

Why tobacco dependency should be treated as a long-term relapsing condition that starts in childhood



Fran Robinson talks to the PCRS-UK Tobacco Dependency Campaign Group about the role of the healthcare professional in treating tobacco dependency as a long-term relapsing condition that starts in childhood



PCRS-UK Tobacco Dependency Campaign group from left to right: Noel Baxter, Oonagh Potts, Bronwen Thomson, Andrew Whittamore

PCRS-UK has launched a campaign to establish tobacco dependency as a long-term relapsing condition starting in childhood and to convince every healthcare professional that treating tobacco dependency needs to be their responsibility. PCRS-UK Executive members Andy Whittamore (a GP in Portsmouth) and Oonagh Potts (Nurse Practitioner, Thornton-Cleveleys) say: "Smoking has too great an impact on health for us to continue to think of it simply as a public health or lifestyle issue that is the remit of someone else. Particularly at a time when local councils are de-prioritising smoking cessation services, we have to take responsibility for it in our practices and recognise that addressing it is one of the most cost-effective actions we can take."

The Government is also keen to reduce smoking prevalence. The Five Year Forward View, which has a strong focus on preventing ill health, has promised 'hard-hitting' national action on smoking, with plans to develop and support new workplace incentives to promote employee health and cut sickness-related unemployment.⁴

Tobacco dependency – a health condition

The aim of the campaign is to change mindsets and beliefs by changing the language from 'smoking cessation' or 'nicotine addiction' to 'tobacco dependency' and reframing it for health professionals and commissioners as a long-term relapsing condition which starts in childhood.

Hilary Wareing, who leads the work of the Tobacco Control Collaborating Centre, part of the research and training organisation Improving Performance in Practice, explains why smoking should be seen as a health condition: "We promote this thinking mainly because you hear people talk about smoking as a lifestyle or personal choice. Smoking isn't a lifestyle choice – we say to people if you continue to smoke it will kill one in two of you and one in four of you will die prematurely before retirement."

- Treating tobacco dependency is a high value healthcare intervention that saves the NHS money and improves health outcomes.
- It is the single most cost-effective intervention for respiratory patients: smoking accounts for over one-third of respiratory deaths¹ (23,800 deaths² a year) and 28% of total hospital admissions.³ About half of all regular smokers will eventually be killed by their addiction.¹
- Although smoking rates are coming down, prevalence is still 18–19%³ and there are currently 9.6 million adult smokers in the UK.¹ This makes tobacco dependency the most prevalent long-term condition.
- Smoking is also related to health inequalities. The Five Year Forward View points out that more than half of the inequality in life expectancy between social classes is now linked to higher smoking rates amongst poorer people.⁴
- Surveys consistently find that smokers want to quit^{5–7} which means that healthcare professionals should, in many cases, find they are pushing at an open door.

Whilst public health measures have and will continue to prevent many from taking up smoking and encourage some to quit, many of those who are most tobacco-dependent will not be able to quit without treatment from a healthcare professional. The World Health Organization's Framework Convention on Tobacco Control includes a specific article on treating tobacco dependence, Article 14, which argues that cessation support is essential.⁸

Tobacco dependency – a long-term relapsing condition

Smoking is a long-term chronic relapsing condition for which people need treatment including behavioural support and pharmacotherapy. Patients will vary in the level and length of treatment they need to remain abstinent and ex-smokers should be offered reassessment on an ongoing basis, especially if they are in a high relapse group. As with other long-term conditions such as diabetes and hypertension, adherence factors, side effects and motivation to take control need to be assessed at routine visits and when otherwise convenient. Using a CO monitor in smokers and ex-smokers is akin to checking a BP or HbA_{1c}. Often we need to titrate and adjust medicines for long-term conditions, and the same goes for treating tobacco dependency. There are many products people can use to help them quit, but choice, strength and formulation all need to be considered so the health professional needs to be aware of the advantages and disadvantages of the available options. The National Centre for Smoking Cessation and Training (NCSCT) online training programmes can help you learn about these pharmacotherapies (see http://www.ncsct.co.uk/pub_stop-smoking-medications.php).

"We also need to remind people that, if they attempt to stop smoking with expert support, they are four times more likely to make the change and be successful," says Hilary.

Tobacco dependency – a condition that starts in childhood

Another key message of the campaign is that smoking starts in childhood with secondhand smoke. Babies and children exposed to their

families' smoking face an increased risk of respiratory infections, increased severity of asthma symptoms, more frequent chronic coughs, phlegm and wheezing, and increased risk of cot death and glue ear.⁹

This means healthcare professionals should be working with mothers to ensure that their babies have a smoke-free pregnancy and aren't exposed to tobacco smoke in utero. When their baby is born, parents should be encouraged to bring them up in a smoke-free environment.

Hilary says: "Smoking in the family not only impacts on children's physical health but, in addition, if you live in a smoking household you are more likely to smoke yourself."¹⁰

"If children are brought in to primary care or taken to hospital with an illness that may be related to smoking, then healthcare professionals should be asking the parents or carers whether they smoke and then remind them of the impact their behaviour has on their children, not only the immediate damage to their child's health but also the consequences of their child further endangering their health by smoking themselves. This is an opportunity to do a brief intervention to encourage any members of the household who smoke to make changes and receive treatment that will help them to quit."

Why smoking should be the responsibility for every healthcare professional

Hilary says helping smokers to quit should be the responsibility of every healthcare professional and they should think in terms of "Every Contact Counts".

"If you have contact with somebody who smokes, you should take the opportunity to do an opportunistic brief intervention. Even if the patient does not have any symptoms of a smoking-related disease, we need to persuade them to stop smoking as soon as possible because we don't want to wait to see what the impact of smoking will be on their health."

She says ideally all general practices should have their own in-house smoking cessation specialists who can ensure that patients can get the treatment they need from someone

they already know rather than having to be referred elsewhere.

"A lot of practices do have one or more people, usually practice nurses or health care assistants, who are trained to support people both with behavioural changes and medication to help them to stop smoking, but many still don't. However, the most important thing is that everybody in the practice is trained to deliver brief interventions and, if they don't have an in-house specialist, knows how to arrange referral to local stop smoking services."

Hilary says the NHS stop smoking services do achieve slightly better quit rates because their experts are doing it every day. However, it is also important that those smokers who want to quit are given the option of being given the treatment in the location that they think will be most likely to help them to stop.

"Healthcare professionals should ensure they can offer patients timely support and treatment. If patients are left to drift for weeks they might decide their smoking is not a serious problem or they may try to quit on their own and then they are more likely to fail," she says.

The credibility of the person giving the smoking cessation message is also important. "It's about the right person giving the right message at the right time. The potential for giving conflicting messages can be damaging. For example, a midwife might lay it on the line to a pregnant woman that smoking will harm her baby and that cutting down isn't good enough. But if the GP subsequently fails to mention the mother's smoking or suggests that cutting down is acceptable, the message that gives is that smoking is not that serious. It's about making sure that everybody in the healthcare system says the same thing about smoking," says Hilary.

The gains from addressing tobacco dependency

The main gain from helping smokers to quit is an immediate improvement in their health and quality of life.¹¹ Stopping smoking is always beneficial to health and is never too late.¹¹

However, some practices may see spending time helping smokers to quit as a drain on

their resources. But Hilary says that instead of thinking what it might cost them, practices should consider that there is a good economic argument that, if smokers quit, it is very likely they will need fewer appointments and their prescribing budget will reduce along with hospital admissions – see page 38 for an example of how one practice has made significant savings.

“So if they can help their population be healthier by stopping smoking, then there is an opportunity there to release time to care,” says Hilary. “Practices tell us that this happens and we are currently trying to get some funding to evaluate some case studies.”

There are some specific groups of vulnerable patients for whom successful smoking cessation treatment will have the greatest beneficial impact. Groups that should be targeted include: patients with asthma and COPD, pregnant women, people with mental health issues, and routine and manual workers.

At the moment practices are incentivised to help smokers to quit through the Quality and Outcomes Framework (QOF), but Dr Andy Whittamore feels that QOF incentives encourage people to ask patients about their smoking in a very superficial way. “Something we’ve done in our practice and across the whole of Portsmouth City CCG is to incentivise all clinicians to do the NCSCT Very Brief Advice training.¹² This means that all clinicians in practices across Portsmouth are now trained to not only inquire about patients’ smoking but also to help them to take the next step towards cessation. Generally, because patients come in with their own agenda, talking about their smoking habit is probably the last thing on their list. A healthcare professional giving a patient that nudge to stop can be very powerful – it has a big impact but takes up very little time.”

References

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Useful Resources

There are a number of online tools available which bring together data on smoking and its impact on the wider population. Designed mainly for use by public health officials, they can also be used by primary care clinicians who are interested to see how their local population data about smoking relate to their practices.

Local Toolkit

The Local Toolkit created by Action on Smoking and Health (ASH), the Faculty of Public Health, the Local Government Association and a number of other organisations is a set of materials for local public health professionals to use with councillors and other stakeholders to help ensure that tackling tobacco use is high on the local public health agenda. The resources demonstrate the scale of the harm locally caused by tobacco use and the contribution this makes to health inequalities, the cost to local communities, local economies and service providers and the evidence of effectiveness of local action on tobacco and health, including tobacco control work and local stop smoking services.

<http://www.ash.org.uk/information/ash-local-toolkit>

Local Tobacco Control Profiles

The Local Tobacco Control Profiles for England, published by Public Health England, provide a snapshot of the extent of tobacco use, tobacco-related harm and measures being taken to reduce this harm at a local level. These profiles have been designed to help local government and health services to assess the effect of tobacco use on their local populations. They will inform commissioning and planning decisions to tackle tobacco use and improve the health of local communities. In June this year four new indicators were added to the profiles: hospital admissions for COPD; GP Patient Survey smoking prevalence – current smokers; GP Patient Survey smoking prevalence – ex-smokers; and GP Patient Survey smoking prevalence – never smoked.

<http://www.tobaccoprofiles.info>

Local Poverty Calculator

A Local Poverty Calculator, published by ASH, shows how many people in an area are in poverty because of smoking. The data show that, of the 5 million households in England that include an adult smoker, 1.4 million (27%) are below the poverty line. An estimated 418,000 households could be lifted out of poverty if they quit smoking. These households comprise roughly 1.1 million people including 325,000 children and 156,000 pensioners. On average, households that include a smoker spend £2,158 a year on tobacco. https://view.officeapps.live.com/op/view.aspx?src=http://www.ash.org.uk/files/documents/ASH_988.xls

Ready Reckoner

The ASH Ready Reckoner is an Excel spreadsheet that provides estimates of the cost of smoking to smokers, the NHS and society at large based on national data. It covers data such as the cost of lost productivity due to early smoking-related deaths, smoking breaks and smoking-related sick days.

<http://www.ash.org.uk/localtoolkit/docs/Reckoner.xls>