Tobacco control

Summary

- Tobacco control policy is described in legislation and supported by national and local policies, health guidance and measures to control access to and impact from tobacco on individuals and society.
- Tobacco usage and smoking is the single greatest, avoidable cause of poor health and preventable disease. Stopping smoking at any age will improve health and reduce risks. When people quit before the age of 30 years many health risks can be avoided completely[1].
- Adult smoking prevalence continues to fall year on year both nationally and locally. The Hampshire average rate of smoking by adults 18+ years is 17.5% (2011-12 estimate).
- There are some significant differences in smoking rates between some boroughs across the county. The boroughs of Rushmoor, Havant, Gosport and Basingstoke have the highest rates and this reflects a link between social deprivation, smoking rates and wider health inequalities and the need to target smoking interventions.
- Data from a Health Impact Assessment and audits undertaken by Hampshire Public Health indicate that commissioned NHS provider services have been proportionate to need.
- Clinical Commissioning Groups (CCGs), community health services, acute trusts, local authorities and wider community partners including local employers all have an important role in referring and advising smokers to quit.
- CCGs and health care providers should be robust in identifying their patients' 'smoking status' and delivering brief advice to quit alongside a systematic referral to a convenient NHS stop smoking service.
- Where parents smoke the research indicates that their children are twice as likely to start smoking between the ages of 13 and 21 years[2].
- Effective local tobacco control measures are as important for reducing smoking and the on-set of smoking by young people, as are accessible stop smoking services. Anecdotal evidence suggests that illicit tobacco and counterfeit tobacco which is sold below shop price, is a significant incentive and driver for people to continue to smoke. Sales of illicit tobacco will prosper most in areas of deprivation, low incomes and wider social hardship.

[1] http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)61720-6/abstract
[2] http://www.medicalnewstoday.com/releases/31304.php

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This chapter should be read in conjunction with *Cancer, Cardio vascular disease, Long term conditions, Mental health, Maternity and Children and young people.*

1. Introduction

Tobacco use is the single most preventable cause of ill health in the UK and there is clear evidence that through reducing smoking prevalence we will improve the overall healthy life expectancy as well as total life expectancy of many people. Reducing smoking prevalence is important nationally, regionally and locally within the context of improving mortality and morbidity for England.

In 2009, 81,400 deaths were directly related to smoking in England. In Hampshire around 1,850 people die each year from smoking-related causes. Supporting people to stop smoking directly contributes to improving health and wellbeing, reducing health inequalities and risks of avoidable and premature ill health and is also a significant factor in reducing infant mortality rates and low birth weights.

Tackling tobacco requires a comprehensive approach, adopting tobacco control policy at national and local level. The Government's Tobacco Control Plan[3] "*Healthy Lives, Healthy People: A Tobacco Control Plan for England*" (March 2011) identified a range of measures to reduce smoking prevalence and set out a comprehensive package of evidence-based action that will be implemented at national level to support local areas. The plan promotes comprehensive and evidence-based tobacco control in local communities. Strategic tobacco control work in Hampshire should take into account these national priorities and aspirations.

Between 2010 and 2013 Hampshire (including the unitary areas of Southampton, Portsmouth and Isle of Wight) implemented a collaborative tobacco control strategy addressing three key areas of work:

- Stopping young people being recruited as smokers by tackling easy access to tobacco, and developing more initiatives around education, prevention and cessation approaches for young people.
- Helping every smoker to receive help to quit if they want to stop.
- Protecting everyone, especially children, from the harms of second-hand smoke by promoting smokefree homes and cars.

There is now an opportunity to develop a new strategic approach to tobacco control in Hampshire to enable:

- Tobacco control activities to be an essential part of the Joint Health and Wellbeing Strategy.
- A strategic, co-ordinated and sustained approach to tobacco control across Hampshire.
- The Hampshire plan to be aligned with district work.

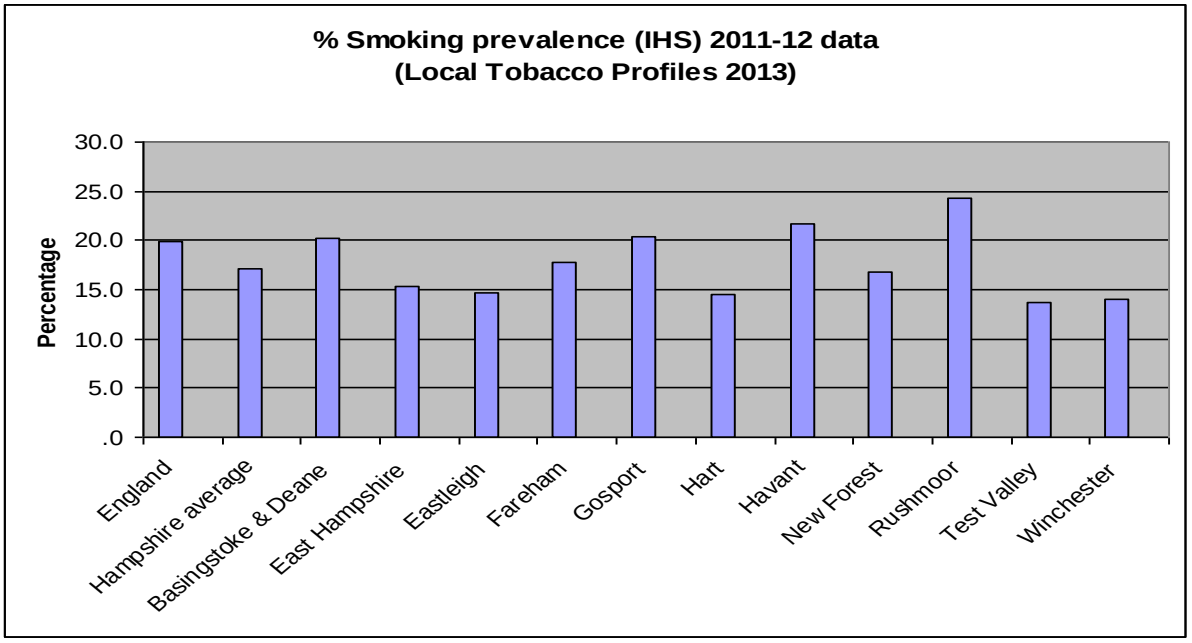
[3] https://www.gov.uk/government/publications/the-tobacco-control-plan-for-england

2. Level of need in the population

In 2010 Hampshire's estimated percentage smoking prevalence as measured by the Health Survey for England 2006-2008 was 18.1%, although rates in different parts of Hampshire varied from 13.9% in Winchester and 14.7% in Hart to 24.3% in Gosport and 23.7% in Rushmoor[4]. The England average was 22.2%. This shows the prevalence of smoking in these areas was higher than the national average and this variation correlates with some features of health inequalities.

The 2013 Tobacco Profiles indicate Hampshire's estimated smoking prevalence to be generally reducing[5] (figure 1). This profile uses a different data set to that used in the previous 2010 figures but the overall trend is downward.

Figure 1: % smoking prevalence in Hampshire, 2011/12



Rates continue to vary across the county with the highest rates being 24.3% in Rushmoor, 21.7% in Havant, 20.4% in Gosport and 20.2% in Basingstoke. It is therefore important to continue to target these areas in order to reduce smoking-related health inequalities and associated costs to society.

Smoking and the onset of youth smoking is a key public health priority. The national prevalence for smoking by 15 year olds was 11% as reported in 2011[6].

Recent Hampshire 2012/13 schools surveys which included a sample of schools in our most deprived areas showed a slightly higher rate than the national figure, with regular smoking amongst 15 year olds showing as 12.2%[7] which may reflect a sample bias.

[4] 2010 Health Profiles, www.apho.org.uk
[5] LHO, Tobacco Profiles, 2013, www.tobaccoprofiles.info
[6] Smoking, Drinking and Drug Use among Young People in England in 2011, National Statistics.
[7] Tyler, R, 2013, Tobacco and cannabis use among school-aged children in Hampshire 2012 – 2013, University of Portsmouth.

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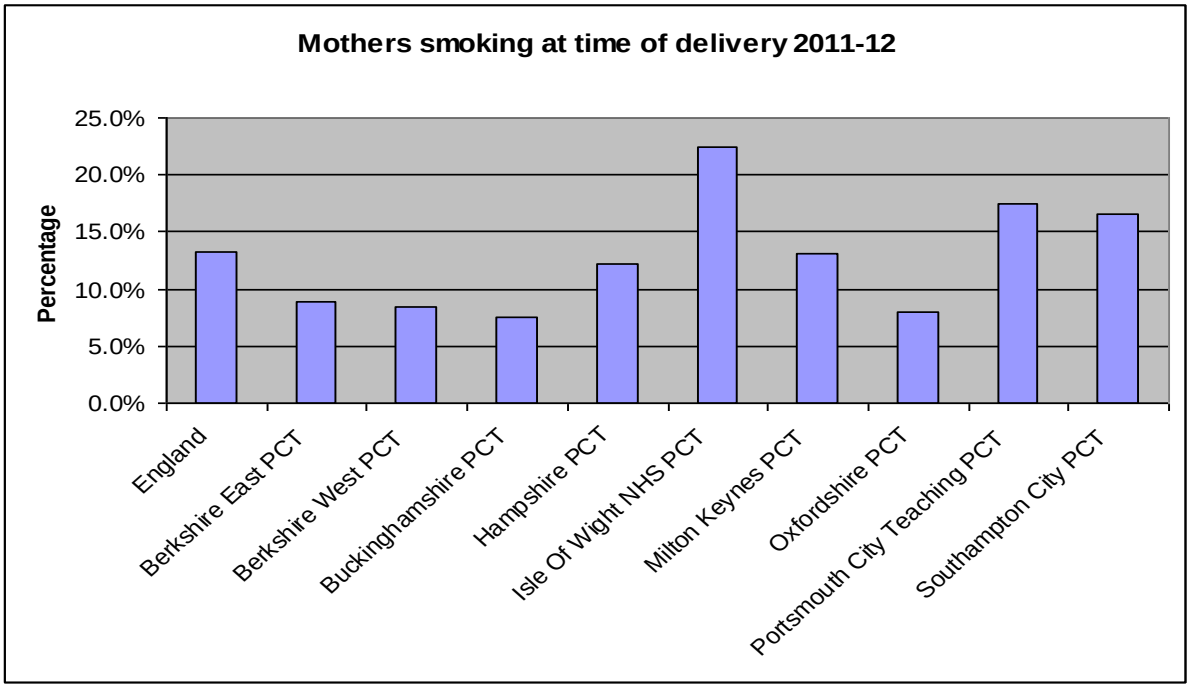
Smoking in pregnancy is a key concern in terms of low birth weight and infant morbidity and mortality. The current Hampshire average rate of smoking by mothers at delivery is 11.8% (2012/13). This is lower than the national average of 13.9% as shown for 2011-12[8] (Table 1 but recognises there are concerns around individual hospitals where smoking mothers correlate with Hampshire's highest district rates of for smoking.

Table 1: % mothers in Hampshire smoking at time of delivery, 2012/13

	Acute Trust providers	2012-13
% Mothers smoking at time of deliver (SATOD)	Frimley Park Hospital Foundation Trust	10.3%
	University Hospital Southampton Foundation Trust	11.0%
	Portsmouth Hospitals NHS Trust	16.3%
	Hampshire Hospitals NHS Foundation Trust	9.5%
	Salisbury NHS Foundation Trust	11.7%
	Western Sussex Hospitals NHS Trust	12.9%
	NHS Hampshire Total	11.8%

Other hospitals outside of Hampshire, where small numbers of mothers deliver are not shown in this table. Hampshire mothers compare favourably to the national average and prevalence rates in surrounding areas in 2011-12 data (figure 2).

Figure 2: Mothers smoking at time of delivery in Hampshire, 2011/12

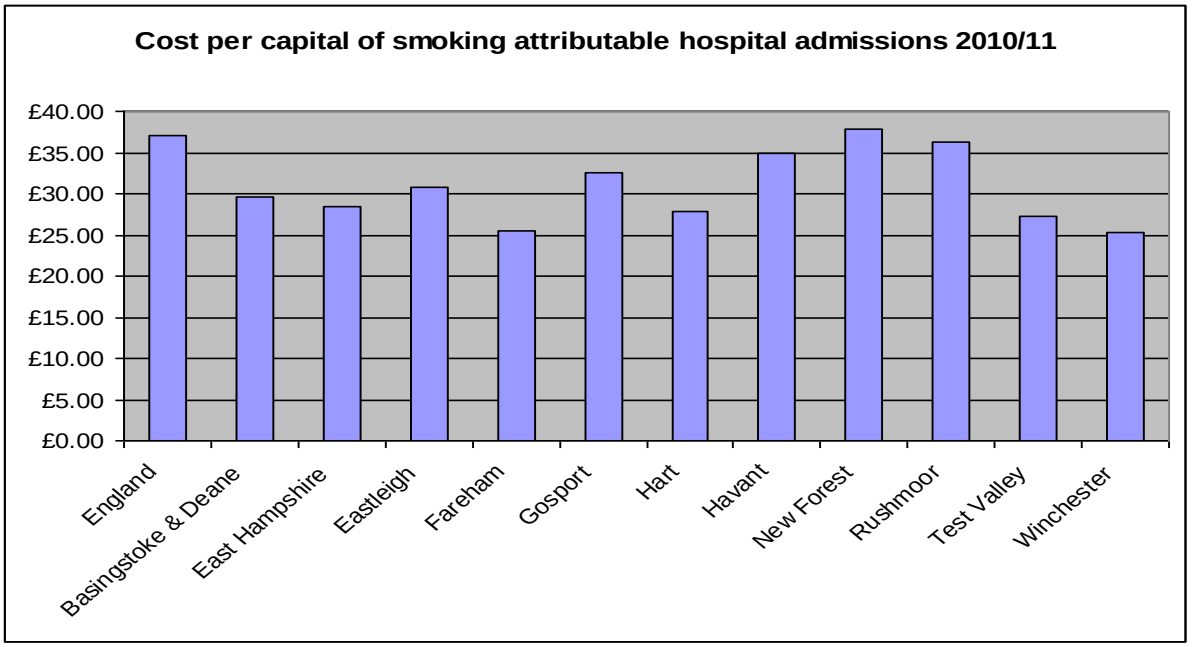


The provision of effective comprehensive NHS stop smoking services have been shown by health care and economic models to deliver vital cost effective interventions and savings in terms of the NICE QALYS[9] measures; which attaches a

[8] LHO, Tobacco Profiles, 2013, www.tobaccoprofiles.info
[9] http://www.nice.org.uk/website/glossary/glossary.jsp?alpha=Q

value of £20,000 per life year saved. Figure 3 shows the cost per capita of smoking-attributable hospital admissions in Hampshire during 2010/11.

Figure 3: Cost per capita of smoking attributable hospital admissions in Hampshire, 2010/11



Local acute hospital costs associated with smoking are mostly lower than the England average, and the higher rates seen in the New Forest will be a factor of a larger older aged population and increased use of acute care.

In 2012 a Hampshire-wide health impact assessment[10] (HIA) of NHS stop smoking services identified that 'life events', pregnancy, a health check, a disease or other diagnosis and referral to secondary care can have a positive impact on the potential for someone to change their health behaviours and lifestyle choices. The HIA report recommended that smoking cessation support is prioritised for people with greatest health need and those that can benefit most from stopping smoking. The commissioning of services going forward needs to reflect these recommendations.

An audit of Quit4life resources and expenditure conducted in 2011/12 confirmed that in the Hampshire areas of highest smoking prevalence i.e. Rushmoor, Havant and Gosport the service is deploying the greatest volume of resources and moreover these resources are working efficiently and effectively in terms of numbers engaged and overall quit success rates achieved. From this analysis we can see that where populations and individuals are highly addicted to tobacco; many will relapse during and following their quit attempt and for some to be successful they will use services several times, sometimes within a single year. This evidence demonstrates that there needs to be a continued drive to reduce smoking prevalence and improve quit rates in these localities. This needs to be combined with wider approaches to enable better lifestyle choices and levels of health literacy and prevention.

[10] Health Impact Assessment. Hampshire's Smoking Cessation Services. NHS Hampshire, 2012

3. Projected service use and outcomes 3-5 years

Comprehensive tobacco control measures are complex and require a multifaceted and multi-agency approach both nationally and locally. Government has made significant changes to tobacco use through policy and legislative changes. These have had deep, wide ranging and positive impact in terms of reshaping the cultural and environmental norms around smoking and deterring people from starting smoking. Alongside this are a range of actions to be explored and delivered locally in partnership with trading standards, the police and community safety teams, environmental health, children's and education services and the voluntary and private sectors. A proposal for the development of a new tobacco control strategy 2013-2015 will take this work forward.

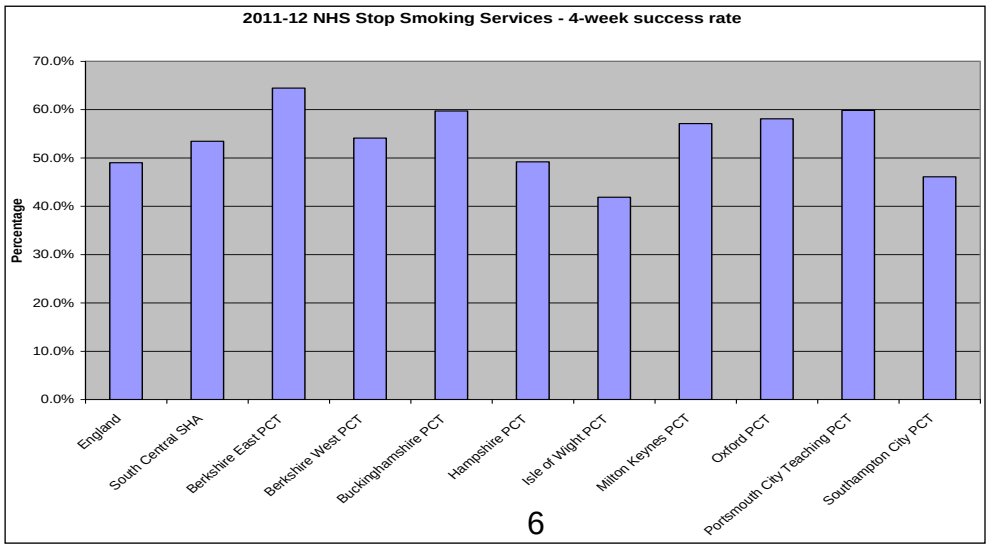
Hampshire aims to change outcomes to:

- Reduce smoking to 18.5% in those districts where it is currently higher than the county average (Rushmoor, Havant, Gosport and Basingstoke), and through universal action reduce rates further in other parts of Hampshire.
- Reduce the rate of smoking amongst 15 year olds in Hampshire to 12% or less in line with the national ambition.
- Reduce the rate of mothers smoking at delivery to 11% or below in partnership with the main provider trusts in Southampton, Portsmouth, Frimley, Winchester and Basingstoke who receive Hampshire mothers.

4. Current services in relation to need

NHS stop smoking services in Hampshire have established a strong brand identity under the Quit4life service since their inception in 2006-07. Patterns of use of NHS commissioned services by Hampshire people trying to quit have been around 16,500 per year over the last 4 years. Of these Hampshire has a success rate of 50%; that is half of all service users are recorded as having maintained abstinence from smoking for at least 4-weeks. This is the evidence-based 'marker indicator' reported to the Department of Health. Research evidence shows that from this cohort there will be a proportion who never smoke again and at 12 months this has been shown to be between about 8-10% of those who quit at 4-weeks (figure 4).

Figure 4: 4 week quit success rate in Hampshire, 2011/12



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As shown previously, in Hampshire 17.2% of the 16+ population smoke. From this estimate it is important to appreciate where smokers reside locally and most importantly how effective commissioned services are at reaching and engaging these people in stop smoking services. The data in Figure 5 and Table 2 demonstrate how local need is being met appropriately and proportionally by the commissioned service.

Figure 5: % smokers engaged in stop smoking services in Hampshire, 2011/12

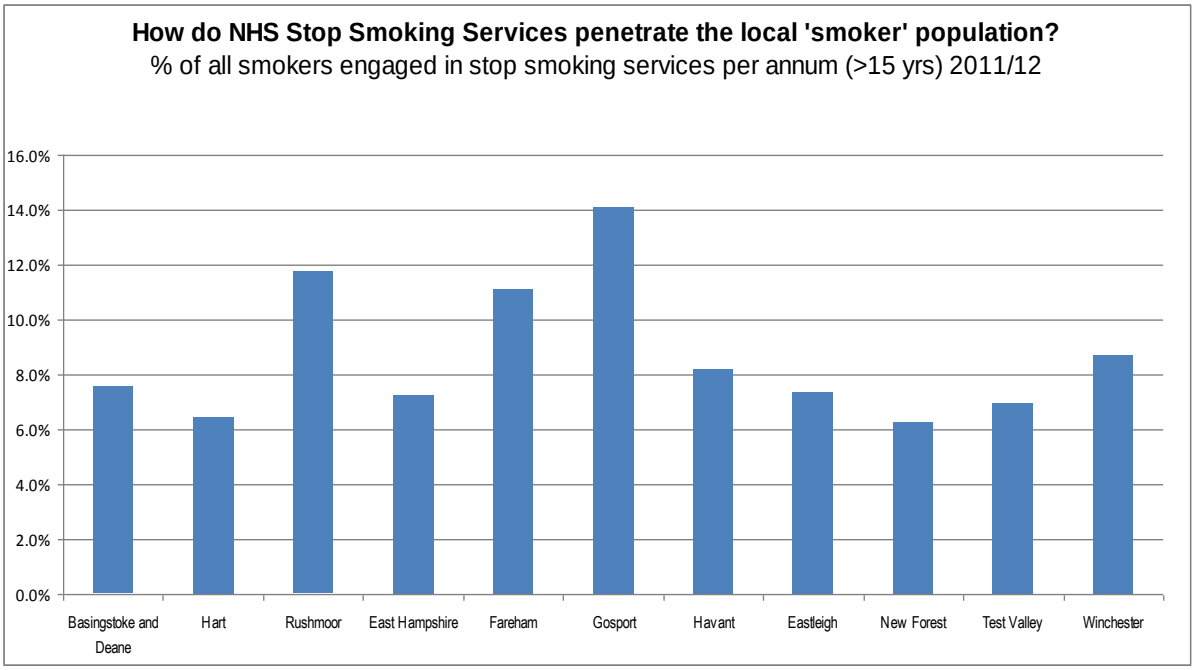


Table 2: Penetration of the Hampshire smoker (service user) market by Hampshire NHS stop smoking service

	2011/12							
Hampshire	**2011 Local Pop. (>15 years)**	**NHS Stop Smoking Service users**	**NHS Service users per 100,000 pop. (>15 years)**	**Successful 4-week quitters per 100,000 pop. (>15 years)**	**% Success Rate**	**% Estimated Adult Smoking Prevalence**	**Estimated Number of Smokers**	**% of all smokers engaged in NHS stop smoking services per annum (>15 years)**
Basingstoke and Deane	135,945	2,040	1,501	829	**55%**	20.2	27,053	**7.5%**
Hart	73,954	825	1,116	608	**55%**	14.5	12,794	**6.4%**
Rushmoor	72,758	1,721	2,365	1177	**50%**	24.3	14,624	**11.8%**
East Hampshire	92,959	1,071	1,152	557	**48%**	15.3	14,780	**7.2%**
Fareham	94,946	1,425	1,501	662	**44%**	17.8	12,818	**11.1%**
Gosport	65,668	1,771	2,697	1243	**46%**	20.4	12,543	**14.1%**
Havant	97,695	1,765	1,807	832	**46%**	21.7	21,493	**8.2%**
Eastleigh	101,633	1,310	1,289	614	**48%**	14.6	17,786	**7.4%**

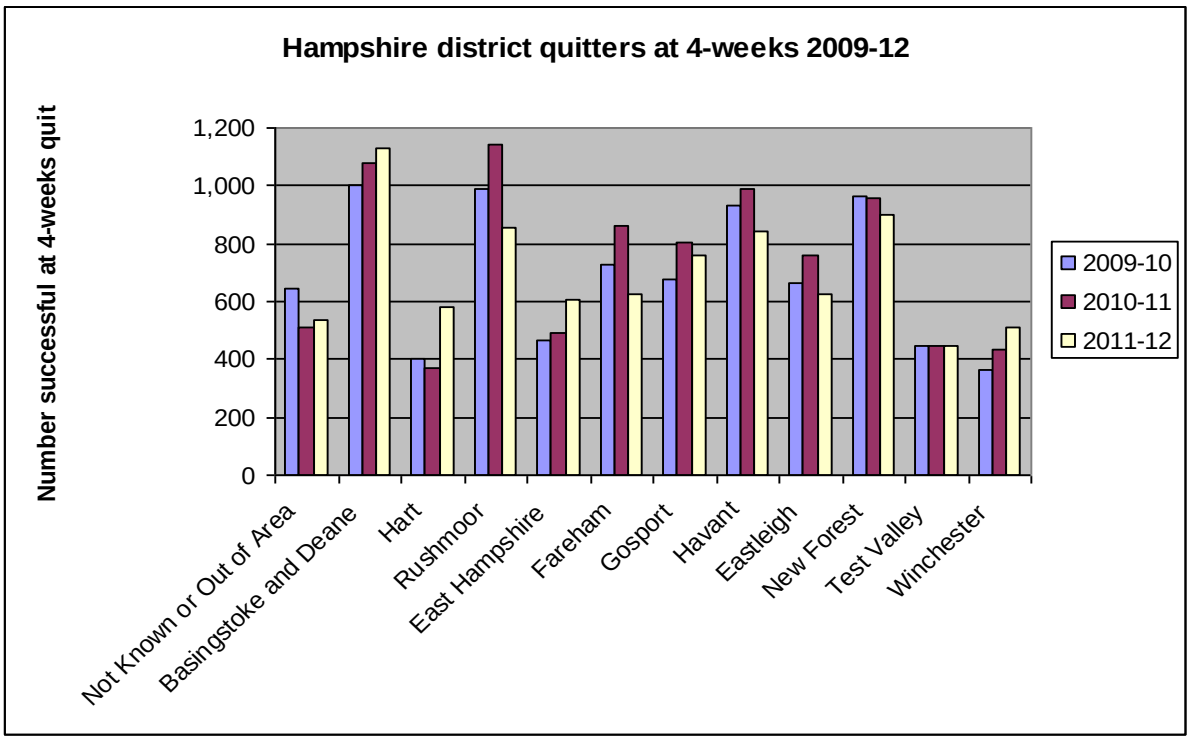
New Forest	150,951	1,645	1,090	596	**55%**	16.8	26,266	**6.3%**
Test Valley	94,171	852	905	477	**53%**	13.6	12,242	**7.0%**
Winchester	94,116	1,088	1,156	545	**47%**	14.0	12,517	**8.7%**

Source: Integrated Household Survey 2011/12

Stop smoking services in Hampshire are mostly delivered in four key client-centred settings under the Quit4life[11] branding. These are in GP surgeries, community pharmacies, community sessions run by specialist advisors and a remote access telephone support service. These servicers are designed to meet the work and home lifestyles of Hampshire residents and enable clients to find the right service that suits them and their lives. The four delivery services are harmonised and clients can move between services as they choose. The services are all supported via a central hub in Aldershot. The overall service has an average success rate of 50% of service users achieving 4-weeks of abstinence following their selected "quit date".

The resources of the complete Hampshire Quit4life service have been developed since 2007 and are generally distributed across the county in relation to the smoking prevalence rates at a ward level in districts and boroughs i.e. areas with a higher prevalence of smokers have proportionately more services. In 2012-13 stop smoking services were being provided under Local Enhanced Service (LES) agreements in 89 GP practice surgeries (including some branch surgeries) and in 56 community pharmacies. Quit4life specialist smoking advisors operate in a variety of community-based venues and some advisors are also embedded within GP practices, where that is the locally preferred option. The telephone and text support service is a growing area of service delivery and currently supports about 200 patients per year.

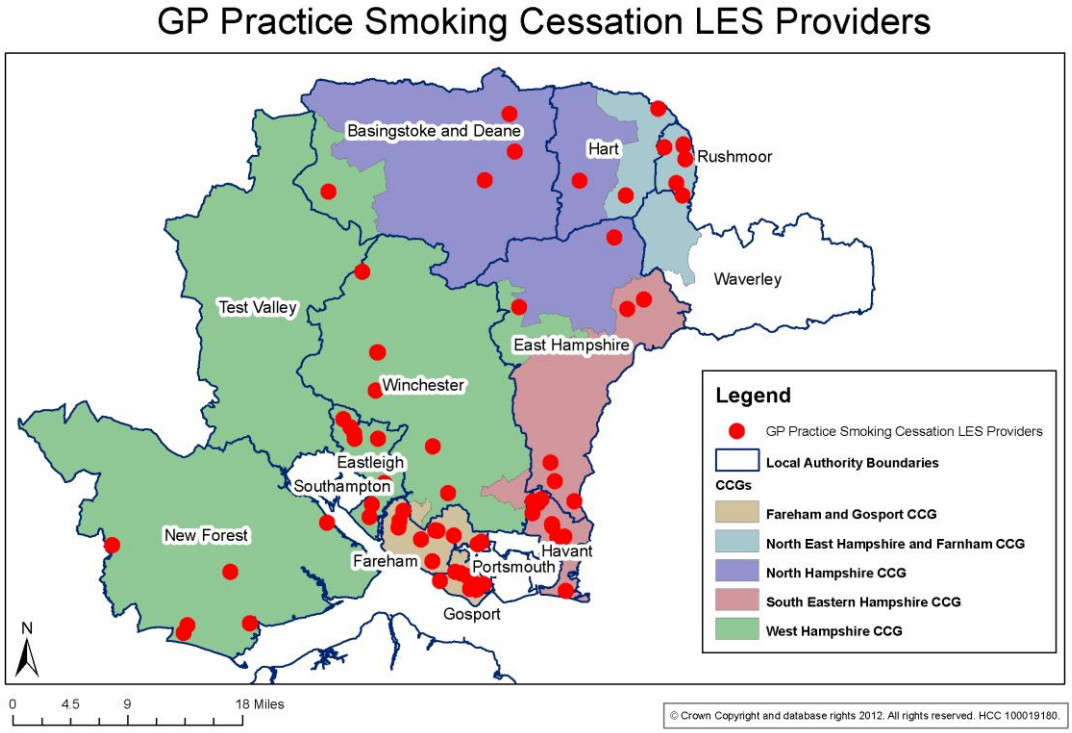
Figure 6: Trend in Hampshire district quitters at 4 weeks, 2009/10 to 2011/12



[11] www.quit4life.nhs.uk

Seventy three GP practices operate in-house smoking cessation services under local agreements between the contracted provider (Quit4life, Southern Health NHS Foundation Trust) (figure 7).

Figure 7: Location of GP smoking cessation providers



Forty five community pharmacies also have similar agreements with Quit4life to provide smoking cessation services.

5. User and provider views

Service user perspectives have been used to significant effect to improve the design of existing NHS stop smoking services and marketing of the Quit4life service to social aims locally. The customer-focussed Quit4life brand reflects service users' views and suggestions. Peer support and mentoring is a significant aspect of the therapeutic model surrounding NHS stop smoking services. The evidence regarding the effectiveness of peer support is well established and clearly demonstrates the heightened success rates of smoking cessation group sessions over one to one supported outcomes. In cases where patients are highly addicted to tobacco, these patients are most likely to be successful in group sessions over most one to one counselling experiences.

The views of service providers have also been captured by the health impact assessment conducted in 2012. This included surveys and qualitative interviews with a range of Hampshire provider staff and stakeholder professionals. The assessment also sought views from outside the county to provide a broader perspective around the merits and reflection of the Hampshire model and service. The health impact assessment has helped shape the proposed service model for 2013-14 and will also

influence the development of a new tobacco control strategy for Hampshire during 2013-14.

6. Evidence of what works

There is a growing body of evidence[12] that supports the adoption of multi-component approaches to tobacco control, comprising education & awareness, regulation, social marketing and support to help smokers quit. Comprehensive tobacco control programmes coordinated over a significant sub-national geographic footprint can have a meaningful impact on attitudes towards tobacco, leading to increased rates of quitting and reduce rates of uptake.

The "English model of NHS stop Smoking Services"[13] remains the Government's health improvement policy in terms of helping smokers to stop. This model has been evaluated and tested by NICE and York University research to be the most cost effective health intervention available for reducing England's overall smoking-related cardiovascular disease and mortality level.

NICE Guidance PH23[14] provides recommendations in relation to young people and children at school or colleges including 'extended schools' (where childcare or informal education is provided outside school hours), pupil referral units, secure training and local authority secure units, plus further education colleges. It provides five key recommendations which relate to organisation-wide or whole school approaches, adult-led interventions, peer-led interventions, training and development and adopting a co-ordinated approach, which could be useful in reducing or delaying the onset of smoking with this group. The guidance provides the following advice for schools:

- Schools smoking policies should support both prevention and stop smoking activities and should apply to everyone using the premises (including the grounds).
- Information on smoking should be integrated into the curriculum. For example, classroom discussions could be relevant when teaching biology, chemistry, citizenship and maths.
- Anti-smoking activities should be delivered as part of personal, social, health and economic (PHSE) and other activities related to Healthy Schools or Healthy Further Education status
- Anti-smoking activities should aim to develop decision-making skills and include strategies for enhancing self-esteem. Parents and carers should be encouraged to get involved and students could be trained to lead some of these programmes. All staff involved in smoking prevention should be trained to do so.
- Educational establishments should work in partnership with outside agencies to design, deliver, monitor and evaluate smoking prevention activities.

[12] http://www.brunel.ac.uk/__data/assets/file/0004/144706/Background-and-rationale-report-16-Dec-2011.pdf
[13] http://www.ncbi.nlm.nih.gov/pubmed/15755263
[14] http://www.nice.org.uk/PH23

The evidence regarding smoking during pregnancy and following childbirth is established in NICE Guidance PH26[15]. NICE says, all pregnant women who smoke – and all those who are planning a pregnancy or who have an infant aged under 12 months should be referred for help to quit smoking. The guidance recognises that helping pregnant women who smoke to quit involves communicating in a sensitive, client-centred manner, particularly as some pregnant women find it difficult to say that they smoke. Such an approach is important to reduce the likelihood that some of them may miss out on the opportunity to get help.

The recommendations mainly cover interventions to help pregnant women who smoke to quit and these are consistent with those effective with the general population in terms of brief advice and brief interventions and referral to smoking cessation services. No specific recommendations have been made for those planning a pregnancy or who have recently given birth. This is due to the lack of evidence available on stop-smoking interventions for these groups.

The underlying behavioural and therapeutic skills owned by current smoking cessation specialists and professionals should not be overlooked as health improvement programmes look more closely at how best to address obesity and alcohol issues in the wider population i.e. those people who are at risk currently but could significantly benefit from early identification and intervention. This type of approach is signalled in the Wanless Report[16] 2004 in terms of the 'fully engaged' scenario as the best option for delivering behaviour change. Currently in Hampshire we are commissioning smoking cessation specialists to screen and advise on alcohol consumption. This enhanced model is a step towards a more holistic "lifestyle intervention" approach and provides the added benefit of supporting improved outcomes from smoking cessation, where we know that alcohol can be a causal factor and interrupter in failing to quit.

The National Social Marketing Centre (NSMC) has a role in demonstrating, evidencing and capacity building social marking with the aim of 'changing behaviours and improving lives'. They have an interest in determining the best mix of tools needed to support smokers to make successful quit attempts and change the social norms that continue to make smoking normal for significant segments of our population. The advocate that a social marketing approach can help to design an integrated approach that can directly respond to the unique needs of different audience segments such as 'hard to reach smokers'. Case studies demonstrate the need to empower people with the confidence and tools to break down their behavioural challenge into manageable steps and then tailor support services to ensure they are made more attractive to their target audiences.

7. Recommendations

Whilst Hampshire has seen an overall steady reduction in smoking prevalence, the impact of smoking and related ill health on the population requires a continued drive

[15] http://www.nice.org.uk/guidance/PH26

[16] http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4076134.pdf

to reduce this further and particularly in the areas where rates are persistently higher than the county as a whole.

The national NHS and public health outcomes frameworks and indicators provide a framework for local plans across the three key ambitions to reduce smoking in pregnancy, young people and adults.

The Hampshire Smoking Cessation Health Impact Assessment (HIA) undertaken in 2012 has provided evidence that supports the case to focus on those people with the greatest health need and those that can benefit most from stopping smoking; and that this should be built into the future planning and commissioning of services and wider tobacco control.

The following recommendations are made:

- Develop a comprehensive tobacco control strategy for Hampshire with support from all key stakeholders.
- Deliver the annual 4-week quitter target and within this maintain performance improvement in the high smoking prevalence districts and improve quit rates.
- Work collaboratively with GPs and community pharmacies to address the needs of the “key patient groups” i.e. pregnant mothers, patients on chronic disease register, patients entering or discharging from secondary care and mental health service users.
- Continue to support young people’s smoking education and prevention programmes and research areas which support greater understanding and knowledge regarding the uptake of smoking by young people.

Commission publicity and social marketing activity and campaigning on tobacco control elements to support a reduction in tobacco usage and increase referral rates of hard to reach groups to Hampshire stop smoking services.