Camden ISLINGTON

# Smokefree Camden and Islington 2016-2021

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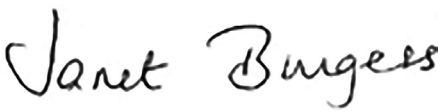
# Foreword

We welcome the Camden and Islington Tobacco Control Strategy 2016-2021 which lays out our bold ambition to become smokefree by 2030. The strategy sets out how, over the next five years, we will work together across Camden and Islington to reduce the number of people who smoke. Our aim is that the number of smokers in the population will fall to 13% in Camden and 16% in Islington.

The strategy sets out the plan for keeping our children and young people safe from the harms of tobacco. It lays out how we intend to provide support for those who already smoke and want to quit and how we intend to create a clean and safe environment while encouraging local businesses to support our work. We welcome our two boroughs working together. We want to focus on those communities in greatest need and work with residents to raise awareness of the issues and what can be done. Members of Camden and Islington's Smokefree Alliance have proposed a wide array of recommendations to achieve these strategic objectives.

In summary, this new strategy focuses on the need for a good start in life for our children and young people to stop them taking up smoking, on efforts to tackle the unequal harms related to smoking suffered by some of our most disadvantaged and, in particular on working with those partners who, through their everyday activities, are often best placed to help smokers quit.

We would encourage you to support this strategy's work, supporting Camden and Islington in our journey to being smokefree by 2030.



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# Executive Summary

## Vision

By 2030 our vision is for a new generation growing up in Camden and Islington where virtually no-one smokes.

By 2021, our vision is that:

- Fewer than 16% of people in Islington and 13% of people in Camden will smoke.
- Fewer people will suffer early preventable deaths or long-term illness and disability due to smoking.
- Young people will understand the harms of tobacco and shisha use and make the choice not to start smoking or to quit.
- Families will choose to be smokefree and give the best start in life for their children.
- Approximately 19,000 more people who live, work, study or access health services in Camden and Islington will have been supported to stop smoking tobacco.
- Communities will be protected from the harms of criminal activity linked to illegal tobacco sales.
- The cost and impact of tobacco litter on the environment will be minimised.
- Smokefree outdoor environments will have become the norm where children study and play and where people access health and social care services.

## Introduction

The Camden and Islington Smokefree Alliance (CISA) was formed in Spring 2014 to address tobacco control issues jointly in both boroughs. The Alliance is a partnership of various organisations across Camden and Islington.

## Overarching priorities

1. **Close the gateways in:** Educate young people and families about the harms of tobacco smoking and the risks of shisha use, to help young people choose not to smoke.
2. **Help people out:** Provide effective support for smokers to quit that also reaches those most at risk of poor health or health inequality to change their smoking behaviours. Look to the future, which includes cautiously harnessing the potential of electronic cigarettes.
3. **Reduce related harm:** Ensure that families are aware of the dangers of exposure to second-hand smoke; achieve a cleaner environment, disrupt illegal sales and enforce smokefree legislation.

## Smoking still matters in Camden and Islington

Smoking still matters to Camden and Islington because it remains the single biggest preventable risk factor for poor health and premature death. The number of people who smoke in Camden and particularly, in Islington,

has remained stubbornly stable since 2010, even though prevalence has been steadily decreasing nationally.

In 2014 there were around 32,100 adult smokers in Camden (17%) and 40,400 adult smokers in Islington (22%). Rates of smoking remain much higher in certain population groups, disproportionally affecting those already disadvantaged. These include people who are less affluent, certain black and ethnic minority communities, LGBT communities, people living with long-term conditions, including mental health, and people in the criminal justice system. The challenge in the coming years will be to tackle the inequalities caused by smoking in our communities.

Our target is to reduce the proportion of adult smokers to 13% in Camden and 16% in Islington by 2021. This is around 7,600 less smokers in Camden and 11,300 less smokers in Islington in five years. We aim to drive reductions in prevalence by at least a quarter specifically in communities with higher smoking rates.

Smoking is still a killer; half of all long-term smokers die of a smoking-related illness. Smoking cannabis with tobacco greatly increases the harms to health. In Camden, there are around 217 smoking-related deaths each year and 225 deaths in Islington.

These are ambitious goals which will require bold action. Everyone must play their part to achieve the vision of a smokefree Camden and Islington and reduce the impacts of tobacco amongst the most affected communities.

## Closing the gateways in

Smoking usually starts at an early age and most smokers start in childhood and develop a life-long habit. That is why it is essential to close the gateways into smoking, for children and young people, to create a smokefree generation. Long-term smoking is closely associated with inequality and social exclusion, with children from low income backgrounds most likely to be smokers in adulthood.

The main influence for children starting to smoke is their immediate family. Therefore, helping adults in the family to stop smoking and creating smokefree environments where children live and play are essential parts of this strategy and will contribute to fewer children starting to smoke and may contribute to a new generation of people addicted to nicotine.

Please see the full list of Recommendations for those related to ‘closing the gateways in’.

## Helping people out

**Supporting those who help smokers quit:** Stop smoking services provide pharmacotherapy and use behaviour change techniques to help smokers quit in the most effective way. In the last two years the number of people accessing NHS stop smoking services has declined nationally for a number of reasons, including the use of e-cigarettes. London Clinical Senate’s project, ‘Helping Smokers Quit’ has particularly highlighted the role for clinicians to more routinely provide advice and support, including appropriate pharmacotherapy, to patients who smoke. There is also a need for a wider variety of ‘front-line’ staff who can help identify residents

who smoke and signpost them to relevant advice and support. Employers also have a role to play and benefit from helping staff quit.

**Smokers with long term conditions:** Smoking can contribute to the development and worsening of several health conditions. Stopping smoking greatly improves outcomes for people with these conditions – it is almost never too late to quit. Offering very brief advice to smokers with long term conditions, at the appropriate 'teachable moments' during their care pathway has many potential benefits and should be an integral part of the management of long term conditions, both in primary and secondary care.

**Smokers with mental health conditions:** Smoking prevalence is twice as common among people with mental health problems, and more so in those with more severe illness. People with mental health problems use 42% of all tobacco consumed in the UK, due to heavier nicotine dependency. However, smokers with mental ill health are just as likely to want to quit as smokers without mental ill health, but are more likely to be heavily addicted to smoking and, historically, have been less likely to succeed when they try to quit. Smokers with mental ill health often need substantially more support to quit, including Nicotine Replacement Therapy provided over a longer time frame and more intensive behavioural support.

**Smokers in Islington's male and female prisons:** Smoking rates among prisoners have changed relatively little in the last few decades: they are estimated to be three to four times higher (up to 80%) than the general population (18% in England). The Prison Service is now actively working towards prisons becoming completely smokefree following their exemption from the 2007 Smokefree legislation. Adequate provision of pharmacotherapy will need to be assured before the smokefree agenda can be rolled across the whole establishment.

**Smoking in pregnancy and the early years:** Stopping smoking is one of the most effective interventions to improve the health of mother and baby and prevent avoidable infant mortality. Camden and Islington both have a higher rate of smoking in pregnancy than the London average (5.1%): 5.5% in Camden and 7.7% in Islington. Stopping smoking in pregnancy can be challenging. Only a small number of pregnant women take up the offer of help to stop smoking. Many of those who successfully stop smoking during their pregnancy go back to smoking within six months of giving birth.

**Young people:** Smoking is a childhood addiction. About two-thirds of adult smokers report they took up smoking before the age of 18. The younger people are when they start smoking the greater the harm is likely to be. Early initiation of smoking is associated with subsequent heavier smoking, higher levels of dependency, lower chances of quitting and higher mortality. Access to stop smoking services by teenage smokers has been historically low. It is important to develop innovative approaches which will ensure young smokers have the best possible chances to quit smoking, before it becomes a life-long habit and impacts on their health.

Please see the full list of Recommendations for those related to 'helping smokers out'.

## Reducing related harm

**Smokefree environments:** One of the aims of this strategy is to protect children from the risks caused by exposure to second hand smoke. It is our ambition to de-normalise smoking for children, by creating environments where children are not exposed to smoking: not only in the home but also outside schools and in playgrounds.

**Smoking litter:** Cleaning up cigarette-related litter is a significant problem in the UK, accounting for 70-90% of street litter in urban areas. Cigarette butts are the most common item of litter in both boroughs with an annual street cleaning bill between £7.5 and £9 million in Camden and £3.5 million in Islington. Those responsible for damaging our environment should be required to pay for the clean-up, i.e. 'the polluter pays'.

**Illicit tobacco:** In 2015, it was estimated that around 10% of all cigarettes and 39% of hand-rolled tobacco consumed in the UK in 2013-14 were illicit. The cost of buying illicit tobacco for the individual can be as little as half the cost of legitimate products. However, the profits from illicit trade are pocketed by criminal networks, such as gangs, which cause further harm to society through other criminal activities such as drug smuggling and human trafficking. Cross-borough, and ideally, regional multi-agency cooperation is needed to tackle illicit tobacco trade.

**Shisha:** In Camden and Islington there is widespread compliance with smokefree laws since the legislation was widely welcomed by the public and most businesses. However, recent proliferation of shisha premises has seen an increase in businesses allowing smoking in enclosed spaces in contravention of the smokefree laws. The problem is best addressed by a combination of user education as to the health effects, early advice to businesses thinking about shisha as a business model, close community liaison, multi-agency working and, where necessary, a robust approach to enforcement where there is persistent non-compliance with smokefree and other laws.

Please see the full list of Recommendations for those related to 'reducing related harm'.

## Conclusion

The three overarching priorities closing the gateways in; helping people out and reducing related harm, are essential and interlocking pieces of the overall strategy. Work in each priority area informs and advances work in others. Without this comprehensive approach, sustained over the long term, we cannot deliver further reductions in prevalence and reduce social and health inequalities caused by smoking.

Work on several of the recommendations proposed has already started. However, many recommendations are new and ambitious and will require strong leadership from a number of partners and making tobacco control everyone's business. Going forward we will strengthen and renew partnerships with a clearer focus on health inequalities. The CISA will work with the wider stakeholder groups to develop a delivery plan, to move ideas into action and achieve results.

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# Summary of recommendations

## Smoking still matters in Camden and Islington

- Reduce smoking in the adult population in Camden to 13% and Islington to 16% or less by 2021, with targets agreed on an annual basis. This is around 7,600 less smokers in Camden and 11,300 less smokers in Islington, in five years.
- Reduce smoking amongst pregnant women to 3% in Camden and 5% in Islington by 2021.
- Reduce regular and occasional smoking among 15 year olds to 5% in Camden and to 7% in Islington by 2021.
- Reduce health inequalities by reducing smoking prevalence in all key target groups with above-average smoking prevalence by at least 25% from the 2015 baseline by 2021. For example, we will reduce smoking in the routine and manual socio-economic group to 20% (from 27%) in Camden and to 29% (from 41%) in Islington by 2021.

## Closing the gateways in

- Implement the health related behaviour questionnaire in Camden and Islington schools and use data on smoking to inform a range of targeted interventions.
- Continue to educate primary and secondary school children, encouraging them to consider the social influences of smoking, highlighting the health risks and costs of smoking, as well as the support available to stop. Extend this work to include environmental and political impacts of tobacco use and tobacco companies' tactics, to resonate further with young peoples' concerns.
- Create a smokefree environment for young people, families and staff using the Healthy Settings Awards as one of the drivers.
- Continue to work with teachers to identify young smokers or pupils at risk of smoking and implement peer education programmes, such as ASSIST, to change attitudes to smoking tobacco and cannabis.
- Ensure that parents and children are educated about the harms of shisha smoking and understand the risks of electronic cigarette use.

- Work with the Youth Council, the Young People's Health Forum, Youth Hubs and other partners to explore ways of reaching young people and ensure the smokefree messages are prioritised.
- Develop a targeted approach for complex/troubled families.
- Work with all Commissioners of children and young people services (including Children and Adolescent Mental Health Services (CAMHS)) to:
  - 'Mainstream' stop smoking-related activity as part of their commissioning of clinical care in line with NICE guidance
  - Ensure adequate resource allocation for age-appropriate stop smoking advice provision
- Work with clinical staff and hospital service providers seeing any children and young people to:
  - Require mandatory training on at least Very Brief Advice for Smoking Cessation (Ask, Advise, Act) for all clinical staff
  - Consider the whole family for smoking cessation referral and support
  - Streamline internal referral systems (in conjunction with Community Stop Smoking Service provision)

## Helping people out

### Support those who help smokers quit

- Ensure good quality, evidence-based stop smoking service is integrated into the wider behaviour change offer available within both boroughs which aims to improve the health and wellbeing of people in Camden and Islington. These services should be accessible to all smokers and particularly those from lower socio-economic groups and disadvantaged populations.
- Develop local communications initiatives based on national campaigns like Stoptober and No Smoking Day, to promote consistent and coordinated messages about stop smoking support and reach high priority groups through effective, targeted communications.
- Ensure that training on providing very brief advice on smoking cessation is required of every clinician seeing Camden and Islington patients and that there is adequate clinical leadership in every NHS organisation, both at senior and ward/clinic levels to support this.
- Ensure clinicians who prescribe are trained and competent to prescribe smoking cessation medication.
- Ensure accurate and timely information about e-cigarette use to reduce public confusion about the relative risks of nicotine products compared to tobacco products and allow an informed choice.
- Increase the number of public sector staff as well as community and voluntary sector volunteers and staff who are trained to provide very brief advice on smoking cessation.
- Use Healthy Settings Awards as one of the drivers to increase stop smoking interventions by staff working with young people.
- Support workplace health and wellbeing, initially focusing on both boroughs' largest public sector employers, to reduce smoking amongst employees.

## Smokers with long term conditions

- Engage primary care leads such as Clinical Commissioning Group (CCG) clinical champions, Local Medical Committee (LMC) and Local Pharmaceutical Committee (LPC) representatives to explore opportunities for better engagement with smoking cessation and sharing best practice in primary care to ensure that people with long term conditions are routinely being encouraged to quit smoking and receive the appropriate support to do so in line with NICE tobacco guidance.
- Work with the clinical champion in every secondary care trust in Camden and Islington, to lead on helping smokers quit and to consider how the London Clinical Senate recommendations on very brief advice training and CO testing can be implemented.
- Promote adherence to NICE guidance on tobacco especially aimed at secondary care (acute, maternity and mental health services), by working with CCG commissioners and secondary care providers.
- Ensure clinicians who prescribe are trained and competent to prescribe smoking cessation medication.
- Encourage clinicians to routinely ask about cannabis use as part of their smoking cessation discussion with their patient.

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## Smokers with Mental Health conditions

- Include stop smoking support in initiatives promoting physical health (e.g. healthy eating, obesity support, physical activity) for mental health service users, including young people.
- Ensure specialist stop smoking services tailored to smokers with mental ill health are available in residential care, in-patient settings and those living independently the community, across Camden and Islington.
- Ensure a network of level 2 trained stop smoking advisors exists across all mental health secondary and community care settings.
- All staff in mental health services are trained in very brief advice and second-hand smoke.
- Work with the fire department to ensure that residential care homes comply with fire safety standards to minimise the risks for residents who continue to smoke
- Ensure that in long term residential care homes all smoking takes place outside.
- Ensure clinicians who prescribe in mental health settings are trained and competent to prescribe smoking cessation medication.

## Smokers in Islington's female and male prisons

- Develop stronger links between prison and in-patient psychiatric services and the community-based stop smoking service to ensure continuity of care, when prisoners return to the community.
- Explore commissioning an "in reach" service, so that when the person is discharged they can continue to receive stop smoking support via the same service.
- Establish links between homeless projects, psychiatric care and the prison service to ensure continuity of care for Camden and Islington residents who cycle through these three services.
- Strengthen the stop smoking provision across the whole criminal justice pathway, so that those leaving prisons have access to support.
- Ensure that prisoners who are transferred to HMP Pentonville and HMP Holloway (until June 2016) whilst they are quitting smoking continue to receive stop smoking support and do not have to go onto a waiting list.
- All psychiatric care staff in all settings, all prison staff and homeless support workers should be trained in very brief advice in smoking cessation and apprised of the dangers of second hand smoke. Any CQUIN or equivalent quality improvement incentive for psychiatric care staff could ensure that the training is mandatory.
- Ensure evidence-based treatments and staff training are commissioned for HMP Pentonville.
- Support HMP Pentonville to become smokefree and develop an updated smokefree strategy.

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## Smoking in pregnancy

- Reduce smoking amongst pregnant women to 3% in Camden and 5% in Islington by 2021.
- Promote adherence to NICE guidance on tobacco in all maternity services in Camden and Islington caring for pregnant women and following childbirth.
- Ensure pregnant women accessing maternity care are routinely screened with a carbon monoxide (CO) monitor by midwifery staff who are equipped, trained and with adequate time, and that pregnant women who smoke are referred to stop smoking services, as part of their care pathway.
- Early years services commissioning should explore the role of health visitors and other professionals in supporting pregnant women and families with young children to stop smoking.

## Young people

- Understand the needs of staff working in children's centres and schools when talking to parents and children who smoke and provide tailor-made training to enable those conversations.
- Showcase successes of staff working in challenging settings where views on smoking are entrenched and share good practice.
- Target vulnerable children who smoke, by working with social services, youth offending service, pupil referral units and looked after children nurses and enable staff to give appropriate advice and support.
- Create innovative partnerships to reach young people 16 or older, such as with student unions, leisure centres and privately owned gyms.
- Conduct insight research to target resources where young people are likely to get advice and support about stopping smoking.
- Work with the youth offending service in Camden and Islington to promote smoking cessation to young offenders.
- Encourage responsible retailer practices, such as not selling tobacco near schools.
- Ensure tobacco retailers near schools are fully compliant with new legislation on tobacco displays in shops, as a priority.
- Explore the provision of specialist stop smoking services for children, young people and their families.

# Reducing related harm

## Smokefree environ-ments

- Raise awareness of the ban of smoking in cars with children, with parents, children and staff (traffic wardens, road safety units, sustainable travel officers).
- Continue to support national smokefree homes and cars awareness campaigns.
- Continue to de-normalise smoking by reducing smoking around children: smoking and cigarette litter is out of sight of school gates and playgrounds in Council parks, housing estates and adventure playgrounds. This work, already under way in Islington will be developed in Camden. If successful, in both boroughs, we will look to expand the number and nature of public spaces e.g. public squares, to further de-normalise smoking in public for all ages.
- Work with partners of Islington's "First 21 Months" and Camden's "A Thousand and One Days" programme teams, to increase the uptake of smokefree homes.
- Use Healthy Settings Awards as one of the drivers to create smokefree environments for young people and their families.
- Work with partners to increase smokefree outdoor environments in Camden and Islington, as part of organisational smokefree policies; such as implementing smokefree hospital grounds.
- Work with employers to support the smokefree element of the London Healthy Workplace Charter awards.

## Smoking litter

- Continue working with smokers of all ages to reduce smoking-related litter in Camden and Islington with a combination of education and enforcement activities.
- Continue partnership work between Camden Environment services and local schools to raise awareness amongst our younger residents about the impact of litter in the borough and show them that tobacco also damages the environment.
- Introduce an innovative scheme, already in operation in other London local authorities, such as Enfield and Haringey: a smoker who is issued a fixed penalty notice for littering smoking material can complete a course with the local Stop Smoking Service as an alternative to a fine.
- Work with local businesses to ensure that staff on smoking breaks dispose cigarette butts responsibly and customers do not litter when sitting in outdoor areas, such as pubs and cafes.

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## Illicit tobacco

- Camden and Islington Trading Standards should continue to play a lead role in the newly established North East North Central London Illicit Tobacco Cluster Group to develop a cross-borough approach to dealing with the problem of illicit tobacco sales. The group includes Trading Standards representatives from Camden, Islington, Haringey, Enfield, Hackney, Waltham Forest and Tower Hamlets.
- Further develop links with the South East London Illicit Tobacco Group with the long-term aim of developing a pan-London approach to dealing with the sale of illicit tobacco, to work more closely with HMRC and Border Control.
- Continue to build on successes in reducing the number of underage sales and the amount of illicit tobacco on sale, by continuing strong enforcement and continue to identify priority areas to target and develop a method for local residents to provide intelligence.
- Work in partnership with the schools' health and wellbeing teams to raise awareness about illicit tobacco amongst young people (and their parents) and to remind young people that shisha is tobacco – it is not always labelled that way and young people in particular are unaware that they are consuming tobacco, often illegally imported.

## Shisha

- Camden and Islington should continue to have a proactive and preventive multi-team approach to monitor shisha premises with routine visits, until they comply with legislation or else stop selling shisha. They should continue to take action when shisha premises are breaking the law, such as allowing smoking shisha and/or cigarettes indoors, or not providing the required warning labels associated with the sale of tobacco. They should continue to identify shisha cafes which routinely allow underage customers and take enforcement action.
- In Camden, map the location of shisha cafes to identify their proximity to local schools. Trading Standards and the healthy schools team should raise awareness with children and their parents that shisha tobacco is not always labelled that way, so young people in particular may be unaware they are consuming tobacco.

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## Electronic cigarettes

- In line with PHE guidance, welcome the use of ECs by existing smokers who make a quit attempt and support smokers further to quit tobacco products using our evidence-based stop smoking services.
- Respond pro-actively to emerging new evidence on ECs and to future availability of licensed products to be used as stop smoking aids.
- Ensure our stop smoking services and all professionals in Camden and Islington providing Level 2 stop smoking advice are equipped to give up-to-date information about the relative risks of nicotine and all nicotine-containing products (including ECs), based on national guidance and regulation.
- Continue to monitor the sale of ECs and ensure that sellers comply with new and existing legislation (for example under-age sales) and with safety regulations, in particular regarding unsafe chargers. Explore potential for partnership work with the Fire Service.

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# Introduction

The first ever joint Camden and Islington Tobacco Control Summit took place on 13 February 2014. The event was hosted by the Lead Members for Health and Adult Social Care in both boroughs and brought together staff from Public Health, Environment, Public Protection, School Improvement Service in both Camden and Islington Councils, as well as the Stop Smoking Service providers, Clinical Commissioning Group, Fire Service and Public Health England. The key priority areas to address the damage caused to the local community by tobacco were agreed in the Tobacco Control Summit: reducing the number of young people taking up smoking; supporting tobacco users to quit using the most effective means possible; and reducing the wider harms caused to the community at large, such as second-hand smoke in the home, cigarette litter and fires.

There was strong support for Camden and Islington to work in partnership to address tobacco control issues in the future, including developing a joint strategy, governance arrangements for tobacco control and an Alliance of local stakeholders who will deliver the goals of this strategy, called the Camden and Islington Smokefree Alliance (CISA). The CISA was formed in Spring 2014 and a two-year tobacco control action plan was developed.

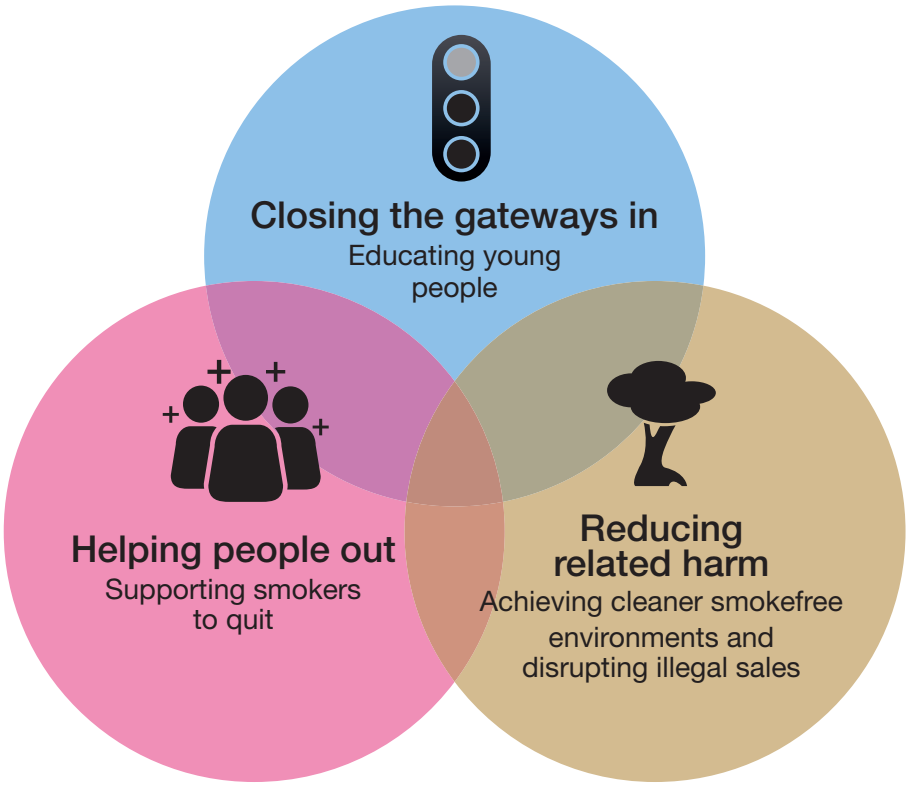
Both Camden and Islington Councils signed the Local Government Declaration on Tobacco Control in March 2014, confirming their commitment to act in order to reduce smoking in our communities, as well as protect tobacco control work from the vested interests of the tobacco industry.[A]

The CISA is working towards realising a smokefree[B] Camden and Islington by 2030; that is, towards a generation of people growing up where virtually no-one smokes.

This Camden and Islington Tobacco Control strategy outlines the ambitions for tobacco control in Camden and Islington in 2016-21. It will be updated in line with national policy, as necessary. Our aim is that smoking prevalence in the adult population is reduced to 13% in Camden and 16% in Islington by 2021, contributing to the ambition for London to have the lowest smoking rate globally (among all cities over 5 million inhabitants).[1]

The Camden and Islington Tobacco Control strategy sets out a range of recommendations for the next five years, across the following three themes:

A. This is in accordance with article 5.3 of the WHO framework convention on tobacco control.
B. For the purposes of this strategy, a smokefree society is defined as 5% or less of the population being current smokers.




1. **Closing the gateways in**
   Educating children, young people and families about the harms of tobacco smoking and the risks of shisha use and supporting them to consider the social influences of smoking, in order to help children and young people to choose not to smoke.
2. **Helping people out**
   Providing effective support for smokers to quit that also reaches those most at risk of poor health or health inequality to change their smoking behaviours. Looking to the future, this includes cautiously harnessing the potential of electronic cigarettes (e-cigarettes).
3. **Reducing related harm**
   Ensuring that families are aware of the dangers of exposure to second-hand smoke; achieving a cleaner environment, disrupting illegal sales and enforcing smokefree legislation.

However, within these themes, we have particular priorities. We recognise that most people become addicted to smoking tobacco whilst they are young. Therefore, we need to focus much of our energy on promoting a smoke-free start in life and childhood. In addition, smoking does not affect communities fairly – those who are poorer or come from certain minority groups are more likely to smoke and therefore be affected disproportionately by the negative effects of smoking. And finally, our healthcare partners are often uniquely positioned to influence and encourage smokers to quit; we must support and invigorate these clinicians for this challenge. But we are clear – while we aspire to be smokefree and anti-smoking, we are not anti-smoker and in fact want to support smokers to tackle their nicotine addiction.

The CISA will realise a smokefree Camden and Islington through the following:

1. **Evidence-based interventions and recommendations**
   In tackling a complex, multifaceted issue such as smoking where multiple interventions are needed, it can be very difficult to tease out clear evidence of impact. We recognise this is a limitation when dealing with such a complex issue. We will look at the available evidence and recommendations drawn from both local and national publications.[2 3 4 5 6] When possible, we will work with partners to use evaluation tools to assess what works. We will draw on tools such as the Public Health England joint strategic needs assessment (JSNA) pack on tobacco control to support effective implementation of our plans.
2. **Partnership working**
   Camden and Islington Smokefree Alliance partners will work together to achieve the ambitions outlined in this strategy and will engage new partners from relevant Council departments, statutory bodies and the community to further support this work.
3. **Making best use of the resources available**
   By working with partners in both boroughs (and across London where appropriate) we will aim to make best use of our combined resources - reducing duplication and taking advantage of economies of scale where possible.
4. **Helping those who need help the most**
   A focus on communities with high levels of deprivation will aim to reduce health inequalities.
5. **A communications strategy**
   Council communications departments in both boroughs will coordinate and enhance smokefree messages and support borough-wide communication campaigns.

To achieve this, CISA partners will develop a detailed delivery plan each year to ensure we are on track to achieve the recommendations set out in this strategy across the three key strategic areas.

# References


1. London Health Commission. Better Health for London. 2014. Available from: http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
2. National Institute for Health and Clinical Excellence. Smoking. Reducing Tobacco Use. QS82; 2015 [Online]. Available from: http://www.nice.org.uk/guidance/qs82/resources/guidance-smoking-reducing-tobacco-use-pdf
3. National Institute for Health and Clinical Excellence. Smoking Cessation: Supporting People to Stop Smoking. QS43; 2015 [Online]. Available from: http://www.nice.org.uk/guidance/qs43/resources/guidance-smoking-cessation-supporting-people-to-stop-smoking-pdf
4. National Institute for Health and Clinical Excellence. Smoking: Harm Reduction. QS92; 2015 [Online]. Available from: http://www.nice.org.uk/guidance/qs92/resources/guidance-smoking-harm-reduction-pdf
5. Action for Smoking and Health. Smoking Still Kills: Protecting Children, Reducing Inequalities. 2015. Available from http://www.ash.org.uk/smokingstillkills
6. Department of Health. Healthy Lives Healthy People: A Tobacco Control Plan for England. 2011. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf

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# Smoking still matters in Camden and Islington

More detailed evidence is available in Chapters 6-8.

## To individuals

### Still the biggest single preventable risk factor

Despite a significant drop in smoking prevalence in England in the last ten years, smoking remains the biggest single preventable risk factor for poor health and premature death. The London Health Commission report outlined the ambitions for a smokefree London to reduce tobacco-related avoidable deaths, currently estimated at more than 8,000 a year in London.[1]

### Smoking prevalence

Even though the proportion of people who smoke has declined in Camden and Islington compared to ten years ago (23.5% in Camden and 27.5% in Islington estimated in 2003-5),[A] data from 2010 to 2014 show that prevalence has stopped decreasing and may still be above the London and England averages.

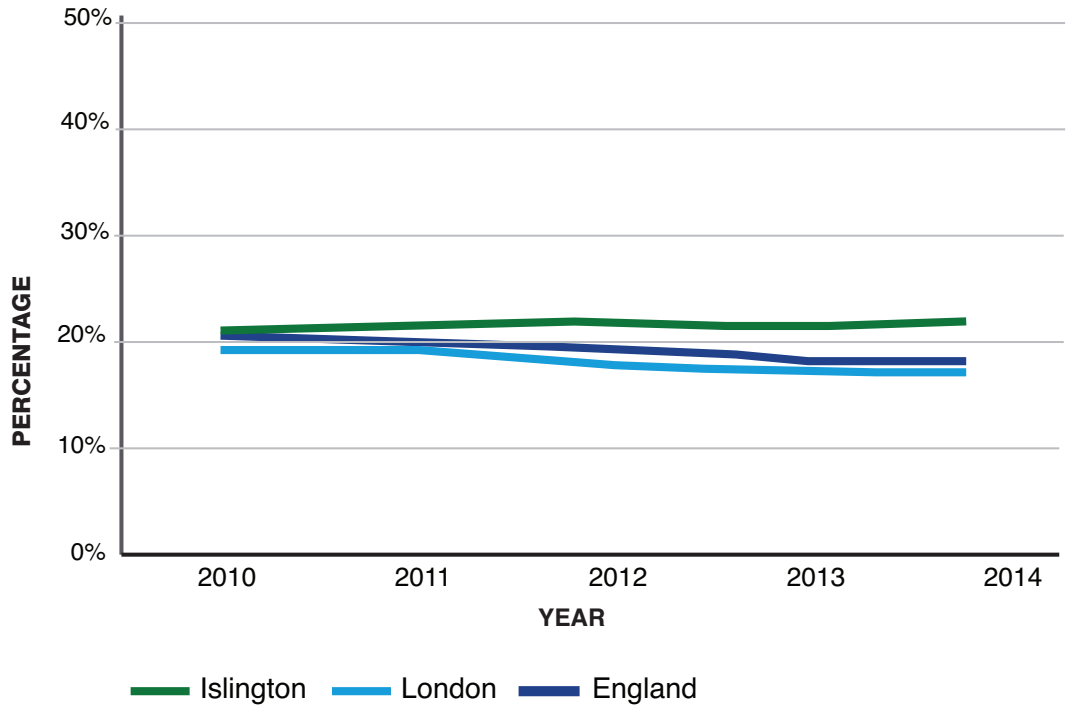
Since 2010 the estimated smoking prevalence[B] has gradually decreased in London and England on average.

In Islington smoking prevalence has remained stable since 2010, widening the gap with the regional and national averages. In 2014 the estimated prevalence was significantly higher in Islington (22%) compared to London (17%) and England (18%) (Figure 1.1). There are around 40,400 adult smokers in Islington.

In Camden smoking prevalence has also remained stable[C] since 2010. In 2014 the estimated prevalence for Camden (17%) was not significantly different to London (also 17%) or England (18%) (Figure 1.2). There are approximately 32,100 adult smokers in Camden.[2]

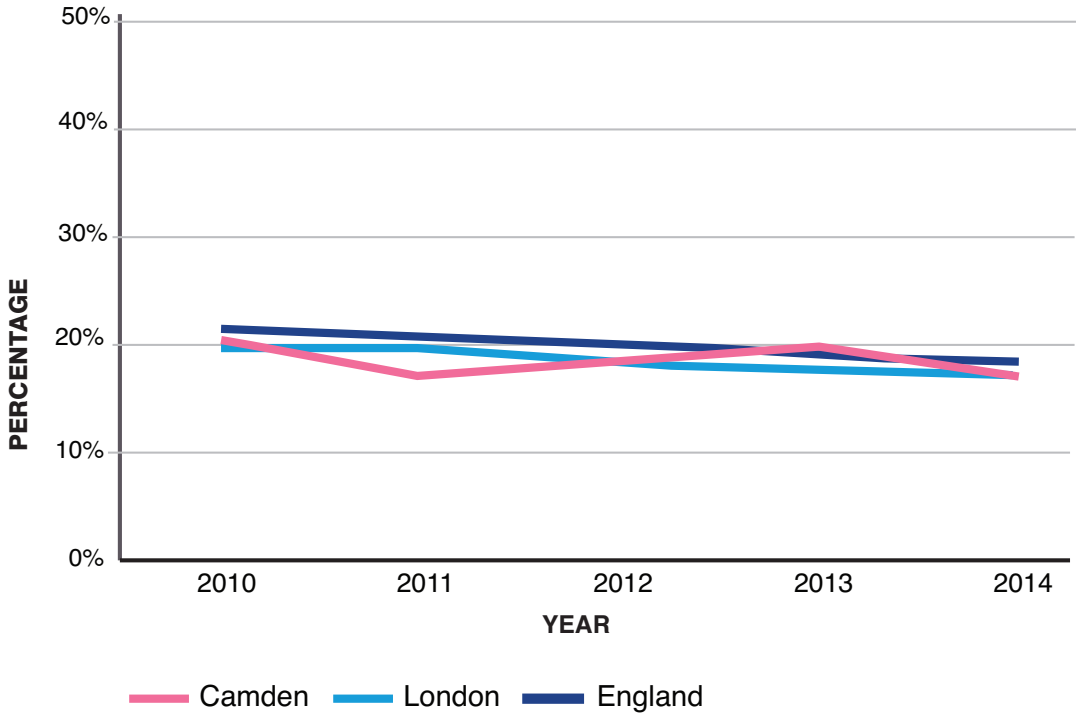
A. Although data available for 2003-5 are from different sources than data post 2010 and cannot be compared directly, it is logical to assume that prevalence has fallen significantly in Camden and Islington in line with national trends.
B. The smoking prevalence for 2010 to 2014 is estimated figures drawn from the Integrated Household Survey.
C. The estimates for Camden have fluctuated, but there is no statistically significant difference in smoking prevalence comparing from year to year, or comparing the change from 2010 (20%) to 2014 (17%).

**Figure 1.1 Prevalance of smoking in adults aged 18 and over Islington, London and England: 2010-2014**




**Islington**

**Figure 1.2 Prevalance of smoking in adults aged 18 and over Camden, London and England: 2010-2014**




**Camden**

## Addiction starts young

Most smokers' addiction to tobacco sets in before the age of 18, as children start smoking due to peer pressure, role modelling of adult smokers in their family environment and other influences. In Camden 3.9% of 15 year olds and 4.5% in Islington are regular smokers[A] and as many are occasional smokers (3.2% in Camden and 4.9% in Islington).[3] An effective way to prevent young people from starting to smoke is to support adult smokers to stop.[4]

## Smoking in pregnancy

Camden and Islington both have a higher rate of smoking in pregnancy than the London average (5.1%). In Camden, 5.5% of women smoke at the time of delivery.[5] After an increase in 2011-12, in Islington the rate of smoking in pregnancy has fallen in the following year to 7.7%.[6] Smoking increases the risk of harm to both mother and unborn child particularly of premature delivery and still birth. We also know that a child whose mother smokes is twice as likely to smoke themselves.[7]

## Still a killer

Half of all long term smokers will die of a smoking-related illness. In Camden, there are around 217 smoking-related deaths every year[8] and 225 deaths in Islington[9]. For every death caused by smoking, there are approximately 20 smokers suffering from a smoking-related disease, many of which cause substantial disability. Smoking cannabis with tobacco is much worse for health, particularly increasing the risk and accelerating the development of lung disease.

# To our communities

## Unequal effects

Tackling smoking is also an issue of social justice. The impact of tobacco use affects different communities disproportionally. Smoking is still the leading cause of avoidable deaths and disability, but also the biggest cause of health inequalities – the gap in health and wellbeing experienced by different groups. Smoking contributes to increased poverty for the less affluent smokers in our communities, who pay the highest price for their tobacco use: poorer physical health, disability and poorer quality of life for them and their families and an earlier death. Smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups. Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.[10]

## Smoking prevalence is highest amongst the most deprived communities

It is 26% in Camden and 28% in Islington in contrast to 14% and 21% respectively amongst the most affluent.[11,12] It is strongly associated with unemployment[13] and lower education.[14,15] In routine and manual groups smoking prevalence is 27% in Camden and 41% in Islington.[16] Some ethnic groups also have much higher rates of smoking, such as the mixed White and Black Caribbean population (32%) in Camden[17] and Turkish-speaking (33%) and Irish (29%) communities in Islington[18]. Smoking is also more prevalent among lesbian, gay, bisexual and transgender communities (LGBT). For people with mental

A. In the Health and Wellbeing Survey questionnaire for 15 year olds, a 'regular' smoker is someone who smokes one or more cigarettes a week, while an 'occasional' smoker is someone who doesn't smoke as many as one cigarette a week.

health conditions, smoking significantly contributes to the burden of ill health. A third of adults with a mental health condition smoke, which is 50% higher than the general population.[19] Rates of smoking amongst people with a psychotic disorder may be as high as 80%. The high prevalence of smoking among prisoners can also be partly attributed to high rates of mental health problems in this group.[20] 71% of sentenced prisoners have two or more mental disorders, whilst 90% of young prisoners aged 15-21 have one mental disorder.[21]

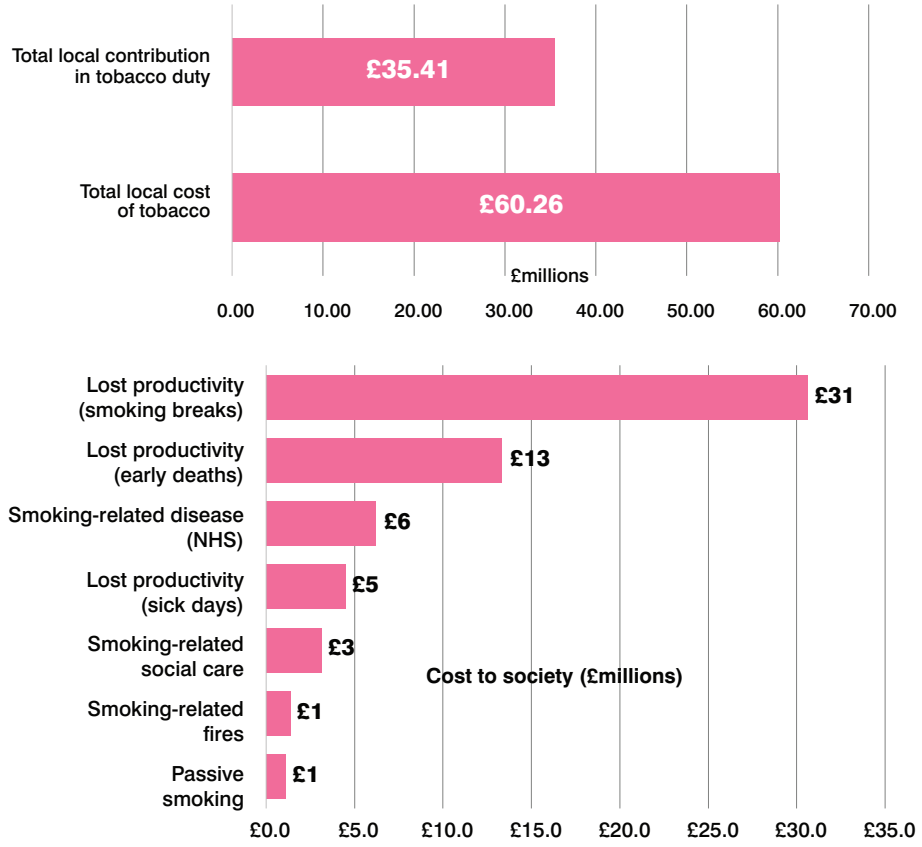
If we are to reduce health inequalities in the two boroughs, we must develop new ways to drive down smoking prevalence amongst the most disadvantaged groups.[22, 23]

# To our wider society

The total annual cost of smoking to society in Camden is £60 million (Figure 1.3), in Islington it's £66.22 million (Figure 1.4). This covers not only the costs to the NHS, but also costs to public services for social care, tackling fires caused by smoking, and costs to business from lost productivity.[24] In contrast tax revenue from tobacco sales by smokers in Camden was £35.4 million and in Islington £37.2 million, creating a shortfall of £24.6 million and £29 million respectively.

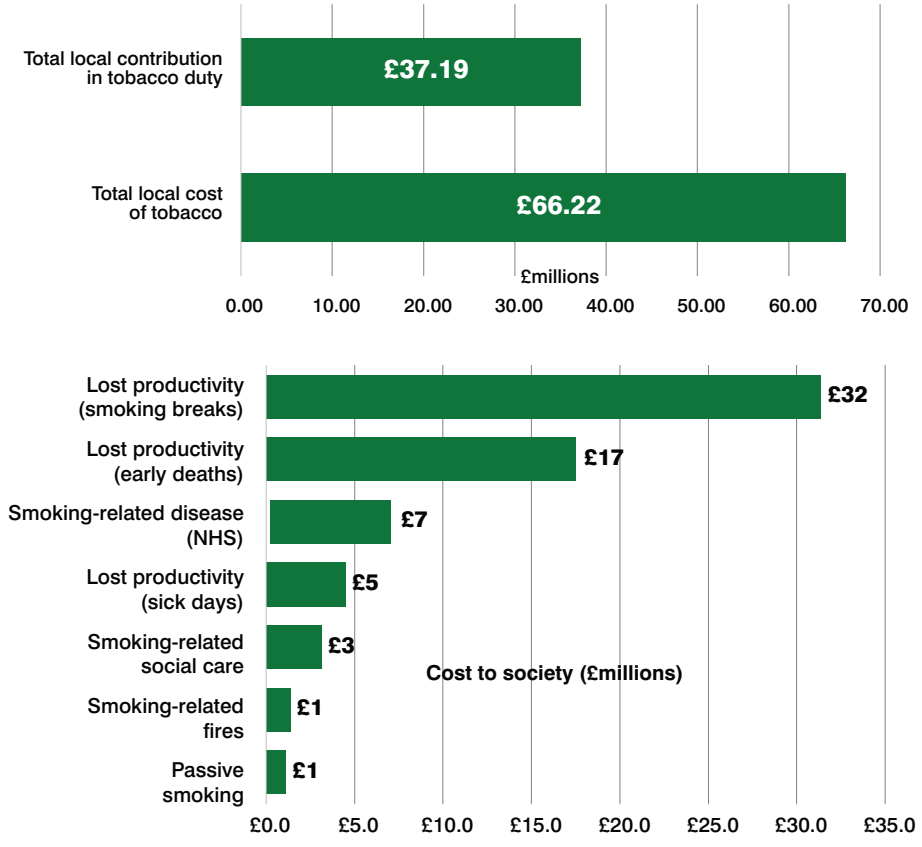
We welcome the NHS Five Year Forward View and its emphasis on prevention.[25] Helping people quit smoking (and preventing them from even starting) has well-documented health, social and financial benefits for individuals and our wider society.

## Figure 1.3 Smoking costs vs taxation (£millions)




Camden

## Figure 1.4 Smoking costs vs taxation (£millions)




Islington

## Unexpected harms

Tobacco use doesn't just damage people's health. It damages business through the loss of productivity related to both 'smoke breaks' but also employee sickness absence. The trade in illicit cigarettes fuels crime in our communities, while carelessly discarded cigarettes are a leading cause of house fires. Cigarette butts are the most commonly littered item in London and are estimated to cost local authorities between £7.5 and £9 million in Camden and £3.5 in Islington to clear up.

At a national level, there are calls for a Tobacco Companies Obligation, similar to the Energy Companies Obligation which requires them to reduce and pay for environmental pollution. While Camden and Islington may not have this financial lever at our disposal, we can still save money 'across the system' if we reduce the number of people who smoke.

## Bold in our ambition

Public Health England's recommendation is for a smokefree generation by 2025, where less than 5% of the population are smokers. For Camden and Islington, balancing pragmatism with aspiration, we are aiming to be smokefree by 2030. This is still an ambitious target, which will require bold action. It will mean reducing the number of smokers by approximately 23,000 in Camden and 31,300 in Islington in the next fourteen years. This will require a huge amount of work. This strategy is an important step along the way to achieve our goal of a smokefree generation. It will outline what we will do locally to achieve our ambitions.

# Recommendations

- Reduce smoking in the adult population in Camden to 13% and Islington to 16% or less by 2021, with targets agreed on an annual basis. This is around 7,600 less smokers in Camden and 11,300 less smokers in Islington, in five years.
- Reduce smoking amongst pregnant women to 3% in Camden and 5% in Islington by 2021.
- Reduce regular and occasional smoking among 15 year olds to 5% in Camden and to 7% in Islington by 2021.
- Reduce health inequalities by reducing smoking prevalence in all key target groups with above-average smoking prevalence by at least 25% from the 2015 baseline by 2021. For example, we will reduce smoking in the routine and manual socio-economic group to 20% (from 27%) in Camden and to 29% (from 41%) in Islington by 2021.

# References


1. London Health Commission. Better Health for London. 2014. Available from: http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
2. Public Health England. Local Tobacco Control Profiles 2014. Available from http://www.tobaccoprofiles.info/profile/tobacco-control/data
3. Health and Social Care Information Centre. Health and Wellbeing of 15 year olds in England: Smoking Prevalence - Findings from the What About YOUth? Survey 2014. 2015 Available from: http://www.hscic.gov.uk/catalogue/PUB17984
4. National Centre for Smoking Cessation and Training with Public Health England 2014. Local stop smoking services. Service and delivery guidance. Available from http://www.ncsct.co.uk/usr/pub/LSSS_service_delivery_guidance.pdf
5. Public Health England. Camden Health Profile 2015. Available from: www.apho.org.uk
6. Camden and Islington Public Health. Focus on Smoking October 2014. Available from: http://evidencehub.islington.gov.uk
7. Hofhuis W, de Jonste JC, Merkus PJFM. Adverse health effects of prenatal and postnatal tobacco smoke exposure on children. Arch Dis Child 2003;88:1086-90.
8. Public Health England. Camden Health Profile 2015. Available from: www.apho.org.uk
9. Public Health England. Islington Health Profile 2015. Available from: www.apho.org.uk
10. Marmot M, Allen J, Goldblatt P, Boyce T et al. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010. 2010. Available from: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
11. Camden Council Joint Strategic Needs Assessment. [Online] 2013. Available from: https://www.camden.gov.uk/ccm/content/social-care-and-health/health-in-camden/joint-strategic-needs-assessment-2012/chapter-8-smoking/?page=4
12. Camden and Islington Public Health. Focus on Smoking October 2014. Available from: http://evidencehub.islington.gov.uk
13. De Vogli R, Santinello M. Unemployment and Smoking: does psychosocial stress matter? Tobacco Control [Online] 2005;14: 389-395 Available from: doi:10.1136/tc.2004.010611
14. Gilman SE, Martin LT, Abraham DB, Kawachi I et al. Educational attainment and cigarette smoking: a causal association. International Journal of Epidemiology [Online] 2008; 37(3): 615-624. Available from: http://ije.oxfordjournals.org/content/37/3/615.short
15. Wagenknect LE, Perkins LL, Cutter GR, Sidney S et al. Cigarette smoking behaviour is strongly related to educational status: the cardia study. Preventive Medicine [Online] 1990; 19(2): 158-169. Available from: http://www.sciencedirect.com/science/article/pii/009174359090017E
16. Public Health England. Local Tobacco Control Profiles 2014. Available from http://www.tobaccoprofiles.info/profile/tobacco-control/data
17. Camden Council Joint Strategic Needs Assessment. [Online] 2013. Available from: https://www.camden.gov.uk/ccm/content/social-care-and-health/health-in-camden/joint-strategic-needs-assessment-2012/chapter-8-smoking/?page=4
18. Camden and Islington Public Health. Focus on Smoking October 2014. Available from: http://evidencehub.islington.gov.uk
19. Wu Q, Szatkiwski L, Britton J et al. Economic cost of smoking in people with mental disorders in the UK. Tobacco Control 2015; 24(5):462-8. Available from: doi: 10.1136/tobaccocontrol-2013-051464.
20. Royal College of Physicians and the Royal College of Psychiatrists. Smoking and Mental Health. 2013. Available from: https://www.rcplondon.ac.uk/publications/smoking-and-mental-health
21. Public Health England. Reducing smoking in prisons. Management of tobacco use and nicotine withdrawal. 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/412567/Reducing_smoking_in_prisons.pdf
22. Walness D. Securing Good Health for the Whole Population. Department of Health. 2004. Available from: http://webarchive.nationalarchives.gov.uk/+/http:/www.hm-treasury.gov.uk/media/D/3/Wanless04_summary.pdf
23. Marmot M, Allen J, Goldblatt P, Boyce T et al. Fair Society, Healthy Lives: Strategic Review of Health Inequalities in England post 2010. 2010. Available from: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review
24. Action for Smoking and Health Ready Reckoner v.4.6 27 August 2015. Available from: ash.org.uk/localtoolkit/docs/Reckoner.xls
25. NHS Five Year Forward View. October 2014. Available from: https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

6

# Closing the gateways in

Smoking usually starts at an early age and most smokers start in childhood and develop a life-long habit. That is why it is essential to close the gateways into smoking, for children and young people, to create a smokefree generation.

There is no single reason why children start to smoke. Prevention needs to address multiple factors that contribute to a young person choosing to smoke. Factors include having parents or siblings who smoke; availability of cigarettes, for example cheap illicit cigarettes; peer pressure; socioeconomic status; tobacco marketing and smoking in popular culture such as in films and television.[1]

Smoking is linked to social deprivation. Long-term smoking is closely correlated with inequality and social exclusion, with children from low income backgrounds most likely to be smokers in adulthood. Vulnerable children, such as children who are looked after by the state, in foster care or in institutional settings, have disproportionately high smoking rates and begin to smoke at a very young age (under 10 years old).[2] Indeed, many of these children and young people are at risk with various problems (e.g. unsafe sex, alcohol and substance misuse, school truancy), so a 'common risk approach' is required to address the needs of the young person holistically. For example, concurrent cannabis and tobacco smoking considerably increases health risks.

Evidence shows that national policies, like the standardised packaging legislation for tobacco products, coming into effect in May 2016, can have a significant effect in discouraging children and young people from starting to smoke. Unappealing, dull-coloured packs with strong and prominent health warnings, will replace the branded, bright-coloured packs which appeal to children and falsely lead them to believe that some brands are 'safer' than others.[3]

The main influence for children starting to smoke is their immediate family. Children with family members who smoke are up to three times more likely to become smokers themselves than children whose parents are non-smokers.[4] Helping adults to stop smoking and creating smokefree environments where children live and play are essential parts of this strategy and will contribute to fewer children starting to smoke. These will be addressed in sections 7 and 8 of the strategy.

Shisha smoking and electronic cigarettes are relatively new ways of smoking tobacco or using nicotine.[5] We know that young people experiment with both shisha and e-cigarettes. One in thirty Year 6 primary school pupils surveyed in 2015 in Islington and one in fifty in Camden have tried an e-cigarette and this goes up to one in eight in secondary school (12% in Islington and 13% in Camden). Many more pupils try shisha smoking: one in five have tried it in secondary school and in Year

10 almost half have tried it (46.5% in Islington and 48% in Camden).[6] Young people are easily influenced by fashions and trends, as well as peer pressure. On the other hand, access to accurate information about these new products may not be easily available. Our recommendations to reduce tobacco related harm are outlined in section 8.

## Recommendations

- Implement the health related behaviour questionnaire in Camden and Islington schools and use data on smoking to inform a range of targeted interventions.
- Continue to educate primary and secondary school children, encouraging them to consider the social influences of smoking, highlighting the health risks and costs of smoking, as well as the support available to stop. Extend this work to include environmental and political impacts of tobacco use and tobacco companies' tactics, to resonate further with young peoples' concerns.
- Create a smokefree environment for young people, families and staff using the Healthy Settings Awards as one of the drivers.
- Continue to work with teachers to identify young smokers or pupils at risk of smoking and implement peer education programmes, such as ASSIST, to change attitudes to smoking tobacco and cannabis.
- Ensure that parents and children are educated about the harms of shisha smoking and understand the risks of electronic cigarette use.
- Work with the Youth Council, the Young People's Health Forum, Youth Hubs and other partners to explore ways of reaching young people and ensure the smokefree messages are prioritised.
- Develop a targeted approach for complex/troubled families.
- Work with all Commissioners of children and young people services (including Children and Adolescent Mental Health Services (CAMHS)) to:
  - 'Mainstream' stop smoking-related activity as part of their commissioning of clinical care in line with NICE guidance
  - Ensure adequate resource allocation for age-appropriate stop smoking advice provision
- Work with clinical staff and hospital service providers seeing any children and young people to:
  - Require mandatory training on at least Very Brief Advice for Smoking Cessation (Ask, Advise, Act) for all clinical staff
  - Consider the whole family for smoking cessation referral and support
  - Streamline internal referral systems (in conjunction with Community Stop Smoking Service provision)

# References


1. The Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group. 2010. Available from: https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf
2. Muller T. Breaking the cycle of children's exposure to tobacco smoke. British Medical Association. 2007. Available from: http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/GR3GIR2QERK36MDPMLKEJ7AFL6AD8A.pdf
3. British Heart Foundation. Standardised packaging for tobacco products. Recent evidence from Australia and United Kingdom. International Tobacco Control Policy Evaluation Project and British Heart Foundation. 2014. Available from: https://www.bhf.org.uk/~/media/files/publications/campaigns/itc-british-heart-foundationa4-v8-web-final-18dec2014.pdf
4. Leonardi-Bee J, Jere ML, Britton J. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis. Thorax 2011; 66: 847-855 Available from: doi:10.1136/thx.2010.153379.
5. Hughes K, Bellis MA et al. Associations between e-cigarette access and smoking and drinking behaviours in teenagers. BMC Public Health 2015; 15: 244. Available from: http://www.biomedcentral.com/1471-2458/15/244
6. Data from the Health Related Behaviour Questionnaire (HRBQ) survey 2015, carried out in primary and secondary schools in Camden and Islington. For more information contact:
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# Helping people out



## 7.1 Supporting those who help smokers quit

### Role of stop smoking services

Compared to ten years ago, smoking prevalence has fallen significantly in Camden and Islington in line with the national trend. Stop smoking services in both boroughs were established and have played a key role in helping smokers to quit, with evidence-based behavioural support and treatments.

Stop smoking services provide pharmacotherapy and use behaviour change techniques and activities to maximise motivation to quit, minimise the desire to smoke and develop coping strategies to deal with high-risk situations, stress and other factors which may cause a relapse into smoking. Pharmacotherapy includes Nicotine Replacement Therapy (NRT), Varenicline and Bupropion. Abstinence is measured by expired-air carbon monoxide (CO) testing.

The evidence shows that the combination of pharmacotherapy and structured behavioural support provided by trained stop smoking advisors increases the chance of quitting by up to four times, compared to trying to give up smoking without help[1] and is highly effective in improving long term quit rates. Long term abstinence rates more than triple when quitting with the stop smoking service, compared to quitting without support.[2]

In the last two years the number of people accessing NHS stop smoking services has declined nationally. A number of factors could have had an impact on this: the increasing use of e-cigarettes, NHS re-organisation in 2013 and reduced revenue for advertising local stop smoking services.[3] Anecdotal evidence from local community stop smoking services highlights that there are now fewer smokers in the population as many 'quick wins', i.e. smokers who are ready and able to quit, were targeted and quit in previous years. The smoking population is, therefore, now mainly made up of 'hard-core' smokers, many of whom have long term health conditions and a reluctance to quit smoking. These smokers are harder to engage, and those that do engage with the programme are less likely

to quit within the nationally defined success criteria of a 4-week quit period. Services report that many people are also choosing to quit on their own by using e-cigarettes over accessing professional support, although NHS stop smoking services are still the most effective way for smokers to quit.

Sections 7.2 to 7.6 outline our strategic recommendations to increase the number of smokers accessing the local stop smoking service from different groups and in particular circumstances, who have distinct support needs to quit successfully.

## Encouraging healthcare clinicians to help smokers quit

Smoking related hospital admissions and premature preventable deaths remain very high in Camden and Islington. In Islington there are approximately 225 smoking-related deaths each year, making Islington the third highest borough for smoking-related mortality in London. In Camden there are around 217 smoking-related deaths each year.

This comes at great cost to both the individual and to services. Islington has the highest rate of smoking-attributable hospital admissions in London (2,534 per 100,000 population in Islington versus 1,606 in London). In Camden there are 1,774 smoking-related hospital admissions.[4]

These hospital admissions are essentially all preventable. It is estimated that annually, smoking costs the NHS in Islington £7 million and in Camden £6 million (and Adult Social Care a further £3 million in each borough).[5]

The NHS Five Year Forward View emphasised the importance of prevention to ensure a more sustainable health system. Recent work of the London Clinical Senate's programme, 'Helping Smokers Quit' has particularly highlighted the role for clinicians to support smokers to quit by: routinely providing advice and support, including appropriate pharmacotherapy, and using carbon monoxide testing as a motivational tool.

However, to provide good support for patients who want to quit, staff need clinical leadership, recognising smoking cessation as a standard part of clinical care for smokers and adequate training (at least very brief advice training on smoking cessation). This needs to occur across all specialties and include mental health and maternity settings in particular. Where this has worked best, it has been a collaboration between senior clinical champions and local ward / clinic-level champions.

## Other front line staff and volunteers

The drive for both integrated health and social care and an increased focus on prevention within the public sector provides new opportunities to increase the number of staff across both the public sector and voluntary and community sector trained in very brief advice on smoking cessation.

Staff come from a wider array of professional backgrounds including housing, social care and the voluntary sector. Programmes in Camden and Islington such as 'Making Every Contact Count' offer a means of providing good quality online and face-to-face training in smoking cessation (and other health improving behaviour change) to reach a wider variety of 'front-line' staff, who can help identify residents who smoke and signpost them to relevant advice and support.

Ultimately, anyone who has the opportunity and ability to influence the health and wellbeing of people in Camden and Islington,

can be offered stop smoking training in very brief advice. This includes employees in the private sector who can champion stop smoking messages with their customers or clients.[6]

### Employers and 'Wellness at Work'

Promoting wellness at work which includes offering opportunities for staff to reduce smoking, have also been seen to be cost-effective. Reducing levels of smoking among employees will help reduce some illnesses and conditions (such as cardiovascular disease and respiratory diseases) that are important causes of sickness absence. This will result in improved productivity and less costs for employers.[7] The workplace has several advantages as a setting for smoking cessation interventions:

- Large numbers of people can be reached (including groups who may not normally consult health professionals, such as working age men)
- There is the potential to provide peer group support
- Seeing colleagues who are quitting encourages people who smoke to quit

## Recommendations

- Ensure good quality, evidence-based stop smoking service is integrated into the wider behaviour change offer available within both boroughs which aims to improve the health and wellbeing of people in Camden and Islington. These services should be accessible to all smokers and particularly those from lower socio-economic groups and disadvantaged populations.
- Develop local communications initiatives based on national campaigns like Stoptober and No Smoking Day, to promote consistent and coordinated messages about stop smoking support and reach high priority groups through effective, targeted communications.
- Ensure that training on providing very brief advice on smoking cessation is required of every clinician seeing Camden and Islington patients and that there is adequate clinical leadership in every NHS organisation, both at senior and ward/clinic levels to support this.
- Ensure clinicians who prescribe are trained and competent to prescribe smoking cessation medication.
- Ensure accurate and timely information about e-cigarette use to reduce public confusion about the relative risks of nicotine products compared to tobacco products and allow an informed choice.
- Increase the number of public sector staff as well as community and voluntary sector volunteers and staff who are trained to provide very brief advice on smoking cessation.
- Use Healthy Settings Awards as one of the drivers to increase stop smoking interventions by staff working with young people.
- Support workplace health and wellbeing, initially focusing on both boroughs' largest public sector employers, to reduce smoking amongst employees.

# 7.2 Smokers with Long Term Conditions

Smoking can contribute to the development of several long term conditions, and other health problems such as coronary heart disease (CHD) and chronic obstructive pulmonary disease (COPD)[A], as well as cause life threatening conditions such as lung cancer. Concurrent cannabis smoking increases the health risks of smoking tobacco, particularly for lung disease. Continued smoking after a person is diagnosed worsens their outcomes, accelerates disease progression, increases mortality and worsens complications. Stopping smoking greatly improves outcomes for people with long term conditions, including CHD, COPD, type 2 diabetes and HIV[8]. For COPD, stopping smoking is a vital part of treatment, which greatly reduces the risks of exacerbation of the condition.[9]

Despite the clear evidence about the significant negative effects of smoking on long term conditions, significant proportions of people with one or more long term conditions continue to smoke – 34% of people with lung cancer and 44% of people with COPD. (See Table 7.2.1).

People with long-term conditions, such as diabetes, asthma, CHD, are generally more receptive to smoking cessation messages and have higher levels of motivation to quit[10]. Therefore, offering very brief advice to smokers with long-term conditions, at the appropriate 'teachable moments' during their care pathway has many potential benefits. The National Institute for Health and Clinical Excellence (NICE) offers guidance on tobacco and recommends that stopping smoking should be an integral part of the management of long term conditions, both in primary and secondary care.[11]

The London Clinical Senate 'Helping Smokers Quit' programme encourages clinicians to use an exhaled carbon monoxide (CO) breath test as a motivational tool, in addition to very brief advice. CO testing is a proven tool in specialist stop smoking settings. When used routinely in the context of a supportive conversation about smoking, it is also a useful motivational tool in every day clinical settings.[12]

**Table 7.2.1**

| Condition | Smoker Camden | Smoker Islington | Ex smoker Camden | Ex-smoker Islington | Non smoker Camden | Non smoker Islington |
|---|---|---|---|---|---|---|
| Lung Cancer (diagnosis within last 5 years) | 34% | 34% | 48% | 51% | 18% | 15% |
| COPD | 44% | 44% | 45% | 48% | 11% | 7% |
| Diabetes | 18% | 19% | 25% | 28% | 57% | 52% |
| Hypertension | 15% | 17% | 28% | 29% | 56% | 53% |

A. A wide range of diseases and conditions are caused by smoking, including cancers, respiratory diseases, coronary heart and other circulatory diseases, stomach and duodenal ulcers, erectile dysfunction, infertility, osteoporosis, cataracts, agerelated macular degeneration and periodontitis. (NICE Quality Standard QS43)

There are examples of good practice across local hospital (secondary care) services which include:

- Whittington Health in Islington offers specialist stop smoking advice and treatment, to all inpatients and outpatients, including a house visiting service to patients with COPD, as part of a comprehensive set of interventions integrating the hospital and community teams. Stop smoking specialists offer advice and CO testing to all smokers on the wards, as well as to outpatients and staff. Training for health professionals enables them to offer very brief advice to smokers. Provision is made for nicotine replacement therapy to be offered to inpatients, for temporary abstinence during their hospital stay.
- In Camden, the Royal Free Hospital (RFH) and University College London Hospitals (UCLH) are developing local best practice, such as RFH's in-house stop smoking service and UCLH's pre-operative assessment pathway, which screens and refers smokers.

It is necessary to share best practice in embedding stop smoking interventions in every clinical contact in secondary care, to enhance clinical outcomes for people with long term conditions.

# Recommendations

- Engage primary care leads such as Clinical Commissioning Group (CCG) clinical champions, Local Medical Committee (LMC) and Local Pharmaceutical Committee (LPC) representatives to explore opportunities for better engagement with smoking cessation and sharing best practice in primary care to ensure that people with long term conditions are routinely being encouraged to quit smoking and receive the appropriate support to do so in line with NICE tobacco guidance.
- Work with the clinical champion in every secondary care trust in Camden and Islington, to lead on helping smokers quit and to consider how the London Clinical Senate recommendations on very brief advice training and CO testing can be implemented.
- Promote adherence to NICE guidance on tobacco especially aimed at secondary care (acute, maternity and mental health services), by working with CCG commissioners and secondary care providers.
- Ensure clinicians who prescribe are trained and competent to prescribe smoking cessation medication.
- Encourage clinicians to routinely ask about cannabis use as part of their smoking cessation discussion with their patient.

# 7.3 Smokers with Mental Health conditions

While smoking rates have been steadily falling in the general community, they remain unacceptably high amongst people with mental health problems. Smoking prevalence is twice as common among people with mental health problems, and more so in those with more severe illness.[13] People with mental health problems use 42% of all tobacco consumed in the UK[14], due to heavier nicotine dependency.

Contrary to the assumption that suicide is the leading cause of death in people with mental ill health, smoking is the biggest cause of reduced life expectancy for people with mental health problems, compared to the rest of the population.[15] People with mental ill health experience substantial physical ill health as a result of their tobacco use – related particularly to cardiovascular and respiratory consequences. The life expectancy of people with serious mental illness (SMI) is estimated to be up to 20 years less than the general population.[16] In fact, it is estimated that people with SMI have the same life expectancy as the general population in the 1950s.[17]

Not only does smoking affect the physical health of people with mental health conditions but it also impacts people's mental health by interacting with some psychiatric medication making it less effective, resulting in increased dosages and more side effects associated with these drugs.

Smoking has been widely accepted and even facilitated in many psychiatric care settings, for many years. Staff attitudes need to change. Smoking should not be seen as 'normal' behaviour, nor as an effective way for a person to manage their mental health. A change in psychiatric care to place more emphasis on physical wellbeing is also necessary. These conversations are happening at both a national and borough level. Significantly, in April 2015, our local mental health provider, the Camden and Islington Foundation Trust went smoke-free – one of the first to do this in London.

Smokers with mental ill health are just as likely to want to quit as smokers without mental ill health, but are more likely to be heavily addicted to smoking and, historically, are less likely to succeed when they try to quit.[18] The current model of stop smoking specialist services offers 6-8 weeks of support, provided during weekly sessions with a trained advisor. Smokers with mental ill health often need substantially more support than this, including Nicotine Replacement Therapy provided over a longer time frame and more intensive behavioural support.[19]

Younger smokers are under-represented in the stop smoking services generally and this is true of services for those with mental ill health: the majority of those currently accessing specialist services are over the age of 65 and already experience smoking-related physical ill health. More needs to be done to support mentally ill smokers to quit smoking before tobacco use impacts on their physical health. Early intervention is particularly important for those with psychosis or with a serious mental illness, as this group has particularly high smoking rates.

# Recommendations

- Include stop smoking support in initiatives promoting physical health (e.g. healthy eating, obesity support, physical activity) for mental health service users, including young people.
- Ensure specialist stop smoking services tailored to smokers with mental ill health are available in residential care, in-patient settings and those living independently the community, across Camden and Islington.
- Ensure a network of level 2 trained stop smoking advisors exists across all mental health secondary and community care settings.
- All staff in mental health services are trained in very brief advice and second-hand smoke.
- Work with the fire department to ensure that residential care homes comply with fire safety standards to minimise the risks for residents who continue to smoke
- Ensure that in long term residential care homes all smoking takes place outside.
- Ensure clinicians who prescribe in mental health settings are trained and competent to prescribe smoking cessation medication.

# 7.4 Smokers in Islington's male and female prisons

There are two Category B prisons in Islington, HMP Pentonville for male offenders and HMP Holloway and Young Offender Institution for female offenders. HMP Holloway is planned for closure in June 2016. There are no prisons in Camden.

Smoking rates among prisoners have changed relatively little in the last few decades: they are estimated to be three to four times higher (up to 80%) than the general population (18% in England in 2014).[20] There is no research available on the prevalence of smoking among prison staff, but it is anecdotally reported as being near 40% which is twice as high as the national average in the community.

A thematic report[21] which analysed the inspection reports of thirty three Category B prisons, including HMPs Holloway and Pentonville, published between 2009 and 2011, found that 33% of prisoners reported mental health or emotional wellbeing issues, one in five (22%) reported they had problems with feeling depressed or suicidal on arrival at prison and many reported a drug (37%) and/or alcohol (28%) problem on arrival. There is a higher incidence of smoking in people with mental health and substance misuse problems.

Both Islington prisons offer stop smoking support to prisoners and staff. All smoking cessation activity is recorded on the prison database system. As per national policy, prisoners receive a health check within 24 hours of admission and this includes Nicotine Replacement Therapy (NRT) if they are on a stop smoking programme or want to be.

When a prisoner is released and still in need of treatment for stopping smoking, this is recorded and the receiving prison will get this information. Smokers who are returning to the community are offered details of local stop smoking services in their discharge pack.

Twice yearly health and wellbeing promotion events are provided in both prisons for staff and prisoners. Community services, including stop smoking services, provide advice and refer interested smokers to clinics for support. Staff have access to in-house stop smoking clinics or can choose to visit the local pharmacies that offer stop smoking support, during breaks.

At the same time that Smokefree legislation was introduced in 2007, the Prison Service applied for exemption stating that people in prison should be allowed to smoke in their cells as it is their temporary 'home'. The Prison Service is now actively working towards prisons becoming completely smokefree. International experience has shown that people held in custody or in secure hospital wards who are told they cannot smoke usually adapt very well to the idea, often making the decision to stop smoking before they are instructed to do so. Adequate NRT provision will need to be assured before the smokefree agenda can be rolled across the whole establishment. Trials are taking place of electronic cigarettes, to assess any impact on security and whether there is take-up and for how long. To date experience has shown that they are a source of interest but only short term, as they are still being sold alongside tobacco. Once tobacco is no longer available, they are likely to form a useful part of the strategy.

# Recommendations

- Develop stronger links between prison and in-patient psychiatric services and the community-based stop smoking service to ensure continuity of care, when prisoners return to the community.
- Explore commissioning an “in reach” service, so that when the person is discharged they can continue to receive stop smoking support via the same service.
- Establish links between homeless projects, psychiatric care and the prison service to ensure continuity of care for Camden and Islington residents who cycle through these three services.
- Strengthen the stop smoking provision across the whole criminal justice pathway, so that those leaving prisons have access to support.
- Ensure that prisoners who are transferred to HMP Pentonville and HMP Holloway (until June 2016) whilst they are quitting smoking continue to receive stop smoking support and do not have to go onto a waiting list.
- All psychiatric care staff in all settings, all prison staff and homeless support workers should be trained in very brief advice in smoking cessation and apprised of the dangers of second hand smoke.  Any CQUIN or equivalent quality improvement incentive for psychiatric care staff could ensure that the training is mandatory.
- Ensure evidence-based treatments and staff training are commissioned for HMP Pentonville.
- Support HMP Pentonville to become smokefree and develop an updated smokefree strategy.

# 7.5 Smoking in Pregnancy and the Early Years

Stopping smoking is one of the most effective interventions to improve the health of mother and baby and prevent avoidable infant mortality. Smoking in pregnancy is associated with increased risk of miscarriage, perinatal death, premature birth, low birth weight and congenital abnormalities in the baby.[22] It is estimated that about one third of all perinatal deaths in the UK are caused by maternal smoking, which means approximately 300 deaths per year. Smoking during and after pregnancy also increases the risk of sudden infant death syndrome (SIDS).[23]

Camden and Islington both have a higher rate of smoking in pregnancy than the London average (5.1%): 5.5% in Camden[24] and 7.7% in Islington.[25]

Smoking during pregnancy contributes to health inequalities because of the increased smoking prevalence among people living in deprived areas, women who are less educated or in routine and manual occupations.[26] Many teenage women smoke in pregnancy. Women aged 20 or younger are more than three times as likely than those over 35 to smoke during their pregnancy.[27] Those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke in pregnancy.

Stopping smoking in pregnancy can be challenging. Only a small number of pregnant women take up the offer of help to stop smoking. Many of those who successfully stop smoking during their pregnancy go back to smoking within six months of giving birth.[28] The attitude of the family, including the woman's partner towards smoking, can have an effect on the mother's smoking behavior which will impact the health of the whole family.

Health care professionals, such as health visitors and other professionals working with pregnant women and families in the early years, have a key role in supporting smokefree environments for families. The focus should not be only on the mother. Partners and other family members should also be offered information on second hand smoke and support to stop smoking. Section 8.1 outlines our approach to smokefree homes.

# Recommendations

- Reduce smoking amongst pregnant women to 3% in Camden and 5% in Islington by 2021.
- Promote adherence to NICE guidance on tobacco in all maternity services in Camden and Islington caring for pregnant women and following childbirth.
- Ensure pregnant women accessing maternity care are routinely screened with a carbon monoxide (CO) monitor by midwifery staff who are equipped, trained and with adequate time, and that pregnant women who smoke are referred to stop smoking services, as part of their care pathway.
- Early years services commissioning should explore the role of health visitors and other professionals in supporting pregnant women and families with young children to stop smoking.

# 7.6 Young People

Smoking is a childhood addiction. About two-thirds of adult smokers report they took up smoking before the age of 18.[29] The 2011 General Lifestyle Survey of adult smokers showed that almost 40% were smoking regularly before the age of 16.[30]

Nationally, the proportion of children who smoke continues to decline. Among 15 year olds, 8% smoked in 2014, compared with 20% in 2006.[31] In Camden 7.1% of 15 year olds smoke and 9.4% smoke in Islington.[32]

The younger people are when they start smoking the greater the harm is likely to be. Early initiation of smoking is associated with subsequent heavier smoking, higher levels of dependency, lower chances of quitting and higher mortality.[33]

Childhood smokers are at high risk of immediate health problems, including respiratory illness such as coughing, wheezing and phlegm. Smoking can also lead to impaired lung growth in children and young adults.[34] Smoking aggravates asthma symptoms in those already diagnosed and increases the risk of asthma in young people with no history of the condition.[35] The earlier children become regular smokers the greater the risk of developing lung cancer or heart disease, if they continue to smoke as adults.[36]

People who start smoking in adolescence are more likely to become life-long smokers than those who start smoking in their 20's or later.[37] Young smokers can become addicted to nicotine very quickly. In some people, symptoms of nicotine addiction can appear within days of occasional (not daily) smoking.[38] A study of brain reactivity in teenagers who smoke fewer than five cigarettes a day showed that there are signs of addiction even at this low level of smoking.[39] During periods of abstinence, young people experience withdrawal symptoms similar to those experienced by adult smokers.[40]

Access to stop smoking services by teenage smokers has been historically low. It is important to develop innovative approaches which will ensure young smokers have the best possible chances to quit smoking, before it becomes a life-long habit and impacts on their health.

# Recommendations

- Understand the needs of staff working in children's centres and schools when talking to parents and children who smoke and provide tailor-made training to enable those conversations.
- Showcase successes of staff working in challenging settings where views on smoking are entrenched and share good practice.
- Target vulnerable children who smoke, by working with social services, youth offending service, pupil referral units and looked after children nurses and enable staff to give appropriate advice and support.
- Create innovative partnerships to reach young people 16 or older, such as with student unions, leisure centres and privately owned gyms.
- Conduct insight research to target resources where young people are likely to get advice and support about stopping smoking.
- Work with the youth offending service in Camden and Islington to promote smoking cessation to young offenders.
- Encourage responsible retailer practices, such as not selling tobacco near schools.
- Ensure tobacco retailers near schools are fully compliant with new legislation on tobacco displays in shops, as a priority.
- Explore the provision of specialist stop smoking services for children, young people and their families.

# References


1. West R/ McEwen A (ed). Stop smoking services: increased chances of quitting. National Centre for Smoking Cessation and Training. Briefing: 8. [Online] 2012. Available from: http://www.ncsct.co.uk/usr/pub/Briefing%208.pdf
2. Shahab L/ McEwen A, Alley K (eds). Effectiveness and cost-effectiveness of programmes to help smokers to stop and prevent smoking uptake at local level. National Centre for Smoking Cessation and Training. [Online] 2015. Available from: http://www.ncsct.co.uk/usr/pub/NCSCT%20briefing-effectiveness%20of%20local%20cessation%20and%20prevention.pdf
3. Taylor D, Craig T, Gill J et al. Will smoking meet its match? UCL School of Pharmacy. 2015. Available from: https://www.ucl.ac.uk/pharmacy/documents/smoking-launch
4. Public Health England. Local Tobacco Control Profiles. Available from http://www.tobaccoprofiles.info/profile/tobacco-control/data
5. Action for Smoking and Health Ready Reckoner v.4.6 27 August 2015. Available from: ash.org.uk/localtoolkit/docs/Reckoner.xls
6. Royal Society for Public Health. Rethinking the public health workforce 2015. [Online] Available from: http://www.rsph.org.uk/filemanager/root/site_assets/our_work/wider_public_health_workforce/rsph_widerworkforce_report_final.pdf
7. National Institute for Health and Clinical Excellence. Workplace interventions to promote smoking cessation. PH5; [Online] 2007. Available from: https://www.nice.org.uk/guidance/ph5
8. Siddiqi K, Dogar OF, Siddiqi N. Smoking Cessation in Long Term Conditions – Is there 'An Opportunity in Every Difficulty'? International Journal of Population Research [Online] 2013; 2013: 1-10. Available from: doi:10.1155/2013/251048.
9. Garvey C, Ortiz G. Exacerbations of chronic obstructive pulmonary disease. The Open Nursing Journal 2012; 6:13-19.
10. Siddiqi K, Dogar OF, Siddiqi N. Smoking Cessation in Long Term Conditions – Is there 'An Opportunity in Every Difficulty'? International Journal of Population Research [Online] 2013; 2013: 1-10. Available from: doi:10.1155/2013/251048.
11. National Institute for Health and Clinical Excellence. Smoking Cessation: supporting people to stop smoking. QS43; [Online] 2015. Available from: http://www.nice.org.uk/guidance/qs43/resources/guidance-smoking-cessation-supporting-people-to-stop-smoking-pdf
12. London Clinical Senate. Helping Smokers Quit. The expired carbon monoxide (CO) test. Guidance for health professionals. Available from: http://www.londonsenate.nhs.uk/helping-smokers-quit/
13. Royal College of Physicians and the Royal College of Psychiatrists (2013). Smoking and Mental Health. 2013. Available from: https://www.rcplondon.ac.uk/sites/default/files/smoking_and_mental_health_-_key_recommendations.pdf
14. McManus S, Meltzer H, Campion J. Cigarette Smoking and Mental Health in England. Data from the Adult Psychiatric Morbidity Survey 2007. National Centre for Social Research. 2010.
15. Bristow S. Nicotine Management Strategy 2014-2016. Camden and Islington NHS Foundation Trust. 2014.
16. Chief Medical Officer's Annual Report: Public Mental Health Priorities: Investing in the Evidence 2013.Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/351629/Annual_report_2013_1.pdf [Accessed 6th November 2014]
17. While D, Bickley H, Roscoe A, Windfuhr K, Rahman S, Shaw J, Appleby L, Kapur N. Implementation of mental health service recommendations in England and Wales and suicide rates, 1997-2006: a cross sectional and before-and-after observational study. The Lancet 2012, Mar 17;379 (9820)
18. Royal College of Physicians and the Royal College of Psychiatrists. Smoking and Mental Health. 2013. Available from: https://www.rcplondon.ac.uk/sites/default/files/smoking_and_mental_health_-_key_recommendations.pdf
19. College of Psychiatrists. Smoking and Mental Health. 2013. Available from: https://www.rcplondon.ac.uk/sites/default/files/smoking_and_mental_health_-_key_recommendations.pdf
20. Public Health England. Reducing smoking in prisons. Management of tobacco use and nicotine withdrawal. 2015.
21. HM Inspectorate of Prisons. Remand Prisoners. A Thematic Review. 2012. Available from: https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/remand-prisoners/#.Ve2IWYd0zUB
22. British Medical Association. Smoking and reproductive life. The impact of smoking on sexual, reproductive and child health. 2004. Available from: http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/8XCT9VIM5S2SDTUIK UAXD5KQPD1D3G.pdf
23. The Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group. 2010. Available from: https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf

24. Public Health England. Camden Health Profile 2015. Available from: www.apho.org.uk
25. Camden and Islington Public Health. Focus on Smoking October 2014. Available from: http://evidencehub.islington.gov.uk
26. National Institute for Health and Clinical Excellence. Quitting smoking in pregnancy and following childbirth. PH26; [Online] 2010. Available from: https://www.nice.org.uk/guidance/ph26
27. McAndrew F, Thompson J, Fellows L et al (2012). Infant feeding survey 2010. A survey conducted on behalf of the Information Centre for Health and Social Care. Leeds: The Information Centre for Health and Social Care
28. National Institute for Health and Clinical Excellence. Quitting smoking in pregnancy and following childbirth. PH26; [Online] 2010. Available from: https://www.nice.org.uk/guidance/ph26
29. Robinson S, Bugler C. Smoking and drinking among adults. General Lifestyle Survey 2008. Office for National Statistics. [Online] 2010. Available from: http://www.ons.gov.uk/ons/rel/ghs/general-lifestyle-survey/2008-report/smoking-and-drinking-among-adults--2008.pdf
30. Office for National Statistics. Smoking. General Lifestyle Survey Overview: A report on the 2011 General Lifestyle Survey. [Online] 2013. Available from: http://www.ons.gov.uk/ons/dcp171776_302558.pdf
31. Action for Smoking and Health. Young People and Smoking. ASH Factsheet 108; [Online] 2015. Available from: http://ash.org.uk/files/documents/ASH_108.pdf
32. Health and Social Care Information Centre. Health and Wellbeing of 15 year olds in England: Smoking Prevalence - Findings from the What About YOUth? Survey 2014. [Online] 2015 Available from: http://www.hscic.gov.uk/catalogue/PUB17984
33. The Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group. 2010. Available from: https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf
34. Muller T. Breaking the cycle of children's exposure to tobacco smoke. British Medical Association. 2007. Available from http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/GR3GIR2QERK36MDPMLKEJ7AFL6AD8A.pdf
35. Action on Smoking and Health. Asthma and Smoking. Research Report 595; 2015. Available from: http://ash.org.uk/files/documents/ASH_595.pdf
36. Muller T. Breaking the cycle of children's exposure to tobacco smoke. British Medical Association. 2007. Available from: http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/GR3GIR2QERK36MDPMLKEJ7AFL6AD8A.pdf
37. Taioli E, Wynder EL. Effect of the age at which smoking begins on frequency of smoking in adulthood. New England Journal of Medicine 1991; 325(13): 968–969.
38. DiFranza JR, Rigotti NA, McNeill AD, Ockene JK, Savageau JA, St Cyr D, Coleman M. Initial symptoms of nicotine dependence in adolescents. Tobacco Control 2000; 9: 313-319.
39. Rubinstein ML, Luks TL, Moscicki AB, Dryden W, Rait MA, Simpson GV. Smoking-cue induced brain activation in adolescent light smokers. Journal of Adolescent Health 2011; 48(1): 7-12.
40. McNeill AD et al. Cigarette withdrawal symptoms in adolescent smokers. Psychopharmacology 1986; 90: 533-536.

8

# Reducing related harm

Tobacco use affects not only smokers and their families, but has multiples impacts across the whole society. To reduce the tobacco related harms for Camden and Islington communities we will focus on five areas:

**8.1 Smokefree environments**
**8.2 Smoking related litter**
**8.3 Illicit tobacco**
**8.4 Shisha**
**8.5 Electronic cigarettes**

## 8.1 Smokefree environments

### Focus on children

One of the aims of this strategy is to protect children from the risks caused by exposure to second hand smoke. The Joint Health and Wellbeing Strategy 2013-16, outlined a vision to ensure every child has the best start in life. Growing up in an environment free of tobacco smoke is a key aspect of that ambition, as children's health and life can be put at risk from second hand smoke.

Existing smokefree legislation protects children from tobacco smoke in enclosed public spaces and from 1st October 2015, also in private vehicles. The principal source of exposure to second hand smoke for children remains the home.[1] In Camden, almost a third of school children surveyed in 2015 said they are exposed to secondhand smoke at home. Three in twenty (15%) primary school children and one in five secondary school children (20%) are exposed to smoking every day in their homes. Another three in twenty (14%) primary school and one in eight (12%) secondary school children are exposed weekly or monthly. In Islington, three in twenty primary school pupils (16%) and one in five secondary school pupils (21%) surveyed in 2015, said they are exposed to smoking in the home every day. Another three in twenty are exposed more infrequently, weekly or monthly (15% in primary school and 14% in secondary school).[2]

Most adult smokers are aware that second hand smoke is a danger to children and claim to do everything they can to minimise their smoking around children.[3] However, the children of smokers continue to experience high levels of exposure to second hand smoke,[4] so more must be done to encourage these parents to refrain from smoking around their children and, at best, stop smoking altogether.

Exposure to second hand smoke in the early years not only has a significant impact on the health of a child but continues to impact their health into adulthood.[5] Children exposed to second hand smoke are at increased risk of asthma[6], chest infections such as bronchitis[7],

middle ear disease[8], sudden infant death syndrome[9] and meningitis.[10] Childhood exposure to second hand smoke is also responsible for impaired mental development[11] and can exacerbate existing chronic conditions such as sickle cell anaemia.[12] There is also evidence which suggests that children exposed to second hand smoke are at increased risk of developing lung cancer and emphysema in adulthood.[13 14 15] Children who grow up with smokers are 90% more likely to take up smoking themselves.[16 17]

Since smoking is strongly linked to deprivation, children living in social housing are much more likely to live with smokers than children in higher socio-economic groups and therefore more likely to become smokers themselves.

It is our ambition to de-normalise smoking for children, by creating environments where children are not exposed to smoking; not only in the home but also outside schools and in playgrounds. Islington launched smokefree playgrounds in all Council parks in 2014-15 with huge support from the public. 94% of playground users surveyed, 40% of which were smokers, supported the voluntary ban of smoking in the playground and no-one opposed it. Camden's park playgrounds are also smokefree.

## The wider environment

Having smokefree grounds in Council and NHS-owned premises and other employer premises gives a strong message about the dangers of smoking and second hand smoke. It also prevents smoke from drifting into open doors and windows, where it can cause harm and nuisance, and reduces fire risks. Furthermore, non-smoking environments encourage people to stop smoking or can result in more smokers voluntarily making their homes smokefree.[18]

# Recommendations

- Raise awareness of the ban of smoking in cars with children, with parents, children and staff (traffic wardens, road safety units, sustainable travel officers).
- Continue to support national smokefree homes and cars awareness campaigns.
- Continue to de-normalise smoking by reducing smoking around children: smoking and cigarette litter is out of sight of school gates and playgrounds in Council parks, housing estates and adventure playgrounds. This work, already under way in Islington will be developed in Camden. If successful, in both boroughs, we will look to expand the number and nature of public spaces e.g. public squares, to further de-normalise smoking in public for all ages.
- Work with partners of Islington's "First 21 Months" and Camden's "A Thousand and One Days" programme teams, to increase the uptake of smokefree homes.
- Use Healthy Settings Awards as one of the drivers to create smokefree environments for young people and their families.
- Work with partners to increase smokefree outdoor environments in Camden and Islington, as part of organisational smokefree policies; such as implementing smokefree hospital grounds.
- Work with employers to support the smokefree element of the London Healthy Workplace Charter awards.

## 8.2 Smoking litter

Cleaning up cigarette-related litter is a significant problem in the UK, accounting for 70-90% of street litter in urban areas.[19] Cigarette butts are the most common item of litter in both boroughs with an annual street cleaning bill between £7.5 and £9 million in Camden and £3.5 in Islington.[20] [21] That is money we would rather spend improving services in the local community and so we are exploring new ways of encouraging smokers to dispose of their butts responsibly.

Islington and Camden Councils enforce littering legislation using fixed penalty notices. Both councils have set the level of fixed penalty fines at the highest permitted level, with penalties for dropping litter, including cigarette butts, set at £80 or £50 if the fine is paid within 10 days. In 2011-12, Islington Council issued 2,348 penalty notices to smokers who littered.

The concept of 'the polluter pays' is gathering momentum in the UK with the national government considering a proposal to introduce a levy on the tobacco industry to pay for the damage they cause.[22] We support this proposal. The majority of our residents do not smoke yet foot the bill for cleaning up after our smoking residents and visitors. That is not right. Those responsible for damaging our environment should be required to pay for the clean-up. This doesn't just mean individual smokers. Businesses and organisations should make sure that the areas around their premises, which are used for smoking by their customers and staff, are kept free of litter.

## Recommendations

- Continue working with smokers of all ages to reduce smoking-related litter in Camden and Islington with a combination of education and enforcement activities.
- Continue partnership work between Camden Environment services and local schools to raise awareness amongst our younger residents about the impact of litter in the borough and show them that tobacco also damages the environment.
- Introduce an innovative scheme, already in operation in other London local authorities, such as Enfield and Haringey: a smoker who is issued a fixed penalty notice for littering smoking material can complete a course with the local Stop Smoking Service as an alternative to a fine.
- Work with local businesses to ensure that staff on smoking breaks dispose cigarette butts responsibly and customers do not litter when sitting in outdoor areas, such as pubs and cafes.

## 8.3 Illicit Tobacco

In 2015, it was estimated that around 10% of all cigarettes and 39% of hand-rolled tobacco consumed in the UK in 2013-14 were illicit. Nearly half of this is counterfeit tobacco produced for the illicit market. The cost to society amounts not only to lost tax revenue but also to crime. The profits from illicit trade are pocketed by organised criminal groups, such as gangs, which cause further harm to society through other criminal activities such as drug smuggling and human trafficking.[23]

The cost of buying illicit tobacco can be as little as half the cost of legitimate products. Smoking is much more prevalent in deprived communities. Where cheap illicit tobacco is available it is likely to encourage people to start and continue smoking. This further increases health inequalities caused by tobacco use in poorer communities.

In a survey conducted in 2015 in seven North East and North Central London boroughs including Camden and Islington, 627 respondents (52%) thought that availability of cheap tobacco makes it more difficult to quit and 56% believed that it makes it easier for children to start smoking. Four in ten respondents agreed that cheap tobacco makes it possible to smoke, when otherwise they could not afford to.[24]

Illegal cigarettes do not meet Reduced Propensity Cigarettes regulations introduced in 2011 and cause a significant number of domestic fires and deaths.

The London Health Commission report recommended that the Mayor launches a crackdown on the trafficking and selling of illegal tobacco.[25] The research report commissioned for the South East London Illegal Tobacco Cluster recommended that a cross-borough and ideally regional multi-agency cooperation is needed to tackle illicit trade.[26]

## Recommendations

- Camden and Islington Trading Standards should continue to play a lead role in the newly established North East North Central London Illicit Tobacco Cluster Group to develop a cross-borough approach to dealing with the problem of illicit tobacco sales. The group includes Trading Standards representatives from Camden, Islington, Haringey, Enfield, Hackney, Waltham Forest and Tower Hamlets.
- Further develop links with the South East London Illicit Tobacco Group with the long-term aim of developing a pan-London approach to dealing with the sale of illicit tobacco, to work more closely with HMRC and Border Control.
- Continue to build on successes in reducing the number of underage sales and the amount of illicit tobacco on sale, by continuing strong enforcement and continue to identify priority areas to target and develop a method for local residents to provide intelligence.
- Work in partnership with the schools' health and wellbeing teams to raise awareness about illicit tobacco amongst young people (and their parents) and to remind young people that shisha is tobacco – it is not always labelled that way and young people in particular are unaware that they are consuming tobacco, often illegally imported.

# 8.4 Shisha

In Camden and Islington there is widespread compliance with smokefree laws since the legislation was widely welcomed by the public and most businesses. However, the recent proliferation of shisha premises has seen an increase in businesses allowing smoking in enclosed spaces in contravention of the smokefree laws.

Shisha has been traditionally used within specific communities, but in London, as in other large cities, shisha use appears to be increasingly popular amongst all ethnic groups and especially with young people. Recent research in South London suggested that shisha smoking is now endemic in London and a public health issue.[27]

Shisha smoking can take place while socialising, for example in a shisha café and in the home. Shisha produces second-hand smoke, so when it is used in public spaces, it is covered by the smokefree legislation, whether or not it contains tobacco.

In the last few years, the numbers of shisha cafes or bars in Camden have been on the increase. In 2013, shisha premises in Camden had increased from 12 to 16 in two years. However, in September 2015, 12 premises were known to be operating. In Islington, as a result of proactive monitoring of premises, they decreased from 27 in 2012 to 12 in 2013 and 6 in September 2015.

In Camden and Islington, we have forged a multi-team approach with Trading Standards, the Environmental Health teams, Licensing teams, Fire Brigade and the local Police. We are addressing enforcement of legislation relating to the sale of shisha products containing tobacco, either pre-packaged or prepared for smoking in shisha premises. We are also ensuring premises do not flout the laws prohibiting shisha smoking in enclosed spaces and do not sell to underage customers.

Islington Council, which has seen a decrease in the number of shisha premises, has largely resolved the problem of non-compliant premises, through a combination of user education as to the health effects, early advice to businesses thinking about shisha as a business model, close community liaison, multi-agency working and, where necessary, a robust approach to enforcement where there is persistent non-compliance with smokefree and other laws.

# Recommendations

- Camden and Islington should continue to have a proactive and preventive multi-team approach to monitor shisha premises with routine visits, until they comply with legislation or else stop selling shisha. They should continue to take action when shisha premises are breaking the law, such as allowing smoking shisha and/or cigarettes indoors, or not providing the required warning labels associated with the sale of tobacco. They should continue to identify shisha cafes which routinely allow underage customers and take enforcement action.
- In Camden, map the location of shisha cafes to identify their proximity to local schools. Trading Standards and the healthy schools team should raise awareness with children and their parents that shisha tobacco is not always labelled that way, so young people in particular may be unaware they are consuming tobacco.

# 8.5 Electronic cigarettes

Electronic cigarettes (ECs), also marketed as 'e-shisha' or 'shisha sticks or pens' are currently the subject of national and international debate, regarding their regulation, effectiveness for smoking cessation and potential to attract non-smokers, especially young people, to tobacco, acting as a 'gateway' to smoking.

The use of ECs (or 'vaping') has grown threefold in the last two years in the UK; 2.6 million adults use them, almost all of whom are smokers or ex-smokers but use among young people is rare (2% monthly and 0.5% weekly use).[28] In a 2014 national survey of 15 year olds, 18% had tried e-cigarettes.This is not significantly different to 2015 survey results for Year 10 pupils in Camden (20%) or Islington (18%).[29] The national survey indicates that most young people use them once or twice and only 3% are currently using one.[30]

The increasing popularity of ECs and use in public spaces has caused concern because of the potential to re-introduce smoking behaviours in smokefree environments. However, there is no current evidence in England that ECs are re-normalising smoking or increasing smoking uptake.[31] ECs have become the most popular quitting aid used by smokers.[32] Thus, they have great potential to help people who want to quit but who cannot overcome their addiction to nicotine to reduce or stop smoking cigarettes, and in doing so, reduce the burden of smoking-related disease and death.

A recent independent evidence review by Public Health England (PHE) concluded that although ECs are not completely risk free, evidence shows they carry just a fraction of the harm compared to smoking. The current best estimate is that EC use is around 95% less harmful to health than smoking. There is no identified risk to bystanders from nicotine released when vaping, as the amounts are negligible.[33]

Under the current regulatory system, individual EC products vary considerably in quality and specification.[34] They are currently subject to regulations relating to general product safety, but there has been criticism of the quality of devices, some of which have leaked or malfunctioned, often causing fires. In addition labelling issues (such as nicotine levels) have been identified in cartridges and e-liquids[35], including in the research completed by Camden Trading Standards of products sold in the borough of Camden.

Nicotine-containing ECs are not currently licensed as medicines and are sold without the safeguards built into the regulation of medicinal products. From 20th May 2016 ECs will come under the revised EU Tobacco Products Directive, except where therapeutic claims are made or they contain over 20 mg/ml of nicotine, when they will require medicines authorisation[36]. In the UK, the Medical Healthcare Regulatory Agency (MHRA) can regulate nicotine products as medicines and it is expected that some products will be authorised in 2015. Following the introduction of the Tobacco Products Directive, ECs which are not licensed under MHRA will be more strictly regulated, including improved safety and quality requirements, such as child/ tamper proof packaging for e-liquids, and new packaging and labelling requirements.[37] Restrictions on their sale to young people under 18 years of age came into effect on 1st October 2015.

The stop smoking services in Camden and Islington are actively supporting smokers who use ECs as part of their quit attempt, with behavioural support and advice on licensed medications. NHS stop smoking advisors cannot currently prescribe un-licensed ECs as stop smoking aids.

Camden and Islington Public Health issued a position statement on ECs in April 2014. It was reviewed in December 2015, in light of PHE's evidence update:

"On balance, having reviewed the evidence, we must consider how we can exploit the potential benefits of ECs in helping smokers quit while building in safeguards to monitor issues such as the safety and quality of the products currently available, promotion to children (and any related potential uptake in tobacco smoking) and their effect on smokefree legislation."

## Recommendations

- In line with PHE guidance, welcome the use of ECs by existing smokers who make a quit attempt and support smokers further to quit tobacco products using our evidence-based stop smoking services.
- Respond pro-actively to emerging new evidence on ECs and to future availability of licensed products to be used as stop smoking aids.
- Ensure our stop smoking services and all professionals in Camden and Islington providing Level 2 stop smoking advice are equipped to give up-to-date information about the relative risks of nicotine and all nicotine-containing products (including ECs), based on national guidance and regulation.
- Continue to monitor the sale of ECs and ensure that sellers comply with new and existing legislation (for example under-age sales) and with safety regulations, in particular regarding unsafe chargers. Explore potential for partnership work with the Fire Service.

# References


1. The Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group. 2010. Available from: https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf
2. Data from the Health Related Behaviour Questionnaire (HRBQ) survey 2015, carried out in primary and secondary schools in Camden and Islington. For more information contact: Gill Morris (Camden Council): gill.morris@camden.gov.uk; Helen Cameron (Islington Council): helen.cameron@islington.gov.uk
3. Office for National Statistics. Opinions Survey Report No. 40. Smoking-related behaviour and attitudes 2008/2009. 2009. Available from: http://www.ons.gov.uk/ons/rel/lifestyles/smoking-related-behaviour-and-attitudes/2008-09/index.html
4. Akhtar PC, Haw SJ, Currie DB, Zachary R, Currie CE. Smoking restrictions in the home and secondhand smoke exposure among primary schoolchildren before and after introduction of the Scottish smoke-free legislation. Tobacco Control [Online] 2009; 18(5):409-15. Available from: doi: 10.1136/tc.2009.030627.
5. Lovasi GS, Diez Roux AV, Hoffman EA, et al. Association of Environmental Tobacco Smoke Exposure in Childhood with Early Emphysema in Adulthood Among Nonsmokers. American Journal of Epidemiology [Online] 2010; 171(1):54-62. Available from: doi: 10.1093/aje/kwp358. Epub 2009 Nov 25.
6. Cabana M, Birk N, Slish K, et al. Exposure to tobacco smoke and chronic asthma symptoms. Pediatric Asthma Allergy and Immunology 2005; 18 (4): 180-188.
7. World Health Organisation. International Consultation on Environmental Tobacco Smoke (ETS) and Child Health. Consultation Report. [Online] January 1999. Available from: www.who.int/tobacco/research/en/ets_report.pdf
8. The Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group. 2010. Available from: https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf
9. The Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group. 2010. Available from: https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf
10. Muller T. Breaking the cycle of children's exposure to tobacco smoke. British Medical Association. 2007. Available from: http://bmaopac.hosted.exlibrisgroup.com/exlibris/aleph/a21_1/apache_media/GR3GIR2QERK36MDPMLKEJ7AFL6AD8A.pdf
11. Yolton K, Dietrich K, Auinger P et al. Exposure to environmental tobacco smoke and cognitive abilities among US children and adolescents. Environmental Health Perspectives 2005; 113(1): 98–103.
12. Best D. Secondhand and prenatal tobacco smoke exposure. Pediatrics 2009; 124; e1017-e1044; originally published online Oct 19, 2009.
13. International Agency for Research on Cancer. Personal habits and indoor combustions. Volume 100E: A review of human carcinogens. Secondhand Smoke. World Health Organisation. 2012. Available from: http://monographs.iarc.fr/ENG/Monographs/vol100E/mono100E-7.pdf
14. Hemminki K, Chen B. Parental lung cancer as predictor of cancer risks of offspring: clues about multiple routes of harmful influence? International Journal of Cancer 2006; 118 (3): 744-748.
15. Lovasi GS, Diez Roux AV, Hoffman EA, et al. Association of Environmental Tobacco Smoke Exposure in Childhood with Early Emphysema in Adulthood Among Nonsmokers. American Journal of Epidemiology [Online] 2010; 171(1):54-62. Available from: doi: 10.1093/aje/kwp358. Epub 2009 Nov 25.
16. The Royal College of Physicians. Passive smoking and children. A report of the Tobacco Advisory Group. 2010. Available from: https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf
17. Centers for Disease Control and Prevention. Exposure to second-hand smoke among students aged 13–15 years – worldwide, 2000– 2007. Morbity & Mortality Weekly Report 2007; 56: 497–500. Available from: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5620a2.htm
18. Action for Smoking and Health. Smoking Still Kills; Protecting Children, Reducing Inequalities. Executive Summary. [Online] 2015 Available from: http://www.ash.org.uk/files/documents/ASH_963.pdf
19. Department for the Environment, Food and Rural Affairs. Preventing cigarette litter in England: guidelines for local authorities. [Online] 2007. Available from: http://www.keepbritaintidy.org/Documents/Products/Files/662358db_2aef_4319_9cdb_bc58350eea09.pdf
20. https://www.camden.gov.uk/ccm/content/transport-and-streets/clean-streets/clean-streets-in-camden.en?page=1

21. http://www.smokefreeislington.nhs.uk/about-smokefree-islington/cleaner-greener/
22. A Government consultation ran from December 2014 to February 2015. Available from: https://www.gov.uk/government/consultations/tobacco-levy
23. HM Revenue & Customs. Tackling Illicit Tobacco: from leaf to light. The HMRC and Border Force strategy to tackle tobacco smuggling. 2015. Available from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418732/Tackling_illicit_tobacco_-_From_leaf_to_light__2015_.pdf
24. Stewart, G. Yoshizaki, M. Illicit and illegal tobacco in North Central and North East London. A report on smokers' perceptions, supply and demand. [Online] 2015. Available from: http://www.tradingstandards.uk/policy/illegaltobacco.cfm
25. London Health Commission. Better Health for London. 2014. Available from: http://www.londonhealthcommission.org.uk/wp-content/uploads/London-Health-Commission_Better-Health-for-London.pdf
26. Power G. Illicit Tobacco in South East London: A Survey of Smokers. 'Tobacco, Crime and Health Inequalities in South East London'. [Online] 2013. Available from: https://www.lambeth.gov.uk/sites/default/files/ssh-illicit-tobacco-survey-report.pdf
27. Power G. Shisha Smoking in South East London. A cross-population survey of shisha use and awareness in South East London. [Online] 2014. Available from: http://www.lambeth.gov.uk/sites/default/files/ssh-shisha-smoking.pdf
28. McNeill A et al. E-cigarettes: An evidence update. Public Health England 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf
29. Data from the Health Related Behaviour Questionnaire (HRBQ) survey 2015, carried out in primary and secondary schools in Camden and Islington. For more information contact: Gill Morris (Camden Council): gill.morris@camden.gov.uk; Helen Cameron (Islington Council): helen.cameron@islington.gov.uk
30. Health and Social Care Information Centre. Health and Wellbeing of 15 year olds in England: Smoking Prevalence – Findings from the What About YOUth? Survey 2014. Available from: http://www.hscic.gov.uk/catalogue/PUB17984/what-about-youth-eng-2014-smok-rep.pdf 2. HRBQ
31. McNeill A et al. E-cigarettes: An evidence update. Public Health England 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf
32. Smoking Toolkit Study [Online] www.smokinginengland.info
33. McNeill A et al. E-cigarettes: An evidence update. Public Health England 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf
34. McNeill A et al. E-cigarettes: An evidence update. Public Health England 2015. Available from: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf
35. McRobbie H/ McEwen A (ed). Electronic Cigarettes. National Centre for Smoking Cessation and Training. Briefing; 2014. Available from: http://www.ncsct.co.uk/usr/pub/e-cigarette_briefing.pdf
36. Action for Smoking and Health. Regulating Nicotine Products [Online]. Available from: http://www.ash.org.uk/current-policy-issues/harm-reduction-product-regulation/regulating-nicotine-products
37. European Commission Memo. Questions and Answers: New rules for tobacco products 26 February 2014 [Online]. Available from: http://europa.eu/rapid/press-release_MEMO-14-134_en.htm

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# Conclusion

This Camden and Islington Tobacco Control Strategy 2016-2021 aims to address the ongoing public health challenge of tobacco use, through three strands of work: closing the gateways in, helping people out and reducing related harm. Our aim is that the rate of smokers in the population will fall to 13% in Camden and 16% in Islington by 2021.

Whilst smoking prevalence has been steadily decreasing nationally and to some extent in Camden, it has remained stubbornly stable in Islington in particular since 2010. A sustained focus on tackling tobacco is essential. We also need to increase our focus on addressing health inequalities caused by smoking by targeting the most disadvantaged areas and groups and promoting a smokefree start in life for young families.

Success cannot be achieved without looking at the bigger picture and ensuring that our plans complement and reinforce each other. Leadership from the NHS and Local Authorities and making the best use of our resources are key ingredients in implementing the recommendations of this strategy effectively. However, it is also important to engage communities with the right messages, in order to shift social attitudes amongst the groups with higher smoking rates and make it the normal thing not to smoke.

To translate this strategy into action, a delivery plan will be developed by Camden and Islington Smokefree Alliance partners, who will monitor and oversee the tobacco control programmes outlined in the strategy over the next 5 years. Working with our Health and Wellbeing Boards, we will strengthen existing partnerships and engage new partners – the public and voluntary sector as well as statutory authority groups, to ensure we are on track.

We would therefore encourage you to support this strategy's work, supporting Camden and Islington in our journey to being smokefree by 2030.

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Our intention is to engage with the public again in 2016 in order to develop the delivery plan for this strategy.

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