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National Cancer Plan for England – call for evidence

Action on Smoking and Health (ASH) response

ASH is a public health charity established by the Royal College of Physicians in 1971 to advocate for policy measures to reduce the harm caused by tobacco. ASH receives funding for its full programme of work from the British Heart Foundation and Cancer Research UK.

Key recommendations

1. Implement the recommendations in the latest APPG on Smoking and Health report: **A Roadmap to a Smokefree Country: No one starts, everyone stops, no profit in tobacco**
2. Ensure funding for NHS tobacco dependence treatment services is protected and enhanced
3. Fund population level prevalence reduction programmes in every region modelled on the programme in the North East
4. Embed stop smoking support into the Lung Health Check programme and pilot support in A&E and using digital interventions.

1. Prevention and awareness

Which cancer risk factors should the government and the NHS focus on to improve prevention? (Optional)

- Alcohol
- Tobacco
- Obesity

Please explain (max 500 words)

Tobacco is a leading preventable cause of cancer and is responsible for 15% of cancer cases in the UK[1] while 28% of cancer deaths are smoking-related. More than 7 in 10 cases of lung cancer are caused by smoking.[2] Over 60% of cancer patients are reportedly current or former smokers.[3]

Investing in stop smoking interventions is one of the most effective ways to reduce cancer incidence and improve treatment outcomes. Quitting smoking following a diagnosis of lung cancer doubles survival rates among those who smoke[4] and improves treatment outcomes for all cancers.[5]

We welcome the government's commitment to creating a smokefree country and strongly support the Tobacco and Vapes Bill. However, more support is needed to help the 6 million current smokers in the UK quit.

Since 2020, the NHS has been rolling out tobacco dependence treatment services in inpatient, acute, mental health and maternity settings. Based on modelling from a similar programme in Ottawa, ASH estimates that if the programme was operating at full capacity and reaching all inpatients who smoke it would engage ~300k smokers in a quit attempt each year leading to a reduction in 30 day readmission of ~20k alongside other benefits.[6]

However, funding for these services is under threat and some Integrated Care Boards (ICBs) have already announced that services will be cut or decommissioned entirely. Cutting these services is a false economy which will result in more cases of preventable death and disease and undermine the goal of shifting the health service towards prevention and the Government's manifesto pledge to "integrate 'opt-out' smoking cessation interventions into routine [hospital] care." The NHS and the government must protect this funding and ensure investment in tobacco dependence services is prioritised by ICBs.

In addition to treatment services, several ICBs have invested in programmes which aim to reduced smoking prevalence across their population. The programme in the North East (Fresh) has been running for 20 years with support from NHS and local government. Recent research from UCL showed that smoking rates have fallen fastest in areas with these programmes, compared to limited progress in other regions.[7]

After smoking, alcohol and obesity are two of the main risk factors for preventable cancers and should be prioritised to improve cancer prevention. Like smoking, these risk factors are directly linked to the consumption of harmful consumer products which are aggressively marketed by manufacturers.

The government and the NHS should apply a consistent approach across these risk factors to address the key drivers of preventable cancers. Harmful alcohol consumption appears to be closely linked with smoking, with smoking associated with higher levels of alcohol consumption and risky drinking.[8] As well as reducing the risk of alcohol-related cancers, addressing risky drinking may help to reduce smoking prevalence.

2. Early diagnosis

What actions should the government and the NHS take to help diagnose cancer at an earlier stage?

- Improve symptom awareness, address barriers to seeking help and encourage a timely response to symptoms
- Develop and expand interventions targeted at people most at risk of developing certain cancers
- Make improvements to existing cancer screening programmes, including increasing uptake

Please explain (max 500 words)

Embed stop smoking support into Lung Health Checks

One of the key criteria for being invited to a Lung Health Check is current and past smoking behaviour. However, there is no standard treatment embedded into these checks to reduce smoking. There is ample evidence from the UK and around the world that doing so could substantially reduce smoking in this key at-risk older population.[9]

Using the Lung Health Check programme to support more people to quit smoking would expand the value of the screening intervention, divert more cancers, improve treatment outcomes from cancers, reduce incidence of other conditions such as CVD and COPD and reduce inequalities in cancer outcomes.

Run national communications programmes to raise awareness about the leading risk factors for preventable cancers

In the North of England campaigns to address smoking have been successfully run and supported by Integrated Care Boards as an evidence-based measure to reduce smoking. Such approaches should be adopted on a national footprint and targeted at the populations most at risk.

3. Treatment

What actions should the government and the NHS take to improve access to cancer services and the quality of cancer treatment that patients receive?

- Increase the availability of physical and mental health interventions before and during cancer treatment

Please explain (max 500 words)

Provide opt out referral to smoking cessation treatment to all smokers at point of cancer diagnosis.

Whether a patient's cancer is smoking related or not quitting at the point of diagnosis will improve treatment outcomes. Even for those with a poor prognosis quitting smoking can increase life expectancy. For example, it's estimated that just over a third of lung cancer patients are smoking at diagnosis. Research has shown that lung cancer survivors who quit smoking within a year of diagnosis will live for longer than those who continue to smoke. Those who quit smoking after diagnosis lived on average 1.97 years, compared with 1.08 years for those who did not quit.[10] NHS tobacco dependence treatment services should be expanded to include patients undergoing cancer treatment to enhance treatment outcomes.

Pilot stop smoking support in emergency departments

Emergency departments are a viable setting for opportunistic stop smoking interventions. The COSTED trial provided smokers in A&E with an e-cigarette starter kit, very brief advice and referral to a stop smoking service. The intervention was effective for sustained smoking abstinence with 7.2% of the intervention group abstinent at 6 months compared to 4.1% in the control group.[11] Several services have implemented the intervention with many others interested in doing so.

Digital interventions

There is growing evidence that well developed digital interventions are a low-cost way to support many more smokers to stop. Smokers on waiting lists for treatment, those accessing primary care and in outpatient treatment are obvious cohorts to engage with a standard digital treatment offer plus access to medication and/or vapes.

4. Inequalities

In which of these areas could the government have the most impact in reducing inequalities in incidence (cases of cancer diagnosed in a specific population) and outcomes of cancer across England? (Optional)

- Improving prevention and reducing the risk of cancer

Please explain (max 500 words)

Smoking rates are highly concentrated among socioeconomically disadvantaged groups who experience higher rates of cancer and worse cancer outcomes. This includes people from the most deprived groups and areas, those with mental health conditions, living in social housing or experiencing homelessness. Smoking attributable mortality rates are 2.1 times higher in the most deprived local authorities than in the least deprived.[12] Smoking accounts for half the difference in life expectancy between the richest and poorest in society.[13]

At the current rate of decline, the most deprived 10% of the population in England won't be smokefree until after 2050 – more than 20 years behind the least deprived.[14] Enhanced support is needed to address this inequality and support people from the most disadvantaged groups to quit smoking and stay smokefree. Smoking cessation is recommended by the NHS for helping to address all 5 key clinical areas in the Core20PLUS5 approach to reducing health inequalities, including inequalities in cancer diagnosis.[15]

As a minimum, the existing funding for tobacco dependence treatment in the NHS and local authorities must be maintained to ensure people who smoke have access to quit support in hospital and the community. Investing an additional £97 million a year in stop smoking activity in mental health settings, lung health screening, primary care, and expanded mass media campaigns – as recommended in the latest APPG on Smoking

and Health report – would help to reduce smoking prevalence among these vulnerable populations and deliver a return of £3.6 billion for the public finances by 2030.

The Government should make good on their pledge to publish a roadmap to a smokefree country (as recommended by the APPG on Smoking and Health). This roadmap should be a clear plan to eradicate smoking within 20 years and contain clear, measurable targets for populations with high prevalence of smoking and the targeted interventions required to achieve this. The interventions in the roadmap could be funded by a 'polluter pays' levy on the tobacco industry.

5. Priorities for the national cancer plan

What are the most important priorities that the national cancer plan should address? (Optional)

- Prevention and reducing the risk of cancer

Please explain (max 500 words)

See response to 'Which cancer risk factors should the government and the NHS focus on to improve prevention?' above.

References

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