Rationale for further evidence

1. During the oral evidence session on 27 March the committee expressed concern about the failure of NHS policies to consistently take account of the evidence base in their policies on e-cigarettes and the apparent lack of sophistication of some policies. In particular that the default position by NHS organisations appears to be prohibitionist, contrary to advice from PHE and others.

2. As ASH said to the Committee the underlying problem is the failure of many parts of the NHS to adequately support smokers to quit. With a few notable exceptions NHS organisations lack clear policies, objectives and staff buy-in around supporting smokers to quit1, and an inconsistent approach to e-cigarettes is just one element in this policy failure.

3. In cases where NHS organisations have developed a strong approach to tackling smoking, and see reducing rates among their patients as a priority, they have also tended to adopt more liberal policies towards e-cigarette use. Examples of such Trusts would include South London and Maudsley NHS Foundation Trust and Tees Esk and Wear Valley NHS Trust.

4. Where NHS organisations have not engaged in a concerted effort to reduce rates of smoking then they have less incentive to invest staff time and energy into developing appropriate policies towards e-cigarettes. A good local policy needs to take account of local circumstances, the current evidence base and seek to maximise the opportunities and minimise the risks of e-cigarette use.

5. Maximising the opportunities from e-cigarettes to support smokers to quit goes hand in hand with having an effective approach to supporting smokers in general, which is not just cost-effective but cost-saving. NICE has estimated that for every £1 invested in smoking cessation £2.37 is saved on the cost of treating smoking-related diseases and reductions in the amount of lost productivity due to smoking.2

Gaps in NHS support for smokers to quit

6. There are currently big differences in the types of help to quit smokers receive depending on where they engage the healthcare system. There are significant differences related both to which part of the system they are engaging with and where it is geographically. This lack of consistency is both inequitable and a false economy given how highly cost effective interventions to reduce rates of smoking have been shown to be.

Secondary care

7. In 2016 the British Thoracic Society undertook an audit of 14,000 patients in acute settings to assess the implementation of activity to support smokers in line with NICE guidance.1 The findings were that:
   - 27% of patients were not asked about their smoking status;
   - Provision of nicotine replacement therapies and other smoking cessation treatments were “poor” in hospital pharmacy formularies;
   - 72% of hospital patients who smoked were not asked if they’d like to stop;
   - Less than 10% of patients who were smokers were referred to a hospital or community-based smoking cessation service; and
50% of organisations had no regular smoking cessation training for staff.

8. The provision of a specialist smoking cessation intervention compared to ‘usual care’ in hospitals in Canada (the Ottawa model) has been shown to be highly effective and cost-effective with immediate impact on outcomes. To summarise the key results:
   - Patients who received the intervention were significantly less likely to be re-hospitalised or to visit casualty in the next two years.
   - The largest reductions were in the 30 days following their initial hospitalisation when those who received the intervention were half as likely to be re-admitted to the hospital for any cause, and 20% less likely to visit an emergency department.
   - More than a third of patients were smoke-free at 6-month follow up, compared to only one in five of the “usual care” participants.
   - The study showed a 50% reduction in 2-year mortality risk among patients who received the intervention.

9. As noted in previous evidence ASH has recently been commissioned by Cancer Research UK to undertake a survey of mental health trusts implementation of NICE guidance. Initial desk-based research finds that the variation in e-cigarette policies found by the Select Committee is matched by a similar inconsistency in implementation of NICE guidance.

Primary care

10. Since the transfer of public health to local government there has been a significant decline in primary care activity to support smokers to quit.
   - The total number of stop smoking medications prescribed in primary care was relatively stable from 2005/6 until 2011/12. In the year leading up to the transition of public health to local authorities, and subsequently, the number of prescriptions has fallen significantly year on year from 2,532 in 2011/12 to 1,154 in 2015/16.
   - Prescriptions of NRT have declined from a peak in 2009/10 when 1,559,000 NRT products were prescribed to 644,000 in 2015/16. A drop of around 1 million in five years. While increased use of e-cigarettes may have contributed to this decline it cannot be the only cause.
   - There has also been a significant variation across the country by CCG. The average number of prescriptions for stop smoking medications per 1,000 is 21, however the range is from 1 to 52.
   - Research from UCL also points to a decline in GP prompted quit attempts over the same period with fewer smokers reporting that their GP has encouraged them to quit.
   - The ASH survey funded by Cancer Research UK of local authority stop smoking leads in 2017 found one in nine reported that GPs locally would no longer prescribe stop smoking medications. This appears to be linked to a growing number of CCGs which are refusing to fund stop smoking medications. One of the first examples was the three Worcestershire CCGs, which wrote to GPs in March 2016 stating that “no prescriptions for nicotine replacement therapy, bupropion or varenicline should be written for new patients from 1 April 2016”.

Supplementary written evidence submitted by Action on Smoking and Health (ECG0107)
People with smoking-related diseases:

11. Not only are there differences in the NHS response by location but also by type of condition. Researchers analysed 12,393 anonymised electronic primary care records between 1999 and 2013. They compared the likelihood that people with smoking-related cancer or coronary heart disease who were smoking at diagnosis would be offered support to quit by their GP. This showed that 24% of cancer patients versus 48% of coronary heart disease patients were offered support to quit and 13% of cancer patients versus 22% of coronary heart disease patients were prescribed medication.

12. In the year following diagnosis 36.7% of cancer patients had stopped smoking, compared to 44.4% of coronary heart disease patients. For both groups the expectation should be that 100% of smokers are offered support to quit. Quitting smoking improves outcomes and efficacy of treatment for both conditions. To give just one example, just over a third of lung cancer patients were smoking at diagnosis, those who stopped smoking and survived their treatment lived on average for 1.97 years, compared with 1.08 years for those who did not quit smoking after diagnosis.

Public health support

13. Since the transfer of public health to local government there have been significant cuts to the ring-fenced public health budget in addition to cuts to overall local government finances, all of which have had an impact on local authority funding for stop smoking services. The 2017 ASH survey, funded by CRUK, found that only 61% of respondents reported having a service which meets the standards set out by NICE and recently updated.

14. These reductions not only mean the loss of evidence based dedicated expert support they also lead to a loss of expertise within the local system. Many stop smoking services have historically trained NHS staff to have a basic understanding of how to identify and support smokers, have advised on the development of local policies and have been a vital referral route for primary care and secondary care pathways. The decline in services therefore has implications for the efficacy of the NHS response to smoking.

ASH recommendations

15. There are commitments to implement NICE guidance throughout the NHS in the Government’s Tobacco Control Plan for England. However, nearly a year into the life of the national strategy, and despite the evidence that NICE guidance is not currently being implemented in the NHS, there is no NHS plan for implementing these commitments, this urgently needs addressing. NHS England should be called to give evidence by the Select Committee and urged to develop an overarching strategy and operational plan for delivering on all the Tobacco Control Plan commitments, including on e-cigarettes.

16. Maximising the opportunities provided by e-cigarettes within the NHS requires a joined-up plan to tackle smoking throughout the NHS, in line with NICE guidance. This should include:
   - All smokers being given brief advice when they come into contact with the NHS and offered further support to quit.
Supplementary written evidence submitted by Action on Smoking and Health (ECG0107)

- All smokers having access to evidence-based support to quit where they live, either provided by the NHS or local authorities.
- All smokers who want, and would benefit from, prescriptions of stop smoking medications being provided with them.
- Smokers being given clear advice about the use of e-cigarettes to quit, and local policies being put in place to support a clear understanding of the reduced risks of vaping compared to smoking.

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References