7.9 Smoking

Smoking is the main cause of preventable death in most industrialised countries. About a third of all deaths from cancer can be attributed to smoking, and at least 90% of deaths from lung cancer are caused by smoking. While the number of people aged less than 75 years who die from cancer is falling nationally, in Barking and Dagenham it is continuing to rise. Smoking is also responsible for about 17% of deaths from heart disease, and 80% of deaths from chronic lung diseases such as bronchitis and emphysema, so it is a major contributor to high premature mortality and decreased life expectancy in Barking and Dagenham.

Mortality locally from smoking in people aged over 35 years was the highest in London over the three years 2011-2013 (Figure 7.9.1). The directly standardised mortality rate from smoking in people aged over 35 years was 384 per 100,000 people.

Figure 7.9.1: Mortality due to smoking, rate per 100,000 population aged 35+ years, London Boroughs, London and England, 2011-13

Nine out of every ten deaths from lung cancer can be attributed to smoking. The incidence of lung cancer in women in Barking and Dagenham is higher than the London or England average (Figure 7.9.2), suggesting higher rates of smoking by local women.
Smoking is also linked to a greater risk of birth defects\(^1\), male impotence and sperm abnormalities, early menopause, asthma and an increased risk of cot death in babies who are exposed to second hand smoke.

**Figure 7.9.2: Incidence of Lung Cancer in women aged under 75 years, Barking and Dagenham and statistical neighbours, London and England, 2010-12**

> Incidence of Lung cancer, females aged <75, 2010-2012

Source: HSCIC Indicators https://indicators.ic.nhs.uk/webview/

**Who smokes?**

There is no reliable method for establishing the actual prevalence of smoking, so smoking prevalence is estimated using information gained through national surveys. In 2009 modelled smoking prevalence in Barking and Dagenham was the highest in London at 32%, and 8\(^{th}\) highest in England. By 2013 it was estimated that local prevalence had declined to 23%, and this remains the highest in London (Figure 7.9.3). However these estimates are based on responses to a national survey and should be treated with caution, particularly in relation to changes and trends.

---

There is a social class gradient in smoking, with people in routine and manual classes most likely to smoke (The Marmot Review: Fair Society, Healthy Lives, 2010).

**Smoking in pregnancy**

In some circumstances actual information on smoking in small sections of the population is gathered. All women from Barking and Dagenham who have a baby are asked whether they are smokers at the time they deliver the baby (Figure 7.9.4). Over 14% of local women who had a baby in 2012/13 were smokers; this was the highest in London, and significantly (2.5 times) higher than the London average and higher than England average of 12.7%.

---

BabyClear - smoking in pregnancy

Barking and Dagenham are working in partnership with local stakeholders, to implement the babyclear within Barking, Havering, and Redbridge University Hospitals NHS Trust. BabyClear is an evidenced-based programme that aims to reduce the prevalence of smoking in pregnancy, and increase smoking cessation referrals. BabyClear © aims to reduce smoking in pregnancy through a systematic approach that identifies pregnant smokers, and supports the process of smoking cessation referrals. All pregnant women are offered a carbon monoxide (CO) screening, and specialist training is provided to both clinical and non-clinical staff that engage with pregnant smokers, across maternity and stop smoking services.

The babyClear programme is being implemented in partnership with Barking and Dagenham Clinical Commissioning Group, BHRUT Maternity Services, Public Health with the London Boroughs’ of Havering, and Redbridge, North East London Foundation Trust Stop smoking Services, and Barking and Dagenham Specialist Stop Smoking Service. The babyClear © programme was co-funded by Public Health England, and will be delivered by the Tobacco Control Collaborating Centre.

Figure 7.9.4: Percentage of women recorded as being smokers at time of delivery, 2013/14

Nationally, there is a social gradient in smoking by pregnant women, with women from poorer socio-economic groups being much more likely to smoke than those from more affluent socio-economic groups. There is also an age gradient, with pregnant mothers aged 20 or under being three times more likely to smoke before or during pregnancy as mothers aged 35 or over, and also being less likely to quit.
In addition, mothers in routine and manual occupations were over four times as likely as those in managerial and professional occupations to have reported that they smoked throughout pregnancy - 29% and 7% respectively (NICE, 2010). Specific guidance on stopping smoking during pregnancy and following childbirth has been published.\(^3\)

The last ‘Tell Us’ Survey (2009) indicates that nationally 18% of young people under the age of 16 either have smoked, or currently smoke tobacco and that at least another 2% smoke more than six cigarettes per week. It is estimated that up to 27% of local young people between the ages of 11 and 19 regularly smoke, the greater proportion being in the older age group. Research supported by the Barking and Dagenham Tobacco Alliance in 2010 looked at smoking by local young people, and how they could best be supported not to start smoking or to stop if they had started. This study concluded that youth specific smoking support is needed in Barking and Dagenham, with further research into the prevalence and patterns of youth smoking behaviour in the borough.

Men are more likely to smoke than women, and although female smoking prevalence is lower than male prevalence in Barking and Dagenham, the proportion of women who smoke is higher than the average for England or London. Women are more likely to access Stop Smoking services than men in London\(^4\). Of smokers who set a quit date, there were 67 women per 1,000 estimated smokers compared with 44 men in 2008/09. Women also had higher successful quit rates than men overall; 33 per 1,000 female smokers compared to 22 per 1,000 male smokers.

Nationally a number of groups have been identified as being at a greater risk of smoking, and thus at greater risk of dying from a smoking related disease. Prevalence is higher in these groups, and it is also suggested they find it more difficult to quit, even with support. These include some BME communities such as Bangladeshi men (40% smoking prevalence according to the 2004 Health Survey for England), and people in poorer socio-economic groups such as those who are ‘routine and manual’ workers (in 2007 prevalence in this group was 26% against a prevalence of 15% in professional and managerial groups). Poorer smokers smoke more cigarettes and obtain a higher dose of toxins when they smoke. People with mental health problems also have a high smoking prevalence. Stop Smoking Services have been asked to actively target people in these groups for support, and to monitor uptake.

**Supporting smokers to quit**

Stop smoking services are commissioned to support local people and an annual target for smoking quitters in each borough in England is set to reduce overall smoking prevalence. Stop Smoking Services are commissioned to provide support to people who would like to stop smoking, through groups, one-to-one counselling and medications. A substantial proportion (about 40%) of these quitters will relapse and quit again, however some will continue to abstain from smoking (Figure 7.9.5).

---


\(^4\) London Health Observatory (September 2009) “Commissioning For Equity: Stop Gaps; Equity of access to London’s stop smoking services”
The effectiveness of Stop Smoking Services is monitored by NHS London, who regularly publishes information such as Table 7.9.1, which shows the number of people who set a quit date with the Stop Smoking Service and the proportion of those who successfully quit. The uptake of the services by people from a black and minority ethnic (BME) background, and by those who are in the socio-economic class of ‘routine and manual workers’, is also monitored. Approximately 20% of successful quitters in Barking and Dagenham in 2013/14 were from routine and manual occupations. More than half of all people who set a quit date had quit
successfully at the end of four weeks. Barking and Dagenham services meet targets for the number of people quitting smoking and have performed well against the requirements for monitoring quitters. However, local modelling suggests that the Department of Health target (around 1,400 annually) is about a fifth of the actual number of quitters (7,000) needed to reduce health inequalities and improve life expectancy in the borough.

Supporting people to quit is just one strand in the approach to reduce smoking prevalence. It is also important to prevent people starting smoking in the first place and to control tobacco availability. Prevention and health promotion is part of the work undertaken by the commissioned Stop Smoking Service, supporting campaigns at New Year and on National No Smoking Day, as well as for recruitment of people into the services.

Review of smoking cessation in Barking and Dagenham

In January 2011 an independent review of smoking cessation activity was carried out on behalf of NHS Barking and Dagenham. This resulted in a number of recommendations that have been incorporated into the recommendations for commissioners below. The review concluded that the comprehensive Tobacco Strategy which was developed by the local Tobacco Alliance should align with a commitment by each organisation in the Partnership to a smokefree borough, with Board level agreement to the contribution of each organisation, and active implementation.

The review also recommended that the Tobacco Alliance should:

“Have more direct influence over the smoking cessation support that is commissioned, ensuring that the service specification sets out in detail the expectations and deliverables for service delivery. Much greater emphasis needs to be given to the potential role of front line staff employed by all members of the Partnership in encouraging and supporting clients and patients to stop smoking, with widespread provision and uptake of Level 1 training.

The Stop Smoking Service that is currently commissioned delivers good outcomes in terms of four week quitters, but with very high service costs and therefore does not represent value for money.

Given that the number of quitters needed to make an impact on health inequalities and premature mortality is at least five times the currently recorded number, investment needs to be maintained and productivity dramatically improved.

Much greater emphasis should be given to the role of primary care practitioners, particularly pharmacists, in supporting people to stop smoking. The primary role of the commissioned service should be in co-ordination of an extensive network of Level 2 trained personnel, encouraging their delivery of support to clients, assessing their service quality and managing performance. Although training could be provided by the commissioned service, it could also be sub-contracted, and value for money assessment of training provision should be undertaken”.

Health and adult services select committee scrutiny of smoking cessation

As well as the independent NHS review of smoking cessation, the London Borough of Barking and Dagenham’s Health and Adult Services Select Committee (HASSC) undertook a scrutiny of smoking cessation which reported in March 2011. The HASSC recommendations were accepted by the Council.

The HASCC Scrutiny Report reviewed all of the work already taking place within the Borough and reported that they were “pleased to note that the Partnership has already made a positive start towards tackling these issues with particular emphasis on the implementation of its Tobacco Strategy, in partnership with agencies such as the NHS Barking and Dagenham, the Stop Smoking Service and the Council for Voluntary Service.”

It should be noted that the Scrutiny Report in March pre-dated a decision by NHS commissioners to remove the funding for the post of Tobacco Control Co-ordinator, whose input was vital to the success of the Tobacco Alliance. In addition, the NHS commissioned work with the Council for Voluntary Services to provide a public health network amongst local community representatives also ended in March 2011.

The HASSC Report commended the work that had gone into focusing attention on preventing young people from taking up smoking, and several of the recommendations arising from the Scrutiny report related to young people. While the work of the local authority in schools and non-school settings is reported below, the NHS has not been able to fund any of the planned initiatives aimed specifically at young people.

Children and young people

The council invests to try to prevent children and young people taking up smoking. Tobacco education is delivered during Science and Personal, Social, Health and Economic Education (PSHEe) lessons in local schools. Despite the non-statutory status of PSHEe, all schools in the borough recognise the importance and relevance of the subject to children and young people and deliver teaching programmes that include tobacco education. Schools take a balanced approach to tobacco education by emphasising the harmful effects of tobacco along with the development of the necessary personal and social skills to resist peer and family pressure to use tobacco. Children and young people are also taught about tobacco and the law.

Typically each young person receives six lessons about drugs, alcohol and tobacco each school year from the age of 5 years. Tobacco education becomes more prominent as the children get older. The School Improvement Service provides guidance to schools in the form of minimum expected year group standards for PSHEe. These are year on year learning outcomes which identify the relevant knowledge and skills for drug, alcohol and tobacco education.

The Council also works with children and young people outside school settings. The local young people’s drug and alcohol support service, CRI Subwize, offers level one smoking cessation support to children and young people. This involves appropriately signposting and referring young people to the local Stop Smoking

---

6 http://moderngov.barking-dagenham.gov.uk/mgConvert2PDF.aspx?ID=29683
Service. Subwize staff have received training to provide this support and do so from both schools and children’s centres.

In 2010 the local NHS involved young people in designing anti-smoking campaigns that they felt would appeal to young people, as well as consulting with young people on the development of a local youth stop smoking service for 8 – 18 year olds. NHS staff also worked with the council to establish a Youth Stop Smoking Network. This involved training a group of 15 young people to act as no smoking ambassadors in a variety of young people’s settings. The aim of the network was to help young people understand the real nature of the tobacco industry. Funding constraints have prevented the network being established, and there are no specific services aimed at young people.

**Tobacco control**

The Barking and Dagenham Tobacco Alliance was reformed in 2015, bringing together partners from a number of agencies including the voluntary and private sector, with the stated aim of “taking a multi-agency approach to improve the health of the local population through a reduction in smoking prevalence in Barking and Dagenham”.

The Alliance leads on a local strategy and action plan to address the harm caused by smoking in Barking and Dagenham. This included additional investment and time spent on enforcement and test purchasing, to ensure that young people under the age of 18 were not being sold tobacco or tobacco products locally, that any tobacco products being sold to anyone locally were not illegally imported or illicit products, and that the national smokefree legislation was being adhered to. Although enforcement work undertaken by the council will continue, the discontinuation of the tobacco coordinator post will compromise the effectiveness of the Alliance.

**Recommendations for Commissioners**

The recommendations below incorporate some of those recommendations arising out of the external review of smoking cessation carried out in January 2011, as well as the recommendations of the Inquiry into smoking carried out by the Barking and Dagenham Health and Adult Services Select Committee in 2010/11.

The Tobacco Strategy agreed by the Tobacco Alliance should be resourced and implemented.

There should be clear outcomes built into specifications and contracts with anyone providing smoking cessation services or advice.

All front line health and social care staff should be trained to provide Level 1 advice on smoking cessation.

There should be investment and a significant increase in the number of local health and social care staff, including primary care staff, who can provide Level 2 smoking cessation services.

Stop Smoking Services should be commissioned which are effective, evidence-based and value for money, delivering a service that meets Department of Health requirements on targeting, monitoring and quality.
Commissioned services should be responsive to local need, i.e. delivered in a range of accessible venues, and available at evenings and weekends.

There should be staff trained to provide at least Level 1 advice in all local NHS opticians and dental practices.

The commissioned service should provide training and support to all local GP practices and pharmacies to ensure that Level 2 support for smoking cessation is available from every site.

Services should be commissioned to deliver at least 3,000 quitters in order to achieve a reduction in smoking prevalence that will impact on the very high levels of morbidity and premature mortality in Barking and Dagenham.

Investment is needed to appoint a post at a senior level in Barking and Dagenham who can oversee tobacco control initiatives, marketing campaigns and performance management of commissioned services.

There should be additional investment in local enforcement activities to support the aspiration to reduce smoking prevalence.

There should be significant investment in prevention initiatives and health promotion, aimed at both preventing people from taking up smoking, and at encouraging smokers to quit.

An evidence-based service should be commissioned specifically aimed at young people, with the aspiration of encouraging young people to quit smoking, or not to start smoking.

All service contracts let by members of the Barking and Dagenham Partnership should address smoking, both by staff and patients or clients. This principle should not only be applied in the obvious contracts for healthcare services, such as those with Barking, Havering and Redbridge University Hospitals Trust, but also to the wide range of general service contracts, where the provider should provide a statement of commitment to reducing smoking prevalence.

The Tobacco Alliance should secure membership of Trade Union representatives on the tobacco alliance to help reach and influence routine and manual workers with smoking cessation interventions.

Local Councillors have made a recommendation that the Partnership should give commitment to funding the posts of tobacco control co-ordinator and tobacco enforcement officer as well as other related tobacco programme costs to mitigate risk of not reaching strategy targets.

More should be done to publicise high profile prosecutions that are related to tobacco control enforcement in the local media to deter sellers of illicit tobacco products.

The Tobacco Alliance should explore the possibility of implementing a smokefree award scheme for local businesses that adopt good smoking cessation practices.