7.3.5 Smoking (Adults and older people) Brighton & Hove JSNA

Why is the issue important?

Tobacco remains one of the most significant public health challenges in England today killing 200 smokers a day.[1]

There are more than eight million adult smokers, half of whom are likely to die prematurely as a result of smoking if they do not quit.[1]

Smoking accounts for over one-third of respiratory deaths, over one-quarter of cancer deaths, and about one-seventh of cardiovascular disease deaths.[2]

Smoking related costs are a huge burden on society costing the NHS alone approximately £2 billion a year for treating diseases caused by smoking.[3]

Smoking cessation is the single most cost effective life-saving intervention. In 2012-13, the government spent £87.7m on services to help people stop smoking and a further £58.1m on stop smoking medication.[2]

Table 1 shows the number of years gained against the age people stopped smoking.[4]

Table 1: Years of life gained by stopping smoking, by age

Age stopped smoking	Years of life gained
30	10
40	9
50	6
60	3

Source: Doll R et al. BMJ 2004.[4]

Key outcomes

- ***Smoking prevalence in adults 18 years or over (Public Health Outcomes Framework)***

Impact on Brighton & Hove

The Public Health Outcomes Framework and Local tobacco profiles provide a snapshot of the extent of tobacco use, tobacco-related harm and the measures being taken to reduce this harm in Brighton & Hove.[5,6] Deaths due to smoking and the smoking prevalence in Brighton & Hove in the adult population are both significantly worse than the England average:

21%

The smoking prevalence in Brighton & Hove in 2015 is estimated to be 21%, significantly higher than England (17%). A fall from 25% in 2012

34%

According to the Annual Population Survey, the smoking prevalence for routine and manual workers in the city is 34% compared with 21% for all adults. The rate is significantly higher than England (26.5%)

370

Between 2012 and 2014 there were on average 370 deaths per year attributable to smoking in the city. This is an age-sex standardised rate of 305 deaths per 100,000 people compared with the England average of 275 deaths per 100,000 people

£82.9million

The estimated annual cost due to smoking in lost productivity, smoking-related illnesses, domestic fires and clean-up operations in Brighton & Hove adds up to a total cost of £82.9 million

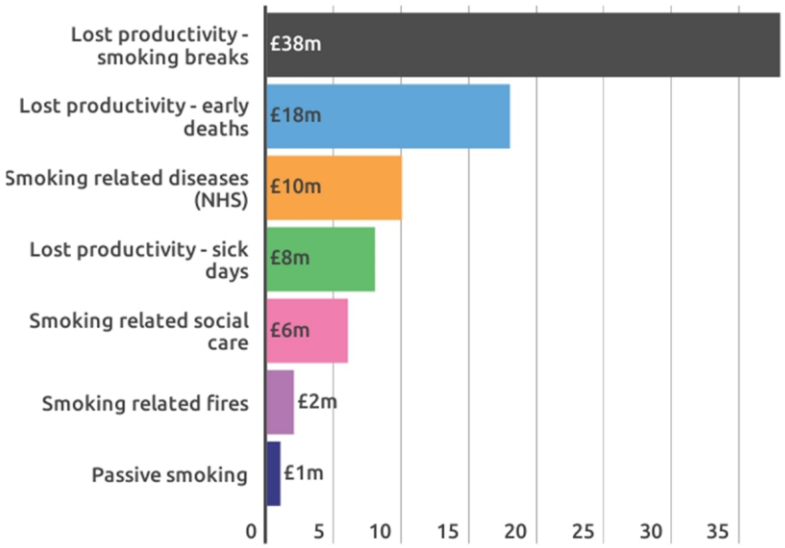
Source: Public Health Outcomes Framework and Local tobacco profiles[5,6]

The Brighton & Hove Health Counts Survey 2012[7] estimates smoking prevalence at 22%. This is similar to the most recent Annual Population Survey (2015) estimating smoking prevalence in Brighton and Hove to be 21%.

Figure 1 highlights the estimated annual cost due to smoking in lost productivity, smoking-related illnesses, domestic fires and clean-up operations in Brighton & Hove – adding up to a total cost of £82.9 million.[3]

[1] ASH. Smoking Still Kills: Protecting children, reducing inequalities. 2015. Available at: http://www.ash.org.uk/files/documents/ASH_962.pdf [Accessed 26/07/2016]
[2] ASH. Facts at a glance: Smoking statistics. 2016. Available at: http://www.ash.org.uk/files/documents/ASH_93.pdf [Accessed 26/07/2016]
[3] ASH. Local toolkit: the case for local action on tobacco. 2015. Available at: http://www.ash.org.uk/information/ash-local-toolkit [Accessed 26/07/2016]
[4] Doll R et al. Mortality in Relation to Smoking: 50 Years Observations on Male British Doctors. BMJ 2004. 328pp. 1519-27.
[5] Public Health England. Public Health Outcomes Framework. Available at www.phoutcomes.info [Accessed 30/08/2016]
[6] Public Health England (2016). Local Tobacco Control Profiles for England http://www.tobaccoprofiles.info/ [accessed 26 July 2016]
[7] NHS Brighton and Hove and Brighton & Hove City Council. Health Counts Survey. 2012. Available at: http://www.bhconnected.org.uk/content/surveys [Accessed 5 July 2016]

Figure 1: Estimated cost of smoking (£m) in Brighton & Hove



Source: Ash local toolkit
http://www.ash.org.uk/information/ash-local-toolkit

Source: NHS Stop Smoking Service data[8]

A recent audit conducted by the Clinical Commissioning Group and Public Health team[9] of premature deaths from cardiovascular diseases, or with respiratory disease (COPD) or diabetes found that most patients had a record of their smoking status (98%), with 83% a last recording within the two years prior to their death. The audit also showed that:

- Whilst the general smoking prevalence in the city was 24% for 18-74 year olds, for those in the audit it was 46% and for patients dying prematurely with COPD it was 56%.
- Those drinking at increasing or high risk levels were significantly more likely to smoke (68% were current smokers) than those drinking at lower risk (40%).
- The median age at death was significantly younger for patients who are current smokers (63.5 years) than for ex-smokers (68).
- There was low recording of advice/ referral for smoking and other lifestyles issues.

Where we are doing well

Local data shows that in 1992, 27% of people in Brighton & Hove were daily smokers and that in 2012 this had statistically significantly decreased to 14%. The percentage of respondents smoking occasionally rose from 6% to 9% over the last twenty years but overall the smoking prevalence rate (daily and occasional smokers) fell from 33% to 22% - a statistically significant fall.[7]

There had been a slight reduction in inequalities in smoking in the city between 2003 and 2012.[7]

Local inequalities

According to the Annual Population Survey, the smoking prevalence for routine and manual workers in the city is 34% compared with 21% for all adults. The rate is significantly higher than England (26.5%).

Other data on local inequalities is available from the 2012 Health Counts Survey,[7] which showed:

- There is no significant difference in smoking prevalence for males (25%) and females 22%)
- There is however, a clear relationship with age, with smoking prevalence falling with age but with a few exceptions – for example in men smoking prevalence increases between

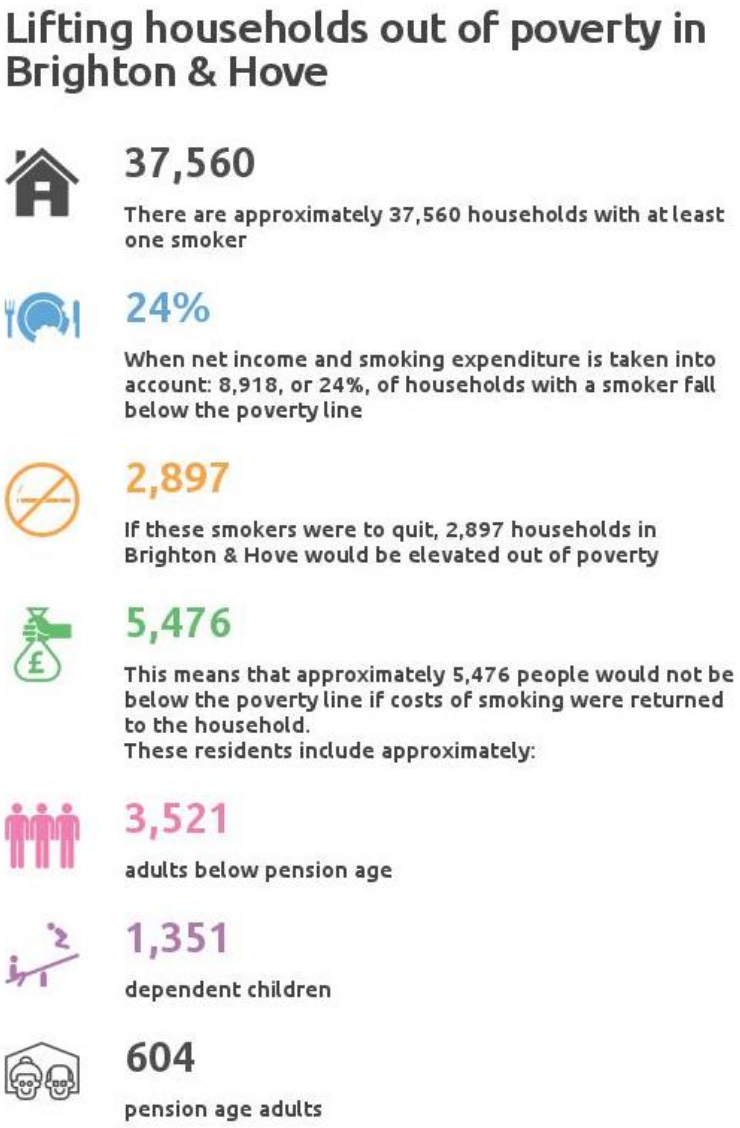
[8] Health and Social Care Information Centre. Statistics on NHS Stop Smoking Services in England - April 2014 to March 2015. Available at: http://www.hscic.gov.uk/catalogue/PUB18002 [Accessed 5 July 2016]
[9] NHS Brighton and Hove Clinical Commissioning Group and Brighton & Hove City Council. Preventing Premature Mortality Audit. 2015

the ages of 18-24 years and 25-34 years where it reaches 35%. By the age of 75 years or over, for males and females, smoking prevalence reaches its lowest point (5% for males and 10% for females).

- Smoking prevalence is strongly associated with deprivation, and those living in the most deprived 20% of areas in the city are more than twice as likely to smoke as those living in the 20% least deprived areas.
- LGB and unsure respondents (30%) are more likely to say that they smoke than heterosexuals (22%) – though neither group was significantly different to all respondents. The highest smoking prevalence is seen amongst bisexuals (40%) – significantly higher than for all respondents.
- Those who are single are significantly more likely to smoke (33%) than those who are married, in a civil partnership or living as a couple significantly less likely (18%).
- There was no difference in smoking prevalence between BME and White British respondents (23%). Smoking prevalence is highest in Mixed ethnic groups (32%) although this difference isn't significant.
- There is no significant difference in smoking prevalence by religion (27%).
- There is no significant difference between carers (24%) and all respondents.
- Respondents who own their own homes (14%) are significantly less likely to smoke, but those who rent from a private landlord (31%), or from a housing association or local authority (42%) or were significantly more likely to smoke daily or occasionally.
- Respondents who are unemployed and looking for work, unable to work due or caring for home and family are significantly more likely to smoke (41%).
- Respondents with degree level, or higher, qualifications are significantly less likely to smoke (15%).

Because smoking is so harmful, differences in smoking prevalence across the population translate into major differences in death and illness rates. Smoking is the single most important driver of health inequalities.

Smoking is so corrosive to individual, family and community health that any success in reducing smoking has benefits beyond health. Supporting people to permanently quit smoking will significantly improve health and reduce health inequalities in Brighton & Hove. The scenario on poverty and smoking shows how smoking cessation can aid reducing poverty in the city.



Source: ASH Smoking and Poverty Calculator [10]

Brighton & Hove stop smoking services work with all smokers who want to quit with a special focus

10 Action on Smoking and Health. Smoking and Poverty Calculator. http://www.ash.org.uk/current-policy-issues/health-inequalities/health-inequalities-resource-pack [accessed July 2016]

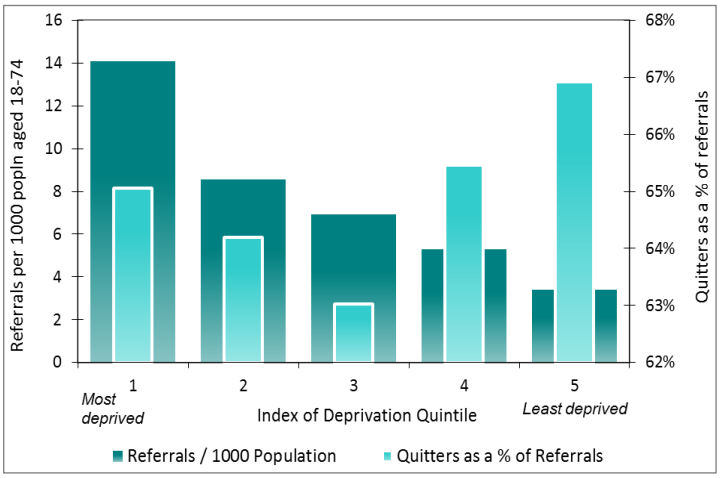
on routine and manual workers, hospital Inpatients, BME Communities, young people, lesbian, gay, bisexual and transgender residents, and individuals with HIV.

In England, routine and manual workers are most likely to be heavily addicted compared with managerial and professional groups.[11]

Local stop smoking data shows that in 2015/16 62% of routine/manual workers quit compared to 70% for intermediate and managerial workers.

Figure 2 shows that the clients referred to the local Stop Smoking Service from the most deprived areas had a relatively low quit rate compared with the least deprived areas. However, the service is effectively targeted, getting more people from deprived areas into the service.

Figure 2: Referrals and quitters for the Brighton & Hove Stop Smoking Service by quintile of deprivation, 2015/16



Source: Public Health Intelligence, Brighton & Hove City Council

Recent intelligence gathered by voices within the community such as gypsy and traveller groups, people with mental health conditions, young men aged 18-24, LGBT communities, carers, people with disabilities, BME groups and older people will inform future work to reduce health inequalities [12]. Common themes that arose from voice information include:

- promoting new evidence around e-cigarettes
- targeting smoking cessation intervention in community settings using health trainers
- use of incentives to help people to quit smoking
- developing resources that are culturally relevant and targeted
- promoting smoking cessation through better use of social media and identifying relevant communication channels to expand reach. Linking in with national campaigns.
- work with existing programmes offered to these communities to identify and raise awareness about smoking
- reducing barriers to NRT and pharmacotherapy support
- identifying role models within communities to promote smoking cessation
- developing messages that resonate with young people around the impact of smoking on development and being clear what a smoker is
- developing peer support groups to support and sustain quits in the community.

Predicted future need

While there has been a significant decline in smoking prevalence since 2003, in the past few years smoking prevalence has plateaued. This is similar to the national trend.

What we don't know

We do not have a good understanding of the extent of illicit tobacco activity in Brighton & Hove. Cheap and accessible tobacco makes it easy for young people to take up smoking and undermines national and local policies and interventions to encourage people to quit.

In order to plan effective methods of reducing health inequalities through tobacco control, we must have a comprehensive understanding of our population and factors that influence tobacco use amongst priority groups in order to target them more effectively and improve resource utilisation.

[11] Department of Health. A smokefree future. A comprehensive tobacco control strategy for England. 2010.
12 Brighton and Hove Clinical Commissioning Group. Commissioned services undertaking health promotion research. 2015

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Recent voice information from CCG commissioned health promotion organisations will help to inform strategies, however it will be important to continue engaging with these groups to improve engagement and services.

Key evidence and policy

- **Stop smoking services** - Research has shown that smokers are four times more likely to stop smoking when accessing a dedicated stop smoking service.
- **Commissioning** - NICE evidence-based guidance which will assist with the commissioning and delivery of stop smoking interventions.
- **E-cigarettes** - There is emerging evidence to suggest that e-cigarettes are 95% less harmful than cigarettes. E-cigarettes are a popular quitting aid and are helping people to reduce the harm of tobacco. The revised EU Tobacco Products Directive places limits on the manufacture and marketing of e-cigarettes to be sold in the UK.
- **Smokefree laws** - Smoking has been prohibited by law in virtually all enclosed and substantially enclosed work and public places throughout the United Kingdom since July 2007. More recently smoking was banned in cars with passengers under the age of 18 years. Smokefree legislation in England forms part of the Health Act 2009. In Brighton & Hove the legislation is enforced by Council Regulated Services Environmental Health team and police.
- **Underage sales** - Underage sales laws makes it is illegal to sell nicotine inhaling products such as e-cigarettes, cigarettes or other forms of tobacco or tobacco products, including cigarette papers, to a person under 18 years. It is also illegal to purchase any of the products on behalf of someone under 18 years.
- **Tobacco display** - Evidence shows that the display of tobacco products in shops can promote smoking by young people and undermine the resolve of adult smokers who are trying to quit. There are provisions regulating tobacco displays in the Health Act 2009 and related regulations which are being implemented in large shops from 6 April 2012 and for all other businesses selling tobacco to the public on 6 April 2015.

A new tobacco plan for England is expected to be published in 2016 to replace the Tobacco Control Strategy in 2011 – Healthy Lives, Healthy People: A Tobacco Control Plan for England.

Recommended future priorities

There is a need to more effectively help the most deprived groups to stop smoking and reduce the associated health inequalities. The current ambitions of the Tobacco Control Plan for England have been met and a new tobacco plan is due for publication in 2016. This will set tough new ambitions for England. Smoking still kills (2015) put forward the following national targets as recommendations to government:

- Reduce smoking in the adult population to 13% by 2020 and 9% by 2025
- Reduce smoking in the routine and manual socio-economic group to 21% by 2020 and 16% by 2025
- Reduce smoking among pregnant women to 8% by 2020 and 5% by 2025
- Reduce regular and occasional smoking among 15-year-olds to 9% per cent by 2020 and 2% by 2025.

The Brighton & Hove tobacco control plan 2016-2019 outlines the priorities for reducing smoking prevalence in adults, young people and preventing the take up of smoking in young people. These include:

1. The NHS Brighton & Hove Stop Smoking Service will continue to provide a specifically tailored service to the community, targeting people in high prevalence groups, such as routine and manual workers, LGBT communities, young people, people with mental health conditions and residents living in areas of deprivation.
2. The Brighton & Hove Tobacco Control Alliance, working together as partners, to succeed in reducing smoking prevalence and health inequalities in the city.

3. Using intelligence provided by the voices in the community, partner with Brighton and Hove Clinic Commissioning Group commissioned Health Inequalities Organisations and other voluntary sector organisation to engage in smoking cessation.
4. Build capacity within the Health Improvement Team to provide targeted community outreach services to reduce health inequalities.
5. Improve data collection from primary care so that up-to-date analysis can be used to target resources more effectively.
6. Raise awareness of the NHS Brighton & Hove Stop Smoking Services in the city including domiciliary services for housebound patients who want to quit smoking and promotion of an 'e-cig friendly' service.
7. Encourage smokers who also vape (dual users) to access stop smoking services for behavioural support and pharmacotherapy to quit smoking cigarettes for good.
8. Train voluntary sector and health professionals in very brief advice on stopping smoking and second-hand smoke to make every contact count.
9. Undertake initiatives to tackle the issue of illicit tobacco in Brighton and Hove including understand the extent of illicit tobacco activity in Brighton and Hove. Such initiatives may involve participating in a regional survey.

Key links to other sections

- Maternal and infant health
- Smoking (Children and young people)
- Cancer
- Coronary heart disease
- Respiratory disease

Further information

Department of Health. Healthy Lives, Healthy People: A Tobacco Control Plan for England
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_124917

Local tobacco control profiles
http://www.lho.org.uk/LHO_Topics/Analytic_Tools/TobaccoControlProfiles/

Action on Smoking and Health
http://www.ash.org.uk/

Health and Social Care Information Centre
http://www.hscic.gov.uk/

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