Tobacco Control Joint Strategic Needs Assessment

A review of tobacco control across Hammersmith and Fulham, Kensington and Chelsea and Westminster

March 2013
(updated with minor amendments April 2013)

Authors
Gayan Perera
Colin Brodie
Sarah Carter
Laura Su

Website - www.jsna.info

Contents

Summary

Smoking is the biggest single preventable cause of disease and premature death in the UK.

Generally, smoking attributable mortality is low in Westminster and Kensington and Chelsea. However, smoking attributable deaths are significantly high in Hammersmith and Fulham compared with other two boroughs and higher than London and England. For Westminster and Kensington and Chelsea, average smoking attributable mortality masks the high mortality rates in the more deprived parts of the boroughs. Furthermore, deaths due to lung cancer and COPD are significantly higher in Hammersmith and Fulham compared with Westminster and Kensington and Chelsea. Hospital admissions due to smoking were also observed to be high in Hammersmith and Fulham compared with other two Inner North West London boroughs.

Health costs due to smoking across the tri-borough are £25.8 million per year and similar amounts are for costs of loss of productivity due to smoking.

There is a high prevalence of smoking in the most deprived parts of Inner North West London. The most deprived parts of Inner North West London are Queen's park, Harrow road, Church street, Golborne, College park and Old Oak, Wormholt and White City, Shepherd's Bush, Westbourne, North End, Churchill and Tachbrook. These areas have a high proportion of social housing, ethnic minority groups and routine and manual workers. These deprived parts of Inner North West London have the highest rates of premature mortality including cardiovascular diseases and cancer.

National evidence suggests that over the last 60 years, male smoking prevalence is decreasing faster than female smoking prevalence and as of 2010 male smoking prevalence is slightly higher than females.

Certain ethnic groups including Black African and Caribbean males and any other ethnic group (Middle Eastern community) groups, Irish men and Eastern Europeans and Bangladeshi men have high prevalence of smoking compared with other ethnic groups.

Routine and manual groups in Westminster and Kensington and Chelsea have high rates of smoking prevalence, while routine and manual groups living in Hammersmith and Fulham have low rates those compared with their respective general population.

All Inner North West London boroughs have low rates of current smokers who are pregnant compared with England and London.

Generally, rates of quitting smoking across the tri-boroughs are either similar of better compared with London and England. The highest rates of smoking quitters were observed in Hammersmith and Fulham compared with other two boroughs.

There are low rates of smoking quitters in certain deprived parts of the tri-borough such as Church Street, Queen's Park, Harrow Road and St. Charles.

According to a recent self assessment looking at current performance with regards Tobacco Control with stakeholders and an additional review of the functioning of the Inner North West London Tobacco Control Alliance across the tri-borough:-

- There is good work with young people in Hammersmith and Fulham

- Compliance of smoke free legislation is high; however, compliance by Shisha Cafes in Westminster is problematic.
- Communication is largely reactive with no communications strategy.
- No strong leadership
- Attendance and membership of the alliance is patchy and unequal
- No lead for Tobacco Control
- No local Tobacco Control Strategy or vision
- Commissioning of services is not joined up with wider strategic plans
- There are no governance or reporting arrangements in place.

Data Limitations

There are limitations in terms of data availability for this needs assessment. For example, data on the prevalence of other tobacco products such as shisha is unknown in Inner North West London. There are a high proportion of shisha bars and Middle Eastern community groups smoke shisha in these bars. Furthermore, data availability is limited for Paan use amongst certain ethnic community groups such as Bangladeshi groups.

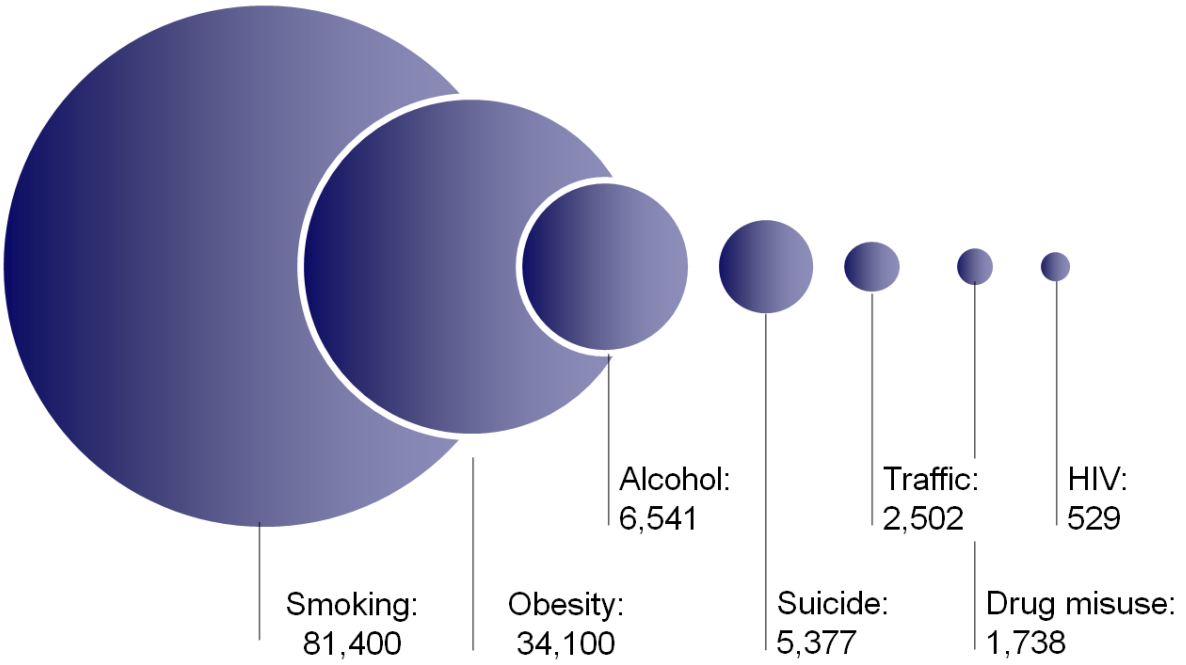
An additional gap in information is for second-hand smoking for those residents in tri-boroughs.

Introduction

Smoking is the biggest single preventable cause of disease and premature death in the UK. One in two regular smokers is killed by tobacco - half dying before the age of 70, losing an average of 21 years of life (ASH, 2012). Preventing people from starting smoking is the key to reducing the health harms and inequalities associated with tobacco use.

According to Action on Smoking and Health (ASH), smoking causes the greatest number of preventable deaths in England.

Figure 1: Number of deaths attributable to life style risk factors in England during 2009 (ASH, 2012).



Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) which includes bronchitis and emphysema) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

Smoking causes almost 90 per cent of deaths from lung cancer, around 80 per cent of deaths from bronchitis and emphysema, and around 17 per cent of deaths from heart disease. Around one-third of all cancer deaths can be attributed to smoking; for example, people who smoke between one and fourteen cigarettes a day have eight times the risk of dying from lung cancer compared to non-smokers. Smokers under the age of 40 also have five times greater risk of a heart attack than non-smokers.

The burden of cigarette smoking continues to be high, particularly in certain groups across the tri-borough and although UK smoking rates have dropped in the past 30 years, very little has changed in the past 5 years.

Stopping smoking at any stage in a person's life can influence mortality and morbidity. The risk of heart disease reduces to about half that of a continuing smoker within a year or so of stopping

smoking, while the risk of lung cancer reduces to almost the same as the risk for people who have never smoked within 15-20 years. Encouraging cessation among adults is also important in providing non-smoking role models for children and young people.

Furthermore, a year of life gained due to stopping smoking can be as much as 10 years as shown in table 1.

Table 1: Years of life gained by stopping smoking at different ages, 30 to 60.

Age at which stopped smoking	Years of life gained
30	10
40	9
50	6
60	3

The 2013-16 public health outcomes framework (DH, 2012) has highlighted the prevention of smoking as a priority and included the following smoking related measures:

- Smoking status at time of delivery
- Smoking prevalence – 15 year olds
- Smoking prevalence – adult (over 18s)

These contribute to the 2013/14 NHS outcomes framework (DH, 2012) measures:

- Life expectancy at 75
- Under 75 mortality rate from cardiovascular disease
- Under 75 mortality rate from respiratory disease
- Under 75 mortality from cancer

Aim

The aim of this report is to describe the size of the smoking problem in the three Inner North West London Boroughs (Hammersmith and Fulham, Kensington and Chelsea and Westminster), to analyse the public health impact and disease burden due to smoking and to analyse the local stop smoking services to date. Furthermore, there is a summary of the local self assessment undertaken in December 2012 and the results of an additional review of the membership of the existing Inner North West London Tobacco Control Alliance.

The tri-borough population

The tri-borough is a diverse in terms of ethnicity, deprivation and socioeconomic status.

Generally the population across the tri-borough is mostly young with a high proportion of 20- 39 year olds compared with the England population.

Current population

- According to the 2011 Census, Hammersmith and Fulham had a total population of 184,500 people. This was the fourth smallest population in London
- Kensington and Chelsea had a total population of 158,700, which was the smallest population in London after City of London
- Westminster had a total population of 219,400 people, making it the 10th smallest population of all 33 London boroughs.

Age structure

The age structure in each of the three boroughs is very different to England, with a much larger working age population and a much smaller proportion of children and older people.

Figure 2: Proportion of resident population by age-band, 2011, Hammersmith and Fulham (Data source: Office for National Statistics, 2011)

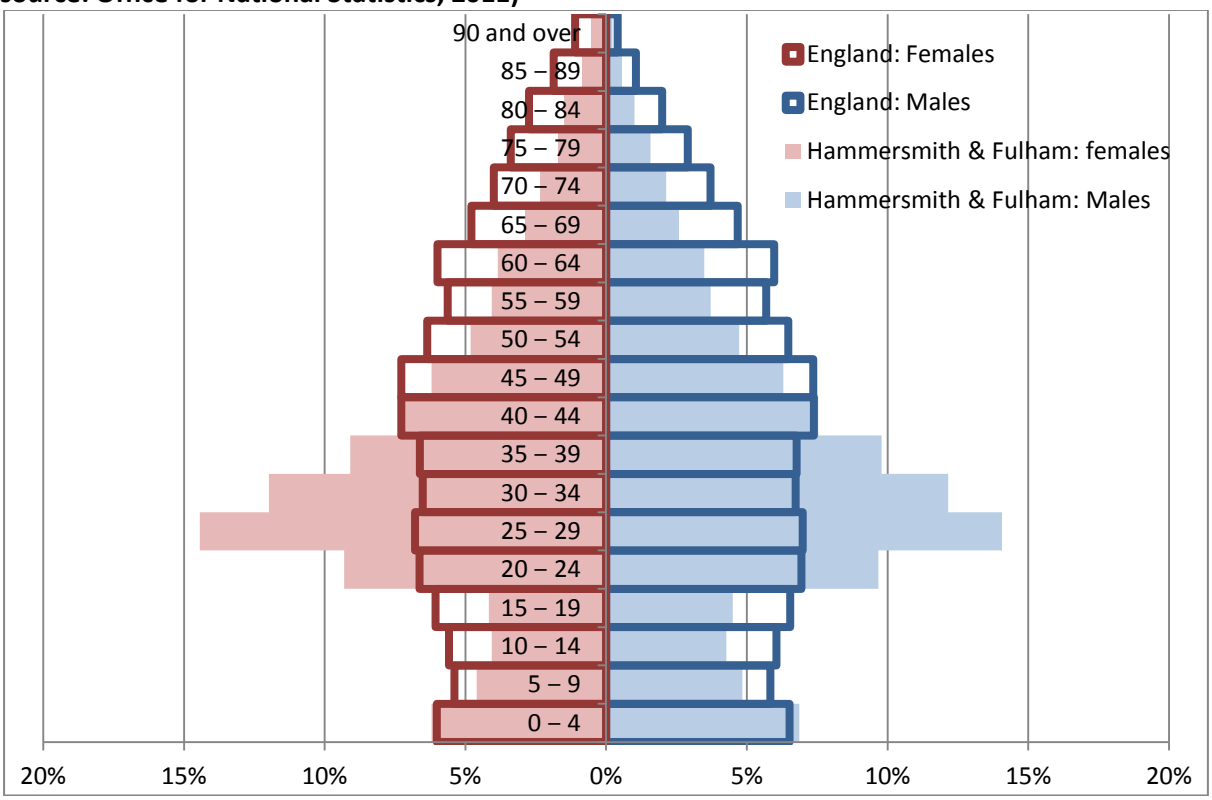


Figure 3: Proportion of resident population by age-band, 2011, Kensington & Chelsea (Data source: Office for National Statistics, 2011)

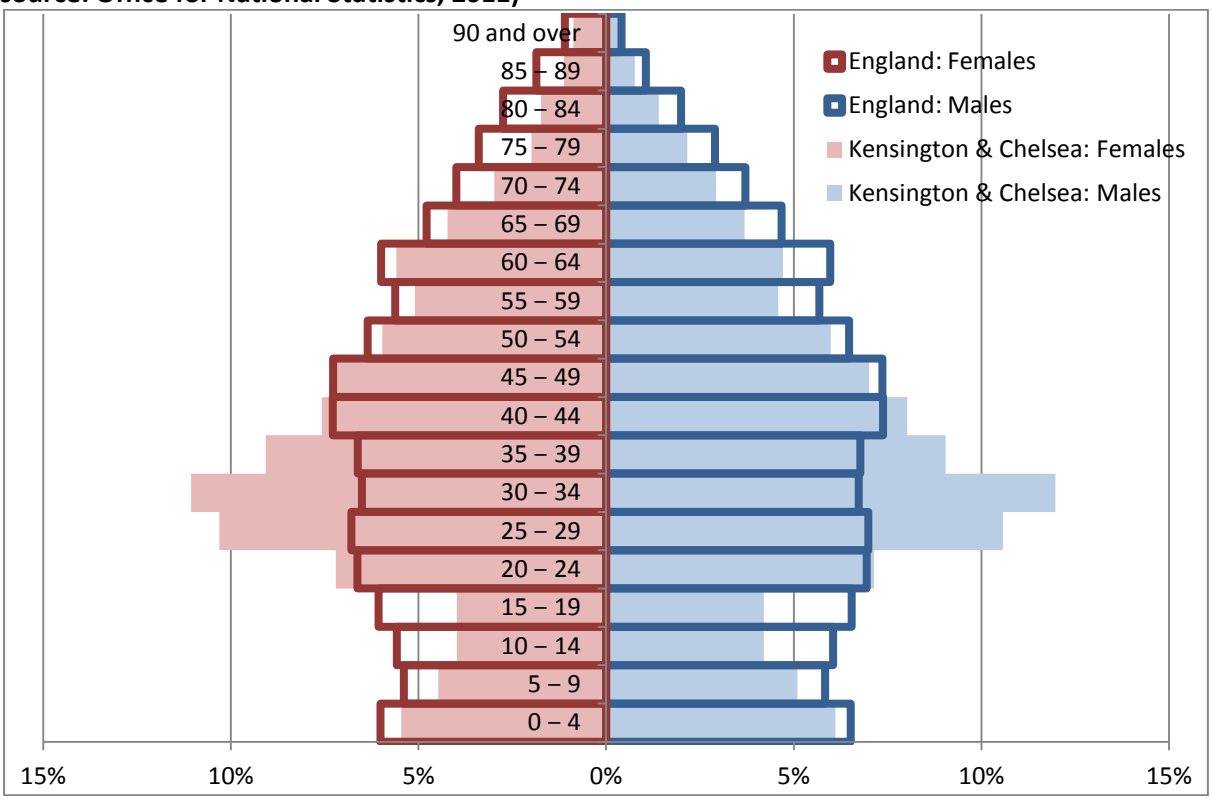
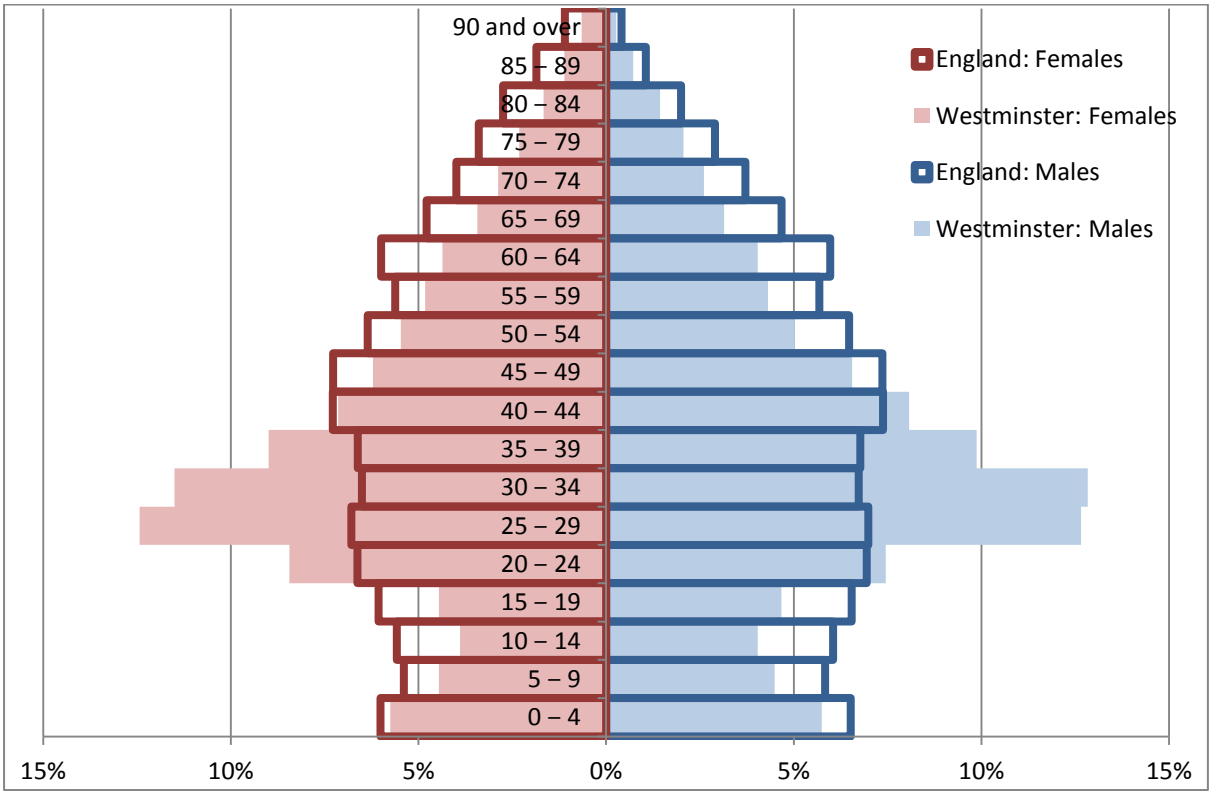


Figure 4: Proportion of resident population by age-band, 2011, Westminster, (Data source: Office for National Statistics, 2011)



All three boroughs have a large young working-age population (20 year olds and 30 year olds) and a smaller proportion of older people than London.

Kensington and Chelsea and Westminster both have a much smaller proportion of children and young people than London, and a broadly similar proportion of older people to London (but far fewer than England)

The CCG profile

- In April 2012, Hammersmith and Fulham CCG comprised of 31 GP practices with a patient list of 200,061. Most of their patients live in Hammersmith and Fulham.
- In April 2012, West London CCG comprised of 57 GP practices with a patient list of 228,779. Most of their patients live in Kensington and Chelsea, or Queens Park & Paddington in Westminster.
- In April 2012, Central London CCG comprised of 36 GP practices with a patient list of 188,986. Most of their patients live in Westminster, with fewer numbers in Queen's Park and Paddington.

Table 2: Tri-borough population by area of residence and boundary comparison with Clinical commission groups (Data source: Office for National statistics, 2011 Census)

Local authority	**Population**	**Boundary comparison with Clinical Commissioning groups (CCGs)**
Hammersmith and Fulham	182,500	Same geographical boundaries as Hammersmith and Fulham CCG
Kensington and Chelsea	158,700	West London CCG include Kensington and Chelsea local authority as well as some parts of Westminster (Queens Park and Paddington locality)
Westminster	219,400	Include all Central London CCG, but excluding Queen's park and Paddington area which belong to West London CCG

According to the latest 2011 ONS Census data the total population in the three boroughs is 560,600.

Table 3: Tri-borough population by area of residence and boundary comparison with Clinical commission groups

Local authority	Local authority resident Population	PCT GP registered population*	CCG GP registered population*
Hammersmith and Fulham	182,500	202,368	202,368
Kensington and Chelsea	158,700	178,421	226,198
Westminster	219,400	232,584	185,651

*GP registered population as at 31st December 2012.

There are 18,000 extra patients seen in Hammersmith and Fulham GP registered population compared with the Hammersmith and Fulham resident population.

Central London CCG covers most of Westminster, except Queens park and Paddington area have 31,000 less population in their GP records compared with the Westminster resident population. The reason for this is that Queens Park and Paddington GPs are now part of West London CCG. Therefore, West London CCG which includes all parts of the Royal borough of Kensington and

Chelsea and Queens Park and Paddington areas have nearly 70,000 extra patients in the GP registered population compared with their Kensington and Chelsea local authority population.

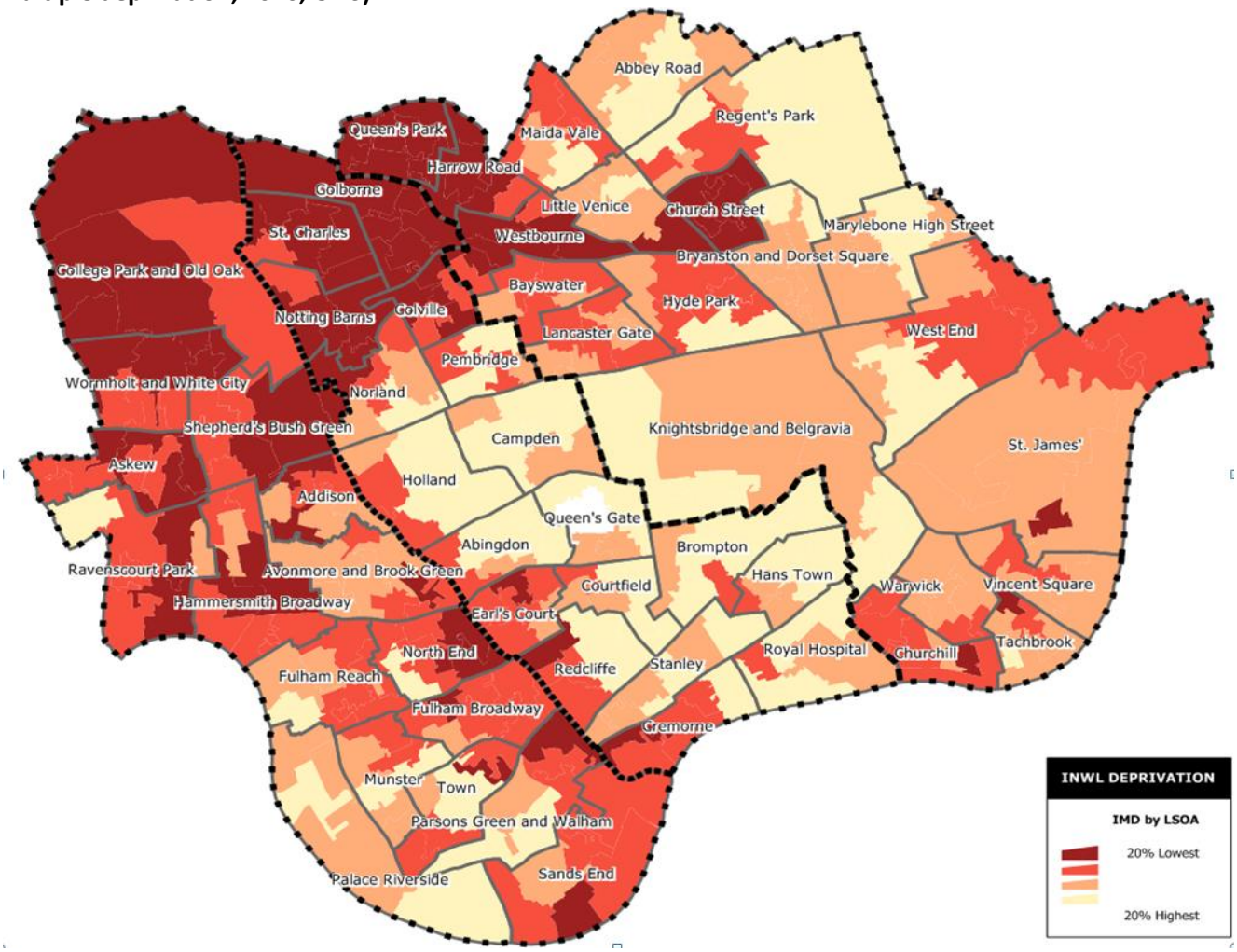
The extra patients seen in Hammersmith and Fulham CCG and West London CCGs could be due to those patients residing outside the tri-borough, but registered with a GP in one of the practices in Hammersmith and Fulham and West London CCGs.

Deprivation

Deprivation is measured using the Index of multiple deprivation (IMD). The latest IMD scores were calculated in 2010 and are called IMD 2010. There are seven components that contribute to an IMD score 2010:

1. Income deprivation
2. Employment deprivation
3. Health deprivation and disability
4. Education, Skills and Training deprivation
5. Barriers to Housing and Services,
6. Living Environment deprivation
7. Crime

Figure 5: Map showing highly deprived areas within the Tri-borough (Data source: Index of multiple deprivation, 2010, ONS)



IMD 2010 varies widely across the tri-borough area. Some of the Northern parts of the boroughs belong to the 10% most deprived areas in England including Queen's Park, Harrow Road and Church Street. Nationally, deprivation is a strong predictor of smoking. Consistent with national evidence, highly deprived areas across the tri-borough have high smoking prevalence.

Most of the northern parts of the tri-borough are considered "deprived". Furthermore, there is a high proportion of social housing in the areas that are known to be highly deprived including Churchill, Tachbrook, North End and Sands End.

Young people across the tri-borough

There were an estimated 98,800 young people aged 15-24 resident across the tri-borough in 2011 (ONS census, 2011) – a number which is expected to increase in the future. Overall, the Westminster population is highly mobile with the highest population turnover rate of any London borough and this is particularly true of the younger population aged 18 and above.

The 0-17 year old population is also extremely diverse; 36% of the population are from BME groups compared to 30% of the Inner North West London population as a whole and 12% of the England population as a whole (ONS, 2010). This diversity is expected to increase in the future. Teenagers are almost 4 times more likely to smoke whilst pregnant compared with those over 35 (ONS 2011)

According to national evidence from ASH, 90% of smokers started to smoke before the age of 19 (ONS 2011b)and 99% of 16 year old regular smokers live in a household with at least one other smoker (Smoking, drinking and drug use among young people in England in 2010, ONS)

There are several universities and colleges based within the boroughs and there are several halls of residence, accommodating large numbers of students.

BME people across the tri-borough

The latest available data from 2011 ONS population estimations, suggests that 23% of the tri-borough resident population belong to BME groups – this is equivalent to 139,185 people. This number is expected to increase in the future.

The population of young people is much more ethnically diverse than the population across the tri-borough as a whole, suggesting that the population of the tri-borough is likely to be more ethnically diverse in the future.

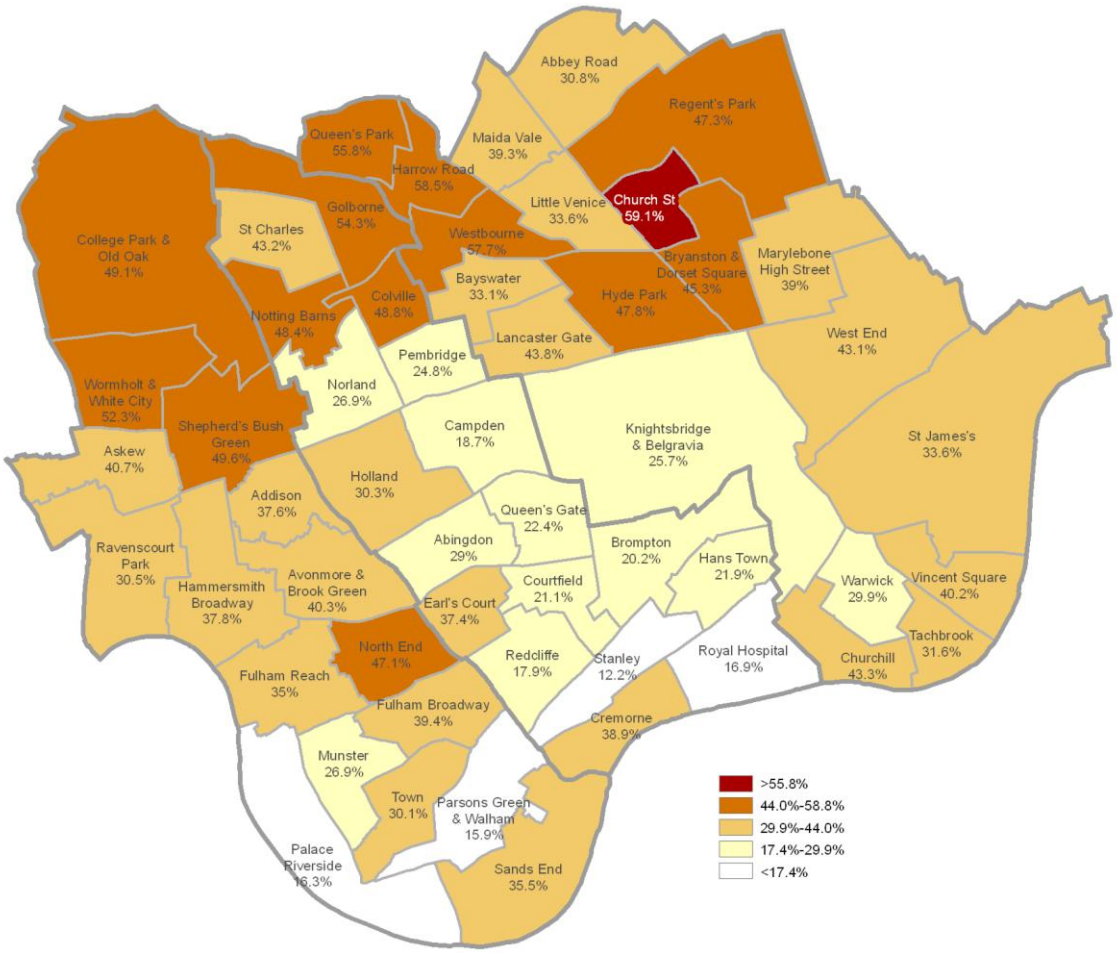
As shown in table 4, white other including Eastern Europeans, other ethnic groups including Middle Eastern and mixed groups are over represented across the tri-borough compared with London and England.

Table 4: Population by ethnicity 2001, all ages (Data source: ONS census 2001)

	Hammersmith & Fulham	Kensington & Chelsea	Westminster	London	England
White British	58%	50%	49%	60%	87%
White Other	20%	29%	25%	11%	4%
Black	11%	7%	7%	11%	5%
Asian	4%	5%	9%	12%	2%
Other/Mixed	7%	10%	10%	6%	2%
White	78%	79%	74%	71%	91%
BME	22%	21%	26%	29%	9%

(Highlighted areas show high proportions population from those ethnic groups compared with London and England)

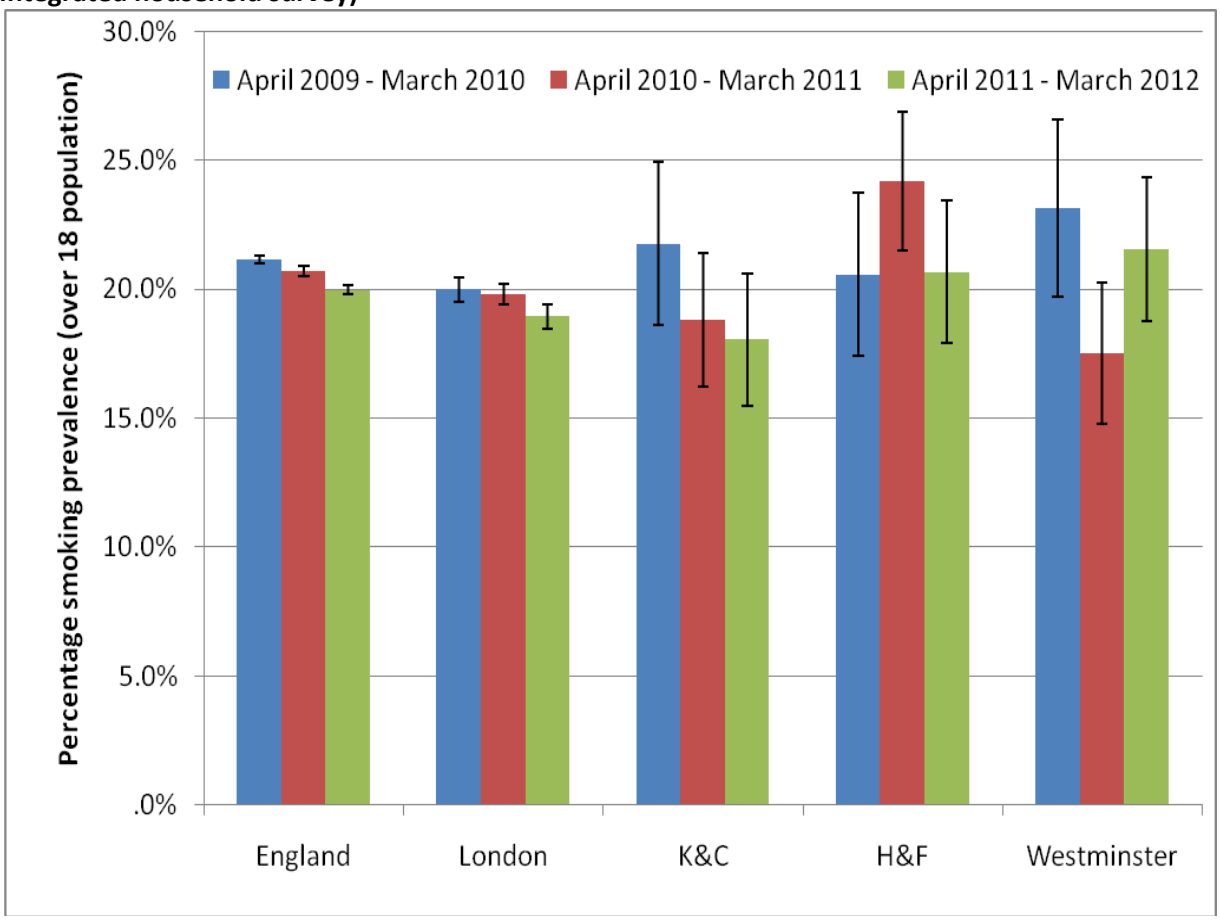
Figure 6: Percentage of residents aged 0-17 years from Black and Minority Ethnic groups, 2001 (Data source: ONS census 2001)



The scale of the problem across the tri-borough

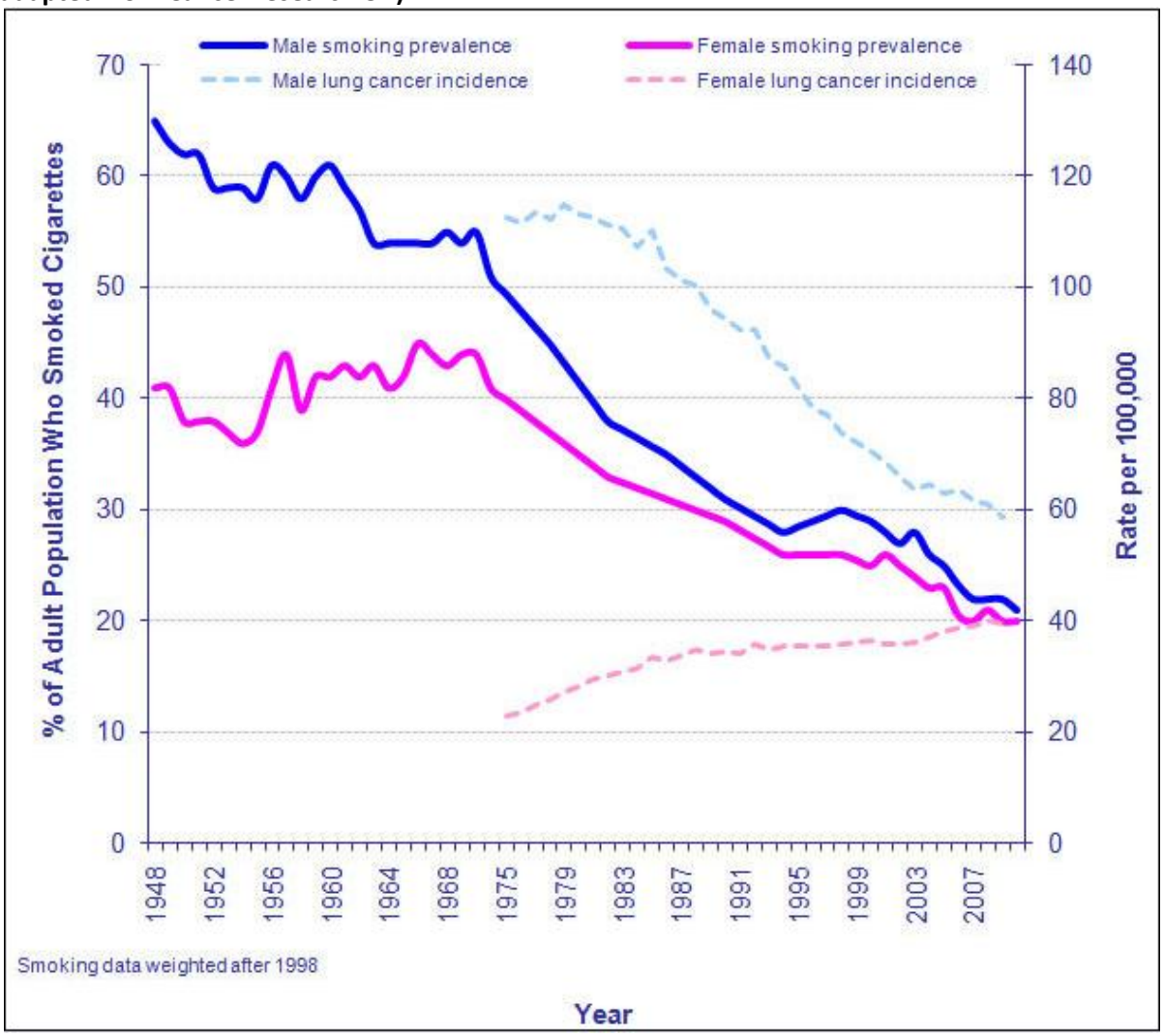
Generally, smoking prevalence in Inner North West London PCTs was not significantly different from the rest of England or London. As shown in figure 7, during the financial year 2011/12, Westminster and Kensington and Chelsea had the highest and lowest smoking prevalence across the tri-borough respectively. However, the trend does not show any significant change in prevalence in the last 3 years across the tri-borough.

Figure 7: Smoking prevalence among adults (18+) during 2009/10, 2010/11, 2011/12 (Data source: Integrated household survey)



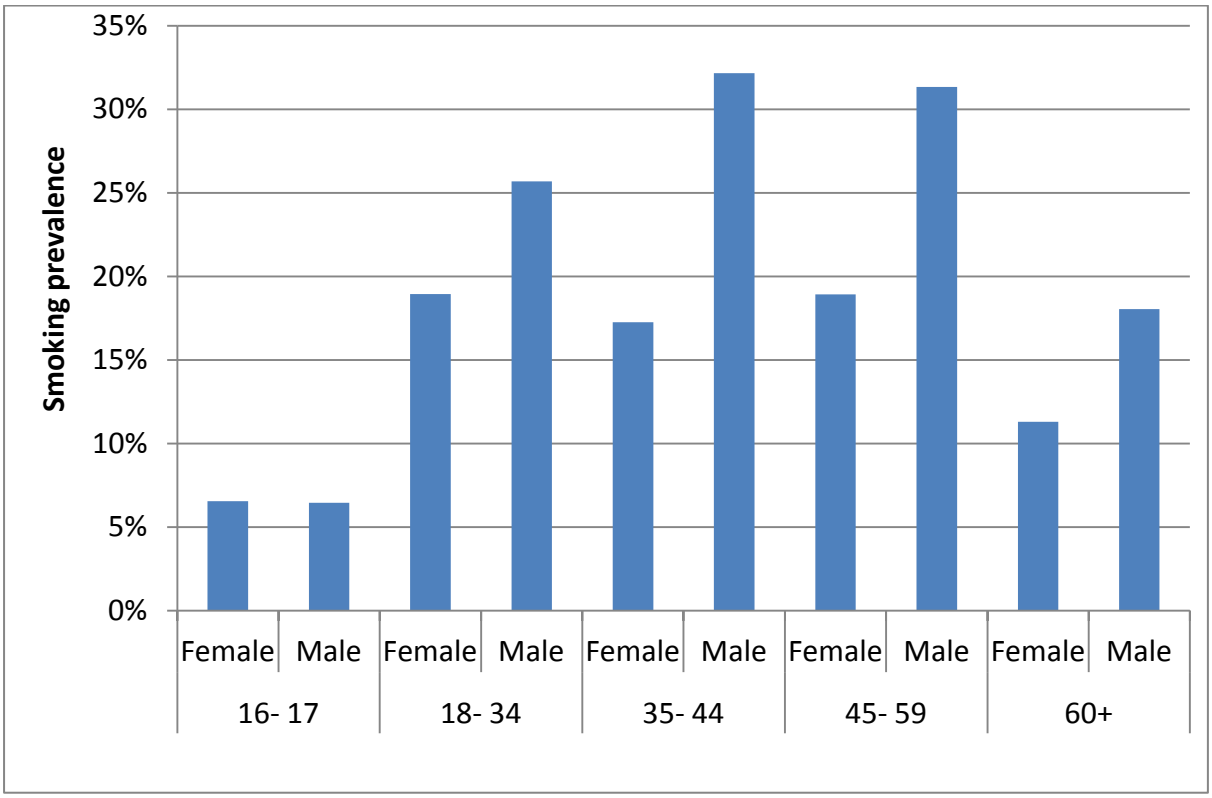
Analyses of smoking data by Cancer Research UK (2012) found that from 1948 to 2010 male smoking prevalence has fallen greater than female smoking prevalence in the UK (figure 7). As of 2010, male smoking prevalence is slightly higher than female smoking prevalence.

Figure 8: Smoking Prevalence and Lung Cancer Incidence, by Sex, Great Britain, 1948-2010 (figure adapted from Cancer research UK)



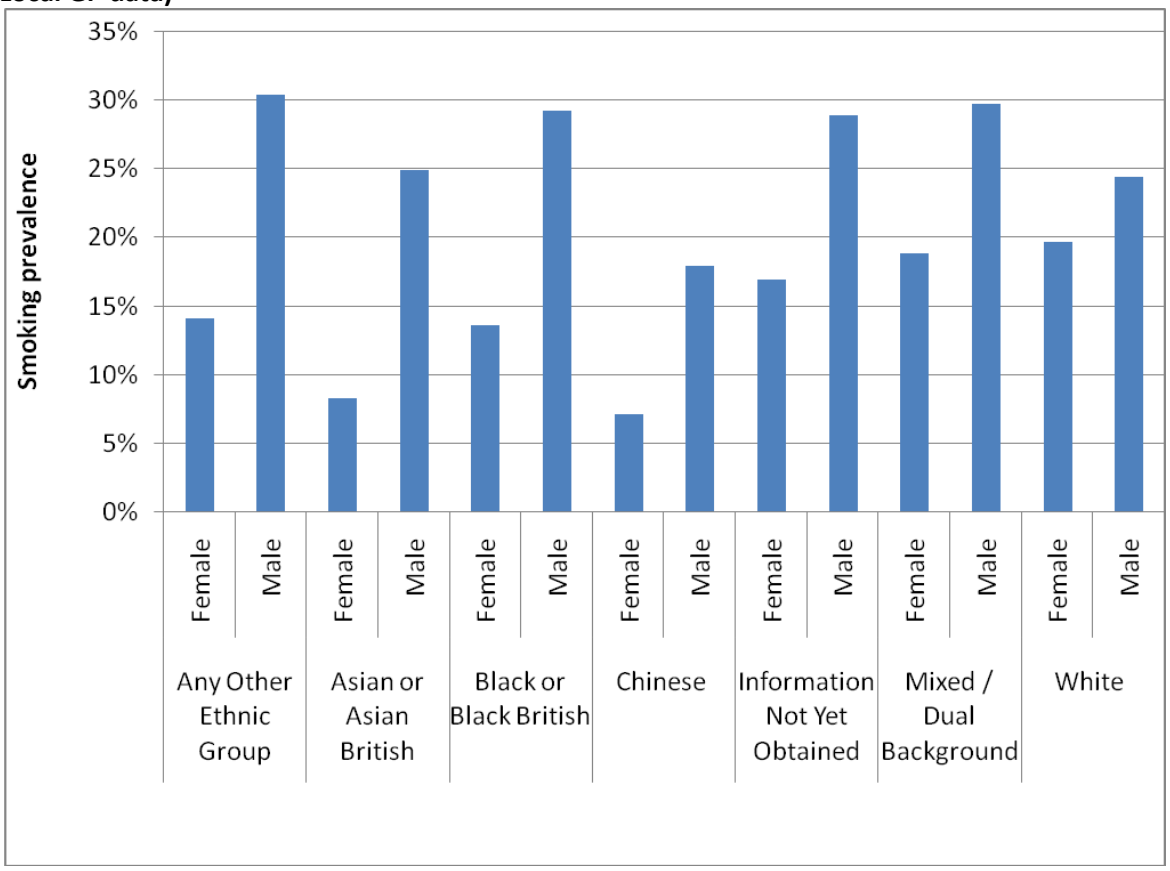
When local smoking data was analysed using local GP data, smoking prevalence among 35-59 males was found to be significantly higher than the average prevalence.

Figure 9: Estimated smoking prevalence by age and gender for INWL PCTs, (Data source: Local GP data)



Ethnic groups such as 'any other ethnic group' (particularly middle eastern ethnic groups in Westminster), Black community groups and mixed ethnic groups are shown to have high prevalence of smoking across the tri-borough.

Figure 10: Estimated smoking prevalence by gender and ethnicity for INWL PCTs, (Data source: Local GP data)



The main source of information about cigarette smoking among minority ethnic groups is the Health Survey for England 2004 (NHS Information Centre, 2004).

It found that:
Bangladeshi men were 43% more likely (risk ratio of 1.43) and Irish men were 30% more likely (risk ratio of 1.30) to smoke cigarettes than the general male population after accounting for age. Indian men were less likely (risk ratio of 0.78) to smoke cigarettes than the general male population in England.

Smoking is less common among women in most - but not all - minority ethnic groups compared to the general female population, when age is taken into account. Compared to the general female population, Bangladeshi women were the least likely to smoke cigarettes (risk ratio of 0.11), followed by Pakistani women (risk ratio of 0.19), Indian women (risk ratio of 0.23), Chinese women (risk ratio of 0.32) and Black African women (risk ratio 0.34). However, Irish and Black Caribbean women were as likely to report cigarette smoking as the general population for women.

Smokeless tobacco (also called oral tobacco) use is prevalent in the UK's South Asian community, while water pipes (also known as hookahs, narghiles, shisha or hubble-bubble pipes) are used primarily by the Middle Eastern and Eastern Mediterranean communities.

Although the use of these other forms of tobacco is not well researched, some of the health impacts are likely to be similar to those of cigarette smoke.

Smoking rates in deprived areas or by Routine and Manual (R&M) groups

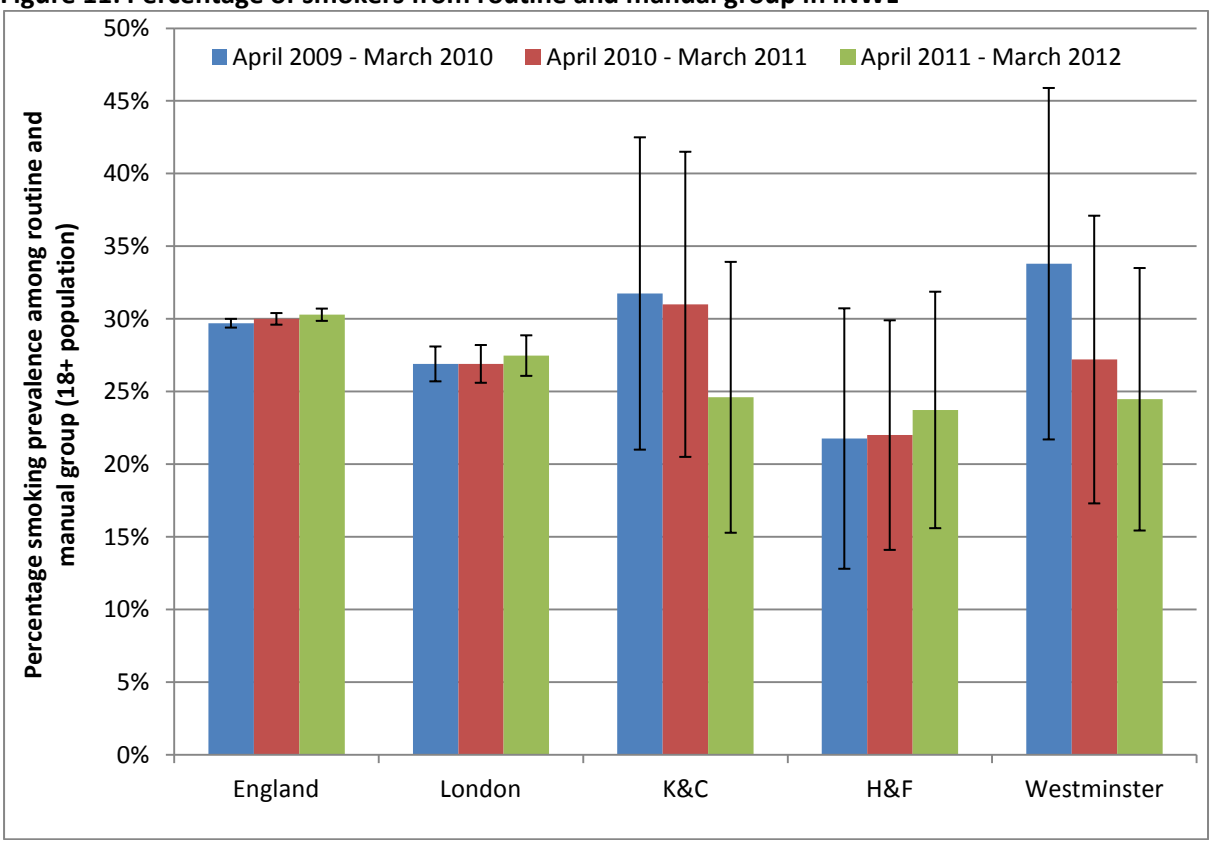
The prevalence of smoking varies markedly between socio-economic groups. People in deprived circumstances are not only more likely to take up smoking but generally start younger, smoke more heavily and are less likely to quit smoking, each of which increases the risk of smoking-related disease.

In England, 28% of adults in routine and manual occupations smoked regularly in 2009 compared with 15% of adults in managerial and professional occupations (ONS 2010).

Smoking accounts for a significant proportion of inequalities in life expectancy at birth in the UK. The health impact for London has been estimated in the London Health Inequalities Forecast. This found that 37% of the difference in life expectancy at birth in males and 30% of the difference in females between the 11 London authorities in the worst fifth for deprivation and health and all English local authorities was accounted for by mortality attributable to smoking.

Across the tri-borough, as shown in figure 11, smoking prevalence is high among routine and manual groups in Westminster and Kensington and Chelsea during 2009/10 , 2010/11 and 2011/12 compared with their general populations. However, Hammersmith and Fulham smoking prevalence among routine and manual groups are similar to their general population. Generally, there was a decrease in smoking prevalence in routine and manual groups in Kensington and Chelsea and Westminster, while Hammersmith and Fulham observed an increase in smoking prevalence from 2009/10 to 2011/12.

Figure 11: Percentage of smokers from routine and manual group in INWL



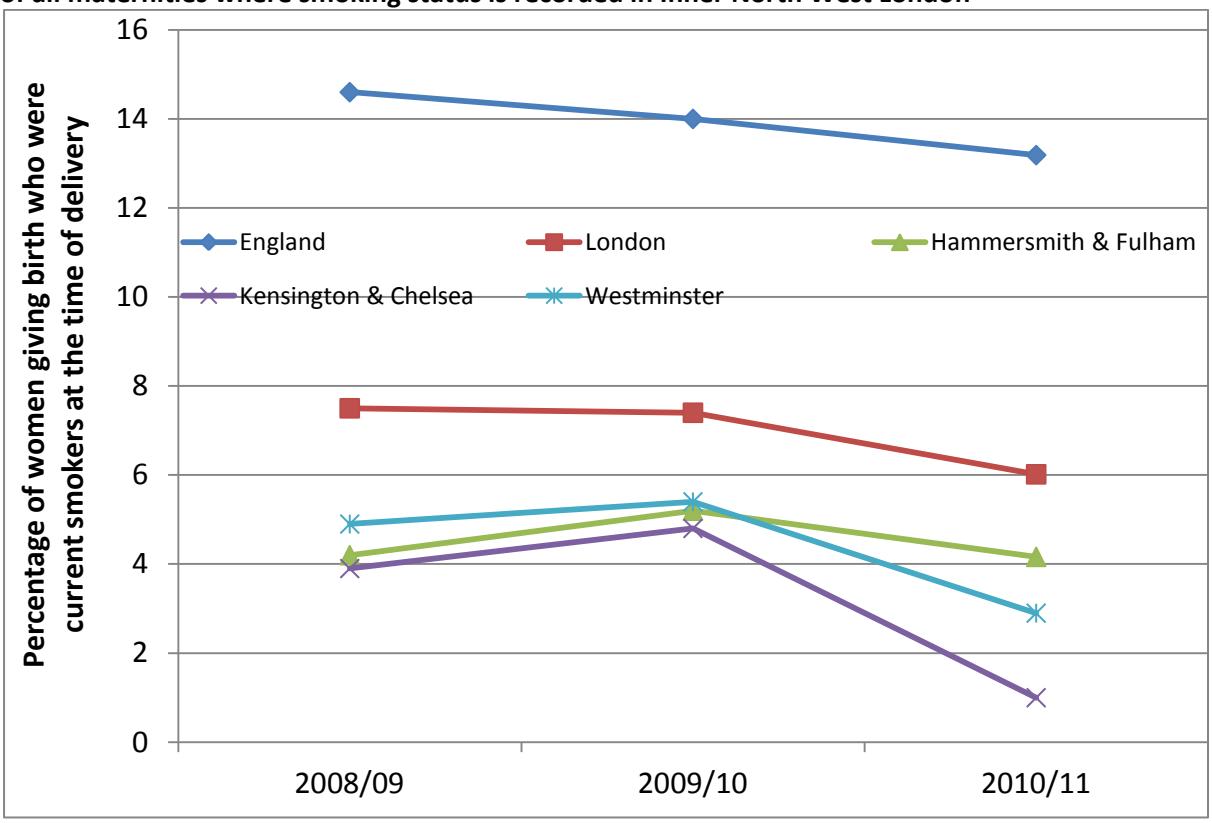
Smoking during pregnancy

Smoking during pregnancy increases the risk of complications during pregnancy and labour, including miscarriage. Women who smoke, or who are exposed to second-hand smoke, while pregnant are more likely to have a baby with low birth weight than non-smoking mothers. Low birth weight is associated with higher risks of death and disease in infancy and early childhood. Smoking during pregnancy, and after pregnancy also increases the risk of sudden infant death ('cot death').

About one in seven (13.2%) women who gave birth in England in 2011/12 reported smoking during their pregnancy. However, the national average masks the wide inequality in the proportion of women who smoked during pregnancy - from 3% in Westminster to 30% in Blackpool (Local Tobacco Control Profiles, 2012).

Smoking in pregnancy is a major contributor to higher infant mortality in the routine and manual socio-economic group in many regions of England compared with all births in England and Wales. It has been estimated that 57% of the gap in infant mortality between the routine and manual group in the East of England and all couple births in England in 2008/09 was due to smoking in pregnancy (London Health Observatory, 2012)

Figure 12: Percentage of women giving birth who were current smokers at the time of delivery out of all maternities where smoking status is recorded in Inner North West London



Smoking among patients with Long term conditions

Table 5: Number and percentage of smokers by CCG that have long term diseases and registered GP disease register* (Data source: Local GP register data)

	Number of smokers in the disease register				Percentage of smokers in the Long term disease register			
Disease register	Central London	H&F	K&C	Queen's Park and Paddington	Central London	H&F	K&C	Queen's Park and Paddington
Atrial Fibrillation	101	245	244	50	9.8%	12.8%	11.9%	13.1%
Asthma	589	2256	1542	370	15.6%	21.8%	21.1%	20.2%
CHD	253	665	530	142	14.7%	20.6%	16.2%	21.2%
CKD	125	971	477	89	8.4%	17.2%	12.3%	13.5%
COPD	242	997	961	192	35.6%	48.0%	44.8%	44.7%
Depression	1611	5272	4956	1049	27.6%	35.0%	29.9%	34.0%
Diabetes	506	1277	1053	322	18.2%	19.6%	18.5%	18.3%
Epilepsy	124	438	337	100	21.0%	26.4%	25.9%	28.7%
Hypertension	924	3153	2436	600	13.0%	18.3%	15.7%	16.6%
Hypothyroidism	292	689	601	158	11.8%	16.1%	14.0%	17.5%
LD	16	59	51	31	14.7%	17.6%	18.0%	18.9%
Mental Health	312	1034	1017	297	40.3%	46.9%	43.6%	51.2%
Palliation	27	71	60	16	18.4%	22.6%	17.5%	21.9%
Stroke & TIA	132	334	298	88	15.1%	18.8%	16.2%	20.0%

*Please note that data is only available for 479,927 patients. Estimated GP registered population for Inner North West London is 606,000. GP register data is not available for some of the Westminster GP practices for analysis.

As demonstrated in table 5, nearly half of COPD and more than half of mental health patients in the disease register are smokers, whilst nearly a quarter of patients with Asthma, CHD, Stroke and in palliative care are smokers.

Table 6: Number of smokers and non-smokers in INWL with co-morbidities and registered with GP long term disease register* (Data source: Local GP register data)

	Current Non-smokers					Current smokers				
Number of Long term conditions	CLH	H&F	K&C	QPP	INWL total	CLH	H&F	K&C	QPP	INWL total
None	59291	120462	109444	22731	311928	8270	22430	16907	4525	52132
1	10173	22079	20912	4423	57587	2380	7125	6292	1497	17294
2	3152	7047	7015	1526	18740	733	2430	2086	513	5762
3	1348	3127	2854	674	8003	274	951	729	168	2122
4	507	1384	1245	253	3389	83	362	256	70	771
5	211	469	464	100	1244	39	136	105	22	302
6 and over	67	221	183	49	520	7	68	49	9	97
Total no. Of patients	74749	154789	142117	29756	401411	11786	33502	26424	6804	78516
No. Of patients with 2 or more co-morbidities	5285	12248	11761	2602	31896	1136	3947	3225	782	9054
Rate per 100	7.1	7.9	8.3	8.7	7.9	9.6	11.8	12.2	11.5	11.5

*Please note that data is only available for 479,927 patients. Estimated GP registered population for Inner North West London is 606,000. GP register data is not available for some of the Westminster GP practices for analysis.

As demonstrated in table 6, 9054 smokers who are registered with a GP practice across the tri-borough have two or more long-term conditions. Therefore, 11.5% of all smokers across the tri-borough who are registered with a Inner North West London GP have two or more co-morbidities.

Smoking in Prisons

HMP Wormwood Scrubs is the only prison located locally in Hammersmith and Fulham PCT area (a category B male prison- Those who do not require maximum security, but for whom escape needs to be made very difficult). Nationally, it is shown that the prevalence of smoking is often much higher in prisons.

In HMP Wormwood Scrubs, 50% of all new prisoners are recorded as current smokers by the prison services. This figure is however very variable due to the high turnover within HMP Wormwood Scrubs.

Smokeless Tobacco

Use of chewing/smokeless tobacco products is common amongst certain population groups, notably those of South Asian origin (people with ancestral inks to Bangladesh, India, Nepal, Pakistan or Sri Lanka). Survey data suggests that amongst the South Asian population in the UK, the use of smokeless tobacco is more prevalent amongst those of a Bangladeshi origin, women, those from older age groups, first generation migrants and those from lower socioeconomic backgrounds. (Moles et al 2008), (NHS information Centre, 2006), (NICE, 2012), (Prabhu et al, 200)

There are currently no local estimates as to the prevalence of smokeless tobacco use amongst South Asian Communities within the three boroughs of Inner North West London, although a piece of local insight work is currently being commissioned to look at usage amongst Bangladeshi women in North Westminster. There is also limited national evidence on the prevalence and severity of smokeless tobacco usage, and patterns have been seen to vary from area to area (NICE, 2012). The Health Survey for England (2004) indicated that 9% Bangladeshi men and 16% Bangladeshi women used smokeless tobacco. In some localities, however, it is likely that prevalence is higher. For instance, one study in Tower Hamlets based on a combination of questionnaire and saliva analysis showed that 49% of adult Bangladeshi women in the local population used these products.

Within South Asian communities a variety of smokeless tobacco products are used, in different combinations. In addition to tobacco itself, products used include Paan leaf, areca nuts, slaked lime, flavourings and sweeteners, which on their own and as a collective can impact on the user's health (Croucher et al, 2002).

Smokeless tobacco products are readily available in shops in areas of England where there are large South Asian communities. Generally, they are cheap compared to cigarettes. Unlike cigarettes and other tobacco products used for smoking, around 85% of smokeless tobacco products are sold without any regulatory health warning (Longman et al, 2010). The recent NICE guidance on Smokeless tobacco cessation (2012) also highlighted the following additional concerns:

- The number of outlets selling these products is increasing (Croucher et al, 2009)
- Over the past 11 years there has been a rise in legal imports of smokeless tobacco, as well as a recent rise in illegal imports (HM Revenue and Customs, 2008)
- That the packaging of the products appears to be targeted at young people (Panesar et al, 2008)

Tobacco chewing products are associated with a number of health problems including:

- nicotine addiction
- mouth and oropharyngeal cancer
- dental disease and late diagnosis of dental problems (because the smokeless tobacco product helps mask the pain)
- cardiovascular disease
- problems in pregnancy and following childbirth (including foetal anaemia, placental pathology,
- stillbirth, pre-term birth, and low birthweight (Boffetta and Straif, 2009), (England et al, 2010), (Gupta and Subramoney, 2004), (Pau et al, 2003) (Quandt et al, 2005) (West et al, 2004),

Studies have also suggested that the health risks may be compounded by the fact that some South Asian users of these products may be less likely to visit the dentist on a regular basis, for prevention, and as such any risk to their health or developing disease may be less likely to be identified.(Pearson et al, 1999), (NICE, 2012)

Since 1989 there has been a steady increase in the rates of oral cancer in the UK (Cancer research UK, 2010). Consumption of tobacco (smoked and smokeless) is one of the most established risk factors for oral cancer. Areca nut, often used with smokeless tobacco, is also carcinogenic in its own right. Although it is not known how the use of smokeless tobacco products are linked to the increase in oral cancer, it is known that South Asian women are 3.7 times more likely to have oral cancer and 2.1 times more likely to have pharyngeal cancer compared with other women (and they are also some of the principal users of smokeless tobacco). This has been found to be the case, even

after controlling for the effect of socioeconomic deprivation) (Moles et al, 2008), (NICE, 2012), (Auluck et al, 2009), (Warnakulasuriya, 2002)

Despite the high prevalence of use and the health risks associated with smokeless tobacco products, NICE has drawn attention to the lack of information nationally about the existence of smokeless tobacco cessation initiatives as well as evidence of their effectiveness and cost effectiveness. In order to provide a more detailed picture of the situation locally and inform service provision, the local insight work being carried out in Westminster will gather information on the perceived health risk of smokeless tobacco amongst the Bangladeshi population, as well their views on the current service offer and how it can be improved.

NICE recommends that any services that are developed to support individuals stop using smokeless tobacco, whether it be brief interventions carried out by trained, health professionals or specialist tobacco cessation service are:

- co-produced with their target population
- accessible and culturally appropriate for the South Asian community
- ensure awareness of the risks and support available is raised amongst the local community using local channels
- refer to smokeless tobacco products using colloquial terminology
- consider how to challenge the perceived benefits of the products and how to advise users to cope with the potential adverse effects of withdrawal
- bear in mind that smokeless tobacco users may also smoke tobacco (NICE, 2012)

The following information was obtained from a Paan user focus group in Church Street.

- There is high prevalence of Paan use among Church Street Asians.
- Chewing Paan is associated with their cultural festivals such as weddings.
- They spent £2-£20 per week depending on the size of the family on Paan.
- Most of the women who use Paan have been chewing it since their teenage days and learnt to do it from their parents.
- Those who use Paan observed that they were likely to have mouth ulcers, gastritis, dependency for Paan, gum problems and toothaches.
- Some Paan users would like to stop using Paan due to their health problems. However, they think that they need more support from GPs and dentists.

Shisha

There is high prevalence of shisha smoking across the tri-borough and there are increasing numbers of shisha bars across the tri-borough. Furthermore, shisha smoking is high amongst Middle Eastern and North African community groups.

Smoking related ill health and deaths

Smoking caused an average of 82,500 estimated deaths per year of adults aged 35 and over in England during the period 2008-10. This figure includes a yearly average of 10,800 deaths from heart disease and 3,600 deaths from stroke that were attributed to smoking (Local Tobacco Control Profiles, 2012) in 2008-10.

There were 28,100 deaths from lung cancer and 22,400 deaths from chronic obstructive pulmonary disease (COPD) on average per year in England over the period 2008-10. The vast majority of these deaths were caused by smoking.

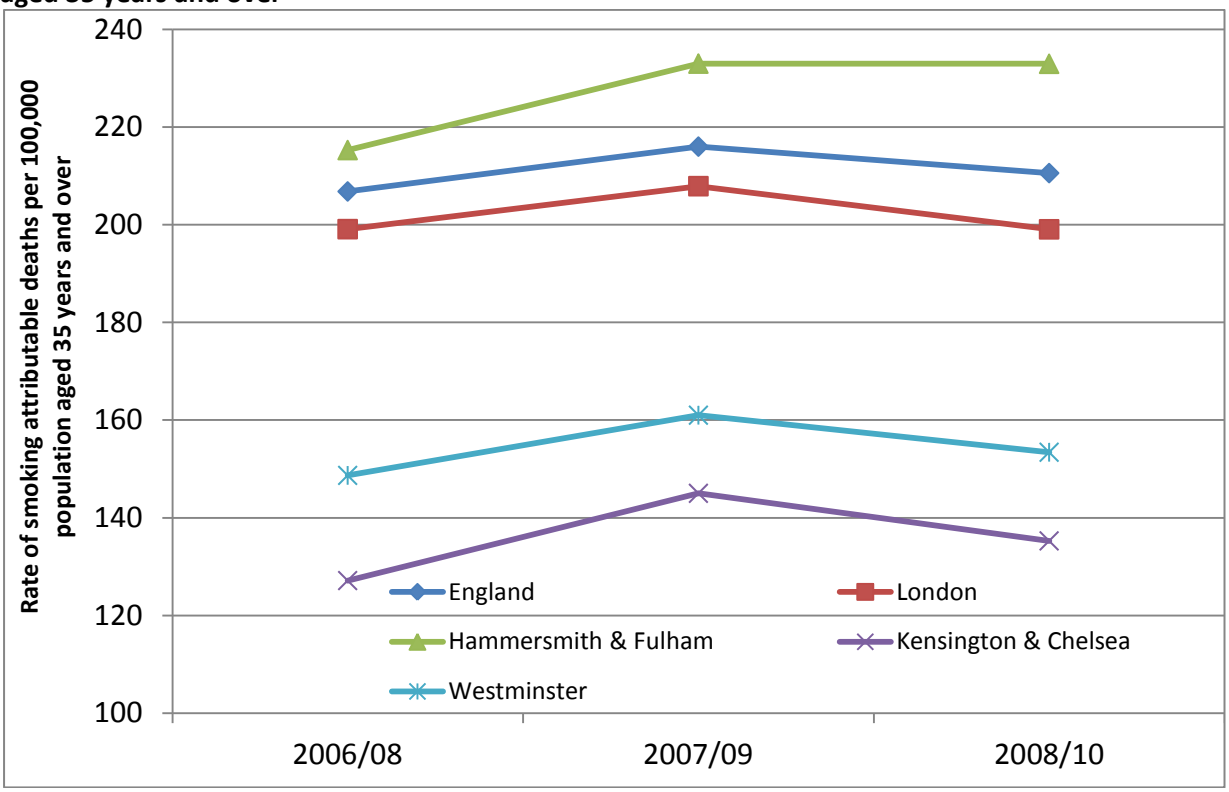
During the period 2008-10, there were 99,500 lung cancer registrations in England, on average 33,200 a year. Registration is a measure of each new diagnosis of cancer.

Smoking is responsible for a larger proportion of deaths among men than women. In England in 2009, an estimated 23% of all deaths among men aged 35 and over were attributed to smoking, compared with 14% of all deaths among women. The number of deaths in 2009 that were attributed to smoking was 49,100 among men and 32,300 among women (the NHS Information Centre).

In 2010/11, the equivalents of 476,500 hospital admissions among adults aged 35 and over in England were attributed to smoking. Rates varied across the English regions, from 1,113 admissions per 100,000 population in the South East to 2,064 in the North (Local Tobacco Control Profiles, 2012).

Smoking attributable deaths

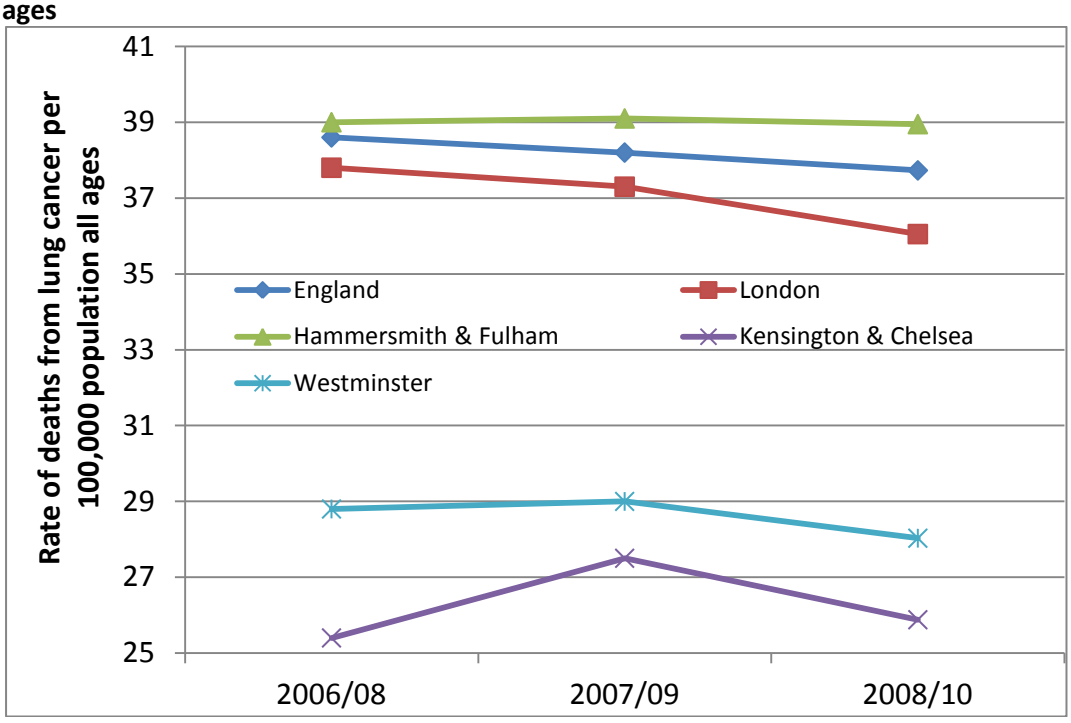
Figure 13: Directly age-standardised rate of smoking attributable deaths per 100,000 population aged 35 years and over



Smoking attributable deaths were significantly higher in Hammersmith and Fulham compared with Westminster and Kensington and Chelsea. Hammersmith and Fulham smoking attributable mortality was higher than London and England.

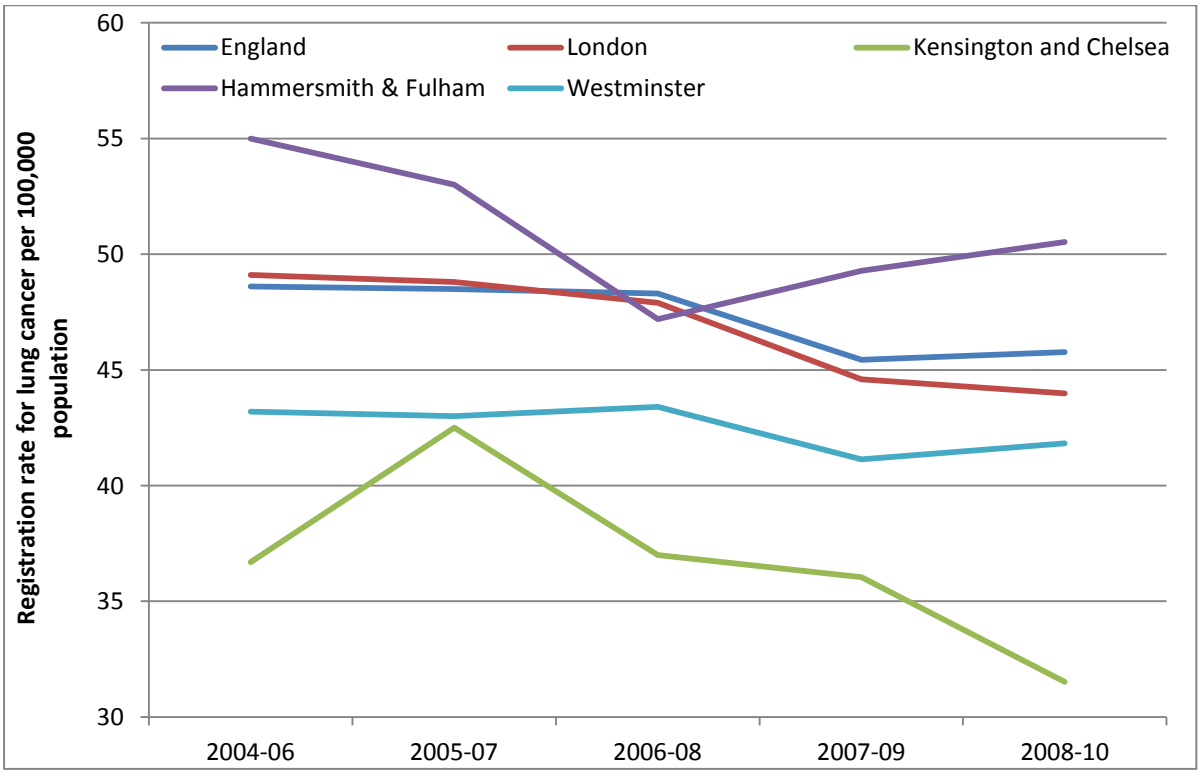
Lung Cancer

Figure 14: Directly age-standardised rate of deaths from lung cancer per 100,000 population all ages



Lung cancer deaths were significantly higher in Hammersmith and Fulham compared with Westminster and Kensington and Chelsea. Hammersmith and Fulham Lung cancer mortality was higher than London and England.

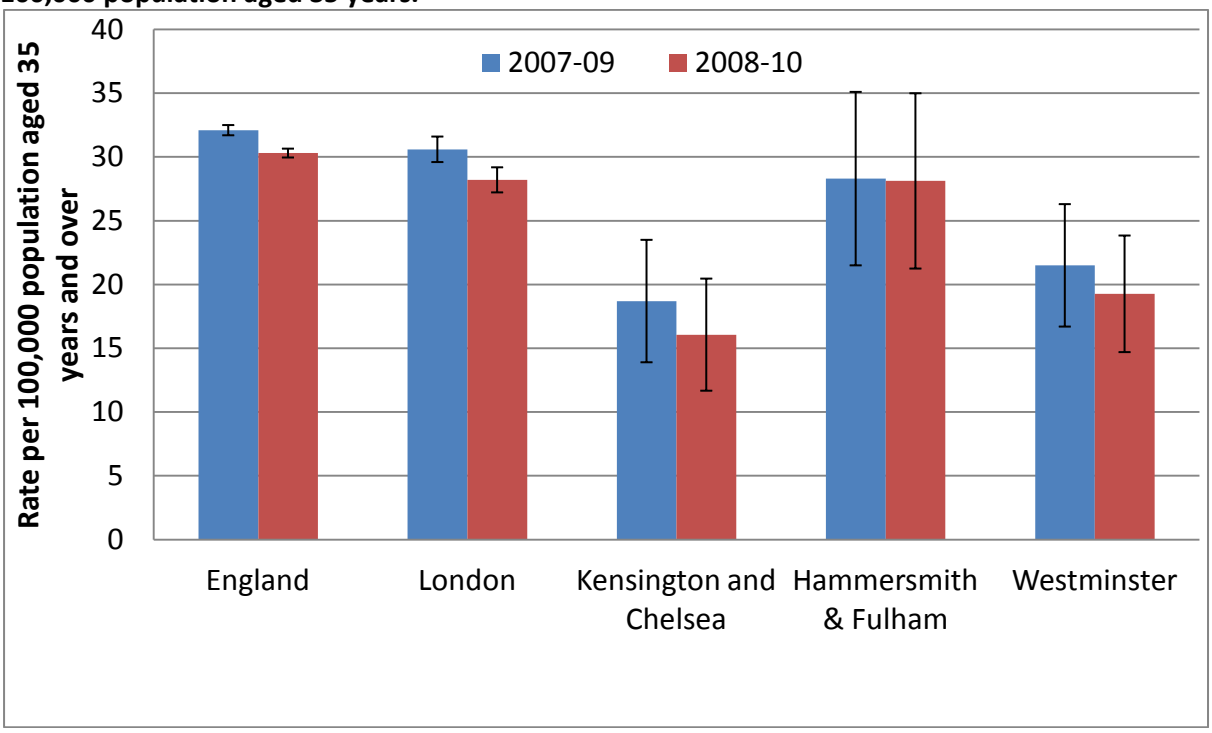
Figure 15: Directly age-standardised registration rate for lung cancer per 100,000 population all ages



Lung cancer registrations (incidence) were significantly higher in Hammersmith and Fulham compared with Westminster and Kensington and Chelsea. Hammersmith and Fulham Lung cancer registrations decreased from 2005-07 to 2006-08 and lower than the rates of England and London.

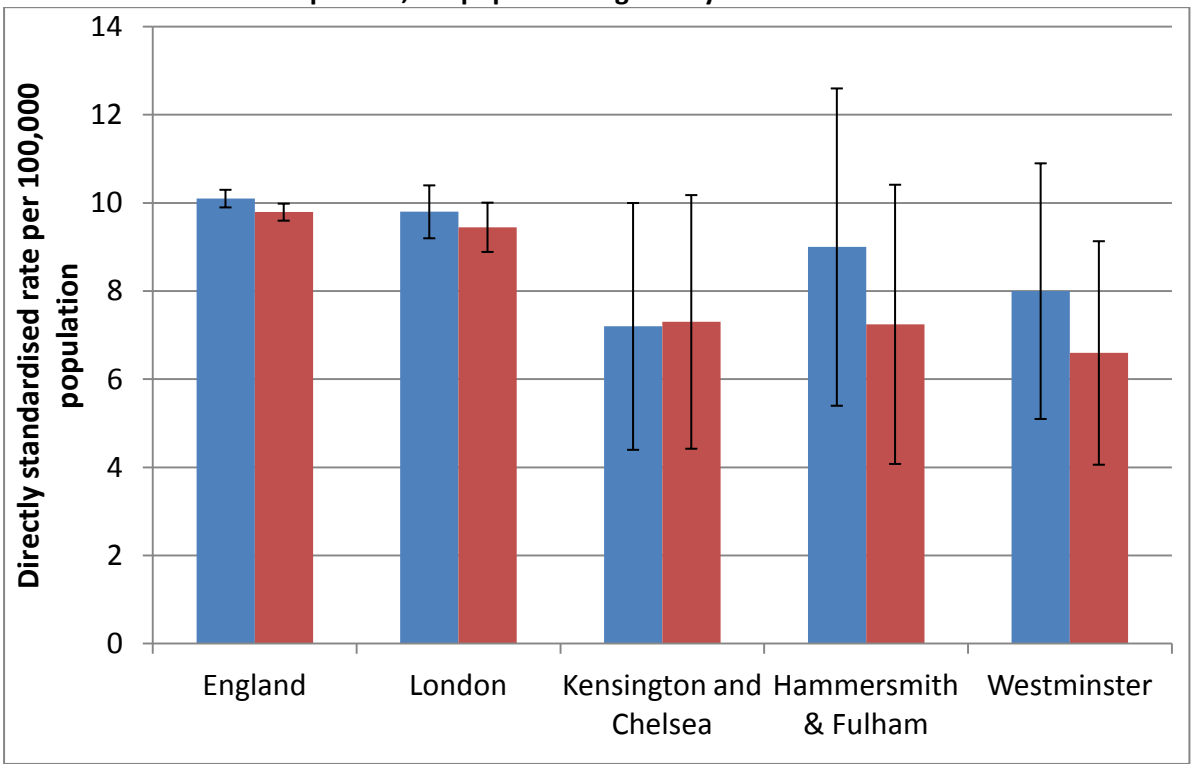
Heart Disease

Figure 16: Directly age-standardised rate of smoking attributable deaths from heart disease per 100,000 population aged 35 years.



Smoking attributable deaths from heart diseases for those patients over 35 was generally higher in Hammersmith and Fulham compared with Kensington and Chelsea and Westminster. However, Hammersmith and Fulham death rates were lower than England and London

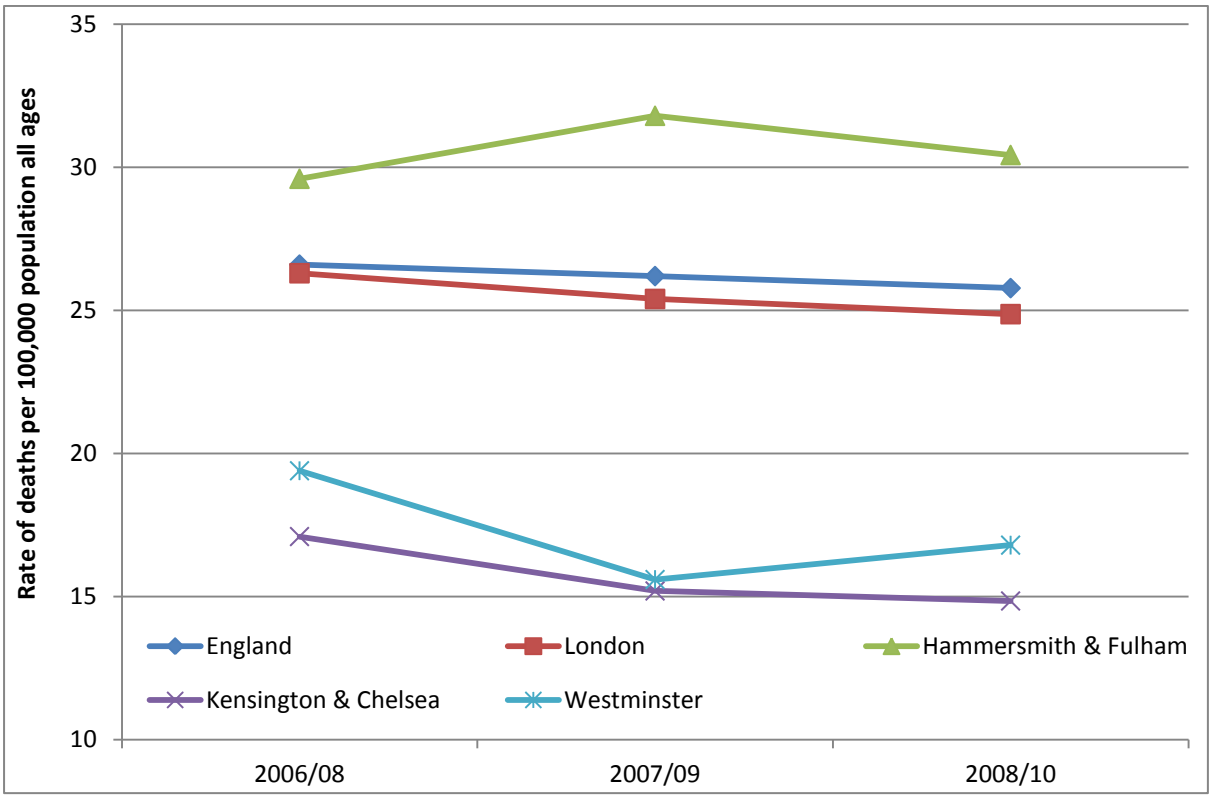
Figure 17: Directly age-standardised rate of smoking attributable deaths from stroke and other cerebrovascular diseases per 100,000 population aged 35 years and over 2007-09



Smoking attributable deaths from stroke and other cerebrovascular diseases for those patients over 35 years were generally lower in all three boroughs compared with England and London.

Chronic Obstructive Pulmonary Disease

Figure 18: Directly age-standardised rate of deaths from chronic obstructive pulmonary disease (COPD) per 100,000 population all ages



Death rates from chronic obstructive pulmonary disease (COPD) were significantly higher in Hammersmith and Fulham compared with Kensington and Chelsea and Westminster. Furthermore, Hammersmith and Fulham death rates due to COPD were higher than England and London, even though those rates were not significantly different.

Oral Cancer

Tobacco use and oral cancer

Most head and neck cancers are triggered by tobacco and alcohol consumption which together account for around three-quarters of cases (Blot et al, 1998). People who drink more than the recommended units of alcohol per week and smoke more than one pack of cigarettes per day are 30 times more likely to develop mouth cancer than non users. (British Dental Foundation) In addition, there is rising evidence to support the fact that Human Papilloma Virus (HPV) is playing a role in the incidence of oral cancer; it is estimated that around 50-60% of patients with oral cancer are HPV positive.

Over 90% of patients with oral cancer use tobacco in some form. Although in the UK cigarette, cigar and pipe smoking are the main forms of tobacco use, smoking bidi(s), which are made of hand-rolled tobacco wrapped in tendu leaf, as well as chewing tobacco products (with or without areca (betal) nut), which are used particularly among some Asian communities, also increase the risk of oral cancer (Swerdlow et al, 1995). In the case of both smoking and chewing tobacco, the risk is dependent on dose and duration of use. A study examining the links between cancer of the mouth and ethnic origin among immigrant residents in the Thames region found oral cancer was significantly higher among South Asians and nasopharyngeal cancer among the Chinese population (Warnakulasuriya et al, 1999).

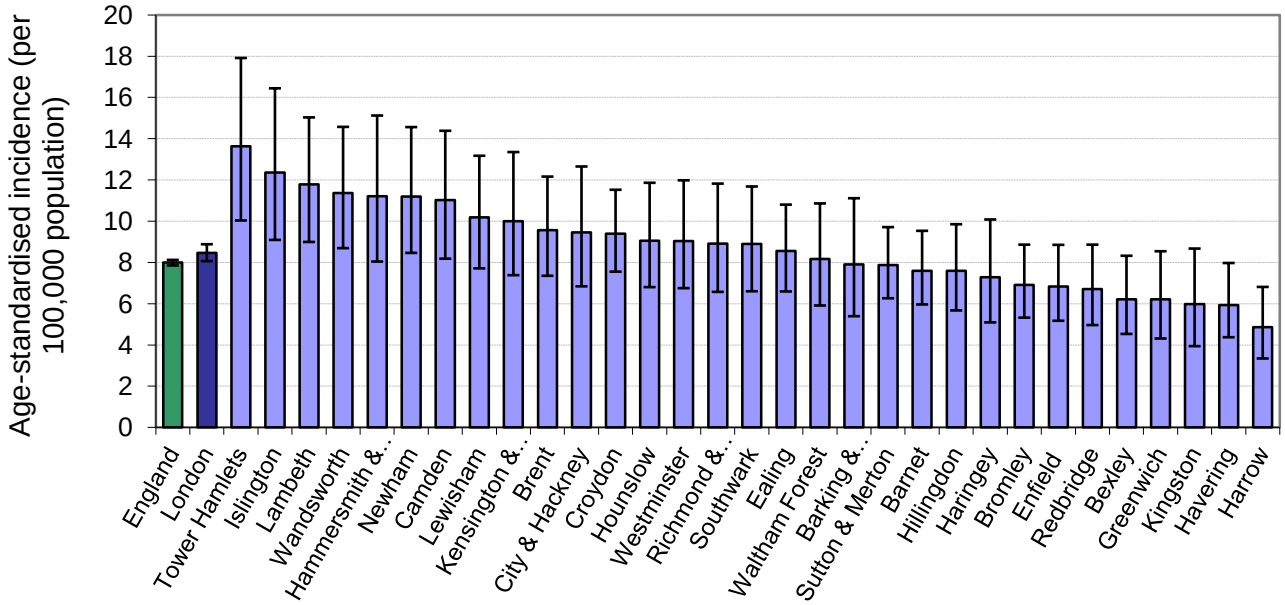
Prevalence and Impact

Oral cancer can affect the tongue, floor of the mouth, lips, cheeks and palate. It is more common in those over 40 years of age and more common in men than women with a ratio of 1.6:1 (males: females), (Department of Health, 2007). However, the number of young people and women developing the condition has been increasing in recent years. In the UK between 2007 and 2009 44% of oral cancer cases were diagnosed in people aged 65 and over. More than 25%, however, were diagnosed in the under 55s (Cancer Research UK, 2012)

In 2009 there were 6,236 new cases of oral cancer in the UK. Oral cancer is the 12th most common cancer among men in the UK, accounting for 2% of all new cases of cancer in males. It is the 16th most common cancer among women, responsible for more than 1% of all new cases of cancer (Cancer Research UK, 2012). Oral cancer incidence rates have increased overall in Britain since the mid-1970s. European age-standardised incidence rates have increased by 25% for men and 28% for women in the last decade.

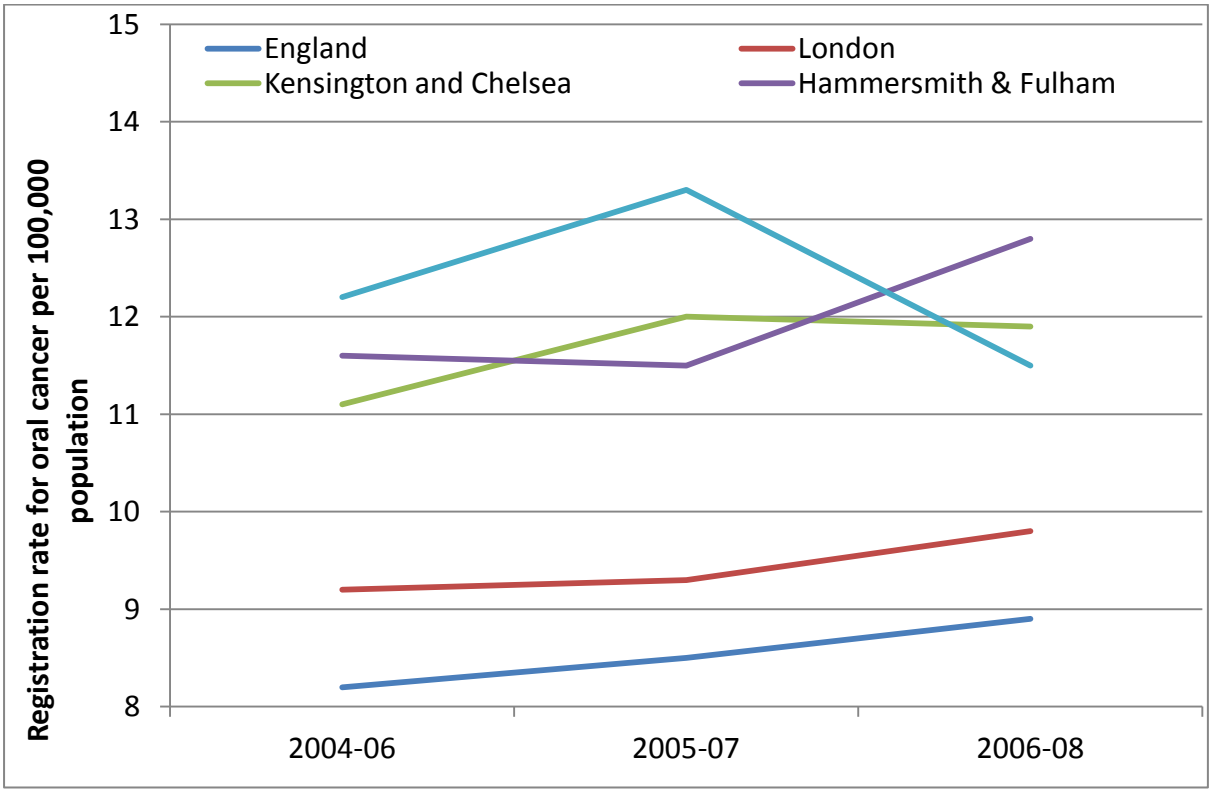
Latest local figures from the Thames Cancer Registry for London indicate that on average between 2007-09 the annual rate of new diagnoses for oral cancer in Hammersmith & Fulham (11.5 per 100,000 European standard population), Kensington & Chelsea (10) and Westminster (9) were higher than England as (8) a whole and London (8.5) (see figure 19 below). This has also been the pattern for the past three reporting periods (2004-2008) (see figure 20 below). Due to small numbers of cases the confidence intervals are very wide for these figures and indicate that the incidence in all three boroughs is not significantly different to the national or London averages.

Figure 19: Age-standardised incidence rates (per 100,000 European population) for oral cancers diagnosed between 2007-2009 by area of residence (London PCTs)



Source: Thames Cancer Registry – Oral cancer (ICD-10 C00-C06, C09-C10, C12-C14), June 2012

Figure 20: Directly age-standardised registration rate for oral cancer per 100,000 population all ages



In 2008 there were 1,444 deaths from oral cancer in England, and 1,822 in the UK as a whole. This is an age-standardised rate of 2.2 per 100,000 population. The overall age-standardised mortality rate has remained relatively stable since 1971 at around 3.3 and 1.4 per 100,000 for males and females respectively (Cancer Research UK, 2010). Aggregated data for head and neck cancers (a slightly wider group than oral cancers) across London PCTs compiled by the Thames Cancer Registry for 2002-04 showed there were 1,103 male deaths and 565 female deaths from cancers of the head and neck across London.

Head and neck cancers, including oral cancers, can have overwhelming effects on the quality of life lives of patients, not only in terms of diagnosis but also treatment which can be disfiguring. Appearance, speech, eating and socializing are affected. For health services, head and neck cancers present particular challenges because of the complexity of the anatomical structures, the variety of professional disciplines involved in caring for patients, and the relatively sparse geographical distribution of patients requiring specialised forms of therapy or support. However, because oral cancers often present late the outcomes tend to be poor.

Oral cancer prevention and improving survival

At least three-quarters of oral cancers could be prevented by the elimination of tobacco use and a reduction in alcohol consumption. The removal of these two risk factors also reduces the risk of second tumours in people with oral cancer. Tobacco cessation is associated with a rapid reduction in the risk of oral cancers, with a 50% reduction in risk within 3 to 5 years (Samet, 1992).

If diagnosed in its early stages cancers can respond well to treatment, therefore it is important that screening takes place in dental practices and patients attend for regular dental check-ups. It is also important that practitioners maintain CPD on diagnosis of suspicious lesions and fast track patients to appropriate services. Furthermore, since patient delay is cited as the main reason for late presentation, it seems probable that the public are unaware of the risks of oral cancer and its symptoms. Considering that incidence rates in younger age groups are rising, this suggests that greater public education is needed. There are local programmes to raise awareness of oral cancer linked into the national annual Mouth Cancer Action campaigns each November.

Hospital admissions

Table 6: Directly age-standardised rate of smoking attributable hospital admissions per 100,000 population aged 35 years and over 2009/10

Area	Rate per 100,000
England	1417.2
London	1342.1
Hammersmith and Fulham	1430.8
Kensington and Chelsea	1108.1
Westminster	1393

Smoking attributable hospital admissions for Hammersmith and Fulham were higher than the rest of Inner North West London boroughs, England and London.

The burden of smoking

Economic costs of Smoking

Table 7: Costs (£) of smoking attributable hospital admissions, in those aged 35 years and over

Area	2008/09	2009/10
England	33.6	37.9
London	35.8	38.8
Hammersmith and Fulham	37.1	41.5
k&C	31.1	34.7
Westminster	36.8	36.5

The cost of smoking attributable hospital admissions was calculated by dividing the total cost of smoking attributable hospital admissions by the total number of weighted population for that Primary Care Trust. Generally, Hammersmith and Fulham have higher costs of smoking attributable to hospital admission per head of population compared with England, London and the rest of Inner North West London.

Table 8: Cost (£) per quitter (NHS Information centre annual data)

Area	2010/11	2011/12
England	220	220
London	308	284
Hammersmith and Fulham*	512	630
Kensington and Chelsea	329	204
Westminster	135	116

*Cost per quitter for Hammersmith and Fulham smoking quitters include overhead costs including building rent, Kensington and Chelsea and Westminster costs does not include overhead costs in the table above.

The cost per smoking quitter is calculated by dividing the total cost of each stop smoking services in the PCT by the total number of successful quitters in the PCT. When overhead costs were removed from the Hammersmith and Fulham smoking cessation services, the cost per smoking quitter was £421 for first quitters for 2012/13 (local analysis)

Smoking costs the National Health Service (NHS) approximately £2.7 billion a year (ASH 2011). This includes the costs of hospital admissions, GP consultations and prescriptions. The government also pays for sickness/invalidity benefits, widow's pensions and other social security benefits for dependants. Analysis of the costs and benefits of achieving the government's targets to reduce smoking has shown that £524 million could be saved because of the reduction in the number of heart attacks and strokes.

When the model built by Action Smoking on Health is applied to the local population in Inner North West London the estimated costs are shown in table 13. Tri-borough smoking related healthcare cost was £25.8 million and a similar cost occurred due to loss of productivity (£22.8 million). Output loss due to early deaths was greater that hospital costs (£31.4 million).

Table 9: Total Societal Costs of Smoking

	Estimated cost of smoking in one year (in millions)				
Category	England (in billions)	Hammersmith and Fulham	Kensington and Chelsea	Westminster	Tri-borough
Healthcare Costs	2.7	8.4	7.3	10.1	25.8
Loss of Productivity	2.9	7.2	6.3	8.7	22.2
Absenteeism	2.5	6.2	5.4	7.5	19.2
Output Loss (early deaths among employed)	4.1	10.2	8.9	12.3	31.4
Passive Smoking	0.7	1.7	1.5	2.1	5.4
Environmental Costs	0.34	0.8	0.7	1.0	2.6
Fire Damage	0.5	1.2	1.1	1.5	3.8
Total cost	13.74	35.9	31.2	43.2	110.4

Second hand smoke exposure

Breathing other people's smoke causes both short and long term health problems.

Immediate effects include eye irritation, cough, dizziness and nausea. Longer term exposure raises the risk of death from lung cancer and from coronary heart disease. For people who already have asthma or coronary heart disease, other people's smoke can precipitate severe symptoms.

A child exposed to second-hand smoke has an increased risk of sudden infant death ('cot death'), asthma, wheeze, lower respiratory infection, middle ear disease and meningitis (Royal College of Physicians, 2012).

Among non-smoking children aged 4-15 in England in 2006-2008, three in five had recently been exposed to second-hand smoke. Children from lower income households were more likely to have been exposed to second-hand smoke than those from higher income households (NHS Information Centre, 2009).

In the 18 months after the introduction of the smokefree legislation (July 2007 – December 2008), children aged 8-15 in England reported being exposed to other people's smoke in their own homes (26% of both boys and girls), in other people's homes (25% of boys, 31% of girls) and 'other places' (41% of boys, 44% of girls). Of those who said they were exposed to other people's smoke, more than half (58%) of children felt bothered by it (NHS Information Centre, 2009).

Secondhand smoke exposure among children in the UK is thought to result in over 165,000 new episodes of disease, 9,500 hospital admissions, at least 200 cases of bacterial meningitis, and about 40 sudden infant deaths each year (Royal College of Physicians, 2012).

The introduction of smoke-free legislation in England in July 2007 resulted in approximately 9,600 fewer bed days for myocardial infarction admissions in the following 12 months, and an estimated cost saving to acute hospital care of £8.4 million (London Health Observatory, 2010).

Enforcement of Smoke Free Environments

Officers from Environmental Health across the tr-borough have actively undertaken enforcement of the smokefree legislation to ensure that the harms related to passive smoking and other tobacco use are minimised.

Kensington and Chelsea
Environmental health officers have visited premises to inspect for compliance with smoking laws. In the past 12 months 7 complaints resulted in 21 inspections for compliance. 1 premise received a final warning and a prosecution is pending.

Westminster
In the past 12 months Westminster has undertaken 27 prosecutions under the Health Act against shisha cafés for the offence of allowing smoking in a smokefree area. In total these prosecutions have resulted in accumulative fines of approximately £4,000 with costs for the council of just over £6,000.

Many of these premises are seeing the risk of prosecution is outweighed by the profit to be made from their activity. Although not many of these premises have premises licences, review applications were also submitted against two premises for issues which resulted from their illegal

smoking activities, in one case the licence was transferred to a new person and the other premises surrendered its licence. Furthermore three premises were threatened with injunctions for continuing to allow breaches of the Health Act.

Table 10: Data related to compliance to smoking laws in tri-boroughs

		2010/11			2011/12		
Theme	**Measure**	**LBHF**	**RBKC**	**WCC**	**LBHF**	**RBKC**	**WCC**
Underage sales	Number of underage test purchases conducted, Source: Local	25	0	28	27	30	20
Underage sales	Number of failed underage test purchases, Source: Local	5	0	0	1	3	2
Illicit tobacco	Quantity in Kgs of counterfeit / non-duty paid / niche tobacco seized, Source: Local	3kg Smokeless 6kg Shisha 55 blunts	0	0	0	24.5 Kg	0
Legal process (Underage Sales)	Numbers of prosecutions and simple cautions for test purchases (LACORS website) (http://tinyurl.com/65889zh)	2	0	0	4	0	2
Legal process (Counterfeit)	Numbers of prosecutions and simple cautions for Counterfeit tobacco (LACORS website) (http://tinyurl.com/65889zh)	0	0	0	0	0	0
Legal process (Non duty paid)	Numbers of prosecutions and simple cautions for Non duty paid. (LACORS website) (http://tinyurl.com/65889zh)	1 Prosecution	0	0	0	0	0

		2010/11			2011/12		
Theme	**Measure**	**LBHF**	**RBKC**	**WCC**	**LBHF**	**RBKC**	**WCC**
Legal process (Niche tobacco seized)	Numbers of prosecutions and simple cautions for Niche tobacco seized (LACORS website) (http://tinyurl.com/65889zh)	1 Prosecution	0	0	1 Prosecution, 1 Enterprise Act Undertaking, 5 Warnings, 3 simple cautions	0	0
Smokefree Interventions	Number of compliant premises following intervention(s)	0	30	0	3	24	0

During 2010/11 and 2011/12, 130 underage test purchases were conducted in the tri-borough. Out of these 11 of those were failed underage test purchases. There were 8 prosecutions or simple cautions for underage test purchases during those 2 years in the tri-borough. After smoke free interventions, 57 premises were compliant to smoke free laws in the tri-borough during the same two year period.

Stopping smoking

More than two thirds (67%) of adult smokers (aged 16 and over) who were surveyed in Great Britain in 2008/09 said they would like to give up smoking. There was no significant difference between men and women. Estimates suggest that, in 2008/09, more than a quarter (26%) of adult smokers in Great Britain attempted to give up smoking in the previous year (ONS 2009).

NHS Stop Smoking Services (SSS) provide counselling and support to smokers wanting to quit. Monitoring of the NHS SSS is carried out via quarterly monitoring returns and reported in an annual bulletin. About 401,000 people in England reported successfully quitting smoking with NHS Stop Smoking Services at the 4 week follow-up in 2011/12 (Local Tobacco Control profiles, 2012).

Nearly half (49%) of people who set a quit date through NHS SSS had successfully quit at the 4 week follow-up in 2011/12 (NHS Information Centre, 2012). There were an estimated 4,700 quitters with NHS SSS per 100,000 smokers in England in 2011/12. Of all the regions in England, the North East had the highest estimated number of quitters per 100,000 smokers (6,200), while South East Coast had the lowest (3,739) (Local Tobacco Control Profiles, 2012).

Factors associated with smoking across the tri-borough

No surveys have been carried out in the Inner North West London areas to investigate the predictors of smoking. However, in 2010, Westminster PCT carried out a Health survey for their population. The survey included a health behaviour and attitude questionnaire to understand risk behaviour and motivation to improve health this included life style risk factors including smoking, diet and alcohol. The survey included nearly 9000 people from randomly selected households according to their deprivation and ethnicity.
The Major Health campaign found that in Westminster, there are high risk groups of smokers.

- Gender: 18% men; 14% women
- Age: 21% of 16-24 year olds; 13% aged 65-74
- Ethnicity: higher rates for Caribbean (27%); Middle Eastern (25%); Bangladeshi (18%); Scottish (18%); Irish (17%) Eastern European (17%) respondents
- Household type: 24% of single parents are smokers
- Work status: 33% of long term sick/disabled; 30% on JSA
- Income: 31% on £5k or less are smokers; 10% on £100k or more
- General Health: 19% with long term condition smoke (27% aged 45-54)
- Tenure: 23% of those living in social housing smoke (10% of owner occupiers)
- Drinking habits: 38% of smokers are hazardous drinkers (26% of non-smokers)
- Mental health: 13% of smokers at high risk of psychological distress (7% of non-smokers)

According to Major Health Campaign findings smokers are willing give up smoking for various reasons.

One of the questions in this survey attempted to understand the motivational factors to quit smoking. As shown in the Table7, more than three quarters of the people in Westminster, wanted to give up smoking at some point and most of them wanted to give up smoking due to their health condition.

Table 11: Motivational factors to quit smoking, findings from Westminster Major Health Campaign 2010

78% intend to give at some point; (67% in Great Britain 2008/09[11])
32% already trying to give up (26% in Great Britain, 2008/09[11])
75% want to give up protecting their future health
23% want to give up due to a current health condition
26% want to give up for financial reasons
25% have friends or family who want them to give up: 19% are worried about effect on friends or family
31% say that the fact that smoking reduces stress or helps them to relax is a barrier to giving up

Stop Smoking Services

Inner North West London Public Health Department commissioned stop smoking services in all three boroughs. The services were commissioned according to NICE guidelines. All services provided a mixture of one to one and group sessions offered through pharmacies, GP practices and specialist stop smoking service advisers. The stop smoking service in Hammersmith and Fulham is provided by Kick It (Live Well LTD) and the stop smoking service in Kensington and Chelsea and Westminster is provided by Central London Community Healthcare (CLCH).

The purpose of stop smoking services is to reduce the number of smokers by providing evidence based treatment and behavioural support to smokers making quit attempts.

Compared with England and London, Hammersmith and Fulham had higher successful quitter rates from 2010/11 and 2011/12. Kensington and Chelsea had the lowest rates of successful quitter rates in Inner North West London. However, Westminster and Kensington and Chelsea successful quitter rates are more or less similar to rates of England and London.

Figure 21: Number of successful quitters per 100,000 population aged 16 and over

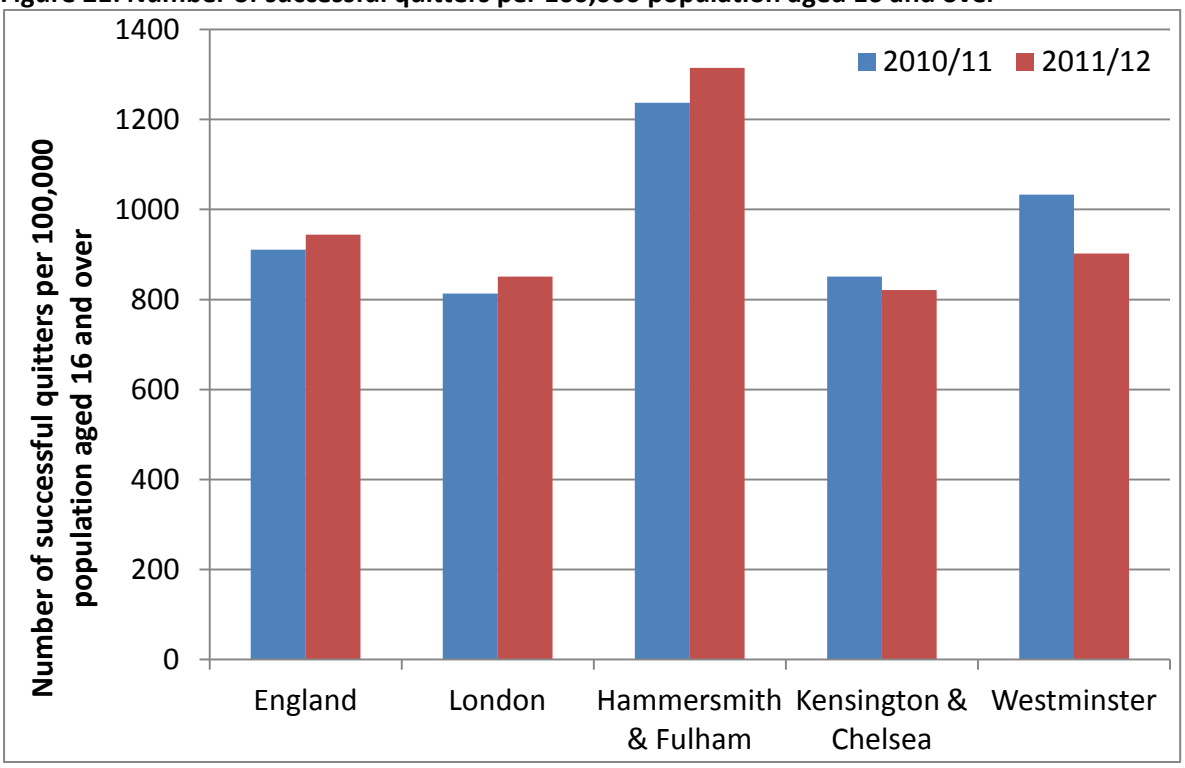
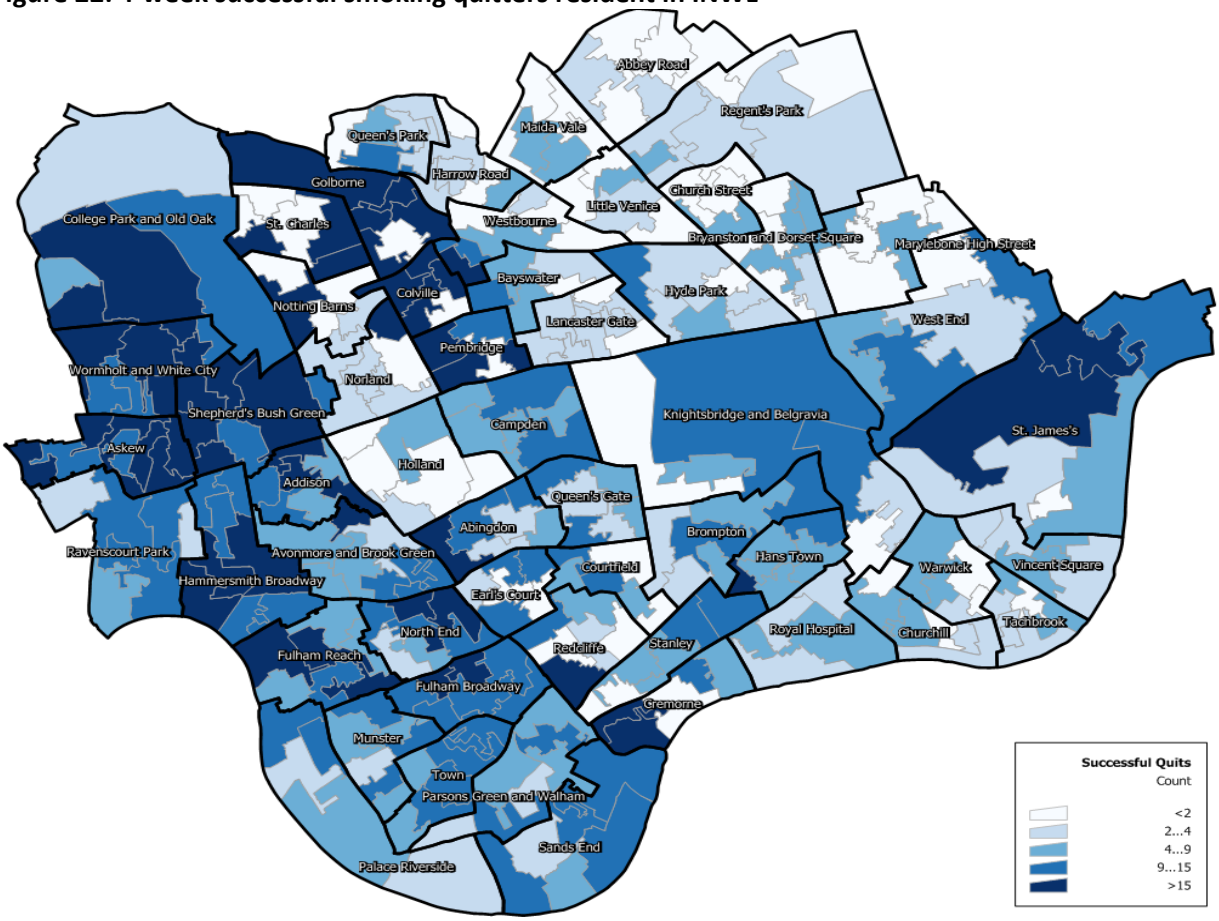


Figure 22: 4-week successful smoking quitters resident in INWL



As demonstrated previously, smoking prevalence is highest in the most deprived parts of Inner North West London especially in Westminster and Kensington and Chelsea and most areas in Hammersmith and Fulham. Those deprived areas have a high proportion of ethnic minorities and routine and manual groups.

Most parts of Hammersmith and Fulham have high rates of smoking quitters. Most parts of deprived areas of Hammersmith and Fulham have high number of smoking quitters. However, there still needs to be more smoking quitters in areas such as Sands end, North end and College Park and Old oak.

Kensington and Chelsea have the lowest rates of smoking quitters across the tri-borough. However, even though some deprived parts of Kensington and Chelsea such as Golborne and Colville had high numbers of successful quitters, deprived areas such as St. Charles, Notting Hill barns need to be improving the numbers of successful quitters.

Westminster needs to target more of their most deprived parts to improve successful smoking quitter rates including areas such as Church Street, Queens Park, Harrow road, Churchill and Tachbrook.

Self Assessment

In January 2013 a self-assessment was conducted with all key stakeholders across Inner North West London to look at current performance with regards to local Tobacco control. The CLeaR self-assessment tool was used to conduct this review. CLeaR is an improvement model provided by ASH (Action on Smoking and Health).

This model aims to provide local government and its partners with a structured evidence based approach to identifying the areas that stakeholders need to work on to achieve excellence in local tobacco control. The model comprises of a self- assessment questionnaire which acts as a benchmarking tool to assess the current performance of local action on 3 key areas: Challenge, Leadership and Results. Below outlines some of the key learning points which emerged as a result of the assessment.

Challenge- Services

There is a new tri-borough smoke free homes project in place as well as brief intervention training in second hand smoke being offered. Both projects are still at initial project delivery stages and therefore too early to access impact. There is also some excellent work in place with young people in Hammersmith and Fulham. All work is based on NICE guidelines and there is a strong partnership in place with the Healthy Schools programme as well as some great examples of joint working to target children.

Results from a smoking prevention online resource demonstrates an effective approach to increasing awareness of smoking within young people.

Prevention work with young people across Kensington and Chelsea and Westminster is less co-ordinated.

Challenge- Compliance

Compliance of the smokefree legislation is high across the three boroughs and there has been no need for formal action.

Hammersmith and Fulham and Kensington and Chelsea scored well on the self assessment for the work they have been doing with illicit tobacco and niche tobacco (shisha) enforcement. Best practice is shared on a Pan London basis as well as across England as a whole and officers are pro-active in taking forward intelligence led targeted approach to enforcement.

However in Westminster compliance of the Health Act by Shisha Cafes and retailers is problematic.

Challenge- Communication and campaigns

Communication is currently reactive and ad-hoc and there is no tri borough strategy for communications.

Leadership

The tri-borough model for commissioning and supporting work across the three areas is recognised as a positive way of working. However there is no strong senior level engagement with tobacco control, including clinical leadership, across the three boroughs.

Recently there has been some focus on Shisha smoking in Westminster.

The local Tobacco Control Alliance does not have a strategy and there is not a clear vision for tobacco control.

Commissioning of services is not joined up with wider strategic plans, for example community safety, housing, education etc.

There are no governance arrangements in place and no system in place to systematically review local action to inform future planning.

Results- Smoking cessation

Hammersmith and Fulham provide a range of high performing stop smoking services that are exceeding targets, however Kensington and Chelsea and Westminster scored lower in the self assessment with less co-ordinated systems in place to motivate smokers to stop smoking through training, marketing and referrals.

Inner North West London Tobacco Control Alliance membership review

Tobacco Control alliances are recommended as a key method of engaging all stakeholders and driving forward the tobacco control agenda. The Inner North West London Tobacco Control Alliance was set up in 2011, as a result of significant political change and the 3 separate Public Health departments merging into a Tri-borough configuration.

A review was undertaken in January 2013 to examine how the Alliance was functioning. All members of the Alliance were involved and interviewed by an independent reviewer.

Findings

- Attendance at meetings is patchy.
- Membership is unequal with some organisations overly represented and others under.
- Some key stakeholders do not attend.
- Reporting arrangements of the Alliance are not clear or working.
- There is an impression that the “Stop smoking” agenda dominates the meetings.
- There is no dedicated Tobacco Control post to co-ordinate Alliance activities and lead on the Tobacco agenda.

References

ASH (2011) Tobacco Economics: Facts at a Glance, Action Against Smoking

ASH (2012) Smoking and disease, Facts at a glance

Auluck A, Hislop G, Poh C et al. (2009) Areca nut and betel quid chewing among South Asian immigrants to Western countries and its implications for oral cancer screening. Rural and Remote Health (9): 1118

Blot WJ, McLaughlin JK, Winn DM, et al. (1998): Smoking and drinking in relation to oral and pharyngeal cancer. Cancer Res; 48:3282-3287.

Boffetta P, Straif K (2009) Use of smokeless tobacco and risk of myocardial infarction and stroke: systematic review with meta-analysis. BMJ 339: b3060

British Dental Health Foundation http://www.dentalhealth.org.uk/

Cancer Research UK (2010) Oral cancer – UK incidence statistics [online]. [Accessed 7 January 2011] – Quoted in National Institute for Health and Clinical Excellence, NICE Public Health Guidance 39: Smokeless Tobacco Cessation: South Asian Communities, September 2012

Cancer Research UK: Oral Cancer – UK Incidence Statistics, 2012
http://info.cancerresearchuk.org/cancerstats/types/oral/incidence/

Cancer Research UK: Oral Cancer – UK Mortality Statistics, 2010
http://info.cancerresearchuk.org/cancerstats/types/oral/mortality/

Colilla SA. An epidemiologic review of smokeless tobacco health effects and harm reduction potential.RegulToxicolPharmacol 2010; 56(2): 197-211).

Croucher R, Islam S, Jarvis M et al. (2002) Tobacco dependence in a UK Bangladeshi female population: a cross-sectional study. Nicotine and Tobacco Research 4 (2):171–6

Croucher R, Awojobi O, Dahiya M (2009) Smokeless tobacco scoping survey of the London Borough of Tower Hamlets. London: Barts and the London School of Medicine and Dentistry

Department of Health (2007), Choosing Better Health

Department of Health (2012) Improving outcomes and supporting transparency: A public health outcomes framework for England 2013- 2016

England LJ, Kim SY, Tomar SL et al. (2010) Non-cigarette tobacco use among women and adverse pregnancy outcomes. Acta Obstetricia et Gynecologica Scandinavica 89 (4): 454–64
Gupta PC, Subramoney S (2004) Smokeless tobacco use, birth weight, and gestational age: population based, prospective cohort study of 1217 women in Mumbai, India. BMJ 26: 328 (7455): 1538

HM Revenue & Customs and UK Border Agency (2008) Tackling tobacco smuggling together. London: The Stationery Office

London Health Observatory (2010) Cost savings from a reduction of emergency admissions for myocardial infarction following smoke-free legislation in England

Longman JM, Pritchard C, McNeill A et al. (2010) Accessibility of chewing tobacco products in England. Journal of Public Health 32 (3): 372–8

Moles DR, Fedele S, Speight PM et al. (2008) Oral and pharyngeal cancer in South Asians and non-South Asians in relation to socioeconomic deprivation in South East England. British Journal of Cancer 98 (3): 633–35

National Institute for Health and Clinical Excellence(2012), NICE Public Health Guidance 39: Smokeless Tobacco Cessation: South Asian Communities, September 2012

NHS Information Centre (2006) Health survey for England 2004. Volume 1: The health of minority ethnic groups. Leeds: The NHS Information Centre

NHS Information Centre (2011) Statistics on smoking: England,

NHS information Centre (2012) Statistics on NHS Stop Smoking Services: England, April 2011 – March 2012, The Health and Social Care Information Centre.

ONS (2009) Omnibus Survey Report No.40. Smoking-related Behaviour and Attitudes, 2008/09. The Office for National Statistics, 2009

ONS (2011) Infant Feeding Survey

ONS (2011b) Smoking Attitudes and Behaviours

Panesar SS, Gatrad R, Sheikh A (2008) Smokeless tobacco use by South Asian youth in the UK. Lancet 12: 372 (9633): 97–8

Pau AKH, Croucher R, Marcenes W et al. (2003) Tobacco cessation, oral pain, and psychological distress in Bangladeshi women. Nicotine and Tobacco Research (5): 419–23

Pearson N, Croucher R, Marcenes et al. (1999) Dental service use and the implications for oral cancer screening in a sample of Bangladeshi adult medical care users living in Tower Hamlets, UK. British Dental Journal 186 (10): 517–21

Prabhu NT, Warnakulasuriya K, Gelbier S et al. (2001) Betel quid chewing among Bangladeshi adolescents living in east London. International Journal of Paediatric Dentistry 11 (1): 18–24

Quandt SA, Spangler JG, Case LD et al. (2005) Smokeless tobacco use accelerates age-related loss of bone mineral density among older women in a multi-ethnic rural community. Journal of Cross-Cultural Gerontology 20 (2): 109–25

Royal College of Physicians (2012) Parliamentary Briefing: Passive smoking and children, www.rcplondon.ac.uk

Samet, J.M. (1992): The health benefits of smoking cessation. Med Clin North Am.76(2): p. 399-414.

Swerdlow AJ, Marmot MG, et al. (1995): Cancer mortality in Indian and British ethnic immigrants from the Indian subcontinent to England and Wales. Br J Cancer;72:1312-1319.

Warnakulasuriya S (2002) Areca nut use following migration and its consequences. Addiction Biology 7: 127–32

Warnakulasuriya S., Harris C., Scarrott D., Watt R., Gelbier S., Peters T. and Johnson N. (1999): An alarming lack of public awareness towards oral cancer. BDJ; 187, 319-322.

West R, McNeill A, Raw M (2004) Smokeless tobacco cessation guidelines for health professionals in England. British Dental Journal 22: 196 (10): 611–8