Tobacco Control & Smoking

Introduction

Smoking is still the single largest cause of preventable morbidity and health inequalities in England. Every day in England more than 200 people die from smoking related illnesses (Smoking Still Kills: Protecting Children, Reducing inequalities). In 2013 approximately 1 in 6 of all deaths among people aged 35 and over were attributable to smoking (HSCIC, 2014). There is no safe level of tobacco use. Smoking causes more deaths every year than obesity, alcohol, road traffic accidents, illegal drugs and HIV combined (ASH, 2014)

Tobacco addiction is a complex combination of factors; chemical addiction to nicotine and behavioural dependence, which cause and sustain regular use. It is the toxins and carcinogens in tobacco, not the nicotine, that cause illness and death. The risk of disease is closely related to continued smoking and the cumulative number of packs smoked. Stopping smoking has both immediate and long term benefits, but for people who continue to smoke after the age of 30, on average three months of life is lost for every year of continued smoking.

Comprehensive tobacco control interventions, implemented at a local level and part of a strategic partnership approach with the specialist Stop Smoking Service, aim to reduce smoking prevalence and the use of tobacco in Bedford Borough. Effective tobacco control measures, including helping people to stop smoking have been proven to reduce social and health inequalities and save more money than they cost.

Reducing smoking rates will impact on:

- **Reducing inequalities**; beyond the well-recognised effects on health, tobacco also plays a role in perpetuating poverty, deprivation and disparity in health. Smoking is a major factor in the mortality divide between the most and least deprived areas and is responsible for around 50% of the difference in life expectancy between the richest and poorest (HM Government, 2011).

- **Cutting costs to local services**; It is estimated that in England each year, smoking costs the public £13.9bn from lost output. This encompasses early deaths, smoking

breaks, NHS care, social care, sick days, the impact of passive smoking, household fires and smoking litter (ONS, 2015).

- **Support the Sustainability and Transformation Agenda**; Smoking is a leading cause of preventable illness and tackling it presents a major opportunity to make services across the entire health and social care system more sustainable. (PHE, 2016)

- **Protecting Children**; two thirds of smokers say they began smoking before the legal smoking age of 18 and 9 out of 10 began before the age of 19 (General Lifestyle Survey 2011). Children exposed to tobacco smoke are at a higher risk of cot death, meningitis, respiratory infections and ear disease (ASH, 2011).

- **Boost the disposable income of the poorest people in Bedford Borough;** Two adults smokers with a 20-a-day habit are likely to spend over £5,000 per year on cigarettes. Workers in routine and manual jobs are twice as likely to smoke as those in managerial and professional occupations (ASH, 2015: Smoking health inequalities). Poorer smokers spend five times as much of their weekly household budget on smoking as richer smokers (ASH, 2015, Smoking: the true economic cost).

- **Drive improvement across key measures of population health**: reducing smoking rates will impact on core indicators included in three out of the four public health domains identified in “Improving outcomes and supporting transparency: A public health outcomes frame work for England” (PHE, 2016). Examples of indicators that would be positively affected include:

    1. The number of children in poverty
    2. The number of low birthweight babies
    3. Pregnant women smoking at time of delivery
    4. Smoking prevalence rates in children and adults
    5. Infant mortality and all cause preventable mortality
    6. Mortality form cardiovascular disease

7. Mortality from cancer
8. Mortality from respiratory disease
9. Preventable sight loss
10. Sickness absence

The Bedford Borough Stop Smoking Service provides effective, tailored support packages, combining behavioural and pharmacological interventions to support clients to stop smoking. It is imperative that work is continued to make tobacco less desirable, less attractive, less accessible and less affordable.

What do we know?

National & Local Strategies (Current best practices)

In March 2011, following the publication of the Public Health White Paper, the Government published a Tobacco Control Plan for England, setting national ambitions (up to 2015). It is imminently expected that the Government will release a new tobacco control plan which will build on the success of the previous.

Tobacco Control

Tobacco Control is an internationally recognised, evidence - based approach to tackling the harm caused by tobacco. Research shows that no single approach to tackling smoking will be successful in isolation. A co-ordinated, multi – faceted approach is required to effectively tackle tobacco use. This means that, tackling smoking is everyone's business.

In England, tobacco control activity is guided by the Department of Health six strand approach,

- support smokers to quit;
- reduce exposure to second-hand smoke;
- run effective communications and educational campaigns;
- reduce tobacco advertising, marketing and promotion;
- regulate tobacco products;
- reduce the availability and supply of tobacco products;

If the recommended interventions are delivered, the evidence indicates that it will save lives and reduce chronic ill-health and disability, resulting in net savings across NHS and local council.

Tobacco control in Bedford Borough is coordinated by Bedfordshire Tobacco Control Alliance – Smokefree Bedfordshire. This group is a multi-agency group that is chaired by Bedford Borough. The Alliance works to an annual action plan that is developed using the six strand approach.

Bedford Borough Specialist Stop Smoking Service – Overview

The Specialist Service provides complex behavioural support and pharmacotherapy (at a prescription charge) for clients wishing to quit tobacco. Support is offered via 1:1 or group sessions based in a variety of community settings and at a range of times to suit the client's needs. Telephone support is also provided. Specialist advisors develop tailored plans for each client and use a variety of behavioural, motivational and coaching techniques in order to empower and maximise success.

The evidence based, 12 week standard abrupt cessation model i.e. stopping in one step, used by the Service (as per NICE guidance) still offers the best chance of lasting success. This involves supporting smokers to commit to a quit date at their first appointment with an advisor and motivating the individual to remain abstinent from the quit date. A maximum of 12 weeks pharmacotherapy and behavioural support is provided, subsequent to the individual remaining smokefree from the quit date.

For several years now the Specialist Service has also offered a treatment programme tailored to pregnant women named – Smokefree Baby & Me. This programme offers the same length of pharmacotherapy as the 12 week model however behavioural support continues up to one month post-delivery with tailored resources.

The probability of success from an unaided quit attempt is typically less than 5%. However with combined behavioural support from a specialist advisor and pharmacotherapy, the chance of a successful quit attempt increases by up to 4 times. There is now research to show that it can take on average 8 attempts for an individual to quit for good. It is imperative

that when an individual makes a quit attempt they get the best support available to maximise their chances of success and minimise their chance of relapse.

Existing evidence is not conclusive about the health benefits of reducing the use of cigarettes or 'cutting down,' but what has been shown is that those individuals who do reduce their use of cigarettes are more likely to quit altogether (NICE, 2013).

In June 2013 the National Institute for Health and Care Excellence (NICE) published Harm Reduction Guidance (PH45) to support and extend the reach of the stop smoking services whilst increasing impact within targeted groups. This guidance is about helping people, particularly those who are highly dependent on nicotine, who:

- May not be able (or do not want) to stop smoking
- May want to stop smoking without necessarily giving up nicotine
- May not be ready to stop smoking, but want to reduce the amount they smoke

In order to support the complexity of needs and 'hard to reach' clients, from 1st September 2015 the Bedford Borough Council Stop Smoking Service began harm reduction programmes to support people with:

1. Mental health Conditions
2. Chronic obstructive pulmonary disease (COPD)
3. Any smoker who has struggled to quit before

The extended treatment pathways for COPD and Mental Health diagnosed individuals provide behavioural support for up to 12 months. This includes a period of up to 12 weeks to cut down to quit; during this period pharmacotherapy will be provided to support the cut down and a tailored cut down plan agreed. A quit date has to be set no later than week 12 of the programme. From weeks 13-24 the individual will be provided with further pharmacotherapy providing they remain abstinent. Tailored resources/ workbooks are utilised to great success within these programmes. Key milestones are celebrated at 4 weeks quit, 6 months quit and 12 months quit with associated certificates.

The second harm reduction programme is a 16 week 'cut down to quit' programme which is open to all service users that have struggled to quit in the past. It offers a 4 week window

for individuals to cut down to quit with pharmacotherapy but they must have set a quit date by week 4. Between weeks 5-16 the individual must remain smokefree and a further 12 weeks of pharmacotherapy will be issued and behavioural support provided.

The Stop Smoking Service has a wider remit than service delivery alone:

- Facilitates and supports the implementation of new projects and services
- Coordinates delivery and performance management of other local providers
- Provides specialist training and professional support to ensure a high quality fully integrated Stop Smoking Service
- Leads on the implementation of new smoking initiatives within Primary and Secondary care
- Developing and leading on local and national marketing campaigns (including social media)
- Supporting the development of organisations smokefree agendas including policies
- Provide the specialist element of service delivery – encouraging referrals for more complex individuals into the specialist service
- Provides a key contributor to the Tobacco Control Alliance

Other Providers: Health and social care services play an important role in reducing smoking in the population. Delivery options include referral into the Specialist Service and/or delivering an in-house, intermediate 12 week standard support programme.

Other providers include:

- GP practice staff
- Bedford Hospital
- Beds and Luton Mind
- The Stroke Association
- HMP Prison Bedford
- South Essex Partnership Trust
- Pharmacies

Cost of the Service:

The main drivers of reduction in smoking prevalence are;

- Decreasing uptake
- Increasing cessation

The largest impact on smoking prevalence in any one year comes from increasing smoking cessation because the numbers affected are so much greater. It is therefore more cost effective to focus resources on smoking cessation. However most of the activities used to promote smoking cessation can also help to reduce smoking uptake. (PHE, 2016)

Stop Smoking Services are highly cost effective (Shahab, 2015) and are a vital element of tobacco control. The cost per quitter 2015/16 for Bedford Borough equates to £410 (including pharmacotherapy) which is lower than the national average of £844 (NHS Digital).

The Department of Health (tobacco control return on marketing and investment COI 2009) has estimated that each quitter would save the NHS £658.22 per year. Based on that figure it is estimated the Public Health Stop Smoking Service in Bedford saved the NHS £347,046 in 2015/16 (excluding savings in social care).

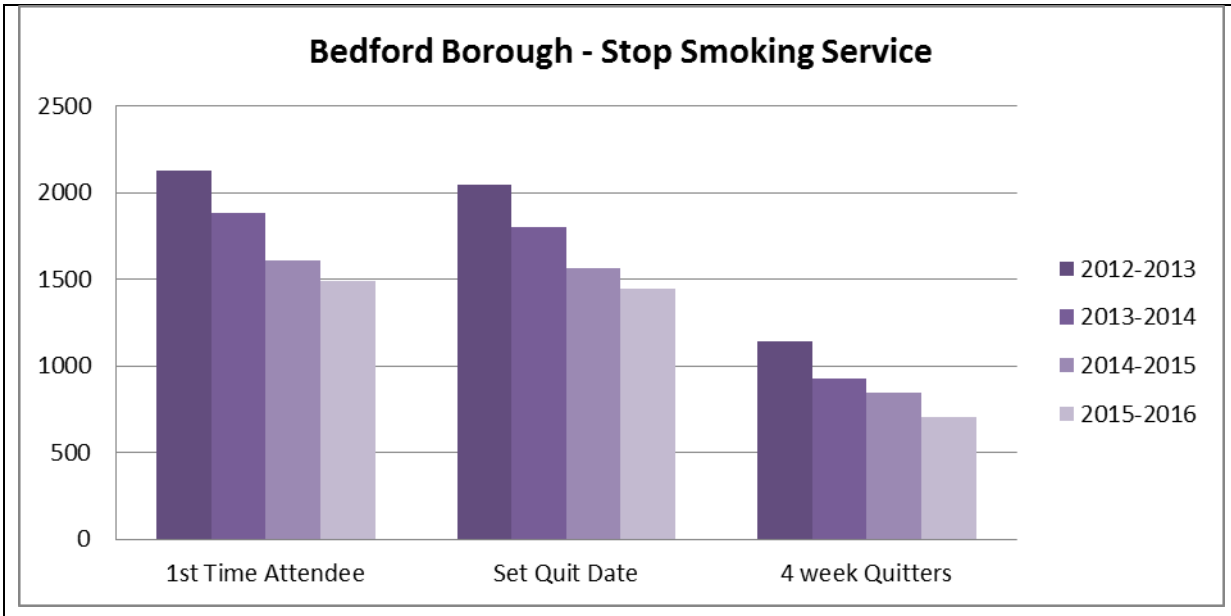
Monitoring; In line with NICE PH10 guidance recommendations, the service aims to treat at least 5% of the local smoking population.

Current Activity

In 2015/16, the Bedford Borough Stop Smoking Service supported 1,444 people to set a quit date and of these 703 quit at 4 weeks which equates to a 49% quit rate. This is just below the national average quit rate of 51% (NHS Digital).

Nationally, NHS Digital reported that the number of people that set a quit date through NHS Stop Smoking Services in 2015/16, declined by 15% on 2014/15 data. Footfall into the Bedford Borough Stop Smoking Service fell by 7% on the previous year (see figure 1). It is not possible to pin point the exact reason as to why footfall is dropping. The general consensus is that it could be attributed to varying factors including increasing numbers of smokers with complex needs and the rising popularity of e-cigarettes.

Figure 1: Bedford Borough Activity



Local Views

Stop Smoking Service users are requested to complete a feedback questionnaire prior to discharge and relevant feedback is subsequently used to further inform future service delivery (see below).

Client 1

"The service I have received has been absolutely outstanding. An advisor was sent to me within 24 hours of phoning for help. The advisor has always been punctual and extremely friendly and approachable. The advisor offered a high standard of information, support and advice for which I have been really grateful. This has all contributed to my success in stopping smoking." 2016

Client 2

"I would recommend this service to anyone finding it hard to give up smoking. The people here are very supportive and make it very clear what pitfalls you may come across along the way. A huge thank you to those who have helped me, this time I quit for good." 2016

Client 3

"The Advisor was really encouraging at our meetings and with the texts sent out. I truly believe it is the meetings that have helped me finally give up smoking after 30 years. I can walk, exercise without getting out of breath and just generally feel fitter + healthier." 2016

Smoking in Pregnancy

Babies born to women who smoke during pregnancy are around 40% more likely to die within the first four weeks of life, than babies born to non-smokers (Gardosi et al, 2005).

For many children the harm of tobacco smoke begins while still in their mother's womb. Smoking during pregnancy increases the risks of miscarriage, premature birth, still birth and low birth weight babies. Exposure to smoking during pregnancy also has a detrimental effect on the development of the child after birth. Mothers who smoked during pregnancy are at greater risk of their babies dying early and suffering from respiratory illnesses, diabetes, obesity and cognitive development problems such as attention deficit and hyperactivity disorder. (PH26. 2010)

Smoking has been associated with:

- 5-8% of premature births
- 13-19% of cases of low birth weight in babies carried to full term
- 5-7% of preterm-related deaths
- 23-34% of deaths caused by sudden infant death syndrome (cot death).

(Dietz et al, 2010)

In the UK, smoking in pregnancy causes up to 5,000 miscarriages, 300 peri-natal deaths and around 2,200 premature births each year (Tobacco Advisory Group, 2010). The prevalence of women smoking at time of delivery in England is 10.6% which is equivalent to nearly 70,000 infants born to smoking mothers each year (PHE 2015/16).

Smoking at time of delivery is related to significant demographic differences and factors relating to inequalities and deprivation. Pregnant mothers under the age of 20 are more than three times as likely to smoke as mothers over the age of 30. Those in routine and manual occupations are four times more likely to smoke through pregnancy than those in managerial occupations (29% and 7% respectively). Children born to smokers are more likely to become smokers themselves, which further perpetuates health inequalities (HSCIC, 2010, Infant feeding survey).

Treating mothers and their babies (0-12 months) with smoking related problems during pregnancy is estimated to cost the NHS between £20m and £87.5 each year (Godfrey 2010)).

Smoking during pregnancy poses a high risk of harm to both mother and foetus and it is therefore important that pregnant women are supported to stop for the duration of the pregnancy and postpartum. More women quit smoking when they are pregnant than at any other time during their lives (Murin et al, 2011). Pregnant smokers are twice as likely to attempt to quit smoking as non-pregnant women, but only about half of pregnant women actually stop smoking during pregnancy (Chen at al, 2006). Support should be offered to other family members that also smoke.

A 2009 report found that interventions from health professionals reduced the proportion of

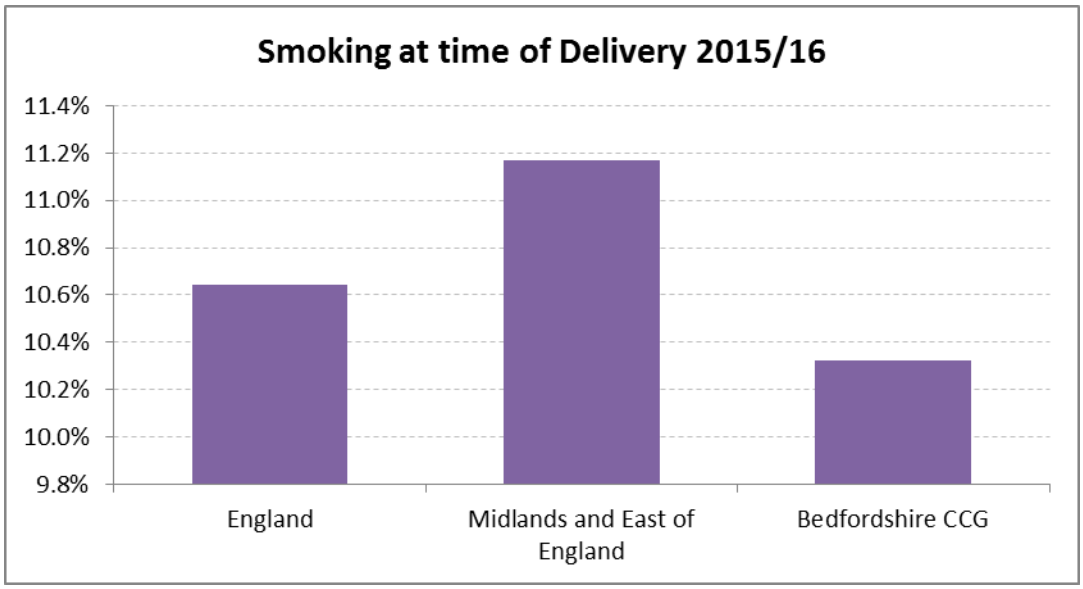
women smoking in late pregnancy by about 6% overall (Lumley et al, 2009). The most effective intervention, particularly among low income women, appeared to be providing incentives (Higgins et al, 2012),

National & Local Strategies (Best Practices)

Public Health Guidance (PH26. 2010)

Local Data

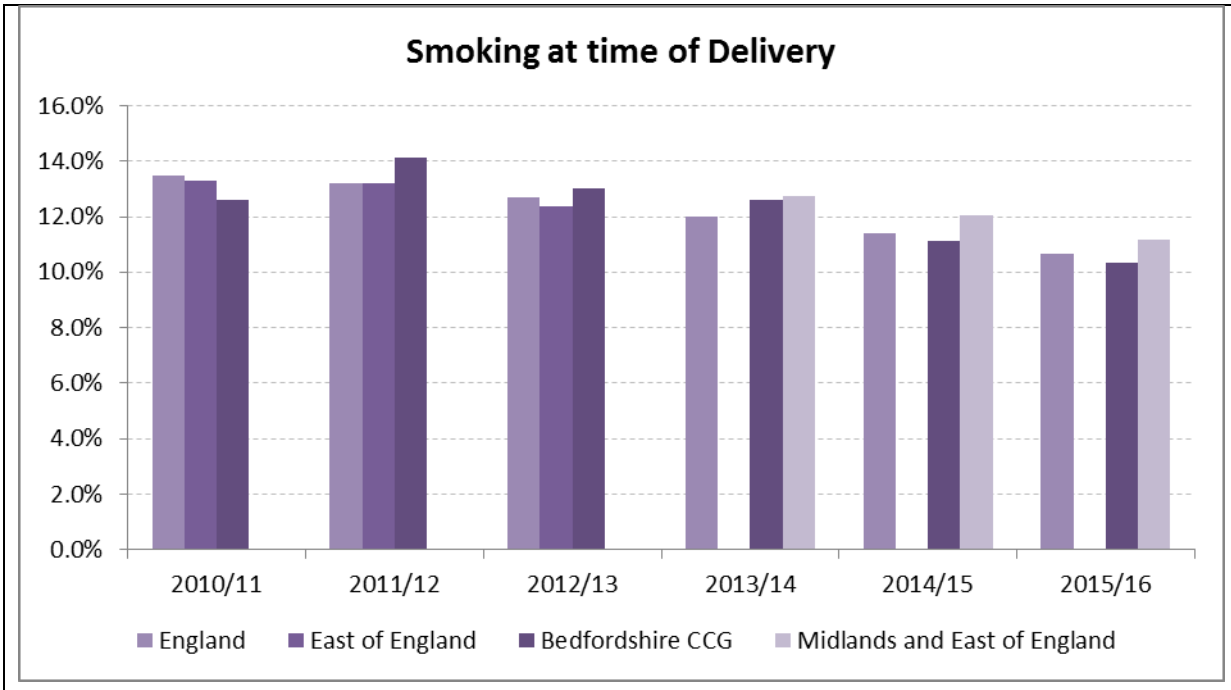
Figure 2a: Smoking at time of delivery 2015/16 comparison



Source: NHS digital (HSCIC) - Statistics on Women's Smoking Status at Time of Delivery England

Local data sets are based on returns from the Bedfordshire Clinical Commissioning Group; for that reason is represented as Bedfordshire data. Current trends show that Smoking at time of delivery is lower in Bedfordshire 10.3% than regional (11.2%) and England (10.6%) averages .

Figure 2b: Smoking at time of delivery comparison across years



Source: NHS digital (HSCIC) - Statistics on Women's Smoking Status at Time of Delivery England

The above graph confirms that Smoking at time of delivery is declining in Bedfordshire year on year.

Current Activity

The Stop Smoking Service has well established links to the Maternity Department at Bedford Hospital Trust and SEPT community services. Just over half of the community midwifery teams (53%) have been trained to deliver brief smoking interventions, take carbon monoxide readings and refer onwards to the specialist Stop Smoking Service. The national lead Smoking in Pregnancy trainer delivered the training to Midwifes around test, question and refer principals. Robust 'opt out' pathways are in place which means all pregnant women that smoke will be referred into the Stop Smoking Service for support unless they decline the invite.

The Specialist Service delivers a tailored programme which supports pregnant ladies with 12 weeks of pharmacotherapy, and behavioural support for up to one month, post-delivery. The financial incentive is no longer used for this group but a focused work book is in

development to support the programme.

What are the unmet needs/ service gaps?

All ward midwifery teams require very brief advice and carbon monoxide training plans are already in place to do this.

Due to local demographics, niche tobacco training needs to be delivered to the maternity departments in order to ensure that mothers who chew tobacco are also supported.

Passive Smoking

What do we know?

There are over 4,000 chemicals in tobacco smoke (United States Environment Protection Agency, 1992). Exposure to other people's cigarette smoke is called passive, involuntary or secondhand smoking. This is a combination of 'sidestream' smoke from the burning tip of the cigarette and 'mainstream' smoke that has been inhaled and then exhaled by the smoker. The toxic gases found in sidestream smoke are in higher concentrations than mainstream smoke and sidestream smoke accounts for almost 85% of the smoke in a room. There are more than 50 cancer-causing chemicals in secondhand smoke and the properties of the other gases include irritants (ASH, 2014).

Exposure to secondhand smoke has immediate and long term health effects. In the long term it can increase the risk of a range of smoking-related diseases including lung diseases and cancers. Children are particularly susceptible with risks that include glue ear, asthma, meningitis and cot death. There is no safe level of exposure to tobacco smoke.

Local Data

ASH estimates that treating the effects of passive smoking in non-smokers costs the NHS £261,664 in Bedford Borough.

Current activity

Bedford Borough encourages parents and other adults living with children to make their homes smokefree. Training has been provided to Health Visitors, Social Workers, and Children Centre staff, enabling frontline staff to positively discuss the harm passive smoking causes. Parents can sign up to a locally developed pledge scheme.

The legislation on Smokefree Cars came into force from 1st Oct 2015 making it an offence to smoke in a private vehicle with someone under 18 years old present, and for a driver to fail to prevent smoking in a private vehicle with someone under 18 years old present. People who fail to comply could be issued with a £50 fixed penalty notice.

What are the unmet needs/ service gaps?

- Review and rebranded local programme to 'Smokefree homes'.

Children and Young People

What do we know?

It is estimated that each year around 207,000 children in the UK start smoking (Hopkinson, NS et al 2013). The 2011 General Lifestyle Survey of adult smokers revealed that almost two-fifths (40%) had started smoking regularly before the age of 16 and 80% of all adult smokers started before they were 20 years old (Robinson et al 2010).

Smoking prevalence is dropping among children. The prevalence of regular smoking increases with age, from less than 0.5% of 11 year olds to 8% of 15-year olds; girls are more likely to smoke than boys (ICHSC, 2014). Children with at least one parent who smokes are 72% more likely to smoke in adolescence. If both parents smoke, children are four times more likely to start smoking than if neither parent smokes (Passive smoke and children, 2010).

Efforts to stop children taking up smoking are much less effective for children when smoking is seen as a norm. The best way to stop children from smoking is to get those around them, particularly their parents, to quit.

National & Local Strategies (Best Practices)

The government is imminently due to release the next set of national ambitions.

The Department of Health recommends that an effective tobacco control approach to smoking in young people should incorporate education methods that de-normalise smoking as a habit, young people specific treatment services and enforcement of regulations.

Local Data

5-19 year olds represent 25% of the total estimated Bedford Borough population (ONS, 2014).

Stop Smoking support is available across Bedford Borough for young people in:

- GP Practices
- Schools via School Nurses
- Community venues

Numbers of under 18's accessing the local service through any of the above are low but have increased slightly on the previous year. In 2015/16, 17 - under 18's set a quit date and 8 quit.

Current Activity – Prevention

Nicotine replacement therapy (NRT) is available to young people aged 12 and above. Any child that presents with a tobacco addiction can access the Specialist Service and will be supported accordingly. School Nurses have been trained to deliver intermediate interventions to children who want to quit and referral in to the specialist service.

During 2015 the Stop Smoking Service supported Healthwatch with their peer teaching scheme. There were approximately 20 students (Youth Ambassadors) who received training. The Youth Ambassadors - a group of Y11/Y12 students undertook Making Every Contact Count (MECC) training and L1 Stop Smoking training in order to deliver key health messages to their peers in Bedford Borough Schools.

The aim of the training was for Youth Ambassadors to feel confident to go into schools and deliver key public health messages around stopping smoking, and to initiate discussion with their peers about lifestyle and signposting to supporting services if and when appropriate. Although the service did not receive any additional referrals during this period however this is not necessarily indicative of success. If this is to be repeated a more robust recording mechanism for qualitative data must be in place to determine effectiveness.

The service is currently reviewing work with schools in relation to Tobacco Control and

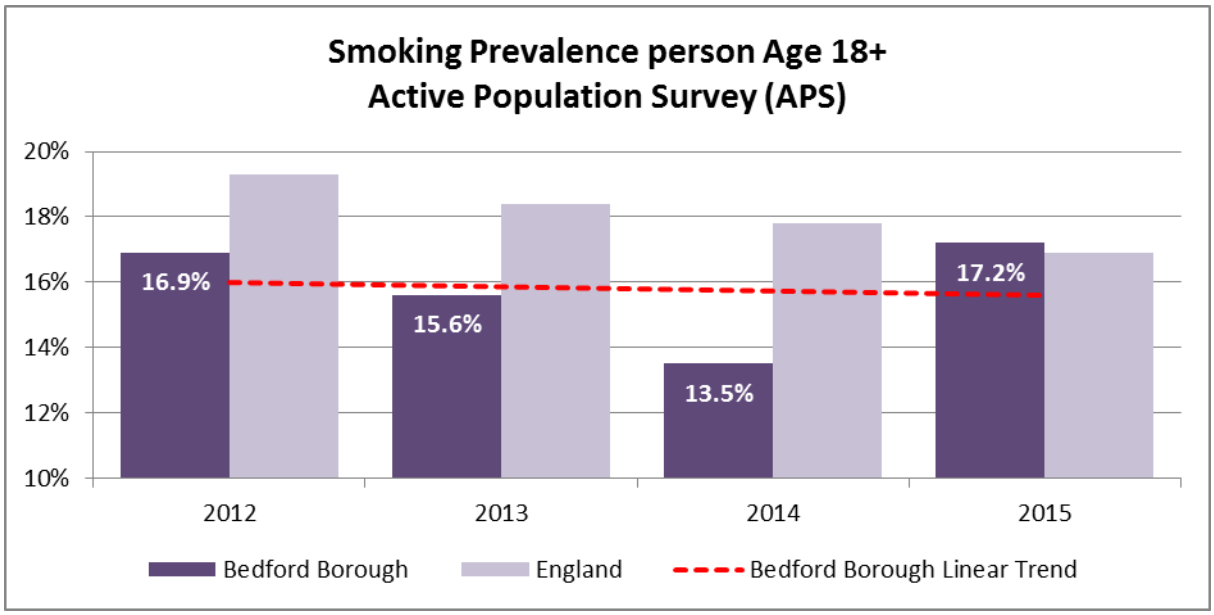
setting out sustainable plans.

What are the unmet needs/ service gaps?

Ensure schools understand the importance of their role in supporting young people to stop smoking, how to raise the issue and make the most of every contact. The implementation of a toolkit which schools can utilise and tailor to their needs will improve the understanding surrounding roles and responsibilities. This toolkit is currently in development and will raise the profile of smoking cessation in schools.

Adult Smoking

Figure 3: Smoking prevalence – persons age 18+



Source: Tobacco Profiles - Smoking Prevalence Annual Population Survey (APS)

Adult (16 years +) smoking prevalence in Bedford Borough is currently 17.2%; this has increased by 3.7% in the past year.). Smoking prevalence is 0.6% higher than the East of England average and 0.3% higher than the England average; the difference is negligible.

Caveat: The data collection methods used to estimate prevalence changed in 2015. Prior to 2015 the Integrated Household Survey (IHS) data was used to estimate prevalence which was reported as 14.2%. From 2015 Annual Population Survey (APS) data is used to estimate prevalence. IHS and APS data cannot be directly compared.

APS data collection methods are small and caution should be applied when using the data.

Small sample numbers were used to estimate the smoking prevalence resulting in large confidence intervals. APS prevalence has shown an increase in smoking prevalence from 2014 to 2015 however the prevalence estimates are not statistically different.

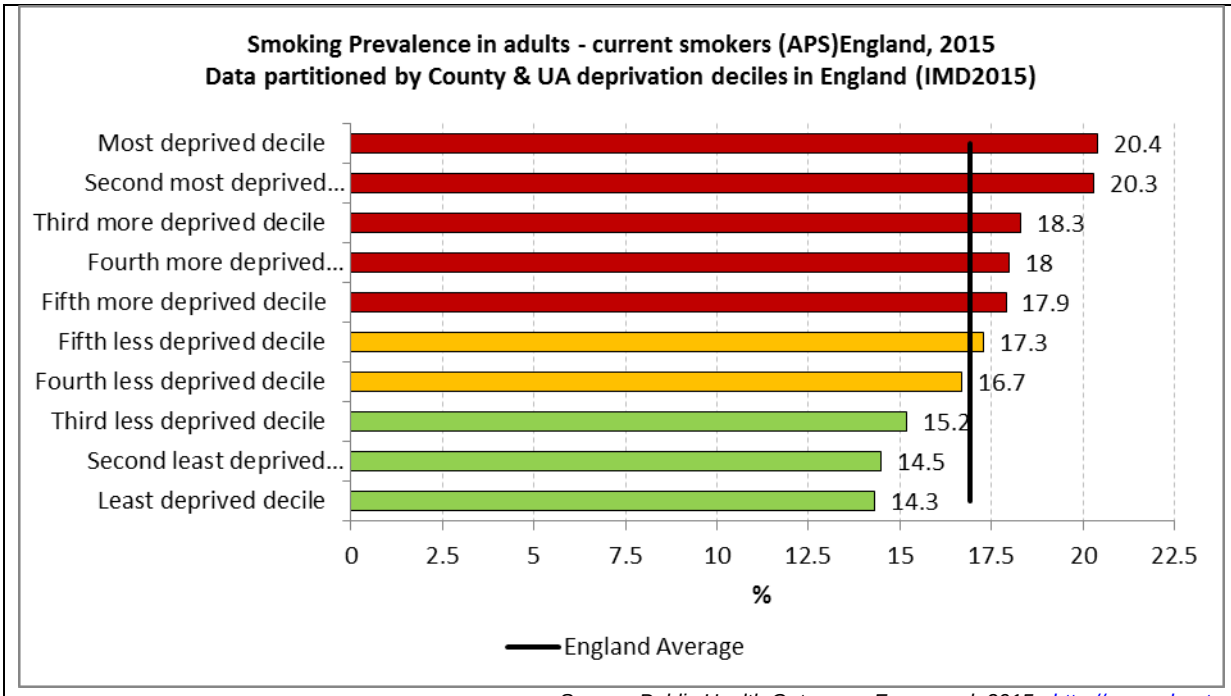
- 2014 - 390 members of the BBC population were surveyed and 53 people were identified as smokers which equated to 13.5% prevalence.
- 2015: 371 members of the BBC population were surveyed and 64 smokers identified which equated to 17.2% prevalence.

Deprivation

Smoking prevalence in England is higher in lower socio-economic groups and disadvantaged groups – the same is true for Bedford Borough. ASH estimates that in Bedford Borough there are about 11,242 households with at least 1 smoker. When net income, and smoking expenditure is taken into account, 3,002 or 27% of households with a smoker fall below the poverty line. If these smokers were to quit, 658 households in Bedford Borough would be elevated out of poverty. ASH also estimates that the residents of these households would include; 1,676 adults below pension age, 414 pension age adults and 957 dependent children.

Figure 4 below shows the smoking prevalence of those living in the most deprived deciles in Bedford Borough, and those living in the least deprived.

Figure 4: Smoking Prevalence Inequalities Gap



Source: Public Health Outcomes Framework 2015: http://www.phoutcomes.info/

There are pockets of the population from deprived communities that are harder to reach, for various reasons which are likely to include:

- More dependant smokers
- Greater levels of nicotine addiction
- Entrenched behaviour
- Long term conditions

Priority group: Whilst progress is being made to reduce prevalence in the general population the priority groups with complex needs, higher levels of deprivation and higher smoking prevalence rates have not seen such declines. These include:

- Routine and manual workers
- People with long term conditions, for example poor mental health and COPD
- Some black and minority ethnic groups

Routine and Manual Workers

What do we know?

Routine and manual (R&M) workers in England make up the largest group of smokers in the general population and also have higher smoking prevalence compared to other occupational groups

Workers in routine and manual occupations are twice more likely to smoke than those in managerial and professional roles. Lower income smokers spend five times as much of their weekly household budget on smoking than higher income smokers.

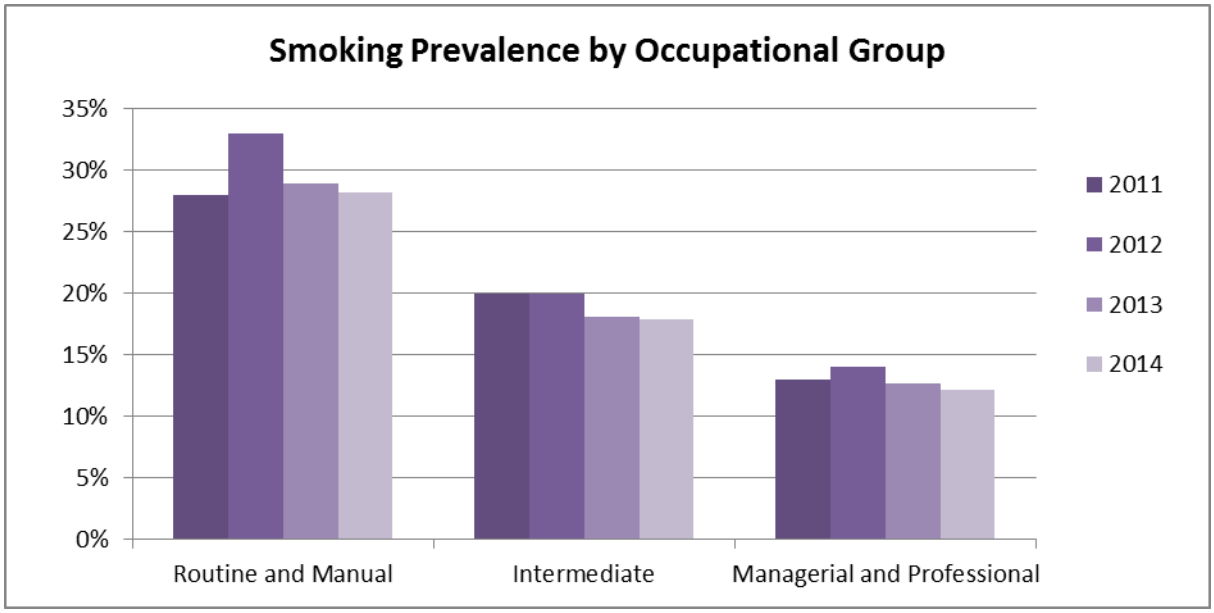
Smoking has an indirect impact on employers. Tobacco smokers generally have poorer health and on average take 4.4 days more time off sick than non-smokers. An estimated 34 million days a year are lost in England and Wales through sickness absence resulting from smoking related illness. The average total cost to businesses for smoking breaks and sick leave alone is estimated at around £15.4m a year. Smoking related sick days cost £2 million annually, equating to 27,794 days of lost productivity (ASH, Ready Reckoner 2016).

National & Local Strategies (Best Practices)

Nice Guidelines PH10

Local Data

Figure 5: Smoking prevalence by occupational group



Source: General Lifestyle Survey and Opinions and Lifestyle Survey, Office for National Statistics.

This graph has been left in for reference only, to demonstrate the difference by occupational group. However the data is no longer available from 2015 onwards.

Figure 6 below shows the prevalence of smoking for routine and manual adults is higher than regional and national averages which highlights the need to work with this group in particular.

Figure 6: Smoking prevalence among routine and manual workers aged 18 years and over

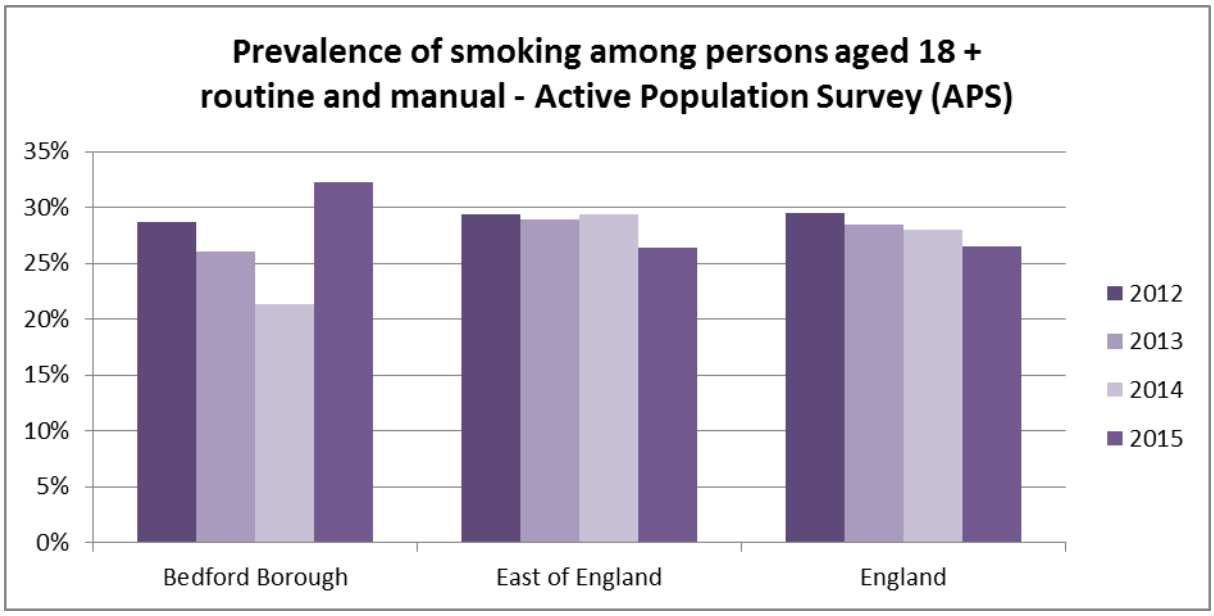


Figure 7: Activity – Routine and Manual

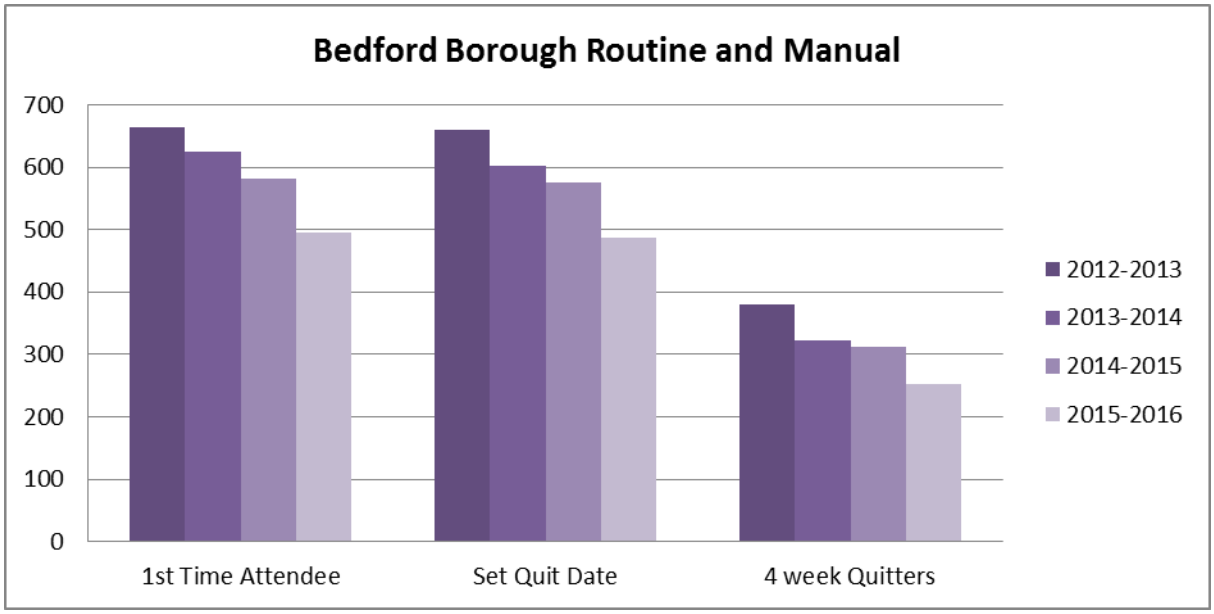


Figure 7 illustrates the steady decrease in activity from routine and manual workers over the

last 4 years; this is reflected nationally.

Current Activity

One of the most effective ways of reaching the routine and manual smoking population is to go to their place of work. The Stop Smoking Service continues to work alongside a range of employers to provide educational stands, employer information booklets and stop smoking quit groups.

The service routinely provides out of hours appointments including evenings and weekends from community clinics. This should enable access to even shift workers.

What are the unmet needs/ service gaps?

- Sustained communication channels with big employers to obtain support for the facilitation of promotional messages and workplace groups.
- The implementation of a toolkit which workplaces can utilise and tailor to their needs will improve the understanding surrounding the importance of smoking cessation and direct implication to businesses. This toolkit is currently in development and will raise the profile of smoking cessation in workplaces.

Mental Health & Addictions

What do we know?

Mental health disorders are the most significant risk factor in the uptake of smoking in children and adolescents (ONS, 2004). Smoking is, on average, twice as common among people with mental health diagnoses and there is a direct trend with smoking prevalence and addiction increasing with severity of mental health condition (Royal College of Physicians et al, 2013). Empowering individuals to make positive decisions about their health by quitting smoking will indirectly and directly promote good mental and physical health.

Smoking continues to be the leading cause of ill health and mortality in people with mental health disorders (Campion J et al 2008). Smokers with mental health conditions are just as likely to want to quit as those without but are inclined to smoke more frequently, smoke a

higher quantity and are more likely to be heavily addicted. These factors combined with the complexity of their needs, make this group less likely to succeed in their attempts to quit smoking (ASH, 2013). However the chances of successful quit attempts within this group are greatly increased if given specialist evidence based support.

Smoking prevalence for this group varies;

- 32% for those with a common mental disorder
- 40% for those with probable psychosis and
- 69% for those with illicit drug dependence,
- Within psychiatric inpatient setting up to 70% are smokers
- Just over 16% of people in England had a common mental disorder, such as anxiety or depression, when interviewed - an overall rate that has not changed since 2000.

(The Adult Psychiatric Morbidity Survey, 2007)

National & Local Strategies (Best Practices)

Nice Guidance PH48.

Local data

The Stop Smoking Service records the number of clients supported who disclose that they have a mental health illness.

The number of smokers accessing the service in 2015 who indicated they had a mental health condition has doubled since the previous year. During 2015, 106 smokers indicated they had a mental health condition and attended their first appointment of these 98 set a quit date and 43 successfully quit.

Current Activity

NHS England has stipulated in the 5 year forward plan that all mental health inpatient units should be smokefree by 2018.The Bedford Borough Stop Smoking Service is continuing to work closely with, East London Foundation Trust (ELFT), the mental health provider, to develop and implement the smoke-free guidance (NICE PH48) and care pathways to specialist support within in patient and community settings.

The service also works in collaboration with mental health charities such as Beds and Luton Mind providing support and training opportunities for staff and information sessions for service users. Beds and Luton Mind also deliver intermediate stop smoking support to clients attending Woburn Road Centre and accessing community ELFT services.

From the 1st September 2015, as part of the harm reduction guidance, the Stop Smoking Service began an enhanced and extended treatment package for this group. This involves 24 weeks of pharmacotherapy and/or Champix (if suitable) and an enhanced tailored support plan with specialist resources, over a 12 month period.

What are the unmet needs/ service gaps?

In order to achieve smokefree inpatient mental health units by 2018 - collaborative work must continue with ELFT and other Smoking Cessation Services within the area. Substance Misuse is strongly linked to mental health. Links need to be harnessed and plans developed to ensure smoking cessation pathways are embedded into Path to Recovery (P2R) Drug and Alcohol Service.

Black and Minority Ethnic Groups (BME)

What do we know?

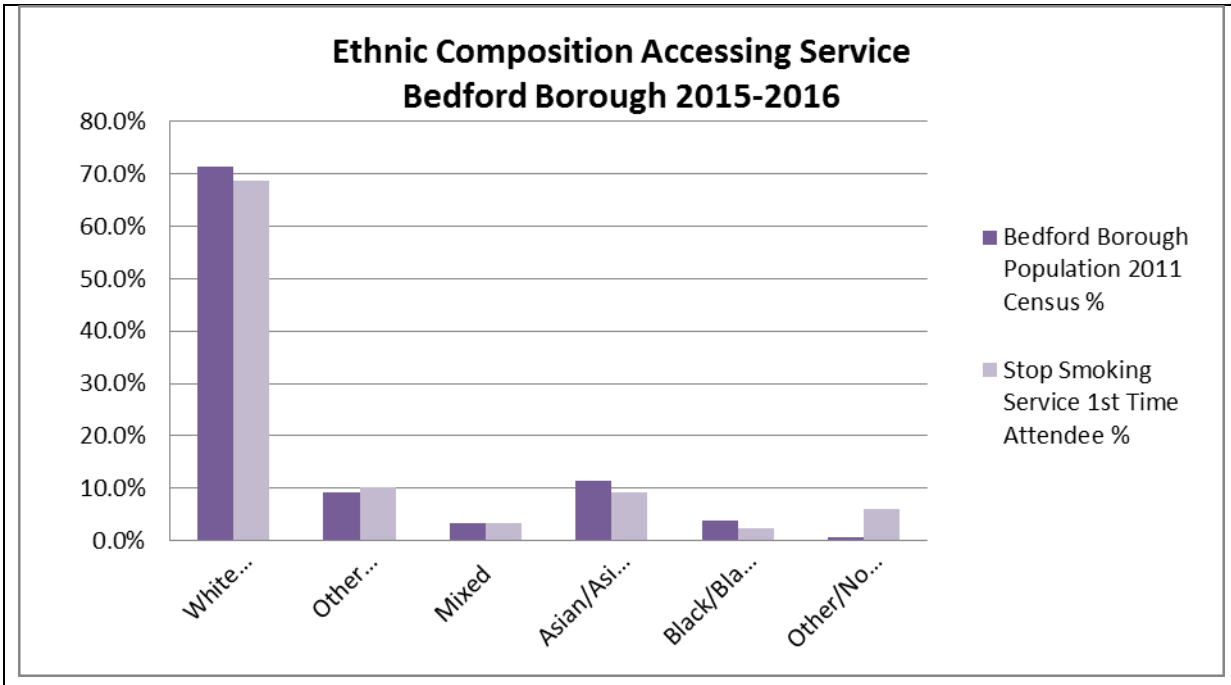
BME groups have high smoking prevalence rates compared to the general population; rates are highest among the Bangladeshi, Irish and Pakistani males (Health Survey for England, 2004).

National & Local Strategies (Best Practices)

Nice Guidance PH39.

Local View

Figure 8: Ethnic Composition Accessing Service, Bedford Borough 2015-2016



Sources: ONS, 2011Census: Ethnic group (detailed) by local authority. Table QS211EW. Public Health Core Team - QuitManager.

The 2011 Census identified that 28.5% of the Borough's population are from Black and Minority Ethnic (BME) groups (defined as all ethnic groups other than White British). The number of BME groups (25.2%) attending their first appointments with the Service during 2015/16 are lower compared to the White British population (68.8%). It is evident that more needs to be done to understand the barriers these groups have in accessing the service. The BME population is concentrated in the urban area of Bedford and Kempston where 37.2% of the population is non-white British, compared to 12.7% in the rural area. Several wards in Bedford town have very high BME populations, particularly Queens Park (74.8%) and Cauldwell (59%).

Current Activity

The Stop Smoking Service has various access points within the community e.g. GP's and Pharmacies as well as Level 3 services within Bedford Town and Kempston. The service offers a variety of appointments in the day time, evenings and weekends.

The service has been working closely with communities to develop local links and community engagement. The service has also been working with community groups/organisations to educate and jointly work on promoting key messages. An example

of this includes focused work during Ramadan to implement a targeted campaign. The service has also supported the Polish Festival, Bedford as One and local Diwali Festival.

Bedford Borough's population is becoming increasingly diverse. This brings different cultures and norms to the area where smoking is prevalent, yet uptake in the service is low. In order to reach these groups the service needs to understand what the barriers are.

What are the unmet needs/ service gaps?

- Community engagement needs to be strengthened in order to support BME groups and better understand the barriers faced in accessing the service.
- The service needs to be tailored to meet the diverse needs of the community, within its resources.

Smokeless Tobacco

What do we know?

Smokeless tobacco is consumed without burning the product, and can be used orally or nasally. It is generally used by some ethnic minority groups, most commonly those from South Asia. Chewing tobacco is more widely used in the Bangladeshi community; with 9% of men and 19% of women reporting that they use chewing tobacco (Sproston et al, 2004). The study has acknowledged that the figures may reflect a degree of under-reporting by some respondents. A separate report found that 15% of Bangladeshi women under-reported their personal tobacco use (Roth et al, 2009).

Chewing tobacco is embedded in many aspects of South Asian culture with symbolic implications at religious and cultural ceremonies. There are also many misconceptions regarding the health benefits of chewing tobacco which are promoted by misleading, false claims from manufacturers, such as chewing tobacco aids digestion and betel quid has curative effects for dental pain. Chewing tobacco is in fact associated with a range of diseases including an increased risk of cardiovascular disease and oral cancer. Smokeless tobacco contains carcinogens, which contribute to cancers of the oral cavity and the risk of other head and neck cancers conditions and can lead to nicotine addiction similar to that produced by cigarette smoking (Niche Tobacco Products Directory - http://www.ntpd.org.uk/).

National & Local Strategies (Best Practices)

Public Health Guidance PH39

Local Data

Two of the largest BME groups in Bedford Borough are Pakistani, and Bangladeshi populations. Chewing tobacco is common practice among South Asian communities.

During November 2013, 6 awareness sessions took place involving 37 members of the public. The evidence indicated that a large proportion of people, particularly from the Bangladeshi community, use smokeless tobacco and are unaware of the related health implications. However, access to the service shows less than 10% uptake from Bangladeshi and Pakistani communities.

Current Activity

The Specialist Stop Smoking Service offers the same level of support to chewers of tobacco and niche products. The service has been working with community groups/organisations to educate and jointly work on promoting key messages.

During Ramadan in 2015 and 2016, the Stop Smoking Service put together key messages to the Bangladeshi community which were broadcast during Friday prayers through the Imam and community radio. There was also a message about chewing tobacco on the Ramadan calendars delivered to Bangladeshi households.

The Stop Smoking Service is developing specific niche tobacco resources. The service has developed specific Niche tobacco training and is working closely on a wider project to train and build engagement from Primary and Secondary Care professionals.

What are the unmet needs/ service gaps?

- Community engagement needs to be strengthened in order to better support BME groups and understand the barriers faced in accessing the service.
- The service needs to be tailored to meet the diverse needs of the community, within its resources.
- Further niche tobacco training sessions with local GP Practice staff and midwives

will be planned in 2016/17 and specific resources developed.

Offender Health

What do we know?

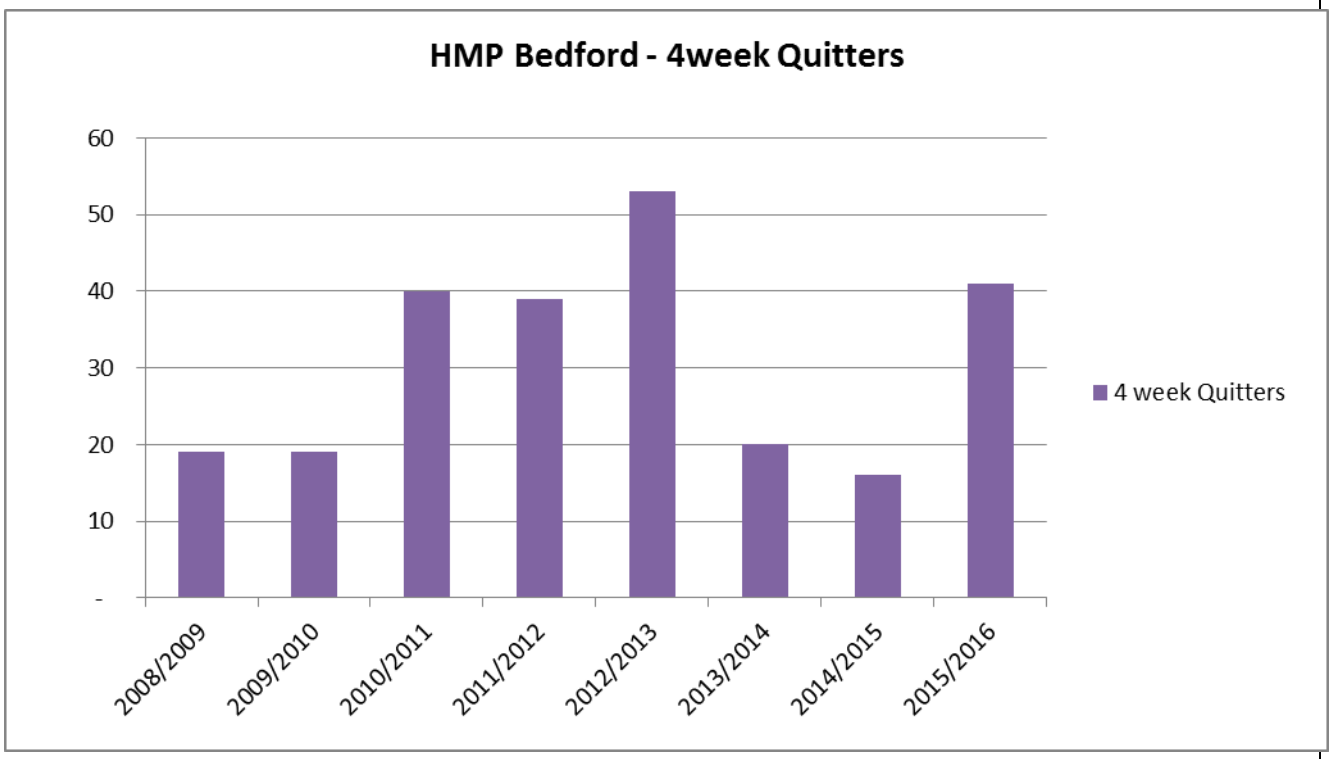
The "health inequalities experienced by people in contact with the criminal justice system are well above the average experienced by the general population" (Revolving Doors Agency, 2012). The report goes on to add that of those in custody one in three are suspected of suffering from anxiety or depression and one in ten from psychosis.

It has been estimated that around 80% of prisoners smoke (Smoking in Prisons, 2014). The offender population is associated with high smoking rates due to greater levels of poor mental health, substance misuse and disadvantaged backgrounds (Singleton N et al, 1999).

Local Data

During 2015/16 the delivery of smoking cessation at HMP Bedford has increased, this could be due to the prison changing from a remand prison to a re settlement prison as it means greater retention. The below graph in figure 9 demonstrates the increase in activity.

Figure 9: HMP Bedford – 4 week quits



Source: Public Health Core Team – Quit Manager.

Current Activity

The Stop Smoking Service provides ongoing support to the Prison including guidance and training. HMP Bedford is scheduled to be completely smoke free under National Guidance but dates have yet to be confirmed. Support will be offered to help the Prison achieve smokefree status when further information has been released.

What are the unmet needs/ service gaps?

- Working with the probation service is vital to increasing access to a high prevalence group. Key links need to be re-built and a joint approach developed.

‘Sick Smokers’

What do we know?

Many health problems are directly linked to smoking, these include cancers, cardiovascular disease and lung diseases, the exacerbation of which often results in a period of hospitalisation. People, who are in hospital for smoking-related illness, are likely to be more receptive to help to give up smoking, as are those waiting surgery.

Stopping smoking at any time has vast health benefits for the individuals themselves and to those around them. There are additional advantages for those using secondary care services which include shorter hospital stays, lower drug doses, fewer complications, higher survival rates, increased wound healing, decreased infections and fewer re-admissions after surgery (British Thoracic Society, 2013).

Local View

The Public Health Profile for Bedford Borough indicates a decline in smoking attributable hospital admissions for 2014/15 (1,216) compared to the previous year (2013/14; 1,276) which is lower than the regional and national data.

Current Activity

Bedford Hospital Trust – Pathways are set up within the Hospital to facilitate staff to identify smokers and refer patients into the specialist service. It has been identified that inpatients

are not routinely offered smoking cessation support due to staffing capacity. For this reason inpatient ward support was established from 2015. One morning a week a specialist smoking cessation advisor continues to provide support to inpatients.

Working relationships at Bedford Hospital continue to be strengthened by ongoing training opportunities and advisor ward presence. The service is supporting the revision of the Hospital Smokefree Policy which will be pivotal in establishing a long term model of delivery and support to smokers.

'Sick Smokers' are not just identified in secondary care but across many health and social care services – a cohesive approach will ensure all these services are relaying consistent messages. Public Health has supported the Clinical Commissioning Group to relaunch 'ready for your op' within primary care during 2016, which will support the preventative agenda. This entails General Practitioners supporting patients to make good lifestyle choices before they are due to undergo surgery by referring into appropriate services. Making positive lifestyle choices will support good post-operative outcomes.

What are the unmet needs/ service gaps?

- A 'fit for purpose' smokefree policy (in line with NICE guidance), which will facilitate a prevention approach at Bedford Hospital.
- Given the complexity of Hospital workings, a collaborative model of long term support and delivery is required to ensure NICE standards are being implemented, met and maintained.

A Trust led smokefree steering/working group to set out strategic plans for the Hospital and to ensure smoking cessation is on the Trust's wider agenda. This will require senior representation from across the Trust and operational input so that decisions can be made and implemented.

Long Term Conditions – COPD

What do we know?

An estimated 3 million people have COPD in the UK and of those, 2 million remain undiagnosed. Smoking is the main cause of COPD which is the fifth largest cause of death in the UK and the second most common cause of emergency admissions to hospital. As a

result it is one of the most costly in-patient conditions and the impact on social care is also great.

This client group has complex needs and often present with other long term conditions, including mental health issues such as depression and/or anxiety. Smoking cessation is a treatment for COPD and can ultimately help to reduce the need for hospital admission and improve the outcomes and quality of life for patients.

Local Data

Current prevalence of COPD for 2015/16 in Bedford Borough is 1.42% which equates to 2,490 people however if the equivalent undiagnosed cases are accounted for, the true prevalence would be much greater.

Current Activity

Extended treatment pathways - Since 1st September 2015, in line with harm reduction guidance (NICE 45), the Bedford Borough Stop Smoking Service has put in place an enhanced and extended treatment package for those diagnosed with COPD. This entails 24 weeks of pharmacotherapy and/or Champix (if suitable) and an enhanced tailored support plan with specialist resources over a 12 month period.

From the 1st October 2015 a COPD 'case finding' initiative has been implemented by the specialist service to help address the high volume of undiagnosed COPD cases in Bedford Borough. The initiative received support from Bedfordshire Respiratory Implementation Group and the Clinical Commissioning Group. Expert advice was been sought from various professionals in the specific fields. Upon review of the pilot there were very few positive results identified. This could have been due to various factors such as; strict exemption criteria and reach of the service. The Pilot has subsequently been put on hold and lessons learnt will be taken into consideration before a relaunch.

Working relationships continue to be strengthened within the Respiratory Department at Bedford Hospital, Pulmonary Rehab, Bedfordshire Respiratory Implementation Group and Breathe Easy.

What are the unmet needs/ service gaps?

Consistent approach across Primary and Secondary care to ensure standard messages and advice around smoking cessation are provided with an onward referral.

Smoking related mortality

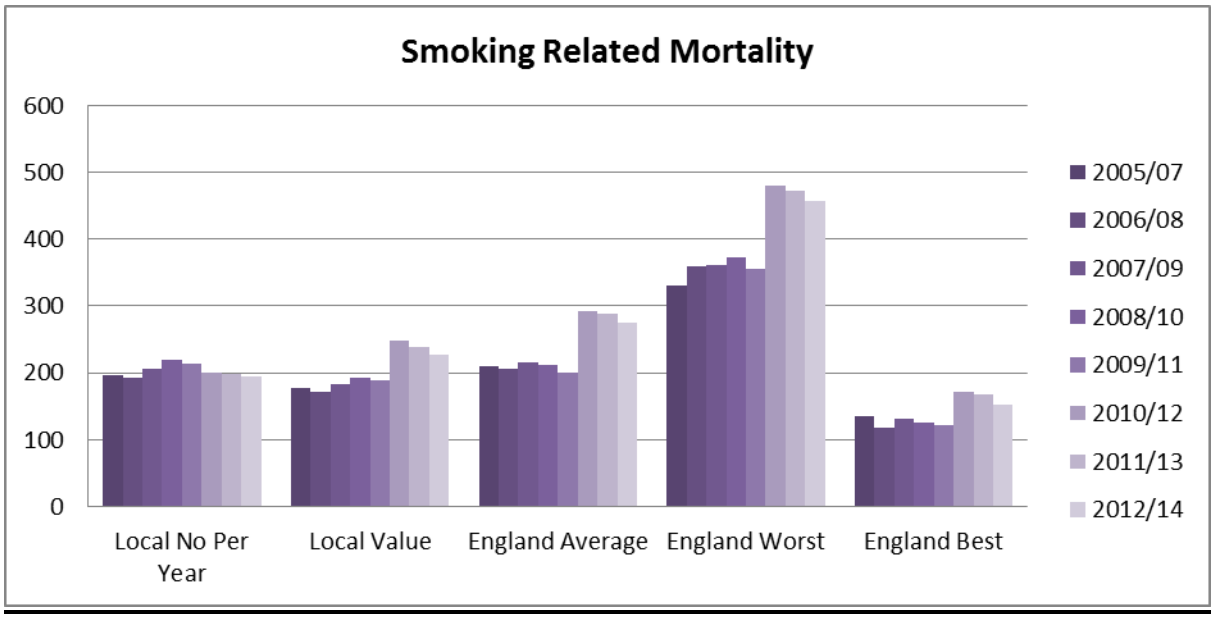
What do we know?

Areas with the highest smoking prevalence experience the highest rates of death from smoking. 'Smoking related deaths rates are two to three times higher in low-income groups than wealthier social groups '(Mental Health of Children and Young People in Great Britain, 2004)

Local Data

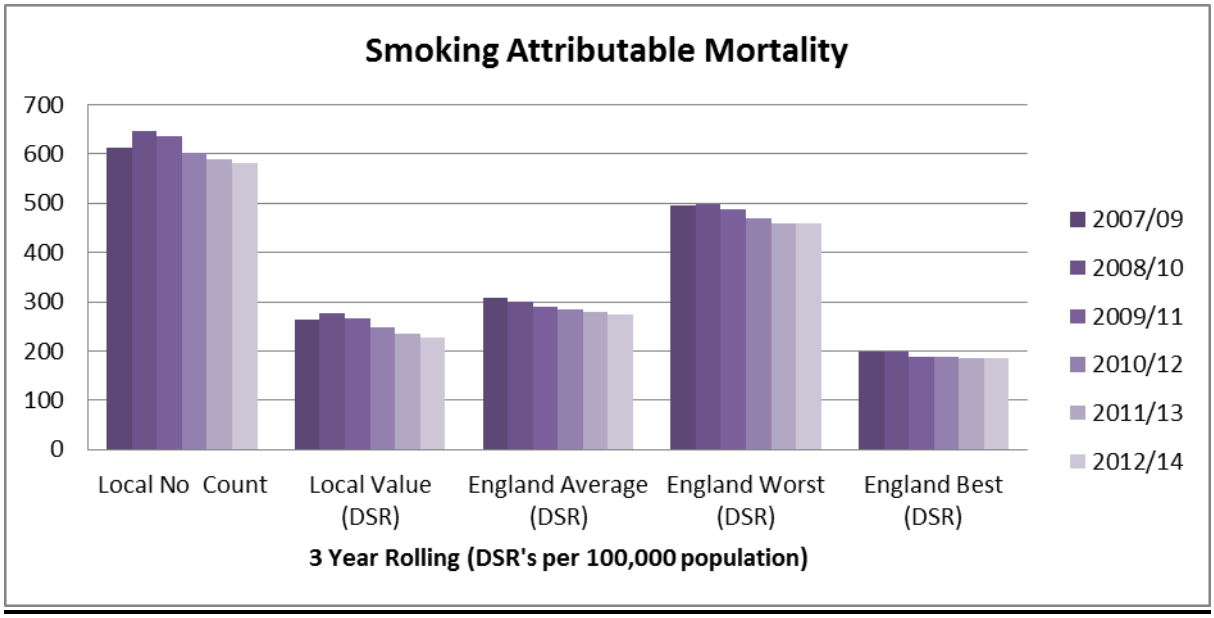
Bedford Borough has lower rates of smoking related mortality than the England average, with smoking accounting for the deaths of 194 people per year. This equates to 227 per 100,000 population aged 35+. The graphs below demonstrate that Bedford Borough is below the national average for smoking related and attributable mortality.

Figure 10: Smoking related mortality



Source: Bedford Borough Health Profiles 2009,2010, 2011 , 2012, 2013, 2014 and 2015.

Figure 11: Smoking Attributable mortality



Source: Tobacco Profiles

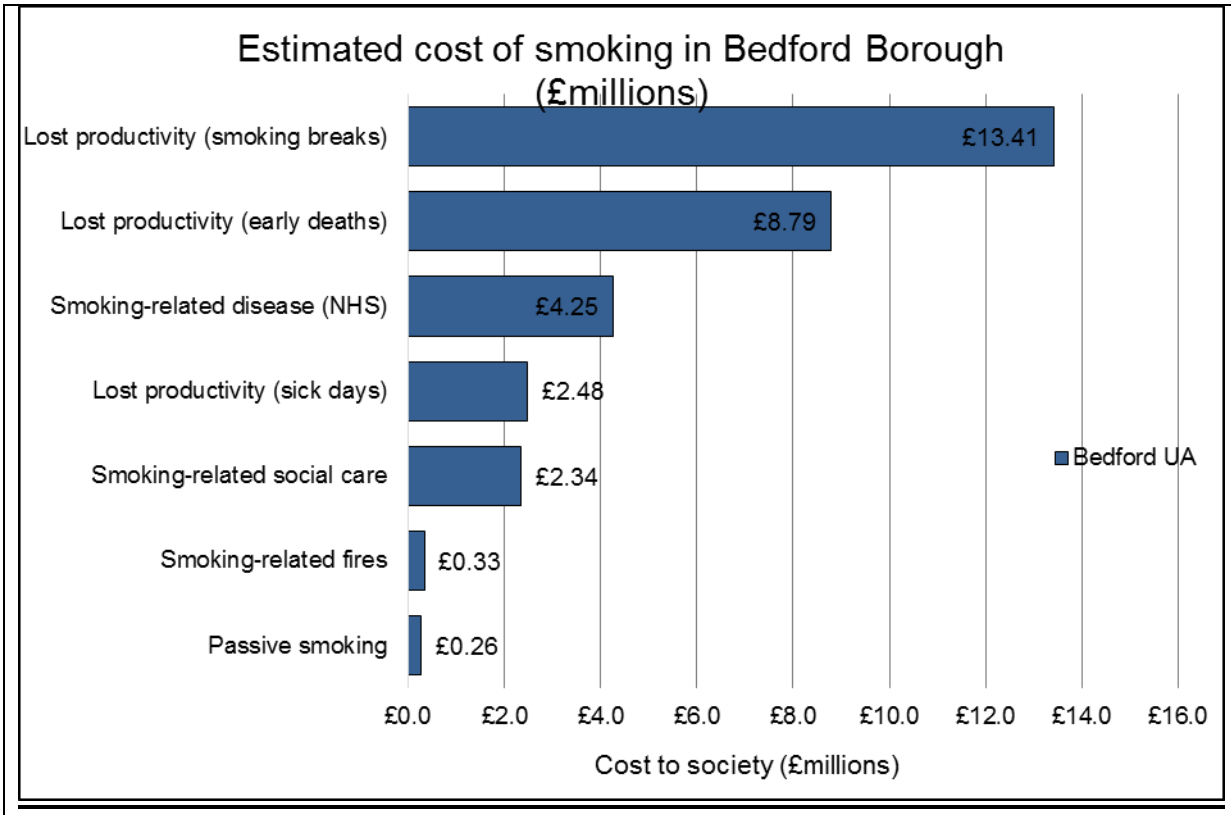
Costs

The ASH ready reckoner tool estimates that in Bedford Borough there are 18,021 smokers, which cost society £31.9 million each year. This is based on prevalence data from the Integrated Household Survey (IHS) but if it was based on Annual Population Survey (APS) data the figures are likely to be higher.

The total annual cost to the NHS in Bedford Borough is estimated at £4.5 million; £4.3 million as a direct result of treating smoking-related ill health and £261,664 due to treating the effects of passive smoking in non-smokers.

Current and ex-smokers who require care in later life as a result of smoking-related illnesses cost society an additional estimated £2.3 million across Bedford Borough. This equates to £1.3 million in costs to the local authority and £997.3 thousand in costs to individuals who self-fund their care.

Figure 12: costs of smoking



Source: ash.org.uk/localtoolkit/docs/Reckoner.xls

Illicit Tobacco

What do we know?

The market for illicit tobacco is reducing but it is still prevalent in some areas and communities. Illicit tobacco undermines tobacco control measures, for example taxation and age restrictions to purchasing however its biggest impact is on those that are more vulnerable. Illicit tobacco is linked to criminal activity and because it is cheap it particularly attracts children and adults on low income, thereby further perpetuating health inequalities. (Tackling Illicit Tobacco for Better Health Partnership www.illegal-tobacco.co.uk)

Poorer smokers are much more likely to smoke cheap illicit tobacco, and nearly half of all hand rolled tobacco is illicit. To address health inequalities and reduce tobacco use, especially in children, the illicit sale of tobacco must be tackled.
http://www.ash.org.uk/localtoolkit/docs/cllr-briefings/Illicit.pdf

Illicit tobacco costs the taxpayer approximately £2 billion per year in lost revenue. It also involves organised crime networks that are likely to be engaged in other criminal activity such as drugs.

Tackling illicit tobacco is cost-effective. The National Anti-smuggling Strategy introduced in 2000, cost around £100 million in 2010 but generated £1.3 billion additional revenue from the reduction in the illicit market.
http://www.ash.org.uk/localtoolkit/docs/cllr-briefings/Illicit.pdf

Current Activity

In order make this work more effective, by covering a wider geographically area, a steering group has been established across Bedford Borough, Central Bedfordshire and Luton, The group has members from Trading Standards and Public health.

Work, funded by the Department for Health, has been undertaken in Bedford Borough . Operation Henry is the first large scale coordinated action by Trading Standards to tackle the local supply of illicit tobacco products across England.

The Operation was developed and managed by the Trading Standards Institute on behalf of the Department of Health. Tobacco detection dogs search teams were provided by Wagtail UK Ltd, Illicit tobacco products were available in every English region.

81 local authority Trading Standards Services took part in Operation Henry; seizures occurred in 67 of those authorities including Bedford Borough.
The majority of seizures were made at small retailers, independent newsagents and off license premises; this was reflected in Bedford Borough.

What are the current unmet needs/service gaps.

In order to continue to reduce Illicit tobacco and smuggling there is a need to ensure that work is funded and local resources are in place to undertake the work.
With the imminent change in law around e cigarettes work should be undertaken to ensure that e cigarettes that are sold in Bedford Borough comply with the required standards. This applies to both age of sale and packaging information.

From 2016 the Medicines and Healthcare Regulatory Authority has stated that manufacturers of e-cigarettes will be able to apply for a licence to have their products regulated as medicines in the UK. When this happens the Stop Smoking Service will be

able to supply e-cigarettes as smoking cessation aids.

Recommendations

Tobacco Control

- Continue to address tobacco control through the Bedfordshire Tobacco Free Alliance, ensuring that it is a strategic multi agency partnership with senior level accountability and a dedicated, well-funded and coordinated resource.
- Continue implementation of the local tobacco control plan using local data and intelligence to ensure appropriate targeting and measurable outcomes.
- Continue to promote compliance with tobacco legislation, for example by funding activities to stop under age sales of tobacco, promote Smokefree legislation and reduce the availability of illicit tobacco.
- Encourage local people to make their homes Smokefree
- Promote Smokefree Cars legislation

The Stop Smoking Service

- Continue to provide training and refresher sessions on Brief Interventions, particularly to frontline staff, ensuring that 'every contact counts'.
- Continue to provide local stop smoking services in ways that maximise accessibility and outreach
- Further develop interventions for identified groups with high rates of smoking prevalence, capitalising on 'teachable moments' such as referral for surgery and unplanned admissions.
- Ensure there is adequate access in the 20% most deprived MSOAs in order to reduce the inequalities gap.
- Accurate collection of data, including ethnicity, in order to better identify BME communities and implement smokeless tobacco programmes.
- Further increase access of support to BME groups encouraging smokers and niche tobacco users.

- Community engagement needs to be strengthened in order to support BME groups
- Continue to work in partnership with key external organisations and internal departments to maximise opportunities to increase referrals to the service and subsequent quits.
- Further develop and sustain links with local businesses to support the facilitation of workplace groups.

This chapter links to the following chapter in the JSNA:

- Cancer
- Cardiovasular Disease
- Respiratory Disease

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