Tobacco: a smoking gun

“We don’t smoke that s***. We only sell it. We reserve the right to smoke for the young, the poor, the black and the stupid.” US Tobacco Company RJ Reynolds

Gateshead Director of Public Health Annual Report 2015/16
FOUR people have died from smoking related illnesses in England.
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Introduction

Welcome

Alice Wiseman, Director of Public Health, Gateshead

I am incredibly proud to be presenting you with my very first annual report as the Director of Public Health for Gateshead.

My report this year tells the story of our ambition for a smoke-free Gateshead, a place where our communities are not affected by the harm caused by tobacco.

In these pages, I’ve tried to describe the many different ways that people are affected by smoking, from causing or exacerbating poverty, to illness and early death.

I want to be clear from the outset that this report contains no judgement of people’s individual choices. In fact, I believe it is the opposite. I recognise the way that people and communities have been intentionally influenced by powerful corporations who have a vested interest in maintaining smoking rates as high as possible.

A quote from an Rj Reynolds executive resonates deeply with me as we continue to fight to address this harm.

“We don’t smoke that s***, we just sell it. We reserve the right to smoke for the young, the poor, the black and the stupid.”

This quote illuminates the unacceptable way that these lethal products are targeted. Some people, in some communities, are still more likely to be negatively affected by smoking and I believe that this is wholly unacceptable.

Every year 462 people die in Gateshead as a result of smoking. As a consequence, every year, in order to maintain their profit levels, the tobacco industry replies to those deaths, with its ability to recruit the same number of new smokers from our young people.
My report is based on the testimony and voices of people living and working in Gateshead. Young people shared their views on smoking and the impact it has on their lives. Colleagues told us about the impact that smoking has on creating and exacerbating poverty, the daily messages our doctors have to give to families affected by the harm, as well as some of the challenging and often tragic journeys that people in our communities have travelled as a result of smoking.

I am sincerely grateful for the time people took out of their lives to share their experiences and personal stories. The full account of these biographies, and an engagement event featuring young people can both be viewed online at: www.gateshead.gov.uk/impactoftobacco and www.gateshead.gov.uk/smokingandyoungpeople

My report is also influenced by my own personal story. The story of my wonderful and inspiring Dad who sadly lost his short fight for life aged only 54 as a result of smoking. I remember that day with the vividness that seems to be saved for those critical points that really change your direction in life. John Wiseman, my Dad, avid Gateshead FC fan, reader in African politics, passionate about equality and human rights, devoted husband, father and grandfather. A life cut short, a family robbed.

Sadly my story is far from unique. Most people, if not everyone, reading this report will be able to tell a similar story of tragedy, of gaping holes in people’s lives, of missed birthdays, holidays, weddings and graduations and that irreplaceable source of support when days are hard.

When is enough, really enough?

Gateshead has an incredible history of doing the right thing in the fight against tobacco. Of advocating for battles that no one thinks we will ever win! As a community we have been one of the loudest in standing up for the things we think will make the biggest difference. We’ve led the fight against the harm of second hand smoke and also the promotion of these lethal products. But there is so much more to do.

My challenge for you is here, whilst we have won many battles along the way the war is by no means over. It will only be over when we can truly say we are a smoke-free community, where no one, irrespective of their personal circumstances or where they live, is adversely affected by tobacco.

We, Gateshead, need you to step up as an individual, a family, a community or an organisation and support us in the war. We need you to help us drive forward with the things we know we need to do as well as helping us find all the other things, that will make a difference but that, we are not yet sure of.

We will do whatever it takes to end the harm that is caused to our families and communities by tobacco. I call for us to all to stand together and to insist that enough is now enough!
Improving the publics’ health
2015-16

April

• A ban on displaying tobacco in small shops comes into force throughout the UK. This completes implementation of the regulations that were initially brought in for large shops in 2012.

• New research shows no increase in Australia’s illicit tobacco trade after the introduction of standardised packaging legislation.

• Successful revocation of a licence for a Gateshead shop caught selling alcohol to children, plus legal highs and drug taking equipment.

May

The NHS Health Checks Programme, run by Gateshead Council’s Public Health Team, was awarded a Certificate of Excellence by the Public Service Transformation and Innovation Award 2015, under the category ‘Working Together’.

June

• The Hot food takeaway Supplementary Planning Document is adopted.

• First planning refusal for a hot food takeaway, and decision is upheld by the Planning Inspectorate.

• Wales passes legislation which prohibits smoking in cars with children present.

July

Innovative collaboration with Fuse, the Centre for Translational Research in Public Health in North East England, results in appointment of researcher in Gateshead Council to promote the use of evidence.


August

November

• Around 20% of the estimated 100,000 people living with HIV in the UK remain undiagnosed. Early diagnosis improves outcomes.

• Gateshead has the second highest HIV prevalence marker in the region. In response Public Health funded an innovative home sampling online kit request service to encourage early diagnosis.

December

• GP Practice profiles on heart disease were produced by the Public Health Team, adding to a series of profiles on Cancer and COPD.

February

A report published by the Australian Government’s Department of Health concludes that the laws introducing plain standardised packaging of tobacco products have been a remarkable success and saved thousands of lives.

October

• Legislation comes into force in England and Wales banning smoking in cars with people under the age of 18 present.

January 2016

• Gateshead is part of a successful bid to fit pollution control technology to buses to improve local air quality.

• Psychoactive Substances Act 2016 receives Royal Assent, leading to the banning of legal highs.

March

The drug Naloxone, which is administered to people who have overdosed on opiate based drugs, is now comprehensively available across Gateshead. To date, this has been used to help save six lives.
In Gateshead 462 people die of smoking related illnesses each year – that’s the equivalent of a passenger jet crashing each year killing all on board.
History of tobacco control

Deception, Denial, Delay - the tobacco industry’s game

Cigarettes are the single most deadly consumer product ever made – it’s also one of the most profitable.

One tobacco company reported a net revenue of $73.8 billion in 2007. Such profitable companies attract investors including governments, who also bear the costs of the care for the resulting diseases caused by smokers. In England the cost to the NHS of treating smoking related illnesses is estimated at around £2 billion a year.

“There is a fundamental and irreconcilable conflict between the tobacco industry’s interests and public health interests.”

This statement, agreed by many nations, explicitly named the entire tobacco industry as the inherent enemy of public health due to the deadliness of its products.

FACT: NO OTHER PRODUCT ON SHOP SHELVES WILL KILL HALF OF THE PEOPLE WHO BUY IT

The fact that a product so destructive and so expensive to society (health, environment, litter and water pollution), remains on the market, highlights the skill of the tobacco industry to adapt and reposition itself and the failure of governments to protect public health from such corporate predators.

The tobacco industry has worked to preserve its products at the expense of its customers. This is corporate disease promotion. “Its use of clever marketing, linking products to freedom and health, and deliberately and systematically hiding the truth about the disease consequences of using them.”

Smoking is not just a bad individual decision but a global industry created and sustained epidemic.
Where did this all start?

Tobacco has been used for centuries. By 1870 the new tobacco companies had established a market dominated by pipes, cigars, snuff and hand-rolled cigarettes.

However, it was not until the 1880s when the cigarette rolling machine was invented and the rise of consumer culture, that commercial cigarettes became popular and smoking increased.

In 1951, Dr Richard Doll published the first large research study on the relationship between smoking and lung cancer. It found that of 5,000 patients in British hospitals: 1,357 were men with lung cancer and of these, 99.5% were smokers.

These stark figures revealed for the first time the huge health risks associated with smoking.

A 1952 Readers Digest article, ‘Cancer by the Carton’ documenting the real danger of lung cancer caused a sensation, and tobacco industries began to work frantically to secure the public’s affection and trust.

Doll however, continued his work, with what was to become a 50 year study of 35,000 British male doctors’ smoking habits and death rates.

Between 1951 and 1964 about half the doctors who smoked gave up, resulting in a dramatic fall in lung cancer incidence compared to those who continue to smoke.

- After 20 years study, Doll concluded that one in three smokers died from their habit
- After 40 years study the findings showed that about half of all regular cigarette smokers were likely to be killed by their habit
- By 2004, the data showed that smoking caused the deaths of up to two thirds of all persistent smokers.

Doll’s 50 years of research has revealed the true health risk from prolonged smoking. Today we know that more than 80% of all lung cancer deaths are directly attributable to smoking.

Slow government action sees a slow decline in smoking

The slow decline of smoking in Britain, accompanied by a long battle of wits between the tobacco industry and health campaigners began.

The government was cautious about economic implications and did not wish to appear over-protective, so its own health campaigns did not swing into action until the mid-1960s. Only in 1971 was a voluntary agreement introduced which placed health warnings on tobacco products.
Villain to hero

Dr Jeffrey Wigand is the former vice-president of research and development at the US Brown and Williamson Tobacco Corporation.

Wigand, who had worked on the development of ‘reduced harm’ cigarettes, was fired in 1993, because he knew that the company had manipulated its tobacco blend to increase the amount of nicotine in cigarette smoke and that the company was knowingly approving the use of cancer causing (carcinogenic) additives in their tobacco.

The subsequent court case revealed that scientific research papers had been altered by company lawyers and in 1996 he told the American public all he knew. This phenomenal story has been made into the film ‘The Insider’ starring Russell Crowe.

It was only in the last decade, 50 years on from the truth being known about the health implications of smoking, that the momentum to become smoke free has increased.

Finally, in 1999 tobacco companies began to admit that cigarettes caused cancer, whilst still aggressively promoting their use.

As smokers with cancer grew and quit attempts increased, the industry maximised cigarettes addictiveness, genetically modifying tobacco plants to have higher levels of nicotine. The companies themselves admitted that they were making it harder for existing smokers to quit.
But the success of this toxic industry is not solely attributed to marketing alone. The industry has used numerous dirty tactics to keep recruiting and maintaining smokers, including:

- supporting and sponsoring major events and festivals
- associating themselves with healthy activities
- employing and training journalists to present their case
- funding biased research
- involvement and influence in politics
- negotiating in international trade agreements to favour their efforts

Although all forms of marketing are now banned in the UK and most of Europe, the tobacco industry continues to aggressively employ these tactics in the developing world to recruit smokers and increase profit margins.
Why it's a good idea to take 7 steps out...
King James I of England described the habit of smoking as unhealthy and vile. Forbidding the use of tobacco in his Kingdom he said that smoking is a “custom loathsome to the eye, hateful to the nose, harmful to the brain, dangerous to the lungs, and in the black and stinking fume thereof, nearest resembling the horrible stygian smoke of the pit that is bottomless”. He was the first to impose a heavy tax on tobacco. He questioned its supposed medicinal benefits and raised the issue of secondhand smoke.

1586
Some of the Virginia colonists return to England smoking pipes. The habit quickly spreads and tobacco takes root in English society.

1930s
Britain has the highest lung cancer rate in the world.

1943
**Advertising:** Philip Morris places an ad in the US National Medical Journal which reads: “Don’t smoke is advice hard for patients to swallow. May we suggest instead ‘Smoking Philip Morris?’ Tests showed three out of every four cases of smokers’ cough cleared on changing to Philip Morris. Why not observe the results for yourself?”

1952
Cigarette in hand, footballing legend Stanley Matthews beams out of this magazine advert. This was the year before the FA Cup final that would cement his place in sporting history, but it was also around this time that research began to deliver results that would change the image of smoking forever. Stanley says that with its ‘smooth, clean smoking’, Craven ‘A’ is ‘the cigarette for me’. At the time, such advertising was commonplace and often featured happy, healthy-looking people. Some, such as Stanley (who didn’t even smoke), were leading sports figures; others were well-known entertainers. Indeed, with the added approval from top Hollywood stars, smoking’s image was both cool and glamorous.

1962
The first Royal College of Physicians (RCP) report, “Smoking and Health”, the recommendations were: restriction of tobacco advertising; increased taxation on cigarettes; more restrictions on the sales of cigarettes to children, and smoking in public places; and more information on the tar/nicotine content of cigarettes. A series of reports of tobacco and health followed.

1995
A major American study concludes that passive smoking is a cause of heart disease in non-smokers and an asthmatic is compensated for illness exacerbated by passive smoking at work.
1761 London physician, John Hill, performs possibly the first clinical study of tobacco effects. He warns snuff users that they are vulnerable to cancers to the nose.

1856 The first cigarette factory in England is opened by Crimean War veteran Robert Gloag.

1868 UK Parliament passes the Railway Bill which mandates smoke-free carriages to prevent injury to non-smokers.

1890 The invention of the cigarette rolling machine and the resulting mass production of the manufactured cigarette, led to a rapid overall increase in consumption that spread right across the world.

1908 Children’s Act bans the sale of tobacco to children under 16.

1912 First strong connection is made between lung cancer and smoking. Dr I Adler is the first to strongly suggest that lung cancer is related to smoking.

1996 Dr Jeffrey Wigand - former tobacco industry Vice-president reveals the truth about the tobacco industry (story later told in film ‘The Insider’ with Russell Crowe)

2003 The UK Chief Medical Officer challenges the UK Government to ban smoking in public places.

2007 Smoking in public places is banned in England.

2008 Law on standardised packaging introduced.

2015 Legislation comes into force in England and Wales banning smoking in cars with people under 18 years of age present.

2016
Traditionally more men than women smoke and the table above highlights these differences over time.
In 1962

- 70% of men smoked
- 40% of women smoked

In 2016

- 18.3% of adults in Gateshead smoke (England 16.9%)
- That’s 29,485 people.

- 12.4% of 15 year olds in Gateshead smoke (England 8.2%)
- That’s 280 15 year olds.
Children who live with smokers are three times more likely to become smokers than those who don’t, continuing the cycle of inequality.
Poverty, inequality and social justice

“Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people from different socio-economic groups experience avoidable differences in health, well-being and length of life is, quite simply, unfair and unacceptable.”


In 2015, 25% of Gateshead’s population lived in the 20% most deprived areas as defined by the Index of Multiple Deprivation (IMD). This is down from 39% in 2010. The IMD gives a score based on measures of:

- Income;
- levels of employment;
- educational attainment;
- health status;
- recorded crime;
- barriers to housing and services; and
- the living environment of populations.

Those ranked higher on the IMD tend to have fewer opportunities than the least deprived.


In Gateshead we are seeing year on year reductions in early death rates in both men and women from all causes, Cancers and Heart Disease, but this hides the fact that the least deprived are improving faster than the England average and most deprived groups are significantly slower.

If you are living in the least deprived area, on average you will live 9.2 years longer (if you are a man) and 7.8 years longer (if a woman) than someone in one of the most deprived areas.
“Tobacco control is central to any strategy to tackle health inequalities as smoking accounts for approximately half of the difference in life expectancy between the lowest and highest income groups.”


Smoking-related death rates are two to three times higher in low-income groups than in wealthier social groups.”

The map above outlines a bus route across Gateshead. Based on information from our 2012 lifestyle survey, the number of people who smoke depends where you get off the bus.  

Where smoking prevalence is highest our life expectancy is lowest. For example, the smoking prevalence in High Fell is almost 35% and the life expectancy for men and women is around three years less than the average.
**Tobacco: the rich and the poor**

Tobacco use is the leading cause of preventable ill-health and premature death, and is responsible for half the difference in life expectancy between the rich and poor.

Whilst smoking rates overall have declined significantly in recent years, they remain much higher in disadvantaged and socially marginalised groups. Smoking is the single most important driver of health inequalities.

More Gateshead people die from smoking related illness than all other causes each year, and a large number of smokers will also be living the last years of their life incapacitated by smoking related conditions such as respiratory disease, circulatory problems and cancers.

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**Gateshead residents die every year from smoking related diseases**

462

That’s almost 9 people a week

One death every 21 hours

More than half of smokers will die early from a smoking-related illness
Smoking is passed between the generations in a cycle underpinned by social norms, familiarisation and addiction. In more deprived communities, young people are more exposed to smoking behaviour, more likely to try smoking and, once hooked, they find it harder to quit.

Smoking is so corrosive to individual, family and community health that any success in reducing smoking in disadvantaged groups has knock on benefits for the wider determinants of health, above all through reductions in poverty.

Remarkably we see higher smoking prevalence associated with almost every indicator of deprivation or marginalisation.

Compared to the population as a whole, smoking rates are higher among people:

- with a mental health condition
- who are unemployed
- who are homeless
- who receive welfare benefits
- with no qualifications
- who are single parents
- from Black and Minority Ethnic groups
- who are prisoners
- looked after children
- the lesbian, gay, bisexual, transgendered and queer community

Cumulative disadvantage increases the likelihood that someone will smoke.

“People whose control over their daily lives is highly constrained and who do not have the resources and opportunities to thrive are most likely to be smokers and least likely to take the necessary steps to quit”

Smoking drives many other health inequalities. Wherever there is a difference in smoking prevalence, the result is a corresponding difference in health outcomes.

Long-term smokers bear the heaviest burden of death and disease related to their smoking. Long term smokers are disproportionately drawn from lower socio-economic groups. People in lower socio-economic groups who smoke, start smoking at an earlier age; of those in managerial and professional households about one third start smoking before age 16 compared with almost half of those in routine and manual households. For more information go to www.ash.org.uk
The tobacco industry relies on the poor to sustain their business

The number of people smoking in Gateshead is falling and now sits at 18.3% in the adult population. This is not significantly different from the England level of 16.9%. The North East Region sits at 18.7% compared to 29% of people smoking in 2005.\textsuperscript{10}

Smoking for adults in routine and manual occupations is higher which further exacerbates inequalities. The rate in Gateshead is 25.6%, well above the rate for the general adult population.\textsuperscript{10}

Although we are seeing reductions in smoking rates we have still to see the benefits in smoking attributable hospital admissions and smoking attributable mortality with Gateshead rates significantly worse than the Regional and national rates.

Rates of smoking attributable hospital admissions have been increasing since 2009/10 from 2,314 per 100,000 population to the 2014/15 level of 2,710 per 100,000 populations. This is significantly worse than the North East Region score of 2,446 per 100,000 population.\textsuperscript{10}

Death rates from tobacco are two to three times higher among disadvantaged social groups than among the better off.

Smoking in pregnancy

Smoking in pregnancy rates are improving with 16.7% of mothers smoking at time of delivery in the North East and 13.2% smoking in Gateshead.\textsuperscript{8} This improvement is in part down to implementation of NICE guidance on Smoking in Pregnancy through a region wide initiative, Baby Clear.

However the rate is still well above the England average of 11.4% and this increases inequalities in health with more mothers in lower income groups smoking than those in higher income groups.

Stopping children smoking

Reducing smoking and stopping children starting is a priority, to be pursued in a way that reduces health inequality and ensures everyone is able to benefit. The best way to stop children smoking is to reduce smoking in the world around them, helping adults to quit so that smoking is no longer the norm.

\textit{“We want to secure a tobacco free generation; our most disadvantaged communities have the most to gain from this.”}\textsuperscript{11}
Tobacco poverty

It costs more to live when you have less money to spend. The phenomenon is called the ‘Poverty Premium’. Families with low incomes can pay around £1,000/year more for basics like gas, electricity, consumer goods and insurance. Go to www.savethechildren.org.uk for more information.

The social gradient of smoking means that a greater number of families on low incomes will have one or more smokers, and the cost of smoking further compounds the effects of the poverty premium.

Despite this, the tobacco industry relies on ‘the poor’ to sustain their businesses. We would like to see a new measure of poverty introduced in the UK.

Tobacco Poverty could be defined as: “the proportion of households in an area spending over 10% of their disposable household income on sustaining the smoking habits of one or more family members”

Poverty is the central issue. As spending on tobacco consumes a relatively high proportion of the household income of poorer smokers, smoking helps to trap these households in poverty as well as damaging personal and family health.

Cost of smoking on Gateshead’s economy

Our vision is for a ban on all burning tobacco products. The total cost to the Gateshead economy is estimated at £65.1m, that’s £1,936 per smoker/year. This is broken down as shown in the graph below. This cost is in comparison to a total contribution in tobacco duty of £34.79m, leaving a shortfall of just over £30m.1

Smoking costs to Gateshead’s economy
Based on 2009 prices, poorer smokers proportionately spend five times as much of their weekly household budget on smoking than richer smokers. This is money going into the hands of criminal gangs, avoiding duty and tax.

Illicit tobacco sales account for approximately 5% of sales. There is strong public support to curb the sale of illicit tobacco.

Early deaths due to smoking result in 1,117 years of lost productivity and a cost of £20m in Gateshead. Smoking 20 a day costs £3,241 each year.

If smokers stopped and the money was recirculated back into the household budget, it would lift around 2,655 Gateshead homes, 4,434 Gateshead people, out of poverty.

23,712 Gateshead households have at least one smoker, 34% of which fall below the poverty line.

37,876 days of productivity lost because of smoking related sick days at a cost of £3m. Early deaths due to smoking result in 37,876 days of productivity lost because of smoking related sick days at a cost of £3m.

Illicit tobacco sales account for approximately 5% of sales. This is money going into the hands of criminal gangs, avoiding duty and tax.

There is strong public support to curb the sale of illicit tobacco.
The Racketeering case against the tobacco industry

On September 22, 1999, the United States filed a lawsuit against the major cigarette manufacturers and two industry-affiliated organizations.

The charges were for racketeering, which is traditionally defined as obtaining or extorting money illegally or carrying on illegal business activities, usually by organised crime. In US law it is defined as “a pattern of illegal activity carried out as part of an enterprise that is owned or controlled by those who are engaged in the illegal activity.”

The Government alleged that Defendants have violated, and continue to violate, the Racketeer Influenced and Corrupt Organizations Act (“RICO”), 1961-1968, by engaging in a lengthy, unlawful conspiracy to deceive the American public about the health effects of smoking and environmental impact of tobacco smoke, the addictiveness of nicotine, the health benefits from low tar, “light” cigarettes, and their manipulation of the design and composition of cigarettes in order to sustain nicotine addiction.

In particular, the Government has argued that, for approximately fifty years, the Defendants had falsely and fraudulently denied:

- that smoking causes lung cancer and emphysema (also known as chronic obstructive pulmonary disease (“COPD”)), as well as many other types of cancer;
- that environmental tobacco smoke causes lung cancer and endangers the respiratory and auditory systems of children;
- that nicotine is a highly addictive drug which they manipulated in order to sustain addiction;
- that they marketed and promoted low tar/light cigarettes as less harmful when in fact they were not;
- that they intentionally marketed to young people under the age of twenty one and denied doing so; and
- that they concealed evidence, destroyed documents, and abused the attorney-client privilege to prevent the public from knowing about the dangers of smoking and to protect the industry from adverse litigation results.

The following voluminous Findings of Fact demonstrate that there is overwhelming evidence to support most of the Government’s allegations.

Read the full judgement at:
Recommendations for action to address inequalities

The following measures are central to any comprehensive package of measures to reduce health inequalities and should form part of a wider Tobacco Control strategy.

Although some rely ultimately on central government intervention, local action and work at a regional level will help lobby for change in the right direction.

Effective taxation to reduce the affordability of tobacco
Increasing the price of tobacco is the one population-level intervention that unequivocally has a greater effect on lower income smokers. As poorer smokers are more price sensitive, they are more likely to quit than wealthier smokers when the price of tobacco rises. To be effective however, the tax regime needs to minimise opportunities for smokers to down trade, above all by preventing tobacco companies from manipulating the prices of their brands to ensure that ultra-low price brands are minimally affected by tax increases.

Tackling the illicit market
The effect of tax increases is lost if smokers can obtain illicit or counterfeit cigarettes that are untaxed. The illicit market has shrunk over the last decade but still remains a major obstacle to effective tobacco control, especially in poorer communities. Ongoing action is needed at local, regional, national and european levels to control and monitor the tobacco supply chain.

Mass media campaigns
There is evidence that mass media campaigns can have a greater impact on more disadvantaged smokers if they are carefully tailored and targeted. This requires both that the content and the tone of the campaigns are suitable for the target audience and that the promotion of the campaigns ensures maximum exposure in this audience.
Targeted specialist stop smoking services
From the outset, specialist stop smoking services were designed to target disadvantaged communities. However, they have had limited impact on inequalities because smokers from disadvantaged areas find it more difficult to stop with the help of stop smoking services than their more affluent neighbours.

These services need to refocus on the task of reducing inequalities and examine every aspect of their referral and treatment pathways to ensure that they are geared to this task. In particular, referral partners who have everyday contact with disadvantaged smokers, such as GPs, mental health services, criminal justice services and children’s services, need to be fully engaged to ensure that opportunities to support people to quit are not missed, both through brief intervention and through referral to specialist services. Recent research in Scotland has identified a key role for debt and money advice providers in identifying and referring smokers on low incomes.

Harm reduction
Smokers who are highly addicted to nicotine can dramatically reduce their risks without having to overcome their addiction by switching to alternative nicotine products. Given the high nicotine dependency of many of the most disadvantaged smokers, and the many socio-economic obstacles that inhibit their motivation to quit and engage with services, such products have the potential to play a major role in reducing smoking prevalence in these groups, especially if they are designed, delivered and priced in ways that make them more attractive than cigarettes. These products include both licensed nicotine replacement therapies, such as gums and sprays, and unlicensed nicotine vapourisers (e-cigarettes).

References 35-40 from ASH Health Inequalities and smoking paper for the above recommendations http://www.ash.org.uk/files/documents/ASH_1017.pdf
In Gateshead 12.4% of 15 year olds smoke compared to the England average of 8.2%
Engagement

Directors of Public Health annual reports are supposed to be purposeful, useful documents. They should tell us something about the health of the population and what needs to happen to maintain good health and improve poor health. It should help to inform decisions that impact upon our health.

Smoking, like many public health issues, requires us to work across entire systems to influence values, beliefs, attitudes and behaviours. This is why it is important that this annual report provides an opportunity for people to tell a wider audience what they think about tobacco and smoking and how it impacts upon their lives.

The views of young people are especially interesting, given how important young people are to the tobacco industry. Many smokers start using tobacco when they are young. The tobacco industry needs to recruit new smokers to replace older smokers who tend to die younger than people who do not smoke.

Young people give their views

In order to provide a platform for young people, we asked workers at a local community organisation, Edberts House, to speak with young people about smoking and tobacco.

Twenty one young people aged under 18, came along and took part in the event which also formed the basis of a video to be used on social media to raise awareness of this issue to a wider public.

They told us what they thought about smoking, some of the ways in which it affects their lives and society in general. The three key things they highlighted were:

“We have the right to choose what we do with our lives, but we don’t want to die”

“We are dying, and they’re (the tobacco industry) getting money, so it’s a bit like people are paying to die”

“I think it’s a bit stupid offering your daughter or your son a cigarette”
This kind of engagement session is invaluable as a way of capturing the thoughts and views of future generations.

The videos of the young people are matched with other videos from people whose life experience brings them face to face with the impacts of smoking and tobacco on individuals and communities in Gateshead.

These people range from those who are suffering from the ill effects of smoking on their health, to the hospital doctors who have to treat these diseases and pass on sometimes devastating news to people. We also spoke with people from community organisations who support those with smoking related illness, and especially recognise the financial impact that smoking has on some of the poorest sections of our community.

To view the videos made around the impact of tobacco go to:

www.gateshead.gov.uk/smokingandyoungpeople and www.gateshead.gov.uk/impactoftobacco
Smoking 20 a day costs you £3,241 each year. That’s more than most people in Gateshead pay for their annual Council Tax.
Tobacco and mental health and wellbeing

First, some facts.

• Mental health conditions affect around a quarter of the population. People with severe mental illness die on average 10-20 years earlier than the general population and smoking is the single largest factor accounting for this difference.

• Around one third of adult tobacco consumption is by people with a current mental health condition with smoking rates more than double that of the general population.

A Public Health England (PHE) report showed smoking rates in those with Severe Mental Illness (SMI) as high as 55% in one Clinical Commissioning Group (CCG) with the lowest level being 27.2%. This equates to an average prevalence across England for those with SMI of 40.5%. In comparison the prevalence in the general population had a high of 27.1%, a low of 12.3% and an average of 18.4%, less than half of the prevalence of those with SMIs.

While rates of smoking in the general population have fallen in past decades the prevalence has remained stubbornly high amongst people with mental health conditions.

A third of all tobacco smoked in England today is by someone with a mental health condition. The result is a shorter life and the final years of life blighted by heart disease, lung disease, stroke and cancers. These are the ‘Stolen Years...of life, of health, of wealth’.

People with mental health conditions face more barriers to quitting, are likely to be far more dependant and therefore need more support. Programmes need to be tailored with this in mind. Add poverty to the mix and you see even greater inequalities. See table below:

Prevalence of smoking by mental health status and social position

<table>
<thead>
<tr>
<th></th>
<th>Prevalence whole population</th>
<th>Prevalence among those in poverty</th>
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<tbody>
<tr>
<td>Common mental disorder</td>
<td>34%</td>
<td>46%</td>
</tr>
<tr>
<td>Currently taking psychoactive medication</td>
<td>34%</td>
<td>46%</td>
</tr>
<tr>
<td>Longstanding mental disorder</td>
<td>40%</td>
<td>52%</td>
</tr>
</tbody>
</table>
Other inequalities relating to smoking and mental health include:

- 43% of smokers reported no health professional speaking to them about their smoking\(^a\)
- 46% of those taking psychoactive medication and 52% of those with a long standing mental health disorder are current smokers\(^b\)
- Around 1,000,000 people with common mental health disorders are both living in poverty and current smokers\(^c\)

**Legislation and guidance**

Recent legislation is making it easier for people with mental health problems to stop smoking with Smoke free NHS Mental Health Trusts across the North East. However if we were to achieve ‘parity of esteem’ for people with mental health issues we would have to see smoking rates tumble in people with mental health issues through real local action with this group of people.

People with mental health issues are no different to the general population; they are just as likely to want to stop and there have been examples where rates have fallen from 85% to less than 50% in some groups with the implementation of smoke free policies in acute settings. However there are suggestions that more could be done, including:

- Harm reduction for those unwilling or unable to stop
- Training for staff in discussing safer alternatives to smoking
- Availability of nicotine products, including e-cigarettes, for those with mental health problems who smoke
We’re not starting from a blank sheet in looking at what will help this group as we can build on existing work: Previous reports on smoking and mental health include:

- RCP and RCPysch 2013 report, Smoking and Mental Health, 2013
- The Mental Health Task force Report, 2016
- The Mental Health Network’s briefing on the importance of addressing smoking in the mental health population
- Public Health England’s work to support mental health units going smokefree

The National Institute for Health and Care Excellence (NICE) has published guidance on smoking in acute, maternity and mental health services. These guidelines suggest that all secondary care providers, including Mental Health Trusts, should:

- make sure secondary care premises (including grounds, vehicles and other settings involved in delivery of secondary care services) remain smoke free - to help to promote non-smoking as the norm for people using these services.
- have an on-site stop smoking service.
- identify people who smoke at the first opportunity, advising them to stop, providing pharmacotherapy to support abstinence, offering and arranging intensive behavioural support, and following up with them at the next opportunity.
- provide intensive behavioural support and pharmacotherapy as an integral component of secondary care, to help people abstain from smoking, at least while using secondary care services.
- make sure continuity of care by integrating stop smoking support in secondary care with support provided by community-based and primary care services.
- make sure staff are trained to support people to stop smoking while using secondary care services.
- support all staff to stop smoking or to abstain while at work.
- make sure there are no designated smoking areas, no exceptions for particular groups, and no staff-supervised or staff-facilitated smoking breaks for people using secondary care services.

Nice guidelines also advise on harm reduction approaches, which may or may not include temporary or long-term use of licensed nicotine-containing products. The recommendations cover:

- Raising awareness of licensed nicotine-containing products.
- Self-help materials.
- Choosing a harm-reduction approach.
- Behavioural support.
- Advising on licensed nicotine-containing products.
- Supplying licensed nicotine-containing products.
- Follow-up appointments.
- Supporting temporary abstinence.
- People in closed institutions.
- Staff working in closed institutions.
- Commissioning stop smoking services.
- Education and training for practitioners.
- Point-of-sale promotion of licensed nicotine-containing products.
- Manufacturer information on licensed nicotine-containing products.
- Learning from Mental Health Trusts which have implemented fully smoke-free sites.
Harm reduction approaches covered by PH45 guidance

Stopping smoking
• by using one or more licensed nicotine-containing products as long as needed to prevent relapse.

Cutting down prior to stopping smoking
• with the help of one or more licensed nicotine-containing products (the products may be used as long as needed to prevent relapse)
• without using licensed nicotine-containing products.

Smoking reduction
• with the help of one or more licensed nicotine-containing products (the products may be used as long as needed to prevent relapse)
• without using licensed nicotine-containing products.

Temporary abstinence from smoking
• with the help of one or more licensed nicotine-containing products
• without using licensed nicotine-containing products.
Lack of progress

Despite all these reports, evidence based information and legislation in the last three years there has been little progress. A new report by Action on Smoking and Health (ASH) has outlined the UK’s stark lack of progress in tackling tobacco use among people with mental health problems.

The past two decades have seen smoking prevalence in the general population drop from 27% to 19%; over the same period, there has been no decline in prevalence among people with mental health problems.

80% of respondents who were current smokers reported having attempted to quit smoking and 46% of current smokers said they consistently feel they wanted to quit in the last year.

Smoking and subjective wellbeing

Subjective wellbeing is another way that we can describe ‘happiness’. Because happiness as a word means different things to different people, the term subjective wellbeing is used to describe the sense that people have that all is well in their life and that things like relationships, health and work are generally going in the right direction.

Smoking affects subjective wellbeing. Individuals who smoke are more likely to report lower satisfaction with many aspects of their lives, eg, jobs, non-working activities, financial conditions, family life, friendships, residential area, health and physical conditions, and self-rated health than those who do not smoke.

• Men who do not smoke have been found to have higher average levels of wellbeing than men who smoke.
• Women who had smoked in the past had lower levels of wellbeing than women who had never smoked.
• Smokers tend to report elevated levels of anxiety, with and without controlling for other factors.

There is evidence of a causal link between smoking and wellbeing: quitting smoking tends to reduce anxiety, with the effect likely to be larger in those who have a psychiatric disorder or those who smoke to reduce stress.

Some research has also shown that smokers’ wellbeing actually improved after the introduction of smoking bans.

There are many factors associated with smoking, including: social class, employment status, income, smoking status of family and friends. A number of these factors are also associated with people’s wellbeing levels, for example employment status.

Smoking behaviour is spread through both close and distant social ties, and evidence suggests that groups of interconnected people stop smoking collectively.
Recommendations for action to address smoking inequalities for people with mental ill health

ASH has called for the following actions to help address this inequality:

- A strong focus for the whole mental health population. Based on HSE figures of current rates of 40% they called for a target of 35% by 2020.

- Leadership and direction to local authorities, NHS and other relevant partner organisations about the role they need to play to reduce smoking.

- Commitment to invest in education and training of mental health workforce.

- Assurances about the provision of high quality support for all those with a mental health condition who need it to help them quit smoking.

- Action to address poor understanding of nicotine and e-cigarettes among smokers and professionals.

If we are going to make a difference in smoking prevalence in this target group at a local level it will require local leadership and commitment to tackling this major inequality in health.
The tobacco industry makes £4,000 profit for every death caused by tobacco. It costs the NHS in around £2 billion to treat smoking relating illnesses each year in England alone. 21
New realities

What have we done in Gateshead, and is the job done?

Gateshead’s population now has the lowest proportion of smokers since records began. Less than one in five adults smoke, with dramatic reductions in smoking amongst young people and in smoking during pregnancy. Deaths due to smoking related diseases like lung cancer and heart attacks have declined with this reduction.

So, is the job now done? Obviously not.

Around 462 people in Gateshead still die every year due to smoking related diseases. These deaths, and the years of poor health preceding them, affect our most challenged communities the greatest, with ongoing emotional, social and financial impacts. These are compelling reasons for smoking to remain a public health priority.

At the same time, public services are facing significant and ongoing financial challenges, with further changes to local government finances on the horizon. More than ever before, each pound must be spend to maximum benefit.

89% of the public in the North East supported banning smoking in cars carrying children

Do people in the North East think that working to reduce smoking further is worth the money?

Public opinion on smoking shows that they do. A 2016 YouGov survey showed that 81% of people in the North East would like smoking to become a thing of the past for future generations, with popular support for a range of measures:
<table>
<thead>
<tr>
<th>North East public opinion</th>
<th>Support</th>
<th>Oppose</th>
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</thead>
<tbody>
<tr>
<td>Support plain, standardised packaging</td>
<td>60%</td>
<td>11%</td>
</tr>
<tr>
<td>Would like smoking to become a thing of the past for future generations</td>
<td>81%</td>
<td>4%</td>
</tr>
<tr>
<td>Banning smoking in cars carrying children</td>
<td>89%</td>
<td>2%</td>
</tr>
<tr>
<td>Put 25p on a packet of cigarettes to fund action to reduce smoking</td>
<td>64%</td>
<td>16%</td>
</tr>
<tr>
<td>Raise age of sales to 21</td>
<td>60%</td>
<td>21%</td>
</tr>
<tr>
<td>Government health policy should be protected from the tobacco industry and its representatives</td>
<td>75%</td>
<td>3%</td>
</tr>
<tr>
<td>Government “not doing enough” or “doing about right” to limit smoking</td>
<td>75%</td>
<td>12% “too much”</td>
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**So, how have we responded to these new realities?**

Gateshead Council is an ambitious council, and it remains ambitious in what it wants to achieve regarding smoking. We remain committed to reducing smoking prevalence below 5% by 2025.

Achieving this relies on encouraging two behaviours amongst our population - fewer people starting to smoke, and more smokers quitting. The Gateshead Joint Strategic Needs Assessment (JSNA) identifies those key actions required to influence these behaviours:

- Develop the infrastructure, skill and capacity in Gateshead to support tobacco control e.g. the leadership and strategic and practical support.
- Reduce the exposure of children and adults to second hand smoke.
- Motivate and support smokers to stop smoking through continued media promotion of the reasons to quit and the most effective ways of quitting, as well as commissioning an effective stop smoking service.
- Develop local media and communications strategies to reduce the social acceptability of tobacco use in Gateshead.
- Reducing the availability and supply of tobacco products (legal and illicit) – and reducing the supply of tobacco to children.
- Reducing tobacco promotion and enforce tobacco regulation through smokefree, point of sale under ages sale legislation.
- Prevent and reduce smoking prevalence amongst children and young people.
The JSNA also identifies our challenges to doing this:

- **Smoking prevalence is decreasing slowly in Gateshead but is still significantly higher than the England average.**

- **Financial constraints means that Gateshead Council may only be able to cover statutory responsibilities with regard to enforcement, this could mean other non-statutory issues which impact on health may not be closely monitored, for example action to tackle illegal tobacco.**

- **Education about smoking and tobacco control issues in educational settings is not being delivered consistently.**

Deciding how best to do this with reduced resources requires us to look across the whole system and develop strong partnerships. According to ASH, effective tobacco control requires three domains:

- **Challenge tobacco control services**
- **Local leadership**
- **Results demonstrated by outcomes.**

We used this ‘CleaR’ approach to identify how we need to work. The CleaR self-assessment considered 11 key areas that contribute to a successful tobacco alliance. The key recommendations identified were:

1. Continue the excellent work being delivered around compliance, including initiatives to tackle illegal tobacco, enforcement and compliance with existing legislation such as plain packaging and support work at national and regional level around licensing of retailers.

2. Review the impact on stop smoking services with the move of support from external providers via a Hub to support from council teams. There is a need to identify positive aspects but also be vigilant for any unexpected downturn in trajectories for access and outcomes.

3. Prevalence is at an all-time low but we have still got to achieve a further 13% reduction to hit the Vision and target of 5% smoking prevalence by 2025. This will require targeted work with specific groups with high smoking prevalence rates such as pregnant women, people with mental health issues and low income groups/communities. Support of FRESH at Regional level is an important contribution to achieving this target.

4. Support at leadership level needs to be enhanced across all partner organisations and there are opportunities to enhance the Gateshead Health and Wellbeing strategy which is being refreshed for 2016 – 2019. There is also the potential for getting the issue onto the Health Overview Scrutiny Committee (OSC) forward plan to enable them to scrutinise progress towards the 2025 target.
5. Leadership could also be taken by ensuring that partner organisations work towards the 5% target using their existing commissioning arrangements but also looking at potential innovation. Two examples might be:

- The CCG including implementation of NICE guidelines on tobacco into all provider contracts e.g. Continuation of Baby Clear model for Midwifery Departments.

- Partnership between Clinical Commissioning Group (CCG) and the local authority to collaboratively commission a secondary care based stop smoking service. This could include the implementation of a “Stop before the Op” intervention.

At this point, we know what we want to achieve and by when, and the things that need to happen to get us there. The next stage is to develop a 10 year Tobacco Action Plan agreeing who will do what.

The Gateshead Smokefree Tobacco Control Alliance brings together partners from across the borough to work together to implement action locally. If we are serious about achieving 5% smoking prevalence by 2025 all partners will need to work together.

10 year Tobacco Action Plan

The 10 year Tobacco Action Plan will set out the work of the Tobacco Control Alliance. Based on the World Health Organisations (WHO) key targets from their Framework Convention on Tobacco Control (FCTC), the plan will identify action across eight themes. These are:

1. Developing infrastructure, skills and capacity at local level and influencing national action
2. Reducing exposure to second hand smoke
3. Supporting smokers to stop
4. Media communications and social marketing
5. Reducing the availability of tobacco products and reducing supply of tobacco
6. Reducing the promotion of tobacco
7. Tobacco regulation
8. Research, monitoring and evaluation

The plan will provide the framework against which the Tobacco Control Alliance will gauge their progress towards making smoking history in Gateshead.
**E-cigarettes and vaping**

Smoking is incredibly bad for you. It kills at least 50% of long term users.

Both Public Health England and the Royal College of Physicians agree that vaping, using e-cigarettes, is at least twenty times less harmful than smoking.

It makes sense to switch from smoking to vaping; it's much safer and there's good evidence that vaping can help smokers to stop smoking. But it doesn’t make sense to start vaping if you don’t smoke. It is much safer than smoking, but it’s not totally safe, and nicotine is addictive.
Recommendations from this report

17 recommendations arising from this report are set out below.

Galvanise action/keep up momentum

International evidence has shown that smoking rates could plateau or start to rise if tobacco control work is not sustained.

Recommendation 1 (National)
The five year strategy set out in the Government’s Tobacco Control Plan for England came to an end in 2015. A comprehensive tobacco control plan for England is now essential setting out the Government’s commitment to address the harm caused by tobacco, not just directly on health, but on social care, poverty and life chances at local, regional and national levels.

Recommendation 2 (Local)
In Gateshead we need to regroup to refresh our vision and reaffirm our commitment, through the local Tobacco Alliance, to the goal of a 5% adult smoking prevalence by 2025. We need to develop and publish a ten year plan clearly setting out action across the whole community to address the harm caused by tobacco.

The plan should principally address inequalities and as such I would recommend specific action to cut smoking rates among routine and manual groups and other groups at risk. The plan should also include a target to address tobacco poverty.

It is critical that plans at both a national and a local level are developed without any influence from the tobacco industry.

Address inequalities

Recommendation 3 (Local)
As part of the Gateshead Ten Year Plan, establish new work-streams to address the harm caused by tobacco with groups we know are at greater risk. These work streams should use opportunities such as implementation of plain, standardised packaging, with larger health warnings, as an opportunity to make tobacco less attractive, as well as encouraging more smokers to quit. Specifically this should prioritise concerted action with:

- Young people
- Looked After Children
- Those living in poverty
- People who experience homelessness or vulnerable housing
- People who experience mental ill-health
- People in secondary care or with long term conditions
Polluters pay

Smoking kills more than 462 people in Gateshead every year and, evidence provided by Cancer Research UK suggests the tobacco industry makes a profit of over £4,000 for every death caused by tobacco. The industry has huge budgets which they spend on activities such as lobbying ministers, MEPs and the European Parliament. These budgets could be put to better use.

Recommendation 4 (National)
Introduce a new annual levy on tobacco companies to ensure they pay more for the harm they cause. Funding from a levy should be used to make smoking history for more families including support and encouragement to help people quit.

Protect children

Evidence shows that children suffer increased levels of harm when they live in a home where a parent or sibling smokes. This harm arises due to the reduction in household income from expenditure on tobacco, as well as the health risks from exposure to second hand smoke. In addition, children who live with people that smoke are 3 times more likely to become smokers than children from non-smoking households thus perpetuating a cycle of inequality.

Recommendation 5 (Local)
Persevere with work to further reduce the number of women who smoke during and after pregnancy. This specifically includes embedding system-wide implementation of NICE guidance PH26 ‘Smoking: Stopping in Pregnancy and After Childbirth’ as part of the maternity review and the 0-19 Public Health services review.

Recommendation 6 (Local)
Local Authority budgets, for wider tobacco control and enforcement activities, including those to tackle underage sales and illicit tobacco, should be protected.

Recommendation 7 (National)
Introduce a national licensing scheme with the aim of eliminating the illicit and illegal trade in tobacco, and to end selling of tobacco products to minors. Any licensing scheme needs to include robust arrangements at every stage of the tobacco supply chain to ensure:

- Significant penalties against those involved at all levels of the illegal tobacco trade
- Sufficient finance is derived from those financially benefitting most from selling tobacco products, to enable all necessary enforcement activity against illegal suppliers is funded by the industry, rather than the taxpayer
- Only people who are classed as ‘fit and proper’ are permitted to be involved in tobacco import, manufacture, wholesale, distribution and retail sale
Recommendation 8 (Local)
Continue support for the new law which bans smoking in cars that are carrying children.

Recommendation 9 (Local)
Embed NICE guidance (PH23) ‘Smoking Prevention in Schools’ across Gateshead schools.

Recommendation 10 (Local)
Strengthen the voluntary code in Gateshead which urges no smoking in or around children’s parks or outside school gates.

Recommendation 11 (Local)
Undertake focussed work to increase the number of smoke free outdoor zones in public areas, including specifically, pubs, restaurants and workplaces.

Reducing smoking prevalence
Evidence shows that smokers are four times more likely to quit with support from specialist stop smoking services compared to quitting ‘cold turkey’. Furthermore, people from routine and manual groups are more likely to access stop smoking services meaning they are an effective measure to address inequalities.

Recommendation 12 (Local)
It is vital that local authority budgets for stop smoking services are protected and that services are provided in a range of settings accessed by those at greatest risk.

Invest in the future

Recommendation 13 (Regional)
Ensure continued support for a regional tobacco office specifically including support for mass media campaigns which have a strong evidence base in triggering quit attempts, encouraging quitters to stay quit, and reducing uptake among children.
Secondary prevention

**Recommendation 14 (Local)**
Trusts should fully implement NICE guidance PH48 ‘Smoking: Acute Maternity and Mental Health Services’. This should include the development of robust approaches to secondary prevention. Early developments should focus on particular secondary care pathways which deal with people experiencing conditions that are most likely to be impacted by smoking e.g. respiratory conditions and ‘stop before the op’ and people with mental illness.

**Recommendation 15 (Local)**
Ensure action on smoking is embedded in all other relevant plans e.g. Cancer and the Long Term Conditions Strategy.

Build capacity in communities

**Recommendation 16 (Local)**
Ensure training is available to provide people living and working in Gateshead, with skills to provide brief advice and intervention on smoking through the development of the Making Every Contact Count initiative.

**Recommendation 17 (Local)**
Communities should be encouraged and supported to identify and develop initiatives to address tobacco harm at a neighbourhood level.
And finally, 

Michelle’s story
Michelle Barthram, 47, from Birtley was diagnosed with smoking-related lung cancer in 2013.

The mum-of-one was the face of a key campaign led by Fresh UK that urged smokers not to underestimate the risks and quit now before it’s too late.

She said: “Even though I was smoking between 15-20 cigarettes-a-day, I felt fine. I was quite active and would walk the dog every morning before going to work. I always thought that I’d be the last person to be affected by smoking. To find out that I had lung cancer was truly shocking for me and my family.

“I never had imagined that my life could be cut short so quickly – it was devastating.

“I quit smoking the moment I was diagnosed with cancer. I still can’t believe that smoking has done this to me - I’m only 47-years-old! I know that I won’t get a second chance now, but I wish I’d realised the damage that smoking was doing to my health sooner. I’d urge anyone who is thinking about quitting smoking to do it now for them and their family’s sake.”

You can watch Michelle’s final plea made two months before her death online at www.freshne.com
Take control and get the power

This annual report brings into focus the ability of the tobacco industry to promote, manipulate and encourage people to take up smoking. But every smoker has the power to stop, and end the control by what is a multi-billion pound industry that is effectively selling products knowing they can kill people.

But the power is not one sided. Many years of campaigning, education and support to encourage people to quit has had an effect.

So I’d urge everyone to take note of Michelle’s story, my dad’s story and others and get help to stub out your last cigarette.

The people below did and it changed their and their families, lives forever.

“**When my daughter Elizabeth said: Will you pack in smoking because I don’t want you to end up like my grandad, I curled up and cried in front of her. It pulled my heart strings. If you love your kids, you will do what they want. The damage is done now. It’s too late for me. I will never get better. I wish I could go back and stop sooner.”**

“**When my granddaughter said: I won’t have a nana by the time I’m 11, it really got to me and I’ve never smoked since. If I had one message for anyone thinking about stopping smoking I’d say just give it a go. It’s your life you’re losing by smoking. Think of your children, grandchildren, partner and loved ones and how it’ll affect them when you’re gone.”**

“**I am very proud of my mum for quitting because she has stopped and started numerous times in the past and I think this time is different. Every time either me or my mum think about wanting a cigarette, we remind each other it’s not worth it.”**

Appendix 1

Update on recommendations from last year’s Public Health Report 2014-15

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<tr>
<th>Recommendations</th>
<th>Progress update</th>
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<tr>
<td><strong>Recommendation 1</strong></td>
<td>An early Help Strategy for Gateshead is being developed setting out how services and professionals will work together to achieve a seamless support offer for children, young people and their families to ensure they get the right help at the right time from the right people. The aim is to secure a borough wide approach within which all partners work together collectively to enable children, young people and their families to achieve success.</td>
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This joined up approach will be across education, family support, social care and health, and will provide a comprehensive support offer preventing duplication and frustration for those involved. We’ll continue to work with families rather than individuals, working with them on the root causes of their issues to ensure change is embedded and provides long term solutions. This should reduce pressure on high level or specialist services as their needs will be met and won’t escalate.  

The delivery model is currently being agreed but will:  
• Bring together a range of services including health, emotional wellbeing, behaviour support, family support, debt advice/support, worklessness and poverty.  
• Use CAF and TAF approaches to wrap support around families to meet the multiplicity of their needs  
• Ensure that practitioners identify and intervene with causes rather than with presenting symptoms  
• Harnesses the social capital of communities and use an asset based approach to developing solutions  

To achieve this and deliver a seamless service we will operate through one front door, with a no wrong door policy. This will provide a managed triage response which may lead to provision of information, signposting and where appropriate background checks in order to determine the appropriate pathway.  

The Early Help Strategy and Model will be taken to Cabinet for approval. It’s envisaged that The Children’s Trust Board will be responsible for its oversight and development reporting to the Health and Wellbeing Board. The LSCB will provide additional scrutiny and its impact on the safety and wellbeing of all children in Gateshead. |
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<tr>
<th>Recommendations</th>
<th>Progress update</th>
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| **Recommendation 2**  
Gateshead Council, in its community leadership role, should use all available opportunities to tackle poverty and inequality, recognising the need to advance longer term objectives of improved education attainment, quality housing, good jobs and economic growth. The proposed devolution deal for the North East Combined Authorities, to which the council is a party, presents a key opportunity to work in partnership with other local authorities, private and public sector partners to build a stronger economy and generate more and better jobs.  
The Council revised its equality objectives in March 2016 to reflect the areas of inequality identified in its Council Plan 2015-2020:  
- To support vulnerable groups most at risk of poverty and deprivation  
- To improve the range of housing across Gateshead for vulnerable groups  
- To promote healthy and inclusive communities  
- To increase levels of ambition and aspiration of vulnerable groups across Gateshead  
- To develop the Council’s workforce which recognises the diversity of the community it serves  
Performance against these objectives is monitored on a six monthly basis by the relevant Overview and Scrutiny Committee. In addition, the Council continues to work in partnership with other local authorities, private and public sector partners to stimulate economic growth and wellbeing. |

| **Recommendation 3**  
Gateshead Council should continue to commit to the priority of ‘giving children the best start in life’, recognising the need to strengthen systems for early intervention with vulnerable families to reduce the numbers of children in need and going into care (See Gateshead Council Plan 2015-2020).  
A key focus of this work is collaboration across the system to ensure the best start in life for children, as advocated by Sir Michael Marmot. This priority was recently reinforced in the publication ‘Health and Wealth - Closing the gap in the North East’.  
This has informed the work of the council, Newcastle Gateshead CCG and our Health and Wellbeing Board.  
Through the Gateshead Strategic Partnerships we’re working to:  
- improve the physical and mental health of people.  
- reduce inequity by prioritising positive development from early childhood.  
- embed health improvement interventions in all contacts.  
- enable healthier behaviours through individual support and providing environments that positively promote health, wellbeing and independence.  
We will adopt asset-based and community centred approaches that give individuals more control, increase individual and community resilience, support the prevention of ill health through earlier diagnosis, intervention and improve self-management of illnesses.  
As part of this work, we will build on the priorities within our Health and Wellbeing Strategy. We will use existing approaches and new powers to reduce the prevalence of smoking, obesity and the impact of alcohol and drug misuse and to develop person centred community led approaches that support people to live well and make positive lifestyle choices.  
We are working to ensure a radical upgrade in our approach to prevention, focusing not only on physical factors and emotional wellbeing but also on the wider determinants of health. |
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<th>Recommendations</th>
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<tr>
<td><strong>Recommendation 4</strong></td>
<td>Gateshead Public Health team and Newcastle/Gateshead CCG continue to develop an approach which supports people in managing their own health conditions and health risk behaviours. This approach should build on the evaluation of the current Live Well Programme, and be supported by an asset-based-approach which recognise and harness assets in local communities (volunteers, skills, social networks and voluntary groups).</td>
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<td>Stop smoking services continue to be provided by a range of community providers including pharmacy and general practice. Live Well Gateshead offers residents an opportunity to access support to achieve optimum levels of physical, mental and emotional health and wellbeing. It aims to target the 35% most deprived wards, offering a combination of individual lifestyle advice, and community capacity building, using asset based community development approaches. The Live Well Gateshead programme was evaluated by a FUSE embedded researcher in July 2016 (Cheetham &amp; Rushmer 2016). NHS Newcastle Gateshead Clinical Commissioning Group (CCG) have been working on a British Heart Foundation (BHF) project to change how long term conditions, particularly cardiovascular disease (CVD), are managed. The project is called the BHF House of Care Project. The focus of the project has been to implement a new approach to the management of long term conditions – the Year of Care Approach. The aim of this approach is to enable patients with CVD and their carers to be engaged, informed and empowered to better care for themselves, and enable health professionals and voluntary sector to support self-care. The CCG also published a Social Prescribing strategy in August 2016. The strategy defines social prescribing as provision of a non-medical referral which aims to connect people with health and wellbeing activities in their community that improve both their physical and mental health.</td>
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<td><strong>Recommendation 5</strong></td>
<td>Gateshead Council continues its commissioning work programme with the Newcastle/Gateshead CCG to ensure redesign of services for children 0-19 (including PH services) are delivered in an integrated way, delivering effective identification of risk, early help and intervention. There should be a particular emphasis on developing a robust pathway from the antenatal stage until a child is age two.</td>
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<td>A well-established Children and Young People's Strategic Commissioning Group with input from all key stakeholders (CCG, NECS, LA Children's Services, Public Health) has been in operation since January 2015. All partners are working in close collaboration in the development of an early help model for children, young people and their families. Public Health 0-19 services (health visiting, school nursing and family nurse partnership) are being reviewed during 2016/17. A Project Board has been established to take this work forward including redesign of service provision in line with the health needs assessment and the development of the early help model. The antenatal to age two pathways will be reviewed and developed in line with the service specifications and relevant guidance and evidence based practice.</td>
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<td>Recommendations</td>
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| **Recommendation 6**  
A consistent approach to promoting infant and maternal mental health for key professionals, with clear pathways and referral routes. A strong focus on training and development of key staff including health visitors, in relation to mental and infant mental health and a clear understanding how agencies can work together to deliver the most appropriate services. | Across Newcastle Gateshead CCG there is a dedicated GP Child Health Lead for each practice. Their role is to champion the needs of children and young people in their primary care teams. The child health lead is a point of contact for commissioners and providers to disseminate key messages, and the leads attend two half day training and information events covering a wide range of topics on child health and maternity issues.  
Health visitors regularly attend primary care team meetings in general practice to support joint working to meet the needs of mothers and babies.  
In addition, the Little Orange Book, providing expert advice on helping babies and young children when they’re poorly, has been produced by Newcastle Gateshead CCG and promotes immunisations in pregnancy, advice on smoking, and empowers parents and carers to manage common illnesses and problems - this book is being given to every expectant mum. Health Visitors are the main distributor of this book at the ante-natal visit, new baby review, 6-8 week assessment, 1 year assessment and the 2-2½ year old review. |
| **Recommendation 7**  
Gateshead Council, in collaboration with partners, communities and families, should continue to proactively promote healthy lifestyles to tackle obesity, smoking and alcohol misuse. | Gateshead Council continues to prioritise and commission the delivery of alcohol brief intervention with GP practices and the Live Well Gateshead service.  
Active Intervention (Stop Smoking services) are commissioned across primary care (GPs and Pharmacy) and community and voluntary sector settings to ensure every opportunity is taken to promote support people to stop smoking and reduce their drinking.  
Public Health is exploring further opportunities to Making Every Contact Count, developing a whole system approach to prevention and brief advice  
Prevalence of Obesity in the borough of approximately 23% (adult population). Live Well's Wellness Service offer a 10-week Healthy Lifestyle programme introducing self-care material in a motivational group setting. This provided 1:2:1 support to enable families navigate and understand the wealth of healthy lifestyle materials available. |
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| **Recommendation 8**  
Gateshead Council should work with partners, schools and communities to encourage the young adult and population of Gateshead to access dental care in higher numbers, and investigate and tackle the high rates of admissions for General Anaesthetics for extraction of teeth in 0-19 year olds.  
Health visitors raise awareness of dental health and prevention and aim to check that all children are accessing primary dental care services for routine preventive care and advice.  
This is carried out as part of the five mandated reviews that take place with families from birth to age two and a half. School nurses carry out oral health promotion work where appropriate and work with partners, including oral health promotion team, to deliver appropriate messages and encourage access to dental care.  
Work is ongoing to identify how best to tackle inequalities in dental health in older children and young people.  
Children and Families OSC are undertaking a review of oral health during 16/17. |  |
| **Recommendation 9**  
Schools are urged to build on existing work to improve children's health and continue to participate in the Healthy Schools Programme (noting that this will be delivered under a new arrangement from September 2016, where Gateshead Council will coordinate the programme and schools will be offered the programme with a modest charge to support delivery).  
The Gateshead Healthy Schools Programme began operating as a traded service in September 2016. We currently have 44 schools signed up to the programme which represents 58% of all Gateshead schools.  
We are hoping to improve on this for the next academic year and with a new Healthy Rating Scheme for schools (due for launch in September 2017) set out in the 2016 Child Obesity Plan, it is hoped that more schools will see the value of being engaged with the Programme. |  |
| **Recommendation 10**  
Gateshead Council and the Health and Wellbeing Board should note that the information provided in this report should be received as provision of assurance that the Health Protection System operated effectively in 2014/15. It should be noted that clear mechanisms are in place to support the DPH in monitoring and ensuring appropriate response to health protection issues as they arise.  
Work continues to ensure that reporting and governance arrangements are suitable, sufficient and appropriate to provide assurance that local health protection arrangements will respond to population health protection needs in a timely and appropriate manner. |  |
Appendix 2

References


11. From evidence into action: opportunities to protect and improve the nation's health. PHE, 2014


16. ASH Smoking and Mental Health Survey. ASH, 2016


Appendix 3

Acknowledgements

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Michala Lount
Sarah Gorman

and the many other people who contributed to this report.

Alice Wiseman
Gateshead Director of Public Health
0191 433 2777
alicewiseman@gateshead.gov.uk

You can view this report online at
www.gateshead.gov.uk/health