Manchester Health & Care Commissioning
A partnership between Manchester City Council and NHS Manchester CCG

MANCHESTER CITY COUNCIL

NHS Manchester Clinical Commissioning Group

SMOKE-FREE MANCHESTER

Our plan for tobacco control 2018–2021

David Regan, Director of Population Health and Wellbeing, Chair of the Manchester Tobacco Alliance

Authors: Julie Jerram and Neil Bendel, with contributions from partners of the Manchester Tobacco Alliance

Our Manchester

Contents

1.

Introduction

1. Manchester has above-average rates of smoking in all age groups and the highest premature mortality rate in the country for the three major smoking-related conditions: lung cancer, heart disease and stroke. Smoking is the single largest cause of health inequalities in Manchester. The human cost of these challenging statistics is why this tobacco control plan is so important for the city.

2. Adult smoking rates have reduced in recent years nationally and in Manchester (see section 2). Major cultural change was achieved when smoke-free legislation was introduced in England in 2007. However, while we still have such stark smoking-related health inequalities, tobacco control remains a high priority as described in the Manchester Population Health Plan.

3. We must continue to help Manchester's smokers to stop, and work towards having a city where children and young people do not start smoking and everyone is protected from tobacco-related harm.

4. In 2017, the Tobacco Control Plan for England, 'Towards a Smoke-free Generation', (1) and the first-ever Tobacco Control Plan for Greater Manchester, 'Making Smoking History, A Tobacco-free Greater Manchester' (2) were launched. In both Plans, ambitious goals were set out for the further reduction in smoking rates and tobacco use, with interim targets set for 2021/22. The Government's vision is to achieve a smoke-free generation, with an adult national smoking prevalence rate at 5% or below by 2030.

5. The Smoke-Free Manchester Plan is consistent with both the national and Greater Manchester (GM) Tobacco plans, and we will continue to work closely with Public Health England and the Greater Manchester Tobacco Programme teams.

6. It is acknowledged that Manchester will benefit from investments in the Greater Manchester 'Making Smoking History' programme; for example, the development of the CURE Programme (3) at Wythenshawe Hospital (see section 5) which, if successful, will be delivered across Greater Manchester.

7. Manchester City Council and Manchester Health and Care Commissioning teams have led work on enforcement programmes, such as tackling shisha smoking, illicit tobacco supplies and cigarette littering. We have a strong platform to build on, but there is much more to be done over the coming years.

8. In December 2016, the Director of Population Health and Wellbeing established the Manchester Tobacco Alliance, a multi-agency partnership. The Alliance has co-produced this plan and will continue to oversee the implementation of the various programmes over the next three years.

8.1 The targets that have been agreed with partners are:

- **By 2021/22 we will aim to reduce adult smoking prevalence from 21.7% to 15% or less in Manchester**
- **By 2021/22 we will aim to reduce smoking in pregnancy from 11.6 % to 6%.**

9. To achieve these targets the Plan will:
   - Adopt an evidence-based approach reviewing new emerging evidence (eg. e-cigarettes) as it becomes available
   - Align with and support the Greater Manchester Tobacco Programme, 'Making Smoking History'
   - Be based on 'whole system' partnership working; tobacco control cannot be achieved by one agency alone
   - Prioritise work with local communities through the Our Manchester approach.

10. The production of the Smoke-Free Manchester Tobacco Control Plan has been co-ordinated by the Tobacco Control and Health Intelligence leads of the Population Health and Wellbeing Team in partnership with the Manchester Tobacco Alliance. The Plan should be read alongside the Joint Strategic Needs Assessment for Tobacco Control (www.manchester.gov.uk/jsna).

11. The Delivery Plan is provided in section 4 and further information can be obtained from Julie Jerram, Manchester Population Health and Wellbeing Team, j.jerram@manchester.gov.uk. The Delivery Plan will be reviewed and refreshed each year.

2. Tobacco-related harm in Manchester

Headlines: Smoking in Manchester

There are estimated to be just under 91,500 smokers aged 18 and over in Manchester. This is equivalent to 21.7% of the population compared with the England average of 15.5%.

Smoking prevalence in Manchester has been falling for a number of years, but the rate of reduction is much slower than in other parts of the country.

There are around 6000 smoking-related hospital admissions per year costing the NHS in Manchester approximately £5.4million per year.

Manchester has the highest rates of smoking-attributable deaths in England

222,288 GP consultations, 43,227 practice nurse consultations, 117,109 GP prescriptions and 27,868 outpatient visits are estimated to be related to smoking, costing the NHS in Manchester approximately £13.5million per year

Lost productivity caused by smoking-related illness, disability or death is estimated to cost the city approximately £106.2million per year.

The additional smoking-related social-care costs of current or former smokers are estimated to be approximately £11.6million per year.

Greater Manchester Fire and Rescue Service attend approximately two smoking-related house fires per week (an average of seven a month) in Greater Manchester, and smoking-related fires are still the biggest cause of fire-related death in Greater Manchester.

Approximately 977,000 cigarettes are smoked in Manchester every day, resulting in 145kg of waste daily. Much of this is dropped as litter, which must be collected and causes environmental damage associated with plastics.

Although cigarettes bought through legal channels raise money for the Exchequer, the costs attributed to tobacco are one-and-a-half times as much as the duty raised, resulting in a net cost to Manchester of about £47.6M per year.

It is estimated that the average smoker in Manchester will spend £2,050 per year on cigarettes.

Sources: Action on Smoking and Health (ASH): Local Costs of Tobacco 2018 and Public Health England Local Tobacco Control Profiles

2.1

Smoking prevalence in Manchester and the wider context

2.1.1 The latest data from the ONS Annual Population Survey (APS), based on a sample of 1,331 adults aged 18 and over in Manchester, shows that in 2016, just over a fifth of all respondents (21.7%) reported that they currently smoke. This compares with an average prevalence of 15.5% across England as a whole. The graph below shows that prevalence has fallen from a high of 25.5% in 2014 to 21.7% in 2016. However, early indications are that rates will remain the same in 2017. The graph showing Greater Manchester data is also provided (Figure 2).

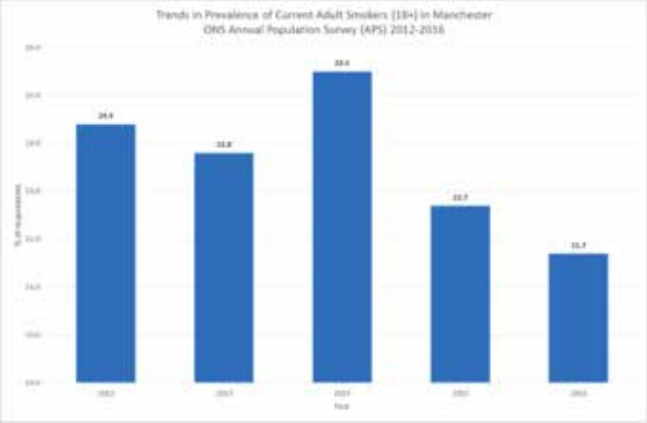


Figure 1: Smoking prevalence in Manchester

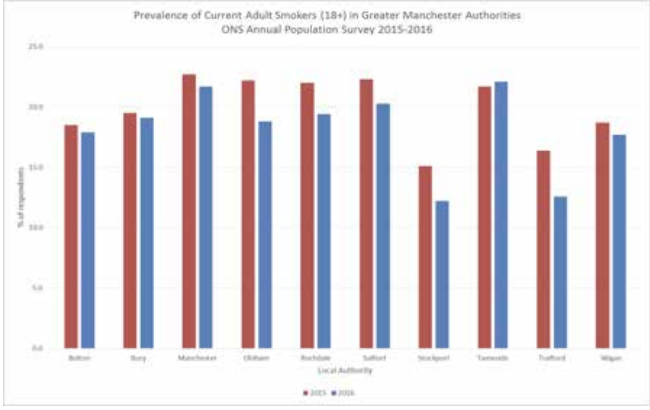


Figure 2: Smoking prevalence in Greater Manchester

2.1.2 It is also helpful to look at the proportion of adults in Manchester who currently smoke, those who have smoked in the past, and those who have never smoked (see Figure 3).

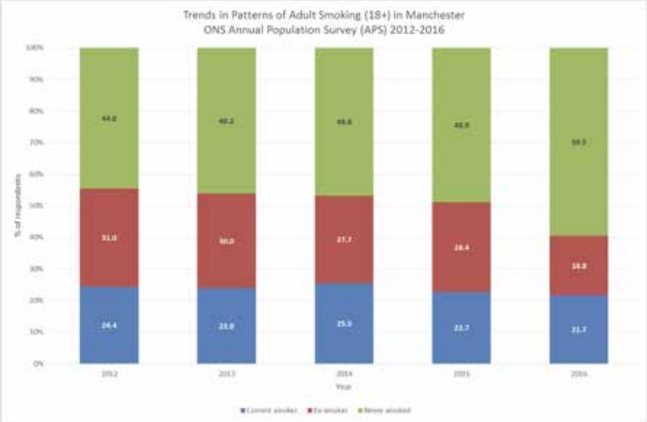


Figure 3: Trends in patterns of adults smoking in Manchester

The latest figures for 2016 show that, compared with 2015, the proportion of people who currently smoke has fallen very slightly. In contrast, the proportion of adults who reported they have smoked (ex-smokers) has fallen sharply from 28.4% to 18.8%. At the same time, the proportion of adults who reported they have never smoked has increased from 48.9% to 59.5%. However, it should be noted that in 2016 there was a change in the questions in the APS, which has had an impact on the calculation of ex-smokers. Furthermore, indicators based on self-reported behaviours are likely to underestimate the true level of cigarette consumption and to a lesser extent cigarette smoking prevalence. Evidence suggests that when respondents are asked how many cigarettes they smoke per day, there is a tendency for respondents across all age groups to round the figure down to the nearest multiple of ten.

2.1.3 Data extracted from primary care systems indicates that just under 119,000 patients registered at GP practices in Manchester were recorded as smokers. This is equivalent to 22.7% of the GP registered population and is similar to the national estimate of smoking prevalence generated from the APS (21.7%). The same analysis shows that 17.6% of the GP registered population were recorded as ex-smokers and 74.4% were recorded as being non-smokers.

2.1.4 We know that in some population groups and areas of deprivation, smoking rates are much higher than the average for the population as a whole. For example, workers in routine and manual occupations are twice as likely to smoke as those in professional or managerial roles. Unemployed people are also twice as likely to smoke as those in employment (4). Smoking is twice as common among people with mental-health disorders, and it is estimated that 37%–56% of people with severe mental illness smoke. People from the lesbian, gay and bisexual communities are also more likely to smoke (5) and prevalence may also vary between minority ethnic groups (6).

2.1.5 Most current adult smokers started smoking before the age of 18, and a key component of this tobacco control plan is to stop people from starting to smoke. Plain packaging legislation introduced in England in May 2017 aims to stop tobacco companies marketing cigarettes in a way that makes them attractive to young people.

2.1.6 People in poorer communities face many other physical and mental-health inequalities and smoking serves to make those inequalities even worse by causing serious damage to their health over time. People are more likely to start smoking if they grow up or live in certain areas and may find it harder to give up than people who live in settings where fewer people smoke, or if their circumstances are materially easier (7), (8). We also know that some groups will be more exposed to illegal tobacco sales or the sale of cheaper, unregulated, illicit tobacco.

2.1.8 In Manchester, smoking prevalence differs from area to area and some groups are more vulnerable to smoking-related harm than others. For example, parts of north and east Manchester have much higher smoking prevalence rates and worse health outcomes. Therefore targeting help and support in these areas is a key element of work to reduce health inequalities in Manchester. Public Health England strongly advise such an approach in order to accelerate decline in smoking prevalence rates (1). This is consistent with our Population Health Plan.

2.2

The impact of smoking in Manchester

Smoking can have a significant impact on the prevalence of other long-term conditions, such as respiratory illness, and also contributes to the higher rate of hospital admissions and early deaths in Manchester.

Long-Term Conditions (LTCs)

2.2.1 Smoking is the major preventable risk factor for Chronic Obstructive Pulmonary Disease (COPD), asthma and other respiratory illnesses. Nationally, around 17% of COPD patients are known to be smokers. However, data from GP practices summarised in the table below shows that 49% of patients with COPD in Manchester are recorded as smokers.

Respiratory condition	Current smokers (%)	Ex-smokers (%)	Combination – never smoked (%)
COPD	49%	33%	82%
Asthma	24%	14%	37%

Table 1: Smoking and LTCs in Manchester

Smoking-related hospital admissions

2.2.2 There are just under 6,000 smoking-related hospital admissions per year, costing approximately £5.4million per year to the NHS in Manchester. High smoking-attributable admission rates are indicative of both poor population health and high smoking prevalence.

2.2.3 The Manchester Health and Commissioning (MHCC) Data Warehouse allows us to look at differences in the care among current and ex-smokers as well as differences in the cost of this care. We can make potential savings from reducing the cost of care among current smokers down to that of ex-smokers, through effective smoking cessation programmes. Analysis of data from June 2016 to July 2017 shows that the rate of non-elective (ie. unplanned) hospital admissions for COPD and asthma was higher for current smokers compared with ex-smokers. This pattern persists across all age groups, although 'excess' was highest in patients aged 40–60 years.

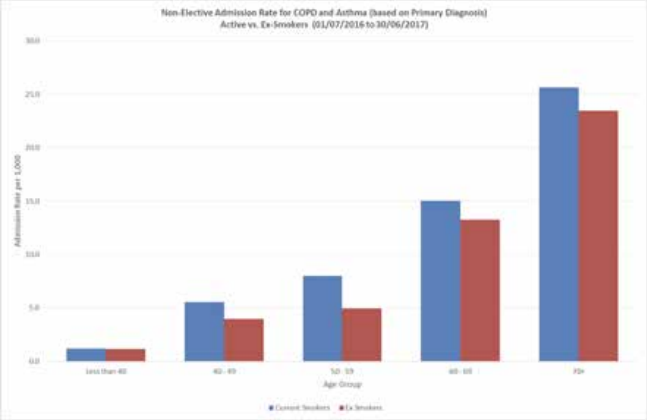


Figure 4: Non-elective admission rates for COPD and asthma

Smoking attributable mortality

2.2.4 Smoking remains the biggest single cause of preventable mortality in the world. It accounts for one in six of all deaths in England, killing some 79,000 people each year. Causes of death related to smoking include various cancers, cardiovascular and respiratory diseases, and diseases of the digestive system. There are huge inequalities in smoking-related deaths: areas with the highest death rates from smoking are about three times as high as areas with the lowest death rates attributable to smoking. (Source: Public Health England 2018). Cancer Research UK have provided an excellent summary on 'what influences the risk of cancer from smoking' and this is provided in Appendix 1.

2.2.5 In the three-year period 2014 to 2016, there was a total of 2,440 deaths attributable to smoking among people living in Manchester. This is equivalent to around 813 deaths each year. Trends show that the rate of smoking-attributable deaths in Manchester fell by just over 8% between 2008–10 and 2012–14, but more recent data suggests that the rate may now be on the increase. The current rate for the period 2014–16 (499.3 per 100,000) is around 9%, higher than that for the period 2012–14.

2.2.6 The rate of smoking-attributable deaths in Manchester is the highest in England and is significantly higher than that of other similarly deprived local authorities, such as Hull, Blackpool, Liverpool and Middlesbrough (see Table 2 below). This suggests that deprivation alone does not fully account for the extremely high level of smoking-attributable deaths in Manchester.

Smoking attributable mortality 2014 - 16

Area	Recent Trend	Count	Value	95% Lower CI	95% Upper CI
England	~	244,470	272.0	270.9	273.1
Most deprived decile (IMD2015)	~	24,151	382.2	377.3	387.0
Manchester	~	2,440	499.3	479.5	519.8
Kingston upon Hull	~	1,681	470.3	447.9	493.5
Knowsley	~	1,083	464.5	436.8	493.4
Blackpool	~	1,149	442.9	417.6	469.4
Liverpool	~	2,917	441.8	425.7	458.2
Middlesbrough	~	845	410.5	383.0	439.4
Rochdale	~	1,267	397.8	376.1	420.9
Nottingham	~	1,429	396.8	375.3	417.1
Stoke-on-Trent	~	1,505	393.0	373.2	413.5
Blackburn with Darwen	~	753	390.0	362.5	419.3
Barking and Dagenham	~	737	364.6	338.5	392.6
Tower Hamlets	~	617	340.3	313.1	369.1
Sandwell	~	1,533	333.6	317.0	350.7
Hackney	~	639	322.4	297.1	349.3
Birmingham	~	4,327	308.5	299.3	317.9
Wolverhampton	~	1,236	305.6	288.7	323.2

Source: ONS mortality file; ONS LSOA single year of age population estimates and smoking status from Integrated Household Survey/Annual Population Survey; relative risks from The Information Centre for Health and Social Care, Statistics on Smoking, England 2010

Table 2: Smoking-attributable mortality

2.3

Improving the use of health intelligence to support tobacco control

2.3.1 Public Health England provide robust data for local authorities to support their work. In Manchester, the MHCC Data Warehouse, referred to in 2.2.3, allows data recorded in primary care to be stored in a central location. This can then be linked to other data sets (eg. secondary care, community services, mental health and social care) via the NHS Number in an anonymised manner. Data recorded in primary care includes smoking status (current smoker, ex-smoker and never smoked) and smoking reviews, along with other demographic and diagnostic data at an individual patient level.

2.3.2 We can now conduct analysis of the current and historical levels of smoking among patients with a recorded long-term condition in primary care, notably COPD and asthma patients who currently smoke or who have smoked in the past.

2.3.3 Another important source of intelligence vital for tobacco control comes from our Council partners (Trading Standards, Environmental Health, Compliance), Greater Manchester Police, and Greater Manchester Fire and Rescue Service. This includes information about the supply and distribution of illicit tobacco, venues where the Health Act is breached (eg. smoking is allowed indoors in some shisha cafes), and areas where the sale of tobacco to children aged under 18 is commonplace. A good example of how intelligence for enforcement work is gathered is the biannual survey carried out by Trading Standards North West (TSNW) since 2005. Through schools in the region, young people are asked to complete confidential questionnaires about their tobacco and alcohol use and attitudes.

3.
The Greater Manchester Programme

3.1 The Smoke-Free Manchester Tobacco Control Plan is aligned with the Greater Manchester 'Making Smoking History' programme. GMPOWER is an acronym for the approach that partners are taking in Greater Manchester, and which we have adopted for the city of Manchester:

- **G**row a social movement for a Tobacco-Free Greater Manchester
- **M**onitor tobacco use and prevention policies
- **P**rotect people from tobacco smoke
- **O**ffer help to quit
- **W**arn about the dangers of tobacco
- **E**nforce tobacco regulation
- **R**aise the real price of tobacco.

'The Tobacco-Free Greater Manchester Strategy sets out a vision that is grounded in an innovative international evidence-based framework, our GMPOWER model. This is based on the World Health Organization (WHO) multi-component GMPOWER model introduced globally in 2008, endorsed by the World Bank and UK Government, 15. This approach advocates a comprehensive, multi-component approach to tackling tobacco. Our Greater Manchester communities offer us a unique opportunity to add a seventh component to the original model to capitalise on co-production and citizen engagement.'
Source: Making Smoking History (2)

3.2 In Manchester, helping smokers to stop smoking is only a part of what needs to be done. We also need to effect a change in social norms across all communities. Social and cultural change was achieved relatively recently when smoke-free legislation was introduced in 2007 in workplaces and enclosed public spaces. Compliance rates are now very high without the need for enforcement action in most cases.

3.3 The de-normalisation of smoking is crucial to prevent generations of future smokers and to protect people from the extremely harmful effects of secondary smoke (also known as environmental tobacco smoke) from pre-birth onwards. National Institute for Health and Care Excellence (NICE) guidance for smoking prevention suggests that school-based interventions, mass-media interventions and enforcement to restrict illegal access to tobacco are effective in preventing young people starting smoking (4). Exposure to second-hand smoke is hazardous to people at any age. Furthermore, there is an increase in the risk of low-birth-weight babies and other harmful effects when women smoke during pregnancy. The Manchester Population Health Plan priority 'The first 1000 days of a child's life' will ensure that support for pregnant women in a range of settings is available.

3.4 We also need to reduce the demand for cigarettes and restrict and regulate their supply. The Council's Enforcement Teams (Trading Standards, and the Licensing and Out-of-Hours Compliance Team) in Manchester work hard to ensure that all the legislation, particularly around sales to people who are underage, is enforced.

3.5 Evidence shows that raising tax is a key tobacco-control intervention. It has been proven to have a greater effect on more disadvantaged smokers at a population level, contributing to reducing health inequalities (4). By making smoking cheaper, sales of illicit tobacco seriously undermine health measures intended to discourage smoking using regulatory and pricing regimes. Enforcement is therefore essential for good tobacco control. The Manchester City Council teams and others excel in this area and they are valuable partners in the Manchester Tobacco Alliance.

3.6 The Manchester Tobacco Alliance is chaired by the Director of Population Health and Wellbeing, and membership of the Alliance is broad in terms of agencies represented. It includes: NHS and Manchester City Council commissioners, NHS providers, clinicians, GP/primary care representatives, Trading Standards, Environmental Protection, VCS organisations, charities such as Cancer Research UK and Macmillan, Greater Manchester Fire and Rescue Service, Manchester Prison, Greater Manchester and Public Health England Tobacco Leads.

Greater Manchester Common Standards for Tobacco Control

3.7 The Greater Manchester (GM) Common Standards for Tobacco Control are set out under five overarching strategic outcomes and 'I' statements to show what the outcome will mean for GM residents:

- Improving the health of the GM population and reducing health inequalities across GM (I will be increasingly unlikely to be affected by tobacco-related health disease as a Greater Manchester resident)
- Start Well: Give every GM child the best start in life (I will ensure that babies, children and young people are protected from the harm caused by tobacco from conception through to adulthood)
- Live Well: Ensure every GM resident is enabled to fulfil their potential (all smokers in Greater Manchester are given the help they need to quit)
- Age Well: Every adult will be enabled to remain at home, safe and independent for as long as possible (I will be supported to give up smoking to improve my quality of life and smoking-related disease at any age)
- Enabling resilient and thriving communities and neighbourhoods (I will be protected from tobacco-related crime, fire risk, litter and environmental smoke in my community and the places I visit).

Manchester will use this GM framework for its Tobacco Control Delivery Plan between 2018 and 2021; this is set out in the next section.

4.
The Delivery Plan

For each strategic outcome contained in the GM Plan, a set of common standards has been agreed by Greater Manchester, with areas adding local standards if required. The tables below show what we are currently doing in Manchester to meet these standards and what else we need to do over the next three years.

4.1

GM Strategic Outcome 1: Improving the health of the population and reducing health inequalities across GM

4.1.1 It is recommended that each area within Greater Manchester will produce its own specific Tobacco Control Plan.

4.1.2 This Smoke-Free Manchester Plan demonstrates the commitment of the members of the Manchester Tobacco Alliance, Manchester City Council, Manchester Health and Care Commissioning, and Manchester Health and Wellbeing Board to adopt a whole-system collaborative approach.

4.2

GM Strategic Outcome 2: Start Well – Give every GM child the best start in life

4.2.1 Under this outcome we need to ensure that:

- Children are protected from tobacco-related harm from conception onwards
- Children and young people will be protected from environmental tobacco smoke.

4.2.2 Reducing smoking in pregnancy is the single most important factor in reducing infant mortality. Smoking during pregnancy can also cause serious health problems for the mother and baby, including complications during pregnancy and labour. Smoking during pregnancy carries an increased risk of miscarriage, premature birth, stillbirth, low birth weight and sudden unexpected death in infancy. The Manchester Population Health Plan priority 'The first 1000 days of a child's life' will focus on this area of work.

4.2.3 We also want to protect children from environmental tobacco smoke by initiating a major new work stream around smoke-free homes. We will be supported by a leading academic from the University of Liverpool in this work, and the Manchester Housing Provider Partnership will be a key partner in our Tobacco Control Programme.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018/19	What we need to do by 2021 in order to meet this standard
All pregnant women will have a carbon monoxide (CO) breath test.	The GM maternity services specification states that all women must have a CO test. However, at the present time not all women in Manchester are offered a CO breath test, so this is an area identified for improvement for 2018/19. Manchester will benefit from GM funding to launch the Baby Clear Programme, which will ask midwives and smoking-cessation staff to give all women a CO breath test. Staff in the newly commissioned North Manchester Smoking Cessation service (part of Be Well) are expected to offer CO breath tests to all women who want one. Plans are now in place to share a midwifery post with Trafford to ensure Baby Clear can be rolled out in central and south Manchester.	All midwives must be trained, equipped and supported to carry out the CO breath test and provide brief advice about the result. We will rebuild our specialist smoking cessation services across all parts of the city and ensure that they work to NICE guidance, offering CO tests to all pregnant women who want one and who want to give up smoking.
All pregnant women who smoke are referred to services that can help them to stop smoking during their pregnancy.	Manchester will benefit from GM funding to launch the Baby Clear Programme, which will ensure that all women can quickly access smoking-cessation services if they need them. In 2018, this standard will be met in north Manchester for the first phase of Baby Clear. The Baby Clear Programme will then be rolled out in central and south Manchester in late 2018. As stated above, additional midwifery capacity will be put in place later this year while plans for 2019/20 are developed.	Sustain the Baby Clear Programme.
All families are supported to live in a smoke-free home.	This standard is met in part; however, the number of children who live in a smoke-free home in Manchester is not quantified. Working towards this standard is a high priority in terms of protecting the health of babies and children, but also in terms of changing norms to prevent teenagers starting to smoke and becoming addicted at a young age. We have initiated a smoke-free homes work stream. This is a long-term piece of work supported by the research findings of a leading academic at the University of Liverpool. Positive early discussions have started with the Manchester Housing Provider Partnership. The smoke-free homes work stream will work across all tenures and types of housing. Greater Manchester Fire and Rescue Service will also be a key partner.	Trying to ensure that Manchester homes, irrespective of tenure, are smoke-free, especially those where children live; this will be a priority for 2019/20. We will focus on voluntary measures 'working with' rather than 'doing to' households and communities. Partnership working will be essential, including children's health professionals, front-line Council staff, Greater Manchester Fire and Rescue Service, as well as landlords and homeowners across all tenures. Good community engagement will be essential. The Manchester Local Care Organisation will be the key delivery vehicle for this standard in future years.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018/19	What we need to do by 2021 in order to meet this standard
Strengthen efforts to prevent young people starting smoking (Manchester Standard).	The Council's Trading Standards team will continue with existing measures to prevent underage sales of tobacco and to reduce the supply of illicit tobacco.	We will work with GM colleagues who are looking at the opportunities afforded by devolution and a GM tobacco licensing scheme. It is possible that Manchester could take a lead role in this area of work on behalf of all ten local authorities, pending further discussions.
Strengthen efforts to prevent young people starting smoking (Manchester Standard).	At the present time, school nurses provide support for young people who smoke, and the Population Health and Wellbeing Team commissioned specialist smoking-cessation training for those working with children and young people who smoke.	We will involve young people in the developmentof other interventions and evaluate change in behaviours and attitudes. This will be done with the Healthy Schools Team.

4.3

GM Strategic Outcome 3: Live Well – Ensure every GM resident is enabled to fulfil their potential

4.3.1 Under this outcome we need to ensure that:

- All smokers in Manchester understand the risks of smoking and tobacco-related harm
- Manchester smokers are able to access all available front-line pharmacotherapies, and combination Nicotine Replacement Therapies (NRT) should always be an option. Any pharmacotherapy supplied should be used alongside motivational support
- Tobacco control measures, including smoking-cessation support, focus on groups that have higher smoking prevalence rates in order to further reduce smoking-related health inequalities
- All smokers admitted to hospital are assessed and treated for nicotine addiction irrespective of the cause of admission. This is a way of working towards zero tolerance to smoking for staff, patients and visitors on all hospital and health service sites.

4.3.2 Statistically, the most effective way to give up smoking is using a dual approach of appropriate pharmacotherapy and psychological/motivational support. Manchester Health and Care Commissioning are committed to rebuilding community-based smoking-cessations services based on the latest evidence and NICE guidance. These community-based services will support the pathways of new programmes such as Baby Clear and CURE. Specialist smoking-cessation services will be commissioned to reach into those communities where smoking prevalence is highest and target population groups, including people in routine and manual occupations, people with mental-health problems, the LGBT community, homeless people and offenders.

4.3.3 In Manchester, we have senior clinicians in our acute hospital trusts who are committed to making sure that their hospitals fulfil NICE guidance PH48 (9) and that all patients are offered a high-quality smoking cessation service. The CURE programme, led by Dr Matthew Evison, is a pioneering example of this (see section 5). Manchester hospitals will benefit from funding made available from the Greater Manchester Health and Social Care Partnership to develop and implement CURE.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018/19	What we need to do by 2021 in order to meet this standard
Each area in Greater Manchester will adopt a 'making every contact count' approach: all front-line staff are able to talk about the risks associated with smoking.	In 2018 we will partially meet this standard. We successfully piloted training for school nurses and staff working with families with complex needs in 2017. This will be repeated. Staff working for our integrated health and wellbeing service, buzz, offer support and advice to people who would like to stop smoking. The staff working for Be Well, our new social prescribing service, will also offer support and advice.	We will identify all front-line staff who need to be trained to talk to people about smoking and to deliver brief interventions. We will work in a creative way with staff and their respective organisations to ensure that appropriate training is provided. This work will also be crucial if we are to increase the number of smoke-free homes in Manchester.
Publicised arrangements are in place for smokers to access pharmacotherapy and motivational support in all areas (including advice about nicotine-inhaling products, ie. e-cigarettes).	Publicised arrangements are in place for services in Manchester. Information has been made available to all GP practices about the Be Well service and buzz, which can offer support for smokers. Information is available on the Health and Wellbeing pages of the Manchester City Council website. Manchester benefits from information hosted on the GM Making Smoking History platform and can access a telephone-based smoking-cessation service. This number is also listed on the Council's website. We are aware that there is controversy around the use of nicotine-inhaling products (e-cigarettes). Manchester supports the approach of Public Health England and Greater Manchester in supporting the use of these products as a harm-reducing aid to giving up smoking completely. E-cigarettes are thought to be 95% safer than smoking normal cigarettes because they do not contain tobacco (source: PHE/CRUK). However, there still appears to be widespread confusion about how safe e-cigarettes are relative to normal cigarettes, and we will make sure that accurate information is available to smoking-cessation practitioners, health care professionals and smokers themselves.	In line with PHE advice we will continue to develop local policies around the use of nicotine-inhaling products for our smoking-cessationservices. As smoking-cessation services develop and change across Manchester, we will ensure that all websites and other communications are up to date and widely available to professionals and residents. We will consider the recent findings of the Parliamentary Science and Technical Committee in relation to e-cigarettes and vaping.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018/19	What we need to do by 2021 in order to meet this standard
All areas will have plans to focus resources on the areas and groups with the highest prevalence of smoking (eg. people in routine and manual occupations, LGBT people, people with mental-health issues, people with complex long-term conditions, and offenders).	In conjunction with our partners, Manchester has made a good start in respect of this standard. The first of our new stop-smoking services was launched in north Manchester in 2018. North Manchester has a high number of smokers from all the vulnerable and at-risk groups mentioned, in addition to high deprivation. The LGBT Cancer Support Alliance has a strategy called Proud2Bsmokefree, which is supported by the Manchester Tobacco Alliance. In 2017, Manchester Prison became smoke-free.	The NHS target for Mental Health Trusts to be smoke-free remains a challenge across the country. We will work with Greater Manchester Mental Health Trust to progress work in local settings. We need to ensure that targeted stop-smoking services for key vulnerable groups are available across the city by 2020. Further work needs to be carried out to address high levels of smoking and subsequent health inequality in our LGBT community. This will include work initiated in 2018 to make Pride smoke-free in the future. The highly successful Lung Health Check Service, which was piloted by the Macmillan Cancer Improvement Programme (MCIP) in north Manchester, will be extended across Manchester and GM. This programme targets smokers in deprived communities, many of whom may be in routine and manual work or unemployed.
All smokers admitted to hospital as inpatients will receive appropriate pharmacotherapy and motivational support as well as ongoing support on discharge. The CURE programme is the model for actioning this in Greater Manchester.	This standard describes what is actually recommended in full by NICE guidance PH48 (9) for people in secondary care, mental-health patients and pregnant women. Acute trusts in Manchester (and beyond) have not met the recommendations of PH48 and this standard is not currently met. However, the CURE programme (8), launched at Wythenshawe Hospital in September 2018, will fulfil and exceed this guidance if fully implemented.	Phase 1 of CURE will be launched in Wythenshawe Hospital in 2018. Phase 1 will test proof of concept and 'iron out' operational issues. This programme is ambitious and innovative, and we anticipate it will not only deliver improved health outcomes for patients, but also reduce hospital admissions. If successful, CURE will be extended across all GM and Manchester sites. We acknowledge that CURE is dependent upon the provision of specialist community stop-smoking services, which all patients will be able to access on discharge from hospital. It is therefore a priority for Manchester Health & Care Commissioning to commission citywide stop- smoking services that will deliver our intended outcomes and support the CURE pathway. Proposals will be developed in 2018/19 for implementationin 2019/20.

4.4

GM Strategic Outcome 4: Age Well – Every adult will be enabled to remain at home, safe and independent for as long as possible

4.4.1 Under this outcome we need to ensure that:

- People who have conditions caused by or exacerbated by smoking will be supported to stop smoking
- All smokers aged 50 and over admitted to hospital will be assessed and treated for nicotine addiction, irrespective of the cause of admission. We will work towards zero tolerance to smoking for staff, patients and visitors at all hospital sites and health service settings.

4.4.2 The important principle underlying our commitment to this standard is that we believe it is never too late to stop smoking. No matter how long an individual has smoked, health outcomes can be improved significantly in the short and long term if smoking is ceased. Stopping smoking will not only impact on life expectancy, but also 'healthy life expectancy'. We recognise that some older people might have smoked for many years and that giving up might be really difficult. However, we will make sure that older people receive the help they need to stop smoking, which will include a pharmacotherapy offer; and working with the Age Friendly Manchester Team will inform our approach. The CURE programme will also be an important intervention for this age group.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018/19	What we need to do by 2021 in order to meet this standard
All people aged 50 and over who have a smoking-related or smoking-exacerbated chronic condition will be offered evidence-based support to stop smoking.	We will promote this standard by making the 2018 Festival of Ageing a voluntary smoke-free event with the support of the GM Making Smoking History team. While many smoke-free events will be aimed at children and families, it is also important to value the health of older people and to address health inequalities in this group.	The first Smoke-Free Festival of Ageing events will demonstrate the commitment to people becoming smoke-free at any age. We also acknowledge the important intergenerational influencethis age group can have. We acknowledge there are gaps in our smoking-cessation service provision citywide and we will address these as described earlier. Over-50s must be offered services based on need, and older smokers must also be supported to stop at any age.
All smokers, irrespective of age, who are admitted to hospital will receive appropriate pharmacotherapy and motivational support as inpatients, and ongoing support on discharge. The CURE programme (8) is the appropriate model for accessing this in Greater Manchester.	Please see information in relation to the CURE programme (see section 5), which will offer support to smokers irrespective of age.	Please see information in relation to plans for the implementation of the CURE programme.

4.5

GM Strategic Outcome 5: Enabling resilient and thriving communities and neighbourhoods

4.5.1 Under this outcome we need to ensure that:

- Tobacco legislation is enforced and the supply of illicit tobacco is tackled
- There are fewer smoking-related accidental dwelling fires, so homes and residents are safer
- All hospitals are smoke-free, by working towards zero tolerance to smoking for staff, patients and visitors at all hospital sites and health-service settings
- There will be more smoke-free public spaces in Manchester
- We have a smoke-free public sector.

4.5.2 This set of standards relates to the wider determinants of smoking and will be challenging to achieve. For example, while there is general acceptance that health services should support people to stop smoking and that children should be protected, there may be resistance to further changes. However, if residents of the city are involved in shaping programmes, much more can be achieved.

4.5.3 We can build on the excellent work of the Council's Enforcement Teams (Trading Standards and the Licensing Out-of-Hours Compliance Team). The Teams enforce all tobacco-related legislation across the city, eg. the partnership work to combat the harm caused by widespread smoking of shisha in some parts of the city. Work is planned and carried out in conjunction with other agencies, such as Greater Manchester Police, HM Revenue and Customs, Greater Manchester Fire and Rescue Service, the Population Health and Wellbeing Team, Border Force and the Prevent Team as part of wider measures to ensure all legislation to keep people and premises safe is monitored.

4.5.4 Manchester has also added 'tobacco-related littering' as a local standard to support the Council's Waste, Recycling and Street Cleansing team. We aim to reduce cigarette littering and associated plastic pollution as part of a wider campaign that was launched this year with Keep Britain Tidy.

4.5.5 Greater Manchester Fire Service are a critical partner in terms of making communities safer by preventing fires and through important work they do in carrying out domestic Safe and Well checks. At the present time, smoking remains the top cause of fire deaths in Greater Manchester, despite the huge improvements in fire prevention and associated reduction in domestic fires generally.

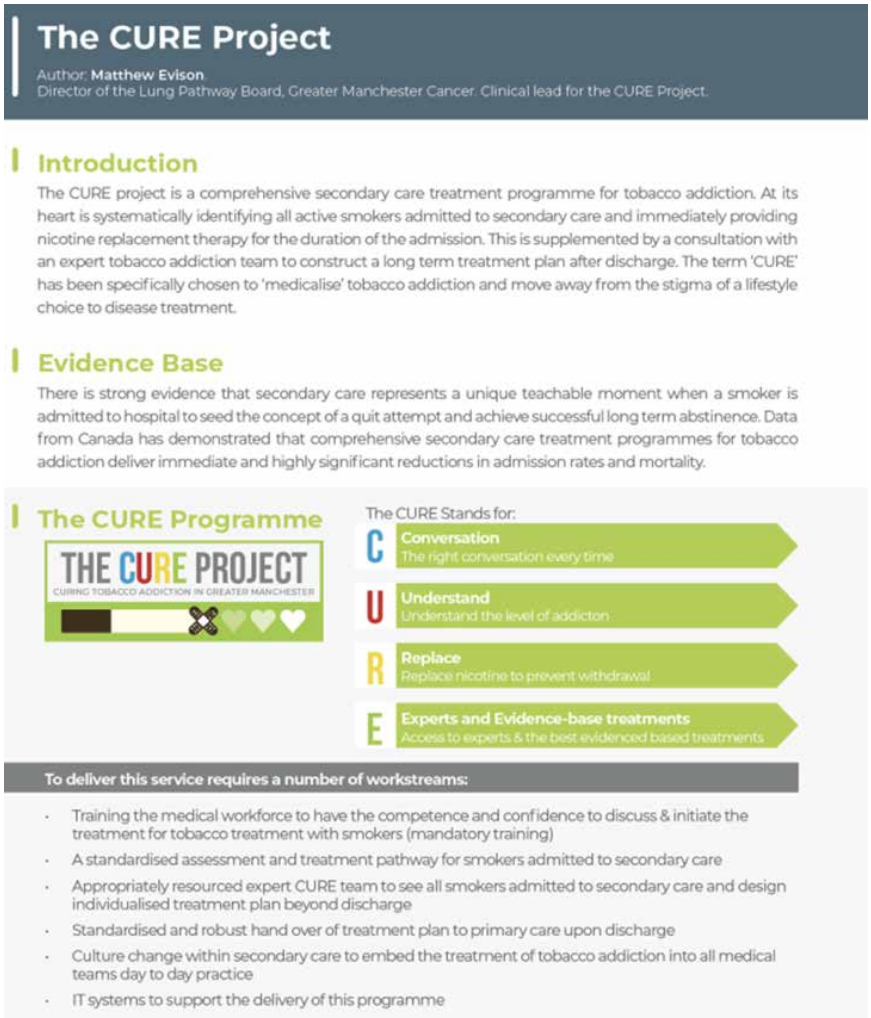
Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018/19	What we need to do by 2021 in order to meet this standard
Publicised arrangements are in place for members of the public to report concerns about illicit tobacco and breaches of legislation, eg. underage sales.	We believe that this standard is met in 2018 and that by running an annual communications campaign we will improve publicised arrangements. Most reports received by Trading Standards come through the National Trading Standard's Helpline, hosted by Citizens Advice. Reports are also received via a website called keep-it-out.co.uk The Council and its partners advertise these places and numbers. We want to do more to improve intelligence reporting and subsequently intelligence-led operations. We have initiated work with the Manchester City Council Communications Team to run a campaign in 2018 that will aim to increase the number of reports received and explain to the public why tackling these issues is important for them and their communities. The shisha work, which has run throughout 2018, will continue. An ongoing programme of operations is carried out by the Council's Trading Standards team to prevent sales of tobacco and related products to people aged under 18. This includes action against the supply of illicit tobacco, and ensuring that legislation around tobacco advertising and plain packaging is complied with.	The objectives of enforcement teams are clear and set out in legislation. Our aim for 2018–2021 would be to ensure that these operations can continue.
Manchester will work towards making all homes smoke-free.	Elements of this standard relate to accidental dwelling fires. The Greater Manchester Fire and Rescue service Safe and Well check programme has been strengthened in recent years.	We will progress our partnership work on smoke-free homes as set out in section 4.2.
All acute and mental-health trusts to develop and implement a smoke-free policy.	While the hospital and mental-health trusts in Manchester do have smoke-free policies, full implementation remains challenging. This situation is not unique to Manchester, and Public Health England and the GM teams will provide additional support to progress local work in 2018/19.	If fully implemented, CURE will provide an excellent catalyst forsmoke-free hospital sites. Further work will be undertaken with the Greater Manchester Mental Health Trust, as described earlier.
All areas will increase the number of voluntary schemes promoting smoke-free family spaces.	In 2018, Manchester does not have any voluntary smoke-free family spaces. We will be making our Manchester Festival of Ageing smoke-free in summer 2018 and are exploring options to include other events.	The Population Health and Wellbeing Team will work with Manchester City Football Club and other partners to look at smoke-free grounds and stadium policies, given the number of children's and families who go to sporting events.

Tobacco Common Standard	What we currently do in Manchester to meet this standard in 2018/19	What we need to do by 2021 in order to meet this standard
All public organisations' sites and grounds are supported to be smoke-free.	Achieving smoke-free outdoor public spaces will be best achieved by working with partners across Greater Manchester. Work has begun to make Pride 2019 partially smoke-free. This is an important step in de-normalising smoking in the LGBT community, where rates are much higher than the population average. The learning from this programme will be helpful in delivering more smoke-free spaces and events.	We will support the work of the GM Tobacco Regulatory Sub Group under the Combined Authority. This group is exploring options for tobacco licensing schemes and legislation to support smoke-free outdoor spaces. Work on other smoke-free spaces must involve the public of Greater Manchester and target population groups building on the survey results from Making Smoking History. For example, there was widespread support for smoke-free children's playgrounds.
To reduce cigarette littering and plastic pollution caused by cigarettes (Manchester standard).	The Council's Waste, Recycling and Street Cleansing Team has launched a major new anti-littering campaign in conjunction with Keep Britain Tidy.	The wider impact of smoking on the environment and the involvement of communities will add momentum to this campaign in future years.

5.
The CURE Programme

A number of standards refer to the CURE programme and this Plan would not be complete without crediting the Manchester team who have developed it. CURE is an approach to smoking cessation based on the Ottawa Smoking Cessation model (10). The approach involves a comprehensive treatment programme for people admitted to hospital both as inpatients and on discharge. It treats smoking primarily as an addiction, necessitating pharmaceutical intervention to help smokers quit.

CURE was a concept (see summary sheet) designed and developed by Consultant Dr Matthew Evison from Wythenshawe Hospital, now part of Manchester University Hospitals Foundation Trust. We hope CURE will save many lives and reduce costs in relation to hospital admissions and morbidity in both the short and long term. The Manchester Health and Wellbeing Board endorsed the CURE project and will support its development and delivery over the coming months and years. In June 2018, Greater Manchester Health and Social Care Partnership committed £2.5million to support the delivery of CURE across Greater Manchester, and phase 1 will be implemented at Wythenshawe Hospital in autumn 2018.



The CURE Project

Author: **Matthew Evison**
Director of the Lung Pathway Board, Greater Manchester Cancer. Clinical lead for the CURE Project.

Introduction

The CURE project is a comprehensive secondary care treatment programme for tobacco addiction. At its heart is systematically identifying all active smokers admitted to secondary care and immediately providing nicotine replacement therapy for the duration of the admission. This is supplemented by a consultation with an expert tobacco addiction team to construct a long term treatment plan after discharge. The term 'CURE' has been specifically chosen to 'medicalise' tobacco addiction and move away from the stigma of a lifestyle choice to disease treatment.

Evidence Base

There is strong evidence that secondary care represents a unique teachable moment when a smoker is admitted to hospital to seed the concept of a quit attempt and achieve successful long term abstinence. Data from Canada has demonstrated that comprehensive secondary care treatment programmes for tobacco addiction deliver immediate and highly significant reductions in admission rates and mortality.

The CURE Programme

THE CURE PROJECT
CURING TOBACCO ADDICTION IN GREATER MANCHESTER

The CURE Stands for:

- **C** — **Conversation** — The right conversation every time
- **U** — **Understand** — Understand the level of addicton
- **R** — **Replace** — Replace nicotine to prevent withdrawal
- **E** — **Experts and Evidence-base treatments** — Access to experts & the best evidenced based treatments

To deliver this service requires a number of workstreams:

- Training the medical workforce to have the competence and confidence to discuss & initiate the treatment for tobacco treatment with smokers (mandatory training)
- A standardised assessment and treatment pathway for smokers admitted to secondary care
- Appropriately resourced expert CURE team to see all smokers admitted to secondary care and design individualised treatment plan beyond discharge
- Standardised and robust hand over of treatment plan to primary care upon discharge
- Culture change within secondary care to embed the treatment of tobacco addiction into all medical teams day to day practice
- IT systems to support the delivery of this programme

6. Summary

The delivery of the Smoke-Free Manchester Tobacco Control Plan aims to reduce smoking prevalence in Manchester and to change norms to make smoking a thing of the past in our city. We will focus our efforts on the parts of the city that have the highest smoking rates, in order to reduce health inequalities and prevent early deaths from the three major killers: cancers, cardiovascular disease, and respiratory conditions.

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8. Authors and Contributors

Julie Jerram, Tobacco Control Programme Lead, Population Health and Wellbeing Team, Manchester Health and Care Commissioning

Neil Bendel, Head of Health Intelligence, Population Health and Wellbeing Team, Manchester Health and Care Commissioning

David Regan, Director of Population Health and Wellbeing, Manchester Health and Care Commissioning

GM Health and Social Care Partnership Making Smoking History Team.

Nicola Jepson, Population Health and Wellbeing Team. Manchester Health and Care Commissioning

Lisa Seamark, Trading Standards, Manchester City Council

Ben Heyworth, Macmillan Survivorship Network Manager/Survivorship Network Macmillan LGBT Strategy Manager/LGBT Cancer Support Alliance

Rebecca Moore, Cancer Research UK

Alex Hill, Licensing, Compliance and Out-of-Hours Team, Manchester City Council

Briege Cobane, Neighbourhood Manager – Environmental Health, Trading Standards, Housing Compliance and Enforcement, Manchester City Council

Christine Raiswell, Population Health and Wellbeing Team, Manchester Health and Care Commissioning

Gail Stott, Manchester Safeguarding Board

Louise Marshall, Population Health and Wellbeing Team, Manchester Health and Care Commissioning

Sarah Hardman, Greater Manchester Fire and Rescue Service

Clare Platt, Greater Manchester Fire and Rescue Service

Coral Higgins, Macmillan Cancer Commissioning Manager, NHS Manchester Clinical Commissioning Group

Stephanie Archer, Manchester Health and Care Commissioning

9. Appendix

Appendix 1

Cancer Research UK
What influences the risk of cancer from smoking?

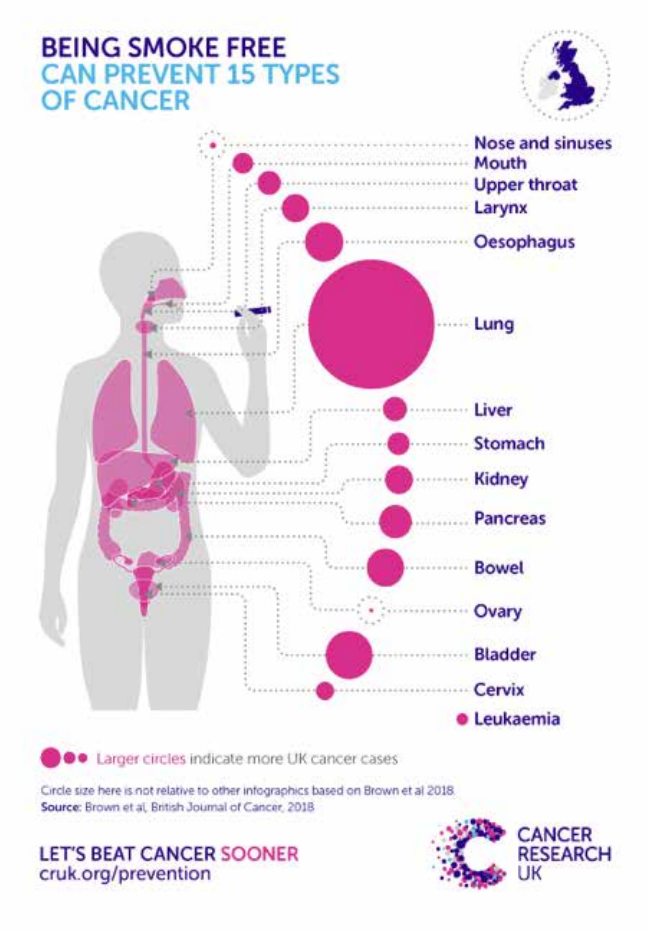
Smokers have a much higher risk of lung cancer than non-smokers, whatever type of cigarette they smoke. There's no such thing as a safe way to use tobacco. Cancer is perhaps the most widely known smoking-related health risk, although as shown above, it is far from the only one. Many people are also not aware of how many cancers can be caused by smoking.

The type of cigarette an individual smokes has not been linked to a changed risk of developing a smoking-related cancer. However, there is a positive relationship between the number of cigarettes smoked and the risk of developing cancer. Even 'light' smoking can increase the risk of cancer.

Research has shown that the number of years spent smoking affects cancer risk even more strongly than the number of cigarettes smoked per day. For example, smoking one pack a day for 40 years is even more dangerous than smoking two packs a day for 20 years.

It usually takes many years, or decades, for the DNA damage from smoking to cause cancer. Our bodies are designed to deal with limited damage, but it's hard for the body to cope with the number of harmful chemicals in tobacco smoke. Each cigarette can damage DNA in many lung cells, but it is the build-up of damage in the same cell that can lead to cancer. Research has shown that for every 15 cigarettes smoked there is a DNA that could cause a cell to become cancerous.

(Information provided by Cancer Research UK)



(Image courtesy by Cancer Research UK)