Agenda Item No: 11

COSTED PROPOSAL TO IMPLEMENT A PILOT HARM REDUCTION PROJECT FOR STOPPING SMOKING

To:	**Health Committee**
Meeting Date:	**8th September 2016**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	*Key decision:* **No**
Purpose:	**The purpose of this paper is to provide the Health Committee with the proposed approach and costs of an evidence based harm reduction pilot project to enable smokers who have not been successful in quitting using the existing quit smoking model.**
Recommendation:	**The health Committee is asked to approve the following.**

- **The approach and costs of the pilot**
- **Implementation of the model in this financial year.**

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1. BACKGROUND

1.1 In July 2016 the Health Committee received a review paper of the Stop Smoking Services. This included the evidence and a request for support for a pilot harm reduction pilot. There is now considerable evidence for the effectiveness and cost-effectiveness of these interventions. They have been found to increase the number of people who stop from particular groups who find quitting smoking especially challenging and require additional support. The evidence and cost effectiveness evidence is attached again in Appendix 1.

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1.2 The Health Committee supported the request to undertake a pilot but wanted further details of scale and costs before it was undertaken by the Stop Smoking Service, CAMQUIT.

2. MAIN ISSUES

2.1 Harm reduction approaches are targeted at those smokers that require an alternative approach and are used with smokers who may be unwilling or unable to stop in one step. The evidence based model currently in use involves setting an abrupt stop smoking date, combined with support for the next four to twelve weeks from a trained advisor and in the majority of cases the use of medicines to assist with the attempt (Nicotine Replacement Therapy (NRT)). Harm reduction approaches involve a “cut down to quit pathway”. This involves following a structured programme of cutting down with NRT over a relatively short time period (e.g. six or twelve weeks) leading up to a quit date. Some models use a two year programme which involves the long term use of NRT. Appendix 2 lays out “abrupt” and “cut down” to quit models of stopping smoking

2.2 The harm reduction model proposed as a pilot would offer a structured programme of cutting down with the help of support from an advisor and NRT. After a period of up to 12 weeks the current model would then be used with a quit date being set and the usual support available for a period of four to six weeks.

2.3 Analysis of the profile of smokers who access the Stop Smoking Services suggests that there are two groups of smokers who would benefit from a harm reduction approach. Factors to be considered include prevalence in certain groups and quit rate success. In Cambridgeshire 51% of those who set a quit date are successful which is comparable to national quit rates but varies with different groups within the county.

<u>Routine and Manual Workers in Fenland</u>

The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) suggest the prevalence of smoking in Cambridgeshire has increased slightly in the last few years, returning to a level statistically similar to the England average (16.4% v. 16.9%). Smoking rates in routine and manual workers are consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where smoking rates have returned to a level worse than the average for England (39.8%).

The figures in Table 1 set out the set a quit date and quit rates for all service users and the routine and manual groups for the county as whole and for routine and manual workers.

Table 1: Smoking set a quit date and quitting rates in Cambridgeshire and Fenland 2015/16 (all service users & routine and manual)

	Set a quit date	Quit	% quit rate
Cambridgeshire			
All service users	4445	2261	51%
Routine and Manual	1242	651	52%
Fenland			
All service users	1021	567	56%
Routine and Manual	320	199	62%

The figures indicate that the Stop Smoking Services in 2015/16 were being accessed by routine and manual smokers and this group has a higher quit rate than the average rate for Cambridgeshire.

However the high prevalence rate of this group in Fenland suggests that there are many smokers who are not using the services which could be attributed to a reluctance to adopt the abrupt stop smoking approach. The use of the harm reduction approach could be twofold by attracting smokers to making a quit attempt and also increasing the success rate of those using the Services.

Home Carers and Never Worked/Long Term Unemployed

The second group to be considered are home carers in Fenland.

Table 2: Smoking set a quit date and quitting rates in Cambridgeshire and Fenland 2015/16 (including home carers & never worked/long term unemployed

	Set a quit date	Quit	% quit rate
Cambridgeshire			
All service users	4445	2261	51%
Routine and Manual	1242	651	52%
Fenland			
	1021	567	56%
Home carers	122	56	46%
Never worked/long term unemployed	112	52	46%

Home carers and those who have never worked/long term unemployed have poorer health outcomes. In addition maintaining the health of those who are carers is an important factor in terms of demand for health and social care services.

2.4 The challenge of calculating the cost of introducing a harm reduction approach is identifying how many smokers would be attracted to using this type of intervention. The evidence for harm reduction does not indicate the impact of their introduction upon the numbers accessing services. Table 3 indicates the percentages and numbers of smokers in Fenland amongst the different groups.

Table3: Estimated numbers of smokers in harm reduction target groups, Fenland

Total population aged 16+, Fenland, 2015		81,756		
Target group		Routine and manual workers	Never worked / long-term unemployed	Carers
Population in target group	Percentage	44.8%	5.4%	13.2%
	Number	36,593	4,440	10,805
Smokers in target group	Prevalence	39.8%	26.4%	26.4%
	Number	14,554	1,173	2,856

Notes and sources:
Total population aged 16+ based on Office for National Statistics mid-year 2015 population estimates
Percentage of population aged 16+ from routine and manual occupations, based on NS-SeC categories 5-7, Office for National Statistics Census 2011, DC6114EW
Percentage of population aged 16+ never worked / long-term unemployed, based on NS-SeC category 8, Office for National Statistics Census 2011, DC6114EW
Percentage of population aged 16+ providing unpaid care, Office for National Statistics Census 2011, LC3304EW
Smoking prevalence taken from Public Health Outcomes Framework indicator 2.14, based on Annual Population Survey data
Smoking prevalence estimates for never worked / long-term unemployed and carers based on estimates for the general population

2.5 The above table demonstrates the challenge for Fenland. Surveys consistently find that a majority of smokers want to quit In 2008, 68% of current smokers in Great Britain reported that they wanted to quit, with 22% saying they would very much like to give up and a further 23% saying they wanted to stop "quite a lot". However, only about 30-40% of smokers attempt to quit in a year. In 2014 39% of smokers attempted to quit and 19% were successful. Support for quitting with the help of the Stop Smoking Services increases the success rate by four but only 2-3% smokers access the services in the England per year.

2.6 In this context the preferred option for the harm reduction pilot would be to focus upon those smokers who have accessed the Stop Smoking Services and failed to quit smoking using the abrupt method, in one or both of the targeted groups. It is known that smokers who are motivated to quit (already accessed the Service) are more likely to be successful when trying to stop smoking. Pragmatically having clear criteria for recruitment to the pilot would make it easier for the GP practices to implement the pilot.

2.7 The following estimated costs have been used to identify the funding required for implementation. Current staff and NRT costs are applied.

- Harm reduction cutting down £171 for support programme + £199 medication costs = £370
- Structured abrupt quit attempt £93 for the support programme + £199 medication costs = £292
- **TOTAL cost of harm reduction programme estimate for one smoker = £662**

Please note that this is not the cost per quitter as that calculation takes into account the quit rate and the marketing for the whole service.

The Stop Smoking Service data indicates that there were in 2015/16 303 unsuccessful quitters with 163 from the targeted groups.

Table 4: Costs for targeted pilot for harm reduction for quitting smoking

Fenland	**Number of targeted smokers**	**Harm reduction cutting down to quit £**	**Abrupt quit attempt**	**Total cost**
Routine and manual	94	£34,780	£27,448	£62,228
Home carers	36	£13,300	£10,512	£23,812
Never worked/long term unemployed	33	£12,210	£9,636	£21,846
Totals	**163**	**£60,290**	**£47,596**	**£107,886**

The cost of the abrupt quit attempt would not be an additional cost, so the additional funding for implementing the pilot would be £60,290

2.8 To summarise it is proposed that the pilot will have the following key elements

- Routine and manual, home carers and never worked/long term unemployed in Fenland to be targeted.
- Smokers from these groups who have failed to quit, who present to or have contacted the services will be offered a harm reduction approach to stopping smoking.
- If the numbers recruited are small then the offer will be made to those who contact the core service for support from the targeted groups.
- The pilot will run for a year and reviewed after six months in terms of numbers accessing the pilot service.

3. ALIGNMENT WITH CORPORATE PRIORITIES

3.1 Developing the local economy for the benefit of all

The report above sets out the implications for this priority in 1.1, 2.7 and Appendix1

3.2 Helping people live healthy and independent lives

The following bullet points set out details of implications identified by officers:

- Tobacco smoking is the single greatest cause of illness and premature death in England with, 78,000 deaths estimated to be attributed to smoking in 2014.
- The number of deaths attributable to smoking remains greater than the total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections combined
- Smoking kills about 754 people in Cambridgeshire each year, which is on average nearly 15 deaths every week

3.3 Supporting and protecting vulnerable people

The report above sets out the implications for this priority in paragraph

4. SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The following bullet points set out details of significant implications identified by officers:

- There is robust evidence that harm reduction approaches are a cost effective intervention for reducing smoking. This is detailed in Appendix 2.
- The cost benefits vary according to the service costs and the stop smoking rates and these vary in different population groups. The outcomes of the pilot will be modelled to identify any costs.
- Funding for implementing the pilot is from the public health grant

4.2 Statutory, legal and risk implications

- There are no significant statutory, legal and risk implications

4.3 Equality and Diversity

The following bullet points set out details of significant implications identified by officers:

- This pilot will target routine and manual, carers and never worked/long term unemployed smokers in Fenland.
- These groups have higher rates of smoking and can require a longer period of support to quit than smokers in other population groups.

4.4 Engagement and communication implications

- There is no significant engagement and communication implications as the smokers targeted with the intervention are those who have already accessed the services and have had a failed quit attempt.

4.5 Localism and Local Member

- There are no localism or local member issues

4.6 Public Health

The following bullet points set out details of significant implications identified by officers:

- This has a significant public health impact. Stopping smoking is the prevention intervention which has the greatest impact on health.
- This intervention targets those groups which have a high prevalence of smoking and in general find it challenging to stop smoking.

Implications	Officer Clearance
Have the resource implications been cleared by Finance?	Yes Name of Financial Officer: Kerry Newson
Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?	Yes Name of Legal Officer: Virginia Moggridge
Are there any Equality and Diversity implications?	Yes Name of Officer: Dan Thorpe
Have any engagement and communication implications been cleared by Communications?	Yes Name of Officer: Ed Strangeways
Are there any Localism and Local Member involvement issues?	No Name of Officer: Wendy Lansdowne
Have any Public Health implications been cleared by Public Health	Yes Name of Officer: Liz Robin

Source Documents	Location
NICE guidelines [PH45] Smoking: harm reduction	https://www.nice.org.uk/guidance/PH45
Lader D, Goddard, E. Smoking-related behaviour and attitudes. 2004.	Office for National Statistics
Smoking-related behaviour and attitudes, 2008.	Office for National Statistics
Lader D. Opinions Survey Report No. 40 Smoking-related behaviour and attitudes, 2008/09. Office for National Statistics	Office for National Statistics
Public Health England Health matters: smoking and quitting in England, 2015	https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england