# ASH Scotland Response to the CSO Research Strategy Consultation

*September 2014*

## General Overview

Action on Smoking and Health (ASH) Scotland is an independent Scottish charity taking action to achieve its vision of a healthier Scotland free from the harm and inequalities caused by tobacco. We work towards improving health and quality of life by trying to:

- limit the number of young people taking up smoking;
- reduce the number of adult smokers;
- protect people from second hand smoke; and
- tackle the health inequality resulting from tobacco use.

Our activities include an expert information service, lobbying and campaigning, providing professional training and taking forward our partnerships and alliances. Smoking is associated with a range of illnesses and is the primary preventable cause of ill health and premature death. Each year, tobacco use is associated with over 13,000 deaths (around a quarter of all deaths in Scotland every year) and 56,000 hospital admissions in Scotland. Smoking is a leading cause of cancer and death from cancer. It causes cancers of the lung, oesophagus, larynx, mouth, throat, kidney, bladder, pancreas, stomach, and cervix, as well as acute myeloid leukaemia. Smoking also causes heart disease, stroke, aortic aneurysm, chronic obstructive pulmonary disease (COPD) (chronic bronchitis and emphysema), asthma, hip fractures, and cataracts. Smokers are at higher risk of developing dementia and of pneumonia and other airway infections.

A pregnant smoker is at higher risk of having her baby born too early and with an abnormally low birth weight. A woman who smokes during or after pregnancy increases her infant's risk of death from Sudden Infant Death Syndrome (SIDS). More generally, tobacco is implicated in a quarter of all deaths in Scotland and amongst the 35-69 age group, an average of 22 years of life are lost for every smoking related death. The smoking rate in the poorest communities is 4-5 times higher than in the richest. Nearly 2/3 of smokers start before they are 18 years old and most now indicate that they want to stop.

We are particularly interested and invested in the topic of the consultation as challenging poverty and health inequalities is a primary strategic aim for ASH Scotland. Smoking makes a significant contribution to creating and maintaining health inequality in Scotland. The Marmot Review[i] of health inequalities states that *'[t]obacco 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.'*

This response refers to Chapters 3 and 4 published on the consultation webpage. All of our responses to the questions are defined by our remit with tobacco use and smoking and reflect our organisation's service provision, experiences, and ethos. We are happy for this response to be published or to provide more evidence to the CSO in any manner deemed appropriate.

## Response to Consultation Questions

**Chapter 3 – Targeted Deployment of Resources and Infrastructure**

**Question 10: What proportion of CSO funding should be available for deployment in new research initiatives relevant to the NHS? In what areas should CSO seek to disinvest to free up resources?**

Scottish Government's tobacco strategy *Creating a Tobacco-Free Generation* sets bold and ambitious targets for reducing the smoking prevalence in Scotland to 5% by 2034[ii]. Not only do we need to provide support for those who wish to stop using tobacco in order to meet this target, we also need to focus on preventing the next generation's uptake of smoking in the first place. This means ensuring engagement with this group as early as possible to raise awareness, and providing effective services that meets the health and social needs of individuals and families.

While there is clear evidence that action, such as the smoking ban, has led to a range of health benefits including: reduced heart attack admissions to hospital; reduced childhood asthma admissions to hospital; and fewer premature births, tobacco use still remains one of Scotland's most significant public health challenges.

Smoking alone costs Scotland nearly £1.1 billion per year. Without a greater focus on prevention, the NHS as a publicly funded system as we know it will be unsustainable given the range of pressures over the medium term. ASH Scotland believes that increasing preventative spend should be a key tenet of CSO's funding deployment going forward. This will reduce future costs and would allow new initiatives to have easily reported and monitored long term gains and outcomes.

**Question 11: Is the focus of the CSO response mode grant schemes adequately defined and understood by the research community? Should there be a narrower focus to complement and avoid overlap with other funding streams Scottish researchers have access to? What is a realistic upper level for CSO grants to allow worthwhile projects to progress?**

A further focus on preventative spend would put CSO more in line with the Health Change Fund and support the greater alignment of budgets across the public sector on a preventative and outcomes-focused basis."[iii]

**Question 12: What should determine the creation and continued funding of a CSO unit? Should any new unit have a plan for CSO funding to be time limited?**

A new CSO unit should be created with a clear outcomes focus, with a reporting mechanism that relates to the Scottish Government National Performance Framework. In doing so, it will be straightforward for CSO and the funded side to monitor the on-going performance within prescribed timescales. This also fits in with the wider societal aspirations of Scottish Government and the mechanisms that underpin this across the public and third sectors.

**Chapter 4 – Working in Collaboration**

**Question 13: Are there other key areas of partnership CSO should be seeking to build?**

It is critical that those in the health service, particularly NHS stop-smoking service workers, support families with reducing and ceasing their tobacco use and smoking in order to help to

address the link between the early years and inequalities. Therefore, CSO should look to use its leverage to monitor and reduce inequalities in service delivery and uptake of services.

**Question 14: Would the creation of a CSO International Advisory Board be a positive step in raising Scotland's research profile and supporting our ambition? What should be the make-up of such a board?**

The UK is a signatory to the World Health Organization Framework Convention on Tobacco Control (FCTC), which is the first coordinated global effort to reduce tobacco use. The FCTC entered into force on February 27, 2005 and requires Parties to implement evidence-based measures to reduce tobacco use and exposure to tobacco smoke. A CSO International Advisory Board that makes reference to the FCTC in its work would support not only the aforementioned ambition of CSO but also create a clearer line-of-sight between CSO and the internationally recognised aims and objectives of the FCTC.

Within the FCTC, CSO's international interests are reflected within Part VII: Scientific and Technical Cooperation and Communication of Information (Articles 20-22). It obliges Parties to develop research and surveillance on tobacco control and to exchange such information (Article 20); submit periodic reports to the Conference of the Parties containing specified kinds of information (Article 21); and cooperate on strengthening capacity to fulfil the tobacco-control obligations of the FCTC, including promotion of the transfer of technical, scientific, and legal expertise and technology (Article 22).

**Question 15: Are there other areas where CSO funded research could better support the Health Directorates Quality agenda?**

ASH Scotland is also keen to see specific work undertaken in the following areas:

**Dementia** - Smokers have a 45 per cent higher risk of developing all forms of dementia than non-smokers, and 14 per cent of Alzheimer's disease cases worldwide are estimated to be potentially attributable to smoking according to a report published by the World Health Organization (WHO) in collaboration with Alzheimer's Disease International (ADI).

As the evidence on risk reduction and protection for dementia grows, we should ensure national approaches to dementia include greater emphasis within prevention programmes of the potential for associated improved brain health. Population level measures should improve protective factors and reduce behavioural and intermediate risk factors linked, for example, to physical inactivity, tobacco, alcohol use and poor diet.

The general public, health professionals and policy makers are increasingly aware of the links between behavioural risk factors and non-communicable diseases (such as tobacco and lung cancer or diet and cardiovascular disease). But few people are aware that many of the same risk factors could impact on the risk of dementia. It is therefore important to communicate more clearly the emerging evidence about dementia risks, protective factors and preventive actions to the public and relevant health and care professionals and policy makers. Further population-based work on the impact of dementia awareness and risk messaging is important in order to assess its contribution to perceptions of stigma and fear, as well as potential to change behaviour at the individual level. This will influence the balance of preventive strategies.

**Mental Health** - In contrast to the marked decline in smoking prevalence in the general population, smoking among those with mental disorders has changed little, if at all, over the past 20 years. Some 42% of tobacco use is by people with mental health problems. Addressing the high prevalence of smoking in people with mental disorders offers the potential to realise substantial cost savings to the NHS, as well as benefits in quantity and quality of life.

**Surgery** - there is strong evidence that smokers who undergo surgery:

- have a higher risk of lung and heart complications
- have higher risk of post-operative infection
- have impaired wound healing
- are more likely to be admitted to an intensive care unit
- have an increased risk of dying in hospital
- are at higher risk of readmission
- remain in hospital longer

A prospective cohort study from the United States found that smoking was associated with an almost sixfold increased risk for post-operative pulmonary complications. Smoking is the single most important risk factor for the development of serious post-operative complications in patients undergoing elective hip and knee replacement as well as the single most important factor for the development of post-operative cardiopulmonary and wound-related complications in elective orthopaedic surgery. Smoking has pronounced effects in foot and ankle surgery, resulting in higher rates of complications, particularly in broken bones failing to heal. Smoking is also an important predictive factor for anastomotic leakage after colonic and rectal resection and smokers are at significantly higher risk of complications during reconstructive breast surgery and breast cancer surgery.

A function of anaesthesia is to reduce coughing and spasms during surgery but because smokers are more prone to coughing during surgery they need a higher dose of anaesthesia than non-smokers. Also, smokers have decreased blood oxygenation, leading to decreased oxygen delivery to their tissues and are consequently more likely to need oxygen therapy. Depriving vital organs of oxygen for even a short period of time can lead to serious complications.

In general, ASH Scotland would advise an increase in preventative funding investment, allowing smoking cessation workers within NHS Scotland to focus on achieving positive outcomes for smokers, supporting engagement with young people to reduce smoking uptake and encouraging research across risk factors. Doing so will not only improve the quality of life for existing populations but reduce future ill-health and mortality, and consequently the future drain on NHS services caused by tobacco use.

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i Fair Society, Healthy Lives' – The Marmot Review. UCL Institute of Health Equity. February 2010. Available at: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review [accessed 24 February 2014]

ii Available at: http://www.scotland.gov.uk/Publications/2013/03/3766 [accessed 27 February 2014]

iii Scottish Government. Scottish Spending Review 2011, p. 224