Public Health England

Protecting and improving the nation's health

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 27 April 2016
Sponsor	Kevin Fenton/Paul Lincoln
Presenter	Martin Dockrell
Title of paper	**Tobacco Update**

1. Purpose of the paper

1.1 The purpose of the paper is to provide an up to date overview of activity at PHE to prevent and reduce tobacco harm and describe the context within which our programme is operating.

2. Recommendation

2.1 The PHE Board is asked to:

a) **NOTE** this overview
b) **ENDORSE** the approach we are taking to inform policy.

3. Background

Current consumption levels

3.1 Since the adoption of the White Paper Smoking Kills smoking prevalence has been in long term decline falling by approximately one third among adults and two thirds among youth. Nonetheless almost 1 adult in five is a regular smoker and the reductions have been principally among more advantaged groups, thus aggravating health inequalities.

3.2 Official data are published from a variety of official sources and published by Office of National Statistics (ONS) in *Statistics on Smoking 2015*. The latest official data is from the Integrated Household Survey, recording a smoking prevalence of 18.4% in 2014.

3.3 In addition we have several independent national surveys including the Smoking Toolkit Study (STS), which is published monthly. The STS reported a prevalence of 18.5% in 2014 and 17.8% in February 2016, suggesting a continuing decline.

3.4 However, it is worth noting that between August and December the STS recorded its first increase in prevalence since the survey began.

3.5 Long term trends suggest that smokers in England are starting older, quitting younger and smoking less. However, smoking rates among young adult males, those in the lowest socio economic groups and those with mental health problems have decreased little.

Summary of the latest data on harmful impact

3.6 Smoking continues to be one of the major sources of preventable mortality and morbidly in the England, accounting for approximately 78,200.

3.7 Smoking is a major cause of health inequalities in the UK, accounting for half the difference in life expectancy between richest and poorest quintiles, with the non-smokers in the poorest quintile having substantially better life expectancy than smokers in the wealthiest quintile.

3.8 Harms from exposure to second hand smoke have declined since the adoption of smokefree legislation in 2007.

3.9 Smoking is prohibited in all indoor areas of 85% of homes in England and 76% of households of SEG DE. Smoking is prohibited in 90% of households with children under the age of 18.

3.10 With regard to smoking in cars, among households with children 75% report smoking is not permitted at all, a further 12% when any non-smokers or children are in the car, and 10% report not having a car. Only 3% report permitting smoking at all times.

3.11 The National Health Service (NHS) spends £3.5 billion each year treating people with alcohol-related diseases and injuries. Overall, the cost to our society each year from alcohol-related harm is £21 billon.

Current Government policy on Tobacco

3.12 Since the Board last received a report on tobacco:

a) Smoking in cars carrying children has been prohibited

b) Sale of e-cigarettes to under 18s has been prohibited

c) The purchase of tobacco products or e-cigarettes on behalf of under 18s has been prohibited

d) Regulations have been introduced to implement the European Tobacco Products Directive including on the standardisation of tobacco packaging (often referred to as plain packs), the introduction of large picture warnings on the front of tobacco packs, the prohibition of sale of packs containing fewer than 20 cigarettes, the comprehensive regulation of e-cigarettes and the notification of novel tobacco products and non-tobacco smoking products.

e) A programme of work to make prisons smokefree has commenced

f) The *NHS Five Year Forward View* places an emphasis on prevention, which supports seizing the opportunities of working with smokers in the healthcare system including mental health, maternity, primary and secondary care. PHE continues to work with Cancer Research UK (CRUK) to ensure that primary prevention is given appropriate prominence, along with early diagnosis, in the National Cancer Plan.

3.13 The Tobacco control plan for England 2010-15 concluded in December, having achieved each of its three ambitions:

a) To reduce rates of regular smoking among 15 year olds in England to 12 per cent or less by the end of 2015. (Achieved 8% at 2014)

b) To reduce rates of smoking throughout pregnancy to 11 per cent or less by the end of 2015 (Achieved 10.6% at October 2015)

c) To reduce adult (aged 18 or over) smoking prevalence in England to 18.5 per cent or less by the end of 2015 (Achieved 18.4% at 2014)

3.14 The Government is currently preparing a new tobacco control plan to be published in the summer 2016.

a) PHE are working closing with DH on the production of a new tobacco control plan. This has involved a period of stakeholder engagement and is now moving into the drafting stage.

Civil society action on tobacco control

3.15 Civil society in England continues to be actively engaged in tobacco control. Notable achievements include:

a) The publication by Action on Smoking and Health (ASH) and over 100 partners of the "Smoking Still Kills" report

b) The publication of the Smoking in Pregnancy Challenge Group report

c) The publication of "*The stolen years: The mental health and smoking action report*"

d) The publication by CRUK and UK Health Forum of "*Aiming high: Why the UK should aim to be tobacco free"*

4. Programme content governance & resourcing

4.1 There are wide ranging programmes of work that support the PHE aspiration of achieving a tobacco free generation by 2025. The work streams that support this include:

a) In January 2015 PHE launched its ambition of securing a tobacco-free generation by 2025 with cross systems collaboration and evidence based interventions

b) We have focused work in the area of mental health, producing a number of resources aimed at supporting the adoption of NICE PH48 in all mental health settings.

c) We are working with National Offender Management Service (NOMS) and NHS England on introducing a smokefree prison estate.

d) The "Smoking in Pregnancy Challenge Group" recently (October 2015) published a review of the 2013 recommendations report, these are being considered in relation to on-going work programmes and PHE continues to

support the Challenge Group work on communicating with pregnant women.

e) PHE have worked closely with NHS England on the development of the Stillbirth Reduction Care Bundle, the first element of which is reducing smoking in pregnancy, and are proactively feeding into the public health response to both the Maternity Services Review and recently announced Government ambition to halve the number of stillbirth and neonatal deaths by 2030.

f) PHE continues to support Local Authorities, particularly in relation to the commissioning and delivery of stop smoking services, through the CLeaR improvement tool, collaborative work with the National Centre for Smoking Cessation and Training (NCSCT) and regional seminars to encourage and support the implementation of NICE Guidance on a range of issues – most recently in relation to local stop smoking services and their response to the increased number of smokers wanting to use electronic cigarettes to help them quit.

g) PHE has built an evidence-based consensus across public health in England around an approach to e-cigarettes that aims to maximise the public health benefits while managing the risks.

h) PHE is currently preparing to become the Competent Authority for the EU tobacco products directives (TPD), in the management and monitoring of the testing of cigarettes for tar, nicotine and carbon monoxide and receiving the notification of all tobacco and novel tobacco products.

4.2 The overall programme is overseen by the Tobacco Control Implementation Board co-chaired by Prof John Britton and Rosanna O'Connor and made up of the leading bodies in UK tobacco control. The Board meets once every three months.

4.3 In addition, Professor Kevin Fenton convenes an informal "public health contact group" including the Chief Medical Officer's office, Association of Directors of Public Health (ADPH), Chartered Institute of Environmental Health (CIEH), Faculty of Public Health (FPH) and Royal Society of Public Health (RSPH) to discuss emerging issues, particularly those related to e-cigarettes and tobacco control.

4.4 A joint delivery framework for tobacco links the tobacco related priorities in 'From evidence into action' document to actions across PHE undertaken by Health & Wellbeing (HWB), Chief Knowledge Officer (CKO), Centres and Communications & Marketing. The Health & Wellbeing (HWB) team act as co-ordinators for the Joint Delivery Framework. The document is in the process of finalisation.

4.5 Executive leadership for the programme sits under Professor Kevin Fenton, with the primary government department policy interface led by Rosanna O'Connor, Divisional Director for Alcohol Drugs and Tobacco (ADT), supported by Martin Dockrell.

4.6 Within the ADT division there are seven staff who are wholly employed to support the tobacco programme. There are many others within the division and other directorates that interface with or have direct responsibility for some aspects of the programme – as alluded to in paragraph 4.4.

Electronic Cigarettes (E-cigarettes)

4.7 Since the last report to the board on Tobacco in 2014, Public Health England has published three evidence reviews on E-cigarettes, the most recent in the summer of 2015.

4.8 E-cigarettes continue to be something of a public health controversy across the globe. Some jurisdictions such as Canada and Australia prohibit the sale of e-cigarettes not licensed as medicines. As only the UK has licensed an e-cigarette as a medicine (and this is not yet on the market) such a policy acts as de facto prohibition. However, international studies show that e-cigarettes use in both Canada and Australia is widespread at levels between half and a third of other jurisdictions where sales are permitted. In Canada e-cigarettes are available for sale openly in specialist and general retailers.

4.9 By contrast, England has arguably the most progressive stance with a highly developed balance of regulation and harm reduction.

a) Stop smoking services are encouraged to include e-cigarettes as part of their offer of support to smokers in conjunction with other medicinal licenced products and behavioural support. Those who combine e-cigarettes with support from a stop smoking service appear to have a higher quit rate than those using other quitting aids.
b) NICE is currently revising its guidance on Tobacco Harm Reduction and examining the use of e-cigarettes.
c) E-cigarettes use is confined almost entirely to smokers and ex-smokers. 0.2% of never smokers report current e-cigarettes use and 40% of e-cigarettes users in the UK have completely stopped smoking.
d) There is no evidence in the UK/England that e-cigarettes are leading young people to smoke and the authors of PHE's most recent review advised against using the term "gateway", referring to a hypothesis which they considered to be poorly defined and difficult to test.

4.10 PHE seeks to create an evidence based consensus on E-cigarettes. In addition to the three expert reports, PHE is organising its second e-cigarette research forum and works with partner agencies to develop shared positions. In 2015 PHE collaborated with Cancer Research UK to establish the UK E-cigarette Research Forum.

4.11 PHE's distinctive stance has provoked criticism in some quarters, including mistaken claims that the most recent review had been funded by the tobacco industry. Nonetheless, PHE is part of a widespread English consensus and immediately following the publication of our report a joint statement was published by PHE, Association of Directors of Public Health, Action on Smoking and Health, British Lung Foundation, Chartered Institute of Environmental Health, Cancer Research UK, Fresh North East, Faculty of Public Health, Royal College of Physicians, Royal Society of Public Health, Tobacco Free Futures, UK Centre for Tobacco and Alcohol Studies and UK Health Forum. An updated version of the statement is currently under development.

5. How we measure our impact

5.1 The Chief Executive's dashboard includes an indicator on the monthly rate of quit attempts recorded in the STS. Peaks in quitting are highly correlated with PHE

national media campaigns in October and January in which months quit attempts are typically 50% higher than in other months.

5.2 Other measures are better indicators of system wide action including smoking at the time of delivery, adult and youth prevalence, smoking in the home and in cars, e-cigarettes use, the proportion of smokers perceiving e-cigarettes to be at least as harmful as smoking.

6. Discussion

6.1 The principle challenges we now face are threefold:

a) Reducing the impact of smoking on health inequalities
b) Maintaining progress in the context of increasingly constrained resources
c) Continuing to build an evidence based consensus on E-cigarettes and monitor the market.

6.2 We must reconcile the competing imperatives of reducing inequalities and an evidence base which suggests that population measures are most effective. Cessation support, marketing campaigns and reducing affordability are highly effective. However, unless interventions are carefully designed to benefit the most disadvantaged, they tend to exacerbate health inequalities.

6.3 There is evidence that some local authorities are disinvesting in local stop smoking services or moving to service delivery models less firmly based in the evidence. PHE will need to work with partners to provide a strong case for continued investment. There is also a case for re-engaging the NHS is smoking cessation. Helping sick smokers to quit (including smokers with long term conditions and those requiring surgery as well as those with smoking related conditions) has the potential to reduce costs to the NHS with early returns on investment. This is also likely to have the effect of targeting the least advantaged smokers.

6.4 So far the evidence base on e-cigarettes has been increasingly supportive but this trend in not inevitable. As with harm reduction in drugs and sexual health in the 1980s, not all interventions will be successful. It will be important for PHE to continue to scrutinise the data swiftly and candidly to maintain the growing confidence in our approach.

References:

http://www.smokefreeaction.org.uk/SiP.html