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To: Health and Wellbeing Board (Shadow) – 30 January 2013

Subject: Kent Tobacco Control Programme

Classification: Unrestricted

Summary

This paper proposes developing the Kent Tobacco Control strategy – Towards a Smokefree Generation- and establishing a Tobacco Control Board for Kent to oversee its implementation and realise the cost savings involved.

1. Introduction

a) As of April local authorities and Clinical Commissioning Groups will be assessed on how well they are reducing health inequalities in their area. The Public Health Outcomes Framework includes a number of measures that are directly related to smoking and several that have very strong links. In time this may also determine whether local authorities will be paid the Health Premium supplement to the public health budget.

- Smoking tobacco is the single biggest cause of health inequalities. To reduce health inequalities we need to reduce the number of smokers in Kent.

- Smoking remains the biggest cause of premature death and is responsible for more loss of life than the next four factors (including obesity and alcohol) combined.

- 70% of smokers want to give up.

b) With a smoking prevalence of 21.34% and an adult population of 1,153,000, Kent has an estimated smoking population of 246,071. To reduce the number of smokers in Kent we need to help existing smokers give up and reduce the number of young people that take up smoking

2. Tobacco use

a) Smoking rates amongst adults are declining and tobacco use is increasingly confined to the poorest sectors of our communities.

b) Smoking is the leading preventable cause of death and ill health in our society and is the prime cause of health inequalities as more affluent people continue to give up smoking.

c) Nicotine is a drug which is as addictive as heroin or cocaine.

d) Every year c.200,000 people stop smoking in England – they either die or quit.

e) Every year c. 200,000 young people start smoking tobacco regularly. In Kent c. 5,600 young people will begin smoking this year. Tobacco companies continue to target young people through social media advertising and cigarette packaging.

f) Demand for tobacco fuels the illicit trade in counterfeit and smuggled cigarettes that is conducted by organised crime syndicates that are also involved in people trafficking and drug misuse.

3. Smoking and children

a) Smoking is an addiction of childhood that reduces the ability of young people throughout their lives to manage their health and wellbeing and also their disposable income and in turn the health and wellbeing of their own children.

b) 90% of smokers begin smoking in childhood (13 – 18 years old) and then spend many of their adult years trying to give it up. The legal age for buying tobacco is 18.

c) The effects of smoking are often most serious for children. It is children that start smoking, hardly ever adults, and children that are most likely to be badly affected by smoking in the home and in cars.

d) The greatest influence on young people that will lead to them start smoking is whether their parents smoke - a child from a smoking household is 4 times more likely to begin smoking themselves than a child whose parents do not smoke.

e) Helping parents to give up smoking will directly affect the number of young people that take it up.

f) Every year nearly 10,000 children nationally are admitted to hospital as a direct result of inhaling second-hand smoke.

g) Children from smoking households display difficult behaviour in schools, especially during the afternoons, as a result of nicotine deprivation.

4. The economics of smoking

a) The economic impact of smoking is extremely serious for the smoker, their family and society as a whole.

- An average smoker – 20 a day – will spend £2,500 p.a. on tobacco. Most smokers are now in our poorest communities and can least afford this level of expenditure. Regressive taxation, designed to discourage smoking actually makes the issue worse for individual smokers and their families and encourages the use of illicit tobacco.
- 25% of all house fires are caused by smoking. (Cost £14.5 mil in Kent)
- Cigarette and smoking detritus is the biggest component of street cleaning and costs district councils in Kent £9.8 mil pa.
- Total cost of smoking to the NHS in Kent is estimated to be £77 mil.

b) A return on investment model has been developed by Brunel University and adopted by NICE that illustrates the cost benefits of various levels of intervention and how these can be apportioned to the different agencies involved. Extrapolation of national data to Kent indicates total cost savings of up to £7 mil in two years and over £30 mil in ten years.

5. Tobacco Strategy

a) Government intentions are clear:

b) In March 2011, the Department of Health published *Healthy Lives Healthy People: A tobacco control plan for England.* The plan sets out how tobacco policy fits with the localism agenda and how, together with local partners, the Government will:

- Help smokers to quit
- Reduce exposure to secondhand smoke
- Stop the promotion of tobacco in shops
- Make smoking less affordable
- Regulate tobacco products more effectively
- Protect health policy from the vested interests of the tobacco industry

c) Smoking services have been concentrated on achieving the DH targets for adult quitters. This has resulted in other groups receiving less attention. These include children and young people, and pregnant women who smoke. The Government has recognised these issues and has widened the focus of its objectives.

"By the end of 2015 we will:

- Reduce adult smoking prevalence in England to 18.5% or less by the end of 2015 (Kent rate currently 21.34%)
- Reduce regular smoking among 15 year olds to 12% (Kent rate currently 13%)
- Reduce smoking throughout pregnancy to 11% (E. Kent rate currently 16.8%, W. Kent 12.1%)"

d) The strategy recognises the importance of helping smokers to quit but places emphasis on prevalence rates that will incorporate how to prevent young people taking up smoking, as well as teenage quit rates.

e) Other priorities in the public health outcomes framework will require action on tobacco use to be achieved. These include reducing rates of cardiovascular disease, cancer and respiratory disease as well as the overarching indicators of reducing inequalities in life expectancy and healthy life expectancy. Prioritising tobacco control programmes can therefore also contribute to the QIPP agenda.

6. Doing it differently in Kent

a) Historically Kent has concentrated investment in services to help adults quit smoking. These have achieved significant success - last year (11/12) the Stop Smoking Services in Kent helped 9,314 people quit smoking at a cost of c. £3.3 million. However the agenda is now much wider and Kent has developed a Tobacco

Control Strategy (Towards a Smokefree Generation) that addresses the use of tobacco across the Life-Course (Marmot 2010) and provides a coherent programme of interventions that address the local priorities for Kent. Critically we need to reduce the number of children that start smoking. The Kent strategy has a clear emphasis on engaging and empowering young people to avoid smoking.

6.1 Smoking Cessation

a) Services to support smokers who want to quit are critical to a successful approach. These services will also need the flexibility to engage with the greater number of referrals that will be generated by a wider approach.

b) Five minutes of advice in general practice to middle-aged smokers to quit smoking can increase quit rates and save £30 per person for a cost of £11 per person (King's Fund 2011).

6.2 Reduce prevalence of smoking in pregnancy

a) Audit current Smoking at Time of Delivery (SATOD) activity, to ensure accuracy of data and self-reporting.

b) Redesign pathways and interventions with midwifery and cessation services including the roll out and continuing evaluation in Kent of the successful "Babyclear" programme.

c) Current costs to NHS in Kent of smoking in pregnancy by NICE modelling are estimated to be £2,486,875 pa.

6.3 Reduce children's exposure to tobacco smoke

a) Currently working with professionals and families in Dartford, Gravesham and Swanley to design community based interventions that will reduce children's exposure to second hand smoke in the home and elsewhere.

6.4 Reduce the number of young people who take up smoking

a) Supporting young people's awareness of, and education in, tobacco issues by leading the delivery of "Reframe the Debate" and introducing the Tobacco Education Quality Standard to Kent schools.

b) Developing Youth Advocacy across Kent for young people to assume control of the tobacco control agenda and develop a Kent Youth voice and associated campaigns.

c) Issues identified by young people include the introduction of plain packaging for cigarettes, sales restrictions and enforcement and using the "Truth Campaign" to demonstrate the targeting of young people by the tobacco industry at home and abroad.

6.5 Illicit tobacco

a) Tackle the demand for and supply of cheap and illegal tobacco in our communities and address the criminal activity involved.

6.6 Smokefree business

a) Targeted workplace smokefree initiatives promoting smokefree policies and supporting workers who wish to quit smoking including Kent's Smokefree Business Awards.

6.7 Establish a Tobacco Control Board

a) To coordinate the strategy it is proposed to establish a Tobacco Control Board for Kent. The Board will develop from the existing Tobacco Control Alliance in Kent and membership will include representatives from KCC Public Health, the District Councils (very important in delivering on all aspects of tobacco), CCG's, Stop Smoking Services, Education and youth services, Trading Standards, Environmental Health, Police, Fire and Rescue, Revenue and Customs, and other key stakeholders.

b) The Board would have a specific remit to use the Brunel/NICE return on investment model (see p3) to deliver the cost savings for Kent generated from a comprehensive tobacco control and smoking cessation programme.

c) The Board would also be responsible for the production and implementation of a Kent Health Inequalities Action Plan (Mind the Gap) for Tobacco Control and identifying further ways in which tobacco use in Kent can be "de-normalised" and reduced.

7. Resources

a) The current programmes of activity require an annual budget of c. £655,000. It is proposed that funding continues from the Public Health ring-fenced budget for Kent at this level. This would bring Kent broadly into line with other areas that have funded similar programmes at a rate of 40p per head of population. Staffing and support for the Board would also be required.

8. Recommendation

a) A Tobacco Control Board for Kent, as described above, is established as soon as practical.

b) A comprehensive Tobacco Control strategy comprising the elements listed above should be funded and implemented with a particular focus on preventing young people from starting smoking.

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London Health Observatory

Kent Tobacco Control Strategy - 2010-2014
Towards a Smokefree Generation
https://shareweb.kent.gov.uk/Documents/health-and-wellbeing/kent-tobacco-control-strategy-2010-2014%20vd1%202.doc

Kent Health Inequalities Action Plan 2012 - 2015
Mind the Gap Building bridges to better health for all
www.kmpho.nhs.uk/health-inequalities