted people to smoking for decades. Striking and eye catching point of sale displays, especially cigarette counters at supermarkets; and the use of movie stars to promote smoking and other 'exotic' tobacco use such as shisha are just two examples.
- Tobacco is widely available and unlicensed to sell in England and can be inexpensive to buy.

What are the national and local policy drivers to reduce smoking prevalence?

Reducing smoking prevalence and tobacco use is a clear national priority. Building on the success of the government's 1998 white paper, *Smoking Kills*, a new national tobacco control strategy for England *A Smokefree Future* was published in 2010. It sets out to achieve the following national 'aspirations':

- To reduce the 11–15-year-old smoking rate to 1% or less, and the rate among 16 and 17-year-olds to 8% by 2020.
- To reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and within the most disadvantaged areas by 2020.
- To increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020.

NHS Brent and Brent Council are committed to the joint development of a co-ordinated and strategic approach to reducing smoking prevalence and tobacco use in line with the national aspirations. The achievement of smoking cessation targets remains a key priority area for NHS Brent, and enforcement of smokefree legislation and restrictions relating to the packaging, sale and promotion of tobacco have been embedded in policy and practice at Brent Council. In addition, a jointly funded Tobacco Control Alliance Co-ordinator has

now been appointed to drive the broader agenda forward, drawing together various other key stakeholders.

What works to reduce smoking prevalence?

- The United Kingdom has been ranked as the leader in Europe for tobacco control and has managed to halve smoking prevalence to 21% over the past decade. This has been largely through implementation of the World Bank's Six Strands Strategy through the *Smoking Kills* agenda. Progress has been made on all of the following guidance actions:

  - Reducing exposure to secondhand smoke
  - Communications and education
  - Reducing availability and supply of cheap tobacco
  - Support for smoking cessation
  - Reducing tobacco promotion
  - Tobacco regulation

- It must be noted that great differences in smoking prevalence between different social groups still persist both locally and nationally. Routine and manual workers have the highest smoking rates along with those from lower socio-economic groups and certain minority and vulnerable groups.

  Building on the Six Strands Strategy to incorporate the successful approaches of other jurisdictions such as California, it is expected that smoking prevalence will be further reduced through the following key priorities:

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

Where are we now in Brent?

- In 2007, 230 out of the 333 deaths classified as preventable in Brent, were attributed to smoking.
- Circulatory diseases including heart disease and stroke, and cancers are the most common causes of death in Brent.
- Smoking prevalence in Brent is somewhere between 17.6% and 24%. This means between 38,200 and 52,500 adults in Brent still smoke.
- Smoking prevalence is estimated to be double in some deprived neighbourhoods in Brent compared with their more affluent neighbours.
- Since 2004, Brent has become more deprived moving from being within the 25% most deprived local authorities in the country to be within the 15% most deprived in 2007.
- There is a 9.3 year gap in life expectancy between one of the most deprived wards (Harlesden) and one of the most affluent wards (Northwick Park).
- The highest proportions of young people in Brent live in the most deprived wards which also have highest smoking prevalence. A third of the residents within the six priority neighbourhoods in Brent are under 16 years. This compares with one fifth in London.

- Brent is extraordinarily ethnically diverse. Over 130 different languages are spoken and 71% of the population is from an ethnic group other than White British. Smoking rates are particularly high among Bangladeshi, Irish and Pakistani men, and Black Caribbean and Irish women. The use of alternative 'niche' tobacco products such as tobacco paan and shisha is also very common by many people from the Asian sub-continent, the Middle East, parts of Eastern Europe and Africa. Health hazards associated with the use of these products appear to be poorly understood. Brent is home to a sizeable number of people from many of these ethnic backgrounds.
- Brent has the highest recorded number of shisha bars of all London boroughs and the use of niche tobacco products is very common.

What have we been doing to tackle smoking prevalence in Brent?

Activity to tackle tobacco use has taken place in Brent over the past several years, however this strategy is the first attempt to develop a shared vision and co-ordinated approach to reducing smoking prevalence and tobacco use. Currently:

- The Brent Stop Smoking Service provides free smoking cessation support and advice with the support of pharmacists, general practitioners and other community based providers.
- Environmental Health and Health Safety and Licensing implement smokefree legislation in Brent food establishments, pubs, clubs and non-food commercial premises.
- Brent and Harrow Trading Standards enforce many of the regulations that control the retail supply of tobacco products locally though under age test purchasing, illicit tobacco operations, the responsible retailer scheme and various other projects.
- The Brent Tobacco Control Alliance has been developed over the past 12 months. This has attracted the support and involvement of additional essential key stakeholders who have contributed to this document (Appendix 1) and who are also committed to implementation of the accompanying action plan. It has also resulted in the development of the Brent Smokefree Ambassadors, a smokefree advocacy youth group.

Our vision, aims and strategic objectives

Vision

In April 2010, the Brent Tobacco Control Alliance participated in a visioning exercise that was part of a strategy development workshop. Collectively the Alliance produced the following vision of a borough where:

1) The number of smokers and smoking related deaths and illnesses are reduced dramatically
2) Smoking and tobacco use are no longer normal activities
3) Young people know the dangers of smoking and second hand smoke
4) Young people feel empowered to make informed choices not to start a tobacco habit.

Aims

The fundamental aim of this strategy in Brent is to reduce smoking prevalence and tobacco use. It is expected that this will also contribute significantly to a reduction in health inequalities and prevention of future generations from the impact of tobacco related harm.

Strategic Objectives

The aims will be achieved through delivery of priorities which tackle both supply and demand elements related to tobacco consumption (see action plan on page 40). These are based broadly on the national priority work streams. In addition we have added a fourth work stream 'Improving and Maintaining Partnership Working':

Workstreams

1	2	3	4
Stopping the inflow of young people recruited as smokers	**Motivating and Assisting Every Smoker in Brent to Quit**	**Protecting families and communities from tobacco related harm**	**Improving and Maintaining partnership working**
1.1 Reducing the attractiveness of tobacco through both school based and peer led activities	2.1 Improving the current Brent Stop Smoking Service	3.1 Smokefree compliance visits	4.1 Monitoring the Brent Tobacco Control Alliance through an annual functionality review
1.2 Reducing the availability of tobacco	2.2 Tackling high smoking rates in disadvantaged and vulnerable communities	3.2 Home fire safety visits	4.2 Creation of a shared database that is accessible to relevant key stakeholders
1.3 Reducing affordability of tobacco	2.3 Deliver strategic Marketing	3.3 Public campaigns	4.3 Creation of clear intelligence sharing pathways with named contact leads
	2.4 Improve data collection and information processing		4.4 Attendance at sector wide, regional and national meetings to feedback to alliance

Enabling Factors in Brent

- Motivated, engaged, committed and well informed Tobacco Control Alliance consisting of a broad cross section of relevant key stakeholders
- Particularly strong new links have been developed with youth engagement officers in both the public and voluntary sectors (including educational establishments)
- Strong evidence base for action
- Creation of links with neighbouring boroughs to engage in joint working on relevant projects

Challenges

- Limited resources and capacity - small budget for a large agenda
- The changing face of the public sector and pending restructure of both NHS Brent and Brent Council may impact on current job roles and responsibilities
- Smoking prevalence data is outdated and broadly estimated making true progress toward reducing smoking prevalence difficult to measure quantitatively
- Collection of robust data on the smoking demographic in Brent is currently limited

1. Introduction

While efforts to curb tobacco use in many countries worldwide have demonstrated undeniable achievements in tobacco control, smoking and tobacco use still continue to kill over 5 million people worldwide every year[1].

In England, despite the success of interventions such as the introduction of smokefree legislation and the development of funded stop smoking services, smoking continues to be the leading cause of preventable death and health inequalities. Smoking is still responsible for over 80 000 preventable deaths a year in England.

This trend is echoed in Brent and is complicated further by an escalating uptake of niche tobacco products such as shisha tobacco and tobacco paan locally.

Coordinated action

Tackling smoking and tobacco use is a complex task. A good tobacco control strategy aims to both reduce smoking prevalence and reduce harm to others. It requires collaboration between various sectors that can have an impact on both supply and demand elements of tobacco sales. Proactive and planned engagement across sectors is essential.

In accordance with national guidance[2], the Brent Tobacco Control Alliance lead is jointly supported by both NHS Brent and Brent Council to co-ordinate a wide range of relevant key community stakeholders. This strategy involves the combined and spirited efforts of such key stakeholders in Brent (Appendix 1).

[1] World Health Organisation – Tobacco Free Initiative. *Why Tobacco is a Public Health Priority.* http://who.int/tobacco/health_priority/en/. Accessed September 2010

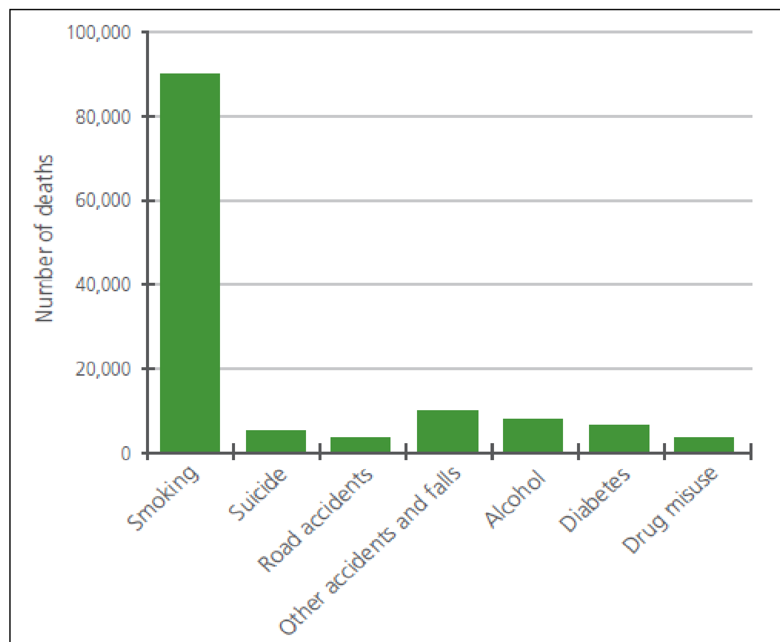
[2] H M Government. *A Smokefree Future – A Comprehensive Tobacco Control Strategy for England.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 p.59. Accessed September 2010.

2. The National Context

2.1 Preventable Death, Smoking Prevalence and Health Inequalities in England

Smoking remains the leading cause of preventable death in England (Figure 1). It kills more than 50% of all long term users and is the biggest cause of health inequalities between the rich and poor in the UK.

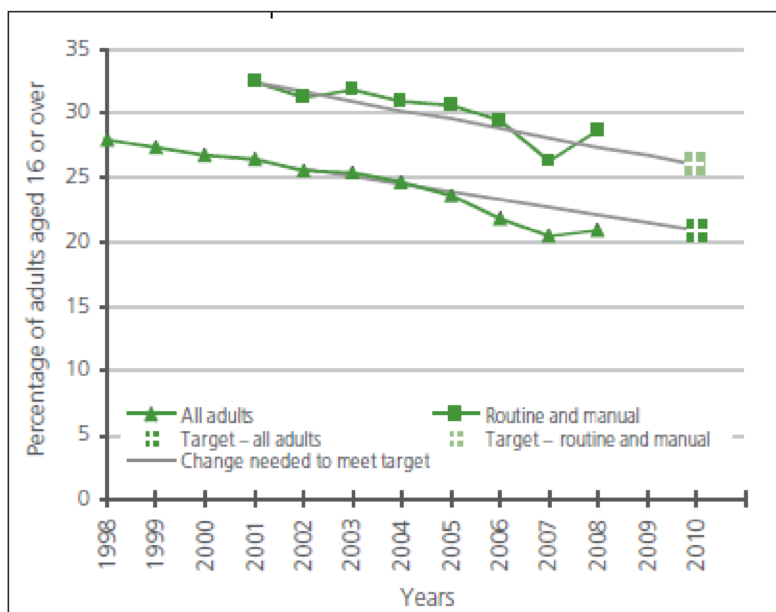
Figure 1: Causes Preventable Deaths in England[3]



Although the smoking rate of 'all adults' in England has reduced remarkably over the past decade, smoking rates among routine and manual workers have been much slower to decline (Figure 2).

[3] H M Government. *A Smokefree Future – A Comprehensive Tobacco Control Strategy for England.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 p.19. Accessed September 2010.

Figure 2: Smoking Rates ion England from 1998 to 2008[4]



Other socio-economically disadvantaged and vulnerable groups in England also still have high smoking rates well above the all adults' rate of 21%. These include young pregnant women, people with mental health problems and some ethnic groups[5].

The persistence of smoking among these groups and the perpetuation of smoking through the generations are held largely accountable for the widening difference in quality of life and life expectancy between the richest and poorest in the country[6].

This suggests that despite enormous successes in the reduction of smoking prevalence and exposure to second hand smoke population-wide, efforts must now be focussed on

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[4] H M Government. *A Smokefree Future – A Comprehensive Tobacco Control Strategy for England.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 p.15. Accessed September 2010.

[5] National Institute for Health & Clinical Excellence. *Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities.*

[6] H M Government. *A Smokefree Future – A Comprehensive Tobacco Control Strategy for England.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 p.10. Accessed September 2010.

populations with continued high smoking prevalence and prevention of young people from starting a tobacco habit.

2.2 Costs to NHS

Smoking related illnesses cost the NHS £2.7 billion per year[7]. The NHS Information Centre calculated that there were approximately 440,000 hospital admissions of adults aged over 35 for a smoking related disease as the primary diagnosis.

Smoking also has a significant impact on the wider economy. The current level of smoking costs the economy about £2.5 billion each year in terms of sick leave and lost productivity alone[8].

2.3 Young People and Smoking in England

> *"Children and young people are the primary victims of tobacco in the 21st century. They suffer today when they get addicted to smoking before they know the meaning of addiction, when they are forced to breathe tobacco smoke in their homes and, in the earliest moments of their lives, when they are exposed to tobacco toxins in the womb. They will suffer tomorrow when they face the reality of the harm of smoking, when they struggle to quit, and when the consequences of not quitting finally hit home".*
>
> *(Beyond Smoking Kills - ASH)*[9]

Two thirds of new smokers are young people under the age of 18[10]. Approximately 190 000 children in England aged 11 – 15 are regular smokers with many more starting every day.

Young people are between three and five times more likely to smoke if they come from a household where either a parent or older sibling smokes[11]. Those who start smoking before the age of 16 are twice as likely to continue to smoke as those who begin later in life. They are also more likely to be heavier smokers [12]and are therefore at greater risk of developing

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[7] H M Government. *A Smokefree Future – A Comprehensive Tobacco Control Strategy for England.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 p.5 [Accessed September 2010].

[8] H M Government. *A Smokefree Future – A Comprehensive Tobacco Control Strategy for England.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 p.22 [Accessed September 2010].

[9] Kellner P & Anderson W et al. *Beyond Smoking Kills – Protecting Children, reducing Inequalities.* http://www.ash.org.uk/beyondsmokingkills p.1 [Accessed September 2010].

[10] Office for National Statistics. *General Household Survey 2007 – Smoking and Drinking among adults 2007*. [Online]. Newport: Office of National Statistics. 2008. Available from: http://www.statistics.gov.uk/downloads/theme_compendia/GHS07/GHSSmokingandDrinkingAmongAdults2007.pdf [Accessed September 2010]

[11] Owen L and Bolling K, 2005 – on computer

[12] Muller 2007 – Helena reference

chronic and life threatening conditions related to smoking and exposure to second hand smoke.

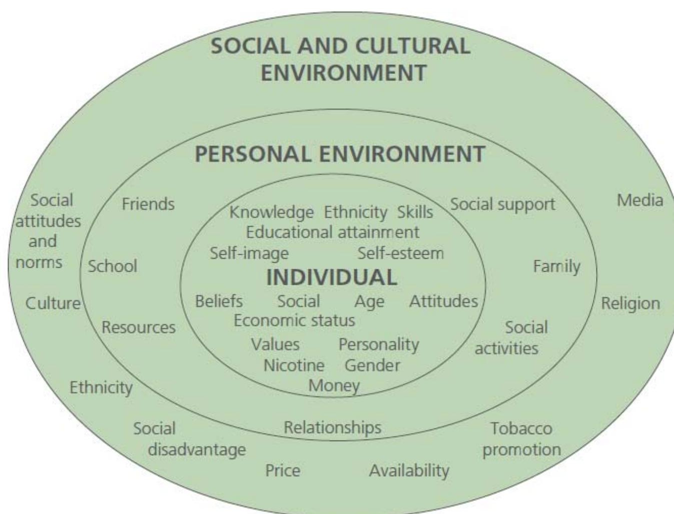
In addition the tobacco industry needs to recruit over 100 000 smokers a year to replace those who die or quit[13]. Targeted marketing toward young people and teenagers has been identified as integral to the survival and continued growth of the tobacco industry.

Tackling youth smoking is most effective if it involves a comprehensive, multi-component, well-funded and sustained approach that addresses the individual, social, community and societal determinants of smoking uptake. Efforts must be proactive, co-ordinated and inventive. Amos et al (2009)[14] also suggest that working with youth focussed partner organisations makes sense in order to allow more freedom of movement and credibility with young people.

2.4 Factors relating to tobacco use

Becoming a smoker is a process which can last from several weeks to many years. Among young people, the process is likely to involve several different stages commonly beginning with experimentation during adolescence, followed by habituation/addiction and finally maintenance or regular 'adult smoking.'[15] As indicated in Figure 3, a complex tapestry of factors is associated with starting smoking.

Figure 3 : Factors Associated with Starting Smoking[14]



[13] H M Government. *A Smokefree Future – A Comprehensive Tobacco Control Strategy for England.* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111749 p.25 [Accessed September 2010].

[14] Amos et al. *A Review on Young People and Smoking in England – Final Report.* Revised 20th May 2009. P.7 http://www.york.ac.uk/phrc/PHRC%20A7-08%20Revised%20final%20report.pdf [Accessed September 2010].

[15] Goddard, E. *Why Children Start Smoking*, Office of Population and Census Survey and Department of Health. 1990

Social and cultural environment

Tobacco is a socially supported addiction. Factors such as accessibility, affordability and attractiveness of tobacco products also affect the uptake of a tobacco habit. Cultural practices and ethnicity also impact on social attitudes and norms toward health behaviours. This can influence uptake, maintenance and type of tobacco use.

Personal and individual environment

In England, almost every indicator of social deprivation, including income, socio-economic status, education and housing tenure, independently predicts smoking behaviour[16]. Consequently the poorer one is the more likely they are to smoke. Age, gender and self image have also been linked to patterns of tobacco use. For example, there is evidence to suggest that smoking prevalence among young people increases with age.

The following groups or people have been found to be more likely to smoke[17] [18]:

- Routine or manual workers
- Young people from households where a parent or older sibling smokes[19]
- Those with low or no educational qualifications or aspirations
- Those experiencing mental health problems
- Gay, bisexual or transgender males
- Those living in crowded accommodation
- Residents living in rented housing
- Recipients of welfare benefits
- Divorcees

As noted in *A Smokefree Future,* disadvantaged groups who have high rates of smoking may also exhibit other unhealthy behaviours. It is therefore apparent that a broad approach to reducing health inequalities is required.

2.5 Niche Tobacco Products

Tobacco products in England that are different to regular cigarettes and hand rolling tobacco are often termed a 'niche tobacco products.' Most of these products are used traditionally by black and minority ethnic (BME) communities for smoking or chewing.

[16] Kellner P & Anderson W et al. *Beyond Smoking Kills – Protecting Children, reducing Inequalities.* http://www.ash.org.uk/beyondsmokingkills p.29 [Accessed September 2010].

[17] Health and Social Care Information Centre. *Synthetic Estimates of Healthy Lifestyle Behaviours at PCO level 2000-2007*, 2005

[18] Dorset R, Marsh A. *The health trap: poverty smoking and lone parenthood.* London: Policy Studies Institute, 1998.

[19] Amos et al. *A Review on Young People and Smoking in England – Final Report.* Revised 20th May 2009. http://www.york.ac.uk/phrc/PHRC%20A7-08%20Revised%20final%20report.pdf [Accessed September 2010].

Tobacco that is chewed is often termed 'smokeless tobacco'. Table 1 below lists different types of smoked and smokeless niche tobacco products.

Table 1 - Niche tobacco products

Smoked tobacco products	Smokeless tobacco products
Shisha Beedi/Bidi (Indian cigarettes)	Creamy Snuff, Dry Snuff, Gul, Gutka, Khaini, Mawa, Mishri, Nass, Paan Masala(Tobacco Paan), Qiwam, Red Tooth Powder, Zarda

Concerns regarding these products include lack of knowledge on the health effects; the absence of adequate health warning labels on the products; possible illegal importation; and avoidance of paying duty, making them a very affordable option. Shisha tobacco, tobacco paan and gutka in particular are in high demand and readily available in Brent.

Similar to smoking cigarettes, the use of such tobacco products is often embedded in the cultural and social practices of some ethnic groups. This brings with it a strong sense of social acceptance, social bonding, tradition and "normality," presenting an additional challenge for tobacco control.

Anecdotal evidence from Cardio-Wellness suggests that young people from some Asian backgrounds in England may be exposed to tobacco paan in the home and that health effects relating to chewing tobacco products and smoking shisha tobacco are poorly understood[20].

In countries such as Sri Lanka, India, Pakistan and Bangladesh, oral cancer is the most common cancer in men and may account for up to 30% of all new cases of cancer compared to 3% of all newly diagnosed cancer cases in the UK and 6% in France[21]. Such alarmingly high rates of oral cancer in these countries are thought to be directly related to risk behaviours such as regular of chewing tobacco, which is commonly mixed with betel nut and other ingredients to produce paan masala or tobacco paan.

Studies of oral cancer incidence in minority ethnic populations in Britain have reported high rates in similar south Asian and Chinese populations. It is logical to suspect that a sizeable proportion of Brent residents are particularly at risk given the large South Asian population and the popularity and accessibility of tobacco paan among this population.

A factsheet on Shisha Tobacco and Tobacco Paan and Gutka can be found in Appendix 2.

[20] Cardio-wellness. http://www.cardio-wellness.com/ Video [Accessed September 2010]

[21] Cancer Research UK. *Oral Cancer – UK Incidence Statistics.* http://info.cancerresearchuk.org/cancerstats/types/oral/incidence/ [Accessed September 2010]

3. National Aspirations for 2020

The Government's 1998 White Paper - *Smoking Kills* - was a landmark public health strategy that achieved great gains in reducing smoking prevalence. Based on the World Bank's Six Strand Strategy, it placed the UK as the leader in tobacco control in Europe. Guiding principles of the Six Stands Strategy included:

- Reducing exposure to second hand smoke
- Communications and education
- Reducing availability and supply of cheap tobacco
- Support for smoking cessation
- Reducing tobacco promotion
- Tobacco regulation

Today there are over 2 million fewer smokers in England than ten years ago however, smoking is still the leading cause of preventable death and health inequalities in England. Building on the successful approach of the past, the latest national tobacco control strategy for England published in 2010 sets out to achieve the following goals:

1) **To motivate and assist every smoker to quit**
   Aspiring to reduce adult smoking rates to 10% or less, and halve smoking rates for routine and manual workers, among pregnant women and within the most disadvantaged areas by 2020.

2) **To stop the inflow of young people recruited as smokers**
   Aspiring to reduce the 11–15-year-old smoking rate to 1% or less, and the rate among 16 and 17-year-olds to 8% by 2020.

3) **To protect our families and communities from tobacco related harm**
   Aspiring to increase to two-thirds the proportion of homes where parents smoke but that are entirely smokefree indoors by 2020.

To achieve this it has been recognised that co-ordinated efforts between communities, businesses, the private and voluntary sectors, local government and NHS are essential.

4. The Brent Picture

4.1 Vision, Aims and Strategic Objectives

Brent has devised a strategy and local delivery plan based on the guidance and aspirations set out in *A Smokefree Future* and the evidence base. In addition to the three key areas set out in national strategy, Brent proposes a forth key area that focuses on developing, improving and maintaining strong partnerships.

As set out in the Marmot Review (2010) many of the levers that shape health inequalities, including those related to smoking, are held by agencies outside the NHS and local government[22]. These include other public sector partners, the police, fire service, third sector and private sector organisations. Therefore development and maintenance of strong and equal partnerships will be an essential additional ingredient for the successful delivery of this strategy.

Brent's Vision:

In April 2010, the members of Brent Tobacco Control Alliance participated in a visioning exercise that was part of a strategy development workshop. Collectively the Alliance produced the following vision of a borough where:

1. The Brent Stop Smoking Service achieves annual four week quit targets as set by the Department of Health, thereby dramatically reducing the number of smokers and smoking related deaths and illnesses. For example, for 2010/11 the Brent Stop Smoking Service will aim to achieve 2360 four week quitters.
2. Smoking and tobacco use are no longer normal activities in Brent
3. Brent youth know the dangers of smoking and second hand smoke
4. Brent youth feel empowered to make informed choices not to start a tobacco habit.

The aims of this strategy in Brent are to:

1. Reduce smoking prevalence and tobacco use
2. Reduce health inequalities in Brent
3. Prevent future generations from the impact of tobacco related harm.

The strategic objectives will therefore include:

1. Motivating and assisting every smoker to quit
2. Stopping the inflow of young persons recruited as smokers
3. Protecting families and communities from tobacco related harm

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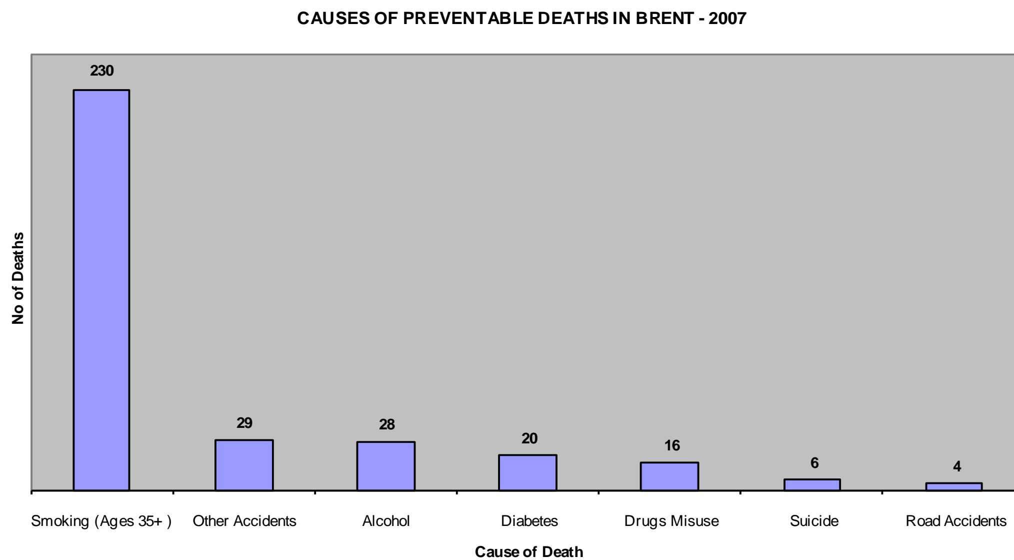
[22] Marmot, M. *Fair Society Healthy Lives – The Marmot Review. Strategic Review of Health Inequalities in England.* P.88. 2010. http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLives.pdf [Accessed September 2010]

4. Developing and maintaining partnership working both within the alliance and with neighbouring boroughs

4.2 Preventable Death, Smoking Prevalence and Health Inequalities in Brent

In 2007, 230 out of the 333 deaths classified as preventable in Brent, were attributed to smoking. Similar to the national picture this makes smoking by far the largest single preventable cause of death locally (Figure 4). Circulatory diseases, including heart disease and stroke, and cancers are the most common causes of death in Brent.

Figure 4[23]



Smoking prevalence in Brent is estimated to be between 17.6%[24] and 24%. This equates to between 38 200 and 52 500 adults in the borough who still smoke cigarettes[25]. Even though this is in line with the national prevalence of 21%, there are wide variations in smoking prevalence between wards, with nearly 40% prevalence reported in some neighbourhoods such as Harlesden and Stonebridge Park, located in the south of the borough (Figure 5).

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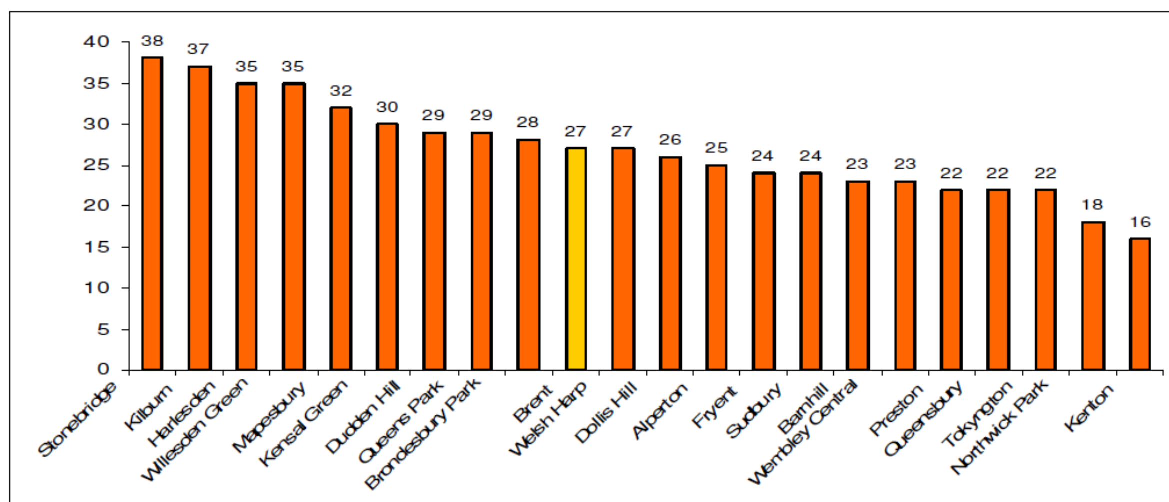
[23] NHS Brent. *Extracted from 2007 ONS Mortality Statistics.* Compiled 2010.

[24] Association for Public Health Observatories. *Health Profile 2010 – Brent.* http://www.apho.org.uk/resource/view.aspx?RID=50215&SEARCH=brent&SPEAR= [Accessed September 2010]

[25] Figures based on calculation of 16+ population figures for Brent (Brent Borough Profile 2009), and estimated smoking prevalence rates. Please note adult smoking prevalence is based on figures for those who are 18+.

Figure 5[26]

Prevalence of Smoking by Ward in Brent

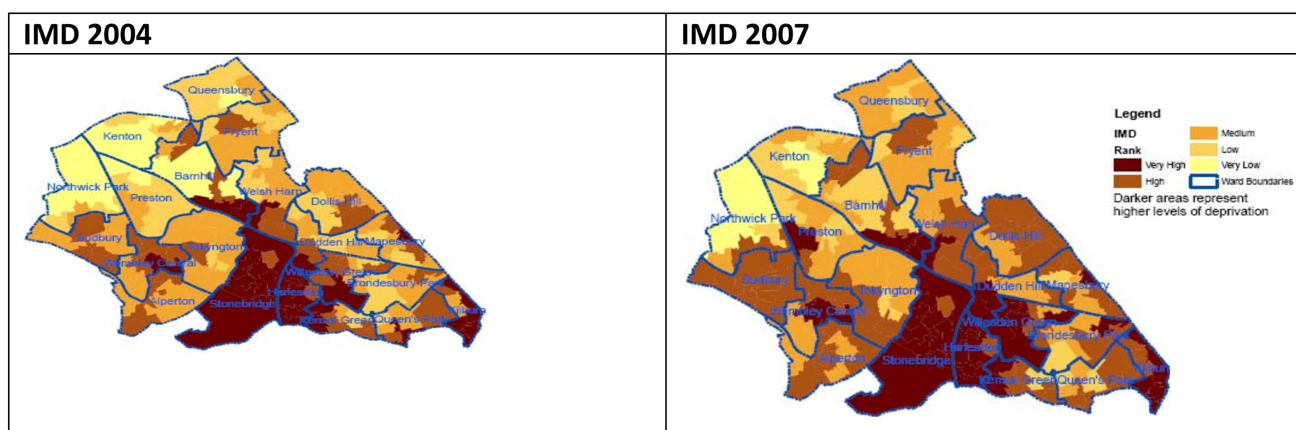


(Source: ASH)

Similar to smoking prevalence rates, deprivation levels are also most acute in the south of the borough. Since 2004, Brent has become more deprived, moving from being within the 25% most deprived local authorities in the country to be within the 15% most deprived (Map 1).

Map 1[27]

Brent Deprivation Levels, 2001 Census



As can be predicted, significant health inequalities exist in the borough. There is a 9.3 year gap in life expectancy between one of the most deprived wards (Harlesden) and one of the most affluent wards (Northwick Park). Lifestyle factors such as smoking are highly likely to contribute to this.

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[26] Bowen S & Fogarty R. *Brent Joint Strategic Needs Assessment.* NHS Brent and Brent Council. 2008. http://www.brentpct.nhs.uk/files/BrentJointStrategicNeedsAssessment2008.pdf [Accessed September 2010]

[27] Bowen S & Fogarty R. *Brent Joint Strategic Needs Assessment.* NHS Brent and Brent Council. 2008. http://www.brentpct.nhs.uk/files/BrentJointStrategicNeedsAssessment2008.pdf [Accessed September 2010]

The Brent Joint Strategic Needs Assessment has identified the following localities as 'priority' neighbourhoods in Brent. These neighbourhoods are all located within the most deprived wards indicated in Map 1.

1. Brentfield
2. St Raphaels
3. Harlesden
4. Stonebridge Park
5. Church End
6. South Kilburn

4.3 Linking Tobacco Use To Health Inequalities in Brent

In addition to smoking prevalence in more deprived neighbourhoods in Brent being more than double than in more affluent neighbourhoods, tobacco use linked to the following factors is also likely to contribute to health inequalities in the borough:

Households

In 2003 the poorest 10% of households spent 2.43% of their income on cigarettes compared to 0.52% in the richest 10% of households.

Overcrowded conditions

Less affluent residents in the south of the borough are more likely to live in poor and overcrowded conditions exposing more people to the harmful effects of second hand smoke.

Poverty and disadvantage

Poorer and disadvantaged residents who smoke also suffer disproportionately from the costs of smoking related diseases. Smoking rates linked to deepened deprivation levels are also linked to increased levels of child poverty in Brent.

Fire risk

Fire risk is higher in households where a smoker is resident. High risk locations for accidental dwelling fires tend to be in the south of the borough in areas where smoking prevalence and deprivation levels are highest (Appendix 3). There have been 34 smoking related fires in private dwellings in Brent since 2008[28].

Proportion of Young people

Approximately 43% of residents in Brent are under 30 years of age, and almost a quarter of these are under 19 years old making Brent a relatively young borough. A high proportion of young people live in the areas of highest deprivation. A third of the residents within the six priority neighbourhoods are under 16 years compared with a fifth in London. Map 2 shows the density and location of young people in Brent aged 13 to 19 years.

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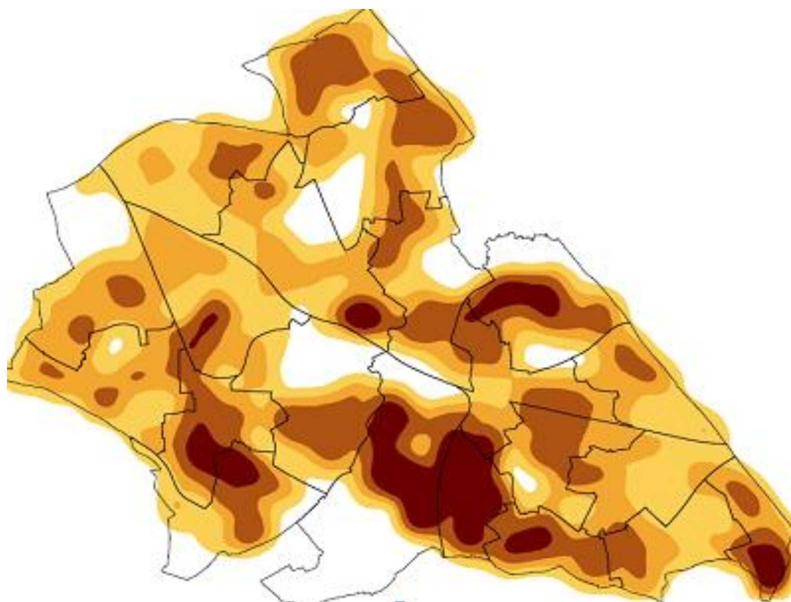
[28] Statistic provided by London Fire Department, 2010.

Since Brent's priority neighbourhoods have the highest numbers of adult smokers and a proportionately young population, and since young people who live with smokers are more likely to smoke and suffer from the effects of second hand smoke, Brent is presented with a potentially cyclical and self perpetuating tobacco problem.

Map 2: Density and location of young people in Brent aged 13 to 19 years[29]



Ethnic Diversity

Brent is extraordinarily ethnically diverse. 71% of the population is from an ethnic group other than White British. Brent is home to the greatest proportion of Irish residents in London. In addition, approximately 33% of the population is Indian, 16% identify as Black Caribbean and 14% as Black African. A further 8% of the population is either Pakistani or Bangladeshi and 11% are classified as 'Other Asian'.[30].

According to ASH[31], smoking rates vary considerably between ethnic groups. Compared to the national average, rates are particularly high among Bangladeshi, Irish and Pakistani men, and Black Caribbean and Irish women. In addition, alternative tobacco products, in particular, shisha tobacco and tobacco paan and gutka are readily available and commonly used in Brent.

4.4 Cost of Tobacco Use in Brent

Inevitably Brent will be absorbing its share of the national cost of smoking, both in terms of treating people who are suffering from smoking related illness, and also the costs of lost productivity due to absence from work because of illnesses caused by smoking.

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[29] Mayhew Associates. *Brent Population Estimation, Household Composition and Change.* 2007. Cited in www.**brent**.gov.uk/tps.nsf/Files/LBBA-593/$FILE/EB%20Part%201.doc [Accessed September 2010)

[30] Source: Brent Borough Profile – Part 1. http://www.brent.gov.uk/evidencebase.nsf/Pages/LBB-2 [Accessed September 2010]

[31] Action on Smoking & Health. *Essential Information on Tobacco & Ethnic Minorities.* *http://www.ash.org.uk/files/documents/ASH_131.pdf* [Accessed September 2010]

In 2001 there were an estimated 1020 hospital admissions for diseases caused by smoking at a cost of £1.8 million. The Brent Commissioning Strategy Plan for October 2007 shows savings of approximately £1.3 million over five years from reducing smoking prevalence (Appendix 4).

There are other costs associated with the use of tobacco products. For example, in Brent, each year the local authority spends approximately £20,000 cleaning unhygienic stains left on pavements due to spitting tobacco paan. In addition, and in response to residents' requests, the council has spent £18,000 on a campaign to stop people from spitting tobacco paan.

4.5 Evidence for Tobacco Use Among Young People in Brent

Robust evidence relating to tobacco use among youth in Brent is limited. Baseline evidence used to inform this strategy are the Ofsted Tellus surveys published in 2007, 2008 and 2009, and the Schools Health Education Unit survey conducted in 2006.

All of these suggest a general trend that Brent children and young people are less likely to smoke, take drugs or consume alcohol when compared to the national averages. However, they also revealed that compared to the national average, a significant proportion of young people feel they need more advice and information on these topics.

The only survey that investigated if young people come from smoking households was the Schools Health Education Unit Survey 2006 which reported that 51% respondents had a parent or sibling or close friend that regularly smoked.

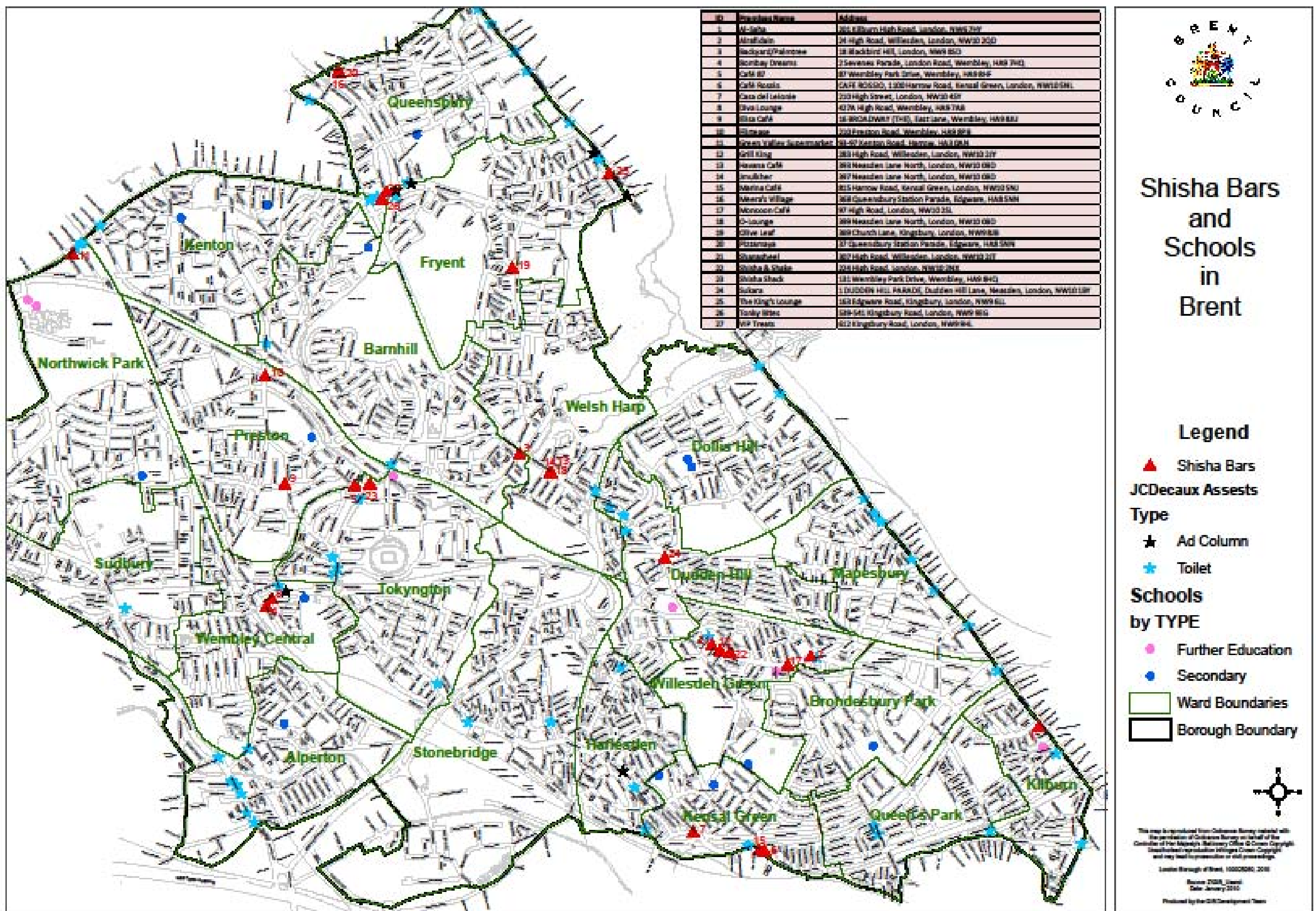
It is important to note that although these surveys state sample size, they do not note response rates and since sample size is relatively small they may not be representative. They also fail to highlight the more intricate issues surrounding smoking behaviour and factors that contribute to youth uptake. Further, none of them are directly comparable, and they fail to investigate tobacco use beyond smoking cigarettes.

4.6 Shisha tobacco in Brent

Environmental Health officers have recorded the existence of over 27 shisha bars/cafes in Brent. This is one of the highest counts in a London borough.

A mapping exercise conducted by Brent Council shows shisha bars in relation to secondary schools and further educational facilities (Map 3). Each further educational facility has at least one shisha bar in very close proximity and no secondary school is further than 1 mile (approximately 20 minutes walk) from a shisha café. The average price for a shisha session is very affordable at between £5 - £7 per session.

Map 3 - Shisha Bars and Schools in Brent



4.7 Young people and smoking shisha in Brent

Anecdotal evidence suggests smoking shisha is a social practice that is rapidly gaining popularity among Brent youth. There are no formal figures on the number of young people who smoke shisha tobacco in the borough however one 15 year old Brent student stated 'many of my friends smoke shisha. Sometimes it's cheaper to buy it in a café than have it at home'.

Another young person stated that a lot of her friends smoke shisha in the park, and that she and her friends had been sold shisha in a café on several occasions. This suggests that under age sale of shisha is likely to occur in Brent.

Brent and Harrow Trading Standards carried out one prosecution in a neighbouring borough in 2009 where shisha tobacco was sold to children in school uniform.

4.8 Marketing of Shisha in Brent

Informal intelligence also suggests that many shisha cafes are marketed directly to young people and many shisha bars use new media to communicate with young people.

Shisha cafes located in Brent commonly use social networks such as Facebook to keep in touch with their clients. The Facebook page from one shisha bar showed as many as 523 young members. Another advertised 'DJ and Arabian Parties' every Saturday night and 'half price discounts' for students. The menu of yet another shisha café served only milkshakes flavoured with your favourite chocolate bar which are reportedly popular with school children from 'three neighbouring schools' at lunch time[32].

Whilst formal studies on knowledge and attitudes toward the health effects of smoking shisha tobacco via a water pipe are lacking locally, anecdotally they appear both limited and casual.

4.9 Tobacco Paan and Gutka

Tobacco Paan and Gutka can be bought readily both from specialist paan stores and standard corner stores in Brent. The average price ranges from 50p – 70p for ready made tobacco paan, around 50p for gutka in a foil pack and 70p for custom made tobacco paan.

The use of tobacco paan and gutka in Brent is common among South Asian populations. Given that a very significant proportion Brent 's population are classified as Asian or Asian British, this is likely to present health concerns for Brent which need further research.

5. Tackling Tobacco Use in Brent

5.1 What have we been doing to tackle tobacco use in Brent?

Instigated by *Smoking Kills* and the introduction of smokefree legislation, activity around tackling tobacco use in Brent has already been taking place over the past several years.

Only recently however has joint Brent Council and NHS Brent investment in the development of a local tobacco control alliance resulted in the development of a shared vision for tobacco control, and a co-ordinated approach to reducing tobacco prevalence.

5.2 Roles of different agencies to date

Brent Stop Smoking Service

The Brent Stop Smoking Service (BSSS) is funded by NHS Brent to offer free smoking cessation support and advice to all smokers living or working in Brent. The service is a 'hub and spoke' model consisting of a core team of specialist stop smoking advisors and level 2 stop smoking advisors based in GP surgeries, pharmacies and community venues.

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[32] Informal conversation with sales assistant in Brent shisha bar

BSSS is currently delivering according to a robust new plan that has benefited from the input of the Regional Tobacco Control Policy Team, NHS London, McKinsey and Company, the NHS Brent Smoking Cessation Performance Board and the Brent Tobacco Control Alliance.

This plan incorporates a triangulated approach which aims to draw on best practice models and input from relevant key stakeholders. Innovation and strategic prioritisation are at the cornerstone of the plan and work is currently being carried out in the following areas:

- Dedicated training and support of GPs and pharmacists in order to increase reach of stop smoking support and increase quits from these large throughput service providers
- Strengthening of core services
- Delivery of a robust marketing plan
- Development of resource tools for level 2 advisors
- Development and delivery of incentive schemes
- Face to face campaigns in targeted local areas
- Working with frontline health workers and employers to raise awareness of BSSS in order to improve accessibility
- Specific activities to reach high smoking prevalence groups

The aspiration of Brent Stop Smoking Services is that *every smoker in Brent* receives good quality stop smoking advice and support that is convenient and available from a range of settings.

Brent and Harrow Trading Standards

Tobacco is subject to many restrictions including those relating to its sale to minors, packaging and promotion. Local Trading Standards Services are tasked with enforcing many of the regulations that control the retail supply of tobacco products locally. In addition to this, statutes such as the Trade Marks Act 1990 can be used to control the sale of counterfeit tobacco products.

Under Age Tobacco Test Purchasing

Section 5 of the Children and Young Person's (Protection for Tobacco) Act 1991 imposes a duty on every local authority to consider, at least once in every 12 month period, an appropriate program of enforcement.

Since 1991, under age test purchasing of tobacco products has been undertaken in Brent. In order to monitor retailers, young volunteers are used to test retailers by attempting to purchase age restricted products. Both Local Authority Co-ordinators Regulatory services (LACORS) and the Court of Appeal hold that this method of enforcement is the only way in which this type of legislation can be enforced.

In 1991, approximately of 70% of all test purchases carried out in Brent resulted in a successful tobacco sale to a minor. Formal action (prosecution of vendors) was considered in all cases where underage sales took place unless there were sound reasons as to why this would not be possible.

Figures for Under Age Tobacco Test Purchasing within Brent have improved remarkably over the past three years (Table 2). An increase in attempts correlates with an increase in the number of successful purchases. However the Trading Standards recognises there is no room for complacency especially with the growing trend toward shisha bars.

Table 2. Underage Tobacco Sales (Brent).

Year	Attempts	Sales
2007/2008	30 attempts	0 sales (0%)
2008/2009	23 attempts	0 sales (0%)
2009/2010	55 attempts	4 sales (2.2%)

In 2008 the Trading Standards also participated in a large scale compliance audit and test purchasing exercise concerning cigarette vending machines. On this occasion it was found that most vending machines had the necessary warning present on their fascia and no underage sales were made.

Shop the Shop

A new project, 'Shop the Shop', has been re-launched with the support and resources of the Brent Tobacco Control Alliance. It aims to encourage residents, including young people, to report vendors they suspect are selling age restricted goods to minors. 'Shop the Shop' additionally aims to understand where young people obtain illicit tobacco and to gain an understanding into thoughts and attitudes toward it. The campaign will also involve Trading Standards visiting five schools to develop a marketing campaign around 'Shop the Shop' that is devised by and with young people.

Responsible Retailer Scheme

To support businesses to comply with the laws surrounding tobacco sales, the Responsible Retailer Scheme was launched by Trading Standards in 2007. This involved the production of a pack that aimed to give retailers and their employees clear information on the law and advice on good practice measures around the sale of age restricted goods. Participation in the scheme is voluntary and retailers are awarded with a certificate to display in their premises. 170 retailers in Brent currently participate in the scheme.

Illicit Tobacco Operations

The Brent and Harrow Trading standards have also carried out operations in illicit sales of counterfeit tobacco and seizure of products that do not conform with the Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002, annually, for the past three years. These can also be seen in the tables below.

Table 3.
Seizure of Illicit (Counterfeit) tobacco in Brent under the Trade Marks Act, 1994

Year	Seizures
2007/2008	3
2008/2009	0
2009/2010	0

Table 4.
Seizure of tobacco not in conformance with Tobacco Products (Manufacture, Presentation and Sale) (Safety) Regulations 2002 (Brent)

Year	Seizures
2007/2008	0
2008/2009	1
2009/2010	4

The Service also participated in a program of enhanced tobacco control activities commissioned by the Department of Health to LACORS and local authorities during 2008/2009. Brent and Harrow Trading Standards, as a part of the North West London cluster, concentrated on four project areas that included test purchasing, retail checks for counterfeit products, enforcement of tobacco advertising in retail premises and mapping of smokeless and other new tobacco products.

Tobacco Paan Project

In 2009, 17 of the main suppliers of smokeless tobacco products in Brent were visited by an officer and advised of their responsibilities regarding the sale of tobacco products. Each trader was given an information sheet which outlined the requirement of the relevant health warning in addition to a sample of one hundred plastic pouches in which to sell the product. The pouches displayed the appropriate health warning.

One month after advising the above traders, 13 shops were visited covertly and paan containing tobacco (where applicable) and a packet of chewing tobacco were test purchased. The shops that only sold pre-packed chewing tobacco and were compliant on the first visit were not re-visited.

Environmental Health & Health Safety and Licensing

Smokefree Premises

Environmental Health and Health, Safety and Licensing at Brent Council are the local bodies that monitor smoke free legislation in Brent food establishments, pubs, clubs and non-food commercial premises under the Smokefree Regulations (Health Act 2006). These regulations are implemented under guidance from LACORS and Chartered Institute of Environmental Health (CIEH).

Enforcement of Smokefree Legislation

Environmental Health actively undertakes enforcement of Smokefree Legislation to minimise passive smoking in public places. An increased need to be vigilant has been noted by Environmental Health officers given the increase in the number of shisha bars in Brent.

Environmental Health officers have already served one fixed penalty notice in a shisha bar and have 4 prosecutions pending for in 2010-2011. Questions relating to smoke free regulation are asked as a matter of routine in inspections.

The food safety team implement smokefree legislation in restaurants and food establishments and have been pivotal in identifying and mapping the location of shisha cafes in the borough, and ensuring their compliance to smokefree legislation. As already mentioned they also carried out shisha tobacco sampling and an introductory survey on knowledge and attitudes relating to the sale of shisha tobacco.

Brent Tobacco Control Alliance

A co-ordinator dedicated to developing the Brent Tobacco Control Alliance was jointly recruited by NHS Brent and Brent Council September 2009, with the aim to create a co-ordinated and strategic approach to reducing smoking prevalence and tobacco use. A wide variety of relevant key stakeholders are currently engaged. New progress so far includes:

- Initial stages of developing a youth group (The Brent Smokefree Ambassadors) for tobacco control advocacy involving members of the Brent Youth Parliament and two other local volunteer groups.
- Working with schools through close involvement with the Healthy Schools Co-ordinator and the commissioned provider for Substance Misuse Education in schools, Addaction.
- Investigation into the link between shisha bars and targeted marketing to young people – including the development of a map that shows shisha bars in relation to schools.
- Financial and professional support for the Trading Standards in the promotion of Shop the Shop.
- Involvement with the Neighbourhoods team and their ‘paan campaign’ in order to raise awareness of the dangers of chewing tobacco paan.
- Liaising with the Fire Brigade to develop joined up working
- Creating links with the Planning Department at Brent Council to discuss planning policies relating to shisha bars in proximity to educational facilities.
- Creating links with large employers of routine and manual workers
- Scoping opportunities for enhancement of the Brent Stop Smoking Service

6. Brent Strategy

6.1 Stopping the inflow of young people recruited as smokers

Two thirds of new smokers are young people under the age of 18. Consequently, long terms cuts in smoking prevalence will only be achieved by preventing children and young people from starting to smoke in the first place.

Although the statistical database in Brent suggests that smoking prevalence among young people is below the national average, the robustness of this data is debateable. Anecdotal evidence also suggests that variations in smoking rates between schools and different local areas are also significant.

It is also important to note that the use of niche tobacco products which are popular in Brent, have not been included in any of the TellUs or School Health Education Unit surveys. As well as being harmful in their own right, use of such products may help to 'normalise' tobacco use or the action of smoking and also act as precursors to smoking cigarettes.

Evidence and experience from abroad suggests that lasting change in smoking behaviour can only be secured by first changing the adult world in which they live. Therefore motivating adults to stop smoking and promoting smokefree environments will remain high priorities within this strategy and will be discussed under separate work stream headings.

The following additional actions will help to tackle uptake of smoking among young people in Brent:

Key Actions

1. ***Reducing affordability***

There is considerable evidence to show that making tobacco less affordable is an effective way of reducing the prevalence of smoking. Reductions in affordability can be driven by taxation on tobacco products or profit on tobacco products. Whilst measures such as these ultimately need to be driven centrally, local action on the sale of cheap illicit tobacco is one way of making tobacco less affordable.

Although previous local operations suggest that sales of counterfeit cigarettes in the borough are minimal, the landscape can change rapidly and must be monitored. Research into the proportion of routine and manual workers who buy illicit tobacco in Brent is required.

Enforcement activity surrounding illicit tobacco nationally is on the increase and, in addition to the imminent release of a new national illicit tobacco strategy, Her Majesty's Revenue & Customs (HRMC) have employed an additional 200 staff devoted to tackling illicit hand rolled tobacco in the UK.

Key Action

Development of clear communication pathways and synchronised work plans between HMRC, Trading Standards, Brent Environmental Health, Brent Health Safety and Licensing, and agencies in bordering boroughs is therefore a priority.

Niche tobacco products are both cheap and fashionable among young people. The use of these is increasing in Brent. Shisha bars and cafes are replacing standard cafes at an alarming rate in Brent. The cost of shisha is relatively low and it is reported that profit margins in these cafes are high. It is possible therefore that duty paid on shisha tobacco products sold in Brent may not always be correct.

Key Action

Over the next two years, Trading Standards will concentrate local investigations and enforcement around ensuring correct duty is paid on tobacco products with particular emphasis on shisha tobacco, tobacco paan and gutka sold in Brent. This will be done in partnership with a link at the HMRC.

2. Reducing availability to children

Reducing the availability of tobacco to young people is a major challenge. Young people are able to acquire tobacco from a wide variety of sources however previous test purchasing attempts in Brent indicate that a young person is more likely to obtain cigarettes from a shop owner than from a vending machine.

Key Action

The Trading Standards will continue to promote, encourage and support the Responsible Trader Scheme and the Shop the Shop campaign. They will also carry out a program of planned test purchasing operations specific to tobacco in the borough annually. This will include shisha bars as well as 'usual' tobacco outlets, and continued surveillance of tobacco paan and gutka sales. Successful prosecutions and fixed penalty fines will be publicised.

3. ***Reducing the attractiveness of tobacco products***
   Children become aware of tobacco from a very young age. Tobacco company advertisements on billboards, in magazines or emblazoned on hoardings at sporting events in the United Kingdom are no longer legal. However, the following continue to foster an attitude of 'normality' around the habit of smoking:

- Tobacco branding
- Point of sale displays
- Adult smoking behaviour
- Smoking role models in movies, on television and in magazines.

Smoking is attractive to young people for a number of reasons including the following misconceptions:

- That it relieves stress
- That it makes you look like an adult
- That it signifies 'independence' or 'taking control' of one's life
- That it enhances one's 'image' and is 'cool'
- That it's not as bad as taking other 'drugs'

Even though it is known that half of all smokers will most likely die from a smoking related illness, tobacco is legal and is generally socially supported. Current school based initiatives give tobacco minimal coverage compared with illicit drugs. Subsequently, health messages relating to smoking are not taken seriously by many young people.

A carefree attitude toward long term effects of smoking, including difficulties associated with giving up smoking, indicate that the effects of tobacco use are grossly underestimated.

School Based Initiatives around tobacco in Brent

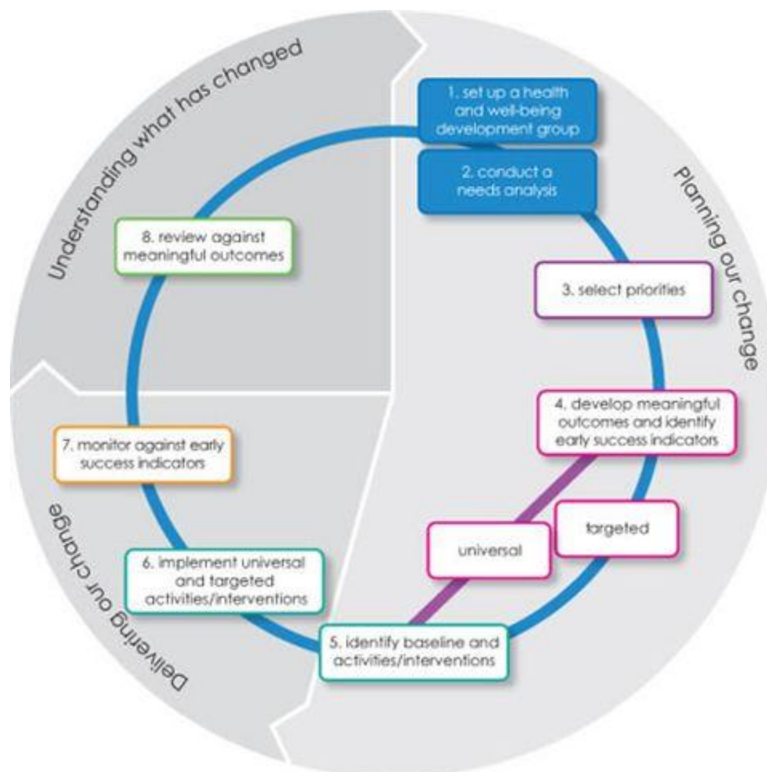
The National Institute for Clinical Excellence (NICE) and *A Smokefree Future* highlight the important role that educational establishments, including schools and colleges have in promoting healthy lifestyles and smokefree behaviour, using a whole systems approach.

It is important to remember that all schools have a statutory duty to promote personal wellbeing and are asked to demonstrate through the Ofsted inspection framework how the school 'discourages smoking, consumption of alcohol and use of illegal drugs and other harmful substances'. The Healthy Schools framework is currently the key delivery mechanism to achieve the government's health and wellbeing agenda for all children and young people in Brent.

By meeting the National Healthy Schools Standards (NHSS), Brent schools will be providing an environment which promotes healthy choices for both pupils and staff. The Healthy Schools model is currently undergoing enhancement and all schools that have reached the NHSS status will move onto a new program called the Healthy Schools Enhancement model (HSEm). This additional model intends to help schools

strive even further for lasting health and well being behaviour changes in children and young people, with particular focus on providing targeted support for those who are most at risk.

Enhanced Healthy Schools programme Model[33]



In Brent 100% schools participate in the Healthy Schools Programme and 63 schools have gained Healthy Schools status. The Healthy Schools team in Brent are committed to encouraging and supporting Brent schools to deliver specific health education on tobacco in it's many and varied forms within the school community.

Brent Schools[34]

Type of School	Total Number of Schools	Healthy Schools
Primary	60	51
Secondary	14	8
Specials	6	2
Pupil Referral Unit[35]	2	2
Total	82 (100%)	63 (76%)

[33] Source: http://resources.healthyschools.gov.uk/s/Enhancement. [Accessed September 2010]
[34] Source: http://reports.healthyschools.gov.uk/Custom [Accessed August 2010]
[35] A pupil referral unit (PRU) is a type of school that offers short-term alternative education for children who are excluded from school, not attending school for other reasons or who are not gaining qualifications at school.

Key actions in schools

The following initiatives around youth prevention and tobacco use in Brent will be supported by Healthy Schools, Young Peoples' Sexual Health & Substance Misuse Partnership Commissioning Service and their commissioned service, Addaction in Brent, and the Tobacco Control Alliance Co-ordinator:

Key Actions

Education plan

Delivery of a separate tobacco education plan through PSHE (or substance misuse) classes delivered by Addaction currently to 10 schools in Brent.

Lesson plans on tobacco education

Preparation and distribution of exemplary lesson plans on tobacco education to all other schools that are age and culturally appropriate, that can be embedded in the school's PSHE Schemes of work.

Screening tool

Inclusion of tobacco use as one of the targeted topics through an existing roving clinic program called 'Clinic in a Box', delivered by Addaction to Brent schools. This will see the inclusion of tobacco in their health screening tool, in order to both identify young people who use tobacco and young people at risk of smoking and/or other tobacco use. In all instances stop smoking education, advice and support will be given.

Statistical information gathered via the screening process will be anonymously reported back to the Tobacco Control Alliance on a quarterly basis. An evaluation tool to measure outcomes of this tool will also be developed.

Smokefree policies

An audit of schools for effective Smokefree policies co-ordinated by Healthy Schools and Addaction and supported by the Brent Tobacco Control Alliance Co-ordinator.

Development, by the Brent Tobacco Control Alliance Co-ordinator, of an exemplary smokefree school policy that is widely publicised and used by schools.

Advice, support and guidance to the school community on Smokefree policies and activities that prevent smoking and the use of tobacco on school premises and surrounding areas.

Promotion of the stop smoking service

Addaction and the healthy Schools Co-ordinator to publicise and signpost the opportunities that promote interventions on smoking cessation in all schools they visit.

Workshops in schools

Addaction to offer workshops to schools / parents specifically aimed at transition stages of education in particular primary to secondary and leaving school. These will be incorporated into allocated health awareness days in schools.

Partnership working

Partnership working to support and deliver training to teachers, school nurses and support staff on drugs and smoking education.

Wider curriculum messages integrated
Delivery of a pilot project to one Brent school to test the integration of tobacco messages into the wider curriculum.

Peer Led Initiatives

Although efficacy of peer led and youth focused initiatives requires further research, consultation with young people around smokefree youth marketing ideas and for information on young persons' knowledge, attitudes and beliefs toward tobacco use produces invaluable insights.

The Brent Smokefree Ambassadors, are group of volunteers aged 12 to 19 that are in the initial stages of development by Brent Tobacco Control Alliance partners. These volunteers will be leading initiatives around other young people and along with other young people. With the support of partners and multi agencies they will help reduce the attractiveness of tobacco products within the community.

The first intake of Brent Smokefree Ambassadors has received bespoke training organised by the Brent Tobacco Control Alliance. They will also be eligible to attend youth forums on tobacco delivered by the regional tobacco policy team.

The Smokefree Ambassadors will not only compliment the key actions set out in the strategy, but they will be at the heart of discussions and decisions that are usually made by adults and the centre focus for community engagement and communication with other young people in the borough.

Key Aims of the Brent Smokefree Ambassadors

Participate

To build a culture of participation within the Tobacco Alliance whereby the young people can have a say in the smokefree initiative and genuine opportunities to influence the strategy and its implementation, thereby bringing about change within their communities.

Increase awareness

Increase the awareness of the harms of tobacco to other young people and family members.

Engage

Engage with the family, friends and the community to reduce the attractiveness of smoking

and raise awareness of the Brent Stop Smoking Service.

Integrate advice

Form a peer-led initiative to integrate advice on smoking and tobacco use into schools and youth groups via multiagency working.

Create young friendly institutions

To create young friendly institutions that recognise the importance of stopping the inflow of young people recruited as smokers

6.2 Motivating and Assisting Every Smoker to Quit

Three quarters of all smokers say they would like to quit, but fewer than half actually go on to make a quit attempt. Only a small fraction, less that 3%, actually successfully quit each year.

Research shows that you are four times more likely to quit smoking if you seek help from an NHS Stop Smoking Service. Continued and enhanced provision of an accessible, flexible, efficient and well marketed stop smoking service that both motivates and assists smokers to quit as well as help to de-normalise smoking is essential to reducing smoking prevalence. Continuing to help adults to stop smoking will also help prevent young people from taking up the habit.

Key Actions

Enhance and Support Service Delivery

Continue to support and enhance local smoking cessation delivery schemes, including general practitioners, pharmacists, secondary care and workplace providers, thereby increasing registrations and direct access to smoking cessation support and advice.

Deliver Strategic Marketing

Deliver marketing campaigns to encourage more quit attempts particularly targeted at smokers from more disadvantaged backgrounds and high smoking prevalence groups.

Increase Service Reach and Quality

Increase access to and quality of BSSS core clinics.

Increase Registration Conversion Rates

Increase the overall conversion rates of registrations to quitters from 33% to average London quit rate[36] of 51%

[36] Source: Stop Smoking Service Audit Report & Evaluation for London, 2009 - 2010

Improve Data

Radically improve the information processing and data collection system for BSSS.

Actively Participate in Tobacco Alliance

Work with the wider tobacco control alliance to create pathways, links and opportunities to reach more smokers in Brent with the smokefree message.

Tackle High Smoking Rates

Tackle high smoking rates in disadvantaged and vulnerable communities.

6.3. Protecting our families and communities from tobacco related harm

Second Hand Smoke

Second hand smoke poses a serious health hazard and there is no safe level of exposure. Second hand smoke consists of over 4000 chemicals, including over 50 known carcinogens. Medical and Scientific evidence shows that exposure to second hand smoke increases the risk of serious medical conditions such as lung cancer, heart disease, sudden infant death syndrome, asthma attacks, childhood respiratory disease and reduced lung function.

The introduction of Smokefee Legislation in England in July 2007 has been popular and has effectively removed second hand smoke from virtually all enclosed work and public places. In Brent, compliance rates have been consistently high except in the case of shisha bars and occasionally after hours in late night premises.

Less is known about the number of smoke free households in Brent. Since smoking prevalence is higher in more deprived wards where overcrowding is higher and the population is younger, it is imperative that the effects of second hand smoke continue to be communicated, for the long term benefit of our population.

Smoking Related Fires

Smoking causes over 3000 house fires every year in the UK and smoking materials are thought to cause 30% of all fire deaths in the home[37]. Fires are often caused by children playing with smoking paraphernalia, smoking in bed, by not using a proper ashtray or by

[37] Milnes D & Hooper P. *Tobacco Control Advocacy Toolkit – A Guide to Planning Advocacy Activity to Tackle Tobacco.* p.156. 2010

not properly extinguishing a cigarette or pipe. There have been 34 smoking related fires in private dwellings in Brent since 2008[38].

Key Actions

Smokefree compliance visits

Environmental Health will make at least 50 visits to Shisha bars to ensure smoke free compliance in 2010 – 2011. This will be supported by enforcement actions where necessary, and publicity.

Health, Safety and Licensing will continue to enforce Smokefree Legislation in bars, pubs and clubs. They have agreed to produce quarterly reports relating to breaches to smokefree legislation.

Home Fire safety visits

The London Fire Brigade will conduct a minimum of 2160 home fire safety visits that deliver the smoke free message per year.

To better inform the Tobacco Control Alliance, the London Fire Brigade will collect data on the number of people who smoke inside their homes as a part of home fire safety visits.

2012 Olympics

Brent will be hosting Olympic events at Wembley Stadium. We will work closely with event organisers and councillors to lobby for smoke free Olympic venues in Brent.

Best practice model

NHS Brent will form a smoke free action group in order to ensure effective implementation of a comprehensive smoke free policy that includes smoke free NHS premises and grounds. This group will consist of the human resources manager, the estates manager, a clinical lead and the Brent Tobacco Control Alliance co-ordinator, and will place the organisation as an exemplary lead in smoke free policy.

Campaigns

Through various community and workplace events tobacco control alliance partners will promote smoke free communities opportunistically through awareness campaigns and projects that highlight the benefits of smoke free homes and cars.

The Brent Tobacco Control Alliance partners will do this in conjunction with public sector and voluntary organisations, private businesses, civil society and local government.

[38] Source: London Fire Department, 2010

6.4. Improving Partnership Working

In order to achieve the outcomes of this strategy, and to reduce duplication, maximise resources, track progress, and optimise co-ordination effective investment in partnership working is imperative. There are many different organisations and individuals involved in delivering, organising, enabling and providing opportunities that support a reduction in smoking prevalence in Brent.

Brent Tobacco Control Alliance partners also need to provide consistent messages across borough boundaries for sustained and effective tobacco control efforts. Therefore, action is required strengthening relationships with neighbouring boroughs.

Key Actions

Monitoring by Brent Tobacco Control Alliance

Brent Tobacco Control Alliance Meetings to be held quarterly.

Alliance Review

Annual review of alliance functionality to be undertaken using the self assessment process contained in 'Tobacco Control Alliances: A Toolkit for London'. Annual leadership and governance improvement plan to be completed on an annual basis.

Shared database

Creation of a database accessible by all relevant Brent Council departments (including EH, H,S &L, Trading Standards and Planning). This will contain profiles on all shisha bars and progress made on smokefree legislation compliance visits, warning letters, and prosecution updates. It can also be used for updates on activity around illicit tobacco, duty unpaid tobacco and niche tobacco products.

Regional tobacco control meetings

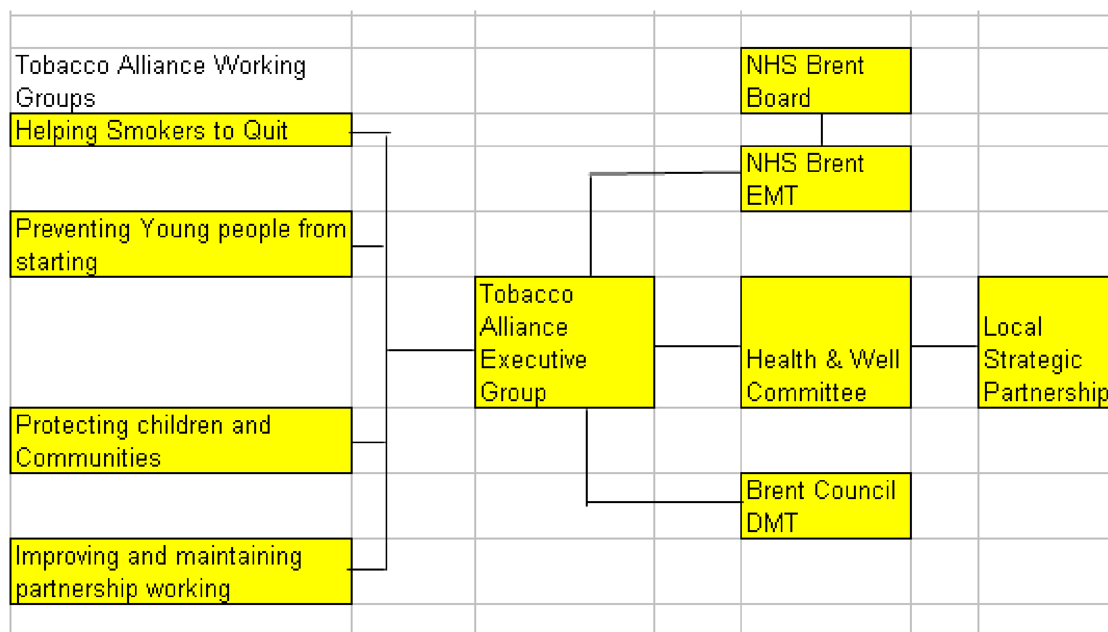
Brent representation at London regional tobacco control meetings.

Information pathways

Information sharing and cross border working with tobacco control colleagues in neighbouring boroughs.

7. Delivery and Review

7.1 Brent Tobacco Control Alliance Governance Structure



This strategy is accompanied by an action plan which has been developed by members of the Brent Tobacco Control Alliance.

The alliance consists of a group of self nominated 'executive' members who form a steering group in addition to 'working groups' who will focus on delivery of the actions.

Monitoring and Evaluation will be conducted on a quarterly basis to feed into quarterly tobacco alliance meetings. Progress will then be fed to the Local Strategic Partnership through the Health and Well Being Group twice a year.

The Tobacco Control Executive group will take responsibility for monitoring and evaluating the strategy. The strategy will be reviewed annually and updated when appropriate taking into consideration any guidance or suggestions from the Local Strategic Partnership, NHS Brent, Brent Council or in the case of new national policy or legislation or any compelling new evidence.

7.2 Action Plan

Work Stream 1					
Stopping the Inflow of Young People Recruited as Smokers					
Focus Areas (Key Actions)					
1.1 Reducing attractiveness of tobacco through both school based and peer led activities	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
* Increase awareness of the harms of tobacco among young people in Brent through school & youth group based initiatives	Develop school lesson plans that increase awareness of harms as well as look into the social, historical, economic and physical aspects of smoking and other tobacco use that appeal to young people	Sep-10	Addaction	*Tobacco Control Alliance Co-ordinator *Healthy Schools Co-ordinator	Brent Tobacco Control Alliance Executive
	Integrate the smokefree message into PSHE lessons and the 'clinic in a box' program and evaluate outcomes in the 10 Brent secondary schools & Pupil Referral Units. Distribute lesson plans to all other schools.	Starting Jan 2011	Addaction	*Healthy Schools Lead *Tobacco Control Alliance Co-ordinator	Brent Tobacco Control Alliance Executive
	Promote the use of lesson plans in Brent PSHE Schemes of Work for 95% of Primary Schools	Jul-11	Healthy Schools Lead		Brent Tobacco Control Alliance Executive
	Identify resources for Smokefree Communications & most effective avenues (including theatre into education)	Feb-11	Brent Healthy Schools Board	Brent Smokefree Ambassadors; Tobacco Control Alliance Co-ordinator; Addaction	Brent Tobacco Control Alliance Executive
*Increase awareness of the harms of tobacco among young people in Brent through peer led Initiatives	Develop a committed team of 'Smokefree Ambassadors' from representatives of Brent Youth Parliament, Brent Youth Volunteers and other young people in the borough.	Mar-10	Tobacco Control Alliance Co-ordinator	* Brent Youth Parliament (BYP) * Brent Youth Volunteers (BYV) * Friends of Brent River Park (FBRP)	Brent Tobacco Control Alliance Executive
	Debate at Brent Youth Parliament on youth smoking and the tobacco industry	Jun-10	Brent Strategic Youth Engagement Officer	* Tobacco Control Alliance Co-ordinator * Substance Misuse and Sexual Health Training Manager	Brent Tobacco Control Alliance Executive

	Develop and disseminate training to Smokefree ambassadors on the effects/dangers of smoking and tobacco (including shisha & tobacco paan)	Jun-10	Tobacco Control Alliance Co-ordinator	* Substance Misuse and Sexual Health Training Manager *Commissioned trainer * BYP, BYV & FBRP	Brent Tobacco Control Alliance Executive
	Raise awareness and regular publicity of the Brent Smokefree Ambassadors through attendance at high profile events, articles in the local press & magazines and on the B My Voice website	Ongoing	Tobacco Control Alliance Co-ordinator	*Brent Strategic Youth Engagement Officer *BYP, BYV & FBRP	Brent Tobacco Control Alliance Executive
	Establish a smokefree youth campaign	Jun-11	Commissioned provider	*Tobacco Control Alliance Co-ordinator *Brent Strategic Youth Engagement Officer * Smokefree Ambassadors	Brent Tobacco Control Alliance Executive
* Improve evidence base and understanding of young peoples' smoking prevalence and tobacco habits	Integrate questions on tobacco use into existent 'clinic in a box' screening tool to assist in more accurate data collection on young peoples' smoking habits in 10 Brent secondary schools & PRU's	Quarterly reporting (ongoing)	Addaction		Brent Tobacco Control Alliance Executive
	Use 'Clinic in a box' screening tool to capture and monitor levels of tobacco use among 16 - 19 year old students at the College of North West London(CNWL)	Quarterly reporting (ongoing)	Addaction		Brent Tobacco Control Alliance Executive
	Evaluate and Review the Smokefree Ambassador Peer Led Initiative	Mar-11			
* Work to denormalise tobacco use	Develop an exemplary smokefree policy template for schools	Feb-11	Tobacco Control Alliance Co-ordinator		Brent Tobacco Control Alliance Executive
	Engage with 100% Brent schools to publicise, encourage and disseminate smokefree policy & link it to healthy schools program	Aug-11	Healthy Schools Lead	Addaction	Brent Tobacco Control Alliance Executive
	Offer advice to the school community on activities that prevent smoking and the use of tobacco on school premises and surrounding area.	Aug-11	Healthy Schools Lead	Tobacco Control Alliance Co-ordinator	Brent Tobacco Control Alliance Executive

* Encourage & support young people to quit smoking and other tobacco use	Pilot targeted smoking cessation support in at least one Brent Secondary School (available to both students and staff)	Apr-10	Healthy Schools Lead	Addaction; Tobacco Control Alliance Co-ordinator; Brent Stop Smoking Service	Brent Tobacco Control Alliance Executive
1.2 Reducing Availability of tobacco	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
* Reduce supply of tobacco to minors	* Carry out operations to identify traders suspected of selling tobacco to minors and conduct 50 underage test purchases of both traditional and niche tobacco products each year	31st March each year	Trading Standards	Environmental Health; Health Safety & Licensing; Police	Brent Tobacco Control Alliance Executive
* Monitor availability of tobacco products	Set up pathways with partner agencies such as Environmental Health, police and Her Majesties Revenue & Customs to share best practice & intelligence on businesses that persistently sell tobacco products to children or illicit tobacco products	Aug-10	Trading Standards	Environmental Health; HMRC; Police	Brent Tobacco Control Alliance Executive
	Hold at least 2 partnership days every year	Conducted by 31st March each year	Trading Standards	Environmental Health; HMRC; Police; Brent Tobacco Control Alliance	Brent Tobacco Control Alliance Executive
	Promote & market the 'Shop the Shop' campaign by doing a borough wide billboard campaign in conjunction with youth group and school talks	May-10	Trading Standards	Tobacco Control Alliance Co-ordinator	Brent Tobacco Control Alliance Executive
* Continue to promote the ‘Responsible Trader Scheme’	Maintain at least 170 Responsible Trader Scheme Members in Brent	Conducted by 31st March each year	Trading Standards		Brent Tobacco Control Alliance Executive
	Carry out compliance audits of 50% of existing members	Conducted by 31st March each year	Trading Standards		Brent Tobacco Control Alliance Executive

1.3 Reducing Affordability of Tobacco	Milestones/Indicators	Timeline	Lead Officer	Partners	Reporting
*Reduce sales of illicit &/or duty unpaid tobacco products	Carry out & publicise enforcement action against traders who sell illicit, duty unpaid or counterfeit tobacco - reporting on number of illicit tobacco enforcement actions compared to previous years	31 March each year	Trading Standards	Environmental Health; HMRC; Police	Brent Tobacco Control Alliance Executive

Workstream 2					
Motivating and Assisting Every Smoker in Brent to Quit					
Focus Areas (Key Actions)					
2.1 Improving the current Brent Stop Smoking Service	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
* Increase service reach and quality	Significantly increase the number of pharmacists and general practitioners delivering stop smoking advice and support through GP and Pharmacy recruitment and support scheme	July 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Improve efficiency, flexibility, access to & capacity of core service clinics increasing the number of 4 week quits to 200 per annum	July 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Empower & support inactive level 2 trained advisors in pharmacies & GP's to become active	June 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Develop & Monitor activity and performance of stop smoking support in secondary care as per pilot evaluation recommendations	Sep-10	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
* Enhance &Support Service Delivery	Develop, plan and action support visits to 100% of GP's and pharmacists that have signed up to the scheme	July 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
* Increase registrations and direct access to services	Establish registration points to recruit & register smokers into services	Jul-10	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive

	Improve capacity & capability of front line staff to identify smokers, offer brief intervention & specialist intervention	Ongoing	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Improve administrative function to ensure all new contacts are followed up within 24 hours, and old contacts from previous campaign lists are followed up as a matter of weekly routine	August 2010 (Ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
* Increase Registration conversion rates	Increase the overall conversion rates of registrations to quitters from 33% to the London average quit rate of 51%	Aug-10	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
2.2 Tackling high smoking rates in disadvantaged & vulnerable communities	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
*Increase Partnership working especially to reach high priority groups	Develop Community Provider & workplace schemes for contracted delivery of stop smoking support	Ongoing	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Recruit champions from acute and community settings to reduce smoking rates in pregnancy	Ongoing	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Provide Level 1 training for midwives & contracted providers	Ongoing	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Joint working with Brent Community Services developing clear referral pathways & agreed level of activity	June 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
2.3 Deliver Strategic Marketing	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
	Development & monitoring of a robust social marketing strategy	July 2010 (ongoing)	Health Promotion	Brent Stop Smoking Service	Brent Tobacco Control Alliance Executive
	Delivery of weekly face to face campaigns; development of new branded marketing materials; billboard, mini-bus and poster campaigns & other actions as set out in separate social marketing strategy	July 2010 (ongoing)	Brent Stop Smoking Service	Health Promotion	Brent Tobacco Control Alliance Executive

2.4 Improve data collection and information processing	Milestones/Indicators	Timeline	Lead Officer	Partners	Reporting
* Radically improve the information processing and data collection system for BSSS	Monitor, review and evaluate the new SONAR information system	May 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Establish administrative protocols to facilitate audit	May 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive
	Establish and implement robust performance management	May 2010 (ongoing)	Brent Stop Smoking Service		Brent Tobacco Control Alliance Executive

Workstream 3					
Protecting Families and Communities from Tobacco Related Harm					
3.1 Smokefree Compliance Visits	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
	Environmental health will make at least 50 visits to shisha bars per year to ensure compliance to smokefree legislation	March 31st each year	Food Safety Team		Brent Tobacco Control Alliance Executive
	Health, Safety and Licensing will continue to enforce smokefree legislation in bars, pubs and clubs as a routine element of visits to venues	Quarterly reports relating to breaches in smokefree legislation	Health, Safety & Licensing		Brent Tobacco Control Alliance Executive
3.2 Home fire safety visits	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
	The London Fire Brigade will conduct a minimum 2160 home safety visits that deliver the smokefree message every year	March 31st each year	London Fire Brigade	Tobacco Control Alliance Co-ordinator	Brent Tobacco Control Alliance Executive

3.3 Public Campaigns	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
	The Tobacco Control Alliance will campaign for smokefree Olympic venues in Brent for the 2012 Olympics.	Ongoing	Tobacco Control Alliance Co-ordinator	Tobacco Control Alliance Partners	Brent Tobacco Control Alliance Executive
	Alliance partners will identify opportunities and promote smokefree communities through various community and workplace events	Aug-11	Tobacco Control Alliance Co-ordinator	Tobacco Control Alliance Partners	Brent Tobacco Control Alliance Executive
Workstream 4					
Improving and Maintaining Partnership Working					
4.1 Monitoring the Brent Tobacco Control Alliance through annual functionality review	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
	Annual functionality review to be undertaken using the self assessment tool contained in 'Tobacco Control Alliances: A Toolkit for London'	Annually in April	Tobacco Control Alliance Co-ordinator	Tobacco Control Alliance Partners	Health and Well Being Committee; NHS Brent EMT; Brent Council DMT; NHS Brent Board
	Action plan to be evaluated annually	Annually in April	Tobacco Control Alliance Co-ordinator	Tobacco Control Alliance Partners	Health and Well Being Committee; NHS Brent EMT; Brent Council DMT; NHS Brent Board

4.2 Creation of Shared database accessible to relevant key stakeholders	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
	Creation of a shared internal database that will contain profiles on all premises in breach of smokefree legislation; progress made on compliance visits; warning letters & prosecution updates - made accessible to relevant Brent Council departments. This will also be expanded to include updates on activities around illicit tobacco, duty unpaid tobacco & niche tobacco products.	Feb-11	Environmental Health	Council based tobacco control alliance partners	Brent Tobacco Control Alliance Executive
4.3 Creation of clear intelligence pathways	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**
	Pathways to be set up and named contact leads communicated in order to share information both within the alliance and within neighbouring boroughs	Feb-11	Trading Standards and Tobacco Control Alliance Co-ordinator	Tobacco Control Alliance Partners	Brent Tobacco Control Alliance Executive
4.4 Attendance at sector wide, regional and national meetings/events and feedback to alliance	**Milestones/Indicators**	**Timeline**	**Lead Officer**	**Partners**	**Reporting**

	Nominated members of the alliance to attend regional, sector wide and national meetings and conferences to feed back into current alliance monitoring & progress	Ongoing	Tobacco Control Alliance Co-ordinator	Tobacco Control Alliance Partners	Brent Tobacco Control Alliance Executive

Appendix 1 – Acknowledgements

The Brent Tobacco Control Alliance is chaired by Kostakis Christodoulou (NHS Brent) and Yogini Patel (Brent Council). This strategy and the Brent Tobacco Control Alliance are coordinated by Amanda Wilson.

Brent Tobacco Control Alliance Members

Name	Title	Organization
Sean Bennett	London Fire Brigade - Brent Borough Commander	London Fire Brigade
Renata Chavda	Strategic Youth Engagement Officer - Brent	Brent Council
Kostakis Christodoulou	Head of Health Promotion	NHS Brent
Andrew Clooney	Brent & Harrow Trading Standards	Brent Council
Kate Crane	Healthy Schools Co-ordinator	Brent Council
Andrew Davies	Policy and Performance Officer	Brent Council
Brigitte Dingle	Health Inequalities Manager	NHS Brent
Adebisi Durotolu	Tobacco Control Alliance Administrator	NHS Brent
John Gaffney	London Fire Brigade Officer	London Fire Brigade
Pamela Gilmore	Brent Youth Volunteers Officer	Brent Youth Volunteers
Dawna Gordon	Stop Smoking Specialist	NHS Brent
Amy Gow	Occupational Health Nurse	McVities
Richard Hay	Neighbourhood Co-ordinator	Brent Council
Susan Hearn	Manager – Stop Smoking Service	NHS Brent
Shamsul Islam	Service Manager, Environmental Health	Brent Council
Ravina Kotecha	Lead of Young People's Substance Misuse Services	Brent Council
Dr Jahan Mahmoodi	PBC Management Committee and GP at Hazeldene Medical Centre	NHS Brent
Helena O'Connor	Team Leader for School Drugs Education, Addaction	Addaction
Natasha O'Donoghue	Licensing Enforcement Officer, Health, Safety and Licensing	Brent Council
Tom O'Callahan	Learning Co-ordinator, Metroline	Metroline Buses
Ogo Okoye	Head of Public Health Services	NHS Brent
Yogini Patel	Deputy Head of Environmental Health	Brent Council

Hema Patel	Pharmacist – Leigh Pharmacy	Leigh Pharmacy
Eileen Sabur	Brent Youth Volunteer Officer	Brent Youth Volunteers
Hashith Shah	Brent and Harrow Trading Standards	Brent Council
Sundip Sheth	PEC member and Pharmacist	Carters Pharmacy
Isabella Smith	Interim Pharmacy Contracts Manager	NHS Brent
Osita Udenson	Wembley Town Centre Manager	Brent Council
Amanda Wilson	Tobacco Control Alliance Co-ordinator	NHS Brent/ Brent Council
Sandy Youngson	Substance Misuse and Sexual Health Training Manager	NHS Brent

Additional contributors

Name	**Title**	**Organization**
Simon Bowen	Acting Director of Public Health	NHS Brent
Sasha Cain	Consultant Health Psychologist/ Head of Smokefree Camden	NHS Camden
Martin Dockrell	Director of Research & Policy	ASH London
Andrew Hayes	Tobacco Policy Manager, Regional Public Health Group	Department of Health
Joyce Ip	Brent Youth Volunteer Officer	Friends of Brent River Park
Meghna Khanna	Information Specialist	NHS Brent
Andreas Kirschner	Enforcement Officer, Environmental Health	Brent Council
Dominick Nguyen	Campaigns & Communication Manager - Tobacco Policy London Regional Public Health Group	Department of Health
Ghazaleh Pashmi	Assistant Regional Tobacco Policy Manager	Department of Health
Brijesh Patel	Senior Public Health Analyst	NHS Brent
Lemoy Patterson	Team Leader - Environmental Health	Brent Council
Sarah Rourke	Project Manager – Community and Workplace Provider Initiative	NHS Brent
Mohammed Shaikh	Manager – Community Engagement	NHS Brent

Appendix 2

Shisha and Paan Fact Sheet

What is shisha?

Shisha tobacco is flavoured tobacco that is smoked through a water pipe (also known as a shisha pipe, hookah, nargile, nargeela, lula or chillam). It originated in South Asia and is popular in the Middle East, parts of Eastern Europe and parts of Africa. It has also gained popularity among young people and ethnic populations in Western countries and carries with it, strong social associations.

What are the effects of smoking shisha?

According to the World Health Organisation (WHO), a typical one hour long shisha smoking session involves inhaling 100-200 times the volume of smoke inhaled with a single cigarette. Since the smoke is 'cooled' by the water pipe, it is also possible to inhale the smoke more deeply into the lungs.

Similar to the cardiovascular response of a cigarette, one's expired air carbon monoxide level, plasma nicotine level and heart rate are substantially increased after smoking shisha. Although more research needs to be done, the WHO suggest that smoking shisha is just as likely as cigarette smoking to increase the risk of lung, bladder and mouth cancers in addition to cardiovascular disease & respiratory disorders.

Smoking shisha also carries wider public health implications. It has been linked to the spread of tuberculosis in Egypt. Further the sharing mouthpieces increases the risk of transmitting viral and bacterial infections.

Does shisha contain tobacco?

Many people erroneously believe that shisha tobacco doesn't actually contain tobacco or nicotine. Whilst herbal 'tobacco-free' varieties do exist, the most commonly used varieties often do. Environmental Health Officers set out to conduct a shisha tobacco sampling exercise and survey of three popular cafes in Brent in early 2010. Samples were taken from seven of the most popularly smoked brands.

Results were as follows:

1. Significant levels of tobacco

All samples contained significant levels of tobacco and nicotine in addition to traces of other heavy metals such as arsenic, lead, mercury and cadmium.

2. Poor Knowledge and attitudes of staff

None of the staff questioned during the sampling survey had detailed knowledge of the compositional details of the products or clear knowledge of the sale of tobacco regulations. There was very little understanding of the adverse affect that smoking shisha has on health. Infact, there

was a general assumption that because the smoke travels through water, there would be little or minimal negative impact to health.

3. No health warnings

None of the tobacco containers from which shisha was served had the appropriate health warning on the packaging, contravening the Tobacco Products (Presentation and Sale) (Safety) Regulations 2002.

What are Paan and Gutka?

Paan is a South, East and South East Asian tradition of chewing a betel leaf roll containing areca nut, catechu, lime and sometimes tobacco. Different spices and flavourings such as aromatic seeds, pods & buds, flowers, fruits, barks, preserves and sugar are also added. It is commonly thought to aid in digestion and act as a mouth freshener. There are different types of paan

- Sweet paan (meetha paan)
- Paan with areca nut (paan supari, paan masala or sada paan)
- Paan with Tobacco (tambaku paan and some varieties of paan masala)

No significant health risks have been associated with occasionally chewing sweet paan, however paan containing tobacco and areca nut are associated with oral cancers, submucosal fibrosis and sever dental problems.

Gutka is described as 'a sweetened mixture of tobacco, betel and catechu chewed together. Packed in attractive satches to target the lower income group; it has slowly become a hot favourite amongst the youth across all income groups'[39]. It gives a more intense 'buzz' than smoking tobacco. It is highly addictive and a known cancer causing agent.

Paan Survey 2009

A 'paan project' conducted in 2009 (by the Brent & Harrow Trading Standards Service) investigated local vendors' knowledge of and compliance with tobacco packaging regulations in relation to tobacco paan and guthka. It indicated that almost half of the 18 sellers that were visited were non-compliant on the first visit and it resulted in two tobacco paan sellers in Brent being prosecuted because they did not supply their goods with the statutory warning after being given satisfactory advice and warning.

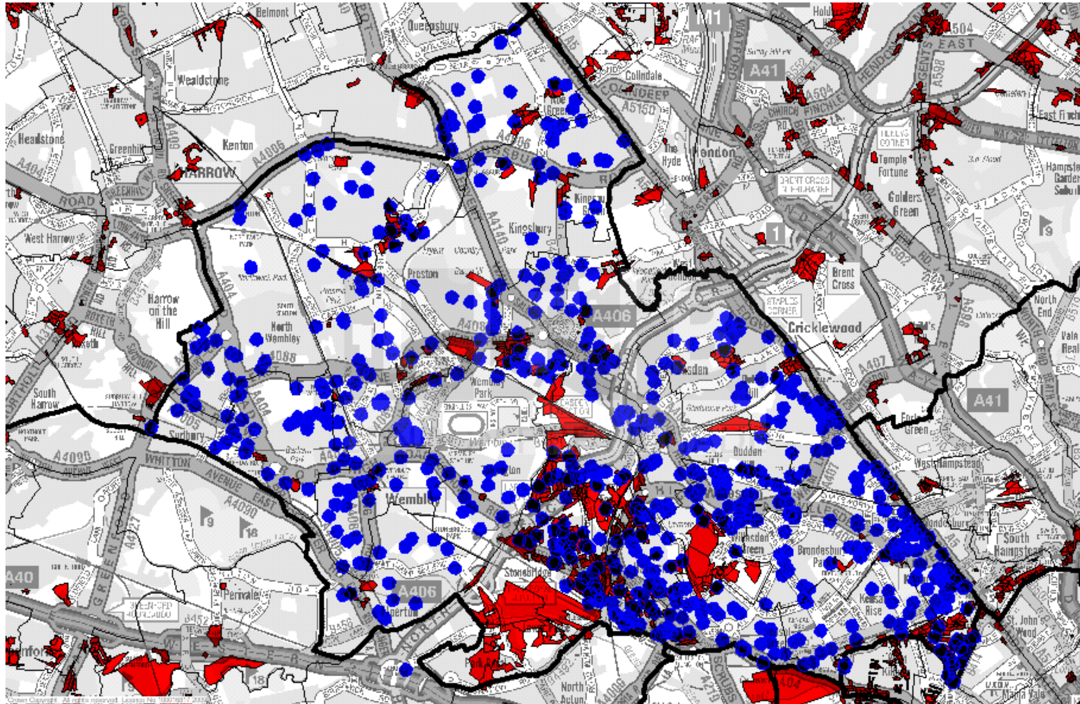
Eleven further compliance visits with respect to the sale of tobacco paan have already been conducted in 2010 and the trading standards plan to follow up these visits with a concerted programme of under age sale attempts.

All tobacco products must be presented in packaging which supports a prescribed health warning product. The Brent and Harrow Trading Standards Service have encountered problems with compliance of smokeless tobacco products, in particular tobacco Paan.

[39] Source: http://www.mr-group.net/gutkha.html

Appendix 3

Brent map detailing all accidental dwelling fires 2009-2010 (blue dots). The high risk locations are shown in red.



Appendix 4

NHS Brent Commissioning Strategy Plan showing the savings from reducing the smoking prevalence from 26% to 23.5% (10301 smokers)

	2007/08	2008/09	2009/10	2010/11	2011/12
Smoking quitters 4 weeks from smoking cessation	2,360	4,720	7,080	9,440	11,800
Long term smoking quitters from smoking cessation	236	472	708	944	1,180
Total long term smoking quitters from tobacco control	1,030	2,060	3,090	4,120	5,151
Investment required in smoking cessation	215,000	330,000	330,000	330,000	330,000
Savings from smoking cessation	73832.6	147665.2	221497.8	295330.4	369163
Net Cost/Gain from smoking cessation	-141,167	-182,335	-108,502	-34,670	39,163
Savings from tobacco control	322235.5	644533.6	966800.4	1289067	1611334
Net Cost/Gain from tobacco control	**107,236**	**314,534**	**636,800**	**959,067**	**1,281,334**

- Assumes that the smoking cessation service will deliver 11,800 4 week quitters which will translate into 1180 quitters at one year
- The remainder of the quitters will be delivered by broader tobacco control initiatives
- The investment required is based on the level of investment prior to Turnaround
- The savings are based on the modelling undertaken in Newham and by the LHO which calculated a cost per smoker of £312.85

The actual costs **per year** of the interventions listed are:
2007/08 – Total Smoking budget of £215k, comprising of core Smoking Cessation budget of £130k, Stop before the Op budget of £60k and LAA funds of £25k to pay for smoking cessation facilitators and running costs.

Appendix 5 - Launch Flier Invitation

Advance Notice

Early application advised

Tackling Inequalities

Launch of Brent Tobacco Control Strategy

Tackling Health Inequalities:
Effective evidence based action to tackle smoking and tobacco use among adults and young people in Brent

Monday 29th November 2010, 5pm – 8pm

Venue: to be confirmed
Finger Buffet provided

Top UK and international speakers,
Unparalleled networking and peer support

Key Speakers & Provisional Topics:

Professor Robert West – *How Best to Motivate and Help Smokers to Stop*
Professor of Health Psychology and Director of Tobacco Studies,
University College London

Ilaria Geddes - ***Tobacco Use and Health Inequalities***
Research Fellow for the Marmot Review, Fair Society, Healthy Lives Team, University College London

Martin Dockrell – *Young People and Tobacco Use*
Director of Policy & Research, Action on Smoking and Health (ASH), London, UK

Andrew Hayes – *Tobacco Control in London*
Tobacco Policy Manager, Regional Public Health Group, London

Target Audience:
Pharmacists, GPs, Practice Nurses, Dentists, Education, NHS, Stop Smoking Advisors, Primary Care, Local Authority particularly Environmental Health, Planning, Health Safety and Licensing , Housing, Social Care and Trading Standards, Community and Voluntary groups, Commerce and Industry, Youth Groups and other relevant groups interested in tackling health inequalities and promoting health in Brent.

Free attendance
(Limited spaces - booking essential)

RSVP by **Friday 5th November 2010** to Adebisi Durotolu

Fax: 0208 795 6231
Email: Adebisi.durotolu@brentpct.nhs.uk
Post: Tobacco Control Alliance, Health Promotion Department, Wembley Centre for Health and Care, 116 Chaplin Road, Wembley, Middlesex HA0 4UZ

☐ Thank you, I will be able to attend on 29th November

☐ Sorry, I will not be able to attend on 29th November

Name: **Organisation:**

Role/job title…………………………………………………………..

Address………………………………………………………………

Phone number……………………………………………………….

Please indicate any Special Needs we need to be aware of:

☐ Parking close to venue – limited mobility

☐ Wheelchair user

☐ Special Dietary needs (please give details below)

…………………………………………………………………………………………

☐ Other