



Public Health  
England

Protecting and improving the nation's health

# **Tobacco Control: JSNA support pack**

## **Key data sources for planning effective tobacco control in 2016-17**

**East Sussex**  
(using latest available data)

## SUPPORTING INFORMATION

Smoking continues to kill almost 80,000 people in England every year and is the number one cause of preventable death in the country, resulting in more deaths than the next six causes combined. Tobacco use is also a powerful driver of health inequalities and is perhaps the most significant public health challenge we face today.

To fully understand how your local tobacco control network is responding to these problems, locally and nationally held data can be used. Data relating to local areas' targeted tobacco control interventions are not collected nationally, though should be available at a local level. A list of wider data sources is referenced below.

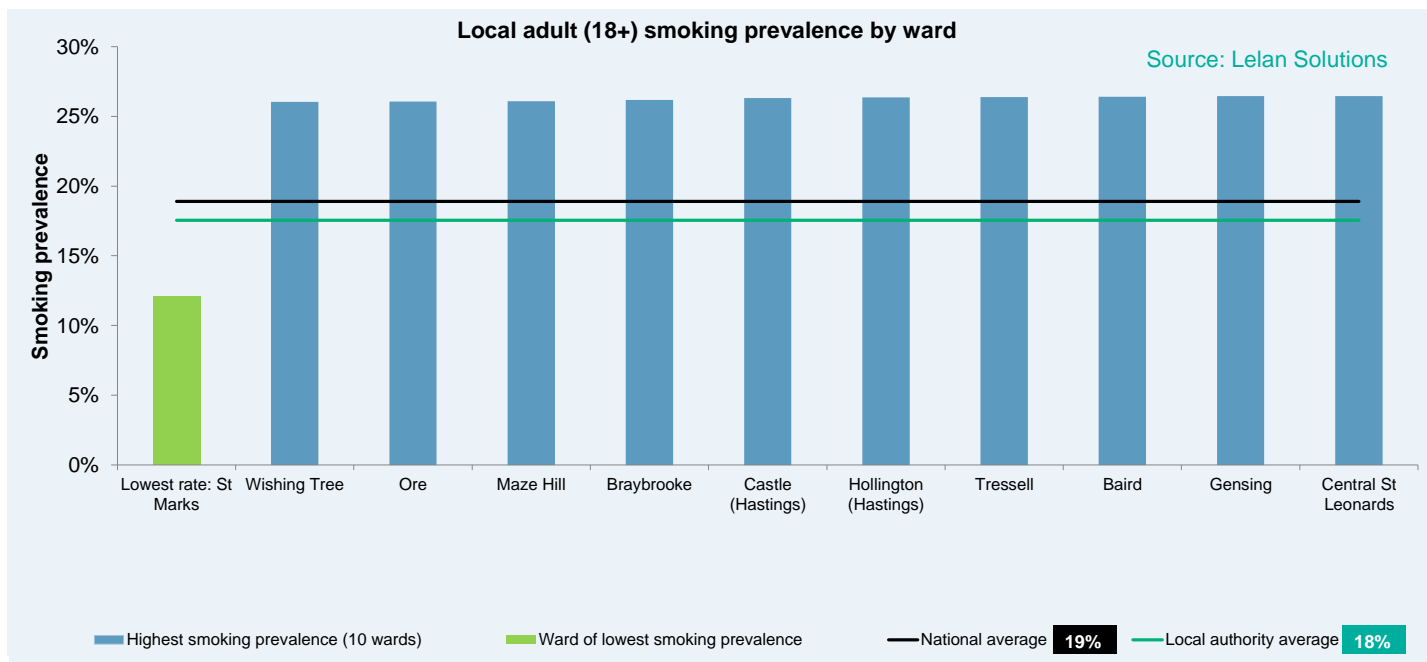
In the first instance, this pack aims to signpost you to available tools and datasets to support the local authorities and partners, to make the case for local tobacco control interventions. It has been produced to encourage feedback and debate on the range of tools and datasets available nationally; as well as an opportunity to champion the creative use of local data sources and analysis. The tools referenced within this pack are routinely updated with the latest datasets. Readers are therefore reminded that this resource is comprised of extracts from the tools referenced at time of publication (September 2015) and are encouraged to access the tools directly for the most up-to-date data.

## HEALTH INEQUALITIES

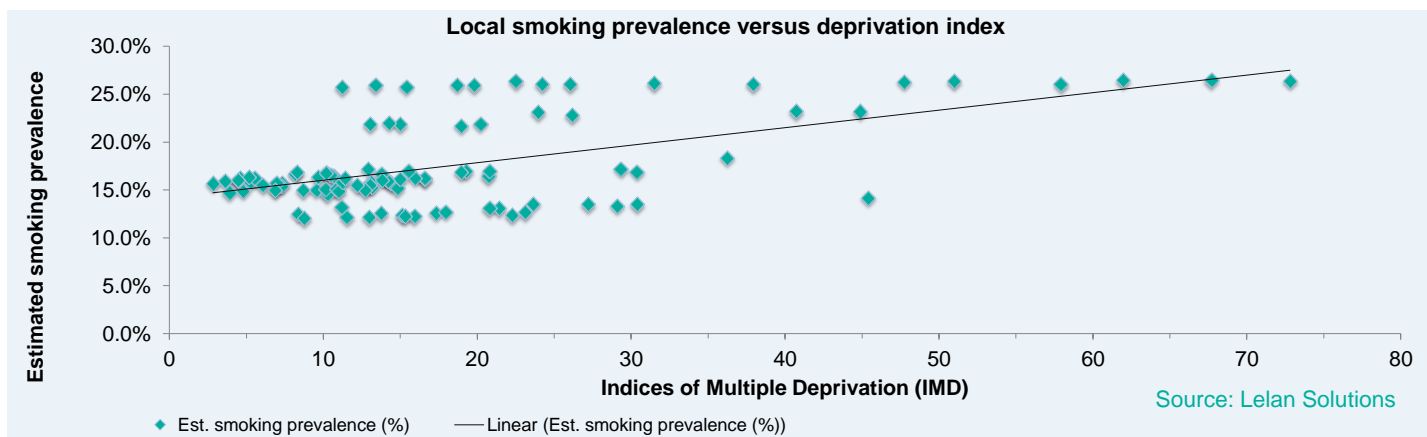
Smoking is the biggest cause of health inequalities in the UK accounting for half the difference in life expectancy between richest and poorest. Not smoking can allow people to leap the health gap, with the poorest non-smokers typically having a substantially longer life than the richest smokers.

Rich smokers have very similar life expectancy to poor smokers, and poor non-smokers live longer than rich smokers, showing that smoking not social status is the greatest cause of health inequalities. On average a smoker loses 10 years of life. The earlier you quit, the less life you lose. Quitting smoking is the best way for smokers to improve their life expectancy and wellbeing.

More people in disadvantaged communities smoke, where smoking is more socially acceptable. Poorer smokers are usually more addicted and smoke more each day. On average all smokers make similar numbers of quit attempts each year but, well-off smokers are much more likely to succeed. To reduce inequalities it is vital that support to quit is tailored to the needs of poorer and more disadvantaged smokers, who find it harder to quit.



Smoking rates are much higher within certain group and deprived communities. Smoking is around twice as common among people with mental disorders, and more so in those with more severe disease. Estimates vary between 37% and 56%. (RCP and RCPsych, Smoking and mental health 2013.) Lesbian, gay and transgendered communities are also significantly more likely to smoke, as are the long-term unemployed, and some minority ethnic groups, which also have gender disparities. Helping disadvantaged smokers quit is the best way to reduce health inequalities.



See also:

Smoking: Health Inequalities (Councillor Briefings) <http://ash.org.uk/localtoolkit/docs/cllr-briefings/HealthInequalities.pdf>

## FAMILY POVERTY

Approximately half of all smokers in England work in routine and manual occupations. Workers in manual and routine jobs are twice as likely to smoke as those in managerial and professional roles and unemployed people are twice as likely to smoke as those in employment. Ill-health caused by smoking is therefore much more common amongst the poorest and most disadvantaged in society.

When expenditure on tobacco is taken into account, around 500,000 extra households, comprising over 850,000 adults and almost 400,000 children, are classified as in poverty in the UK compared to the official Households Below Average Income figures. This shows that tobacco imposes a real and substantial cost on many low-income households.

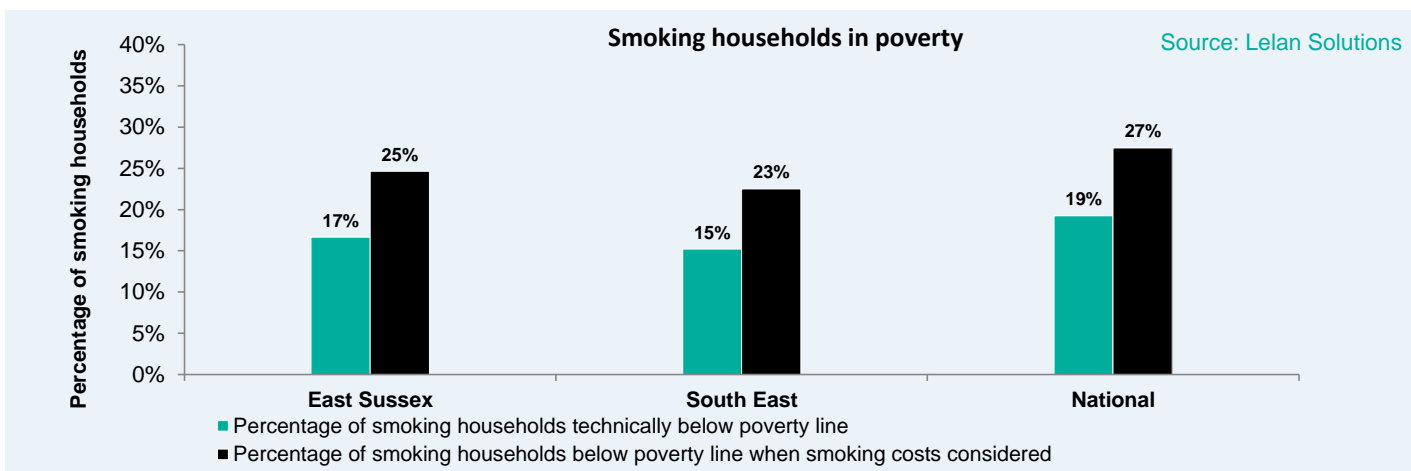
It is important, however, to avoid concluding from these results that a suitable policy response would be to reduce tobacco taxation to make tobacco products more affordable. Previous research shows that increases in tobacco taxation are potentially a progressive measure in economic and health terms because poorer smokers are more likely to quit, and young people less likely to take up smoking, when tobacco prices increase, because poorer households and young people are more sensitive to price increases<sup>1</sup>. Indeed, raising tax is the only tobacco control intervention which has been proven to have a greater effect on more disadvantaged smokers at population level and so contribute to reducing health inequalities<sup>2</sup>.

<sup>1</sup> The World Bank. Curbing the epidemic: governments and the economics of tobacco control. 1999

<sup>2</sup> Amos A, Bauld L, Clifford D et al. Tobacco control, inequalities in health and action at a local level. York, Public Health Research Consortium, 2011.

See also:

Estimates of poverty in the UK adjusted for expenditure on tobacco: [http://www.ash.org.uk/files/documents/ASH\\_964.pdf](http://www.ash.org.uk/files/documents/ASH_964.pdf)



## INVESTMENT AND VALUE FOR MONEY

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

The following is an example analysis for East Sussex. It assumes that East Sussex commissions NICE-approved services and that the provision matches the expected NICE-recognised levels of effectiveness.

Example Scenario: investment in a sub-national tobacco control programme
Example investment cost for LSSS interventions: £843,470
Number of quitters per 1,000 smokers expected as a result of LSSS interventions: 32
Additional investment required for sub-national programme at £0.41 per capita: £221,036
Number of additional quitters per 1,000 smokers expected as a result of sub-national programme: 29
Total number of additional quitters expected locally as a result of LSSS interventions + sub-national programme: 61
5 year returns expected as a result of LSSS interventions + sub-national programme: £2.84 for every £1 invested

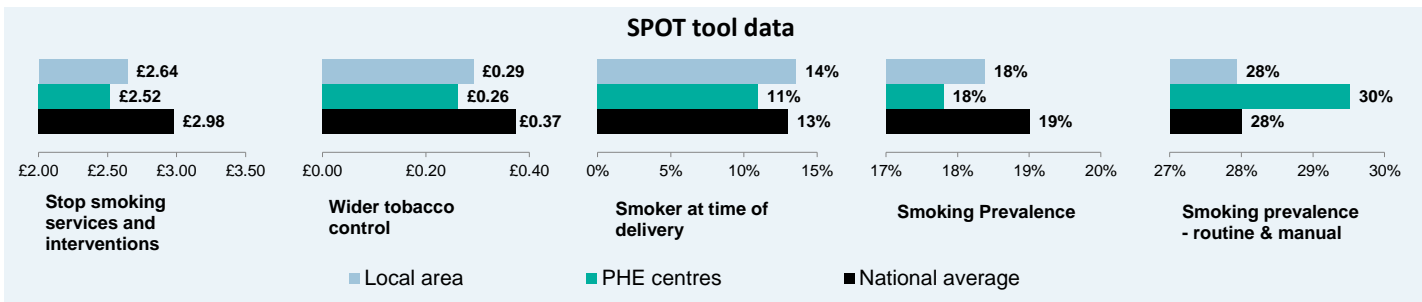
The above scenario is provided as an example only; localities are invited to use the tool to comprehensively replicate their currently-commissioned package of interventions against the NICE baseline. The above example gives an indication of returns over a five year period; increased returns are demonstrated by running the analysis for ten years and lifetime scenarios.

To support local authorities to explore the NICE ROI and SPOT tools further, PHE provide training and access to expert users of the tools.

For more information please email: [HealthEconomics@phe.gov.uk](mailto:HealthEconomics@phe.gov.uk).

The tool can be downloaded via the NICE website or at: <http://bit.ly/NiceROI-TC>

The Spend and Outcome Tool (SPOT) gives an overview of spend and outcomes across key areas of business. Local authority data for 2015 has been refreshed and clinical commissioning data for 2014 has been included. SPOT includes a large number of measures of spend and outcomes from several different frameworks. Similar organisations can be compared using a range of benchmarks and potential areas for further investigation identified. You can download a PDF factsheet for each local authority or clinical commissioning group. There is also an interactive spreadsheet that allows you to explore the data in detail.



The tool allows the identification of areas requiring priority attention where shifts in investment will optimise local health gains and increase quality. The programme budgeting data for CCGs is from Primary Care Trust (PCT) returns. Programme budgeting is a method assessing investment in programmes of care rather than services.

The tool can be accessed at: <http://www.yhpho.org.uk/spot>

A "Why Invest" document will be published alongside the JSNA packs to support the case for investment in local tobacco control interventions:

<http://www.nta.nhs.uk/healthcare-JSNA.aspx>

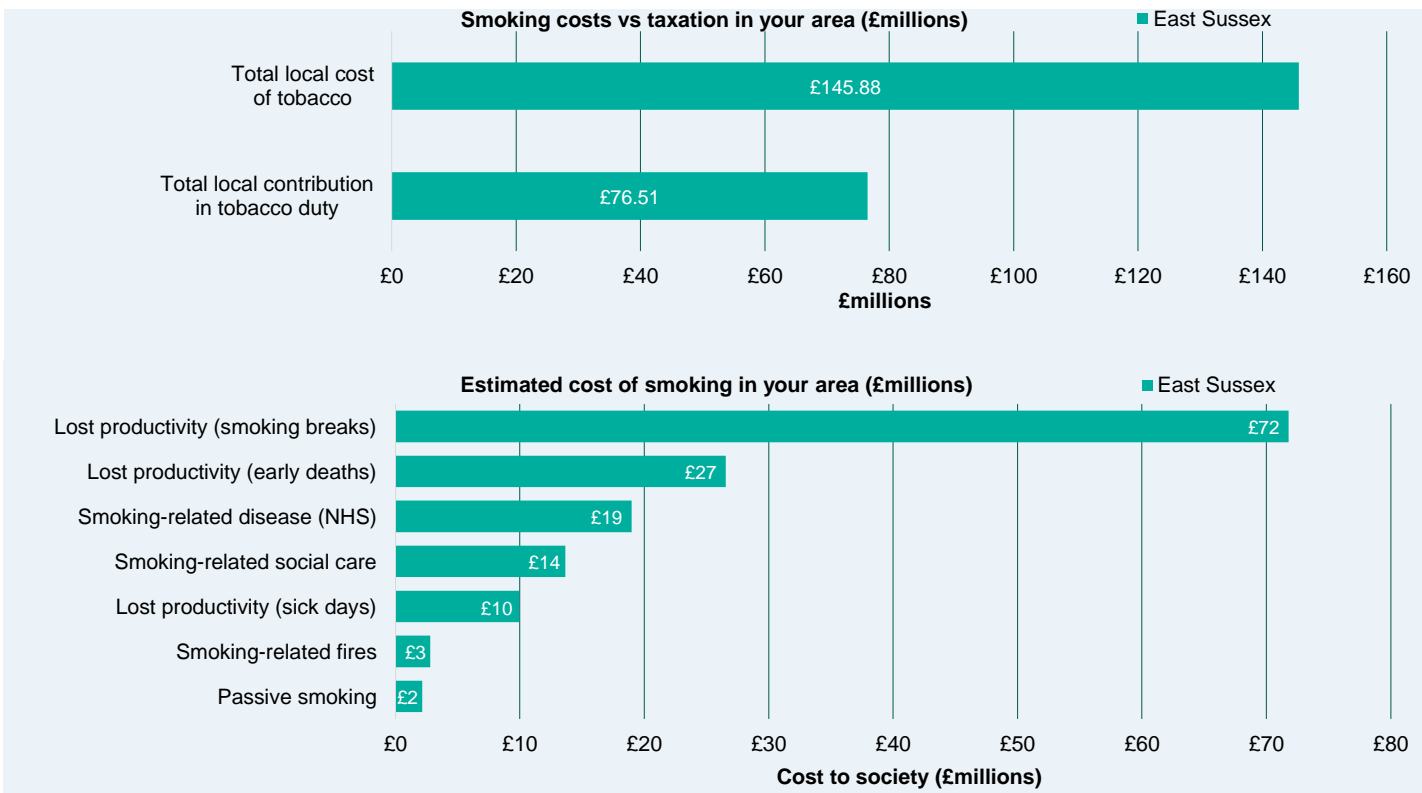
## SOCIETAL COST OF TOBACCO CONTROL

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

Together these resources will allow you to:

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

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

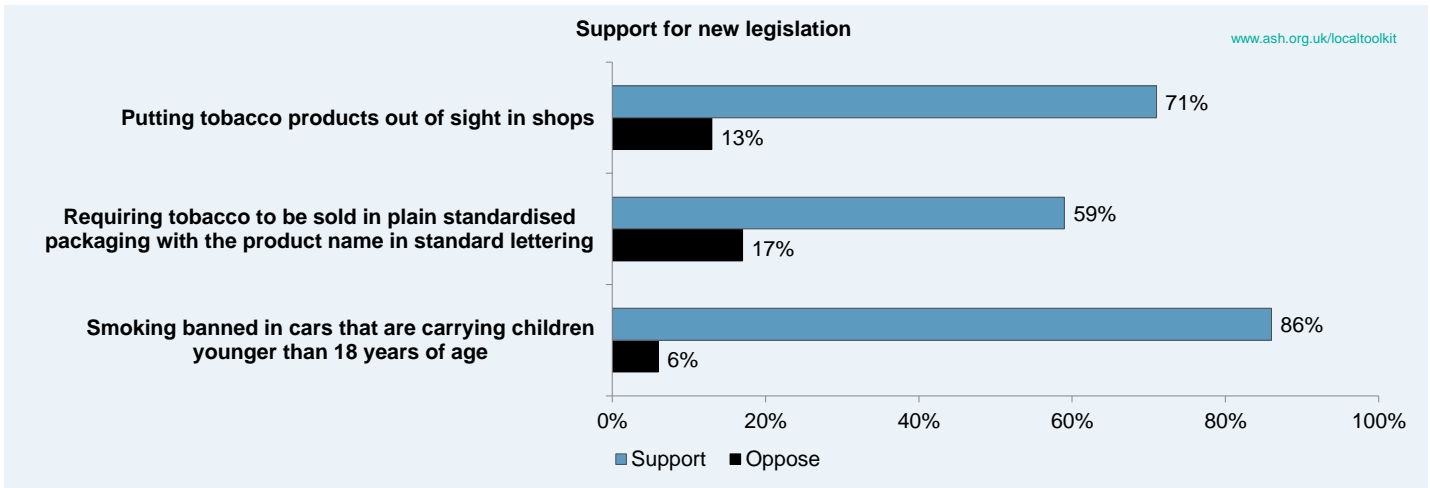


**In 2013/14, smokers in East Sussex paid approx. £76.5m in duty on tobacco products.**

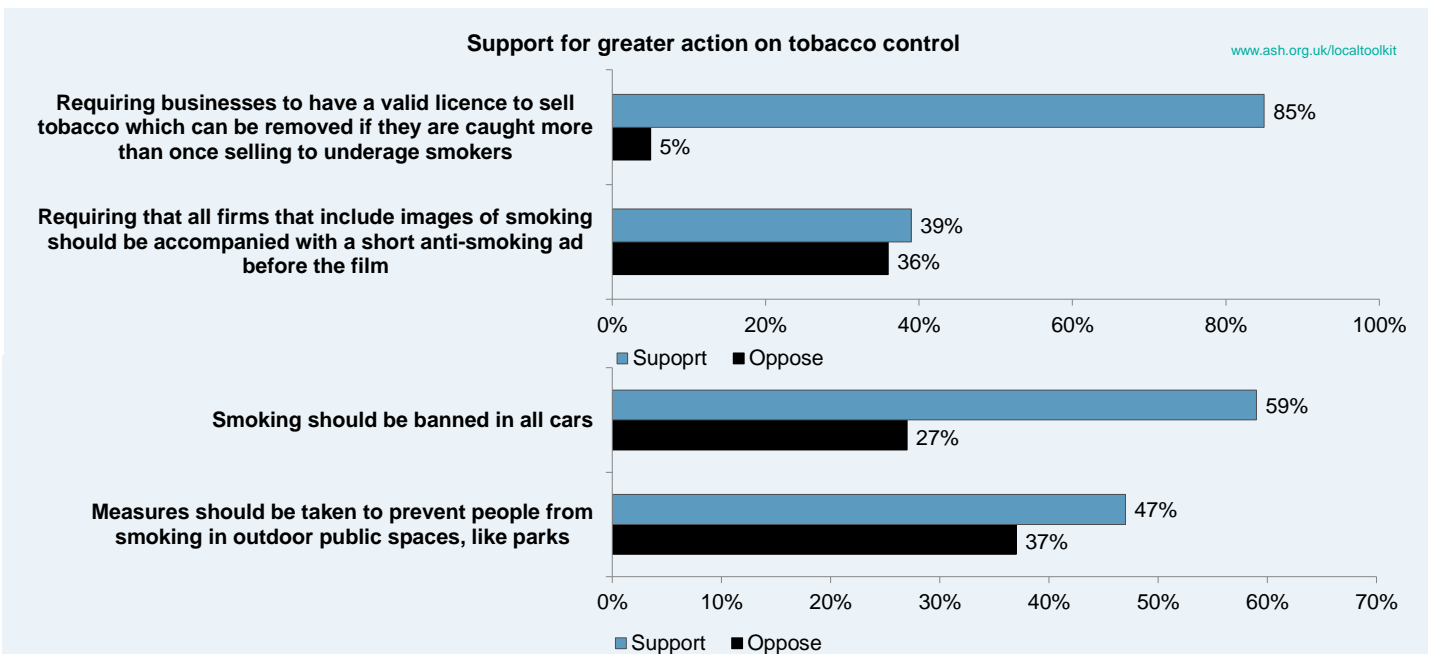
**Despite this contribution to the Exchequer, tobacco still costs East Sussex roughly 1.9 times as much as the duty raised. This results in a shortfall of about £69.4m each year.**

### What further tobacco control action should be taken?

Support for recent measures introduced by the Government to tackle the harm caused by tobacco is very high in the South East region. Support for the ban on smoking in cars carrying children younger than 18 years of age is particularly high at 86%.

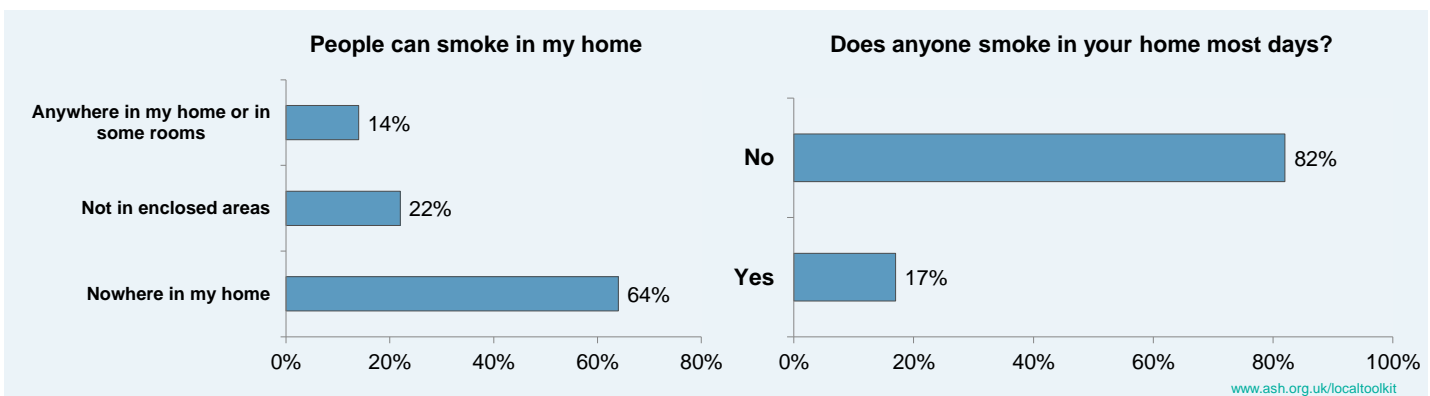


Adults in the South East region see a need for greater action on tobacco control, with the introduction of a positive tobacco licencing scheme particularly popular.



### Smoking in the home

In this survey, over 8 in 10 adults in the South East region said that they do not allow smoking anywhere in their home or only in places that are not enclosed (such as in the garden or on a balcony). Only a minority (14%) stated that they would allow smoking anywhere in their house, or only in some rooms.



For more information please visit:  
[www.ash.org.uk/localtoolkit](http://www.ash.org.uk/localtoolkit)

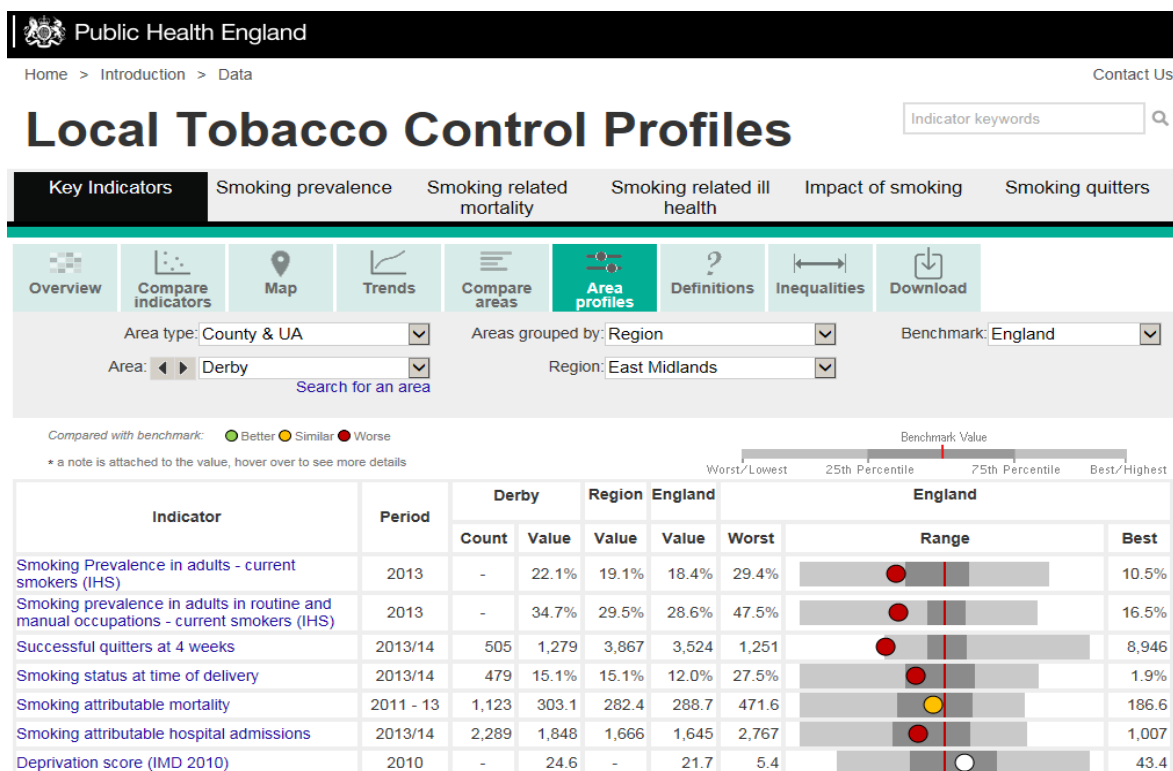
## LOCAL TOBACCO CONTROL PROFILES

The Local Tobacco Control Profiles for England provides a snapshot of the extent of tobacco use, tobacco related harm, and measures being taken to reduce this harm at a local level. These profiles have been designed to help local government and health services to assess the effect of tobacco use on their local populations. They will inform commissioning and planning decisions to tackle tobacco use and improve the health of local communities.

The online tool allows you to compare your local authority against other local authorities in the region and against the England average. The tobacco control profiles are part of a series of products produced by Public Health England providing local data alongside national comparisons to support local health improvement.

Tobacco Control Profiles	Period	Local value	Eng. value	Eng. worst	England range	Eng. best
Smoking Prevalence in adults - current smokers (IHS)	2013	18.4	18.4	29.4		10.5
Smoking prevalence in adults in routine and manual occupations - current smokers (IHS)	2013	27.9	28.6	47.5		16.5
Successful quitters at 4 weeks	2013/14	3103.6	3524.0	1251.0		8946.0
Successful quitters (CO validated) at 4 weeks	2013/14	1922.0	2472.0	525.0		6950.0
Completeness of NS-SEC recording by Stop Smoking Services	2013/14	76.3	86.2	25.2		100.0
Smoking status at time of delivery	2013/14	13.6	12.0	27.5		1.9
Low birth weight of term babies	2012	2.3	2.8	5.0		1.5
Lung cancer registrations	2010 - 12	59.4	76.0	146.8		40.1
Oral cancer registrations	2010 - 12	11.9	13.2	21.5		8.1
Deaths from lung cancer	2011 - 13	49.7	60.2	111.6		32.3
Deaths from chronic obstructive pulmonary disease	2011 - 13	40.1	51.5	101.0		26.8
Smoking attributable mortality	2011 - 13	260.0	288.7	471.6		186.6
Smoking attributable deaths from heart disease	2011 - 13	25.8	32.7	65.5		20.6
Smoking attributable deaths from stroke	2011 - 13	9.7	11.0	21.5		7.2
Smoking attributable hospital admissions	2013/14	1426.0	1645.0	2767.0		1007.0
Cost per capita of smoking attributable hospital admissions	2011/12	37.9	38.0	59.3		23.0
Cost per quitter	2013/13	544.6	283.0	1316.0		124.0
Indicative tobacco sales figures (£ millions)	2013	156.2	15446.1			

Further information can be found on the Local Tobacco Control Profiles website: [www.tobaccoprofiles.info](http://www.tobaccoprofiles.info)



## YOUTH SMOKING PREVALENCE

There is some evidence that multi-component prevention programmes for the prevention of substance misuse in young people can be effective.<sup>[i]</sup> These are approaches that deliver interventions in multiple settings, e.g., in school and family settings, typically combining the school curriculum with a parenting intervention.

There are many risk factors associated with increased likelihood of youth smoking including whether a parent, carer or sibling smokes. Lower socio economic status, higher levels of truancy and substance misuse are all associated with higher rates of youth smoking. Smoking prevention is therefore not achieved by youth targeted interventions alone.

There is evidence that school based interventions are effective in reducing uptake and NICE have published a series of recommendations<sup>[ii],[iii]</sup> which set out clear guidelines for commissioners. However, the impact of these interventions are considered more effective when delivered as a package of cross cutting tobacco control measures in the community aimed at adults and away from school grounds.

Current data sources for youth smoking prevalence are:

The children and young people's health benchmarking tool;

<http://fingertips.phe.org.uk/profile/cyphof>

The smoking, drinking and drug use amongst young people survey 2014:

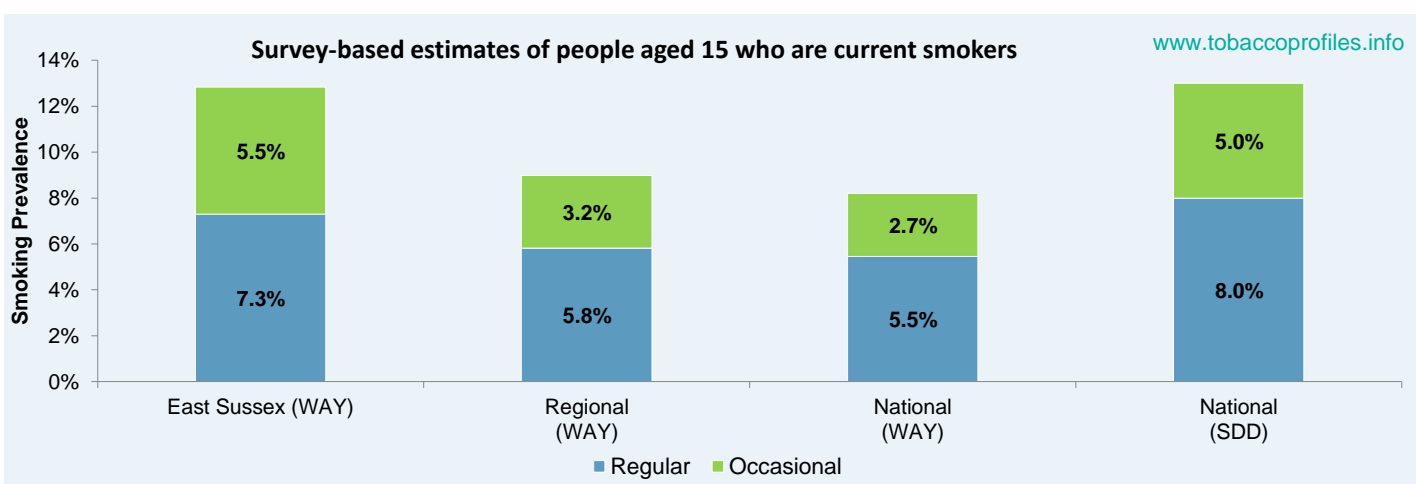
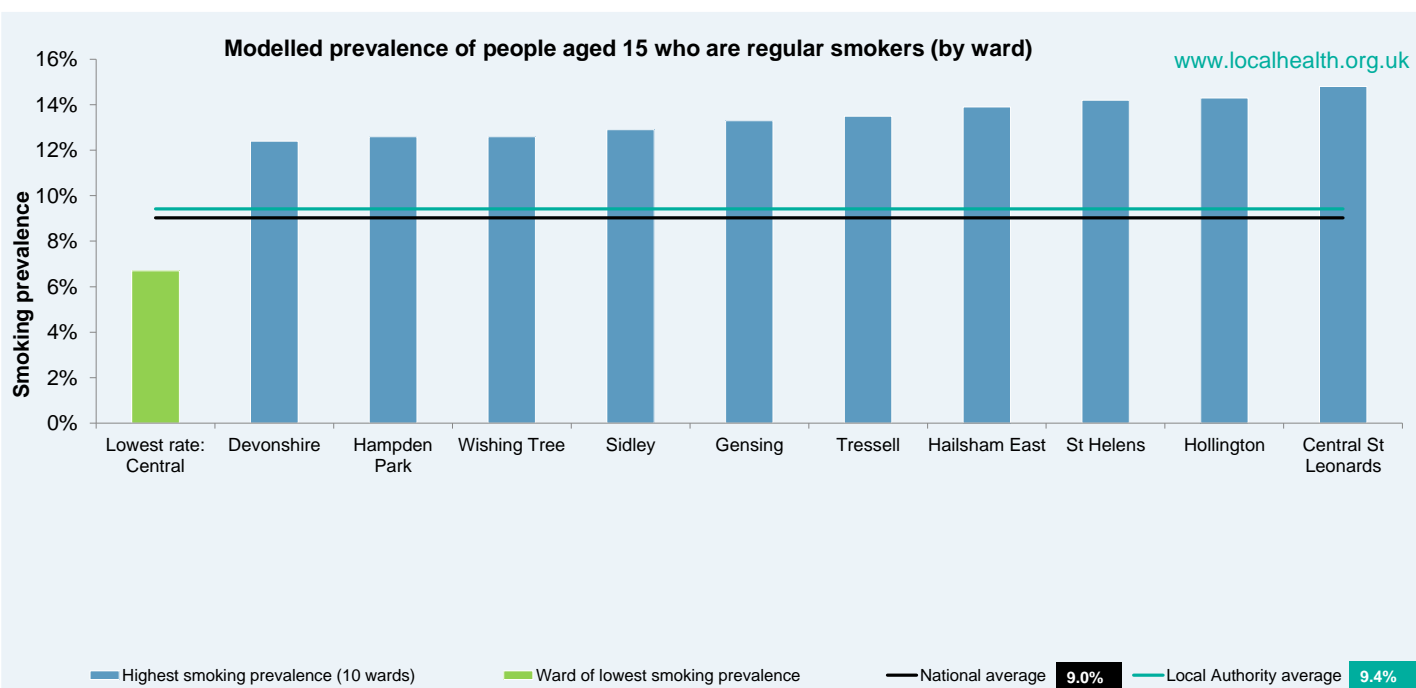
<http://www.hscic.gov.uk/searchcatalogue?productid=18273&returnid=3945>

The What About YOUth survey:

<http://www.whataboutyouth.com>

Whilst these are useful they do not provide local data, therefore collection of this at a local level will be useful to direct where action will be best targeted to reduce inequalities and in the absence of such local level data, introducing the ward level estimates to be found from:

[www.localhealth.org.uk](http://www.localhealth.org.uk)



## LOCAL CESSATION DATA

### Stop Smoking service data

This data enables local authorities to benchmark their performance and identify which treatment settings and intervention types are consistently getting the best results. The statistics also inform members of the public, who may intend to stop smoking, about the local services available to them and their relative success rates.

The data for 2014/15 can be found on the HSCIC website: [www.hscic.gov.uk/lifestyles](http://www.hscic.gov.uk/lifestyles)

	Local					National	Comparison of LA 2014/2015 data with National data
	2013/2014		2014/2015			2014/2015	
18+ smoking population (data from ASH reckoner)	75407	18%	78941	18%	▲	18%	
Number setting a quit date per 100,000 of population aged 16 and over	1214		1104		▼	1,024	
Number successfully quit (self-report) per 100,000 of population aged 16 and over	549		735		▲	522	
Number setting a quit date	5370		4941		▼	450,582	
Number not known/lost to follow up	1193	22%	527	11%	▼	23%	
Number of successful quitters (self-report)	2427	45%	3287	67%	▲	51%	
Number who had successfully quit (self-report), confirmed by CO validation	1503	28%	2125	43%	▲	35%	

Local ● National ●

### Cessation in Mental Health Settings

People with mental health problems smoke significantly more and are more dependent on nicotine than the population as a whole, with levels about three times those observed in the general population. It is recognised that admission to a secure mental health unit can be an opportunity to intervene to reduce smoking and that interventions are welcomed and effective. Supporting individuals to stop smoking while receiving NHS care represents a significant opportunity to close the gap in morbidity and mortality, between those people experiencing mental health conditions, and the general population. NICE public health guidance PH48 recommends that all NHS funded secondary care sites should become completely smokefree. PHE has published a NICE endorsed tool to support MH trusts in assessing their progress towards being smokefree. This and other useful resources can be found at:

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

	Local	National
<b>Interventions in MH Acute:</b>	<b>0</b>	<b>389</b>
<b>Interventions in MH Community</b>	<b>0</b>	<b>522</b>

### Cessation in Secondary Care Settings

Stopping smoking at any time has considerable health benefits and for people using secondary care services, there are additional advantages including shorter hospital stays and fewer complications. Secondary care providers have a duty of care to protect the health of, and promote healthy behaviour among, people who use, or work in, their services.

	Local	National
<b>Interventions in Secondary Care</b>	<b>220</b>	<b>13469</b>

\* Numbers less than 5 have been suppressed.

Further information and resources:

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

<https://www.brit-thoracic.org.uk/document-library/clinical-information/smoking-cessation/bts-case-for-change/>

NICE (2013) Smoking cessation in secondary care: acute, maternity and mental health services. NICE public health guidance 48. London: National Institute for Health and Clinical Excellence

<http://www.nice.org.uk/guidance/PH48>



## Smoking in Pregnancy

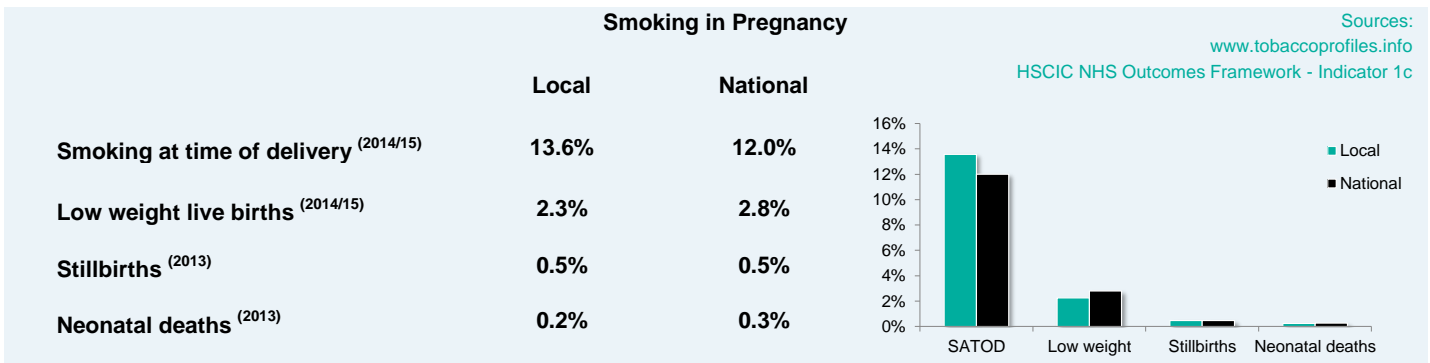
Addressing smoking in pregnancy should be a focus for all localities as this impacts on a range of issues related to health, inequalities and child development. NICE has produced guidance on how best to support women to stop smoking in pregnancy.<sup>ii</sup>

Smoking during pregnancy causes up to 2,200 premature births, 5,000 miscarriages and 300 perinatal deaths every year in the UK. It also increases the risk of developing a number of respiratory conditions, attention and hyperactivity difficulties, learning difficulties, problems of the ear, nose and throat, obesity and diabetes.<sup>iii, iv, v</sup>

Although rates are lower than in the past, 11.4% of women in England are recorded as smoking at the time of delivery, which translates into around 70,000 infants born to smoking mothers each year.<sup>vi</sup>

There are significant demographic differences and factors associated with inequalities related to this issue. For instance, pregnant mothers under the age of 20 are more than three times as likely to smoke as mothers aged 35 or over. Those in routine and manual occupations are more than four times as likely as those in managerial and professional occupations to smoke throughout pregnancy (29% and 7% respectively). Infants born to smokers are much more likely to become smokers themselves, which further perpetuates health inequalities.<sup>vii</sup>

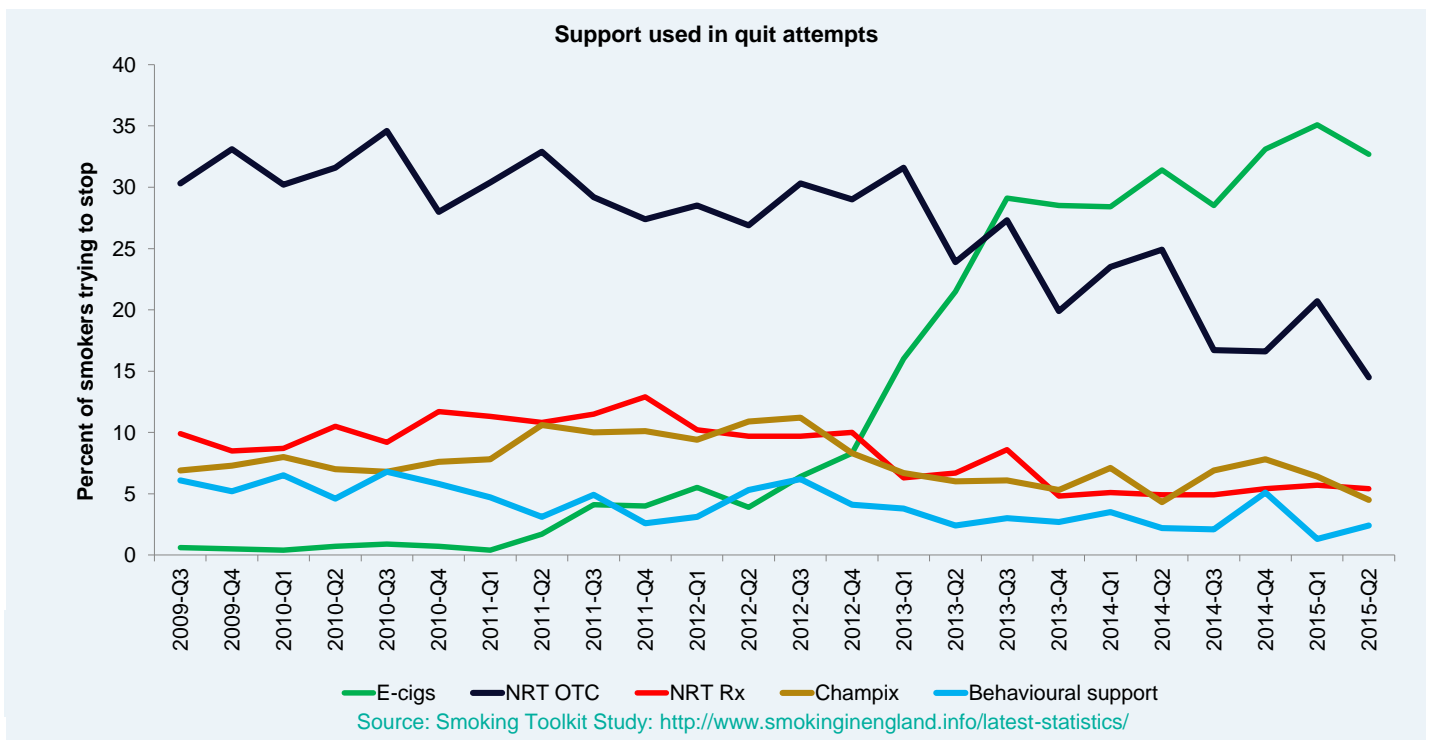
**Treating mothers and their babies (0-12 months) with problems caused by smoking during pregnancy is estimated to cost the NHS between £20 million and £87.5 million each year.<sup>viii</sup>**



## IMPACT OF E-CIGARETTES ON QUITTING BEHAVIOUR

### E-cigarettes and smoking cessation

Many people are turning to e-cigarettes to help them quit smoking. Regular e-cigarette use is confined almost entirely to smokers and ex-smokers. E-cigarettes are now the most popular quitting aid, according to a survey in the Smoking Toolkit Study, and emerging evidence indicates they can be effective for this purpose. Stop smoking services should be open to supporting smokers who want to use electronic cigarettes to quit.



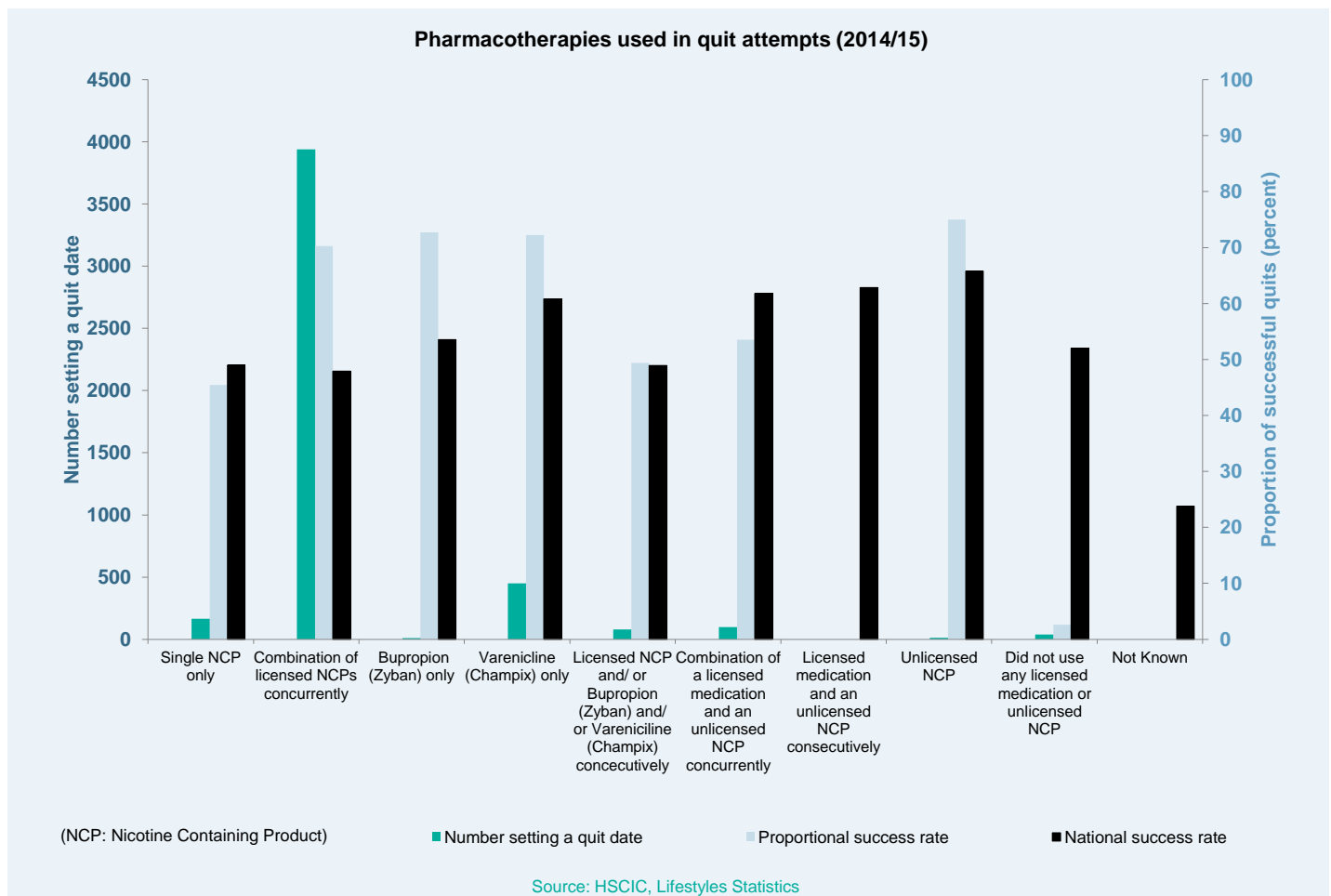
## Service level quitting methods

Stop smoking services are a key component of highly cost-effective tobacco control strategies at local and national level. Targeted, high-quality stop smoking services are essential to the reduction of health inequalities for local populations. All health and social care services can play a key role in identifying smokers and referring people to stop smoking services. For those people who are not ready, willing, or able to stop in one step, harm reduction interventions can support them in moving closer to becoming smokefree.

- In 2014/15, the number of people using Stop Smoking Services continued to decline as seen in recent years. Anecdotal evidence suggests this may be due to an increase in people using e-cigarettes to help them stop smoking rather than making use of these services. It is possible that the fall in smoking prevalence may also be a factor, but the decrease in smoking prevalence is a long established trend which covers the earlier period of increasing use of Stop Smoking Services as well as the recent decline.
- 450,582 people set a quit date through the NHS Stop Smoking Services in 2014/15, down 23 per cent on 2013/14 and the first time this number has fallen for three consecutive years, since NHS Stop Smoking Services (previously Smoking Cessation Services) were set up in all Health Authorities in England in 2000/01. It is now lower than the number of people setting a quit date 10 years ago in 2004/05 when it was 529,567.
- 229,688 people successfully quit (self-reported), (also down 23 per cent) which gives a quit rate of just over half (51 per cent) which was similar to 2013/14.
- 69 per cent (158,678) of successful quitters (self-reported) had their results confirmed by Carbon Monoxide (CO) verification.
- The success rate of giving up smoking generally increased with age for both men and women, with 41 per cent for those aged under 18 successfully quitting compared to 57 per cent of those aged 60 and over.
- 18,887 pregnant women set a quit date with NHS Stop Smoking Services, compared to 19,833 in 2013/14 and 15,060 in 2004/05. This represents a reduction of 5 per cent on 2013/14 and an increase of 25 per cent on 2004/05.
- Of all pharmacotherapies used to help people quit smoking, 'Combination of licensed NCPs concurrently' had the highest number setting a quit date (135,719) and the second highest number of successful quitters (65,061). 'Varenicline (Champix) only' had the highest number of successful quitters (68,296) and 'Unlicensed NCP' had the highest quit rate (66 per cent). 24,281 people setting a quit date 'did not use any licensed medication or unlicensed NCP' and 52 per cent of these successfully quit.

Source: Taken from Health and Social Care Information Centre. Statistics on NHS Stop Smoking Services in England - April 2014 to March 2015. Publication date: August 19, 2015.

<http://www.hscic.gov.uk/catalogue/PUB18002/stat-stop-smok-serv-eng-2015-q4-rep.pdf>



<sup>i</sup> HSCIC (2015) Statistics on Smoking in England

<http://www.hscic.gov.uk/catalogue/PUB17526/stat-smok-eng-2015-rep.pdf>

[i] Interventions to reduce substance misuse among vulnerable young people: NICE public health guidance 4 (NICE, 2007, PH4 )

[ii] School-based interventions to prevent smoking. NICE public health guidance 23.

[iii] Preventing the uptake of smoking by children and young people. NICE public health guidance 14

<sup>ii</sup> Annual Report of the Chief Medical Officer 2012. Our Children Deserve Better: Prevention Pays:

<https://www.gov.uk/government/publications/chief-medical-officers-annual-report-2012-our-children-deserve-better-prevention-pays>

<sup>iii</sup> Royal College of Physicians (2010) Passive Smoking and Children

<https://www.rcplondon.ac.uk/sites/default/files/documents/passive-smoking-and-children.pdf>

<sup>iv</sup> NICE (2010). Quitting Smoking in Pregnancy and Following Child Birth. NICE public health guidance 26. London: National Institute for Health and Clinical Excellence

<http://www.nice.org.uk/guidance/pH26>

<sup>v</sup> Challenge Group Report (2013). Smoking cessation in pregnancy: A call to action

[http://ash.org.uk/files/documents/ASH\\_893.pdf](http://ash.org.uk/files/documents/ASH_893.pdf)

<sup>vi</sup> HSCIC (2015). Smoking at Time of Delivery (SATOD)

<http://www.hscic.gov.uk/catalogue/PUB17668>

<sup>vii</sup> HSCIC (2010). Infant Feeding Survey (IFS)

<http://www.hscic.gov.uk/article/2021/Website-Search?productid=9569&q=Infant+Feeding+Survey+&sort=Relevance&size=10&page=1&area=both#top>

<sup>viii</sup> Godfrey C. et al. (2010). Estimating the costs to the NHS of smoking in pregnancy for pregnant women and infants. York: Department of Health Sciences, The University of York.

[http://phrc.lshrm.ac.uk/papers/PHRC\\_A3-06\\_Final\\_Report.pdf](http://phrc.lshrm.ac.uk/papers/PHRC_A3-06_Final_Report.pdf)

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