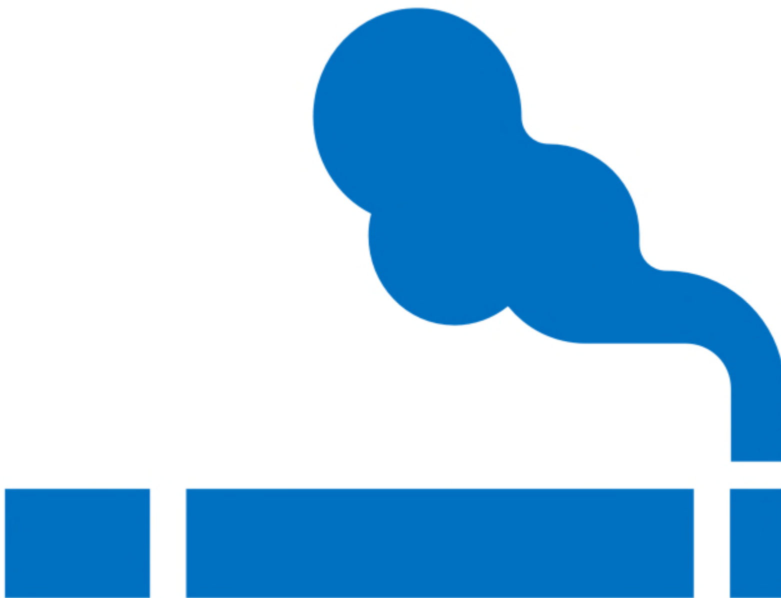
Thurrock Tobacco Control Strategy

2023-2028



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Introduction

Smoking is widely accepted as one of the most detrimental behaviours that can affect the health of our communities and increase the risk of suffering serious illness and premature death.

Cigarettes are the main cause of death for about half of all long-term smokers and are a significant contributor to increased morbidity in others.[1]

Smoking causes conditions ranging from cancers, vascular disease, respiratory diseases, dementia, rheumatoid arthritis, sight loss, and events such as heart attacks and strokes. It is the 4,000 chemicals in tobacco which cause the harm to health, over 50 of which can cause cancer.[1]

In England there have been concerted efforts to reduce the number of smokers in the population and to increase education about the health harms of smoking as well as the wider societal impacts. While there have been considerable reductions in the smoking population of England from 45% 1974, the Annual Population Survey from 2021 indicates that 13% of adults in England and 12.6% in Thurrock still smoke.[2]

While the significant reduction in smoking both nationally and locally is welcome, these reductions and the harms that tobacco causes on those in the community who smoke is not equally distributed. There are deep inequalities related to tobacco use. The use of tobacco and its associated harms continue to fall hardest on some of the poorest and most vulnerable people in our communities.

Smoking and inequalities

Smoking is the single largest driver of health inequalities in England, accounting for half the difference in life expectancy between those living in the most and least deprived communities.

Smoking is much more common among people with lower incomes. The more disadvantaged a person is, the more likely they are to smoke and to suffer from smoking related illness and early death related to smoking.

As spending on tobacco consumes a relatively high proportion of the household income for people with low incomes who smoke, smoking can lock people into poverty. In addition to its impact on health inequalities, smoking also brings a huge financial cost to wider society.

Action on Smoking and Health (ASH) estimates the cost of smoking to England's economy to be £12.6billion each year.

Nearly all of those who start smoking do so as young people in their teens or early twenties. Where smoking is more visible in homes, communities and workplaces, there is higher likelihood that smoking will be taken up by the next generation.

Children and young people who live with parents who smoke are nearly three times more likely to become smokers themselves than their peers who do not live with smokers. If smoking is more visible and perceived to be socially normal behaviour, there is a higher likelihood to experiment with tobacco. The "de-normalising" of smoking is important in changing attitudes in children and young people to the use of tobacco.

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[1] Cancer Research UK.
[2] NHS Digital Fingertips

There has traditionally been a focus on the provision of universal Stop Smoking Services to address the reduction in the prevalence of smoking in our communities. This was the best approach when the numbers of smokers in society were much higher. Since there are fewer smokers generally, smoking has become an issue of inequality and therefore, an approach needs to be taken in order to specifically target groups where rates remain high.

Reducing tobacco-related harm

The likelihood of successfully quitting in the long term is increased by three times through the use of Local Stop Smoking Services, which provide behavioural support to aid quitting.[3]

While about half of attempted quits are made without the use of Nicotine Replacement Therapy (NRT) or other aids[2], the use of NRT and licensed pharmacotherapy helps reduce the nicotine cravings that arise with stopping smoking. There are 6 internationally recognised strands of tobacco control[3], which have become the core of tobacco control policies across the world.

The 6 strands are:

1. **making smoking less affordable**
2. **regulating tobacco products more effectively**
3. **reducing exposure to second hand smoke**
4. **stopping the promotion of tobacco products**
5. **helping smokers to quit**
6. **effective communications for tobacco control**

To achieve a smoke-free Thurrock, there is a need to continue to prevent the uptake among young people, reduce the supply and demand of illicit tobacco through regulation and enforcement, reduce exposure to second hand smoke through creating smoke-free environments, and focus efforts to support people to stop smoking in communities where smoking rates are still higher than the wider population.

This strategy will take an inequalities approach to tobacco control, ensuring that action is targeted where it will have the greatest impact for the groups of greatest need within Thurrock. Due to the wide range of areas impacted by smoking, and the variety of interventions required to address it, a comprehensive and strategic approach to tobacco control is needed. To achieve this, all parts of our system will have their part to play.

This strategy is based on the detailed analysis in the Thurrock Whole System Tobacco Control JSNA 2021.

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[3] Healthy Lives, Healthy People: a tobacco control plan for England

National context summary

The main form of tobacco used in the United Kingdom (UK) is cigarettes.

While the proportion of people in England who smoke has reduced, smoking cigarettes continues to be the main 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 people's lives – it:

- causes permanent lung damage to children exposed to second hand smoke
- is a common cause of sickness absence
- increases the risk and severity of long-term conditions and infectious diseases
- reduces the effectiveness of many medicines and treatments
- shortens healthy life expectancy
- increases mortality

Smoking is not a lifestyle choice. Evidence has demonstrated that it is an addiction.

Most smokers want to quit – recent data suggests about 58% – and many try each year, mostly on their own and increasingly with the support of e-cigarettes, but the most effective method of stopping smoking is through evidence-based stop smoking services.

Thurrock has reached a similar smoking prevalence rate to the England average. However, people from poorer socio-economic groups and people living with mental ill health continue to be more likely to smoke than the general population. This has far-reaching consequences on the health of residents, household budgets, health and care services, the economy, and the environment.

Full national context can be found in the Thurrock Whole System Tobacco Control JSNA 2021.

Local context

There is a continuing decline in the proportion of people who smoke in the Thurrock.

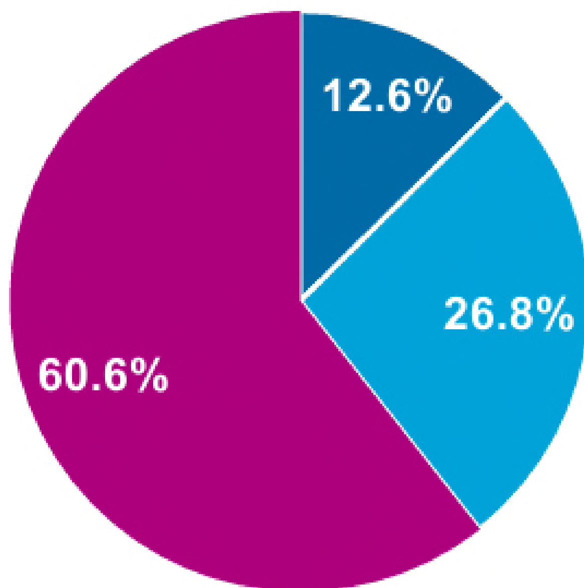
As of 2021, the annual Population Survey (APS) indicates that 12.6% of people in Thurrock smoke. This is similar to the estimated rate of smoking in England (13%) and in the East of England region (12.9%).

However, there has been a change in the method of collecting these data due to the COVID-19 pandemic, which appeared to show a large and unexplained decrease in smoking prevalence nationwide. It is therefore recommended to interpret these prevalence numbers with caution.

The true prevalence of smoking in Thurrock could be as high as 15.6% (95% confidence interval: 9.5%-15.6%).

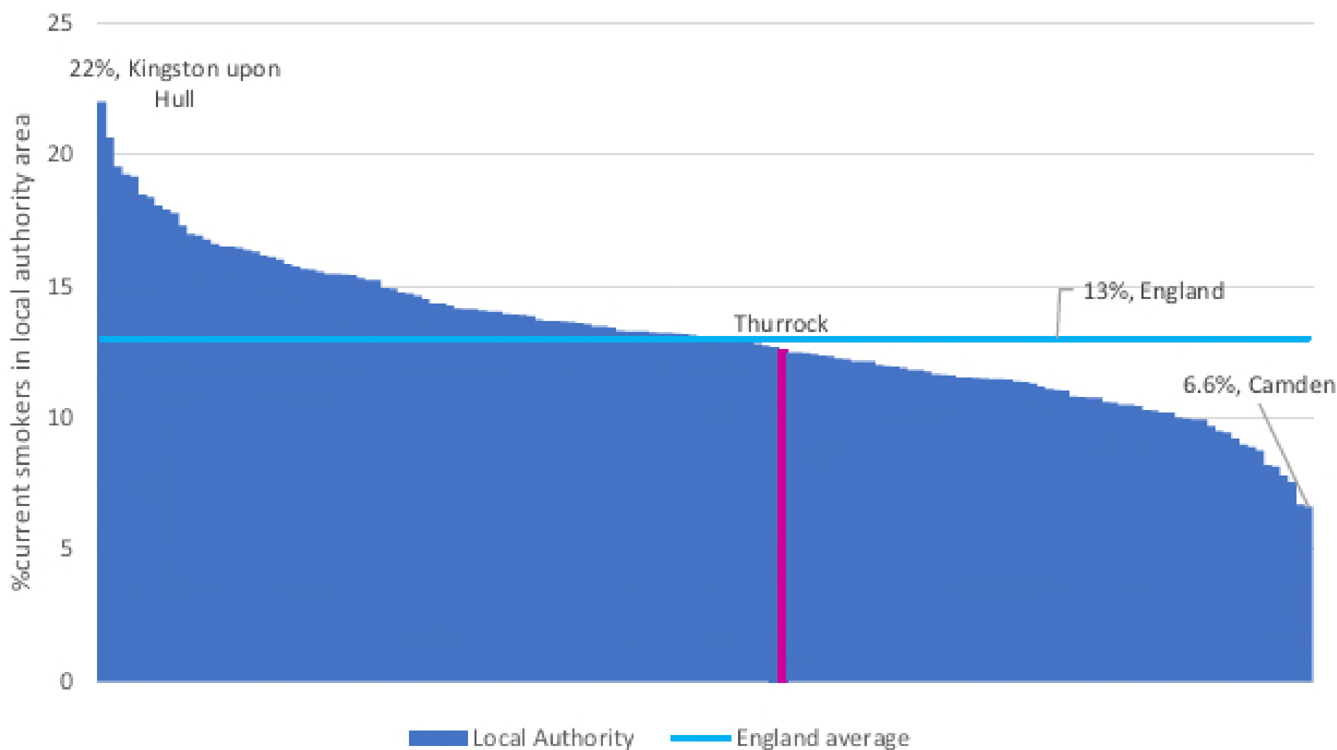
Thurrock still has a long way to go to reach the UK government's ambition to be ‘smokefree' by 2030, meaning only 5% or less of the population smoke. Data from Camden shows it is possible to get close to that ambition; their 2021 smoking rate was 6.6%.

The chart below shows 12.6% are current smokers, 26.8% are ex-smokers and 60.6% have never smoked.



Source: NHS Digital Fingertips (2021)

The following chart shows Thurrock is slightly better than the average for percentage of current smokers in England, and slightly better than midway in a list of local authority areas ordered by percentages of current smokers in each area.



Source: NHS Digital Fingertips (2021)

Inequality

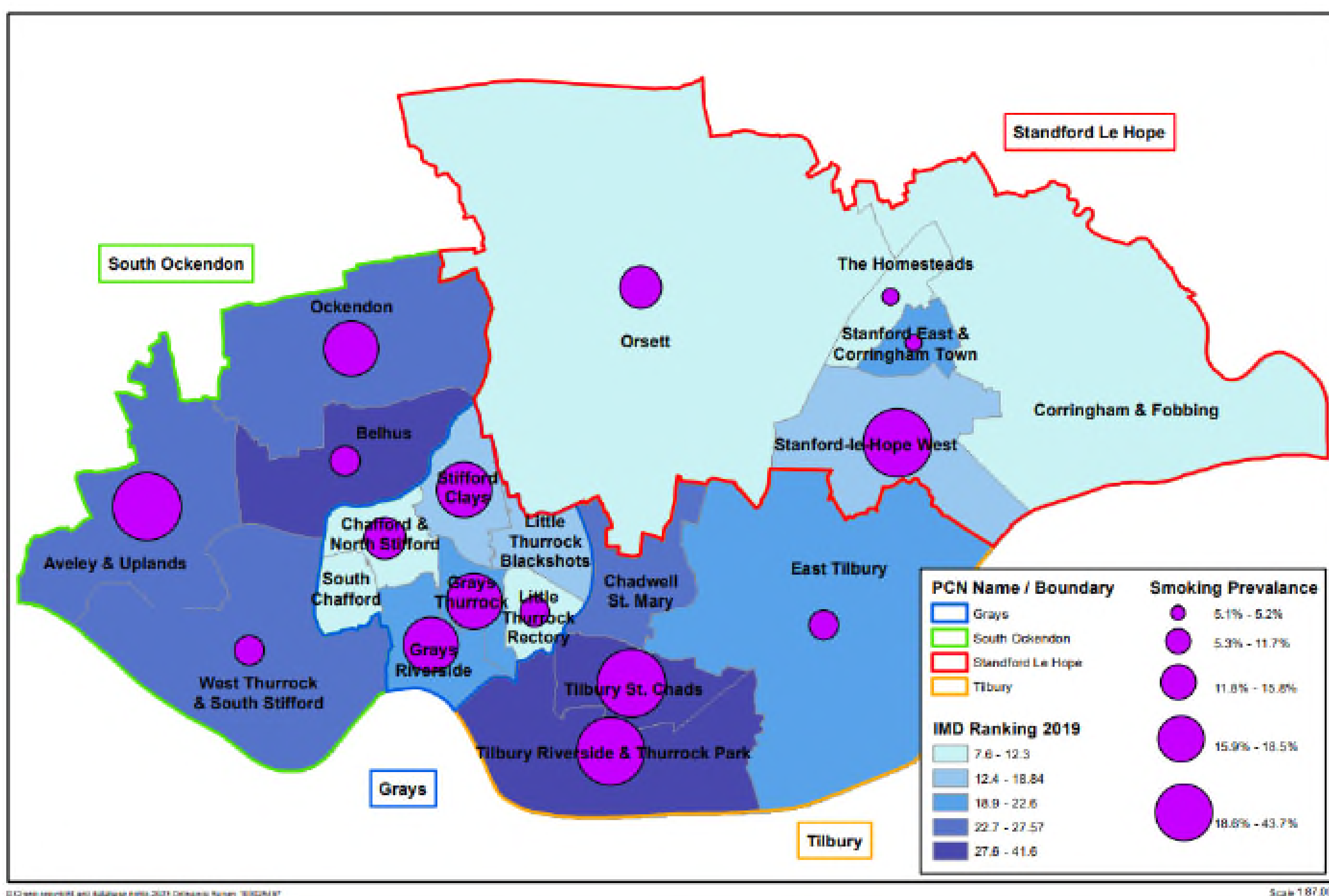
The decrease in smoking rates across Thurrock has not been evenly distributed. Areas of higher deprivation have seen slower progress than their more affluent neighbours.

The difference in life expectancy between the most and least deprived wards is 9 years for men and 7 years for women, and half of this can be attributed to smoking. It is vital that the 8 most deprived wards in Thurrock, which account for 63% of smokers, receive targeted attention across all areas of this strategy to make the largest possible difference to the equity of health across the borough. The 63% does not count Chadwell St Mary ward, where GPs are now part of college health and no longer reporting QOF separately.

NICE recommends that an effective stop smoking service reach 5% of the smoking population; in 2021/22, the Thurrock SSS reached slightly below that target (4.5%) across the borough. In individual wards, 10 were below the 5% target, half of those were among the 8 most deprived areas.

Thurrock Ward-Level Smoking Prevalence (QOF 2021/22)

The map of Thurrock below shows rates of smoking are highest in Belhus, Tilbury Riverside and Thurrock Park, and Tilbury St Chads wards. The rates are lowest in Chafford Hundred and North Stifford, Corringham and Fobbing, Little Thurrock Rectory, Orsett, and South Chafford wards.



High risk groups

While the overall smoking prevalence has been decreasing in Thurrock, there are still some groups that are disproportionately affected by smoking, which contributes significantly to health inequality in the borough.

The figures below show that the rates of smoking among routine and manual workers, those with mental health conditions, and adults with substance misuse are all much higher than the 12.6% Thurrock average. This means that these groups are disproportionately affected by the harms of smoking compared to the overall population.

Smoking at the time of delivery is higher than the regional (8.5%) and national (9.1%) averages and due to the unique harms caused by smoking during pregnancy, targeted reduction is required.

Group	Smoking prevalence
Routine and manual workers	17.5%
Long-term mental health condition	22.1%
Adults with substance misuse	50% – opiates 47.2% – alcohol and non-opiates
Smoking at time of delivery	10.1%

Source for all: NHS Digital Fingertips (2021).

Support to Stop Smoking – current service provision

The primary stop smoking service in Thurrock is provided by Thurrock Healthy Lifestyles Service (THLS). The offer supports residents to quit using a variety of Nicotine Replacement Therapy (NRT) products and weekly telephone sessions with a Health Improvement Practitioner.

NICE guidance cites a 35% quit rate at 4 weeks as the benchmark for an effective stop smoking service, the THLS service supports quits for 12 weeks, so we hold the Thurrock service to a higher standard than the NICE recommendations mandate.

The Stop Smoking Service is one of the main tools Thurrock has to tackle inequality in smoking rates. Targeted outreach to high-prevalence areas, and tailored interventions for high-risk groups will help to increase service impact within hard to reach communities.

Based on performance data, the service is generally an effective one, but it is not achieving equally across all ethnic groups and we do not currently know success rates for all high-risk groups.

Routine and manual workers are 30% of referrals and 34% have successfully quit at 12-weeks. The service appears to work well for this group, and the focus should be on increasing referrals.

Clients with recorded **mental health conditions** are 13% of referrals and 28% of these achieved a 12-week quit. Ways to increase both referrals and effectiveness for this group should be explored and implemented.

We don't have robust data for service users with **substance misuse**. A solution should be explored to ensure we can monitor equity of service for this group.

Pregnant women who are referred to the service are a minority, but 33% of them successfully quit after 12-weeks. The THLS service is effective for this group, so an effort should be made to increase referrals. We will also look to adopt a whole family approach to support the wider household.

Referrals into the service do not reflect the ethnic makeup of the Thurrock population and successful quit rates vary between groups. More outreach is needed within **minority ethnic groups**, and adjustments to make the service more effective for Black and mixed race service users should be explored and implemented.

Ethnic group	Population %	Referrals %	Quit rate %
White	76.7%	92.7%	33.5%
Asian	6.9%	2.6%	35.6%
Black	11.9%	1.9%	22.2%
Mixed	3.0%	1.5%	27.8%

Previous work

Thurrock's previous 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

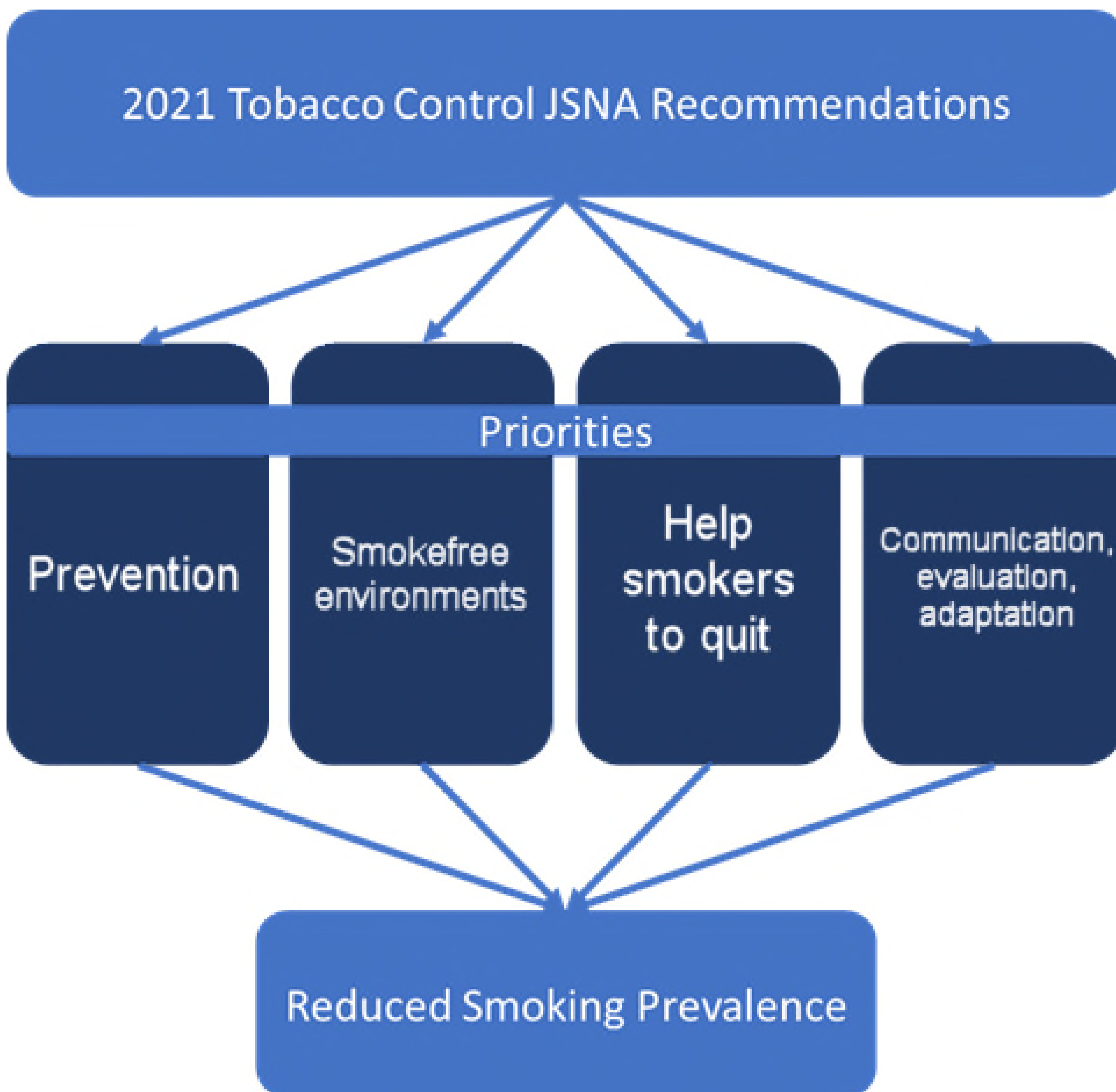
Alongside a universal stop smoking offer, the strategy proposed targeted support to people living in more socio-economically deprived areas, people with long term conditions, mental ill health, and pregnant women.

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.

Due to a number of factors, including the COVID-19 pandemic, the Tobacco Control Alliance is no longer in place, therefore it will be necessary to find a new home for leadership of this current strategy if success is to be driven forward.

Priorities

The overarching goal of this Tobacco Control Strategy is to reduce overall smoking prevalence in Thurrock to 7.1% by 2027/28, with a view to achieve the UK Government's ambition of ≤5% by 2030. This goal will be supported by four priority workstreams that will ensure activity is focussed on areas of greatest impact as identified by the 2021 Tobacco Control JSNA.



Principles

Due to the potential volume of priorities, we have sought to prioritise delivery options against the JSNA recommendations based on the following underpinning principles:

- **strategic alignment** – there are a number of innovations in the local system that could support delivery of the whole systems tobacco control approach, and we will prioritise capitalising on such innovations to make most efficient use of local resources and to support a holistic approach to tobacco control
- **inequalities** – where research evidence indicates an intervention is more likely to impact on inequalities in smoking prevalence
- **evidence strongest** – where evidence is available, interventions that have the strongest research evidence have been chosen
- **co-production** – where research evidence is weak / unavailable but there is an inequality, we will prioritise co-producing solutions with local population groups
- **evaluation and monitoring** – where research evidence is weak / unavailable but there is a need to innovate, we commit to undertaking timely and good quality evaluation to enable the strategy to have the agility to adapt as we learn what works best locally

Prevention

This priority will focus on stopping smoking before it starts. This will be achieved through working with children and young people (CYP), expectant parents and education settings. We will:

1. reduce access to illicit tobacco
2. continue enforcement against illegal sales of tobacco products to children
3. increase screening for smoking/vaping among young people
4. reduce smoking among pregnant women and their partners / households

Ambition	Reason	Principle	Evidence base	Responsibility
1a. Reduce access to illicit tobacco.	Illicit tobacco undermines national initiatives to reduce the affordability of smoking.	Strategic alignment.	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners.	Trading Standards.
1b. Continue enforcement against illegal sales of tobacco products to CYP.	The majority of smokers start before the age of 21.	Strategic alignment.	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners.	Trading Standards.
1c. Work with schools and other education settings to co-design and deliver relevant tobacco and vaping messaging.	The majority of smokers start before the age of 21, and vaping amongst young people is increasing.	Co-production.	NICE guidance – Tobacco: preventing uptake, promoting quitting and treating dependence.	Schools. Children's Services and Education. Brighter Futures Board. Trading Standards.
1d. Increase screening for smoking/vaping among young people.	The majority of smokers start before the age of 21.	Evidence strongest.	Thurrock Whole System Tobacco Control JSNA 2021.	Schools. Young people's services (youth offending service, substance misuse, etc). Brighter Futures.
1e. Tackle smoking among pregnant women and their partners / households.	Smoking in pregnancy has reduced at a slower rate than the general population and poses unique risks to child development.	Strategic alignment. Inequalities. Evidence strongest.	NHS long-term plan.	THLS. BTUH. Tobacco Dependency Prevention Sub-group (MSE ICS).

Smoke-free environments

This priority will focus on reducing the harm caused by second-hand smoke by restricting smoking in public spaces and de-normalizing smoking, as well as increased enforcement of national smoke-free initiatives. We will:

1. explore enforcement strategies for smoke-free healthcare settings
2. smoke-free pledge across the council estate
3. smoke-free homes approach for expectant parents
4. smoke-free settings for children and young people

Ambition	Reason	Principle	Evidence base	Responsibility
2a. Explore enforcement strategies for smoke-free hospitals/healthcare settings and NHS smokefree pledge.	A clear and visible way for NHS organisations to show their commitment to helping smokers to quit and to providing smokefree environments which support them.	Strategic alignment.	Action on Smoking and Health (ASH) The NHS Smokefree Pledge.	BTUH. Tobacco Dependency Prevention Sub-group (MSE ICS).
2b. Smoke-free pledge across the council estate.	The council should lead this strategy by example and ensure that smoke-free pledge commitment is visible and enforced.	Strategic alignment.	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners.	Human Resources. Estates Security.
2c. Smoke-free homes approach, particularly for expectant parents.	Promotion and support for smoke-free homes, particularly council housing, will align with NHS LTP smoke-free pregnancy pathway.	Strategic alignment. Inequalities.	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners.	NHS. Housing Team. Community Teams. Mental Health Providers.
2d. Smoke-free settings for children and young people.	Protect the public, especially young children, from second-hand smoke and de-normalise smoking more broadly.	Inequalities.	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners.	Parks Team. Public Health. Schools.

Help smokers to quit

This priority will focus on getting more Thurrock smokers to quit. There will be a particular focus on reducing health inequalities by targeting smokers from groups that are disproportionately affected by smoking. We will:

1. increase quitters from the 8 most deprived wards
2. increase quitters from high risk groups
3. work with NHS partners to build smoking cessation into all clinical pathways and strengthen existing pathways into the Stop Smoking Service
4. increase accessibility of Stop Smoking Service
5. improve and expand vape offer

Ambition	Reason	Principle	Evidence base	Responsibility
3a. Increase quitters from the 8 most deprived wards.	63% of smokers in Thurrock live in the 8 areas with highest deprivation.	Inequalities. Evidence strongest.	Thurrock Whole System Tobacco Control JSNA 2021.	Primary Care. THLS.
3b. Increase quitters from high-risk groups.	Smoking amongst those with long-term mental health conditions, substance misuse, those working in routine & manual jobs, and pregnant women remains high, despite an overall decrease in rates.	Inequalities Evidence strongest	Thurrock Whole System Tobacco Control JSNA 2021.	Primary Care. EPUT. Inclusion. CGL. THLS.
3c. Work with NHS partners to build smoking cessation into all clinical pathways and strengthen existing pathways into the Stop Smoking Service.	Referrals into the SSS have fallen in recent years, pathways need to be reviewed.	Strategic alignment. Evidence strongest.	Thurrock Whole System Tobacco Control JSNA 2021. Better Together Thurrock: The Case for Further Change 2022-2026.	Primary Care. EPUT. Inclusion. CGL. THLS. Tobacco Dependency Prevention Sub-group (MSE ICS). BTUH.

Ambition	Reason	Principle	Evidence base	Responsibility
3d. Increase accessibility of Stop Smoking Service (apply learning from ambition 4c).	Adjustments need to be made to achieve more successful quits from Black and mixed ethnic groups as well as those with long-term mental health conditions and substance misuse.	Inequalities. Co-production.	Thurrock Whole System Tobacco Control JSNA 2021.	Public Health. THLS. EPUT. Inclusion.
3e. Improve and expand vape offer.	Vapes are an effective harm-reduction tool that help smokers to quit.	Evidence strongest.	The Khan Review: making smoking obsolete.	Public Health. THLS.

Communication, evaluation, adaptation

This priority will focus on targeted marketing of smoking cessation support, evaluating initiatives to understand what works, and ensuring the delivery of this strategy is dynamic, responsive to change, and open to innovation. We will:

1. develop a targeted communication plan
2. re-establish a monitoring framework to track and ensure strategy delivery
3. conduct research and engagement to understand the needs of groups that are underrepresented in the Stop Smoking Service
4. collect feedback to inform evaluation

Ambition	Reason	Principle	Evidence base	Responsibility
4a. Develop a targeted communication plan.	Mass media campaigns are effective at increasing quit attempts.	Evidence strongest.	Action on Smoking and Health (ASH) 10 high impact actions for local authorities and their partners.	Communications Team. Public Health.
4b. Re-establish a monitoring framework to track and ensure strategy delivery.	Tobacco Control Alliance was successful in driving forward previous strategy aims.	Evaluation and monitoring.	Thurrock Whole System Tobacco Control JSNA 2021.	All stakeholders.
4c. Conduct research and engagement to understand the needs of groups that are underrepresented in the Stop Smoking Service (inform delivery of ambition 3d)	The SSS in Thurrock is not equally accessible to and effective for all groups.	Inequalities. Co-production.	Thurrock Whole System Tobacco Control JSNA 2021.	Public Health.
4d. Collect feedback to inform evaluation	Interventions should be evaluated, especially areas for innovation to assess their effectiveness and equity impact.	Evaluation and monitoring.	Thurrock Whole System Tobacco Control JSNA 2021.	Monitoring group.

Next steps

Sign-off from Thurrock Integrated Care Alliance (TICA) and Health and Wellbeing Board (HWB) will be sought prior to publication.

This strategy will be supported by a delivery plan detailing specific actions to achieve the aims across each priority area.

Progress will be monitored against the delivery plan with regular updates on agreed actions from accountable stakeholders reported to strategy coordinator.

The strategy group will report to: Better Care Together Thurrock via the Population Health and Inequalities Working Group.