Aneurin Bevan University Health Board

Smoking Cessation

1 Introduction

The purpose of this paper is to seek Board support for investment in smoking cessation to reach the Tier 1 target in the NHS Delivery Framework 2013/14. This target is based on NICE guidelines for smoking cessation services.

The Aneurin Bevan University Health Board (ABUHB) has an important leadership role in relation to reducing smoking prevalence within the population. The Board has nominated an Independent Board Member as Tobacco Control Champion to ensure smoking remains a top priority for the organisation. ABUHB has also set up a Tobacco Control Delivery Group which reports directly to Public Health & Partnerships Committee.

The Board is asked to consider:

- the health gain associated with smoking cessation and potential cost savings due to reduce admissions and better patient outcomes
- note the expansion of Community Pharmacy (Level 2) Scheme, especially in Blaenau Gwent, Caerphilly and Monmouthshire
- extending the five Community Pharmacy (Level 3) Enhanced Services across ABUHB, subject to: resources being identified, development of a costed pathway for NRT prescribing and professional engagement
- agree a Hospital Smoking Cessation Service, particularly for inpatients at the Royal Gwent Hospital and Nevill Hall Hospital, subject to an identified nursing lead for the service and the redirection of resources from Stop Smoking Wales
- agree a dedicated service for pregnant women, subject to evaluation of the MAMSS pilot, redirection of resources from Stop Smoking Wales and ongoing engagement with the Family & Therapies Division
- learning from smoking cessation service models in other Health Boards
- recognise the need for a step change in smoking cessation and alignment to the Inverse Care Law programme

Financial Assessment and link to

This proposal presents the costs of increasing the scale of smoking cessation services, against the saving associated with reduced hospital admissions and
<table>
<thead>
<tr>
<th><strong>Financial Recovery Plan</strong></th>
<th>improvements in maternity and post operative outcomes. Smoking cessation is also highly cost effective in terms of cost per Quality Adjusted Life Year (QALY) gained.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>If the Board does not support this proposal, it is likely to fail to reach the Tier 1 target for ‘treated smokers’ in the NHS Delivery Framework for 2013-14. There is insufficient capacity within Stop Smoking Wales to achieve this target for ‘treated smokers’ and therefore further investment is needed within primary care, maternity and hospital settings.</td>
</tr>
</tbody>
</table>
| **NHS Delivery Framework and Annual Quality Framework** | **NHS Delivery Framework**  
The NHS Delivery Framework for 2013-14 includes a new **Tier 1 target** for smoking cessation. The target is for 5 per cent of smokers make a quit attempt with the support of any smoking cessation service, with at least 40 per cent CO validated quit rate at 4 weeks. Primary care has a major role in delivering this target alongside Stop Smoking Wales, especially through Community Pharmacy.  

**Together for Health Delivery Plans**  
The **Heart Disease Delivery Plan (2013)** states that health boards should develop and deliver local strategies and services to tackle underlying determinants of health inequality and risk factor for coronary heart disease.  
The **Stroke Delivery Plan (2012)** states that health boards should work through their locality networks to plan and deliver a more systematic and coordinated approach to identifying those at risk of vascular disease and manage that risk effectively.  

**Delivering Local Health Care**  
The Inverse Care Law programme is setting out the steps needed to achieve a measurable closing of the gap in health outcomes between the most and least deprived areas. Welsh Government requires ABUHB to carry out a review of smoking prevalence, hypertension and cholesterol, with agreed targets to be met by April 2016. |
<table>
<thead>
<tr>
<th>Standards for Health Services Wales</th>
<th>This proposal aims to provide population scale smoking cessation interventions, that will meet the following requirements in Standards for Health Services in Wales:</th>
</tr>
</thead>
</table>
| **Standard 3**: Health promotion, protection and improvement | Organisations and services work in partnership with others to protect and improve the health and wellbeing of citizens and reduce health inequities by:  
 a) supporting citizens to maintain and improve their health, wellbeing and independence;  
b) promoting healthy lifestyles and enabling healthy choices;  
c) ensuring that needs assessment and public health advice informs service planning, policies and practices;  
d) having effective programmes to screen and detect disease.  |
| **Standard 6**: Participating in quality improvement activities | Organisations and services reduce waste, variation and harm by:  
a) identifying and participating in quality improvement activities and programmes;  
b) supporting and enabling teams to identify and address local improvement priorities;  
c) using recognised quality improvement methodologies;  
d) measuring and recording progress; and  
e) spreading the learning.  |
| **Equality Impact Assessment** | This programme will specifically reduce inequalities by focussing on populations where smoking prevalence is highest.  It will also focus on disadvantaged and vulnerable groups who are not currently in meaningful contact with services. For these groups the services will take account of the barriers people experience in accessing services. |
1. Introduction

The Welsh Government has published a Tobacco Control Action Plan for Wales which sets out a challenging aim to reduce smoking levels to 16% by 2020. Welsh Government indicate that reaching the prevalence target by 2020 will require a step change in efforts to motivate and assist smokers to quit.

The Tobacco Control Action Plan suggests that community pharmacies serve local communities and have the potential to reach and treat large numbers of people who smoke. They also recognise that they are able to meet the needs of minority ethnic communities and disadvantaged groups and those who may have difficulty accessing other community services. Within the Tobacco Control Action Plan there is a specific action relating to community pharmacy:

Local Health Boards should agree the delivery of pharmacy smoking cessation services with community pharmacy contractors, taking account of the national enhanced services specification, to achieve closer integration of pharmacy smoking cessation services with those provided by Stop Smoking Wales (Action 3.16).

In relation to secondary care, the Tobacco Control Action Plan highlights that five of the 18 hospitals in Wales have in-house services. In contrast, around two-thirds of hospitals in England and Scotland have such services. Welsh Government indicates that as this is a cost-effective intervention, Health Boards whose hospitals do not have such services should consider setting up on-site smoking cessation services:

Local Health Boards should consider investing in in-house smoking cessation services, in collaboration with Public Health Wales (Action 3.20).

The NHS Delivery Framework for 2013/14 identifies smoking cessation as a Tier 1 target. The target set by Welsh Government is:

5% of smokers make a quit attempt via smoking cessation services, with at least a 40% CO validated quit rate at 4 weeks.

It is envisaged that this target will be met through a network of services provided by Stop Smoking Wales, Community Pharmacy, Maternity and Hospital settings. At present, the main provider of smoking cessation services in ABUHB is Stop Smoking Wales. However, in 2012/13, Stop Smoking Wales only treated 1,075 smokers, which was 4,299 fewer that the Tier 1 target of 5,374 smokers.
The Tobacco Control Action Plan for Wales identified a number of other areas for action with local authorities and third sector partners. These actions focus on reducing uptake of smoking and exposure to environment tobacco smoke. A summary of activity in each of the localities is attached as Appendix A.

### 2. Impact of smoking

Smoking remains the greatest single cause of avoidable mortality in Wales. It is also a preventable cause of morbidity, hospital admissions and causes poor outcomes in pregnant women and patients receiving elective surgery. Smoking is a major contributor to health inequality and should therefore be the focus of action to reduce the gap in premature mortality from CHD and cancer between the most and least deprived areas.

Smoking also has a financial and economic impact. In 2008, UK smokers spent £16 billion on tobacco products. An average 20-a-day smoker will spend about £2,000 a year on cigarettes. A study by Swansea University has estimated that smoking related illness costs NHS Wales £386 million annually, which is more than £7 million each week or over £1 million a day (Phillips & Bloodworth, 2009). This is the equivalent of £129 per head of population, which accounts for around 7 per cent of total healthcare expenditure. An overview of the health and financial costs associated with smoking is set out in Appendix B.

In England and Wales, there were some 68,230 fewer CHD deaths in 2000 compared with 1981. Approximately, 42% (26,000 deaths) of the mortality decrease was attributable to medical and surgical treatments. However, about 58% (36,000 deaths) of the decline in mortality was attributable to the change in risk factors, with the largest proportion coming from a fall in smoking prevalence (Unal et al., 2004). Although this model has limitations, as it combines trial and epidemiological data, it does indicate the magnitude of health gain associated with reducing smoking prevalence.
Figure 1: Contribution of treatments and reduction in risk factors to the decline in CHD mortality in England and Wales between 1981 and 2000

<table>
<thead>
<tr>
<th>Risk Factors worse +13%</th>
<th>Risk Factors better -71%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity (Increase)+3.5</td>
<td>Smoking -41%</td>
</tr>
<tr>
<td>Diabetes (increase)+4.8%</td>
<td>Cholesterol -9%</td>
</tr>
<tr>
<td>Physical activity (less)+4.4%</td>
<td>Population BP fall -9%</td>
</tr>
<tr>
<td></td>
<td>Deprivation -3%</td>
</tr>
<tr>
<td></td>
<td>Other factors -8%</td>
</tr>
<tr>
<td>Treatments -42%</td>
<td>AMI treatments -8%</td>
</tr>
<tr>
<td></td>
<td>Secondary prevention -11%</td>
</tr>
<tr>
<td></td>
<td>Heart failure -12%</td>
</tr>
<tr>
<td>Angina: CABG &amp; PTCA -4%</td>
<td>Angina: Aspirin etc. -5%</td>
</tr>
<tr>
<td></td>
<td>Hypertension therapies -3%</td>
</tr>
</tbody>
</table>


2.1 Mortality
In people aged 35 and over, smoking causes nearly one in five of all deaths. Around one third of the inequality in mortality between the most and least deprived areas is due to smoking. In Wales, around 5,450 deaths per year in people aged 30 and over are attributable to smoking. Around 46 per cent of these deaths were caused by cancer, 27 per cent were due to respiratory disease and 26 per cent were caused by circulatory disease (Public Health Wales Observatory, 2010). Of all deaths from lung cancer and chronic obstructive pulmonary disease (COPD), around 80 per cent were considered attributable to smoking.
Figure 2: Breakdown of deaths attributable to smoke for selected cause, persons aged 35 and over, Wales, 2010.

Source: Public Health Wales Observatory using Annual District Deaths Extract (ONS); smoking attributable fractions published by NHS Information Centre

2.2 Hospital admissions

Smoking accounts for around 5 per cent of all admissions to hospital in people aged 35 and over. When considering the most deprived areas, the number of attributable admissions increases to 8 per cent in males and 5 per cent in females. This is likely to be a result of the increased prevalence of smoking in more deprived areas (Public Health Wales Observatory, 2010). Two thirds of all admissions caused by smoking in 2010 were the result of circulatory and respiratory diseases, with the remainder mainly due to cancers.
2.8 **Elective surgery**

Smoking substantially increases the risk of poor outcomes after surgery. There is strong evidence (Furlong, 2005; Thomsen et al, 2008) that after surgery smokers are more likely than ex-smoker or non smokers to:

- have lung, heart and infectious complications
- have reduced bone fusion after fracture and impaired wound healing
- be admitted to an intensive care unit
- have longer length of stay in hospital
- have an increased risk of dying in hospital.

A report by the London Health Observatory (Furlong, 2005) estimated that if patients admitted for elective surgery in Wales, were to stop smoking at least eight weeks prior to their operation, up to 1,500 fewer post-operative complications would be avoided each year. This equates to a minimum of 700 and maximum of 7,000 bed days.
The table in Appendix C shows that the estimated number of bed days that could be saved in ABUHB is between 688 and 1,434 per year. In terms of saving to the Health Board this is a minimum of £46k to a maximum possible saving of £493k per year. It is important to note that these costs are for beds and do not include treatment costs.

### 2.4 Maternal and child health outcomes

The risks of smoking during pregnancy include substantially higher risk of miscarriage, and complications in pregnancy and labour. Smoking in pregnancy increases risk of preterm and low birth weight babies. Babies are born on average 200-250g lighter, and the more cigarettes smoked the greater the reduction in birth weight. Smoking during pregnancy increases the risk of infant mortality by an estimated 40 per cent. Low birth weight has also been associated with coronary heart disease, type 2 diabetes, and being overweight in adulthood. Babies born to mothers who smoke are more likely to develop middle ear infections, respiratory infections and asthma. Passive smoking during pregnancy can reduce foetal growth and increase the risk of preterm birth and second hand affects severity of childhood illnesses (British Medical Association, 2004).

A report by the Public Health Research Consortium (2010) suggests smoking in pregnancy costs NHS Wales between £352,000 and £2,816,000 per year prior to birth and a further £528,000 to £1,034,000 in the first year of life. It has been estimated that around 570 childhood hospital admissions in Wales were attributable to second-hand smoke exposure, with the majority due to lower respiratory infections.

### 2.5 Illicit tobacco

Illicit tobacco products can pose a particular problem by undermining the effectiveness of high prices, as they are often supplied at prices much lower than those of genuine tobacco products (for example, less than £3 per pack of 20 cigarettes). This increases affordability for young people who are particularly sensitive to price, as well as effectively removing the price incentive to quit smoking, especially in the most deprived communities. Counterfeit tobacco is part of the illicit trade (alongside smuggled products and bootlegging) and refers to the illegal manufacture of tobacco products. Typically, the tobacco products are made from inferior materials with the final product made to look genuine.

### 3. Patterns of smoking

The pattern of smoking in Aneurin Bevan University Health Board (ABUHB) varies according to geographical area, age, gender and other demographic factors.
3.1 Geographical area

The Welsh Health Survey suggests that around 24 per cent of adults are currently smokers. However, smoking prevalence in ABUHB varies considerably from 28 per cent in Blaenau Gwent to 18 per cent in Monmouthshire. This represents the highest and lowest levels of smoking at local authority. Analysis of smoking prevalence by Upper Super Output Area shows that the highest level are in the South Wales valleys areas of Blaenau Gwent, North Caerphilly and inner-city Newport.
Figure 4: Percentage of the adult population who report currently smoking, age standardises, persons, age 16+, Welsh local authorities, 2010-11

95% confidence interval

<table>
<thead>
<tr>
<th>Authority</th>
<th>% Currently Smoking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isle of Anglesey</td>
<td>25</td>
</tr>
<tr>
<td>Gwynedd</td>
<td>21</td>
</tr>
<tr>
<td>Conwy</td>
<td>22</td>
</tr>
<tr>
<td>Denbighshire</td>
<td>23</td>
</tr>
<tr>
<td>Flintshire</td>
<td>21</td>
</tr>
<tr>
<td>Wrexham</td>
<td>25</td>
</tr>
<tr>
<td>Powys</td>
<td>21</td>
</tr>
<tr>
<td>Ceredigion</td>
<td>22</td>
</tr>
<tr>
<td>Pembrokeshire</td>
<td>24</td>
</tr>
<tr>
<td>Carmarthenshire</td>
<td>21</td>
</tr>
<tr>
<td>Swansea</td>
<td>23</td>
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<tr>
<td>Neath Port Talbot</td>
<td>25</td>
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<tr>
<td>Bridgend</td>
<td>23</td>
</tr>
<tr>
<td>The Vale of Glamorgan</td>
<td>21</td>
</tr>
<tr>
<td>Cardiff</td>
<td>21</td>
</tr>
<tr>
<td>Rhondda Cynon Taf</td>
<td>26</td>
</tr>
<tr>
<td>Merthyr Tydfil</td>
<td>24</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>23</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>28</td>
</tr>
<tr>
<td>Torfaen</td>
<td>26</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>18</td>
</tr>
<tr>
<td>Newport</td>
<td>24</td>
</tr>
</tbody>
</table>

Source: Public Health Wales Observatory using Welsh Health Survey

Figure 5: Percentage of the adult population who report currently smoking, age standardises, persons, age 16+, Upper Super Output Areas (USOAs)

Source: Public Health Wales Observatory using Welsh Health Survey
3.2 Age and gender

Most age groups have seen a slight decline in smoking rates since 2003/04, although most of the decreases are not statistically significant (see figure 6, below). The rates of male smokers aged 25-34 and 35-44 in 2010 remain at similar levels to 2003/04, however, female smoking rates have decreased for these age groups. The rates of male smokers aged 45-54 and 75+ have decreased since 2003/04, but there has been little change in those aged 65-74. It can be seen that the prevalence of smoking decreases with age.

**Figure 6: Percentage of adults who report smoking daily or occasionally, Wales, by age and gender, 2003/04 and 2010**

Source: Public Health Wales Observatory using Welsh Health Survey data.

3.3 Deprivation and socio-economic classification

Further analysis of smoking prevalence by deprivation fifths shows that rates in the most deprived areas is around 35 per cent and is more than twice as high as the least deprived. An analysis of smoking prevalence according National Statistics Socio-economic Classification shows that around 45 per cent of those that have never worked or are long-term unemployed report smoking daily or occasionally, compared to around 15 per cent in managerial or professional occupations. Furthermore, the gap in smoking prevalence between these socio-economic classifications appears to have widened between 2003/04 and 2010.

3.4 Minority ethnic groups

In minority ethnic groups, different tobacco products are used more commonly than in the general population (Millward & Karlsen, 2010). Smokeless tobacco comes in a variety of forms, including chewing tobacco, which a survey found to be particularly common in Bangladeshi women (NHS Information Centre, 2005). The packaging of these alternative forms of tobacco is less likely to have appropriate health
warnings and their use is embedded in South Asian culture, which presents considerable challenges to cessation services.

The smoking of waterpipes (also known as shisha), which originated in the Middle East and parts of Asia and Africa, is becoming more popular in Europe and can give a misleading impression of being a “safe” alternative to cigarettes since the smoke passes through water first (ASH, 2010). According to the British Heart Foundation, a single puff of shisha is equivalent to inhaling the smoke from a whole cigarette (British Heart Foundation, 2012).

### 3.5 Mental health

People with mental health problems are more likely to smoke, and also to smoke more heavily, than the general population (McManus S et al., 2010). The reasons for higher rates of smoking in this population group are complex. It may be that increased socio-economic deprivation acts as a confounding factor, contributing to increased prevalence of both mental illness and smoking. Each factor is considerably more common in the most deprived areas of Wales than in the least deprived (Welsh Government, 2011). Life expectancy in people with schizophrenia is thought to be 20 per cent lower than the general population, a difference which has been partly attributed to high rates of smoking (Faculty of Public Health, 2008). The prevalence of smoking is thought to be as high as 70 per cent amongst inpatients in mental health units (Brown et al., 2000). This places an imperative on health services to ensure that both physical and mental health needs are considered (Jochelson & Majrowski, 2006).

### 4. Effective action

A multifaceted approach is needed to prevent smoking uptake, support smoking cessation and reduce environmental exposure to second-hand smoke. In terms of smoking cessation there is a need for all professionals to make every contact count either through brief advice or structured brief intervention. This must be supported by effective prescribing of pharmacological aids and access to smoking cessation services.

The table below summarises the evidence of effectiveness for smoking cessation interventions that can be systematically delivered through services. The most effective intervention (using smoking abstinence at 6 months or more as the outcome indicator) is a combination of physician advice, NRT (or prescription only medicines such as Varenicline) and behavioural support through smoking cessation services.
### Figure 7: Efficacy of smoking cessation interventions

<table>
<thead>
<tr>
<th>Level of intervention</th>
<th>% abstinent at 6 months or longer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Willpower alone</td>
<td>3%</td>
</tr>
<tr>
<td>Willpower plus: Self-help materials</td>
<td>4%</td>
</tr>
<tr>
<td>Willpower plus: Brief advice from Physician</td>
<td>5%</td>
</tr>
<tr>
<td>Willpower plus: NRT</td>
<td>6%</td>
</tr>
<tr>
<td>Smoking cessation clinic</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Smoking cessation clinic plus NRT</strong></td>
<td><strong>20%</strong></td>
</tr>
</tbody>
</table>


NICE have published guidance on smoking cessation services in primary care, pharmacies, local authorities and workplaces, particularly for manual working groups, pregnant women and hard to reach communities (NICE, 2008). They have also published separate guidance on brief interventions and referral for smoking cessation in primary care and other settings (NICE, 2006) and smoking cessation in acute, maternity and mental health services (NICE, 2013). In terms of pharmacotherapy, NICE have also produced a technology appraisal on Varenicline for smoking cessation (NICE, 2007). The recommendations and standards set out in these documents should be considered when commissioning smoking cessation services to meet the needs of the local population.

### 5. Current position

Stop Smoking Wales are currently the main provider of smoking cessation services in ABUHB. However, there are also services provided in Community Pharmacies and a service for reparatory patients receiving care at Nevill Hall Hospital.

#### 5.1 Stop Smoking Wales

Stop Smoking Wales are the main provider of smoking cessation services in the ABUHB area. The service provides an initial assessment session followed by 6 weekly treatment sessions. Stop Smoking Wales offer clinics in all localities (Appendix D), but the availability of these sessions is not always convenient and provision is often limited in rural areas. In 2012/13, Stop Smoking Wales treated 1,075 smokers, which was 4,299 fewer than the Tier 1 target of 5,374 smokers (see figure 8 and 9, below).
Figure 8: Number and percentage of smokers treated by Stop Smoking Wales, but local authority area

Number and percentage of smokers treated by Stop Smoking Wales, Wales and local authorities, financial year 2012-13

<table>
<thead>
<tr>
<th>Local authority</th>
<th>Smoking prevalence</th>
<th>Estimated population aged 16+</th>
<th>Estimated number of smokers</th>
<th>If 5% treated</th>
<th>Actual number treated</th>
<th>% treated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isle of Anglesey</td>
<td>24</td>
<td>58,036</td>
<td>13,814</td>
<td>691</td>
<td>85</td>
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<tr>
<td>Gwynedd</td>
<td>21</td>
<td>101,064</td>
<td>21,641</td>
<td>1,082</td>
<td>56</td>
<td>0.3</td>
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<td>Conwy</td>
<td>24</td>
<td>96,446</td>
<td>23,169</td>
<td>1,158</td>
<td>241</td>
<td>1.0</td>
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<tr>
<td>Denbighshire</td>
<td>21</td>
<td>77,137</td>
<td>16,566</td>
<td>828</td>
<td>183</td>
<td>1.1</td>
</tr>
<tr>
<td>Flintshire</td>
<td>22</td>
<td>124,261</td>
<td>26,858</td>
<td>1,343</td>
<td>493</td>
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<tr>
<td>Wrexham</td>
<td>24</td>
<td>109,806</td>
<td>26,161</td>
<td>1,308</td>
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<tr>
<td>Powys</td>
<td>20</td>
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<td>Ceredigion</td>
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<td>Swansea</td>
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<td>2,388</td>
<td>949</td>
<td>2.0</td>
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<tr>
<td>Neath Port Talbot</td>
<td>24</td>
<td>115,476</td>
<td>27,268</td>
<td>1,363</td>
<td>624</td>
<td>2.3</td>
</tr>
<tr>
<td>Bridgend</td>
<td>23</td>
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<td>26,126</td>
<td>1,306</td>
<td>344</td>
<td>1.3</td>
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<tr>
<td>The Vale of Glamorgan</td>
<td>20</td>
<td>103,017</td>
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<td>Cardiff</td>
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<td>Blaenau Gwent</td>
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<td>791</td>
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<td>1.4</td>
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<td>Torfaen</td>
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<td>941</td>
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<td>254</td>
<td>0.9</td>
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<tr>
<td>Wales</td>
<td>23</td>
<td>2,517,515</td>
<td>569,457</td>
<td>28,473</td>
<td>6,299</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Produced by Public Health Wales Observatory, using Stop Smoking Wales data, Mid-year estimates (ONS), Welsh Health Survey (WG)

Source: Public Health Wales Observatory using Stop Smoking Wales data, Mid-year population estimates and Welsh Health Survey.

The chart below (figure 9) shows that the percentage of treated smokers ranged from 1.4 per cent in Blaenau Gwent to 0.8 per cent in Caerphilly.
Figure 9: Chart showing percentage of treated smokers against the Tier 1 target recommended by NICE

Estimated percentage of smokers treated by Stop Smoking Wales, Wales and local authorities, financial year 2012-13
Produced by Public Health Wales Observatory using Stop Smoking Wales data, Mid-year estimates (ONS), Welsh Health Survey (WG)

Source: Public Health Wales Observatory using Stop Smoking Wales data, Mid-year population estimates and Welsh Health Survey.

Stop Smoking Wales have recently reviewed their service capacity and estimated a shortfall against the Tier 1 target. In order to reach the target of 5 per cent treated smokers there is currently a capacity gap within ABUHB of 38 per cent or 2,100 smokers per year. It is important to note that this estimate is based on unpublished figures from Stop Smoking Wales and existing capacity levels during 2012/13.
Figure 10: Current capacity with Stop Smoking Wales and estimated shortfall against the Tier 1 target

<table>
<thead>
<tr>
<th>LOCALITY</th>
<th>5% Target</th>
<th>Current Capacity</th>
<th>Current Shortfall (A)</th>
<th>2012/13 Treated smokers (B)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blaenau Gwent</td>
<td>798</td>
<td>714</td>
<td>84</td>
<td>223</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>1697</td>
<td>1008</td>
<td>689</td>
<td>272</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>665</td>
<td>448</td>
<td>217</td>
<td>120</td>
</tr>
<tr>
<td>Newport</td>
<td>1403</td>
<td>777</td>
<td>626</td>
<td>253</td>
</tr>
<tr>
<td>Torfaen</td>
<td>995</td>
<td>511</td>
<td>484</td>
<td>219</td>
</tr>
<tr>
<td>ABHB</td>
<td>5557*(1)</td>
<td>3458(62%)</td>
<td>2100 (38%)</td>
<td>1087</td>
</tr>
</tbody>
</table>

Capacity figures are based on running 7 sets of sessions/clinics per venue per year i.e. assuming that cover for absence is always available.

(A) the total 5% target and shortfall figures are not solely owned by SSW.

(B) 2012/13 treated figures are calculated based on the % of smokers treated by SSW in relation to smoking population by area (taken from the SSW draft 2012/13 Annual Report) applied to the current 5% target figures.

5.2 Community Pharmacy

Community pharmacies are the most widely accessed health outlets in Wales, with approximately 36,000 visits per day. Pharmacy services are available at times when other primary care services are not, including evenings and weekends. Pharmacy staff routinely have contact with people who are in good health, as well as those who are visiting a pharmacy due to illness. They are accessible to young people and those who may be less likely to attend more formal healthcare settings. Community pharmacies can offer three levels of smoking cessation service.

Level 1: This level of the service is covered by the Essential Service ‘Promotion of healthy lifestyles (Public Health) ES4’ element of the Community Pharmacy Contractual Framework. This provision of opportunistic, prescription-linked advice is for patients presenting prescriptions at the pharmacy. This service is provided by every community pharmacy in Wales for patients presenting prescriptions for dispensing. It includes those with diabetes, those at risk of coronary heart disease, especially patients with high blood pressure, those who smoke and those who are overweight or obese. Community pharmacies also participate in public health campaigns organised by the Health Boards in Wales, such as No Smoking Day. In addition, this level of
service covers the supply of smoking cessation leaflets, referral to other sources of support and over-the-counter sales of NRT and appropriate advice to clients wishing to purchase these products.

**Level 2:** Pharmacies (accredited pharmacists/pharmacy technicians) will undertake a supply and support role for clients who are receiving intensive behavioural support and advice from Stop Smoking Wales. This service is designed to improve access to NRT and professional advice by linking community pharmacies with intensive behavioural support service. Under this arrangement the community pharmacist will consider supplying NRT to smokers directly, whilst they are receiving intensive behavioural support from Stop Smoking Wales. This advantage of this service is that it simplifies access to NRT therapy and reduces unnecessary appointments in GP practices. There are currently 23 pharmacies participating in the Level 2 scheme.

**Level 3:** Pharmacies (accredited pharmacists) will provide one-to-one assessment of clients’ needs; initiate, supply and monitor the use of appropriate nicotine replacement therapy and provide motivational support each time nicotine replacement therapy is supplied to a client. This is the pharmacy led provision of both the motivational support for quitting, and NRT when appropriate as part of a complete support service.

In addition, a Varenicline Support function can be added which supports and motivates patients taking Varenicline to quit smoking. This has been expanded in some areas to include a Patient Group Directive (PGD) which enables community pharmacists to supply Varenicline directly to clients without the need for a prescription. Varenicline has shown to be as effective as dual NRT approach and has been successfully supplied through a PGD. This should be further developed as the service progresses improving the access to NICE approved therapy in a controlled manner.

**5.3 Hospital Service**

Currently, there is no dedicated hospital based inpatient service within ABUHB. However, smoking cessation support is offered at Nevill Hall Hospital for patients receiving care within the Respiratory Directorate. This is delivered by a very experienced and committed Respiratory Nurse Specialist, which provides the foundation for a wider service.

**5.4 Maternity Service**

The Models for Advice to Maternal Smoking Cessation Support (MAMSS) project is working with partners from Public Health Wales, Cardiff University and 3 other health boards to evaluate the pilot. ABUHB is implementing a pilot project in the Torfaen locality to increase the number
of pregnant women who smoke to engage with smoking cessation services and then to go on to quit. A dedicated Stop Smoking Wales specialist pregnancy advisor has been employed, until March 2014, to work more flexibly with pregnant women to offer intensive interventions at times/settings of women’s choice. The project has won an award under the at ASH Wales’ annual Excellence in Tobacco Control Awards.

6. Proposal

This section sets out a proposal for improving access to smoking cessation services by creating a network of providers all subject to availability of funding. It recommends expanding the Community Pharmacy (Level 3) Enhanced Service pilots and an expansion of the Community Pharmacy (Level 2) Scheme across the ABUHB area (see Appendix E). It also recommends that a dedicated Hospital Based Smoking Cessation Service around the successful model developed within the Respiratory Directorate in Unscheduled Care. Finally it proposed continuation of a dedicated service for pregnant women, building on the award winning MAMSS pilot in Torfaen.

6.1 Community pharmacy

Community pharmacists trained in behaviour change methods are effective at helping clients to stop smoking. Abstinence rates from one-to-one services are similar to those of primary care nurses (Department of Health, 2008; Boyd & Briggs, 2008). Whilst there is evidence to support the suggestion that group behavioural support from specialist smoking cessation advisors may result in a higher abstinence rates than one-to-one counselling, it is argued that absolute numbers of quitters may increase due to the ease of access (Tyler, 2009). Indeed there is evidence to suggest that as many quitters access support for quit attempt through non-formal methods such as over-the-counter or prescription only interventions, as those who access formal smoking cessation services (West, 2006). Therefore, community pharmacy is in unique position to compliment current services by engaging patients that do not currently access Stop Smoking Wales.

This paper recommends the expansion of the Pharmacy (Level 3) Locally Enhanced Service, commissioned strategically in areas of defined need. The following section outlines the payment schedule and costs associated with the proposal, based on an equivalent scheme in Powys.
(a) Payments based on Powys service specification:

**Level 3 NRT Service fees:**

<table>
<thead>
<tr>
<th>Total cost per patient</th>
<th>£47.50</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment per client initiated in the program</td>
<td>£15</td>
</tr>
<tr>
<td>Level 3 NRT follow up, weeks 2, 3, 4</td>
<td>£5</td>
</tr>
<tr>
<td>Level 3 NRT further follow up, weeks 5, 7, 9, 11, 12</td>
<td>£3.50</td>
</tr>
</tbody>
</table>

**Level 3 Varenicline Support Service Fees**

<table>
<thead>
<tr>
<th>Total Cost per patient</th>
<th>£31.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment per client initiated in the program</td>
<td>£10</td>
</tr>
<tr>
<td>Level 3 Varenicline follow up, weeks 3, 5, 7, 9, 11, 12</td>
<td>£3.50</td>
</tr>
</tbody>
</table>

(b) Future development with the addition of PGD for smoking aids in line with NICE guidance PH10, fees would need to be agreed with Community Pharmacy Wales.

**Level 3 Varenicline PGD Service fees**

<table>
<thead>
<tr>
<th>Total cost per patient</th>
<th>£41.00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment per client initiated in the program Initial consultation/supply</td>
<td>£20</td>
</tr>
<tr>
<td>Level 3 Varenicline follow up, weeks 3, 5, 7, 9, 11, 12</td>
<td>£3.50</td>
</tr>
</tbody>
</table>

NB. All smoking cessation product costs to be reimbursed monthly by submission of claim form.

The cost of the proposal is based on the estimated number of clients that would need to be treated, in addition to current service levels, to reach the Tier 1 target of 5 per cent treated smokers per year. Based on the current capacity within Stop Smoking Wales (see section 4.1) this represents 2,100 smokers each year.

Using the average prices of the Powys scheme (this takes into account patients with failed quit attempt that did not attend all follow up appointments), in which 275 patients accessed the service. The total professional fees were £10,158 and the total NRT costs were £33,373. Based on this data it is possible to calculate the estimate cost per patient for professional fees and NRT.
Average cost professional fee per client 10,158/275 £37

Cost of NRT per client 33,373/275 £121

Therefore the total costs for 2,100 clients per annum:

Total cost for professional fees 2100 x £37 £77,700
NRT costs 2100 x £121 £254,100

Total £331,800

This scheme will be introduced over a 2 year period with a further 25 pharmacies providing this enhanced service in year 1 and 20 pharmacies in year 2.

It is difficult to assess what proportion of these costs would be additional to projected use of NRT products across ABUHB. It is likely that this scheme will, in fact, reduce wastage in prescribing of NRT and Varenicline by identifying non-adherence early in therapy and dispensing smaller durations of supply. The Health Board currently spends £450k per annum on NRT prescribing. Therefore is potentially a reduction in wastage in NRT prescribing may offset the professional fees (£77,700) whilst ensuring patients receive behavioural support and advice on the effective use of pharmacotherapy.

6.2 Hospital Service

In March 2012, the Health Board introduced a Smoke Free Environment Policy at all sites which prohibits smoking on hospital grounds. Although the policy has generally been accepted, particularly in at Ysbyty Aneurin Bevan and Ysbyty Ystrad Fawr, there are still concerns about patients that continue to smoke on hospital grounds. In response to this, two part-time Smoke Free Environment Officer posts are being appointed to promote a culture of no smoking within hospital. Part of the role will be to provide brief advice and information resources about coping with nicotine withdrawal and liaise with nursing and medical staff on the wards to ensure appropriate prescribing of NRT. However, withdrawal from nicotine needs to be recognised and treated appropriately. It will often be the ward nurses who are relied on to recognise the symptoms and may be asked to instigate therapy without the patient being seen by specialist services and assessed more fully.
Within ABUHB, patients that intend to make a quit attempt in hospital, are only able to access specialist support on discharge. Patients admitted to hospital with an acute exacerbation of a chronic condition should have access to a specialist inpatient service. This is particularly important if they are admitted due to a smoking-related condition such as chronic obstructive pulmonary disease, ischaemic heart disease or a stroke. Hospital-based smoking cessation services can provide support during the inpatient stay and liaise with the appropriate community service to provide ongoing support and treatment after discharge. Patients may prefer to continue to use the hospital service as out-patients or via telephone support. A dedicated hospital service will know how this is going to work prior to discharge, which is important, as patients are more likely to relapse after discharge from hospital. Hospital based services can also see patients prior to elective surgery, and those attending outpatient clinics such as respiratory and cardiac rehabilitation.

Costs for a dedicated hospital based smoking cessation service with ABUHB:

- Hospital smoking cessation advisor (1.2 WTE) £36k
- Admin and clerical support (0.2 WTE) £2k
- Non staffing costs and equipment £2k
- Training costs £1k

**Total costs** £41k

The service model will be introduced over 2 years and will be built around the in-house service provided by the Respiratory Nurse Specialist in Nevill Hall Hospital.

This proposal is linked to the part-time Smoke Free Environment Officer posts. The postholders will work synergistically by engaging patients that are found smoking on the grounds and referring them to the specialist inpatient support. The hospital service may also be possible to provide opportunistic and low intensity support to ABUHB staff through links with the Employee Well-Being Service.

### 6.3 Maternity Service

There is good evidence to support interventions to promote smoking cessation in pregnancy. The evidence shows that pregnant women require intensive and ongoing support to stop smoking throughout pregnancy from specialist NHS service.
This paper recommends the continuation of the dedicated smoking cessation advisor for pregnant women and the roll-out of this service across ABHB. The following section outlines the costs associated with this, based on the costs for the MAMSS pilot project (see below).

Costs for a dedicated smoking cessation service for pregnant women within ABUHB:

- Smoking cessation pregnancy advisor (2.0 WTE) £51k
- Non staffing costs and equipment £4k
- Training costs £1k

**Total costs** £56k

This universal service for pregnant women will build on the evaluation of the MAMSS pilot. Funding to sustain the existing service will be required in year 1 and expanded across Aneurin Bevan University Health Board in year 2.

The Public Health Division has provided all community midwives with Carbon Monoxide (CO) monitors for use at booking appointments and antenatal clinics. Community midwifery teams have also received brief intervention training through Stop Smoking Wales.

### 7.0 Lessons learnt from other Health Boards in Wales

There are number of models of service delivery from other Health Boards in Wales, which help to make the case for smoking cessation investment in Community Pharmacy, Maternity and Hospital settings.

#### 7.1 Community Pharmacy

Abertawe Bro Morgannwg University Health Board has a well established Pharmacy (Level 2) Scheme. An evaluation report (Harris, 2010) of the scheme operating in Swansea since December 2007, showed:

- 80 per cent year-on-year increase (1,824 compared with 1,012) in the number of smokers who contacted the service compared to the year before the scheme commenced. A significant increase (2,390 compared with 1,012) in the number of smokers who contacted the service in the second year of operation compared to the year before the scheme commenced.

- 29 per cent decrease in the total amount spent on all smoking cessation pharmacological aids in Swansea by the Health Board over the first year of the pharmacy level two scheme, compared to
the same period the previous year; giving a saving of approximately £90,000

- 11 per cent reduction in the total amount spent on all smoking cessation pharmacological aids in Swansea by the Health Board over the second year of the pharmacy level two scheme, compared to the 12 months prior to the pharmacy scheme commencing.

Cwm Taf, Powys and Betsi Cadwaladr University Health Boards have also invested in Pharmacy (Level 3) Locally Enhanced Services. Reports published on these pilot services showed they were well received by stakeholders and clients and achieved quit rate close to or within the threshold recommended by NICE.

The pilot enhanced pharmacy scheme in Merthyr Tydfil showed a 15 per cent decrease in expenditure on NRT and a lower cost per item of NRT. The authors of this report suggest that this is likely to be due to the enhanced service model which offers appointments at set intervals for regular reviews of quit status, motivation and NRT needs. Clients continuing with their quit attempt were provided with a maximum of 2 weeks supply of NRT at a time. NRT supply became more targeted to individual clients need in terms of dose, form, quantity and motivation to continue quit attempts. This removes much of the potential for waste.

The run charts (Figure 11, below) show the cumulative effect of investment in Pharmacy (Level 3) Locally Enhanced Services on treated smokers. However, it is important to note that these data refer to number of smokers making quit attempts and therefore may be counted more than once if they access more than one service in a year.
Figure 11: Comparison of progress against the Tier 1 target in Health Boards that have a well developed Pharmacy (Level 3) Locally Enhanced Service

Number of smokers recorded as treated by Stop Smoking Wales and Pharmacy Level 3 Services compared to the Tier 1 target, Cwm Taf Health Board (Oct 2012-May 2013)

Number of smokers recorded as treated by Stop Smoking Wales and Pharmacy Level 3 Services compared to the Tier 1 target, Betsi Cadwaladr University Health Board (2011/12 to 2012/13)
7.2 Hospital Service

There are two well established hospital based services in Hywel Dda and Cardiff & Vale Health Boards. A report on the early pilot scheme in Carmarthenshire NHS Trust indicated that patients who have started smoking cessation in hospital do well with secondary care support with up to 37 per cent quitting at 4 weeks. Information from the pilot study indicated that 60 per cent of smokers contacted the smoking cessation counsellors during their inpatient stay. This compares to just 5 per cent of inpatients who, prior to the pilot, contacted the community service as a result of being given a leaflet and contact details by medical and nursing staff on the wards. Prior to the pilot, a survey of 69 adults attending the Medical Admissions Unit, showed 62 per cent of smokers would like to have been offered NRT and 39 per cent would have liked counselling on smoking cessation during their hospital admission.

When patients were advised to contact the community service less than 1 in 4 of these actually did. A placebo arm of the study randomised some hospitalised smokers to just receive the NHS Quitline number as part of usual care (i.e. no hospital service). The study reported that only 7 per cent of these patients actually did so within 3 months. It is suggested that a continued program within an existing hospital based service may be a better alternative for some patients than follow up in the community. However, it is important that hospital based services are properly networked with community-based support through Stop Smoking Wales, Community Pharmacy and GP practices. Hospital based services should discuss with the patient the most appropriate setting for this support. Details of their quit attempt should also be included in the discharge notification.

7.3 Maternity Service

As part of the Early Years Pathfinder programme, Public Health Wales have set up the Models for Access for Maternal Smoking Cessation (MAMSS) project. This project has funded four pilots in Wales to evaluate the extent to which improvements in the delivery of smoking cessation services to pregnant women can increase the proportion of (pregnant) treated smokers and reduce the number of women smoking during pregnancy. The four pilots being rolled out are:

- **Betsi Cadwaladr University Health Board**: Maternity support workers in selected areas in North Wales will receive referrals directly from midwives and provide intensive
interventions at times/settings of women’s choice, including home visits.

- **Cwm Taf Health Board**: Maternity support workers in the selected areas will receive referrals directly from midwives and provide intensive interventions at times/settings of women’s choice, including home visits.

- **Aneurin Bevan Health Board**: A dedicated Stop Smoking Wales specialist pregnancy advisor will be employed to work more flexibly with pregnant women to offer intensive interventions at times/settings of women’s choice.

- **Abertawe Bro Morgannwg University Health Board**: Two qualified midwives will receive referrals directly from midwife colleagues in selected areas and provide intensive interventions at times/ settings of women’s choice, including home visits.

### 8. Conclusion

The evidence base and benefits associated with smoking cessation are unequivocal. It is also clear from the data that greater investment in smoking cessation services is needed to achieve the Tier 1 target recommended by NICE. The target is that smoking cessation services should aim to treat 5 per cent of the smoking population each year and achieve a success rate of at least 35 per cent at 4 weeks, validated by carbon monoxide monitoring.

Community pharmacy and hospitals are ideally placed to contribute to this target, as they are frequently in contact with patients who smoke. It is also possible to construct these services to capitalise on “teachable moments” across the care pathway. Building a network of services in this way will ensure patients receive smoking cessation support in the most appropriate setting. This system of delivery will increase the scale of smoking cessation interventions and provide greater choice for patients making a quit attempt. The impact will be monitored in terms of the proportion of the smoking population accessing smoking cessation services each year and 4-week validated quit rates. There is also the potential to model the service impact associated with a reduction in smoking prevalence among specific groups such as patients referred elective surgery and pregnant women.

This proposal is additional to the Inverse Care Law programme which has identified smoking cessation as a priority to reduce premature mortality in deprived communities. The Inverse Care
Law programme requires support from a wider range of partners such as Communities First, Housing Association and other third sector organisations to engage the ‘seldom seen, seldom heard’ in targeted areas. Achieving a step change in smoking cessation in these communities will be achieved through new models of primary care delivery and will include, for example, vascular risk screening, an expanded the role for health care assistants, health trainers and community health champions.

8. Recommendation

The Board are asked to:

- Acknowledge the health gain associated with smoking cessation and potential cost savings due to reduced admissions and better patient outcomes.

- Approve the principle of extending Community Pharmacy Enhanced Services across ABUHB. This will be subject to resources being identified through the Annual Plan and will be phased over two years. This scheme will also require further professional engagement and the development of a costed pathway for NRT prescribing.

- Agree a Hospital Smoking Cessation Service, particularly for inpatients at the Royal Gwent Hospital and Nevill Hall Hospital.

- Agree a dedicated service for pregnant women in line with the evaluation of the MAMSS pilot.

- Note learning from the models of smoking cessation delivery in other Health Boards.

- Recognise the need for a step change in smoking cessation and alignment to communities targeted by the Inverse Care Law programme.
Report prepared by: Will Beer, Principal Health Promotion Specialist, Public Health Division

Mererid Bowley, Consultant in Public Health, Public Health Division

Mike Curson, Senior Primary Care Pharmacist, Primary Care & Networks Division

Dr Matt Jones, Consultant Chest Physician, Unscheduled Care Division

Deb Jackson, Head of Midwifery, Family and Therapies Division.

Report sponsored by: Dr Gill Richardson, Director of Public Health, Consultant in Public Health Medicine

Date: December 2013
References


cco-use-among-minority-ethnic-populations-and-cessation-interventions


Appendix A - Smoking Prevention

In addition to smoking cessation, the Public Health Strategic Framework sets out evidence based action to prevent smoking uptake. This includes support for local implementation of national programmes such as ASSIST, Fresh Start Wales and the ASH Wales Filter.

Blaenau Gwent

Blaenau Gwent has previously received British Heart Foundation (BHF) funding for a Hearty Lives Project which focussed on:

- Quality standards for smoking education in schools
- Youth advocacy
- Smoke free homes and cars
- Community mobilisation
- Regulatory action

The BHF recognise that resources developed with project funding could be used in other localities. The Health Board has received a Trade Mark Licence Agreement which would allow the branding and resources to be re-produced in other areas. This would be subject to certain conditions being met in relation to branding and acknowledgement of previous BHF involvement.

Caerphilly

Caerphilly Wellbeing Network has identified a number of areas for action over the next three years:

- Ensure all schools receive and implement NICE guideline on smoking prevention
- Develop a framework for schools to adopt “whole school policies” linked the PSE curriculum and Health Schools
- Engage with the national ASSIST programme to ensure selected schools are recruited
- Support for the Fresh Start campaign on smoking in home and cars
- Create smoke-free environments e.g. local authority and NHS premises and playgrounds
The implementation of this plan is being supported by local authority partners such as Healthy Schools and Environmental Health, Communities First, Health Challenge Caerphilly and Gwent Association of Voluntary Organisations.

**Torfaen**

Torfaen have implemented a number initiatives on smoking cessation, but have been unable to progress work on smoking prevention in schools due to the Healthy Schools Officer post being vacant. However, the Single Integrated Plan ‘Torfaen Together’ identifies a number of key indicators (e.g. low birth weight) that indicate the need for more action on tobacco control, which would include action prevent smoking uptake.

**Newport**

Newport Health Partnership has set up a Tobacco Control Project which has identified the following actions for the next three years

- Support the implementation of smoking interventions to prevent the uptake of smoking amongst children and young people, through schools and youth support services
- Support the introduction of smoke-free environments including playgrounds and other settings used by young people

As part of this project Newport Health Partnership will be ensuring the ASSIST peer education programme is integrated with the smoke-free projects in targeted schools. There will also be links to wider tobacco control action, particularly point-of-sale measures to prevent under age sales around targeted schools. Health Challenge Newport will promote smoke-free messages and increase awareness of these initiatives both with the public and stakeholders.

**Monmouthshire**

Monmouthshire has supported locality work on smoking cessation through the NCNs, but have not explicitly identified smoking prevention as priority under the Single Integrated Plan. However,
there is scope for further partnership working on smoking prevention linked to national initiatives such as No Smoking Day.
### Appendix B – Health and financial costs of smoking

#### Health Impact

**Preventable ill health and mortality**

Smoking is the largest single cause of avoidable ill health and early death in Wales. Smoking is associated with more than 50 different diseases and disorders and a major cause of health inequalities; it accounts for more than half of the difference in risk of premature deaths between social classes (Dolman, et al., 2007)

In the United Kingdom, in 2000, smoking caused (Peto et al., 2006)

- 29% of all cancer deaths
- 86% of lung cancer deaths
- 13% of cardiovascular deaths
- 30% of respiratory deaths
- 19% of all total deaths.

In Wales during 2010, smoking causes 5,450 death

- 2480 due to malignant cancers
- 1470 due to respiratory disease
- 1420 due to circulatory disease

#### Surgical outcomes

Smoking substantially increases the risk of poor outcomes after surgery. There is strong evidence\(^5\) that after surgery,  

#### NHS and Economic Impact

**Financial costs to NHS Wales**

There is a significant burden of illness due to smoking which has major costs for the NHS in Wales. A study undertaken by Swansea University reported that treating smoking related diseases cost the NHS in Wales:

- 7% of total healthcare expenditure in 2007/08
- equivalent to £129 per head of population
- an estimated £386 million annually; more than £7 million each week and over £1 million a day.

Secondary care accounted for 67% of the total cost and primary care 33%. In terms of breakdown, smoking accounted overall for an estimated:

- 22% (> £235 million) of adult hospital admission costs
- 6% (> £21 million) of outpatients costs
- 13% (> £43 million) of GP consultations
- 12% (> £6 million) of practice nurse consultation costs
- 14% (>79 million) of prescribing costs.

(Phillips & Bloodworth, 2009)

A technical report by the London Health Observatory,
compared with ex-smokers and non-smokers, smokers are more likely to:

- have lung, heart and infectious complications
- have reduced bone fusion after fracture and impaired wound healing
- be admitted to an intensive care unit
- have longer length of stay in hospital
- have an increased risk of dying in hospital.

### Maternal and child health

In 2005, an estimated 22% of mothers smoked throughout their pregnancy. The risks of smoking in pregnancy include substantially higher risk of miscarriage, and complications in pregnancy and labour. Smoking in pregnancy increases risk of preterm and low birth weight babies. Babies are born on average 200-250g lighter, and the more cigarettes smoked the greater the reduction in birth weight. Smoking during pregnancy increases the risk of infant mortality by an estimated 40%. Low birth weight has also been associated with coronary heart disease, type 2 diabetes, and being overweight in adulthood. Babies born to mothers who smoke are more likely to develop middle ear infections, respiratory infections and asthma (BMA, 2004).

Passive smoking during pregnancy can reduce foetal growth.

<table>
<thead>
<tr>
<th>Health Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>- have lung, heart and infectious complications</td>
</tr>
<tr>
<td>- have reduced bone fusion after fracture and impaired wound healing</td>
</tr>
<tr>
<td>- be admitted to an intensive care unit</td>
</tr>
<tr>
<td>- have longer length of stay in hospital</td>
</tr>
<tr>
<td>- have an increased risk of dying in hospital</td>
</tr>
</tbody>
</table>

A recent study by the Public Health Research Consortium (2010) estimates the economic costs to the NHS, in the UK, of smoking in pregnancy for pregnant women and infants during their first year following birth. This study was confined to NHS costs and did not consider the longer term costs to health and health related quality of life.

- The cost of smoking, to the NHS in the UK, during pregnancy was estimated to be in the range of £8 million - £64 million per year based on different costing methodologies. This relates to an increased risk of spontaneous abortion, ectopic pregnancy, placenta previa, abruptio placenta, preterm rupture of membranes, and increased risk of pre-eclampsia.

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*a* Figure of £337 was used in this report based on the average unit cost of a bed day in Wales in 2005/06 and does not include treatment costs.

*b* Costs were taken from the NHS Reference Cost schedules for 2005/06. The mean costs for elective and non-elective care were calculated, weighted by the number of cases.
and increase the risk of preterm birth. Second hand smoke can increase the severity of illness in those already affected.

<table>
<thead>
<tr>
<th>Cost of smoking in pregnancy for infants during the first year following birth was estimated to range between £12 million and £23.5 million per year, and relates to an increased risk of pre-term delivery, low birth weight, Sudden Infant Death Syndrome, perinatal mortality, asthma, otitis media, and upper and lower respiratory infections. The care of low birth weight and preterm infants accounted for most of the costs. (Godfrey et al., 2009)</th>
</tr>
</thead>
<tbody>
<tr>
<td>If the number of births(^c) is used as a crude proxy, the proportion of pregnancies in Wales is 4.4% of UK pregnancies, the cost to the NHS of smoking during pregnancy in Wales can be calculated at between an estimated £352,000 and £2,816,000 per year. Similarly, if the proportion of births in Wales is 4.4% of UK births(^c), then a crude estimated total cost to the NHS of smoking during pregnancy for infants (0-12 months) in Wales can be calculated at between an estimated £528,000 and £1,034,000.</td>
</tr>
</tbody>
</table>

**Cost to the NHS workforce**

A review of the health and well-being of the NHS workforce found that among NHS employees, the likelihood of sickness absence is a third higher for smokers compared to non-smokers; and smokers are more likely to be absent due to ill

\(^c\) UK births for England (671,372), Scotland (59,049), Wales (34,876) and Northern Ireland (24,900) for 2009, ONS.
A health economic review (Flack et al., 2007), conducted to inform the development of National Institute for Health and Clinical Excellence guidelines *Workplace interventions to promote smoking cessation* (NICE, 2007a), reported that productivity losses due to illness and increased absences from work amounted to 33 hours per smoking employee per year. This is 33 hours more that a non-smoking employee and does not include lost productivity due to smoking breaks.

The NHS could also incur additional costs for agency/locum cover for sickness absences. The rates for cover can range from around £10 to more that £104 per hour depending up on grade and speciality.

**Cost to the economy**

It is estimated that each year 34 million working days are lost in England and Wales through sickness absence caused by smoking related illnesses (Parrot & Godfrey, 2004). Smoking also costs the wider UK economy an estimated £2.5 billion per annum for sick leave and lost productivity (McGuire & Raikou, 2008).
Appendix C – Pre-operative smoking cessation

Estimated number of bed days saved associated with preoperative smoking cessation

<table>
<thead>
<tr>
<th>LHB</th>
<th>Conservative quitting estimate</th>
<th>Higher quitting estimate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Conservative effect size (-0.4)</td>
<td>Sensitivity analysis (-2)</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>21</td>
<td>106</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>43</td>
<td>217</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>16</td>
<td>82</td>
</tr>
<tr>
<td>Newport</td>
<td>31</td>
<td>156</td>
</tr>
<tr>
<td>Torfaen</td>
<td>25</td>
<td>127</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>136</strong></td>
<td><strong>688</strong></td>
</tr>
</tbody>
</table>

Estimates savings associated with preoperative smoking cessation

<table>
<thead>
<tr>
<th>Financial implications Wales 2005/06 LHB</th>
<th>Potential savings (Minimum –Maximum estimate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blaenau Gwent</td>
<td>£7,167 - £74,786</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>£14,612 - £152,476</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>£5,526 - £57,665</td>
</tr>
<tr>
<td>Newport</td>
<td>£10,493 - £109,497</td>
</tr>
<tr>
<td>Torfaen</td>
<td>£8,533 - £89,044</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£46,331 - £483,468</strong></td>
</tr>
</tbody>
</table>
Appendix D – Stop Smoking Wales clinics (received Dec 2013)

Stop Smoking Wales
Sessions held in Aneurin Bevan Health Board

Caerphilly
- Blackwood
- Bargoed
- Caerphilly Centre
- Lansbury Park
- Newbridge
- Rhymney
- Risca

Newport
- Alway
- Liswerry
- Stow Hill
- Pillgwenlly
- St Woolos
- Newport Centre

Blaenau Gwent
- Abernant
- Abertillery LAC
- Brynmawr
- Cwm
- Ebbw Vale
- Llanhilleth
- Tredegar

Torfaen
- Abersychan
- Blaenavon
- Cwmbran
- Tredthin
- Pontypool

Monmouthshire
- Chepstow
- Caldicot
- Abergavenny
## Appendix E – Smoking Cessation in Community Pharmacy

### Pharmacy (Level 2) Scheme

<table>
<thead>
<tr>
<th>Locality</th>
<th>No</th>
<th>NCN</th>
<th>Pharmacy Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newport</td>
<td>1</td>
<td>West</td>
<td>Superdrug</td>
<td>Commercial Street</td>
</tr>
<tr>
<td>Newport</td>
<td>2</td>
<td>East</td>
<td>Liswerry Pharmacy</td>
<td>Pontfaen Rd</td>
</tr>
<tr>
<td>Newport</td>
<td>4</td>
<td>East</td>
<td>LT Chemist</td>
<td>Corporation Rd</td>
</tr>
<tr>
<td>Newport</td>
<td>5</td>
<td>East</td>
<td>Llanmartin Pharmacy</td>
<td>Birch Grove Stores</td>
</tr>
<tr>
<td>Newport</td>
<td>6</td>
<td>East</td>
<td>Always Pharmacy</td>
<td>Aberthaw Rise</td>
</tr>
<tr>
<td>Newport</td>
<td>7</td>
<td>Central</td>
<td>Co-op Pharmacy</td>
<td>Caerleon Road</td>
</tr>
<tr>
<td>Newport</td>
<td>8</td>
<td>Central</td>
<td>Watkin Davies Ltd</td>
<td>Bettws Centre</td>
</tr>
<tr>
<td>Newport</td>
<td>9</td>
<td>West</td>
<td>Tesco Pharmacy</td>
<td>Harlech Retail Pk</td>
</tr>
<tr>
<td>Newport</td>
<td>10</td>
<td>Central</td>
<td>Martin Davies Ltd</td>
<td>Caerleon Road</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>1</td>
<td>South</td>
<td>Boots the Chemist</td>
<td>High Street, Chepstow</td>
</tr>
<tr>
<td>Monmouthshire</td>
<td>2</td>
<td>South</td>
<td>PC Merrick</td>
<td>Steep St, Chepstow</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>1</td>
<td>South</td>
<td>Sheppard</td>
<td>Troed y Bryn, Caerphilly</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>2</td>
<td>East</td>
<td>Vida Rogers</td>
<td>Cefn Fforest Ave</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>3</td>
<td>South</td>
<td>Superdrug</td>
<td>Cardiff Rd, Caerphilly</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>4</td>
<td>North</td>
<td>Vida Rogers</td>
<td>High St, Fleur-de-Lys</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>5</td>
<td>North</td>
<td>Vida Roger</td>
<td>Commercial Aberbargoed</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>6</td>
<td>North</td>
<td>Vida Roger</td>
<td>Hanburt Rd, Bargoed</td>
</tr>
<tr>
<td>Torfaen</td>
<td>1</td>
<td>South</td>
<td>Candwir Brooks</td>
<td>Stokes Court, Ponthir</td>
</tr>
<tr>
<td>Torfaen</td>
<td>2</td>
<td>North</td>
<td>New Inn</td>
<td>The Walk</td>
</tr>
<tr>
<td>Torfaen</td>
<td>3</td>
<td>South</td>
<td>Shil</td>
<td>Leadon Court, Thornhill</td>
</tr>
<tr>
<td>Torfaen</td>
<td>4</td>
<td>South</td>
<td>Boots</td>
<td>The Mall, Cwmbran</td>
</tr>
<tr>
<td>Torfaen</td>
<td>5</td>
<td>North</td>
<td>Co-op</td>
<td>Stanley Rd Gardiffaith</td>
</tr>
</tbody>
</table>
Pharmacy (Level 3) Locally Enhanced Service pilots

<table>
<thead>
<tr>
<th>Locality</th>
<th>No</th>
<th>NCN</th>
<th>Pharmacy Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newport</td>
<td>1</td>
<td>East</td>
<td>Alway Pharmacy</td>
<td>Alway Parade, Newport</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>2</td>
<td>East</td>
<td>Williams Pharmacy</td>
<td>Beaufort St, Brynmawr</td>
</tr>
<tr>
<td>Blaenau Gwent</td>
<td>3</td>
<td>West</td>
<td>Co-op Pharmacy</td>
<td>James St, Ebbw Vale</td>
</tr>
<tr>
<td>Torfaen</td>
<td>4</td>
<td>South</td>
<td>Boot Pharmacy</td>
<td>The Mall, Cwmbran</td>
</tr>
<tr>
<td>Caerphilly</td>
<td>5</td>
<td>North</td>
<td>Vida Rogers Pharmacy</td>
<td>High Street, Fleur De Lys</td>
</tr>
</tbody>
</table>
Appendix F - E Cigarettes or electronic nicotine delivery systems (ENDS)

This position statement represents the views of Public Health Wales based on the best available evidence at the time or writing. It does not represent Welsh Government Policy. It has been produced to enable Public Health Wales to provide consistent professional advice to the public, our partners and our service users. Please check to see if a more recent version of this advice is available.

What are e-cigarettes? Electronic cigarettes, e-cigs or ENDS (electronic nicotine delivery systems) are devices whose function is to vaporize and deliver to the lungs of the user a chemical mixture typically composed of nicotine, propylene glycol and other chemicals, although some products claim to contain no nicotine. A number of ENDS are offered in flavours that can be particularly attractive to adolescents. Electronic cigarettes (e-cigs) are the most common prototype of ENDS. (1)

Most ENDS are shaped to look like their conventional (tobacco) counterparts (e.g. cigarettes, cigars, cigarillos, pipes, hookahs or shishas). They are also sometimes made to look like everyday items such as pens and USB memory sticks, for people who wish to use the product without other people noticing (1).

Why is there concern about e-cigarettes? There has been a rapid increase in the use, availability and promotion of e-cigs. While there is potential for ENDS to reduce the harm from smoking or help smokers to quit, their effectiveness or safety has not been demonstrated. The current position on regulation of ENDS is unclear. The MHRA had previously announced that the government intended to regulate electronic cigarettes and other nicotine containing products (NCPs) as medicines (2) however the outcome of the European Parliament vote in October 2013 on a revision to the Tobacco Products Directive (3) did not support this approach to regulation.

Public Health Wales, in line with a number of national and international bodies (4) (1) (5) (6) has identified the following potential risks to health and proposes that a precautionary approach is adopted until further information becomes available.

- Nicotine is a poison, scientific testing indicates that the products vary widely in the amount of nicotine and other chemicals they deliver and there is no way for consumers to find out what is actually delivered by the product they have purchased.
- Use of e-cigs may reduce the likelihood of smokers quitting by displacing scientifically proven methods to help people quit.
- ENDS mimic smoking a cigarette and could play a role in normalising smoking behaviour. Considerable strides have been made in denormalising smoking but there is much more to do. Anything which may reverse the progress made to denormalise smoking would be a risk to population health.
- The presentation of e-cigs as a safe way to smoke may provide a route to nicotine addiction for children and young people, this may in turn lead to smoking tobacco.
Public Health Wales advises that:

- Smokers who wish to quit or reduce their smoking, should be advised to access one of the free NHS services which provide scientifically proven support including a range of tested nicotine replacement products (Stop Smoking Wales 0800 085 2219).
- The promotion of e-cigs/ENDS should be strictly limited to smokers only. It should not promote the concept of safe smoking and should only be as a way of cut down and quit. Whether any marketing should be allowed at all requires urgent review.
- Their use should be prohibited in workplaces, educational and public places to ensure their use does not undermine smoking prevention and cessation by reinforcing and normalising smoking.
- ENDS should not be available to those under 18. Anything that might increase their appeal to children should be avoided e.g. flavouring; packaging.
- Promotion must not appeal to non-smokers, in particular children and young people. This could include product appearance and packaging being plain in order not to attract people into using it. There should be no flavoured products.
- Research is needed to increase our understanding of ENDS in particular the safety; effectiveness; role in normalising smoking behaviour and role as a gateway to nicotine addiction and smoking, particularly in children.


