Introduction

Tobacco use is the leading behavioural cause of health inequalities in the UK. Reducing the prevalence of smoking is a national priority as smoking is the biggest single preventable cause of disease and premature deaths in the UK. Preventing people from starting smoking is key to reducing the harms and inequalities associated with tobacco use. In 2013-14 the government received £9.5 billion in revenue from tobacco tax (excluding VAT). In 2012-13 the Government spent £87.7m on services to help people stop smoking and a further £58.1m on stop smoking medication.

Tobacco products are made entirely or partly of leaf tobacco as raw material intended to be smoked, sucked, chewed or snuffed. All contain the highly addictive psychoactive ingredient, nicotine. Smokeless tobacco (also called oral tobacco) use is prevalent in the UK’s South Asian communities. Although the use of these other forms of tobacco is not well researched, some of the health impacts are likely to be similar to those of cigarette smoke.

Consequences of tobacco use include:

- Smoking tobacco is linked to an estimated 86% of lung cancers in the UK and is associated with cancers in other organs, including lip, mouth, throat, bladder, kidney, stomach, liver and cervix.
- An association with respiratory infections including chronic obstructive pulmonary disease (bronchitis and emphysema), pneumonia, asthma, and other ear, nose and throat problems.
- Smoking tobacco damages heart and blood circulation, increasing risk of developing conditions such as: coronary heart disease, heart attack, stroke, peripheral vascular disease, cerebrovascular disease.
- People who breathe in secondhand smoke are at risk of getting the same health conditions as smokers; for example, breathing in secondhand smoke increases a non-smoker’s risk of developing lung cancer or heart disease by about 25%. Infants and children are particularly vulnerable to effects of secondhand smoke resulting in developing respiratory infections.

Risk factors and vulnerable groups

- Two thirds of adult smokers start before the age of 18 and few people take up smoking after the age of 21.
- Prevalence of smoking decreases with age, with more than one in five 18-24 year olds and nearly one in four 25-29 year olds smoking compared with less than 10% in those aged 70 years and over.
- There is a higher rate of tobacco use amongst certain Black and Minority Ethnic groups. Nationally, it is estimated that 40% of Bangladeshi men, 30% of Irish men, 29% of Pakistani men and 25% of Black Caribbean men smoke. Men from Chinese, Indian and Black African backgrounds have lower rates of smoking. Apart from Black Caribbean (24%) and Irish women (26%), smoking amongst women from ethnic minority groups is generally very low. However, chewing tobacco is popular in the Bangladeshi community and 9% of men and 19% of women say they chew paan. Self-reported use of all tobacco products in the Bangladeshi community is 44% for men and 17% for women and when a saliva cotinine test was used to assess prevalence of tobacco use, it rose to 60% of men and 35% of women.
- Tobacco use amongst people with mental health conditions and with those with addictions is significantly higher in people with mental health conditions than in the general population, and
is responsible for the additional deaths observed in mental health mortality statistics.\textsuperscript{xii} Round 42% of tobacco use in the UK is by people who have a mental health problem.

- A higher smoking prevalence than England average in those with no religion in Gay/Lesbian and Bisexual populations and men.

There is a strong link between tobacco use and socio-economic status. People from socio-economically deprived backgrounds are more likely to smoke than wealthier people.\textsuperscript{xiii} Smoking accounts for over half the difference in risk of premature death between the highest and lowest social classes in the UK. Although just as likely to want to quit, trends in smoking in these groups makes stopping smoking more challenging. In 2013, 14% of adults in managerial and professional occupations smoked compared with 29% in routine and manual occupations.\textsuperscript{xiv}

The reasons for this are complex and incompletely understood, but include reduced social support for quitting, low motivation to quit, stronger addiction to tobacco, increased likelihood of not completing courses of drug treatment or behavioural support sessions, psychological differences such as lack of self-efficacy, and tobacco industry marketing. Whatever the explanation, smoking is an important contributor to health inequalities.\textsuperscript{175}

**What is the evidence base?**

The NICE Local Government Briefing on Tobacco\textsuperscript{v} highlights the types of activities covered by NICE’s recommendations published up to January 2015 using the best available evidence from their guidance and quality standards. They are grouped as:

- Leadership – including workplace smoke free policies and supporting employees to quit, training, monitoring and evaluation of services, community engagement, including secondary care in local strategies, ensuring referral systems are in place and including tobacco harm-reduction approaches when commissioning services.
- Prevention – including working with schools to discourage children and young people from smoking.
- Complying with legislation – including ensuring environmental health and trading standards services prioritise tobacco control, auditing test purchases, training for retailers and prosecutions.
- Communications – including regional and local campaigns integrated with national communication strategies.
- Innovation and learning – providing flexible, coordinated and accessible services which are planned and developed with disadvantaged groups.
- Helping people to quit or reduce harm from smoking – including flexible and accessible stop smoking services, partnership working, harm reduction, realistic performance targets, auditing of services, effective brief interventions, action in the workplace and interventions in pregnancy and following childbirth.

These are informed by the following NICE guidance and quality standards on engaging people and successful smoking cessation:

- Smoking cessation services.\textsuperscript{xvi, xvii}
- Workplace interventions to promote smoking cessation.\textsuperscript{xviii}
- Quitting smoking in pregnancy and following childbirth.\textsuperscript{390}
- Brief interventions and referral for smoking cessation.\textsuperscript{xix}
- School-based interventions to prevent smoking.\textsuperscript{xx}
- Tobacco harm reduction.\textsuperscript{xxi}

There is reasonable evidence to support that smoking cessation interventions that work for the general population can also work for people with a mental disorder and may be just as effective.\textsuperscript{xii}
Two further smoking quality standards are in development due to be published in 2015 focussing on harm reduction and reducing tobacco use in the community.

Local picture

Prevalence

Prevalence of adult smoking in Luton in 2013 was 19.98%. The rate remained above the national average (18.5%) but was not significantly different. As shown in Table 34 the rate also remained above the London comparator areas (Hillingdon and Redbridge with the latter showing a rate significantly below the England average).

Table 34: Adult smoking prevalence

<table>
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<td>17.51</td>
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<td>20.21</td>
<td>19.53</td>
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</tbody>
</table>

Source: Integrated Household Survey, Office for National Statistics; graph by Luton Public Health; Green = significantly lower smoking prevalence compared with England; Amber = no significant difference; Red = significantly higher prevalence

Prevalence amongst routine and manual occupations is considerably higher than the rest of population in Luton at 29.1%, which is a contributing factor to health inequality. The rate is similar to comparator areas and the national average as shown in Figure 76.
Smoking attributable illnesses

Smoking presents an economic challenge, costing the NHS an estimated £2 billion a year to treat related illness. Modelled estimates of the impact of tobacco in Luton (shown in Figure 77) suggest a £47 million loss to the total economy which includes NHS, fire, litter, absenteeism and lost productivity. For adult social care the cost to the local authority and self-funders is estimated at £3.2 million, which is approximately 1,440 people requiring some level of support due to a smoking-related illness. More detailed return on investment work will be carried out as part of the evaluation for the refreshed Smoking strategy, due to be produced in 2015-16.

Figure 77: Estimated costs due to smoking in Luton

Source: ASH

Figure 78 shows smoking attributable admissions in Luton are significantly higher than in England and increased slightly in 2012-13, widening the inequality gap with England. The rate is similar to comparators from the West Midlands but higher than comparators from the South of England.
Smoking attributable mortality and inequality

Smoking remains the biggest single cause of preventable mortality and morbidity in the world.\textsuperscript{xxvi} It still accounts for 1 in 6 of all deaths in England, and there exist huge inequalities in smoking related deaths. Figure 79 shows the smoking attributable mortality (SAM) rate for Luton is following a similar trend to England as a whole. SAM for cardiovascular diseases and stroke are similar to the national rate, however heart disease SAM is significantly higher (Figure 79).

Smokeless tobacco

Smokeless tobacco refers to any type of product containing tobacco that is placed in the mouth or nose and not burned and which is typically used in England by people of South Asian origin. The phrase people of South Asian origin is used in this context to mean people with ancestral links to Bangladesh, India, Nepal, Pakistan or Sri Lanka.\textsuperscript{xxvii} Smokeless tobacco is highlighted in many studies to be linked to certain cancers. However, there are other health risk factors to its usage such as poor oral health, reduced fertility in men and in pregnancy higher risk of pre-eclampsia, premature birth and low birth weight.366
The findings from the local smokeless tobacco needs assessment showed the use of smokeless tobacco is more prevalent in the Bangladeshi community, especially older women, in Luton. The recommendations from the report included support for those using smokeless tobacco in the local stop smoking service, raising awareness in local communities, training of healthcare professionals, smoking education sessions to children, better collection of local data and compliance of retailers of products in regards to labelling and the age of sale.

**Smoking in pregnancy**

See Section 5.2

Smoking during pregnancy causes complications during labour and an increased risk of miscarriage, premature birth, stillbirth, low birth-weight and sudden unexpected death in infancy. It also increases the risk of infant mortality by an estimated 40%. Children exposed to tobacco smoke in the womb are more likely to experience asthma, bronchitis and pneumonia. It is also associated with psychological problems in childhood such as attention and hyperactivity problems and disruptive and negative behaviour. In addition, it has been suggested that smoking during pregnancy may have a detrimental effect on the child's educational performance.

Smoking status at time of delivery continues on a downward trend in Luton and is now not significantly different from the England average. This was a reduction from 14.6% in 2011/12 to 12.1% in 2013/14. Estimated NHS savings based on implementing NICE guidelines in 2011/12 predicted savings of around £31,000 per year over the following three years.

**What is being done locally?**

Tobacco Free Luton is the partnership responsible for the strategy and annual action plan and reports to the Health Inequalities Delivery Board. It undertook a self-assessment in 2013 and a peer review in 2014 through the national CLeaR programme. The partnership was commended for the high engagement of senior officers and elected members and for embedding tobacco control in local strategies. Recommendations included closer working with NHS partners and responding to Luton’s changing demographics. Below are highlights of the previous three years work.

**Pregnancy and early years**

- In 2012 Luton introduced the NICE recommendations for routine carbon monoxide monitoring in all pregnant women with the acute trust which increased referrals into the stop smoking service.
- The smokefree homes message is integrated into the Baby Safe programme delivered through children’s centres and partners.

**Young people and adults**

- Targeted smoking cessation work took place in Leagrave/Hockwell Ring area for women smokers.
- Social norms project in Luton Sixth Form College to change perception of the number of young people who smoke.
- QUIT, a national charity, delivered a youth advocacy programme over two years.
- A new smoke free policy for the Council.

**Niche products**

- A smokeless tobacco health needs assessment was conducted in 2013 with recommendations for supporting people who use these niche products. Initial scoping took place for a harm reduction service in partnership with Dental Health Promotion and a dental surgery for implementation in 2015.
- A shisha enforcement and education campaign targeting businesses and communities.
• Youth shisha campaign using social media to change perceptions and raise awareness of the health risks.

**Supra-local tobacco control**

• Continued participation in regional networks and an illegal tobacco campaign which ran in 2012 involving local partners and regional Trading Standards and HM Revenue & Customs. This continues as a key work strand for Trading Standards.

**Perspective of the public/service users**

Three public surveys were conducted since the 2011 JSNA

• Shisha survey for 16-25 year olds (2012) – the survey highlighted the need to do targeted work to debunk myths and provide clear facts on the health harms of shisha use, linking it to tobacco. The survey provided intelligence for the enforcement activity.

• Smokeless tobacco health needs assessment (2013) – the survey provided insight into communities, product use and willingness and support needed to stop. A harm reduction approach was recommended and will be implemented in 2015.

• The council Citizen Panel survey on smoking and vaporisers (electronic cigarettes) (2013). The survey indicated a lower smoking prevalence in Luton than data released nationally. Vaporiser use was low and reflects national data. Public Health will continue to monitor the trends in smoking prevalence.

**Priorities**

1. The Tobacco-Free Luton Strategy ends in 2015. It is recommended that the strategy is evaluated and the findings from this and the CLeaR peer review are used to refresh the strategy and action plan. It is expected that three of the key recommendations to come out of the review are:
   a. Invest in sustained, evidence-based prevention work with young people and those with diagnosed mental health problems.
   b. Incorporate a harm reduction approach to tobacco by the beginning of commissioning year 2016/17.
   c. Support Tobacco-Free Luton partners to further embed tobacco control within their organisations, including enhanced smoke-free policies and smoke-free grounds.

2. Understand the three key gaps in local data and understanding are:
   • Smoking prevalence and behaviour amongst young people under 18 years.
   • Baseline data for niche tobacco product use. An attempt was made to establish prevalence of shisha amongst young people (16-25 years) and smokeless tobacco products; however the sample size was insufficient to draw firm conclusions.
   • Impact of migration on smoking prevalence in routine and manual groups. Large fluctuations in communities emigrating from countries with a significantly higher smoking rate is likely to have an impact on prevalence in the lower socio-economic groups and potentially those who are pregnant.
References


