Impact of smoking on Core20PLUS5

April 2022

Introduction

1. This briefing note provides **specific recommendations for ICS prevention plans**. Delivery of the NHS Long Term Plan commitments on tobacco dependency treatment are supplemented with recommendations to support building back better from the pandemic and achieving the Government's smokefree 2030 ambition.

2. The most effective approach to prevention will be through NHS collaboration with local government with the full engagement of Directors of Public Health who are the system leaders for public health. There needs to be a shared plan for reducing smoking across the population that will in turn reduce inequality and the burden of preventable mortality and morbidity on the whole system.

Core20

3. Smoking is the leading modifiable risk factor responsible for health inequalities, accounting for half the ten year difference in life expectancy between the most and least disadvantaged in society.[1] In 2019 the bottom two deciles had smoking rates of 17% compared to top two deciles where smoking rates are 11%. Whether one smokes or not has a far greater impact on life expectancy than a person's social position in society.[2]

4. Annually around 64,000 people die from smoking in England with an estimated thirty times as many suffering from serious smoking-related diseases.[3] [4]

5. Smoking also has a damaging economic impact on smokers and their families. Analysis of government data before the current cost of living crisis found that 1.2 million households in England that include a smoker live in poverty when the cost of smoking is taken into account, including a million children and 400,000 children.[5]

PLUS

6. Smoking is independently associated with every indicator of disadvantage. For example, the odds of smoking are:
    - 2.46 times greater for routine and manual workers (23.4%) than those in professional and managerial jobs (9.3%); and
    - 1.82 times greater for those who are unemployed and seeking work (26.4%%) than those in employment (14.5%); while [6]
    - the highest rates of smoking are associated with the greatest disadvantage, for example in those living without a home (77%).[7]

7. Smoking rates among BAME populations are diverse and mediated by intersectionality with gender and socio-economic status. Smoking rates by ethnicity are highest among those identifying as of mixed ethnic origin (19.5%, more than a quarter higher than the population average). Smoking rates among women are highest among those of mixed (17.2%) or white (13.1%) ethnic origin and are below 10% in all other ethnic groups.**Error! Bookmark not defined.**

5 areas of clinical focus

Maternity

8. One in ten women smoked at time of delivery in 2019/20, with smoking heavily concentrated among younger poorer women in disadvantaged communities (23.1% in Blackpool compared to 2.1% in West London[8]). Smoking during pregnancy is the leading modifiable risk factor for poor birth outcomes, including miscarriage, fetal growth retardation, pre-term birth and stillbirth.

Severe mental illness

9. Mental health conditions are associated with higher rates of smoking are particularly high among those with Serious Mental Illness and higher still for those with complex addictions[9]. Smoking makes a major contribution to the excess mortality and morbidity in these populations and stopping can improve both physical and mental health[10]. For all groups of smokers quitting improves mental wellbeing[11] and some anti-psychotic medications can be reduced when a patient stops smoking[12]. For those addicted to other substances stopping can also aid those treatment outcomes[13].

Chronic respiratory

10. Stopping smoking leads to immediate improvements in respiratory health. Current smokers are:[14]
    - More than five times as likely as non-smokers to have microbiologically confirmed influenza, and twice as likely to develop pneumonia.
    - 36% more likely to be admitted to hospital than non-smokers, and twice as likely to be re-admitted within 30 days.

Early cancer diagnosis

11. Smoking is a major cause of preventable cancers and common cause of those often detected late such as lung and bowel cancer. Smoking status is a key indicator of risk particularly among older patients who have accumulated a lifetime of smoking-related risk. Even following a diagnosis stopping smoking can make a difference to treatment outcomes to the benefit both not just of smokers but also the NHS.[14] For example:
    - A third of patients are smokers at time of diagnosis with lung cancer, by quitting they can increase their average life expectancy from 1.08 to 1.97 years.[15]
    - Smokers undergoing surgery require longer hospital stays and higher drug doses; and have higher risks of heart and lung complications, post-operative infection, impaired wound healing, to be admitted to intensive care and require re-admission to hospital.[16] This is relevant to other priority clinical areas.

Hypertension

12. About 70% of CVD cases are attributed to modifiable risk factors, with hypertension the leading metabolic risk factor, and smoking the leading behavioural factor.[17] It is particularly important for those who have other risk factors such as high blood pressure, raised blood cholesterol levels, diabetes, obesity, or are physically inactive to quit smoking. People who smoke are twice as likely to suffer acute coronary events, and when they do, twice as likely to die from them. Stopping smoking can significantly reduce risks
    - Among heavy smokers, smoking cessation is associated with significantly lower risk of CVD within 5 years compared to current smokers.[18]

- Around 10-15 years after quitting former smokers showed a similar CVD risk to never smokers. Moreover, almost half of the decline in coronary heart disease mortality in England and Wales between 1981 and 2000 has been attributed to reductions in smoking prevalence.[19]

Recommendations

13. **Prioritise implementation of the NHS LTP funded tobacco dependency treatment pathways at pace**. These services are a commitment in the NHS Long Term Plan which should be at the heart of ICS prevention strategies. Funding is provided to fully implement these services across acute, maternity and mental health services by 23/24. However, the speed of implementation is proving variable across ICS's and NHS Trusts and in many cases back-loaded. ASH is tracking the planned and actual implementation of these services and will report back to ICBs on relative progress. ICB leaders have a responsibility to ensure that local implementation is on track and services will be operational at the earliest opportunity.

14. **Develop a joined-up strategy across the NHS and local government for the system on tobacco control.** Directors of Public Health have a wealth of experience to bring to this and can help ensure that comprehensive tobacco control strategies are in place not just locally and at ICS level. Despite significant budgetary constraints during the pandemic local authorities proved their ability to deliver effective and cost-effective smoking cessation and tobacco control interventions to their populations. [20]

15. **Maximise the opportunities of wider national NHSE investment in smoking**. In addition to the tobacco dependency treatment services. NHSE are also piloting approaches to help NHS staff to stop smoking. The NHS employs around 73,000 smokers, who cost the NHS approximately £206 million each year[21]. There are also new pharmacy-based programmes to support people to maintain an inpatient quit started in the community[22]. These should be integrated into a system-wide approach to cessation.

16. ICSs can increase the probability that disadvantaged smokers will try to quit, and that when they do they will succeed by integrating additional activity into their prevention plans:

At population level

- **Fund mass media campaigns to motivate smokers to quit. This can be done across an ICS footprint or at regional level.** Models for regional mass media campaigns can be seen in the North East, Yorkshire and Humber and Greater Manchester (see paras 21-25 for evidence of cost-effectiveness). These regional approaches have a track record of increasing the rate of decline in smoking prevalence.[23]
- **Improve the integration of smoking cessation into cancer screening programmes.** Both invite letters and screening interventions for lung health checks and bowel cancer should include evidence-based advice to quit for all smokers. Screening interventions should encourage smokers to quit on an opt out basis.

In secondary care

- **Require all NHS Trusts to include smoking status on the admission checklist.** The latest British Thoracic Society audit[24] found that 23% of patients weren't

asked if they smoked on admission. This is an important requirement for delivery of the LTP but also in ensuring all patients get timely VBA.

- **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.**

Leadership

- **ICBs and Trusts should sign the NHS Smokefree Pledge[25] and local councils should sign the Local Government Declaration on Tobacco Control[26].** These are public commitments to tackling smoking by NHS and local government leaders on behalf of their organisations. 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,

Effectiveness of treatment services

17. Tobacco dependence treatment, including pharmacotherapy and behavioural support, increases successful quitting by three times over quitting abruptly also known as "cold turkey" and is the most cost-effective intervention after flu vaccinations.[27]

18. Stop Smoking Services are atypical in not conforming to the inverse care law.[28] [29]In fact, although throughput has fallen due to lack of promotion of the Services, in 2018/19 only 11% of those setting a quit date came from those in managerial and professional occupations, compared to 27% who were routine and manual. All together more than half (52%) were from disadvantaged groups (27% R&M; 14% unemployed for over a year or never worked; 10% sick/disabled and unable to return to work; 1% prisoners) compared to only 11% from professional and managerial groups.[29]

19. Success in quitting is linked to the level of addiction, and the environment smokers live in (poorer more disadvantaged smokers live in communities where smoking is more common, making it harder to quit). Quit success varies from 43% of students to 59% of retired smokers, but there was not much difference between managerial and professional (58%) and R&M smokers (55%). [29]

Evidence of effectiveness of mass media

20. Mass media campaigns have immediate impact, can be targeted with precision at disadvantaged smokers and are highly cost-effective. Comprehensive evaluation of the FDA mass media campaign, Tips from Former Smokers found that it cost less than £400 per quitter, and £220 per QALY gained (at current exchange rates), far below the £20,000 to £30,000 cost per QALY threshold set by NICE, and less than the cost per QALY of smoking cessation treatment.[30]

21. Such campaigns play an important role in motivating smokers to try to quit. In 2008 40% of adult smokers in England had tried to quit in the last year, in 2018 this had fallen by a quarter to only 30%. Over the same time period funding for mass media campaigns had fallen by 90% from £23.3 million in 2008/9 to around £2.4 million in 2018/19.[31] [32]

22. The annual PHE anti-smoking campaign, Stoptober, was estimated in 2012 to have generated an additional 350,000 quit attempts in England and saved 10,400 discounted life years (DLY) at less than £415 per DLY in the modal age group. In 2012/13 the national spend on mass media by PHE was over £8 million. [33] Broadcast media (TV and radio) are also the most trusted media, while trust in the Internet and social media is low.[34]

23. When due to funding cuts Stoptober only ran on digital media in 2016, there was a reduction in campaign recognition from 71% the previous year to 48% and the campaign was less effective at reaching older and poorer smokers.[35] The evidence is clear that exposure to campaigns is needed to drive awareness; digital and social media alone are not effective.

24. Such campaigns can be effective regionally as well as nationally, when implemented across logical media footprints. The NHS across the north of England has already invested successfully in a number of such campaigns, for example the 16 cancers campaign in 2019,[36] originated by Fresh North East, the dedicated regional tobacco control programme. The ICS in the North East of England is currently funding a campaign by Fresh North East on TV and radio, backed up by digital and social media.

25. The most sustained investment in recent years has been by the GM Health and Social Care Partnership. Since campaigns started in Greater Manchester in 2018. the proportion of adult smokers trying to quit in the last year has been sustained at around 40%.

To discuss any of these recommendations further please get in touch with our Deputy Chief Executive (email hazel.cheeseman@ash.org.uk)

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