Smoking

Smoking remains the leading cause of preventable morbidity and premature death in England today, and is estimated to be responsible for up to 86,500 deaths per year (1). Reducing smoking rates represents a huge opportunity for public health as 1 in 5 adults still smoke. The NHS spends over £2.7 billion a year on treating smoking-related illness, but less than £150 million on smoking cessation (2).

The number of hospital admissions for smoking related diseases is rising among adults. In 2008/09 around 5% of hospital admissions for all diseases in England among adults aged 35 and over were attributable to smoking with a larger proportion of admissions among men (7%) than women (4%). In 2009, it was estimated that almost one in five deaths in England of people over 35 years of age were due to smoking. Over a third of all deaths from respiratory diseases and almost three in ten of all deaths from cancers in this population are estimated to be caused by smoking (3).

Awareness of the adverse effects of smoking on health is now relatively widespread. 70% of smokers in Great Britain say they want to stop smoking and many have tried to give up in the past. For every two smokers who quit, one premature death will be prevented. Every year nearly three million smokers try to quit, although most find it very difficult and on average, will take five attempts to quit for good. In 2009/10 757,537 people in England set a quit date through NHS Stop Smoking Services and at the four week follow up 49% had successfully stopped smoking (3).

It has been shown that older smokers are more successful than younger ones at quitting, and men are more successful than women in stopping smoking; this has been a contributory factor to the narrowing of the life expectancy gender gap. The least successful groups for quitting have been identified as pregnant women, smokers in areas of deprivation, some ethnic groups and those with high dependency, usually shown when smoking is started at an early age (4). More than 8 out of 10 adults who have ever smoked regularly started smoking before 19 (2) and it has been shown that those who start smoking when they are young are three times more likely to die of a smoking-related disease (4).

Reducing smoking remains a key priority and smoking-related disease will remain a significant factor in population ill health and healthcare for the future. Although smoking prevalence has declined consistently, with a reduction of 7% since 1998 and 18% since 1980, there is no room for complacency (3). The decline in smoking prevalence has been greater in higher-income groups than lower-income groups, which has contributed substantially to the widening of health inequalities (1). Moreover, certain groups have poorer health and some are uniquely disadvantaged because of a combination of their circumstances. For example, a UK study found that, of those living with schizophrenia in the community, a much lower life expectancy was experienced than the general population. The largest single cause of this inequality was identified as an increased rate of smoking, more than three times that of the general population (5).

Smoking remains one of the few modifiable risk factors in pregnancy. More than 1 in 6 mothers smoke during pregnancy and smoking rates during pregnancy are much higher among lower socioeconomic groups and teenage mothers. Smoking during pregnancy contributes to 6% of all infant deaths and accounts for about a third of the difference in infant deaths between the most and least deprived groups in the population. Smoking in pregnancy also increases infant mortality by about 40% and is a key risk factor associated with low birth-weight (5).

For over ten years, since the publication of the White Paper Smoking Kills (6), the UK government has demonstrated a strong commitment to reducing smoking prevalence through many actions, including the creation of a national network of smoking cessation

---

(1) National Statistics
(2) Department of Health
(3) Health Protection Agency
services - the NHS stop smoking services. These services represent a unique national initiative to provide support for smokers motivated to quit and the available evidence suggests that they are effective in supporting smokers to quit in the short and longer term (4). Stop smoking services are one of the most cost effective of all NHS health interventions and studies have shown that investment of £0.3m on stop smoking services could realise a saving of £1.2m for the NHS (1).

Stop smoking support is one of the most frequently commissioned services through community pharmacy (7), with 77% of PCTs in England commissioning these services from pharmacy, and in 2009-10, an increase in successful quits through community pharmacy of 15% was achieved over the previous year (3).

In recent years, the majority of NHS Stop Smoking Services have modified their treatment protocols, dramatically increasing the proportion of treatment delivered in healthcare settings such pharmacies (8). Community pharmacies serve local communities and have the potential to reach large numbers of people who use tobacco. They are able to meet the needs of minority ethnic and disadvantaged groups and those who may have difficulty accessing other community services (9). The use of nicotine replacement therapy (NRT) and stop smoking techniques are well known, with many patients visiting their pharmacy to commence such treatment. Community pharmacy is now an established and trusted provider of stop smoking services, and an integrated partner of the NHS Stop Smoking services in many areas, enabling a co-ordinated approach, quality assurance and use of consistent messages to people.

Many smokers per day pass through a pharmacy and pharmacists and their staff are ideally placed to opportunistically provide brief interventions on stopping smoking and increase access to stop smoking products through patient group directions (PGDs).

Helping people to stop smoking is a high priority for NHS Sheffield. It recognises that smokers who quit through using the NHS Stop Smoking services commissioned in their area will have improved health outcomes and lower levels of healthcare utilisation. The service supports 3000 people a year to successfully quit, has additional services to support pregnant women and works in partnership with community pharmacies. A flexible one-to-one service of up to seven interventions tailored to the client’s individual needs has been commissioned through community pharmacy, building on the results of 2009-10 which showed that community pharmacy was the most effective local independent provider having achieved the highest outcome figures with a 54% success rate (10).

There is a strong evidence base for the effectiveness of pharmacy-led stop smoking programmes (11). Community pharmacy teams trained in behavioural change are effective at helping clients to stop smoking. Abstinence rates from one-to-one services provided by community pharmacists are similar to those of primary care nurses and community pharmacy-based stop smoking services are cost effective (16). The Department of Health has stated that it will strengthen its partnership working with community pharmacies to secure their support and investment in campaigns to promote effective routes to quit smoking (2).

References


10) Information from the PSNC Community Pharmacy Services database www.psnc.org.uk

11) Pharmacy-based stop smoking services: optimising commissioning. NHS Employers (2009)