All Party Parliamentary Group on Smoking and Health

Burning Injustice

Reducing tobacco-driven harm and inequality

Recommendations to the government, local authorities and the NHS

January 2017

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About the All Party Parliamentary Group on Smoking and Health

The All Party Parliamentary Group (APPG) on Smoking and Health is a cross-party group of Peers and MPs which was founded in 1976 and is currently chaired by Bob Blackman MP. Its agreed purpose is to monitor and discuss the health and social effects of smoking; to review potential changes in existing legislation to reduce levels of smoking; to assess the latest medical techniques to assist in smoking cessation; and to act as a resource for the group's members on all issues relating to smoking and public health. The secretariat of the group is provided by Action on Smoking and Health.

Expert witnesses providing evidence to the Inquiry orally and in writing:

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- Dr Sanjay Agrawal, Consultant in Respiratory and Intensive Care Medicine, University Hospitals of Leicester NHS Trust
- Deborah Arnott, Chief Executive, ASH
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Foreword

The APPG on Smoking and Health launched this Inquiry to review current action on tobacco control by central Government, local authorities and the National Health Service in a period of tight public spending restraints. There are grounds for serious concern in all three cases that funding is being reduced for work on tobacco control and that the funds that are available are not always being used effectively. The report makes evidence-based recommendations to central Government, local authorities and the NHS about this critically important public health issue in a time of limited resources and increasing pressures on the NHS and social care systems.

In her first major speech as Prime Minister, the Rt Hon Theresa May said that she committed to fighting against "*the burning injustice that if you're born poor you will die on average nine years earlier than others*". This objective cannot be achieved without further progress in reducing smoking prevalence. Reducing smoking prevalence is also essential to the sustainability of public services, and delivers value for money to national and local Government by reducing costs to the NHS and the social care system, and increasing productivity.

Since implementation of a sustained and comprehensive tobacco control programme in 1998 smoking prevalence has reduced considerably, by a third amongst adults and two thirds amongst children. However, smoking remains the leading preventable cause of premature death and disease, responsible for half the difference in life expectancy between richest and poorest social classes.

All the key tobacco control measures set out in the WHO Framework Convention on Tobacco Control have now been implemented in England. Many of these measures, such as the advertising ban, smokefree laws, taxation and standardised packaging, are self-sustaining. However other measures, including mass media campaigns, smoking cessation services and enforcement measures such as tackling tobacco smuggling, require ongoing funding. The inequalities created by smoking will only be eliminated if these measures are sustained.

Given that public spending will be tightly constrained for some years to come, it may be necessary to find new ways of raising funds to pay for tobacco control measures. The tobacco manufacturers, whose products cause so much health, social and economic damage, should make a greater contribution to mitigating that harm. The four major tobacco manufacturers remain among the most profitable companies on Earth, so they could certainly afford to do this.

I hope to see many of the recommendations in this report included in the next tobacco control plan for England, which is now more than a year overdue, and will be crucial to ensuring that central Government, the NHS and local authorities work together effectively to continue to tackle the smoking epidemic.

Bob Blackman MP
Chair of the All Party Parliamentary Group on Smoking and Health

Recommendations

Government

1. The Government should renew its commitment to reducing smoking prevalence by publishing the latest tobacco control plan for England without further delay. Tobacco control is most effective when there is effective collaboration between all relevant agencies at national, regional and local level, and the new tobacco control plan should set out how the Government intends to ensure this.

2. To motivate quitting and reduce smoking initiation Government should provide sustained funding for national mass media campaigns in line with best practice.

3. Funding to local authorities for public health services should be protected with local authorities held to account for improving outcomes.

4. Any funding solution for public health in the context of the return of business rates to local authorities must be properly, and equitably, funded, so as not to exacerbate health inequalities.

5. The Government should reconsider its decision not to proceed with a levy on tobacco manufacturers to fund measures to reduce smoking prevalence, in line with the principle that has been established by the soft drinks industry levy. Alternatively excise duties could be increased with the money raised used to support tobacco control work, including that by local authorities under their public health function.

Local Authorities

6. Local authority budget decisions for the 2017/18 financial year and subsequently should be informed by a written assessment of their impact on public health in the local authority area, produced by the local Director of Public Health and considered by all Councillors. The interaction between local authority budget decisions and budget decisions by local NHS trusts and clinical commissioning groups should be included in this assessment. The impact of budget decisions on social care costs should be specifically addressed.

7. Local authorities should have tobacco control plans, developed in line with NICE guidance and advice from Public Health England. Tobacco control alliances should be established and sustained to help ensure effective delivery of the plans. Plans should be based on best practice, within the financial constraints under which local authorities are working.

8. Health and Wellbeing Boards (HWBBs) should have a strengthened scrutiny role in overseeing the development and delivery of the tobacco control plan, and to ensure effective collaboration between the local authority and the NHS. HWBBs should review data on local preventable morbidity and mortality; prioritise population groups, review plans, and help ensure value for money.

9. Decisions on tobacco control should be informed by the best available evidence on the impact and cost effectiveness of different interventions, including the NICE Return on Investment tool, and this evidence should be fully reported to councillors.

10. If a local authority's budget position makes it impractical to fund a comprehensive stop smoking service, it should consider how to reconfigure the service so that it provides an effective, well publicised and free, specialist service to the most vulnerable groups of smokers, including pregnant women, people with mental health conditions, and patients referred by hospitals. It should continue to provide support for other groups of smokers seeking to quit, using a less intensive but evidence-based model of service (particularly provision of stop-smoking medicines and advice on the best method of self-quitting).

11. Local authorities should seek to collaborate across boundaries and with other agencies to form robust regional partnerships to work on tobacco control. Such partnerships should work on the six internationally recognised strands of tobacco control:[1] stopping tobacco promotion; making tobacco less available and less affordable; effective regulation; helping tobacco users to quit; reducing exposure to secondhand smoke; and effective communications on tobacco control.

12. Local authorities should commit to sharing best practice and evidence on what works best and to exploring joint working and joint commissioning.

National Health Service

13. The NHS should adhere to relevant National Institute for Health and Care Excellence (NICE) guidelines on smoking cessation and tobacco control, and best practice advice and guidance from Public Health England.

14. National regulators such as the Care Quality Commission (CQC) should hold hospital boards accountable for the delivery of smoke-free and smoking cessation hospital policies.

15. All NHS hospitals should ensure that they:

    • Are fully smoke-free across all sites.
    • Refer all hospital patients who smoke to specialised stop smoking support services.
    • Prescribe nicotine replacement therapy to aid quit attempts and reduce symptoms of nicotine withdrawal to all hospitalised patients who smoke.
    • Employ an appropriately skilled senior clinician within the hospital to oversee, drive forward, and be accountable for the hospital's smoking cessation service.
    • Employ smoking cessation practitioners in every hospital, as recommended by NICE in 2013.
    • Ensure that hospital boards are fully involved in delivering plans on smoking and receive regular reports of action on smoking within their hospitals.

16. Clinical Commissioning Groups (CCGs) should use the Commissioning for Quality and Innovation (CQUIN) payment framework, and specifically the CQUIN indicators *Preventing ill health from risky behaviours – alcohol and tobacco* and *Improving the physical health for patients with severe mental illness (PSMI)*.

17. CCGs should commit to improving their joint working with local authorities and should recognise the importance of their preventive role in relation to smoking.

18. The CQUINs relating to tobacco use should be extended to cover all secondary care and community settings including mental health services, and should last until a set point is reached, i.e. when smoking prevalence among patients reaches a set target rate.

19. CCGs should not issue instructions to GPs to cease prescriptions of nicotine replacement therapy (NRT) or other stop-smoking medicines (varenicline or bupropion). Where such instructions have already been issued, they should be withdrawn.

20. Trust boards should be held accountable by regulators to enforce smoke-free grounds.

Introduction

21. The report is split into three sections, which cover the roles and responsibilities of central government, local government and the NHS.

Central Government

Why Tobacco Control is Important

22. The cost of smoking in England was estimated in 2014 to be £12.9 billion a year.[2] This included around £2 billion in costs to the NHS and £1.1 billion in social care costs as well as considerable costs to the economy due to lost productivity. The social care costs have been updated for ASH and have increased considerably since then to £1.4 billion annually, including £760 million to local authorities and £630 million in private funding.[3] The costs of smoking to the social care system are discussed in paragraphs 45-47 of this report.

23. Smoking remains the leading cause both of preventable premature death in England and of health inequalities.[4] It is responsible for nearly 80,000 premature deaths every year in England, more than the next five causes put together, including obesity, alcohol and illegal drugs.[5,6] Half die before normal retirement age,[7,8] during productive life years. Twenty times the number of smokers that die each year suffer from disease and disability caused by their smoking.[9,10] Research looking at the social care needs of smokers found they needed care and support on average nine years earlier than ex-smokers and those who had never smoked.[11]

24. The consequences of inaction on this priority issue for public health are well established. At least partly because of a lack of leadership from central Government over the period, smoking rates flat-lined in the 1990s, and by 1996 around 30% of 15 year olds smoked, higher than the adult average of 29%. A comprehensive strategy to tackle smoking was first implemented from 1999 onwards and since then Government policy has evolved progressively and smoking rates have fallen rapidly.

25. Adult smoking prevalence in England has declined by more than a third to around 18% in 2015. The proportion of 15 year olds in England who are regular smokers has fallen even faster, to 8% by 2014. These are the lowest figures, both for adults and children, ever recorded. This success is a direct result of progressive action on tobacco control, including legislation, tax rises and support for smokers seeking to quit. Tobacco control policy must be both progressive and dynamic since, as each policy is introduced, those smokers who do not then quit can be assumed to have discounted its effects and those of previous policies.

26. Other stated Government commitments which are affected by smoking prevalence include:

    • To reduce the rate of stillbirths, neonatal and maternal deaths in England by 50% by 2030.[12]
    • To transform the life chances of the poorest in our country.[13]
    • To improve the physical health of those with mental health conditions.[14]
    • To help the NHS deliver on its commitment to achieve significant efficiency savings by a radical upgrade in prevention and public health.[15]
    • To meet the Independent Cancer Task Force targets to reduce adult smoking prevalence to 13%, and to 21% in routine and manual workers by 2020.[16]
    • To reduce the mortality from the four main preventable non-communicable diseases – cardiovascular disease, cancer, chronic lung disease and diabetes – by 25% between the year 2010 and 2025 with a target for reduction in smoking prevalence of 30%.[17]
    • To develop, implement, periodically update and review comprehensive multisectoral national tobacco control strategies, plans and programmes in accordance with the World Health Organization's Framework Convention on Tobacco Control.[18]

Tobacco Control Plan for England

27. The previous *Tobacco Control Plan for England* was published in March 2011 and expired at the end of 2015.[19] This was the third tobacco control plan, the first being published in December 1998. The Plan was central to achieving a number of important changes that helped to reduce smoking prevalence rates, including:

- legislation to end tobacco displays in shops,
- standardised packaging of tobacco products,
- progressive tax rises to maintain the high price of tobacco products at levels that impact on smoking prevalence, and
- encouraging more smokers to quit by using the most effective forms of support, through local stop smoking services.

The Plan recognised that: "*There is clear evidence that the most effective tobacco control strategies involve taking a multi-faceted and comprehensive approach at both national and local level*".

28. The publication of a replacement tobacco control plan has now been delayed by more than a year. This suggests either that there is opposition within Government to further action on reducing smoking prevalence, or that the issue is not being given the priority it deserves. In January 2017, more than 1,000 doctors, including heads of royal colleges and public institutions, wrote a public letter to the Prime Minister, published in the British Medical Journal, calling on her to ensure that a new plan is published without further delay.[20]

29. A new plan should contain ambitious commitments and targets, such as those set out in the ASH report, *Smoking Still Kills*,[21] which has been endorsed by 129 health organisations. These could include:

- An ambition for the country to become smokefree by 2035.
- Interim targets to reduce adult smoking prevalence to 13% by 2020, and 9% by 2025, and smoking prevalence among people in routine and manual occupations to 21% by 2020 and 16% by 2025.
- Specific targets to reduce smoking prevalence among pregnant women to 8% by 2020 and 5% by 2025.
- Specific targets to reduce regular and occasional smoking prevalence among 15 year olds to 9% by 2020 and 2% by 2025.
- Specific targets to reduce smoking among people with a mental health condition to less than 5% by 2035, with an interim target of 35% by 2020.
- Sustained and adequately funded mass media campaigns.
- A continuing commitment to high and rising tobacco taxation, to make smoking progressively less affordable.
- A strong strategy to reduce the level of illicit tobacco in the UK market, including licensing of retailers and the early ratification of the WHO Illicit Trade Protocol.
- Funding for tobacco control measures to be provided by the tobacco manufacturers.

NHS Funding

30. In October 2014, NHS England published its *Five Year Forward View*, which stated that: "*In order to provide the comprehensive and high quality care the people of England clearly want, Monitor, NHS England and independent analysts have previously calculated that a combination of growing demand if met by no further annual efficiencies and flat real terms funding would produce a mismatch between resources and patient needs of nearly £30 billion a year by 2020/21. So to sustain a comprehensive high-quality NHS, action will be needed on all three fronts - demand, efficiency and funding. Less impact on any one of them will require compensating action on the other two.*"[22]

It concluded 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. 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"*.[22]

31. Even after additional NHS funding committed by the Government, there remains a predicted funding shortfall of more than £20 billion by 2020.[23] This funding gap is highly unlikely to be closed entirely through increased efficiency levels alone. Therefore, further radical action to reduce smoking prevalence is urgently required if the NHS is not to suffer a continuing and progressively more damaging funding crisis.

Funding for Public Health

32. Local authorities were given responsibility for public health by the Health and Social Care Act 2012. This transfer of functions was funded through a ring-fenced grant. The grant is used to commission a variety of services, some mandatory (including sexual health services, NHS health checks, national child measurement programmes) and others to address local priorities, including stop smoking services.

33. In September 2014 the Department of Health published public health ring-fenced grant allocations to local authorities (upper tier and unitary local authorities) in England: £2.79 billion for 2015/16. However, in June 2015, the Chancellor announced an in-year cut to this grant of £200 million. In the 2016 Autumn Statement, it was announced that the public health budget for England would be reduced by a further £84 million in 2017/18 compared to 2016/17, and that local authorities' funding for public health would be reduced by an average of 3.9% in real terms each year until 2020.[24] This means a reduction in cash terms of about 9.6% over the same period which is already having a significant impact on spending on tobacco control at local level.[25]

34. A report by the House of Commons Health Committee on the impact of the Spending Review on health and social care recognised that "*cuts to public health budgets set out in the Spending Review threaten to undermine the necessary upgrade to prevention and public health set out in the [NHS] Five Year Forward View*". It calls these a "*false economy*" which may "*create avoidable costs in the future.*"[26]

35. In the 2015 Autumn Statement it was proposed that a future funding solution for public health could come through returning more of business rates to local authorities. Absent other measures, this could worsen health inequalities, as the authorities with the highest deprivation, and therefore highest smoking rates, are also the authorities with the lowest share of business rates.[27] Therefore, any funding solution for public health in the context of the return of business rates to local authorities will need to ensure that it is properly, and equitably, funded.

Mass Media Campaigns

36. Tobacco control activity is greatly assisted if it is accompanied by mass media campaigns aimed at encouraging smokers to try to quit, or to reduce their risky behaviour (for example smoking close to children).

37. Research shows how effective such mass media campaigns can be. Studies on mass media campaigns in England show they can be effective in triggering quit attempts, supporting quitting, and discouraging children and young adults from starting to smoke.[28,29] A systematic review of economic evaluations of mass media campaigns noted that all of these found mass media campaigns to be cost effective, but these campaigns need to be both intense in coverage and sustained in order to have a serious effect.[30]

38. It is therefore deeply worrying that spending on such media campaigns in England has dropped in the past five years from just under £25 million in 2009-10 to £5.3 million in 2015-16. The Government recently stated in the House of Lords that the marketing spend on tobacco for 2016-17 would be £4 million in total, so the actual spend on mass media campaigns will be significantly lower than this.[31]

39. By contrast, a recent study found that between 2007 and 2015, UK Film Tax Relief provided subsidies worth an estimated £473 million to at least 90 top-grossing UK or US-UK films that contained tobacco imagery, with 97% of this granted to films which are youth-rated in the UK.[32]

Making the Tobacco Industry Pay

40. The tobacco industry is one of the most profitable in the world. An analysis of the industry published in 2015 estimated total profits to manufacturers and importers in the UK tobacco market at a minimum of £1 billion in each of the last five years, and that profits were still rising, to around £1.5bn in recent years. Tobacco manufacturers and importers are also found to enjoy consistently high profit margins of up to 68%, compared to only 15-20% in most consumer staple industries.[33]

41. Public health organisations including ASH, Cancer Research UK, and the UK Centre for Tobacco and Alcohol Studies have called for the introduction of a levy on the tobacco manufacturers and importers to fund tobacco control measures[34] and this was consulted on by the Government.[35]

42. In his July 2015 Budget Statement, the then Chancellor, George Osborne, announced that he would not introduce the levy, claiming that the impact of a levy on the tobacco market would be similar to a duty rise, as tobacco manufacturers and importers would be likely to pass the costs on to consumers.[36] However, in his 2016 Budget he announced the introduction of a new levy on soft drinks that contain added sugar, to help tackle childhood obesity.[37] These two decisions appear to be inconsistent, and the Government needs to reconsider the tobacco levy proposal. Alternatively tobacco excise taxes should be increased and the money raised used to fund tobacco control measures.

Priorities for Local Authorities

Why Tobacco Control is Important

43. Action taken by local authorities is also essential in driving down smoking rates. Since the transition of public health from primary care trusts to local authorities in 2013, stop smoking services have been at the heart of local authorities' efforts to reduce smoking prevalence and tackle health inequalities. Local authorities also pursue wider tobacco control action including preventing smoking uptake among young people, tackling the illicit trade in tobacco, and promoting smokefree public environments.

44. The principal reasons why smoking should be a priority concern for all local authorities with a public health function or other functions related to tobacco control such as trading standards include:

   • Giving young people a better start in life, since smoking is an addiction of childhood and few smokers start as adults.[38] Children whose parents smoke are about three times more likely to become smokers than those raised in non-smoking households.[39]
   • Boosting the disposable income of the poorest social groups, since around 1.2 million children in the UK are living in poverty in households where adults smoke. If these adults quit and return the money they save to household budgets, about 400,000 children would be lifted out of poverty.[40]

- Tackling crime, through reducing the illicit trade in tobacco and enforcing legislation on smoking in enclosed public places, and sale of tobacco to minors.
- Improving the productivity of local businesses, through reducing time lost at work due to smoking-related illness.
- Tackling the growing crisis in adult social care. The costs of smoking to the social care system are discussed below.

Social Care

45. Because of the impact of smoking on health in later life, smoking imposes a direct cost to local authorities in the form of additional requirements for social care. ASH has recently updated its estimates of the social care costs of smoking in England.[41] The latest estimates are as follows:

Social care costs of smoking – updated January 2017

Cost to local authorities from increased social care needs	£760m
Cost to self-funders from increased social care needs	£630m
Increased number of people receiving social care support (funded by local authorities)	35,000
Increased number of people receiving social care support (self-funded)	17,000
Increased number of people receiving care from friends and relatives	234,000
Difference in age between when smokers and non-smokers need to access care	4 years

46. It should be noted that the Care Act 2014 placed a duty on local authorities to enable access to services that reduce the need for support among people and their carers in the local area, and contribute towards preventing or delaying the development of such needs. Since smoking doubles the risk of developing care needs, it is highly relevant when considering the provision of preventive services. Reducing smoking prevalence reduces social care costs.

47. Central Government has allowed the 152 English local authorities responsible for social care to introduce an extra precept, increasing council tax rates by up to an extra 1% in 2017/2018, and 2% in 2018/2019, but with a cap on total increases to 2019/20 of 6%. However, according to the LGA there remains a funding gap for social care provision of about £2.6 billion by the end of the decade. The LGA also reports that local authorities still face overall funding pressures of £5.8 billion by 2019/20 (the gap between the likely cost of the services they currently provide and the maximum revenue they will be able to raise).[42]

Local Authority Budgets

48. Local authorities across England face tight and contracting budgets. In his speech on the 2015 Autumn Statement, the previous Chancellor of the Exchequer announced Spending Review reductions of 56% in the amount English local authorities receive in central grant funding by 2019–20.[43] According to the Local Government Association, in 2017/18 English local authorities will receive £2.2 billion less in Revenue Support Grant to run local services, compared to 2016/17, an overall reduction of 6.7%.[44]

49. Despite the significant immediate and long-term costs of smoking, there is already evidence that local authorities are reducing their spending on public health services, and in particular their spending on tobacco control. In November 2016, ASH published its third annual *Survey of Tobacco Control Leads in English Local Authorities*, commissioned by Cancer Research UK.[45]

Of 129 local authorities surveyed (out of 152 of local authorities in England with public health responsibilities):

- Smoking cessation budgets were cut in 59% of surveyed authorities in 2016/17 (subsequent to cuts in 39% of local authorities in 2015/16).
- Budgets for wider tobacco control work, including trading standards enforcement, campaigns and tackling the illicit trade, were cut in 45% of local authorities in 2016/17 (subsequent to cuts in 28% of local authorities in 2015/16).

50. The major reasons cited for these decisions were successive reductions in the national public health grant and the wider cost pressures on local authority budgets. Cuts have not been driven by changes in the priority given to tobacco control within local authorities. Over the last three years, the proportion of local authorities where tobacco control is reported to be an above average or high priority has risen from 52% to 55%.

Impact on Stop Smoking Services

51. Specialist smoking cessation services, until recently a universal offer, are currently provided by three quarters of upper-tier local authorities in England. In one in five local authorities surveyed, the specialist service has been wholly replaced by an integrated "lifestyle" service of some kind. In one in twenty local authorities there is no longer a smoking cessation service of any kind beyond that offered by GPs and pharmacists.

52. Among those local authorities that still provide a specialist service, there is a trend towards targeting services. This is appropriate, given the importance of tackling inequalities, but should not mean the loss of a universal offer. This has happened where the policy is driven principally by budget cuts.

53. Intensive interventions (as provided by specialist smoking cessation services) typically include scheduled face-to-face meetings between the smoker and a counsellor trained to provide stop smoking support. Discussions include practical advice about goal-setting, self-monitoring and dealing with the barriers to stopping smoking. Intensive behavioural support also includes anticipating and dealing with the challenges of stopping. Support is typically offered weekly for at least the first four weeks of a quit attempt (that is, for four weeks after the quit date). The evidence is clear that this kind of practical support, delivered by specialists who are highly trained and experienced, makes a substantial difference to a smoker's chances of quitting.[46]

54. The prescription drug varenicline has been found to be highly effective and cost-effective in helping smokers to stop, and is provided by almost all stop smoking services. Nicotine replacement therapy (NRT) is also available and can yield results almost as good as varenicline, if nicotine skin patches are combined with other products such as lozenges or inhalers.[47]

Cost Effectiveness

55. It has been calculated that specialist stop smoking services together with stop smoking medicines end up saving more money than they cost because of their healthcare and economic benefits. NICE has estimated that for every £1 invested, £2.37 will be saved on treating smoking-related diseases and lost productivity.[48] These services are therefore recommended by NICE[49] and their Return on Investment tool for local authorities can provide estimates for different combinations of treatment at local level.[50]

56. Recognising that many local authorities feel obliged by budget pressures to reduce funding for stop smoking services, a model has been proposed (Stop-Smoking+) that aims to provide the most efficient use of resources with reduced budgets. The model proposes that specialist

support be offered to the approximately 1-2% of smokers each year who are willing to engage with it and can benefit from it most, with a prescription for a stop smoking medicine being provided to the approximately 5-7% of smokers who want this kind of support. Additionally, clear advice should be provided on the most effective methods of quitting without professional support through the Internet to those who do not wish to engage with health professionals when quitting. This model could provide a way for local authorities to configure existing services to obtain maximum value for the resources they are able to devote to smoking cessation.[51]

Youth Prevention

57. Smoking is an addiction that typically starts in childhood. Two thirds of current smokers report that they started before they were 18 years old.[52] Some local authorities have therefore funded programmes designed to discourage children from starting to smoke.[53]

58. In 2015, the National Centre for Smoking Cessation and Training (NCSCT) reviewed the return from programmes to support smoking cessation versus school-based programmes aimed at reducing youth uptake.[54] It concluded that while the latter may seem attractive to many local authorities, they do not represent anything like the same value for money that stop smoking services provide. It would therefore be a mistake to devote resources to these programmes at the expense of local stop smoking services.

59. Specific youth-based programmes do not have the level of cost-effectiveness as stop smoking services, and wider population level programmes that reduce access to tobacco and deter its use have been found to be as or more effective in reducing youth uptake.

60. There is a duty of care to ensure that the harm caused by smoking is clearly set out in the school curriculum, and that schools create a strong anti-smoking ethos. But youth prevention programmes should not be considered as an alternative to stop smoking services, and a shift in funding away from these services to youth prevention is not considered a cost-effective use of scarce resources.

Trading Standards and Environmental Health

61. Trading standards departments are important for tobacco control because they are responsible for enforcement in key areas including tobacco display bans, prohibition of sale to minors and illicit tobacco.

62. Trading standards departments have also been subject to budget reductions, although most continue to make work on tobacco a priority. Total spend nationally has fallen from £213m in 2010 to £124m today. There has been a 12% drop in staff working in trading standards since 2014.[55]

63. It should be noted that trading standards departments can suffer from the same perverse incentives as apply to some other local authority services. For example, the financial benefit from action on illicit trade will generally accrue to central Government, in the form of increased tax revenues, and not to local authorities. It may be appropriate therefore to consider allocating some of the proceeds of a levy on the tobacco industry to enforcement work carried out by trading standards.

64. Environmental health departments, which are also crucial in tobacco control work, for example in enforcing smokefree legislation, have also faced budget reductions. The Chartered Institute of Environmental Health reported in July 2015 that: "*the resilience of vital environmental health services designed to protect businesses and the public is close to or already at a tipping point*".[56] The *CIEH Environmental Health Workforce Survey* for 2014/15 showed that the average budget for environmental health services fell by 6.8% in real terms

between 2013-14 and 2014-15. Almost half of the respondents stated that resources were only just adequate to provide a basic statutory service, while local authorities that were able to estimate their budget for 2015-16 expected a further fall in real terms of up to 30%.

Regional Activity

65. In addition to tobacco control work at a local authority level, collaborative work at regional level is known to be effective but is threatened by budget reductions. The North East of England has a strong tobacco control alliance: Fresh. Fresh was established in 2005 because the North East region had the highest smoking rates in England. The model is based on the successful evidence based approach from California; the goal is to change the broad social norms around the use of tobacco and indirectly influence current and potential future tobacco users on a population level. This approach aims to create a social environment and legal climate in which tobacco becomes less desirable, less acceptable and less accessible. Fresh works on a wide range of tobacco control issues, including illicit trade, where a successful partnership has been established between public health and enforcement officers at local and national level (trading standards officers, customs officers and police).

66. All twelve local authorities jointly fund this regional programme. County Durham & Darlington NHS Foundation Trust (CDDFT) is the commissioner of Fresh and Balance, with the current contract due to expire on 31 March 2017. Balance is the regional programme working on alcohol control issues, which is run together with Fresh for reasons of efficiency and economies of scale.

67. The current annual contract value is just under £1.5 million, with spend per authority based upon 2011 population figures and calculated at a rate of 27p per head. Hartlepool, Middlesbrough, Redcar & Cleveland and Stockton local authorities pay a higher rate of 33p per head towards Fresh, since the Tees area had a higher rate of tobacco use when the organisation was founded.

68. There is clear evidence that this strong regional partnership has been effective: between 2005 and 2014, smoking prevalence in the North East fell by 9.1 percentage points, compared to a reduction of 6.0 percentage points across England.

Priorities for the NHS

Why Tobacco Control is Important

69. Smoking is the primary cause of preventable illness and death in England. In February 2010, the Marmot Review concluded 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*".[57] Smokers under the age of 40 have a five times greater risk of a heart attack than non-smokers. Smoking causes around 80% of deaths from lung cancer, around 80% of deaths from bronchitis and emphysema, and about 14% of deaths from heart disease. More than one quarter of all cancer deaths can be attributed to smoking. These include cancer of the lung, mouth, lip, throat, bladder, kidney, pancreas, stomach, liver and cervix. About a half of all life-long smokers will die prematurely. On average, cigarette smokers die 10 years younger than non-smokers.[58]

70. A national health service that is truly committed to improving the health of the UK population, and not simply to treating patients when they present with specific conditions, must therefore make reducing smoking prevalence a very high priority.

71. The NHS England *Five Year Forward View* forecasts a £30 billion shortfall in funding by 2020, and even after additional NHS funding committed by the Government, there remains a predicted funding shortfall of £22 billion by 2020.[59]

72. This funding gap is highly unlikely to be closed entirely through increased efficiency levels alone, since this would require efficiency savings of up to 3% per year. Between 2004/05 and 2011/12 the NHS is estimated to have made efficiency savings of about 1.5% per year, and analysis by the Health Foundation suggests efficiency savings may have slowed down in the following two years, 2012/13 and 2013/14.[60] The King's Fund think tank has concluded that closing the gap to £8 billion would be "*very challenging*".[61] Therefore, to avoid large reductions in the supply of NHS services, it will be necessary to reduce demand for NHS services by improving public health. The Inquiry heard strong evidence that continuing to drive down smoking prevalence will be essential to the success of this strategy.

73. A number of Cochrane reviews published in 2013[62,63] showed that:

   - Brief simple advice from a physician increases quit rates – therefore health professionals have influence.
   - More intensive advice can double quit rates.
   - Smoking cessation advice in hospital can be very effective: patients have often been admitted for a smoking-related reason and are therefore receptive to advice; the family may be keen to provide additional encouragement (and will not provide temptation by smoking nearby); patients are in an environment where quitting will be easy (smoke-free site); and pharmacotherapy is easily available.
   - Novel interventions such as text reminders or interactive websites may help enhance quit rates.
   - Intensive support should normally be given alongside pharmacotherapy.

74. Smoking cessation treatment is known be very cost-effective for those already diagnosed with smoking-related diseases, or yet to be diagnosed. For example, about 900,000 people in England have been diagnosed with COPD out of a total estimated number of sufferers of around 3 million. Around 25,000 people die a year from COPD and in 2010/11 the NHS spent £720 million on treatment for COPD.[64] This is a disease which is almost entirely preventable. Smoke is the cause of more than three quarters of COPD cases, and in England the exposure to smoke is primarily through smoking.

75. Clearly it is better to prevent COPD through provision of smoking cessation treatment to help smokers quit before it develops. However, even after onset of COPD smoking cessation can help improve quality of life, lower exacerbation rates and reduce the number of GP visits and emergency hospital admissions. It is also highly cost-effective compared to other treatments. According to a systematic review "*Smoking cessation is the most important treatment for smokers with chronic bronchitis and emphysema*".[65] The value pyramid produced by the London Respiratory Network illustrates that the cost per QALY (quality-adjusted life year) for smoking cessation treatment for people with COPD is around £2,000 per QALY while the costs of drug treatment for COPD range from £5,000 per QALY at the bottom end to £187,000 per QALY for triple therapy.[66]

Sustainability and Transformation Plans

76. Sustainability and Transformation Plans (STPs) were announced in NHS planning guidance published in December 2015. NHS organisations and local authorities in different parts of England have come together to develop "*place-based plans*" for the future of health and care services in their area. Draft plans were produced by June 2016 and final plans were submitted in October 2016. All 44 are now available online.[67]

77. STPs are five-year plans covering all aspects of NHS spending in England. Forty-four areas have been identified as the geographical "*footprints*" on which the plans are based, with an average population size of 1.2 million people (the smallest covers a population of 300,000 and the largest 2.8 million). A named individual has led the development of each STP. Most STP leaders come from clinical commissioning groups (CCGs) and NHS trusts or foundation trusts, but a small number come from local government.

78. More than nine in ten of the STPs include action on tobacco and smoking, with four in ten making such action a priority. It is obviously important that these plans are followed through in practice: Health and Wellbeing Boards have a crucial role to play in monitoring implementation and in wider governance.

79. Smoking should be treated as a "*vital sign*", not only clinically for individual patients, but as an overall indicator of NHS sustainability.

NHS Work with Local Authorities

80. For tobacco control to work effectively at a local level there needs to be a close relationship between local authorities and their local NHS trusts and clinical commissioning groups. Relationships with the NHS are strengthened by shared strategy and priorities, good personal relationships, effective communication, political leadership and strong partnerships.

81. NHS commissioners should consider whether in their local area there may be a role for joint commissioning of stop smoking services, in line with the increasing emphasis on "*commissioning across the system*".[68]

82. The ASH/CRUK survey results for 2016 showed that:

   • Overall, 88% of tobacco control leads reported productive relationships with maternity services.
   • 70% reported productive relationships with mental health services.
   • 68% reported productive relationships with GPs.
   • 64% reported productive relationships with clinical commissioning groups.
   • 52% reported productive relationships with acute services.

83. These results suggest that:

   • Relationships with GPs and clinical commissioning groups are not as strong as their potential contributions to tobacco control warrant.
   • The relatively poor results in the local authority survey for relationships with acute services may reflect a lack of attention being given by some trusts to helping patients who smoke. According to the respondents to this survey, there is no funding from any local body for inpatient specialist stop smoking services in 14% of local authorities.

84. According to a recent report by the British Thoracic Society (BTS), some hospitals across the UK are falling "*woefully short*" of national standards on helping patients who smoke to quit and enforcing smokefree premises.[69]

85. The BTS Report *Smoking cessation: policy and practice in NHS hospitals* reviewed the smoking cessation and smokefree policies and practices of 146 hospitals, not including mental health hospitals, across the UK between April and May 2016. As part of this review almost 15,000 patient records were analysed.

86. The report found that:

   • 72% of hospital patients who smoked were not asked if they'd like to stop.
   • 8% of hospital patients who smoked were referred for hospital-based or community. treatment for their tobacco addiction.
   • 27% of hospital patients were not even asked if they smoke.
   • Only 10% of hospitals completely enforce their fully smokefree premises. Rates of enforcement were even lower for hospitals which provided areas where smoking was allowed. The report highlights the importance of a smokefree NHS – to trigger and

support quit smoking attempts for patients and reduce secondhand smoke exposure for children, staff and the public.

- Provision of nicotine replacement therapies and other smoking cessation treatments were "*poor*" in hospital pharmacy formularies.
- Only 26% of hospitals had an identified consultant "*lead*" overseeing their smokefree and smoking cessation plans.
- 50% of frontline healthcare staff in hospitals were not offered training in smoking cessation.
- In the study, 25% of hospital patients were recorded as being "*current smokers*" – which is higher than rates in the general adult population (19%). Other studies have shown that approximately 1.1 million smokers are admitted to NHS hospitals a year.[70]

87. Commenting on these findings, Dr Sanjay Agrawal, Consultant Lung Specialist and Chair of the British Thoracic Society's Tobacco Group, said:

"Critically, hospitals are missing out on a golden opportunity to help supply often THE most effective treatment for illnesses that smokers are admitted with – support and treatment for their tobacco dependence. If patients in other disease areas were not offered, by default, the most effective way to treat their condition - there would probably be an uproar. Nevertheless, this happens all too frequently with people with smoking-related illnesses."

Smoking and Mental Health

88. It has been estimated that 42% of all tobacco now smoked in England is consumed by someone with a mental health condition.[71] Yet the desire to quit is just as strong as for the average smoker. These smokers do not lack motivation to quit but are more likely to be highly addicted and heavily dependent on tobacco, and therefore need more help. If the ambition of improving physical health outcomes in people with mental illness is to be achieved, smoking rates have to be driven down.[72]

89. The *Stolen Years* report, endorsed by 27 health and tobacco control organisations, sets out a series of recommendations on how this help should be provided, and recommends a specific target for England of reducing smoking among people with a mental health condition to less than 5% by 2035, with an interim target of 35% by 2020.[73]

CQUIN Framework

90. The Commissioning for Quality and Innovation (CQUIN) payment framework enables NHS commissioners to reward excellence by linking a proportion of NHS providers' income to the achievement of local quality improvement goals.

91. The national CQUIN indicator on improving physical healthcare to reduce premature mortality in people with severe mental illness was introduced in 2014 and continues to be one of the CQUIN goals going forward. It aims to support NHS England's commitment to reduce the 15 to 20 year premature mortality in people with severe mental illness (SMI) and improve their safety through improved assessment, treatment and communication between clinicians.

92. The aim is to ensure that patients with SMI receive comprehensive cardiometabolic risk assessments and have access to the necessary interventions. This includes the assessment and recording of smoking status and ensuring clear pathways for smoking cessation are in place. In 2018/19 it includes a new requirement that at least 10% of patients using Early Intervention Services who were previously identified as smokers have stopped smoking. Whilst this is welcome, a quit target across all mental health services is needed.

93. There is also a new national CQUIN indicator *Preventing ill health from risky behaviours – alcohol and tobacco*, which asks NHS trusts to identify and record the smoking status of all

inpatients and to provide smokers with Very Brief Advice and an offer of medication and referral. The scheme applies to acute trusts in 2018/19 and to community and mental health trusts in both 2017/18 and 2018/19.

94. These CQUINs, which include measures on how many people have been referred for treatment and stopped smoking, offer an incentive to embed tobacco dependence treatment into care pathways. However, they appear to be limited in the range of settings and duration. They should be extended to cover all secondary care and community settings including mental health services, and should last until a set point is reached, i.e. when smoking prevalence among patients reaches a set target rate.

95. There is an obvious risk that these CQUINs are being implemented at a time when any increase in referrals to stop smoking services coincides with cuts in funding to these services.

Funding for NRT and Stop Smoking Pharmacotherapies

96. A combination of behavioural support and pharmacotherapies is known to give smokers the best chance of succeeding when they attempt to quit.[74] However, there is alarming evidence that some CCGs are already refusing to fund the prescription of NRT and other stop smoking pharmacotherapies by GPs. For example:

   • In March 2016, Worcestershire CCGs (Wyre Forest, South Worcestershire, Redditch and Bromsgrove) wrote to GPs stating that "*no prescriptions for nicotine replacement therapy, bupropion or varenicline should be written for new patients from 1 April 2016. Practices that have previously provided a Council funded Stop Smoking Service are permitted to continue prescribing for existing patients until a maximum of 12 weeks after their quit date*".[75]
   • Similar instructions have been issued by the East Kent Prescribing Group (Ashford CCG, Canterbury and Coastal CCG, South Kent Coast CCG and Thanet CCG) in April 2016, instructing GPs "*Do not supply NRT on FP10: Patient to self-refer to Stop Smoking Services*".[76]
   • Windsor, Ascot and Maidenhead CCG wrote to local GP practices in May 2016 stating that "*the Royal Borough has commissioned a new stop smoking service … to support only 3 groups, pregnant smokers, smokers with mental health issues and young people… The prescribing budget has not received an uplift to allow for prescribing to patients no longer eligible for treatment via Solutions4Health.*" [the local SSS provider] [77]
   • Vale of York CCG wrote to all GP practices within the City of York boundary on 14 March 2016, stating that referrals to stop smoking services should only be made for pregnant women, pre-operative patients, and patients with serious respiratory disease or cancer. From the end of March 2016, the CCG terminated its free NRT voucher scheme.[78]

97. ASH is surveying all the CCGs in England through Freedom of Information requests and follow up, to identify those which are now not providing funding for GP prescriptions to patients seeking to stop smoking and to cross reference with local authorities that are reducing funding for stop smoking services.

98. As well as being undesirable in principle, this development will coincide in some cases with local authorities reducing or eliminating funding for stop smoking services, leaving smokers with no way to get an NHS prescription for pharmacotherapy to help them stop smoking, and possibly no way to get intensive behavioural support. This will be a particular problem for people on low incomes – a population that already has higher than average rates of smoking.[79] This dangerous development threatens to slow or even halt the long-term decline in smoking prevalence and urgently needs to be reversed.

99. The October 2016 report of the North East Commission for Health and Social Care Integration (North East Combined Authority (NECA) and NHS)[80] recommended that:

- *NECA partners should set themselves an ambition to radically increase preventive spending across the health and care system.*
- *Public sector partners across the NECA area should integrate preventive action and action to tackle inequalities in all decisions.*
- *Leaders within organisations will need to look beyond the interests of their own organisations to drive improvement in wellbeing outcomes across NECA, leading a cultural change to a health and care system in which health and care funds are used most effectively to support wellbeing independent of the source of the funding.*
- *The NECA area should align financial payment systems and incentives within the overall objectives of the health and care system to improve health and wellbeing and reduce health inequalities.*

These important objectives are inconsistent with reductions in public health services by local authorities and with NHS refusal to fund prescriptions for people seeking to quit smoking, which remains the biggest single public health challenge facing the country.

References

1. Healthy Lives, Healthy People: A Tobacco Control Plan for England. HM Government, March 2011.
2. Tobacco Levy: consultation document. HM Treasury, December 2014.
3. The costs of smoking to the social care system in England. Second Edition. ASH, January 2017.
4. Marmot M. Fair Society Healthy Lives (The Marmot Review), 2010.
5. Statistics on Smoking, England - 2015. HSCIC, 2015
6. Smoking statistics. Illness and death. ASH, November 2014.
7. Doll R, Peto R, Boreham J, Sutherland I. Mortality from cancer in relation to smoking: 50 years' observations on male British doctors. British Journal of Cancer 2005: 92: 426-429.
8. Pirie K, Peto R, Reeves GK, Green J, Beral V. The 21st century hazards of smoking and benefits of stopping: a prospective study of one million women in the UK. The Lancet 2013: 381: 133-141.
9. US Department of Health and Human Services. How Tobacco Smoke Causes Disease: The Biology and Behavioral Basis for Smoking-Attributable Disease: A Report of the Surgeon General. Atlanta, GA: USA, 2010.
10. Cigarette smoking-attributable morbidity – United States, 2000 MMWR Weekly Report. 5th September 2003
11. Reed H. Costs of Smoking to the Social Care System and Society in England. ASH, 2014
12. New ambition to halve rate of stillbirths and infant deaths. Dept. of Health, 13th November 2015
13. Prime Minister's speech on Life Chances, Prime Minister's Office, 11th January 2016
14. Five Year Forward View for Mental Health, A report from the independent Mental Health Taskforce to the NHS in England, February 2016
15. As set out in the Autumn statement 2015 and NHS Five Year Forward View
16. Achieving world-class cancer outcomes: a strategy for England 2015-2020, A report of the Independent Cancer Taskforce
17. 66th World Health Assembly decision WHA66.10
18. World Health Organization's Framework Convention on Tobacco Control.
19. Healthy Lives, Healthy People: a Tobacco Control Plan for England, HM Government, 9th March 2011
20. Doctors urge Theresa May to publish anti-smoking strategy, The Guardian, 4th January 2017
21. Smoking Still Kills. ASH, 2015
22. NHS England Five Year Forward View: Executive Summary, paragraph 13
23. The Autumn Statement: NHS Funding. The King's Fund, 2014
24. Autumn Statement 2016: Joint statement on health and social care from the King's Fund, Nuffield Trust and The Health Foundation, 8th November 2016
25. Cutting Down: The reality of budget cuts to local tobacco control. ASH & Cancer Research UK, November 2016.
26. Public health post 2013: House of Commons Health Select Committee, September 2016
27. Calkin S. Business rates reform explained. Local Government Chronicle 7th October 2015
28. Langley T, McNeill A, Lewis S, Szatkowski L, Quinn C, 2012. The impact of media campaigns on smoking cessation activity: a structural vector autoregression analysis. Addiction 107(11), 2043-2050
29. Sims M, Salway R, Langley T, Lewis S, McNeill A, Szatkowski L, Gilmore A. Effectiveness of mass media campaigns to change tobacco use in England: a population-based cross-sectional study. 2014; 109(6):986-94.
30. Atusingwize E, Lewis S, Langley T. Economic evaluations of tobacco control mass media campaigns: a systematic review. Tobacco Control. 2015 Jul; 24(4):320-7.
31. Lord Prior of Brampton: "£4 million has been allocated for tobacco-specific marketing activities, £1 million of which is for the Stoptober campaign launching next month." Hansard. HoL Debate 14 September 2016, column 1537
32. Hopkinson NS, Millett C, Glantz S, Arnott D, and McNeill A (2016) UK government should fund stop smoking media campaigns not give tax breaks to films with smoking imagery. Addiction. doi: 10.1111/add.13511
33. Branston JR and Gilmore A. The extreme profitability of the UK tobacco market and the rationale for a new tobacco levy University of Bath, 2015
34. Smoking Still Kills. ASH, June 2015
35. Tobacco Levy: consultation document. HM Treasury, December 2014
36. Summer Budget 2015, HM Treasury, July 2015
37. Budget 2016, HM Treasury, March 2016
38. Passive Smoking and Children A report of the Tobacco Advisory Group of the Royal College of Physicians. London, RCP, 2010
39. Leonardi-Bee J, Jere ML, Britton J. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis. Thorax 15 Feb. 2011 doi:10.1136/thx.2010.153379
40. ASH estimates of poverty in the UK adjusted for expenditure on tobacco
41. The costs of smoking to the social care system in England has cost estimates for every top tier English local authority. The full report with the detailed estimates can be found online at Social Care Costs. The study was conducted by economist Howard Reed from Landman Economics for ASH. The report excludes costs borne by the national government such as the payment of welfare benefits.
42. LGA responds to the Local Government Finance Settlement. LGA media release.15 December 2016
43. Spending Review and Autumn Statement 2015
44. LGA responds to the Local Government Finance Settlement: Local Government Association Media Release 15 December 2016
45. ASH CRUK report. Cutting Down: the reality of budget cuts to local tobacco control. November 2016.

46. Bauld L et al. The effectiveness of NHS smoking cessation services: a systematic review Journal of Public Health Journal of Public Health 2009; doi:10.1093/pubmed/fdp074
47. Cost-effectiveness of pharmacotherapy for smoking cessation NCSCT Briefing, 2012
48. Pokhrel S. Owen L. Coyle K. et al. Costs of disinvesting from stop smoking services: an economic evaluation based on the NICE Tobacco Return on Investment model Lancet Public Health 2016; 388;S95.
49. Stop Smoking Services. Public Health Guideline [PH10], Feb. 2008
50. Tobacco Return on Investment Tool. Version 3.05 NICE.
51. West R. The very best support for stopping smoking. Presentation to UK Nicotine and Smoking Cessation Conference. UKNSCC 2016
52. Robinson S, Bugler C. Smoking and drinking among adults. General Lifestyle Survey 2008. ONS, 2010
53. See for example ASSIST: A stop smoking in schools trial
54. Effectiveness and cost-effectiveness of programmes to help smokers to stop and prevent smoking uptake at local level. NCSCT, 2015
55. Chartered Trading Standards Institute Workforce Survey. June 2016
56. Environmental Health Workforce Survey 2014/15. Chartered Institute of Environmental Health
57. 'Fair Society Healthy Lives'. Report of the Marmot Review, February 2010
58. ASH Fact Sheet: Smoking and disease, ASH, June 2016
59. Five Year Forward View NHS, 2014
60. Lafond S, Charlesworth A, Roberts A. Hospital finances and productivity: in a critical condition? The Health Foundation, April 2015
61. The Autumn Statement: NHS Funding The King's Fund, 2014
62. Cahill K, Stevens S, Perera R, Lancaster T. Medications to help people to stop smoking: an overview of reviews. Cochrane Database of Systematic Reviews, 31st May 2013
63. Chamberlain C, O'Mara-Eves A, Oliver S. et al. Psychosocial interventions for supporting women to stop smoking in pregnancy Cochrane Database of Systematic Reviews, 23 October 2013
64. IMPRESS Guide to the Relative Value of COPD Interventions.
65. Leonardi-Bee J1, Jere ML, Britton J. Exposure to parental and sibling smoking and the risk of smoking uptake in childhood and adolescence: a systematic review and meta-analysis. Thorax. 2011 Oct;66(10):847-55
66. COPD 'Value' Pyramid. What we know so far…. Cost/QALY, London Respiratory Team, NHS London.
67. Sustainability and Transformation Plans. NHS England
68. See for example: DH consultation on funding and commissioning public health services
69. Smoking cessation policy and practice in NHS hospitals. British Thoracic Society, December 2016
70. Szatkowski L, Murray R, Hubbard R et al. Prevalence of smoking among patients treated in NHS hospitals in England in 2010/2011: a national audit. Thorax 2015;70:498-500
71. McManus S, Meltzer H, Campion J. Cigarette smoking and mental health in England. Data from the Adult Psychiatric Morbidity Survey. National Centre for Social Research, 2010
72. Five Year Forward View for Mental Health A report from the independent Mental Health Taskforce to the NHS in England, February 2016
73. Harker K, Cheeseman H. The Stolen Years: The Mental Health and Smoking Report. ASH, 2016
74. Stead LF, Koilpillai P, Fanshawe TR, Lancaster T. Does a combination of stop smoking medication and behavioural support help smokers to stop? Cochrane Database of Systematic Reviews, March 2016
75. Medicines Commissioning News: Wyre Forest CCG, South Worcestershire CCG, Redditch and Bromsgrove CCG, March 2016
76. East Kent Prescribing Group. Information for practices. April 2016
77. Mailing from Windsor, Ascot & Maidenhead CCG to GP practices, 12th May 2016
78. NHS Vale of York CCG Practice Communication, 14th March 2016
79. See for example: ONS Adult smoking habits in Great Britain: 2014
80. Health and Wealth - Closing the Gap in the North East Report of the North East Commission for Health and Social Care Integration