KENT PUBLIC HEALTH OBSERVATORY

Smoking and Tobacco Control

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Produced by

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Introduction

Smoking is still the leading cause of preventable death and disease in the UK, responsible for more deaths than obesity, alcohol, drugs and HIV combined (ASH 2013). About half of long-term smokers will die prematurely losing, on average, about 10 years of life (*ibid)*. In Kent, there were 7,036 premature deaths related to smoking mortality between 2012 and 2014 (Tobacco Control Profiles 2016*)*.

In August 2016 datasets for recording smoking prevalence changed from the Integrated Household Survey (IHS) and is now based upon the Annual Population Survey (APS) which showed an estimated smoking prevalence in Kent of 17% against a national average of 16.9% in 2015. In 2014, the smoking prevalence rate recorded by the IHS was 19.1% in Kent but due to differences in survey coverage and weighting methodology differences in the HIS and APS cannot be directly compared.

The consequences of smoking, however, still impact considerably on the economic and resource burden on the NHS at an estimated cost of £55.7 million per year in Kent which includes treatment for the following preventable smoking related health conditions:

Table 1: Attributable Deaths Related to Smoking

	Kent (per 100,000 population)	England (per 100,000 population)
Smoking related mortality	266.7	274.8
Smoking attributable deaths from stroke	8.6	9.3
Deaths from lung cancer	55	58.7
Smoking attributable deaths from heart disease	27.4	29.7
Deaths from chronic obstructive pulmonary disease (COPD) 2013-15	53.8	52.6

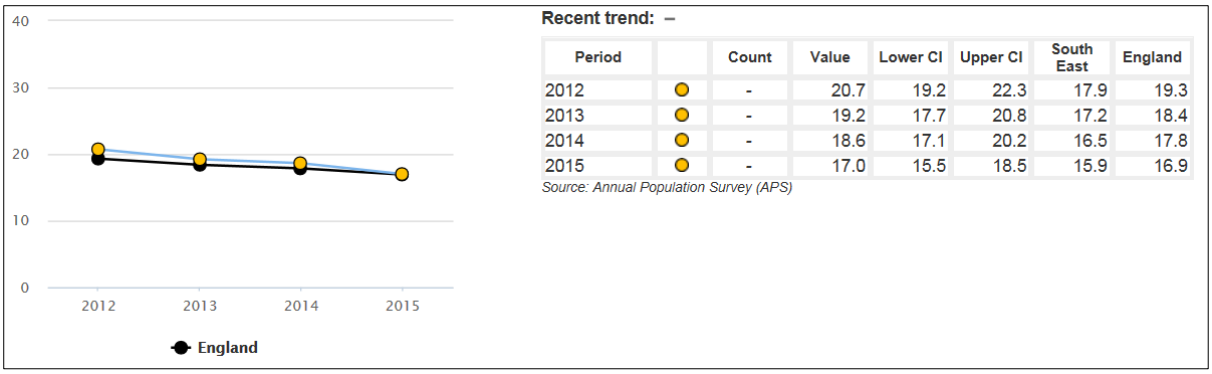
*PHOF data 2012-14

Source: Local Tobacco Health Profiles 2016

Key Issues and Gaps

Nationally smoking prevalence declined (from 18.4% in 2013 to 18% in 2014) and with prevalence data now being measured by the Annual Population Survey, Kent had a revised estimated prevalence of 17% in 2015, similar to the national average of 16.9%.

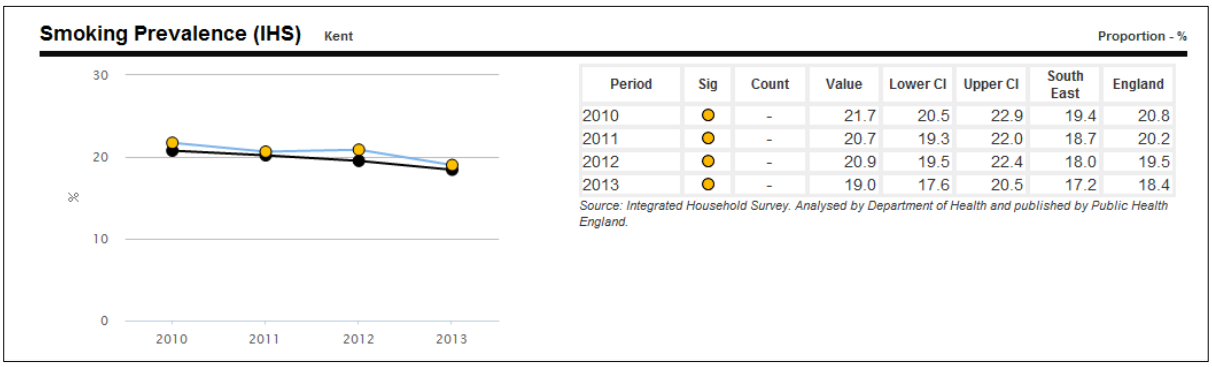
Figure 1: Prevalence of Smoking in Kent



Recent trend: –

Period		Count	Value	Lower CI	Upper CI	South East	England
2012		-	20.7	19.2	22.3	17.9	19.3
2013		-	19.2	17.7	20.8	17.2	18.4
2014		-	18.6	17.1	20.2	16.5	17.8
2015		-	17.0	15.5	18.5	15.9	16.9

Source: Annual Population Survey (APS)



Period	Sig	Count	Value	Lower CI	Upper CI	South East	England
2010		-	21.7	20.5	22.9	19.4	20.8
2011		-	20.7	19.3	22.0	18.7	20.2
2012		-	20.9	19.5	22.4	18.0	19.5
2013		-	19.0	17.6	20.5	17.2	18.4

Source: Integrated Household Survey. Analysed by Department of Health and published by Public Health England.

Source: Local Tobacco Control profiles 2016

The relationship between deprivation and smoking is even more apparent as prevalence within the most deprived wards remains consistently high. High smoking prevalence rates among routine and manual workers highlight the inequity and pockets of deprivation within all districts. Statistically, these are likely to be heavy smokers with a high nicotine dependency and are less likely to consider quitting.

Table 2

	Smoking Prevalence 2015	
	Smoking prevalence whole population 2013	Smoking prevalence among routine and manual workers
England	**16.9**	**26.5**
Kent	**19.0**	**24.5**
Ashford	**14.6**	**24.5**
Canterbury	**15.3**	**28.2**
Dartford	**17.5**	**18.3**
Dover	**29.7**	**41.7**
Gravesham	**17.9**	**11.4**

Maidstone	**13.1**	**21.5**
Sevenoaks	**15.6**	**32.7**
Shepway	**15.7**	**17.6**
Swale	**18.2**	**28.9**
Thanet	**19.2**	**28.8**
Tonbridge & Malling	**14.1**	**23.2**
Tunbridge Wells	**15.3**	**24**

Source: Local Tobacco Control Profiles 2016

Some smokers try to quit through stop smoking services. This is likely to be four times more successful than trying to give up smoking unaided or without behavioural support. Success rates are also more likely to be successful with the support of nicotine replacement therapy (NRT) which can be prescribed by stop smoking advisors or purchased over the counter in shops and pharmacies. It is reported that 68% of smokers want to give up smoking (Ash, 2014[1]) but there has been a national decline in the take up of stop smoking services and use of NRT. This indicates that:

a More smokers are giving up smoking without stop smoking services and without NRT despite evidence suggesting these are the most successful methods of quitting.
b There is a decline in people starting smoking.
c Nearly three million people nationally are using e-cigarettes and the majority are using them to give up or cut down on smoking although this figure is now declining.
d Those who do smoke are finding it hard to quit or are less likely to feel ready to quit smoking. These are likely to be heavier smokers, people who have smoked for a long time and those who have a heavy nicotine dependency.

[1] Stopping smoking: The benefits and aids to quitting, Ash Fact Sheet, September 2014

Figure 2: Tobacco Control Profiles

Indicator	Period	Kent		Region	England	England		
		Count	Value	Value	Value	Worst	Range	Best
Smoking Prevalence (IHS)	2013	-	19.0%	17.2%	18.4%	29.4%		10.5%
Smoking prevalence - routine & manual	2013	-	28.4%	29.2%	28.6%	47.5%		16.5%
Successful quitters at 4 weeks	2013/14	6,131	2,432	3,146	3,524	1,251		8,946
Successful quitters (CO validated) at 4 weeks	2013/14	5,176	2,053	2,319	2,472	525		6,950
Completeness of NS-SEC recording by Stop Smoking Services	2013/14	10,919	92.8%	85.9%	86.2%	25.2%		100%
Smoking status at time of delivery	2013/14	2,111	13.0%	10.8%	12.0%	27.5%		1.9%
Low birth weight of term babies	2012	400	2.4%	2.3%	2.8%	5.0%		1.5%
Smoking prevalence age 15 years - regular smokers	2013	-	-	-	8%	-	-	-
Smoking prevalence age 15 years - occasional smokers	2013	-	-	-	10%	-	-	-
Lung cancer registrations	2009 - 11	2,694	65.8	62.4	75.5	144.2		42.1
Oral cancer registrations	2009 - 11	464	11.1	11.9	12.8	21.1		6.7
Deaths from lung cancer	2011 - 13	2,311	54.2	50.2	60.2	111.6		32.3
Deaths from chronic obstructive pulmonary disease	2011 - 13	2,216	51.3	44.4	51.5	101.0		26.8
Smoking attributable mortality	2011 - 13	7,285	281.8	252.7	288.7	471.6		186.6
Smoking attributable deaths from heart disease	2011 - 13	792	30.6	26.4	32.7	65.5		20.6
Smoking attributable deaths from stroke	2011 - 13	264	10.2	9.2	11.0	21.5		7.2
Smoking attributable hospital admissions	2010/11	12,353	1,226	1,114	1,420	2,536		808
Cost per capita of smoking attributable hospital admissions	2010/11	30,196,761	35.8	32.2	36.9	61.7		15.6

Indicator	Period	Kent			Region	England	England		
		Recent Trend	Count	Value	Value	Value	Worst	Range	Best
Smoking Prevalence in adults - current smokers (APS)	2015	–	-	17.0%	15.9	16.9	26.8%		9.5%
Smoking Prevalence in adults - ex smokers (APS)	2015	–	-	37.0%	38.0	34.5	13.9%		47.8%
Smoking Prevalence in adults - never smoked (APS)	2015	–	-	46.0%	46.1	48.6	36.1%		66.1%
Smoking Prevalence in adults in routine and manual occupations - current smokers (APS)	2015	–	-	24.8%	26.2	26.5	36.3%		15.8%
Smoking Prevalence in adults in routine and manual occupations - ex smokers (APS)	2015	–	-	34.2%	33.6	30.4	13.3%		40.5%
Smoking Prevalence in adults in routine and manual occupations - never smoked (APS)	2015	–	-	41.0%	40.1	43.1	27.3%		66.3%

Source: Public Health England Tobacco Control Profiles 2016

NICE Guidance PH48 encourages Acute, Maternity and Mental Health Trusts to become totally smokefree, promoting stop smoking support (including Nicotine Replacement Therapy (NRT)) and to ensure that the trust grounds are smokefree. This has provided opportunities for stakeholders to work collaboratively towards a Smokefree Trust, acknowledging smoking as a medical condition as well as a social condition.

Illicit tobacco remains a concern in Kent as it undermines efforts to reduce smoking and is often targeted at young, vulnerable individuals living in poor and disadvantaged communities, often linked to wider organised crime. Kent Public Health is working collaboratively with Trading Standards and Kent Police, to deliver Illicit Tobacco Roadshows in town centres to raise awareness of the harms the illicit market has on local communities.

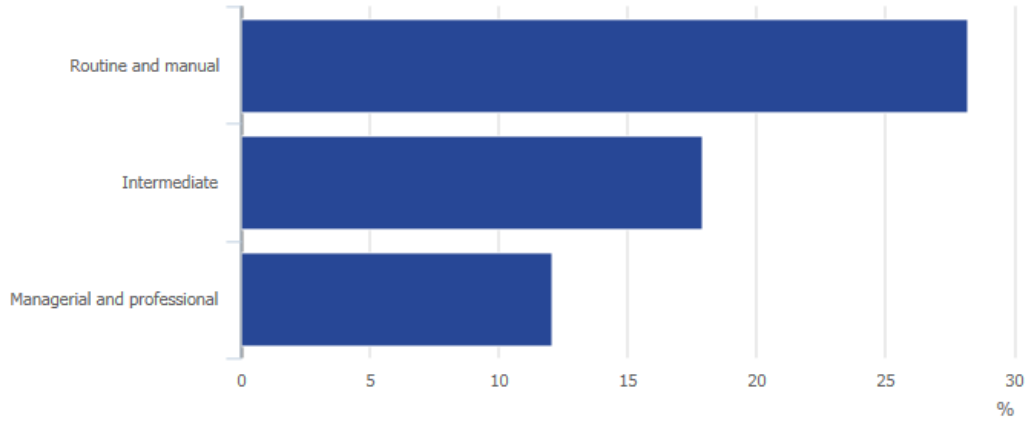
Who's at Risk and Why?

Lower Socio-Economic Groups

There is a strong link between smoking and socio-economic groups. Nationally, it is estimated that in 2014, adults in routine and manual occupations were more than twice as likely to be cigarette smokers than adults in managerial and professional occupations, 28.2% and 12.1% respectively.

Table 3

Figure 12: Cigarette Smokers by occupation, UK, 2014



Source: Integrated Household Survey - Office for National Statistics

Prevalence of cigarette smoking by socio-economic classification

Persons aged 16 and over. Great Britain: 2012 (%) [4]

	Men	Women	Total
Large employers and higher managerial	9	12	10
Higher professional	13	9	12
Lower managerial and professional	19	13	16
Intermediate	19	17	18
Small employers / own account	27	16	24
Lower supervisory and technical	30	31	30
Semi-routine	32	30	31
Routine	37	36	36

Source: ONS (2014) Opinions & Lifestyle Survey 2014

Gender and Age

a Smoking rates in England remain higher in men (20.7%) than women (15.9%), contributing to the life expectancy gap between the sexes.

b Nationally, smoking rates have increased slightly between 2013 and 1914 for the 18-24 age group but has decreased for all other age groups.

- c The 25-34 years age group has the highest smoking prevalence rate (23.3%) compared to the 65+ age group which has the lowest rate of smoking (9.5%) in 2014.

Smoking and Young People

Smoking uptake among young people is linked to socio-economic disadvantage. They are most at risk of becoming smokers if they grow up in families and communities where smoking is the norm and where they have access to cigarettes. Children whose parents and/or siblings smoke are more likely to become smokers.

Disadvantaged children, young people and adults are also likely to be exposed to higher levels of second hand smoke than those from more privileged backgrounds.

Smoking prevalence among young people has declined in recent years, but the prevalence in Kent is still higher than the national average. In Kent it is estimated that 10.5% of 15 year olds in Kent smoke regularly against a national average of 8.2% (Local Tobacco Control Profiles 2016). As over 40% of long-term smokers reported to have started smoking before the age of 16 (ASH 2014b), effective preventative approaches are a priority for this age group.

Smoking in Pregnancy

Babies from deprived backgrounds are more likely to be born to mothers who smoke, and to have much greater exposure to second hand smoke in childhood. Smoking remains one of the few modifiable risk factors in pregnancy. It can cause a range of serious health problems, including lower birth weight, pre-term birth, placental complications and perinatal mortality. Studies have shown that there is a 24% higher risk of spontaneous abortion among women who smoke compared to non-smokers and an estimated 3,000 to 5,000 miscarriages are caused by smoking each year (Royal College of Physicians 2010).

Reducing smoking in pregnancy continues to be a major priority in Kent. During pregnancy, 13% of women in Kent continued to smoke (2015-16), a slight increase from last year (12.5%) at a time that the England average shows a decreasing trend Local Tobacco Control Profile 2016).

Mental Health

Smoking rates among people with mental health disorders can vary according to condition.

It is estimated that 40-50% of people with depressive and anxiety conditions are likely to smoke and 70% of people with schizophrenia (Olivier, Lubman and Fraser 2007). Smoking levels are also likely to be higher among mental health patients; and studies have associated smoking with increased depression. In addition, the high smoking rates among people with mental health problems may contribute towards their overall low average life expectancy.

In 2015/16 Kent reported that the smoking prevalence in adults with serious mental health illness was similar to the England average (40.4%). (Health and Social Care Information Centre 2016)

Adults with Learning Disabilities

It is estimated that there are fewer adults with learning disabilities who smoke compared to the general population; smoking rates among younger people with milder learning disabilities, however, are likely to be higher than their peers (Emerson and Baines 2010). Accuracy around recording smoking prevalence among people with learning disabilities remains a problem, particularly for those with mild learning disabilities who do not access, or are unknown to, social care services. The commissioning of future services will need to ensure that service provision is accessible and, also that it is appropriate to support people with learning disabilities to cut down or quit smoking should they wish to do so. Greater awareness and support should also be provided to carers of those with learning disabilities, especially if the carer also smokes.

The Level of Need in the Population

With a smoking prevalence of 17% (APS, 2016), there are an estimated 225,000 smokers aged 18+ in Kent. In 2015-16 6,236 people set a date to quit smoking with Kent's stop smoking services and 3,417 people went on to quit smoking which is a continual decline from the previous year's figures. Nationally there has been a decline in access to stop smoking services.

A higher proportion of people from lower socio-economic groups and those who live in areas of deprivation are likely to be heavier smokers and to have smoked over a longer period of time. More effective targeting of services should be prioritised, ensuring they meet the needs of specific groups and are well marketed. There is additional need for local and national stop smoking campaigns to promote awareness of stop smoking services and harm reduction approaches.

Support for stop smoking also needs to be institutionalised. This includes hospitals and health settings all being smoke free environments and businesses investing to save by promoting stop smoking services in the workplace and discouraging smoking breaks as a social norm.

Current Services in Relation to Need

Stop Smoking Services

The core Stop Smoking Service is provided by Kent Community Health Foundation Trust (KCHFT). The trust provides training and a range of targeted services in hospitals, mental health units, prisons, businesses, and smoking-in-pregnancy settings (BabyClear). It records profiles of servicer users and also commissions GPs and pharmacies to provide outreach services.

There has been a steady decline in the number of people quitting smoking through the stop smoking services: from 6,131 quitters in 2013-14 to 3,417 quitters in 2015-16. Although the numbers of quitters have reduced, KCHFT provides highly effective services. It operates at

the national average of 55% of successful quitters (3% increases on 2014). KCHFT offers a range of quit service support with one to one support provided to 92% of those who have set a quit date. This is statistically less likely to result in a successful quit, than group support, which is a less favoured method among potential quitters. This raises the challenge of how to best combine support models to maximise opportunities for successful quits. Further work is being undertaken to shape commissioned smoking cessation in the future to ensure that health inequalities are reduced. We propose that a greater focus is made on areas of high deprivation and high levels of smoking prevalence.

Role of District Councils

All district councils across Kent are represented on the Kent Tobacco Control Alliance. One of the objectives of the alliance is to share good practice and collaborate where possible in delivering the Kent Tobacco Control Action Plan. By having a joint responsibility for the overall health and wellbeing of their residents, districts are engaged in addressing the local needs in their areas. Smoking related indicators are being used to prioritise the tobacco control agenda at a district level. Other responsibilities include enforcement of smoke free cars legislation, smoke free parks and contributing to delivering quits through healthy living centres and children's centres. There is potential for districts to set their own targets to reduce the number of people who smoke.

Role of Clinical Commissioning Groups

Smoking in pregnancy initiatives such as babyClear and the pilot Baby Be Smoke Free will be delivered by the midwifery service in Kent (together with other service providers). Clinical commissioning groups (CCGs) will want to ensure that these services are effectively reducing the prevalence of smoking in pregnancy and the risks associated with premature birth and perinatal mortality caused by smoking. Further partnership working across agencies, including CCGs, can maximise opportunities for further quitters and awareness amongst the general public by designing and promoting new campaigns.

Clinical commissioning groups may also oversee the progress of their practices in providing quits to enable them to achieve their objectives of reducing health inequalities and reducing premature mortality.

Role of Community Pharmacies

Currently community pharmacies are responsible for a third of quits. Through the Healthy Living Pharmacy initiative it is hoped that community pharmacies will increase the number of quits they currently provide.

Greater public awareness of services are promoted through the Kent SmokeFree campaign and through One You: Public Health England's new brand to campaign for healthier lifestyles.

Kent County Council e-cigarette guidance is based on the Public Health England report on e-cigarettes and National Centre for Smoking Cessation and Training (NCSCT)

recommendations. Kent Public Health and Trading Standards are working with local authorities and vaping retailers to share plans and processes for interim regulations that will be enforceable from May 2017 and identify ways to share accurate and consistent messages to the public.

Evidence of What Works

Core stop smoking services are an effective treatment service to help people give up smoking and reduce their nicotine addiction. Services in the future will need to rise to the challenge of successfully supporting smoking populations who are most vulnerable and more likely to be heavy smokers.

E-cigarettes

More research and evidence on e-cigarettes are being presented all the time. Although the composition and safety of e-cigarettes are still unknown, evidence suggests that they are safer than smoking cigarettes and can be useful in helping smokers quit. There is also evidence that demonstrates there is negligible take up of e-cigarettes among non-smokers. Pilot programmes have used stop smoking services to support smokers to quit using e-cigarettes and have seen a 76% success rate. The National Centre for Smoking Cessation and Training (NCSCT) offers guidance to stop smoking services on how best to support quit attempts with e-cigarettes.

Local tobacco profiles and Public Health Outcomes Framework (PHOF) data are readily available at district and county levels to help target services effectively. The data is routinely updated and shared within the Kent Tobacco Control Alliance to assist with planning and prioritisation of need.

User Views

Of smokers, 68% say they would like to give up smoking (Lader 2009); this equates to an estimated 149,000 smokers in Kent.

Insights have been commissioned into young people's views and attitudes to quit smoking services and their desire to quit smoking. The outcomes of this work will help co-design an awareness campaign and shape the future of stop smoking services appropriate for young people.

The stop smoking services undertake regular feedback from service users to improve service delivery and user satisfaction. Some of the views and feedback are articulated through case studies to help encourage potential quitters to access the service.

Further public engagement will inform the development of new Stop Smoking Service specifications.

Recommendations for Commissioning

Core stop smoking services are vital to sustaining smoking quit rates and future provision will include a range of delivery models commensurate to the needs of different target populations:

- high smoking populations where smoking is an entrenched lifestyle behaviour and there is a high dependency on nicotine
- a stop smoking model for young people
- a harm reduction programme
- smoking in secondary care
- smoking among vulnerable groups (such as people with mental health problems, people with learning disabilities and within prisons)
- prevention
- smoke free homes and spaces
- campaigns and marketing
- smoke free workplaces
- training.

Specialised delivery models will be tailored to need and will be evidence based, promoting best practice where possible. They may be commissioned as independent services or part of a wider or core service model. Commissioners will work closely with partners in the design of future services.

Recommendations for Needs Assessment and Health Needs Assessment Work

a Tackling smoking prevalence among people with learning disabilities, ensuring that services are equitable and ensuring that reasonable adjustments are in place to maximise opportunities to support people with learning disabilities to quit smoking.

b Tackling smoking prevalence among people with mental health problems, ensuring that services are accessible and commensurate to their needs; supporting the smoke free mental health trust agenda by supporting staff and carers to also quit smoking.

c Gaining intelligence on local counterfeit and smuggled tobacco; establishing local data collection, recording and monitoring methods. This should inform future strategies on tackling illicit tobacco in Kent.

Key Contacts

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References

ASH (2013) *Fact sheet on smoking statistics: Illness and death.* Available from www.Ash.org.uk [Accessed 27/11/14]

ASH (2014a) *Fact sheet on smoking statistics: Who smokes and how much.* Available from www.Ash.org.uk [Accessed 27/11/14]

ASH (2014b) *Fact sheet on young people and smoking.* Available from www.Ash.org.uk [Accessed 27/11/14]

Emerson & Baines (2010) Health Inequalities & People with Learning Disabilities in the UK: 2010, IHAL. Available from http://www.improvinghealthandlives.org.uk/ [Accessed 27/11/14]

Health and Social Care Information Centre (2014) *Smoking drinking and drug use among young people in England in 2013*. In ASH (2014a) *Fact sheet on smoking statistics: who smokes and how much.* Available from www.Ash.org.uk [Accessed 27/11/14]

Lader D. Opinions Survey Report No. 40 *Smoking-related behaviour and attitudes, 2008/09*. Office for National Statistics in ASH (2014) *Fact sheet on stopping smoking: the benefits and aids to quitting* Available from www.Ash.org.uk [Accessed 27/11/14]

Local Tobacco Control Profiles for England http://www.tobaccoprofiles.info/

Millward D & Karlsen S (2011) *Tobacco use among minority ethnic populations and cessation interventions: A race equality foundation briefing paper*, in ASH (2011) *Fact sheet on tobacco and ethnic minorities.* Available from www.Ash.org.uk [Accessed 27/11/14]

Office of National Statistics (2013) 2012 Opinions & Lifestyle Survey. Office for National Statistics, Sept. 2013*in* ASH (2014) *Fact Sheet on Smoking Statistics: Who smokes and how much.* Available from www.Ash.org.uk [Accessed 27/11/14]

Olivier D, Lubman DI, Fraser R (2007) *Tobacco smoking within psychiatric inpatient settings: biopsychosocial perspective*. Aust & NZ J Psych 2007; 41: 572-580 in ASH (2013) *Fact sheet on smoking and mental health* Available from www.Ash.org.uk [Accessed 27/11/14]

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

Royal College of Physicians (2010) *Passive Smoking and Children: A report by the tobacco Advisory Group of the Royal* College of Physicians London: Royal College of Physicians