APPENDIX 1

HARINGEY TOBACCO CONTROL STRATEGY

2009-2012

Executive Summary

Smoking tobacco is the single greatest preventable cause of ill health and premature mortality in the UK. It is also the primary reason for the gap in life expectancy between rich and poor. It has long since been acknowledged by national bodies that smoking is harmful to the nation's health and that targeted methods are needed to help people stop smoking. These have included the workplace ban on smoking on 1st July 2007, which was extended to include mental health services on 1st July 2008.

There is now a wide body of evidence on effective practice to reduce smoking uptake and increase smoking cessation, most recently set out in NICE Guidance on Smoking Cessation Services, the Department of Health's (DH) '10 High Impact Changes to Achieve Tobacco Control' and most recently NHS Stop Smoking Services: service and monitoring guidance 2009/10. The documents have significantly informed the content of this strategy.

This document will form a coherent strategy and action plan for a range of stakeholders, who will form a 'Tobacco Control Alliance'. Together they will both implement and monitor progress of the strategy. The intention is that the Tobacco Control Alliance will be a fixed-term group, which will have overseen implementation of this strategy by the end of March 2012.

The aim of this strategy is to reduce the impact of smoking on health and health inequalities in Haringey by setting out the key actions to be taken by the end of March 2012.

The outcomes are as follows:

- To reduce smoking prevalence and increase smoking quitters in the following groups:
    - People with a mental health diagnosis
    - Teenage pre and post-partum mothers
    - Young parents
    - Those living in areas of high deprivation
    - Specific BME groups, particularly Irish and Turkish men
    - Routine and manual workers
- To reduce the impact of smoking on health inequalities in Haringey
- To denormalise smoking in Haringey
- To develop measures to assess achievement against the above outcomes

In order to achieve those outcomes, the following objectives have been set and are derived from the DH 10 High Impact Changes.

- Work in partnership
- Gather and use a full range of data to information tobacco control
- Use tobacco control to tackle health inequalities
- Deliver consistent, coherent and co-ordinated communication
- Integrated stop smoking approach
- Build and sustain capacity in tobacco control
- Tackle cheap and illicit tobacco
- Influence change through advocacy
- Help young people to be tobacco free
- Maintain and promote smokefree environments

1 Introduction

1.1 Background information

Smoking tobacco is the single greatest preventable cause of ill health and premature mortality in the UK. It is also the primary reason for the gap in life expectancy between rich and poor. It increases infant mortality by about 40% and more than a quarter of the risk of sudden infant death is attributable to smoking.

It is an addiction rarely acquired in mature adulthood and between the ages of 14 and 15, there is a 92% increase in smoking behaviours amongst young people. It is most common amongst the socio-economic groups exhibiting the worst health profiles in the community: low-income groups, pregnant and post partum teenage mothers and lone parents. Almost half of all teenage mothers smoke during pregnancy and 55% of single mothers. 31% of routine and manual workers are smokers, compared to 22% of the total population. Amongst people with mental health problems, the prevalence of smoking is estimated to be approximately 70% and for hard-drug users the figure is 'practically 100%'.

The highest prevalence for men is between the ages of 20-34 and for women between the ages of 25-34. Cigarette smoking is highest amongst Turkish, Bangladeshi and Irish men.

As well as cancer, respiratory and circulatory diseases, smoking is responsible for stomach and duodenal ulcers, erectile dysfunction, infertility, osteoporosis, cataracts and age-related macular degeneration (ARMD). It also contributes to a lower survival rate following surgery, delayed wound healing and post-operative respiratory complications. It contributes to higher rates of infant mortality and child illness, including asthma. Smoking costs the NHS an estimated £1.5 billion a year, excluding payment of sickness or invalidity benefits. [1]

'Smokeless tobacco' is a very broad term that refers to over 30 different types of products. Smokeless tobacco products include chewed tobacco ('dry chewing tobacco') and sucked tobacco ('moist oral tobacco'), rather than smoked tobacco in the form of cigarettes. There are some inhaled tobacco products ('nasal snuff'), but these are less common in the UK. Some people believe that smokeless tobacco is a harmless alternative to smoking cigarettes. But scientists have shown that many forms of smokeless tobacco increase your risk of mouth cancer. They could also increase your risk of pancreatic cancer, oesophageal cancer, and other conditions including gum disease and heart disease. Almost all types of smokeless tobacco can cause mouth cancer. But some types or brands can be more dangerous than others. This is because different products can have very different levels of cancer-causing chemicals.

Most smokeless tobacco products in the UK are used by South Asian communities. In these communities, dry chewing tobacco is often used as part of a 'betel quid' or 'paan'. These consist of a mixture of betel nut (or areca nut), slaked lime and various herbs and spices, wrapped in a betel leaf. Betel nut itself can cause cancer, so chewing betel quids can cause mouth cancer even if no tobacco is added.
Smokeless tobacco contains as much, if not more, nicotine than smoked tobacco products do. So like cigarettes, it is highly addictive. People who use smokeless tobacco absorb 3-4 times as much nicotine as smokers do. The nicotine is also absorbed more slowly and stays in the blood for a longer time.

[1] Stoten and Wigley (2008) A Tobacco Control Strategy to address Health Inequalities in the London Borough of Haringey, unpublished

1.2 The national context

It has long since been acknowledged by national bodies that smoking is harmful to human health and that targeted methods are needed to help people stop smoking. In the three years prior to April 2006, NHS services were expanded to support smoking quitters and a target for primary care trusts was introduced. In that period, 800,000 people were reported to have remained quit at four weeks. At the end of 2006, the NHS and all Government Departments became 'Smokefree'. This preceded the workplace and public places ban on smoking on 1st July 2007, which was extended to include mental health services on 1st July 2008.

The greatest single reduction in smoking prevalence appears to have followed the announcement of this ban. Recent research has demonstrated a 1.6% reduction in smoking in the 9 months leading up to the ban with a further reduction of 5.5% in the first 9 months of the ban. It has estimated that this will prevent as many as 40,000 deaths over the next 10 years. [2]

Tobacco advertising is prohibited nationally and picture warnings appeared on tobacco products from late 2007. Tobacco marketing of any sort is likely to become increasingly curtailed as measures are formulated to reduce the visibility of tobacco goods for sale in retail outlets.[3]

The Tackling Tobacco Smuggling Strategy (launched in March 2000) has succeeded in cutting the illicit cigarette market by a quarter to 16%. A new strategy was announced in the Budget 2006 to reduce the illicit cigarette market to 13%.

There is now a wide body of evidence on effective practice to reduce smoking uptake and increase smoking cessation, most recently set out in NICE Guidance on Smoking Cessation Services[4] and the Department of Health's '10 High Impact Changes to Achieve Tobacco Control'.[5] Both these documents have significantly informed the content of this Strategy.

1.2.1 Nice guidance

NICE sets out the following recommendations for smoking cessation services:

Specific groups

1. Target ethnic minorities and socio-economically disadvantaged groups and tailor services to those groups, providing services in the language chose by clients, wherever possible (more use of link workers and language line)
2. Aim to treat BME and disadvantaged groups at least in proportion to their representation in the local population of tobacco users
3. Needs of target groups must be put first and relationships must be developed with target groups and stakeholders

[2] Stoten and Wigley (2008) A Tobacco Control Strategy to address Health Inequalities in the London Borough of Haringey, unpublished
[3] Stoten and Wigley (2008) A Tobacco Control Strategy to address Health Inequalities in the London Borough of Haringey, unpublished
[4] NICE public health guidance 10: Smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities, February 2008
[5] Department of Health (2008) Excellence in Tobacco Control: 10 High Impact Changes to Achieve Tobacco Control, Tobacco Control National Support Team May 2008

4. Mothers eligible for Healthy Start – use registration as an opportunity to offer information, advice and support on stopping smoking

Stop Smoking Service

5. Provide a good Stop Smoking Service by maintaining adequate staffing levels, including a full-time co-ordinator

6. Set realistic performance targets for both the number of people using the service and the proportion who successfully quite smoking

7. Aim to treat at least 5% of the estimated local population of people who smoke each year

8. Audit performance of services regularly, especially those with under 35% or over 70% success rate

Links with other services

9. Establish links with contraceptive services, fertility clinics and ante/postnatal services

10. At first contact with pregnant woman, discuss smoking status, provide information about risks and offer personalised information and cessation advice

11. Monitor smoking status and offer smoking cessation advice through pregnancy and beyond

12. All hospital patients should be advised to quit and offered appointment

13. Fast-track referral system after discharge for patients trying to quit in hospital, particularly cardiac rehabilitation teams

Social marketing and interventions

14. Learning from social marketing theory suggests that efforts to combat smoking should be multifaceted: media campaigns coordinated with smoking cessation services, policy change and school interventions. Initiatives should aim to bring about sustained individual and social change, which takes time.

15. Workplace – most effective strategies are those successful elsewhere i.e. group therapy, individual counselling, pharmacological treatment

16. NICE recommends that there is a range of interventions which have proven to be effective:

- Brief interventions, usually opportunistic and referral to more intensive treatment
- Individual behavioural counselling
- Group behaviour therapy
- Pharmacotherapies
- Self-help materials
- Telephone counselling and quitlines
- Mass media

NHS Haringey commissioned Porter Novelli to conduct a local social marketing scoping exercise the findings were published April 2009 and have been integrated into the action plan.

In addition to the NICE Guidance, NHS Haringey has identified two additional categories for further specific attention, as part of its developing Tobacco Control Strategy. These are: Smoke Free Homes and Enforcement activity.

Smoke Free Homes – Tackling Second Hand Smoke
Second hand smoke (also known as 'Environmental Tobacco Smoke' (ETS) or 'passive smoking') is a mixture of side stream smoke from the burning tip of a cigarette, and mainstream smoke exhaled by a smoker. Second hand smoke kills, and scientific evidence shows that there is no safe level of exposure.

The Government's independent Scientific Committee on Tobacco And Health (SCOTH) reported in 2004 (reaffirming the conclusions of its report in 1998) that exposure to second hand smoke can cause a number of serious medical conditions:

- Lung cancer
- Heart disease
- Asthma attacks
- Childhood respiratory disease
- Sudden infant death syndrome, and
- Reduced lung function

The World Health Organisation has classified second hand smoke as a known human carcinogen. In 2006, the US Surgeon General concluded that:

- second hand smoke causes premature death and disease in children and adults who do not smoke.
- children exposed to second hand smoke are at an increased risk of sudden infant death syndrome (SIDS), acute respiratory infections, ear problems and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in children.
- exposure of adults to second hand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.
- the scientific evidence indicates that there is no risk-free level of exposure to second hand smoke.

The Royal College of Physicians has also published a comprehensive report on second hand smoke, July 2005. Pages 43-49 look at deaths from second hand smoke. The report is available www.smokefreeengland.co.uk/files/going-smokefree.pdf

In view of this evidence, a key objective therefore of Haringey's Tobacco Control Strategy, is to increase the number of smoke-free homes, particularly in identified targeted settings and areas – such as Social Housing and Residential Care. The aim of the scheme is to encourage people to pledge to either make their home smoke-free or to limit where and when they smoke.

Enforcement – Ensuring Compliance & Tackling Illegal & Illicit Tobacco Sales
Local Authorities are responsible for enforcing the no smoking legislation and supporting people and organisations to comply with the law across the community. This is usually the department responsible for Environmental Health and/or Trading Standards.

The no smoking legislation referred to above, is contained in the Health Act 2006, which was implemented on 1st July 2007. However, further information of what is and is not allowed is set out in detail in secondary legislation. These are as follows: *the Smoke-free (Premises and Enforcement) Regulations 2006* - these regulations set out definitions of 'enclosed' and 'substantially enclosed' premises, and the bodies responsible for enforcing smoke-free legislation. *The Smoke-free (Exemptions and*

Vehicles) Regulations 2007 - these regulations set out the exemptions to smoke-free legislation and vehicles required to be smoke-free. *The Smoke-free (Penalties and Discounted Amounts) Regulations 2007* - these regulations set out the levels of penalties for offences under smoke-free legislation. *The Smoke-free (Vehicle Operators and Penalty Notices) Regulations 2007* - These regulations set out the responsibility on vehicle operators to prevent smoking in smoke-free vehicles and the form for fixed penalty notices. *The Smoke-free (Signs) Regulations 2007* requires a sign to be displayed at each entrance to smoke-free premises containing the words "No smoking. It is against the law to smoke in these premises".

In addition to the legal requirements covering the monitoring of tobacco control in workplaces and public places, enforcement activity also extends to ensuring compliance regarding under age sales, advertising, and illegal supply of tobacco (and related products).

Implementing the tobacco control legislation (2006), in practice also means that it is an offence for retailers and their staff to sell cigarettes or any tobacco products to a person under the age of 18 years. It is up to the retailer and their staff, to decide whether or not that person looks 18 years of age. If in doubt, they should not sell cigarettes or tobacco products to them. Cigarettes can only be sold in packets of 10 or more and in their original packaging. Retailers must display a clear sign where they sell cigarettes stating "It is illegal to sell tobacco products to anyone under the age of 18". Retailers selling cigarettes to any person under the age of 18 years, could face a fine of up to £2,500.

Retailers must not sell or supply cigarette lighter fuel or any cigarette lighter re-fill canister containing butane, or any other substance containing butane, to any person under the age of 18 years. The penalty for selling the above to an under age person is up to 6 months imprisonment, or a fine of £5,000, or both.

Environmental Health and Trading Standards Officers continue to enforce the law relating to the sale of tobacco products to under–age consumers. Both the sales person and the business owner could be prosecuted for any illegal sales, even if it was believed that the purchase was being made on behalf of an adult or if the person looked like they were over 18. The recently passed Health Act 2008-9, will further strengthen the powers of Local Authorities to tackle the advertising and illegal sales oftobacco.

Smuggling & Illicit Sales

Since the UK's first Tackling Tobacco Smuggling Strategy was published in 2000, HM Revenue & Customs and the UK Border Agency have reduced the proportion of illicit cigarettes from 21% in 2000 to 13% in 2009. HM Revenue & Customs and the UK Border Agency have also seized more than 14 billion cigarettes and more than 1000 tonnes of hand rolling tobacco in the UK and abroad. They have broken up 370 criminal gangs involved in large-scale smuggling; prosecuted more than 2,000 people; and issued more than £35m worth of confiscation orders.

From 1 April 2009, HMRC established nine regional inland enforcement teams to focus on tackling the sale of inland illicit tobacco sales. These teams will concentrate on retailers who sell illicit products. However they will also look at low level illicit trade, such as car boot sellers and sales from vans, since these are unregulated and could be supplying tobacco to children. Evidence from a survey undertaken by Action on Smoking Health (ASH), 2008, found that 1 in 5 'poorer' smokers and 1 in 3 younger smokers (16-24) buy smuggled tobacco. www.ash.org.uk/ash_1spmepp7.htm

Against this background, a further key objective of Haringey's Tobacco Control Strategy is to reduce access to tobacco products - with the specific intention of

reducing illegal tobacco sales to minors; and sales of counterfeit and smuggled tobacco products. LB of Haringey, together with members of the Tobacco Control Alliance will work with the Metropolitan Police, local retailers, the Licensing Trade, and local employers to raise awareness to illegal and illicit sales and enforce law.

1.2.2 10 high impact changes

This document sets out that the driving principle of tobacco control is that of fairness for children and young people to grow up in an environment where smoking is not seen as the norm, for smokers to get help to quit and for people to live and work without being exposed to second-hand smoke.

There are a number of central themes running through this policy:

- Working in partnership
- Social marketing
- Denormalising smoking
- Tobacco control is everybody's business, not just the domain of the health sector
- Each approach is founded upon an evidence base

The objectives in 2.3 use the central themes from the High Impact Changes as their starting point. These themes seem to get to the heart of what is required to address Tobacco Control in Haringey.

The 10 High Impact Changes are as follows:

1. Work in partnership
2. Gather and use full range of data to information tobacco control
3. Use tobacco control to tackle health inequalities
4. Deliver consistent, coherent and co-ordinated communication
5. Integrated stop smoking approach
6. Build and sustain capacity in tobacco control
7. Tackle cheap and illicit tobacco
8. Influence change through advocacy
9. Help young people to be tobacco free
10. Maintain and promote smoke free environments

1.3 The local context

Haringey is the 5th most ethnically diverse borough in London[6] and the 18th most deprived borough in England. 26% of Super Output Areas are amongst the 10% most deprived in the country (2007 data). Over half the population is under the age of 35 and a quarter of the population are under 18 years of age. The current population is 225,700[7] and the GLA estimates the population will reach over 270,000 by 2031. 8.9% (8,311) of households were identified as living in overcrowded[8] conditions in the 2005 Haringey Housing Needs Survey. As at June 2007, there were

[6] The ethnic diversity of an area can be measured using Simpson's Index. It takes into account the number of individuals in categories present, as well as the number of categories. The Simpson's Diversity Index was applied to the 2001 Census in this example (source GLA).
[7] Haringey Strategic Partnership Wellbeing Strategic Framework for Improving Adults' Well-being 2007-2010 http://www.haringey.gov.uk/well-being_strategic_framework.pdf
[8] The standards used to check for overcrowding/under-occupation in the Haringey Housing Needs Survey 2005 were as follows: Overcrowding: each household was assessed as to the number of bedrooms required. Any household without enough bedrooms was deemed to be over-crowded

around 5,700 households living in temporary accommodation in Haringey and just over 30% of households live in social housing[9].

In 2006/07, 8,000 people were estimated to be unemployed in Haringey[10], 71% of the working age population. The employment rate is 69.0% (2006/07), compared with 69.3% in London and 74.3% in England.

Whilst all age all cause mortality in people aged under 75 years has been steadily reducing in Haringey between 1993 and 2006, consistent with the trend observed in London and in England as a whole, premature mortality in Haringey males is still considerably higher than London and England/Wales and male life expectancy in Haringey is also lower than in England/Wales. Male life expectancy is lower than the borough average in the wards of Tottenham Green, Northumberland Park, Bruce Grove, White Hart Lane, Tottenham Hale and Hornsey. However, female premature mortality is lower than in England/Wales and London respectively.

Smoking is currently the principal avoidable cause of premature death and ill health in England and a major cause of health inequalities. Reducing prevalence is therefore a key priority in improving the health of the population in Haringey, particularly in the more deprived boroughs, where smoking rates tend to be higher. Every year in Tottenham there are 130 deaths related to smoking and 600 hospital admissions, at a cost of nearly £1.4m (as at 2004)[11].

Modelled smoking prevalence data derived from the Health Survey for England (2003-2005)[12], predicts that Haringey has a prevalence of current smoking of 23.5% (95% confidence interval), compared with 23.3% in London and 24.1% in England. However, smoking prevalences of between 29 and 33% were predicted for Noel Park, Tottenham Green, Northumberland Park, Tottenham Hale & White Hart Lane.

The prevalence of current smoking is reported for major ethnic groups. Respondents from the Black African, Indian, Pakistani, Bangladeshi and Chinese minority ethnic groups were less likely to be current smokers than England as a whole, whereas Irish respondents were more likely to be current smokers. However, it should be noted that these estimates do not reflect the ethnic diversity within Haringey and the complex relationship between ethnicity and smoking prevalence. More accurate local estimates of smoking behaviour are required to better understand needs relating to this important health determinant.

1.4 Purpose of this strategy

Tobacco control in Haringey is intended to be a wide ranging schedule of work, not focusing on any one specific subject, which ultimately reduces the prevalence of smoking in the borough, improves public health and reduces health inequalities. Tobacco control and reducing smoking prevalence requires partnership working on a wide scale and should not be seen as being the responsibility of any one service or organisation within Haringey.

The purpose of the strategy and action plan is to set a clear direction for the Haringey Strategic Partnership and its member bodies to reduce the impact of tobacco in Haringey. The intention is that a Tobacco Control Alliance will be created as a fixed-term group to oversee implementation of this strategy by the end of March 2012.

---

[9] 2001 Census
[10] Using International Labour Organisation (ILO) definition
[11] Tobacco in London: The preventable burden.
http://www.lho.org.uk/viewResource.aspx?id=8716
[12] Available at: www.neighbourhood.statistics.gov.uk

1.5 Reason for the change in policy

For the past 7 years, tobacco control has been seen as the domain largely of the Stop Smoking Service (commissioned by NHS Haringey) and the Council's Enforcement Services. The national documents set out above make it clear that if Haringey is going to succeed in denormalising tobacco and reducing health inequalities, this has to be the business of a range of organisations that comprise the Haringey Strategic Partnership. For this policy change to be successful the strategy will be implemented in a structured, measurable, justifiable and targeted way. The Comprehensive Approach to Tobacco Control, as developed and prescribed by the Health Inequalities National Support Team will be used. This approach represents a holistic model of tobacco control with seven broad themes:

The aim of the model is to focus specifically on local delivery, so there is naturally a greater emphasis on multi-agency formulation of local strategy, rather than waiting for policy development at a national level. At the centre of the model is multi-agency partnership working. This is vital for tobacco control work to be planned strategically and to deliver evidence based interventions. A multi-agency Tobacco Control Alliance will be formed to implement this strategy. Closely aligned to multi-agency partnership working is the need for the effective planning and commissioning of tobacco control/stop smoking work, based on needs assessment and identification of those populations and areas with the highest burden from tobacco. These, together with monitoring evaluation and response, form the most important areas of the model.

The four remaining elements form the basis of the interventions needed for effective local tobacco control. Normalising smoke free lifestyles is central to reducing the perceived attractiveness of smoking. Making it easier to stop smoking looks to the provision and accessibility of evidence based ways to help smokers stop. Tackling illegal and underage availability remains crucial since price sensitivity and young people is crucial in preventing the uptake of smoking. Communication is vital to publicise the benefits of stopping smoking, the means of doing so, to advocate for further progress in denormalising smoking and to fully capitalise on social marketing. Communication between different organisations who work around tobacco control in the borough also needs to be excellent.

2 Policy statement

2.1 Aim

The aim of this strategy is to reduce the impact of smoking on health and health inequalities in Haringey by setting out the key actions to be taken by the end of March 2012.

2.2 Outcomes 2009-2012

- To reduce the impact of smoking on health inequalities in Haringey
- To denormalise smoking in Haringey
- To reduce smoking prevalence and increase smoking quitters in the following groups:
    - People with a mental health diagnosis
    - Teenage pre and post-partum mothers
    - Young parents
    - Those living in areas of high deprivation
    - Specific BME groups, particularly Irish and Turkish men
    - Routine and manual workers
- To develop measures to assess achievement against the above outcomes

2.3 Objectives 2009-2012

In order to achieve those outcomes, the following objectives have been set and are derived from the 10 High Impact Changes[13] set out above.

- Work in partnership
- Gather and use full range of data to information tobacco control
- Use tobacco control to tackle health inequalities
- Deliver consistent, coherent and co-ordinated communication
- Integrated stop smoking approach
- Build and sustain capacity in tobacco control
- Tackle cheap and illicit tobacco
- Influence change through advocacy
- Help young people to be tobacco free
- Maintain and promote smokefree environments

In addition, we will develop measures to assess our achievement against the above outcomes

2.4 Current position

A diagram of the current tobacco control services is set out in Appendix D.

NHS Haringey has consistently met its 4 week quitter smoking target although in recent years it has become more and more challenging.

Due to the challenging target and a number of key staff leaving the Stop Smoking Team, it became clear in February 2008 that a significant restructure of the team was necessary. The restructure resulted in the separation of commissioning and provision of tobacco control services, with the creation of a fixed-term Joint Tobacco Control Commissioner post, accountable to both NHS Haringey and the local authority. The Stop Smoking Service became part of the Provider side of NHS Haringey.

[13] Department of Health (2008) Excellence in Tobacco Control: 10 High Impact Changes to Achieve Tobacco Control, Tobacco Control National Support Team May 2008

As part of the separation of the commissioning function, NHS Haringey has commissioned Innovision to project manage all the primary care stop smoking services i.e. those being delivered from GP practices, pharmacies and dental surgeries. Innovision is an existing partner of NHS Haringey, which provides support to a number of GP practices locally and achieved a large number of quitters for Haringey in 07/08 and 08/09. As part of the PMA findings, Innovision were found to have achieved a significant correlation in their quitters with those from high prevalence groups, particularly in the east of the borough.

In addition to commissioning Innovision to deliver primary care services, NHS Haringey has commissioned other providers to work with voluntary and community groups within Haringey, where those groups represent one of the priority areas. These providers are delivering services in settings such as CONEL and a school with whom they have existing relationships, and also developing relationships with faith groups, and areas such as the Broadwater Farm and Tiverton estates.

The Stop Smoking Service went through a formal HR consultation to create a number of new roles in particular the new Service Manager. As set out above, the recommendations from NICE and the tobacco control review suggest that new pathways into the service are required e.g. from other health service providers (sexual health, mental health, children's services), from BME and deprived communities, from other services for vulnerable adults (e.g. supported housing, DAAT, social care, worklessness), and from employers. Therefore, the restructure also created new 'Advisors with a Special Interest', which are focused around the following priority areas:

- teenage pregnancy, young parents and young people generally
- supporting quitters in hospital, particularly surgical, respiratory, cardiac and maternity patients
- mental health patients and 1st July 2008 smokefree implementation for mental health inpatient wards
- those from deprived communities particularly in N17, N15 and N22, and those from BME (black and minority ethnic) groups known to have a high smoking prevalence, such as Turkish and Irish men
- Workplaces, particularly with manual workers.

The restructure coincided with the launch of the new NHS Haringey Smokefree Policy. Amongst other things, it sets out that staff can access stop smoking clinics during working hours, with agreement of their line manager and dependent on the needs of their particular service. The Stop Smoking Service has set up a stop smoking clinic during lunchtime. The policy also makes it clear that it is everyone's responsibility to maintain a smokefree environment at St Ann's Hospital and staff have been asked to lead by example in not smoking on site.

2.5 Scope of strategy

This strategy applies to anyone who smokes or who is affected by second-hand smoke in the borough of Haringey.

3 Equalities statement

As part of the development of the strategy, an Equalities Impact Assessment (EIA) has been carried out.

The purpose of EIAs is for any specific piece of work, to:

- identify the needs of each equality target group

- identify gaps in knowledge
- identify the positive impacts
- identify the negative impacts
- identify what needs to be done to reduce negative impacts and add to positive ones
- amend what is being done accordingly.

The Greater London Authority (GLA) and the other organisations in the GLA group, (and adopted by Haringey) have specified the equality target groups (ETG) as

- women
- Black, Asian and minority ethnic people
- disabled people
- children and young people
- older people
- faith groups
- lesbians, gay men, bisexual and trans people

The EIA looked at the following:

i. whether the strategy leads to any of the ETG groups being discriminated against and if so, whether the discrimination is lawful.

   The EIA concluded that the aim of the strategy is to reduce the impact of smoking on health inequalities. Therefore, it is targeted towards groups of people with high smoking prevalence, for whom smoking has the greatest impact on their health. However, there is nothing in the strategy that discriminates against any of the ETG groups either explicitly or by omission. The ETG groups form part of the high prevalence communities and will be targeted in the same way as anyone who is not part of an ETG group.

ii. what the positive outcomes for each of the ETGs should be

   The positive outcomes are that those people within ETGs who form part of high prevalence communities will be targeted to support their smoking cessation. There is a focus on pregnant women, particularly teenagers and also on young people more generally. In addition, those minority ethnic groups for which there is known to be high prevalence of smoking will have a specific focus.

iii. what the negative outcomes for each of the ETGs could be

   The negative outcomes could be that if anyone in these ETGs does not form part of a high prevalence community, they will not be targeted for smoking cessation support. However, there are also generic actions for all areas of Haringey, in terms of delivering smoking cessation and wider tobacco control measures and all residents will have access to these, without discrimination on any of these grounds.

iv. what amendments can be made to remove any unlawful discrimination and/or negative outcomes or to improve the neutral and/or positive outcomes

   The EIA concluded that more work needs to be done to identify the minority ethnic groups which have high prevalence to ensure that the focus is evidence-based and not anecdotal and thus to ensure that no unlawful discrimination occurs against Black, Asian and minority ethnic people.

   This recommendation will be referred to the Joint Strategic Needs Assessment steering group for consideration in developing the data set on health needs in Haringey.

4 Links with the other strategies

4.1 Links with the Sustainable Community Strategy

The key outcome of the Sustainable Community Strategy to which this strategy relates is' Healthier people with a better quality of life'. On page 24, it states that 'people need access to information and support to help them make healthy lifestyle choices [and]. it is crucial that people are also given ready support to give up smoking.' This strategy sets out how people can be supported to give up smoking and how they can have access to information tailored to their needs and that ensures all sections of the community can access information and support, particularly those groups within the community with high smoking prevalence.

The Sustainable Community Strategy also has as one of its outcomes 'economic vitality and property shared by all'. It sets out to 'target poverty: putting efforts into income maximisation'. As has already been stated, the aim of this strategy is to address the health inequalities related to smoking. In the introduction, it is clear that these inequalities also impact economically upon certain groups and by addressing health inequalities amongst disadvantaged groups in Haringey, this will have a positive economic impact also.

4.2 Links with Haringey's well-being strategic framework

The strategy aids in the achievement of improved health and emotional well-being, which is Outcome 1 of the Well-being Strategic Framework. The objective of this is to promote healthy living and reduce health inequalities in Haringey. This strategy has as its aim the reduction of the impact of smoking on health inequalities and the 'denormalising' of smoking in Haringey.

4.3 Links with other relevant strategies

'Changing Lives: the Children and Young People's Plan'[14] sets out some key actions related to smoking in order to meet the vision of enabling children and young people to be healthy. They are as follows:

- Reduce the number of women smoking in pregnancy
- Ensure that all midwives, health visitors and children's centre staff are trained to encourage smoking cessation and to access smoking cessation services
- Reduce the number of children and young people who take up smoking

All of these actions are addressed specifically in the recommendations and action plan in Appendix 1. Pregnant women and young people are priority groups for this strategy.

5 Monitoring the strategy

The responsibility for day-to-day implementation of the strategy will be through the Tobacco Control Commissioner supported by the Tobacco Control Alliance.
A tobacco control alliance can be defined as collaboration between two or more multi-agency parties that pursue a set of agreed goals for tobacco control. Local tobacco alliances have been crucial in the delivery of tobacco control work throughout the country. A Tobacco Control Alliance for Haringey will implement the targets in the strategy. Members will contribute to the reaching of objectives and will work to reduce the prevalence of smoking within Haringey. The major function of the alliance in Haringey will be to develop, implement and monitor the Tobacco Control Action Plan (Appendix E).

[14] http://www.haringey.gov.uk/changing_lives_-_the_children_and_young_peoples_plan.pdf

Key members of the Tobacco Control Alliance will be NHS Haringey, London Borough of Haringey, North Middlesex Hospital, Barnet, Enfield & Haringey Mental Health Trust, Police/Fire, Voluntary/Charitable Organisations, Housing Associations, Chamber of Commerce, Connexions, CONEL and Schools. The alliance needs to consist of participants who can beneficially contribute to developing and implementing the Tobacco Control Action plan. The alliance will ensure a structured and well informed approach to tobacco control and ensure partnership working across Haringey. It will be a major step to creating a Smoke free Haringey. The alliance will meet bi monthly for its duration. This alliance will report formally to the Wellbeing Strategic Partnership Board.

5.1 Links with Haringey's Local Area Agreement

There is an LAA target for stop smoking which is to support 1008 per 100,000 population aged 16 and over each year until 2010/11. In addition, there is a stretch target from April 2007 to March 2010, to achieve 300 quitters each year from the N17 area. The target to achieve a reduction of 1008 per 100,000 is also the NHS Operating Plan target, meaning that targets for the Alliance are now aligned. Reporting of these targets are now to both the Council's Performance Team and to the Department of Health.

This strategy will also contribute to achievement of the following LAA targets:

- NI121- mortality rate from all circulatory diseases at age under 75 years
- Number of accidental dwelling fires

Appendix A: Needs assessment

The development of this strategy builds on an understanding of the needs of Haringey residents that has been developed over time. Key sources include:

- Haringey Health Report (2006)
- Health equity audit of utilisation of smoking cessation services in Haringey (2007)
- Joint Strategic Needs Assessment: minimum data set (2008)

In addition, PMA associates were commissioned to undertake a review to inform the development of this strategy. The objectives were:

1. Identify health inequalities due to tobacco in Haringey, and the population groups on which interventions should focus.
2. Review the effectiveness and cost-effectiveness of interventions currently in place in reducing health inequalities including quit smoking, enforcement, licensing, maternity and health promotion services.
3. Review the literature to identify relevant guidance or good practice that could be applied in Haringey.
4. Consider how tobacco-related performance management arrangements could be used to support work to reduce health inequalities.

Table A below sets out by Super Output Area the areas in Haringey where smoking prevalence is likely to be highest. The indicators used to derive this result included the following:

- % lone parent households with dependent children
- IMD 2007 Barriers to Hosing and Services score
- IMD 2007 Education Skills and Training score
- Job Seeker's Allowance claimants
- % working age persons unemployed
- IMD 2007 Income Score
- IMD 2007 Living Environment Score

Table A. Smoking prevalence likely to be highest

SOA code	Score	Ward	Postcodes (4 digits)
E01002037	19	Northumberland Park	N17-0
E01002035	17	Northumberland Park	N17-8
E01002038	16	Northumberland Park	N17-0, N17-8
E01002039	16	Northumberland Park	N17-0, N17-8
E01002066	16	Tottenham Green	N15-4, N17-9
E01002012	15	Hornsey	N8-7
E01002093	15	White Hart Lane	N17-7
E01001979	14	Bruce Grove	N17-6
E01002034	14	Northumberland Park	N17-0, N17-8
E01002054	14	Seven Sisters	N15-6
E01002074	14	Tottenham Hale	N17-0, N17-9
E01002094	14	White Hart Lane	N17-7
E01002099	14	Woodside	N22-5
E01001978	13	Bruce Grove	N17-6
E01002026	13	Noel Park	N22-6
E01002081	13	Tottenham Hale	N17-9
E01002089	13	West Green	N17-6
E01002033	12	Noel Park	N22-5, N22-6
E01002072	12	Tottenham Green	N15-4, N15-5
E01002091	12	White Hart Lane	N17-7, N17-8
E01002003	11	Haringey	N15-3, N8-0
E01002029	11	Noel Park	N22-6
E01002082	11	West Green	N17-6
E01002096	11	White Hart Lane	N17-7
E01001971	10	Bounds Green	N22-4, N22-8
E01002032	10	Noel Park	N22-5, N22-6
E01002045	10	St. Ann's	N15-5
E01002077	10	Tottenham Hale	N17-9
E01002095	10	White Hart Lane	N17-7
E01002097	10	White Hart Lane	N17-7

It can be seen that, in addition to targeting N17, parts of N8, N15 and N22 are also areas where there is likely to be a significant concentrated population of smokers.

Appendix B: Development of the strategy

Development of a coordinated, strategic approach to tobacco control in Haringey is a key priority in the Well-Being Strategic Framework, and an evidence review was commissioned through a tender process from Public Management Associates (PMA) in January 2008. The development of the strategy was led by the Improving Health and Emotional Well-being sub group of the Well-Being Partnership Board, in consultation with a range of stakeholders from across the Haringey Strategic Partnership.

Appendix C: Consultation about the strategy

The Consultation has gone through a number of stages already:

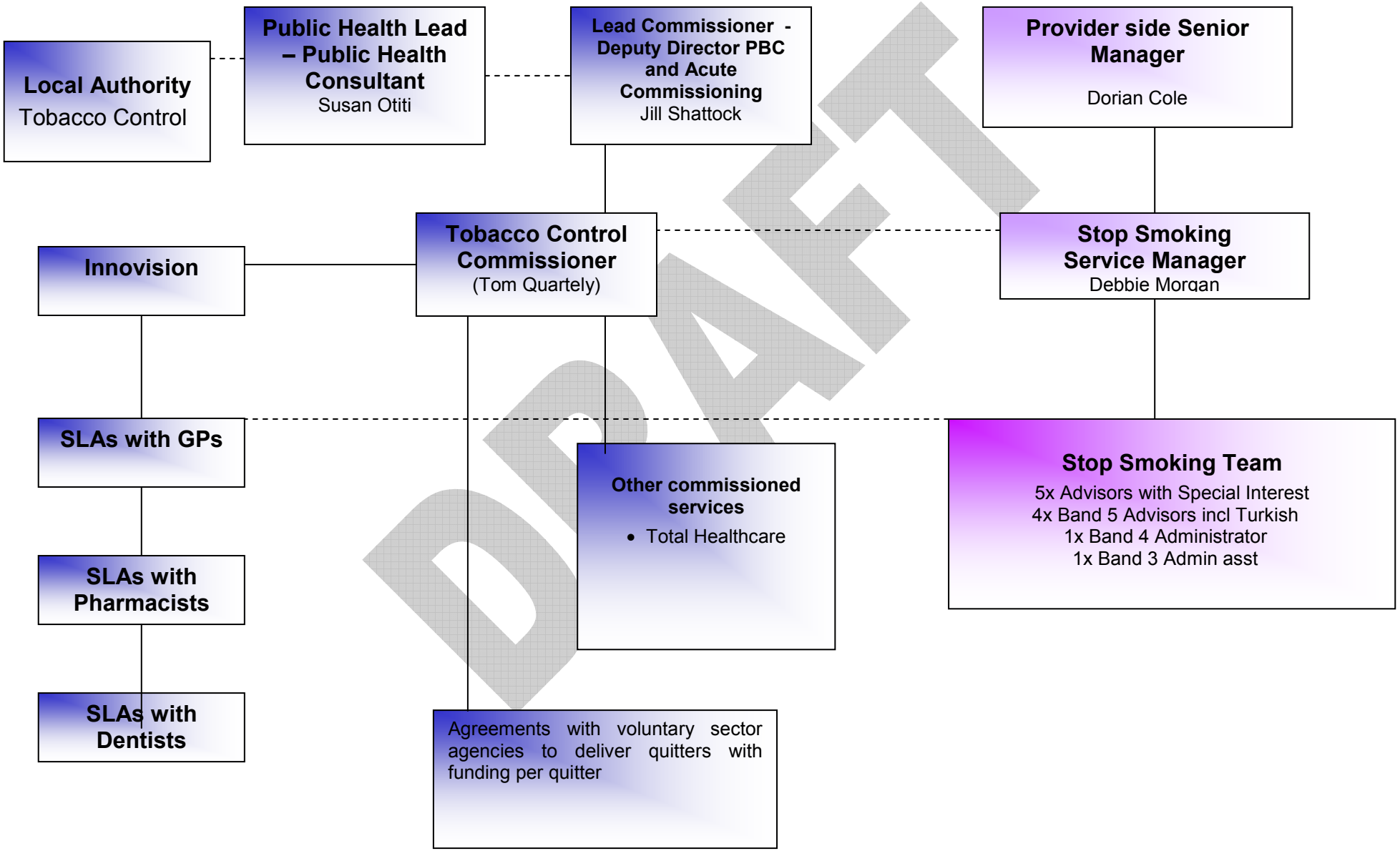
- PMA Associates consulted with over 20 stakeholder individuals and groups during February and March 2008, covering the Council, NHS Haringey CONEL, HAVCO and Tottenham Traders Association.

- To develop this strategy, further discussions were undertaken with a number of the stakeholders referred to above and additional Council staff and voluntary sector organisations.

- The draft strategy was presented to the Improving Health and Wellbeing Sub-group in April 2009

- A workshop held with Well Being Strategic Partnership Board members in September 2009 to provide members with an opportunity to shape the action plan.

Appendix D: Tobacco control diagram



APPENDIX E ACTION PLAN

Haringey Tobacco Control Strategy 2009-12

The overall aims of Haringey's Tobacco Control Strategy are to:

- Reduce the total consumption of cigarettes and other tobacco products across the community; and
- Reduce the number of people exposed to environmental or second-hand smoke.

To meet these aims there are five objectives:

- Increase support for smokers who want to stop smoking;
- Increase the number of smoke-free environments;
- Increase awareness and understanding of tobacco use and health;
- Reduce access to tobacco products; and
- Make sure developments are informed, co-ordinated and supported by a trained workforce.

Underpinning the aims and objectives of this strategy are a number of important guiding principles:

- Smoke-free is best for health; there is no safe level of exposure to smoke or second-hand smoke.
- People should have the right to be protected from the harmful effects of second-hand smoke.
- Tobacco control should be anti-smoking not anti-smoker.
- Tobacco control should seek to shift public opinion and promote non-smoking as the social norm.
- Children should have the right to be free from exposure to tobacco advertising and promotion.
- All smokers should have the opportunity to receive smoking cessation advice and support.
- Tobacco control should target neighbourhoods and communities and those with the highest prevalence of smoking and smoking related disease.

Haringey Tobacco Control Strategy 2009-12 – ACTION PLAN

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Leading and Monitoring Strategy	Set up a Tobacco Control Alliance that is committed and active in reducing the impact of smoking on health inequalities - with a clear but detailed purpose.	Set up a committed and active Tobacco Control Alliance formed from all relevant partners in the HSP, in order to monitor implementation and evaluate the strategy.	Associate Director of Public Health & Tobacco Control Commissioner (TCC).	First meeting November 2009	Robust multi-agency Tobacco Control Alliance Established. Monitoring and Evaluation of Haringey's Tobacco Control Strategy 2009-12.
		Dedicated managerial capacity to develop effective working relationships and shared sense of mission.	Appoint a fixed-term commissioner to implement strategy.	NHS Haringey Commissioning Team.	November 2009	NHS Management Trainee.
	Commissioning Services	Commission cost effective stop smoking services - with the aim of increasing support for smokers who want to stop smoking.	1. Continue to commission Innovision to project manage primary care stop smoking services 2. Commission other providers to deliver stop smoking within priority groups 3. Review current Commissioning arrangements.	TCC	By February 2009	Revised Commissioning of services based on DH Commissioning Guidance and DH 10 High Impact changes.
		Services will target the N17 area.	Continue this activity until 2010.	TCC	Ongoing	Local Area Agreement stretch target will be achieved.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Commissioning Services	Practice Nurses and Community Pharmacy staff to be offered Level 2 training and regular updates, including a quarterly visit. GPs will be incentivised to mail out to smokers with offers of support and to refer them to Stop Smoking Service.	1. Innovision to set up service level agreements with GP practices, pharmacies and dental surgeries which will include ensuring training and updates and quarterly monitoring. 2. The Stop Smoking Service will continue to deliver Level 2 training, updates and advice for primary care advisors. 3. GPs, pharmacists and dentists will receive £15 per quitter they refer to Stop Smoking Service under their SLA with Innovision.	TCC	Ongoing	NHS Haringey achieves the 4 week quitter target for 2009-10.
		Ensure that all contracts with Acute Providers specify that training of ALL Midwives provides level 2 interventions.	Negotiate new SLAs with acute providers which clarify obligation to refer patients and provide stop smoking clinics at Acute Trusts.	TCC	By March 2010	Acute Providers actively engaged with Tobacco Control agenda and referring patients to SSS.
		All cases of myocardial infarction will be offered cessation support and NRT on discharge.	Pilot automatic referral process to hospital-based stop smoking clinic at North Middlesex or cardiac and respiratory outpatients and vascular surgery.	SSS	Ongoing	Pilot underway – monitor progress by April 2010.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Priority Groups	Align Tobacco Control services with priority areas by postcode set out in Appendix A - to contribute to reducing health inequalities.	1. Stop Smoking Service to work in defined localities 2. Advisors to use the recommendations from Social Marketing to understand how to effectively engage different population groups.	SSSM TCC	Ongoing	Targeted activity to reduce Health Inequalities.
		Practice Nurses and Health Visitors will be asked to prioritise lone parents for smoking cessation advice.	SSS to work with Practice Nurses and Health Visitors.	SSS NHS Haringey – Provider Services.	By March 2010	Increase referrals to SSS.
	Pregnancy	All women will be offered CO monitoring and nicotine testing at first booking with referral to stop smoking clinic.	Pilot automatic referrals for pregnant women with positive smoking status at North Middlesex.	SSS	Ongoing	Evaluate impact, outcome and effectiveness of current Pilot.
		Utilise early booking programme in Children's Centres as an opportunity to refer for smoking cessation support.	Tobacco Control Commissioner to explore with LB Haringey Children's Services and Commissioned Services.	TCC SSS	Ongoing	Increase in number of people referred to SSS.
	Young Smokers	Sexual health services will offer referral to smoking cessation clinics.	Work with sexual health services and teenage pregnancy services to identify referral pathway and train staff to provide stop smoking advice.	SSS	By January 2010	Increase in the number of people referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Young Smokers	Promote Tobacco Control in the School Setting.	1. Work with Healthy Schools Co-ordinator to integrate Tobacco Control messages in PSCHE curriculum and 2. School Nursing Service.	SSS and Healthy Schools Co-ordinator	By March 2010	Tobacco Control messages integrated into PSCHE curriculum and School Nursing.
	BME Groups	Target specific ethnic groups such as Turkish and Irish men, known to have high prevalence.	1. Engage with Turkish voluntary sector groups, and Irish Groups, to explore commissioning of stop smoking services &/or delivering clinics in partnership.	TCC SSSM	November 2009 – March 2011	Targeted Stop Smoking Services available to people from identified BME Groups.
		Materials developed in community languages to target communities known to have highest prevalence - Turkish and Bangladeshi.	Work with Local Authority language services to ensure correct languages selected and obtain translations of smoking cessation materials.	SSS	By February 2010	Tobacco Control information and learning materials available to people from identified BME Groups.
	Workplaces	Target public sector employees on low incomes and set up referral routes through Occupational Health in Local Authority/NHS.	Work with the Local Authority's occupational health department to identify and target relevant employees and set up clinic.	SSS	November 2009 – March 2011	Tobacco Control Programmes, plus Stop Smoking Services targeted at and made available to Workplaces and employees across Haringey.
		Target large employers with 250 employees or more, to promote Tobacco Control with referral routes to SSS.	Identify 4 large employers - with a special focus on routine and manual workers - who would support Tobacco Control and/or referral routes to Stop Smoking Services.	SSS	November 2009 – March 2011	Tobacco Control Programmes, plus Stop Smoking Services targeted at Corporate employers and their employees across Haringey.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Workplaces	Target small and medium size businesses, particularly those with routine and manual workers.	1. Contact the local Chamber of Commerce, place an article in their newsletter about cost of smoking to employers. Mailout to members to seek their views on running workplace clinics 2. Contact North London Business (inward investment agency) and to place an article in their magazine about cost of smoking to employers 3. Develop links with Haringey businesses to run 6 workplace stop smoking clinics 4. Contact Green Lanes Traders Association to engage in providing clinics for members & aid Tobacco Ctrl compliance; 5. Identify best practice examples, where changing the "built-working" environment can help support no-smoking policy implementation; 6. Seek Local Authority assistance to target no-smoking support in workplaces with high levels of tobacco rubbish.	SSS	April 2010	Tobacco Control Programmes, plus Stop Smoking Services targeted at SMEs and their employees across Haringey.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Workplaces		7. LB Haringey Enforcement and SSS to work together to develop incentives for employers to send staff on stop smoking programmes.	SSS	April 2010	Tobacco Control Programmes, plus Stop Smoking Services targeted at SMEs and their employees across Haringey.
	Mental Health	Target people with mental health diagnoses.	1. Stop Smoking Service to offer a co-ordinated staff training programme 2. Identify opportunities to deliver clinics in mental health settings 3. Promote the Tobacco Control ban.	SSS	November 2009 to March 2011	Training Programme delivered.
		Stress Management.	Target smokers with identified stress related ill-health symptoms. Focus prevention and support activities on workplace based programmes in first phase.	SSS	November 2009 to March 2011	Targeted Stop Smoking Services available to people affected by stress at work.
	Community	Train to Level 1 and Health Trainers to provide appropriate advice to members of the community.	Continue to develop the Health Trainer in order to provide community based Level 1 advice – and increase referrals to Stop Smoking Services.	Michele Daniels	Ongoing	Health Trainer Programme developed. Health Trainers equipped to deliver this targeted programme. Increased referrals to SSS.
		Major professional sports facilities will be offered Stop Smoking Services support & publicity.	Integrate Smoking Cessation into Men's Health programme.	SSS together with Tottenham Hotspur FC	Ongoing	Increased referrals to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Community	Work with Citizens Advice Bureau (CAB) to offer referral to smoking cessation clinics and provide information.	Offer Level 1 advice and promotion materials at CABs especially in N17.	SSS	By March 2010	CAB facilities actively engaged in Tobacco Control. Users referred to SSS.
		Promote, and where possible, deliver smoking cessation services aimed at the hard to reach communities through the following: supermarkets, job centres, pharmacies, local health centres, schools, pubs, libraries, bookmakers, community centres, sports centres, places of worship.	Already delivering services in pharmacies, health centres, schools, libraries, community centres and places of worship. Seek opportunities to commission other services.	TCC	Ongoing	Hard to reach communities actively engaged. Users referred to SSS.
		Passive Smoking - working together with key stakeholders, continue to raise awareness to the dangers to health associated with environmental passive smoking across the community.	NHS Haringey to support the Local Authority Environmental Health teams to continue to promote the dangers to health caused by "environmental" passive smoking.	SSS	By March 2010	Programme to deal with environmental tobacco/passive smoking produced. Promotional publicity campaign established.
		Unemployed and Vulnerable Groups.	1. NHS Haringey to identify ways in which it can work closely with LB Haringey, Connexions and Jobcentreplus (JCP) employment programmes	SSS	By March 2010	LB Haringey, Connexions & JCP facilities actively engaged in the Tobacco Control agenda. Users referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Community		in order to promote tobacco control and Stop Smoking support to the unemployed. 2. NHS Haringey to identify ways in which it can work closely with Local Authority and 3rd Sector organisations in order to promote tobacco control and Stop Smoking support to vulnerable grps.			
		Tobacco Control programmes will be explored with the Health Visiting service to target households with <5 year olds.	Engage Health Visitors and Children's Centres in providing stop smoking support and identifying clients for referral and whether they could provide stop smoking clinic(s).	SSS NHS Haringey – Provider Services	By March 2010	Community Nursing Services & Children's Centres actively engaged with SSS and referring patients.
	Enforcement	The Tobacco Control Alliance in association with Trading Standards and Environmental Health will monitor the No Smoking ban.	1. Enforcement to provide information on Stop Smoking Services in food hygiene and health and safety courses 2. SSS to prepare leaflets on the smoking ban, in appropriate community languages, for Enforcement Teams to distribute to shops, restaurants and the hospitality settings, as part of routine visits.	SSS and LB Haringey Enforcement Teams	By March 2010	Tobacco Control integrated into LB Haringey Enforcement programmes. illegal Sales reduced. More smokers referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Enforcement	Tackle the availability of cheap and illicit Tobacco; Reduce illegal tobacco sales to minors; and Reduce sales of counterfeit & smuggled products.	LB Haringey and Metropolitan Police to reduce (and prevent) the availability of cheap and illicit tobacco. Key examples of proposed activity include: 1. Police – to target areas/outlets where illicit tobacco is being sold; 2. Licensing Trade – to target identified pubs/clubs where "illegal" imports & selling is prevalent; seek support of the Licensed Victuallers Society in undertaking this activity; 3. Employers – to support local employers (HR Teams) to implement & maintain "robust" no-smoking restrictions at work; 4. HMRC - Customs & Excise to prevent the importation/sales of illicit tobacco; explore linkages with Border Control Agencies too; 5. Prevention & Marketing – LB Haringey to set up & co-ordinate a PR/media campaign (plus local helpline) to raise awareness on illicit/illegal tobacco imports/sales	Police, SSS, Enforcement	By March 2010	Programme of activity on Enforcement to deal with cheap and illicit tobacco produced. Action plan agreed and implemented. Tobacco control measures enforced. Illegal Sales reduced - more smokers referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Enforcement		and what the community (as a whole) can and should do to tackle it - link this activity to other London Boroughs where possible. (see Publicity below).	Police, SSS, Enforcement	By March 2010	Programme of activity on Enforcement to deal with cheap and illicit tobacco produced. Action plan agreed and implemented. Tobacco control measures enforced. Illegal Sales reduced - more smokers referred to SSS.
		Explore developing a proof of 18 year age card to distribute through secondary schools and colleges.	Work towards introducing an existing Proof of Age scheme and distribute through schools and colleges.	SSS, Healthy Schools and Enforcement	By March 2010	Proof of Age Scheme established - with take up from local schools and colleges.
		All licensed premises will receive 'Responsible Retailers' information packs, giving advice on sale of tobacco particularly underage sales.	1. Use Responsible Retailers Scheme template from Barnsley as a model 2. Utilise materials from Portman Group to support proof of age and Responsible Retailers Sch	Enforcement Team	By March 2010	Packs produced and distributed - link to enforcement and illicit sales above.
	Smoke Free Homes - focus on Social Housing & Care Sectors	1. All social housing tenants will be targeted with cessation support materials and access to Stop Smoking Service. 2. Explore opportunities for No-Smoking Policy development in residential care homes; plus increased referrals to Stop Smoking Services.	1. Work with Local Authority Housing Team to identify potential quitters from social housing tenants 2. Provide stop smoking materials to social housing tenants through Local Authority Housing Team 3. Work with parents to make homes smoke free - via Community Nursing.	SSS, Housing Services, Community Health Services, Voluntary Sector	By March 2010	Reduce the impact of second-hand smoke. Increase the number of users referred to SSS.

	Action Area	Recommendations (with reference to PMA Strategy & 10 High Impact Changes)	Action	Lead Officer/ Team	Timescale	Outcome
	Smoke Free Homes - focus on Social Housing & Care Sectors		Services and voluntary organisations 4. Scope potential for provision of no-smoking support in residential & wider Homecare Care Sector.	SSS, Housing Services, Community Health Services, Voluntary Sector	By March 2010	Reduce the impact of second-hand smoke. Increase the number of users referred to SSS.
	Data and Audit	Develop economic data to demonstrate smoking costs locally - and to inform future developments and progress.	Provide economic data for partners to highlight the cost of smoking to the local economy.	Public Health	By March 2010	Robust data monitoring systems agreed and implemented. Evidence directly impacting on future commissioning arrangements.
		Reflect priority areas better in quit numbers.	Develop an audit cycle to ensure priority groups are being reached.	Public Health	By March 2010	Robust data monitoring systems agreed and implemented. Evidence directly impacting on future commissioning arrangements.
	Publicity	Establish a co-ordinated multi-agency media campaign.	Tobacco Control Alliance members to implement and ensure integration of Social Marketing recommendations.	Tobacco Control Alliance members	By February 2010	Multi-agency publicity and marketing campaign agreed and implemented across the community - more smokers referred to SSS.
	Consultation and Engagement	Engage locally elected members, Citizens' Panels, and New Deal for Communities.	SSS to work with HAVCO and the Local Authority to provide information at area assemblies and other forums on a regular basis.	SSS and Voluntary Sector	By March 2010	Promote the Tobacco Control Alliance's programme of activities. Increase the number of referrals to Stop Smoking Services.