Smoking and Tobacco Control

# Summary

## Introduction

Smoking remains the biggest preventable cause of death and disease in England1. It damages and cuts lives short throughout the whole of the life course; from increasing the risks of stillbirths and childhood asthma, to cancers, circulatory, and respiratory diseases in adulthood, and dementia in older age.

Despite smoking being less widespread amongst the general population, it remains more common amongst people who are affected by social, economic, and health disadvantages. This leads to the poorest in society having an additional and unfair burden of ill health. The extra expenditure on smoking can take families below the poverty line and limit the life chances of children, stopping them from reaching their potential for achievement and growth2.

In addition to the health and economic costs of smoking, there are further costs to society such as the impact of health and social care related spending as well as lost productivity.

Approaches to reducing tobacco related harm include reducing the uptake of smoking, protecting non-smokers from the effects of passive smoke, stopping the uptake of vaping by people who have never smoked, and the environmental effects associated with nicotine containing products.

This needs analysis considers current smoking cessation and tobacco control initiatives in Medway and identifies gaps and challenges to inform decisions to reduce tobacco related harm across all population groups.

## Key issues and gaps

In Medway, adult smoking prevalence has reduced from 25.5% in 2012 to 12.7% in 2023. This is similar to the England average (11.6%)3. Despite the success in reducing overall rates of smoking, there are groups of people where existing approaches haven’t been as effective and where rates of smoking remain as high as 71.8%4. Smoking prevalence in the following groups is significantly higher than that of the general population:

* People with mental illnesses
* People diagnosed with specific long-term health conditions
* People who have a substance misuse disorder
* People who live in rented accommodation and those who live rent free
* People living in areas of deprivation
* People identifying as LGBTQIA+
* People from some ethnic groups
* People who work in routine or manual jobs or are unemployed

Individuals belonging to these groups are often affected by poorer health outcomes which are often preventable. Removing barriers to accessing stop smoking support and providing tailored interventions to meet the specific needs of these groups will help to reduce the gap in health inequalities.

It is also important to address the emerging issue of vaping in children and young people who have never smoked, as well as the increase in rates of smoking amongst 11-17 year olds since 2021.56.

## Recommendations for commissioning

Reducing the wide gaps in smoking prevalence between different population groups is key to reducing health inequalities and achieving the government’s ambition of a Smokefree 2030.

1. Barriers to accessing support should be identified and interventions tailored for and targeted at those most in need. New evidence-based stop smoking aids should be included in service delivery models, alongside nationally produced resources.
2. People belonging to high smoking prevalence groups, including people with mental illnesses and those with substance misuse disorders, are likely to present with more complex needs. Stop smoking practitioners working with these groups should have an enhanced understanding about the unique needs of these service users. Staff should receive training and be supported in knowing how to be responsive to these complex needs whilst maintaining their own levels of resilience.
3. Staff in settings that work with groups with higher rates of smoking should be trained on how to deliver the ‘Very Brief Advice’ intervention. This intervention should be routinely included at a wide range of service delivery touchpoints and pathways should be established that facilitate access to support for groups with higher rates of smoking.
4. Contracts and service specifications should prioritise tobacco control measures and be kept updated to reflect emerging evidence and practice. Resource should be allocated for staff training and implementation of referral and treatment pathways.
5. Collaboration across boundaries and agencies should be strengthened to make sure all six aims of the World Health Organisation’s tobacco control framework are implemented effectively7.
6. Steps should be undertaken to protect children, young people. and non-smokers from developing nicotine dependency using vapes.
7. A CLeaR assessment should be carried to identify opportunities for development and improvement of local tobacco control initiatives.
8. A local Tobacco Control Strategy developed jointly with system partners will provide focus and clarity on Medway’s vision for prevalence reduction targets and promote partnership working.
9. Comprehensive smoking related data should be gathered at a local level and in-depth analyses carried out to inform the level of need and the allocation of resources for the following groups:

* People with different types of mental health diagnoses
* People identifying as LGBTQIA+
* Ethnic minority groups, especially newer migrant communities.

# 1) Introduction

Nearly every organ in the body is affected by smoking and almost every minute of every day, someone is admitted to hospital because of smoking8. About half of all life-long smokers will die early, losing on average about 10 years of life. The gap in life expectancy is even worse for smokers who have a serious mental illness who can die up to 20 years early9. After the age of 35-40 years, for every year of continued smoking, a person loses about three months of life expectancy10. For every death caused by smoking, around 30 smokers will be suffering from a smoking related disease that can severely limit their day to day lives, affecting their ability to work, take care of themselves and their family, and enjoy leisure time11.

The poorest in society often have the highest rates of smoking and carry an additional and unfair burden of ill health because of their smoking habit. They spend a bigger share of their household income on tobacco which can take them further below the poverty line. For households with children, this limits access to opportunities that would improve their potential for achievement and growth.

In addition to smoking related health and social care costs, there is also the cost of lost productivity. In Medway, lost productivity accounts for 69% (£180m) of the total costs from tobacco use. A further £11.1m is spent on hospital and primary care costs12. In 2019/20, around five people each day were admitted to hospital in Medway because of smoking related ill-health13.

The national ambition is to create a smokefree generation by reducing smoking prevalence to 5% or less by 2030. Achieving this is key in supporting smokers to enjoy better health and wellbeing7. This ambition must apply equally to all smokers and achieving it requires a joint effort to reduce the gap in smoking prevalence between different groups of people.

There are broader factors to consider when putting measures in place to reduce tobacco related harm. These extend to addressing the availability and sale of illicit tobacco, sales of nicotine containing products like vapes (e-cigarettes) to under-age young people, protecting non-smokers from the effects of passive smoke through the creation of smokefree environments, and protecting the environment itself from the harms associated with the use and disposal of tobacco and nicotine delivery devices. Considering these issues alongside other tobacco control measures will complement the provision of smoking cessation support and create an environment where the use of tobacco continues to be seen as an activity that is uncommon, instead of the norm.

# 2) Who’s at risk and why?

Each day in the United Kingdom, around 350 young adults between the ages of 18 and 25 years start smoking regularly14. Smoking is only a choice at the point of initiation, making the prevention of smoking uptake in children, young people, and young adults extremely important. Cigarettes are highly engineered to rapidly deliver nicotine and it is this repeated administration that leads to the onset of addiction. Once someone starts smoking, it can take on average thirty attempts to stop and some people never succeed15. Over half of smokers want to quit and three quarters of smokers say they would never have started if they had the choice again10,16.

Multiple factors can help to determine how likely someone is to start smoking, as well their level of dependency on cigarettes. These factors include:

* Age
* Sexuality
* Deprivation
* Socioeconomic status
* Ethnicity
* Co-occurring behavioural health issues like substance misuse disorders and mental health illnesses

## Age

Since 2010, smoking has become less common across all age groups. Nationally, it continues to be lowest in the 65 years and over age group17. Although this group are more likely than younger people to have ever been smokers, they are also more likely to have stopped smoking10. Many smokers will have died before reaching older age and this will be reflected in smoking prevalence rates in older population groups.

The highest prevalence rates are to be found in the 25–59-year age group17,18. Within this group, there are variations ranging from 14.5% in 25-29 year olds to 13.5% in 55-59 year olds18. Historically, most smokers would have adopted the habit when under the age of 18 years, but we are now seeing higher rates of smoking in people between the ages of 25-34 years. This may suggest that smoking uptake is happening at a later age. One reason for this may the combined effects of education17, legislation, and enforcement relating to tobacco19. It could also be because of factors such as media messaging20 and changing social networks as young people transition to adulthood.

Vaping, whilst different from smoking and offering a less harmful alternative to combustible forms of tobacco21, is an emerging concern for those under the age of 18 years. Vapes should not be used by those who have never smoked, and it is illegal to sell vapes to anyone under the age of 18 years, or for vapes to be purchased on their behalf.

The uptake of vaping by people under the age of 18 years has increased in recent years and rates of vaping in young people are now higher than rates of smoking22.

## Sexuality and gender

In general, men are more likely to smoke than women and this trend has been consistent over the last five decades11. This gender difference is more pronounced in some ethnic groups because of cultural influences and social norms in their countries of origin23,24.

In 2018, the Annual Population Survey found that adults identifying as lesbian, gay, or bisexual were more likely to be current smokers when compared to heterosexual adults18. The reasons why people take up smoking are multiple and complex. Some research suggests that mild poor mental health (which might include minority stress, mild anxiety and low self-esteem) could contribute to high smoking rates in these groups25,26.

Evidence submitted by Action on Smoking and Health to the UK Parliament, revealed that smoking may be seen as a coping mechanism25,26. Survey respondents suggested that growing up and coming out can be a very challenging and stressful time. The daily levels of stress related to prejudice and stigma can make smoking difficult to resist and the long-term harmful consequences of smoking can be overlooked in favour of the perceived immediate gains 25,26.

Research also suggests there is an element of sexualisation attributed to smoking in parts of the gay and bisexual community. This relationship to smoking is important to consider as a potential barrier to positive health messages about smoking cessation25,27.

## Deprivation

Deprivation refers to a wide range of living conditions that can impact individuals and communities. People may be living in poverty if they lack the financial resources to meet their needs, whereas people can be regarded as deprived if they lack any kind of resources, not just income.

A person’s likelihood of smoking increases in line with the level of deprivation in their neighbourhood28. This is reinforced by local data which shows that the highest levels of smoking are in the most deprived electoral wards29. Health behaviours such as smoking are closely related to the conditions people are living in, and it is more difficult for individuals to change unhealthy behaviours when they are under stress caused by factors such as debt or poor housing29. In addition, poverty limits support options and makes it difficult for people to make less harmful choices28.

The Office for Health Improvement and Disparities (OHID) has a focus on reducing the inequalities in harmful health behaviours that are the causes of ill-health. This includes closing the gap in smoking prevalence between those who are most well off and those who least well off. The association between smoking and deprivation means that only treating smoking in isolation address the wider determinants of unhealthy behaviours30.

The higher rates of smoking in deprived areas causes an increase in smoking related diseases such as lung cancer and respiratory disease31 within these areas. This also leads to further inequalities in health and life expectancy.

## Socio-economic status

Socio-economic status (SES) reflects an individual or group’s position in society based on a broad combination of factors. This includes economic factors , as well as others such as social, employment, housing, education and deprivation.

There is a strong link between smoking and socio-economic status32. For example, a person’s occupation type and status are key indicators of their likelihood to smoke. This also applies to a person’s housing tenure, level of education and level of deprivation2,33. There are various reasons why smoking is higher in groups affected by one or more of these disadvantages and these include:

* Social networks
* Societal norms
* Stressful environments and experiences
* Limited choices that go hand in hand with lower levels of income
* Lack of opportunity
* An affinity for engaging in risk-taking behaviours
* Low levels of education

Smoking rates are higher in groups facing multiple disadvantages compared to the general adult population2 One example of this is the historically higher rates of women smoking during pregnancy. These women are often affected by several disadvantages, are more likely to smoke before pregnancy, less likely to quit in pregnancy, and among those who do quit, are more likely to resume smoking after childbirth34.

Smoking in pregnancy can have serious consequences for both the mother and the unborn baby. Harmful chemicals from cigarettes can restrict the essential oxygen supply to the baby, increasing the risk of complications during pregnancy and childbirth. Babies born to smokers are more likely to be premature, have low birth weight, and face health problems. They are also at greater risk of sudden infant death syndrome (SIDS), birth defects, and childhood health issues such as glue ear and asthma. In addition to maternal smoking, exposure to passive smoke whilst pregnant can have similar detrimental effects on the unborn baby34.

## Ethnicity

Although tobacco causes health problems across all ethnicities, tobacco use can vary between different ethnic backgrounds35. Some ethnic groups are more likely to use smokeless tobacco, and others will use shisha. Smokeless tobacco, (e.g., naswar, paan or betel quid), is most often used by South Asian Britons, whereas shisha is more likely to be used by people of Middle Eastern descent. However, smoking remains the most common form of tobacco use in all communities35.

In general, men are more likely to smoke than women, but in some ethnic groups such as people with Asian or Chinese ethnicity, this gender difference is likely to be larger. Over time, smoking is becoming less common in people of all ethnicities35.

Immigration has an impact on the use of tobacco in the UK. When people immigrate to the UK, many come from countries with higher smoking rates, and this is particularly the case for migrants from Eastern Europe. Many migrants also come from countries with a different legal framework for tobacco control to the UK, and a different cultural approach to tobacco use24.

## Co-occurring health behaviours

The term co-occurring is used when people experience different conditions at the same time. The relationship between smoking and behaviours such as alcohol consumption, substance misuse, and mental health is complex and multi-faceted.

Smoking rates are higher in people who have a dependency on alcohol36. Alcohol can make people more likely to do things without thinking them through which increases their chances of smoking. For some people, alcohol is a trigger that makes them want to smoke more. Situations where alcohol is present may also include more smokers and being around smokers can increase an individual’s urge to smoke.

Alcohol and nicotine act on common mechanisms in the brain, creating complex interactions that can reinforce negative behaviours by providing a perceived temporary relief from stress and anxiety37. The more a person drinks, the more likely it is that they smoke, with heaviness of drinking going hand in hand with heaviness of smoking. Studies suggest that alcohol causes feelings of pleasure which reinforce the effects of nicotine. There is also research on genetic predispositions that may increase the likelihood of an individual using tobacco and consuming alcohol concurrently38. This same predisposition may also put people at higher risk of diseases associated with smoking and drinking38.

Nicotine addiction and substance misuse addiction often encourage each other, with smoking prevalence being higher in people who engage in substance misuse. While smoking rates have decreased and are at historically low levels, people with substance misuse disorders continue to smoke at high rates39.

Tobacco use and the misuse of drugs are both described as chronic relapsing conditions. Like smoking, the initial decision to take drugs is voluntary for most people. Similar to tobacco, the repeated misuse of drugs can lead to brain changes that challenge an addicted person’s self-control and diminish their ability to resist intense urges to take drugs. Both smoking and drug misuse are considered chronic relapsing diseases because people who are in recovery are at increased risk of returning to use these products.

Young people are more at risk of using tobacco and drugs at the same time because of several factors including peer pressure, other social influences, and a greater likelihood of engaging in risk-taking behaviours40. Young people may resort to smoking or drug use as a means of managing stress and anxiety. For some young people, there can be a lack of awareness about the links between smoking and drug use and the development of addiction. They may also underestimate the long-term consequences of their choices40.

## Mental Illnesses

Mental health conditions cover a broad range of psychological conditions and symptoms, characterised by a combination of abnormal thoughts, emotions, and relationships with others.

There is a strong association between smoking and mental health conditions as smoking rates in this group are significantly higher than the general population. This association becomes stronger with the severity of the mental health condition. The highest levels of smoking are found in psychiatric in-patients9.

It is not clear whether smoking is a cause or effect of mental health conditions, however, there is some evidence that smoking could act as a trigger for mental ill-health. People with a mental health condition have high mortality rates compared to the general population and smoking is the single largest contributing factor to their 10–20-year reduced life expectancy41,42.

People who smoke develop an addiction to nicotine, a drug which stimulates dopamine production, a chemical associated with pleasurable feelings43. In between cigarettes, the blood level of nicotine drops and causes an urge to smoke again. Repeated smoking alleviates the agitation caused by reducing nicotine levels and provides a sense of relief which smokers commonly describe as relaxing.

For smokers with a mental health condition, the association between smoking and relaxation is stronger. It is commonly believed that people with a mental health condition use tobacco to self-medicate symptoms of depression, anxiety, boredom, or loneliness9.

### Depression

Smoking rates in adults with depression are twice as high compared to adults without depression44. As dopamine levels are often low in people with depression, individuals affected may use cigarettes as a temporary way to increase their dopamine supply. However, smoking negatively affects the brain’s mechanism for making dopamine and decreases the supply over time. In the long term, this encourages people to smoke more9.

### Bipolar Disorder

Bipolar Disorder (also known as manic depression) is a condition characterised by shifts in a person’s mood, energy, and ability to function. Although a relationship between smoking and bipolar disorder has not been firmly established, smoking prevalence in people with the condition is significantly higher than in the general population9.

### Attention Deficit Hyperactivity Disorder (ADHD)

Research has shown that both children and adults with ADHD are significantly more likely to smoke than those without the condition45. There is also strong evidence to show that maternal smoking during pregnancy is a risk factor for ADHD46.

### Schizophrenia

Smoking rates for people with schizophrenia are significantly higher than in the general population. One study comparing research across 20 countries showed that the average smoking prevalence rate for individuals with schizophrenia is 62%47. Research has shown that nicotine may improve attention and short-term memory in people with schizophrenia. It may also stimulate areas in the brain such as the subcortical reward system and the prefrontal cortex which are impaired in people with this condition48.

### Post-Traumatic Stress Disorder (PTSD)

There is a clear link between PTSD and smoking. Research suggests rates of 40%-86% amongst people with clinical PTSD, and 34%-61% in non-clinical populations49. This association has been confirmed by studies of war veterans where smokers have been reported to experience higher levels of PTSD symptoms and nicotine cravings50.

# 3) The level of need in the population

Smoking rates are measured by a range of different sources and methods which can cause variation in estimates of smoking prevalence. However, all methods report a continued downwards trend in smoking prevalence across all population groups. Some groups have shown a slower reduction in smoking rates compared to others, making them ‘priority populations’ within this report.

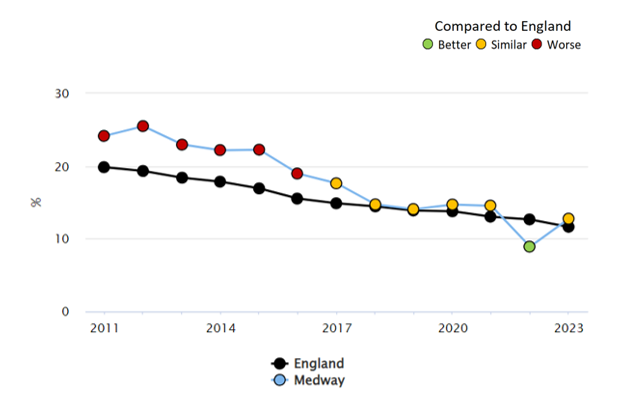
The most used and established data source for smoking prevalence is the Office for Health Improvement and Disparities (OHID) ‘Smoking Profile’. This profile brings together data from a range of sources including the Annual Population Survey (APS), and provides prevalence and incidence data for the following reporting categories:

1. Smoking prevalence in adults
2. Smoking prevalence in priority populations
3. Smoking related mortality
4. Smoking related ill health

These categories are summarised within a ‘Key Indicators’ section which shows the data trends over time and a comparison between Medway and England51.

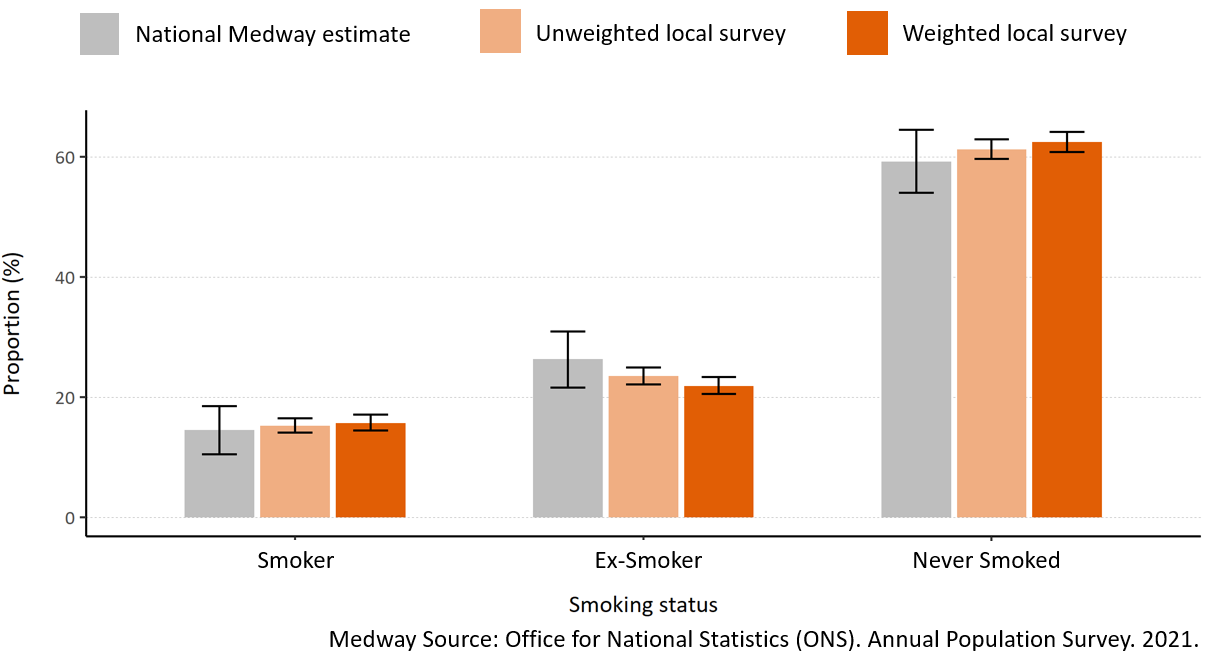
## Smoking Prevalence in Adults

Medway has seen a steep decline in smoking rates over the past 10 years. The current smoking prevalence in adults in Medway (12.7%) is similar to England (11.6%)52 (figure one). This means that around 19,200 adults in Medway smoke, with many of these individuals found in Medway’s most deprived areas.



***Figure one:******Smoking prevalence in adults 18+ (Annual Population Survey). Medway compared to England 2011-2023. Source: Fingertips ID 92443****52*

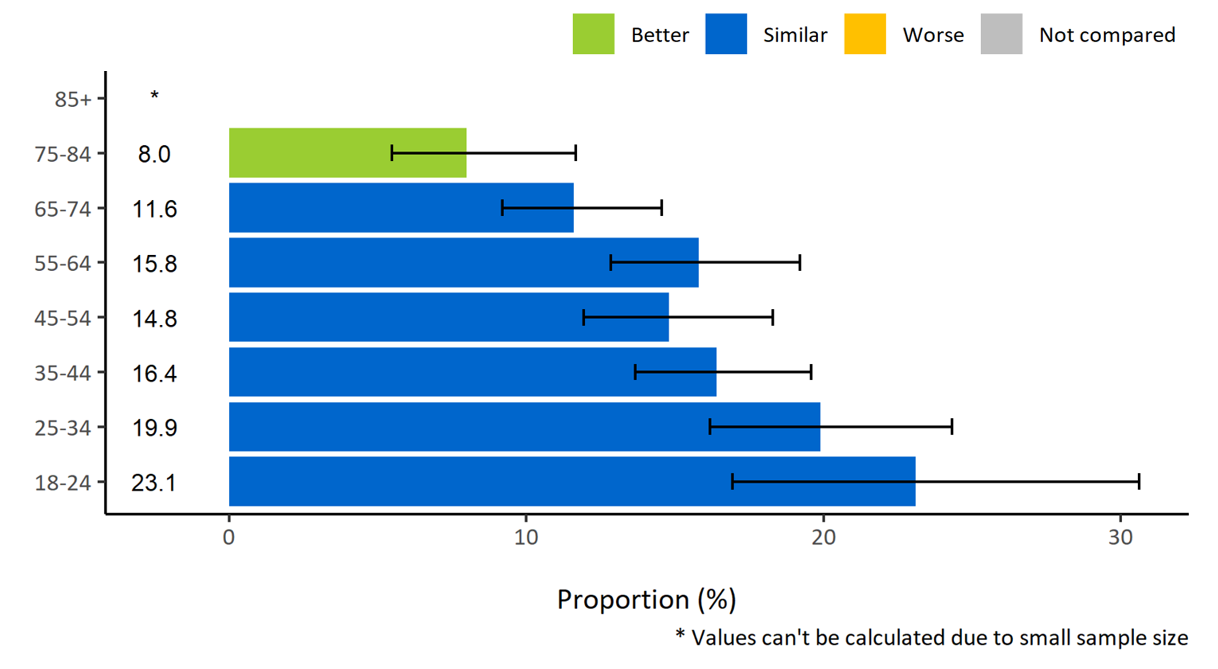
In 2021, Medway Public Health carried out a census style local [Health and Wellbeing Survey](https://www.medway.gov.uk/downloads/file/8104/medway_health_and_wellbeing_survey_-_full_analysis_v20)53 which produced estimates at electoral ward level for health conditions and risk factors. Selected residents were asked questions on a range of health-related topics including tobacco use. The survey methodology was designed to produce data that was more representative of Medway’s population and shows an adult smoking prevalence of 15.7% (Figure two). This compares to the APS reported prevalence of 14.5% for the corresponding period. The data also shows that the number of ex-smokers is now greater than the number of current smokers which reflects the work undertaken in Medway over the past 25 years53.



***Figure two: Estimated proportion of Medway adults by smoking status (2021*).**53

## Smoking prevalence by age

Since 2010, smoking has become less common across all age groups and continues to be lowest in people aged 60 years and over. This age group is more likely than younger people to have ever been smokers and they are also more likely to have stopped smoking. Locally gathered data shows that the highest rates of smoking are in the 18–24-year age group, with smoking rates declining as people get older (Figure three).



***Figure three: Medway smoking prevalence by age (2021).****53*

## Smoking Prevalence in Priority Populations

### LGBTQIA+

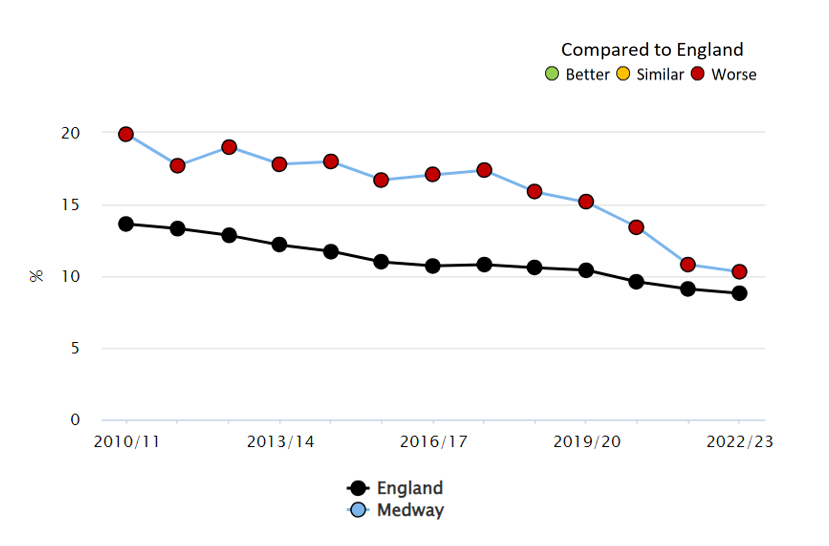
Adults identifying as LGBTQIA+ are more likely to be current smokers when compared to heterosexual adults, with LGBTQIA+ women the most likely to be current smokers.

The Annual Population Survey, 2018 found that smoking prevalence for adults identifying as gay/lesbian was 21.9% and 19.7% for bisexual respondents. This was higher than the prevailing smoking rate of 15.2% in heterosexual respondents18. Reasons for this will include many factors and may include daily levels of stress related to the prejudice and stigma this group may face54.

### Smoking in Pregnancy

Smoking in pregnancy has detrimental effects for both the growth and development of the baby and health of the mother. Smoking has an adverse effect on fetal development and childhood health. These negative health experiences can extend into adulthood, placing the individual at a disadvantage from the very start of their life34.

In 2022/23, 311 women were recorded as smoking at time of delivery in Medway (10.3%)55. Although this is worse than England (8.8%), the trend for Medway is decreasing and getting better (figure four). The Smoking in Pregnancy Challenge Group recommends a smoking at time of delivery target of 4% by 2030, although this has not yet been adopted by the government56.

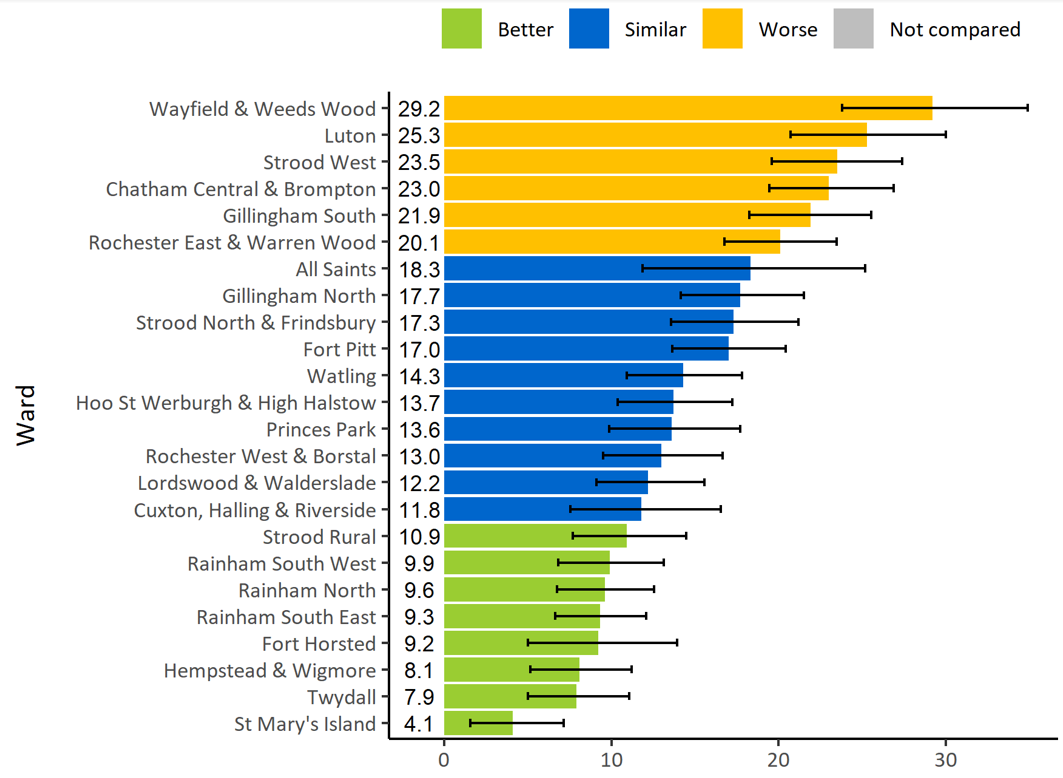


***Figure four: Smoking at time of Delivery in Medway 2010-2023*.**55

### Smoking and Inequalities

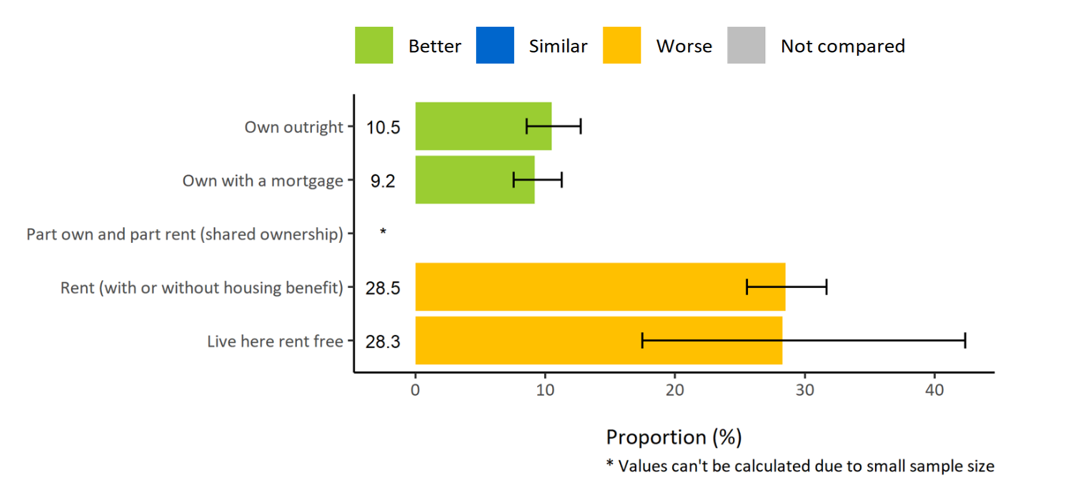
Education plays a significant role in determining a person’s life chances and the opportunities that become available to them for improving their socio-economic status. There is a correlation between high smoking rates and lower levels of educational attainment57. In Medway, smoking prevalence in people whose highest level of qualification is at either level one or level two is reported to be 20.1%, compared to 8% for those whose have achieved an academic qualification at level seven or eight53. Although smoking prevalence generally reduces in line with higher levels of educational attainment, for those who report they have an ‘other professional qualification’, smoking rates are almost as high (18.5%), as for those whose highest qualification is at level one or below53.

There are large variations in smoking rates between different groups of people at both national and local levels. The highest rates of smoking are in the most deprived population groups. In Medway, the highest rates of smoking are concentrated in the poorest electoral wards, with Wayfield & Weedswood having a prevalence of 29.2%, compared to 4.1% in St Mary’s Island (Figure six)53.



**Figure six: Estimated proportion of Medway adults who are current smokers by ward. HWB survey, 2021.**53

Housing tenure predicts smoking more precisely than any other factor33. Nationally collected data reports that in Medway, smoking prevalence is 21% in people who rent their home from either the local authority or a housing association, and 13.5% in those who rent their home privately18. Locally collected data shows an even higher smoking rate (28.5%), for these groups53. National data does not capture smoking status for those living rent free, but Medway’s Health and Wellbeing Survey identified that smoking prevalence stands at 28.3% for this group in Medway (Figure seven).

**Figure seven: Smoking prevalence in Medway by housing tenure, 2021.**53

### Smoking and employment status

Economic activity is a strong indicator of smoking prevalence and people in lower paid jobs are more likely to smoke than people in higher paid jobs58.

Nationally reported data shows that there has been a slower decline in smoking amongst routine and manual workers in Medway, leading to smoking becoming more concentrated in this population. Despite the good progress already made in Medway, more work needs to be done to reduce the gaps in prevalence between people in different economic activity groups18.

Unemployed people are more likely to smoke than people in employment53. Medway’s Health and Wellbeing Survey supported this by showing that 29.9% of people who were unemployed reported that they smoked, compared to 14.9% of people who were in employment. There are multiple reasons for this including levels of education, social networks, boredom, and in some cases, existing health conditions. People who are unemployed will also be spending a relatively higher proportion of their income on tobacco, reducing the amount of money available for essentials which widens existing inequalities.

### Smoking and ethnicity

The Annual Population Survey (APS) reports smoking prevalence data for different ethnic groups at a national level only. The APS reports that smoking prevalence is 17% in people of mixed ethnicity 18. When smoking status is considered by country of birth, the highest prevalence (20.8%) is reported for people whose country of birth is Poland, followed by the Republic of Ireland (14.1%)18.

The 2021 Census data showed that 0.6% (1,771) of people in Medway described themselves as White Polish and 0.7% (1,866) described themselves as Irish59. This means that in Medway, using the national prevalence rates, there are an estimated 368 people of polish origin and 263 people of Irish origin who smoke.

Smoking and ethnicity data is not available at a local level and there is also an absence of data for other migrant groups. The lack of complete data creates a risk that some ethnicities, especially newer migrant groups may be overlooked, leading to worsening of any existing health and socio-economic disparities.

In Medway, 13.8% of the population were born outside the UK60 . Women born outside of the UK are less likely to smoke than their male counterparts. Residents born in the newer EU accession countries have the highest share of smokers61. This suggests that of people who are usually resident in Medway but were born outside the UK, there may be some groups that have higher rates of smoking if prevalence rates in their countries of origin are applied directly to these groups. It should be noted that prevalence rates in countries of origin may not be entirely representative of migrant communities and a further assessment of needs would help to inform service delivery decisions.

Table one shows ONS ethnicity data for Medway and smoking prevalence rates in 2019 in the countries listed to help estimate possible smoking values for these population groups 24,59.

***Table one: Different ethnicity groups residing in Medway and smoking rates in their respective countries of origin.****24*

|  |  |  |  |
| --- | --- | --- | --- |
| **Country of origin** | **Number of usual residents in Medway** | **Smoking rate in country of origin -Men** | **Smoking rate in country of origin -**  **Women** |
| Poland | 1771 | 31.8% | 24.4 |
| Romania | 1477 | 38.4% | 23.5% |
| Bulgaria | 842 | 42.5% | 32.5% |
| Lithuania | 665 | 37.9% | 20.3% |
| Latvia | 368 | 46.9% | 21.3% |
| Slovakia | 292 | 33.3% | 20.9% |
| Turkey | 210 | 43.2% | 18.4% |

Census 2021 data is not available for residents born in Ukraine but smoking prevalence data for this country suggests that around 42% of men in Ukraine smoke compared to 14.4% of women24.

### Smoking and Substance Misuse

Substance misuse includes opiates, non-opiate drugs, and alcohol. Despite high rates of smoking in people affected by substance misuse, only 4% of people admitted for treatment for their condition were recorded as having been offered a referral for smoking cessation support in 2022/2362.

In Medway, 75 people were admitted to treatment for alcohol misuse in 2019/20 were recorded as smokers, representing 50.3% of the total number admitted for treatment. This compares to 43.9% for England62.

Locally, of those admitted to treatment in 2019/20 for all opiates misuse, 135 were recorded as smokers, (71.8%), compared to 70.2% for England62.

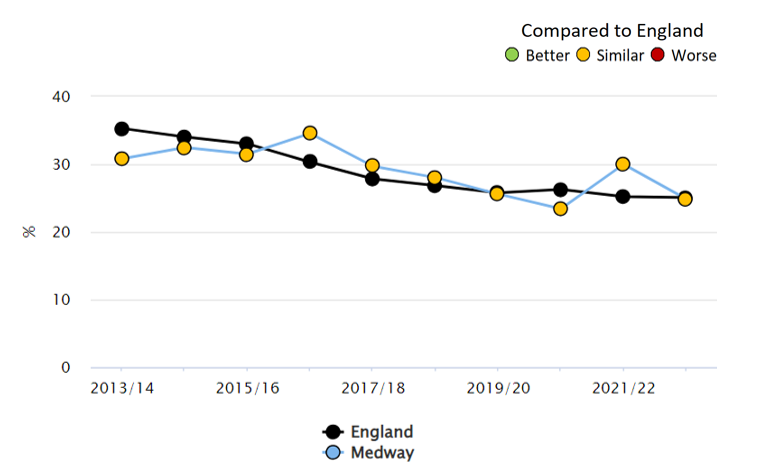
In Medway, 38 (66.7%) of adults admitted to treatment for misuse of alcohol and non-opiates in 2019/20 were also smokers compared to 64.6% in England. In the same year, of those admitted to treatment for misuse of non-opiates, 23 (62.2%) were recorded as smokers compared to 62% in England63.

### Smoking and Mental Health

Mental health conditions vary but there is evidence that smoking rates increase with the severity of mental illnesses. Since the mid-1990s, smoking in the general population in England has fallen from around 27% to the current rate of 12.7%52. In contrast, some publications suggest that 40.5% of adults with a serious mental health illness (SMI) smoke, a figure that has remained steady over the past 20 years9.

Datasets for local level prevalence are only available for a limited range of mental health diagnoses with GP reported data showing that in Medway in 2022/23, 24.8% of people with a long-term mental health condition were also smokers, similar to the England average (25.1%)64. Data trends suggest an improvement in Medway since 2013/14 although progress has been slower compared to England over the same time period (Figure nine).

Between 2013/14 and 2022/23, smoking prevalence in England for adults with a long-term mental health condition reduced by 10.2% compared to a reduction of 6% in Medway64.



***Figure nine: Smoking prevalence in adults with a long-term mental health condition (18 years+), current smokers.****64*

Adults diagnosed with a serious mental illness (SMI) have the highest rates of smoking. There are no recently collected data to quantify the current level of need in the population. The last data collection was in 2014/15 which reported that 594 (44.3%) adults in Medway who had an SMI were also smokers, compared to 40.5% in England64.

As well as having higher rates of smoking, people with mental health conditions smoke significantly more and have increased levels of nicotine dependency. This puts them at an even greater risk of smoking-related harm9.

The limited data available for different types of mental health diagnoses makes it difficult to understand the level of need and impact of targeted interventions for this subgroup of smokers. This is important to highlight as smokers with a serious mental illness have a higher rate of ill health and die much earlier than the general population.

### Smoking related mortality and ill-health

Smoking is the leading cause of preventable death and disease in the UK. NHS England estimates that there were 74,600 deaths attributable to smoking in England in 201965.

In Medway, smoking attributable mortality accounted for 939 deaths during the period 2017-2019. The leading causes of smoking related deaths are lung cancer66 and chronic obstructive pulmonary disease (COPD)67, followed by cardiovascular diseases. Medway’s overall smoking attributable mortality rate is worse than that of England and this is also the case for smoking related deaths that are attributable to cancer and COPD67,68 (Table two).

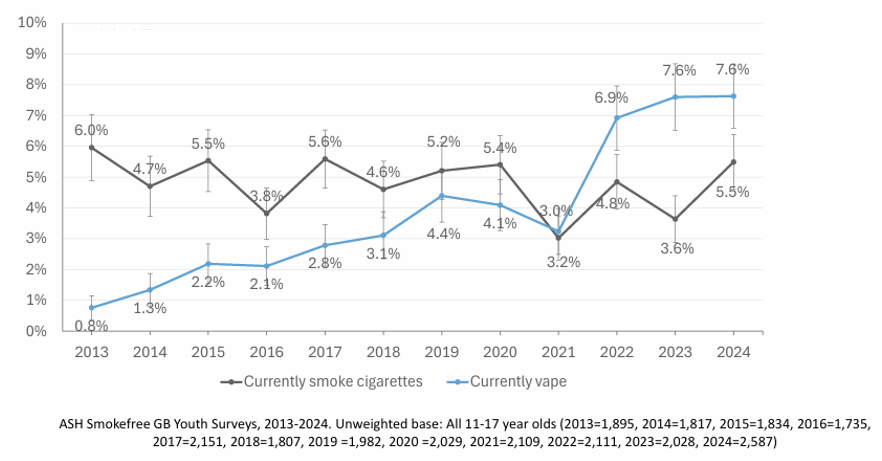
***Table two. Smoking attributable mortality, Medway compared to England.****66–69*

|  |  |  |  |
| --- | --- | --- | --- |
| **Indicator** | **Period** | **Medway**  **(per 100,000 of population)** | **England**  **(per 100,000 of population)** |
| Smoking attributable mortality68 | 2017-19 | 235.3 | 202.2 |
| Smoking attributable deaths from cancer | 2017-19 | 102.2 | 89.6 |
| Mortality rate from lung cancer (all ages) | 2021-23 | 55.0 | 47.5 |
| Mortality rate from COPD (all ages) | 2021-23 | 63.5 | 43.9 |

The rates for both lung cancer registrations and emergency hospital admissions for COPD in Medway are worse than the England average69. In Medway in 2019/20, there were 1,701 smoking related admissions to hospital for people over the age of 35 years69. Although the rate of admissions is better than the England average, it is still equivalent to nearly five admissions each day.

### Use of vapes (e-cigarettes) among young people

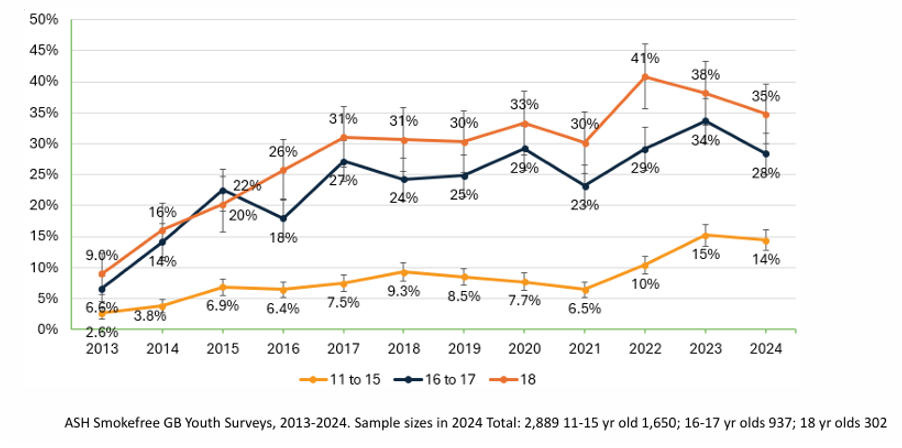
In the UK, it is illegal for anyone under the age of 18 years to buy a vape. Despite this, there has been a recent increase in the proportion of children experimenting with vapes in recent years. In 2023, 20.5% of children in Great Britain had tried vaping, up from 15.8% in 2022 and 13.9% in 2020 (before the first COVID-19 lockdown)19. Out of those who had experimented (tried once or twice), 7.6% were reported as currently vaping. Since 2021, the proportion of young people who have been reported as current vapers has been greater than that of current smokers (7.6% compared to 5.5% in 2024) (Figure 10)5.



***Figure 10. Trends in Great Britain – 11 -17 year old use of cigarettes and vapes over time. Action on Smoking and Health (ASH) Smokefree GB Youth Survey, 2013-24.****5*

Local insights work in Medway suggests that professionals working with young people have observed an increase in the numbers of young people who vape, including children as young as eight or nine years old who are vaping regularly70.

National data shows a clear relationship between age and young people ‘ever vaping’, with the incidence of vaping increasing in line with age (Figure 11)5.



***Figure 11. Young people (11-18) who have ever vaped by age in youth in Great Britain. Action on Smoking and Health (ASH) Smokefree GB Youth Survey, 2013-24.****5*

# 4) Current services in relation to need

Medway provides a universal stop smoking service and comprehensive tobacco control function led by the Council’s Public Health team and delivered in partnership with a network of organisations and services. The adoption of a collaborative approach ensures a broad reach and greater accessibility for smokers who want to quit. Organisations working in partnership with the Public Health team can either deliver in-house quit support or refer smokers to Medway Stop Smoking Service.

In addition to the Council led stop smoking service and tobacco control function, the NHS Tobacco Dependence Programme supports delivery of smoking cessation treatment services in line with the NHS Long-Term Plan’s commitments to tackle avoidable illness71. This programme sits within NHS settings and the key goals are:

* Ensure all people admitted to hospital who smoke are offered NHS-funded tobacco treatment services.
* An adapted service to be implemented for pregnant women and their partners, with a new smoke-free pregnancy pathway including focused sessions and treatments.
* A new universal smoking cessation offer to be available as part of specialist community mental health services for long term users.

## Providers of Stop Smoking Support

### Medway Stop Smoking Service

Medway Council’s Stop Smoking Service provides evidence-based support and operates from the ‘Smokefree Advice Centre’ in the heart of Chatham’s shopping area. The visibility of the centre makes it easier for people to access help when needed.

Specialist interventions are delivered by trained practitioners and smokers can choose from licensed nicotine replacement therapies, prescription only stop smoking medications, and unlicensed vapes/e-cigarettes to aid their quit attempt. Except for prescription only medications, quit aids are provided directly by the service. Behavioural support is a key component of the treatment programme and is provided alongside the use of the stop smoking aids. The support programme meets the guideline and standards set out by the National Centre for Smoking Cessation Training (NCSCT), and the National Institute for Health and Care Excellence (NICE).72,73

The service is available six days a week and offers daytime, evening, and weekend support. Smokers can either make an appointment or simply ‘walk-in’. Interventions can be provided face to face, over the telephone, or digitally.

The annual funding allocation for the service for the period April 2023 to March 2024 was £536,749 and as of 31st December 2023, a total of 783 smokers had set a quit date of which 450 (57%) had successfully quit74.

During the five-year period 2018/19 to 2022/23, over 9,000 people accessed quit support through the service, with an average of 970 (53%) of people each year achieving a successful quit. The average cost per quit during this period was £574 per year and demonstrates excellent value for money74. Research suggests that for every £1 invested in a tobacco control intervention, a return of £2.07 is gained by year five and £11.38 over the lifetime of a smoker who quits75.

### Medway Maritime Hospital (Medway NHS Foundation Trust)

Medway Maritime Hospital is a smokefree site and patients’ smoking status is identified on admission. Smokers are supported with a combination of stop smoking medications and behaviour change techniques. Support is delivered by an in-house tobacco dependency adviser employed by the hospital and the funding for this is currently renewed on a yearly basis.

In-patients who spend less than 14 days in hospital and are still receiving tobacco dependency treatment at the point of discharge, are referred to a community-based stop smoking support service for continuation of treatment. People spending 14 days or more as an in-patient continue to receive their quit support from the hospital-based tobacco dependency service following their discharge.

Out-patients who want to quit smoking can be referred by the hospital to Medway Stop Smoking Service and a pathway exists to support transfer of care.

Medway Maritime Hospital provides a midwife led specialist smoking cessation service for pregnant women. In line with NICE guidance, women are asked about their smoking status at specific points in their antenatal care pathway and an ‘opt out’ referral system is in place for stop smoking support. Smoking status is verified by means of a carbon monoxide (CO) test. Quit support is provided as a key part of a woman’s maternity care package by a midwifery led tobacco dependency service provided by the hospital. Funding for this is currently renewed on a yearly basis.

Pregnant smokers who prefer to receive their quit support outside of the hospital setting can be seen by Medway Council’s Stop Smoking Service where they are supported by specialist adviser.

### General Practice & Pharmacy settings

Staff employed by GP surgeries and pharmacies across Medway are trained by the Medway Stop Smoking Service to deliver stop smoking support to NCSCT and NICE guidance standards. Regular support and supervision is provided by dedicated relationship managers within the Council’s public health team. GP practices and pharmacies can both refer smokers to Medway Stop Smoking Service for quit support where time constraints do not allow them to offer in-house quit support.

## Referral pathways for stop smoking support

As part of its partnership approach to working, Medway Stop Smoking Service has referral pathways in place with internal council services, council commissioned services, and external organisations that provide support to Medway residents. Staff within these services and organisations receive training in how to make a referral for help with stopping smoking. People who smoke can also self-refer to the service.

### Medway Community Healthcare (MCH)

Referral pathways are in place for patients receiving care from MCH for chronic health conditions including COPD and CVD. MCH receives regular training, support from the public health team and this includes activity and outcome reports.

Postnatal care for pregnant women includes following up on smoking status by Medway Community Healthcare’s Health Visitor Team at the two week and six-to-eight-week Health Visitor appointments. Women who smoke following the birth of their baby are referred by their Health Visitor for quit support from Medway Council’s specialist stop smoking adviser. This adviser’s core role is to provide post-natal quit support to new parents/carers. Key performance indicators are in place as part of the Health Visitor Service contract, and these specify minimum referral rates.

### Mental Health Settings

Limited pathways exist for mental health service providers to refer out-patients to Medway Stop Smoking Service for quit support. Where pathways exist, these include protocols for dose adjustments for specified medications that form part of a client’s existing medication n routine.

### Workplace Health

Medway Council’s public health team work with employers based in Medway to offer information to staff about ways in which they can improve health and wellbeing. Information about smoking cessation and access to support is included within the range of interventions offered.

## Tobacco Control functions

Tobacco Control is the term used to define a comprehensive approach to reducing tobacco use and the harm associated with it for both smokers and non-smokers. Actions are based on six key aims which align to international guidelines7:

1. Stopping the promotion of tobacco
2. Making tobacco less affordable
3. Effective regulation of tobacco products
4. Helping tobacco users to quit
5. Reducing exposure to secondhand smoke
6. Effective communications for tobacco control

Medway Council’s public health team work with organisations including Kent Police, Trading Standards, Kent Fire & Rescue and HM Customs and Excise to ensure regulations and guidelines that make tobacco less affordable and less socially acceptable, are implemented effectively. A key element of this work is tackling the availability and sale of illegal tobacco products and making sure tobacco products and e-cigarettes are not sold to people under the age of 18 years.

The team also carry out educational work and marketing campaigns to raise awareness of the harms associated with exposure to secondhand smoke.

The pooling of resources means plans and actions carried out are robust and informed by input from a range of enforcement agencies that each bring their respective insights, knowledge, and expertise to the decision-making process. This approach enables challenges to be managed within the relevant statutory frameworks. This is especially important for challenges that involve legislative processes.

The Tobacco Control team also leads on trialling new initiatives that have legislative implications such as the introduction of vapes as a treatment model in groups where smoking prevalence is high.

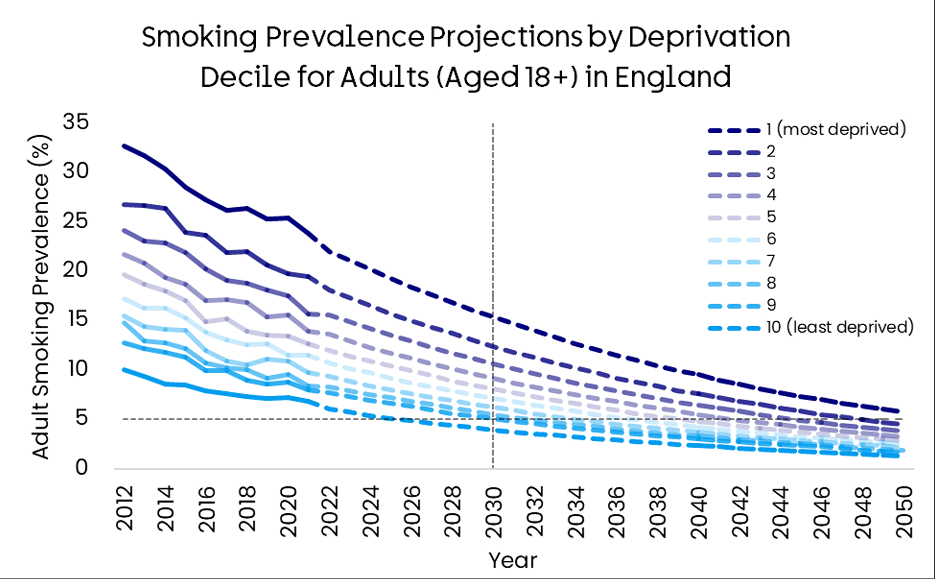
# 5) Projected service use and outcomes in 3-5 years and 5-10 years

For any service use projections, the key limitations are:

* The assumption that past trends will continue in the future.
* The inability to predict changes in societal, policy, and legislative factors.

## National projections for smoking prevalence

Cancer Research UK report that if recent smoking trends continue, the average adult smoking prevalence in England will reach 5% in 2039. This is almost a decade later than the government’s 2030 target. People living in the most deprived decile are predicted to take until 2050 to achieve the 5% target, while those in the least deprived decile are expected to have achieved the target in 2024 (Figure twelve)76.



***Figure 12. Smoking prevalence projections by deprivation decile for adults (18+) in England. Observed (solid lines) and projected (broken lines) smoking prevalence by deprivation decile, adults (aged 18 years +) in England.****76*

The accuracy of any data projection decreases the further into the future it looks. This means that longer-term projections should be interpreted with caution. Whilst recent trends show that the decline in smoking prevalence is likely to continue, the rate of decline is not fast enough to reach the government’s ambition.

The government has not yet clarified its ambitions on the future smoking prevalence rates for both people in deprived groups and for other groups where smoking prevalence remains high.

## Local projections for smoking prevalence

Projected service use and outcomes over the next 3-5 and 5-10 years will be affected by a range of factors. Some of these include:

* Population and demographics
* Societal influences
* Economic drivers
* Health conditions
* Relocation from within the UK as well as migration from outside the UK
* Funding of stop smoking services
* Impact of tobacco control legislation and policy

Many of these factors influencing service projections will be associated with each other and vary over time.

ONS population projections for Medway suggest the local population aged 15 years and over will increase as shown in table three77:

**Table three. Projected population in Medway - 3, 5, and 10 years.**77

|  |  |  |
| --- | --- | --- |
| **Year** | **Population aged 15 years+** | **Total population** |
| 2027 | 229,750 | 283,750 |
| 2029 | 231,568 | 284,763 |
| 2034 | 235,395 | 287,161 |

One way to estimate the future smoking prevalence in Medway would be to apply the average annual rate of reduction in adult smoking prevalence in recent years to the projected adult population. However, as the current adult smoking rate in Medway is 12.7% and the average annual rate of reduction since 2017 has been 1.45%, applying these data to population projections would not produce an accurate estimation of future smoking rates. This is because the local projection would not represent and break down the level of need that exists within disadvantaged groups.

The success in reducing smoking prevalence means there are fewer smokers in the population and this has meant that uptake of stop smoking support through some local authority commissioned services has reduced compared to previous years. However, uptake data for local authorities does not take into account delivery of stop smoking support through new settings within the NHS as part of the NHS Long Term Plan’s Tobacco Dependence Treatment programme. Any estimate of projected needs must consider the level of need for quit support that exists within hospital settings, community mental health setting, and in groups where smoking prevalence remains high. It must also consider inconsistencies across different datasets for values relating to age, gender, sexuality, and ethnicity.

The level of need and service gaps relating to specific population groups can be found in the following sections of this report:

Section 3: Level of need in the population

Section 8: Unmet needs and service gaps

These data can be used to inform service planning decisions to meet the future needs of the population.

# 6) Evidence of what works

Evidence-based stop smoking services, together with a broad range of comprehensive tobacco control measures, have been highly effective in helping smokers quit and saved thousands of lives.

Dependence on cigarettes doesn’t make it impossible to quit smoking, but it does mean there are powerful urges and daily smoking cues that must be overcome. Any intervention that strengthens smokers’ resolve to resist these urges and cues and reduce their frequency and intensity can help in overcoming dependence10.

Stopping smoking is the best thing a person can do to improve their health and quality of life. It is also one of the most cost-effective treatments available. For every £1 invested in a tobacco control intervention, a return of £2.07 is gained by year five, and £11.38 over the lifetime of a smoker who quits75.

There is a strong evidence base for the efficacy of quit support and a range of harm reduction and quit support approaches are available. These are endorsed by organisations such as the National Institute for Health and Care Excellence (NICE), and the National Centre for Smoking Cessation and Training (NCSCT)72,73.

The Office for Health Improvement and Disparities (OHID) also releases policies and resources to support the delivery of quit support, and these are included in the NCSCT’s ‘Local Stop Smoking and support: commissioning, delivery, and monitoring guidance’ 72. This guidance provides clear steps for service provision and includes evidence updates and developments in best practice.

The following evidence-based approaches have been proven to reducing rates of smoking:

* Very Brief Advice (VBA): A life-saving 30 second intervention that can be delivered by all health and social care professionals in almost every consultation with patients who smoke. VBA involves asking patients about their current smoking status, advising them on the best method of stopping available to them, and helping them access stop smoking support. VBA is recommended by NICE as evidence-based and cost-effective72.
* NICE Guidance NG209 – Tobacco: Preventing uptake, promoting quitting and treating dependence covers support to stop smoking for everyone aged 12 years and over. It helps reduce people’s harm from smoking if they are not ready to stop in one go. It also covers ways to prevent children, young people and young adults aged 24 years and under from taking up smoking. This guidance brings together and updates all NICE’s previous guidance on tobacco use, including smokeless tobacco, the use of nicotine replacement therapy, and e-cigarettes73.
* The Ottawa Model for Smoking Cessation and ‘The CURE Project’ are both well-established approaches proven to deliver successful quit outcomes for smokers in specific healthcare settings. These models have informed the implementation of tobacco dependency treatment services in the hospital setting.78,79
* The ‘Smoking Cessation Intervention for People with Severe Mental Ill Health (SCIMITAR+ Trial)’ is an intervention led by the University of York. It demonstrates that when people with severe mental ill health (SMI) are provided with bespoke stop smoking support, quit rates can be double that of smokers with SMI who receive usual care. The trial also demonstrated increased stop smoking service engagement from people with SMI. This group of smokers can have multiple and complex health and wellbeing needs that make it harder for them to quit and tailored support provided at the right intensity can deliver successful treatment outcomes80.
* Financial incentives to help pregnant smokers to quit is an approach that has been recommended by the Khan Review (2022), ‘Making Smoking Obsolete’33. Research suggests financial incentives of up to £400 to help pregnant women to stop smoking, in addition to usual care, appears to be highly cost effective over a lifetime for mother and infant81.
* Vapes (e-cigarettes) are now the most popular and most effective quitting aid. The Khan Review (2022) recommends increasing the availability of vapes as a quitting tool to current smokers. It further recommends providing free ‘Swap to Stop’ vape starter packs for deprived communities and people in social housing33,81. Vapes are a less harmful alternative to smoking combustible cigarettes and any safety concerns relating to vapes are addressed by OHID in its latest evidence update82.

# 7) User views

The Medway Stop Smoking Service Client Satisfaction Survey carried in 2023/24 received 44 responses. In total, 66% of the respondents had received their quit support at the Smokefree Advice Centre in Chatham town centre and a further 23% at the Medway Archive Centre in Strood. Of the remaining respondents, a small number had received their support at Balmoral Health Living Centre and the others had received telephone support. Overall, a high level of satisfaction was observed as follows:

* 98% said they were very satisfied with the booking process.
* 93% were very satisfied with the venue.
* 95% were very satisfied with the stop smoking aids provided.
* 100% were very satisfied with the support received from their stop smoking adviser.

**Feedback from service users include:**

* ‘Staff were very supportive and understanding’.
* ‘I quit 40 or more a day. I can’t thank you guys enough’.
* ‘I can’t believe how much more energy and money I have’!
* ‘Thank you to the advisers for being so understanding of my physical health conditions which meant that some weeks I had to stay home, therefore they text me and sent out products – amazing service’!
* ‘Very helpful advisers, going each week gives you extra incentive to stop smoking, I'm still addicted to nicotine and will keep trying to wean myself from vape & lozenges’.

# 8) Unmet needs and service gaps

The higher rates of smoking in specific population groups suggests that the unique needs of these groups are not being fully met. Smokers who experience co-occurring health conditions, those with substance misuse disorders and people from disadvantaged backgrounds often face barriers in accessing adequate support for quitting smoking. Despite their desire to quit, they may receive less assistance and either fewer resources compared to the general population, or resources that are not adequate for their level of need. Addressing these disparities is crucial to ensuring equitable access to effective stop smoking support.

The **‘Level of Need in the Population’** section of this report highlights eight groups where smoking prevalence is higher than in the general population. Of these groups, unmet needs and gaps in service provision exist for the following:

* People with mental illnesses
* People diagnosed with a specific major health condition
* People who have a substance misuse disorder
* People identifying as LGBTQIA+
* People from some ethnic groups

In addition to the above, consideration should also be given to addressing the increase in rates of smoking in 11–17-year-olds since 2021, and an increase in rates of vaping for the same group over the same period6.

## Smoking and mental illnesses

In Medway, there are established referral pathways for settings to refer patients with a mental illness to quit smoking support. Effort should be made to make sure that all settings coming into contact with mental health patients have these referral pathways in place. This should be supplemented by the provision of specialist training to staff in mental health settings so that they can confidently promote engagement with, and uptake of quit support.

Tailored evidence-based quit support using tried and tested approaches like SCIMITAR+ can increase numbers of mental health patients successfully quitting smoking80. The introduction of the Tobacco Dependency Treatment service in specified community mental health settings as part of the NHS Long Term Plan will provide a new support option for long term users of mental health services. Specialist programmes like this can make it easier to harness motivation to quit and manage any existing medication regimes that need adjustments during a quit attempt. Any new treatment programmes should allow smokers the choice of licensed and unlicensed stop smoking aids to maximise their chances of successfully quitting.

## Smoking and major health conditions

Tackling smoking is central to the government’s proposed Major Conditions Strategy. This strategy will focus on actions that aim to narrow the gap in healthy life expectancy by 2030 and add another five years of healthy life expectancy by 203583. Smoking contributes to both the onset and worsening of some major disease conditions and is the leading cause of deaths for lung cancer, chronic obstructive pulmonary disease, and cardiovascular disease. Preventing and managing these diseases is a key aim of the strategy. People who smoke and who have one or more of these conditions, will experience significant improvements to their health and wellbeing if they can be supported to stop smoking.

Referral pathways that exist in community-based services where care is provided to people diagnosed with a major condition, can be reinforced and extended to new settings that also provide care to this population cohort. Pathways can be supplemented with specialist training and support for staff to deliver the ‘Very Brief Advice’ intervention and can be supported with metrics that monitor and measure the effectiveness of referral and treatment outcomes. Increasing awareness amongst services of the availability of specialist treatment programmes for specific groups of smokers can support increased rates of referrals, higher quit rates, and improved quality of life for people living with a major health condition.

## Smoking and substance misuse disorders

Smoking rates amongst people dependent on alcohol or drugs are high and treatment to reduce smoking in this group is rare. Only 4% of people who misuse opiates, non-opiate drugs, or alcohol are being offered a referral for stop smoking support. One reason for this is the perception that adding stop smoking treatments will reduce the effectiveness of substance misuse treatments. Evidence suggests that this is not the case, and offering help to stop smoking can be safely provided84.

Interventions already in place can deliver quit rates of around 10% in this under-treated group. Including smoking cessation as an integral part of an individual’s care plan would support the provision of holistic care that addresses the multiple addiction related needs of people with a substance misuse disorder84.

## Smoking in people identifying as LGBTQIA+

Adults identifying as LGBTQIA+ are more likely to be current smokers when compared to heterosexual adults. National datasets do not report local level smoking prevalence data in this population group, creating a risk that this population group may be overlooked18. Effort should be made to identify the local level of need, establish an understanding of barriers to accessing support, and develop interventions that are responsive to the needs identified.

The quarterly data reporting submissions made by local stop smoking services to national data collection centres and published by NHS Digital shows activity and outcome using male and female gender descriptors only74. Given that prevalence data published by OHID shows higher rates of smoking amongst people identifying as LGBTQIA+, local services would benefit from having processes in place to understand the level of need and current service uptake for this group. Effort should be made to identify and overcome barriers that may exist that prevent these groups from accessing quit support.

## Smoking and ethnicity

Smoking prevalence is higher in some ethnic groups than others and data suggest residents born in new EU accession countries have the highest proportion of smokers61. National smoking prevalence data does not capture detailed information on migrant groups. This makes it difficult to understand the level of need in these population groups and put plans in place to meet the identified needs.

In addition to smoking, the use of smokeless tobacco (ST) and shisha is high in some population groups. Smokeless tobacco constitutes products that are non-combustible but may be chewed, inhaled, or placed in the mouth.

The available national data shows that in 2004, self-reported ST use among Indian and Pakistani men (4% and 2%, respectively) and women (approximately 1%) remained comparable to 1999 estimates61. A significant decline was observed in Bangladeshi men and women from 19% and 26%, respectively, in 1999 to 9% and 19% in 2004. However, cotinine (a metabolite of nicotine), adjusted prevalence estimates of any tobacco use were higher than self-reported estimates, especially among Bangladeshi men (60% adjusted vs 44% self-reported), Bangladeshi women (35% adjusted vs 17% self-reported) and Pakistani women (14% adjusted vs 7% self-reported). The adjusted estimates, especially in women which were twice as high as self-reported estimates, point towards the possibility of higher ST use than that observed through self-report measures85.

Shisha (water pipes) have traditionally been used to smoke tobacco in the middle east although recent years has seen shisha bars becoming popular among young people from ethnic minority groups in the UK. Data collected in 2023 shows that 15% of people of South Asian ethnicity, 8% of Black/African/Caribbean people, and 11% of those identifying as other or mixed ethnicity, use shisha pipes once a year or more. In comparison, usage in the white population is 2%85.

The health risks of SLT and shisha have not been researched as extensively as that of cigarette smoking, but both produce harmful levels of chemicals and are associated with higher rates of tobacco related diseases.

## Smoking and vaping uptake in children and young people

Between 2017 to 2020, rates of smoking among 11-17 year olds sat within the range of 4.6% and 5.6%. A sharp decline to 3% was seen in 2021 but since then, rates have increased to 5.5% in 20246. This corresponds to a sharp increase in the rates of vaping within the same age cohort. Interventions recommended by NICE to prevent the uptake of smoking in among children and young include media campaigns, helping retailers to avoid illegal tobacco sales, whole-school and organisation-wide smokefree policies and adult- and peer-led school-based interventions73. These should be considered as part of a broad range of local tobacco control measures.

The increase in recent years in the proportion of children and young people experimenting with vapes has led to discussions at national level on addressing inconsistencies in legislation. For example, it is illegal for anyone under the age of 18 years to buy a vape, but it is lawful for tobacco companies to give free vape samples to school children33. In Medway, despite the age of sale legislation, children and young people predominantly buy vapes from local corner shops, markets, tanning shops, and nightclubs. The drivers for young people to vape include:

* Social desirability to ‘fit in’
* Easy access to vapes
* A lack of negative associations
* Marketing, packaging, and flavours

Local research highlights inconsistencies amongst children and young people about perceptions of harm associated with vapes. It also identifies that children and young people mainly look to schools and their family for information, yet across the parents and professionals who participated in the research, few felt knowledgeable about vapes70.

The Khan Review highlights key actions that national government can carry out to address uptake of vaping in children and young people33. Whether or not these actions are implemented depends on political processes and protocols. Local actions can, however, still be carried out to address local needs. Key actions informed by insights gathered include:

* Education about the facts relating to vaping
* Restricting access to vapes
* Consistent messaging about vaping
* Supporting young people to manage situations where they feel pressure to experiment with vapes.

The implementation of these actions presents an opportunity for Medway’s tobacco control function to work with partner organisations to carry out work that has been informed by the needs of local people.

## CLeaR (Challenge, Leadership and Results)

The CLeaR model is an approach to improving local tobacco control in England through self-assessment followed by peer-assessment and includes multiple domains of tobacco control including:

* Effective enforcement of legislation: e.g., age of sale restrictions and smoke free laws.
* Commissioning and promoting stop smoking services.
* Working with partners who deliver care in smokefree environments.

These measures have several benefits including saving money for local health and care services, protecting children from harm, increasing the disposable income of local populations and reducing inequalities caused by smoking86.

Although Medway delivers a comprehensive set of tobacco control measures, CLeaR can help identify areas of strength as well as opportunities for development and improvement of local tobacco control activities. The peer-review element will mean that Medway will benefit from both independent challenge and an opportunity to benchmark local work against others. CLeaR is not an inspection regime or an external audit and results from the assessment process belong to the local authority and will help identify any service gaps.

# 9) Recommendations for commissioning

Reducing rates of smoking across the whole population is key to reducing health and socio-economic inequalities and achieving the government’s Smokefree 2030 ambition.

Whilst smoking prevalence has been declining in all population groups, the rate of decline has been slower in some groups. These groups also started from a higher baseline prevalence which further compounds some of the challenges around providing effective interventions. A targeted approach that considers the multiple factors that influence smoking prevalence, system interfaces where smokers are likely to present, and tailored intensive support to help smokers quit, can help reduce the gap in prevalence between these groups and the general population. As these smokers are likely to present with more complex needs, it is important that staff who deliver stop smoking interventions have the right level of training so they have an enhanced understanding about the unique needs of these service users. Staff should also be supported in knowing how to be responsive to those needs whilst maintaining their own levels of resilience.

The following actions are recommended:

* Interventions that raise awareness of the availability of free, evidence-based quit support should be routinely included at a wide range of service delivery touchpoints, with a particular focus on pathways that facilitate access for groups who have disproportionately high rates of smoking. Staff in these settings should be trained on how to deliver the ‘Very Brief Advice’ intervention so that they can have effective conversations with people who smoke.
* Smokers with complex needs such as those with mental illnesses and people with substance misuse disorders should be supported with the most effective interventions that are tailored to their needs and integrated into their overall care plan.
* Smoking cessation should consistently be included in service specifications for commissioned services, and these should be kept updated to reflect emerging evidence and new approaches. Service contracts should include key performance indicators to measure activity and outcomes, and this should be supported by mechanisms that enable relevant information to be captured, recorded, and reported.
* Smoking cessation support and tobacco control measures should be routinely considered in all new strategies and policies, and actions to implement initiatives should be included in service models and funding allocations.
* Action is needed to protect children and young people and non-smokers from developing nicotine dependency using vapes. Raising awareness of the addictive nature of nicotine and the potential health effects associated with vapes, as well as helping young people build resistance and impulse regulation skills, can help prevent or reduce the use of these devices.
* Strengthen existing partnerships with enforcement agencies and explore new ways of working collaboratively on cross boundary projects. This will help further reduce the availability and supply of illegal tobacco and the sale of tobacco and vape products to young people under the age of 18 years.
* Implementation of the CLeaR assessment will support the identification of opportunities for development and improvement of local tobacco control initiatives.
* Develop smoking cessation workforce resilience. This will help staff who deliver quit support to people belonging to high smoking prevalence groups, understand and respond to the unique and complex needs these service users present with.
* Work with system partners to develop a local Tobacco Control Strategy that articulates Medway’s vision for prevalence reduction targets. Make use of national resources such as ‘The End of Smoking’ strategic guidance pack to ensure all aspects of the tobacco control agenda are implemented at a local level.

# 10) Recommendations for needs assessment work

Significant gaps exist in smoking prevalence data for some groups. In some cases, there is no data available and in other instances data that is available is old, inconsistent, and/or lacks detail. This makes it difficult to plan and implement effective initiatives to reduce smoking related health inequalities.

It is recommended that comprehensive smoking related data is gathered at a local level, and in-depth analyses carried out to inform the level of need and the allocation of resources for the following groups:

* People with different types of mental health diagnoses
* People identifying as LGBTQIA+
* Ethnic minority groups, especially newer migrant communities.

# Bibliography

1. Office for Health Improvement and Disparities (OHID). (2022) Smoking and tobacco: applying All Our Health. Published online April 5, 2022. https://www.gov.uk/government/publications/smoking-and-tobacco-applying-all-our-health/smoking-and-tobacco-applying-all-our-health

2. Action on Smoking and Health (ASH). (2019) Health Inequalities and Smoking. https://ash.org.uk/uploads/ASH-Briefing\_Health-Inequalities.pdf#:~:text=Smoking%20remains%20the%20single%20biggest%20preventable%20cause%20of,hospital%20admissions%20in%20England%20were%20attributable%20to%20smoking.5

3. Office for Health Improvement and Disparities (OHID). (2023) Fingertips: Smoking prevalence in adults (18+) - current smokers (APS). Indicator ID: 92443. Published online 2023. Accessed February 9, 2024. https://fingertips.phe.org.uk/search/smoking#page/6/gid/1938132694/pat/6/par/E12000008/ati/501/are/E06000035/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

4. Office for Health Improvement and Disparities (OHID). (2021) Fingertips: Smoking prevalence in adults (aged 18 and over) admitted to treatment for substance misuse; ID: 93672. Published online 2021. https://fingertips.phe.org.uk/search/smoking#page/4/gid/1938132900/pat/15/par/E92000001/ati/502/are/E06000035/iid/93672/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

5. Action on Smoking and Health (ASH). (2023) Use of E-Cigarettes (Vapes) among Young  People in Great Britain. https://ash.org.uk/uploads/Use-of-vapes-among-young-people-GB-2023-v2.pdf?v=1697209531#:~:text=ASH%20Smokefree%20GB%20Youth%20Survey%2C%202023.,-Unweighted%20base%3A%2011&text=Neither%20current%20vaping%20nor%20current,was%20first%20measured%20in%202014.

6. Action on Smoking and Health (ASH). What is comprehensive tobacco control? https://ash.org.uk/resources/local-toolkit/comprehensive-tobacco-control-guidance/local-alliances-roadmap/1-what-is-comprehensive-tobacco-control#:~:text=These%20reflect%20the%20six%20strands%20set%20out%20by,smoke%3B%20and%206%20Effective%20communications%20for%20tobacco%20control

7. Department of Health & Social Care. (2023) Stopping the Start: Our New Plan to Create a Smokefree Generation. https://www.gov.uk/government/publications/stopping-the-start-our-new-plan-to-create-a-smokefree-generation/stopping-the-start-our-new-plan-to-create-a-smokefree-generation

8. Smith J. (2023) Ending smoking could free up 75,000 GP appointments each month. Cancer Research UK. Published 2023. https://news.cancerresearchuk.org/2023/03/07/ending-smoking-could-free-up-gp-appointments/

9. Action on Smoking and Health (ASH). (2019) Smoking and Mental Health. Published 2019. https://ash.org.uk/resources/view/smoking-and-mental-health#ref4

10. Action on Smoking and Health. (2019) Stopping Smoking .

11. Action on Smoking and Health (ASH). (2024) Smoking Statistics. Published online 2024. https://ash.org.uk/uploads/Smoking-Statistics-Fact-Sheet.pdf?v=1697728811

12. Action on Smoking and Health (ASH). (2025) ASH Ready Reckoner January 2025: Costs of smoking to society. Published online 2025. https://ashresources.shinyapps.io/ready\_reckoner/

13. Office for Health Improvement and Disparities (OHID). (2021) Fingertips: Smoking attributable hospital admissions (new method); ID: 93753. Published online 2021. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/4/gid/1938132888/pat/6/par/E12000008/ati/402/are/E06000035/iid/93753/age/202/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/car-do-0

14. Action on Smoking and Health (ASH). (2024) Every day 350 young adults aged 18-25 start smoking regularly. Published online 2024. https://ash.org.uk/media-centre/news/press-releases/every-day-350-young-adults-aged-18-25-start-smoking-regularly

15. Chaiton M, Diemert L, Cohen JE, et al. (2016) Estimating the number of quit attempts it takes to quit smoking successfully in a longitudinal cohort of smokers. *BMJ Open*. 2016;6(6):e011045. doi:10.1136/bmjopen-2016-011045

16. Office for National Statistics (ONS). (2024) Adult smoking habits in Great Britain. Published online 2024. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/datasets/adultsmokinghabitsingreatbritain

17. Office for National Statistics (ONS). (2024) Adult Smoking Habits in the UK: 2023. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2023#percentage-of-smokers-by-age-sex-and-other-personal-characteristics

18. Office for Health improvement and Disparities. (2023) Fingertips: Smoking Prevalence in Adults (APS) aged 18 and over, current smokers, inequalities. Published online 2023. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/7/gid/1938132886/pat/6/par/E12000008/ati/501/are/E06000035/iid/92443/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1/page-options/ine-ao-1\_ine-pt-2\_ine-ct-36\_ine-yo-1:2023:-1:-1

19. Department of Health and Social Care. (2024) Tobacco and Vapes Bill: creating a smoke-free UK and tackling youth vaping factsheet. Published online 2024. https://www.gov.uk/government/publications/the-tobacco-and-vapes-bill-creating-a-smoke-free-uk-and-tackling-youth-vaping/tobacco-and-vapes-bill-creating-a-smoke-free-uk-and-tackling-youth-vaping

20. Durkin S, Brennan E, Wakefield M. (2022) Optimising tobacco control campaigns within a changing media landscape and among priority populations. *Tobacco Control* . Published online 2022. https://tobaccocontrol.bmj.com/content/31/2/284.info

21. NHS Digital. (2025) Vaping to Quit Smoking. Published online 2025. https://www.nhs.uk/better-health/quit-smoking/ready-to-quit-smoking/vaping-to-quit-smoking/#:~:text=Evidence%20shows%20that%20vaping%20is,like%20heart%20attack%20and%20stroke.

22. Action on Smoking and Health (ASH). (2024) Use of vapes (e-cigarettes) among young people in Great Britain. Published online 2024. https://ash.org.uk/resources/view/use-of-e-cigarettes-among-young-people-in-great-britain

23. Action on Smoking and Health (ASH). (2019) Health Inequalities and Smoking . Published online 2019. https://ash.org.uk/uploads/ASH-Briefing\_Health-Inequalities\_2022-03-24-183145\_yuaf.pdf?v=1648146705

24. The Tobacco Atlas. (2025) The Tobacco Atlas: Country Factsheets . Published online 2025. https://tobaccoatlas.org/factsheets/united-kingdom-of-great-britain-and-northern-ireland/

25. Action on Smoking and Health (ASH). (2018) Written evidence submitted by Action on Smoking and Health (ASH) (HSC0058)  . Published online 2018. https://committees.parliament.uk/writtenevidence/95792/html/

26. The LGBT Foundation. Queer as Smoke. 2011. https://lgbt.foundation/

27. FS Magazine. (2018) Fetish and the Gay Scene. Published online 2018.

28. Office for National Statistics (ONS). (2018) Likelihood of Smoking Four Times Higher in England’s Most Deprived Areas than Least Deprived. https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/drugusealcoholandsmoking/articles/likelihoodofsmokingfourtimeshigherinenglandsmostdeprivedareasthanleastdeprived/2018-03-14

29. Office for Health Improvement and Disparities. (2025) Smoking and Health Inequalities. *Fingertips*. Published online 2025.

30. Marmot M. (2020) Health Equity in England: The Marmot Review 10 Years On. https://www.health.org.uk/reports-and-analysis/reports/health-equity-in-england-the-marmot-review-10-years-on-0

31. Action on Smoking and Health (ASH). (2020) Smoking and Respiratory Disease. Published online 2020. https://ash.org.uk/resources/view/smoking-and-respiratory-disease

32. Hitchman SC, Fong GT, Zanna MP, Thrasher JF, Chung-Hall J, Siahpush M. (2014) Socioeconomic status and smokers’ number of smoking friends: findings from the International Tobacco Control (ITC) Four Country Survey. *Drug Alcohol Depend*. 2014;143:158-166. doi:10.1016/j.drugalcdep.2014.07.019

33. Office for Health Improvement and Disparities (OHID). (2022) The Khan Review: Making Smoking Obsolete. https://www.gov.uk/government/publications/the-khan-review-making-smoking-obsolete

34. Action for Smoking and Health (ASH). (2021) Smoking, Pregnancy and Fertility. https://ash.org.uk/resources/view/smoking-pregnancy-and-fertility#:~:text=Women%20from%20disadvantaged%20backgrounds%20are%20more%20likely%20to,are%20also%20more%20likely%20to%20smoke%20during%20pregnancy.

35. Action for Smoking and Health (ASH). (2024) Tobacco and Ethnic Minorities. https://ash.org.uk/resources/view/tobacco-and-ethnic-minorities

36. Office for Health Improvement and Disparities (OHID). (2019) Health Matters: tobacco and alcohol CQUIN. Published online 2019. https://www.gov.uk/government/publications/health-matters-preventing-ill-health-from-alcohol-and-tobacco/health-matters-preventing-ill-health-from-alcohol-and-tobacco-use

37. Nicotinell. (2025) Smoking And Alcohol: The Facts Behind Two Big Addictions. Published 2025. Smoking And Alcohol: The Facts Behind Two Big Addictions

38. Garnett C, Oldham M, Shahab L, Tattan-Birch H, Cox S. (2022) Characterising smoking and smoking cessation attempts by risk of alcohol dependence: A representative, cross-sectional study of adults in England between 2014-2021. *The Lancet Regional Health - Europe*. 2022;18:100418. doi:10.1016/j.lanepe.2022.100418

39. Verplaetse TL, McKee SA. (2017) An overview of alcohol and tobacco/nicotine interactions in the human laboratory. *Am J Drug Alcohol Abuse*. 2017;43(2):186-196. doi:10.1080/00952990.2016.1189927

40. RCPCH. (2020) Alcohol and drug use in young people. Published 2020. https://stateofchildhealth.rcpch.ac.uk/evidence/health-behaviours/alcohol-drug-use-young-people/

41. Jha P, Ramasundarahettige C, Landsman V, et al. (2013) 21st-Century Hazards of Smoking and Benefits of Cessation in the United States. *New England Journal of Medicine*. 2013;368(4):341-350. doi:10.1056/NEJMsa1211128

42. Action for Smoking and Health (ASH). (2022) Is There a Causal Effect of  Smoking on Mental Health? Accessed March 21, 2025. https://ash.org.uk/uploads/Causal-effect-smoking-and-mental-health.pdf?v=1662645856

43. Levy S. (2021) Nicotine addiction explained — and how medications can help. Harvard Health Publishing. Published 2021. Accessed March 21, 2025. https://www.health.harvard.edu/blog/nicotine-addiction-explained-and-how-medications-can-help-202107272554

44. Mathew AR, Hogarth L, Leventhal AM, Cook JW, Hitsman B. (2017) Cigarette smoking and depression comorbidity: systematic review and proposed theoretical model. *Addiction*. 2017;112(3):401-412. doi:10.1111/add.13604

45. Fuemmeler BF, Kollins SH, McClernon FJ. (2007) Attention Deficit Hyperactivity Disorder Symptoms Predict Nicotine Dependence and Progression to Regular Smoking from Adolescence to Young Adulthood. *J Pediatr Psychol*. 2007;32(10):1203-1213. doi:10.1093/jpepsy/jsm051

46. Langley K, Heron J, Smith GD, Thapar A. (2012) Maternal and Paternal Smoking During Pregnancy and Risk of ADHD Symptoms in Offspring: Testing for Intrauterine Effects. *Am J Epidemiol*. 2012;176(3):261-268. doi:10.1093/aje/kwr510

47. de Leon J, Diaz FJ. (2005) A meta-analysis of worldwide studies demonstrates an association between schizophrenia and tobacco smoking behaviors. *Schizophr Res*. 2005;76(2-3):135-157. doi:10.1016/j.schres.2005.02.010

48. Chambers RA, Krystal JH, Self DW. (2001) A neurobiological basis for substance abuse comorbidity in schizophrenia. *Biol Psychiatry*. 2001;50(2):71-83. doi:10.1016/S0006-3223(01)01134-9

49. Fu S, McFall M, Saxon A, et al. (2007) Post-traumatic stress disorder and smoking: A systematic review. *Nicotine & Tobacco Research*. 2007;9(11):1071-1084. doi:10.1080/14622200701488418

50. Beckham JC, Roodman AA, Shipley RH, et al. (1995) Smoking in vietnam combat veterans with post-traumatic stress disorder. *J Trauma Stress*. 1995;8(3):461-472. doi:10.1007/BF02102970

51. Office for Health Improvement and Disparities (OHID). (2025) Tobacco control profiles. Smoking related mortality. *Fingertips*. Published online 2025. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/1/gid/1938132887/pat/15/par/E92000001/ati/502/are/E06000035/yrr/1/cid/4/tbm/1

52. Office for Health Improvement and Disparities (OHID). (2025) Fingertips:Smoking Prevalence in adults (aged 18 and over) - current smokers (APS); ID: 92443. Published online 2025.

53. Medway Public Health Intelligence Team. Medway Health and Wellbeing Survey, Full Analysis. *2021*. https://www.medway.gov.uk/downloads/file/8104/full\_analysis

54. Cochran SD, Bandiera FC, Mays VM. (2013) Sexual orientation-related differences in tobacco use and secondhand smoke exposure among US adults aged 20 to 59 years: 2003-2010 National Health and Nutrition Examination Surveys. *Am J Public Health*. 2013;103(10):1837-1844. doi:10.2105/AJPH.2013.301423

55. Office for Health Improvement and Disparities (OHID). (2024) Fingertips: Smoking status at time of delivery. Published online 2024.

56. Action for Smoking and Health (ASH). (2023) A Manifesto for  Smokefree Beginnings. https://ash.org.uk/uploads/Challenge-Group-manifesto-online.pdf?v=1702375056

57. Gilman SE, Martin LT, Abrams DB, et al. (2008) Educational attainment and cigarette smoking: a causal association? *Int J Epidemiol*. 2008;37(3):615-624. doi:10.1093/ije/dym250

58. NHS England. (2024) Health Survey for England, 2022 Part 1. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-1/adults-health-related-behaviours

59. Office for National Statistics (ONS). (2023) How Life Has Changed in Medway: Census 2021. https://www.ons.gov.uk/visualisations/censusareachanges/E06000035/

60. Office for National Statistics (ONS). (2023) Census 2021 Maps . Published online 2023. https://www.ons.gov.uk/census/maps/choropleth/population/country-of-birth/country-of-birth-3a/born-outside-the-uk?lad=E06000035

61. Fernández-Reino M. (2020) The Health of Migrants in the UK. https://migrationobservatory.ox.ac.uk/resources/briefings/the-health-of-migrants-in-the-uk/

62. Office for Health Improvement and Disparities (OHID). (2023) Adult Substance Misuse Treatment Statistics 2022 to 2023: Report. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2022-to-2023/adult-substance-misuse-treatment-statistics-2022-to-2023-report#smoking

63. Office for Health Improvement and Disparities (OHID). (2021) Fingertips: Smoking prevalence in adults (aged 18 and over) admitted to treatment for substance misuse (NDTMS) - non-opiates; ID: 93673. Published online 2021. https://fingertips.phe.org.uk/profile/tobacco-control/data#page/6/gid/1938132900/pat/6/par/E12000008/ati/402/are/E06000035/iid/93673/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

64. Office for Health Improvement and Disparities (OHID). (2024) Fingertips: Smoking prevalence in adults with a long term mental health condition (18+) - current smokers (GPPS). Indicator ID: 93454. Published online 2024. https://fingertips.phe.org.uk/search/smoking#page/6/gid/1/pat/6/par/E12000008/ati/502/are/E06000035/iid/93454/age/168/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

65. NHS Digital. (2023) Statistics on Public Health, England 2021. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-public-health/2021/part-2-mortality

66. Office for Health Improvement and Disparities (OHID). (2024) Fingertips: Mortality rate from lung cancer, all ages; ID: 1203. *2024*. Published online 2024. https://fingertips.phe.org.uk/search/1203#page/6/gid/1/pat/15/par/E92000001/ati/502/are/E06000035/iid/1203/age/1/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1/page-options/car-do-0

67. Office for Health Improvement and Disparities (OHID). (2024) Fingertips: Mortality rate from chronic obstructive pulmonary disease, all ages; ID: 1204. Published online 2024. https://fingertips.phe.org.uk/search/mortality#page/6/gid/8000008/pat/6/par/E12000008/ati/501/are/E06000035/iid/1204/age/1/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

68. Office for Health Improvement and Disparities (OHID). (2021) Fingertips: Smoking attributable deaths from cancer (new method); ID: 93749. Published online 2021. https://fingertips.phe.org.uk/search/93749#page/6/gid/1/pat/159/par/K02000001/ati/15/are/E92000001/iid/93749/age/202/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

69. Office for Health Improvement and Disparities (OHID). (2021) Fingertips: Smoking attributable mortality (new method); ID: 93748. Published online 2021. https://fingertips.phe.org.uk/search/smoking%20attributable#page/6/gid/1/pat/6/par/E12000008/ati/501/are/E06000035/iid/93748/age/202/sex/4/cat/-1/ctp/-1/yrr/3/cid/4/tbm/1

70. Medway Council Public Health. (2024) Solutions Research – youth vaping. Published online 2024.

71. NHS. (2019) The NHS Long Term Plan. https://www.longtermplan.nhs.uk/publication/nhs-long-term-plan/

72. NCSCT. (2025) Local Stop Smoking Services and Support: Commissioning, Delivery and Monitoring Guidance. https://www.ncsct.co.uk/publications/commissioning-delivery-monitoring

73. NICE. (2025) Tobacco: Preventing Uptake, Promoting Quitting and Treating Dependence. https://www.nice.org.uk/guidance/ng209

74. NHS Digital. (2024) Statistics on NHS Stop Smoking Services in England. https://digital.nhs.uk/data-and-information/publications/statistical/statistics-on-nhs-stop-smoking-services-in-england/april-2023-to-december-2023-q3

75. Office for Health Improvement and Disparities (OHID). (2015) Health Matters: Smoking and Quitting in England. https://www.gov.uk/government/publications/health-matters-smoking-and-quitting-in-england/smoking-and-quitting-in-england

76. Cancer Research UK. (2023) Smoking Prevalence Projections for England Based on Data to 2021. https://www.cancerresearchuk.org/sites/default/files/cancer\_research\_uk\_smoking\_prevalence\_projections\_england\_0.pdf

77. Office for National Statistics (ONS). (2018) National population projections for Local Authorities . Published online 2018. National population projections: 2021-based interim

78. NHS Greater Manchester. (2025) The CURE Project. Published online 2025. https://gmcancer.org.uk/programmes-of-work/treatment/the-cure-project/

79. Ottawa Heart Institute. (2025) The Ottawa Model for Smoking Cessation . Published online 2025. https://ottawamodel.ottawaheart.ca/

80. University of York. (2025) The SCIMITAR Programme. Published online 2025. Accessed March 21, 2025. https://www.york.ac.uk/healthsciences/closing-the-gap/scimitar-programme/

81. McMeekin N, Sinclair L, Robinson‐Smith L, et al. (2023) Financial incentives for quitting smoking in pregnancy: Are they cost‐effective? *Addiction*. 2023;118(8):1445-1456. doi:10.1111/add.16176

82. Office for Health Improvement and Disparities (OHID). (2022) Nicotine Vaping in England: 2022 Evidence Update Summary. https://www.gov.uk/government/publications/nicotine-vaping-in-england-2022-evidence-update/nicotine-vaping-in-england-2022-evidence-update-summary#chapter-16-conclusions

83. Department of Health and Social Care. (2023) Major Conditions Strategy: Case for Change and Our Strategic Framework. https://www.gov.uk/government/publications/major-conditions-strategy-case-for-change-and-our-strategic-framework/major-conditions-strategy-case-for-change-and-our-strategic-framework--2

84. NIHR. (2017) Stop Smoking Services Can Work for People in Treatment or Recovery from Substance Misuse Disorders. doi:10.3310/signal-000460

85. Action for Smoking and Health (ASH). (2020) Smokeless tobacco products. Published online 2020. https://ash.org.uk/uploads/smokelesstobaccoeip.pdf

86. Office for Health Improvement and Disparities (OHID). (2020) The CLeaR Improvement Model: Excellence in Tobacco Control. https://www.gov.uk/government/publications/clear-local-tobacco-control-assessment/the-clear-improvement-model-excellence-in-tobacco-control