**Agenda Item No: 7**

**REVIEW OF THE SMOKING HARM REDUCTION PILOT**

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| *To:* | **Health Committee** |
| *Meeting Date:* | **19th October 2017** |
| *From:* | **Director of Public Health** |
| *Electoral division(s):* | **All** |
| *Forward Plan ref:* | **N/a** *Key decision:* **No** |
| *Purpose:* | **The purpose of this paper is to provide the Health Committee with the findings from the evidence based harm reduction stop smoking pilot project which aimed to enable smokers who had not been successful in stopping smoking through using the existing quit smoking model.** |
| *Recommendation:* | **The Health Committee is asked to note the findings and support the approach adopted the Sop Smoking Services.** |


| *Officer Contact:* | | *Member Contact:* | |
|---|---|---|---|
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## 1. BACKGROUND

1.1 In September 2016 the Health Committee approved a proposal for the Stop Smoking Service, CAMQUIT to undertake a pilot harm reduction programme in Fenland, where smoking rates are the highest. 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 smoking from particular groups. These are smokers who find quitting smoking especially challenging and require additional support. The evidence and cost effectiveness evidence is attached for information in **Appendix 1**.

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1.2 The Health Committee supported the request to undertake a pilot and requested feedback on the findings. The pilot would run for a year and be reviewed after six months in terms of numbers accessing the pilot service. This paper presents data for the first 6 months of the pilot that is from October 2016 to April 2017.

## 2. MAIN ISSUES

2.1 The standard evidence based model for smoking cessation that is widely used 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 are targeted at smokers who require an alternative approach and are used with those who may be unwilling or unable to stop in one step. They focus upon a “cut down to quit pathway”. The harm reduction pilot model offered 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 was used with a quit date being set and the usual support available for a period of four to six weeks. 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 pilot adopted the following criteria for identifying the target population.

- Routine and manual, home carers and never worked/long term unemployed in Fenland to be targeted.

- Smokers from these groups who had failed to quit, who presented to or had contacted the services were offered a harm reduction approach to stopping smoking.

- If the numbers recruited were small then the offer would be made to those from the targeted groups who contacted the core service for support

2.3 These criteria were based on analysis of the profile of smokers who access the Stop Smoking Services. Population groups that had a high prevalence and/or a lower quit rate were identified as the targets for the pilot. In Cambridgeshire 51% of those who set a quit date were successful which is comparable to national quit rates but it varied with different groups and areas within the county. The harm reduction approach was therefore twofold through attracting more smokers to make a quit attempt and also increasing the success rate of those using the Services.

## Routine and Manual Workers in Fenland

The most recent Public Health Outcomes Framework figures (August 2016 data for 2015) at the launch of the pilot suggested that the prevalence of smoking in Cambridgeshire had increased slightly in the previous few years, returning to a level statistically similar to the England average (16.4% v. 16.9%). The figure for the Fenland population was 26.4% which was an increase on previous years when the trend had been downwards. Smoking rates in routine and manual workers had been consistently higher than in the general population (27.2% in Cambridgeshire), and notably in Fenland where smoking rates had returned to a level worse than the average for England (39.8%).

The analysis of service activity for different groups and their quit rates are found in Table 1. It sets out the numbers accessing the service to initiate a quit attempt and the quit rates for all service users and the routine and manual groups for the county as whole and in Fenland.

**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 indicated that the Stop Smoking Services in 2015/16 were accessed by routine and manual smokers and this group had a higher quit rate than the average rate for Cambridgeshire.

## Home Carers and Never Worked/Long Term Unemployed

The other two groups considered were home carers and never employed/long term unemployed in Fenland. These groups have poorer health outcomes and in Fenland these groups have a lower quit rate than other groups. Maintaining the health of those who are carers is an important factor in terms of demand for health and social care services.

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

| 2015/16 | Set a quit date | Quit | % quit rate |
|---|---|---|---|
| **Cambridgeshire** | | | |
| All service users | 4445 | 2261 | 51% |
| Home Carers | 352 | 162 | 52% |
| Never worked/long term unemployed | 393 | 156 | 40% |
| **Fenland** | 1021 | 567 | 56% |
| Home carers | 122 | 56 | 46% |
| Never worked/long term | 112 | 52 | 46% |

| | | | |
|---|---|---|---|
| unemployed | | | |

Smokers from these three groups were accessing the services. However there was little difference between the percentage of those accessing the Stop Smoking Services in Cambridgeshire and Fenland despite the associated higher prevalence in Fenland especially amongst routine and manual groups.

**Table 3: Proportion of the pilot target groups who access the Stop Smoking Services in Cambridgeshire and Fenland**

| | Routine and Manual | Carers | Never worked/long term unemployed |
|---|---|---|---|
| Cambridgeshire | 28% | 8% | 7% |
| Fenland | 31% | 12% | 9% |

These factors determined the approach of the pilot as it suggested, given the higher prevalence or high risk of negative impacts, that there were many smokers who were not using the services. This was associated with a reluctance to adopt the abrupt stop smoking approach especially in the case of routine and manual workers who if engaged in Fenland have a high level of success in stopping smoking

2.4 The challenge of calculating the cost of introducing a harm reduction approach was 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 in 2015.

**Table4: 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 demonstrated the challenge for Fenland in terms of the number of smokers in these groups. 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 it was estimated that 39% of smokers attempted to quit and 19% were successful. Again in 2017 it was estimated that 34% 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 was to focus upon those smokers from the targeted groups who had accessed the Stop Smoking Services and failed to quit smoking using the abrupt method. 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 that provide stop smoking services to implement the pilot.

2.7 The following estimated costs were used to identify the funding required for implementation. The staff and NRT costs that were current at the time were 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 indicated that there were in 2015/16 in Fenland, 303 unsuccessful quitters with 163 from the targeted groups.

**Table 5: 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**F** | £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 was estimated to be £60,290.

2.8 Data from the pilot was analysed after the first six months and clearly demonstrated that the target population did not engage with the harm reduction approach. A total of 227 people from the targeted groups were invited to take part in the Harm Reduction pilot. All clients who registered their interest were telephoned by a trained stop smoking advisor within 48 hours. This telephone conversation further explained the programme and booked clients for an appointment at a local stop smoking clinic or to arrange a telephone consultation. Only

seven people from the routine and manual, carers and the never worked groups registered interest in taking part in the pilot. In view of this low number the invitation was extended to skilled technical or craft i.e. intermediate occupations which elicited only two more interested responses. The outcomes of those clients who registered their interest are also disappointing and are found in Table 6.

**Table 6: Outcomes of clients who registered their interest in the Harm Reduction Pilot**

**Routine and manual, carers, never worked group:**

| | |
|---|---|
| Failed to start the programme: | 4 |
| Started the programme but did not quit | 1 |
| Quit smoking but with an abrupt quit attempt: | 2 |
| **TOTAL** | **7** |

**Intermediate group:**

| | |
|---|---|
| Failed to start the programme: | 1 |
| Quit smoking but with an abrupt quit attempt: | 1 |
| **TOTAL** | **2** |

2.9. It is difficult to explain why the response rate was so low and the outcomes all unsuccessful. Table 7 shows the Stop Service activity for 2016/17. Overall there was little change between 2015/16 and 2016/17 in the level of activity and the numbers of quitters in each group and their success rates.

**Table 7: Stop Smoking Service Activity 2015/16 and 2016/17**

| | **Set a quit date** | | **Quit** | | **% quit rate** | |
|---|---|---|---|---|---|---|
| | **2015/16** | **2016/17** | **2015/16** | **2016/17** | **2015/16** | **2016/17** |
| **Cambridgeshire** | | | | | | |
| All service users | 4445 | 4243 | 2261 | 2253 | 51% | 53% |
| Routine and Manual | 1242 | 1177 | 651 | 638 | 52% | 54% |
| Home carers | 352 | 344 | 162 | 172 | 46% | 50% |
| Never worked/long term unemployed | 393 | 386 | 156 | 146 | 40% | 38% |
| | | | | | | |
| **Fenland** | 1021 | 1029 | 567 | 569 | 56% | 55% |
| Routine and manual | 320 | 339 | 199 | 202 | 62% | 60% |
| Home carers | 122 | 130 | 56 | 65 | 46% | 50% |
| Never worked/long term unemployed | 112 | 107 | 52 | 47 | 46% | 44% |

2.10. The 2016 smoking prevalence information shows that the overall downward trend and comparability to the England figure had been maintained. The Cambridgeshire prevalence was 15.2% and England 15.5%. The Fenland prevalence was 21.6% which was in line with the downward trend that had occurred prior to 2015. Routine and manual prevalence statistics are not available.

2.11 The Stop Smoking Services made considerable efforts to contact and engage former clients to take part in the pilot. All targeted clients received an Invitation, booklet and registration form. This invitation was followed up by a phone call two weeks after the letters were sent.

No-one attended the event launch to which all targeted clients were invited. Those who registered were called (up to 3 attempts were made) to engage them in the programme. The people that did start the programme were given an assessment appointment and follow up sessions which included all the different types of support. The target population was also expanded to include another socio-economic group but this had virtually no effect. It should also be noted that the pilot ran over a period when historically recruitment to the Service is at greatest, that is during the Stoptober campaign, post Christmas promotion and No Smoking Day campaign in March.

2.12 The intensive engagement programme along with the continued fall in prevalence and the unchanged levels of activity and numbers of quitters accessing services suggests that some smokers have found an alternative means of support to help them stopping smoking. There have been numerous reviews of the impact of e cigarettes which positively support the use of e cigarettes to support a quit attempt. A Cochrane Review in 2014 and Public Health Evidence review in 2015 both concluded that electronic cigarettes can help people to quit smoking and contributing to the decline in smoking. In April any further efforts to recruit clients to the Programme were discontinued as the efforts required and the outcomes were not considered to be cost-effective.

## 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 were very limited and the pilot was discontinued after 6 months as it was considered as being not cost-effective.
- Funding for implementing the pilot was 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 targeted 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 were 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 4 October 2017<br>Name of Financial Officer: Clare Andrews |
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| | |
|---|---|
| **Has the impact on Statutory, Legal and Risk implications been cleared by LGSS Law?** | Yes 29 September 2017<br>Name of Legal Officer: Fiona McMillan |
| | |
| **Have Procurement implications been cleared?** | Yes 29 September 2017<br>Name of Officer: Paul White |
| | |
| **Are there any Equality and Diversity implications?** | No 4 October 2017<br>Name of Officer: Liz Robin |
| | |
| **Have any engagement and communication implications been cleared by Communications?** | Yes: 5 October 2017<br>Name of Officer: Matthew Hall |
| | |
| **Are there any Localism and Local Member involvement issues?** | No 4 October 2017<br>Name of Officer: Liz Robin |
| | |
| **Have any Public Health implications been cleared by Public Health** | Yes 4 October<br>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 |
| McRobbie H, Bullen C, Hartmann-Boyce J, Hajek P. Electronic cigarettes for smoking cessation and reduction. The Cochrane Library, Dec. 2014. | The Cochrane Library, Dec. 2014. DOI: 10.1002/14651858.CD010216.pub2 |
| Public Health England: E-cigarettes: an evidence update 2015 | https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/457102/Ecigarettes_an_evidence_update_A_report_commissioned_by_Public_Health_England_FINAL.pdf |
| 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 |