Tobacco FREE Lancashire

Towards a Smokefree Generation

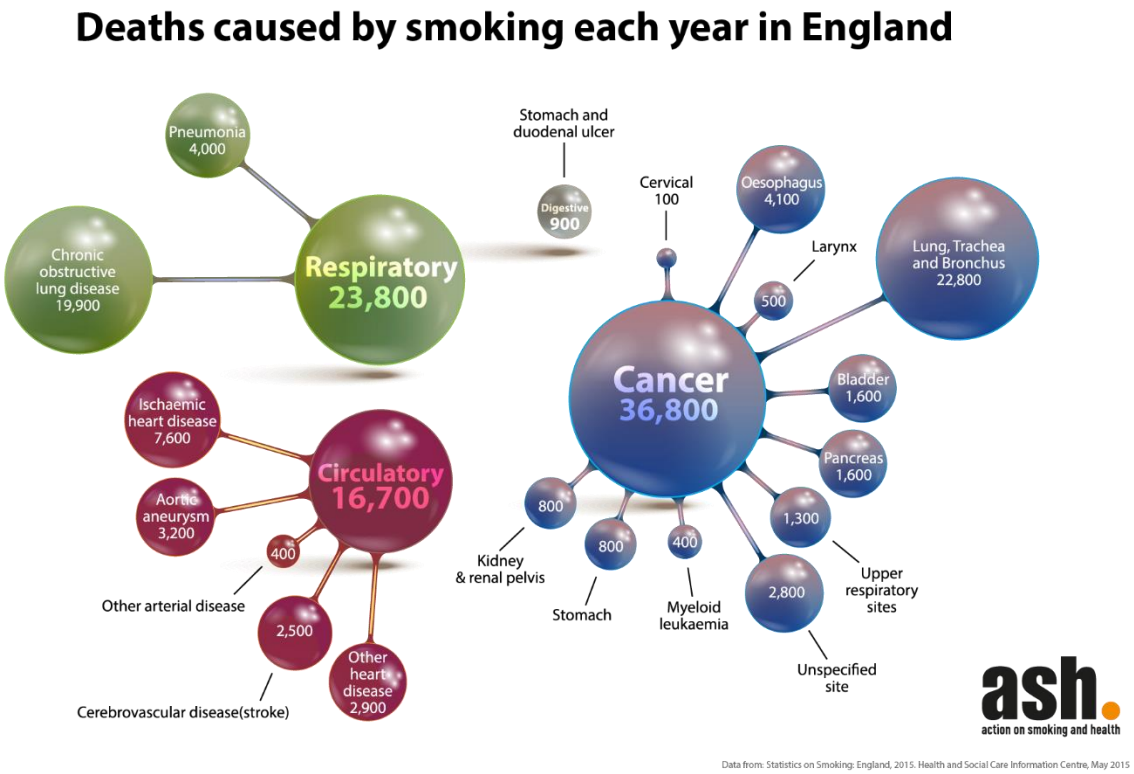
2018-2023

Contents

Foreword

Whilst we have made great progress in reducing the harms caused by tobacco and smoking, this remains the single largest preventable cause of ill health, premature death and health inequalities in Lancashire. One in two long-term smokers die prematurely as a result of smoking, half of these in middle age; and on average, each smoker loses 16 years of life and experiences many more years of ill-health than a non-smoker (Department of Health, 2011)[1].

Smoking kills approximately 79,000 people each year in England and 2,905 adults aged 35 years and over in Lancashire, Blackpool and Blackburn with Darwen. 36% of deaths from respiratory disease and 54% of cancer deaths are estimated to be attributable to smoking (NHS Digital, 2017)[2].



Reducing the health inequalities resulting from smoking, and protecting successive generations of children and young people from the harms of tobacco, therefore remains a public health priority in Lancashire.

We are committed to reducing the prevalence of smoking from 16.9% (in 2016) to the England national ambition of 12% or less by 2022 and will continue to challenge the social norms that we currently see; that smoking is acceptable or normal behaviour.

Our new Tobacco Free Lancashire strategy has the overarching framework of ‘smokefree’ – to reduce the damaging impact of tobacco by helping people to quit smoking, reducing the availability of illicit tobacco and challenging the social norm of smoking. We will be seeking to create more smokefree environments and spaces across our communities so that we can challenge the norm of smoking. We need to promote the message that non-smoking is the norm in our society, as we know that young people are significantly less likely to take up smoking themselves if they experience restrictions on smoking in public places, schools and at home. In addition, a person’s behaviour is influenced by the perception of how others behave in society, meaning that an individual is more likely to engage in harmful behaviour if that behaviour is seen as typical (Linkenbach, J., 2003)[3].

This Strategy is ambitious; whilst we have such high rates of smoking prevalence in parts of Lancashire, we feel we need to challenge and create the drive, impetus, and partner and public engagement needed to achieve this.

County Councillor Turner, Lancashire County Council

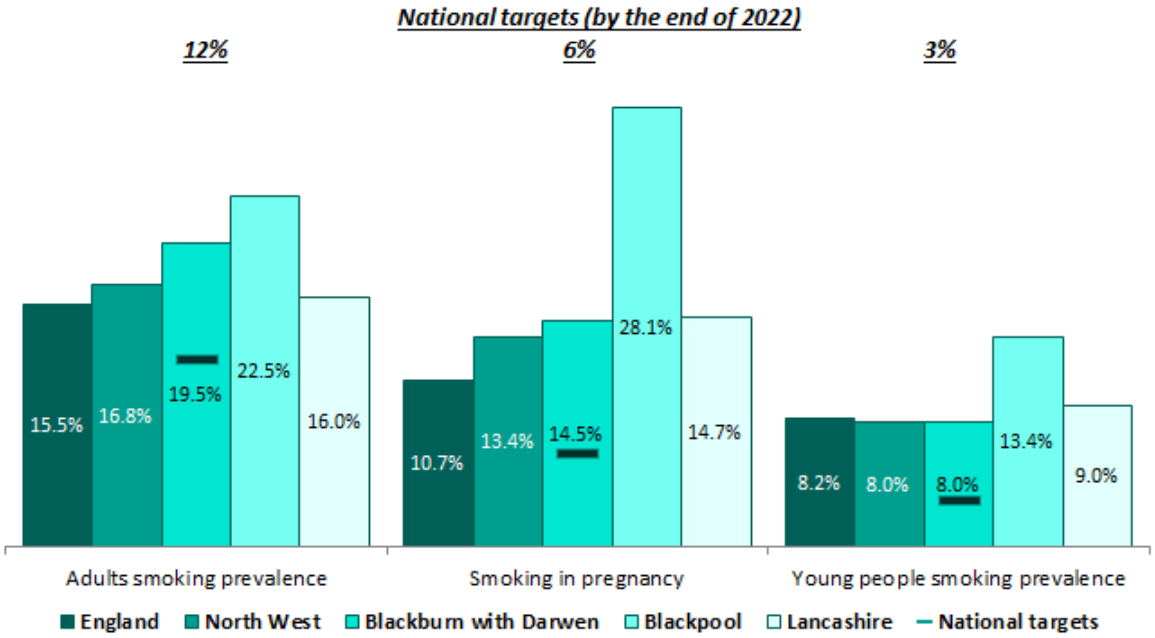
Councillor Taylor, Blackburn with Darwen Council

Councillor Cross, Blackpool Council

Tobacco use in Lancashire

Tobacco use remains one of the most significant public health challenges. While rates of smoking have continued to decline over the past decades, nationally 15.5% of adults still smoke. Smoking rates remain higher in Lancashire than England in adults, pregnant women and young people. Within this is great variation in prevalence when comparing Lancashire, Blackpool and Blackburn with Darwen.

Figure 1: Progress against national targets



Source: PHE, Local Tobacco Profiles

The majority of people who smoke become addicted as children before they are legally old enough to buy cigarettes; with two-thirds initiating smoking under the age of 18, the legal age of sale, and almost two-fifths under 16 years[4].

Smoking disproportionally affects those disadvantaged by poverty and is a major contributor to health inequalities, accounting for half of the difference in life expectancy between social classes I and V[5,6]. Adults in routine and manual occupations are around twice as likely to smoke as those in managerial and professional occupations (27% vs 13% respectively)[7].

Women who smoke in pregnancy are more likely to be younger, single, of lower educational achievement and in unskilled occupations[8]. Smokers from routine and manual groups comprise 44% of the overall smoking population and reducing smoking in this group is critical to reducing inequalities.

Smoking rates are also higher among Bangladeshi and Irish males[8] (40% and 30% respectively), prisoners[9] (80%) and people living with a mental health condition. Nationally, a third (32%) of people with depression or an anxiety disorder and 40% for those with probable psychosis smoke[10]. Even higher rates are experienced in mental health inpatient settings, where up to 70% of patients smoke and around 50% are heavy, more dependent smokers[11].

Smoking is the primary cause of preventable ill health and premature death from respiratory diseases, circulatory disease and cancer (Appendix 1) accounting for approximately 2,800 deaths in adults aged 35 years and over each year in Lancashire alone (PHE, Local Health Profiles 2017)[12]. One in 20 hospital admissions are smoking related[13] and the estimated lifetime cost of treating a smoker with a smoking-related disease in Lancashire is £15,121[14].

Reducing health inequalities resulting from smoking, therefore, remains a public health priority in Lancashire and we need to take new and braver action to drive smoking rates down further.

Smokefree Lancashire

This Strategy has the overarching framework of 'smokefree' – to reduce the damaging impact of tobacco by; encouraging young people not to start smoking, helping people to quit smoking, reducing the availability of illicit tobacco and challenging the social norm of smoking. An essential element of this framework is to create more and more smokefree environments and spaces across our communities so that we can challenge the norm of smoking.

The World Health Organisation (WHO) has listed secondhand smoke (SHS) from tobacco as a human carcinogen, to which there is no safe level of exposure[15]. Thirty minutes exposure to SHS reduces blood flow to the heart in fit, healthy adults and long-term exposure increases a non-smoker's risk of developing heart disease and lung cancer by a quarter, and stroke by three-quarters[16,17].

Children are especially at risk from the effects of SHS because they have smaller vessels and their organs are still developing. Therefore, they breathe faster and breathe in more toxic chemicals than adults[18]. Children exposed to SHS are at increased risk of bronchitis, asthma symptoms, middle ear infections (glue ear), meningitis and sudden infant death syndrome (cot death) [18].

It is estimated that there are approximately 3,900 additional incidents of childhood diseases each year within Lancashire, directly attributable to SHS [18,19]:

- 470 new cases of lower respiratory tract infection in children under two years old
- 2,900 new cases of middle ear infections in children of all ages
- 540 new cases of wheeze and asthma in children
- at least 16 new cases of bacterial meningitis

Infographic 1: Additional incidents of childhood diseases in Lancashire attributable to secondhand smoke

Smokefree homes and cars scheme is one such initiative which aims to reduce exposure to SHS and assist pregnant women to quit, and for them and their families to remain smokefree. When implemented effectively the scheme has the potential to improve the health of children and young people through preventing exposure to secondhand smoke in the home and when travelling in a car.

Ambitions

- we will support NHS Trusts across Lancashire to implement the new CQUIN and NICE guidance PH48[21] in fulfilling smokefree policies and effective ways to help people stop smoking, in acute, maternity and mental health settings
- we will work with local businesses to support their workforce to stop smoking, including the development of smokefree policies and supporting the implementation of NICE guidance PH5[22] on workplace interventions to help people stop smoking
- we will work with a range of partners across Lancashire to support the implementation of smokefree parks, schools and public places

Policy context

This Tobacco Free Lancashire strategy has been developed in-line with the new Tobacco Control Plan for England[23] which sets out the ambition to achieve a smokefree generation by:

- preventing children from taking up smoking in the first place
- stamping out inequality for example smoking in pregnancy
- supporting smokers to quit

The national strategy has also identified the need to address parity of esteem in terms of the health inequalities that exist for people with a mental health condition who 'die on average 10 to 20 year earlier than the general population' (DH, 2017)[23]. It has also identified the need to create more working environments which encourage smokers to quit, such as the NHS as a workplace and NHS Trusts as a setting.

Our strategy supports these ambitions and provides some high-level priorities which will inform more detailed action planning at both the pan-Lancashire and local levels in order to achieve improvements in outcomes.

Key priorities for Lancashire

This strategy has an overarching framework of achieving a smokefree Lancashire and has prioritised the following areas based on detailed local intelligence at an individual level in order to reduce health inequalities and improve quality of life by reducing smoking prevalence in the following groups:

- pregnancy
- people with mental health conditions
- people with long-term conditions

Smoking in pregnancy

Overall, smoking during pregnancy increases the risk of infant mortality by around 40% and causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths in the UK every year[24]. It has been estimated that a 10% reduction in infant and fetal deaths could be achieved if all pregnant women stopped smoking[25].

Rates of smoking in pregnancy are variable throughout the UK and are strongly linked to age and social economic deprivation. Mothers aged 20 or under are five times more likely than those aged 35 and over to have smoked throughout pregnancy (45% and 9% respectively)[26]. Women in routine and manual occupations are more than five times as likely to smoke throughout pregnancy compared to those in managerial and professional occupations. As a result, those from lower socio-economic groups are at much greater risk of complications in pregnancy[27].

Reducing smoking in pregnancy is a key public health priority for Smokefree Lancashire. The recently published Tobacco Plan for England[23] aims to reduce prevalence of smoking in pregnancy from 10.7% to 6% or less by the end of 2022. This is an ambitious challenge considering recent smoking at time of delivery (SATOD) figures vary considerably over the fourteen areas from 28.1% in Blackpool to 9.8% in Chorley and South Ribble[23]. SATOD data

provides a measurable outcome and working in partnership can provide the opportunity to reduce the leading modifiable risk to stillbirth.

Table 1: Reported SATOD Data Annual Reporting for 2016/17 (source NHS Digital, 2017)[2].

Smoking At Time Of Delivery (SATOD) 2016/17	2016/17 (Annual)		
	Maternities	No. of Smokers	%
England	619,234	65,023	**10.7**
NHS England North	172,929	24,228	14.0
NHS England North (Lancashire)	16,203	2,595	**16.0**
NHS Blackburn with Darwen	2,147	309	14.4
NHS Blackpool	1,804	507	28.1
NHS Cumbria	4,686	569	12.1
NHS Chorley and South Ribble	1,861	183	**9.8**
NHS East Lancashire	4,354	716	**16.4**
NHS Fylde & Wyre	1,266	208	**16.4**
NHS Greater Preston	2,413	288	**11.9**
NHS Lancashire North	1,462	262	**17.9**
NHS West Lancashire	896	122	**13.6**
Lancashire	12,252	1,779	**14.5**

The Saving Babies Lives Care Bundle[29] has been designed to tackle stillbirth and early neonatal death. It is a significant driver to deliver the ambition to reduce the number of stillbirths, bringing four elements of care together which incorporates:

- reducing smoking in pregnancy
- risk assessment and surveillance for fetal growth restriction
- raising awareness of reduced fetal movement
- effective fetal monitoring during labour

Developing a care bundle has previously demonstrated a more rapid response to smaller interventions, such as stop smoking, when implemented as part of a package as opposed to individually. In order to improve outcomes, partnership working is essential.

As a result, the Lancashire wide Smoking in Pregnancy Task and Finish Group will continue to meet and work with multi-partners in order to improve early intervention and to prevent poor outcomes before, during and after pregnancy as proposed in the Maternity Transformation Programme[30].

The group will focus on reducing the number of women who smoke in pregnancy, in accordance with NICE guidance PH26[31], improving maternity pathways to better incorporate stop smoking interventions and sharing good practice. This will include training, which will support reassessing cultural norms, lifestyles and behaviours as well as quit attempts.

Ambitions

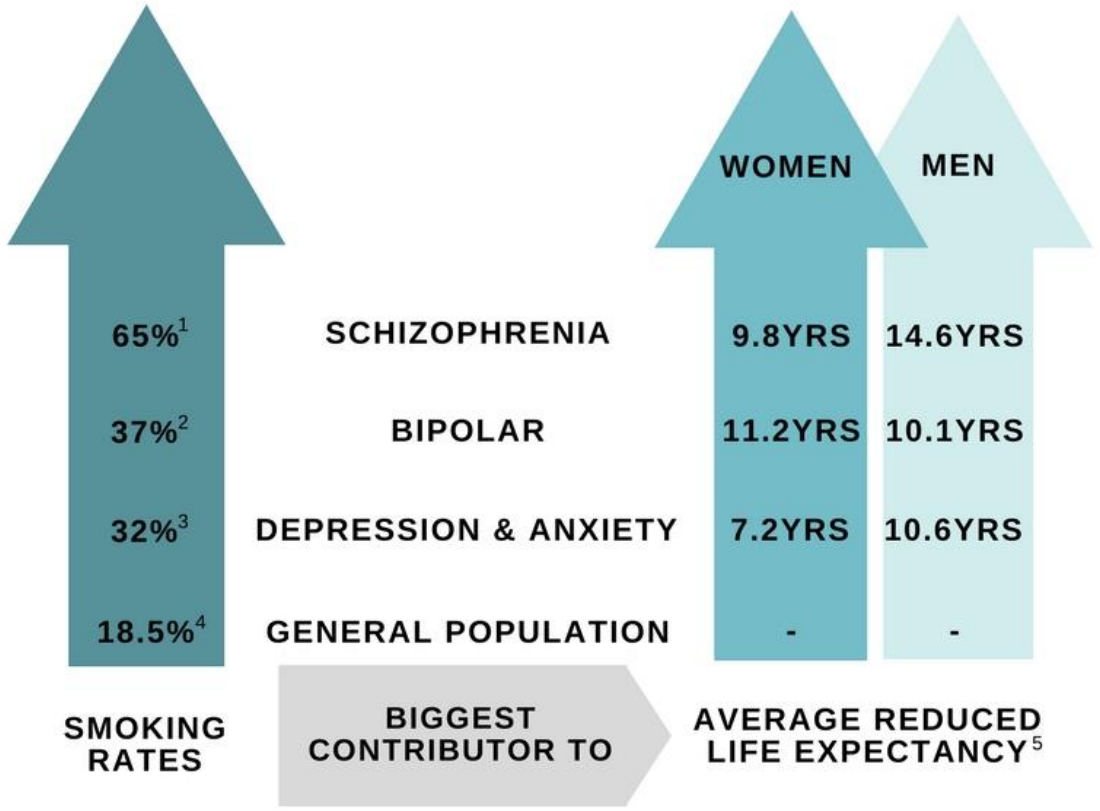
- we will encourage all health care professionals, who come into contact with pregnant women who smoke, to be trained as a minimum in giving very brief advice, so they can provide a consistent message for women (NCSCT online training)
- we will encourage the inclusion of carbon monoxide (CO) screening as routine practice; minimum at booking and delivery (36 weeks)
- we will ensure that midwifery leads are kept up-to-date with current evidence and national guidance through the Smoking in Pregnancy group
- we will work towards reducing smoking in pregnancy SATOD to 6% or less
- we will work to improve pathways between midwifery and stop smoking services, with an opt-out system being the preferred approach
- we will review the smoking status of partners and advise accordingly around the impacts of SHS

Smoking and mental health conditions

It is estimated that one in four people are affected at some point in their life from a mental health illness, and the life expectancy of those diagnosed with a mental health illness is on average 10-20 years less than someone without a mental health diagnosis. The main reason for this difference in life expectancy is due to smoking. More than two fifths (42%) of all cigarettes smoked in England in 2007 were by people with a mental health condition[32].

Figure 2 illustrates the association between the severity of a mental illness, smoking prevalence rates and reduced life expectancy.

Figure 2: Smoking rates and average reduced life expectancy by mental health condition



1: Wu C.Y et al. (2013). PLoS ONE 8(9): e74262. 2: THIN data 3: McManus et al (2010) NCSR
4: www.smokinginengland.info 5: Chang et al, Life Expectancy at Birth for People with Serious Mental Illness and Other Major Disorders from a Secondary Mental health Care Case Register in London, PLoS ONE, 2011

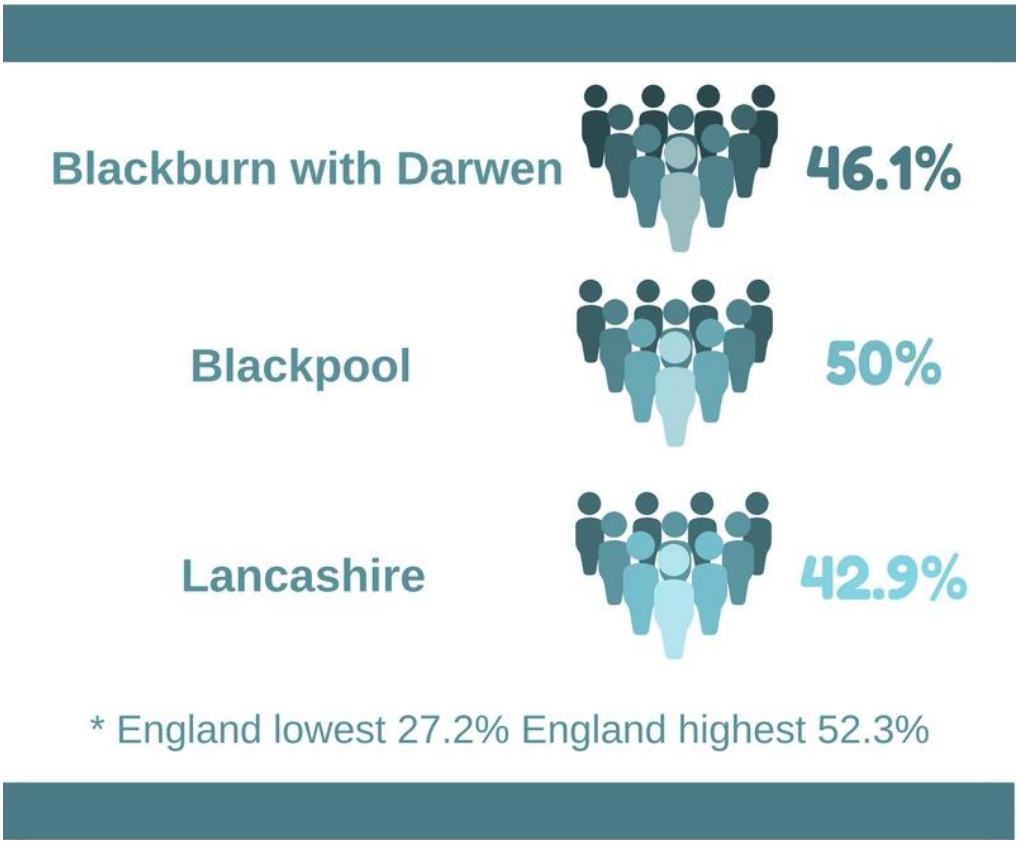
The correlation between the prevalence of smoking and people with mental health conditions has been shown to dramatically increase with the severity of the mental health illness. In 2014 it was estimated that 31% of men and 23% of women who had ever been diagnosed with a mental health condition smoked, compared to 19% of men and 13% of women in the general population. People with more severe mental health illnesses, such as psychosis, have been

shown to have smoking rates as high as 60% whilst prevalence rates for inpatients in psychiatric units have been estimated at 70%[32]. People with severe mental health illnesses are also at more risk from physical health conditions, for example cardiovascular disease, and the life expectancy for people with schizophrenia is estimated to be 15-20 years less than the general population[33].

Whilst smoking rates in the general population have been declining in England since the mid-1990s to a reported level of approximately 19% in 2014, smoking rates for people with a mental health condition over the 20-year period have remained the same at an estimated 40%[34].

Statistics illustrating smoking prevalence for people living in Blackpool, Blackburn with Darwen and Lancashire who have a severe mental health condition are shown in Infographic 2 below.

Infographic 2: Smoking Prevalence for people with a severe mental health condition



*PHE 2015. *Data quality query*

A number of explanations have been made for this high prevalence rate which include:

- the complexity of the issue. People with mental health conditions have often been smoking for many years, smoke more cigarettes and are more addicted to nicotine
- a combination of a number of factors including biological, environmental and social norm.

- lack of encouragement to quit[35]. In some instances, the use of cigarettes to 'manage patients' has been reported[36,37]

A change in attitudes and culture towards smoking is required to ensure this trend is reversed. People with a mental health condition are more likely to engage with health services as it is estimated that 80% of people with a severe mental health condition seek medical treatment from different settings including GP surgeries or outreach teams to name but a few[38]. It is, therefore, a prime opportunity for health professionals to engage in a conversation about smoking cessation.

People with a mental health condition are also just as likely to want to quit smoking but are aware of the hardship of trying to quit and have been known to be less likely to succeed[39]. A Health Survey for England conducted in 2010 reported that 66% of people with a mental health condition would like to quit[40].

The majority of mental health services are provided in the community. Therefore, primary care and community care providers are essential in ensuring the delivery of an integrated tobacco treatment pathway. This will include identification of a smoker, provision of advice and timely access to stop smoking support services[23].

Ambitions

- we will support and advise CCGs to implement NICE guidance PH45 and PH48
- we will increase awareness of the benefits of peer support and mental health champion programmes to improve confidence, knowledge and dispel myths on smoking and mental health within healthcare settings and the wider community
- we will work in partnership, whenever possible, with primary and secondary healthcare services to improve pathways to stop smoking services
- we will increase awareness and understanding in local health and social care systems of the needs of smokers with a mental health condition(s) in relation to targeted smoking cessation approaches and interventions
- we will work with Primary Care to share the latest evidence, improve confidence, knowledge and dispel myths on smoking and mental health

Smoking and long-term conditions

Over a quarter of the population in England have a physical long-term condition and an increasing number of these people have multiple conditions, with the number of people with three or more conditions expecting to increase from 1.9 million in 2008 to 2.9 million by 2018[41]. A long-term condition is one that can be controlled but not cured. Smokers are more likely to live with a long-term condition and many are either caused or exacerbated by smoking.

People with long-term conditions use a significant proportion of health care services, accounting for 50% of all GP appointments; 64% of outpatient appointments, 70% of inpatient bed days and 70% of the total health and care spend in England[42].

Chronic Obstructive Pulmonary Disease (COPD) causes 24,000 deaths in England every year[43] and smoking accounts for 85% of COPD related deaths[44]. People suffering from asthma who smoke experience higher rates of hospitalisation, worse symptoms and a more rapid decline in lung function than those with asthma who do not smoke[45]. Smoking significantly increases the risk of heart disease and stroke, and smokers with diabetes have increased risks of complications and premature death.

Lancashire experiences higher prevalence rates of diagnosed long-term conditions than England as a whole. Table 2 shows the diagnosed prevalence of long-term conditions (2014/15) for Lancashire in comparison to England.

Smokers and the socially deprived suffer disproportionately. Those in lower socio-economic groups are significantly more likely to live with a long-term condition and also have high rates of smoking, which has significant implications for their health and wellbeing. Smoking is responsible for half the difference in life expectancy between the rich and poor, and smokers are likely to need care on average nine years earlier than non-smokers[45].

Table 2: Prevalence of long-term conditions in Lancashire compared with England

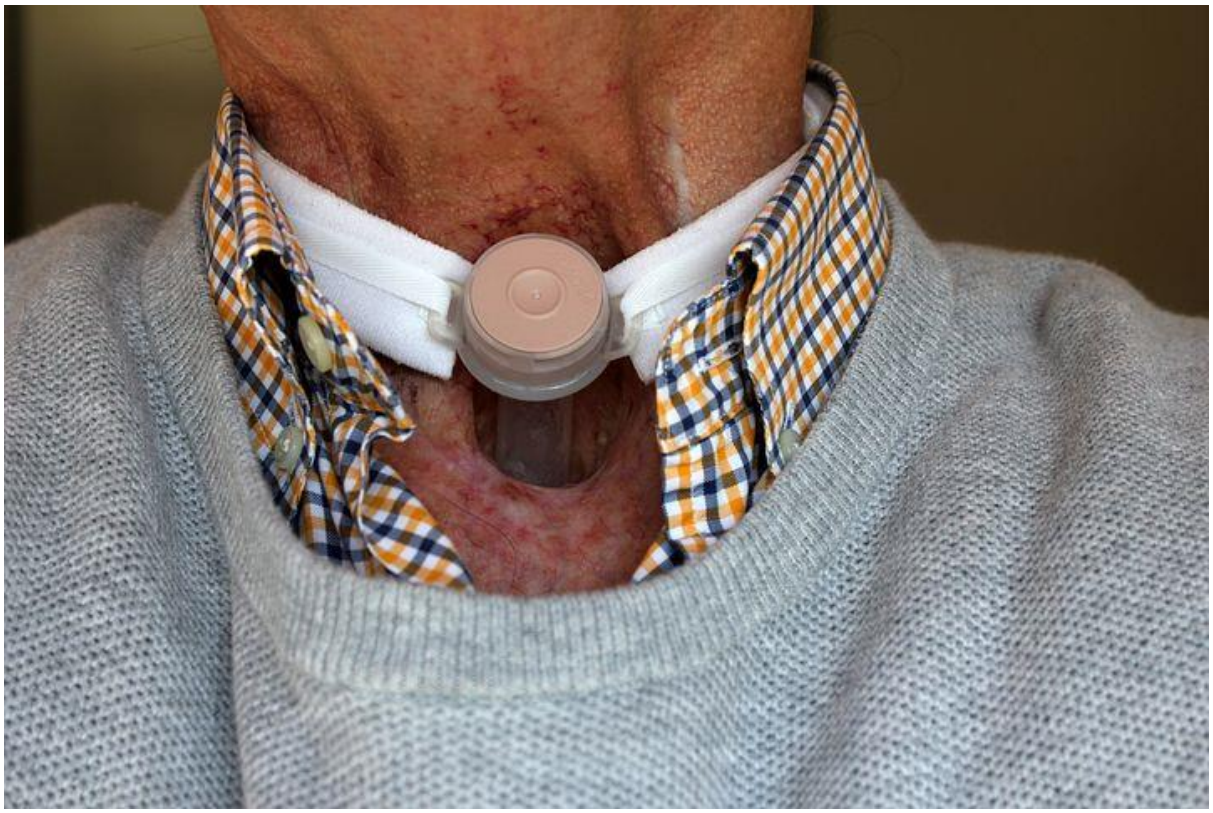
Long-term condition	England		Lancashire	
	Number affected	% affected	Number affected	% affected
Hypertension	7,833,779	13.8	223,779	14.7
Depression (18+)	3,305363	7/3	112,863	9.3
Asthma	3.402,437	6.0	103,935	6.8
Diabetes (17+)	2,913,538	6.4	85,290	6.9
Coronary Heart Disease	1,843,813	3.3	62,788	4.1
Chronis Kidney Disease (18+)	1,859,963	4.1	62,278	5.1
Chronic Obstructive Pulmonary Disease	1,034,578	1.8	37,598	2.5
Cancer	1,281,811	2.3	37,243	2.4
Stroke & TIA	981,836	1.7	30,727	2.0
Atrial Fibrillation	926,551	1.6	27,058	1.8
Mental Health	500,451	0.9	15,368	1.0
Heart Failure	410,783	0.7	15,131	1.0
Dementia	419,073	0.7	13,107	0.9
Epilepsy	357,096	0.8	11,266	0.9

Source: HSCIC, Quality and Outcomes Framework (QOF) for April 2014-March 2015, England

Smoking doubles the risk of developing care needs and every year Local Authorities spend an additional £600 million providing care as a result of smoking-related diseases (ASH, 2015)[45].

Ambitions

- we will encourage NHS organisations across Lancashire to provide very brief advice to patients identified as a smoker, so they can provide a consistent message (NCSCT on-line training)
- we will encourage the inclusion of carbon monoxide (CO) screening as routine practice on admission to hospital, pre-operatively, on outpatient assessments and in other settings
- we will encourage the development of smokefree champions and brief intervention training to increase confidence and change attitudes of professionals who are supporting people with long-term conditions
- we will encourage staff to identify at-risk groups for them to be supported as a priority



Tobacco control enforcement

The trade in illicit tobacco impacts on public health policy and has a devastating effect on individuals and communities nationally. It impacts on legitimate businesses and allows tobacco to be more accessible to children[23].

Environmental health services are responsible for enforcing the bans on smoking in enclosed public spaces and cars transporting children. In the main, the bans introduced in 2007 and 2015 are respected. The main focus of work for some local authorities is in dealing with shisha bars where shisha pipe smoking often takes place in enclosed spaces.

Trading Standards services deal with the following tobacco controls:

- removing illegal tobacco from the market – counterfeit, foreign labelled and cheap white tobacco products
- display and pricing requirements
- health warning and other labelling requirements
- standardised packaging
- pack size controls and ban on the sale of single cigarettes
- sale of tobacco to children (under 18-year olds)
- niche tobacco such as shisha, chewing tobacco and snuff

Trading Standards are also responsible for dealing with the following issues around e-cigarettes

- underage sales of products and e-liquids to under 18s
- enforcement of health warnings/usage instructions on packs
- control of nicotine content
- refill pack size
- childproof packaging

In 2014, studies showed that 46% of children aged 11-15 years purchased cigarettes from shops, even though the law prohibits the sale to young people under 18 years of age. This

illustrates the need for robust enforcement of the legislation preventing underage sales of tobacco[45].

Local authorities use a range of techniques when tackling tobacco problems including offering advice and guidance, test purchasing, seizure of illegal products and the prosecution of those who flout the law. This work involves strong partnership working with the police and HM Revenue and Customs (HMRC).

Environmental impacts of smoking

Environmental impacts of smoking and littering of streets and urban areas are costly to remove. More than £1 billion of taxpayers' money was spent in England in 2013 to clean up tobacco litter[46]. Cigarette butts constitute 25-50% of all litter and in some areas, the percentage of littering by smokers' materials is even higher. Studies of littering have found that smokers' materials remain the most prominent littering item since 2003[47].

Cigarette butts are made from cellulose acetate which is not biodegradable. The butts often contain the carcinogenic components of cigarettes such as pesticides[48]. A study of the impacts of heavy metals leaching from cigarette butts in watercourses concluded the leachate from cigarette butts was toxic to fish[49]. Cigarette butts have also been known to be poisonous to bird life and animals when ingested.

It is therefore important to acknowledge the impact of littering from smokers' materials and to consider policies to reduce the impact. A method to reduce this burden on society may be through the expansion of smokefree outdoor areas[48].

Ambitions

- we will review the sanctions for tobacco retailers who repeatedly flout the legislation which is designed to protect children and young people
- we will work with a range of partners across Lancashire to support the expansion of smokefree parks, schools and public places
- we will raise awareness that it is a criminal offence to drop cigarette litter and ensure local enforcement strategies are implemented
- we will minimise tobacco industry influence on local public health policy through implementing Article 5.3 of the World Health Organisation Framework Convention on Tobacco Control*[16]

*The WHO Framework Convention on Tobacco Control, to which the UK is a party, states in Article 5.3 that, "In setting and implementing their public health policies with respect to tobacco control, Parties shall act to protect these policies from commercial and other vested interests of the tobacco industry in accordance with national law."

Electronic cigarettes

Lancashire Directors of Public Health endorse the Association of Directors of Public Health (ADPH) position statement on nicotine vapourisers (December 2015).

"Throughout this position statement we use the term nicotine vapourisers – to encompass the range of products variously described as electronic cigarettes or Electronic Nicotine Delivery Systems (ENDS), etc.

ADPH recognises the significant burden that smoking places on individuals and society. Stopping smoking, however this is achieved, is the single best thing anyone can do for their health. ADPH supports the updated NICE guidance on tobacco harm reduction.

We believe that restrictions and regulations on the advertising, marketing and use in enclosed public spaces of smoked tobacco products should also apply to nicotine vapourisers, given the lack of knowledge on their long-term health risks and to prevent undermining of the successful efforts that have been made to de-normalise smoking behaviour.

We are cognisant of arguments for the potential impact of nicotine vapourisers as a means of quitting or reducing harm by substituting for conventional tobacco products. However, we believe that more research is needed to establish clear evidence of safety and their long-term impact on health – as well as on wider questions relating to re-normalisation of smoking behaviour, and the impact on young people of product development, advertising and marketing. Therefore, we do not advocate their use beyond supporting smokers who have unsuccessfully tried other methods of quitting.

The involvement of the tobacco industry in product development raises concerns, and whilst efforts to de-normalise tobacco use are welcomed, attempts to maintain a population addicted to nicotine (including tobacco) are not.

We welcome the introduction of regulations in 2016. We will continue to review our policy position in the light of further research and evidence, in response to product development and after assessing the impact of new regulations. We will continue to work in collaboration with other Public Health organisations to support the development of evidence-based approaches to nicotine vapourisers."

Governance and accountability

Tobacco Free Lancashire is a multi-agency group which has individual lines of reporting to each of the partner organisations. Overall accountability for the work of the group is however to each of the three Health and Wellbeing Boards (HWBs); Lancashire, Blackpool and Blackburn with Darwen.

Links are made with national and regional expert advisors and good governance dictates that latest evidence, policy and practice are regularly reviewed to ensure that work continues to be relevant and current in the context of local needs and circumstances.

Learning and development are essential, and the Tobacco Free Lancashire group is committed to using key tools and resources in order to enhance and improve the role and influence of the group – for example using the CLeaR assessment, CQUIN and NHS Right Care Patient Decision Aids.

It is essential that this work also provides guidance and advice to the wider Sustainability & Transformation Partnership (STP) and relevant links have been made with cancer and CVD prevention work streams.

Achieving our ambitions

The main areas of activity required to achieve these aims and ambitions fall into the following broad categories, around which detailed action plans can be built:

- communication
- training
- advocacy
- performance management
- specialist support
- regulation and enforcement

Progress towards achieving our ambitions will be measured against the Tobacco Free Lancashire strategy action plans in line with the Public Health Outcomes Framework and reported to the three Health and Wellbeing Boards.

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