Health and Wellbeing Board Locally Determined Priority: Smoking

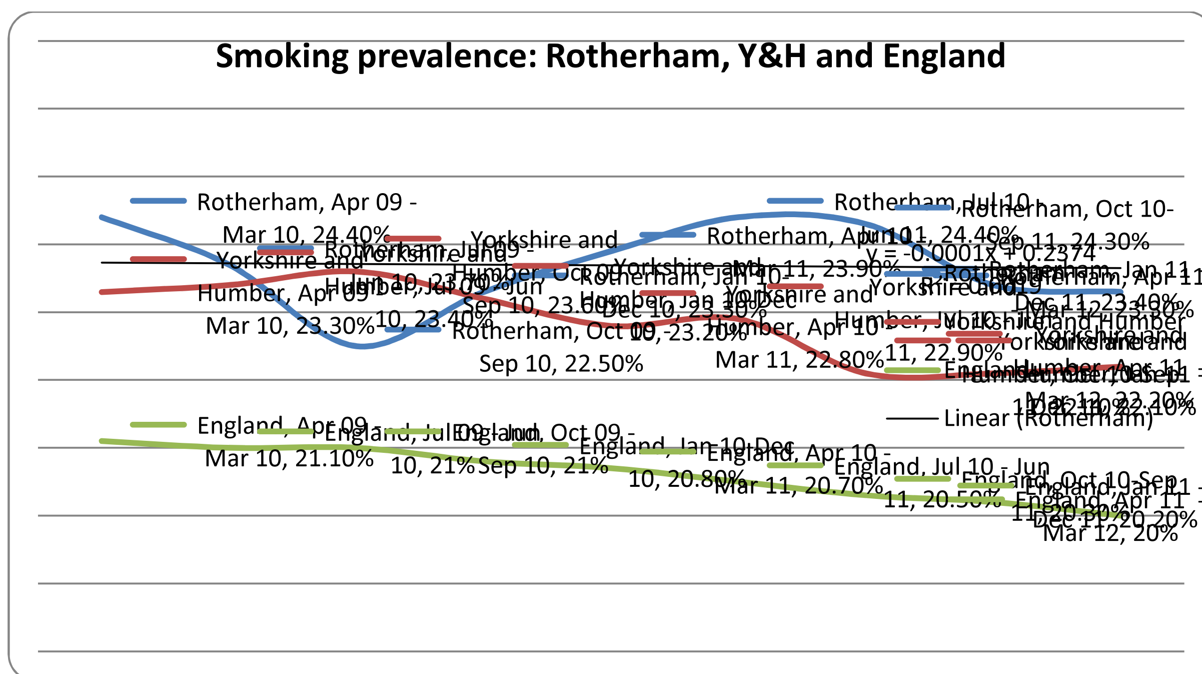
Briefing paper on tobacco control

Providing background information to the presentation

Smoking and tobacco control remains a key national priority as the decline in smoking rates slows and tobacco use continues to be the main cause of preventable death. The public health outcomes framework contains three indicators for smoking prevalence: adult prevalence, prevalence at age 15 and prevalence at time of delivery (smoking in pregnancy rate). Tobacco use in Rotherham is higher than the England average on all indicators. Tobacco is the only product that, when used as directed by the manufacturer, kills 50% of its consumers.

Adult smoking

Rotherham smoking prevalence is currently around 23.5%, compared to an England average of 20%. This masks vast differences between boroughs, with some areas having rates of close to 50%.



Source: Integrated Household Survey, ONS (experimental statistics)

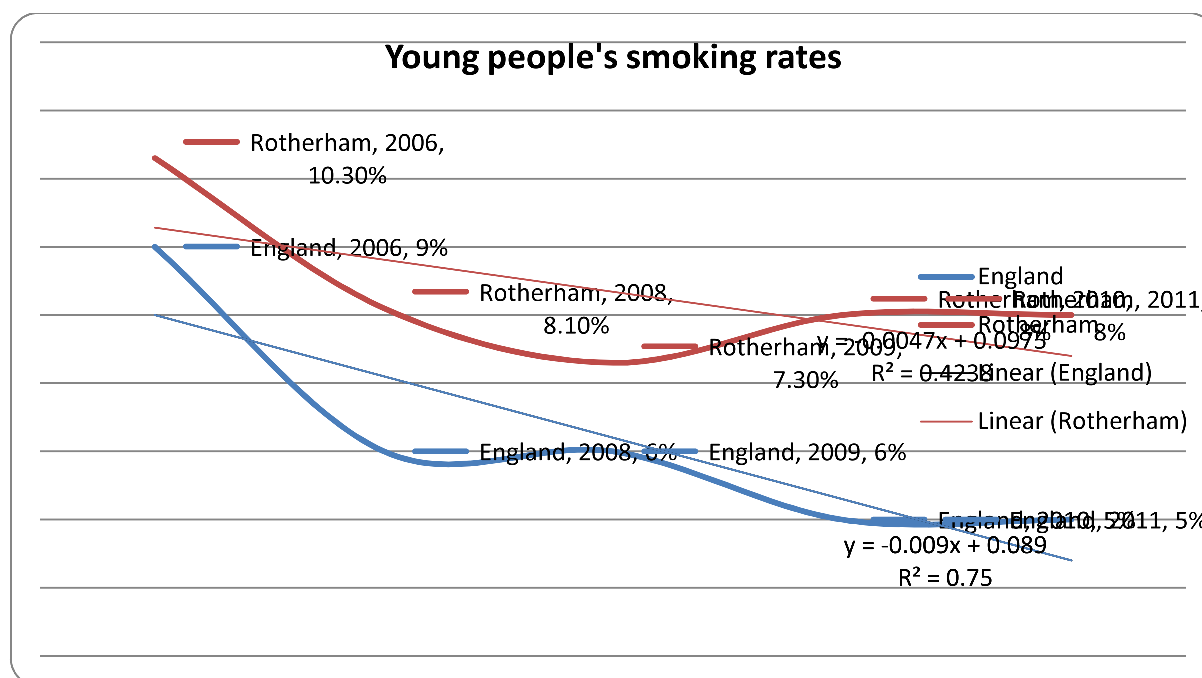
The required measure for adult smoking, up until 31 March 2013, was achieving a set number of 4-week quitters. Our local services have regularly delivered more successful quitters per 100,000 population than the regional and national average. However, the relapse rate for 4-week quitters is high with only around 20% of 4-week quitters still being non-smokers at 12 months. The number of new and relapsed smokers is similar to the number who quit or who die, which means smoking prevalence is remaining fairly static.

National data shows that desire to quit and quit attempts are also reducing. In 2011 two-thirds (67%) of smokers said they wanted to quit smoking, significantly less than the 74% who reported

they wanted to quit in 2007 (Smoking Toolkit Study). The same study also found a year on year decline in people making quit attempts, from 42.5% people making a quit attempt in 2007 to 33.5% in 2011.

Young people's smoking

Children, not adults, start smoking. Over 80% of smokers will start before they are 19, and nearly 40% before they are 16. Exposure to adult smoking increases the likelihood of a child taking up smoking with 99% of all 16 year old smokers living in a household where at least one other smoker (ASH, 2012).



Sources:
1. Smoking, drinking and drug use among young people in England in 2011. National Centre for Social Research, 2010: NHS Information Centre for Health and Social Care.
2. Rotherham Young People's Lifestyle Survey

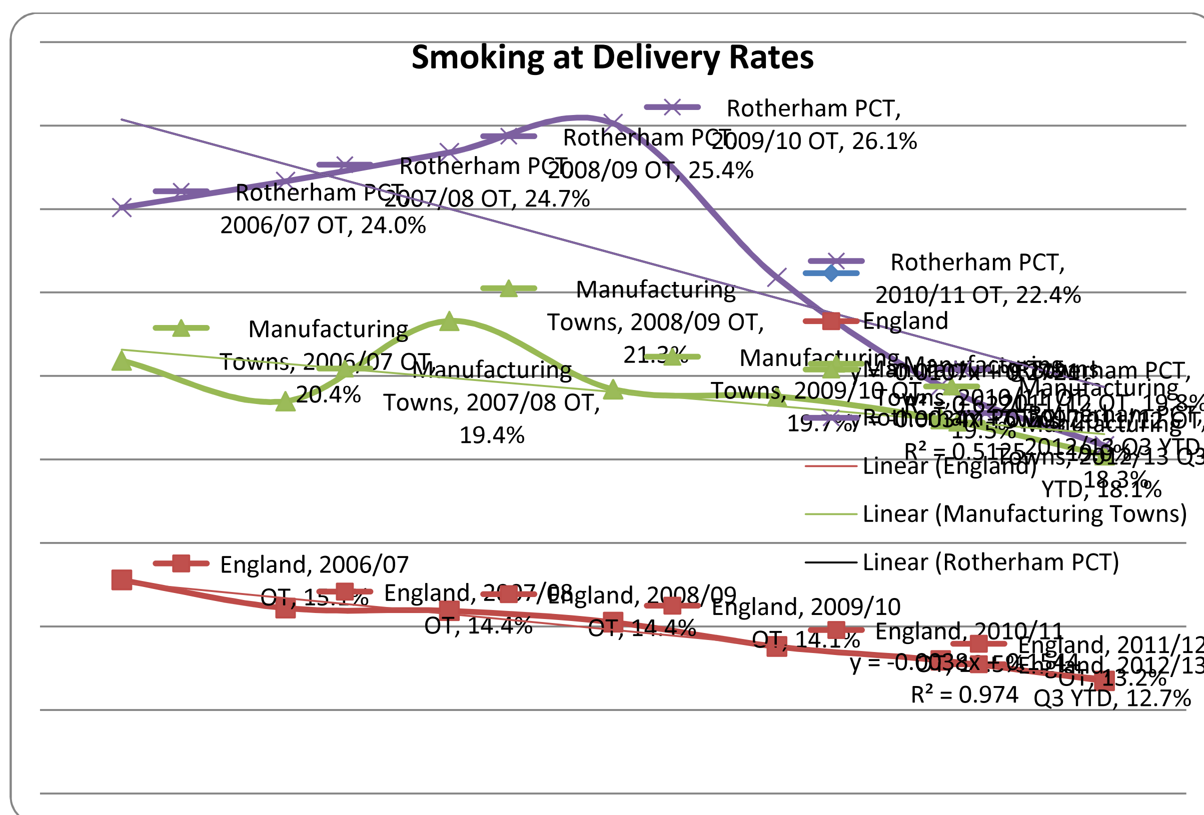
Smoking rates among young people in Rotherham are higher than the England average and the gap is widening, but these figures need to be viewed with caution as they are taken from two different surveys. There is currently no consistent data collection of young people's smoking rates that can be broken down to local areas, although this is in development to fulfil the PH outcomes framework indicator. The local survey asks young people to make a judgement on whether their smoking is social/occasional or regular whereas the Information Centre survey asks whether people smoke every day, more than once a week, once a week etc and then applies the descriptor of 'regular' to those who smoke daily or weekly. The national survey also asks a range of young people between ages 11 and 15, whereas our local survey is conducted at years 7 and year 10 only.

Smoking rates increase as children get older. Both sets of data include younger pupils who will have lower smoking rates. The PH outcomes indicator is for smoking prevalence at 15 years, so we would expect the rates to be higher than those shown here. For information, 11% of 15 year olds nationally smoke regularly; in the local lifestyle survey 14% of Year 10 pupils identified themselves as regular smokers.

There is little evidence for the effectiveness of cessation support for young people; the focus should be on prevention of uptake. We currently provide smokefree class resource packs for secondary and primary schools, each providing a series of 10 in-class activities focusing on promoting the benefits of not smoking and challenging the social norms around young people and smoking. Rotherham also has an active Smokefree Homes programme. Another key issue for tackling young people's smoking rates is to reduce their access to tobacco products. Trading standards obtain intelligence and take action on cheap and illicit tobacco, underage sales and 'fag houses', but the local Lifestyle Survey shows nearly 40% of Year 10 smokers get their cigarettes from local shops.

Smoking in pregnancy

Smoking in pregnancy causes serious complications for mother and baby, including increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy (Royal College of Physicians (RCP), 1992; Salihu and Wilson, 2007). Active maternal smoking causes about 5000 miscarriages, 300 perinatal deaths and 2200 premature births in the UK each year (RCP, 2010).



Source: The Health and Social Care Information Centre, Lifestyle Statistics / Omnibus

Smoking in pregnancy rates are falling at a rate faster than national rates, but the gap between Rotherham and the England picture is still too large. The recent falls are a result of the new pathway embedding smoking cessation advice into routine antenatal care. All pregnant smokers have at least one intervention from the specialist stop smoking midwives as part of their routine antenatal care, whether or not they have expressed an interest in stopping smoking. When a woman attends for her routine scan or any other antenatal appointments, if she is a smoker she will be directed to see the midwife. If she is already receiving support to quit this can provide an additional contact and motivation. If she has not shown any interest before, the midwife delivers a hard-hitting

intervention to describe the harms of smoking to the mother and baby, relating it to local data on still-births, labour complications etc. If the woman still declines help this is recorded in her notes as having refused treatment.

However, the rate of reduction has flattened this year. We still need to continue to encourage women to quit before they get pregnant, to get more women choosing to quit at the earliest point in pregnancy and to support those women who have achieved a 4-week quit to maintain that quit through to delivery and beyond.

Smoking is not just a health issue

Cheap and illicit tobacco

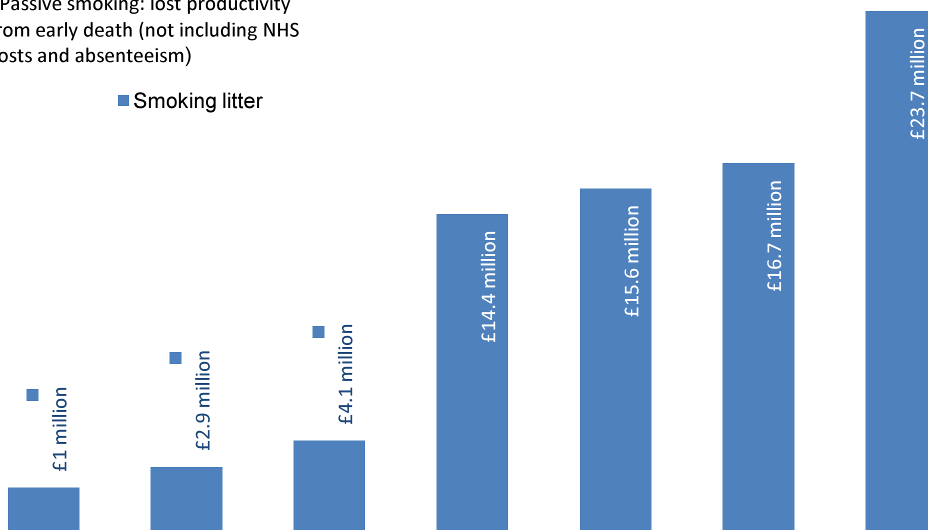
There is a growing supply and use of cheap and illicit tobacco. The term 'cheap and illicit' covers all non UK duty paid products, whether they are genuine products purchased abroad for 'personal use' and sold on by the purchaser, counterfeit versions of regular brands, or brands that have no legal market anywhere (eg Jin Ling). Illicit tobacco is associated with organised crime, with brands such as Jin Ling being produced specifically for smuggling and funding criminal activity. The sale of illicit tobacco takes place in retail premises (under the counter sales), from individuals selling in face to face (car boot sales, markets, white van trade) and 'fag houses', where single cigarettes are often sold to children and young people, which also raises safeguarding concerns.

Cheap and illicit tobacco is not subject to the same quality standards as legal tobacco products. They frequently have higher levels of the toxins that are found in standard cigarettes, as well as factory detritus including floor sweepings, sawdust and rat droppings.

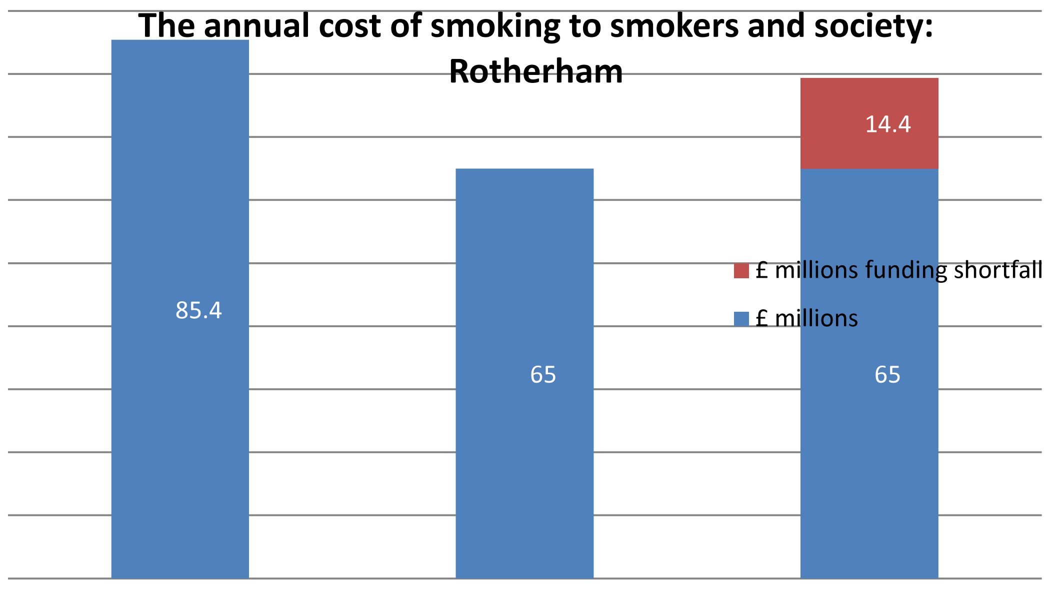
There is a direct relationship between the price of tobacco and smoking prevalence; the World Bank estimates a 10% increase in price leads to a 4% reduction in prevalence. However, the continued availability of cheap and illicit tobacco undermines any impact of price rises.

Economic consequences

The economic consequences of smoking are significant to the local economy, estimated to cost around £79m each year, and are not just additional healthcare costs.



Source: ASH *The case for local action on tobacco*, 2012



Source: ASH *The case for local action on tobacco*, 2012

Smokers in the borough spend more than £85 million on tobacco each year, which contributes £65m to the Exchequer. However, the societal cost is far greater than this, meaning we have a shortfall in funding of £14.4m, or 18%. The figures assume that all tobacco expenditure is on legal, duty-paid products, but we know that national estimates are that 10% of cigarettes and 46% of hand rolling

tobacco is illicit with no contribution to the public purse, and therefore the funding shortfall is likely to be far greater.

A comprehensive programme of tobacco control

Healthy Lives, Healthy People: A Tobacco Control Plan for England (DH, 2011) states that 'Comprehensive tobacco control is more than just providing local stop smoking services or enforcing smokefree legislation.' A comprehensive commissioned tobacco control programme should fulfil the locally deliverable aspects of the World Bank's six strand approach to tobacco control:

- stopping the promotion of tobacco
- making tobacco less affordable
- effective regulation of tobacco products
- helping tobacco users to quit
- reducing exposure to secondhand smoke
- effective communications for tobacco control

Historically almost all funding for tobacco control goes into support to stop smoking and almost nothing into preventing uptake, dedicated activity to reduce the availability of cheap and illicit tobacco and to promoting smokefree as the social norm. This situation isn't unique to Rotherham, and is a result of the 4-week quitter targets – when the target was to achieve larger and larger numbers of 4-week quitters the funding inevitably went into increasing capacity to support quit attempts. We know from the Smoking Toolkit Study that only around 5-6% of quit attempts are made with NHS support despite widespread promotion of services, yet we currently do nothing to provide information and advice to the majority of smokers trying to quit who don't want or use NHS support about what they can do to maximise their chances.

Collaborative work across South Yorkshire and with the School for Health and Related Research (SChARR) at the University of Sheffield has determined a plan for future commissioning of a broader programme of tobacco control, with a shift in the balance of funding away from stop smoking support to free up resources to support the other aspects of a tobacco control programme.

References:

Action on Smoking and Health (ASH) (2012) *The case for local action on tobacco.* Available at: http://ash.org.uk/localtoolkit/index.html

Department of Health. Healthy Lives, Healthy People: A Tobacco Control Plan for England. 2011

Office for National Statistics. Social Survey Division. *Integrated Household Survey*

National Centre for Social Research, 2010: NHS Information Centre for Health and Social Care. *Smoking, drinking and drug use among young people in England in 2011*

Rotherham Metropolitan Borough Council (2012) *Rotherham Young People's Lifestyle Survey* available at http://www.rotherham.gov.uk/downloads/file/7914/lifestyle_survey_2012

Royal College of Physicians (1992) *Smoking and The Young.* RCP, London

Royal College of Physicians (2010) *Passive smoking and children: A report by the Tobacco Advisory Group of the Royal College of Physicians*. RCP, London

Salihu HM, Wilson RE (2007) Epidemiology of prenatal smoking and perinatal outcomes. *Early Hum Dev* **83**(11): 713–20

The Health and Social Care Information Centre, Lifestyle Statistics / Omnibus (2013) *Statistics on Women's Smoking Status at Time of Delivery*

West R, Brown J (2013) Smoking Toolkit Study. Latest data and publications available at: www.smokinginengland.info