Agenda Item No: 7

REVIEW OF CAMBRIDGESHIRE STOP SMOKING SERVICES

To:	**Health Committee**
Meeting Date:	**3rd September 2015**
From:	**Director of Public Health**
Electoral division(s):	**All**
Forward Plan ref:	***Key decision:*** **No**
Purpose:	**For the Committee to consider a Review of the Cambridgeshire Stop Smoking Service and its current challenges.**
Recommendation:	**The Committee is asked to comment on the challenges and the options for the Service identified in the paper, and indicate whether the 'harm reduction' model should be further considered during the prioritisation process for 2016/17 business planning.**

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1. BACKGROUND

1.1 Tobacco use is the single greatest cause of preventable deaths in England – killing 80,000 people per year. This is greater than the **combined** total of preventable deaths caused by obesity, alcohol, traffic accidents, illegal drugs and HIV infections (Smoking Statistics: illness and health. Office of National Statistics). Smoking kills about 772 people in Cambridgeshire each year (Public Health England, 2013). That is an average of nearly 15 deaths every week. Two-thirds of smokers say they began smoking before age 18, and 9 out of 10 started before the age of 19 (General Lifestyle Survey 2009).

1.2 Each year in England research estimates that smoking costs society approximately £13.74 billion. This is made up of output lost from early death, smoking breaks, NHS care, sick days, passive smoking, domestic fires, and smoking litter (Nash & Featherstone, 2010).

1.3 Just under a fifth of the population of England smokes (18.4%) **(Table1).** The estimated prevalence of smoking in Cambridgeshire as a whole is 13.5% which is significantly lower than the England figure. However smoking prevalence varies between its five districts. The estimated prevalence in Fenland (21.9%) is statistically significantly higher than all the other districts with the exception of East Cambridgeshire (18.1%).

Table 1: Estimated smoking prevalence and number of smokers aged 18 years and over, Cambridgeshire, 2013

Local Authority	Prevalence	95% Confidence Interval	Estimated number of smokers
Cambridge	9.5	5.7 to 13.3	10,004
East Cambs.	18.1	13.2 to 23.0	12,025
Fenland	21.9	16.2 to 27.7	16,983
Hunts.	11.6	8.4 to 14.8	15,671
South Cambs.	11.4	8.1 to 14.6	13,373
Cambridgeshire	13.5	11.7 to 15.3	67,895
England	18.4	18.3 to 18.6	7,794,123

* Number of smokers estimated by applying the point estimate of prevalence to local population estimates
Sources: Public Health England - Public Health Outcomes Framework (Integrated Household Survey data - 2013), Office for National Statistics mid-2013 population estimates.

Although smoking prevalence nationally has dropped sharply since the 1970s, the decline has been much slower in the last decade. Estimates suggest that it is dropping by 0.4% points a year. New data is expected shortly that will indicate if the substantial drop in prevalence in Cambridgeshire from 17.9% in 2012 to 13.5% in 2013 has been maintained.

2. MAIN ISSUES

2.1 Historically in Cambridgeshire smoking has been primarily addressed through the evidence based Stop Smoking Service. Since its launch in 1999, the Service has supported over 35,000 people to stop smoking in the short term. The Camquit Service provides support from specialist advisors for smokers to make an evidenced based 4 week quit attempt. It comprises a core Team, which is part of the Public Health Directorate, contracted GP practices and community pharmacies. **Appendix 1**provides an overview of the Service

which includes performance, functions, activity and costs, developments and evidence for stop smoking services. The following describes the current challenges the Service is confronting that are related to activity, performance, costs, its delivery model and the impact of e-cigarettes.

Activity and Performance

2.2 There is a countywide quitting target based on prevalence. This includes individual GP targets. **Table 2** indicates the decline over the past three years in the numbers of smokers accessing Camquit and in the number of successful quitters. This reflects the picture in services across England.

Table 2 : Camquit achievement against target			
Year	**Target**	**Quit**	**% target achieved**
14/15	3600	2297	64%
13/14	3900	2978	76%
12/13	3914	3720	95%

It is likely that this decrease in activity reflects to some degree the fall in prevalence. However it is clear from Service reporting that there is an increasing difficulty in attracting smokers into the Service.

2.3 **Table 3** describes how the provider proportions of activity have changed over the past three years.

Table 3: Number of successful Camquit quitters, by service provider						
P	2012/13		2013/14		2014/15	
Provider p r a c t i c e s	**Number of Quitters**	**% of total quitters n: 3720**	**Number of Quitters**	**% of total quitters n: 2978**	**Number of Quitters**	**% of total quitters n: 2297**
GPs	2082	56%	1,618	54%	1249	54%
Core	1098	30%	944	32%	827	36%
Community Pharmacy	484	13%	382	13%	162	7%
Misc.	56	1%	34	1%	59	3%

GPs have traditionally provided the majority of quitters but they are providing an increasing range of services that limits their capacity to provide stop smoking services. Considerable support has been given to pharmacists but they report difficulties in engaging smokers. The core team is spending more time supporting GPs and pharmacists.

Service Costs

2.4 **Table 4** indicates how the funding for smoking cessation is divided between the different districts and the decrease in costs over the past three years, associated with the fall in the numbers of people attending the service.. It includes the core Camquit team costs, GP and community pharmacist payments and pharmacotherapy costs (medicines to assist in stopping

smoking). Please note that pharmacotherapy and service costs are combined and therefore do not align with the finance reporting schedules.

Table 4: Smoking Cessation Spend Breakdown by District						
2012-13	Fenland (£)	Hunts. (£)	Cambs City (£)	East Cambs (£)	South Cambs (£)	Total
2012-13	£208,372	£221,521	£152,887	£132,896	£120,735	£1,522,810
2013-14	£177,298	£151,614	£123,391	£98,395	£101,074	£1,323,395
2014-15	£193,503	£151,840	£109,876	£80,768	£68,180	£1,196,671

2.5 **Table 5** indicates the Cost per Quitter (CPQ) for each of the three Camquit principle providers. Although the overall cost of the service has fallen over the past three years, the numbers of quitters has fallen by a greater percentage, meaning that the 'cost per quitter' has increased. GP and community pharmacy providers are paid for each quitter they produce. The increase in their CPQs is the cost of the additional support in the form of training and visits provided to them by the core Camquit service. The Camquit core team also provides an increasing number of clinics at practices. Quitters from these clinics contribute to the practice figures. In 2014/15 Camquit provided 21 weekly clinics in practices. This has increased to 25 in the first three months of 2015/16. This has helped the GP practices to maintain, as indicated in **Table 2**, but not increase their proportion of quitters

Table 4: Cost per Quitter				
	Core	GP	Pharmacy	Whole Service
14/15	545	539	704	596
13/14	552	399	425	459
12/13	534	391	369	431

. Measures have been taken to address the fall in activity. A number of initiatives have been launched with the majority having a focus upon Fenland to target its higher prevalence. Other developments include expanding the Health Trainer Service to provide additional support, targeted interventions for pregnant smokers, children and families and young people, promotional and media activity and a workplace programme. Social marketing intelligence has been collected to help understand the fall in demand and to design appropriate interventions.

Electronic Cigarettes

2.6 The decline in the number of smoking quitters nationally, as well as locally, has been attributed to the rapid increase in the use of electronic cigarettes. The benefits and risks of electronic cigarette use are still being researched and as yet none have been licensed by the the Medical Healthcare Products and Regulation Agency (MHRA), the responsible body for regulating all medicines and medical devices in the UK, ensuring they work and are acceptably safe. This is set to change next year under revisions of the EU Tobacco Product directive (May 2016). However, a product similar to electronic cigarettes, VOKE, has been licensed by the MHRA, but has not yet been available in the UK. Public Health England commissioned an academic review of the current evidence on electronic cigarettes. Although long term effects are still unknown due to the novel nature of these products, the review concluded that electronic cigarettes are about 95% less harmful than

traditional tobacco cigarettes. Emerging evidence is also suggesting that some of the highest successful quit rates are now seen among smokers who use an electronic cigarette and who also receive additional support from their local stop smoking services. This is the same behavioural support that a smoker accessing a service would receive when combined with a licensed nicotine containing product (e.g. NRT), or other stop smoking medication.

Harm Reduction Service Model

2.7 Helping smokers to stop smoking using behavioural support and medication remains the most effective and cost-effective intervention to improve health and reduce the inequalities caused by smoking (Hughes *et al*, 2004). Harm-reduction refers to any attempt to reduce the harm, psychological or physical, from smoking without complete cessation (West *et al*, In Press).

2.8 NICE has outlined evidence-based harm reduction recommendations within their Public Health Guidance 45 (NICE, 2013). This guidance is supported by Public Health England (PHE), the Department of Health (DH), Action on Smoking and Health (ASH), and the National Centre for Smoking Cessation and Training (NCSCT). Interventions can involve behavioural support and medication to support quitting (Nicotine Replacement Therapy). It generally takes three forms;

- Temporary abstinence: (e.g. longer-term in situations where smoking may not be an option such as in hospital or prison, or shorter term such as during the working day) with or without the help of medication (Nicotine Replacement Therapy –NRT) or behavioural support
- Cut-down to quit: reducing smoking with medication (NRT)
- Longer term medication (NRT) used as a replacement for some or all of smoking

2.9 The harm reduction approach acknowledges that nearly 70% of smokers want to quit smoking, however only about a quarter of them will make a quit attempt in any one year (Larder, 2009). Not all smokers are able, or willing to successfully quit smoking over the long term. These approaches could offer greater benefit to these heavier and more addicted smokers. It is known that people from routine and manual groups, who tend to be more dependent on nicotine, are more likely to cut down first, rather than stop 'abruptly' (Siahpush *et al*, 2010).

2.10 Abrupt quitting remains the best option for smokers but reducing levels of smoking is able to provide some benefits. Low-level smokers (i.e. those smoking fewer than 15 cigarettes per day) have been found to have a 17% reduced mortality risk than other smokers (Doll 2004). Compared with other smokers, a person aged 25 years who reduces (defined as reducing to less than 15 per day), their smoking levels will live for an additional two years and will save the NHS £882. A smoking intervention that achieves one additional 'reducer' aged 50 will save the NHS approximately £767 over the person's lifetime. An intervention that leads to one quitter will save the NHS £1,412 over the same period (NICE 2013).

2.11 Smokers who reduce their level of tobacco intake are significantly likely to attempt a quit attempt in the near future (Beard). People who reduce smoking are 1.51 times more likely to quit smoking at six months and 1.61 times more

likely to attempt to quit smoking. The quit rate (the proportion of quit attempts that are successful) for smokers not reducing their intake was 6% at six months. For those who did reduce their smoking level, the quit rate at six months was 9.4%. In addition 11.2% of smokers who used medication to aid their reduction were abstinent at six months.

2.12 Providing licensed nicotine-containing products (i.e. NRT) for a period of up to 10 years is considered a cost-effective use of resources for an intervention that achieves a quit rate of 6%, and this falls to five years for an intervention with a 4% quit rate (NICE, 2013). Longer term use of NRT and temporary abstinence using NRT increases the likelihood of making a quit attempt (Beard *et al*, 2011; Beard *et al,* 2013). As yet there are no cost-effectiveness studies of specific interventions.

2.13 Harm reduction approaches will incur an additional cost in terms of staff time and medication (NRT). Although the cost is dependent on the product price, dosage, duration of use, and existing local commissioning arrangements. **Table 5** shows the estimated cost of medication (NRT) per smoker although the cost is likely to reduce over time as usage falls. Currently those making a quit attempt receive medication for 12 weeks. It has not been possible to identify from the research any estimation of how many smokers would want to adopt this approach to estimate the full cost of implementing a harm reduction approach.

Table 5: Cost of nicotine replacement therapy (NRT) per smoker smoking more than 20 cigarettes a day Duration of use (Adapted from p 10 NICE, 2013a)

Duration of use	1 week (£)	12 weeks (£)	24 weeks (£)	52 weeks (£)	104 weeks (£)
NRT patches	9.80	117.6	235.2	510	1020
NRT gums	10.85	130.2	260.4	565	1130
NRT inhalators and spray	29.68	356.16	712.32	1542	3084
NRT lozenges	15.82	189.84	379.68	823	1648
Average cost	16.54	198.45	396.9	860	1720
The prices of NRT products were obtained from the eMC dictionary of medicines and devices browser. Unit costs are based on the maximum dosage for each item per day.					

2.14 The recent announcement of a reduction in the Public Health Ring Fenced Budget and the required savings necessitates current public health investments to be reviewed taking into consideration, need, effectiveness of interventions, and any economic benefits. The fall in the activity of Camquit has created savings mostly from the decreased medication costs. These could potentially be used to contribute to the savings target. This provides the context for any decision to incorporate the harm reduction model into the Camquit service and is reflected in the potential options for the Service found below.

2.15 **Option 1:** Continue with the existing model of a 4 week quit attempt that involves support for behavioural change and medication (pharmacotherapy). The Service model is based on sound evidence of effectiveness and of cost savings to the whole system. This approach would include maintaining the developments that are cost neutral and aimed at increasing demand and preventing the fall in activity by the contracted services. The Stop Smoking Services currently offer behavioural support for those who are using electronic cigarettes to help them quit, although they are not available on prescription. The recent Public Health England commissioned review of electronic cigarettes could increase the demand for this behavioural support for

electronic cigarette users. Stop smoking services are one of a comprehensive range of tobacco control measures that are considered to be the most effective way to secure a sustainable reduction in smoking (DH, 2011). There are some tobacco control initiatives in Cambridgeshire including an illicit tobacco control campaign that is externally funded. Maintaining and supporting these will also enhance the work of Camquit.

2.16 **Option 2:** Adopt a harm reduction model that focuses upon cutting down to quit. Of the 70% of smokers who want to quit, only 25% access stop smoking Services. The evidence for the current 4 week quit attempt Cambridgeshire model indicates that it is more effective and cost effective than the harm reduction model. However harm reduction offers an alternative method of quitting that can be successful, for those who do not want to quit abruptly and for the more dependent smoker associated with areas of deprivation. Based on the evidence and potentially useful ways of implementing harm-reduction into Camquit, a new harm reduction service model has been developed. The flow chart found in **Appendix 2** illustrates the pathways that a smoker could take through the Camquit service, all with the ultimate aim of complete abstinence. Support for harm reduction could be up to two years at a cost of £2,100 based on NICE (2013) costings and local costs.

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 ***2.4***

3.2 Helping people live healthy and independent lives

The report above sets out the implications for this priority in **1.1**

3.3 Supporting and protecting vulnerable people

The report above sets out the implications for this priority in ***2.1, 2.3***

SIGNIFICANT IMPLICATIONS

4.1 Resource Implications

The report above sets out details of significant implications in ***2.4***

4.2 Statutory, Risk and Legal Implications

There are no significant implications within this category

4.3 Equality and Diversity Implications

The report above sets out details of significant implications in **2.3, 2.4**

4.4 Engagement and Consultation Implications

There is the potential for Service change outlined in the paper that would require consultation with Service users

4.5 Localism and Local Member Involvement
See wording under 4.1 and Appendix 2.

4.6 Public Health Implications
See wording under 4.1 and Appendix 2.

Source Documents	Location
NICE (The National Institute for Health and Social Care) (2013). PH 45: Tobacco: Harm reduction approaches to smoking. Available from:	https://www.nice.org.uk/guidance/ph45
NICE (The National Institute for Health and Social Care) (2013a). Costing report: Tobacco harm reduction.	https://www.nice.org.uk/guidance/ph45/resources/tobacco-harmreduction-approaches-to-smoking-costing-report2
Doll R., Peto R., Wheatley K., Gray R., Sutherland I. (2004) Mortality in Relation to Smoking – 40 Years Observations on Male British Doctors.	BMJ 2004; 328:7455
Siahpush M, Yong H-H, Borland R et al. (2010). Socioeconomic position and abrupt versus gradual method of quitting smoking: findings from the International Tobacco Control Fout-Country Survey.	
Nash, R & Featherstone, H. (2010). Research Note: Cough Up: Balancing tobacco income and costs in society. Policy Exchange: London. Available from:	Nicotine and Tobacco Research 12 (supplement 1): S58-63
DH (Department of Health) (2011). Healthy Lives, Healthy People: A Tobacco Control Plan for England. Available from:	http://www.policyexchange.org.uk/images/publications/cough%20up%20-%20march%2010.pdf
Beard, E, McNeill, A, Aveyard, P, et al. (2011). Use of nicotine replacement therapy for smoking reduction and during enforced temporary abstinence: a national survey of English smokers.	https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213757/dh_124960.pdf
Beard, E, McNeill, A, Aveyard, P, Fidler, J, Michie, J, West, R. (2013). Association between use of nicotine replacement therapy for harm reduction and smoking cessation: a prospective study of English smokers.	*Addiction. 106:197e204.*
Ferguson, J, Bauld, L, Chesterman J, et al (2005). The English smoking treatment services – one-year outcomes.	*Tobacco Control 22:118–122.*

Hughes, J, Keely, J, Maud, S. (2004). Shape of the relapse curve and long-term abstinence among untreated smokers.	*Addiction 100 (Supplement 2): 59-69*
Jarvis, M. (2010). Smoking and Health Inequalities In: Inquiry into the effectiveness and cost-effectiveness of tobacco control. London: All Party Group on Smoking and Health.	*Addiction. 99 (1): 29-38.*
Larder, D. (2009). Smoking-related behaviour and attitudes, 2008/2009. Opinions survey report.	Addiction.
West R, Beard E, Michie S, et al. (In press). A taxonomy of harm reduction for use in tobacco control.	Addiction
Ash (2014a). Factsheet: Use of electronic cigarettes in Great Britain (July 2014):	http://www.ash.org.uk/files/documents/ASH_891.pdf
CAP (Committees of Advertising Practice). (2014). Advertising codes. CAP	: http://www.cap.org.uk/