Thurrock Whole Systems Tobacco Control JSNA

2021 – 2026

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1 Contents

2 Executive summary: 5

3 Introduction 9

4 National and local strategic and contextual factors relevant to tobacco control in Thurrock 11

4.1 National tobacco control strategy 11

4.2 National NHS tobacco control policy 12

4.3 Impact of the COVID-19 pandemic on tobacco control 13

4.4 Local strategies and targets relevant to tobacco control 14

5 Smoking prevalence 15

5.1 National smoking prevalence 15

5.2 Thurrock smoking prevalence 17

5.3 Geographic variation and deprivation 19

5.4 Smoking prevalence in primary care 25

5.5 Smoking prevalence and mental health 27

5.6 Smoking prevalence and people with long term conditions (LTCs) 30

5.7 Smoking and pregnancy 32

5.8 Children and young people 34

5.9 Protected characteristics groups and smoking prevalence 39

5.10 Scale of illicit tobacco 42

6 Impact of smoking 43

6.1 Impact of smoking in the UK 43

6.2 Overview of the health impact of smoking on the Thurrock population 43

6.3 Financial impact of smoking related harm in Thurrock 46

6.4 Impact of smoking on health inequalities in Thurrock 48

6.5 Respiratory health impacts of smoking in Thurrock 49

6.6 Cardiovascular impacts 54

6.7 Children and young people 55

6.8 Wider social impacts 56

6.9 Impact of illicit tobacco 57

7 Current tobacco control approach in Thurrock 59

7.1 Prevention 59

7.2 Enforcement 60

7.3 Treatment 62

7.3.1 Whole population treatment 63

7.3.2 Priority groups 68

7.4 SWOT analysis of Thurrock's current Tobacco Control offer 79
8 Evidence 81
8.1 Prevention evidence 84
8.2 Evidence for enforcement 86
8.3 Evidence for stop smoking treatment 88
9 Gap analysis 96
9.1 Preventing never smokers becoming regular smokers 96
9.2 Motivating current regular smokers to attempt to quit smoking 97
9.3 Supporting smokers attempting to quit to have success in doing so 98
9.4 Leadership and operational factors 99
10 Recommendations 101
11 References 103

2 Executive summary:

The main form of tobacco used in the United Kingdom (UK) is cigarettes. Smoking cigarettes continues to be the leading cause of premature and preventable death in England. It is also the largest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities. Smoking impacts health across the life course; it causes permanent lung damage to children exposed to second hand smoke; it is a common cause of sickness absence; it increases the risk and severity of long-term conditions and infectious diseases; it reduces the efficacy of many clinical treatments, and shortens healthy life expectancy and increases mortality. Smoking is not a lifestyle choice; evidence has demonstrated that it is an addiction. Most smokers want to quit (58%) and many try each year, mostly on their own and increasingly with the support of e-cigarettes; however, the most effective method of stopping smoking is through evidence-based stop smoking services.

This Joint Strategic Needs Assessment on Tobacco Control has been prepared to update the Thurrock Tobacco Control Strategy, which expires in 2021. It focuses mostly on cigarette smoking as prevalence of other forms of tobacco use in the UK is very low. A whole systems approach, recommended by DHSC for tobacco control, has been taken in recognition of the breadth of impact tobacco has and the scale of change needed. Given the importance of the NHS as a partner in delivering the change needed, a population health management approach has also been taken. This is to facilitate translation of the needs assessment into NHS contexts.

The needs assessment aims to identify the areas where Thurrock is currently having and could have the most impact on reducing tobacco related harm locally. Its structure follows the strategic themes used in the current local tobacco control strategy, which are prevention, enforcement, and treatment for smoking addiction.

This executive summary highlights the key questions that have been addressed in the needs assessment and answers to them.

How does smoking prevalence in Thurrock compare to the national and regional averages and how has this changed over time?

Thurrock has one of the highest smoking prevalence rates in England (17.5% in 2019 compared to the England average of 13.9%). Prevalence reduced by -1.1% in Thurrock since 2017, significantly less than the England average reduction of -6.7%.

A priority population recognised by the Association of Directors of Public Health is pregnant women. There has been little change in smoking among this group in Thurrock and the East of England since 2016/17. The current prevalence in Thurrock is equivalent to approximately one in ten women smoking during their pregnancy. This data does not recognise pregnant women exposed to smoke in their homes from other household members though.

What is the scale of inequalities in smoking prevalence within Thurrock?

Largely, inequalities in smoking are associated with socio-economic deprivation and other markers of disadvantage and mental ill health. In Thurrock, over half the

people who smoke live in the eight most deprived wards and smoking prevalence is concentrated in the two most deprived wards. Nationally and locally there has been no significant change in smoking prevalence in the last five years among routine and manual workers, a group used as a proxy for relative deprivation, while prevalence has declined in the general population.

Thurrock mirrors the national picture regarding mental illness and smoking; an increasing number of mental health diagnoses and increasing severity of the condition is associated with a higher likelihood of smoking. However, while there has been a significant decline in smoking prevalence among people with mental illness since 2016 nationally, there has been no significant change in Thurrock.

What is the impact of tobacco in Thurrock?

Thurrock's high smoking prevalence translates into higher smoking attributable mortality (25% higher than England average), years of life lost, which is a measure of premature death, (13% higher than the England average) and healthcare usage (27% higher smoking attributable hospital admissions than the England average). It also carries a significant financial cost to the local economy, estimated to be an annual £17.6 million deficit.

What are the gaps between smoking prevalence in Thurrock, Thurrock's current tobacco control strategy and research evidence?

Prevention: One of the most effective ways of preventing people from becoming addicted to smoking is to prevent them from starting in childhood. Limiting access to cigarettes is a particularly effective way of doing this. Thurrock Council's Trading Standards team continue to deliver a programme of work called "Challenge 25", which supports local shops to stop underage sales of cigarettes. This work has proven locally to be an effective deterrent. It does not however prevent access to cigarettes accessed by other means such as 'social supply'. Another strategy for reducing uptake of smoking in childhood is communications and education among children, young people, and families to reduce the acceptability of smoking. Thurrock Council's stop smoking team delivered an intervention called 'ASSIST' in schools but a local evaluation found it was not as cost effective as research evidence indicated and the programme was discontinued. Mainly this was because smoking prevalence has declined, making it harder to deliver a significant change to the relatively low prevalence. Since then there has been limited delivery of smoking related communications work aimed at young people.

Based on the offer described above for children and young people and current research evidence, Thurrock's prevention offer should adopt two areas of focus. one is a whole area approach since smoking among children and young people is distributed across the wards. Local evidence suggests this should be a holistic offer concerning risk taking behaviours since individuals participating in one risk such as smoking are much more likely to be engaging in other risky behaviours such as unsafe sex or drug use. The other strategy is for services working with vulnerable young people and their families / carers to screen for smoking and refer to the stop smoking service. Smoking among family and close peers is a strong influencing

factor on smoking uptake so this work should take place with children, young people and their families.

Both strategies also need to balance messages about smoking with harm reduction messages for vaping e-cigarettes that are appropriate to young people, especially given the trend in increasing use of these products.

Enforcement: Thurrock Council's Trading Standards team deliver a robust local enforcement approach, which continues to impact underage sales of tobacco and limits the supply of illicit tobacco. The team are developing a partnership with officers addressing modern slavery to strengthen links in this area. This is a complex area of work but there is some evidence nationally of links between organised crime gangs, illicit tobacco, and modern slavery.

Another aspect of tobacco related enforcement is Smoke-free policies; Thurrock Council has in place a smoke free policy, as do the local NHS Trusts as part of their legal obligations to do so. These policies have not been audited or evaluated but doing so might help to identify ways to strengthen their effect. An aspect of local Smoke-free policy that could be improved is having an equitable policy approach to Smoke-free homes. Nationally there is a policy gap in this area and local areas are expected to develop their own policy approach. Thurrock currently has a robust offer of education and support through referral to stop smoking services as part of the Well Homes service in private housing. This approach should be considered in other housing settings for which the council has authority to act.

Treatment: In 2019/20 Thurrock almost achieved the NICE recommendation of at least 5% of the smoking population being supported to quit per year through stop smoking services. Thurrock Healthy Living Service and the two Vape Shops commissioned to deliver stop smoking services have achieved the highest number of people setting a quit date, quitting at 4 weeks and remaining quit at 12 weeks compared to pharmacies and GPs offering the service. More people who smoke will need to be encouraged to use the service to enable Thurrock to deliver against the government's ambition to reduce smoking prevalence to 5% or less by 2030. Achieving this will require a shift from reducing prevalence by -2.5% per year (current trend) to -6% per year. Modelling suggests this will mainly be driven by an increase in the number of current smokers attempting to quit rather than necessarily improving the effectiveness of the stop smoking service, although this will have some effect.

In addition to this whole population approach, Thurrock also needs to better target smokers living in the eight most deprived wards and other population groups where prevalence is higher to reduce smoking related inequalities. The current service offer is not designed in a way that targets groups with higher smoking prevalence such as people living in areas of deprivation, routine and manual workers or people with mental ill health. While the local stop smoking service has worked with providers to encourage more referrals from some relevant settings such as mental health services, more needs to be done, for example, work with employers of routine and manual staff. This also includes intervention by members of the Health and

Wellbeing Board to increase referrals from relevant services and Thurrock Council should review options to enhance its stop smoking service offer for priority groups.

Smoking in pregnancy will be another important theme of the 2021-2026 Tobacco Control Strategy due to the intergenerational impact this has on health. The number of referrals from Basildon and Thurrock University Hospital has increased since the last strategy and this has resulted in more pregnant women quitting. However local insight suggests a need to also support partners' or 'significant other supporters' of pregnant women to stop smoking, regardless of the pregnant woman's smoking status. Smoking prevalence among partners / 'significant other supporters' is high in Thurrock and evidence indicates offering support to stop is effective in reducing exposure to second hand smoke and supporting pregnant women who do smoke to stop and stay quit.

Conclusion

Since the last Tobacco Control Strategy in Thurrock, progress has been made in reducing smoking prevalence and Thurrock continues to offer a robust enforcement and treatment offer. Prevention among children and young people could be improved and the treatment offer needs to increase both its scale and the equity of its offer. To deliver this, tobacco control and especially the treatment aspect needs to be embraced as a responsibility of members of the Health and Wellbeing Board. Given the contribution of smoking to premature mortality and health inequalities, doing so could be the single most effective intervention local partners deliver to make improvements to these outcomes.

3 Introduction

This Joint Strategic Needs Assessment (JSNA) takes a whole systems approach to understanding tobacco related health needs in Thurrock, focusing on cigarette smoking, the most common form of tobacco used in the United Kingdom (UK). The needs assessment however refers to 'tobacco control' to include wider physical, mental and social health impacts; for example, crime associated with the illicit tobacco trade[1]. A whole systems approach means responding to the complexity of a problem by recognising the breadth of factors impacting it. Identifying and developing solutions to these problems requires engagement with diverse stakeholders (Stansfield J, 2020). This is appropriate for a needs assessment about tobacco because smoking is a prevalent issue and tobacco related harm is strongly associated with deprivation and many other measures of disadvantage (ASH, 2019). The psychosocial and socio-economic drivers of these associations are complex and require action by many institutions and in many settings.

Tobacco is an important topic because smoking has long been recognised as the leading cause of health inequalities in the UK (PHE, 2020d) (ASH, 2019). Smoking also continues to be the leading cause of premature and preventable death in the UK[2] (PHE, 2020d). It is especially important for Thurrock because it has one of the highest smoking rates in the UK and Thurrock's tobacco control strategy expires in 2021. Therefore it is timely to prepare a needs assessment that can inform a refresh of the strategy.

The aim of this work is to identify the extent to which the current tobacco control strategy is impacting on smoking prevalence and tobacco related harm in Thurrock, whether this is equitable and where improvements could be made. The purpose is to reduce tobacco related harm in Thurrock.

The needs assessment will present and discuss data and evidence regarding:

- strategic and contextual factors impacting tobacco control and smoking;
- smoking prevalence and how this has changed over time;
- the health and economic impacts of tobacco, especially smoking;
- tobacco control interventions currently in place in Thurrock and their impact;
- research evidence regarding effective tobacco control interventions;
- a gap analysis to understand areas for improvement in Thurrock's current strategy;
- recommendations for improvement;
- a conclusion to summarise what has been found and propose next steps.

A population health management approach has been adopted; this means using data to identify how changes in local services and systems can improve outcomes. In this context, that means using the data about smoking prevalence and its impacts

[1] Illicit tobacco refers mainly to cigarettes that have either been lawfully produced but brought into a country without the appropriate tax being paid / at all and cigarettes that have been manufactured illegally (ASH, 2017).

[2] Premature deaths are those that occur in people aged below 75 years and preventable deaths are those that could have been avoided through public health interventions.

to improve outcomes such as helping people who smoke to quit, to prevent the harm caused by second hand smoke and to reduce uptake of smoking, especially in younger generations.

Priority population groups for work concerning smoking are those that either have higher smoking prevalence or among whom there is greater capacity to benefit from stopping smoking such as pregnant women (or both). Those included in this needs assessment include:

- People living in more deprived areas
- People working in routine and manual occupations
- People with a diagnosed mental illness
- People with a learning disability
- People with a long term condition
- Pregnant women
- Children and young people (people aged under 18)

The questions this needs assessment will answer are:

- How does smoking prevalence in Thurrock compare to the national and regional averages and how has this changed over time?
- What is the scale of inequalities in smoking prevalence between priority groups or those with protected characteristics and the general population within Thurrock?
- What are the health and economic impacts of tobacco in Thurrock?
- What is included in Thurrock's current tobacco control strategy and how effective is this?
- What does recent research evidence suggest is effective for tobacco control and in particular, smoking cessation (stopping smoking / supporting people to 'quit' smoking)?
- What are the gaps between smoking prevalence in Thurrock, Thurrock's current tobacco control strategy and research evidence?
- How could organisations and communities in Thurrock address these gaps?

The next section of this needs assessment discusses the current national and local strategic and contextual factors most relevant to tobacco control.

4 National and local strategic and contextual factors relevant to tobacco control in Thurrock

4.1 National tobacco control strategy

Tobacco continues to be a national public health priority; in the Prevention Green Paper consultation, the Government stated its ambition for England to be smokefree by 2030 (Department for Health and Social Care, 2019). This is defined as having a smoking prevalence of 5% or less (Smokefreeaction, 2020) and is a very challenging target, requiring a pace of change estimated to be 40% faster than the current trend (Cancer Research UK, 2020). Achieving the ambition would require a significant change in tobacco control strategy nationally and locally.

The government have not yet responded to the Green Paper consultation and the UK Tobacco Control Plan published in 2017 comes to an end in 2022; the current plan's emphasis is summarised below (Department for Health and Social Care., 2017).

- **Supporting people not to start smoking**, by:
    - Reducing the prevalence of 15 year olds who regularly smoke from 8% to 3% or less by 2022. This is because most people who smoke as adults started smoking before the age of 18.
    - Reducing smoking prevalence amongst adults in England from 15.5% to 12% or less by 2022. This is because smoking uptake is partly influenced by smoking within social groups and especially impacts children and young people.
    - Reduce the inequality gap in smoking prevalence between those in routine and manual occupations and the general population. This is to reduce the intergenerational impact of higher smoking prevalence in these groups.
- **Supporting smokefree pregnancies**, with the aim of reducing the prevalence of smoking in pregnancy from 10.7% to 6% or less by 2022.
- **Providing parity of esteem for those with mental health conditions** by:
    - Improving data collection on smoking and mental health to inform stop smoking support for this population group.
    - Implementing smokefree policy in all mental health inpatient services sites by 2018.
- **Providing access to innovations that support people to stop smoking**, maximising safer alternatives to cigarette smoking.

In response to the national tobacco policy gap, a coalition of charities, research institutions and professional bodies prepared a smokefree plan, based on research evidence, expert advice and community perspectives (Smokefree Action Coalition, 2020). The actions are summarised below:

Strategies:

- Legislate to require tobacco manufacturers to finance a Smokefree 2030 Fund to support education campaigns, tobacco control campaigns and universal quit support – the 'polluter pays' ethos.
- Implement greater reductions in affordability via increased taxation of tobacco products.

Approaches:

- Ensure the NHS Long Term Plan's smokefree commitments are realised across the NHS, including smoking cessation screening, referral, and where viable, treatment.
- Consultation on policy proposals, such as demanding tighter regulation of tobacco via licenses for tobacco retailers and increasing the age of sale from 18 to 21.
- Review and revise e-cigarette regulation.
- Renew and refresh the Government's strategy for tackling the illicit tobacco trade.
- Sustain government commitment to support the WHO Framework Convention on Tobacco Control (WHO, 2020).

These are mainly functions for ministers and central government but should be supported by Thurrock Council, for example through response to consultation about these strategies and approaches.

4.2 National NHS tobacco control policy

The Government's Tobacco Control Plan and the smokefree coalition's roadmap to a smokefree generation emphasise the important role the NHS has in this agenda. The main NHS policy response to tobacco control is made in the NHS Long Term Plan (LTP), which sets new commitments for NHS organisations, including: (NHS, 2019):

- By 2023/24, all people admitted to hospital who smoke will be offered NHS-funded tobacco treatment services.
- This model will be adapted for expectant mothers, and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.
- A new universal smoking cessation offer will be available as part of specialist mental health services for long-term users of specialist mental health, and in learning disability services.

The main change to current practice is committing the NHS to deliver tobacco treatment services for people admitted to hospital and expectant mothers and their partners. This is being supported by funding through the NHS Long Term Plan Tobacco fund, which will be granted to NHS organisations at Integrated Care Partnership level starting in 2021/2022 financial year. Thurrock Council is working with Mid and South Essex Health Care Partnership (MSE HCP) to help prioritise the funding inline with local need.

At the time of writing this needs assessment, there is an ongoing pandemic of the COVID-19 coronavirus. This has significantly impacted the NHS and had much wider social and economic effects. This is important context for this needs assessment and the next section expands on this.

4.3 Impact of the COVID-19 pandemic on tobacco control

Evidence suggests that smoking has a strong correlation to mortality and morbidity related to COVID-19. A systematic review found that smokers were 1.4 times more likely to have severe symptoms of COVID-19 and were approximately 2.4 times more likely to be admitted to an intensive care unit (ICU), need mechanical ventilation, or die compared to non-smokers (Nikitara, 2020). There is already an established association between smoking and the risk of contracting respiratory infection and more severe symptoms once infected. As a result, Public Health England (PHE) have advised smokers that quitting at this time is particularly important for their health.

E-cigarettes are a useful quitting aid, but it is unclear what effect vaping may have on susceptibility to severe disease if infected with COVID-19. Vaping remains significantly less harmful than smoking and it is very important to avoid returning to smoking. Shisha smoking carries all the health risks of smoking, and sharing the mouthpiece greatly increases the risk of spreading COVID-19.

The impact of the COVID-19 pandemic on smoking prevalence or tobacco related harm is not yet fully understood. Data from the Office for National Statistics is not yet available for the period covering the pandemic. However, research undertaken by University College London and Action on Smoking and Health (ASH) found that in the first phase of the pandemic, more people attempted to quit smoking and more people successfully achieved this than would have been expected, based on trends in recent years. By July 2020, one million people had stopped smoking since the start of the pandemic and another 440,000 smokers had tried to quit (UCL, 2020). However more recent poll data indicates that many ex-smokers may have relapsed and current smokers, especially younger people, may be smoking more (ASH, 2021b). The poll of 1,935 adults found that 10% of ex-smokers had relapsed and 39% of smokers aged 18-35 years reported smoking more than usual.

Surveys have also been used to assess the impact of COVID-19 pandemic response policies. Survey evidence has identified that lockdown (a policy response to the pandemic) may be leading to more children being exposed to the harms of second-hand smoke. Some evidence comes from the YouGov COVID tracker, which shows that people who live in households that include children are 50% more likely to report being exposed to second-hand smoke since lockdown compared to those without children (10% compared with 6%) (YouGov, 2020). Also, 12% of smokers who live with children report they are smoking indoors more than they did before lockdown.

While there are many unknowns concerning the full impact of COVID-19 on population health, there is an opportunity to act on the factors that are known. For tobacco control this includes evidence of an increase in awareness of smoking related harm and desire to stop smoking (ASH, 2021b). Also, health inequalities linked to deprivation have been exacerbated by the pandemic. The tobacco control strategy that is written

following this needs assessment must include some proactive and immediate actions that respond to these factors.

4.4 Local strategies and targets relevant to tobacco control

The Public Health Outcomes Framework (PHOF) has five outcomes relevant to Tobacco Control and the duties placed on the local authority:

These are important outputs and outcomes for the Council and Thurrock's Health and Wellbeing Board (HWB) to deliver on. Reducing the proportion of people who smoke remains a priority in Thurrock's Health and Wellbeing strategy, which is currently being refreshed. This needs assessment and the tobacco control strategy that will be based on its content will be reviewed annually to remain responsive to the HWB's direction and challenge, and should expand into the MSE HCP. Only by doing this can the opportunities and benefits of taking a system-wide approach be delivered.

The NHS has a shared goal via the LTP, so this needs assessment can support NHS organisations to target their resources around gaps in the current offer, responsive to local need. This will be supported partly through LTP funding being granted to the NHS at Integrated Care System level for acute trusts to spend on tobacco control. For Thurrock, this is the MSE HCP / Integrated Care System.

Thurrock Council has also signed a commitment to the Local Government Declaration on Tobacco Control, which requires the council to:

- Act at a local level to reduce smoking prevalence and health inequalities and to raise the profile of the harm caused by smoking to our communities;
- Develop plans with partner organisations and local communities to address the causes and impacts of tobacco use, according to local priorities and securing maximum benefit for our communities;
- Participate in local and regional networks for support; and
- Monitor the progress of plans against our commitments and publish the results.

These actions areas should feed into the 2025 targets for this strategy and the longer term 2030 smokefree target.

The next section of this strategy will explore the scale of smoking prevalence in England and Thurrock.

5 Smoking prevalence

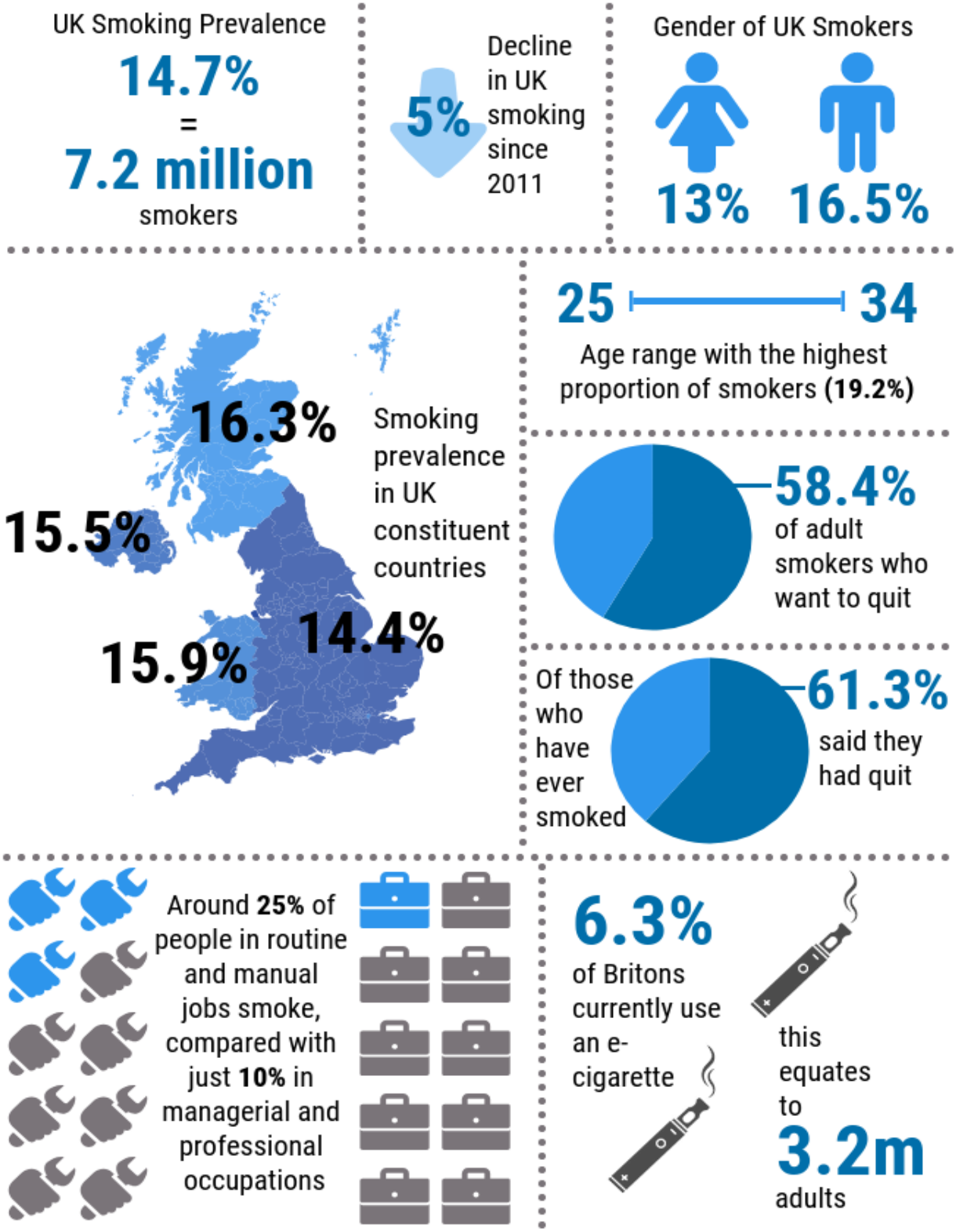
5.1 National smoking prevalence

Figure 1 summarises smoking prevalence statistics in the UK; in 2018, 14.7% of the population smoked cigarettes, although this differs by sub population and the data / model used (Office for National Statistics , 2019). Sub populations with higher smoking prevalence include men; it is estimated that 16.5% of men smoke compared to 13% of women; young adults (a higher proportion of smokers are aged between 25 and 34, 19.2% of this age group smoke); and routine and manual workers where 25% of people in these occupations smoke. Higher smoking prevalence is also associated with almost every indicator of deprivation and among groups who may be marginalised such as people living with mental illness, people in contact with the criminal justice system, people experiencing homelessness, lone parents and lesbian, gay, bisexual, transgender and questioning (LGBTQ) people (ASH, 2019). Furthermore, cumulative disadvantage increases the likelihood of smoking.

The majority of smokers want to quit (58.4%) and many try each year, mostly on their own and increasingly with the support of e-cigarettes. Currently 6.3% of the UK population use e-cigarettes (known as vaping), mostly ex or current smokers but with some never smokers included in that group. Approximately two thirds of people who have ever smoked (61.3%) manage to quit, which is excellent news but there is a risk of relapse and still means there are many people who do not manage this. Markers of deprivation are also associated with success of quit attempts, with evidence that people from more deprived populations are less likely to achieve their quit attempt, despite being as likely to attempt to quit. Reasons for this include evidence of higher dependency on nicotine, lack of social support, a focus on present needs over future plans and failure to complete smoking treatment programmes. Work is required locally to tailor interventions to priority groups such as those living in areas of deprivation to ensure attempts to reduce prevalence in these groups are successful.

The full impact of the COVID-19 pandemic on smoking prevalence is not yet clear, however structural inequalities have increased susceptibility to and exposure to the virus among some of the same groups where smoking prevalence is higher. This may exacerbate existing health inequalities, so tobacco control interventions nationally and locally will need to focus on achieving the 2030 target of 5% smoking prevalence equitably. For example, it is estimated that to reach the target, prevalence would need to decline by 37% among people with intermediate level qualifications, compared to 149% among people with low qualifications (Song F, 2020).

Figure 1: UK smoking prevalence statistics 2018

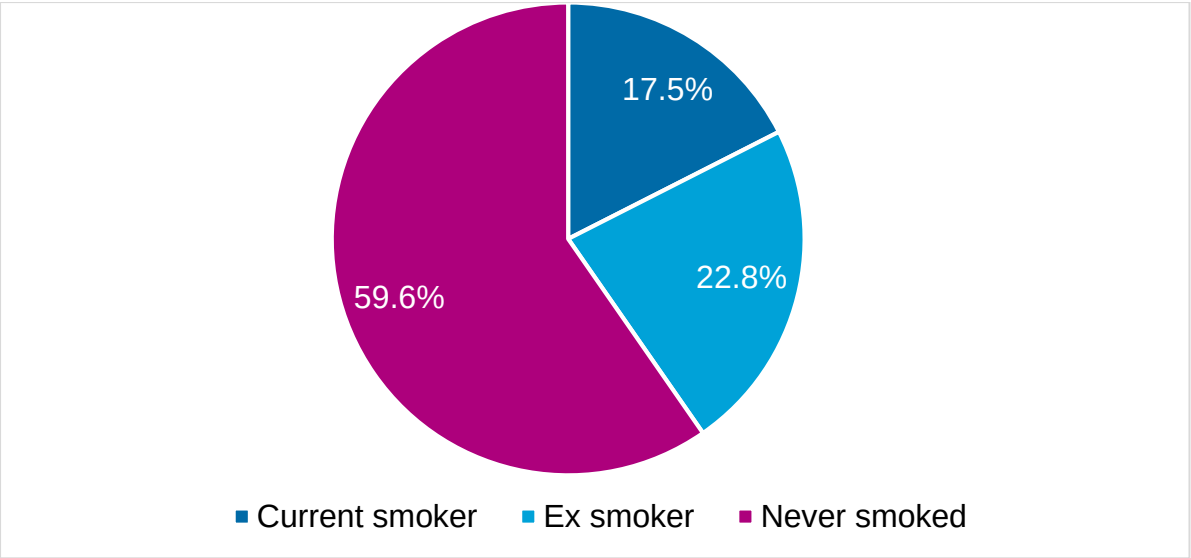


Source: (Office for National Statistics , 2019)

5.2 Thurrock smoking prevalence

In 2019, based on the Annual Population Survey (APS) estimate, approximately 17.5% of the Thurrock population smoked, 22.8% were ex-smokers and 59.6% had never smoked (figure 2) (PHE, 2020). Thurrock's APS smoking prevalence estimate is statistically significantly higher than the England average (13.9%).

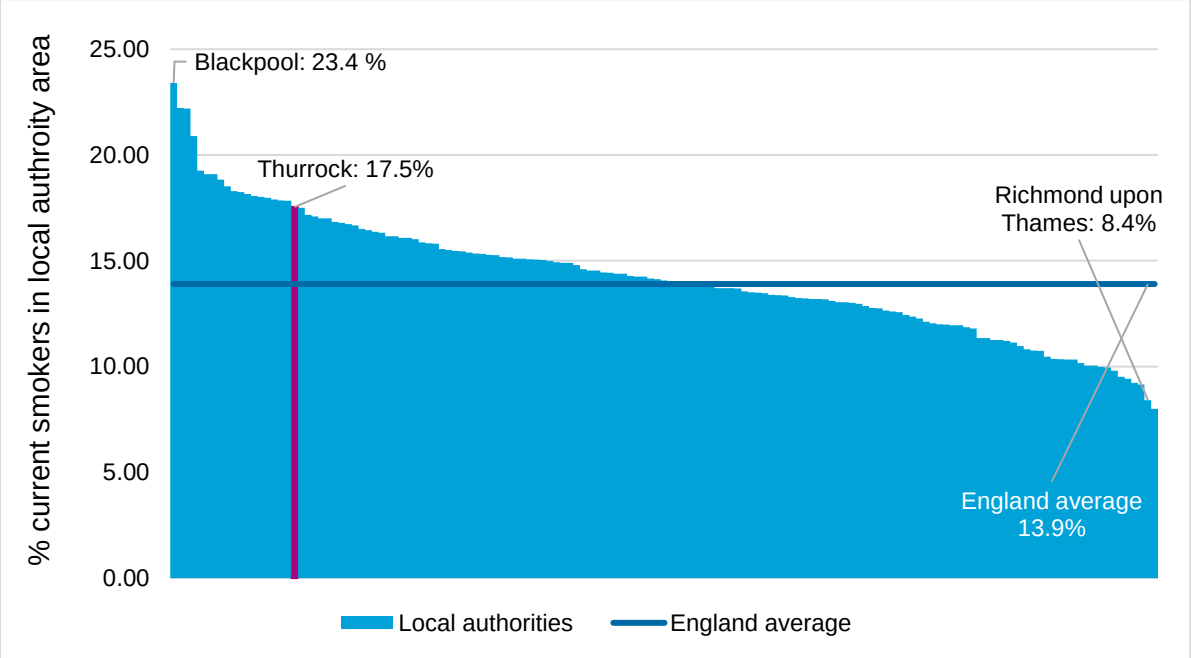
Figure 2: Thurrock population by smoking status 2019 (APS estimate)



Source: Annual Population Survey, 2019 (PHE, 2020)

Thurrock has one of the highest smoking prevalence rates in England (figure 3) (PHE, 2020).

Figure 3: Thurrock's smoking prevalence compared to all other local authorities in England (APS estimates for 2019).



Source: PHE Fingertips (PHE, 2020)

While prevalence estimates vary (table 1), Thurrock's smoking prevalence is consistently higher than the England average.

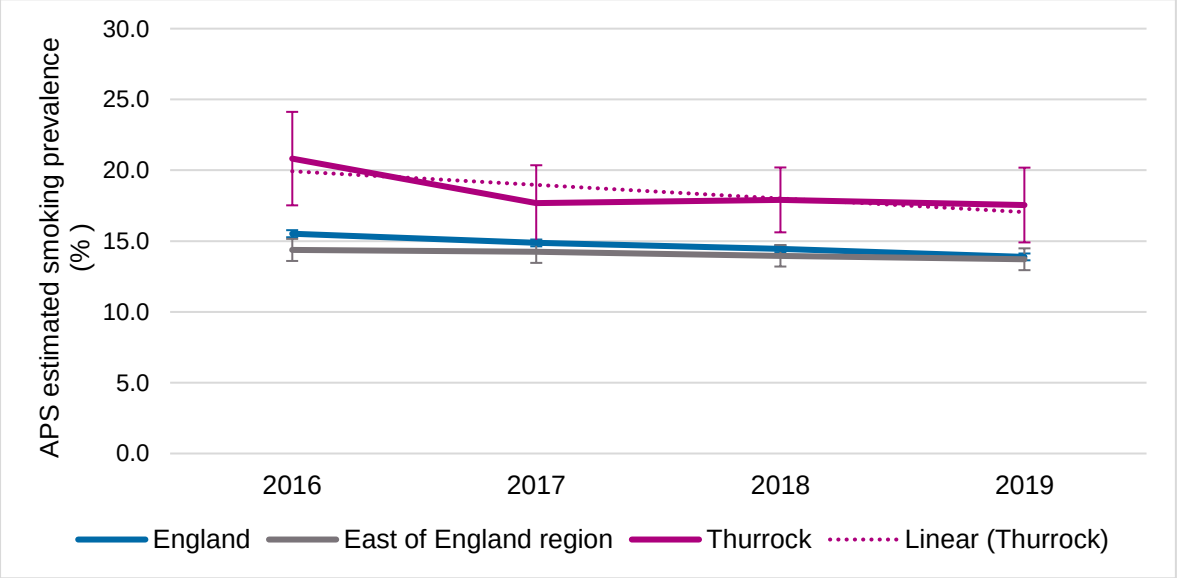
Table 1: Smoking prevalence estimates for Thurrock and England 2017-2019

Prevalence source	Thurrock 2019 prevalence	England 2019 prevalence	Difference Thurrock-England prevalence	Prevalence reduction 2017-2019 Thurrock	Prevalence reduction 2017-2019 England
Annual Population Survey (APS)	17.5%	13.9%	3.7%	-1.1%	-6.7%
General Practice Population Survey (GPPS)	16.5%	14.5%	2.0%	-2.4%	-7.1%
Quality and Outcomes Framework (QOF)	18.0%	16.7%	1.6%	-5.2%	-5.1%

Source: PHE Tobacco Control Fingertips, 2020 (PHE, 2020)

Table 1 also shows that smoking prevalence has reduced in England and Thurrock, although this also varies. The APS estimate is considered by PHE to be the most accurate; based on this, prevalence has reduced by 1.1% in Thurrock since 2017, significantly less than the England average (-6.7%). QOF data is drawn from information recorded in GP patient records; this data suggests Thurrock has seen a similar decline to the national average but is impacted by GP practices refreshing the practice list of smokers by asking and recording whether patients smoke. Figure 4 compares the trend in smoking prevalence using APS estimates since 2016. As Thurrock is a smaller geographic area, year on year changes are more noticeable, but the shape of the trend line suggests the decline in prevalence in Thurrock has been closer to the England than East of England trend, which has been less steep.

Figure 4: Trend in smoking prevalence 2016-2019 Thurrock, East of England and England (APS estimate)

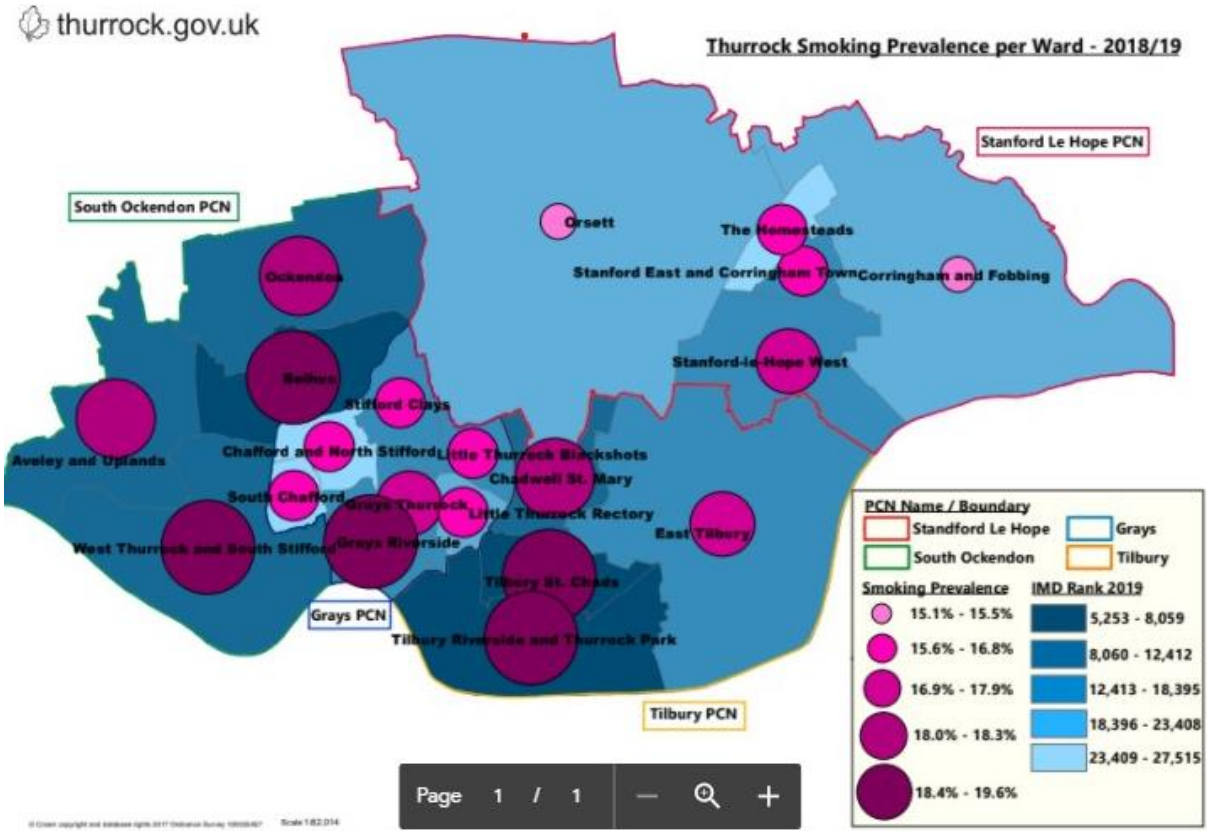


Source: PHE Fingertips (PHE, 2020)

5.3 Geographic variation and deprivation

Geographically, Thurrock's highest smoking prevalence is mainly in the most deprived wards. Figure 5 uses QOF data, allowing analysis at a more detailed geographic level than APS estimates; the map shows where smoking prevalence is highest by ward and Primary Care Network (PCN). Smoking prevalence is indicates by the size and depth of colour on the pink circles (larger darker circles indicate higher prevalence) and IMD rank is shown by the depth of blue (darker blue indicates increasing deprivation). The map shows the highest smoking prevalence is concentrated in the South West of Thurrock, mainly in Tilbury, Grays, Belhus and West Thurrock and South Stifford. At PCN level the map shows all PCNs have areas with high smoking prevalence.

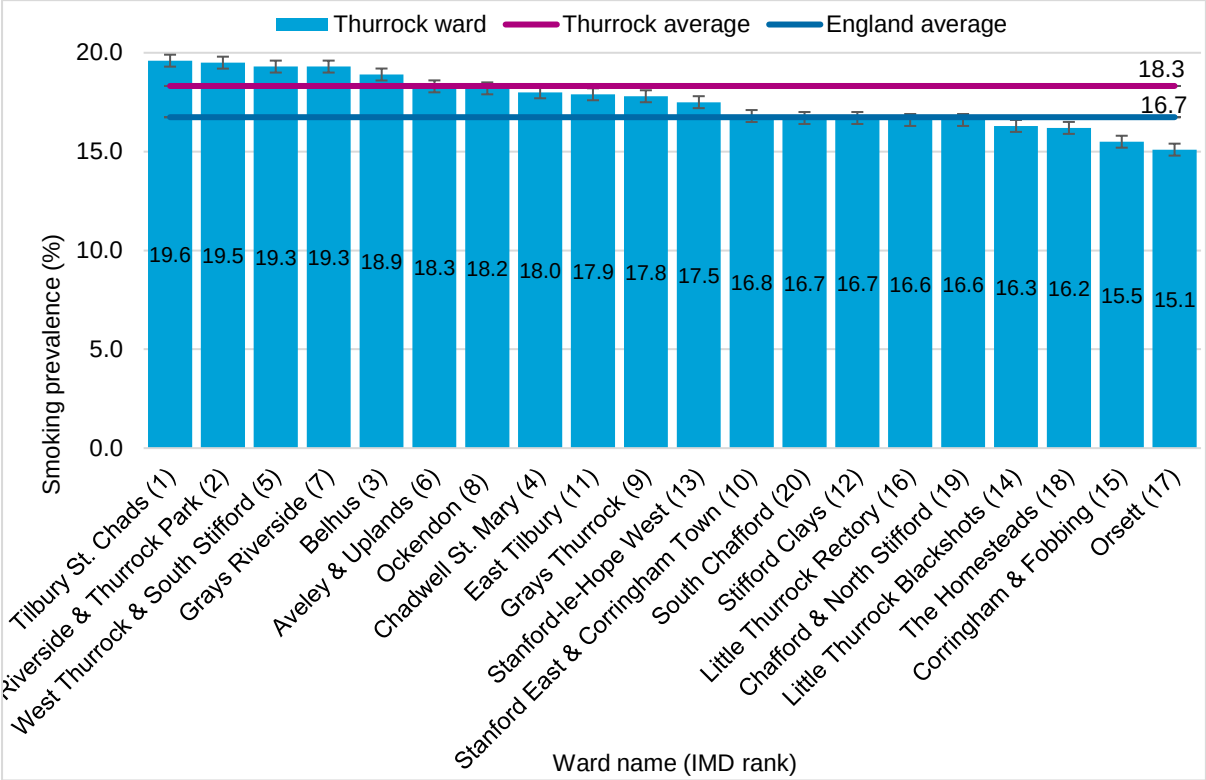
Figure 5: Map of smoking prevalence per ward 2018/19 using QOF estimates



Source: NHS Digital QOF, (2018/19)

Figure 6 also shows ward level QOF data for smoking prevalence and deprivation by IMD but in bar chart format, allowing a more detailed comparison of the range of variation. Five wards have higher prevalence than the Thurrock average: Tilbury St. Chads; Tilbury Riverside & Thurrock Park; West Thurrock & South Stifford; Grays Riverside; and Belhus. While the relative position of the wards in terms of IMD rank does not map perfectly to levels of smoking prevalence, the eight wards with the highest levels of deprivation are also the wards with the highest smoking prevalence.

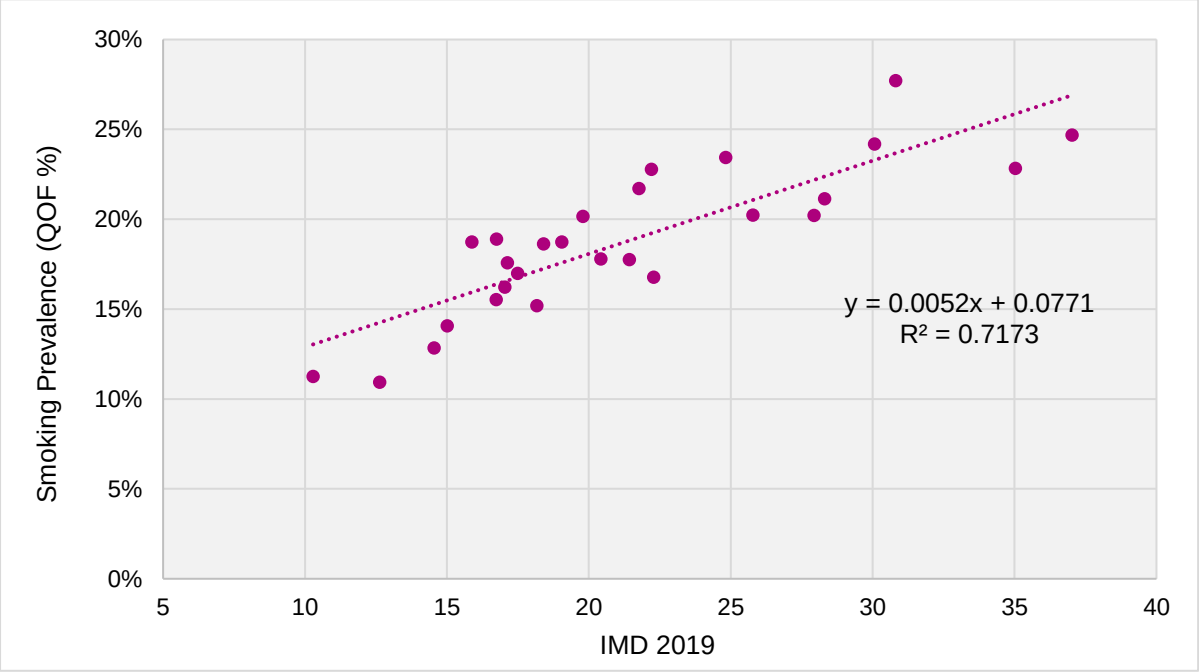
Figure 6: Thurrock QOF smoking prevalence by ward (2018)



Source: NHS Digital QOF, (2018/19)

The wards with higher smoking prevalence tend to be those that are more deprived; the strength of this relationship is shown in figure 7. An R^2 result of one represents a perfect correlation so the result of 0.7 indicates a strong relationship.

Figure 7: Association between smoking prevalence and deprivation (2019 QOF)

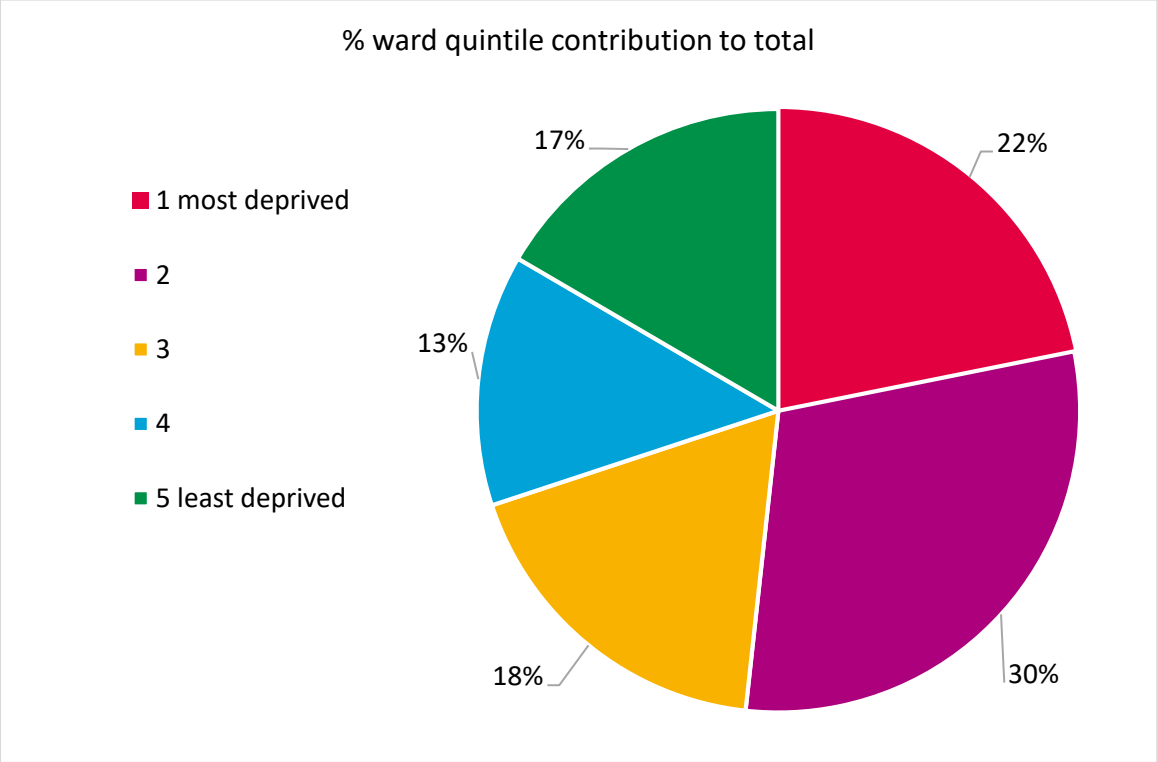


Source: NHS Digital QOF 2018/19 & IMD GP Scores, (2019)

While smoking prevalence is strongly correlated with deprivation, the relative contribution of a geographical area to the total number of smokers is also impacted by the population density. For Thurrock, the two most deprived wards have the highest smoking prevalence but have relatively small populations. West Thurrock & South Stifford and Grays Riverside (ranked 5th and 7th most deprived in Thurrock) contribute the highest number of smokers to Thurrock's overall prevalence (17% of smokers in Thurrock live in these areas). These two wards have the largest population size in Thurrock and some of the highest smoking prevalence. This data highlights the importance of taking a proportionate universalism approach to address Tobacco Control; in other words, all smokers should be able to receive support, but more effort needs to be made with increasing levels of deprivation (not only the most deprived). Over half of smokers (51.7%) live in the eight most deprived wards in the borough (based on local quintile of deprivation ranking). These statistics are summarised in figure 8 and table 2. Thus, interventions that are particularly effective at supporting quitting or reducing uptake in poorer areas would still reach over half of the smokers in Thurrock. This presents an opportunity to address smoking both at scale and reducing inequity in Thurrock.

Figure 8: Contribution (%) by quintile of deprivation to the number of smokers in Thurrock (2018 QOF).

1 = least deprived 4 wards, 5 = most deprived 4 wards



Source: NHS Digital QOF 2018/19

Table 2: Number of smokers by ward in Thurrock and IMD quintile rank

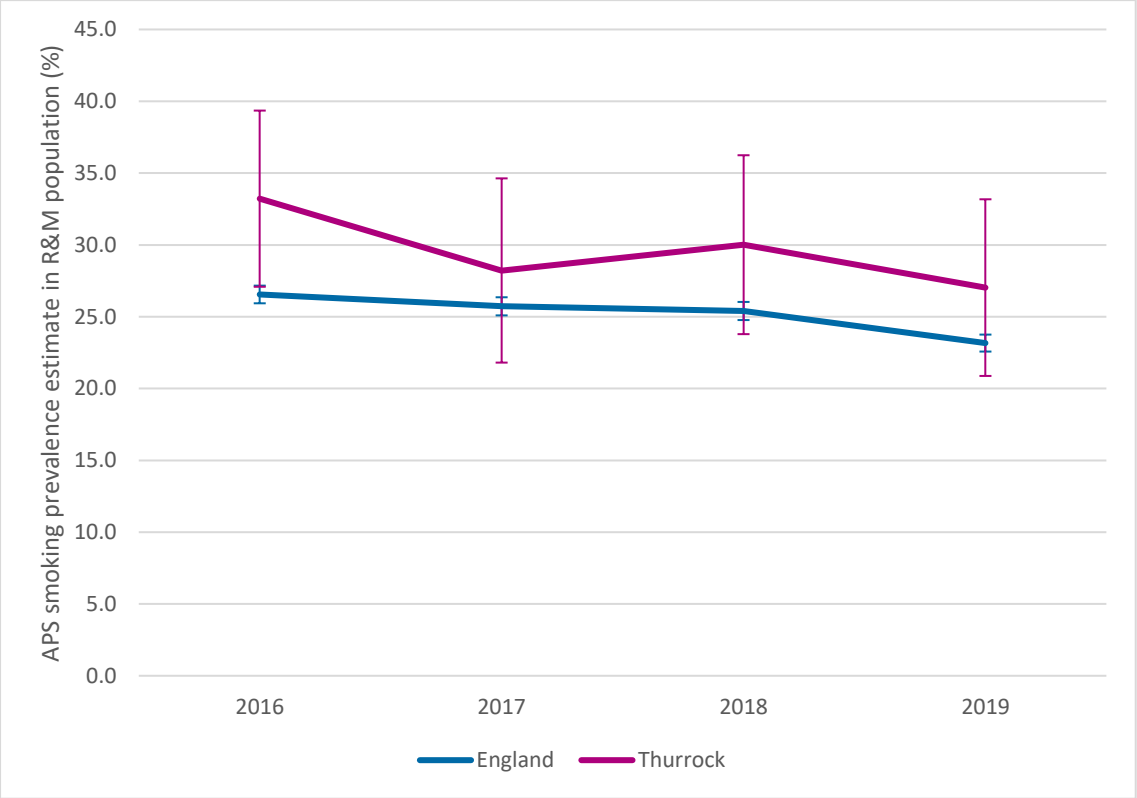
Quintile rank	Ward	N smokers in 2018
1	Tilbury St. Chads	1,241
	Tilbury Riverside & Thurrock Park	1,501
	Belhus	1,993
	Chadwell St. Mary	1,848
2	West Thurrock & South Stifford	2,562
	Aveley & Uplands	1,845
	Grays Riverside	2,553
	Ockendon	2,047
3	Grays Thurrock	1,719
	Stanford East & Corringham Town	1,427
	East Tilbury	1,204
	Stifford Clays	1,132
4	Stanford-le-Hope West	1,199
	Little Thurrock Blackshots	1,020
	Corringham & Fobbing	838
	Little Thurrock Rectory	1,007
5	Orsett	932
	The Homesteads	1,352
	Chafford & North Stifford	1,384
	South Chafford	1,330

Source: NHS Digital QOF 2018/19

Another indicator used as a proxy for socio-economic status is routine and manual professions (R&M). Smoking prevalence is higher among these groups. Figures' 9 and 10 on the next two pages show the trend in smoking prevalence among R&M groups.

Figure 9 shows a statistically significant decline in smoking prevalence among R&M professionals across England between 2016 and 2019 (26.5% to 23.2%). The estimated trend in Thurrock is also a decline (33.2% to 27.0%) but the confidence intervals (CI) overlap so this may not reflect actual change.

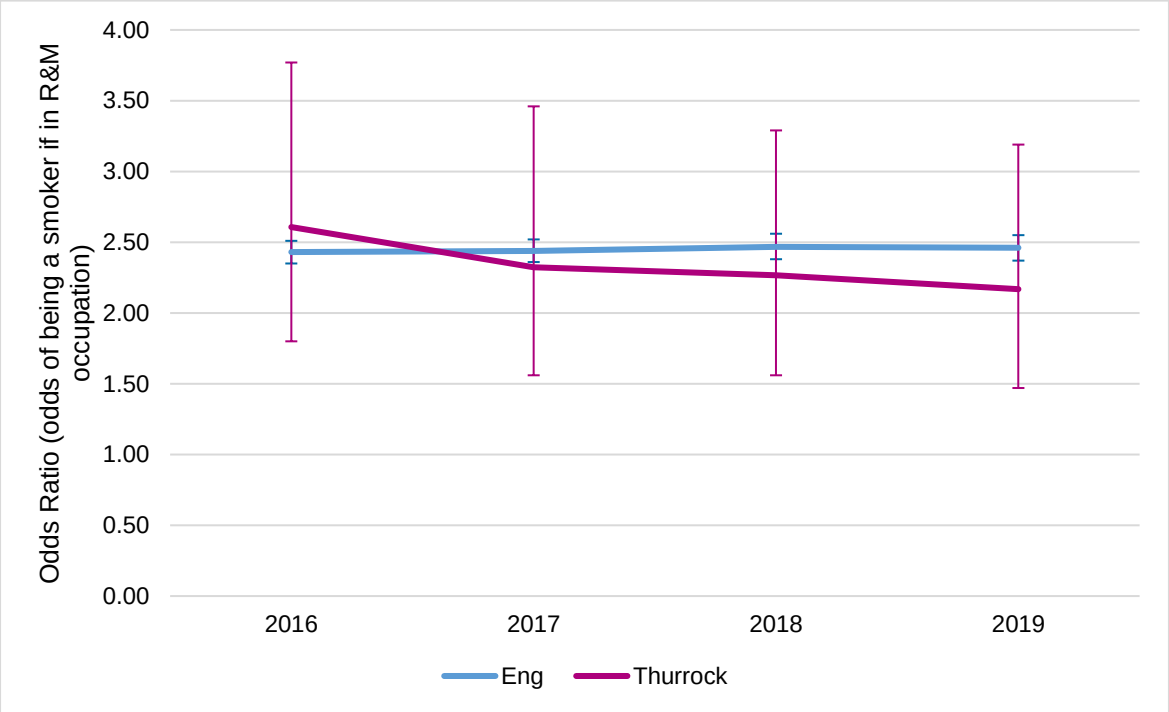
Figure 9: APS estimated smoking prevalence among people working in R&M professions (2016-2019)



Source: PHE fingertips (PHE, 2020)

Figure 10 is a measure of relative inequity, comparing the odds of smoking among people working in R&M occupations, with smoking among people working in other occupations. The estimated trend suggests there has been a decline in relative inequity in smoking prevalence for Thurrock (OR 2.61 to 2.17 from 2016 to 2019) but an increasing trend across England (OR 2.43 to 2.46 from 2016 to 2019). Currently these trends are not statistically significant (shown in the graph by the error bars, which overlap). However, projections suggest that without targeted intervention the trend across England will worsen over time (Song F, 2020). While the data suggests Thurrock's approach may be successfully reducing relative inequity, Thurrock still has higher rates of smoking among R&M workers than the England average. Also, the reason the relative inequity figures are lower is because more people across all socio-economic groups smoke in Thurrock. This is another reason for taking a proportionate universalism approach to Thurrock's tobacco control strategy.

Figure 10: Relative inequity in smoking prevalence Thurrock, odds of smoking prevalence in routine and manual (R&M) occupation compared to smoking prevalence in non R&M occupations (2016-2019)



Source: PHE Fingertips (PHE, 2020)

The data presented in this section has shown the extent of inequality in smoking prevalence associated with deprivation in Thurrock and for England. Thurrock does not differ significantly in the extent of this inequality, measured by occupational group, compared to England and there has been little change since 2016.

Within Thurrock, the two most deprived wards have the highest smoking prevalence and smoking prevalence is strongly associated with IMD score. However, it is not a perfect association and the data shows that a proportionate universalism approach should be adopted. The highest smoking prevalence and highest number of smokers are spread across the eight more deprived wards compared to the remaining twelve wards in Thurrock.

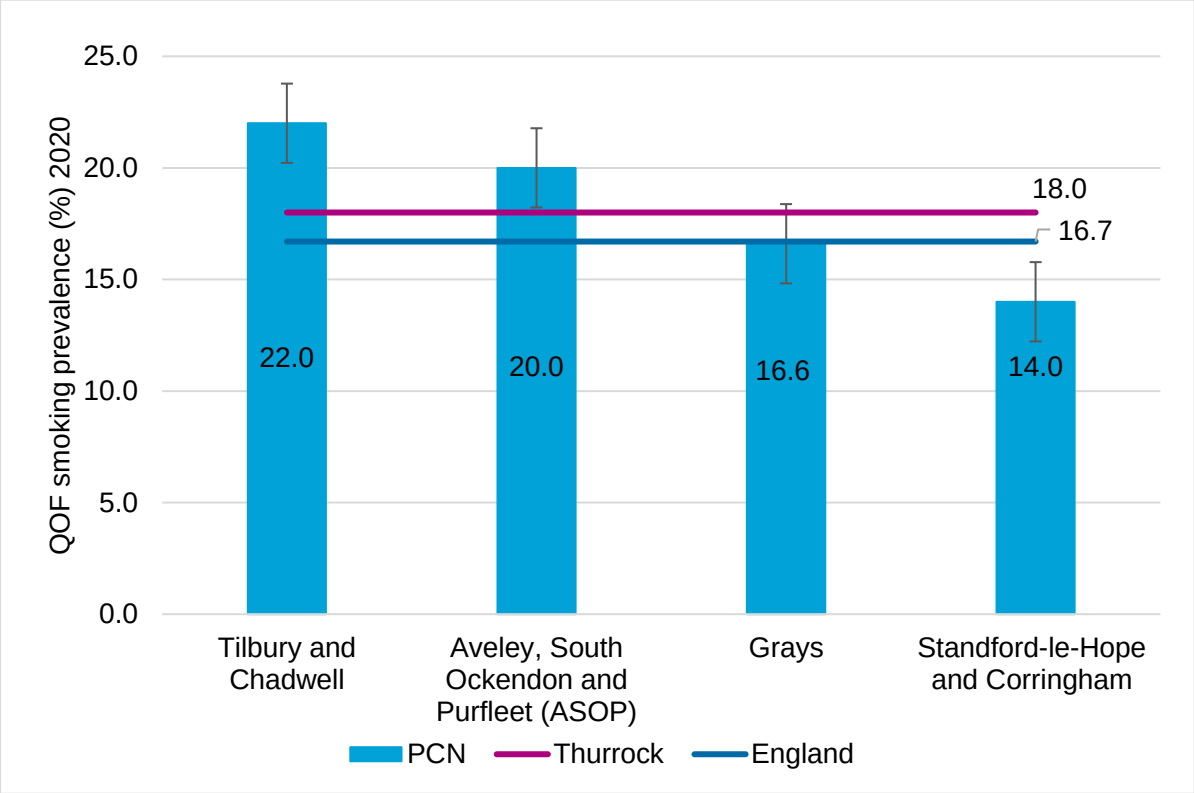
The next section discusses variation in smoking prevalence across Thurrock's Primary Care Networks (PCNs) and GP practices.

5.4 Smoking prevalence in primary care

The data used in this section is drawn from QOF, but analysis have been undertaken at different time points, so comparisons cannot be made between graphs, only within graphs as the data is relative to the point of data capture.

Thurrock has four PCNs and figure 11 shows that in 2020, Tilbury & Chadwell PCN had the highest smoking prevalence, which was above the average for Thurrock at 22%. Aveley, South Ockendon, and Purfleet (ASOP) PCN also had smoking prevalence higher than the Thurrock average at 20%. The error bars show these findings are significant. Analysis for MSE HCP ranks these PCNs as having the third and sixth highest smoking prevalence in the MSE HCP geography.

Figure 11: Thurrock QOF smoking prevalence by PCN (2020)

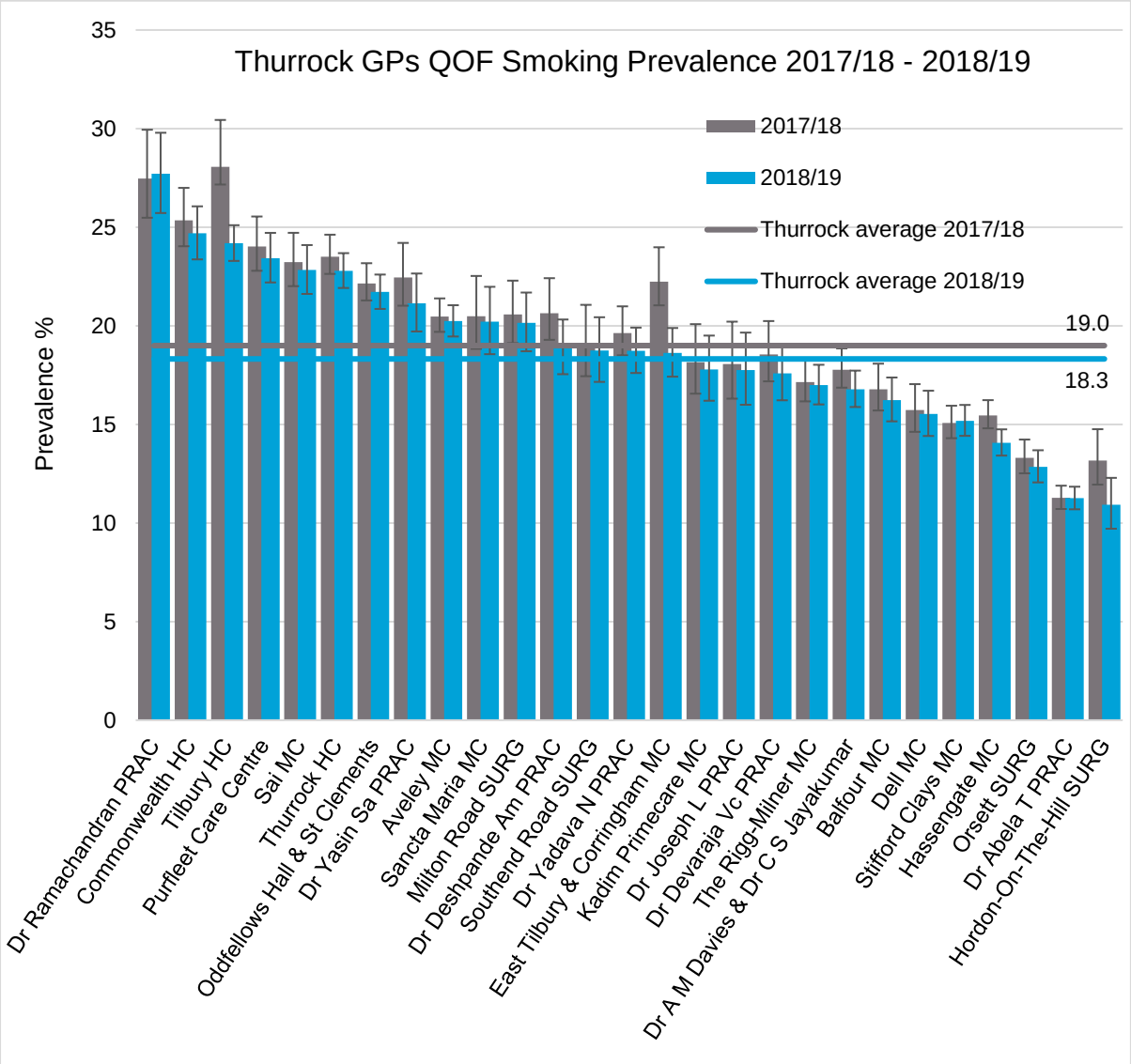


Source: NHS Digital QOF, (2020)

Figure 12 highlights the variability in smoking prevalence at practice level across the PCNs and between years; in this case data has been captured for 2017/18 and 2018/19. Thurrock Health Centre in Grays PCN for example, had a consistently higher smoking prevalence during this period that the Thurrock average. Most other practices from this PCN had lower prevalence than the Thurrock average during this time. The ethos of PCNs is for the GPs to support one another to improve the health of their patients and therefore their performance as a PCN. All PCNs need to address tobacco control and more needs to be done particularly in Tilbury & Chadwell and ASOP PCNs. Deprivation is a key contributing factor, accounting for 94% of smoking variance across the MSE. It is therefore important that PCNs in more deprived areas are supported to put in place stop smoking services tailored to their local population needs.

Figure 12 also shows the annual change in smoking prevalence at GP practice level; it demonstrates how much change can be made in a year. For instance, Tilbury Health Centre achieved a reduction of 14.3% between 2017/18 and 2018/19 and East Tilbury & Corringham MC achieved a reduction of 16.2% in the same period. This shows how a combination of asking and offering support and refreshing practice lists can reduce smoking prevalence. Dr Ramachandran Practice and Stifford Clays Medical Centre had an increase in smoking prevalence; this could be due to the practice more routinely asking patients if they smoke and so isn't necessarily an indicator of poor performance. However these practices and their associated PCNs should work to understand change in prevalence and address this.

Figure 12: Thurrock GPs QOF Smoking Prevalence 2017/18 – 2018/19



Source: PHE fingertips – National General Practice profiles, (2018)

The next section of this needs assessment will explore smoking prevalence among populations where nationally there is higher prevalence and / or increased vulnerability to tobacco harm. Prevalence among groups with protected characteristics will also be discussed.

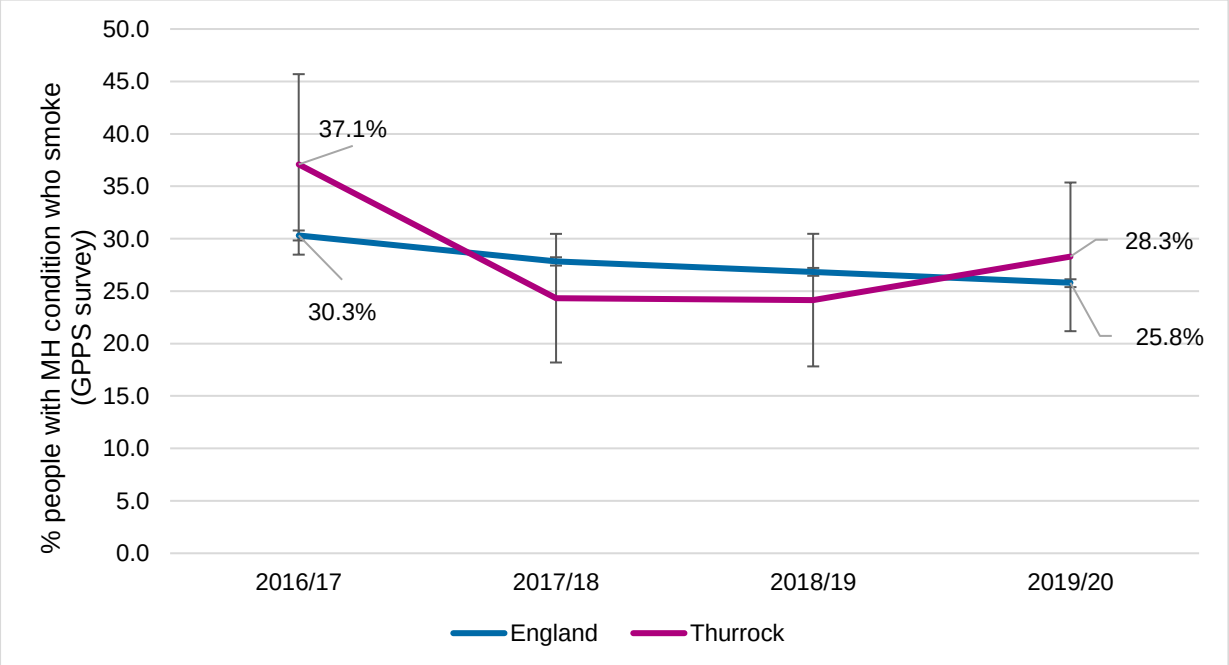
5.5 Smoking prevalence and mental health

Nationally, while smoking prevalence has declined among adults with a long-term mental health condition, prevalence remains substantially higher than the general population, despite the same levels of motivation to quit (PHE, 2020b). As the severity of mental health conditions increases so too does smoking prevalence (PHE, 2020b); for example prevalence in 2014/15 among people with specific mental health conditions was:

- anxiety or depression: 28.0%
- a long-term mental health condition: 34.0%
- serious mental illness: 40.5%

PHE's Tobacco Control Profile offers local data based on the General Practice Patient Survey (GPPS); figures 13 and 14 show the prevalence trend among people who responded to say they have a long term mental health condition and who also responded to say they smoke. The data suggests smoking prevalence among people who have a long term mental health condition has reduced in England from 30.3% (CI 29.8 to 30.8) to 25.8% (CI 25.4 to 26.1) between 2016/17 and 2019/20 (figure 13). It is not possible to confirm whether there has been a similar change in this period in Thurrock as the confidence intervals are very wide and overlap. The trend suggests there may have been a decline but the latest data point indicates a possible increase from the previous two years. Throughout this period smoking prevalence has been higher among respondents of this survey who reported having a long term mental health conditions than the equivalent year estimates in the general population for Thurrock and England.

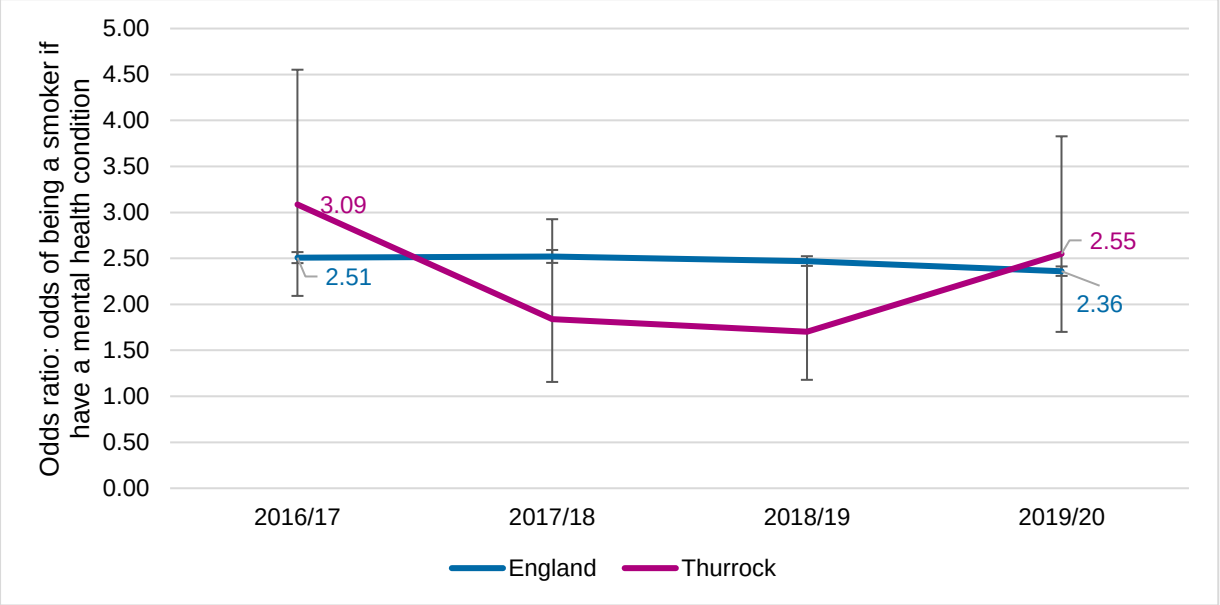
Figure 13: Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS) (2013/14-2019/20)



Source: PHE Fingertips (PHE, 2020)

Figure 14 shows the odds of being a smoker if a person reported they have a long term mental health (LTMH) condition compared to those who do not, which is a measure of relative inequality. For England and Thurrock, the odds of being a smoker are higher for people with a LTMH condition. In England the odds have reduced since 2016/17[3] but there has been no significant change in this trend in Thurrock. In 2019/20, the odds of someone with a LTMH condition smoking compared to people who did not have a LTMH condition were over double (England OR = 2.36, Thurrock OR = 2.55). The Thurrock confidence intervals are very wide and overlap the England average confidence intervals. This means the data does not indicate a significant difference in relative inequity regarding smoking prevalence among people with a LTMH condition between the England average and Thurrock.

Figure 14: Smoking prevalence in adults (18+) - gap by mental health status (GPPS) (2016/17 – 2019/20)



Source: PHE Fingertips (PHE, 2020)

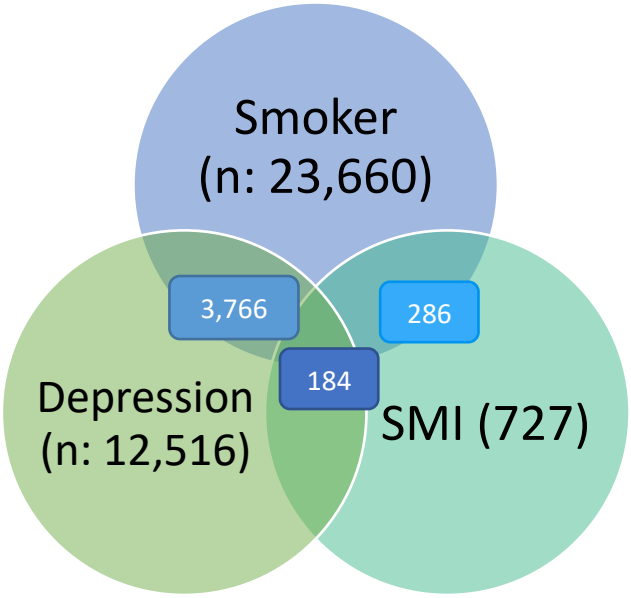
The GPPS data used in figures 13 and 14 is based on a relatively small population sample. Data from GP records offers data on the local GP registered population and while not all records are up to date, it is an alternative source of prevalence data.

Of the 23,660 patients registered with GPs in Thurrock who have a record to say they currently smoke, almost one fifth (18%) have either depression, an SMI or both. Thurrock patients are more likely to smoke if they have a mental health condition and smoking prevalence increases with the severity of mental illness and the number of diagnoses; mirroring the national pattern. Smoking prevalence among people with a diagnosed mental health condition in Thurrock is summarised below and in figure 15.

- Patients recorded as having depression who smoke: 30%
- Patients recorded as having an SMI who smoke: 39%
- Patients recorded as having depression and SMI who smoke: 44%

[3] England 2016/17 OR = 2.51, CI 2.45 to 2.57; 2019/20 OR = 2.36, CI 2.31 to 2.41

Figure 15: Venn diagram showing the number of patients who are coded as having depression and / or having an SMI and who smoke (2020 QOF)



Source: SystmOne, Thurrock Council Public Health Intelligence team 2020

Data has also been sought from Essex Partnership University NHS Foundation Trust (EPUT) and Thurrock's Increasing Access to psychological Therapies (IAPT) service. This data can indicate people accessing support from mental health services who have also been supported to stop smoking through these services. IAPT do not collect data on the smoking status of their service users so it is not possible to estimate this. Data from EPUT was not available at the time of writing this JSNA but will be considered in the development of the strategy should this information become available. Targeted work with these services is a mechanism for offering tailored support to some of the local population living with mental illness, however data in this section also shows more work needs to be done in primary care to address smoking in this population.

The data presented in this section does not show hidden need among people with undiagnosed mental illness; there may therefore be unmet need regarding smoking cessation support among people who have poor mental health.

Overall this section shows that Thurrock mirrors the national picture regarding mental illness and smoking; an increasing number of mental health diagnoses and increasing severity of the condition is associated with a higher likelihood of smoking. Across England, data from the GPPS survey suggests there has been a reduction in absolute and relative inequality in smoking prevalence comparing people with a mental health condition to the general population since 2016/17. There has however been no significant change in Thurrock during this period.

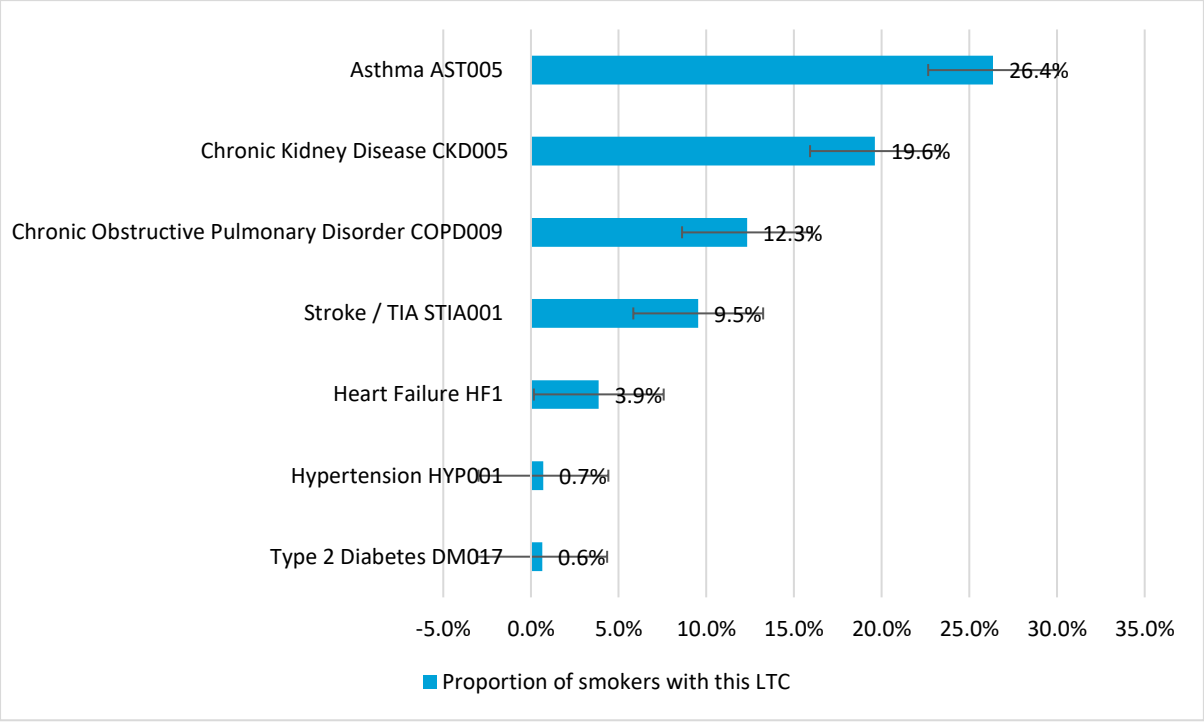
The next section discusses prevalence among people with a long term condition and focusses on physical illness as mental health has been discussed here.

5.6 Smoking prevalence and people with long term conditions (LTCs)

Smoking increases the risk of LTCs, so prevalence among people with conditions such as cardiovascular disease is higher and also associated with how addicted people are (ASH, 2020b). For example national evidence shows that 44% of heavy smokers have at least one LTC, compared to 38% of moderate smokers and 32% of never smokers (ASH, 2020b). People from more deprived populations are more likely to smoke more cigarettes per day and smoke more of each cigarette; this impacts the higher prevalence of LTC in these populations. There is a need to identify and support smokers from poorer socio-economic groups who have LTCs to reduce tobacco related inequalities in health outcomes.

Figure 16 shows the proportion of smokers in Thurrock with one or more of the following LTCs; Asthma, Chronic Kidney Disease, Chronic Obstructive Pulmonary Disorder, Stroke/ TIA, Heart Failure, Hypertension and Type 2 Diabetes. For example, the data indicates that over a quarter of smokers in Thurrock have asthma. The figure does not show the proportion of patients with Cancer as the data only indicated 10 patients who smoke were recorded with QOF code CAN001. There may be other QOF codes that would more accurately demonstrate the proportion of smokers in Thurrock who have cancer. Some smokers may have more than one of these LTCs and so may be double counted. Asthma and CKD are the most common of these LTCs, however all patients with a LTC who smoke can benefit from quitting. This data indicates which LTCs PCNs and GP practices may wish to focus on to support smokers with a LTC.

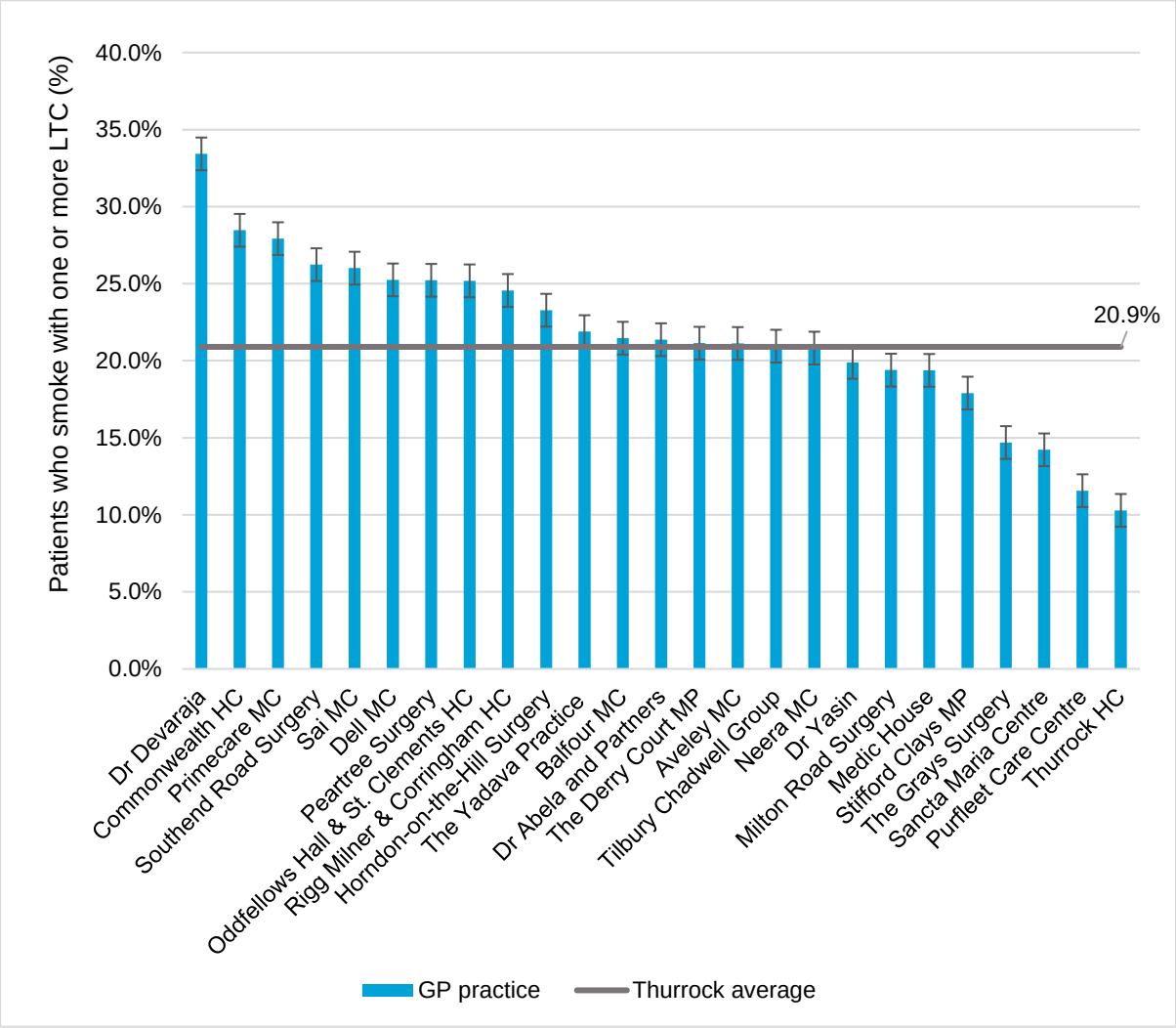
Figure 16: Proportion of registered patients who smoke in Thurrock and who have a LTC (2021)



Source: Thurrock Council Public Health Intelligence Team (QOF)

Figure 17 shows the GP practices that have the highest proportion of patients who smoke with one or more of the LTCs selected for this analysis. Dr Devaraja has the highest proportion of patients who smoke with one or more of the LTCs included in this analyses, with one third of these patients being recorded as smokers (33.4%, n=124). In total, ten practices have higher smoking prevalence among patients with a LTC than the Thurrock average. These practices should consider their offer to smokers with LTCs as part of a practice approach to reducing inequalities.

Figure 17: Proportion of patients who smoke who have a LTC (asthma, CKD, COPD, Stroke/TIA, HF, Hypertension, T2D) by Thurrock GP practice (2021)



Source: Thurrock Council Public Health Intelligence Team (QOF)

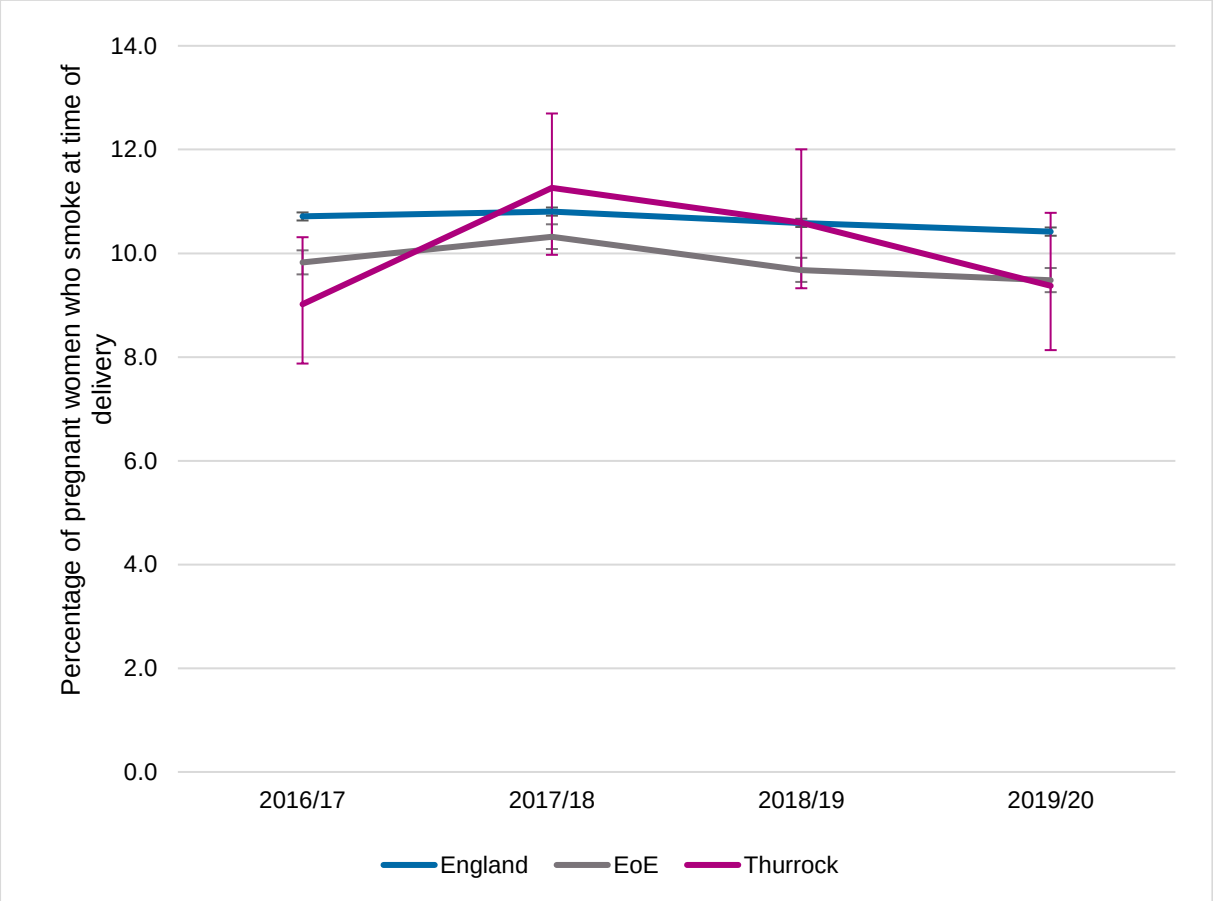
Data showing the association between smoking and LTCs differs based on which LTCs are included in the analysis. Based on the Thurrock analysis, there is a high proportion of patients who smoke who have Asthma and COPD, both conditions that are exacerbated by smoking. Furthermore, there is wide variation between GP practices in Thurrock regarding the proportion of their patients who smoke who also have one or more of the LTCs included in this analysis. All practices should consider their offer to patients with a LTC who smoke, but especially those with a high proportion of smokers who have LTCs.

The next section is about smoking during pregnancy; this is a priority group nationally because of the risk of harm to unborn babies and their mothers from smoking.

5.7 Smoking and pregnancy

Smoking at time of delivery (SATOD) is a nationally used marker of smoking prevalence among pregnant women. This is because smoking is the largest modifiable risk factor for poor birth outcomes such as miscarriage and low birth weight (PHE, 2020f). It is also a major cause of inequality in child and maternal health. Figure 18 shows that in England, the East of England (EoE) region and Thurrock there has been little change in SATOD since 2016/17. The change nationally has been small, but there has been a statistically significant reduction in SATOD (10.7% in 2016/17 (CI 10.6 to 10.8), to 10.4% in 2019/20 (CI 10.3 to 10.5)). The EoE region has consistently had statistically significantly lower SATOD than the England average during this period. For Thurrock, SATOD was significantly lower than the England average in 2016/17 but it is not possible to say whether the current prevalence of 9.4% is significantly lower as the confidence interval crosses the England average. The current prevalence in Thurrock is equivalent to approximately one in ten women smoking during their pregnancy (NHS Digital, 2020).

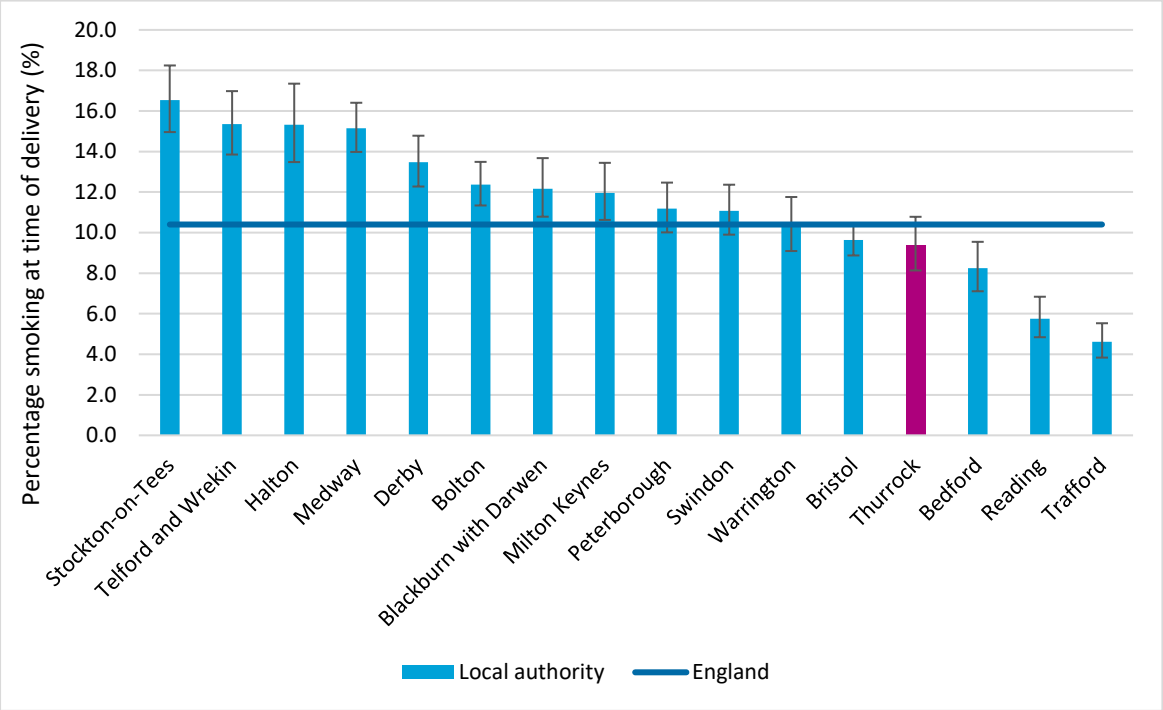
Figure 18: Smoking status at time of delivery 2012-2020 (England, EoE and Thurrock)



Source: PHE Fingertips (PHE, 2020)

Figure 19 shows that Thurrock has statistically significantly lower SATOD compared to six of its fifteen CIPFA comparator areas. This is important since CIPFA neighbours have similar socio-demographic profiles. The factors considered in these profiles are also risk factors for smoking during pregnancy, which suggests Thurrock is performing relatively well given its socio-demographic profile in addressing smoking prevalence among pregnant women.

Figure 19: Smoking status at time of delivery among Thurrock's CIPFA neighbours (2019/20)



Source: PHE Fingertips (PHE, 2020)

However, work to support pregnant women to quit smoking needs to continue locally; compared to other districts in MSE, Thurrock ranks fourth highest out of nine for SATOD. MSE district analysis shows that 22% of SATOD is explained by the district's IMD 2019 score; this is evidence that locally, deprivation is a factor impacting smoking during pregnancy but less so than in the general population. Smoking during pregnancy is also likely to be concentrated among younger women, based on national smoking prevalence in pregnancy data. Addressing smoking for these groups is particularly important for reducing health inequality pre-birth, health inequality in the early years and is an opportunity to reduce childhood poverty (ASH, 2020c).

Asking about smoking status in pregnancy is part of the 'Ask, Advise, Act' (AAA) smoking cessation intervention; the impact of this intervention in Thurrock is discussed in section six of this needs assessment. The AAA approach could also be used by Health Visitors to strengthen support for women after having a baby. However data on smoking prevalence in families is not a national data collection; the evidence for this approach is discussed in section seven of this needs assessment.

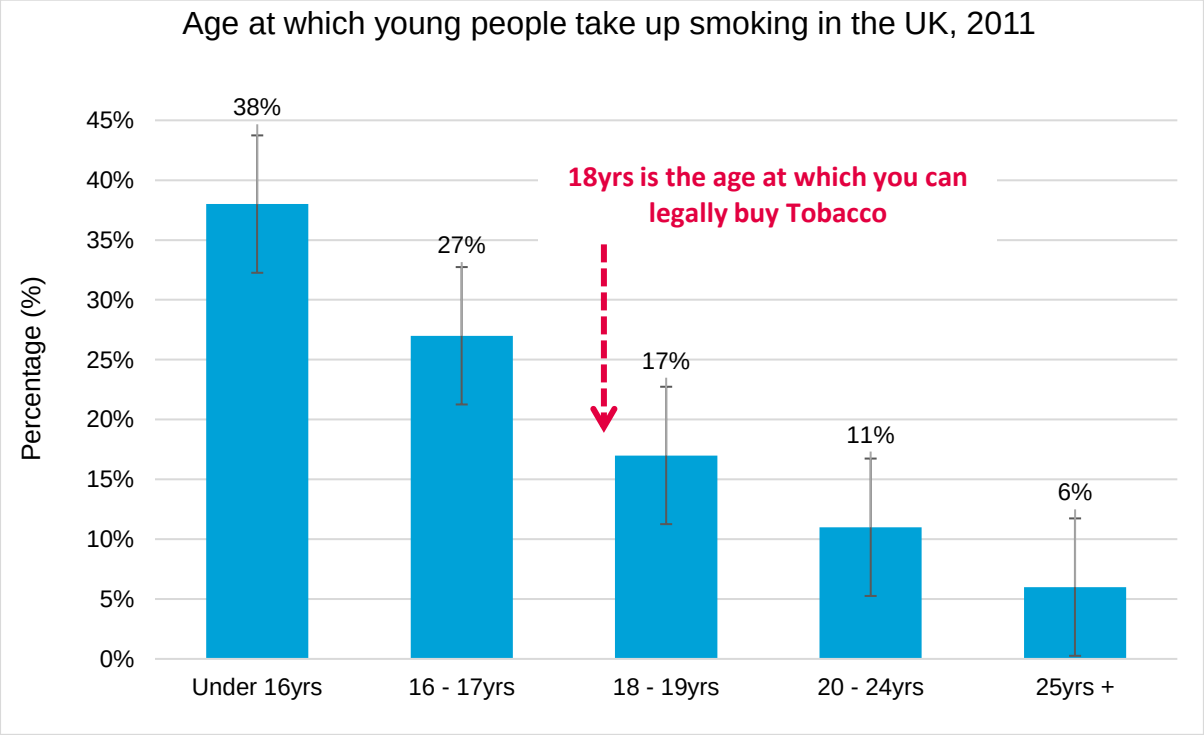
The risk of second hand smoke is another important factor impacting the health of pregnant women and their babies. Data on second hand smoke exposure is not currently available at local authority level, but nationally an estimated 20% of women are exposed to second-hand smoke in the home throughout their pregnancy. Women who live with a smoker are six-times more likely to smoke throughout pregnancy and, if they do quit, are more likely to relapse into smoking once the baby is born (Smokefree Action Coalition, 2020). Therefore more pregnant smokers' partners, and wider household members who smoke should also be asked about their smoking status and encouraged to stop (NICE, 2014) (NICE, 2010). Interventions to reduce risk of exposure to second hand smoke are discussed in section seven of this needs assessment.

The next section discusses smoking prevalence among children and young people.

5.8 Children and young people

Understanding smoking prevalence among children and young people is important partly because around two thirds of adult smokers report that they took up smoking before the age of 18 and over 80% before the age of 20 (ASH, 2019b). Furthermore, experimentation with cigarette smoking at a young age poses a greater risk of developing into addiction; children may show signs of addiction within four weeks of starting to smoke and before they commence daily smoking (ASH, 2019b). Figure 20 demonstrates the long term potential of reducing prevalence overall by stopping uptake at a young age.

Figure 20: Age at which young people take up smoking in the UK (2011)



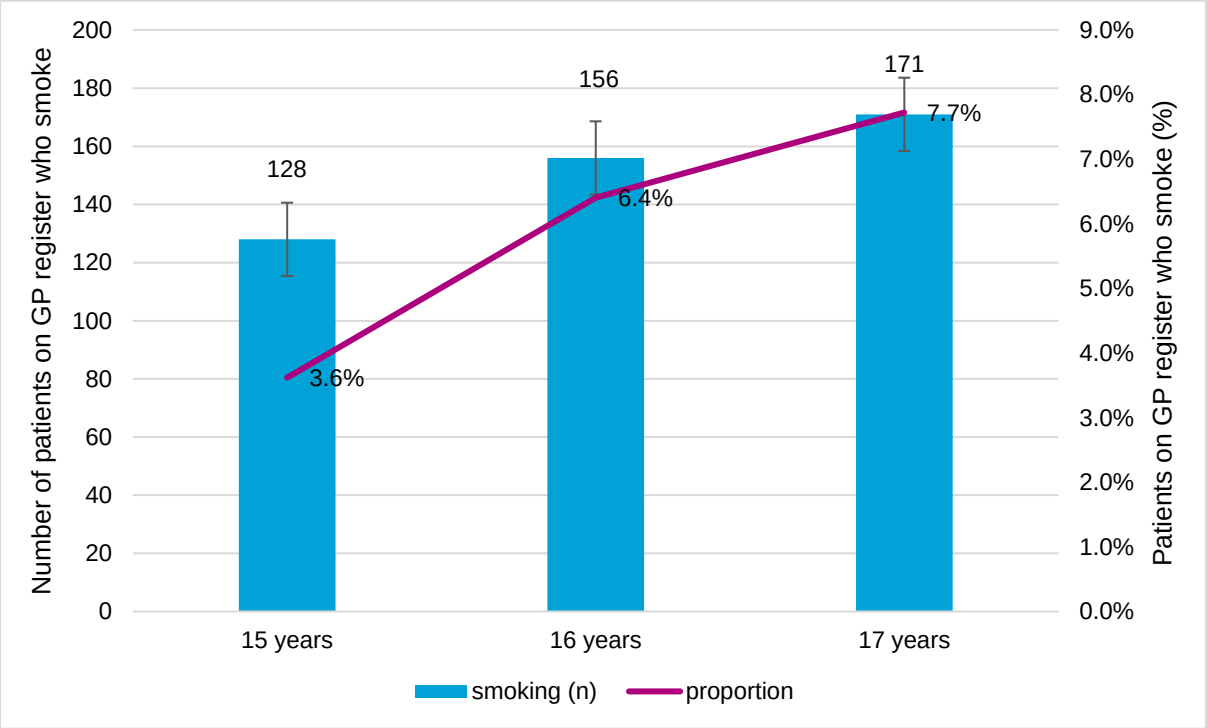
Source: Smoking Attitudes & Behaviours, ONS (2011)

Factors that increase the risk of children and young people taking up smoking include smoking among parents, siblings and peers, ease of obtaining cigarettes, socio-economic status, and exposure to tobacco marketing and in media. Children who live in households with people who smoke are up to three times more likely to become smokers themselves (ASH, 2019b). School truancy and engagement in other risk taking behaviours such as drinking alcohol and taking drugs are also associated with cigarette smoking in this age group.

There are several data sources that demonstrate attitudes to and uptake of smoking cigarettes, other tobacco products and e-cigarettes among children and young people. These include GP records and survey data. This section summarises these for Thurrock.

Figure 21 shows the number of registered smokers and the proportion of patients who smoke among people aged under 18 in Thurrock, which increases with age. Over 450 children under the legal age for purchasing cigarettes have disclosed to their GP that they smoke. There are likely to be more young people who have not disclosed this to their GP. While GPs are in a position to offer advice and support, including referral to stop smoking services for young people who disclose that they smoke, interventions must also be available in other settings to encourage young people to seek support to stop smoking.

Figure 21: Number of smokers aged under 18 in Thurrock based on QOF smoking records (2021 data).



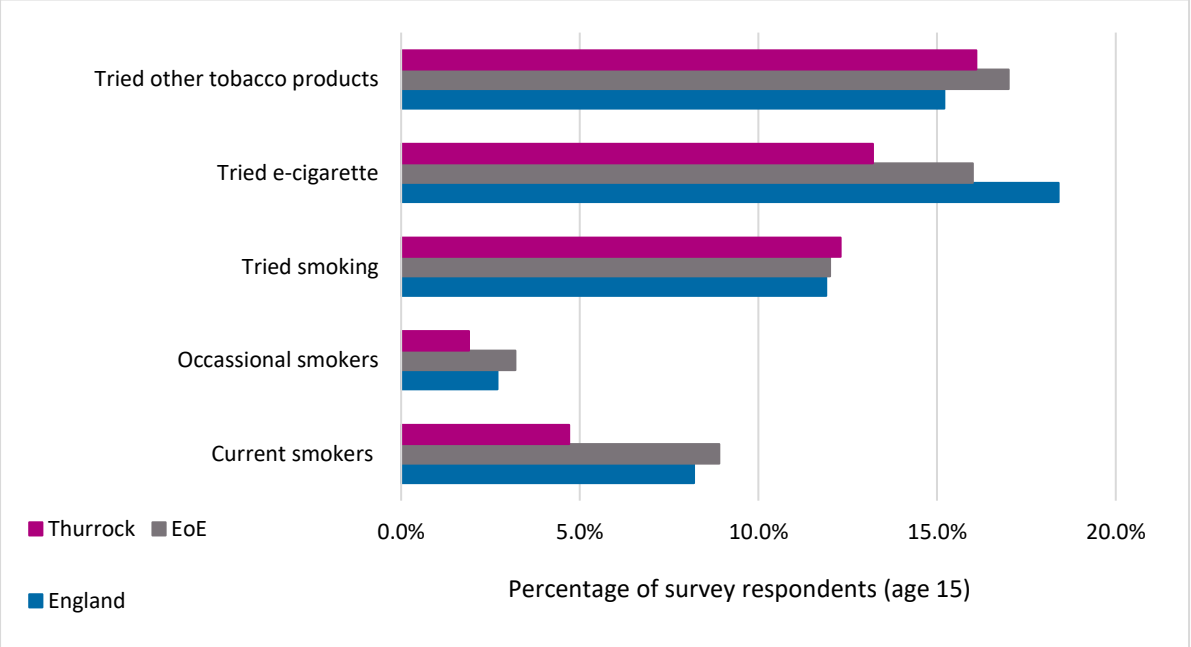
Source: Thurrock Council Public Health Intelligence team. QOF records February 2021

Modelling of national data estimates that 372 children aged 11-15 years old a year start smoking in Thurrock (Hopkinson NS, 2014), two thirds (248) of whom will go on to become daily smokers (Birge M, 2018). The difference between this estimate and

the QOF data in figure 21 indicates the potential scale of the gap in information about young people who smoke. These data also indicate that interventions to address smoking in Thurrock need to start from an early age and with particular support for children as they reach their mid-teens, across settings that have regular contact with young people.

Nationally, the 'What about YOUth' (WAY) survey and 'Smoking, Drinking and Drugs' (SDD) surveys offer insight into attitudes and prevalence of smoking among children and young people. These are supplemented by the 'Brighter Futures Survey' in Thurrock. The most recent national data comes from the SDD survey but data is not available at local authority level; in England in 2018 the estimated prevalence among 15 year olds was 5% (PHE, 2020). Data from the What about YOUth survey offers data regarding smoking behaviours among 15 year olds at local authority and ward level but was undertaken in 2014. Data from this survey suggests Thurrock may have a lower proportion of young people who have tried e-cigarettes, occasional smokers and current smokers than the regional and national averages (see figure 22). The data also indicates that Thurrock may have a higher proportion of young people who have tried smoking than the regional and national average and a higher proportion of young people who have tried other tobacco products than the national average. Confidence intervals are not available for these data to allow comparison of the significance of these local, regional and national differences so these patterns might not reflect the true scale of differences at the time.

Figure 22: Results from the WAY survey showing tobacco and e-cigarette use in Thurrock, EoE and England among 15 year old survey respondents (2014/15)



Source: PHE fingertips Child and Maternal Health Profiles (PHE , 2021)

While the results from the WAY survey are promising, estimates vary by ward; smoking prevalence was estimated to be highest in The Homesteads (6.8%), Orsett (6.5%) and Corringham and Fobbing (6.1%). Prevalence was lowest in Tilbury

Riverside and Thurrock Park (3.7%), West Thurrock and South Stifford (3.8%). This is an unexpected finding since it reflects the opposite situation compared to adult smoking prevalence. Wards with the lowest smoking prevalence among 15 year olds are those with the highest adult prevalence and wards with the highest smoking prevalence among 15 year olds are those with the lowest among adults. This may be an anomaly in the modelling work to estimate prevalence in this age group at ward level, but may truly reflect higher prevalence in these wards. The message from this data is that work to prevent smoking uptake must reach children across Thurrock. While risk factors that impact uptake must be included in intervention design, all children are influenced by their peer groups and wider marketing and advertising.

Another finding from the WAY survey is that a relatively high number of children had tried e-cigarettes and 'other tobacco products' (such as shisha pipe, hookah, waterpipe); use of tobacco through smoking marijuana is not included in this. More evidence is needed regarding the relationship between children and young people trying e-cigarettes and cigarette smoking uptake in this age group, however trend data does not suggest an association. Prevalence of trying e-cigarettes has increased but there continues to be a downward trend in cigarette smoking (ASH, 2019c). There is little data regarding regular use of other tobacco products once they have been tried, but these products are harmful to health and interventions for young people about tobacco should include these.

Brighter Futures Survey: insight into smoking among young people in Thurrock

An annual survey called "Brighter Futures" is delivered in primary and secondary schools in Thurrock to assess the health, wellbeing and behaviours of children (Thurrock Council, 2018). Data from the survey is used by the schools to inform education and support programmes and by the council to inform commissioning of the School Wellbeing Service. It should be noted that the survey results do not represent all schools; for instance data for 2020 represents responses from 4 secondary schools and 23 primary schools. The irregular composition of the sample from one survey year to the next limits the conclusions that can be drawn about trends. Recent survey findings (2020) relevant to tobacco control intervention planning for children and young people in Thurrock are summarised below:

- Cigarettes:
  - Year 4 pupils were given a 'yes/no' answer choice for a question asking 'smoking: which statement describes you best'; 1% responded to say 'yes', however it is not known whether these pupils regularly smoke.
  - Year 7 and 9 pupils were given a scale to rate their smoking status; among year 7 pupils, 1% reported they had tried a cigarette and among year 9 pupils, 7% reported they had tried a cigarette. Zero year 7 pupils reported regular smoking / having quit regular smoking, while 1% of year 9 pupils reported smoking occasionally (less than one cigarette per week) and 1% reported having given up smoking.
  - The survey results across all year groups have varied widely regarding prevalence of having ever tried a cigarette in different school pupil

samples over time in Thurrock (2017-2020 samples varied from 18% prevalence to 3% prevalence of having tried a cigarette).

- Vaping:
  - Using the same question format as for smoking, 3% of year 4 pupils answered 'yes' to vaping. While 5% of year 7 pupils and 15% of year 9 pupils reported having tried vaping once or twice. No year 7 pupils reported more regular vaping use and 2% of year 9 pupils reported vaping occasionally and 2% reporting having given up vaping.
  - The survey results across all year groups have varied widely regarding having ever tried vaping in different samples over time; 2017 = 22%, 2018 = 16%; 2019 = 27%; 2020 = 6%.

- Marijuana use and exposure:
  - More males than females in year 9 reported having ever used cannabis (7% vs 5%). Fewer pupils had tried skunk; 1% of males and no females.

- Risk taking behaviour.
  - The survey assessed the correlation between risk taking behaviours among year 9 pupils. The findings identified that if a year 9 pupil has experience of any substance, they are more likely to have experience of other substances and of sex.
  - For smoking specifically, among pupils who had tried smoking, 75% had tried vaping (compared to 19% who hadn't tried smoking); 80% had tried alcohol (compared to 56% who hadn't tried smoking); 53% had tried drugs (compared to 8% who hadn't tried smoking) and 10% had sex (compared to 2% who hadn't tried smoking).

Implications of these findings for planning local interventions to stop smoking uptake among children and young people are:

- There is consistently higher prevalence of trying vaping and regular to occasional vaping than cigarette use; harm reduction communications among children and young people must take this into account.
- Primary schools as well as secondary schools must consider how to engage in prevention interventions for smoking since by year four, some pupils have already tried smoking, vaping and other risk taking behaviours.
- Tobacco control interventions for young people may be better framed as part of a more holistic offer covering all risk taking behaviours. Understanding the contributing factors is necessary to tailoring this appropriate to the needs.
- Children and young people's exposure to crime should also be considered in planning interventions for stopping smoking uptake. The relationship between illicit tobacco, underage sales for cigarettes, alcohol, e-cigarettes and drugs such as marijuana needs to be better understood and used to support children at highest risk of exposure to this.

Exposure to second-hand smoke

Children may be exposed to tobacco, even if they do not smoke; while 77% of smokers report they would not smoke at all if they were in a room with a child, in 2018, over half (55%) of young people reported exposure to second-hand smoke in their homes and 23% in cars. Interventions to reduce the risk of children and young people taking up smoking must also consider the home environment, to reduce their exposure to second-hand smoke but also because having household members stop smoking can lift families out of poverty (ASH, 2019b).

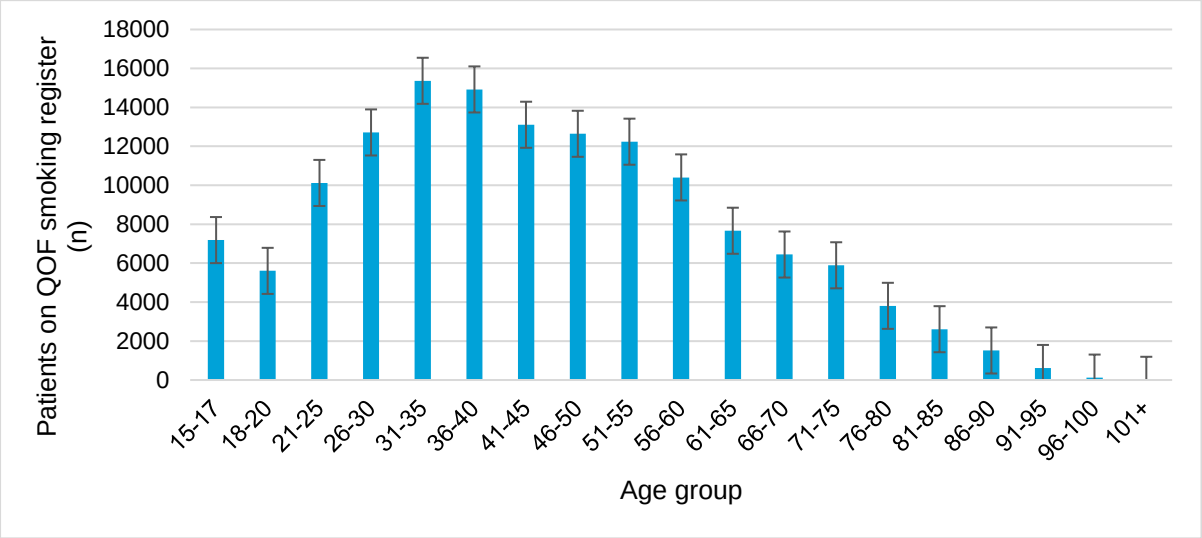
The next section discusses smoking prevalence among adult populations in protected characteristics groups.

5.9 Protected characteristics groups and smoking prevalence

This section explores smoking prevalence in groups with protected characteristics; pregnancy and maternity has already been discussed as this is a priority group for tobacco control. Local data has been used where possible and otherwise, national data are given to highlight groups that may have higher smoking prevalence locally.

- Gender: Smoking prevalence is divided equally among men and women in Thurrock, with a 50:50 split, similar to the demographic split in the Thurrock general population. This differs to the national picture where more men are recorded as smokers than women. Also, national data shows that prevalence by gender varies by age and ethnic group; this latter point should be especially considered in Thurrock when targeting services to certain communities by ethnic group as this is where gender differences are most pronounced (ASH, 2016). The data used here is based on GP records and does not represent all gender identities as recording of this is not sufficient for reliable estimates.
- Age: Figure 23 shows the age distribution of smokers in Thurrock, which peaks among people aged 31-35 and 36-40 and with relatively large numbers of people aged 41-60. This has implications for targeting stop smoking service availability (job seekers / employment settings with higher prevalence) and for secondary prevention. Lower prevalence in the age categories 21-30 could indicate a positive change in future prevalence as most smokers have started smoking by the age of 20.

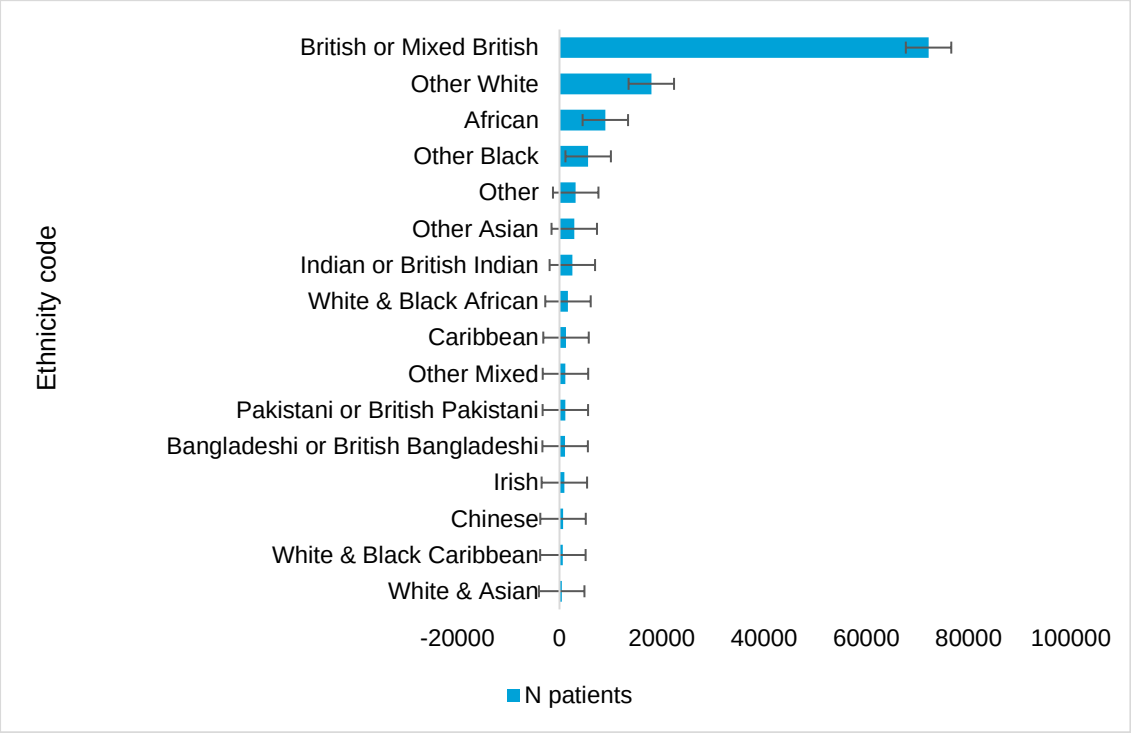
Figure 23: Age distribution of smokers in Thurrock (2021)



Source: Thurrock Council Public Health Intelligence team. QOF records February 2021

- Ethnicity Nationally, smoking prevalence is higher than average in Mixed (19.5%) and White (14.4%) ethnic groups and lower than average in Chinese (6.7%), Asian (8.3%) and Black (9.7%) ethnic groups.
- Analysis was performed using QOF coded data to assess prevalence among different ethnic groups in Thurrock. The data has its limitations as it presents only the ethnic code selected for a patient and may not fully represent their ethnic identity. Nonetheless, the data gives some indication of smoking prevalence across the ethnicity codes used in this analysis.
- Figure 24 shows that in Thurrock, most smokers are coded as 'British or Mixed British'. The next category contributing the most smokers is 'Other White'. These categories may mask higher prevalence among some sub populations. For example among the 'Other White' population, it is likely there is a high proportion of people from countries with higher smoking prevalence compared to the UK such as Poland, which has a prevalence of 28.2% (ASH, 2019D). This data also does not show use / prevalence of other tobacco products; for example national data indicates that 7% of the South Asian population use chewed or sucked tobacco, particularly of Bangladeshi ethnicity (12%) compared to 1% of the white population (ASH, 2019D). Smoking prevalence varies among genders within ethnic groups and there may be particularly high prevalence in some sub categories. Local insight from qualitative, community based work should be used to identify communities who are recent migrants and for whom there may be more exposure to smoking or groups among whom use of other tobacco products may be higher.

Figure 24: Percentage of smokers by ethnic group in Thurrock (2021)



Source: Thurrock Council Public Health Intelligence team. QOF records February 2021

- Religion: National data indicates that people who identify as having no religion are significantly more likely to smoke than people who have any other religion (ONS, 2020).
- Disability: at the time of writing this needs assessment, no national data was identified regarding physical disability and smoking prevalence.
- Nationally, the population living with a learning disability are identified as a priority group regarding smoking, although data on prevalence in this population is not available. The local LeDeR report indicates that smoking is particularly prevalent in the older population living with a learning disability, who spent time in long stay institutions. This addiction is very challenging to change among this group and even people living independently in the community may not be able to access the mainstream stop smoking service offer. People with a learning disability are offered an annual health check but coding on GP registers of people having a learning disability is not sufficiently accurate to allow assessment of smoking prevalence in this population. Work must be undertaken locally to gain insight into the fit of the current service offer with need.
- Gender reassignment: Smoking prevalence among transgender people is higher than the general population but there is no recent evidence to suggest the scale of this. A 2012 survey indicated that 56% of transgender participants reported they had smoked at some point in their lives (McNeil, 2012).
- Sexual orientation: Smoking prevalence is higher among lesbian, gay and bisexual people; rates are highest among bisexual men (26.7%) and LGB women (25%) (ASH, 2019c).

- Marriage and civil partnership: national survey data suggests married adults and those who are widowed / divorced are the least likely to be current smokers. Prevalence is higher and similar for those who are cohabiting or single (ONS, 2020).

This section has so far discussed prevalence of smoking cigarettes, which is based on data reported by members of the public through surveys and modelling estimates. Of the cigarettes purchased, a share will be those classed as illicit tobacco; the next section summarises evidence of the scale of this.

5.10 Scale of illicit tobacco

It is important to consider illicit tobacco in this needs assessment because it blunts the effectiveness of tobacco duty as a tool to reduce prevalence; it tends to be sold at a lower cost and since cigarette smoking is an addiction that is sensitive to price, this has an impact on demand (ASH, 2017). Also, understanding the scale of illicit tobacco supply has implications for wider social impacts associated with crime, which are discussed elsewhere in this document. While it is not possible to estimate the proportion of smokers who use illicit tobacco, the scale can be understood to some extent through estimates from Her Majesty's Revenue and Customs (HMRC) and local data from seized goods.

HMRC data indicates that the illicit market share for cigarette sales decreased to 9% in 2017/18 from 15% in 2016/17. The illicit market share for hand rolled tobacco increased to 32% from 27% in 2016/17 (ONS, 2019).

This data is not available locally, however Thurrock's Trading Standards Team seized 32,255 illicit and counterfeit cigarettes and 8.5kg of counterfeit hand rolling tobacco in 2019/20. For illicit and counterfeit cigarettes, these quantities would be sufficient to supply approximately ten cigarette smokers smoking the average number of cigarettes per day (nine) (ASH, 2021) for a year. It isn't possible to estimate the equivalent for hand rolled tobacco as there isn't sufficient quality data on the average amount used per cigarette. This data only shows the amount of illicit tobacco that was seized and therefore still doesn't allow estimation of the true scale of illicit tobacco circulating in Thurrock. The Trading Standards team report that much of the illicit tobacco trade in Thurrock is concentrated in Grays town centre

This is a challenging aspect of tobacco control to thoroughly quantify but these data show its supply is present in Thurrock and work needs to continue to stop this to increase the effectiveness of the overall strategic approach.

The next section of this needs assessment will discuss the impact of smoking and more broadly tobacco on the health of the Thurrock population. Emphasis has been given to the health of smokers as this is the group most directly impacted by smoking, but where data on second hand smoke harm or other tobacco harm is available, this has been included. The health impact is mainly expressed in terms of physical health but social health and economic impacts are also discussed. Mental health impacts are not discussed. This is because most data and evidence regarding the impact of smoking is concerned with physical health, mainly because it is the most direct impact.

6 Impact of smoking

6.1 Impact of smoking in the UK

Smoking continues to be the leading cause of premature[4] and preventable[5] death in England, responsible for more deaths than obesity, alcohol, drug misuse, road traffic accidents and HIV combined (PHE, 2020d), (ONS, 2019b). It is also the largest single contributor to health inequalities, accounting for half the difference in life expectancy between those living in the most and least deprived communities. The impacts of tobacco on health are felt at all ages, from low birth weight, to respiratory disease in childhood and increased risk of infectious and non-communicable diseases in adulthood. It also has social health risks such as the relationship between illicit tobacco and crime and antisocial behaviour associated with second hand smoke. This chapter explores the impact for Thurrock on mortality, morbidity, inequalities and the local economy.

6.2 Overview of the health impact of smoking on the Thurrock population

Table 3 summarises the overall impact of smoking in Thurrock; the data shows that Thurrock's high smoking prevalence translates into significantly higher smoking attributable mortality, premature mortality (measured by years of life lost (YLL)) and hospital admissions than the England average.

Table 3: Summary of smoking impact in Thurrock

Impact Measure	Thurrock	England	% difference
Smoking attributable mortality per 100,000 (2016-18)	**313.0**	**250.2**	**25% higher mortality**
Potential YLL due to smoking related illness per 100,000 (2016-18)	**1,478**	**1,313**	**13% higher rate of YLL**
Inequality in life expectancy at birth (years) (males) (2016-18)	**8.4**	**9.5**	**13% smaller gap in life expectancy**
Inequality in life expectancy at birth (years) (females) (2016-18)	**7.4**	**7.5**	**1% smaller gap in life expectancy**
Smoking attributable hospital admissions per 100,000 (2018/19)	**2,050**	**1,612**	**27% more hospital admissions**

(A red cell represents worse rates than the England average, blue represents better).

Source: PHE Fingertips Tobacco Control Profiles

[4] deaths before the age of 75

[5] deaths that could mainly be avoided through effective public health and primary prevention interventions

Table 3 also shows that Thurrock has a smaller gap in life expectancy compared to the England average for males and females; this is more pronounced for males. There are many factors that contribute to the gap but smoking is the largest single contributor. Thurrock's smoking prevalence is more distributed across socio-economic groups, meaning the impact is not only concentrated in the most deprived areas, which could partly explain this figure.

Figure 25: Attributable mortality in Thurrock and England

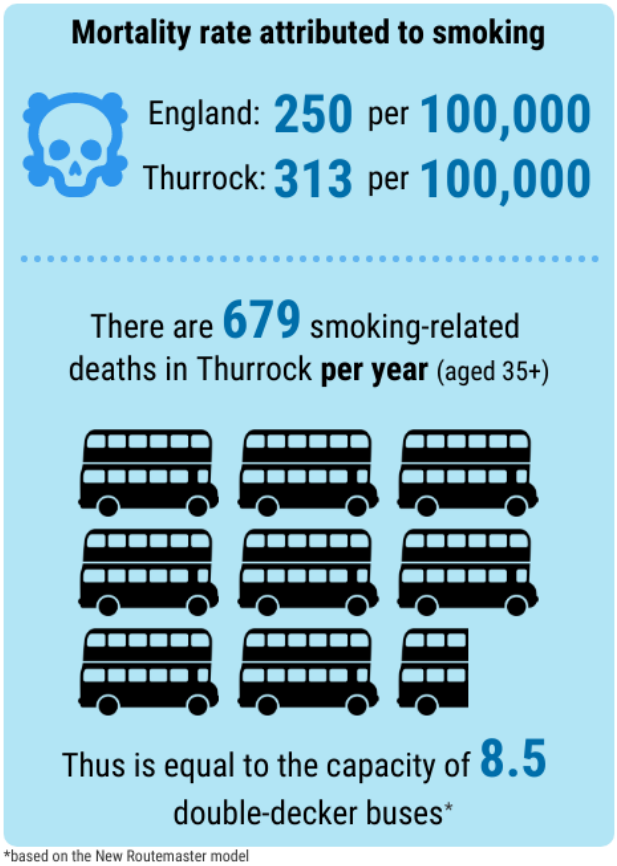


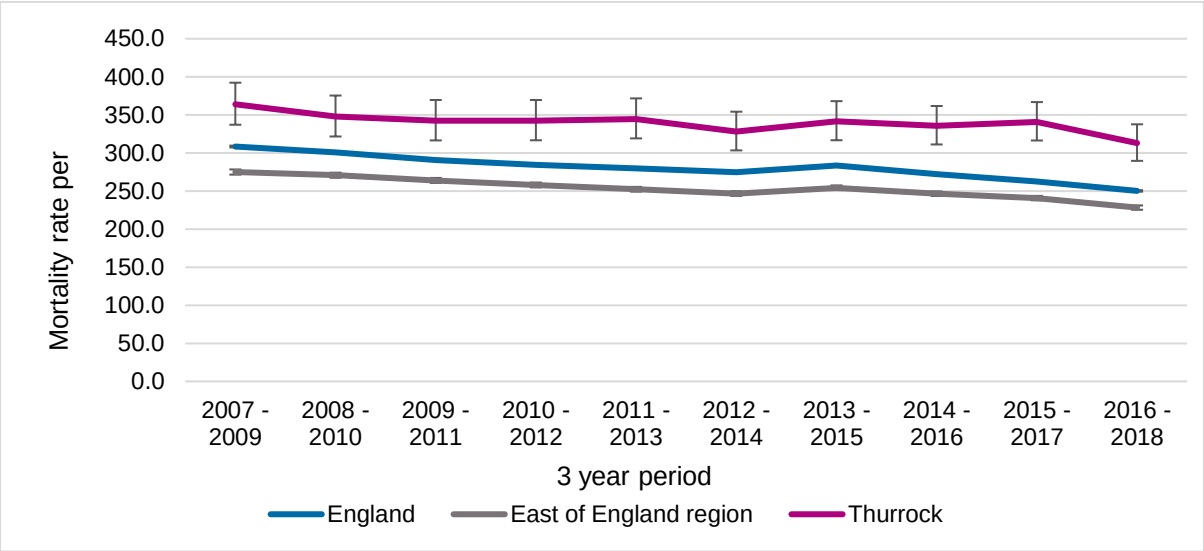
Figure 25 illustrates the scale of smoking related deaths each year in Thurrock. The number of deaths is the equivalent to filling the seating capacity of eight and a half double-decker buses (seating 80 passengers each).

While the gap in life expectancy at birth is smaller in Thurrock compared to the England average, children born in Thurrock's most deprived areas are predicted to live 8.4 years (males) and 7.4 years (females) less than those living in the least deprived areas. Reducing the prevalence of smoking in these communities is essential to reducing inequities in life expectancy, as well as a range of other measures of health that will be discussed in this section.

Smoking attributable mortality

Thurrock had 25% more smoking attributable deaths than the England average in the most recent reporting period (2016-18), with a rate of 313 deaths per 100,000, which is equivalent to 679 deaths a year. Trend analysis shows that Thurrock has consistently had significantly higher smoking attributable mortality than the England and East of England averages (see figure 26).

Figure 26: Trend in smoking attributable mortality per 100,000 population in Thurrock, East of England and England 2007 to 2018

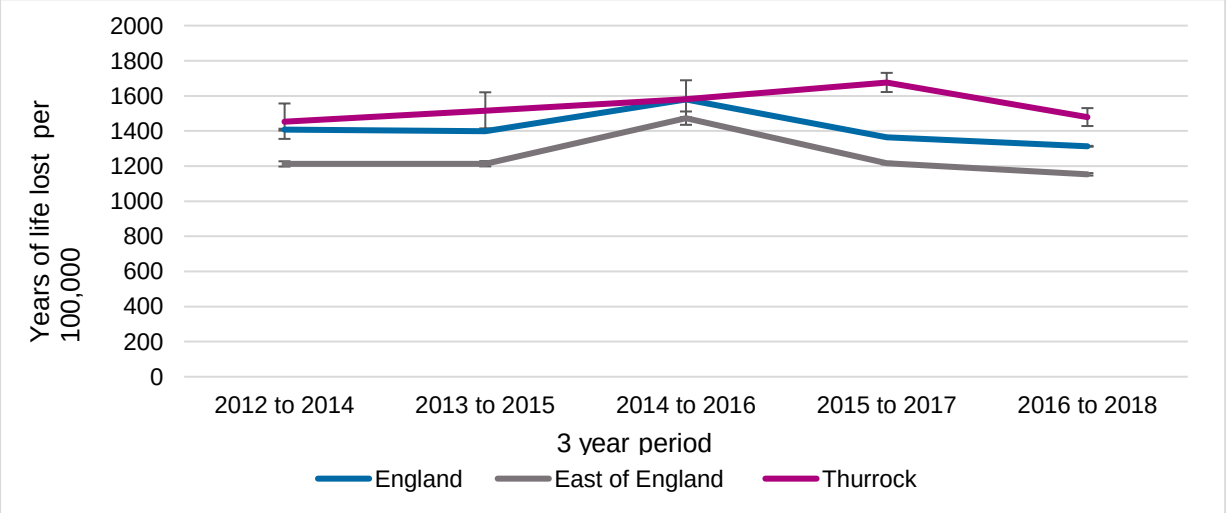


Source: PHE Fingertips Tobacco Control Profiles (PHE, 2020)

Years of life lost (YLL) due to smoking

YLL is a measure of premature mortality, which summarises the number of years lost among people aged 35+ who die of smoking related disease before the age of 75. Between 2016 and 2018, 3,306 years of life were lost due to smoking among the Thurrock population aged under 75 (at a rate of 1,478 per 100,000 population). Until the most recent reporting period, the trend was increasing for this statistic in Thurrock (figure 27). It is promising that the trend may be reversing but Thurrock continues to lose many years of life in the under 75 population due to its high smoking prevalence and in the last two reporting periods this has been significantly higher than the England and regional averages.

Figure 27: Trend in years of life lost per 100,000 population in Thurrock, East of England and England 2012 to 2018

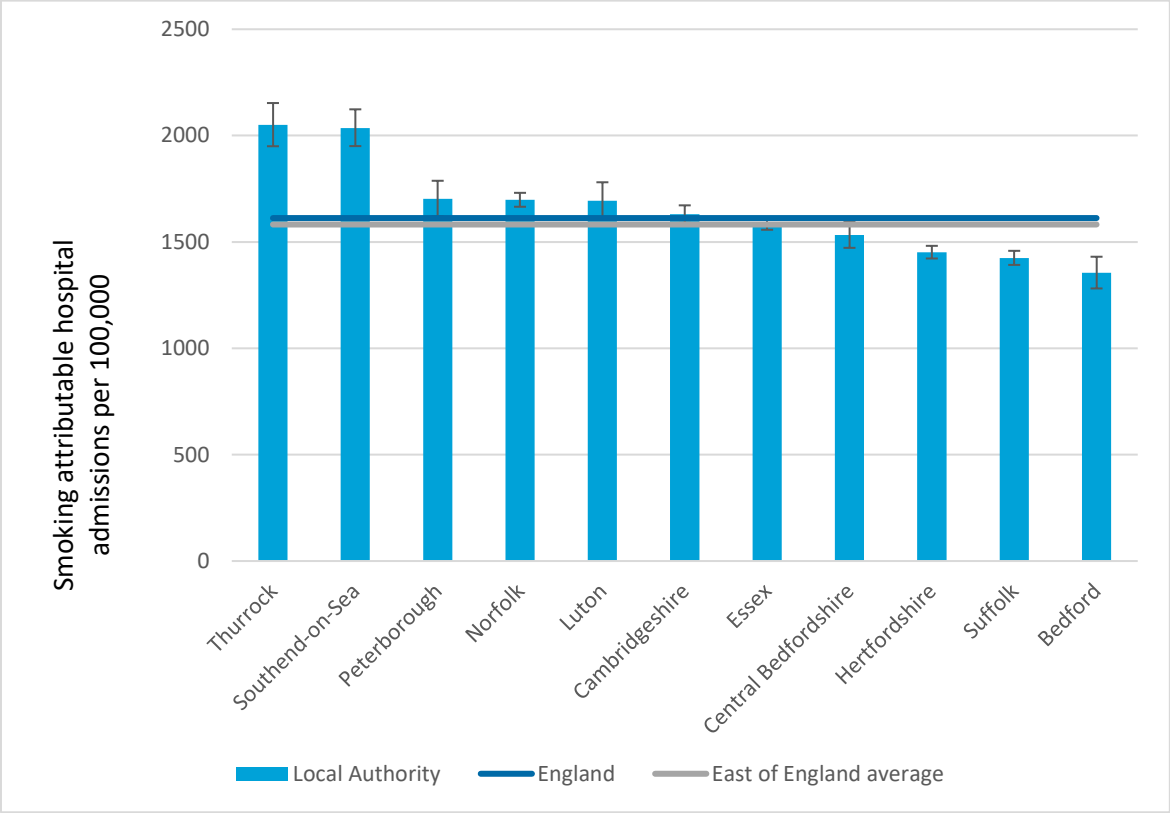


Source: PHE Fingertips Tobacco Control Profiles

Smoking attributable hospital admissions and cost per capita of smoking attributable hospital admissions

These statistics indicate the impact of preventable smoking-related conditions on inpatient hospital services and are an indicator of smoking related morbidity. Thurrock has 27% more smoking attributable hospital admissions than the England average and along with Southend-on-Sea, the highest rate among its CIPFA neighbours and in the East of England (figure 28).

Figure 28: Smoking attributable hospital admissions in the East of England by area of residence (2018)



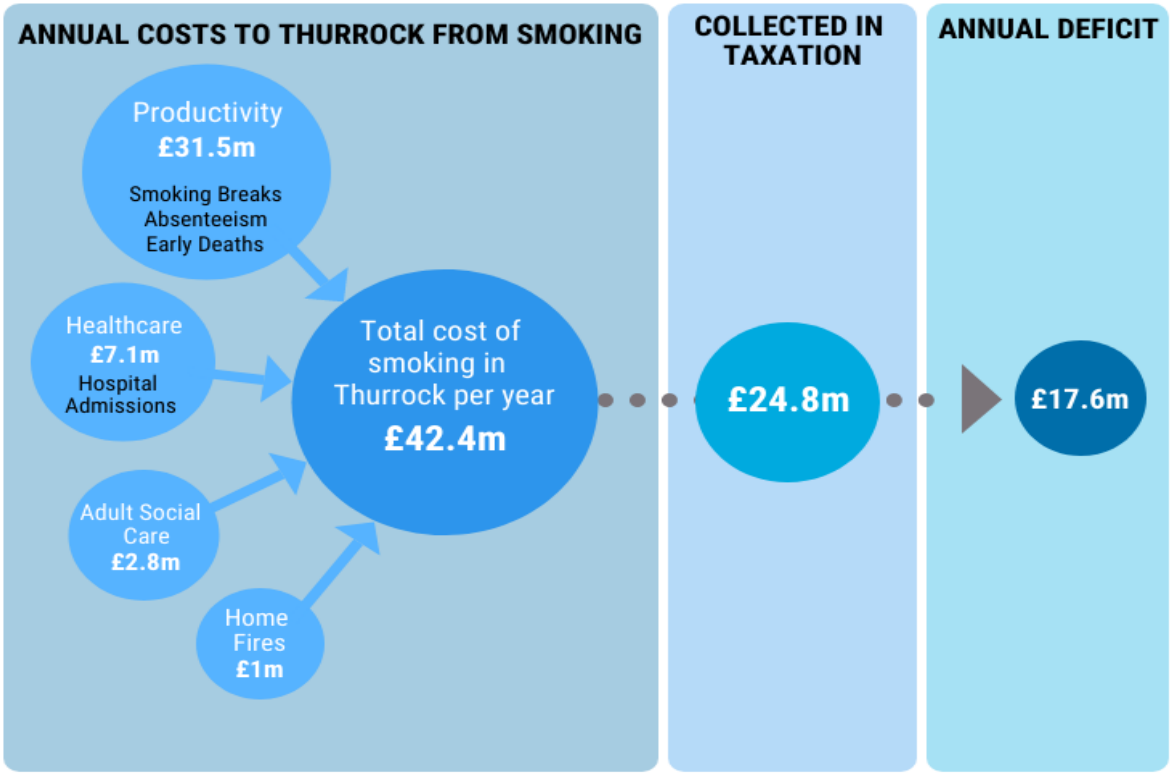
Source: PHE Fingertips Tobacco Control Profiles

Thurrock spends £9 more per capita than the best performing CIPFA neighbour on smoking attributable hospital admissions (Thurrock = £33.20 per capita, compared to Bedford = £24.20 per capita in 2016/17, the most recent reporting period). If Thurrock had the same cost per capita as Bedford, it would have spent almost £800,000 less on smoking attributable admissions in that year.

6.3 Financial impact of smoking related harm in Thurrock

Smoking costs the Thurrock economy approximately £42.4 million per year. While £24.8 million is raised through taxation of tobacco products, the costs associated with smoking related illness are over one and a half times the amount of the duty raised, creating a net annual deficit to society of £17.6m (figure 29).

Figure 29: Estimated cost of smoking to the local economy



Source: ASH Ready Reckoner, (2019) (ASH, 2019e)

The adult social care associated costs were recently updated by ASH based on new data and modelling (ASH, 2021d). For Thurrock the service and residential social care costs associated with smoking for 2021 are estimated to be over £3.8 million. In addition, the ASH model estimates that there are approximately 3,505 people receiving unpaid care from friends and family for smoking – attributable needs; if this care was purchased from formal services, it is estimated the cost would be over £26 million per year.

Figure 30: Costs to smokers

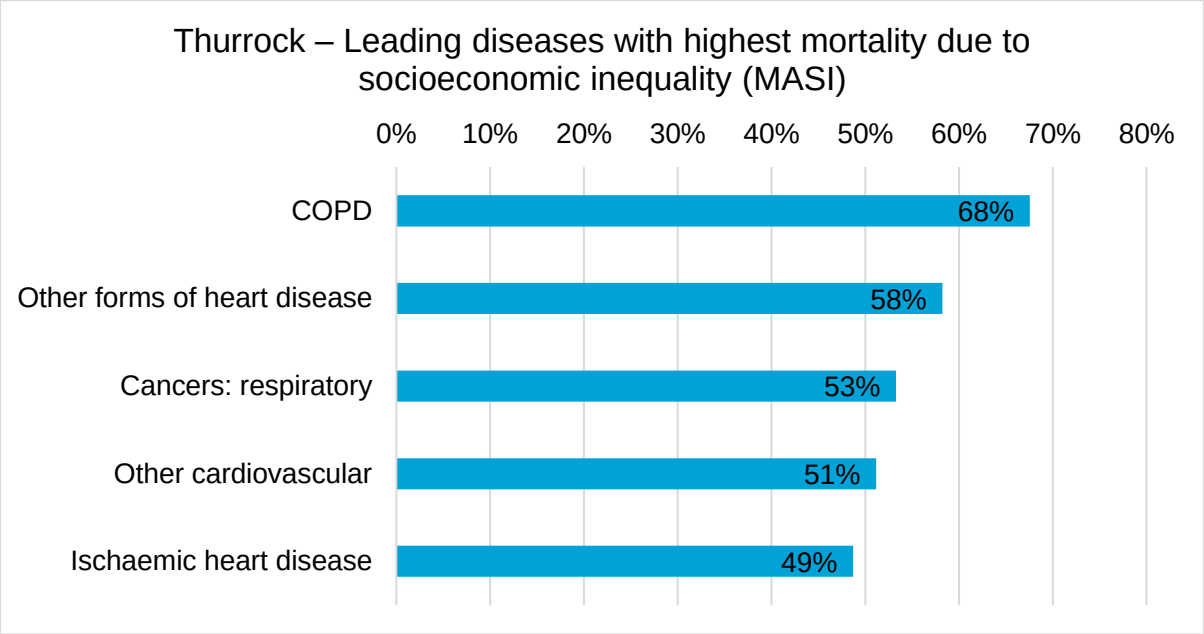
Smoking also impacts household budgets; the cost of smoking 20 cigarettes a day equates to almost £4,000 a year (figure 30). Smoking has become 30% less affordable than in 2008. Although tobacco use impacts the health of people across the socio-economic gradient, the financial burden is greatest for those on low income. The next section shall explore the impact of tobacco use on inequalities, including the health and financial implications.

6.4 Impact of smoking on health inequalities in Thurrock

The effect smoking has on health regardless of socio-economic group is so large that non-smokers in the most deprived areas live longer than smokers in the least deprived areas. Thus, while work to address the root causes of health inequalities is important, addressing smoking offers the fastest route to reduce health inequalities due to the scale of impact it has on survival. Smoking accounts for half the difference in life expectancy at birth between the most and least deprived population groups. In Thurrock, the total difference in life expectancy at birth is 8.4 years for males and 7.4 years for females; smoking will be a contributing factor to this difference.

Figure 31 shows the proportion of premature deaths (deaths before the age of 75) that are attributable to socioeconomic inequalities in Thurrock; COPD and heart disease are the main causes. If everyone in Thurrock had the same risk of death as people living in the least deprived district nationally, there would be 68% fewer premature COPD deaths and 58% fewer premature heart disease deaths in Thurrock. Given the strong association between smoking and deprivation, and between smoking and these conditions, this figure also indicates the potential scale of improvement that could be made in reducing premature mortality if smoking prevalence was reduced.

Figure 31: Proportion of premature deaths due to socioeconomic inequality (2020)



Source: Thurrock Council Population Health MSE analysis 2021

Compared to the other districts in the MSE HCP, of all the total attributable deaths to socioeconomic inequality, Thurrock has the highest number due to circulatory disease, and third highest due to Cancer. Thus, addressing the high smoking prevalence in Thurrock will be an important strategic opportunity to reduce premature deaths for MSE.

Tobacco use also impacts on people's lives through household expenditure. Almost 15% of social renters are likely to be living in poverty as a result of smoking (compared to 7% of home owners and 6% of private renters) (ASH, 2019d). Locally, regardless of smoking status, approximately 52.9% of Thurrock households are not likely to meet the affordability requirements to purchase the smallest types of property available on the housing market. For those renting, a claimant in an average one bedroom private rental property would have an annual shortfall of £1,872 between the cost of renting and the amount of Housing Benefit or Universal Credit housing element. As highlighted earlier in this needs assessment, smoking 20 cigarettes a day costs a household £3,942 a year; supporting people to stop smoking can therefore also help protect them from debt and insecure housing (Thurrock Council, 2020).

Tobacco impacts health inequalities across other groups where smoking prevalence is higher such as people living with a mental illness, LGBTQ communities, people who have a learning disability (ASH, 2019). At the time of writing this needs assessment, local data was not available on health outcomes and morbidity associated with tobacco for all these sub populations.

For mental illness there is data regarding premature mortality in adults with severe mental illness (SMI); for Thurrock the premature mortality rate among people with an SMI is higher than the England average (159.6 per 100,000 population compared to the England average of 90.5) (2015-17). Although smoking is not the only factor contributing to this inequality, it is a major contributor.

The evidence showing the impact of tobacco on health in the general population is strong and suggests worse health can be expected among all groups with higher smoking prevalence.

The next sections discuss the impact of tobacco on respiratory and cardiovascular health as smoking has a particularly strong impact on these aspects of physical health.

6.5 Respiratory health impacts of smoking in Thurrock

Smoking is a leading cause of most respiratory diseases and second-hand smoke also impacts the respiratory health of people exposed to it, even for short periods of time (ASH, 2020e). It is estimated that in 2017, 37% of all deaths from respiratory diseases in England were attributable to smoking. Lung cancer and COPD account for approximately one quarter of the excess mortality among smokers. The recent COVID-19 pandemic has highlighted the risk smokers' face to infectious diseases every year. For example, smokers are twice as likely to get pneumonia compared to non-smokers and children living in household where someone smokes are also at risk. Smoking is also a risk factor for TB and relapse of TB after treatment. Table 5 summarises how Thurrock is performing against some key respiratory impact measures and shows generally, Thurrock has higher prevalence and worse outcomes for these measures.

Table 5: Summary of respiratory measures relevant to tobacco control

Respiratory Impact Measures (metrics represented per 100,000 population)	Thurrock	England	Difference (per 100,000)
Mortality rate from lung cancer	73.5	53.0	+ 20.5 deaths
Lung cancer registrations	104.2	77.9	+ 26.3 registrations
Mortality rate from COPD	66.0	50.4	+ 15.6 deaths
Emergency hospital admissions for COPD	493	414	+79 admissions
Hospital admissions for asthma (under 19 years) (2018/19)	98.4	178.4	-80 admissions

Source: PHE Public Health Profiles (PHE, 2020c)

Table 6 shows the relative risk (RR) of respiratory diseases for people who currently smoke; for example the RR for Lung Cancer of 10.9 suggests smokers are almost 11 times more likely to develop lung cancer compared to non-smokers. The table shows there are a range of other respiratory diseases that impact smoker's health more than non-smokers.

This impacts the health and longevity of smokers and healthcare resource; for instance, smoking is attributable for 21% of all respiratory disease hospital admissions (ONS, 2020B).

Table 6: Estimated RR for respiratory disease (95% CI) for current smokers relative to non-smokers

Disease	RR (95% CI)
Lung Cancer	10.9 (8.3 – 14.4)
Influenza (microbiologically confimred)	5.7 (2.8 – 11.6)
COPD	4.0 (3.2 - 5.1)
Pneumonia	2.2 (1.7 – 2.8)
Obstructive Sleep Apnoea	2.0 (1.0 – 3.8)
Asthma	1.6 (1.1 – 2.4)
Idiopathic Pulmonary Fibrosis	1.6 (1.3 – 2.0)
Tuberculosis	1.6 (1.2 – 2.1)
Influenza (clinically diagnosed)	1.3 (1.1 – 1.6)

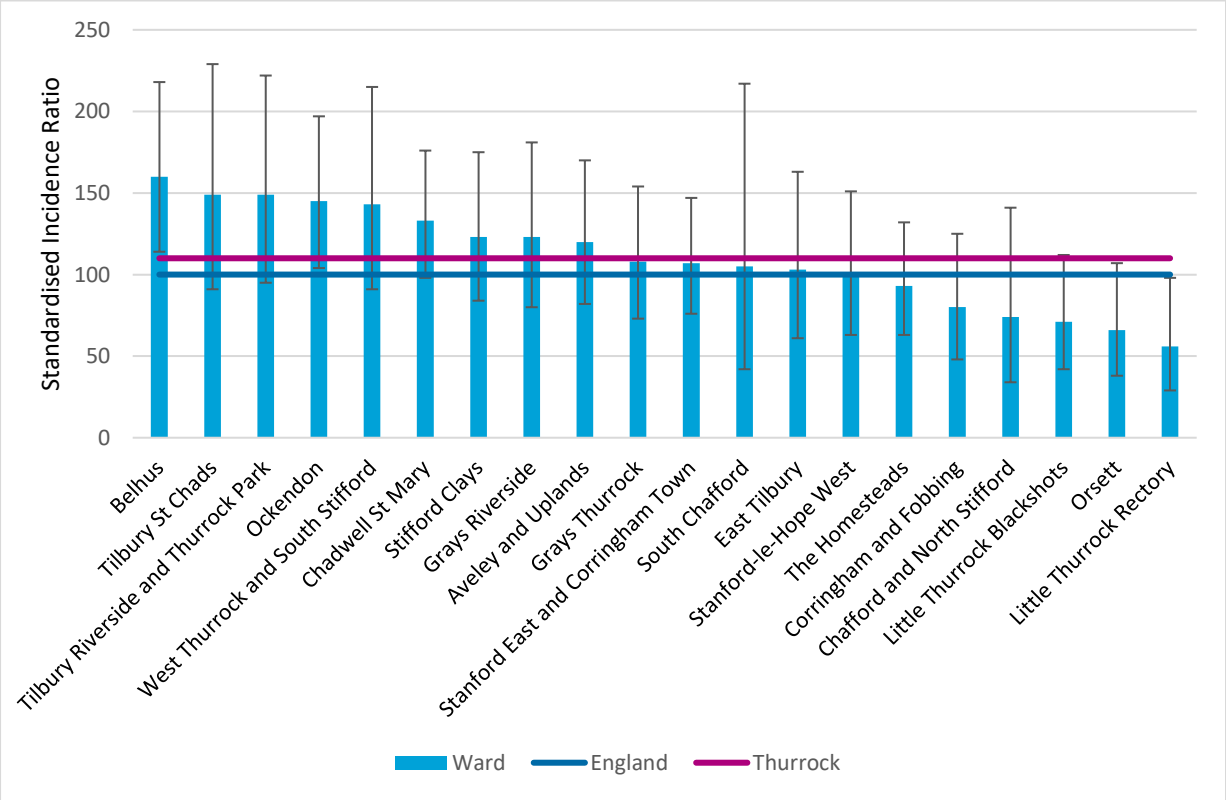
Source: PHE Atlas of variation in risk factors and healthcare for respiratory disease in England (PHE, 2019)

Lung Cancer:

Tobacco use is the biggest cause of lung cancer in the UK, responsible for over 72% of cases of lung cancer (ASH, 2020e). Current smokers are 11 times more likely to develop lung cancer compared to non-smokers. The longer someone has quit smoking, the lower their risk and the younger people quit, the more pronounced their risk reduction for lung cancer is (ASH, 2020e). Quitting smoking is the most effective way for people diagnosed with early-stage lung cancer who smoke to improve outcomes including survival and better general health (ASH, 2020e). Evidence suggests smoking relapse is a significant issue for lung cancer patients with recent smoking histories (ASH, 2020e).

Thurrock has a 10% higher incidence of lung cancer than would be expected if it had the same age and gender profile as England (standardised incidence ratio (SIR) = 110). Figure 32 shows that one ward in Thurrock has significantly higher incidence than the Thurrock SIR (Belhus) and another higher than the England SIR (Ockenden). The error bars for this indicator are very wide because the number of cases of lung cancer is low, which impacts the accuracy of the SIR.

Figure 32: Lung cancer standardised incidence ratio (SIR) for wards in Thurrock compared to the Thurrock average



SOURCE: PHE Fingertips Public Health Profiles

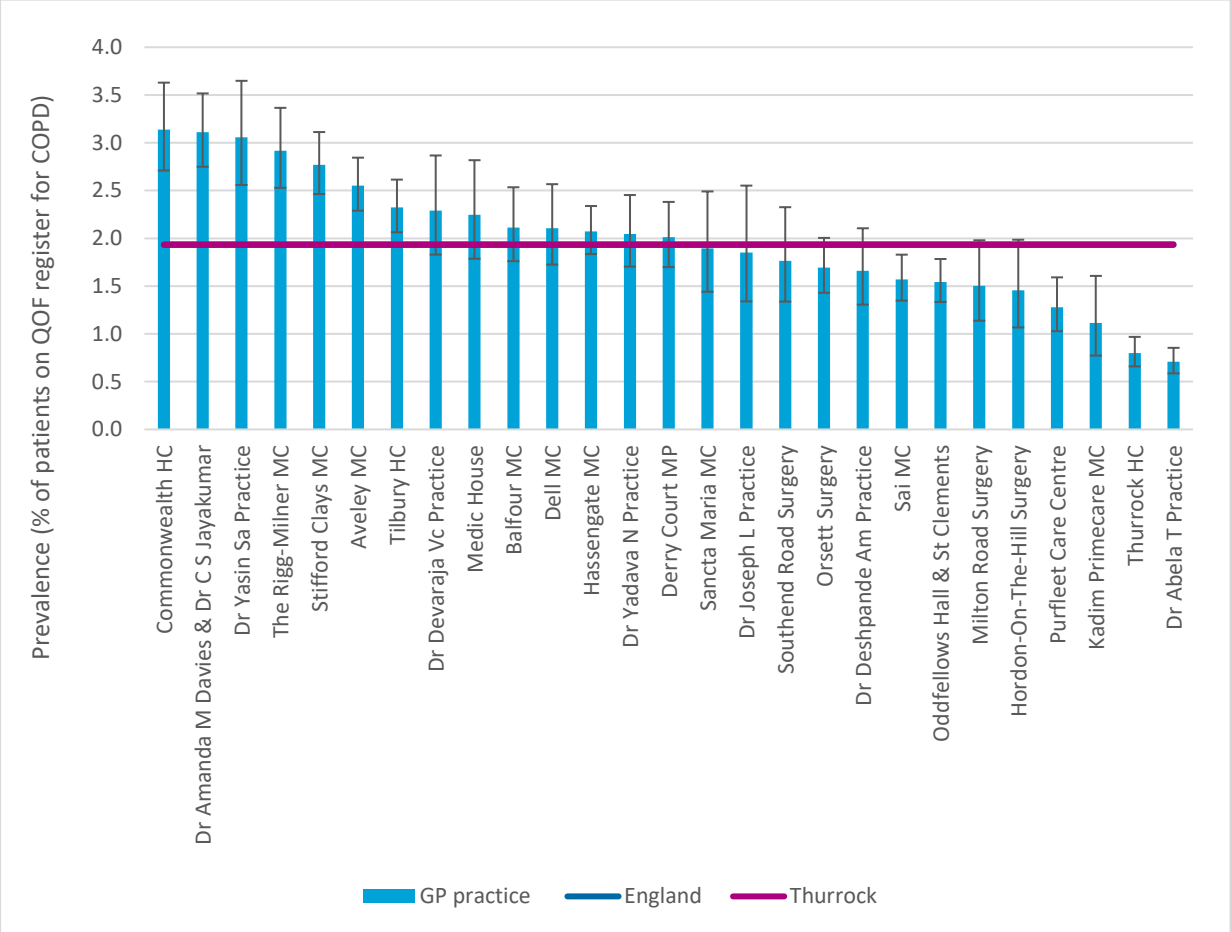
Chronic Obstructive Pulmonary Disorder (COPD):

COPD is predominantly caused by active or second-hand tobacco smoke exposure, although occupational exposures and air pollution are also risk factors. Current smokers are four times more likely to develop COPD, around half develop some sort

of airflow obstruction and 10-20% develop clinically significant COPD (ASH, 2020e). Most COPD deaths are caused by smoking (80%). The impact of second-hand smoke is also a significant risk factor for non-smokers. Survey data suggests smokers living with COPD tend to be more addicted to cigarettes and have no greater interest than other smokers in trying to quit smoking. Yet quitting smoking is more effective than all known pharmacological treatments for COPD and can reduce the severity of COPD symptoms (ASH, 2020e).

Thurrock CCG's COPD QOF prevalence is 1.9%, the same as the England average for 2019/20. This equates to approximately 3,512 patients diagnosed with the condition; there has been little change in this indicator since the previous year (PHE, 2020c). Seven GPs in Thurrock have a significantly higher QOF COPD prevalence compared to the England and Thurrock average (Figure 33). COPD is underdiagnosed and high prevalence in some practices may be in part due to efforts to identify and support patients with COPD. Higher prevalence may also be associated with higher smoking prevalence; of the seven practices with significantly higher COPD prevalence four had higher QOF smoking prevalence in 2018/19 (Commonwealth Health Centre, Dr Yasin Sa Practice, Aveley Medical Centre, Tilbury Health Centre).

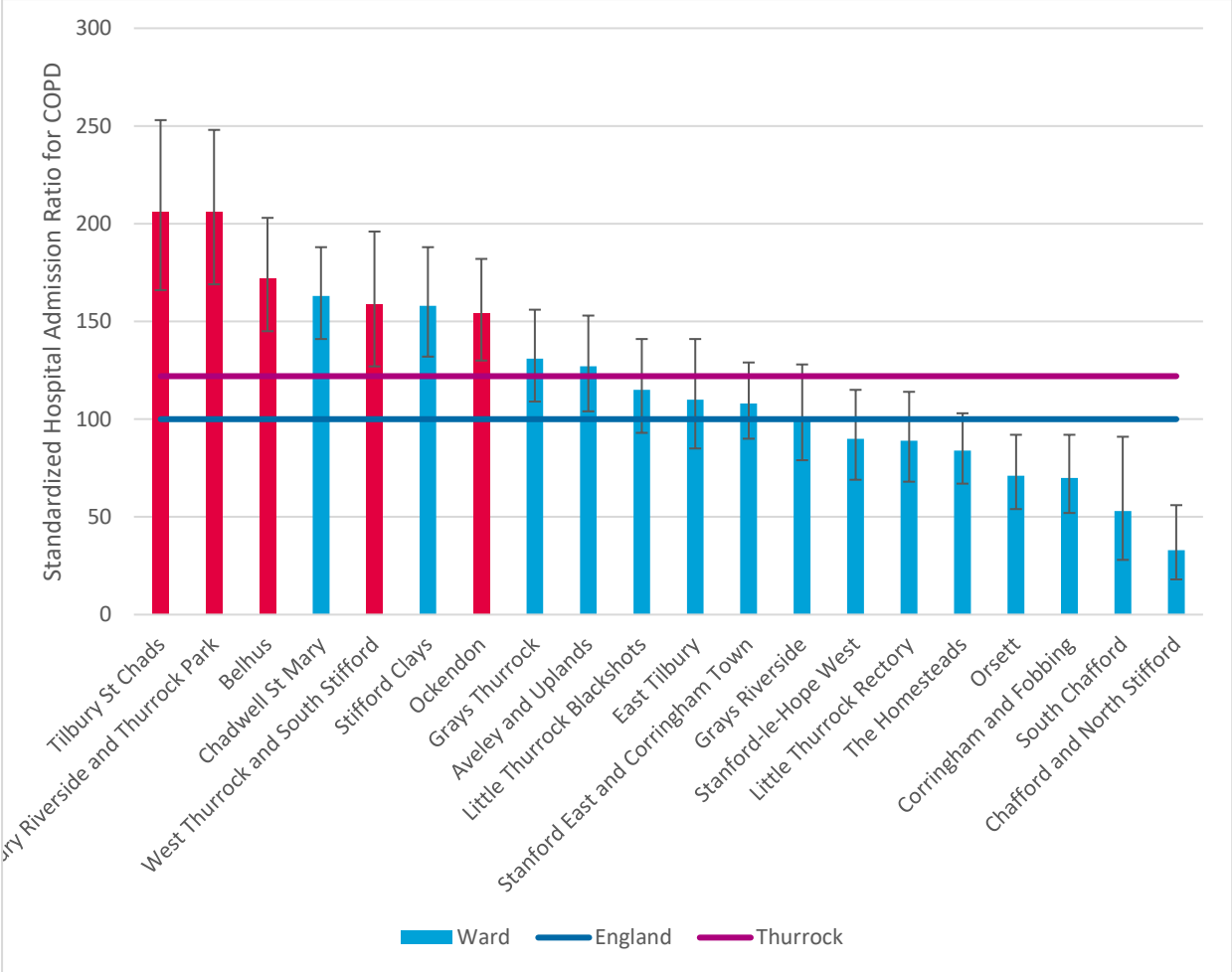
Figure 33: QOF prevalence of COPD in Thurrock GP practices (2019/20) compared to the Thurrock and England average



SOURCE: PHE Fingertips Public Health Profiles

The Standardized Hospital Admission Ratio (SAR) for Chronic Obstructive Pulmonary Disease (COPD) in Thurrock is 121.9 (2013/14-2017/18) (PHE, 2020c). The SAR indicates Thurrock has almost 22% more hospital admissions for COPD than would be expected if it had the same age and gender profile as England; this is also statistically significantly higher. Thurrock has one of the highest COPD related hospital admissions relative to its population structure in the East of England (average EoE SAR: 85.6, highest Luton SAR: 136.5, lowest North Norfolk SAR: 51.8). Management of the condition in primary care and the community can reduce the risk of hospital admissions for COPD, including stopping smoking. Eight wards in Thurrock have significantly higher SAR for COPD compared to the England average (figure 34). These are Tilbury St Chads, Tilbury Riverside and Thurrock Park, Belhus, Chadwell St Mary, West Thurrock and South Stifford, Stifford Clays, Ockendon, Grays Thurrock. The wards that also have significantly higher smoking prevalence than the Thurrock average are coloured red (n=5/8).

Figure 34: Standardized Hospital Admission Ratio (SAR) for Chronic Obstructive Pulmonary Disease (COPD) in Thurrock wards compared to Thurrock average (all compared to England reference = 100)



SOURCE: PHE Fingertips Public Health Profiles

6.6 Cardiovascular impacts

It is estimated that 14% of deaths from heart and circulatory disease are attributable to smoking (ASH, 2016b) and compared to non-smokers, smokers have a two to four times increased risk of developing heart disease or having a stroke. The risk of mortality from cardiovascular diseases is higher the younger a person started to smoke, independent of the number of years they smoked. The reduction in smoking prevalence between 1981 and 2000 has been attributed to almost half of the decline in coronary heart disease mortality in England and Wales during this period.

Stopping smoking is an important secondary prevention intervention; prognosis for CHD and stroke patients who quit smoking is better than those who continue (ASH, 2016b).

The risk of second hand smoke is also important in considering cardiovascular disease risk; the 2004 report of the Government appointed Scientific Committee on Tobacco and Health (SCOTH) found that exposure to second-hand smoke is a cause of heart disease. The Committee estimated that there is an increased relative risk (RR) of about 25%.

Smoking also impacts on cardiovascular related hospital admissions; 16% of admissions for cardiovascular diseases most associated with smoking are attributable to smoking.

Table 6 shows that Thurrock has a higher rate of smoking attributable deaths for heart disease (29.4 per 100,000) and stroke (8.4 per 100,000) compared to the England average.

Table 6: Cardiovascular disease impact measures associated with smoking

Cardiovascular Impact Measures	Thurrock	England	Difference
Smoking attributable deaths from heart disease per 100,000 (2016-18)	**29.4**	**22.9**	**+6.5 deaths / 100,000**
Smoking attributable deaths from stroke per 100,000 (2016-18)	**8.4**	**7.7**	**+0.7 deaths per 100,000**

Source: PHE Public Health Profiles (PHE, 2020c) (yellow indicates non-significant difference to England)

This section and the last have demonstrated the extent of impact smoking has on deaths, morbidity and healthcare use, focussing on respiratory and cardiovascular impacts. The evidence regarding such impacts makes a strong case for supporting people to stop smoking throughout their life course and along care pathways, including secondary and tertiary prevention.

The next section considers the impacts of smoking on children and young people.

6.7 Children and young people

The largest impacts of tobacco relevant to children and young people include direct health risks from exposure to second hand smoke and increased risk of taking up smoking. Both have lifelong health impacts.

Almost a third (30%) of all deaths from second-hand smoke occur in children, with the largest disease burden due to lower respiratory infections in children aged under 5 years (ASH, 2020e). Evidence suggests the lungs may not recover completely from early life exposure, whether that be development of conditions such as asthma that can be caused by second-hand smoke exposure or development of COPD in later life (ASH, 2020e). More immediate impacts on children include factors such as school days missed due to ill health. For instance, children who suffer from asthma, and whose parents smoke, are twice as likely to suffer asthma symptoms all year round compared to the children of non-smokers (ASH, 2020e).

There are numerous other health impacts associated with smoking during pregnancy and in early childhood. Some of the most strongly associated impacts are summarised in table 7 for Thurrock compared to the England average. For premature birth, low birth weight of term babies and hospital admissions for asthma among people aged under 19, Thurrock has similar performance to the England average. It is challenging to quantify the association of this performance with exposure to second hand smoke as this data is not routinely collected. A promising sign is the relatively low smoking prevalence among pregnant women in Thurrock compared to England. However this data may mask inequalities in some sub populations such as families living in more deprived areas and children growing up with parents who have a diagnosed mental illness, which are groups with higher smoking prevalence.

Table 7: summary measures of tobacco impact on children and young peoples health

Early years Impact Measures	Thurrock	England	Difference
Premature births (less than 37 weeks) (2016-18)	83.9 per 1,000	81.2 per 1,000	+2.7 per 1,000
% term babies born as low birth weight babies (2019)	2.5%	2.9%	-0.4%
Hospital admissions for asthma (under 19 years) (2019/20)	171.9 per 100,000	160.7 per 100,000	11.2 per 100,000

Source: PHE Tobacco Control Profiles (PHE, 2020)

The next section discusses wider social impacts of tobacco across the population.

6.8 Wider social impacts

Beyond the physical health impacts of tobacco, there are wider societal harms and costs to services. Some examples are summarised below:

- Social care need: Smokers on average need social care support ten years earlier than never smokers.

- Risk of death from fire: Essex County Fire and Rescue Service (ECFRS) attend roughly eight smoking-related house fires each year in Thurrock. House fires caused by cigarettes are more likely to result in death and serious injury than due to other causes.

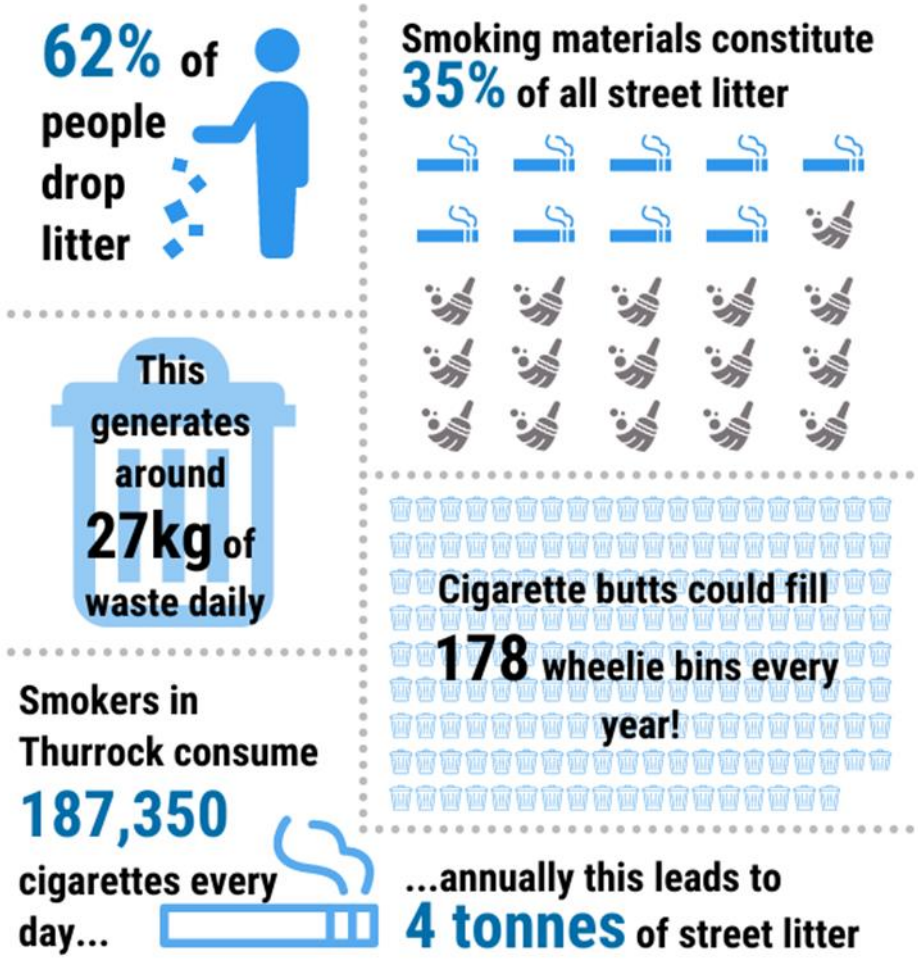
- Modern slavery: there is evidence nationally to suggest some people who are suffering modern slavery are involved in illicit tobacco sales; cases have not been identified in Thurrock but risk factors for Modern Slavery have been identified and associated with organised crime groups supplying illicit tobacco.

- Self-neglect: Cases of self-neglect associated with tobacco use include risk of breach of contracts where individuals smoke in smoke free accommodation (risking fines). Also there is a risk of people not meeting basic needs for food, warmth and shelter through funding nicotine addiction, as is the case with other addictive substances. Approximately 29% of smokers in the East of England live below the poverty line and there is evidence that stopping could lift them out of poverty (ASH, 2015b) (ASH, 2019).

- Smoke drift: Smoke drift occurs where a person is exposed to smoke in their home from a smoker living outside their home. Harms associated with this can include physical health risks, risk of fire and mental / social health risks linked to stress / neighbour disputes. This can be a safeguarding issue where the victims have mental or social risk factors that would make it harder for them to address this issue. Exposure to smoke drift can be as high as 35% in social housing settings, 23.1% in private rental and 17.5% in owner occupied (ASH, 2019f).

- Cost of littering: There is also a littering cost to smoking, which impacts heavily on the environment from the toxins in plastic-based cigarette filters that do not biodegrade (Novotny TE, 2009). An estimated 62% of people drop litter and smoking materials constitute 35% of all street litter. Smokers in Thurrock consume some 187,350 cigarettes every day, with roughly 158,740 having filters. This generates around 27kg of waste daily. Annually this equates to 10 tonnes, of which 4 tonnes is discarded as street litter. Not including cigarette packets and other smoking-related litter, cigarette butts could fill 178 wheelie bins every year. Figure 35 summarises this.

Figure 35: Costs and impact of cigarette litter in Thurrock



Some of the wider societal impacts of tobacco discussed here are associated with illicit tobacco; the next section explores such impacts in more detail.

6.9 Impact of illicit tobacco

Illicit tobacco sales undermine public health interventions to reduce smoking prevalence, damage legitimate business, facilitate the supply of tobacco to young people, and is associated with organised crime, including proven links to Modern Slavery (HMRC, 2020) (The Centre for Social Justice, 2020).

The largest impact of illicit tobacco on health is the physical health impact associated with its effect on smoking prevalence. In preparation of this JSNA, no recent modelling data to quantify the impact of illicit tobacco on physical health was identified. However estimates produced in 2008 indicated that four times more people die per year as a result of illicit tobacco use than all other illicit drugs combined.

Local data is available regarding the scale of criminal activity through the Trading Standards team's work to identify and take to court cases where illicit tobacco has

been sold. In Thurrock four cases of illicit tobacco supply were taken to court in 2020/21, although only one of these had been concluded in court at year end, the defendant was found to be guilty. The numbers of illicit tobacco suppliers identified fluctuate each year and may not give a true indication of the scale of the issue. Furthermore, illicit tobacco supply is often associated with organsied crime gangs, which tend to operate nationally. So these are not Thurrock specific issues but cases that require a combination of local surveillance and action and shared intelligence nationally.

Links between illicit tobacco supply, organised crime groups and modern slavery has been explored through data and insight among Thurrock Council officers and currently there is no evidence of this impact in the area. It is however challenging to identify and so new partnership work developing between the teams should help identify cases.

The next section of this needs assessment summarises the current strategy for tobacco control in Thurrock, which focuses on reducing smoking prevalence but includes efforts to stop the supply of illicit tobacco.

7 Current tobacco control approach in Thurrock

Thurrock's Tobacco Control Strategy for 2016-2021 included three strategic themes:

- **Prevention**: interventions that aim to reduce the visibility of smoking, normalise quitting and inform the public about the risks of smoking and how to get support.
- **Enforcement**: interventions that deliver against legal obligations concerning tobacco and mainly aim to reduce exposure to second hand smoke and the impact of illicit tobacco.
- **Treatment**: includes brief interventions advice, referrals and stop smoking services. For people who are not yet ready to quit, treatment also includes harm reduction approaches.

Alongside a universal stop smoking offer, the strategy proposed targeted support to people living in more socio-economically deprived areas, people with long term conditions, mental ill health, and pregnant women. Delivery of this was supported by strong leadership and governance through its Tobacco Control Alliance. Also, Thurrock was awarded with CLeaR accreditation (in 2015), which assesses the extent to which local authorities deliver their tobacco control programmes against best practice principles. Thurrock's Tobacco Control Alliance ceased in late 2019, partly due to reducing attendance from a sufficiently diverse membership to make it effective. However, Thurrock public health team has continued to work with partners across the local authority, the NHS and Public Health England to deliver against its three strategic themes.

This section describes the offer in 2021 and evidence of its effectiveness in Thurrock, starting with interventions offered to the whole population and then any tailored support for local priority populations.

7.1 Prevention

Thurrock Council focuses its prevention work on stopping uptake of smoking among children and young people. It also delivers whole population communications to inform the public about specific tobacco harms such as shisha / second hand smoke and to normalise quitting.

National campaigns

Every year Thurrock Council and Thurrock CCG engage with national tobacco control communication campaigns such as Health Harms" (January), No Smoking Day (March) and Stoptober (October). The impact of these on population attitudes towards quitting and tobacco harm has not been evaluated locally but national evaluation of the Stoptober campaign found that in 2018/19, over 80% of respondents had heard of the campaign and 66% agreed it helps people to quit smoking (PHE, 2020e).

Local campaigns

In local secondary schools, Thurrock Council delivered an intervention to prevent uptake of smoking called "ASSIST". Evidence of the impact of this is discussed in the

evidence section of this needs assessment. In addition, The Stop Smoking Service is not currently engaged with services that work with CYP more likely to smoke.

7.2 Enforcement

This part of Thurrock's current tobacco control strategy includes development and enforcement of Smoke-free policies, application of licensing powers and the work of Trading Standards officers to investigate, gather insight and take action against breach of relevant tobacco control legislation.

A regulatory framework for the point-of-sale of tobacco is complemented by the work of the UK Border Force and Her Majesty's Revenue and Customs (HMRC) concerning wider supply chain (tobacco imports and exports). Effective enforcement ensures that products available at the point-of-sale are genuine products with UK duty paid and are sold only to those old enough to purchase tobacco products.

In the last decade, national measures to reduce the appeal of tobacco have been put in place, including bigger and more graphic health warnings on cigarette packets and installation of plain screens in front of tobacco cabinets. In 2016 plain (standardised) cigarette packets were implemented, following the Chantler review finding no evidence to support the tobacco industry's argument that standardised packaging would increase the illicit trade in tobacco (DHSC, 2014). Boxes of ten cigarettes have been banned since 20th May 2016 due to new rules regarding the size of the health warnings carried on cigarette packs. These will only fit on twenty-packs of cigarettes. In 2015, legislation took effect to ban adults from smoking in cars that carry children.

These measures are implemented nationally by the UK government. Locally, work by the council's Trading Standards and Licensing departments enforces these regulations where it is within the council's powers to do so. A key part of the work locally is in stopping purchasing among people aged below the legal limit for purchasing tobacco and reducing supply of illicit tobacco due to its relationship with the price of cigarettes available.

Smoke-free policies:

Thurrock Council has a Smoke-free policy and the requirements of not smoking any tobacco product are extended to vaping e-cigarettes. The policy does not allow smoking or vaping on any council premises, site or vehicle, other than residential settings where people may smoke in their own home. The policy recognises the council's responsibility to protect staff from second hand smoke and is supportive to staff who wish to quit, allowing some paid time off work to attend stop smoking services. Managers and HR are responsible for enforcing the policy and the repercussions of breaching it are made clear. While the policy includes council contractors, it is not known if these employers offer similar supportive policies to help smokers in their workforce to stop.

All local NHS Trusts have in place a Smoke-free policy as part of their legal requirement to do so. The policies have been developed in line with NICE guidance and the Health Act (2006), which recommends that all hospital sites should be 100 per cent smoke-free.

The impact of these Smoke-free policies in Thurrock is not known as they are not audited and have not been evaluated locally.

The 2016-2021 Tobacco Control Strategy described ambitions to introduce policies for Smoke-free places in other settings, including homes and play areas; these have been explored but not been developed. Section eight of this needs assessment will explore current evidence and legislation regarding other settings for Smoke-free policy, including homes and parks.

Licensing:

Local authorities have limited licensing powers regarding tobacco control as premises are not licensed for tobacco sales. Thurrock Council encourages premises to sign up to the 'Challenge 25' policy, (discussed below under Trading Standards), however, usually compliance/enforcement work is conducted in relation to alcohol sales.

Trading Standards:

Thurrock Council's Trading Standards team support tobacco control mainly through enforcement work regarding age restricted sales and addressing illicit tobacco, education and supporting wider intelligence.

Age restricted sales: The Trading Standards team promote the "Challenge 25" policy, which is something most large retailers already have in place but smaller retailer and independent retailers are encouraged to adopt it. In practice it means if a member of the public wishes to purchase an item with a legal minimum age of 18, they will be asked to show ID if they look 25 years of age or younger. The team conduct two types of test purchases. One is called a Challenge 25 test where a person aged 18 or older attempts to buy an age restricted item to see if they are asked for ID. The result of this test provides good intelligence as to whether the retailer is adhering to the Challenge 25 policy. The second type of test purchasing is where a young person aged 16 or younger is supervised by Trading Standards Officers to try and buy age restricted items. The outcome of a successful sale is a criminal offence and both the seller and business owner can face sanctions including a fixed penalty notice, prosecution and a licence review. Thurrock's Trading Standards team also inspect vape shops as part of this work.

Illicit tobacco: Trading Standards Officers undertake inspections and overt and covert operations at retail premises using tobacco detection sniffer dogs. In 2019/20 the trading standards team inspected 89 retail premises; this resulted in 32,255 illicit and counterfeit cigarettes and 8.5kg of counterfeit hand rolling tobacco being ceased and a number of people were found working illegally. The sale of illicit tobacco is also linked to wider criminal activity and organised crime groups so this work informs intelligence to protect the public from these wider risks.

Education: Trading Standards offer support to local businesses regarding legislation and how to work in line with this. Examples include point of sale display, labelling, age restricted sales and due diligence and support is given in part through responsible retailer packs. The team also deliver promotional activities to raise awareness in the community about illicit tobacco through press and social media as well as tobacco dog roadshow events.

Wider intelligence and protection: for example, work with the Immigration Service to identify people working who are not entitled to work in the UK; an association has been found between illicit tobacco sales and this type of employment in Thurrock.

The impact these activities includes prosecutions and fines associated with underage sales and sales of illicit tobacco. Outcomes data is not collected but the rationale for this work is that such impacts serve as a deterrent and reduce the availability and acceptability of underage sales and illicit tobacco. The work also helps to reduce wider criminal activity in Thurrock.

7.3 Treatment

Interventions to support smokers to stop include asking people if they smoke, recording this, offering advice about the risks and benefits associated with smoking and quitting, and referring people to a stop smoking service if they want to quit. This intervention is known as Very Brief Advice (VBA) and is delivered under a wider intervention umbrella known as 'Making Every Contact Count' (MECC) (NICE, 2020). MECC recognises the opportunity health and care workers have with regard to engaging people in conversations about improving their health.

NICE recommends that a minimum of 5% of the local smoking population should be supported to stop through the availability of evidence-based services per year. For Thurrock this currently equates to approximately 1,183 people[6]. In 2019/20 Thurrock almost achieved this, supporting 1,146 people to stop smoking four weeks after their quit date. This is an improvement on previous years (4 week quitters = 333 in 2017/18 and 531 in 2018/19). The service has adapted to changing circumstances and needs; for instance commissioning vape shops to support smokers to quit and bringing the service in house. The new stop smoking service offer is mainly delivered through Thurrock Healthy Lifestyles Service (THLS), which is an integrated service including provision of weight management and health checks.

Other adaptations to the service model include a 2020/21 pilot of the Allen Carr stop smoking programme, which has been commissioned to offer an alternative service. For information about the method, please see: https://www.allencarr.com/help-and-faqs/ . So far in Thurrock the programme has supported circa 300 people to stop and is on target. The stop smoking service delivery model was also adapted in response to the COVID-19 pandemic, with services no longer being delivered face to face;

[6] Based on total QOF registered smokers (=23,660)

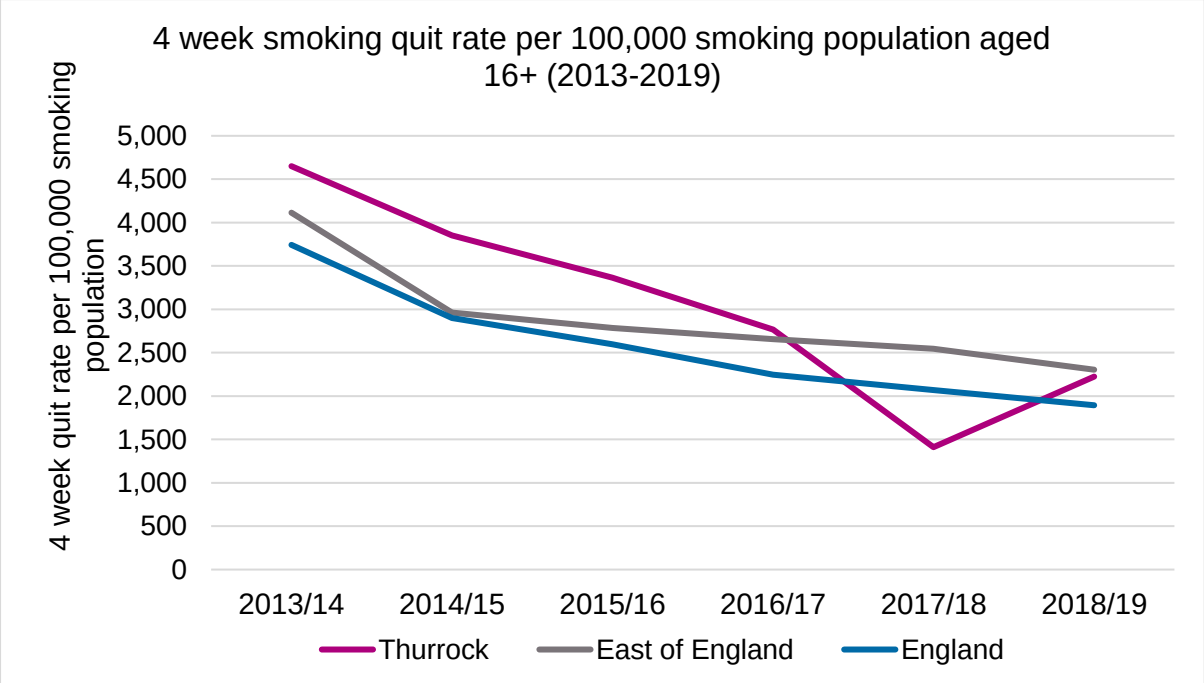
video link seminars have been available as an alternative to face-to-face support and engagement with this offer has been positive.

7.3.1 Whole population treatment

THLS has its own smoking cessation advisors and provides training to GP practices, pharmacists and vape shops to support these providers to deliver stop smoking services in other settings. Just over half of the GP practices (n=15) in Thurrock have an in house stop smoking offer, five pharmacies and two vape shops. The GP practices participating are distributed across the local authority area and the vape shop and pharmacy offer is based in locations where there has been market interest rather than targeted to areas of high smoking prevalence, deprivation or high numbers of smokers. Market development work would need to be undertaken to develop or better target this part of the SSS offer.

Stop smoking treatment data is captured and managed by THLS via the "Quit Manager" database, which is used by most SSS providers nationally. Figure 36 illustrates combined 4-week quit data across all SSS providers, a key outcome metric used nationally to compare performance of SSS. It shows that Thurrock was performing above the regional and national rates from 2012/13 to 2016/17. The stop smoking service was retendered in 2017/18 and awarded to a new provider, however performance reduced and as a result the contract was terminated. The new in-house service, THLS has recovered performance and is now delivering smoking quits in line with the rate recommended by NICE.

Figure 36: Stop smoking service 4 week quit rate per 100,000 smokers for Thurrock, East of England and England (2013-2019) [7]



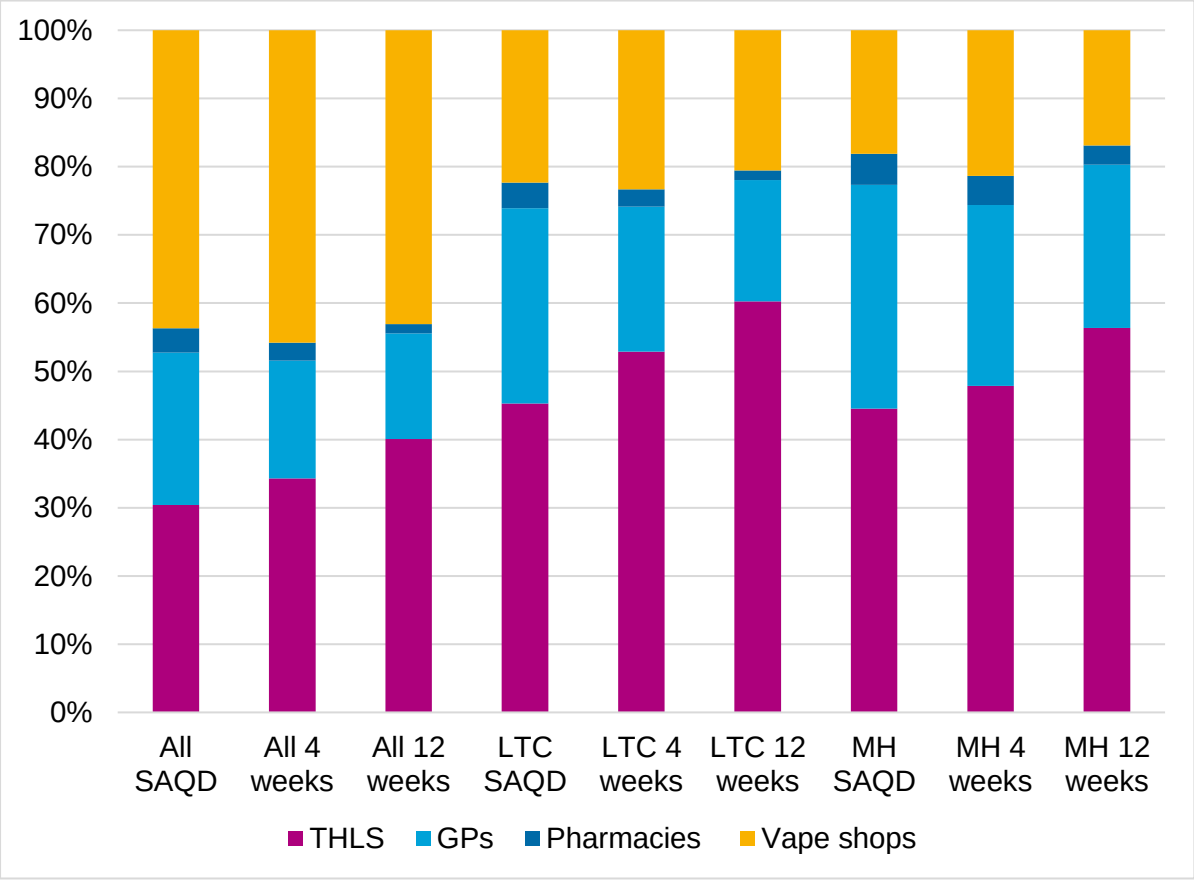
Source: QuitManager

[7] Thurrock smokers who successfully quit smoking at 4 weeks through council commissioned stop smoking services

Thurrock incentivises its providers through the local payment structure to support people for up to 12 weeks; this approach is in place because it might be more effective in achieving long term behaviour change and is unique in the East of England region. The impact of areas offering 12 week support has not yet been evaluated and local evaluation has not yet taken place to assess the impact of this approach in Thurrock (National Centre for Smoking Cessation and Training , 2021).

Figure 37 shows the proportion of outcomes (set a quit date (SAQD), 4 week and 12 week quits) delivered by each service provider in 2019/20. This data represents the 2,320 people who SAQD in that year. The figure also shows delivery against these outcomes for the whole population (all) and of those, people with a long term condition (LTC) and with a mental health condition (MH).

Figure 37: Number of Thurrock residents supported to SAQD, remain quit at 4 weeks and remain quit at 12 weeks by service provider type (2019/20)

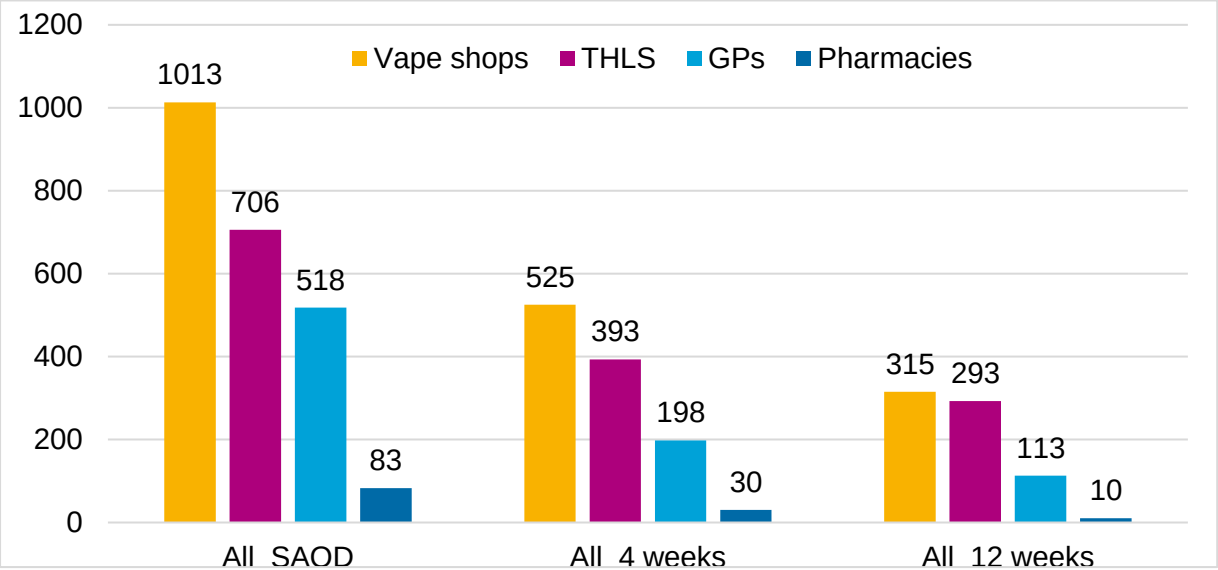


Source: QuitManager

Figure 37 shows that in 2019/20, the two Vape Shops accounted for the greatest proportion of people SAQD and quitting at 4 and 12 weeks, followed by THLS. However THLS have supported a greater proportion of people who have a LTC and MH condition to SAQD and quit at 4 and 12 weeks than other provider types. The data indicates that the GP offer attracts a higher proportion of people with LTCs and MH conditions, while the pharmacy offer generates a relatively small proportion of the outcomes for the SSS.

Figure 38 indicates the scale of this difference, showing the number of people SAQD, and quitting at 4 and 12 weeks in the general population. This also reflects the pattern of service delivery where the vape shops attract the highest footprint, but THLS appears to have a more effective delivery model.

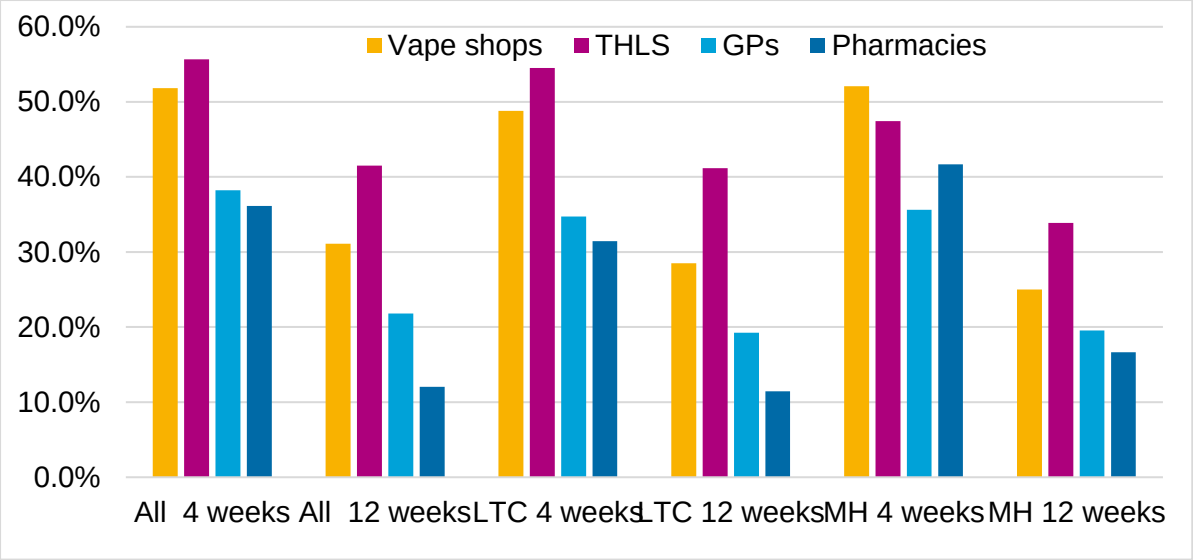
Figure 38: Number of people accessing Thurrock SSS in 2019/20 (all providers)



Source: QuitManager

A way of measuring this and a national indicator of SSS service quality is the conversation rate of people SAQD to quitting at 4 weeks; in 2014 this was around 50% at 4 weeks in England (HSCIC, 2014). Figure 39 summarises the conversion rates of people SAQD with Thurrock SSS at 4 and 12 weeks in 2019/20.

Figure 39: 4 and 12 week conversation rates among people accessing Thurrock SSS in 2019/20 (all providers)



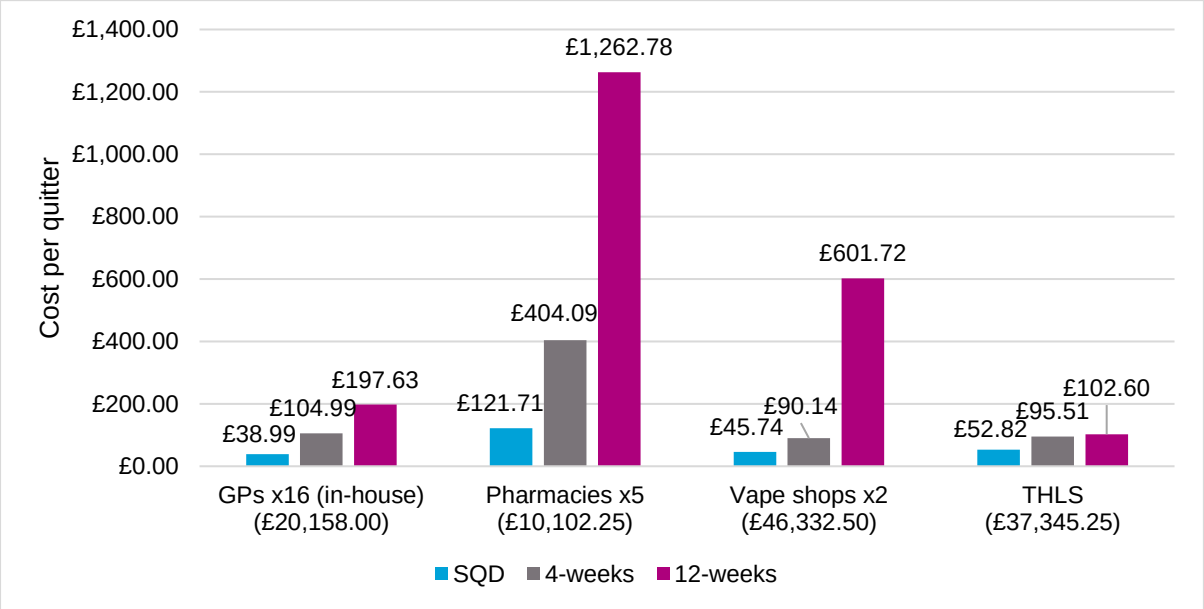
Source: QuitManager

The data shows that THLS has had the highest conversion rate at 4 and 12 weeks for the general population and for people with a LTC and a MH condition, apart from the MH 4 week conversion rate where the Vape shops had a higher conversion rate. The conversion rate is below 50% at 4 weeks among people using the GPs and pharmacies in the general population and among people with LTC and MH, while THLS and the vape shops achieved a 4 week conversion rate of close to or over 50% for all population groups. While the pharmacy offer has generally attracted fewer clients and had lower conversion rates compared to other SSS in Thurrock, it is worth noting that the conversion rate at 4 weeks for people with a MH condition is higher than the conversion rate in the general population for this service. This finding may be due to chance, especially because the client numbers are very low but should this service offer continue, opportunities regarding the target audience of this offer should be considered.

Regarding long term impact of this work, evidence shows that people who use these services are more likely to remain a non-smoker than those who try to quit on their own. By 12-months, smoking abstinence among people who attempt to quit without any formal / service support is about 4% compared to 15% of people abstaining long term after using a SSS (Hughes JR, 2004) (Song F, 2020). Based on this evidence, of the Thurrock residents who SAQD with the SSS in 2019/20, approximately 348 are likely to remain non-smokers. While this will have a large impact on the health of these individuals, it makes a relatively incremental change to reducing the population of people who smoke in Thurrock, which is currently approximately 22,500 people. Thus, while SSS services are an important tool in reducing smoking prevalence, there is a need to reinforce prevention and opportunities to prompt more smokers to attempt to quit.

Cost effectiveness is another key consideration to inform future commissioning of SSS in Thurrock. Figure 40 shows the cost per 12 week quitter broken down by the four main types of service delivery in Thurrock. The current contract specifies payment is made per 12 week quit to incentivise providers to support smokers to abstain from smoking for longer. In addition to the costs shown, the NRT used by clients in the various service settings cost £38,086 in 2019/20; CCGs receive the funding for this medication from central government and refund the Public Health team for these costs. Vape shops do not use any licensed NRT, but quitters will be using unlicensed e-cigarette liquid to quit, which usually contains nicotine and is factored into those costs.

Figure 40: Cost per quitter by service, excluding NRT costs (2019/20)



The data shows that Vape shops deliver the lowest cost per 4 week quitter and THLS deliver the lowest cost per 12 week quitter. Pharmacy costs are significantly higher. These service output costs should be considered in the context of their reach to priority groups, which is discussed further in the section 7.3.2.

In addition to the provision of a SSS in Thurrock, Thurrock Council's public health team work with local organisations to increase referrals to the service and deliver training to enhance the quality of the service. In addition to the referral routes discussed already, Thurrock Council uses its relationship with tenants to encourage smokers to consider stop smoking:

Private housing: The Council delivers a Well Homes Service; the assessment for this promotes the stop smoking service and Well Homes will make a direct referral to Thurrock Healthy Lifestyle Solutions.

Sheltered housing: Thurrock Council delivers an annual health and wellbeing assessment to tenants living in sheltered housing; this does not include a question on smoking status. If tenants indicate they'd like to stop smoking, they are signposted to support. Anecdotal data suggests that currently support for stopping smoking is not often requested. Given the likely higher prevalence of people with LTC in this group and the risk of smoke drift, consideration should be given to improve equity in the council's offer to support smokers to stop smoking.

The Mid and South Essex STP respiratory board will be using NHS Long Term Plan funding to improve access to SSS treatment for smokers and enhance referral pathways to support people using hospital services to SAQD, quit and maintain a quit. This funding has been established for the NHS to address commitments made in the NHS Long Term Plan regarding tobacco control.

The next section of this needs assessment considers the SSS offer and referral pathways for priority groups.

7.3.2 Priority groups

Priority groups that were identified in the 2016-2021 TC strategy included people living in more socio-economically deprived areas, people with long term conditions (LTCs), mental ill health and pregnant women. This section will discuss SSS support that has been made available to these groups and its success; this is part of a proportionate universalism approach, meaning services are offered to the whole population but targeting of some aspects of the service design are developed to support populations with higher need.

Socio-economic deprivation

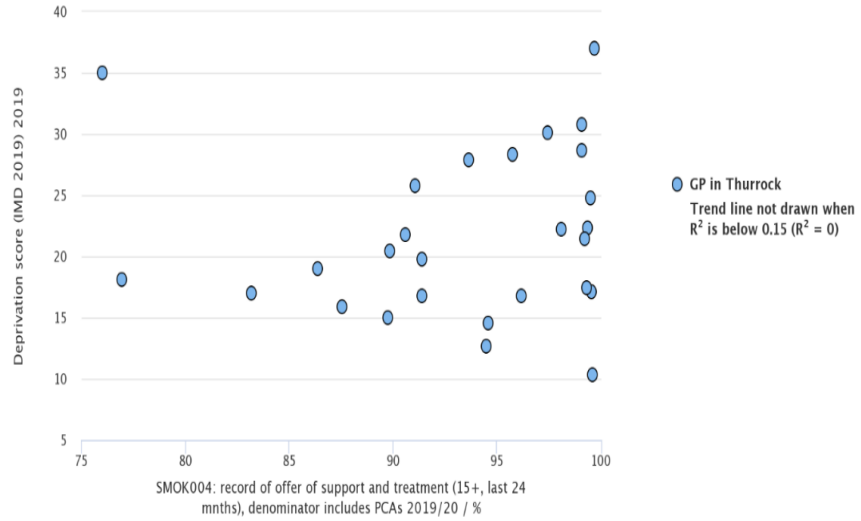
People from lower socio-economic groups have higher smoking prevalence; the reasons for this are complex but associated with factors such as uptake in childhood impacted by higher prevalence in the family, higher prevalence among peer groups such as professional groups.

In Thurrock, all residents, regardless of their postcode, profession, housing tenure or income are offered the same stop smoking service support offer. However, Thurrock Council has delivered targeted communication campaigns to encourage increased quit attempts by smokers from more socio-economically deprived groups. THLS also provides direct supply of NRT for free to all smokers who set a quit date (SAQD), including those who are not entitled to free NHS prescriptions, as part of a proportionate universalism approach. This means people living in relative deprivation but who are not eligible for free prescriptions can still access free NRT support in Thurrock.

The location of SSS providers in Thurrock is not currently targeted to wards with higher levels of deprivation / higher smoking prevalence or a higher total number of smokers. This is due to market factors that have limited the ability of the SSS to offer the service in this way. An alternative means of encouraging more quit attempts among people from more socio-economically deprived groups is to encourage referrals from services that have contact with people from these populations, including GPs.

Figure 41 shows the association between the deprivation score of GP practices in Thurrock compared to the percentage of patients who have been offered support to quit smoking in the last 24 months. The closer the R number is to 1, the stronger the association. This figure shows no correlation, meaning GP practices in more deprived areas, where smoking prevalence is higher, are not more likely to offer support to smokers on their practice register than those in less deprived areas with lower smoking prevalence.

Figure 41: association between practice level deprivation and offer of smoking support in the last 24 months.



Source: PHE Fingertips Public Health Profiles (PHE, 2020c)

Analysis was undertaken to assess the correlation between area of deprivation and the proportion of smokers who SAQD in these areas for each service setting (vape shops, THLS, GPs and Pharmacies[8]. This analysis also found no correlation between deprivation and the proportion of smokers who SAQD and quit at 4 weeks.

This section has highlighted that the 2021-2026 Thurrock Tobacco Control Strategy will need to include interventions to support more people from socio-economically deprived groups to attempt to quit and have success in doing so. The evidence regarding physical location, service setting and service offer should be explored to inform this.

People with long term conditions (LTCs)

Smoking impacts the risk of, severity of and treatment efficacy for many LTCs, including common diseases such as COPD, Cancer and Cardiovascular Disease. An important means of reaching people living with LTCs to support them to stop smoking is through NHS services since people with LTCs are more likely to access these services to diagnose, manage and treat their condition/s. This section of the needs assessment describes current collaborative work with the NHS to improve access to SSS for this population.

THLS has been working with Basildon and Thurrock University Hospital (BTUH) to ensure VBA is offered to patients coming in to hospital who smoke. This has included weekly physical presence in the hospital to support and train physicians, generating signposts for quit support. There is not currently a referral form or electronic referral pathway allowing direct referrals into Thurrock's SSS. Work

[8] Figures prepared by Thurrock Council's public health intelligence team in 2019 using data from QuitManager and practice IMD score

through the MSE HCP's Long Term Plan Tobacco Control fund will help to embed access to treatment on hospital sites and improve pathways with Thurrock's SSS.

Thurrock CCG has been developing an initiative called 'Targeted Lung Health Checks', which was launched in early 2019, to find early signs of lung cancer and improve outcomes for smokers and ex-smokers aged between 55 and 74 (Thurrock CCG, 2021). Thurrock CCG was partnered with Luton CCG as one of 10 pilot sites; the programme involves identification of smokers and ex-smokers through GP practice lists and inviting these patients to have a low dose CT scan for early detection of lung cancer. Current smokers' are also offered a referral to stop smoking services. Programme testing took place with one GP practice in February 2020 and learning from this will be used to inform future development, which has been impacted by the COVID-19 response. There is scope to make large improvements in lung cancer outcomes for Thurrock; not only does Thurrock have some of the highest smoking prevalence at PCN level in the MSE geography but also has some of the lowest two week wait referrals for lung cancer. This is summarised in figure 42; for example Tilbury and Chadwell has the third highest smoking prevalence out of the 28 PCNs but is ranked 20th with regard to the number of referrals made for lung cancer on the two week wait pathway.

Figure 42: Thurrock PCN rank in MSE area for smoking prevalence and two week lung cancer referrals

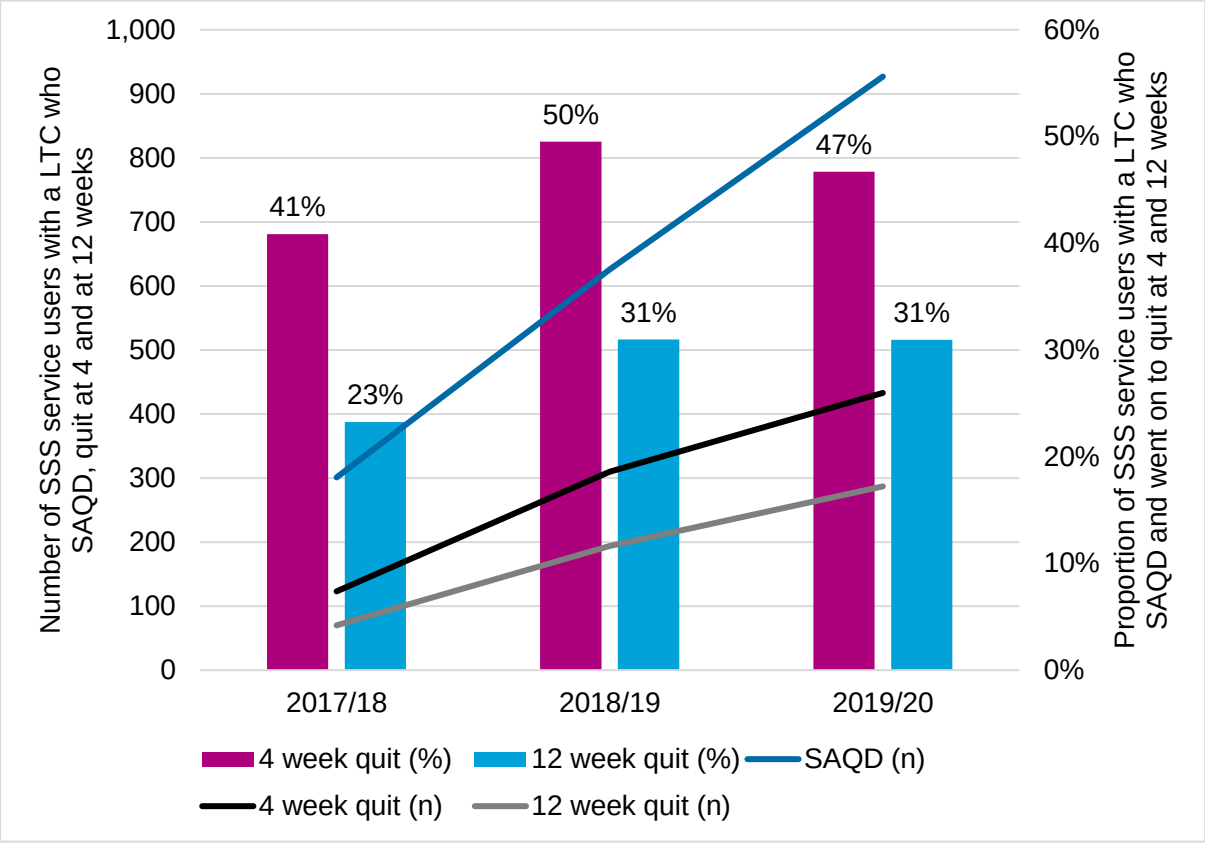
Thurrock – **Smoking prevalence rank** (*1=highest prev. within MSE PCNs*), **Number of 2 week wait lung cancer referrals rank** (*1=most referrals, 28=least referrals within MSE PCNs*)

- Tilbury and Chadwell: 3rd, 20th
- ASOP: 6th, 25th
- Grays : 12th, 21st
- Standford-le-hope: 16th, 1st

THLS has also supported GPs in auditing their registered smokers who have LTCs to encourage more offers of support to these patients to stop smoking.

Thurrock SSS has had increasing success in supporting people with a LTC to stop smoking. Figure 43 shows the number of people living with a LTC who SAQD, who quit within 4 weeks and who remained quit at 12 weeks across all SSS providers in Thurrock. The number across all categories increased over time but the proportion of people with LTCs who SAQD and went to quit at 4 weeks and remain quit at 12 weeks increased and then has remained similar since 2018/19. Ultimately this has resulted in a net increase in the number of smokers with a LTC who have remained quit at 4 and 12 weeks. An evaluation of the service would be required to understand how to maintain or increase conversion rates as the number of clients' increases.

Figure 43: Number of people with a LTC SAQD and quitting by 4 and 12 weeks and the proportion quitting at 4 and 12 weeks (2017-2020)



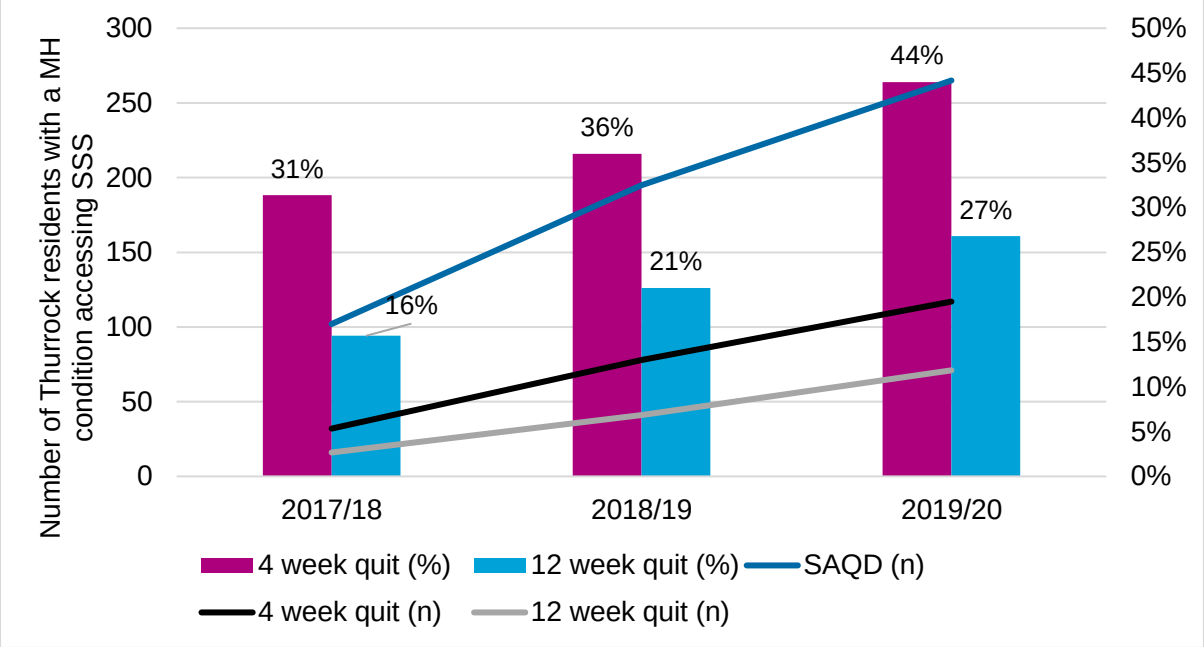
Source: THLS (QuitManager)

Mental ill health

Smoking prevalence is higher among people with a mental health condition and this has a significant impact on the inequalities in physical health outcomes experience by this population, compared with the general population.

Thurrock's SSS records whether service users have a mental health condition; figure 44 shows that over time, the SSS has improved its reach to people with mental ill health. The number of people accessing the service has increased and the proportion attempting to quit and successfully doing so has increased. The service model regarding location, service provider type and service offer has not changed significantly in this time so it is not clear without a service evaluation / referral flow chart to understand why this change has occurred.

Figure 44: Number of people with a mental health condition SAQD and quitting by 4 and 12 weeks and the proportion quitting at 4 and 12 weeks (2017-2020)



Source: THLS (QuitManager)

One source of referrals to the SSS for people living with mental ill health is through the annual physical health check for people with a severe mental illness (SMI). Nationally, GP practices and mental health trusts are responsible for conducting this check with at least 60% of the GP practice registered population with a diagnosed SMI. Data recorded at quarter 4 in 2019/20 shows that while Thurrock CCG did not meet this target, it performed better than the England and regional averages. In Thurrock, 43.4% of SMI registered patients received the physical health check in the previous 12 months reporting period, compared with 35.8% and 33% in England and EoE respectively. Of those receiving the physical health check, 81.2% of patients in Thurrock had the smoking aspect of the intervention conducted; the proportion of these patients who were actively referred for SSS support to quit versus signposting to services is not known. Developing a referral pathway for this service offer will be a useful way of supporting people with a MH condition to quit.

THLS also works with NHS Essex Partnership University Trust (EPUT) to encourage referrals from this setting to the stop smoking service. EPUT are the main mental health secondary care provider for Thurrock residents. Progress has been made for tobacco control at the Trust. A smoke free policy is in place and although challenges and breaches are still occasionally experienced, the Trust is committed to supporting patients and staff in achieving a smoke free environment. Many staff have trained to become smoking cessation advisors to take this agenda forward. Also, on admission and throughout an episode of care, smoking status is assessed, and smoking cessation support is offered. In many cases, support for vaping and e-cigarette use is required and the Trust recognise that this can often be the preferred method of reducing tobacco use. This has been the case for many people residing in secure settings, some of whom have not used tobacco since the policy was introduced.

Support for staff to stop smoking is available from the occupational health service provider. Going forward, EPUT recognise that a more robust approach is needed to patients on transfer to community services to ensure that smoking cessation support continues to be available, and this is an area for development. This includes exploring why currently there is no offer of Varenicline, despite this being a recommended intervention by the Royal College of Psychiatrists (RCP, 2018). Data was not available at the time of writing this needs assessment regarding the number of people using EPUT services who were referred to Thurrock SSS.

Thurrock CCG commissions an increasing accessing to psychological therapies (IAPT) service called Inclusion for Thurrock residents who need support for common mental health difficulties including depression and anxiety disorders such as OCD, PTSD and social phobia. Currently the service does not ask service users about their smoking status but will signpost them to THLS if the client discloses that they smoke. Inclusion also offer employment support (called EIP) and take the same approach to tobacco control with these service users. A barrier to more proactively offering smoking VBA in this setting that has been identified locally is that smoking is not included in the IAPT national minimum dataset, meaning there is no prompt in the national database for IAPT staff to ask about smoking and record the answer. Advice from PHE and ASH has identified other IAPT service providers in England have found workarounds to this issue so this could be an area for development to be considered in the 2021-2026 Thurrock TC strategy. Opportunities to engage other local mental health providers should also be considered.

In summary, progress has been made regarding mental health and smoking support, with an increasing number of people using the SSS services, the introduction and delivery of physical health checks for people with SMI and in the approach being taken in the mental health trust. However, stronger referral pathways with local mental health providers should be developed and use of CQUINs should be considered as a mechanism to improve the service offer around smoking within mental health providers.

Maternity

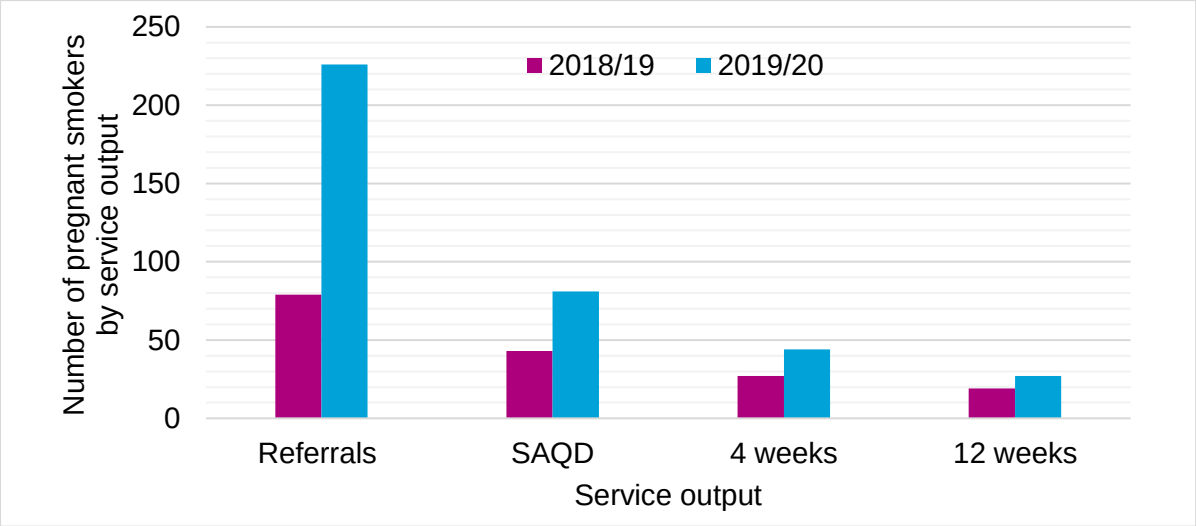
Addressing smoking in pregnancy is important because when pregnant women smoke or are exposed to tobacco smoke in the home, the risk of negative health outcomes for the mother and the unborn baby are increased.

Most stop smoking maternity referrals come from Basildon and Thurrock University Hospital (BTUH). Currently THLS do not receive the opt-out data from maternity services, which would enable them to determine the percentage of pregnant smokers that opt-out of quit support and subsequently never get referred. Maternity services no longer have a ‘not known’ option on their database for smoking status, which greatly improved the accuracy and certainty of SATOD data.

Thurrock Council have supported the smoking in pregnancy agenda through training midwives in VBA by the specialist stop smoking services, although this is largely now provided by Essex County Council. On 1st October 2019 BTUH implemented two specialist stop smoking role; these midwives receive the details of all pregnant

smokers and seek to engage those who at the time of booking have opted out of a referral for quit support. Those willing to quit smoking are referred by email to THLS, who contact referred women within 48 hours. Figures 45 and 46 illustrate the THLS treatment activity for pregnant women who smoke.

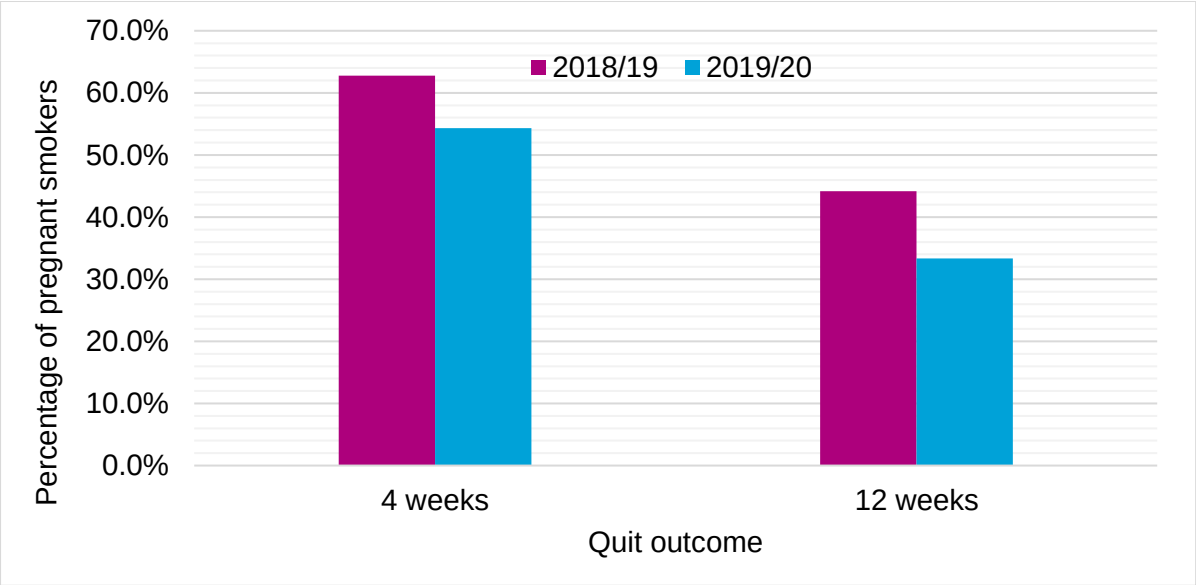
Figure 45: Number of referrals to THLS from maternity services and number who SAQD and who quit at 4 and 12 weeks



Source: Quit Manager, accessed June 2020

Figure 45 shows that the number of referrals increased substantially in 2019/20 and this resulted in more pregnant women who smoke setting a quit date, quitting by 4 weeks and remaining quit at 12 weeks. Figure 46 shows that the conversion rates for pregnant women SAQD are higher than the general population but these reduced at 4 and 12 weeks in 2019/20 compared to the previous year.

Figure 46: Proportion of referrals to THLS from maternity services that resulted in SAQD, 4 week and 12 week quits



Source: Quit Manager, accessed June 2020

There were five referrals from maternity services for males in 2019/20 that are not represented in these data. The evidence tells us that women who live with partners who smoke are less likely to stay quit themselves. Midwives capitalising on the motivation of these partners to quit smoking is excellent practice and to be welcomed. Three of these five males (66%) went on to stay quit. The QuitManager database should be updated to record 'partner', since some female referrals might have been partners too. A recent analysis undertaken by BTUH midwives shows the potential number of partners who could be offered support, including those of pregnant women who do not smoke themselves but who are exposed to secondhand smoke at home (table 8). This snapshot shows the potential high prevalence of smoking among partners of pregnant women in Thurrock; around one quarter of those coming through the service in quarter 4 of 2020/21 smoked, higher than the Thurrock smoking prevalence in the general population.

Table 8: the number and proportion of partners who were recorded as smoking at booking for women who smoke and who do not smoke

	Women who smoke at booking	Partners who smoke at booking	Women who smoke whose partners also smoke (current 2nd hand smoke capture)	**Women who DON'T smoke but partners do**
Jan 2021	47/408 12%	100/408 24%	32/408 8%	**68/408 16%**
Feb 2021	40/398 10%	96/398 24%	21/398 5%	**75/398 19%**
March 2021	51/467 11%	142/467 30%	34/467 7%	**108/467 25%**

Support for pregnant women who smoke has improved in recent years through partnership work between BTUH and the surrounding local authorities, including Thurrock. This has resulted in a net increase in the number of pregnant women who quit at 4 and 12 weeks. However, options should be explored to increase conversion rates and to support partners or other household members of pregnant women who smoke, regardless of whether the woman smokes. Furthermore, overlap with other aspects of healthy living such as health weight in pregnancy should be considered as part of a holistic offer for to improve pregnancy outcomes.

Health Visitors deliver very brief advice to new mums regarding safe sleeping, which includes advice for people who smoke not to share a bed with the baby due to increased Sudden Infant Death syndrome risk and smoke free homes advice at the new birth visit and other contact points as appropriate. How this impacts referrals or signposts to the Stop Smoking Service is not known due to data quality issues.

Children and young people

The Healthy Families Service deliver the 0-19 Healthy Child Programme in Thurrock including drop in services at secondary schools. They offer brief advice and

signposting to stop smoking services opportunistically. Various health promotion opportunities are used by the service in delivering messages on social media around health and wellbeing that includes risky behaviours such as stop smoking/tobacco control messages.

In addition to the priority groups identified in the previous tobacco control strategy, there are other groups supported by Thurrock SSS. The current offer to these is described below. Where population groups are not mentioned such as some of the protected characteristics groups, this is because no current local targeted work was identified in preparing this JSNA.

Substance misuse

Smoking prevalence is higher among people who use drugs. The data in figure 47 is taken from the local adult treatment service and is illustrated here for context. Only percentages are shown and it must be noted that the numbers behind these are generally small. Figure 47 shows that there are far fewer people in substance misuse treatment that smoke, compared to the national average. This has been the subject of local discussion with the providers for several years, so there is some degree of confidence that this is not a data recording error. The service offers smoking cessation to all clients, however, the clients' motivation tends to be towards reducing or abstaining from substance misuse, rather than quitting smoking. While more clients in the non-opiate, alcohol, and alcohol & non-opiate groups should be encouraged to attempt to stop smoking, it is promising to see a proportion are interesting in attempting to quit.

Figure 47: Smokers and quit rates in the adult drug and alcohol treatment service – 2018/19

The following smoking data is taken from the local adult treatment service, and illustrated here for context - 01/10/2018 to 30/09/2019

	Opiate	Non-opiate	Alcohol	Alcohol & non-opiate
Clients identified as smoking Tobacco Client indicated smoking in at least 1 of the 28 days prior to starting treatment/clients who provide valid tobacco data from the TOP (i.e. 0-28 days) at both the start of treatment and the six month review	Thurrock - 51.7% National - 71.0%	Thurrock - 42.9% National - 62.9%	Thurrock - 34.6% National - 33.3%	Thurrock - 33.3% National - 66.6%
Smoking cessation interventions provided to clients who smoke tobacco Smoking cessation interventions received by clients identified as smokers prior to starting treatment/ client indicated smoking in at least 1 of the 28 days prior to starting treatment	Thurrock - 13.3% National - 1.3%	Thurrock - 0.0% National - 1.4%	Thurrock - 0.0% National - 2.3%	Thurrock - 0.0% National - 3.1%

Source: NDTMS, (2020) [Numbers redacted].

Offender health

Smoking prevalence among offenders is higher than the general population.

While Thurrock does not have a prison within its local authority boundary, there are offenders living in the community who are supported by the probation service. Approximately 80% of offenders in prison smoke; all prisons in England are now smokefree places. To support smoking cessation in prison, part of the FNIP (first night in prisons induction) asks offenders if they smoke; those who respond to say they do, are offered a vape pack, which they have to purchase or buy on credit. Thereafter prisoners can purchase capsules with their canteen on a weekly basis and those who want to stop smoking can attend an eight week smoking cessation course. This includes provision of nicotine replacements, however offenders cannot attend the course if they continue to vape.

The probation service covering Essex, Thurrock and Southend-on-Sea is working with the councils to develop referral pathways so that offenders moving into or living in the community can be supported to stop smoking too.

This needs assessment has also explored the fit of the current smoking treatment offer for some of the protected characteristics groups, where data has been available to do so. The next sections describe the effectiveness of the SSS for these groups.

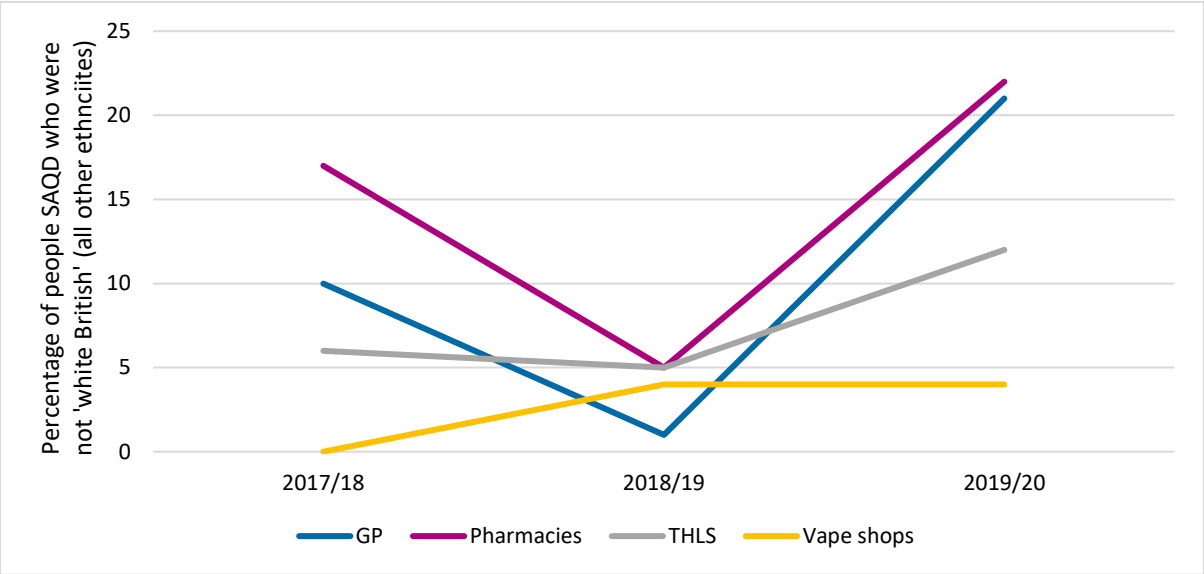
BME

It is important to understand smoking and tobacco use among different ethnic groups to assess whether the local stop smoking service offer is well designed around need for this protected characteristic. Use of tobacco by type and gender differs among ethnic minority groups nationally so local insight is required to identify local need.

The number of people from specific ethnic groups other than ‘White British’ accessing the SSS is very small and it is therefore not possible to present data on individual ethnicity categories. In 2019 it was estimated that 80.9% of Thurrock’s population were ‘White British’; the SSS client ethnicity profile has consistently included a higher proportion of people of this ethnic category since 2017 (2017/18 = 92%; 2018/19 = 96%; 2019/20 = 85%).

Figure 48 shows the proportion of people coded as not having ‘White British’ ethnicity per year and by service provider type. It shows that across service providers, the proportion of clients who were not ‘White British’ increased. This could be a promising sign of a more equitable offer or a change in data recording/coding but should be monitored given the high variation in annual use of the service by ethnicity. The data also shows that pharmacies have consistently attracted a higher number of people whose ethnicity was not coded as White British compared to the other provider types; this should be explored in reviewing the SSS model, especially given the relatively low number of service users accessing pharmacy SSS.

Figure 48: Percentage of people of any other ethnicity than 'White British' SAQD with Thurrock SSS by provider type



Source: Quit Manager, accessed June 2020

It isn't possible to directly compare this data with the QOF prevalence of smoking by ethnic group since the ethnicity categories used are different. These findings can also mask prevalence differences by gender and generation in ethnic groups. Thurrock SSS should consider its intelligence regarding ethnicity to make sure people of other ethnic groups are adequately supported to stop smoking, including in use of other tobacco products.

The number of people SAQD of non 'White British' ethnicity is too small to conduct analysis on 4 and 12 week quit success.

This section has so far focussed on the SSS itself; the next sections will summarise wider work taking place to support referrals and self-referrals into the SSS.

7.4 SWOT analysis of Thurrock's current Tobacco Control offer

The following section summarises strengths, weaknesses, opportunity and threats for the current smoking treatment offer in Thurrock:

Strengths

- THLS and vape shops: attract high number of clients.
- THLS and vape shops: achieve high conversion rates to 4 and 12 week quits in the general population.
- Pharmacies: may achieve better reach with BME groups.
- Strong partnership with maternity service, that has improved the number of quits in recent years.
- Mental health: improvement in stop smoking culture at the mental health trust.

Weaknesses:

- Data: there are aspects of information that could inform the local tobacco control response where there is currently no or insufficient data to inform decision making. For example, service user experience data is not currently collected and smoking prevalence among some protected characteristic groups is not available.
- Evaluation: local evaluation of service innovations will improve understanding of what is working locally and help to share good practice regionally and nationally. For example, evaluation of the 12 week quit support, of the appeal of different service offers to priority groups and evaluation of prevention / marketing interventions, especially among priority groups.
- Socio-economic inequalities: the current service offer does not target routine and manual groups and this is seen in the impact data. Efforts through promotional activity and reviewing the market and service offer should be considered to better reach this group.
- Mental health: need to improve data and ensure continuity of SSS between inpatient and community mental health services.
- Understanding the tobacco control needs of protected characteristics population groups locally; specifically BME, LGBTQ and people with a learning disability.
- NHS capacity / leadership: locally the tobacco control agenda is currently driven by the council's public health team. The NHS are an important delivery partner in this agenda and a beneficiary of reducing smoking prevalence. Clear NHS accountability and leadership is recommended by PHE and ADPH for tobacco control and this is an area where Thurrock could make improvements such as through the new LTP fund for tobacco control.

Opportunities:

- Allen Carr: Thurrock Council commissioned a pilot of the Allen Carr stop smoking service. This presents an opportunity to offer a different type of SSS to smokers in Thurrock and should be monitored for effectiveness and equity impacts.
- There are very few pharmacies and vape shops currently offering stop smoking services in Thurrock; identifying sites interested and able to offer the service

could increase accessibility of the offer in target areas with higher prevalence and for client groups among whom this may be a more effective service offer. Recent market testing in Thurrock did not identify new providers however Essex County Council have developed a strong pharmacy offer working with the Local Pharmaceutical Committee. Further work needs to be done in Thurrock therefore to grow these markets.

- Integrate brief interventions for smoking for partners or significant others of pregnant women as part of a smoke free homes approach to smoking cessation in this population.
- Explore ways of making the SSS more effective for pregnant women referred to the service.
- Explore opportunities with health visitors to continue the smoking cessation support offer for mothers and their household.
- Compliance with the Ask, Advise, Act (AAA) approach from the NCSCT should be reviewed.
- Social prescribing service in Thurrock: patients aged 18+ who present to their GP with issues that have a non-clinical underlying cause. There is an opportunity to explore the opportunities of referral from this service to SSS.
- NHS LTP funding for tobacco dependency treatment: work is underway with PHE to ensure this funding effectively aligns with the current tobacco control offer in Thurrock.
- Integrating smoking cessation into mainstream services for priority groups should be explored further, as part of the long-term plan fund programme but not only via this mechanism.
- Work with the Learning Disability Specialist Health service to identify reasonable adjustments that could be made to the SSS core offer on an individual basis. The support needs and abilities of people in this population are broad and will need tailoring to each person.
- Explore the role of adult social care in asking service users about their smoking status and programmes such as Thurrock first.
- Align findings from the self-care JSNA with the tobacco control agenda.
- Scoping meetings with the probation service have identified a new role in the service that has been created to support the health of ex-offenders. The Senior Probation Officer for South Essex LDU has requested support to develop referral pathways for Thurrock, Essex and Southend-on-Sea.

Threats:

- COVID-19: the pandemic continues to impact capacity across services working alongside the SSS. It may also impact the motivation of some people to quit, especially where mental health has been negatively impacted. While the UK appears to be in the recovery phase of the pandemic, the situation and the mid to long term impacts on smoking will need to be reviewed and adaptations made.

The next section discusses the current evidence regarding tobacco control and specifically stop smoking treatment.

8 Evidence

The three strategic themes through which Thurrock delivers its tobacco control programme (prevention, treatment and enforcement) are supported by current evidence for whole population approaches (ADPH, 2019) (ASH, 2019g). The Tobacco Control Scale (TCS) is an international scale used to assess the impact of tobacco control policies on smoking prevalence and quit rates (Feliu A, 2019). It considers evidence of impact of the six policies included in the World Health Organization's MPower framework (shown in table 9, alongside their alignment with the UKs Tobacco Control Plan Principles). Countries with a higher TCS rating have seen greater reductions in smoking prevalence compared to those with lower TCS ratings. These policies, in combination, are effective in reducing tobacco harm.

Table 9: key action areas for tobacco control

TCS rank	WHO MPower Framework	UK Tobacco Control Plan
1	Raise taxes on tobacco.	
2	Protect people from second-hand smoke.	Implement a truly smokefree NHS.
3	Monitoring tobacco use and prevention policies / public information campaigns	Identify local priority groups and actions. Develop action plans to reduce tobacco-related health inequalities.
4	Enforce bans on tobacco advertising, promotion and sponsorship.	Deliver effective enforcement.
5	Warn about the dangers of tobacco.	
6	Offer help to quit tobacco use.	Provide evidence-based support to quit. Develop pathways for people with mental ill health to access effective support to quit. Work with local employers to help staff to quit.

The TCS ranks these policies by evidence of the likely scale of their impact on prevalence and quit rates. However this is based on ecological studies, meaning the results can show a correlation between policy changes and impact but cannot imply causation. While treatment for smokers is ranked lowest here, it has the highest quality evidence for its impact since it is easier to measure this and a combination of behavioural support and NRT has been found to be the most effective form of treatment; evidence based smoking cessation services are effective in supporting smokers to quit (NICE, 2018).

The key message is that the combination of these policies is effective and to deliver them, a whole systems approach is required, to motivate more quit attempts and

address people's capability and opportunities regarding tobacco use (initiating quitting and relapse) (ADPH, 2019).

Professor Robert West of University College London modelled the impact of various whole population level interventions, like those summarised in table nine and developed a 'smoking pipe model' to represent the opportunities to reduce smoking prevalence (figure 49 and figure 50). The findings from this work were that raising concern among smokers about smoking by tax increases, social marketing and brief inventions advice from health professionals can increase the rate at which smokers attempt to quit. Also that provision of evidence based stop smoking services can improve the rate at which those quit attempts succeed (West, 2017).

Figure 49: Robert West's smoking pipe model

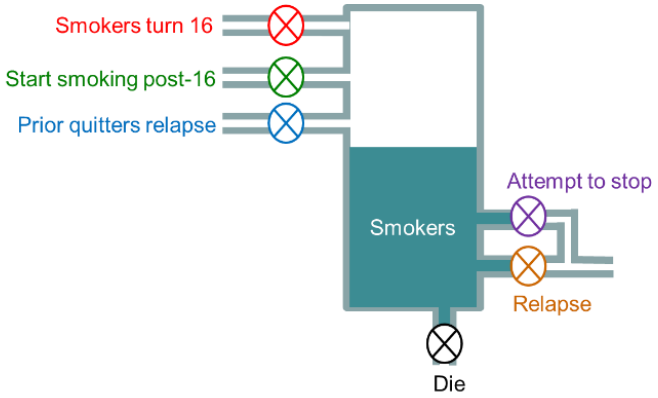
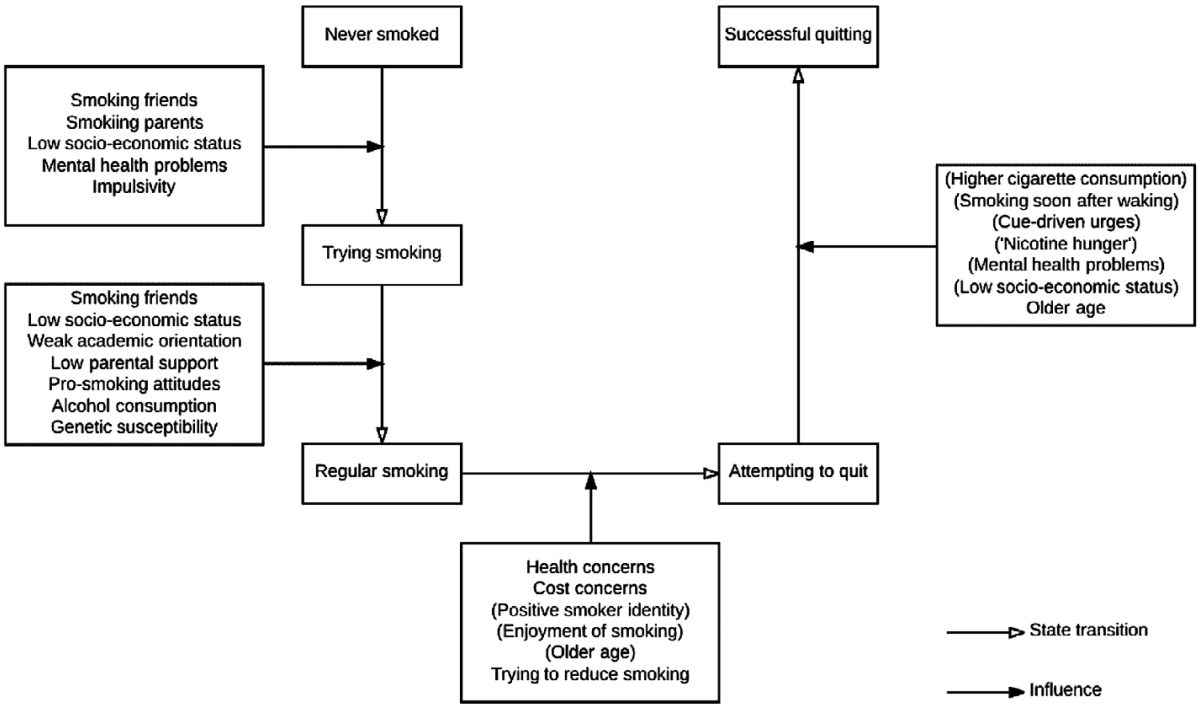


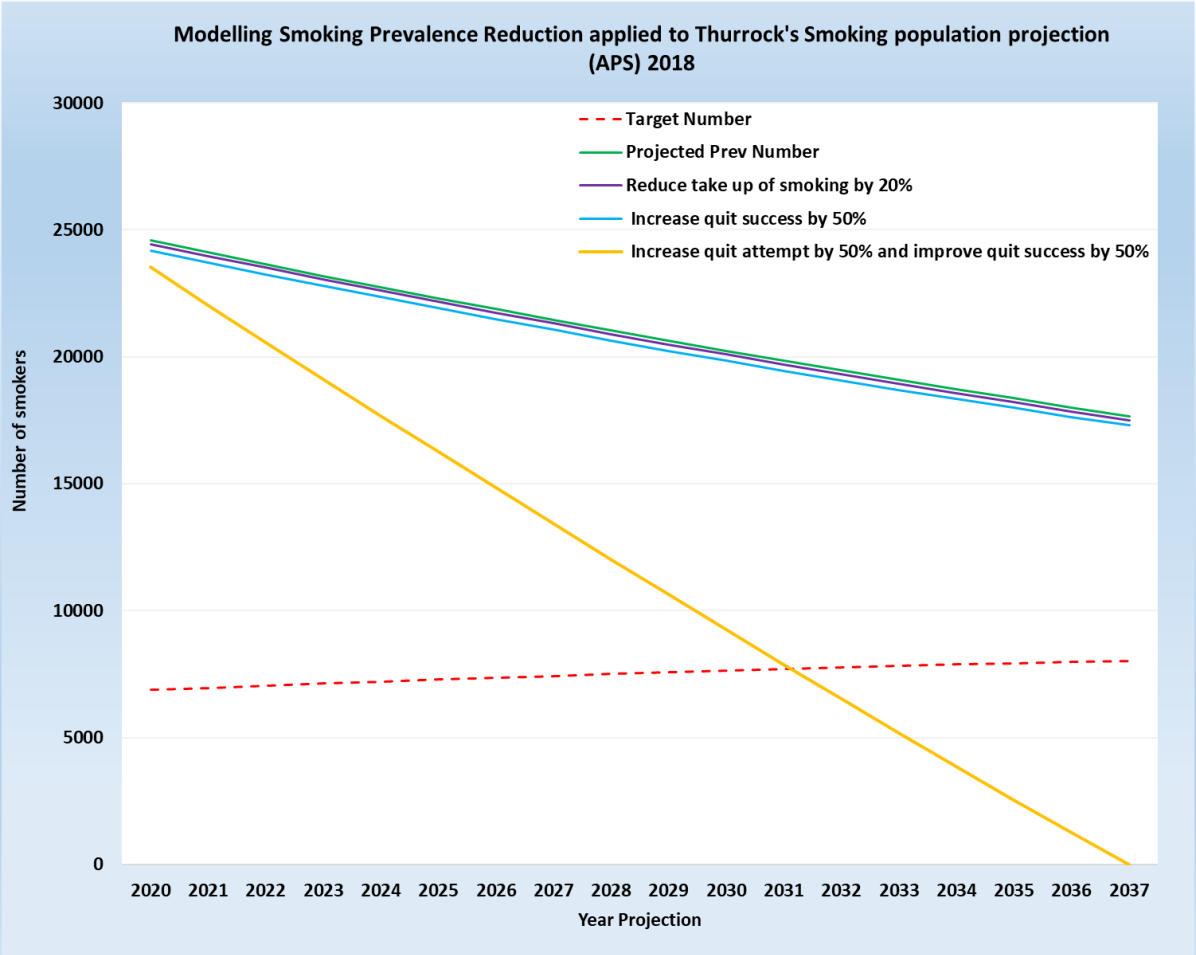
Figure 50: Influences and transition points to reduce smoking prevalence



Source: (West, 2017)

Professor West's model has been applied to Thurrock; this identified that to achieve the 2030 SmokeFree ambition of reducing smoking prevalence to 5% or less, Thurrock will need to increase its efforts through a combination of interventions to reduce prevalence from the current rate of -2.5% per year to -6% per year. The impact of different intervention options were tested and figure 51 demonstrates the result of this work, which found increasing quit attempts was by far the most important intervention to reduce prevalence in Thurrock.

Figure 51: Options for reducing smoking prevalence in Thurrock



Reducing uptake of smoking (an intervention mainly aimed at young people) has very little impact on achieving this target, as does increasing quit success rates above current levels. However, this model does not address equity of impact and only focuses on reducing smoking prevalence as an outcome, where interventions for enforcement for example, address wider tobacco impacts. Thus this section will consider evidence for all three of Thurrock's strategy action areas (prevention, enforcement and treatment).

8.1 Prevention evidence

Since initiation of smoking mostly happens before the age of 18 (approximately 65% of smokers started before this age), this section presents evidence for preventing uptake of smoking among children and young people.

Mass media campaigns

Mass media campaigns can have a significant effect on reducing smoking prevalence among children and adolescents but the evidence is mixed (Carson KV, 2017). Successful campaigns seem to be characterised by having a theoretical basis, use formative research in designing the campaign messages, and use message broadcasts of reasonable intensity over extensive periods of time. While these attributes have also been found in unsuccessful campaigns, it seems the most important factors for success include:

- Longer duration (minimum 3 years)
- High intensity (more contact time) for both school-based lessons (minimum eight lessons per grade) and media spots (minimum four weeks' duration across multiple media channels)
- Combined school-based components (e.g. school posters) and use of repetitive media messages delivered by multiple channels (e.g. newspapers, radio, television).
- Sufficiently complex to respond to the many issues that characterise young persons' smoking. In particular those that combine motivational enhancement and support combined with approaches based on social cognitive theory.

School based programmes

There is limited evidence for school-based programmes alone (Grimshaw, 2006), school policies to prevent smoking (Coppo A, 2014) or strategies to enhance the implementation of such policies (Wolfenden L, 2017). School programmes that use a social competence approach and those that combine this with a social influence approach have been found to be more effective than other programmes (Thomas R.E., 2013). These approaches take one year or more to have an impact.

A number of current UK programmes designed to prevent tobacco use in young people are available such as ASSIST. In 2017 Thurrock Council's public health department signed a three-year contract with Decipher-ASSIST to deliver their school-based peer-led prevention programme via NELFT. Resourcing and delivering the programme across participating academies proved a challenge. Evaluation after one year indicated that while the programme could impact smoking uptake among young people, its cost effectiveness was not as high as the original research indicated; mainly due to reduce smoking prevalence in this age group[9].

When the ASSIST intervention was originally trialled in 2001 and its cost-effectiveness estimated, smoking in Year 8 (age 12 – 13) was much more common than in 2017. In the Thurrock evaluation, less than 1% of students were weekly smokers at baseline. The impact was that the Thurrock evaluation was under-powered to demonstrate

[9] How much does it cost to stop children from smoking? objective://edrms.thurrock.gov.uk/id:qA150610

effectiveness but it was possible to derive an updated estimate of cost-effectiveness. This found that the cost of preventing one child from smoking at 2-years was £7,313 compared to £1,836 in the original trial. The major reasons for the decline in cost-effectiveness were:

- A dramatic fall in the prevalence of smoking among 12 and 13 year olds
- The cost of purchasing a licence for the intervention

The conclusion of the local study was that while ASSIST is regarded as a cost-effective, evidence-based intervention, changes in smoking prevalence have radically changed its cost-effectiveness. Based on the Thurrock evaluation, it is likely that the cost of preventing a child from taking up smoking (£7,313) is now greater than the cost of supporting an adult to quit (£5,000).

Other opportunities to impact smoking among children and young people

Education programmes aimed at children and young people tend to focus on harm reduction messages, rather than the zero tolerance messages that were common in sexual health or drug misuse national campaigns in the 1980s and 1990s. There is an opportunity to use harm reduction messages about tobacco, which recognise risk taking behaviour among this age group, within the relationships and health aspects of Personal, Social and Health Education (PSHE). This is an important opportunity partly because PSHE became a compulsory element of the national curriculum from 2020 (PSHE Association , 2021). This presents an opportunity for schools to embed lessons about the risks, harms and costs of tobacco use in PSHE lessons as well as across the curriculum in other lessons. Another area where schools could influence is to raise awareness of how Big Tobacco seeks to influence lifestyle choices and behaviours. Tobacco advertising targeted at young people on social media is a global problem and while at a local level it is not possible to influence this content, work to help children and young people navigate this is (ASEAN Tobacco Control Resource Centre, 2020).

As highlighted in the prevalence section of this needs assessment, it is known that some young people are more likely to smoke than others. Factors such as low educational attainment, coming from low income families and those with household members who smoke increase the likelihood of young people starting to smoke. There is also evidence of a relationship between engagement in other risk taking behaviours such as alcohol use and poor school attendance and smoking. Services that reach groups of children and young people more likely to be exposed to or engage in these risk factors are vital in reaching groups more likely to smoke. These may include mental health services and children's social care for example. They are more likely to be engaged in offending behaviour and could already be in the criminal justice system, perhaps already on the caseload of the youth offending service. It is recognised that not all young people in these sub populations smoke but screening approaches in these settings may help find those that do. For example, Thurrock's young person's substance misuse service has conducted screening and referral for stop smoking support for a number of years.

In summary,

- Mass media campaigns can have a significant effect on reducing smoking rates in children and young people.
- There is some evidence regarding the effectiveness of school-based interventions to prevent young people from starting to smoke. Schools remain a key setting for education work to ensure all children and young people are informed about tobacco harm and how to navigate this as part of a harm reduction approach.
- There is stronger evidence of impact of mass media campaigns but these need to be of high intensity and for a long duration.
- Screening for smoking and other tobacco use and referral to smoking services should be incorporated in services that work with children in groups more likely to smoke.
- There is also evidence that increasing the cost of cigarettes and addressing illicit tobacco can reduce uptake in young people; this is discussed in the next section (West, 2017).

8.2 Evidence for enforcement

Underage sales

Evidence indicates that enforcement interventions to prevent underage sales can reduce youth smoking prevalence, especially test purchasing for underage sales (Kaptein, 2017). There is weaker but positive evidence for retailer education programmes about stopping underage tobacco sales (Kaptein, 2017). There is less evidence currently on interventions to limit the social supply of tobacco to people under the legal purchase age; there is positive evidence however that education campaigns on this subject can be effective. Any local work done to address this should be well evaluated to enhance the evidence base on this aspect of enforcement.

NICE guidance supports the approach currently taken in Thurrock to address underage sales, including training/guidance for retailers; prosecuting retailers who break the law including use of test sales to identify these; sharing intelligence to improve the effectiveness of locations where underage tobacco sales are a problem; and to sustain such efforts (these are not a one off intervention) (NICE, 2015). In addition, evidence of the components of underage sales interventions that seem most effective include:

- youth recruitment (young people working with Trading Standards should reflect the socio-demographic profile, train and maintain test shoppers, and the ideal age of test shoppers seems to be 17)
- test shopping protocol (vary requested tobacco products according to the demographic of the test shoppers; require under 18s to carry ID and show if

asked; training test shopper to reduce risk of disclosure that the sale is a compliance check; and send the same test shopper multiple times to the same retailer).

Price sensitivity and illicit tobacco

Demand for cigarettes is sensitive to price; when prices rise, fewer cigarettes are purchased. The most recent analysis by HMRC estimated that a 1% increase in the price of cigarettes results in a fall in consumption of 0.57% (Johal, 2010). Other tobacco products are also sensitive to price; for example a 1% price increase would reduce demand by approximately 0.8% for cigars, 0.6% for roll your own tobacco, 0.6% for bidis and 0.2% for smokeless tobacco (Jawad M, 2018). The UK has the most expensive cigarettes in Europe however, illicit tobacco is generally cheaper, and it can be more harmful and may be used more by people in poorer socio-economic groups. It is therefore essential that work continues to reduce illegal tobacco sales and consumption within Thurrock.

Smoke-free policy

Smoke-free policies reduce exposure to tobacco smoke, encourage quit attempts, generate health benefits, protect children, de-normalise smoking and have strong public support (Royal College of Physicians , 2021). Evidence regarding the effectiveness and equity impact of such interventions is limited because of the variety in ways smoke free policies are applied and the quality of evaluations conducted. A literature review of the published research evidence on the subject found mixed reviews regarding the effectiveness. The main challenge that has emerged is that smoke free policies risk having an inequitable impact, reducing prevalence or exposure to second-hand smoke among less deprived communities. Such policies should be targeted to populations to maximise equity impact and well evaluated and monitored where they are implemented locally.

The Royal College of Physicians recommend that smoke-free policies do not automatically restrict vaping as it is one of several non-tobacco nicotine products that can support smokers to abstain while in smoke-free areas.

Regarding smoke-free homes specifically, there is a national policy gap concerning how best local authorities offer support to landlords regarding this area of law and for their own social housing premises. Non-smoking residents of multiple occupancy buildings may be affected by environmental tobacco smoke (ETS) from neighbouring units and The Court of Appeal has ruled that smoking bans do not engage human rights principles. However other legislation needs to be interpreted specific to circumstances regarding the degree of impact. Until the national policy gap in this area is rectified, Thurrock Council should explore its position and provide advice to landlords and for its own tenants regarding the risks associated with smoking in the home. Evidence indicates people are responsive to communications messages about the risk to others and this may serve as a useful tool in working with residents, alongside support offers to help people considering quitting to do so.

Some local authorities in England have developed policies for Smoke-free pavements around the outside dining areas if cafes and bars / pubs. There is not currently evidence of the impact of this, however survey data from ASH indicates that two thirds of respondents would support banning smoking in the outside areas of cafes, pubs and bars. This factor is particularly of relevance in the current COVID-19 pandemic context since many venues have increased or changed their outside dining / seating offer to enable greater capacity for customers outdoors.

8.3 Evidence for stop smoking treatment

Whole population

Economic analysis shows that stop smoking interventions, which increase the smoking quit rate by 1% are cost-effective when the costs are below £225 per service user (NICE, 2018). Based on data for 2019/20, Thurrock's SSS delivers its service at a cost on average of £78 per service user, although this varies by service provider, and all are below the NICE threshold (per person SAQD rather than quitting).

The most effective intervention is Stop Smoking Services (SSS) that offer a combination of nicotine replacement therapy (NRT) with behavioural support. This intervention is three times more effective at helping people to stop smoking compared to people who make an unassisted quit attempt (NCST, 2019). NICE also recently undertook an evidence review of Allen Carr's Easyway (ACE) programme as it is not currently considered as a stop smoking intervention in NICE guidelines but is increasingly being piloted in the UK, including Thurrock. The review was based on limited but good quality data (two randomised controlled trials) and found that compared to standard stop smoking services, there was no difference in the quit rates at any of the follow-up points compared to ACE. When compared to an online service that provided behavioural support but not combined with NRT, ACE was more effective, with quit rates significantly higher at all follow up points (NICE, 2020b). During the COVID-19 pandemic, Thurrock's SSS has adapted, offering online and telephone behavioural support but this has still been combined with an offer of NRT. Local evaluation allowing comparison of ACE with the current offer will enhance the evidence on this topic.

Thurrock offers smokers across all its SSS the opportunity to have an increased duration of support for 12 weeks (the usual period of support offered is to 4 weeks). Quit duration is one of the factors that impact risk of smoking relapse six to twelve months after quitting; other pre quit baseline factors include quit intentions and the number of friends who smoke (Yong HH, 2018). The number of friends smoking has been found to be the only remaining predictor of relapse in the 1-2 years post quit period, making ex-smokers about twice as likely to relapse (Yong HH, 2018). This has implications for addressing smoking prevalence among groups where smoking prevalence is higher to start with such as people working in routine and manual occupations or those with mental illness.

E-cigarettes are currently the most popular method used by smokers attempting to quit and there is evidence to suggest they have increased the number of people who quit smoking successfully (PHE, 2018). This is based on population level estimates of additional quitters resulting annually from the availability of e-cigarettes. Research evidence comparing e-cigarettes to other forms of stop smoking intervention has produced mixed results and the current consensus is that more evidence is required regarding the relative effectiveness of e-cigarette use alone (PHE, 2018) (Hartmann-Boyce J, 2020). There is promising evidence that when e-cigarettes are used as part of standard SSS in the UK, around two thirds of smokers successfully quit. However in 2016/17, only 4% of people using SSS also used an e-cigarette. In Thurrock, two vape shops have been commissioned to offer behavioural stop smoking support alongside e-cigarette sales; monitoring and evaluation of this method will add to the evidence base and can further inform the tobacco control agenda locally and nationally.

Some other factors for consideration regarding the evidence concerning e-cigarettes role in tobacco control include (PHE, 2018):

- There is now no clear gradient in prevalence by occupational grade.
- Prevalence of dual use (vaping and smoking) is similar for e-cigarette users and users of nicotine replacement therapy.
- E-cigarette use among ex-smokers needs monitoring as there is an increasing trend in this cohort taking up vaping; further evidence is needed to understand whether this is associated with an increase or decrease of relapse to smoking.

In summary, stop smoking treatment services delivered in line with NICE guidance on the method of delivery consistently have a strong evidence base for effectiveness. Increasing the duration of support available may help reduce the risk of relapse and Thurrock can play an important role in developing the evidence around this. This also applies to building the evidence base regarding the effectiveness of e-cigarettes when combined with behavioural support. The evidence of their use is promising and suggests they can help people who smoke to quit but more comparative evidence is required. Furthermore, their role in relapse into smoking among ex-smokers needs to be monitored; work with local vape shops could support development of insight locally. An important predictive factor for relapse among ex-smokers is the number of friends they have who smoke; attracting high prevalence networks to quit together may be effective in reducing this risk and will require community insight data.

This section of the needs assessment will now present evidence specific to the priority population groups for Thurrock. The focus is on smoking treatment as this is the most important factor in reducing prevalence and the intervention for which there is the greatest opportunity to target support locally. However, all three aspects of Thurrock's tobacco control strategy (enforce, prevent, treat) have been considered where there is evidence about their impact in these sub population groups.

Priority population groups

Socio-economic inequalities:

A recent equity impact review of the WHO tobacco control intervention areas cited in table 9 earlier in this needs assessment found an increase in research on this topic. However, an increasing proportion of studies were unable to establish a positive or negative equity impact (Smith CE, 2020). The price of cigarettes/taxation measures are the only intervention to consistently demonstrate an equity-positive impact with regard to having a greater proportionate impact on smokers in low SES groups (Smith CE, 2020). Local interventions that are important in supporting this intervention area include political support for bringing the rate of tax for hand-rolled tobacco to match the rate for manufactured cigarettes and action to stop supply to illicit tobacco. Measures for the latter have already been discussed in this chapter.

There is also evidence that SSSs can deliver equity-positive effects on quitting if they are designed to attract proportionally more low SES smokers to set a quit date, to compensate for the lower quit success rates in this population (Smith CE, 2020). Specifically, referral and treatment pathways that engage key referral partners such as money advice providers or GPs in areas of greater socio-economic deprivation are effective (ASH, 2019). Recent studies (published since 2019) have found the following:

- ASH Scotland undertook insight research with anti-poverty organisations to understand the acceptability and feasibility of their engagement with stop smoking interventions (ASH Scotland, 2019h). While there was recognition of the importance of smoking on impacting health for their client group, it was not a subject the staff felt able to proactively address, nor a priority their clients raised when asked. Suggestions to improve joint work included positively framing marketing materials (offer of support, rather than taking something away); identifying with the community alternative coping mechanisms to smoking; and training for antipoverty organisations. Thurrock does not currently have referral pathways or deliver training to ‘anti-poverty organisations’. Based on ASH’s recommendations to design referral pathways that improve access of SSS among lower NSSEC groups, this insight can help Thurrock address this aspect of its SSS design.
- A study exploring the impact of a Lung Health Check (LHC) service in an area of greater deprivation found that most smokers felt the service had an impact on their ability to or motivation to quit (Balata H, 2020). There was a 10.2% quit rate among attendees, which was closely associated with baseline symptoms. A small proportion of the attendees (5%) attributed quitting to the LHC, while 44% reported the LHC had made them consider stopping, 29% it made them try to stop and 25% made them smoke less. In Thurrock, if the local Lung Health Check programme is delivered in areas of deprivation, it could have a positive equity impact on smoking quits and quit attempts in the area.
- A mobile, drop-in stop smoking service in Nottingham, UK found that compared with smokers accessing the standard SSS, mobile SSS smokers were significantly more likely to be from a routine and manual occupation group (33.3% vs 27.2%, p=0.002), and to be first-time SSS users (67.8% vs 59.3%,

p<0.001). Nearly 1 in 10 smokers setting a quit date through the mobile SSS had no prior quit intentions. The cost per smoker SAQD for the mobile SSS was slightly higher than the standard SSS in Nottingham (£224) but still within NICE's cost effective price limit for SSS (£225). This is evidence from a single study and therefore more evidence is required to see if the same effect could be replicated elsewhere. However it offers an alternative SSS approach for Thurrock to consider that has had a significant positive equity impact.

There is mixed evidence regarding the impact of smoke free policies and media interventions, with more studies indicating an equity-negative effect than those that find a positive or neutral impact. The main limitation of literature reviews on this subject is the heterogeneity of the studies; individually, there are some studies that have found equity positive potential in smoke free policies through employers that reach people in routine and manual roles and smoke free policies in cars (Smith CE, 2020). The same is true of media interventions, where those specifically tailored to reach people in poorer socio-economic groups have been found to be effective (ASH, 2019). Such interventions require local insight to the fit of their use alongside the wider tobacco control approach and close monitoring and evaluation to assess and respond to their impact.

In addition to the WHO intervention areas, ASH also recommend taking a harm reduction approach to support people in more deprived areas to stop smoking. Specifically it is recommended that NRT and e-cigarettes are made available at low / no cost. As a strategy, there may be concern about creating future inequity by increasing prevalence of vaping in more deprived populations; it is true that this carries a cost implication long term but continuing a smoking habit does too. Furthermore, there is evidence that while people from more affluent socio-economic groups may be more motivated to stop vaping, they are less likely to try to stop. Locally, harm reductions strategies should be routinely monitored and evaluated to assess the equity impact but currently published evidence does not indicate an inequitable impact on long term behaviour in this respect.

People in contact with the criminal justice system (PCCJS)

People in contact with the criminal justice system (PCCJS) were not identified in the previous Thurrock Tobacco Control Strategy as a priority population, however a greater proportion of PCCJS live in areas of higher deprivation. Smoking rates in this population are high; national data from 2013 found 80% of PCCJS smoked. This reflects the high rates of mental health conditions and other aspects of disadvantage that are more prevalent in this population. Since 2018, all closed prisons in the UK have been smokefree; it is recommended that local authorities are able to support individuals moving from prisons to the community to maintain abstinence from smoking or to quit in the transition from a smokefree environment (ASH, 2019).

Mental health:

Progress has been made with regard to smokefree policy culture in inpatient mental health settings; one process evaluation in a local area used "Normalization Process Theory" to evaluate the impact and culture change and found this a feasible method

of evaluating and monitoring the impact (Jones SE, 2020). The results indicated a mixed picture with regard to agreement with the policy and recognition of its rationale; a need for better monitoring was highlighted. Another study explored the impact of different interventions on the delivery of very brief advice interventions for smoking cessation among people with psychosis (Spaducci G, 2020). Results indicated that financial incentives and recording forms can be effective at increasing the proportion of patients who are asked about their smoking status. Smoke free policy increased the odds of patients being advised about smoking, but it was introduction of a recording form that had the greatest impact on action around smoking, which increased the likelihood of a referral over 4 times that of pre intervention care (Spaducci G, 2020). An electronic referral system was also effective in encouraging staff to ask about smoking status and refer but less impactful than the recording form.

There is evidence of the effectiveness, acceptability and feasibility of offering smoking cessation support in mental health services both for people with common mental illness and people living with SMI. The SCIMITAR+ trial is a high quality study (randomised controlled trial) that has found delivery of smoking cessation through mental health services to be more effective for people with SMI than usual care (Peckham E, 2019). The SCIMITAR intervention includes stop smoking support delivered by a mental health professional (care co-ordinator, support worker, mental health nurse) trained in smoking cessation interventions. Specific adaptations made to the stop smoking service design for this cohort included several assessment sessions prior to setting a 'quit date'; recognising the purpose of smoking in the context of their mental illness; recognising the need to involve other members of the multidisciplinary team in planning a successful quit attempt for those with complex care needs and multiagency programmes of care; arranging meetings so they could take place in a mutually agreeable location, often in the participant's home rather than in the GP surgery or on NHS trust premises; providing additional face-to-face support following an unsuccessful quit attempt or relapse; and informing the GP and psychiatrist of a successful quit attempt so that they can review antipsychotic medication doses in line with changes in metabolism. People with SMI who received the intervention were more likely to have stopped smoking at 6 months. Although more people who received the intervention had stopped smoking at 12 months, this was not statistically significant (Peckham E, 2019).

Qualitative research with service users and staff in IAPT services has found that patients and staff accept evidence that smoking tobacco may harm mental health and some patients described it as a form of self-harm. However, patients also reported psychological benefits from smoking and stop smoking advisors external to IAPT were pessimistic about the success of models supporting people with common mental health conditions to quit. The IAPT staff who were interviewed however had positive attitudes towards helping this population to quit and felt confident in offering smoking cessation treatments to patients, but suggested a caseload reduction may be required to deliver smoking cessation support in IAPT (Taylor GMJ S. K., 2020).

Barriers to addressing smoking with patients have been highlighted in other research; these include psychological capability to recall training content, misunderstand the potential benefits of addressing patient smoking and harm reduction approaches; time

constraints; social opportunity in terms of increased cultural value of tobacco following inpatient smoke-free policy implementation, and lack of support from colleagues to enforce the smoke-free policy; intrinsic biases regarding patients abilities and motivations to quit, and perceptions around job role and decision making processes related to addressing behaviours deemed more important than smoking. The main facilitating factors identified were MHPs' having opportunity in the form of patients asking directly for support, and MHPs having access to resources such as stop smoking services and spirometers (Smith CA, 2019). These factors should be considered in service planning for people with mental health conditions.

Supporting smoking cessation in this group not only improves physical health but also has potential to improve mental health; a recent Cochrane review found that people who stop smoking are not likely to experience a worsening in their mood long-term. They may also experience improvements in their mental health, such as reductions in anxiety and depression symptoms (Taylor GMJ L. N.-J., 2021).

Children and Young People (CYP):

Raising the age of sale for tobacco to 21 is identified as one of the most effective ways to reducing uptake of smoking among children and young people (ASH, 2019). Current legislation that limits the age of sale to 18 has had some effect, but local work by trading standards teams is an important part of this intervention in stopped underage sales. This work does not however prevent the social supply of cigarettes or address the impact of social norms on uptake, especially among CYP from poorer socio-economic groups. Media campaigns have been found to be more effective in addressing this than schools programmes, although there is potential use in offering both; the previous section on whole population methods for ‘prevention’ have summarised the evidence relevant to this, including for CYP.

With regard to smoking cessation services, a Cochrane review of evidence found only one study in a UK setting; most studies were undertaken in the US. The review assessed the effectiveness of different types of smoking cessation support for young people who smoked at least once a week for at least six months. While the quality of the evidence found was weak, there was evidence that interventions involving group counselling, some peer-led, were effective at stopping smoking after at least six months follow-up, pooled relative risk (RR) 1.35 (95% confidence interval [CI] 1.03 to 1.77). Other forms of support including individual counselling were not found to be effective.

It is especially important for local tobacco control approaches to direct support to groups of CYP most likely to smoke. This includes efforts to prevent uptake and to support young people who smoke to stop. Children who are in, or have been through, the care system are more likely to smoke, have a diagnosable mental health condition and many have experiences and interactions with social groups that increase their exposure to smoking. Placement in smokefree homes, while also ensuring that looked-after children who do smoke have every opportunity to quit, are interventions recommended by ASH (ASH, 2019). Evidence specific to these groups was not identified and broadly, Cochrane reviews have established that there is limited and weak evidence with regard to interventions for CYP regarding tobacco control.

Therefore any local interventions should be well evaluated and the results published to enhance tobacco control in the UK for young people.

Maternity:

ASH identify the three most effective, evidence based interventions that will have the most impact on communities vulnerable to smoking in pregnancy are (ASH, 2021):

- well-funded tobacco control programmes
- social marketing campaigns aimed at smokers from socio-economically deprived communities
- raising the age of sale to 21 (from 18)

Although these three interventions do not specifically mention the maternity care pathway, the rationale for them is recognition that most pregnant women who smoke are from younger age groups and from more deprived areas. Reducing smoking prevalence among these groups will reduce the proportion of women from these groups who become pregnant as a smoker, and will improve the social circumstances for those trying to quit in pregnancy and reduce the risk of relapse for those who manage to quit. These interventions have been discussed elsewhere in this needs assessment and can inform the wider tobacco control agenda (ASH, 2021).

Specifically for maternity pathways, ASH recommend monitoring and benchmarking of NICE's 'Saving Babies Care Bundle', which includes opt out referrals to specialist stop smoking support. How this intervention is resourced and planned for should include joint work planning between Integrated Care Systems and Local Maternity Systems. This is particularly important for women receiving support through the Continuity of Carer model since the groups being targeted for this type of support are likely to have a greater proportion of smokers (ASH, 2021). ASH also recommend monitoring smoking at booking, at 36 weeks and at delivery and exploring the role of smokefree homes. This approach has been found to be effective with partners of smokers; for example one NHS Trust that piloted CO monitoring for both pregnant women and their partners during pregnancy found an increase in engagement by partners in stop smoking support from 4% to 39% and increase quit rate from 2% to 60%. There is also strong evidence for the effectiveness of incentives for reducing smoking in pregnancy; a Cochrane review of the evidence found women receiving incentives are almost twice as likely to quit smoking and that the effect is sustained post-partum. There is also evidence that offering this support to "significant other supporter" (SoS) of pregnant women is effective in enabling pregnant women to quit and stay quit. Partnering with social housing providers is another measure recommended for piloting (ASH, 2021).

LTCs:

The evidence of impact of smoking cessation among people with LTCs is strong. For example, surgical outcomes for patients who smoke are significantly worse than for those who do not smoke while quitting smoking four weeks before surgery significantly reduces the risk of post-surgical complications (ASH, 2020h). Behavioural change theory also highlights health crises and diagnosis as a prompt for behaviour change; such opportunities can be used by healthcare professionals through MECC.

However, there is little published evidence regarding the most effective methods for delivering stop smoking services specific to individual long term conditions. This is most likely because people with LTCs receive support through stop smoking services aimed at the general population and the specific impact on these groups has not been well researched.

A Cochrane review of evidence regarding smoking cessation interventions for people with lung cancer concluded that it could not make recommendations at this time and called for RCTs to help answer this question (Zeng L, 2019)**.** One study of high intensity behavioural interventions that begin during a hospital stay found smoking cessation interventions in a hospital setting to be effective, regardless of the patient's admitting diagnosis. Patients received at least one month of supportive contact after discharge (Rigotti NA, 2007). Local studies, especially work undertaken through the LTP tobacco control fund in acute trusts should be well evaluated and results shared to assess which models of smoking cessation support are most effective for patients.

The next section of this needs assessment will now reflect gaps identified between the current evidence for tobacco control and the provision and tobacco related need in Thurrock.

9 Gap analysis

This JSNA has identified that Thurrock continues to deliver a robust approach to Tobacco Control through its three strategic action areas, prevention, enforcement and treatment. In particular:

- The Stop Smoking Service is close to supporting the NICE recommended reach of 5% of the smoking population per year. The service performs well compared to the national average for supporting people to the 4 week quit target and demonstrates leadership in its offer to support smokers for 12 weeks to encourage a more sustained quit.
- The Trading Standards work regarding enforcement has led to measurable impact on stopping the supply of illicit tobacco and should be continued. This is a particularly important area of work for reducing uptake among children and young people and reducing access to cheaper cigarettes, which has a higher impact on poorer socioeconomic groups.

There are areas for improvement and particularly regarding reducing socio-economic and mental health inequalities in smoking. This section of the JSNA highlights the main areas where improvements could be made using Professor Robert West's model referenced earlier in this document showing the main influences on smoking prevalence.

9.1 Preventing never smokers becoming regular smokers

Table 10 summarises the influences that increase the risk of non-smokers becoming regular smokers, the local response and opportunities to improve the local response.

Table10: Influences, local response and opportunities to encourage smokers to quit

Influences	Local response	Opportunities
Smoking friends Weak academic orientation	-NELFT School Health Service -Brighter Futures Survey	-Social supply – knowledge gap -Marketing -Services working with vulnerable YP: screen for YP trying smoking to reduce the risk of them becoming regular, long term smokers
Smoking parents Low parental support	-Midwives at BTUH working to address smoking in pregnancy	-Health Visitors: identify how this role impacts smoking in the home post birth -Service working with families: scope to assess and offer support for families with a smoker/s in the household

Low socio-economic status	-Illicit tobacco: Trading standards work to reduce supply of low-cost tobacco may impact on ability of people to become regular smokers (cost pressure)	-Work with employers, relevant council services to screen for occasional / relapsed smokers as well as regular smokers to offer support early. Especially services working with CYP. -Review access of treatment offer
Pro smoking attitudes	Marketing e.g. Stoptober	
Mental health problems	-SmokeFree EPUT: having a smokefree environment in the mental health trust will help reduce the risk of inpatients who do not regularly smoke taking up smoking -SMI physical health check: an opportunity to review whether people with poor mental health are occasionally smoking and offer treatment support	-Review MECC at end of MH service pathways -Review MECC in non MH services
Alcohol consumption	-Referrals from substance misuse services	-Review offer with bars, restaurants on smoke-free enforcement
Impulsivity	-Trading Standards work on shop display compliance	

9.2 Motivating current regular smokers to attempt to quit smoking

Table 11 summarises the influences, current offer and opportunities to encourage regular smokers to attempt to quit.

Table11: Influences, local response and opportunities to encourage smokers to quit

Influences	Local response	Opportunities
Health concerns	GP and pharmacy treatment offer Lung health checks	LTC pathways Breathe easy groups and other vol sector groups Acute care - LTP

Cost concerns		Work with relevant services e.g. housing, debt management
Positive smoker identify	Marketing e.g. Stoptober	Work with services that support groups with higher prevalence – culture change
Enjoyment of smoking	SmokeFree	
Older age		LTC pathways Sheltered housing
Trying to reduce smoking	Marketing e.g. Stoptober THLS marketing and links with other services	

9.3 Supporting smokers attempting to quit to have success in doing so

Table 12 summarises the influences, current offer and opportunities to better support smokers who are attempting to quit to do so successfully.

Table12: Influences, local response and opportunities to encourage smokers to quit

Influences	Local response	Opportunities
Higher cigarette consumption	THLS smoking treatment offer includes behavioural support advice that considers this.	
Smoking soon after waking		
Cue driven urges	Trading Standards work re point of sale etc	
Mental health problems		Review MECC at end of MH service pathways

		-Review MECC in non MH services
Low socio-economic status		-Work with employers -Work with relevant council services -Review access of treatment offer
Older age		LTC pathways

In addition to the broad intervention responses described in the tables above, there are also opportunities to improve leadership and some operational aspects of the local tobacco control approach. These are summarised below:

9.4 Leadership and operational factors

Leadership: for Thurrock to significantly increase the rate at which smoking prevalence declines in the area, all local institutions and systems need to be engaged in the tobacco control agenda. The current approach is driven by the council's public health team. Local commissioners across all public sector organisations need to be considering the relevance to outcomes they are responsible for; work with local business needs to take place to make employers aware of the relevance to their workforce; local communities in priority groups need to be engaged in coproducing solutions. This systems work needs to take place at all relevant geographies including the local authority and MSE HCP footprint. The Tobacco Alliance ceased pre COVID and its role should be reviewed; there may be potential in working at a larger geographic scale to develop a shared alliance with Essex and Southend on Sea to support work with providers that deliver services impacting residents and the workforce across these areas. It may also be an opportunity for enforcement activity, social marketing, and research/ evaluation.

Further consideration should also be given to Thurrock's harm reduction approach to the tobacco control and e-cigarette agenda, building on the work established with the Adult Safeguarding Board.

Integrated / holistic offer: For some population groups who may have multiple social and health needs that the council and its partners are seeking to address, including smoking as part od a more holistic assessment and response may better enable the individual to address the issue most of concern to them at any given point in time. In this way, some populations less likely to consider smoking cessation support may feel better prepared to attempt to quit once other social / health challenges are better

managed / resolved. This approach would require a strategic intervention across the council.

Evaluation and research: Thurrock has delivered high quality evaluations such as the ASSIT programme, however there is insufficient research evidence supporting some areas of Tobacco Control. Also, some aspects of Tobacco Control require highly localised approaches. For these reasons evaluation and monitoring of areas of innovation is an important strategic element of Tobacco Control. It will allow Thurrock to respond based on whether local interventions are effective, cost effective, or produce unintended harm. It will also enable Thurrock to contribute to the wider research agenda and there may be opportunities to work with the regional Academic Research Hub and other academic institutions to help fund this work.

10 Recommendations

The recommendations prepared here will be addressed in Thurrock's 2021-2026 Tobacco Control Strategy.

1. Thurrock Council should deliver localised prevention campaigns that aim to increase the number of people attempting to quit and normalise quitting. These interventions should use social marketing insight to increase their effectiveness. This work should target high prevalence communities and also children and young people across the borough.

2. Thurrock Council should continue to fund its stop smoking service and explore opportunities to improve access in the eight wards contributing over half of the boroughs smokers.

3. Member organisations of the Health and Wellbeing Board should ensure their organisations have an integrated MECC offer for smoking and develop referral pathways (rather than signposts) to the SSS. This includes NHS providers, social care services and children's services but should also reflect wider partners such as those providing support around employment and debt management for instance.

4. Thurrock Council's public health team should identify local organisations who work with people from high prevalence groups and work with them to create referral pathways, use system levers such as contractual incentivisation and deliver training to internal staff to encourage more quit attempts from these communities.

5. PCNs and in particular, Tilbury and Chadwell and ASOP, should work with high performing practices to improve their service offer. There are particular opportunities in this setting to enhance the offer to people with long term conditions as part of a holistic approach in the Integrated Medical Centres.

6. Through the LTP tobacco control funding, it is recommended that MSE HCP employ a member of staff for each acute trust to coordinate MECC and improve referrals into stop smoking services.

7. The maternity service at BTUH should extend its smoking cessation offer to a Smoke-free homes approach, including MECC and referral for partners /significant others of pregnant women. This should include the partners /

significant other of pregnant women who do not smoke themselves. The impact of this should be well evaluated; the use of incentives in this population should be considered depending on the impact of first offering a wider Smoke-free homes approach.

8. Opportunities to increase screening for smoking and vaping among children and young people should be explored, in part based on the Brighter Futures Strategy.

9. Opportunities to increase and strengthen referral pathways from mental health services in Thurrock and at MSE level should be developed. Thurrock CCG should integrate requirements to enhance the stop smoking service offer into contracts to encourage action in this area.

10. Work with community organisations should be undertaken to reach groups that are not yet well understood in regard to the effectiveness of the stop smoking offer. This mainly includes BME groups as little is known locally about the nature of tobacco use in BME communities and the SSS data indicates this group may be underrepresented. However work to support other groups with protected characteristics should also be explored including transgender and LGBTQ groups and people with a learning disability.

11. A Tobacco Control Alliance or other leadership mechanism should be reinstated to ensure the profile of tobacco is high on the agenda of local partners and to support delivery of the whole systems approach required to achieve a substantial reduction in smoking prevalence.

12. Interventions should be evaluated, especially areas for innovation to assess their effectiveness and equity impact.

13. Opportunities to enhance the enforcement offer should be explored, inline with updates to legislation that are anticipated in the lifetime of the tobacco control strategy that will follow this JSNA.

14. THLS should work with the learning disability health provider to ensure reasonable adjustments are made to the core SSS offer for individuals appropriate to their needs.

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