Public Health Outcome Framework (PHOF) Summary

Outcome Title: Smoking Prevalence

Context
The Public Health Outcomes Framework (PHOF) 'Healthy lives, healthy people: Improving outcomes and supporting transparency' sets out a vision for public health, desired outcomes and the indicators that will help us understand how well public health is being improved and protected. The framework concentrates on two high-level outcomes to be achieved across the public health system, and groups further indicators into four 'domains' that cover the full spectrum of public health. The outcomes reflect a focus not only on how long people live, but on how well they live at all stages of life.

Definitions
2.14 – Smoking prevalence
The number of persons aged 18+ who are self-reported smokers in the Integrated Household Survey. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.

2.14 – smoking prevalence routine and manual
The number of persons aged 18 + who are self-reported smokers in the Integrated Household Survey in a subset of the routine and manual group. The number of respondents has been weighted in order to improve representativeness of the sample. The weights take into account survey design and non-response.

Why is smoking an issue?
Smoking is the most important cause of preventable ill health and premature mortality in the UK. Smoking is a major risk factor for many diseases, such as lung cancer, chronic obstructive pulmonary disease (COPD) and heart disease. It is also associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.

In 2008/09, some 463,000 hospital admissions in England among adults aged 35 and over were attributable to smoking, or some five per cent of all hospital admissions for this age group[1]. Illnesses among children caused by exposure to second-hand smoke lead to an estimated 300,000 general practice consultations and about 9,500 hospital admissions in the UK each year[2].

Smoking is a modifiable lifestyle risk factor; effective tobacco control measures can reduce the prevalence of smoking in the population.

The Government's Tobacco Control Plan[3] published in March 2011 sets out the Government's strategy to reduce smoking prevalence among adults and young people, and to reduce smoking during pregnancy.

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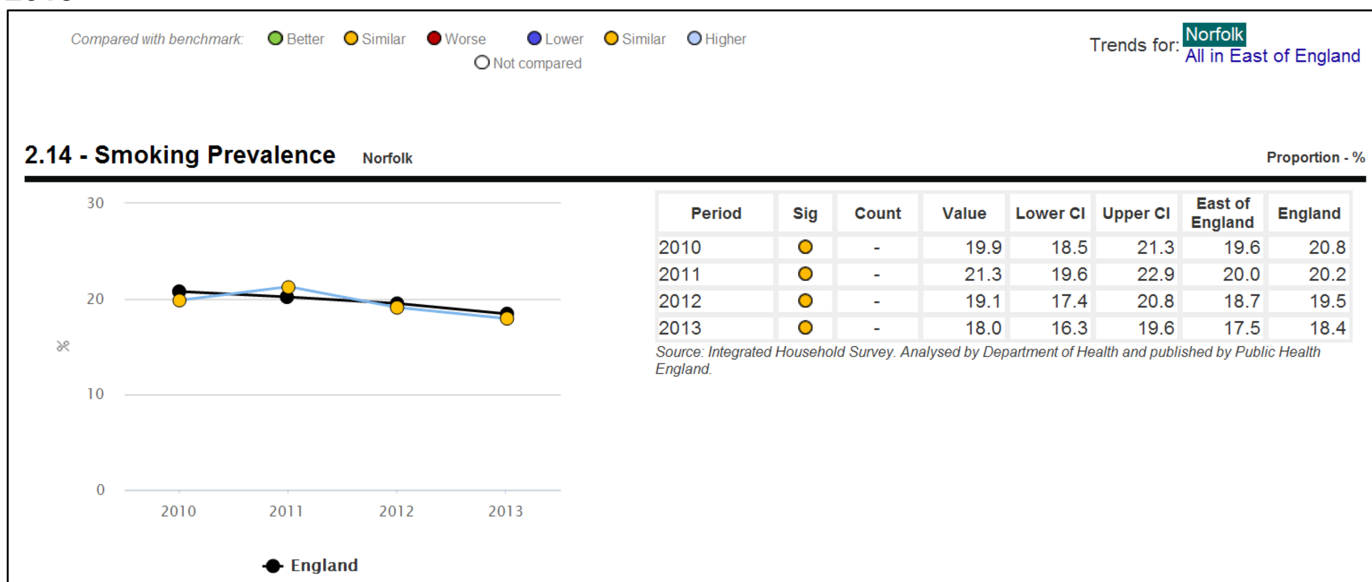
[1] NHS Information Centre (2010). Statistics on Smoking: England, 2010, NHS Information Centre, Leeds
[2] Royal College of Physicians (2010). Passive Smoking and Children. Royal College of Physicians, London
[3] Healthy Lives, Healthy People: A Tobacco Control Plan for England, http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf

What does the evidence show?

Smoking has been identified as one of the biggest contributors to inequalities in life expectancy and causes of death within Norfolk. Data from the ONS (Office of National Statistics) illustrate that smoking is more prevalent within the 16-50 age bracket in comparison to other ages.[12]

In Norfolk prevalence of smoking increased from January 2010 to September 2011 by around 2-3% (**Figure 1**). From September 2011 the smoking prevalence gradually decreased in line with the England average. One reason for this could have been reduced accessibility due to the ban on cigarette vending machines. Nationally, the smoking prevalence from April 2009 to March 2012 has followed a steady downward trend. This was similar for the East of England[12].

Figure 1: Prevalence of smoking among persons aged 18 years and over, Norfolk. 2010 to 2013

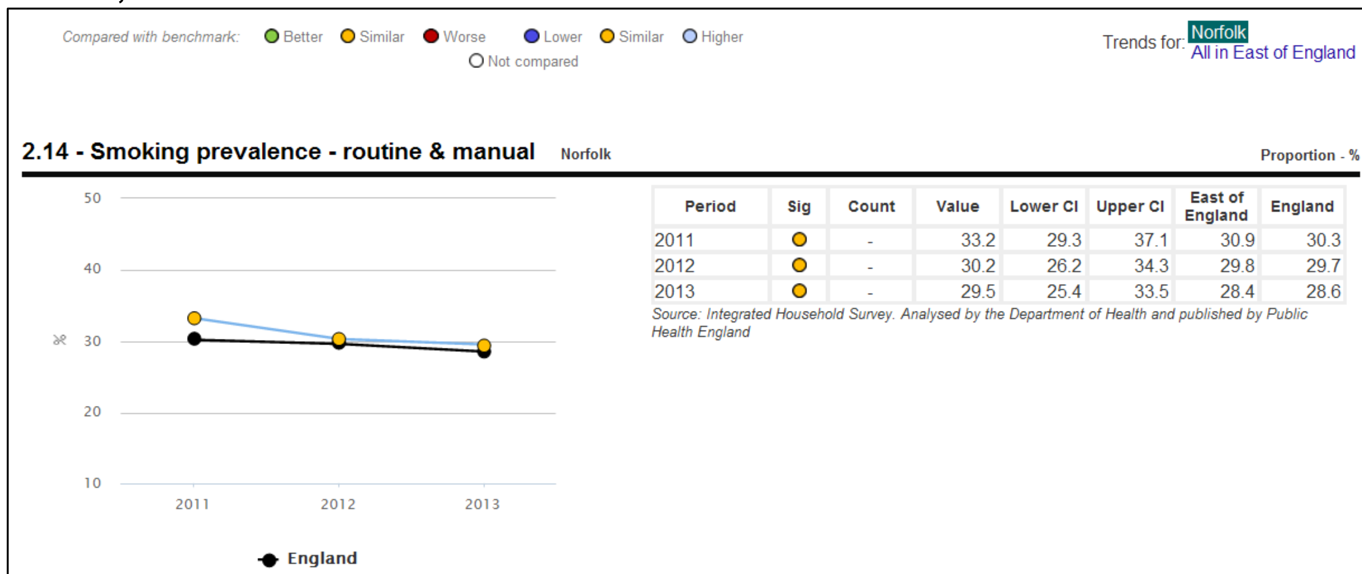


Period	Sig	Count	Value	Lower CI	Upper CI	East of England	England
2010		-	19.9	18.5	21.3	19.6	20.8
2011		-	21.3	19.6	22.9	20.0	20.2
2012		-	19.1	17.4	20.8	18.7	19.5
2013		-	18.0	16.3	19.6	17.5	18.4

Source: Integrated Household Survey. Analysed by Department of Health and published by Public Health England.

The smoking prevalence amongst people classed as routine and manual workers is higher than that of the general population (**Figure 2**). The proportion of these people who smoke has decreased from 33.2% in 2011 to 29.5% in 2013. These rates were not significantly higher than the national average.

Figure 2: Prevalence of smoking among persons aged 18 years and over - routine and manual, Norfolk. 2011 to 2013

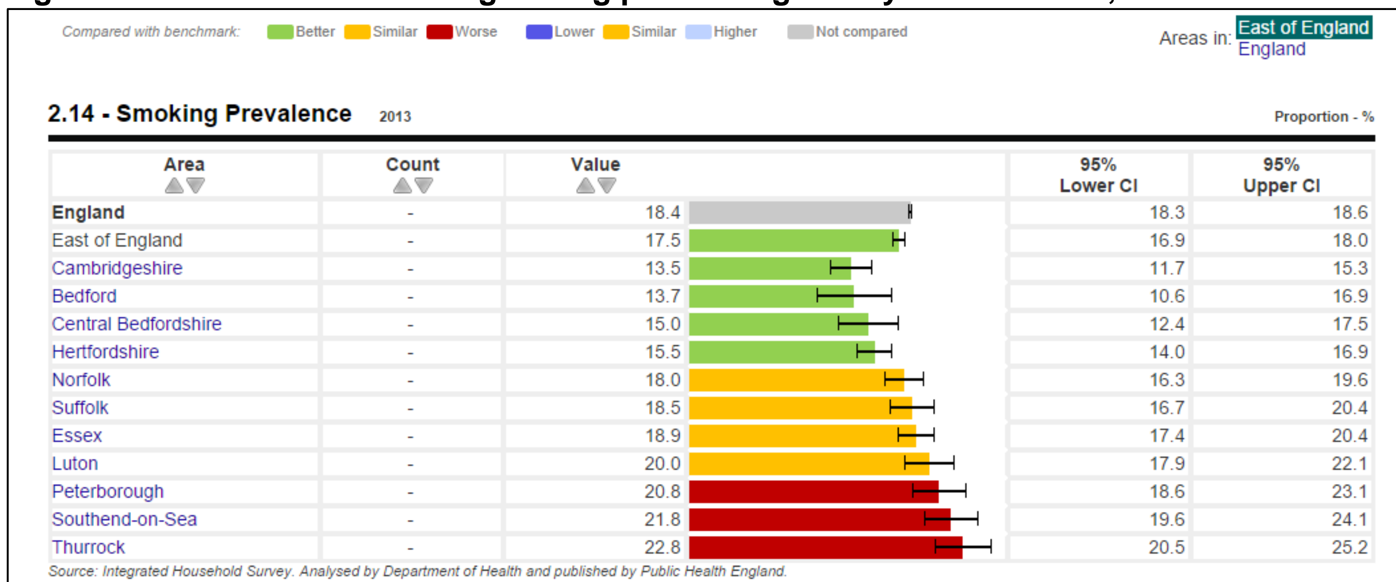


Period	Sig	Count	Value	Lower CI	Upper CI	East of England	England
2011		-	33.2	29.3	37.1	30.9	30.3
2012		-	30.2	26.2	34.3	29.8	29.7
2013		-	29.5	25.4	33.5	28.4	28.6

Source: Integrated Household Survey. Analysed by the Department of Health and published by Public Health England

Within the PHOF, Norfolk's rate of people over the age of 18 who smoke is compared nationally, alongside other East of England local authorities, and **Figure 3** shows Norfolk is not significantly better than the national benchmark for this indicator in 2013. The three East of England local authorities that are worse than the benchmark (18.4%) are Peterborough, Southend-on-Sea and Thurrock.

Figure 3: Prevalence of smoking among persons aged 18 years and over, Norfolk. 2013



Compared with benchmark: Better Similar Worse Lower Similar Higher Not compared

Areas in: East of England England

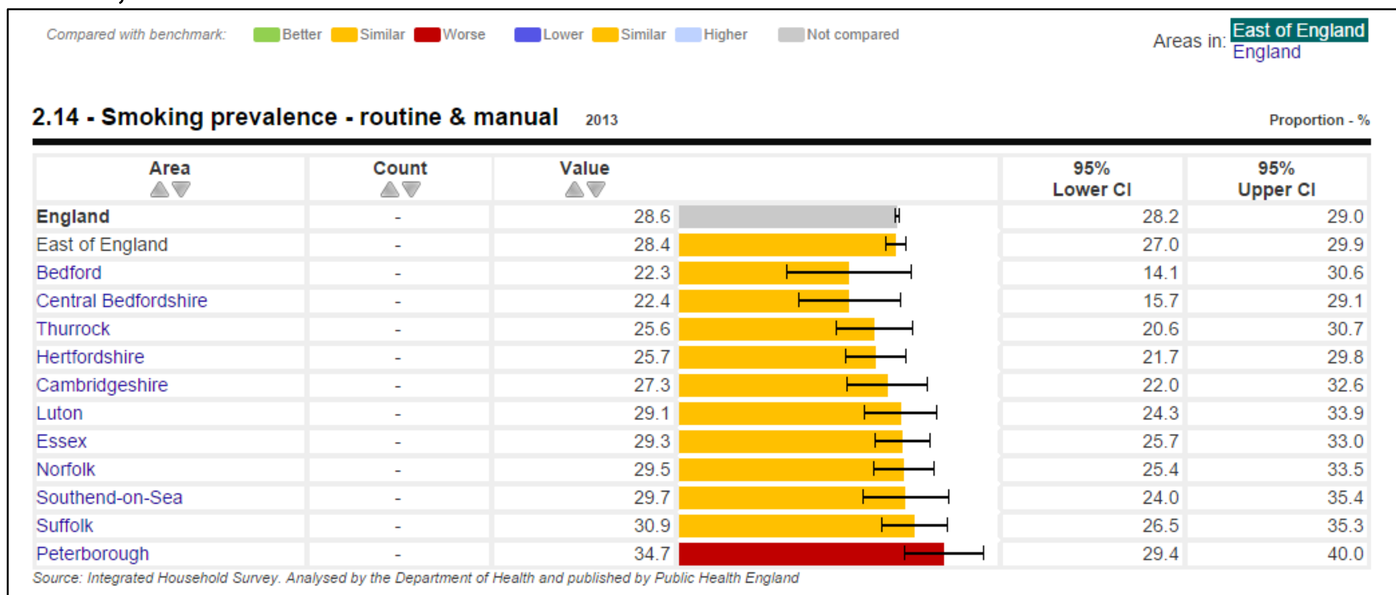
2.14 - Smoking Prevalence 2013 — Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	18.4	18.3	18.6
East of England	-	17.5	16.9	18.0
Cambridgeshire	-	13.5	11.7	15.3
Bedford	-	13.7	10.6	16.9
Central Bedfordshire	-	15.0	12.4	17.5
Hertfordshire	-	15.5	14.0	16.9
Norfolk	-	18.0	16.3	19.6
Suffolk	-	18.5	16.7	20.4
Essex	-	18.9	17.4	20.4
Luton	-	20.0	17.9	22.1
Peterborough	-	20.8	18.6	23.1
Southend-on-Sea	-	21.8	19.6	24.1
Thurrock	-	22.8	20.5	25.2

Source: Integrated Household Survey. Analysed by Department of Health and published by Public Health England.

Figure 4 shows Norfolk's rate of routine and manual workers who smoke compared with nationally, alongside other East of England local authorities. Norfolk is not significantly below the national benchmark for this indicator in 2013. Peterborough is the only unitary authority worse than the benchmark (28.6%).

Figure 4: Prevalence of smoking among persons aged 18 years and over - routine and manual, Norfolk. 2013



Compared with benchmark: Better Similar Worse Lower Similar Higher Not compared

Areas in: East of England England

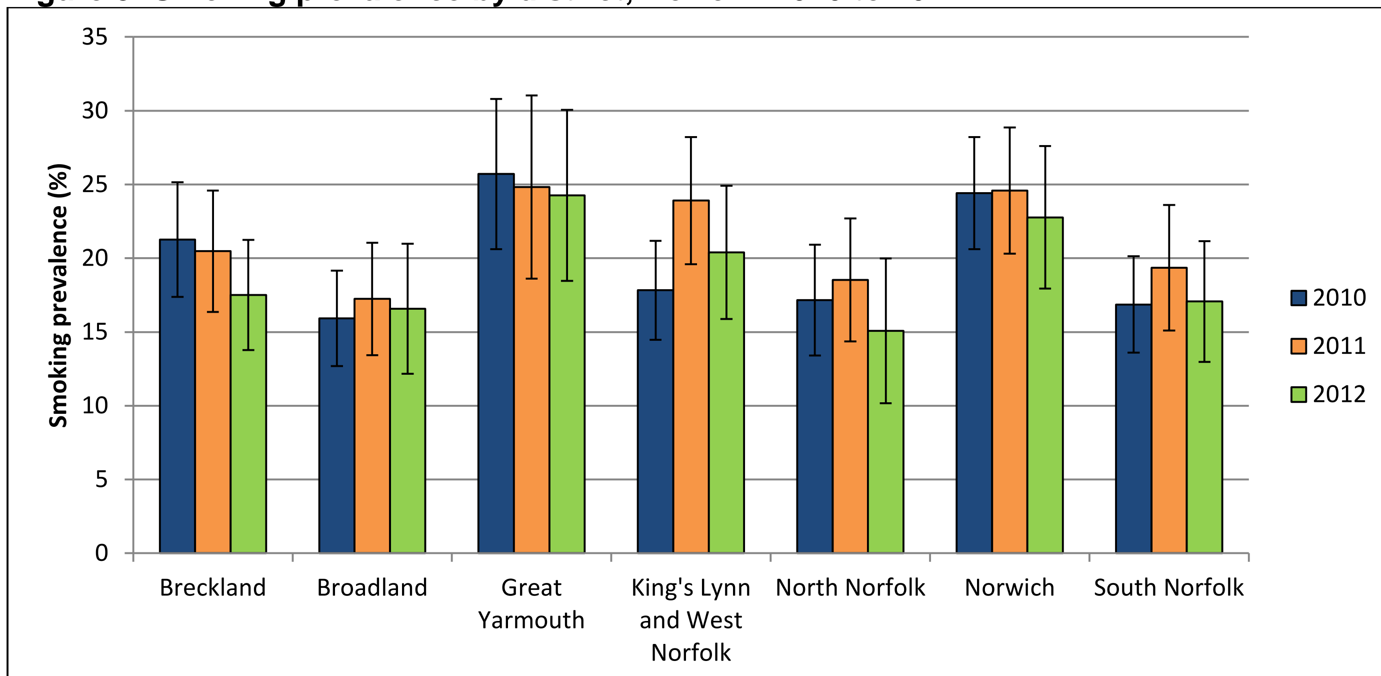
2.14 - Smoking prevalence - routine & manual 2013 — Proportion - %

Area	Count	Value	95% Lower CI	95% Upper CI
England	-	28.6	28.2	29.0
East of England	-	28.4	27.0	29.9
Bedford	-	22.3	14.1	30.6
Central Bedfordshire	-	22.4	15.7	29.1
Thurrock	-	25.6	20.6	30.7
Hertfordshire	-	25.7	21.7	29.8
Cambridgeshire	-	27.3	22.0	32.6
Luton	-	29.1	24.3	33.9
Essex	-	29.3	25.7	33.0
Norfolk	-	29.5	25.4	33.5
Southend-on-Sea	-	29.7	24.0	35.4
Suffolk	-	30.9	26.5	35.3
Peterborough	-	34.7	29.4	40.0

Source: Integrated Household Survey. Analysed by the Department of Health and published by Public Health England

Looking at the local picture, Great Yarmouth had a smoking prevalence of 24.3% which was 6.3% higher than the rest of Norfolk (18%). Norwich had a smoking prevalence of 22.8%, which was 4.8% higher than the Norfolk average. This high prevalence has been linked to deprivation and a higher proportion of routine and manual workers in the area (**Figure 5**).[12]

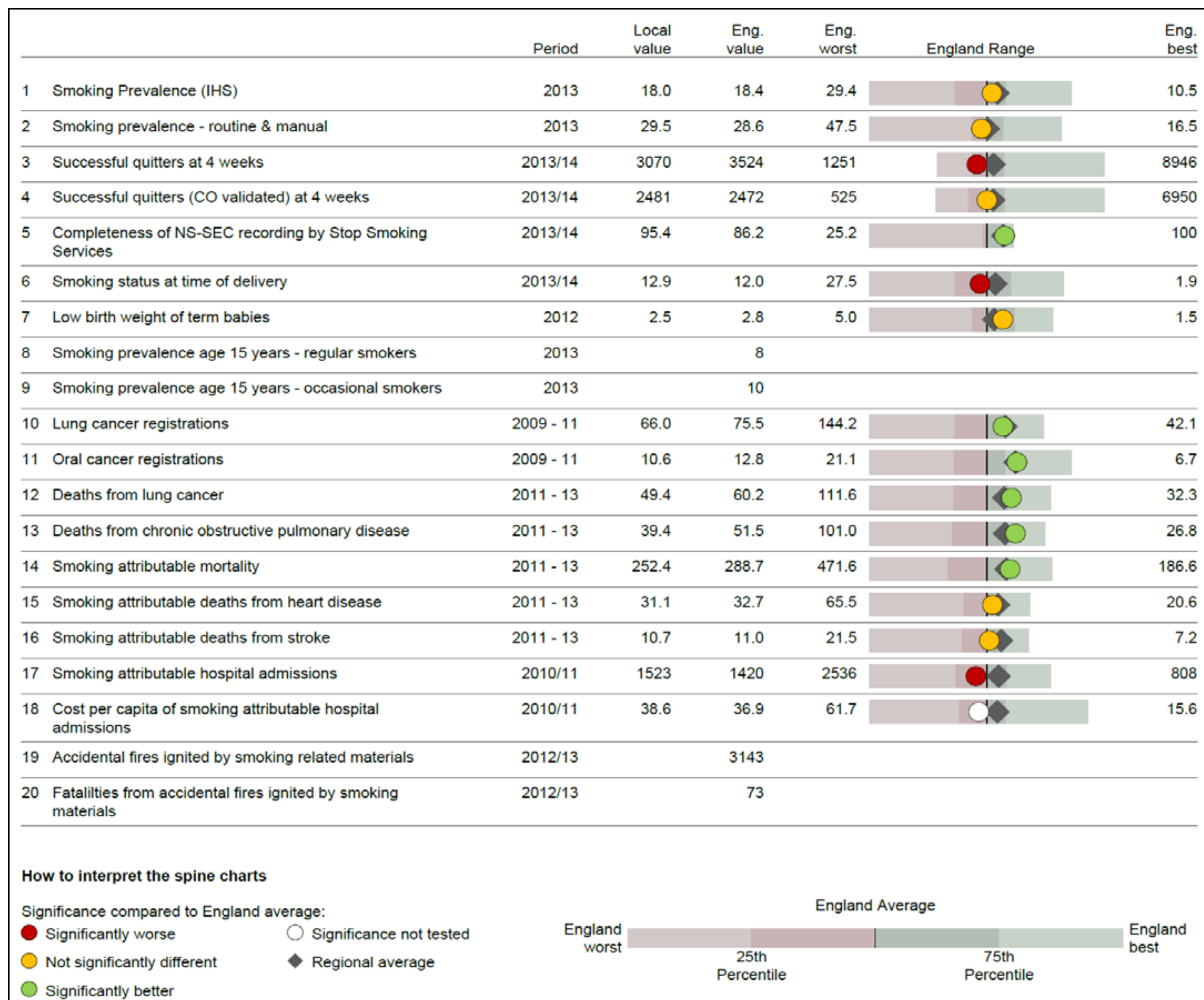
Figure 5: Smoking prevalence by district, Norfolk. 2010 to 2012



Along with smoking prevalence, other indicators for Norfolk are not significantly different from the East of England average, with the exception of successful quitters at 4 weeks, smoking status time of delivery in maternity (SATOD) and smoking attributable hospital admissions (**Figure 6**).

Looking at the neighbouring regions within East of England, Norfolk has the highest prevalence of smoking at time of delivery (12.9%). This is despite a decline in recent years against a backdrop of an overall decline in England[12]. It is to be noted that the data collected are not particularly accurate or consistent as the questions asked (if at all) are often not asked at the time of delivery but most often at the first antenatal visit. This is perhaps before any pregnancy influenced behaviour change has taken place and, as it is self-reported, women may fear judgement so their responses may not be reliable[46]. This highlights that further work needs to be explored to achieve the national SATOD target (11%) which could be achieved through the Tobacco Control Alliance, as it is a joint responsibility for CCGs and NHS England[20].

Figure 6: Tobacco control profiles, Norfolk. 2014



		Period	Local value	Eng. value	Eng. worst	England Range	Eng. best
1	Smoking Prevalence (IHS)	2013	18.0	18.4	29.4		10.5
2	Smoking prevalence - routine & manual	2013	29.5	28.6	47.5		16.5
3	Successful quitters at 4 weeks	2013/14	3070	3524	1251		8946
4	Successful quitters (CO validated) at 4 weeks	2013/14	2481	2472	525		6950
5	Completeness of NS-SEC recording by Stop Smoking Services	2013/14	95.4	86.2	25.2		100
6	Smoking status at time of delivery	2013/14	12.9	12.0	27.5		1.9
7	Low birth weight of term babies	2012	2.5	2.8	5.0		1.5
8	Smoking prevalence age 15 years - regular smokers	2013		8			
9	Smoking prevalence age 15 years - occasional smokers	2013		10			
10	Lung cancer registrations	2009 - 11	66.0	75.5	144.2		42.1
11	Oral cancer registrations	2009 - 11	10.6	12.8	21.1		6.7
12	Deaths from lung cancer	2011 - 13	49.4	60.2	111.6		32.3
13	Deaths from chronic obstructive pulmonary disease	2011 - 13	39.4	51.5	101.0		26.8
14	Smoking attributable mortality	2011 - 13	252.4	288.7	471.6		186.6
15	Smoking attributable deaths from heart disease	2011 - 13	31.1	32.7	65.5		20.6
16	Smoking attributable deaths from stroke	2011 - 13	10.7	11.0	21.5		7.2
17	Smoking attributable hospital admissions	2010/11	1523	1420	2536		808
18	Cost per capita of smoking attributable hospital admissions	2010/11	38.6	36.9	61.7		15.6
19	Accidental fires ignited by smoking related materials	2012/13		3143			
20	Fatalilties from accidental fires ignited by smoking materials	2012/13		73			

How to interpret the spine charts

Significance compared to England average:

- Significantly worse
- Not significantly different
- Significantly better
- Significance not tested
- Regional average

What can we do to reduce prevalence?
In Norfolk, since the tobacco alliance was formed in 2000, it has been a focal point for multi-agency working. It has allowed partners from various agencies to come together to discuss and plan the implementation of tobacco control activity within local communities. This multi-agency working allows the alliance to be fully aware of tobacco control legislation[4].

In 2012 smoking was made a priority for the Health and Wellbeing Strategy, this has highlighted to other partners the importance to reduce smoking prevalence within Norfolk. Some initial suggestions for the focus of the work of Tobacco Control were put forward and on the advice of Dr Jenny Harries, the Director of Public Health for Norfolk. It was then agreed to move forward with a tobacco control partnership. The first meeting of the rejuvenated Norfolk Tobacco Alliance took place in September 2014[4].

Within Norfolk there are numerous activities ensuring effective tobacco control, this includes:

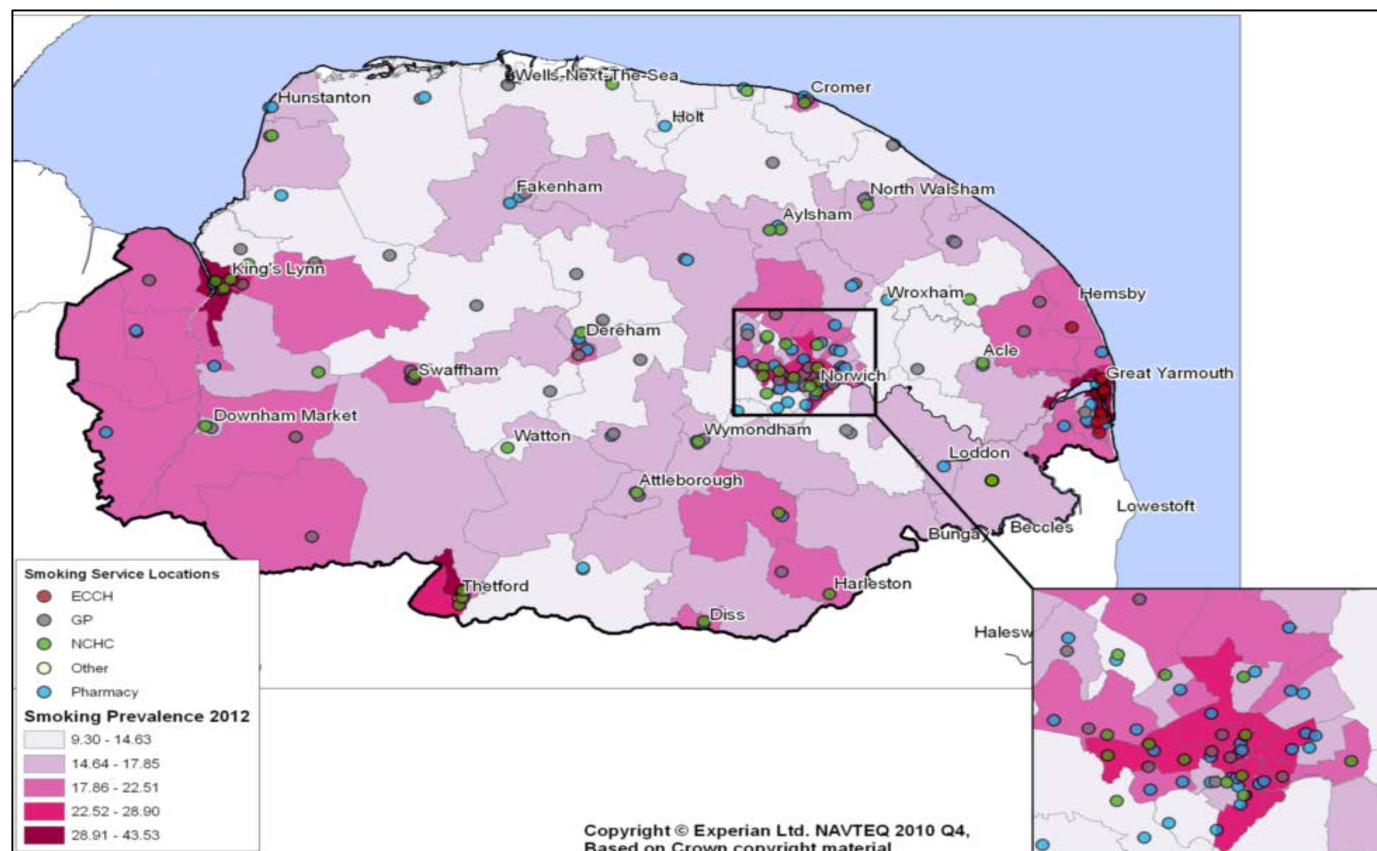
- A multi-agency Tobacco Alliance. The alliance has membership from Public Health, Norfolk County Council Trading Standards, and Children Services - Healthy Schools, Norfolk County Council Communications and Norfolk smoke free services. The chair of these meetings is to be confirmed due to a restructure within the Consultants work streams. One of the main aims of the alliance is focused on illicit tobacco working closely with Trading Standards.
- Stopping the promotion of tobacco – is conducted by Norfolk Trading Standards who enforces age-restricted products by completing activities such as project based inspections, intelligence led "test purchasing" programme and publicity and promotional activities.
- Effective regulation of tobacco products - Norfolk Trading standards (NTS) has been actively working to identify the sale of illicit Tobacco across the region and work closely with HM revenue and customs to ensure legal sales. Trading Standards monitor the sales of illicit tobacco on an intelligence basis and take action on those providers with evidence against them.
- Helping tobacco users to quit – numerous organisations in Norfolk encourage individuals to stop smoking, these include Matthew Project, Norfolk Youth Offending team, Mancroft Advice Project (MAP), Pharmacies, GP practices, City borough and district councils, smoke-free service and various voluntary organisations. Stop Smoking is also promoted and signposted through the Healthy Communities, a key team of Public Health, and Healthy Norwich. Schools are encouraged to have leaflets around the health impacts of smoking and signposting to Stop Smoking services.
- Effective communications – Trading Standards produced advertisement for illicit tobacco and underage sales which enforced action around these issues. To ensure that illicit tobacco in Norfolk is monitored and seized, Norfolk Trading Standards work with HMRC and have developed a range of intelligent sources since 2000. In 2013 Smokefree Norfolk went to Norwich City Football club before a match to promote Stoptober with the support of Delia Smith, their most famous supporter. The service was based at the Jarrolds stand before and during the match to encourage quits and raise awareness of the benefits of quitting. Effective communications also includes educational messaging through Personal, Social and Health Education (PHSE) within schools; this is not mandatory but briefly covers the exchanges of gases and the health implications. The aim is prevent children from initiating or continuing smoking.
- Reducing exposure to second hand smoke – within workplaces in Norfolk such as District, city and borough councils there is strict legislation in place and specified smoking areas. Within the Norfolk Hospitals (with the exception of Queen Elizabeth hospital which has a smoking shelter) and schools there is a strict no smoking policy on the site. Breckland District Council in 2010 developed a smoking policy which mandated that staff taking a

[4]Tobacco Control in Norfolk, a report for the shadow health and wellbeing board - Norfolk County Council, NHS Norfolk and NHS Great Yarmouth and Waveney, (2011). www.norfolkinsight.org.uk/resource/view?resourceId=491

cigarette break must clock in/out for the duration of a break, which is then taken in specific smoking areas. This is to encourage smokers to quit and ensure fairness between smoking colleagues and non-smoker colleagues.

- Making tobacco less affordable – a key part of this is ensuring that illicit tobacco is monitored as individuals are likely to choose this due to the cheaper cost. Trading standards are working closely with HM Revenue and Customs to monitor and deal with individuals who bring illicit tobacco into Norfolk and UK. Trading standards monitor communities, allowing them to identify areas and search areas which have been reported to be selling illicit tobacco to the Public[4].

Figure 7: Service Provision/Mapping



The map above illustrates the prevalence of smoking within Norfolk and the provision of smoking cessation providers. There is a greater smoking prevalence within Norwich, Great Yarmouth, King's Lynn and West Norfolk ranging from 14.64-43.53%. This reflects the availability of providers within these areas, as the majority are found with the Norwich and Great Yarmouth locality. In rural areas of Norfolk such as North and South Norfolk there appears to a sparse spread of services which is related to the lower smoking prevalence.

Going forward, Public Health will be reviewing and refreshing the Tobacco Control Alliance to meet the new challenges and working towards Norfolk County Council aims.

Local actions to address the issue

The most recent Health Needs Assessment for Norfolk[5] provided the following recommendations:

1. Further contractual work needs to be completed with the service providers to ensure targets are met and service is commissioned effectively.
2. Organisations and the general population should know how/where to access their local stop smoking service.
3. To work with schools/community groups to understand the young person's perception of smoking and influences around them.
4. Recruit further members to the Tobacco Control Alliance to develop working partnerships.
5. Development of smoking campaigns reviewing best practice from other regions within the UK.
6. Raising awareness of illicit tobacco within communities and the implications surrounding it.
7. Multi agency working to reduce second-hand smoking.
8. Multi agency working to improve the reduction of smokers within Norfolk.
9. Development of a Tobacco Control Strategy and the relating priorities.
10. Harm reduction by multiagency working.
11. To engage with the voluntary sector to develop relationships.
12. To work with agencies such as midwives to tackle smoking at the time of delivery in maternity.
13. To understand further why the proportion of pregnant women successfully quitting smoking in Norfolk and Waveney is lower than the East of England and England levels.
14. To understand the implications the external environmental has on the uptake of tobacco use.
15. To work with Norfolk organisations to assist with their workplace health.

[5] Tobacco Control health needs assessment for Norfolk 2014: http://www.norfolkinsight.org.uk/resource/view?resourceId=1049

For more information on this subject
Public Health Outcomes Framework**:**
http://www.phoutcomes.info/

Tobacco Control health needs assessment for Norfolk 2014:
http://www.norfolkinsight.org.uk/resource/view?resourceId=1049

Tobacco Control in Norfolk, a report for the shadow health and wellbeing board - Norfolk County Council, NHS Norfolk and NHS Great Yarmouth and Waveney, (2011):
www.norfolkinsight.org.uk/resource/view?resourceId=491

Healthy Lives, Healthy People: A Tobacco Control Plan for England:
http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_124960.pdf

NICE- Health Needs Assessment, a practical guide, (2005.) accessed at:
http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/health_needs_assessment_a_practical_guide.jsp

NICE Tobacco return on investment tool:
http://www.nice.org.uk/About/What-we-do/Into-practice/Return-on-investment-tools/Tobacco-return-on-investment-tool

ASH -The Cost of Local Tobacco Control Tool:
http://www.ash.org.uk/localtoolkit/docs/Reckoner.xls

ASH. Smoking: Illicit tobacco. (2013) accessed at: http://ash.org.uk/localtoolkit/docs/cllr-briefings/Illicit.pdf

Local Tobacco Control Profiles for England, Public Health England. (2013.) accessed at
http://www.tobaccoprofiles.info/

CLeaR, Excellence in Local Tobacco Control. ASH. (2014) accessed at
http://www.ash.org.uk/CLeaR

Tobacco Control Alliances – A toolkit for London. (2010) accessed at
www.cieh.org/publication/tobacco_control_alliances.html

Public Health England Local Health Indicator maps:
http://www.localhealth.org.uk

For further information on this report please contact Josh Robotham at:
joshua.robotham@norfolk.gov.uk

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Additional PHOF summaries are available on Norfolk Insight JSNA Page:
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