Public Health England

Protecting and improving the nation's health

Tobacco Control: JSNA support pack

Key data sources for planning effective tobacco control in 2017-18

Somerset

(using latest available data)

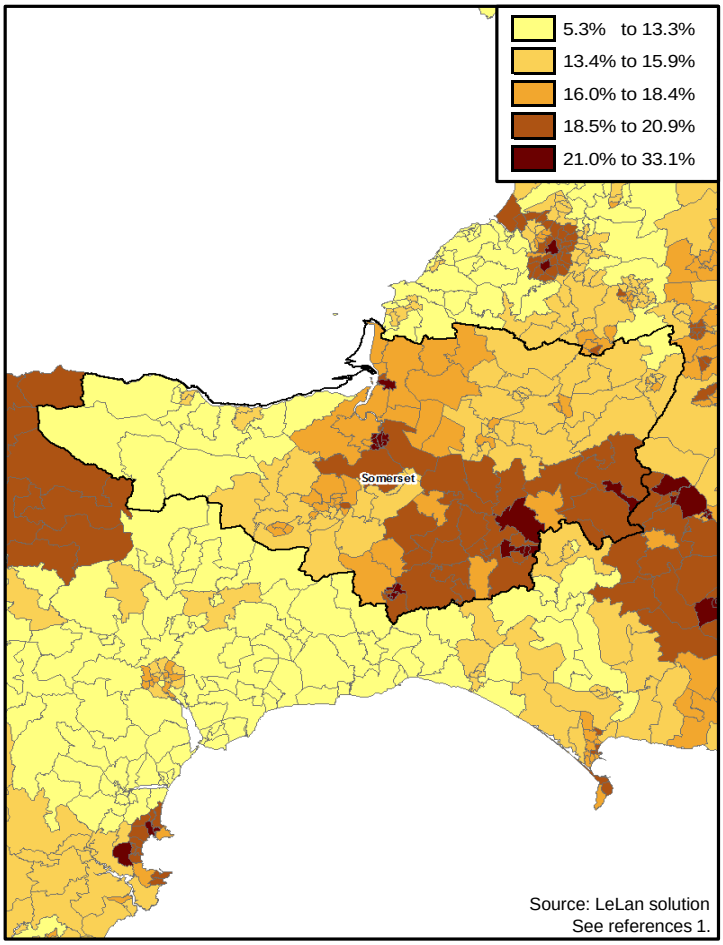
INTRODUCTION

Smoking continues to kill almost 80,000 people in England every year and is the number one cause of preventable death in the country, resulting in more deaths than the next six causes combined. Tobacco use is also a powerful driver of health inequalities and is perhaps the most significant public health challenge we face today. To fully understand how your local tobacco control network is responding to these problems, locally and nationally held data can be used. Data relating to local areas' targeted tobacco control interventions are not collected nationally, though should be available at a local level.

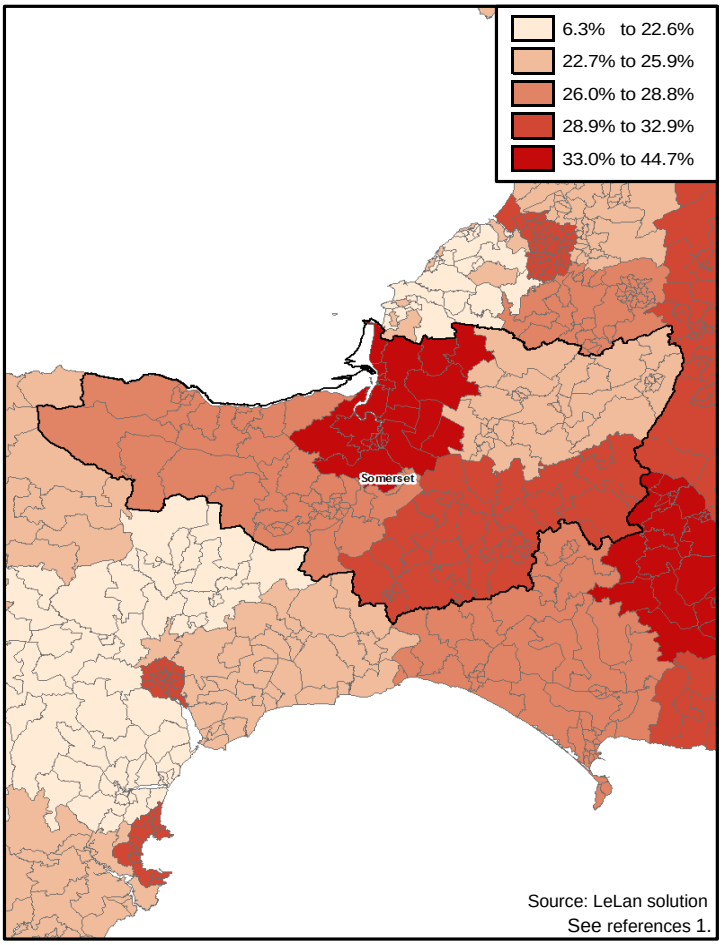
This pack aims to signpost you to available tools and datasets to support your work in making the case for local tobacco control interventions. Feedback and debate on the range of tools and datasets available nationally is encouraged; as well as an opportunity to champion the use of local data sources and analysis. The tools referenced within this pack are routinely updated with the latest datasets. Readers are reminded that this resource is comprised of extracts from the tools referenced at time of publication (October 2016) and are encouraged to access the tools directly for the most up-to-date data.

REDUCING HEALTH INEQUALITIES

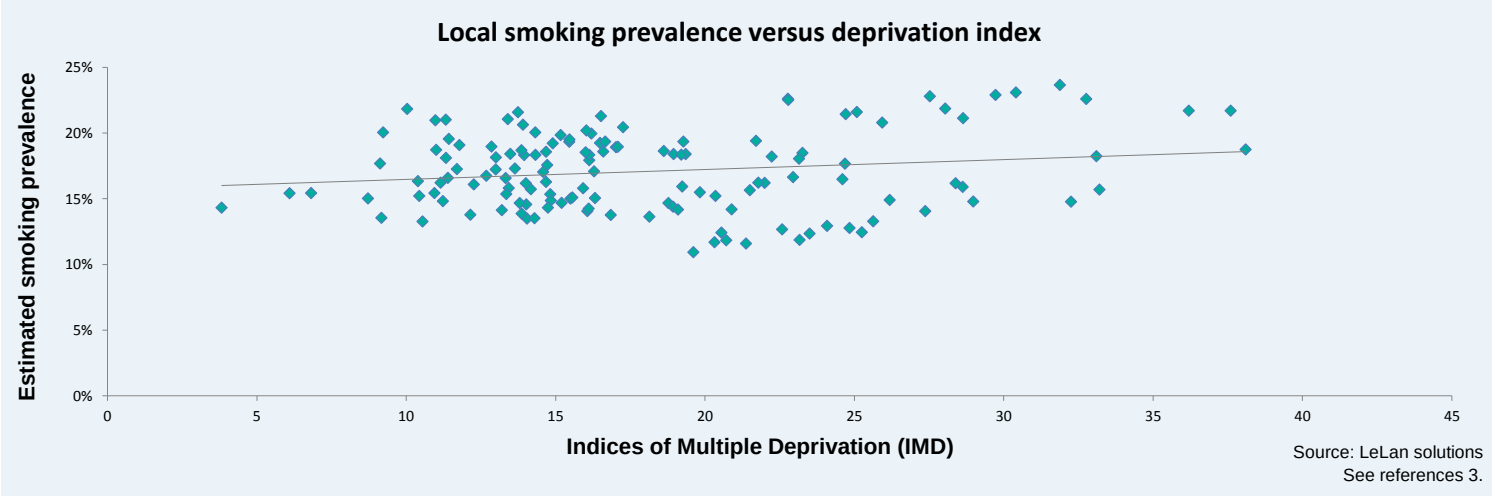
Smoking prevalence 18+ (Ward level)



Smoking prevalance 18+ routine and manual (Borough level)

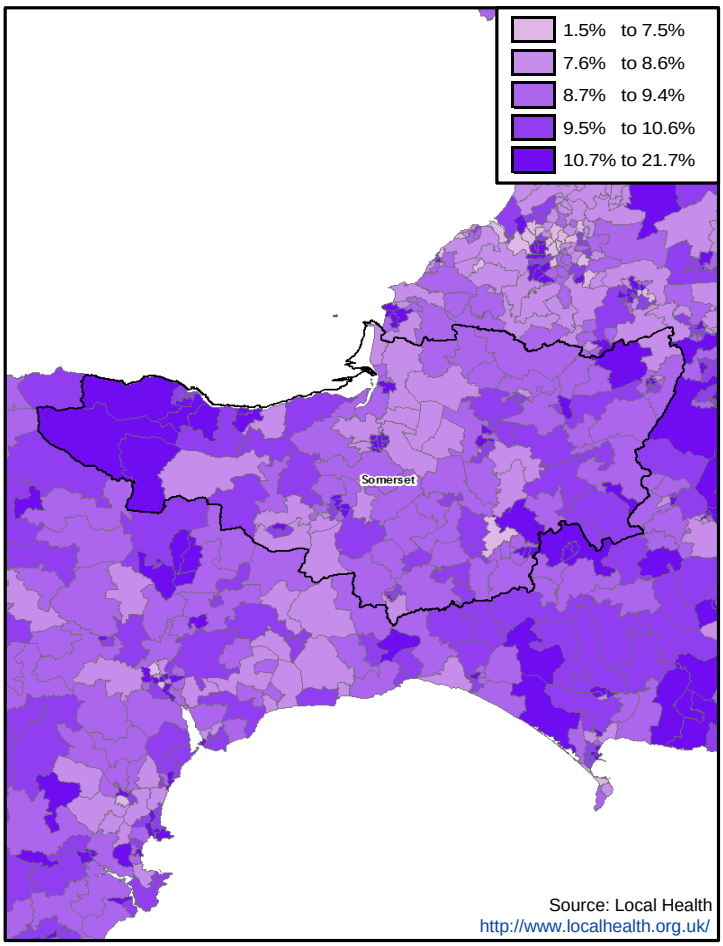


Smoking rates are much higher within certain groups and deprived communities. Smoking is around twice as common among people with mental disorders, and more so in those with more severe mental illnesses (estimates vary between 37% and 56%).[2] Lesbian, gay and bisexual communities are also significantly more likely to smoke, as are the long-term unemployed, and some minority ethnic groups, which also have gender disparities. Helping disadvantaged smokers quit is the best way to reduce health inequalities. Commissioners are encouraged to identify their communities most in need and target evidenced based interventions accordingly.



YOUTH SMOKING PREVALENCE

Regular smoker, modelled prevalence age 15 (Ward level)



There are several risk factors associated with increased likelihood of smoking initiation among young people. The following are associated with higher odds of youth smoking: exposure to parent, carer, sibling and peer smoking, lower socio economic status, higher levels of truancy and substance misuse.[4] Smoking prevention is therefore not achieved by youth targeted interventions alone.

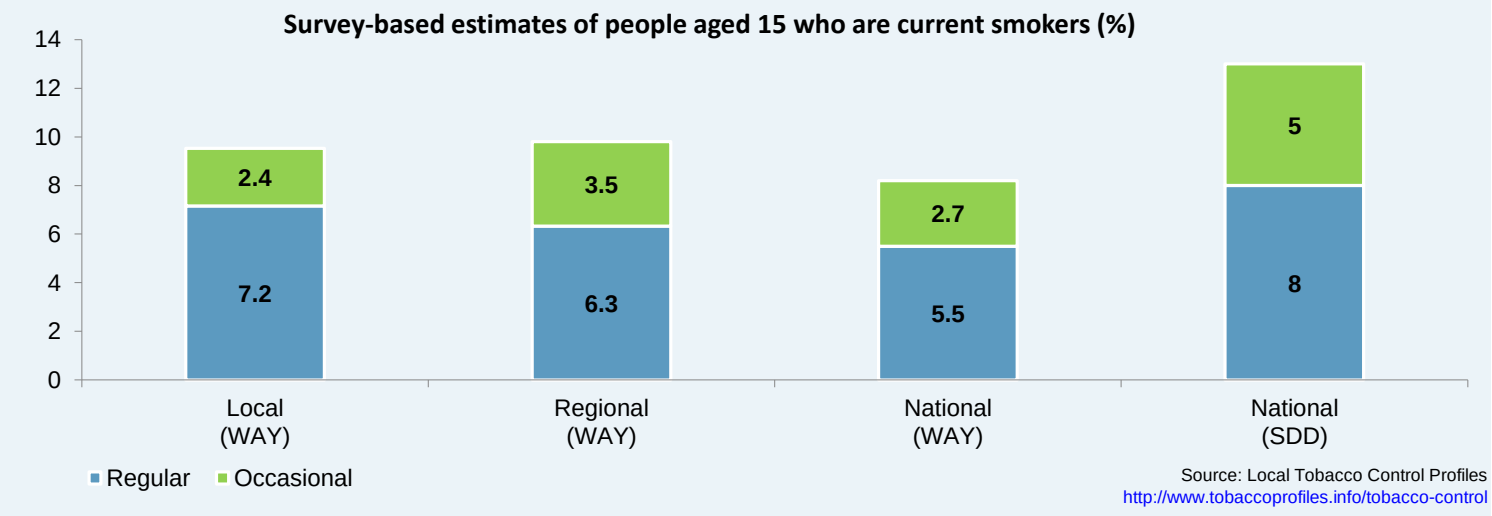
NICE guidance for smoking prevention suggests that school based interventions, mass media interventions and enforcement to restrict illegal access to tobacco among young people are effective.[5,6] The impact of these interventions are considered more effective when delivered as a package of multi component interventions in family and community settings, particularly where there is an increased emphasis on reducing adult smoking through cessation.[7]

'Securing a Tobacco Generation' resources

These resources have been created with content from Public Health England's national conference 'Working together to secure a tobacco-free generation'. The conference, delivered in association with the UK Centre for Tobacco and Alcohol Studies (UKCTAS) and Action on Smoking and Health (ASH) attracted delegates from across England working at national, regional and local levels to focus on effective strategies for tobacco control.

The resources include video presentations, instructions for facilitated discussion and tools for planning tobacco control interventions and can be used to i) facilitate delivery of local seminars, and ii) to inform planning of tobacco control interventions.

http://prezi.com/ovi0oixi92oy/working-together-to-secure-a-tobacco-free-generation/



Current data sources for youth smoking prevalence are:

The Children and Young People's Health Benchmarking Tool:
fingertips.phe.org.uk/profile/cyphof

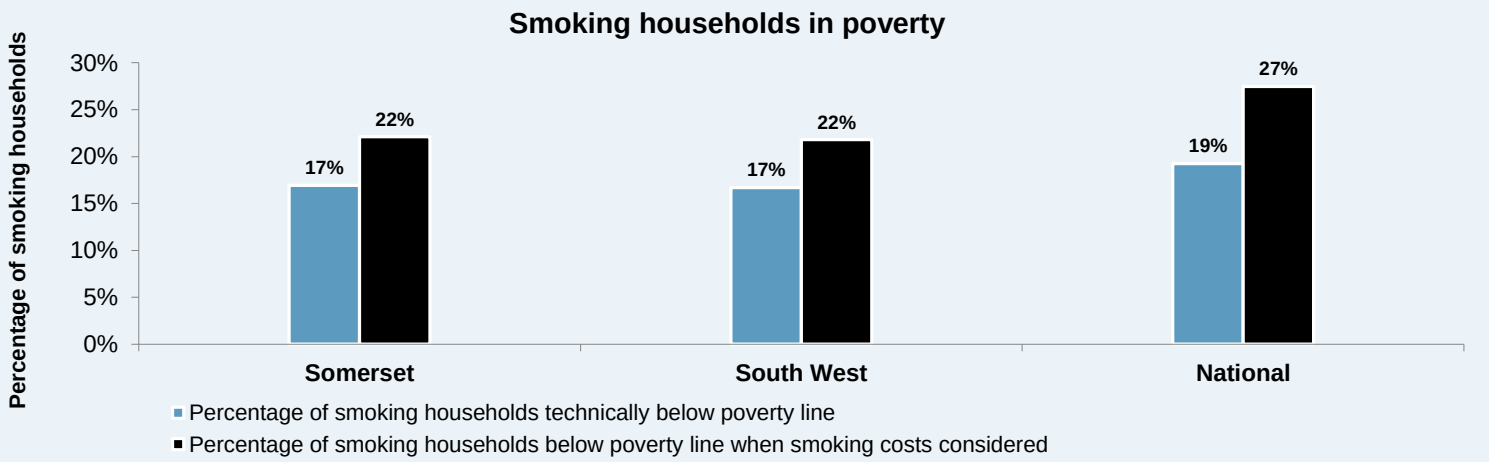
The Smoking, Drinking and Drug Use Amongst Young People in England survey 2014:
http://content.digital.nhs.uk/catalogue/PUB17879

The What About Youth survey:
www.whataboutyouth.com

FAMILY POVERTY

Approximately half of all smokers in England work in routine and manual occupations. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles and unemployed people are twice as likely to smoke as those in employment. Ill-health caused by smoking is therefore much more common amongst the poorest and most disadvantaged in society.
When expenditure on tobacco is taken into account, around 500,000 extra households, comprising over 850,000 adults and almost 400,000 children, are classified as in poverty in the UK compared to the official Households Below Average Income figures. This shows that tobacco imposes a real and substantial cost on many low-income households.
It is important, however, to avoid concluding from these results that a suitable policy response would be to reduce tobacco taxation to make tobacco products more affordable. Previous research shows that increases in tobacco taxation are potentially a progressive measure in economic and health terms because poorer smokers are more likely to quit, and young people less likely to take up smoking, when tobacco prices increase because poorer households and young people are more sensitive to price increases.[8] Indeed, raising tax is the only tobacco control intervention which has been proven to have a greater effect on more disadvantaged smokers at population level and so contribute to reducing health inequalities.[9]

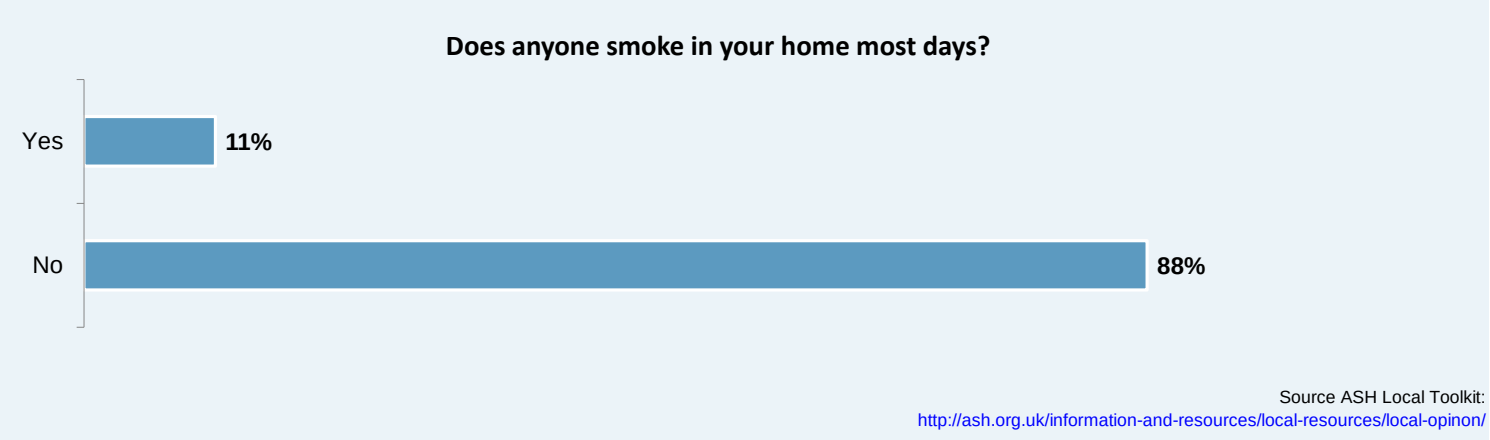
See also
Estimates of poverty in the UK adjusted for expenditure on tobacco:
http://ash.org.uk/category/information-and-resources/health-inequalities/health-inequalities-resources/



Source: Estimates of poverty in the UK adjusted for expenditure on tobacco
http://ash.org.uk/category/information-and-resources/health-inequalities/

SMOKING IN THE HOME

In this survey, over 8 in 10 adults in the South West region said that they do not allow smoking anywhere in their home or only in places that are not enclosed (such as in the garden or on a balcony). Only a minority (11%) stated that they would allow smoking anywhere in their house, or only in some rooms.



Source ASH Local Toolkit:
http://ash.org.uk/information-and-resources/local-resources/local-opinon/

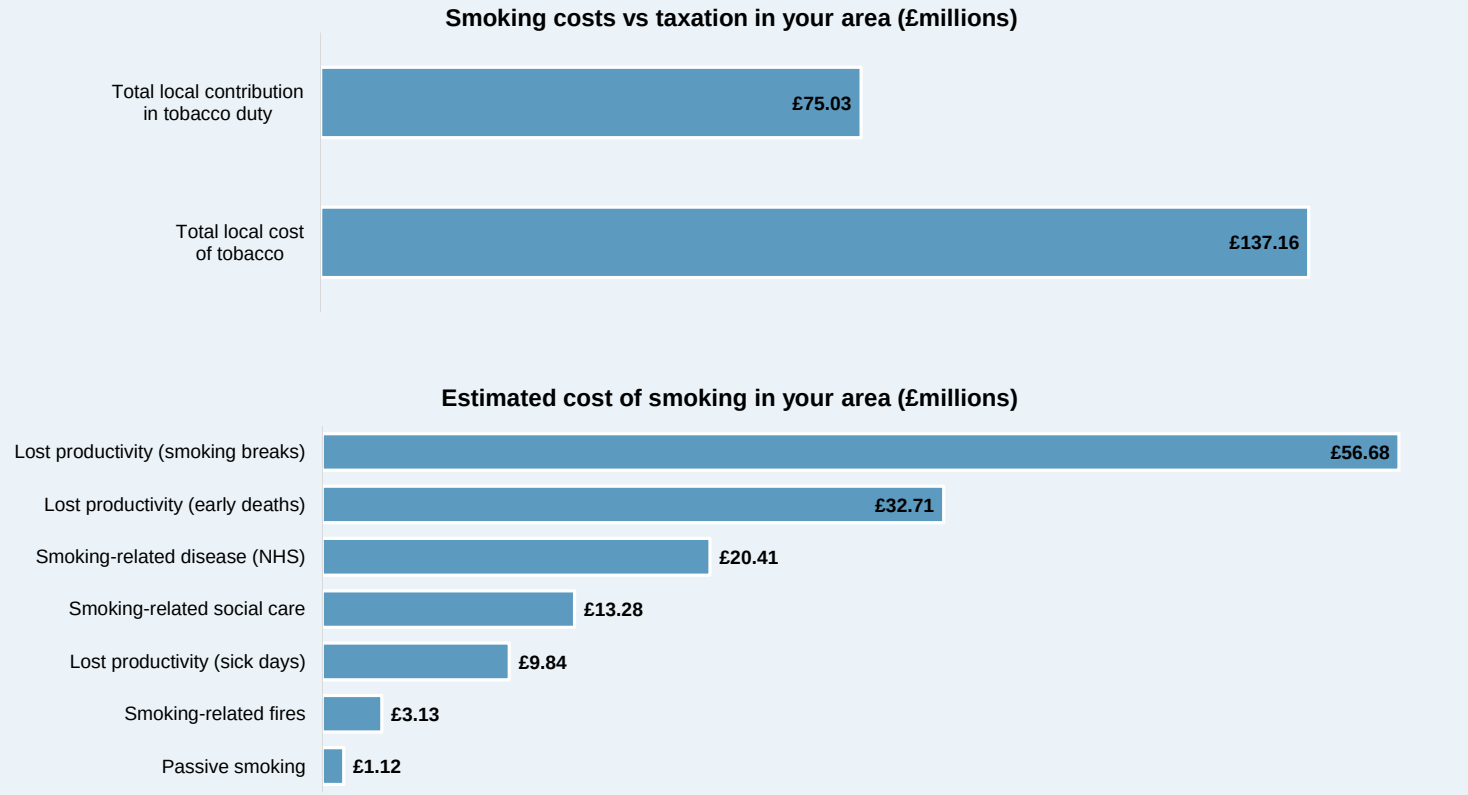
SOCIETAL COST OF TOBACCO CONTROL

Working together, ASH, the Faculty of Public Health, the Local Government Group, FRESH North East, Healthier Futures and Public Health Action have produced the Local Tobacco Control Toolkit. This provides local public health professionals with a set of materials to use with Councillors and other stakeholders to help ensure that tackling tobacco use is high on the local public health agenda. The online tool allows for analysis down to the local district and ward level.

Together these resources will allow you to:

- demonstrate the scale of the harm locally caused by tobacco use and the contribution this makes to health inequalities,
- demonstrate the cost to local communities, local economies and service providers,
- demonstrate the evidence of effectiveness of local action on tobacco and health.

The materials are designed for you to easily integrate local data from the Local Tobacco Control Profiles and the NICE Return on Investment tool.



In 2014/15, smokers in Somerset paid approx. £75.0m in duty on tobacco products.

Despite this contribution to the Exchequer, tobacco still costs the local economy in Somerset roughly twice as much as the duty raised. This results in a shortfall of about £62m each year.

Source: ASH Ready Reckoner Dec 2015 update. Version 5.3 (15 Jul 2016)
http://ash.org.uk/download/reckoner-local-costs-of-smoking/

COST OF SMOKING TO SOCIAL CARE

The total spending on social care for adults aged 50 and over during 2012-13 in Somerset was approximately:

£ 11,941,777

This represents 10,371 individuals requiring additional social care.

Total local authority spending on social care for adults aged 50 and over in 2012-13:

£ 6,857,384

This equates to 425 state-dependant individuals

Total spending by self-funded individuals aged 50 and over on social care:

£ 5,084,393

In addition, a further 9,945 individuals receive informal care from friends and family, the impact of which cannot be estimated here.

Research shows that smoking not only contributes to the social care bill but also has a significant impact on the wellbeing of smokers who need care on average nine years earlier than non-smokers.

The information in this extract synthesises data based on an analysis by Howard Reed of Landman Economics, for Action on Smoking and Health, entitled “The Cost of Smoking to the Social Care System in England” June 2014. The full report can be downloaded at: www.ash.org.uk/SocialCareCosts

LOCAL STOP SMOKING SERVICES

Stop smoking services are a key component of highly cost-effective tobacco control strategies at local and national level. Targeted, high-quality stop smoking services are essential to the reduction of health inequalities for local populations. All health and social care services can play a key role in identifying smokers and referring people to stop smoking services. For those people who are not ready, willing, or able to stop in one step, harm reduction interventions can support them in moving closer to becoming smokefree. Specialist interventions provided by trained practitioners are the most effective way of quitting smoking successfully. The quality of services has remained consistently high (51%), with services supporting 382,500 people during 2015/16, 195,170 for whom were successful at 4 weeks.

Stop Smoking Service Data

This data enables local authorities to benchmark their performance and identify which treatment settings and intervention types are consistently getting the best results.

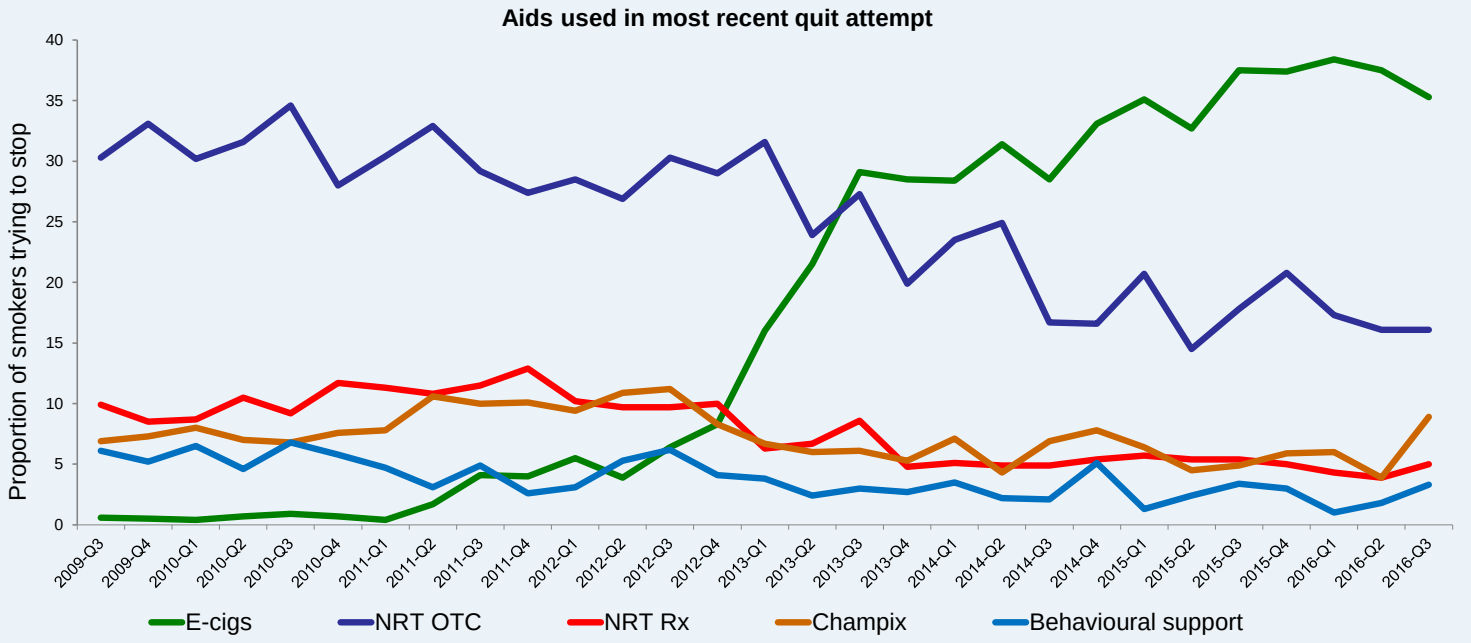
	Local					National	Comparison of 15/16 local and National data
	2014/2015		2015/2016			2015/2016	
18+ smoking population (data from ASH reckoner 2015 and 2016)	**78,690**	**18%**	**77,163**	**18%**	▼	**18%**	
Number setting a quit date per 100,000 of population aged 16 and over	**1,033**		**566**		▼	**862**	
Number of successfully quit (self-report) per 100,000 of population aged 16 and over	**447**		**276**		▼	**440**	
Number setting a quit date	**4,612**		**2,546**		▼	**382,500**	
Number not known/lost to follow up	495	11%	774	30%	▲	23%	
Number of successful quitters (self-report)	1,994	43%	1,240	49%	▲	51%	
Number who had successful quit (self-report), confirmed by CO validation	1,707	37%	925	36%	▼	36%	
Number of pregnant women setting a quit date	**395**		**423**		▲	**17,443**	
Number not known/lost to follow up	112	28%	88	21%	▼	24%	
Number of successful quitters (self-report)	211	53%	232	55%	▲	45%	
Number who had successful quit (self-report), confirmed by CO validation	178	45%	199	47%	▲	28%	

Source: Statistics on NHS Stop Smoking Services
2014/15: http://content.digital.nhs.uk/catalogue/PUB18002
2015/16: http://content.digital.nhs.uk/catalogue/PUB21162

* Data suppressed in source

E-cigarettes and quit smoking support

E-cigarettes have become the most popular stop smoking aid in England. There is growing evidence that they can be effective in helping smokers to quit, particularly when combined with behavioural support from local stop smoking services. Currently, there are no medicinally licensed e-cigarettes available on the market and they cannot be prescribed for smoking cessation. However stop smoking services are encouraged to be open to smokers who want to use an e-cigarette in their quit attempt, and to provide the expert support that will give them the best chance of stopping smoking successfully.



Adults who smoke and tried to stop or who stopped in the past year.
Any use of quit aids during quit atempt, groups are not exclusive.

Source: The Smoking Toolkit Study, Electronic cigarettes in England
http://www.smokinginengland.info/latest-statistics/

SMOKERS WITHIN THE HEALTHCARE SYSTEM

Over a quarter of all hospital admissions are attributable to smoking and smoking is the primary reason for the gap in life expectancy between rich and poor. Direct costs to the NHS are estimated to be c£2.5bn and costs to social care c£1.1bn. Smoking causes cancers, circulatory disease, respiratory disease as well as impotence and infertility. Smokers that manage to quit reduce their cost to the NHS and social care providers by 48%. Greatest long-term savings would result from preventing people from ever smoking altogether, but the short-term opportunity lies in helping smokers who are in contact with the NHS to stop smoking.

Smoking in Pregnancy

Addressing smoking in pregnancy should be a focus for all localities as this impacts on a range of issues related to health, inequalities and child development. NICE has produced guidance on how best to support women to stop smoking in pregnancy.[10] Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risk of developing a number of respiratory conditions, attention and hyperactivity difficulties, learning difficulties, problems of the ear, nose and throat, obesity and diabetes.[11,12,13] Although rates are lower than in the past, 10.6% of women in England are recorded as smoking at the time of delivery, which translates into nearly 70,000 infants born to smoking mothers each year.[14] There are significant demographic differences and factors associated with inequalities related to this issue. For instance, pregnant mothers under the age of 20 are more than three times as likely to smoke as mothers aged 35 or over. Those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke throughout pregnancy (29% and 7% respectively).[15] Infants born to smokers are much more likely to become smokers themselves, which further perpetuates health inequalities. Treating mothers and their babies (0-12 months) with problems caused by smoking during pregnancy is estimated to cost the NHS between £20 million and £87.5 million each year.[16]

	Local		National		
Smoking at time of delivery (2014/15) *Denominator: Maternities*	752	14.1%	70879	11.4%	Source: www.tobaccoprofiles.info
Low weight live births (2014) *Denominator: Live births*	106	2.1%	17231	2.9%	Source: www.tobaccoprofiles.info
Stillbirths (2015) *Denominator: Live births*	17	0.3%	2952	0.4%	Source: ONS - Birth Summary Tables - England and Wales
Neonatal deaths (South West, 2014) *Mortality rates, see source*	156	2.7	1811	2.7	Source: ONS Death registrations summary tables England and Wales

* Value missing in source

Cessation in Secondary Care Settings

Savings to the NHS can be accelerated by treating tobacco dependence as an essential part of care plans for patients.

This can be achieved by a whole hospital approach as per *NICE PH48 guidance* by: 1) screening and recording smoking status during every patient episode; 2) providing immediate access to nicotine replacement therapy (NRT) and or pharmacotherapies; 3) enabling smokers to access specialist in-situ support to quit; 4) automatic e-referral for intensive behavioural support and other specialist treatment; 5) training of healthcare staff to deliver interventions; and 6) making secondary care settings smoke-free.

Initiating treatment for tobacco dependency in hospital is critical but success will depend on continuing care after discharge. Patients who smoke should leave hospital with a clear treatment plan to address their tobacco dependence.

	Local		National		
Interventions in Secondary Care (2015/16) *Denominator: All interventions*	133	5.2%	11228	2.9%	Source: Statistics on NHS Stop Smoking Services England, April 2015 to March 2016 http://content.digital.nhs.uk/catalogue/PUB21162

Cessation in Mental Health Settings

People with mental health problems smoke significantly more and are more dependent on nicotine than the population as a whole, with levels about three times those observed in the general population. It is recognised that admission to a secure mental health unit can be an opportunity to intervene to reduce smoking and that interventions are welcomed and effective. Supporting individuals to stop smoking while receiving NHS care represents a significant opportunity to close the gap in morbidity and mortality, between those people experiencing mental health conditions, and the general population.

	Local		National		
Interventions in MH Acute (2015/16) *Denominator: All interventions*	0	0.00%	658	0.17%	
Interventions in MH Community (2015/16) *Denominator: All interventions*	1	0.04%	358	0.09%	Source: Statistics on NHS Stop Smoking Services England, April 2015 to March 2016 http://content.digital.nhs.uk/catalogue/PUB21162

Tools & Resources

PHE has published a NICE endorsed tool to support MH trusts in assessing their progress towards being smokefree. A tool aimed at Acute trusts has also been developed.

This and other useful resources can be found at:

https://www.gov.uk/government/publications/smoking-cessation-in-secondary-care-mental-health-settings

British Thoracic Society (2013) The Case for Change: Why dedicated, comprehensive and sustainable stop smoking services are necessary for hospitals

National Centre for Smoking Cessation and Training; including the clinical case for proving stop smoking support to hospitalised patients

London Clinical Senate programme: Helping Smokers Quit: Adding value to every clinical contact by treating tobacco dependence

LOCAL KNOWLEDGE AND INTELLIGENCE SERVICE (LKIS)

The Local Knowledge and Intelligence Service (LKIS) is one of the six functional areas within the knowledge and Intelligence Division, and part of the Chief knowledge Officer Directorate in PHE. They support the development and use of nationwide health intelligence tools and rescources. There is a single point of access to all PHE data and analysis tools:
www.gov.uk/guidance/phe-data-and-analysis-tools

This includes Public Health Profiles on over 20 topics such as the Public Health Outcomes Framework, Children and Young People, Mental Health, Cardiovascular Disease, and other tools such as Local Health and Spend and Outcomes Tool (SPOT).

If you have a specific request for support, including please contact your local team:
LKISSouthWest@phe.gov.uk

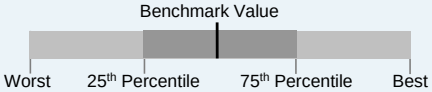
LOCAL TOBACCO CONTROL PROFILES

The Local Tobacco Control Profiles for England provides a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level. These profiles have been designed to help local government and health services to assess the effect of tobacco use on their local populations. They will inform commissioning and planning decisions to tackle tobacco use and improve the health of local communities. The online tool allows you to compare your local authority against other local authorities in the region and against the England average. The tobacco control profiles are part of a series of products produced by Public Health England providing local data alongside national comparisons to support local health improvement.

Tobacco Control Profiles	Period	Local value	Eng. Value	Eng. Worst	England range	Eng. Best
Smoking Prevalence in adults - current smokers (IHS)	2014	17.8%	18.0%	26.9%		9.8%
Smoking prevalence in adults in routine and manual occupations - current smokers (IHS)	2014	29.6%	28.0%	41.1%		14.0%
Successful quitters at 4 weeks	2014/15	2,438	2,829	957		5,741
Successful quitters (CO validated) at 4 weeks	2014/15	2,087	1,954	478		4,953
Completeness of NS-SEC recording by Stop Smoking Services	2014/15	68.6%	88.3%	30.8%		100%
Smoking status at time of delivery	2014/15	14.1%	11.4%	27.2%		2.1%
Low birth weight of term babies	2014	2.1%	2.9%	5.8%		1.6%
Lung cancer registrations	2012 - 14	62.4	79.7	154.6		38.3
Oral cancer registrations	2012 - 14	12.0	14.2	23.4		9.8
Deaths from lung cancer	2012 - 14	45.7	59.5	107.7		29.8
Deaths from chronic obstructive pulmonary disease	2012 - 14	42.7	51.7	103.6		28.1
Smoking attributable mortality	2012 - 14	228.9	274.8	458.1		184.9
Smoking attributable deaths from heart disease	2012 - 14	25.4	29.7	58.1		18.9
Smoking attributable deaths from stroke	2012 - 14	8.2	9.3	17.8		6.3
Smoking attributable hospital admissions	2014/15	1,602	1,671	2,835		1,030
Cost per capita of smoking attributable hospital admissions	2011/12	36.0	38.0	59.3		23.0
Cost per quitter	2014/15	£519	£420	£1,185		£98
Indicative tobacco sales figures (£ millions)	2013	£156	£15,446			

Compared with benchmark Better Similar Worse

* Value missing in source



Source: Local Tobacco Control Profiles (October 16)
www.tobaccoprofiles.info/tobacco-control

INVESTMENT & VALUE FOR MONEY

The NICE tobacco return on investment tool has been developed to help decision making in tobacco control at local and sub-national levels. The tool evaluates a portfolio of tobacco control interventions and models the economic returns that can be expected across different payback timescales. Different interventions, including pharmacotherapies and support and advice, can be mixed and matched to see which intervention portfolio or package provides the best 'value for money', compared with 'no-services' or any other specified package. It also demonstrates the significant added value and return from GP's providing brief interventions and investing in sub-national activity.

The following is an example analysis for Somerset. It assumes that Somerset commissions NICE-approved services and that the provision matches the expected NICE-recognised levels of effectiveness. The following example models the potential returns of additional investment in sub-national programmes.

Example Scenario: investment in a sub-national control programme
Example investment cost for LSSS interventions: £1,267,754
Number of quitters per 1,000 smokers expected as a result of LSSS interventions: 37
Additional investment required for sub-national programme at £0.41 per capita: £0.84
Number of additional quitters per 1,000 smokers expected as a result of sub-national programme: 29
Total number of additional quitters expected locally as a result of LSSS interventions + sub-national programme: 66
5 year returns expected as a result of LSSS interventions + sub-national programme for every £1 invested: £2.43

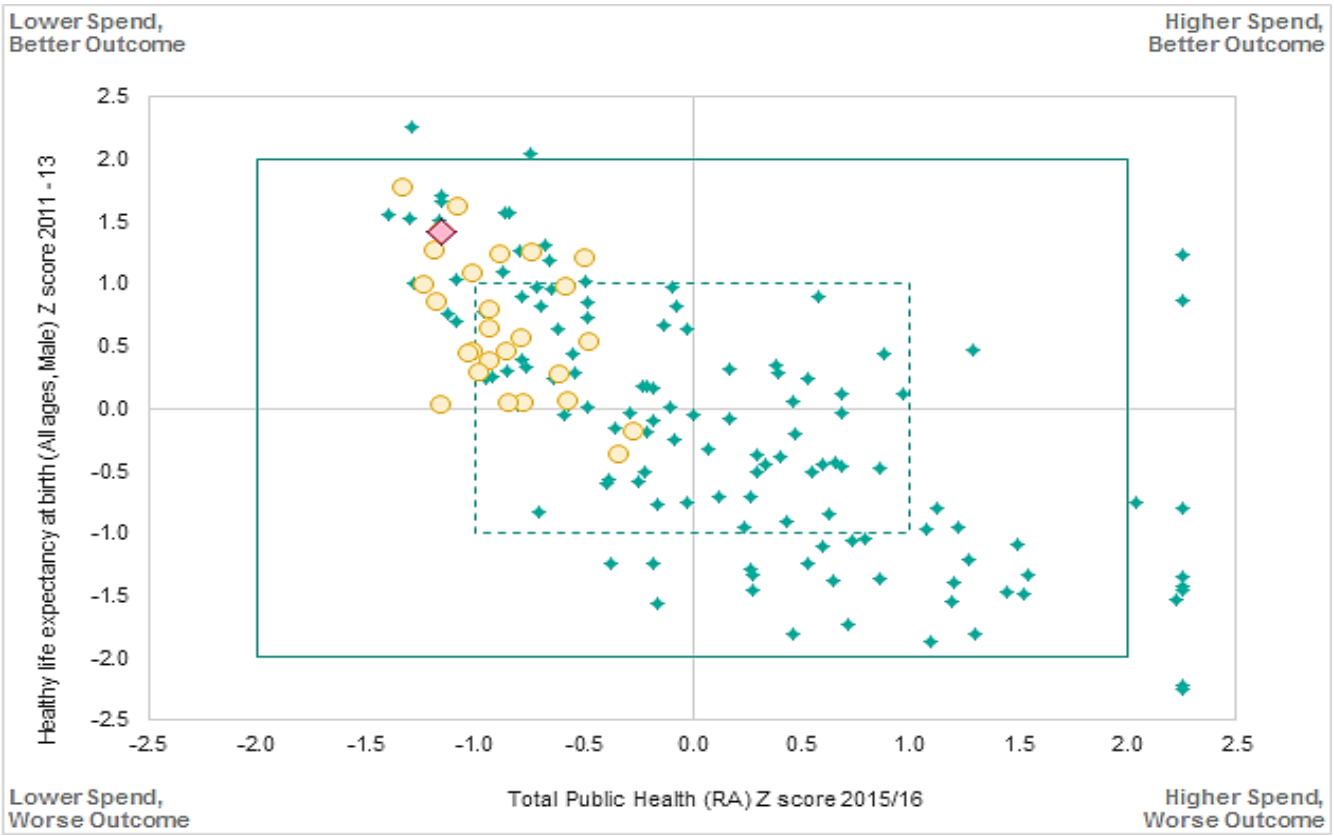
The tool also allows commissioners to define a specific sub-population and target interventions accordingly; whether that be a priority population such as smokers in the healthcare system, a particular geography or a specific demographic.

The above scenario is provided as an example only; localities are invited to use the tool to comprenhensively replicate their currently commissioned package of interventions against the NICE baseline. The above example gives an indication of returns over a five year period; increased returns are demonstrated by running the analysis for ten years and lifetime scenarios. The tool can be downloaded via the NICE website or at: https://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Tobacco-Return-on-Investment-tool

SPEND AND OUTCOME TOOL - SPOT

The Spend and Outcome Tool (SPOT) gives an overview of spend and outcomes across key areas of business. Local authority data for 2015 has been refreshed and clinical commissioning data for 2015 has been included. SPOT includes a large number of measures of spend and outcomes from several different frameworks. Similar organisations can be compared using a range of benchmarks and potential areas for further investigation identified. You can download a PDF factsheet for each local authority or clinical commissioning group. There is also an interactive spreadsheet that allows you to explore the data in detail.

The tool can be accessed at: www.yhpho.org.uk/



Legend:
- Somerset
- Other county councils
- All other local authorities

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