ASH submission to Integrated Care Systems: autonomy and accountability – call for evidence

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Introduction to you or your organisation:

- Action on Smoking and Health (ASH) is a public health charity that works to eliminate the 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.

Your reason for submitting evidence:

- The NHS has a key role to play in achieving national targets to reduce smoking prevalence and tackle health inequalities. ICSs are central to these objectives, and it is vital that initiatives to tackle smoking and other preventable risk factors are prioritised and embedded in ICS strategies.

Key questions the submission addresses:

- What can be learned from examples of existing good practice in established ICSs?
- How can a focus on prevention within ICSs be ensured and maintained alongside wider pressures, such as workforce challenges and the electives backlog?

Recommendations are in **bold** followed by supporting information and evidence where relevant.

1. **The impact of preventable risk factors such as smoking on NHS services and budgets should be clearly communicated to ICBs and other internal stakeholders. ICS prevention plans should clearly set out the prevalence of preventable risk factors like smoking and explain how investment in prevention is cost effective will reduce pressure on NHS services.**
2. In England in 2019[1] 13.9% of the population smoked, equivalent to 5.7 million adults.[2] However, prevalence varies considerably across society, with smoking the leading modifiable risk factor responsible for health inequalities, accounting for half the difference in life expectancy between the richest and poorest.[3] In 2019 the bottom two deciles had smoking rates of 17% compared to top two deciles where smoking rates are 11%.
3. For those who smoke, smoking is the main modifiable risk to their health, reducing life expectancy and quality of life. 64,000 people die a year from smoking in England with an estimated thirty times as many suffering from serious smoking-related diseases.[4] [5]
4. This has a considerable impact on NHS services at a time when they are already under severe strain and will be for the foreseeable future. Smoking costs the NHS around £2.4bn every year through smoking related hospital admissions and the cost of treating smoking related illness via primary care services.[6]
5. Smoking among NHS staff also exacerbates workforce pressures and impacts service provision. Smokers are more likely than non-smokers to have to leave the workforce early due to illness or death while of working age. The NHS employs around 73,000 smokers, who cost the NHS approximately £206 million each year, comprising £101 million from sickness absence, up to £99 million from smoking breaks, £6 million in sickness treatment costs, or around £2,800 per

smoker per year.[7] Smokers are also much more likely to need social care than non-smokers, which puts further pressure on NHS services.[8]

6. **Prevention and addressing health inequalities should be at the core of any ICBs Strategy. ICBs need to invest in their capacity to deliver on prevention to ensure it can be maintained long term. This should be facilitated by partnership working and putting joint working arrangements in place to harness the collective resources & expertise within the system. This will allow ICSs to invest effectively in prevention, build upon current provision, avoid duplication, and increase value for money.**

7. **ICSs should appoint Programme leads and Clinical leads for each of the prevention workstreams to drive the agenda forwards, engage clinicians and ensure prevention retains a high profile within the system.**

8. In North East and North Cumbria (NENC) ICS, Clinical leads have been vital for gaining senior management buy-in and making the case for additional ICS funding to maximise the impact of the NHS Long Term Plan by implementing enhanced NHS tobacco dependency treatment services at scale across all Trusts at the same time. Gaining senior leadership buy-in for prevention is particularly important while ICBs are still in an 'establishing' phase and priorities/strategies are still being formed.

9. **ICSs should make signing the NHS Smokefree Pledge[9] and implementing the commitments a core part of prevention plans and should encourage all trusts to do the same. Local councils within the ICS should be encouraged to sign the Local Government Declaration on Tobacco Control[10].**

10. These are public commitments to tackling smoking by NHS and local government leaders on behalf of their organisations. The commitments are in line with national targets and NICE guidance on smoking. The Pledge has been endorsed nationally by the NHSE Chief Executive, ADPH, AoMRC, BMA, FPH and RCM. The Local Government Declaration has been endorsed nationally by the CMO, ADPH, CIEH, CTSI and the LGA.

11. By signing the Pledge, NHS organisations commit to reduce the harm caused by tobacco through implementing NICE guidance on smoking and NHS Long Term Plan tobacco dependence treatment services. Signing the Pledge is an opportunity to review local policies and practice and embed the Pledge's commitments into prevention activity.

12. NENC ICS was one of the first ICSs to sign the NHS Smokefree Pledge and has encouraged trusts within the ICS to do the same. NENC has used the Pledge to promote smokefree initiatives and ensure treating tobacco dependency is prioritised within the system. Specific activity within this has included updating smokefree policies, identification of operational leads and the establishment of Smokefree Steering Groups.

13. **ICSs should integrate the recommendations from the ASH briefing on the Impact of smoking on Core20PLUS5 into prevention plans. Implementing these recommendations will help to reduce smoking across the population and in turn reduce inequality and the burden of preventable mortality and morbidity on the whole system.**

14. As Core20PLUS5 sets out, smoking cessation positively impacts all 5 key clinical areas: maternity, severe mental illness, chronic respiratory disease, early cancer diagnosis, and hypertension case-finding.[11] The ASH briefing sets out recommendations to support delivery of the NHS Long Term

Plan commitments on tobacco dependency treatment, supplemented with recommendations to support building back better from the pandemic and achieving the Government's smokefree 2030 ambition. Supporting evidence and rationale for the recommendations is included in the briefing.

Key recommendations for ICS prevention plans to address Core20PLUS5 clinical areas:

- Prioritise implementation of the NHS LTP funded tobacco dependency treatment pathways at pace.
- Develop a joined-up strategy across the NHS and local government for the system on tobacco control.
- Maximise the opportunities of wider national NHSE investment in smoking.

At population level:

- Fund mass media campaigns to motivate smokers to quit. This can be done across an ICS footprint or at regional level.
- Improve the integration of smoking cessation into cancer screening programmes.
- Require that all letters referring patients who smoke for a hospital stay include information about hospital smokefree policies, advice on the benefits of quitting, and (where appropriate) on the importance of quitting prior to surgery (including information about harm reduction/temporary abstinence).

In primary care:

- Require that all smokers attending their GP surgery or local pharmacy for flu or Covid vaccination are given very brief advice to quit and referred to stop smoking services where available or NHS Smokefree if not.
- Require all NHS Health Checks to include brief advice to quit for smokers and referral to stop smoking services where available, or NHS Smokefree if not.

References

1 2019 data is cited throughout the document. Data collected through the Annual Population Survey in 2020 had methodological problems due to the change in data collection forced by the pandemic.

2 Office for National Statistics. Adults smoking habits in the UK: 2019. ONS. July 2020. Accessed July 2020.

3 Jha P, Peto R, Zatonski W, et al. Social inequalities in male mortality, and in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland, and North America. The Lancet 2006; 36: 367–370.

4 Public Health England (PHE). Smoking and tobacco: applying all our health. June 16, 2020. Accessed July 2020.

5 Centers for Disease Control and Prevention (CDC). Smoking & Tobacco Use. May 2020. Accessed June 2020.

6 ASH ready reckoner 2022: https://ash.org.uk/ash-local-toolkit/ash-ready-reckoner-2022/

7 Royal College of Physicians. Hiding in plain sight: treating tobacco dependency in the NHS. June 2018

8 ASH. The cost of smoking to the social care system. March 2021

9 The NHS Smokefree Pledge: https://smokefreeaction.org.uk/smokefree-nhs/nhs-smokefree-pledge/

10 The Local Government Declaration on Tobacco Control: https://smokefreeaction.org.uk/declarationsindex-html/

11 NHSE. Core20PLUS5 – An approach to reducing health inequalities