ASH response to: House of Lords Select Committee on the Long-Term Sustainability of the NHS
September 2016

About ASH

1. ASH is a health charity working towards the elimination of harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK. It has also received project funding from the Department of Health to support tobacco control. ASH does not have any direct or indirect links to, or receive funding from, the tobacco industry. ASH provides the secretariat for the APPG on Smoking and Health.

2. ASH welcomes the opportunity to provide evidence to the Select Committee, and would be pleased to provide further written information or give oral evidence if asked.

Answers to Consultation Questions (those relevant to ASH)

Question 1. Taking into account medical innovation, demographic changes, and changes in the frequency of long-term conditions, how must the health and care systems change to cope by 2030?

3. The NHS England Five Year Forward (FYFV) view forecast a £30 billion shortfall in funding for the NHS by 2020. [1] Even after the £8 billion in additional funding committed by the Government, there remains a predicted shortfall of £22 billion.[2] This funding gap is highly unlikely to be closed through increased efficiency alone, since this would require efficiency savings of about 3% per year, a higher level of efficiency saving annually than the NHS has achieved since its foundation.

4. Therefore, some of the funding gap will have to be met through cuts in NHS services, longer waits for treatment, or through reductions in demand for NHS services, which is obviously the best option of the three. To reduce demand requires a sustained effort to improve public health, and to tackle the major causes of illness, in particular smoking.

5. This is why the FYFV stated that: "*The future health of millions of children, the sustainability of the NHS, and the economic prosperity of Britain all now depend on a radical upgrade in prevention and public health."* The report notes that this has been long called for: *"Twelve years ago, Derek Wanless' health review warned that unless the country took prevention seriously we would be faced with a sharply rising burden of avoidable illness. That warning has not been heeded - and the NHS is on the hook for the consequences.*" [3]

6. Smoking remains the major cause of preventable premature death in England, causing about 80,000 premature deaths every year. This is more than the next five causes put together, including obesity, alcohol and illegal drugs.[4]

7. The Rt Hon Theresa May, in her first statement as Prime Minister on 13th July 2016, said that: *"if you're born poor, you will die on average 9 years earlier than others"*. [5] In November 2008, Professor Sir Michael Marmot was asked by the then Secretary of State for Health to chair an independent review on reducing health inequalities in England. His report stated that: *"Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups"*. [6] The highest smoking prevalence rates are found in the poorest communities, and these communities need to be made a principal focus of tobacco control activity. Smoking has a major impact on the household incomes of poorer families. If the poorest smokers were to quit, over half a million households would be lifted out of poverty.[7]

8. The majority of smokers take up smoking when they are still children, and over 80% do so before the age of 20.[8] Children who grow up in households where people smoke are much more likely to become smokers themselves, so there is an inter-generational impact of smoking. Uptake of smoking appears to be falling progressively while quit rates appear to be remaining relatively constant across successive cohorts.[9] So while preventative action to stop people taking up smoking is important, it is essential that more is done to help addicted smokers quit.

9. Mental health conditions affect almost a quarter of the adult population, who die on average 10-20 years earlier than the general population.[10] Smoking is the single largest cause of this health inequality. Adults with mental health conditions are more heavily addicted to smoking and around one third of adult tobacco consumption is by people with a mental health condition. As such they experience much greater smoking related harm.[11]

10. The UK is rightly regarded as a global leader in tobacco control, and there has been a steady fall in smoking rates over several decades. However, international evidence shows that where tobacco control work is not properly funded, the rate of decline slows, or even goes into reverse. In New York, for example, sustained investment in tobacco control led to a sharp fall in prevalence between 2002 and 2010. But when funding was cut in 2010 this decline ceased. Following new investment from 2014, smoking rates began to decline again. [12] To be effective, tobacco control policy and activity has to be both sustained and progressive, one reason being that people who continue to smoke when a particular policy or control action is introduced can be said to have "discounted" it and therefore will require new incentives to quit. To plan sustained and progressive action of this kind requires a considerable degree of certainty about future funding.

11. ASH believes that changes are needed to ensure the sustainability of the health and care systems, and ensure an integrated tobacco control (and wider public health) strategy at local, regional and national level. These changes include:

    - Long-term secure (and probably ring-fenced) budgets for the public health function in local government
    - A stronger requirement on NHS bodies and local authorities to co-operate in improving public health and reducing long-term demands on the health and social care system
    - Consideration of how financial incentives can be aligned so that those organisations delivering services that reduce demand on the health and social care system are adequately rewarded.

Question 2. To what extent is the current funding envelope for the NHS realistic?

a. **Does the wider societal value of the healthcare system exceed its monetary cost?**
b. **What funding model(s) would best ensure financial stability and sustainability without compromising the quality of care? What financial system would help determine where money might be best spent?**
c. **What is the scope for changes to current funding streams such as a hypothecated health tax, sin taxes, inheritance and property taxes, new voluntary local taxes, and expansion on co-payments (with agreed exceptions)?**
d. **Should the scope of what is free at the point of use be more tightly drawn? For instance, could certain procedures be removed from the NHS or made available on a means-tested basis, or could continuing care be made means-tested with a Dilnot-style cap?**

12. As well as the considerable human cost, smoking also places an enormous financial burden on society. The costs of this were estimated at £12.9 billion in HM Treasury's consultation document on a possible Tobacco Levy.[13] This figure was made up of:
    - £2 billion cost to the NHS of treating diseases caused by smoking
    - £3 billion loss in productivity due to premature death
    - £5 billion cost to businesses of smoking breaks
    - £1 billion cost of smoking-related sick days
    - £1.1 billion of social care costs of older smokers
    - £391 million cost of fires caused by smokers' materials

    These figures have been updated by ASH and now total an estimated £13.9 billion [14]

13. Tobacco control, encouraging smokers to quit and dissuading others from taking up smoking, is extremely cost-effective. An inquiry by the APPG on Smoking and Health concluded that: '*Government expenditure on tobacco control is excellent value for money and provides a net annual revenue benefit of £1.7 billion'*.[15]

14. Further investment in tobacco control could bring greater financial rewards. The APPG on Smoking and Health's Representation to the 2015 Spending Review, argued for the Government to invest a further £100 million a year in tobacco control. This additional funding could bring a return on investment of £11 for every £1 invested over five years and increase the rate of decline in smoking prevalence by an additional 0.57 percentage points each year.[16]

15. The greatest return on investment in tobacco control comes when there is a comprehensive approach, which must include appropriately funded action at a national, regional and local level.[17] However, as shown in the answers below, spending on tobacco control is falling, not rising. This will simply increase costs to the NHS in future years, and threatens the long-term sustainability of both the health and social care system.

16. ASH therefore strongly supports the introduction of a levy on the major tobacco companies, to raise additional funds for tobacco control work. This is justified on the "polluter pays" principle: the tobacco industry is the only legal commercial activity in the world based on the sale of a product that first addicts consumers and then kills half of all lifetime users. The principle is the same as that behind the Soft Drinks Industry Levy, known colloquially as the "sugar tax", which the Government has committed to implement.[18]

17. We suggest that the levy should be calculated and allocated nationally, regionally and locally to support tobacco control measures. At local level it should be allocated to local authorities, the NHS and other public and voluntary organisations providing relevant services, on the basis of local sales data, or (our less favoured option) local smoking prevalence rates.

18. In the 2015 Autumn Statement,[19] the then Chancellor proposed that a future funding solution for public health could come through returning more of business rates to local authorities. ASH is concerned that far from addressing variation in funding between local authorities, a solution based on local business rates could entrench inequalities even further. Councils' income from business rates vary widely, with richer areas raising more income than poorer ones, and since richer local authority areas generally have lower smoking rates than poorer ones, this form of funding would be unlikely to be allocated to areas with the highest need.

Question 3: What are the requirements of the future workforce going to be, and how can the supply of key groups of healthcare workers such as doctors, nurses, and other healthcare professionals and staff, be optimised for the long term needs of the NHS?

a. **What are the options for increasing supply, for instance through changing entry systems, overseas recruitment, internal development and progression?**
b. **What effect will the UK leaving the European Union have on the continued supply of healthcare workers from overseas?**
c. **What are the retention issues for key groups of healthcare workers and how should these be addressed?**

19. Stop smoking specialists, who provide highly skilled specialist support to tobacco dependant people across the health and social care system, are highly cost effective. Stop smoking services are estimated to quadruple the success rate of quit attempts, but cost under £1,000 for each additional Quality Adjusted Life Year ("QALY"). [20] This compares with, for example, up to £57,000 per QALY for statins to prevent coronary heart disease, [21] up to £130,000 per QALY for treatments for COPD, and as much as £100,000 for a course of treatment of the lung cancer treatment opdivo. [22]

20. However, research by ASH (unpublished at time of writing) carried out in Summer 2016, shows that for the 2016-17 financial year, 59% of local authorities have reported a cut in their smoking cessation budget (including almost half who reported a cut of more than 5%) and 45% reported a cut in their wider tobacco control budget.[23] The NHS has not replaced the decommissioned stop smoking specialists to treat smokers accessing health care. Between April 2015 and March 2016, 68,082 fewer smokers set a quit date with the Stop Smoking Services in England, compared with the previous year. This is the 4th consecutive year to show a fall in the number of people using the services.[24]

21. This small segment of the NHS workforce requires significant, sustained and closely monitored expansion to deliver the comprehensive treatment of tobacco related health and social care burden, paid for by the proposed tobacco levy and in partnership between the NHS and Public health budgets.

Question 4. How can the UK ensure its health and social care workforce is sufficiently and appropriately trained?

a. **What changes, such as the use of new technologies, can be made to increase the agility of the health and social care workforce?**

b. **What are the cost implications of moving towards a workforce that is equipped with a more adaptable skill mix being deployed in the right place at the right time to better meet the needs of patients?**
c. **What investment model would most speedily enhance and stabilise the workforce?**

22. Currently there is no requirement that health and social care workers are trained to treat or to refer people who are tobacco dependant, despite tobacco being the largest preventable cause of morbidity and mortality in the UK.

23. Training in treating tobacco dependency is low cost and could easily be integrated into the curriculum of all health and social care workers at both undergraduate and postgraduate levels. Mandatory training in treating tobacco dependence should be introduced for all health and social care professionals as part of continuous professional development. The National Centre for Smoking Cessation Training (NCSCT) provides high quality free online distance learning that should be adopted across the health and social care professions. [25]

24. Workforce regulatory authorities such as the GMC and NMC can introduce and monitor clear standards of training for health care professionals in tobacco control.

Question 5. What are the practical changes required to provide the population with an integrated National Health and Care Service?

a. **How could truly integrated budgets for the NHS and social care work and what changes would be required at national and local levels to make this work smoothly?**
b. **How can local organisations be incentivised to work together?**
c. **How can the balance between (a) hospital and community services and (b) mental and physical health and care services be improved?**

25. The structure of the current health and social care system can militate against investment in tobacco control.

26. Reductions in smoking prevalence, and other changes in smoking behaviour, are known to lead to clear and measurable benefits to the NHS. Reductions in smoking can have an in-year benefit to NHS outcomes for example through reducing incidence of CVD, poor birth outcomes, surgical complications and complications from asthma and diabetes. Specific tobacco control policies can also have a measurable benefits, for example the latest Cochrane review on the impact of smokefree legislation confirmed that there is *"robust support for the previous conclusions that the introduction of a legislative smoking ban does lead to improved health outcomes through reduction in SHS for countries and their populations. The clearest evidence is observed in reduced admissions for acute coronary syndrome"*. [26]

27. Local authorities also recoup medium and long-term benefits from investing in reductions in smoking, through a reduced burden on social care services and improved productivity in the local economy. Other local authority activities, such as trading standards officers' enforcement action against the illicit tobacco trade, protect state revenues and improve public health, but the immediate financial benefits accrue to central government rather than to the local authority concerned.

28. However, ASH is not aware of any systematic effort to measure the aggregate financial benefits of integrated tobacco control policies: the best estimates probably remain those commissioned by ASH and by the All Party Parliamentary Group on Smoking and

Health. At local and sub-national levels NICE has produced a return on investment tool to help decision making in tobacco control in local authorities and the NHS. The tool evaluates a portfolio of tobacco control interventions and models the economic returns that can be expected in different payback timescales. Disappointingly, despite the positive returns from tobacco control shown by the tool, this does not seem to be preventing disinvestment by local authorities from tobacco control (see point 29).

29. As suggested above, a funding structure for tobacco control which included an industry levy, using local sales data, with the proceeds allocated both nationally and at regional and local level to local authorities, NHS bodies and other service providers (e.g. in the voluntary sector) could help address this problem of maladjusted incentives.

30. ASH understands that although CCGs have been provided with guidance on their responsibilities in relation to health inequalities,[27] at present NHS Trusts do not have a direct responsibility to reduce health inequalities. Data analysed by researchers at the University of York for NHS England also shows that the performance of individual CCGs in tackling the social divide in preventable hospital admissions is not always linked to how rich or poor the CCG's patient population is. [28]

31. Inadequate statutory duties and a poorly allocated set of incentives to reduce health inequalities result in obvious failures in public health provision. For example, it appears that many NHS Trusts have no means of getting real time information on the number of smokers in their care, nor measuring and assessing any interventions designed to promote quitting, nor measuring the proportion of previous smokers who quit while they are being treated. NHS England advocates the principle of *'Making Every Contact Count'*, stating that ***"****Opportunities exist to promote the benefits of healthy lifestyles through routine contacts that people have with health services, by engaging individuals in conversations which support them in the steps they wish to take towards a healthier lifestyle. This includes provision of information, signposting or referral for individual support, and encouragement for behaviour change".* However, this principle is not systematically applied and there appears to be no reliable means of aggregating information on the actual practice of NHS organisations.

32. A minimum standard of public health protection should require that smokers are given appropriate advice on the risks of their behaviour, including information about available support for quitting, at all points of contact with the NHS and social care system. ASH would also like to see this extended to all relevant public services. All public bodies should ensure that their grounds as well as their buildings are smokefree, and should provide readily accessible information about stop smoking services. Occupational health services in NHS trusts and other relevant public bodies should ensure that they make regular contact with employees who smoke to advise them of the availability of support for quitting.

33. NHS planning guidance, which sets out the operating framework that will support the delivery of the 44 place-based sustainability and transformation plans (STPs) was published on 22nd September provides some opportunities. We have not had the opportunity for a detailed analysis but we did note a shift to upscaling prevention through commitment to the national prevention transformation programme and two-year prevention-focused Commissioning for Quality and Innovation (CQUIN) schemes, including brief advice for tobacco and alcohol use. In order to be able to measure the impact of CQUIN schemes NHS Trusts should be required to measure smoking behaviour among patients, stop smoking interventions provided, and outcomes.

Question 6. What are the practical changes required to enable the NHS to shift to a more preventative rather than acute treatment service?

a. **What are the key elements of a public health policy that would enhance a population's health and wellbeing and increase years of good health?**
b. **What should be the role of the State, the individual and local and regional bodies in an enhanced prevention and public health strategy; and what are the key changes required to the present arrangements to support this?**
c. **Is there a mismatch between the funding and delivery of public health and prevention, compared with the amount of money spent on treatment? How can public health funding be brought more in line with the anticipated need, for instance a period of protection or ring-fencing?**
d. **Should the UK Government legislate for greater industry responsibility to safeguard national health, for example the sugar tax? If so how?**
e. **By what means can providers be incentivised to keep people healthier for longer therefore requiring a lower level of overall care?**
f. **What are the barriers to taking on received knowledge about healthy places to live and work?**
g. **How could technology play a greater role in enhancing prevention and public health?**
h. **What are the best ways to engage the public in talking about what they want from a health service?**

34. In 2013/14, local authorities received £2.7 billion as a ring-fenced grant for public health services, in 2014/15 the grant was £2.79 billion, and the original grant for 2015/16 was also £2.79 billion (a reduction of 2% in real terms) [29] [30] However, in his 2015 Budget statement, then Chancellor George Osborne announced a further in year reduction in the 2015/16 grant of £200 million. In the 2015 Autumn Statement further progressive reductions in real terms of 3.9% annually over the next five years.[31] This translates into a further cash reduction of 9.6%. From the baseline of £3,461m (after the £200 million grant reduction), the additional reductions savings will be phased in at 2.2% in 2016/17, 2.5% in 2017/18, 2.6% in each of the two following years, and flat cash in 2020/21.

35. The Kings Fund has described the cuts to the public health budget as the 'falsest of false economies' [32] a criticism also made by local authorities [33] and those working in the NHS. [34]. The King's Fund has also pointed out that: *"The most significant local authority-funded public health services - including sexual health, substance misuse, smoking cessation - and "NHS" health checks services are either intimately entwined with NHS pathways or are directly commissioned from the NHS."* [35]

36. There are already wide variations in local spending on reducing smoking. Using local authority revenue expenditure and financing for 2016 to 2017, ASH has calculated the intended spend per smoker by each local authority for this financial year. [36] The average intended spend is £14.99 per smoker and the range is from £3.52 per smoker to £29.48 per smoker. There is a correlation between smoking prevalence and spending: areas with higher prevalence spend more per head of population (but not more per smoker) than areas with lower smoking prevalence.

37. England currently has two regional offices of tobacco control operating at a subnational level, funded by local authorities in the northeast and northwest. These have been shown to be highly effective and cost-effective in increasing the rate of decline in smoking prevalence above the national average, and they are included in the NICE return on investment tool for tobacco control as a good return on investment. The work they do is highly innovative, for example they have run successful paid for mass media campaigns backed up by intensive media advocacy, and campaigns to reduce the supply of, and demand for, illicit tobacco. Until this year there was also a regional office

in the southwest but it had its funding terminated in January with six months' notice. Funding for the offices in the northeast and northwest, both areas of deprivation with high smoking rates, is also under threat.

38. Research has shown that mass media campaigns are highly effective and cost-effective in motivating quit attempts and discouraging uptake of smoking.[37] However, the UK is currently falling far below best practice spending on mass media campaigns. In 2009 funding for anti-smoking mass media campaigns in England was just under £25 million: by 2015 this figure had been cut to only £5.3 million, with further cuts expected this year. If England were to fund mass media campaigns at levels recommended by the US Centers for Disease Control and Prevention, it should be spending around £60 million; more than ten times the amount spent in 2015.[38]

39. Studies carried out in England in the past few years have found that mass media campaigns have been effective in triggering quit attempts and have been responsible for a significant proportion of the reduction in smoking prevalence,[39] and that the freeze on mass media campaigns at the time of the 2010 election was associated with a reduction in quitting activity.[40] A systematic review of economic evaluations of mass media campaigns noted that all of these found mass media campaigns to be cost effective[41], but these campaigns need to have sufficient intensity and be sustained in order to have a meaningful effect.[42]

40. A 2016 regional mass media campaign conducted by Fresh North East and Smokefree Yorkshire and Humber illustrates the value of mass media in promoting quit attempts. The campaign which focused on 16 cancers caused by smoking, reached approximately 333,000 people via TV, radio, print and online. Of those who saw the campaign 16% (around 55,300 people) cut down on their smoking. A further 8.4% (around 28,000 people) made a quit attempt as a result of the campaign while 4% switched to electronic cigarettes. This shows the clear impact mass media campaigns have on triggering quit attempts and changes in behaviour.

41. This is why ASH, together with other organisations concerned with public health, has called for urgent Government action to establish **a sustainable funding model for tobacco control**.[43] As advocated in the answers to previous question, ASH believes that this funding should be secured through a levy on the tobacco manufacturers, allocated to local areas on the basis of local sales data, ring-fenced for tobacco control purposes and tied to specific performance targets based on measurable outcomes for the organisations and services it funds (including NHS organisations, local authorities, other public bodies contributing to tobacco control work and the voluntary sector).

Question 8. How can new technologies be used to ensure the sustainability of the NHS?

- **a. What is the role of technology such as telecare and telehealth, wearable technologies and genetic and genome medicine in reducing costs and managing demand?**
- **b. What is the role of 'Big Data' in reducing costs and managing demand?**
- **c. What are the barriers to industrial roll out of new technologies and the use of 'Big Data'?**
- **d. How can healthcare providers be incentivised to take up new technologies?**
- **e. Where is investment in technology and informatics most needed?**

42. Current NHS IT and data collection systems are often a mixture of electronic and paper records. Often, this means that a hospital trust may not be able to aggregate real-time

data on the number of smokers in its care at any particular time. [44] Even if there is a working and comprehensive Electronic Patient Record (EPR) system in operation, data on smoking may still not be collected and aggregated. A hospital is likely to know precisely how many patients it has with c-difficile at any particular time, but not how many patients are smokers. This in turn means that it cannot track their progress through the hospital and specifically cannot accurately assess the impact of the repeated interventions advocated above. This is despite the fact that international evidence shows that systematic hospital wide anti-smoking interventions work well. [45]

43. It should be a requirement of future procurements of EPR and related systems in the NHS that it include the capacity to record and aggregate information on patients' smoking behaviour, and to assess how this behaviour changes as patients move through the system. It should be a requirement for existing hospital patient information systems (whether fully digital, or a combination of digital and paper) that they are developed in order to provide this information.

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