Havering Tobacco Harm Reduction Needs Assessment June 2024

Document Control

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Contents

1. Executive Summary

Background

Smoking is the primary cause of preventable ill health and deaths in the UK and is a major driver of persistent health inequalities. In addition to its health impact smoking results in a range of costs-to the individual, the NHS and to the wider economy.

In recognition of the preventable harm caused by smoking the government published the Tobacco Control Plan (2017-2022) outlining four key areas of action to reduce tobacco harm. More recently in 2023 it published a command paper[1] setting out a range of measures to drive forward its smoke free ambition including:

- Creation of the first smoke-free generation by legislating to raise the age of sale of tobacco one year every year (from 2027 onwards) to ensure children born on or after 1st January 2009 will not legally be able to buy tobacco products.
- Strengthening support for people to quit smoking.
- Tackling youth vaping.

Needs Assessment

This report sets out the findings of a tobacco needs assessment using a range of methods and is aimed at providing understanding of the extent of smoking in Havering, groups most at risk, the associated factors as well as the level of service provision. It ends with a set of recommendations to inform refresh of the tobacco harm reduction strategy and action plan.

Whilst the primary focus of the needs assessment is on smoked tobacco amongst the Havering population, it touches on the growing concern of vaping amongst young people.

Key Findings

- Havering's smoking prevalence has risen in recent years and accounts for the highest smoking rates across North East London in 2021 with prevalence of 15.9%, compared to London (11.7%) and England (12.7%) averages.
- Key groups in Havering with high smoking rates are males, the homeless, those misusing substances, individuals with serious mental illness, routine and manual workers as well as those living in rented accommodation and social housing. See Table 1.
- Anecdotal evidence indicate certain groups, such as those from Eastern European, Roma, Gypsy or Traveller backgrounds, are more likely to smoke but currently no local data is available for these populations, as they are often overlooked in surveys.
- Residents living in the most deprived areas of the borough exhibit a higher smoking prevalence.
- In early pregnancy, 9.5% of women in Havering smoke, compared to the England average of 12.8% with 4.8% of women smoking at the time of delivery in 2022/23 compared to 8.8% England average.
- 993.1 out of 100,000 hospital admissions and 198.2 out of 100,000 deaths were attributed to smoking.

[1] Stopping the start: our new plan to create a smokefree generation

- Smoking costs the borough £266.8 million each year, while tax revenue amounts to only £64.5 million.
- A significant number of children are exposed to second hand smoke with 10,200 children residing in smoking households, and 480 children start smoking each year.
- Vaping among young people as well as sale of illegal and disposable vapes are a rising challenge to Havering.

Table 1. Smoking prevalence by demographics in Havering

Demographic	Havering Prevalence	England/UK Prevalence
Gender	Smoking prevalence is higher among males, at 22.5% compared to 8.5% in females.	13% of current smokers are male and 10% of current smokers are female[2].
Occupation	Routine and manual workers exhibit a higher smoking prevalence (28.1%).	In England, the routine and manual worker smoking prevalence is 22.5%[3].
Ethnicity	Main white residents have the highest smoking prevalence at 40.30% according to GP data	The percentage of adults who smoke is higher than average in the Mixed (19.5%) and White (14.4%) ethnic groups[4].
Substance Use	60% of adults admitted for alcohol and non-opiate misuse smoke, while 69.7% of adults admitted to treatment for all opiate misuse smoke.	Across all substance groups, the level of smoking for individuals is higher (53%) than the general adult population in England[5].
Homelessness	Among those registered as homeless with GPs, 51% report smoking.	In the UK, smoking prevalence is estimated at 78% amongst adults experiencing homelessness[6].
Mental Health	Individuals with a serious mental illness have a smoking prevalence of 33%.	England's smoking prevalence in adults with a long term mental health condition who currently smoke is 25.1%[3].
Housing	Smoking prevalence in both private housing tenants (29%) and social housing tenants (22.5%) are high.	33% of those who live in social housing are cigarette smokers[7].

[2] Statista, 2021: Distribution of cigarette smoking status in England in 2021, by gender.
[3] Fingertips Public Health Data, 2022/23: Smoking Profile.
[4] GOV.UK, 2021: Cigarette smoking among adults.
[5] GOV.UK, 2023: Adult substance misuse treatment statistics 2021 to 2022: report.
[6] School of Psychology, University of East London and Centre for Addictive Behaviour Research, 2017: smoking amongst adults experiencing homelessness: A systematic review of prevalence rates, interventions and the barriers and facilitators to quitting and staying quit.
[7] Jackson S, Smith C, Cheeseman H, West R, Brown J. (2019). Finding smoking hot-spots: a cross-sectional survey of smoking patterns by housing tenure in England. *Addiction (Abingdon, England)*, *114*(5), 889–895.

Key Recommendations

Smoking

- Expand service provision and ensure availability of a full range of behavioural interventions and cessation aids, including vapes.
- Prioritise tailored support for high-smoking prevalence groups based on specific needs.
- Improve ward level data collection and for specific groups to facilitate targeted interventions.
- Provide carbon monoxide testing and intensive support for pregnant women, including using smoking cessation incentives.
- Provide training for front line health & social care staff (including Very Brief Advice training) to improve knowledge, skills and confidence to engage and signpost those smoking to support services.
- Raise awareness of tobacco harm and local stop smoking services through campaigns and align local campaigns with community needs.
- Ensure that services are accessible and are culturally and linguistically sensitive to different groups, including the homeless and those with learning disabilities.

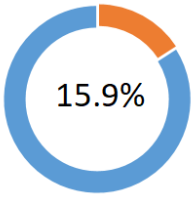
Vaping

- Strengthen partnership work with trading standards to address sale of illegal vapes and cigarettes and tighten enforcement measures.
- Work with educational establishments and young people to raise awareness of harm from both tobacco and vapes.
- Conduct a separate needs assessment to understand extent of vaping amongst young people and types of vape substances sold in Havering.

See below chapters for detailed recommendations for the following groups:

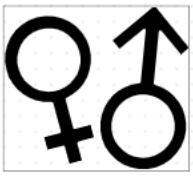
- Pregnant Women
- Serious Mental Illness (SMI)
- Housing (Those experiencing homelessness, social housing, private renters)
- Young People
- Learning Disabilities
- Substance Use

Smokers



15.9% of Havering's 18+ population smoke.

Smoking by Gender

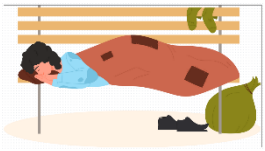


22.5% of males in Havering smoke compared to 8.5% of females.

Manual Occupations

28.1% of routine and manual workers (aged 18-64yrs) in Havering smoke.

Homelessness



51% of those registered as homeless with Havering GPs smoke.

Private Renters

29% of Havering's private housing tenants smoke.

Social Housing

In Havering, 22.5% of social housing tenants smoke.

Learning Disability

7.9% of those with a learning disability in Havering smoke.

Serious Mental Illness (SMI)

In Havering, 33% of those that have a serious mental illness smoke.

Alcohol Users

60% of Havering adults admitted to treatment for alcohol and non-opiate misuse are smokers.

Opiate Users

69.7% of Havering adults admitted to treatment for all opiate misuse are smokers.

Children Smoking

Every year, 480 children start smoking in Havering.

Children Vaping

Nationally, in 2023, 20.5% of children tried vaping.

Second-Hand Smoke

10,200 children live in smoking households within Havering.

E-cigarettes

Nationally, in 2023, 9.1% of adults used e-cigarettes.

Tax

Havering receives £64.5 million in tax revenue, annually, from cigarettes and hand-rolled tobacco.

Smoking Costs

Smoking costs Havering £266.8 million per year.

Sources of data: NEL ICB GP Data (September 2023), Annual Population survey (APS) 2022, Action on smoking and health (ASH) Data Jun to Nov 2023, National Drug Treatment Monitoring System 2019/20.

2. Introduction

Smoking is the leading cause of avoidable ill health and premature deaths. Smoking poses severe risks to an individual's health by increasing the likelihood of developing more than 50 health conditions such as lung cancer, heart disease, stroke, and Chronic Obstructive Pulmonary Disease (COPD). Smoking during pregnancy increases the risk of a range of adverse health outcomes to the unborn child and to their subsequent development including low birth weight, miscarriage, preterm birth and stillbirth. Nationally, smoking is linked to over 500,000 hospital admissions each year, with smokers 36% more likely to be admitted to hospital than non-smokers[8]. According to NHS Digital, in 2019, an estimated 74,600 deaths were attributable to smoking in England.

According to Action on Smoking and Health (ASH), smoking is the single largest cause of life expectancy gap with about half of all lifelong smokers estimated to die prematurely, losing an average of 10 years of life.

Exposure to second-hand smoke introduces both short-term and long-term consequences with long-term exposure increasing risk of lung cancer, coronary heart disease stroke and dementia with children especially vulnerable, facing heightened risks of cot death, glue ear, asthma and other respiratory issues.

Smoking is al known major driver of persistent health inequalities –the harm caused is not evenly distributed. People living in disadvantaged areas are more likely to smoke, less likely to quit and more likely to have reduced life expectancy[9].

Death rates from tobacco use are two to three times higher among those in deprived areas than those in more affluent areas[10]. About 1 in 4 people in routine and manual occupations smoke compared with 1 in 10 people in managerial and professional occupations[11]. Smoking therefore exacerbates existing health inequalities between deprived and affluent areas.

Economically, smoking poses a burden to the individual, the NHS and also to the wider economy with costs surpassing the revenue generated through taxation. The average smoker of 11.3 cigarettes a day, spends at least £1800 annually with the cost rising to at least £3180 for a 20-a-day addiction, contributing significantly to their relative poverty. The healthcare and social care burden are derived from smokers typically needing care 4 years sooner than non-smokers, (costing additional £1.4 billion), and from unemployment costs, according to ASH.

The London Fire Brigade claims smoking remains the primary cause of fatal home fires. Over a quarter of fire-related deaths result from smoking-related incidents in London[12]. Along with fatalities, fires can result in injuries, respiratory problems, and other secondary health risks.

On the environmental side, every stage of the tobacco supply chain contributes to environmental damage. Deforestation for cultivation, energy-intensive curing processes, manufacturing and packaging all contribute to environmental harm, as does cigarette butt litter (the most common type of litter worldwide, according to ASH).

[8] Royal College of Physicians, 2018: Hiding in plain sight: Treating tobacco dependency in the NHS
[9] Public Health England. Smoking Profile – Smoking and Inequalities.
[10] Office for National Statistics. Deprivation and the impact on smoking prevalence, England and Wales: 2017 to 2021.
[11] Public Health England. Health matters: Stopping smoking – what works.
[12] London Tobacco Alliance. London Fire Brigade joins the London Tobacco Alliance.

Control of Tobacco Harm
There are a number of approaches to reducing smoking, referred to nationally and internationally as 'tobacco control.' The World Health Organisation Framework for Tobacco Control, which the UK commits to[13], includes:

- Restricting and regulating supply of tobacco products
- Reducing demand through price and non-price measures, including protecting people from second hand smoke through smoke free places, packaging, campaigns and support for people to stop smoking.
- Not working with the tobacco industry, given their long history of being unreliable collaborators.

3. Aim and objectives

Aim
The aim of this needs assessment is to determine the prevalence of smoking in Havering and identify the specific groups most impacted, serving as a foundation for strategically commissioning services and interventions aimed at reducing tobacco-related harm and addressing associated inequalities.

Objectives:

- To provide an understanding of smoking in Havering and the harm caused.
- To identify demographic groups most affected by smoking, considering factors such as age, gender, ethnicity and socioeconomic status and where they are located.
- To outline current services available for smoking cessation and identify any gaps.
- To gain insight into the prevalence and implications of vaping among youth in Havering.
- To recommend key actions to reduce tobacco harm and vaping.

4. Scope, Methods and Data Sources

Scope

The scope of this needs assessment focuses on two primary areas:

- Smoked tobacco amongst the Havering population.
- Vaping amongst young people in Havering.

In the UK, an array of tobacco products are available for consumption, broadly categorised into smoked and smokeless variants. For this needs assessment, the focus lies on smoked tobacco products, including manufactured cigarettes, hand-rolled tobacco (HRT or Roll Your Own Tobacco), cigars, pipes and water pipes.

Methods: This assessment uses a combination of methods:

- Collation and analysis of epidemiological data.
- Comparative analysis to London, England and neighbouring local authorities.
- Focus groups to gather insights from stakeholders including health professionals, housing officers, and providers of stop smoking services across the borough.
- Stakeholder workshops to identify key issues, groups and actions.

Data Sources

A range of data sources were used, including from OHID and local service data from the NEL ICB. Relevant national indicators for the needs assessment were selected and approved by the Tobacco Harm Reduction Partnership group.

[13] World Health Organisation, 2005: WHO Framework on Tobacco Control.

5. National Context

In the UK, smoking remains the primary contributor to preventable health issues, including cancer, heart disease and lung conditions, resulting in approximately 74,000 deaths annually[14]. The association between smoking tobacco and healthcare burden in the UK is clear, with over 500,000 hospital admissions each year and with smokers facing a 36% higher likelihood of hospitalisation compared to non-smokers[15].

National strategies addressing tobacco-related harms are guided by the Tobacco Control Plan (2017-2022)[16] focusing on four key areas: helping smokers with cessation, promoting smoke-free pregnancies, improving access to smoking cessation support and ensuring equitable assistance for individuals with mental or physical health conditions. Efforts are also underway to combat underage tobacco sales and the rising trend of youth vaping[17].

Aligned with the objectives of the Tobacco Control Plan, the NHS Long Term Plan commits to extending tobacco dependency to all inpatients who smoke, with the target of providing access to services for overnight admissions by the end of 2023/24. Additionally the government's ambition for England to be smoke-free by 2030, with no more than 5% of the population smoking, is driving forward a variety of measures to achieve this goal, including:

- Proposals to legislate the gradual increase of the age of sale of tobacco by one year annually from 2027 onwards, ensuring that children born on or after January 1st, 2009, cannot legally purchase tobacco products.
- Strengthening support for smoking cessation including through measures including:
    - Increased funding to local authorities' stop-smoking services.
    - Additional funding for anti-tobacco marketing campaigns.
    - national vaping enforcement team to reduce illegal vape sales to young people.
- 'Swap to stop' scheme, supporting 1 million smokers to switch from cigarettes to vapes as well as financial incentives for pregnant smokers to quit smoking and the introduction of mandatory cigarette pack inserts.

[14] Public Health England, 2019: Smoking and tobacco: Applying all our health.
[15] Royal College of Physicians, 2018: Hiding in plain sight: Treating tobacco dependency in the NHS
[16] Tobacco control plan: delivery plan 2017 to 2022 - GOV.UK (www.gov.uk)
[17] Department of Health and Social Care, 2017: Tobacco Control Plan 2017 to 2022.

6. Havering Context

Smoking prevalence in Havering

In Havering, an estimated 32,512 residents aged 18 and above smoke, accounting for 15.9% of the adult population (264,703 in 2022). This translates to approximately 1 in 6 adults being smokers, marking a 5.5% increase compared to rates from 2021 (10.3% of residents). Not only does Havering have the highest prevalence across North East London[18], Havering's smoking rate surpasses the smoking rates of 11.7% in London and 12.7% in England[19].

Figure 2. Northeast London Smoking Prevalence by Borough, 2012-2022.

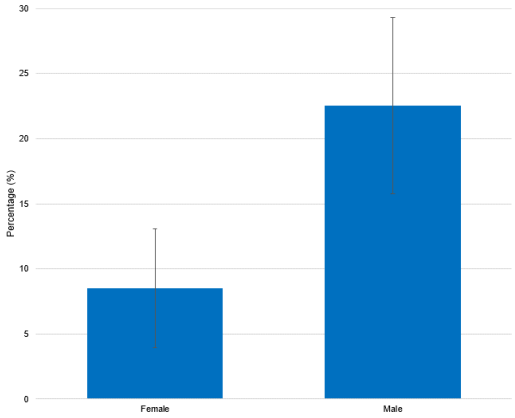
Source: Office for Improvement and Disparities (OHID) and London Tobacco Alliance.

Smoking by demographics

Smoking by gender

Data from OHID demonstrates a significant gender disparity in smoking among Havering residents, with a higher proportion of males smoking (22.5%) compared to females (8.5%). This indicates that smoking is 2.5 times more prevalent in males than in females, mirroring trends observed at the national level where 14.6% of men smoke compared to 11.2% of women[20].

Figure 3: 18+ Smokers by Gender in Havering



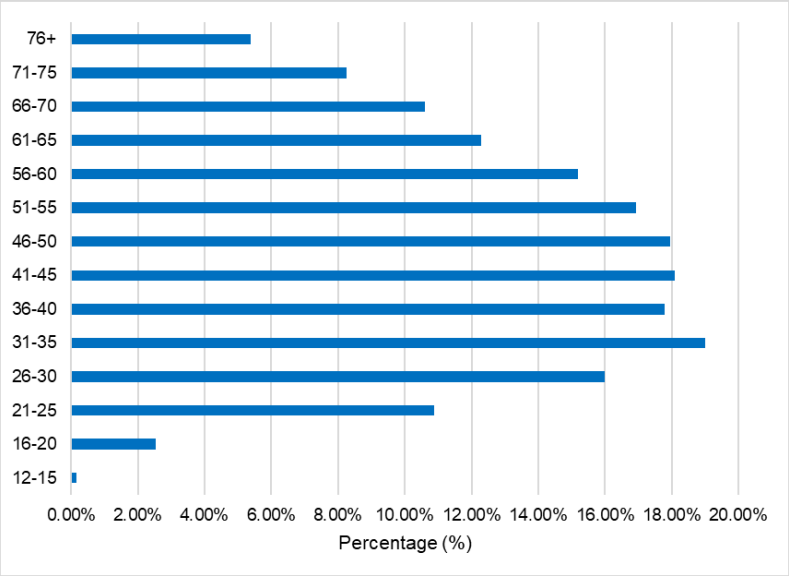
Source: Annual Population Survey, 2022

[18] ONS Smoking habits in the UK and its constituent countries (2022) Table 4 Smoking prevalence in local and unitary authority areas
[19] Public Health England, 2022: Health Profiles: Data.
[20] Office for National Statistics, 2022: Adults smoking habits in Great Britain: 2022.

Smoking by age

The prevalence of smoking in Havering varies across age groups. It is highest among those aged 31-35, at 18.99%, and lowest among adolescents aged 12-15, at 0.10%. There is a steady rise in smoking prevalence with age peaking at 18.99% amongst those aged 31-35. Prevalence remains high in the 36-40 (17.80%), 41-45 (18.10%) and 46-50 (17.94%) age groups. It then gradually declines from 16.92% in the 51-55 group to 5.38% in those aged 76 and older. This shows that smoking is predominant among those of working age groups in Havering.

Figure 4: Smokers by 5-year age brackets in Havering, 2023



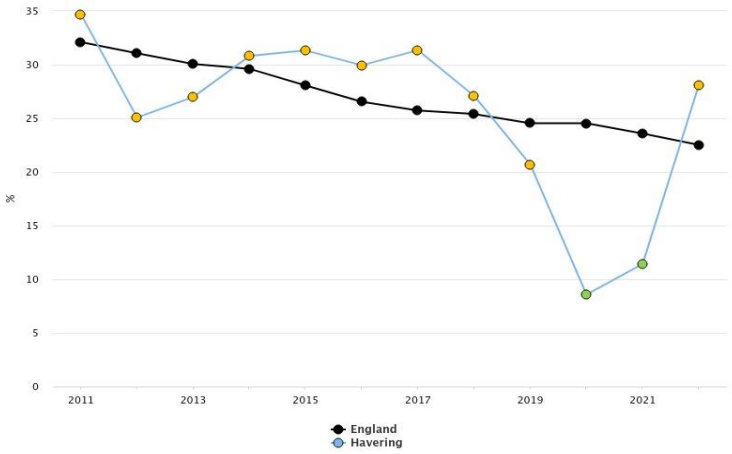
Source: ICB GP Data, September 2023.

Smoking by socioeconomic status, occupation and housing

In Havering, smoking prevalence varies across different socioeconomic groups. Residents in routine and manual occupations exhibit higher smoking rates, with a prevalence of 28.1%, notably higher than London's 20.2% and England's 22.5% averages[21]. The rise in smoking in Havering could be attributed to the rise in the routine and manual occupations which jumped from 11.4% in 2021 to 28.1% in 2022. A large proportion of men are in these occupations.

Additionally, Havering smokers are disproportionately clustered in more deprived areas. While detailed ward-level analysis for smoking prevalence in Havering is unavailable, Local Insights suggests a clear link between high smoking rates and socioeconomic disadvantage. Local Insights maps indicate that areas characterised by deprivation, rented or social housing and routine and manual occupations tend to have higher smoking prevalence.

Figure 5: Smoking prevalence in adults in routine and manual occupations (18-64) – current Havering smokers



Source: Annual Population Survey, 2022

Further examination of the data reveals striking differences in smoking rates among demographic groups in Havering. For instance, 29% of Havering's residents renting in private housing smoke while 22.5% of social housing tenants smoke. Similarly, 28.1% in routine and manual occupation in Havering smoke. Notably, these groups are concentrated in areas with higher levels of deprivation within the borough. The association between smoking prevalence and socioeconomic factors underscores the critical role of socioeconomic status in shaping smoking behaviours within Havering.

[21] Public Health England, 2023: Tobacco Control: Data.

Smoking by ethnicity

Analysis of 2023 GP data reveals varying smoking rates among ethnic groups in Havering, with higher prevalence among the main white population and individuals categorised as 'Other white background' and Irish, while rates are lowest within the African population.

However, data on certain groups, such as Eastern Europeans and the Gypsy, Roma and Traveller (GRT) communities, are lacking. It is likely these groups are categorised under the 'Other white background' but there is a need for further analysis. Insights from focus groups undertaken with Havering health visitors suggest higher smoking rates within these populations. They report that pregnant women from these ethnic groups live in households with multiple members of their extended family. The families in these households reportedly actively encourage each other to smoke, which leads pregnant women to feel pressured to continue smoking, as well as exposing them and children to second hand smoke.

In Havering, limited data exists for smoking in these groups due to discrepancies between census categories (which include Gypsy/Roma and Traveller communities) and NEL ICB categories. As a result, individuals from these groups may be categorised under different ethnicities in GP data, such as 'Other White' or 'Irish,' leading to incomplete representation, even though they may have a higher proportion of smokers than other groups.

Recommendations
• Provide additional support in more deprived areas where smoking prevalence is higher. • Improve data collection Eastern Europeans and GRT communities to produce more effective interventions. • Provide tailored education and information resources and support to families, emphasising the dangers of second-hand smoke, especially in households with pregnant women and children. • Collaborate with community organisations to better reach and support residents in underrepresented groups.

Impact of smoking in Havering

- **Smoking-attributable deaths**: Between 2017 and 2019, over 900 people in Havering died from smoking-attributable causes, translating to 198.2 deaths per 100,000 people—higher than London's rate (171.3) but lower than England's (202.2)[22].
- **Cancer:** Smoking is the largest avoidable risk factor for cancer. Between 2017 and 2019, Havering recorded 393 smoking-attributable deaths from cancer (88.4 per 100,000), higher than London's average but lower than England[23]. From 2020 to 2022, Havering recorded 353 deaths from lung cancer (47.8 per 100,000), higher than London but lower than England[22].
- **Chronic Obstructive Pulmonary Disease (COPD):** In 2020 to 2022, Havering recorded 342 deaths from COPD (45 per 100,000), higher than both London and England[22].
- **Cardiovascular disease:** In 2017 to 2019, there were 123 smoking-attributable deaths from heart disease in Havering[22].
- **Hospital admissions:** In 2019 to 2022, Havering had 1,452 hospital admissions attributable to smoking (993.1 per 100,000), lower than both London (1152) and England (1398). In the same year, there were 530 emergency hospital admissions in Havering for COPD (363 per 100,000), similar to London (358) and lower than England (415) [22].

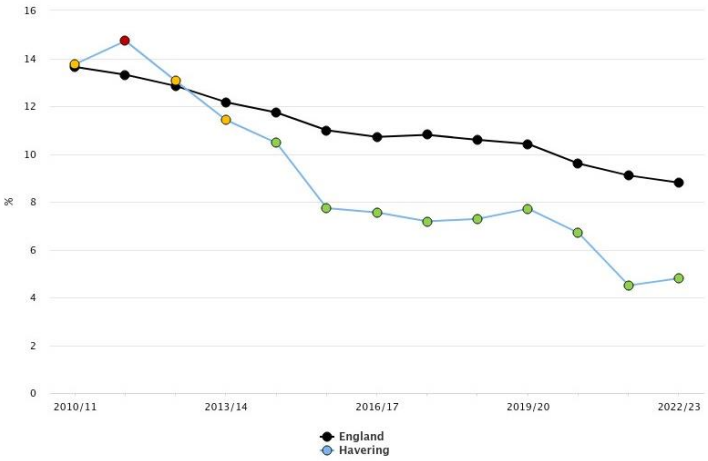
[22] Office for Health Improvement and Disparities (2024): Public Health Profiles.

7. Smoking in Pregnancy

Over the past decade, the percentage of pregnant women smoking at the time of delivery in Havering has consistently declined, from 13.1% in 2012/13 to 4.8% in 2022/23[22]. This rate is comparable to London (4.6%) and significantly lower than the national average for England (8.8%). However, the data for 2022/23 indicates a slight increase to 4.8% from the previous year.

Recent NHS Digital data shows that from April 2022 to March 2023, 64% of pregnant women in Havering self-reported successfully quitting smoking, a higher rate than the national average[24]. See Table 2 below.

Figure 6: Smoking rates at time of delivery for Havering and England.



Source: Office for Health Improvement and Disparities (2024): Public Health Profiles.

Table 2: Pregnant women setting a quit date and outcome, April 2022 to March 2023.

Region name	**Number of successful quitters** (self-reported), **confirmed by CO**	**% of Successful quitters** (self-reported)	**% of Not quit**	**% of Not known/lost to follow up**	**% of Successful quitters** (self-reported)**, confirmed by CO**	**% of CO validated quitters as a percentage of successful quitters** (self-reported)
England	1,975	46	31	22	14	31
Havering	16	52	44	4	33	64

Source: Population Health, Clinical Audit and Specialist Care, NHS England.

This sustained reduction in smoking rates among pregnant women in Havering is largely due to the specialised pregnancy stop smoking service provided by the London Borough of Barking and Dagenham, available to pregnant women and household members. This service, in collaboration with the Barking Havering and Redbridge University Trust (BHRUT), offers routine CO level screening, opt-out referrals for specialist midwife support, behavioural therapy and nicotine replacement therapy (NRT). Pregnant women can be referred by maternity services or self-refer directly. In December 2023, the service expanded to include post-natal quit smoking support.

Impact of smoking in pregnancy

Smoking during pregnancy poses significant health risks to both the mother and the unborn child. Pregnant smokers face increased risks of low birth weight (babies are typically 250g lighter), miscarriage (up to three times more likely), premature birth (up to 27% more likely) and stillbirth (twice as likely). Additionally, according to ASH, smoking triples the risk of sudden unexpected death in infancy (SUDI).

Inequality implications

[24] Statistics on Women's Smoking Status at Time of Delivery: England - NHS England Digital

Nationally, smoking prevalence among pregnant women is markedly higher in disadvantaged groups and younger women (20 years old) compared to older and more affluent groups. Pregnant women in the most deprived areas of England are over five times more likely to smoke than those in the least deprived areas[25]. Furthermore, women in routine and manual occupations are also five times more likely to smoke throughout pregnancy than those in managerial and professional roles[25]. Children growing up in households with a smoking parent are more likely to become smokers themselves, perpetuating a cycle of inequality and affecting their life changes.

Local data from the pregnancy stop smoking service from April 2022 to March 2023 reflects similar disparities in service uptake by age, ethnicity and socio-economic status. Most supported service users, both pregnant women and their household members, were aged 25-35 (67%), followed by those aged 18-24 (18%). The majority were White British (60%) or White other (25%), reflecting the borough's demographic makeup. Socioeconomically, the majority were from more deprived areas of Havering, such as Rainham (25%) and Harold Hill (22%), with 50% in routine and manual occupations and 33% having never worked or being long-term unemployed.

Key issues	**Recommendations:**
• Smoking remains higher among young pregnant women compared to older ones, and among those in more deprived wards. • There is a high chance of relapse among mums/parents within first 12 months after birth. • There are cultural norms among pregnancy in smoking in certain groups, like Eastern European populations. • There is a lack of awareness of impact of second or third hand smoke among pregnant women. • There needs to be better data to inform service provision and address inequality.	• Training community based workers* to be able to effectively discuss smoking and potential harm. • Provide carbon monoxide (CO) monitors to Health Visitors to assess smoking status at 28 weeks (and new birth visits. • Use Making Every Contact Count (MECC) approach to offer Very Brief Advice (VBA) – Ask, Advise, and Act to pregnant women smoking. • Raise awareness of risks and of second and third hand smoke. • Seek ways to engage pregnant women outside of healthcare setting –e.g. Children's Centres/ play areas. • Encourage partners and family members to support pregnant women to quit. • Review local pregnancy service and strengthen monitoring arrangement. • Ensure more robust and regular data collation to identify and address inequality.

[25] Royal College of Paediatrics and Child Health (2020). Smoking in pregnancy, State of Child Health.
* e.g. Social Prescribers, Local Area Co-Ordinators, Health Champions

8. Smoking and serious mental illness

While smoking rates have seen a decline in the general population over the years, they persist at notably higher levels among individuals with mental health conditions, particularly with more severe diagnoses. Serious Mental Illness (SMI) encompasses psychological disorders (e.g. Schizophrenia and bipolar disorders) that can impair one's functional and occupational capabilities.

Those with SMI exhibit heightened nicotine dependence, are predisposed to smoking-related ailments and face a staggering reduction in life expectancy by an average of 10 to 20 years compared to the general population. Smoking is the largest cause of this life expectancy gap, with approximately half of all deaths in individuals with SMI attributed to tobacco[26]. The prevalence of smoking within this demographic drives significant health disparities, primarily stemming from increased risks of cardiovascular diseases, respiratory issues and cancers.

Despite a greater desire to quit smoking, individuals with SMI are more likely to be heavy smokers. The latest data from OHID for 2022/23 in Havering illustrates a smoking prevalence of 29.2% among those with long-term mental health conditions, surpassing both London (26.3%) and England (25.1) averages[22]. Among individuals with severe mental illness in Havering, the prevalence skyrockets to 33%, more than double that of the general population (15.9%). With over 2,000 individuals in Havering diagnosed with SMI, an estimated 660 individuals are smokers.

Impact among individuals with SMI:

- Illness (e.g. lung cancer, COPD)
- Early mortality due to smoking (reduced life expectancy)
- Hospital admission attributable to smoking
- Social impact
- Poor physical health
- Increased risk of major mental health conditions
- Unemployment
- Increased metabolism of some antidepressants, antipsychotic medications and benzodiazepines, meaning that smokers can need higher doses of medication compared to non-smokers[27]

Benefits of quitting among individuals with SMI:

- Stopping smoking improves symptoms of depression and anxiety, equivalent to the impact of taking antidepressants[28]. And for people taking certain antipsychotic medications, stopping smoking can mean that lower doses are needed.
- There is strong evidence to show that stopping smoking can improve mental health. The most recent Cochrane evidence review found that within 6 weeks of stopping smoking, people saw an improvement in their mental health[29].
- Implementing an SMI stop smoking service will help in reducing the prevalence of smoking, the morbidity and mortality associated with smoking as well as reduce the unequal impact of harm caused by smoking to vulnerable smokers with SMI.

Inequality Implications

Smoking affects the mental health across all demographics, with detrimental effects extending both indirectly—through its impact on physical health, financial stability and

[26] Callaghan, Veldhuiezen, Jeysingh, Orlan, Graham, Kakouris, Remington, Gatley. (2014) Patterns of tobacco-related mortality among individuals diagnosed with schizophrenia, bipolar disorder, or depression. Journal of psychiatric research, 48(1), 102-110.
[27] Jones L, Hayes F, MacASkill S (2007). Evaluation of the impact of the PATH Support Fund – Final Report. Path (Partnership Action on Tobacco and Health)
[28] Taylor G, Lindson N, Farley A, Leinberger-Jabari A, Sawyer K, te Water Naude R, Theodolou A, King N, Burke C, Aveyard P (2021). Smoking Cessation for improving mental health. Cochrane Data base of Systematic Reviews, 2021(3).
[29] Stopping smoking linked to improved mental health | NIHR

employment prospects—and directly—by increasing the risk of some mental health conditions, such as depression and schizophrenia through fuelling addiction[30].

Individuals with SMI are more likely to experience socioeconomic deprivation. This is partly due to deprivation contributing to the development of mental health conditions through the stress-vulnerability model, and partly because poor mental health can results in the loss of employment, housing, income and other resources. This cyclical relationship shows smoking is strongly linked to socioeconomic deprivation. Addressing higher dependence on tobacco is likely to support smoking cessation, and in turn, reduce health disparities[31].

Existing community support services lack tailored provisions for people with SMI or mental health condition. While NELFT offers stop smoking support to inpatients through the Tobacco Dependency Treatment Programme, post-discharge community support is absent. Due to this gap in provision a specialised stop smoking service for individuals with SMI has been commissioned to mitigate smoking prevalence and alleviate associated health risks and is scheduled to start 2024 and will offer extensive range of support and aids for both smoking cessation or harm reduction strategies (such as transitioning to vaping).

Key issues	**Key Recommendations:**
• Smokers with SMI are more likely to be heavier smokers (strong culture around smoking) with higher nicotine dependency and therefore more likely to develop a smoking-related illness. • Those with SMI have more of a desire to quit compared to the general population. • Universal smoking cessation programmes are not sufficient to meet the needs of people with SMI. • There is no follow-up support for mental health inpatients that then are discharged into the community. • There is a lack of awareness that stopping smoking improves symptoms of anxiety and depression. • Smoking is used as a coping tool. • Smoking cessation is not always seen as priority by professionals dealing with complex mental health issues.	• Develop a specialist stop smoking service for people with SMI that is flexible and tailored to their needs, led by specialists with direct access to mental health professionals. • Adapt the universal smoking cessation service for individuals with mild mental health conditions within Havering. • Increase targeted support in local services frequented by those with SMI. • Expand access to alternative nicotine products for those with or at risk to poor mental health. • Provide training on smoking cessation techniques (VBA+) and the NCSCT speciality module for mental health to frontline staff, charities and mental health service providers. • Raise awareness of impact of smoking on mental health through engagement and communications activities.

[30] ash.org.uk/uploads/Public-mental-health-and-smoking
[31] ASH (Action on Smoking and Health), 2022: Public mental health and smoking.

9. Smoking and housing

9.1 Homelessness

Between 50.59 and 51.63% of individuals experiencing homelessness that are registered with Havering GPs smoke. However, this percentage likely underestimates the true prevalence of individuals experiencing homelessness who smoke due to challenges in accessing accurate data in this population. Nationally, around 78% of individuals experiencing homelessness smoke[32].

Impact on homeless population

ASH reports highlight the alarming rate of cigarette consumption among homeless populations, with many smoking over 20 cigarettes per day, far exceeding the general population's average of 11. Consequently, individuals experiencing homelessness face a threefold higher risk of dying from chronic lower respiratory diseases, and their average life expectancy is tragically 30 years lower than that of the general population**Error! Bookmark not defined.**, underscoring the severe health consequences of smoking in this demographic.

Inequality Implications

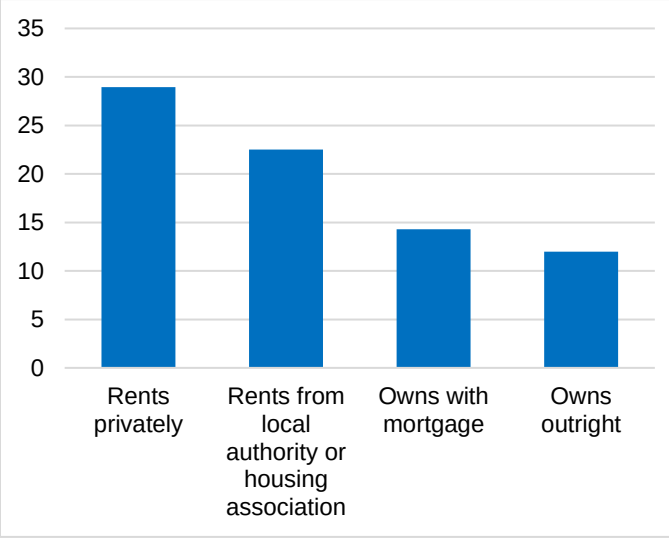
The intersection of poverty and homelessness exacerbates smoking-related risks, with behaviours like cigarette sharing and using discarded butts being common. Despite these challenges, over 50% of individuals experiencing homelessness who smoke express a desire to quit. However, they encounter significant barriers, including limited access to cessation services, mental health struggles, peer-group influences and smoking as a coping mechanism for the stress inherent in homelessness. Addressing these barriers is crucial for improving health outcomes and promoting health equality.

9.2 Social Housing and Private Renters

Smoking prevalence among residents living in social housing in Havering stands at 22.5%, a figure notably higher than the smoking rates among those who own a mortgage (14.3%) and those who own their homes (12%). These statistics underscore a concerning trend of elevated smoking rates within the social housing demographic compared to other housing arrangements in Havering.

Insights from a focus group, provided in more detail in the Stakeholder Insights chapter, shed light on smoking in this population. Social housing providers expressed significant concerns about smoking, tobacco use and vaping, estimating that approximately 30% of individuals encountered are smokers. Given that the smoking rate among social housing residents is among the highest in

Figure 7: Percentage of smokers by housing status in Havering.



Source: OHID Fingertips – APS 2022

[32] Dawkins L, Ford A, Bauld L, Balaban S, Tyler A, Cox S, 2019: A cross-sectional survey of smoking characteristics and quitting behaviour from a sample of homeless adults in Great Britain, *Addictive Behaviours*, 95, 35-40.

England[33], with around 1 in 3 people in social housing being smokers, the reported 22.5% figure is likely lower than the true prevalence.

In addition to the high prevalence of smoking among social housing residents, private renters in Havering also exhibit a significant smoking rate, standing at 29%. This figure surpasses the national average of 22.6%, indicating a notable smoking challenge within this housing demographic[34]. Unlike social housing residents who can be engaged through housing providers, the wide-ranging nature of the private renter population poses logistical challenges for targeted interventions.

Inequality Implications

The disproportionately high rates of smoking among social housing residents worsen existing health and economic inequalities associated with smoking. Despite recognition of the importance of addressing smoking for fire risk assessment by social housing providers, there is a notable absence of systematic recording storage of smoking data in housing services. However, smoking inquiries are sometimes incorporated into settling-in questionnaires, although inconsistently. Compounding the issue is the lack of awareness of stop smoking services in Havering, coupled with the absence of smoking cessation training for housing providers.

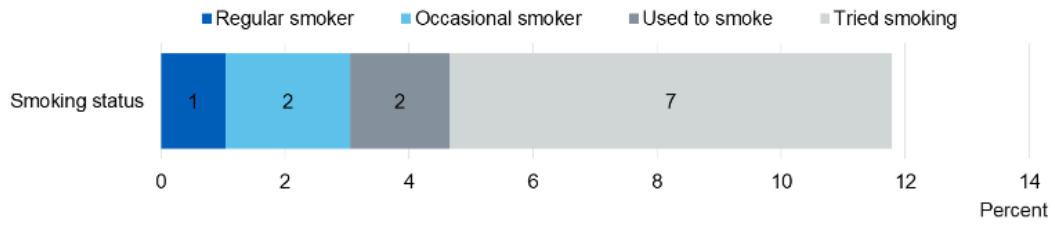
Key Issues	Recommendations
Homeless smokers • People who experience homelessness are more likely to smoke, and smoke more cigarettes per day compared to other smokers. • A large proportion of people who experience homelessness want to quit, but there are many more barriers in place to do so.	• Facilitate a joint approach between Public Health and homeless services and increase information about specialised stop smoking support to these services. • Encourage those working with individuals experiencing homelessness and social housing providers to participate in VBA (Very Brief Advice) Training.
Social Housing • Smoking prevalence among social housing residents is notably high, which can further fuel inequalities. • There is an absence of storage of smoking data in Havering housing services and staff lack training around smoking cessation.	• Work with social housing providers to develop policies to reduce smoking in social housing and identify innovative ways to support residents who smoke to stop. • Embed social housing-based tobacco control programmes within other strategies such as the Housing strategy and Poverty Reduction Strategy.
Private Renters • Private renters exhibit a high smoking rate in Havering compared to the national average.	• Collaborate with landlords and property management companies to promote smoke-free living and provide resources for tenants interested in quitting smoking.

[33] Action on Smoking and Health, 2022: Smoking and social housing: supporting residents, addressing inequalities.
[34] Office for National Statistics, 2019: Adult smoking habits in Great Britain: 2018.

10. Smoking among young people

Despite an overall reduction in smoking rates, 207,000 children in the UK start smoking annually, with 480 children in Havering alone, according to ASH. In 2021, 1 percent of young people (aged 11-15 years) were identified as regular smokers in England, as depicted in the detailed breakdown provided in Figure 1, outlining pupils aged 11-15 who have ever smoked[35].

Figure 8: Smoking status of pupils (aged 11-15) who have ever smoked in England.



Source: NHS Digital (2021) Smoking, drinking and drug use among young people in England, 2021.

Initiating cigarette use at a young age increases the risk of addiction, with signs of addiction appearing within four weeks of starting[Error! Bookmark not defined.]. Various factors contribute to smoking initiation, including exposure to familial and peer smoking, easy access to cigarettes, lower socioeconomic status and exposure to tobacco marketing.

Noteworthy reasons provided by pupils for smoking include the desire “to look cool in front of friends” (81%), because “they were addicted to cigarettes” already (73%) and because “their friends pressure them into it” (72%) [Error! Bookmark not defined.]. The social contagion of smoking is evident, with almost all current smokers reporting having a friend who smokes, contrasting with around one-third of non-smokers. Additionally, children in smoking households are up to four times more likely to become smokers[36]. Higher levels of truancy and engagement in other risk taking behaviours, such as drinking alcohol and taking drugs, are also associated with cigarette consumption in this age group[37].

National policies aimed at reducing tobacco and vaping use face challenges in Havering. Despite local regulations prohibiting cigarette and e-cigarette advertising, young people still encounter promotions on social media and around tobacco shops. Illicit tobacco sales pose an obstacle to public health efforts, necessitating enforcement interventions targeting underage sales[38].

In Havering, 87 premises retail tobacco and vapes. Despite efforts, such as three raids in 2023, the actual count of illegally sold products likely exceeds reported figures. Substantial quantities of counterfeit tobacco and vapes, valued at £69,000, were seized, including 2,500 vapes, 58,000 cigarettes and 223 packets of hand-rolling tobacco, according to Havering Trading Standards.

[35] Smoking, Drinking and Drug Use among Young People in England (2022). NHS Digital.
[36] Children whose parents smoke are 4 times as likely to take up smoking themselves (2021). Department of Health and Social Care.
[37] Green R and Ross A (2010). Young people’s alcohol consumption and its relationship to other outcomes and behaviour. Department for Education.
[38] Wilson L, Avila Tang E, Chander G, Hutton H, Odelola O, Elf J, Heckman-Stoddard B, Bass E, Little E, Haberl E, and Apelberg B (2012). Impact of tobacco control interventions on smoking initiation, cessation, and prevalence: a systematic review. Journal of Environmental and Public Health.

Impact

The majority of adult smokers start before the age of 18, with more than 80% starting before turning 20[Error! Bookmark not defined.]. Early initiation of smoking in young individuals is correlated with increased levels of smoking and dependence, a lower chance of quitting and higher mortality rates. Smoking can reduce a child's lung function, increase the risk of a young person developing asthma, decrease their exercise tolerance and may even impair growth.

Inequality Implications

Analysing smoking prevalence among 15-year-olds across various demographic factors unveils notable differences. Ethnicity plays a significant role, with lower smoking rates in Black, Asian and Other ethnic groups, and higher rates in White and Mixed ethnic groups[39]. Age is another determinant, with 2022 smoking rates starting at 2% among 11-year-olds and reaching 24% in 15-year-olds[35].

The impact of socioeconomic status is also evident, as a connection exists between area-level deprivation and smoking[40]. In 2018, over 55% of pupils reported experiencing second-hand smoke in the home, with disadvantaged children more disproportionally affected. Not only does this further heighten the risk of them becoming smokers, it also increases risks to a child's health, including cot death, glue ear, asthma and other respiratory disorders[Error! Bookmark not defined.].

Gender-specific patterns reveal that among boys, smoking typically aligns with area-level deprivation, whereas among girls, the odds of smoking increase with both individual and area-level deprivation, possibly explaining the higher likelihood of smoking among girls compared to boys[35,40].

Key Issues	Recommendations
• There is a high initiation rates of smoking among children and young people in the UK, leading to addiction and health risks. • Social influences, such as peer and familial smoking, contribute to smoking initiation. • There is continued exposure to tobacco marketing and easy access to cigarettes, despite regulations in Havering. • There is a reduced number of enforcement officers and low capacity within existing team to effectively enforce tobacco and vape control measures. • There is a lack of effective regulations and enforcement measures to control sale of tobacco products.	• Increase capacity of trading standards. • Strengthen enforcement of tobacco marketing and sales regulations. • Launch localised anti-tobacco campaigns across various media platforms targeting youth. • Encourage retailers to implement Challenge 25 for ID verification. • Improve data accuracy on vape retailers in the area. • Conduct outreach programmes in schools and community centres for child smoking and vaping cessation. • Collect Havering-specific data on smoking prevalence and demographics of smoking in children and young people.

[39] Children smoking among 15 year olds (2021). What About YOUth (WAY) Survey, NHS Digital.

[40] Levin K, Dundas R, Miller M, and McCartney G (2014). Socioeconomic and geographic inequalities in adolescent smoking: a multilevel cross-sectional study of 15 years olds in Scotland. Social Science and Medicine, 107(100), 162-170.

11. Smoking and learning disabilities

Although adults with learning disabilities (LD) are less likely to smoke than the general adult population, smoking rates among adolescents with mild LDs are higher than peers without mild LDs[41]. In Havering, the number of GP-registered patients recorded as having an LD who also smoke is 6.97-7.88%, a rate similar to the UK average of 6.2%[42]. Meanwhile, in adolescents, the prevalence of smoking at ages 14-17 are similar among adolescents with and without LDs. There was even evidence that showed the prevalence of more frequent vaping was higher among girls with LDs than their female peers without LDs[43].

Inequality Implications and the impact on population with LD

Although causes of an LD can be genetic, exposure to tobacco smoke significantly increases the odds for children to have a learning disability[44]. This turns into a cycle, as those with parents who smoke are more likely to smoke themselves. Furthermore, adults with intellectual disabilities may be particularly vulnerable to the financial implications of tobacco use because they are three times more likely than the general population to live in poverty[45].

Focus groups with professionals working with those with LDs (See Stakeholder Insights) verified that vaping and smoking is highest among young patients. Furthermore, they emphasised the importance of education for clients, parents and carers, noting a lack of awareness of smoking risks. Those working with individuals with LDs had no staff training on smoking and vaping cessation. Service providers emphasised the need for additional support, particularly in addressing aggression and social aspects associated with cessation.

Historically, those with LDs have often been neglected to educational resources about tobacco use. Information on the risks of smoking is often not presented in a manner sensitive to the needs and abilities of those with LDs[46]. To make services more accommodating, basic learning disability and autism awareness training for all staff was recommended, as well as sensory-friendly environments and easy-to-read information.

Key Issues	Recommendations
• Adolescents with mild LDs vape more than their peers. • Tobacco smoke exposure raises risk of LDs in children. • Training on smoking and vaping cessation is lacking for those working with LDs. • Support is needed for addressing aggression and social aspects of smoking cessation. • Education resources about tobacco for individuals with LDs have been historically neglected.	• Increase awareness about smoke exposure risks. • Provide Very Brief Advice training and smoking information for staff working with individuals with LDs. • Investigate and support addressing aggression and social aspects of smoking cessation. • Distribute educational materials on smoking that are accessible for individuals with LDs. • Implement basic LD and autism awareness training for service providers.

[41] Emerson E and Baines S, 2010: Health inequalities and people with learning disabilities in the UK. Learning Disabilities Observatory.
[42] Smoking and People with an Intellectual Disability, 2016: University of Hertfordshire.
[43] Emerson E, 2023: The prevalence of smoking and vaping among adolescents with/without intellectual disability in the UK. Journal of Intellectual Disability Research.
[44] Anderko L, Braun J, Auinger P, 2010: Contribution to tobacco smoke exposure to learning disabilities. Journal of Obstetric, Gynaecologic and Neonatal Nursing, Volume 39, Issue 1, pages 111-117.
[45] Steinberg M, Heimlich L, and Williams J, 2009: Tobacco use among individuals with intellectual or developmental disabilities: a brief review. *Intellectual and developmental disabilities*, 47(3), 197-207.
[46] Kelman L, Lindsay W, McPherson F, Mathewson Z. (2009). Smoking Education for People with Learning Disabilities, British Journal of Learning Disabilities.

12. Smoking and substance use

Smoking rates among individuals with substance misuse disorders are two to four time higher than the general population, with half of all smoking-related deaths attributed to this group[47]. Over 40,000 people (49%) admitted to treatment reported smoking tobacco in the 28 days before starting treatment[48]. Smoking rates among both men and women across all substance groups were significantly higher than the adult population in England, which reported rates of 14.5% for men and 10.9% for women. However, despite these smoking rates, only 4% of individuals were documented as having been offered referrals for smoking cessation interventions.

In Havering in 2019-20, 33.7% of adults admitted to treatment for alcohol misuse were smokers, which is lower than the rates in London (44.4%) and England (43.9%), yet still more than double the prevalence of smoking among the general adult population. Conversely, 69.7% of adults admitted to treatment for all opiate misuse in the same period were smokers, which is 68.2% in London and 70.2% in England, but more than four times the prevalence of smoking in the general adult population[48].

Impact on population with substance use disorders

There have been concerns that recommending smoking cessation alongside treatment for alcohol or substance misuse might jeopardise recovery efforts. However, providing stop smoking services to individuals with substance misuse disorders has been shown to increase smoking cessation rates by about 10% without compromising rates of abstinence from drugs or alcohol[49]. The most effective approach involves combined drug treatment and counselling, although pharmacotherapy alone has also proven successful. Counselling alone, however, was not found to be beneficial[50].

Inequality Implications

Prevalence remains stubbornly high within this vulnerable demographic. The limited access to smoking cessation interventions further compounds this issue, as only a small fraction of individuals receive the necessary support to quit smoking. This disparity often stems from the misconception that smoking cessation may trigger substance use relapse. However, tailored approaches that integrate drug treatment with counselling presents a promising avenue to prove equity for this specific group.

Key Issues	Recommendations
• The highest prevalence of smokers are those with substance misuse disorders, up to 4 times higher than general population. • There is a lack of tailored stop smoking support available to people that smoke with a substance dependency. • There are a lack of referrals into smoking cessation interventions. • There are concerns of substance treatment being compromised if focus is on smoking cessation.	• Develop a specialist stop smoking service tailored to support people with drug/alcohol dependency that smoke. • Work with providers/targeted services to offer in-reach cessation support. • Strengthen referral pathways from treatment into smoking cessation programmes. • Offer pharmacotherapy/vapes within treatment centres. • Train drug/alcohol service providers and addiction charities/support workers to offer VBA.

[47] Apollonio D, Philipps R, Bero L. (2016). Interventions for tobacco use cessation in people in treatment for or recovery from substance use disorders. Cochraine Database of Systematic Reviews 2016, Issue 11.
[48] UK Government (2022 to 2023). Substance misuse treatment for adults: statistics 2022 to 2023 report.
[49] Stop smoking services can work for people in treatment or recovery from substance misuse disorders (nihr.ac.uk)
[50] National Institute for Health Research. (2017). Stop smoking services can work for people in treatment or recovery from substance misuse disorders.

13. E-cigarettes

An e-cigarette is a device that allows for the inhalation of nicotine in a vapour rather than smoke. E-cigarettes do not burn tobacco and do not produce tar or carbon monoxide, two of the most damaging elements in tobacco smoke. They work by heating a liquid (called an e-liquid) that typically contains nicotine, propylene glycol, vegetable glycerine and flavourings. Using an e-cigarette is known as vaping.

Although e-cigarettes are distinct from traditional tobacco products, the rise in e-cigarette use and its connection to tobacco warrants a chapter in this needs assessment.

Adults

The proportion of the population using e-cigarettes in 2023 was 9.1%, the highest rate ever, equal to 4.7 million adults in the UK. Of those e-cigarette users:

- 2.7 million (56%) were ex-smokers
- 1.7 million (37%) were current smokers
- 320,000 were never smokers (7%)[51].

Moreover, 1.7 million of those who vape – over half of the total – have managed to stop smoking completely and ONS figures suggest that more than 900,000 people have given up both smoking and vaping, according to ASH. This suggests that for many smokers, dual use (vaping while continuing to smoke) may be a stage in their journey to becoming smoke free and, ultimately, nicotine free[52]. However, while recognising its efficacy as a smoking cessation aid, it is important to discourage individuals from taking up vaping for recreational purposes.

Youth

Growing concerns surround vaping among children and young people, with the Havering Youth Wellbeing Census (2023) revealing that 12% of Havering pupils have experimented with vaping. This raises concerns about potential long-term health impacts, addiction risks and the possibility of vaping leading to smoking[53]. Nationally, 4% of 11–15-year-olds, 14.1% of 16–17-year-olds, and 20.2% of 18-year-olds are reported to be vaping, according to ASH. Despite the novelty of e-cigarettes, their long-term impact remains uncertain, underscoring the need for caution.

Youth exposed to vaping are at risk of developing chronic respiratory issues like coughing, bronchitis and exacerbation of asthma, along with potential long-term cardiovascular consequences. Additionally, unintended ingestions of vaping liquids, especially among children are a concern, highlighting the importance of child-proof packaging. Furthermore, vaping can lead to nicotine dependence, which can adversely affect brain development, particularly in adolescents[54].

Regulations and Challenges in E-Cigarette Control

Despite local bans on e-cigarette advertising, young people still encounter promotions through social media and in proximity to tobacco shops. Advertisements are often designed to appeal to children, featuring sweet flavours and colourful packaging. Additionally, illicit sales of vaping products present a challenge, requiring enforcement measures to combat

[51] Action on Smoking and Health (ASH), 2023: Use of e-cigarettes among adults in Great Britain.
[52] Public Health England, 2019-20: Tobacco Commissioning Support Pack: Key Data. Bath and NE Somerset.
[53] #BeeWell Youth Wellbeing Census (2023).
[54] Chadi, N., Vyver, E., & Bélanger, R. E., 2021: Protecting children and adolescents against the risks of vaping. *Paediatrics & child health*, *26*(6), 358–374.

underage sales. In the raids conducted in Havering in 2023, the £69,000 worth of counterfeit tobacco and vapes included 2,500 vapes.

Key Issues	Recommendations
• E-cigarettes are effective for smoking cessation and during the transition to quit smoking. • Discouraging recreational vaping initiation is crucial, especially for children and young people. • There are concerns about vaping among youth, especially with unknown long-term impacts. • Despite local bans, young people still encounter targeted e-cigarette advertising.	• Encourage vaping as a smoking cessation tool rather than a recreational activity. • Provide targeted smoking cessation programmes focusing on transitioning from smoking to vaping, supplying vapes. • Educate smokers about the potential benefits of switching to vaping to aid in smoking cessations. • Strengthen regulations to prevent underage access to vaping products, including age verification checks. • Work with schools to implement campaigns to highlight the risks of vaping. • Strengthen enforcement of bans on e-cigarette advertising, particularly on social media platforms and near schools. • Increase efforts to combat illicit sales through enhanced enforcement measures and penalties for illegal sales. • Conduct a needs assessment specifically focusing on vaping in young people.

14. Smoking cessation service provision in Havering

At the time of the needs assessment the smoking cessation services currently available in Havering consisted of:

- A Specialist stop smoking service for pregnant women and their households and for new parents for 12 months after baby is born.
- A hand full of (5) Community Pharmacy service -established March 2023 and located in most deprived parts of the borough.
- Stop Smoking London Telephone and online stop smoking service (universal).

Additional services have/ are in the process of being commissioned in 2024 and they include:

- specialist stop smoking service for people with Severe Mental Illness (SMI) and
- Tobacco Dependence Advisor-led community service for priority groups such as routine and manual workers, people experiencing homelessness, social housing tenants, individuals dependent on drugs and/or alcohol.
- In addition, the pharmacy service is being scaled up with additional 5 pharmacies being commissioned to provide support to quit smoking bringing the number to 10 pharmacies.

15. Benchmarking

In April 2022, a ministerial announcement outlined new measures to support the goal of achieving a smoke-free country by 2030[55]. These initiatives included:

1. Preventing youth vaping
2. Using vaping as a cessation tool
3. Increasing enforcement of illicit sales
4. Improving access to cessation medications
5. Integrating cessation services into the healthcare system
6. Offering financial incentives for pregnant women
7. Supporting individuals with mental health conditions in cessation
8. Implementing cigarette pack inserts (providing support resources)

ASH and Cancer Research UK conduct an annual survey to evaluate tobacco control efforts across local authorities in England, Scotland and Wales[56]. The 2022 survey revealed significant insights:

- **Targeted services commissioning:** Only 33% of all surveyed local authorities commission targeted services for smoking cessation. Notably, over half (54%) engage pharmacists to provide stop smoking support.
- **Priority group targeting:** Activities are primarily focused on high-priority groups such as pregnant women, socio-economically vulnerable areas and individuals with mental health conditions.
- **Provision of e-cigarettes:** 52% of local authorities provide electronic cigarettes to smokers.
- **Collaboration with other local authorities:** 59% of local authorities have established local tobacco alliances, and 79% collaborate with other local authorities on tobacco control and stop smoking initiatives.

This benchmarking shows that Havering's stop smoking services align with national guidance, affirming the approach of current strategies. Although Havering has the "Swap to Stop" initiative and an SMI stop smoking service, opportunities for further improvement exist. Havering can further target youth vaping, can incentivise pregnant women to stop smoking through financial support and build relationships with neighbouring local authorities.

[55] O'Brien, N, 2023: Minister Neil O'Brien speech on achieving smoke free 2030: cutting smoking and stopping kids vaping.
[56] Action on Smoking and Health (ASH), 2023: New paths and pathways: The role of vaping nicotine in a tobacco-free future.

16. Stakeholder Insights

Stakeholder Workshops
In June 2023, a stakeholder workshop was held where participants discussed areas of tobacco harm reduction, focusing on high-priority groups: smoking in pregnancy, smoking and vaping among children and young people, smoking about individuals with mental illness and learning disabilities and smoking in routine and manual occupations. The issues raised informed the action plan.

In December 2023, a second workshop was held to share initial findings of the needs assessment as well as the proposed areas to focus investment from the 2024-25 government grant. This enabled the stakeholders to prioritise groups and agree on the recommended actions and the spending plan, as well as the timescale and responsibility of each action. This collaborative process led to the finalised action plan.

For a list of those engaged in the stakeholder workshop, as well the activities they completed, see Appendix A.

Focus groups
Focus groups were conducted with those that work with certain priority groups in Havering. Stakeholders were asked to assess the significance of smoking, tobacco use and vaping within their sphere of influence, detailing specific products used and emerging trends. Stakeholders were also asked about their awareness of existing referral services and perceived gaps within these services, as well as the level of training provided to staff on smoking.

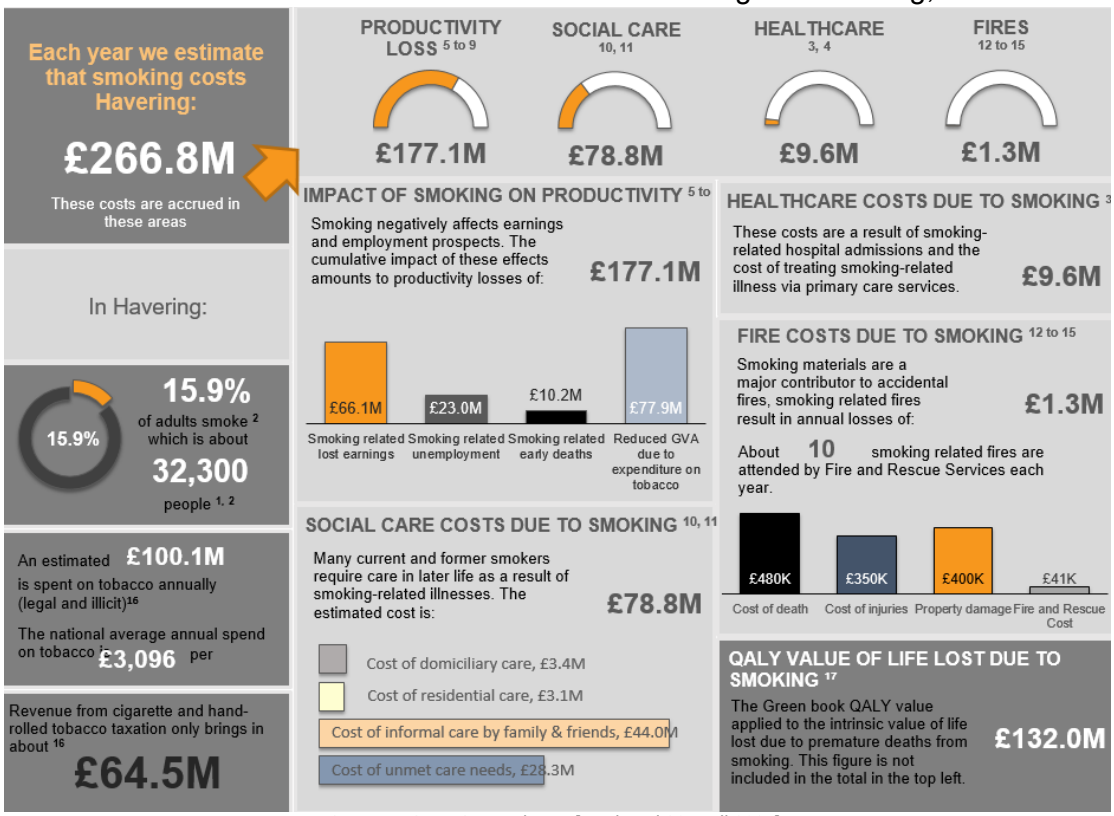
For a list of those who participated in the focus groups, as well as key findings, see Appendix B.

Key Recommendations
• Ensure accessibility of stop smoking materials for those with LD, through easy-to-read formats and visual aids. • Increase efforts targeting not only clients, but also parents and carers, about the risks of vaping/smoking within the LD community. • Improve information dissemination about smoking cessation programmes, especially for post-discharge referrals from inpatient services. • Encourage Very Brief Advice training to those who work with LD, housing officers, social prescribers and health & wellbeing coaches. • Promote stop smoking initiatives at community hubs and events. • Update the Joy App to include information on Havering smoking cessation resources.

17. The Cost-Effectiveness of Tobacco Control

In Havering, the societal cost of smoking amounts to £266.8 million annually, with £177.1 million lost in productivity, £78.8 million in additional social care costs, £9.6 million in additional healthcare costs and £1.3 million in costs to fire and rescue services attributable to cigarettes[57]. See the graphic below for a further breakdown of tobacco's cost to Havering.

Figure 9: Breakdown of tobacco's cost to the London Borough of Havering, 2024.



Source: ASH: ASH Reckoner [Retrieved 29 April 2024].

Investing in smoking cessation programmes is effective, as evidence by its return on investment. For every £1 allocated to smoking cessation, £10 are saved in future health care costs and health gains[58]. Additionally, the central government's objective to eradicate smoking would free up 75,000 GP appointments each month, according to Cancer Research UK. Consequently, tobacco control serves as a long-term investment to alleviate pressure on the healthcare system and save money for society and smokers themselves. Analysis shows that smokers lose a substantial portion of their annual income to tobacco – an estimated £14.3 billion annually in England, equating to an average income loss of £2,451 per smoker, according to ASH.

Tailored stop smoking services play an important role in improving quit rates. Smokers using a combination of behavioural support and pharmacotherapy in their quit attempts exhibit almost three times the odds of success than those who use neither support avenue[59]. Implementing recommended interventions can save lives and reduce chronic illness and disability, thereby offering potential economic benefits for Havering's economy.

[57] ASH: ASH Ready Reckoner (Accessed 29 April 2024).
[58] Public Health England. Health matters: preventing ill health from alcohol and tobacco use.
[59] Kotz, D., Brown, J., & West, R. (2014). 'Real-world' effectiveness of smoking cessation treatments: a population study. *Addiction (Abingdon, England)*, *109*(3), 491–499.

18. Conclusion and Recommendations

While nationally, smoking prevalence has declined significantly over the years, the smoking rates in Havering, which previously have been falling, have reversed in recent years. Havering has the highest smoking rate in northeast London. The smoking rates remain stubbornly highest amongst those in our society who already suffer from poorer health and other disadvantages.

Better data and insight into those high smoking prevalence groups is therefore needed to shape targeted intervention to meet their needs and support them to quit or reduce smoking.

By expanding the current provision, prioritising key groups, embracing evidence-based practices and adhering to best practice guidance, Havering can realise its commitment to reduce tobacco harm in the borough with government ambition for a Smoke free nation by 2030. Refer to Appendix C and Appendix D for detailed best practices guidance.

Key Recommendations:

Smoking

- Expand service provision and ensure availability of a full range of behavioural interventions and cessation aids, including vapes.
- Prioritise tailored support for high-smoking prevalence groups based on specific needs.
- Improve ward level data collection and for specific groups to facilitate targeted interventions.
- Provide carbon monoxide testing and intensive support for pregnant women, including using smoking cessation incentives.
- Provide training for front line health & social care staff (including Very Brief Advice training) to improve knowledge, skills and confidence to engage and signpost those smoking to support services.
- Raise awareness of tobacco harm and local stop smoking services through campaigns and align local campaigns with community needs.
- Ensure that services are accessible and are culturally and linguistically sensitive to different groups including the homeless and those with learning disabilities

Vaping

- Strengthen partnership work with trading standards to address sale of illegal vapes and cigarettes and tighten enforcement measures.
- Work with educational establishments and young people to raise awareness of harm from both tobacco and vapes.
- Conduct a separate needs assessment to understand extent of vaping amongst young people and types of vape substances sold in Havering.

19. Appendices

Appendix A: List of workshop stakeholders and activities completed.

Workshop	Participants/organisations	Activities
Stakeholder Workshop 1 (June 2023)	NELFT – Mental Health lead, 0-19 children's service lead, Carers Lead BHRUT – maternity, tobacco dependency lead NHS NEL Smokefree Manager My Health Matters (Age UK) Public Protection/Trading Standards Health & Wellbeing Coaches Community Connector Programme Lead	Stakeholders split into 4 groups for discussion as below: • Preventing Smoking & Vaping Amongst Young People • Developing an effective stop smoking service for people with SMI • Identify priority groups and actions to reduce tobacco harm • Smoking in pregnancy Identified key issues, key groups, and key actions to be considered for each of the areas.
Stakeholder Workshop 2 (December 2023)	NELFT – Mental Health lead, Carers Lead, Learning Disabilities BHRUT – maternity, tobacco dependency lead NHS NEL Smokefree Manager My Health Matters (Age UK) Public Protection/Trading Standards Local Pharmaceutical Committee Change Grow Live (Drug & Alcohol Service)	1. Review findings from Needs Assessment data, and recommended actions given. 2. Split into groups to agree top 10 priority actions to be delivered in years 1-5. Groups included: • Smoking and vaping among young people • Smoking among people with mental health and learning disability, LD • Smoking among workers in routine and manual occupation • Smoking in pregnancy 3. For each of the agreed 10 actions specify fully the ACTION, WHEN to be delivered (Yr. 1 to yr. 5) and LEAD.

Appendix B: List of focus group participants and key findings.

Stakeholders	Key Findings
Learning Disability Services	**Perception of Smoking and Vaping:** Within learning disability spheres, service providers noted smoked tobacco as the most popular, but vaping and smoking is highest among individuals in their 20s and 30s, noting age as the main noticeable trend. Individuals with LD with mental health hospital admissions were identified as higher risk smoking groups. Furthermore, stakeholders emphasised the importance of education for clients, parents and carers, noting a lack of awareness regarding the risks of smoking. **Referrals**: Learning disability providers expressed limited awareness of referral services, facing challenges in identifying appropriate resources. While existing pathways were acknowledged, they were deemed inaccessible. Structured smoking cessation support exists within inpatient facilities, but uncertainty comes with post-discharge referrals. Although recent NHS initiatives were noted, better dissemination of information was urged, alongside the importance of self-referral options with detailed programme information. **Staff Training and Support**: Service providers noted there was no staff training on smoking cessation and vaping due to funding constraints, despite plans to train two cessation officers. Interest was expressed in Very Brief Advice training. Service provides emphasised the need for additional support, particularly in addressing aggression and social aspects associated with cessation. **Barriers and Accommodations**: To make services more accommodating, basic learning disability and autism awareness training for all staff were recommended, along with sensory-friendly environments and easy-to-read information. Visual communication methods were favoured, recognising the importance of building trust over time. Service providers expressed the importance of early intervention and preventative measures.
Housing Service Providers (Resident Services)	**Perception of Smoking/Vaping:** Housing providers identified smoking, tobacco use and vaping as significant concerns, estimated that about 30% of encountered individuals are smokers. While acknowledging the importance of addressing smoking for fire risk assessment, there is no systematic storage of smoking data in housing services. However, smoking enquiries are incorporated into settling-in questionnaires and kept on file. Participants noted a noticeable increase in vaping alongside a decrease in traditional smoking. Of concern was the initiation of vaping among non-smokers. **Referrals**: Housing providers noted a lack of awareness of Havering's stop smoking services. Housing representatives discussed integrating smoking-related enquiries into settling-in visits and welfare checks, promoting stop smoking initiatives at community hubs and events and providing Very Brief Advice to housing officers. **Barriers:** There is no smoking cessation training among housing staff in the borough. Housing providers indicated that asking tenants about their smoking habits may not be within the remit of housing officers. However, they suggested leaving educational materials in community spaces, such as food pantries, youth centres and community hubs to increase awareness of Havering smoking cessation resources.
Health & Wellbeing Coaches and Social Prescribers	**Joy App:** Social Prescribers primarily access information on smoking cessation and other services through internal directories. The Joy App serves as a central resource and is being updated. Thus, there were recommendations to promoted Havering smoking cessation support within the Joy App.

Appendix C: Smoking Cessation Interventions and effectiveness.

A report from Public Health England outlines cessation interventions and ranks them for evidence of effectiveness and effect size[60]. Table III summarises these findings.

Table III. Stop smoking interventions ranked for evidence of effectiveness and effect size

Rank	Component	Summary	Boosts quit rate by:
1	Face–to-face group support with pharmacotherapy	6-12 weekly group sessions led by stop smoking specialists with a minimum of 8 members per group. Smokers receive their preferred medication and carbon monoxide (CO) levels are monitored. This is more suitable for areas with sizeable smoking populations.	300%
2	Face–to-face group support with pharmacotherapy	6-12 weekly individual sessions with a stop smoking specialist. Smokers receive their preferred medication and CO levels are monitored.	200-300%
3	Supported use of pharmacotherapy	Smokers receive their preferred stop smoking medication with guidance on effective usage in one initial appointment and one-follow up check. The easiest way to commission this is through GP prescriptions, but pharmacies are also an option.	50-100%
4	Telephone support	Telephone support for 6-12 weeks with multiple sessions in the first week, ensuring access to stop smoking pharmacotherapy.	50-100%
5	Text message support	Text messaging has less evidence but shown to improve quit success rates compared with nothing. It is not recommended that new local programmes are developed without evaluation.	40-80%
6	Online	Websites may be cost-effective way of informing smokers about methods of stopping, but they should not be the sole form of support offered to smokers.	Unknown
7	Mobile digital applications	Limiting evidence exists, mobile digital applications need further research and should not be used instead of the strongly evidence-based programmes.	Unknown

[60] Models of delivery for stop smoking services, Options and evidence, 2017: Public Health England.

Appendix D: NICE Recommendations for Best Practice for Smoking Cessation[61].

The National Institute for Health and Care Excellence (NICE) provides comprehensive guidelines aimed at combatting tobacco use. The table below outlines key recommendations that Havering Public Health can leverage to inform strategies and interventions.

Category	Recommendation	Description
I. Recommendations on preventing uptake	Media Campaign	Develop campaigns with partners targeting youth under 18, integrating regional efforts and using research-based messages across diverse media challenges.
	De-normalise tobacco	Assess need for advocacy campaigns against illegal tobacco sales, avoiding collaboration with tobacco organisations and promoting policy changes.
	Retailer support	Train retailers to prevent illegal sales, strengthen enforcement, collaborate with agencies and publicise legislation against underage policies.
	School interventions	Ensure evidence-based interventions are in schools, integrating them into curricula and promoting whole-school smoke-free policies.
	Smoke-free policies	Develop comprehensive smoke-free policies, integrating prevention activities and ensuring universal application and accessibility.
II. Recommendations on promoting quitting	Use medicinally licensed nicotine-containing products	Raise public awareness of smoking harm and provide information on using nicotine products as substitutes for tobacco, highlighting reduced risk and safety compared to smoking.
	Promote stop-smoking support	Coordinate strategies involving healthcare, governmental and non-governmental organisations. Develop evidence-based campaigns, engage pharmacies and ensure accessible information on local support services.
	Promote support for smokeless tobacco	Collaborate with community initiatives to raise awareness of local cessation services. Tailor information to address various needs and use local networks, media and venues to engage communities.
III. Recommendations on treating tobacco dependence	Identify and quantify people's smoking	Find out smoking habits, guide smokers on cessation, discuss past quit attempts and offer advice on available cessation aids.
	Stop smoking interventions	Ensure behavioural interventions, NRT products, nicotine-containing e-cigarettes and group support are available to those wanting to quit.
	Choose a harm-reduction approach for those not ready to quit	Engage smokers in discussion about reducing harm from smoking, offering approaches such as cutting down before quitting, smoking reduction and temporarily not smoking.
IV.Recommendations on treating tobacco dependence in pregnant women	Identify and refer pregnant women who smoke.	Provide routine carbon monoxide testing and provide an opt-out referral for all pregnant women who smoke.
	Follow up women who have been referred for support	Contact all pregnant women who have been referred, provide information, and address any concerns they have.
	Provide support to stop smoking	Provide pregnant women with intensive and ongoing support, biochemically validate, provide NRT support and establish links with contraceptive, fertility, antenatal and postnatal services. Provide incentives to stop smoking.
V. Recommendations on policy, commissioning and training	Encourage smoke-free grounds.	Encourage to organisations, such as hospitals and schools, smoke-free premises.
	Commission and design services with high-priority groups in mind	Prioritise groups at high risk of tobacco-related harm, including people with mental health conditions, people who misuse substances, people with health conditions caused or made worse by smoking, people with smoking-related illnesses, and populations with a high prevalence of smoking-related morbidity communities or groups with high smoking prevalence, people with low socioeconomic status and pregnant women who smoke.
	Encourage training to prevent uptake of smoking	Encourage smoking prevention training among partners, including healthcare staff.

[61] National Institute for Health and Care Excellence, 2024: Tobacco: preventing uptake, promoting quitting and treating dependence.