TOBACCO NEEDS ASSESSMENT FOR CITY AND HACKNEY

2024

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ABBREVIATIONS AND ACRONYMS

APS - Annual Population Survey

ASH - Action on Smoking and Health, an organisation that works collaboratively on providing information, advocacy and campaigning on policy measures to reduce the burden of disease and premature death caused by tobacco.

CI - confidence interval

CO - carbon monoxide

COPD - chronic obstructive pulmonary disease, includes emphysema and chronic bronchitis

CVD - Cardiovascular disease

ELFT - East London Foundation Trust

GP - general practitioner ('family doctor')

HCVS - Hackney Community and Voluntary Service

IMD - Index of Multiple Deprivation

LSOA - Lower Layer Super Output Area

MECC - 'Making Every Contact Count' (very brief opportunistic conversations to support healthy behaviours)

NCSCT - National Centre for Smoking Cessation and Training

NICE - National Institute for Health and Care Excellence

NRT - nicotine replacement therapy

PCN - Primary Care Network

Ppm - parts per million

PSHE - personal, social, health and economic education

RSE - relationship and sex education

SMI - severe mental illness

SSS - stop smoking service

TCA - Tobacco Control Alliance

VBA - very brief advice

VCS - voluntary and community sector

GLOSSARY OF TERMS

CO-validated 4-week quitter - carbon monoxide (CO) validation is the most cost-effective and least invasive method of measuring someone's smoking status. CO validation rates are important markers of service data quality as an objective measure of smoking status. The national outcome measure of stop smoking services is success rates at the 4-week post-quit date. A smoker is counted as a 'CO validated 4-week quitter' if they are a self-reported quitter and their expired-air CO is assessed four weeks after the designated quit date (minus three days or plus 14 days) and found to be less than 10 parts per million (ppm). Due to the pandemic, CO validation was suspended in March 2020 and many smokers continue to be supported via virtual appointments, which poses challenges for CO validation.

Deprivation quintile - The Index of Multiple Deprivation (IMD, here used 2019 scores) shows how deprived different areas are. It is an indicator that assigns scores to each area based on various domains (income, employment, education, health, crime, barriers to housing and services, and living environment). The population was split into five groups called quintiles, which each contain 20% of residents. The first quintile is the most deprived and includes the 20% of residents living in the most deprived areas. The fifth quintile is the least deprived and includes 20% of residents in the least deprived areas.

Smoking prevalence - the proportion of individuals in a population who smoke at a specific point in time.

Confidence intervals - a way to estimate the range of values that we can be reasonably confident contain the true value we are trying to estimate.

EXECUTIVE SUMMARY

INTRODUCTION

The aim of this report is to set out the national and local policy context in relation to tobacco control, provide insights on the local picture of smoking behaviours, examine the latest evidence and best practice as well as the local response, and make recommendations for local action. It focuses on key areas such as prevention, identification, treatment, and support, addressing inequalities in access across demographics, geography, socioeconomic factors, and vulnerable groups, while also exploring the role of e-cigarettes and workplace interventions in combating smoking.

Despite progress in the last decade, smoking remains the leading cause of preventable disease and death and is one of the most significant factors contributing to health inequalities. Each year smoking kills approximately 74,600 people in England; the societal cost of smoking is estimated at £17 billion per year, with a significant impact on productivity, healthcare, and social care. With a strong link between smoking and poverty, deprived communities exhibit higher smoking rates and dependency. In Hackney, smoking-related costs are estimated at £101.9 million annually.

POLICY CONTEXT

Despite significant strides in reducing smoking prevalence, nearly six million individuals in England continue to smoke, contributing to persistent health inequalities. Sustained efforts at local, regional, national, and international levels are essential to further mitigate the significant harms of tobacco.

National policies

- The 2017 national tobacco control plan set an ambition for England to be smoke-free by 2030, but this expired in 2022 and its objectives were only partly achieved.
- The 2022 independent Khan review assessed whether the ‘smoke-free 2030’ ambition is likely to be achieved and made 15 recommendations, prompting the government's response in April 2023, introducing initiatives such as the "Swap to Stop" scheme to support one million smokers to switch to vaping and financial incentives for pregnant smokers to quit. A comprehensive suite of further measures announced in October 2023 include: legislation to raise the age of sale of tobacco every year from 2027 onwards; increased funding for local authority stop smoking services, national awareness campaigns and enforcement activity; and a consultation to address youth vaping.

Local policies

The Khan recommendations, and Action on Smoking and Health's (ASH) '10 high-impact areas,' serve as an evidence-based framework for local partnership action. Both have shaped the local tobacco control work in City and Hackney. Highlights include:

- Hackney policies align with national goals, with the elected Mayor committing to a smoke-free Hackney by 2030, supported by the Community Strategy and Strategic Plan which included a focus on improving health and reducing health inequalities.
- The City of London Corporate Plan emphasises a focus on health and wellbeing; addressing tobacco-related harms is key to achieving this aim.

THE LOCAL PICTURE

Estimates of the number of adult residents who smoke in Hackney range from 28,900 to 51,700 with an estimated 800-900 in the City of London plus an unknown but likely significant number of smokers among the City's large daytime worker population (around 587,000 people). Smoking prevalence is significantly higher for adult men in City and Hackney, which can be seen across almost all ethnic groups. While local smoking data is unreliable for individuals younger than 18, most smokers start before this age and are more likely to start smoking if they live with someone who smokes.

Socioeconomic factors, including housing tenure and occupation, correlate with smoking rates, with those in social housing and manual occupations exhibiting higher prevalence. Specific ethnicities, such as Bangladeshi, black Caribbean, 'other black,' 'white and black Caribbean', 'Irish' and 'other mixed' and 'other white,' show elevated smoking rates in Hackney. Examining specific ethnicities in Hackney, various subgroups exhibit significantly higher smoking prevalence than the overall average: Turkish/Kurdish/Cypriot, Eastern and Western European, Vietnamese men, as well as Gypsy/Roma/Traveller females. Variation in smoking prevalence is also observed between ethnic groups in the City of London, but small numbers mean these differences are less discernible.

Vulnerable groups, including LGBTQ+ individuals and those with mental illness, substance use, and homelessness, experience higher smoking prevalence. Psychological, social, economic, and cultural factors contribute to smoking initiation, emphasising the need for targeted strategies. While smoking among pregnant women as recorded at time of delivery in City and Hackney is lower than national averages, there is likely underreporting at play, and local insights point to the complexities of quitting in pregnancy overall.

While smoking-attributable mortality rates in Hackney have declined, they remain higher than London averages; in contrast, City's rates are notably lower. This underlines the need for tailored interventions and the importance of nuanced approaches based on population characteristics.

EVIDENCE AND GOOD PRACTICE

This needs assessment highlights the wealth of evidence and guidance available to inform both national and local efforts to address the substantial health risks linked to tobacco smoking.

The 2022 Khan review provides the blueprint for the national response, and the government's recent announcements respond to most of the recommendations of this review. Complementing these national recommendations, ASH proposes partnership action across 10 high-impact areas as part of a robust local tobacco control strategy.

The report summarises the latest evidence and good practice related to prevention of smoking uptake, identification of smokers and early intervention, as well as treatment of tobacco dependency. It emphasises the effectiveness of evidence-based school interventions, enforcement activity, targeted mass media campaigns, and the pivotal role of health and care staff in identifying and assisting smokers to quit. The report also describes the critical role of high quality stop smoking services as a necessary component of a broader tobacco control strategy. Notably, NICE now endorse nicotine-containing e-cigarettes (vapes) as a primary quit aid for adult smokers, with evidence suggesting their effectiveness in smoking cessation. However, misconceptions about the relative risks of vaping vs smoking prevail, highlighting the need for education and effective communication to challenge these. The report also addresses concerns about the rise in e-cigarette experimentation among young people, emphasising the role for school-based peer-led interventions. Enforcement activity is also key in reducing under-age sales of both e-cigarettes and tobacco.

Workplace interventions are also recommended, with employers having an important role in developing smokefree policies and providing support for employees seeking to quit.

THE LOCAL RESPONSE

City and Hackney's long-standing commitment to tobacco control is demonstrated through Hackney Council's signing of the Local Government Declaration on Tobacco Control (in 2014) and local NHS partners' signing of the NHS Smokefree Pledge (in 2018). Guided by ASH's '10 high impact' actions, the local Tobacco Control Alliance prioritises strategic, proactive and coordinated approaches for a smoke-free society.

Local prevention efforts include funding of a dedicated trading standards officer (focused on reducing under-age sales and supply of illicit tobacco, vapes and also alcohol) and health outreach in schools (including lesson plans focused on the harms of smoking and use of e-cigarettes). City and Hackney continues to invest in an evidence-based high performing community stop smoking service, which includes delivery of smoking 'very brief advice' training. Integrated pathways between the community stop smoking service and local NHS tobacco dependency treatment services are being established to provide a streamlined offer of support for all smokers to quit.

The local stop smoking service is effective at targeting smokers living in the most deprived neighbourhoods. However, geographic and socioeconomic disparities in service uptake reveal potential unmet needs locally, especially among younger smokers (under 40 years of age), male smokers and those from some high prevalence communities - all of whom appear less likely than average to access support. Similarly, there is evidence to suggest that smokers with severe mental illness and homeless people are under-represented in the current stop smoking service. Local insights underscore the importance of making available a diverse range of options to support smokers to quit, including targeted/discreet outreach locations plus longer interventions and/or peer support where needed. Tailored interventions are needed especially for vulnerable groups in recognition of the complexity of the wider context in which they live their lives, which may require a harm reduction approach.

The rise in e-cigarette use, particularly disposable vapes, among young people is of concern locally as well as nationally. Local efforts to root out the supply of illegal vapes is led by a dedicated trading standards officer. Insights from local people suggest that misperceptions about the relative risks of e-cigarettes are common, which may be hindering their use as quit aids by adult smokers.

Two major local employers (Hackney Council and Homerton Hospital) have developed evidence-based smokefree policies and the current stop smoking service is promoted to local employers via council/Corporation communication channels.

RECOMMENDATIONS

This report concludes with a set of recommendations which are summarised below.

1. Addressing persistent inequalities in smoking prevalence requires strong and sustained collaborative efforts.
2. Prioritise preventing smoking uptake and supporting quitting among young smokers, emphasising whole school approaches and peer-led actions.
3. De-normalise smoking through a comprehensive tobacco control plan, promoting smoke-free public spaces and revitalising partnership commitments.
4. A tailored and targeted approach is needed to support high prevalence communities to quit, collaborating with organisations that work with/represent these communities and exploring opportunities within Family Hubs.
5. Continue funding evidence-based community stop smoking services, offering flexible support, harm reduction and transparent information on vaping.
6. Improve reporting of smoking status in GP records to facilitate targeted very brief advice (VBA) and referrals to evidence-based quit support.
7. Sustain investment in enforcement to reduce supply of illicit tobacco and e-cigarettes, preventing underage sales and related health and social harms.
8. Launch a coordinated communications campaign to dispel misconceptions about vaping, emphasising its efficacy for adult smokers while strongly discouraging uptake among non-smokers and children/young people.
9. Implement a comprehensive local communications strategy to increase quit attempts, delivering clear messages about the harms of tobacco and the hope of positive action to quit, promoting all opportunities to access support.

1. INTRODUCTION

Significant progress has been made in tackling smoking in recent years, with prevalence (or the proportion of people who smoke) in England now at the lowest level recorded, at 13%. (1) Despite this, **smoking remains a leading cause of preventable disease and death** and is one of the most significant factors contributing to **health inequalities**. (2) The latest data from Action on Smoking and Health (ASH) found smokers are more likely to become ill and die while they are of working age and more likely to need health and social care services at a younger age than non-smokers. (3)

Every year, smoking kills approximately 74,600 people in England. (4) In 2020, 506,100 hospital admissions in England were attributable to smoking. (4) Smoking causes lung cancer, respiratory disease and heart disease as well as numerous cancers in other organs including lip, mouth, throat, bladder, kidney, stomach, liver and cervix. (5) For every death caused by smoking, approximately 20 smokers are living with a smoking related disease. (6) These include Alzheimer's disease, angina, asthma, Crohn's disease, gastric and duodenal ulcers, gum and tooth disease, osteoporosis, rheumatoid arthritis, cataracts, macular degeneration, psoriasis, reduced fertility, impotence, depression, sight loss, hearing loss, multiple sclerosis and diabetes. (7) Tobacco smoking harms others through second hand smoke, while smoking in pregnancy impairs foetal growth and development and increases the risk of stillbirth and infant mortality. (7–9)

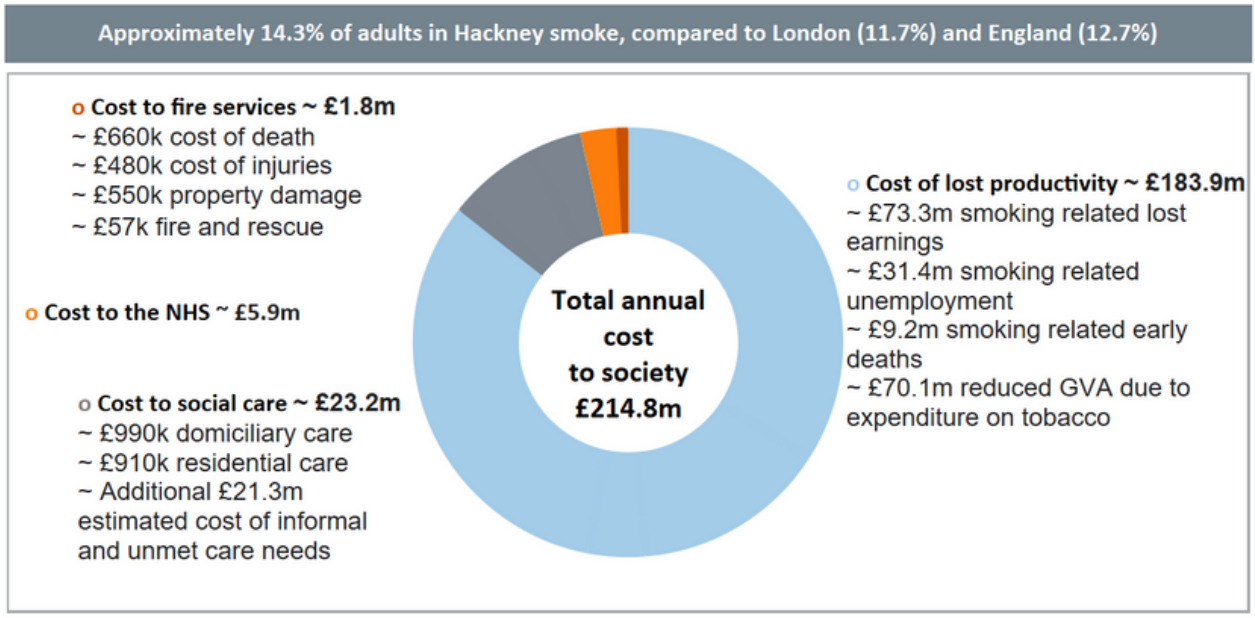
Smoking continues to be the leading cause of premature death and exacerbates health inequalities.

Not all groups are affected by smoking in the same way. Some are at greater risk of harm (such as pregnant women) and others find it harder to give up (such as people living in socioeconomically deprived circumstances and those with a mental illness). In some communities, smoking appears to be promoted through cultural norms. (10)

There is a strong link between **smoking and poverty**. Smoking tends to be more common in deprived communities, people in these communities tend to start smoking at a younger age and have higher levels of dependency on tobacco. Recent data confirms the link between poverty and smoking, with around 3,000 households in Hackney estimated to be pushed into poverty as a result of expenditure on tobacco. (11) In 2022, smokers were estimated to spend an average of £2,421 a year on tobacco, equivalent to the average household's annual energy bill (£2,500). (12)

The **total cost of tobacco smoking** to society in England is approximately £17 billion each year, with more than 75% of this cost a result of lost productivity (due to smoking-related ill-health), 15% the cost to the NHS and the remaining 10% the cost to social care. (13) In Hackney, the annual total costs of tobacco smoking are estimated at around £215 million as shown in figure 1. (3) Again, these costs are spread across the economy, health services, local government, and the fire service. Equivalent data are not available for the City of London.

Figure 1: The local costs of tobacco in Hackney, 2023



Notes: Adapted from the ASH ready reckoner by City and Hackney Public Health Intelligence Team. (3)

The substantial social and financial cost of smoking means that tobacco control and reducing the harms from tobacco continue to remain a priority nationally and locally, as outlined in the policy context in Section 2.

This JSNA has been written in partnership with multiple organisations (including stop smoking service providers, Trading Standards, and colleagues in the NHS) to assess the smoking needs of City and Hackney residents. This report summarises the national and local policy context; describes the local picture of smoking prevalence, inequalities and related harms; highlights the latest evidence and best practice in tackling smoking; and sets out actions being taken locally. The first section proposes some key recommendations to address the inequalities and gaps identified and capitalise on opportunities to strengthen local action on tobacco.

2. POLICY CONTEXT

Although good progress has been made in reducing smoking prevalence, almost 6 million people still smoke tobacco in England and smoking is still one of the largest causes of health inequalities. There is a need for sustained local, regional, national and international action to continue to make progress in reducing the significant harms related to tobacco.

NATIONAL POLICIES

A national tobacco control plan was previously published in 2017, which outlined the government's ambition for England to be **smoke-free by 2030** (that is to reduce smoking prevalence to below 5%). (14) This national plan expired in 2022. The objectives set out in this plan have been partially, but not wholly, met.

In 2022, the **independent Khan review 'Making smoking obsolete'** reviewed the government's current tobacco control policies to assess whether the smoke-free 2030 ambition is likely to be achieved, and made 15 recommendations for the government to take action on to achieve its ambition (figure 2). (15) The recommendations highlighted in blue below are those that can be actioned on a local level, to a greater or lesser extent.

Figure 2: Summary of recommendations from the Khan review, 2022

Source: UK Government, The Khan Review: making smoking obsolete, 2022. (15)

In April 2023, the government partially responded to the Khan review recommendations outlining the following plans: (16)

- a national **"Swap to Stop" scheme** to support one million adult smokers to quit smoking by switching to vaping - this scheme will initially target at-risk and high smoking prevalence groups
- **financial incentives** to all **pregnant women who smoke** by the end of 2024
- investment of £3m in an **enforcement package** to tackle underage vape sales and illicit tobacco
- as a minimum, all **mental health practitioners** will be able to signpost to specially developed digital resources to support people with mental health problems to quit smoking
- **joined-up working between the NHS and local authorities** to support smokers to quit, facilitated by Integrated Care Boards
- a **government consultation** on the introduction of mandatory pack inserts with messages and information to help smokers quit.

In October 2023, the government announced further measures to significantly ramp up action to create a 'smoke-free generation' through a comprehensive range of funded interventions. (17) These announcements respond to many more of the recommendations of the independent Khan review, including proposals to:

- **legislate to raise the age of sale** one year every year from 2027 onwards
- **double the funding** for local authority **SSS** from next year
- **increase funding for awareness-raising campaigns** by £5 million this year and £15 million from next year onwards
- **increase funding for enforcement of illicit tobacco and e-cigarettes** by £30 million from next year
- launch a **consultation** shortly on specific measures to tackle the increase in **youth vaping**. The consultation on measures to tackle youth vaping and smoking was launched in October 2023 and closed in December 2023. (18)

The government announced that they will legislate the age of sale for tobacco, increase funding for stop smoking services, among other measures.

ASH 10 high-impact areas for local authorities

The Khan recommendations that are relevant to local action echo many of the '10 high-impact areas' set out by ASH in 2022 (figure 3). (19) These recommendations were published in the absence of a refreshed national tobacco control plan and provide an evidence-based framework for local partnership action to continue to drive down smoking prevalence and reduce the many health, social and economic costs of smoking.

Figure 3: ASH 10 high impact action areas, 2022

Source: ASH, 2022 (19)

LOCAL POLICIES IN HACKNEY

The recommendations highlighted by the Khan review and ASH have shaped local tobacco control work in City and Hackney (led by a Tobacco Control Alliance, see Section 5) and align well with the local policy context.

Manifesto pledge

Smoking is a key priority for Hackney's elected Mayor, whose manifesto includes a commitment for Hackney to become smoke-free by 2030, mirroring the national ambition. Further details can be found in the Labour manifesto.

Community Strategy and Strategic Plan

The Hackney Community Strategy describes an ambition for Hackney to be 'a borough with healthy, active and independent residents. (20) Reducing the harms from tobacco (as a primary driver of poor health and inequalities) plays an important role in achieving this. Similarly, action on smoking supports the achievement of one of Hackney Council's three overarching priorities in its Strategic Plan, to 'work together for a greener, healthier Hackney', as well as the plan's cross-cutting theme to reduce inequalities. (21)

LOCAL POLICIES IN THE CITY OF LONDON

City of London Corporate Plan (2022)

The current City of London Corporate Plan states that "our aims and priorities are to contribute to a flourishing society, where people are safe and feel safe and enjoy good health and wellbeing." Again, reducing the harms of tobacco will play an important part in realising these aims.

3. THE LOCAL PICTURE

ESTIMATED NUMBER OF SMOKERS

The two main data sources used to estimate the prevalence of smoking locally are the Annual Population Survey (APS) and data from general practice (GP) records. Both of these sources have limitations, which are discussed further in Appendix 1. Throughout this document, APS data has been used when looking at trends and making comparisons with other areas, and GP data has been used for the analysis of local inequalities.

Adult (age 18+) smoking prevalence varies depending on the source used, ranging from approximately 14% (APS) to 21% (GP) in Hackney, and from 10% (GP) to 11% (APS) in the City of London. Given these variations in estimated prevalence, the number of residents who smoke is estimated to range between 28,900 and 51,700 in Hackney, and between 800 and 900 residents in the City of London (Table 1). The City of London also has a large worker population of approximately 587,000 in 2021, and a previous survey (from 2012) suggested a high prevalence of smoking in this group. (22)

Table 1: Prevalence and equivalent estimated number of adult (18+) smokers, City of London and Hackney residents

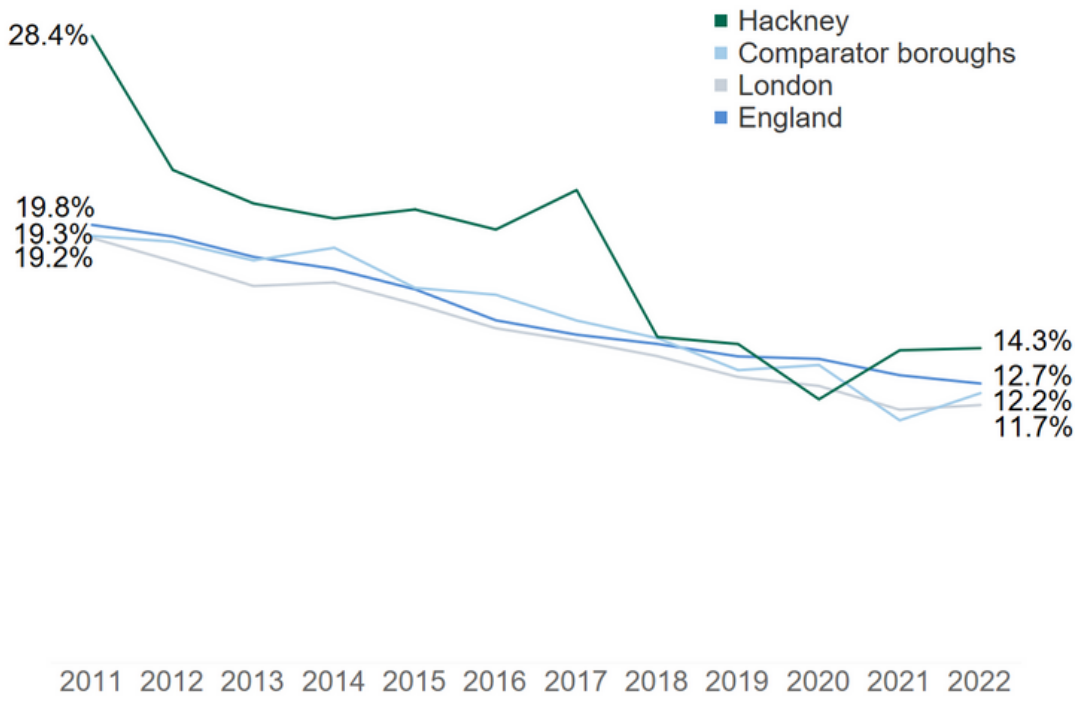
	Prevalence		Estimated number	
	APS 2021*	GP 2022	APS 2021*	GP 2022
City of London	11.5%	10.5%	916	772
Hackney	14.2%	21.3%	28,920	51,685

Sources: GP data: Clinical Commissioning Group (CEG), East London Database, 2022; APS data: Annual Population Survey (APS) 2021 prevalence applied to ONS mid-year 2021 population aged 18 and over to calculate the estimated number based APS(23). As Census 2021 data was collected during the COVID-19 pandemic when the local resident population may have been temporarily lower, ONS mid-year 2021 population is used in this document.
Note: GP data covers the City of London and Hackney residents registered with a GP in North East London (NEL), which includes eight local authority areas: Barking & Dagenham, City of London, Hackney, Havering, Newham, Redbridge, Tower Hamlets and Waltham Forest. The prevalence calculated amongst those with smoking status known in the last 5 years (from 2017/18 to 2021/22) was applied to the whole adult population registered to calculate the estimated numbers.
*No prevalence value available for City of London in APS, so London value was used.

Trends in smoking prevalence

Local data on smoking prevalence was first published in 2011. Between 2011 and 2022, the prevalence of smoking amongst Hackney adults aged 18 and above has been steadily declining, in line with national and regional trends (figure 4). Although it is too early to conclude, and firm conclusions are difficult to draw due to small sample sizes, there is some evidence that **progress may have stalled locally** in recent years.

Figure 4: Prevalence of smoking amongst residents aged 18+ over time, Hackney, 2011-2022



Source: Smoking prevalence in adults (18+) - current smokers (APS), OHID Fingertips, 2023. (24)
Notes: Comparators are the 'statistical neighbours' described in Appendix 2. The data from 2020 may not be comparable due to changes in the methodology as a result of the pandemic (25). Publish trend data are not available for the City.

Inequalities in smoking prevalence

A range of interacting psychological, social, economic and cultural factors are linked to an increased likelihood of people starting and continuing to smoke. These include living with parents or siblings who smoke, the level of exposure to tobacco industry marketing, the availability of cheap tobacco, lower socioeconomic status, mental illness, higher levels of school absence and substance use. (26-27). Smoking is also more common in certain cultural and global majority communities.

Demographic

Sex

In 2022, based on GP data, the prevalence of smoking among adult (18+) men in Hackney (around 27%) was significantly higher than among women (around 17%). In the City of London, the adult (18+) smoking prevalence was also higher among men (around 13%) than among women (around 7%). (28)

Age

Tobacco smoking is largely taken up in childhood and teenage years. In the UK, around 90% of people who smoke start between the ages of 10 and 20 (29). As such, discouraging young people from smoking remains a priority locally and nationally. (14)

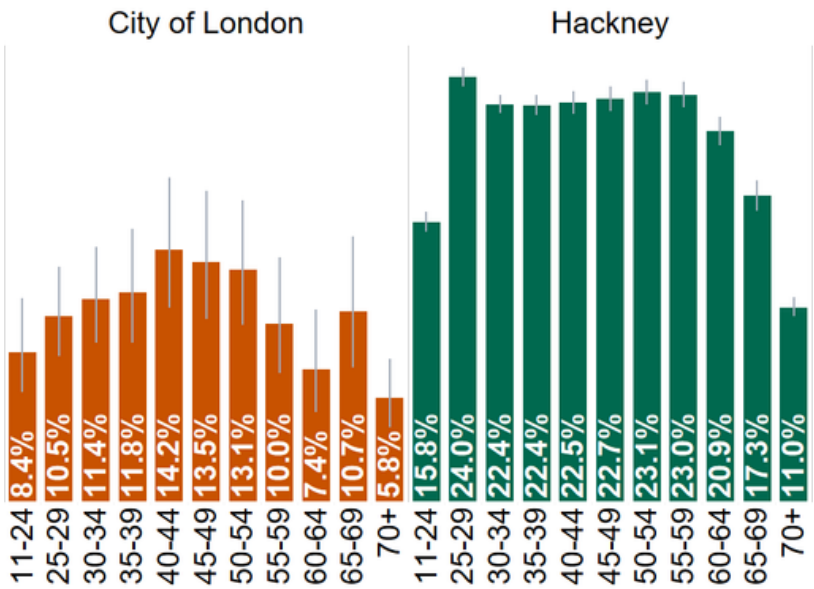
There is no reliable up-to-date local data on smoking prevalence among individuals younger than 18 in City and Hackney. Nationally, smoking amongst 11-15-year-olds decreased between 2018 and 2021: the percentage of those who had tried smoking at least once in this age group decreased from 16% to 12% over this period, while the percentage of current smokers decreased from 5% to 3%, and regular smokers decreased from 2% to 1%. (30) Applying these national prevalence figures to local population sizes, an estimated 488 residents in Hackney and 14 residents in the City of London aged between 11 and 15 were current smokers in 2021.[1] However, local GP data indicates that approximately 700 Hackney residents aged 11 to 15 were current smokers. These data, taken from 2022 data and based on smoking status recorded over the past 5 years, are likely to be subject to under-reporting bias and yet the estimates are roughly 50% higher than national figures would suggest.

Local GP records suggest that 4% of 16-17 year olds in both Hackney and the City are current smokers, equating to 256 young people in Hackney and five young people in the City of London. However, these numbers need to be considered with caution due to under-recording of smoking status in younger groups, and notably for the City of London due to small numbers. (28)

In Hackney, the proportion of the population recorded as a smoker on their GP record increases up to the 25-29 age group. There is a small decline from 25-29 to 30-34. From this point, smoking prevalence remains relatively stable until age 55-59, at which point it begins to decline. (24) This decline is likely to be a combination of stopping smoking in older age due to smoking-related poor health and smoking-related premature mortality. (31) The patterns in the City of London are broadly similar, but due to small numbers (demonstrated by the wider confidence intervals in figure 5) statistically significant differences are not observed (figure 5).

Figure 5: GP recorded smoking prevalence by age group (11+), City of London and Hackney residents, 2022

Data source: Clinical Effectiveness Group, East London Database, 2022. (28)
Notes: Age categories have been combined when numbers were smaller than 30 to provide a more robust analysis among age groups under 25 and over 70. The denominator is the total population with smoking status recorded in the last 5 years (from 2017/18 to 2021/22). The vertical lines represent confidence intervals, which are a way to estimate the range of values that we can be reasonably confident contain the true value we are trying to estimate.



[1] The denominator used for this was the ONS mid-year population 2021.

Insight gathered from local young people (aged 16 to 25) to inform this needs assessment, through a local survey (please see appendix 3 for details), highlighted the reasons underlying their smoking behaviour (Box 1). Please note that these findings are not necessarily representative of all young people in City and Hackney.

Box 1: Local insight from a survey aimed at young people

The young people who answered the survey provided similar reasons for smoking as other smokers; for many, it was a social thing they did with peers that they enjoyed. When asked about reasons to quit smoking, young people provided reasons that were similar to other smokers; many were concerned about the impact of smoking on their health. Others stated financial reasons given the rising costs of cigarettes. One young person mentioned being a good role model for her son as her main reason for quitting.

When asked about barriers to quitting, young people mentioned the difficulty in breaking smoking habits. They also mentioned how smoking was perceived as a way of reducing their stress, as well as social reasons (being with friends who also smoked) making it more difficult to quit themselves.

The remaining data in this section focus on smoking prevalence in adults (18+). As the numbers of recorded smokers under 18 are very small, their omission is unlikely to affect the observed patterns.

Ethnicity

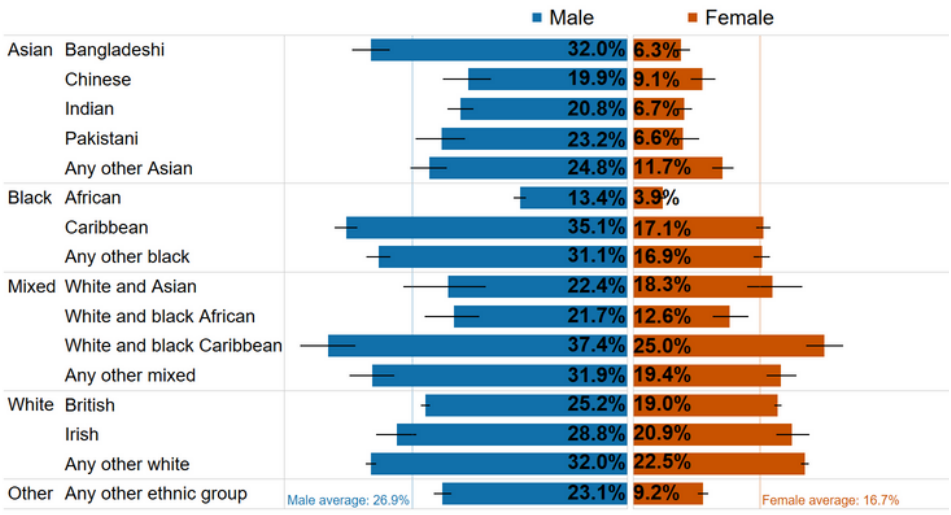
The pattern of higher male (compared with female) smoking prevalence can be seen across almost all ethnic groups in Hackney, and a similar pattern is observed in the City (although comparisons are less reliable here due to small numbers). (28)[2]

In Hackney, smoking prevalence is higher than average amongst Bangladeshi men, black Caribbean and 'other black' men, 'white and black Caribbean' men and women, 'British', 'Irish' and 'other mixed' ethnicity women, and 'other white' men and women (Figure 6).

Figure 6: GP recorded smoking prevalence by ethnicity and sex (18+), Hackney residents, 2022

Data source: Clinical Effectiveness Group, East London Database, 2022. (28)

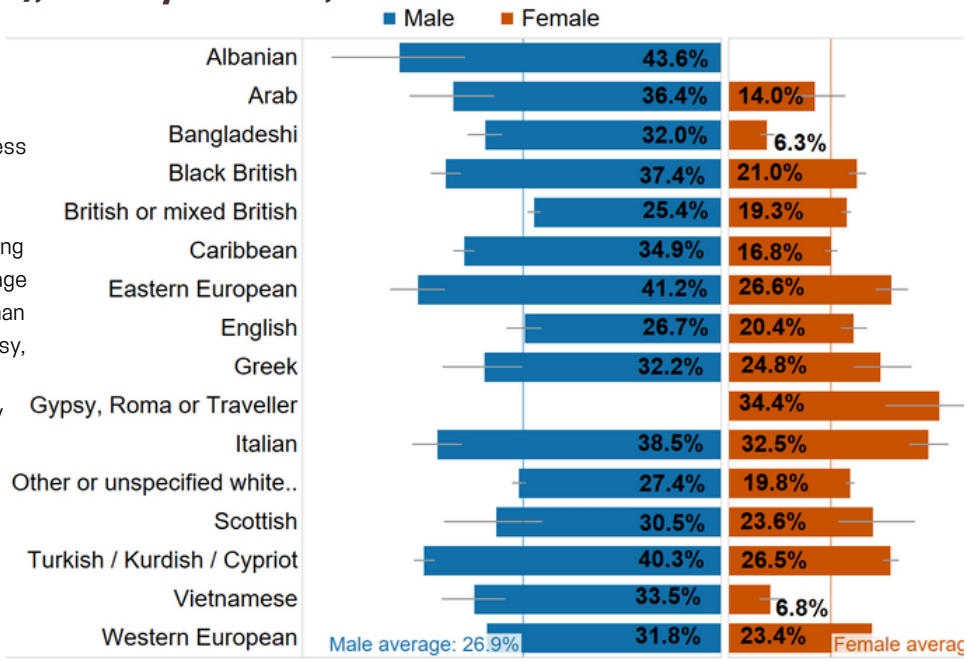
Note: only those with smoking status recorded in the last 5 years (from 2017/18 to 2021/22) were included.



[2] The ethnic categories were based on GP records. With City data, some categories have had to be combined for analysis purposes.

Looking at a more detailed ethnicity breakdown, the data below show several other ethnic subgroups with a recorded smoking prevalence that was significantly higher than the average in Hackney. These groups include Turkish/Kurdish/Cypriot, Eastern and Western European, plus Vietnamese (men only), as well as Gypsy/Roma/Traveller females (data for males not reported due to small numbers). These patterns are highlighted in Figure 7 below.

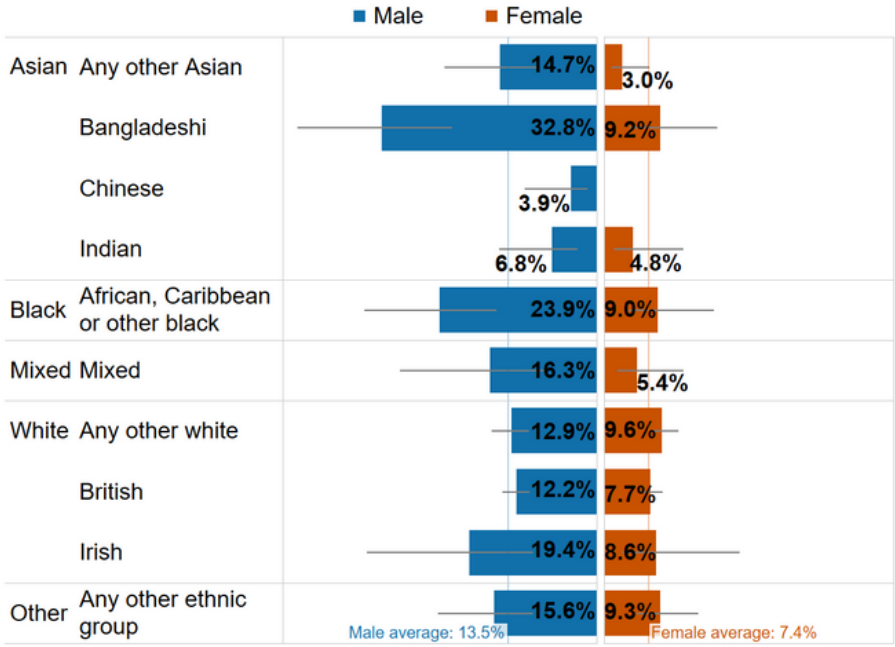
Figure 7: GP recorded smoking prevalence that exceeds Hackney average by detailed ethnicity and sex (18+), Hackney residents, 2022



Data source: Clinical Effectiveness Group, East London Database, 2022.
Notes: Ethnic groups with smoking prevalence at or below the average for both sexes, groups of less than 30 individuals (this includes Gypsy, Roma and Traveller males) and terms that did not represent any specific group (e.g. 'other') are excluded from this analysis.

Similar to Hackney, GP recorded smoking prevalence is significantly higher than average amongst Bangladeshi and black men in the City of London (Figure 8). However, further comparisons by ethnic group are more difficult for the City due to small numbers (demonstrated by the wider confidence intervals in Figure 8).

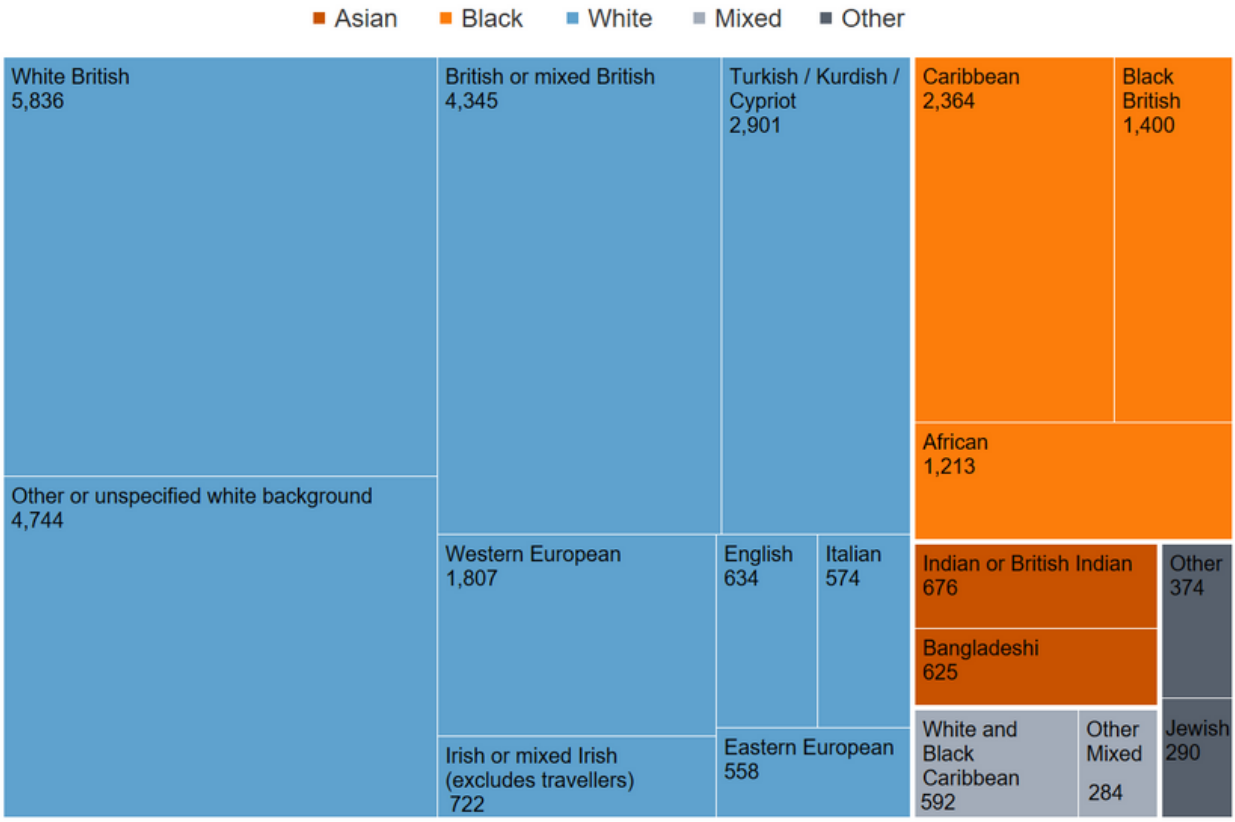
Figure 8: GP recorded smoking prevalence by ethnicity and sex (18+), City of London residents, 2022



Data source: Clinical Effectiveness Group, East London Database, 2022. (28)
Note: only those with smoking status recorded in the last 5 years (from 2017/18 to 2021/22) were included. Pakistani ethnicity is excluded as there were no smokers identified in this group.

It is important to note that while certain groups may have a high smoking prevalence, this doesn't always correspond to the groups with the highest number of smokers, which is driven by the size of the population as well as the proportion of smokers (see Figure 9 below).

Figure 9: Number of City and Hackney resident smokers (18+) registered to a GP by the main ethnic terms referred, 2022



Data source: Clinical Effectiveness Group, East London Database, 2022. (28)

Notes: Because there are many different terms used for self-reported ethnicity, only the most common ones are included in this figure. These terms account for 80% of smokers in Hackney, excluding those with blank, unclassified, or unknown ethnicities. The colours in the figure represent broader categories of ethnicity that group together more specific self-reported ethnic terms.

Local insight was gathered from Turkish, Cypriot and Kurdish residents and black Caribbean residents (Box 2) to inform this needs assessment. The findings from the insights highlight the complexity of people's beliefs when it comes to tobacco and its harms, as well as the impact of culture, family and friends on their behaviours and beliefs.

Box 2: Local insight gathered from Turkish, Cypriot and Kurdish residents and black Caribbean residents

Residents highlighted a number of reasons for smoking. One reason identified was that in the countries where they grew up, smoking was a daily part of life. They saw everyone around them smoking (which is often how they started smoking) and so they identified it as part of their cultural norms:

"Drinking coffee is part of our culture and all of my neighbours would give me one coffee and one cigarette a day and that led to me starting to smoke in 1974. I was 26."

As with other groups, smoking was often described as a mechanism for calming themselves down and relaxing. They also spoke of peer pressure to start smoking as it was something friends and colleagues around them were doing. One participant spoke about smoking as a way of maintaining her 'image' in her career role and another felt their smoking was justified because they didn't engage in other behaviours:

"I don't drink so I think smoking is ok"

Many recognised that smoking was harmful and identified a number of reasons for wanting to quit smoking, such as the health impacts on themselves and their families. They also identified a number of barriers to doing so, such as being around other people who are smoking and not knowing how to deal with feelings of craving/addiction and the related impacts on their body:

"You have to stay away from places where they smoke cigarettes, not to drink."

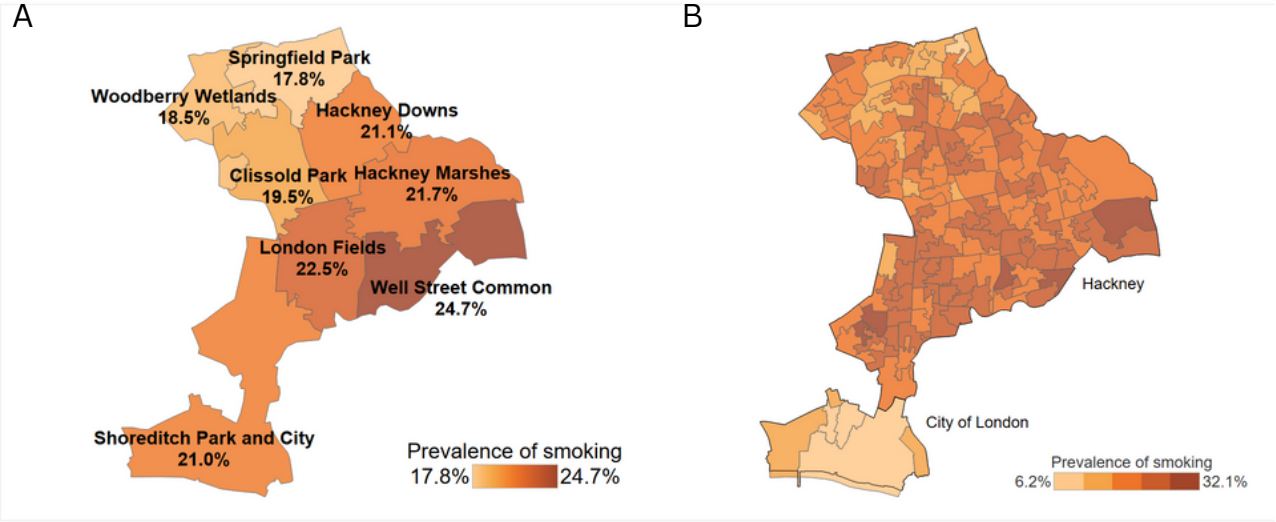
"I tried many times, most recently 14 hours, but I give into the craving."

"[After you quit smoking] you eat more and put on weight... But if you are strong you stay no [to cigarettes still]."

Geography

GP recorded smoking prevalence varies across the local area. The highest prevalence is seen in areas in the south east of Hackney, in Well Street Common Primary Care Network (PCN)/Neighbourhood (Figure 10, A). A smaller area map, however, shows a notable variation within the City and Hackney PCNs (Figure 10, B). (28)

Figure 10: GP recorded prevalence of current smokers (18+) by primary care network (PCN, A) and LSOA (B), City of London and Hackney, 2022

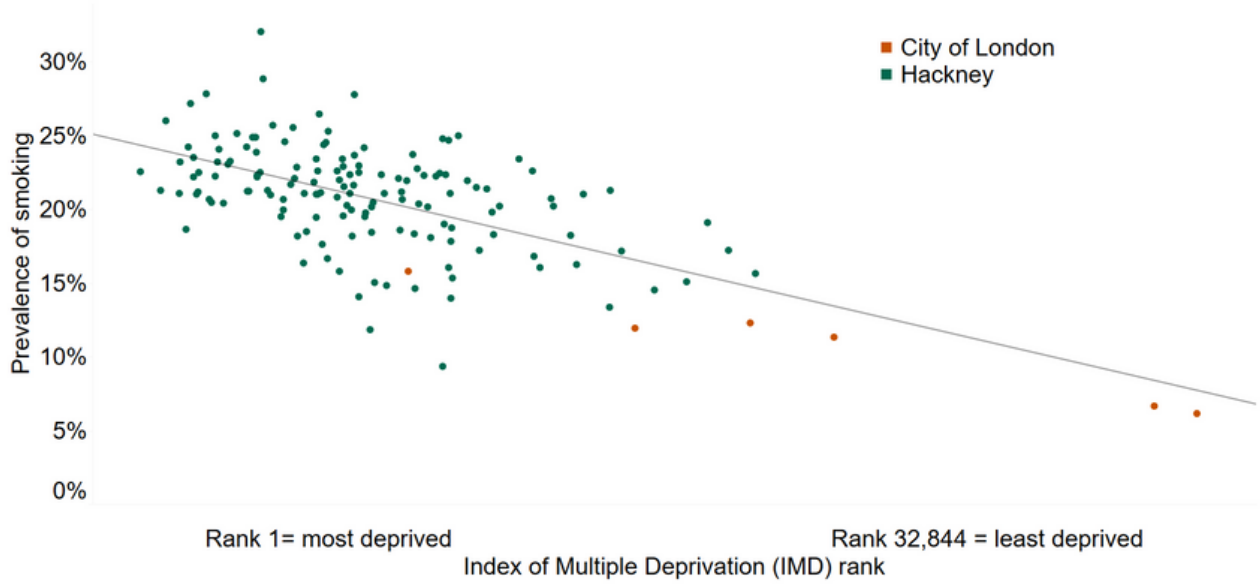


Data source: Clinical Effectiveness Group, East London Database, 2022. (28)
Notes: Lower Layer Super Output Areas (LSOAs) are small geographical areas consistent in population size (between 1000 and 1500 residents).

Socioeconomic status

Across the whole of the City and Hackney smoking prevalence is strongly positively correlated with area deprivation. This generally means that as area deprivation increases, so does smoking prevalence in that area (Figure 11). (28)

Figure 11: Correlation of LSOA level smoking prevalence and area deprivation (IMD rank), City and Hackney, 2022

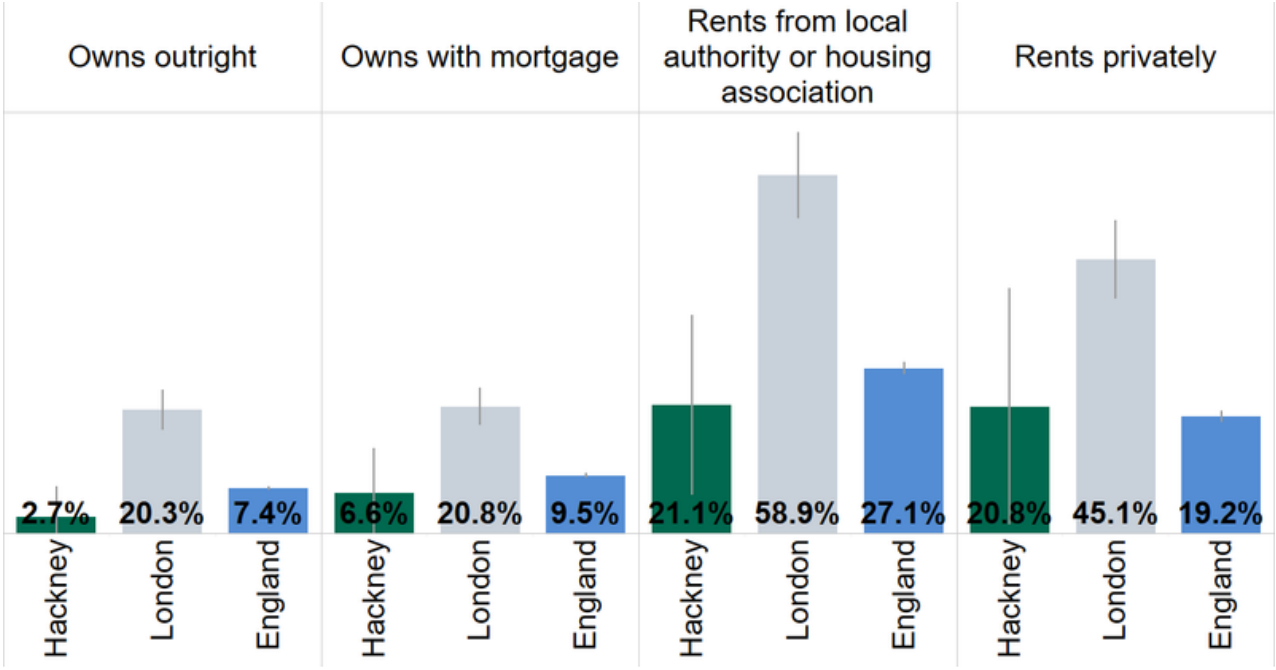


Data source: Clinical Effectiveness Group, East London Database, 2022 (28)
Ministry of Housing, Communities & Local Government, IMD, 2019.
Notes: The index of multiple deprivation (IMD) is an area-based indicator of deprivation across a range of domains (income, employment, education, health, crime, barriers to housing & services and living environment) in England. National quintiles have been used here. The denominator for the prevalence estimate is the total population with smoking status recorded in the last 5 years (from 2017/18 to 2021/22). Lower Layer Super Output Areas (LSOAs) are small geographical areas consistent in population size (between 1000 and 1500 residents).

Smoking prevalence also varies by other socioeconomic characteristics, such as occupation and housing tenure: [3]

- **Occupation**: People in **routine and manual** occupations are the most likely to smoke. The most recent data for Hackney (2020) show that smoking prevalence varied from around 10% among those working in managerial and professional occupations to around 25% among residents employed in routine and manual occupations. (8) [4]
- **Housing tenure**: In Hackney in 2021, adults living in **social housing** (that is renting from a local authority or housing association) were almost eight times more likely to smoke, and those renting privately were about seven times more likely to smoke than residents who owned their house outright (Figure 12).

Figure 12: Smoking prevalence in adults (18+) by housing tenure for Hackney, London and England, 2021.



Data source: OHID, Fingertips, 2023. (34)
Note: Data not available for the City of London.

National evidence shows that higher rates of smoking are also observed across many other indicators of social disadvantage, including among people with no qualifications and those who receive income support. (32) Local data are not available for analysis.

When combined with the individual economic cost of smoking, these patterns act to further exacerbate inequalities. Research by ASH Scotland suggests that poorer households spend almost 30% of their income on tobacco. This is about **ten times more** than the proportion estimated to be spent by households in the highest income group, which is around 3%. (33)

[3] Equivalent data broken down by occupation or housing tenure are not available for the City of London.
[4] This difference was not statistically significant, most likely as a result of small sample sizes.

Vulnerable groups

Smoking prevalence is higher in certain vulnerable population groups, including the following.

- **Severe mental illness (SMI)**: The prevalence of GP-recorded smoking among adults (18+) in 2022 was significantly higher among those diagnosed with SMI in Hackney (around 41%) and the City of London (around 20%), compared to adults without SMI (around 21% and 10%, respectively). (28) This is thought to be linked to lower levels of health literacy and social factors such as small or poor social networks (35-36). People with SMI are also more likely on average to have a history of substance use (see below) than the wider population. (37)

- **Substance use**: A significantly higher proportion of adult Hackney residents (18+) with GP-recorded substance use issues were smokers (around 72%), compared to those without a record of substance use (around 21%) in 2022. (28) Less than five people who were both smokers and substance users were recorded in the City of London.

- **Homeless**: Homeless adults (18+) in Hackney and the City of London are significantly more likely to smoke than those who are not homeless. Among those registered with a GP across NEL in 2022, around 55% of homeless people in Hackney and 71% in the City of London were recorded as smokers, compared to 21% and 10%, respectively, among those who were not homeless. (28)

- **Lesbian, gay and bisexual**: Nationally, more lesbian, gay and bisexual adults (27%) than heterosexual adults (18%) were current smokers in 2021. (38) Local primary care data have low level of completeness when it comes to sexual orientation and were, therefore, excluded from the analysis.

City of London and Hackney residents with GP-recorded **learning disabilities** are significantly less likely to smoke (around 15%) than the general population (around 21%). (28) However, underlying smoking prevalence in the wider population with learning disabilities is likely to be underestimated. This is because less is known about those with milder learning disabilities who may not be identified on GP records and, due to their greater independence, they may be more likely to smoke. (39)

Pregnant women

Smoking in pregnancy has well-documented detrimental effects on the growth and development of the baby and the health of the mother. In 2021/22, 4.5% of pregnant women were recorded as smokers at the time of delivery in City and Hackney combined (N=173), which is similar to London (4.5%) and Hackney's statistical neighbours (4.3%), and lower than England (9.1%). (1) Reported smoking prevalence at the time of delivery has been relatively stable in the last 10 years locally.

It is, however, worth noting that the recorded prevalence of smoking at the time of delivery is likely to be underestimated due to the stigma attached to reporting smoking status in pregnancy. (40) In addition, methods used to ascertain smoking in pregnancy (self-reported vs CO validated) vary between different areas. Moreover, the high number of births in the local Orthodox Jewish community, where smoking rates are thought to be low, is likely to skew overall prevalence in Hackney in particular. (41-42) Comparisons presented here should therefore be treated with caution.

As part of this needs assessment, insight was gathered from women who were currently pregnant or had a baby in the last year and were current or ex-smokers. A selection of the findings are summarised in Box 3 below. This local insight confirms the complexity of quitting in pregnancy, with women aware of the harms of smoking to themselves and their babies, but struggling with nicotine addiction and willpower to quit.

Box 3: Local insight gathered from pregnant and postpartum women

Pregnant and recently postpartum women were all aware of the health risks of smoking during pregnancy, both to themselves and their unborn babies. They recalled having conversations with various health professionals they encountered over the course of their pregnancy (for example, doctors and midwives) about the health harms:

"Of course, I know it's bad for me and my unborn child, it's very important if I can quit, I know it's extremely important to want to stop. It will reduce the risk of terminating pregnancy."

Despite knowing the harm to health, they expressed difficulty in quitting due to the 'enjoyment' of smoking. This was similar to views expressed by other smokers.

"Smoking makes me feel better, sometimes I do feel guilty that I shouldn't be doing it, it's making me feel good so I do it, but [I feel] guilt that health wise you shouldn't be doing this."

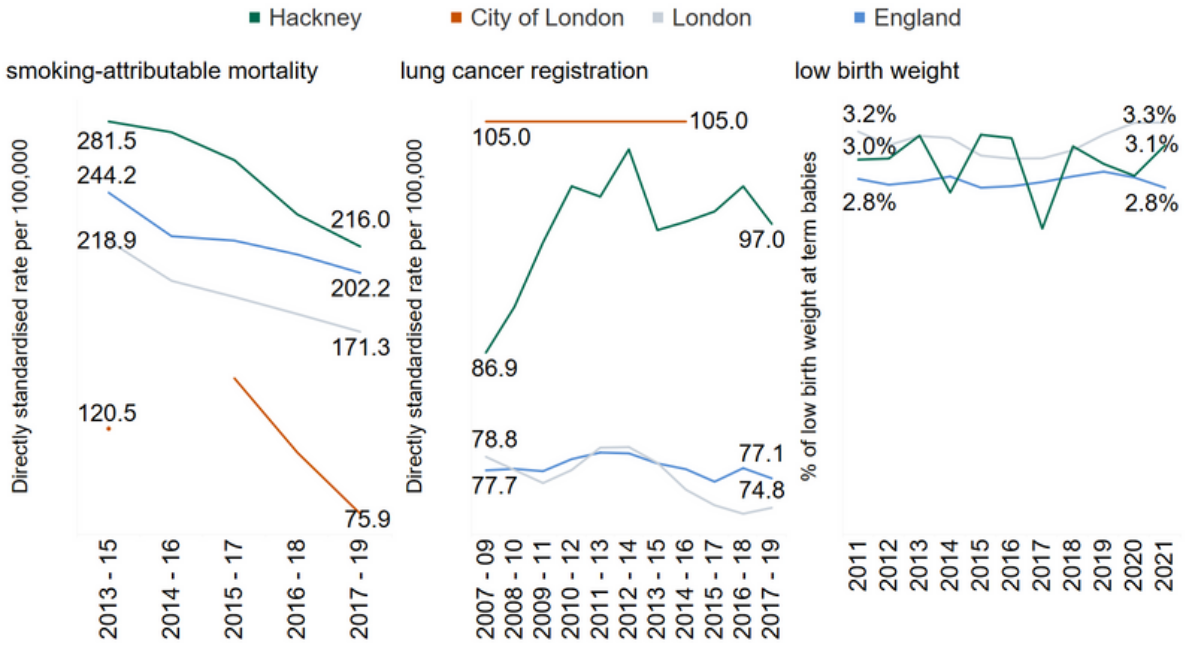
MORTALITY AND SMOKING-RELATED HEALTH OUTCOMES

As described in the introduction to this report, smoking is a major cause of premature mortality and serious health problems such as cancer, heart disease, stroke, lung diseases, diabetes, and chronic obstructive pulmonary disease (COPD, including emphysema and chronic bronchitis).

Figure 13 shows that smoking-attributable mortality rates in Hackney fell by 30% between 2013-15 and 2017-19. Despite this decrease, mortality rates in Hackney remain significantly higher than the London average. In contrast, the smoking-attributable mortality rate for the City of London remains significantly below the Hackney, London, and England average. However, caution is needed when interpreting City findings due to very small numbers (11 deaths in 2017-19).

Locally, lung cancer registrations also remain significantly above the London and England averages, while the low birth rate is broadly in line with regional and national trends (Figure 13).

Figure 13: Trends in smoking-related health outcomes, City of London and Hackney.



Source: OHID, Fingertips, 2022. (24)

Notes: For the indicator "smoking-attributable mortality", City rates were statistically significantly lower than London and England in all periods but from 2015-17. Hackney rates were statistically significantly higher than London and England up to 2015-17 and statistically higher than London only from this period. For the indicator "lung cancer registration", the City of London and Hackney were combined from 2016-18. Rates for both City and Hackney combined or separately were higher than London and England since 2008-10. For the indicator "low birth weight", the City of London and Hackney were combined, except for 2016 and 2017, which includes Hackney-only data. For this indicator, there was no statistically significant difference between City and Hackney and both London and England since 2011.

4. EVIDENCE AND GOOD PRACTICE

There is a wealth of evidence and good practice guidance available to guide comprehensive action at the national and local levels to reduce the significant harms of tobacco smoking. The 2022 Khan review made 15 recommendations to ensure the Government's 'smoke-free 2030' target is met (see Section 2 for more details), including three 'critical' interventions requiring national action:

1. urgently invest an additional £125m per year in tobacco control (preferably through a tobacco industry levy)
2. raise the age of sale of tobacco from 18, by one year, every year
3. NHS to prioritise further action to stop people smoking.

The government has announced a range of proposed measures to create a 'smoke-free generation' that responds to most, but not all, of the Khan review recommendations (again, see Section 2).

Complementing the Khan review recommendations, ASH has made its recommendations for local partnership action across 10 'high impact' areas, as part of a comprehensive tobacco control strategy (again as described in Section 2).

The National Institute for Health and Care Excellence (NICE) has published a wealth of evidence-based guidance on tobacco control and smoking. (43) Much of this has recently been consolidated into a single guidance document, published in 2021 and last updated in January 2023: **NG209 Tobacco: preventing uptake, promoting quitting and treating dependence**. This is complemented by Quality Standard **QS207 - Tobacco: treating dependence** (last updated December 2022). This latest guidance sets out a range of recommendations relevant to smoking prevention; identification and early intervention; plus treatment, care and support. The remainder of this section provides further detail on evidence-based approaches under each of these headings, as well as e-cigarettes and workplace interventions.

PREVENTION OF SMOKING UPTAKE

Young people are more likely to start smoking tobacco if they live with a parent, carer, or sibling who smokes. (27) Other factors influencing smoking uptake include smoking by friends and peer group members, the ease with which young people can obtain cigarettes (often illegally), exposure to tobacco marketing, and depictions of smoking in films, television, and other media. (9) Therefore, to be successful in preventing smoking uptake, it is not sufficient to focus on youth-targeted interventions alone.

Other elements of tobacco control activity - such as tackling the sale of cheap or illegal tobacco and proxy purchasing, and reducing exposure to secondhand smoke through national legislation and smoke-free policies - also support work to prevent smoking uptake (44). Illegal tobacco is a public health concern because it undermines efforts to reduce the impact of smoking by offering a cheaper alternative to people who may otherwise be persuaded to quit because of the expense. Illicit tobacco has not been subjected to quality control and may contain even more harmful chemicals and toxins compared to their legal counterparts. There is also a concern with such products being cheaper and easier to access by children and young people. Supporting retailers to avoid illegal tobacco (and vape) sales is a key recommendation in NICE NG209, for example through training and guidance, test purchases, improved inspection and enforcement through partnership action, and campaigns to publicise legislation.

School-based interventions have also been effective in reducing smoking uptake. (44) NICE NG209 recommends taking a coordinated approach to school-based interventions that are evidence-based, linked to the school's smoke-free policy and integrated into the curriculum. The school should develop an organisation-wide smoke-free policy in consultation with staff and young people that includes prevention activities (led by staff or young people themselves) and training and development for staff. The policy should apply widely to anyone using the school premises (including caretakers and facilities maintenance staff) and shouldn't allow designated smoking areas on the premises.

School-based interventions should be led by both adults and young people (peers), if appropriate. They should feature the health effects of tobacco use, as well as the wider legal, economic and social aspects of smoking. The interventions should encourage family participation where possible. In secondary schools and further education settings, interventions should be peer-led, both formally and informally, and aim to challenge the norms on smoking.

NICE also recommends using targeted mass media and advocacy campaigns to prevent the uptake of smoking among young people. (45)

IDENTIFICATION AND EARLY INTERVENTION

All frontline health and care staff can play a key role in identifying smokers, delivering very brief advice (VBA), and referring people to local stop smoking services (SSS). (45) This is in line with the Making Every Contact Count (MECC) agenda (see Box 4 below) and with NICE guidance on identifying and supporting people most at risk of dying early from cardiovascular disease (CVD). (46,47) In particular, owing to the links between CVD, social deprivation, and smoking, targeting adults who are disadvantaged and at high risk of premature death from CVD is recommended.

Box 4: The making every contact count (MECC) approach

The MECC approach is about using the power of very brief conversations to help people to stay well, access the support they need and generally cope better in these challenging times. MECC training empowers staff and volunteers to have opportunistic, strengths-based conversations with residents to improve their health and wellbeing. At a population level, very brief advice has been shown to be effective in improving the uptake of preventative services and modifying health-harming behaviours. MECC can support conversations on a range of 'traditional' public health topics (for example healthy weight, physical activity, tobacco, alcohol, mental wellbeing, vaccine uptake) as well as conversations around wider determinants of health (for example housing, employment, financial support).

Supporting pregnant women to stop smoking

Given the significant harm from smoking during pregnancy, NICE recommends that pregnant women are provided with routine carbon monoxide (CO) testing at the first antenatal appointment and at the 36-week appointment, to assess every pregnant woman's exposure to tobacco smoke. (44) If the pregnant woman smokes, is in the process of quitting, used to smoke, or tested with 4 ppm or above at the first antenatal appointment, CO testing at all other antenatal appointments is recommended.

NICE also recommends that an opt-out referral to local SSS is provided for all pregnant women who say they smoke or have stopped smoking in the past 2 weeks, have a CO reading of 4 ppm or above or have previously been provided with an opt-out referral but have not yet engaged with stop smoking support. (45)

NHS Long Term Plan

The NHS Long Term Plan states that by 2023/24, NHS-funded tobacco dependency treatment services will be offered to:

- anyone admitted overnight to a hospital who smokes
- pregnant women and members of their household
- long-term users of specialist mental health services.

These tobacco dependency services, currently being rolled out across England, have a key role in identifying those with smoking-related health conditions and referring them to in-house support and/or to community SSS, depending on local arrangements.

TREATMENT, CARE AND SUPPORT

Targeted, high-quality SSS are a necessary, although not sufficient, component of cost-effective tobacco control strategies. Research shows that people who access evidence-based SSS are three times as likely to quit as if they tried to go it alone. (48) A summary of current NICE guidelines on delivery of SSS can be found in Box 5 below. (44) Further detailed guidance for providers and commissioners of SSS are produced by the National Centre for Smoking Cessation and Training (NCSCT). (49)

Box 5: Summary of current NICE recommendations for delivery of stop smoking interventions (45)

- All people who smoke should be made aware of the range of interventions available to help them stop smoking and how to access them.
- The most effective stop smoking intervention for adults (age 18+) involves a combination of the following:
  - behavioural support (individual and/or group)
  - medicinally licensed products (including varenicline and short/long acting nicotine replacement therapy, NRT) and/or
  - nicotine-containing e-cigarettes.[5]
- NRT can be considered for young people aged 12 and over who are smoking and dependent on tobacco, in combination with behavioural support.
- The intervention should be flexible to the needs and preferences of smokers and agreed in discussion with them.
- Services should aim to treat at least 5% of the estimated local population who smoke, and aim for a success rate of at least 35% of service users having quit at four weeks (validated by CO monitoring) - four week quitters are much more likely to remain smoke free once they reach this point
- Success should be validated by a CO monitor reading of less than 10 ppm of CO in their exhaled breath four weeks after the quit date. This does not imply that treatment should stop at four weeks.
- Those who do not want, or are not ready, to stop smoking in one go should be supported to reduce the amount they smoke, as part of a harm reduction approach.

Source: NICE, 2023 (45)

[5]As of August 2022, varenicline (Champix) has been unavailable in the UK. A new prescription only drug (cytisine) has been developed, which works in a similar way to reduce withdrawal symptoms and urges to smoke. Cytisine is due to be launched on the UK market in January 2024.

E-CIGARETTES

Nicotine-containing e-cigarettes are now recommended as a 'first line' smoking quit aid for adults (age 18+) who smoke. For those who are not ready, willing or able to stop in one step, e-cigarettes can also be used as part of a harm reduction approach, to support people in reducing the amount they smoke. (44)

E-cigarette use has increased significantly in recent years in the UK, both among adults and young people. A recently published survey from ASH found that in 2023 around 21% of children aged between 11 and 17 had tried vaping, up from 16% in 2022 and 14% in 2020; the 50% growth in experimentation (trying once or twice) from 8% in 2022 to 12% in 2023 was significant, while the change in current vaping (from 7% to 9%) was not. (50) Among adults (18+), regular e-cigarette use was estimated at around 7% of the population in 2022. (51)

There is now good evidence that e-cigarettes are an effective stop-smoking aid (52): e-cigarettes remain the most common aid used by people to help them stop smoking and were associated with the highest quit rates in SSS in 2020/21 (65% of quit attempts involving vaping products were successful compared with 58.6% of attempts not involving a vaping product) (52). The most popular device in 2022 remained tank-type products (used by 64% of adult vapers) but the popularity of disposable vaping products has increased from 2% in 2021 to 15% in 2022 among adults. (51) Disposable vapes are particularly attractive to children and young people (aged 11 to 17), with use increasing dramatically in recent years - from 5% in 2020 to 53% in 2022. (50) As well as concerns about appealing to children, disposable vapes are detrimental to the environment.

E-cigarettes are an effective stop-smoking aid for adults, but should be strongly discouraged among non-smokers

The most comprehensive evidence review of e-cigarettes to date recently confirmed that the use of such devices poses a fraction of the risks of tobacco smoking in the short to medium term. (51) However, this does not mean e-cigarettes are risk-free and further research is required to examine the longer-term health effects of vaping. (51) Despite this, a significant proportion of both adult and younger populations continue to believe, incorrectly, that vaping is at least as harmful as smoking, with this misperception becoming more prevalent (in 2022, just 45% of adults and 42% of 11 to 17-year-old believed that e-cigarettes were less harmful than cigarettes). Evidence suggests that education and communication around the absolute and relative risks of e-cigarette use is effective in changing these misperceptions. (51)

Counterfeit e-cigarettes have not been subjected to quality control and may contain many harmful chemicals and toxins compared to their legal counterparts. The government has published guidance on e-cigarette regulation, which is used to guide enforcement activity by Trading Standards colleagues. (53) They have also announced funding to support investigations into underage sales and usage of e-cigarettes, which will guide a review of current legislation and possible new legislation to strengthen sanctions. Supporting retailers to avoid illegal e-cigarette sales is a key recommendation in NICE NG209, for example through training and guidance, test purchases, improved inspection, and enforcement through partnership action and campaigns to publicise legislation.

It is possible that e-cigarette use in younger populations could be a 'gateway' to tobacco smoking, increasing smoking initiation. (54) There is no clear evidence of this to date, but these trends are being closely monitored by ASH to further guide tobacco control work.

School-based, peer-led interventions covering the impacts of using e-cigarettes and clarifying myths surrounding their use can be useful. (55) E-cigarettes should be discussed separately from tobacco products and it should be made clear that anyone who doesn't smoke should avoid e-cigarettes. There are resources available to support this work, such as the ASH youth vaping resources. (56) OHID has also produced a new resource pack for schools on vaping, aimed at Years 7 and 8 (ages 11 to 13), featuring films made with young people in which they talk in their own words about the issues around vaping, as well as a clear presentation of the latest evidence. (57)

WORKPLACE INTERVENTIONS

The workplace presents an opportunity to encourage and facilitate action on smoking. There is specific NICE guidance on how to encourage and support employees to stop smoking. Recommendations are outlined below. (45)

1. Employers should develop a smoking cessation policy, provide employees with information on local SSS, publicise local interventions, and allow staff time off to attend smoking cessation services.

2. Employees and their representatives should encourage employers to provide advice, guidance and support to help employees who want to stop smoking.

5. LOCAL RESPONSE

There is a strong local commitment to taking broad action on tobacco control. Hackney Council signed up to the Local Government Declaration on Tobacco Control (13) in 2014 and, in 2018, NHS partners Homerton Healthcare Foundation Trust, East London Foundation Trust (ELFT) and the GP Confederation all signed the NHS Smoke free Pledge.

Local partnership action on tobacco control is overseen by a Tobacco Control Alliance (TCA), which is chaired by Hackney Council Cabinet Member for Health and has membership across a broad range of local authority services, the NHS and voluntary sector, as well as the locally commissioned SSS provider. The work of the TCA is guided by ASH's 10 'high impact' local actions (see Section 2) and its priorities shaped by the outputs of a recently refreshed self and peer assessment, using the CLeaR (Challenge, Leadership and Results) tool. (58) At the time of writing, the current partnership priorities of the TCA are described in Box 6.

Box 6: Local Tobacco Control Alliance partnership priorities 2023

1. Re-set our strategic approach through senior level re-engagement, and ensure alignment of tobacco control priorities with the Health & Wellbeing Strategy implementation plans and City & Hackney Place Based Partnership delivery plan.
2. Develop and implement a proactive, coordinated approach to local communications about smoking - consistent messaging, maximise use of all available channels, focused on high prevalence communities/groups, measure impact.
3. Co-design a new stop smoking service that is explicitly focused on reducing stubborn inequalities in smoking prevalence and addresses the needs of disadvantaged communities.
4. Ensure careful coordination (and effective communication) of NHS and local authority funded tobacco dependency and stop smoking treatment pathways.
5. Review/refresh our approach to smoke free environments - including promotion of smoke free homes (including training and comms) and social housing public spaces, and refresh of NHS and local authority smoke free policies.
6. Better enable young people to live smoke free by 'denormalising' smoking - targeted comms for parents who smoke, continue work to reduce supply of illegal tobacco (and vapes, see below), education outreach, youth engagement (e.g. system influencers, youth leaders, young black men inspirational leaders).
7. Review and strengthen coordinated system-wide action to address illegal and niche tobacco use.
8. Improve local understanding of how to maximise the benefits and balance the risk of using e-cigarettes and agree a partnership position to inform our local communications and service delivery.

PREVENTION OF SMOKING UPTAKE

There are a number of local initiatives to support the prevention of tobacco smoking uptake.

Illicit tobacco

City and Hackney Public Health Service fund a senior Trading Standards Officer role to focus on illicit tobacco and alcohol enforcement work. The overall aim is to reduce access to tobacco, illegal tobacco, counterfeit alcohol and underage sales in City and Hackney. This enforcement work helps to support wider tobacco control efforts in reducing the available supply of cheap tobacco, as this can undermine efforts to support smokers to quit.

This joint work has been undertaken in Hackney since 2019 and since 2022 has expanded to include a partnership with the City of London Corporation Trading Standards team to widen the scope of the work. More recently, the focus has also shifted to enforcement work around underage and illicit sales of e-cigarettes (see later in this section).

Prevention work in schools

At the time of writing, a health and wellbeing education outreach service (funded by Public Health and delivered by Hackney Council's young people's service) was leading work with primary and secondary schools to offer a suite of personal, social, health and economic education (PSHE) and relationship and sex education (RSE) curriculum topics. This includes lessons for pupils on the harms of smoking and the use of nicotine-containing electronic cigarettes, with 20 lessons delivered between May 2019 to July 2023. In addition, drop-in information sessions are offered, where the harms of smoking are presented as one of a range of health and wellbeing topics.

The local insight gathered from young people (aged 16 to 25) as part of this needs assessment showed that school-based education sessions are a useful way to raise awareness of the harms of smoking and prevent uptake.

IDENTIFICATION AND EARLY INTERVENTION

Nationally recognised training on smoking very brief advice (VBA) is available to all frontline staff and volunteers working in the City of London and Hackney through the local SSS. At the time of writing, over 1,000 people have been trained in VBA since 2018. This is complemented by a local offer of MECC training, covering a broad range of public health issues (including smoking). Since 2018, more than 1,800 staff and volunteers have been trained in MECC across the City and Hackney (at the time of writing).

General practice

Smoking status is assessed in primary care settings in several ways: new patients are asked when they register with the GP surgery, patients with a long-term condition are routinely asked their smoking status at their annual review appointments, and patients without a long-term condition will be asked opportunistically if their smoking status record is correct. This can be done by practice nurses, healthcare assistants, GPs, or reception staff members. Practices also send out messages to smokers about stop smoking support. This usually has a facility for patients to text back to update their smoking status if this is incorrect.

NHS Health Checks

The NHS Health Check service targets adults aged 40-74 to assess their risk of CVD and offer early preventative advice and support to reduce this risk. It helps spot early signs of heart disease, stroke, diabetes, kidney disease and dementia, and provides people with advice on how to reduce the risk of disease (such as through quitting smoking) and facilitates referrals to relevant local services (such as SSS). The NHS Health Check service in City and Hackney is commissioned by the local Public Health Team and is currently delivered through GP practices.

NHS targeted Lung Health Check programme

As described previously, smoking significantly increases the risk of lung cancer. Lung cancer causes more deaths than any other cancer in the UK and very often there are no early signs or symptoms. Lung health checks are being introduced for anyone aged between 55 and 74 who has ever smoked. The aim of the targeted Lung Health Check programme is to find lung cancer early, sometimes before an individual shows symptoms. Early diagnosis can make lung cancer more treatable and make treatment more successful.

Anyone who has been identified as a current smoker following a lung health check who would like support to quit is referred to a local SSS, providing an important early intervention opportunity for a group of high-risk smokers.

Lung health checks have recently been delivered in neighbouring north-east London boroughs, with good uptake. While this service does not currently exist locally, there is a proposal to roll out a targeted lung health check programme in City and Hackney in 2026/2027.

TREATMENT, CARE AND SUPPORT

Evidence-based support to quit for smokers aged 18+ is currently available through a local SSS, Smokefree City and Hackney. This service is commissioned by Public Health and delivered by telephone and in person from a range of community settings including GP practices, community pharmacies (via walk-in), hospitals and a number of other outreach locations.[6]

[6] This includes drug and alcohol services, health centres, City office buildings and (soon) in a library and via a mobile clinic.

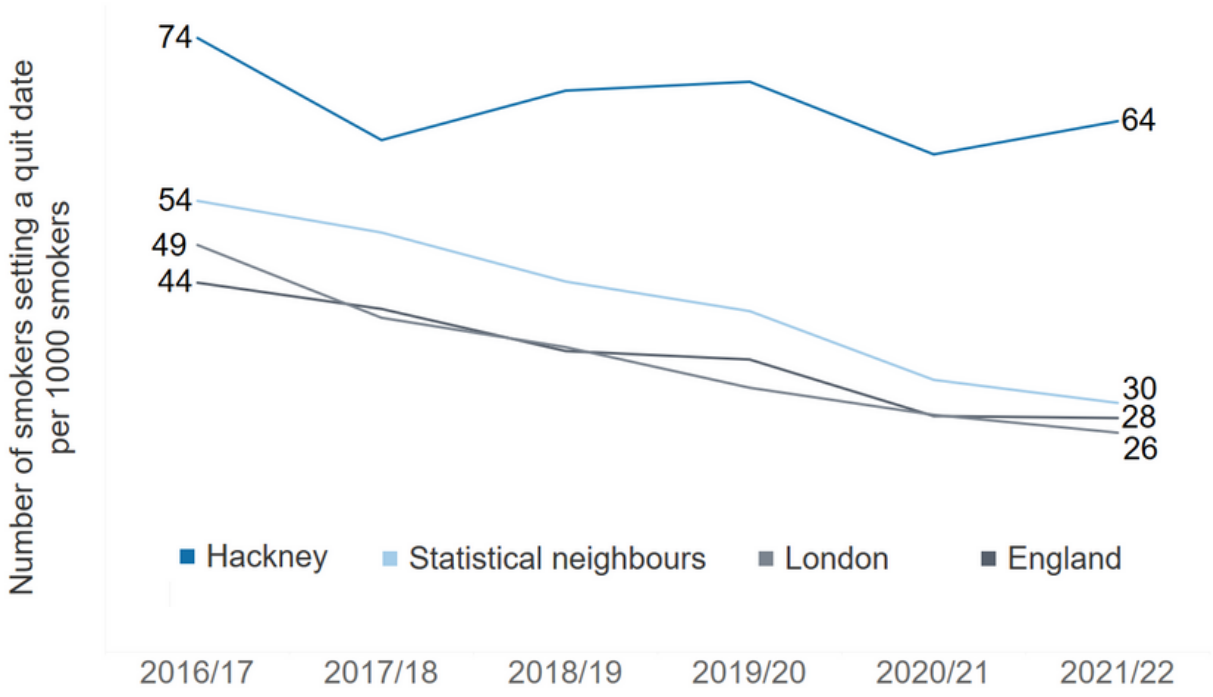
The Hackney-based SSS largely serves local residents (around 86% of people setting a quitting date in 2018-22 lived in Hackney). Most of City-based SSS clients are registered with a City GP (around 70% of people setting a quitting date in 2018-22), but most are not City residents (only around 38% are City residents). (59)[7]

Across both the City and Hackney, 2,132 people set a quit date with the SSS in 2021/22 (the latest full year of data available at the time of writing). (59) This represented 7% of the estimated number of smokers locally (see Section 3), which is above the NICE standard of 5% of the estimated local smoker population who should be treated each year. (44)

There has been a decrease in the rate of smokers setting a quit date over the past five years in Hackney, in line with trends observed elsewhere.[8] However, Hackney continues to outperform the average of its statistical neighbours, London, and England on this measure (Figure 14).

Despite this decline in the rate of smokers setting a quit date, 4-week quit rates in Hackney have remained broadly stable in recent years and above the London and England averages (Figure 15).[9] Locally, the percentage of those setting a quit date who had successfully quit at 4 weeks has consistently exceeded the target set by NICE (at least 35%), and in 2021/22 stood at 59%.[10]

Figure 14: Smokers setting setting a quit date (per 1,000 smokers) over time, Hackney and comparators



Data source: NHS Digital, Statistics on NHS stop smoking services

Notes: Smoking prevalence estimates at local authority level for those aged 18+ (calculated from the Annual Population Survey) were multiplied by the corresponding ONS mid-year population estimates for age 16+ to calculate the smoking population (denominator). A smoker is counted as a 'self-reported 4-week quitter' if s/he is a 'treated smoker', is assessed (face to face, by postal questionnaire or by telephone) 4 weeks after the designated quit date (minus 3 days or plus 14 days) and declares that s/he has not smoked even a single puff on a cigarette in the past 2 weeks. (49)

[7] Data on the number of City workers accessing the service are not available.

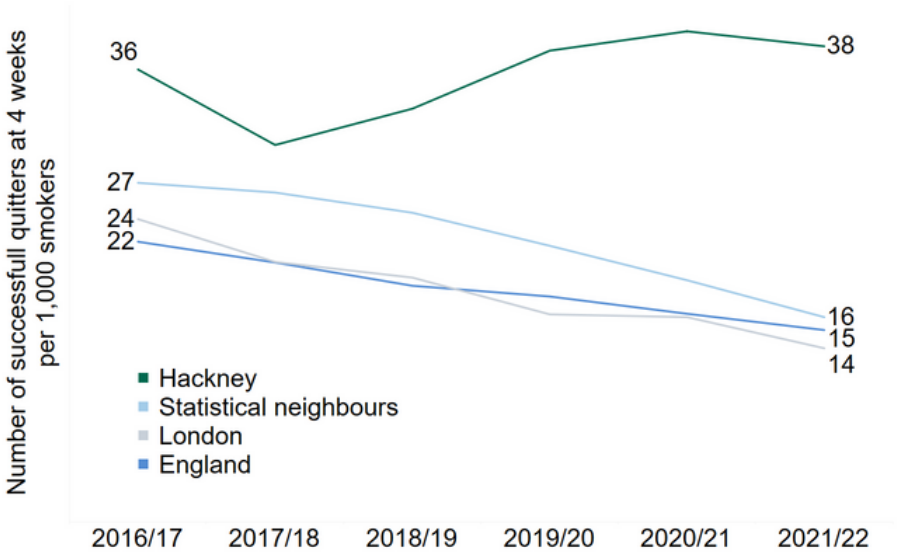
[8] Data for the City of London are not available.

[9] The main quality standard for local stop smoking services.

[10] Please note, this figure is based on self-reported quits, due the suspension of CO monitoring (used to validate successful quit attempts) during the coronavirus pandemic.

Figure 15: Smokers that have successfully quit at 4 weeks (per 1,000 smokers) over time, Hackney and comparators

Data source: NHS Digital, Statistics on NHS stop smoking services
Notes: See Figure 14 notes.



Most people (76%) set a quit date with the local SSS through their GP. Those accessing via community pharmacies were the least likely to successfully quit at 4 weeks (Table 2).

Table 2: Number of clients who set a quit date and % success at 4 weeks, City and Hackney, 2021/22

Intervention Setting	Number of clients who set a quit date	% of those setting a quit date who successfully quit at 4 weeks
GP setting	1,617	60.8%
Pharmacy setting	316	44.1%
Community setting	134	63.4%
Hospital setting	60	56.5%
Total	**2,127**	**58.4%**

Data source: Smokefree City and Hackney, 2023
Notes: Information on intervention setting is missing for 23 people.

Pregnant women

In 2021/22, 53 pregnant women in City and Hackney set a quit date with the local SSS, 26 were successful quitters at 4 weeks (49% of those setting a quit date). These represent lower success rates than were seen across the general population.

Local NHS tobacco dependency treatment pathways

The NHS tobacco dependency treatment services within Homerton Healthcare NHS Foundation Trust (acute and maternity) and East London Foundation Trust (mental health) are currently being developed (December 2023). Integrated pathways are being established with the community SSS to ensure a streamlined local offer as part of a patient's healthcare journey, from inpatient stay through to post-hospital discharge support. A new national pharmacy SSS (the Advanced Pharmacy Service) is also in place, which will enable NHS trusts to refer patients to a community pharmacy of their choice to continue their treatment following hospital discharge. Many City and Hackney pharmacies are already signed up for this scheme and will deliver this service, providing additional choices for patients on top of the locally commissioned SSS.

Local insights

Boxes 7 and 8 summarise relevant local insights from young people and key high-smoking prevalence communities, respectively, gathered to inform this needs assessment. The insights highlight the importance of offering a variety of options for accessing support to quit, including different locations and formats (for example face to face and virtual options). Some people felt that a service offer that was more discreet and convenient to access would potentially reduce the stigma that might otherwise discourage them from accessing support to quit.

Box 7: Local insight gathered from young people

Young people (aged 16 to 25) were also asked about the stop smoking service (SSS). They showed a good awareness of SSSs, despite the current SSS not being directly promoted to their age group (17 and below); 60% stated they could go to the NHS SSS or to their GP to access support. They mentioned seeing promotional materials from the local SSS (Smokefree City and Hackney) in their GP surgeries and local pharmacies. One person mentioned hearing about the service through the City and Hackney Young People's Service (CHYPS+). Fewer young people (40%) were aware of what that support entailed.

Some young people suggested using social media to attract young people to health services (in general) in an engaging way, for example using animations rather than actors to make young people feel less judged for smoking. They also spoke about the importance of stopping young people from smoking in the first place by offering education and awareness raising in schools.

Box 8: Local insight gathered from Turkish, Cypriot and Kurdish residents, black Caribbean residents (high smoking prevalence communities)

Residents talked about quitting smoking using a range of methods, including "going it alone", using a stop smoking service and switching to nicotine containing e-cigarettes.

"I got rid of cigarettes, ash trays, and alcohol. And when I would go out, I sat in the no-smoking section. I got rid of any reminders in my house. But 6 months is difficult. When I see someone smoking, it makes me want to smoke a cigarette".

Residents in these groups cited health reasons as an important reason to quit, and those who had managed to quit reported noticing improvments in their health as a result.

"I was surprised personally how many bad things are in tobacco like tar and mouse poison. The sticky stuff and you pay your money to kill yourself".

"[Since quitting] I now have more energy now and can move more. I can now walk a bit".

Being able to access support via non-health settings was deemed to be important for some in encouraging the uptake of an SSS, by reducing the stigma and 'shame' in seeking support.

"[Services should be offered at] a community centre or youth centre rather than hospital or clinic or GP, everyone can see you entering. People might see me and judge me".

"Personally I wouldn't go to a pharmacy, I'm Muslim, my culture and religion plays a part so I wouldn't really go to pharmacy and openly say that [I need help to stop smoking], someone might see me".

Insight was also gathered from people who had used the Smokefree City and Hackney service to quit smoking. When asked about what would make it easier to quit, smokers and ex-smokers said having support available beyond the 12-week treatment period currently offered would potentially prevent them from relapsing and going back to smoking. One resident suggested this could be in the form of a 'buddy system', whereby other ex-smokers could provide them with support and advice. They felt their first-hand experience of stopping smoking would help the advice feel more relevant and trusted.

Many previous service users reported that speaking to their GP was the trigger for them accessing the SSS. This echoes feedback received from GPs, who perceive that patients expect to be asked about their smoking status. This suggests that providing VBA training to enable consistent messages to be promoted through healthcare professionals, including GPs, about support available to quit and the benefits of doing so can influence whether smokers go on to eventually seek out this support.

Further relevant insights gathered from GPs to inform this needs assessment are summarised in Box 9.

Box 9: Local insight gathered from GPs

GPs who provided feedback perceived that some patients were reluctant to discuss smoking and felt "humiliated by something they may already feel ashamed and embarrassed about".

They identified the importance of self-referral for many patients, indicating this is an important element to retain:
"My understanding is that if clinicians refer patients they don't attend and patients are much more likely to attend if they are able to refer themselves. Something to do with agency".

When asked about changes to the existing service, GPs had some suggestions including providing support to people after they had quit to prevent relapse (as highlighted by ex-smokers). They also expressed support for a GP-based stop smoking service delivery model, where there are stop-smoking advisors within the practice.

INEQUALITIES IN ACCESS

This section describes inequalities in the local stop-smoking pathway, comparing the characteristics of smokers to those setting a quit date and successfully quitting at four weeks. As such, it provides evidence of an unmet need to access specialist support to quit.

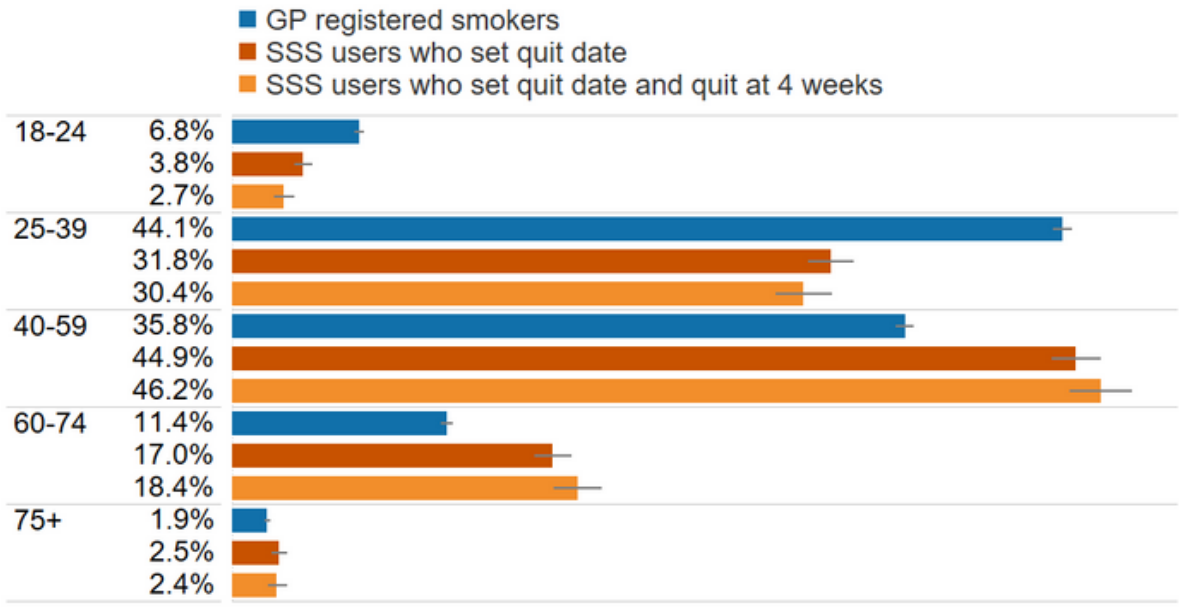
Data on the characteristics of City and Hackney residents who were smokers were taken from GP records (28) and from the APS (24) (see Section 4). Data on the characteristics of those setting a quit date and 4-week quitters are from the local SSS, covering the period 1/07/2018 to 30/06/2022 (to create a larger sample size and allow for more detailed analysis). (59)

Demographic

Comparing the demographic profile of the City and Hackney adult (18+) smoking population to the characteristics of service users highlights a significant unmet need among some groups.

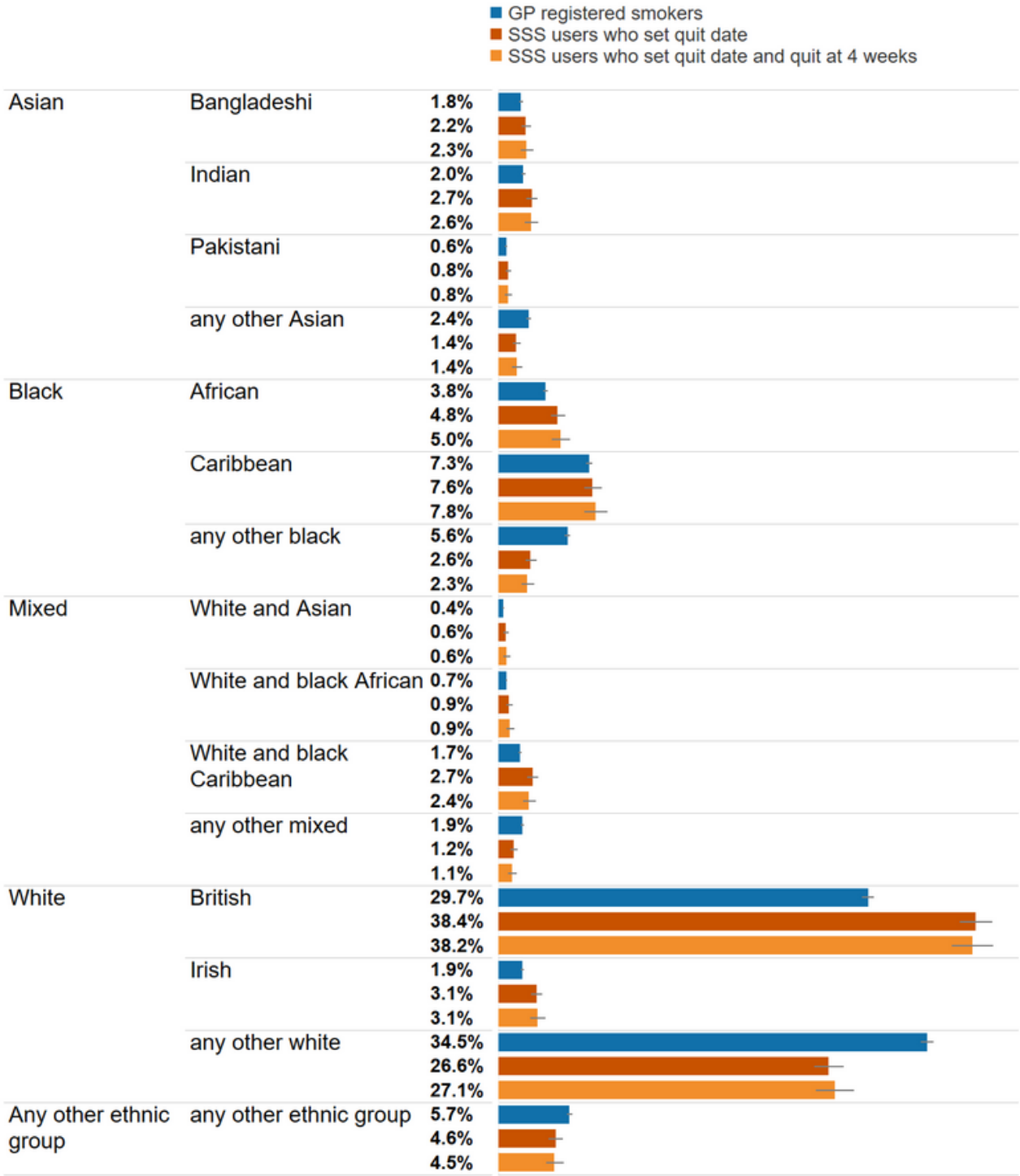
- **Younger adults** (18-39 years) are under-represented among service users (that is they represent a larger proportion of the local smoker population than the SSS user population), and residents aged 40 and older are over-represented (Figure 16).
- The **female** smoker population is over-represented in the service while the male population is under-represented: 43% of GP-recorded smokers are women, while 49% of those setting a quit date (and 49% of 4-week quitters) are women.
- Those classified as white ethnicity as well as black African, mixed white and black Caribbean, and white Irish people are over-represented among service users. **Under-represented** groups (that is where there is potential unmet need) include those of **'other' white**, **'other' black**, **'other' Asian** and **'any other' ethnicity** (Figure 17). The main groups within the 'other white' category are **Turkish, Kurdish or Cypriot** (making up more than 40% of this category), followed by people from **Eastern Europe** (at least 15% of this category) and **Western Europe** (accounting for more than 12%).

Figure 16: Comparison of the % of GP registered smokers and % of stop smoking service users (setting a quit date and quitting at 4 weeks) by age group, City and Hackney, 2018/19 to 2021/22



Data source: GP data - Clinical Effectiveness Group, East London Database, 2022; stop smoking service data - City and Hackney stop smoking service data between 01/07/2018 to 30/06/2022.

Figure 17: Comparison of the % of GP registered smokers and % of stop smoking service users (setting a quit date and quitting at 4 weeks) by age group, City and Hackney, 2018/19 to 2021/22



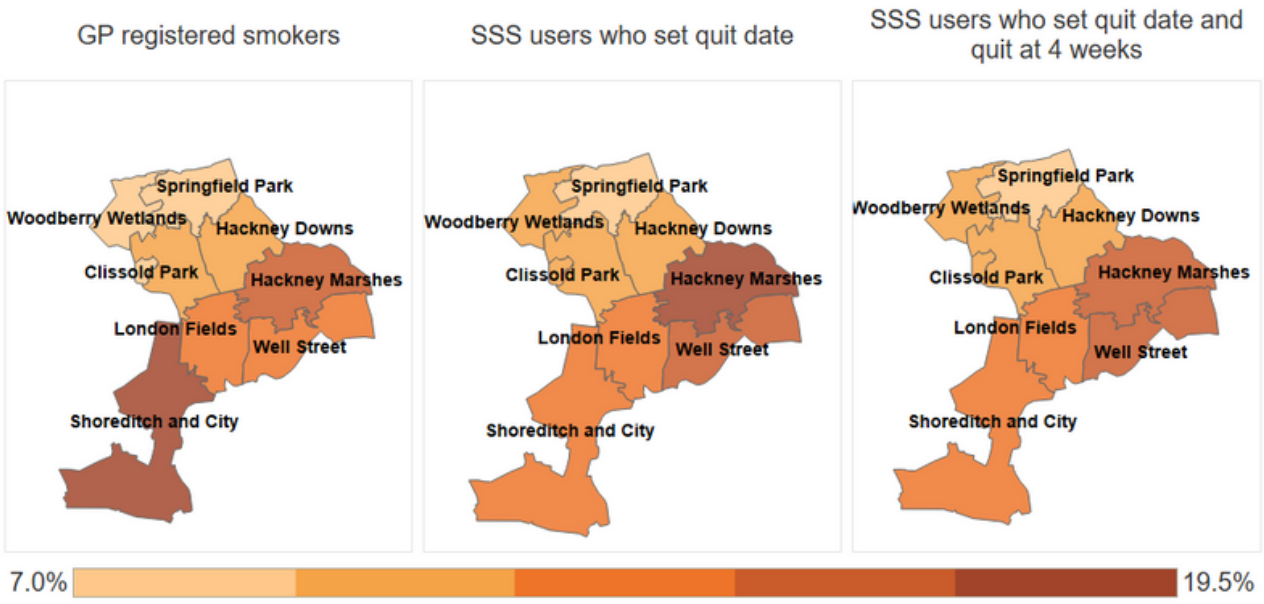
Data source: GP data - Clinical Effectiveness Group, East London Database, 2022; stop smoking service data - City and Hackney stop smoking service data between 01/07/2018 to 30/06/2022.

Of those who access the local SSS (that is set a quit date), the 4-week quit success rate is broadly the same across all demographic groups, except among those aged 18-24. Although the percentage of 4-week quitters in this age group is higher than recommended by NICE (42% compared to 35%), it is lower than among other age groups (55+). This suggests that there may be a need for **tailored treatment approaches for younger adults** to improve outcomes.

Geography

Figure 18 compares the percentage of GP-registered smokers who live in each Neighbourhood/PCN with the percentage of SSS users who live in each locality. The darker the colour, the higher the percentage. The figure shows that the percentage of smokers who live in Shoreditch Park and City Neighbourhood/PCN is higher than the percentage of service users who live in this area, which suggests some degree of unmet need in this locality. Conversely, smokers living in Well Street Common and Woodberry Wetlands appear to be over-represented among service users, that is, residents from these Neighbourhoods/PCNs access SSS at a higher rate compared with other localities.

Figure 18: Comparison of the % of GP registered smokers and % of stop smoking service users (setting a quit date and quitting at 4 weeks) by Neighbourhood/Primary Care Network (PCN), City and Hackney, 2018/19 to 2021/22

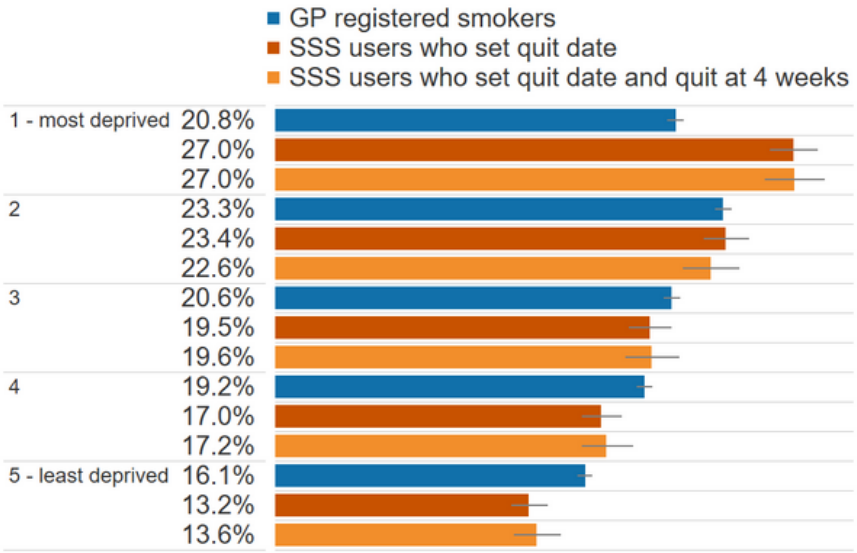


Data source: GP data - Clinical Effectiveness Group, East London Database, 2022; stop smoking service data - City and Hackney stop smoking service data between 01/07/2018 to 30/06/2022.

Socioeconomic factors

Service data suggest that the current SSS is successful at engaging with and supporting the most socially deprived smokers. Figure 19 indicates that smokers from the most deprived areas of Hackney and the City are over-represented among service users (both those setting a quit date and successfully quitting at 4 weeks). However, those living in the least deprived areas appear to be under-represented in the service.

Figure 19: Comparison of the % of GP registered smokers and % of stop smoking service users (setting a quit date and quitting at 4 weeks) by local deprivation quintile, City and Hackney, 2018/19 to 2021/22



Data source: GP data - Clinical Effectiveness Group, East London Database, 2022; stop smoking service data - City and Hackney stop smoking service data between 01/07/2018 to 30/06/2022.
Notes: The local deprivation categories determined by CEG show the variation of deprivation within City and Hackney. The scores were ranked and divided into five groups, each containing an equal number of LSOAs in City and Hackney.

Although information on the client's **occupation** is available in both population data and the SSS data, there is a mismatch between the categories used, and, therefore, **no comparison can be drawn**.[11]

Another key socioeconomic group with high smoking prevalence is individuals living in social housing (see Section 3). However, **data on housing tenure for SSS users are not available** to enable an analysis of unmet needs. A recent survey of over 200 local residents living in social housing (142 of whom were ex or current smokers, administered to inform this needs assessment) gathered feedback on attitudes to smoking and quitting and highlighted the potential barriers and enablers to accessing SSS. While this service was not designed to be representative of all social renters in City and Hackney, most of those who did respond who were current or ex-smokers were aware of the local SSS, and approximately half of ex-smokers said they had accessed the service. Similar to the reasons given by other smokers (see Sections 3 and 5), the most commonly cited reason for making a quit attempt in this survey was health concerns (their own health and/or that of their children/families). The drivers for smoking include relieving stress, social triggers, and daily habits - all of which make it harder to quit, which again is similar to other groups (see Sections 3 and 5).

[11] In order to improve population coverage, the National Statistics Socioeconomic Classification User Manual states that the normal procedure is to classify retired people; those looking after a home; and people who are sick or disabled according to their last main job. However, at SSS this is not the standard and these categories stand alone, omitting the information about the last main job. The SSS has also an additional category of individuals in prison. As it is not possible to classify these people and also the full-time students in one of the categories used by ONS to calculate the smoking prevalence by occupation, they needed to be excluded from the analysis. This leads to a reduced proportion of 'never worked' in the population estimate and an increase in one or some of the other categories presented, making any comparison unreliable.

Much of this local insight echoes the findings of national research recently commissioned by ASH, which examined the experiences of smokers and ex-smokers living in disadvantaged communities and challenging environments (Box 10). (60) Again, these findings provide some valuable insight into the potential barriers and enablers to accessing SSS among disadvantaged communities.

Box 10: National insights from disadvantaged communities (ASH)

Smoking is commonly perceived as an essential coping tool for many in dealing with the challenges of daily life, which manifests itself in a lack of interest in trying to quit.

There are many barriers to quitting in these communities, dominated by mental health concerns. Smoking was seen to actively relieve stress and tension, diffuse tense situations/anger and give them space ('time out', 'me-time'); as well as relieve isolation, loneliness, and boredom. People often stated that they weren't ready to quit and there was "no point in trying if you're not". For many, life felt difficult enough and quitting would layer on more difficulty, more anxiety, and more stress while simultaneously removing their main coping mechanism and a key pleasure. They found it hard to believe that quitting would ultimately help with their mental health.

When asked about what they perceived as the benefits of accessing specialist support to quit smoking, some people were unaware that this was available. Many believed quitting was all down to willpower and, without that, there was no point in accessing stop-smoking support. There was, however, a recognition that quitting alone is hard and that peer support could be helpful.

For those who had successfully quit, they had used many different methods to do so. Many saw cutting down their cigarette smoking as an obvious route to quitting for good, having learned through failed attempts at going 'cold turkey'. Many had tried e-cigarettes, as a way of reducing their smoking or quitting. Those living below the poverty line had all tried vaping in an attempt to save money, but everyone perceived this to be a cheaper option.

Vulnerable groups

Comparing the proportion of smokers in the primary care or general population to the proportion of people setting a quit date who have successfully quit at 4 weeks in the local SSS, there is evidence of significant unmet needs within several vulnerable groups.

- **SMI**: Adults with recorded SMI are under-represented in the service, accounting for 3% of all adults setting a quit date and 2.9% of those successful at 4 weeks (59) while making up 4.8% of GP-recorded adult smokers (28). This is despite strong evidence of the effectiveness and safety of SSS specifically designed for people with SMI (61).

- **Homelessness**: Adult smokers who are homeless are under-represented in the SSS. Homeless people represent 1.6% of those setting a quit date and 1.4% of 4-week quitters (59) but 2.5% of GP-recorded smokers (28). However, these comparisons should be treated with caution because it is likely that there is under-reporting of homeless status, especially within the SSS.
- **Prison population**. While smoking prevalence is very common among the prison population, there are no prisons located in the City or Hackney. (62) Care pathways have been established for those leaving prison to connect them with local substance use, housing, and mental health services, amongst others. However, currently, SSS is not part of this post-release care planning in City and Hackney.

To help understand some of the potential reasons for unmet needs among smokers with SMI and those who are homeless, insight was gathered from two 'expert witnesses' working with these groups (see Boxes 11 and 12). This insight shows the barriers to quitting are similar to other smokers, but they are often exacerbated in these groups due to the challenging contexts in which they live.

Box 11: Local insight gathered from 'experts witness' working with people with SMI

Insight was gathered from a mental health specialist currently working in an acute setting supporting patients with SMI. They provided their views from the perspective of the client group they work closely with.

Similar drivers of smoking behaviour and motivators for quitting were described as for other groups (see Sections 3 and 5). For example, smoking is often used as a stress reliever and a way to calm down when life becomes challenging. Health gains, or positive impacts on the efficacy of their prescribed medication, along with financial reasons were cited as common motivators to quit smoking.

Commonly cited barriers to quitting include mental capacity to make decisions, stress associated with hospital admission, and discouragement following a previous failed quit attempt.

Much like other smokers, a range of methods are used by those who do make a quit attempt. This includes going 'cold turkey', using NRT without support, professional help from a stop-smoking advisor (in a hospital or at a community pharmacy) and nicotine-containing vapes (with or without support).

A harm reduction approach is often the most effective approach for people with SMI in terms of leading to an eventual quit attempt, supporting them to cut down the amount of tobacco they smoke gradually, with NRT or e-cigarettes/vapes.

Box 12: Local insight gathered from 'experts witness' working with homeless people

Insight was gathered from a specialist who conducts research into the health and wellbeing needs of homeless people and how best to tailor services to make them more accessible. They provided their views from the perspective of the findings of their own research and the wider evidence base.

Overall, to encourage this group to access any healthcare services (not just stop smoking services), the key factor is building trust, which can often take some time. Therefore, the support that is offered needs to be flexible to allow for this. This group is also more likely to take up health care services that go to them and are provided in the spaces where they are, rather than asking them to travel to another service location. Other generic barriers to service access include financial barriers (for example not having sufficient funds to be able to make calls for telephone appointments, and/or not having access to the data or devices needed for virtual/digital services).

Additional complex needs (including SMI) often lead to deprioritisation of other health issues, such as quitting smoking. Their lives are also often quite chaotic and quitting smoking may not be a priority in this context. While homeless people do access support to quit smoking, they often relapse when their personal circumstances become challenging. Smoking is also often viewed as 'their last pleasure' and sometimes even support staff may be reluctant to raise the issue of smoking cessation and take this 'pleasure' away from them.

To encourage a quit attempt, again a harm reduction approach (gradually reducing tobacco use) was identified as the most effective approach for people with SMI in terms of leading to an eventual quit attempt. Financial gain may also be an important motivating factor. Once a decision has been made to quit, support needs to be available immediately, as any delay often leads to disengagement (with any service, not just stop smoking services).

E-CIGARETTES

While there is evidence of increasing use of e-cigarettes at national level (see Section 4), no data are available on the prevalence of vaping at a local authority (or even London) level. Local insight from young people suggests that the use of disposable vapes may be common, as national survey data would suggest.

The current City and Hackney SSS does not supply e-cigarettes as part of the service offer, but the service is 'vape friendly'. This means that anyone wishing to access the service and use an e-cigarette to reduce or quit smoking tobacco will be supported to do so. Local insight suggests that there may be a future need to provide support for nicotine-containing e-cigarette users to quit this habit, including those who have never smoked tobacco.

In recent years, there has been an increase in the number of illicit/non-compliant e-cigarettes available on the market. Tackling this issue forms a core part of the enforcement work undertaken by local Trading Standards teams, including test purchase operations and seizing non-compliant products. For a number of years, the City & Hackney Public Health Service have funded a Senior Trading Standards Officer in Hackney Council to lead this work. Between 2019 and 2023, this has resulted in over £132,000 of illicit goods (including tobacco and vapes) removed from Hackney retail businesses. This was through a combination of visits to premises, multi-agency enforcement work and public awareness campaigns (such as "Stamp it Out" London). More recently, the Hackney and City Trading Standards teams have been working collaboratively on joint operations.

To inform this needs assessment, a sample of local residents were asked their views on the use of e-cigarettes. Box 13 below highlights the views of Turkish, Cypriot and Kurdish residents, black African and Caribbean residents, young people, current smokers and ex-smokers. The insight work shows there are many concerns across all groups of residents about e-cigarettes and what the potential harms to health might be. People also expressed common misconceptions about the usage of e-cigarettes as a quit aid. They did not always view e-cigarettes as being less harmful when compared to tobacco cigarettes. E-cigarettes were viewed as another mechanism for developing a nicotine addiction.

Box 13: Local insight gathered from Turkish, Cypriot and Kurdish residents, black African and Caribbean residents, young people and smokers and ex-smokers on e-cigarettes

The insight gathered identified common misperceptions of the relative risks of using e-cigarettes in comparison to smoking tobacco cigarettes. Many were discouraged from trying e-cigarettes as a quit aid due to a belief that they are more harmful than tobacco. Specific concerns were raised about the longer-term health risks associated with using a product that was still relatively new, even among those persuaded of the lower harm profile of e-cigarettes.

"You don't know what type of effects [e-cigarettes] will have on people, the one where you put liquid inside. You don't know what the effect will be in years to come."

"My daughter told me that the e-cigarettes are more harmful and not to try it. Potentially even worse than cigarettes and shisha."

"I think because we don't yet know the health implications of a long time of using vapes, we can't yet say they are safe to use. Vapes are so new and therefore it is hard to accurately judge and compare them to cigarettes. However, I would say with the information that we currently know vapes are healthier than cigarettes, only because we know cigarettes are so bad for your short-term and long-term health."

Some smokers and ex-smokers expressed concerns that using e-cigarettes as a quit aid was simply "swapping one [nicotine] addiction for another".

WORKPLACE INTERVENTIONS

Two of the major employers in Hackney, Hackney Council and Homerton Healthcare NHS Foundation Trust, have produced smoke-free policies, setting out clear expectations of staff who smoke and enforcing smoke-free premises. These policies are in line with NICE guidance on encouraging and supporting employees to stop smoking. (45) As described earlier in this section, Hackney Council also previously signed up to the Local Government Declaration on Tobacco Control and Homerton have signed the NHS Smoke-Free Pledge.

Smokefree City and Hackney promotes the service to employees via the Hackney Council and City of London Corporation communications channels and also via the Business Healthy network in the City. The service works with any employer who wants to include stop-smoking support as part of their health and wellbeing offer, tailoring their approach where possible (e.g. translating promotional materials for specific staff groups with common languages). Service information is also promoted in the workplace to NHS staff via intranet and screensavers.

6. RECOMMENDATIONS

1. Smoking prevalence has been steadily declining locally (as nationally) over the past decade. However, stubborn inequalities remain, which require robust and sustained **partnership action** to address.

2. Most smokers start before the age of 18 and so **preventing smoking (and vaping) among young people** and offering a **tailored offer of support to quit** for those who already engage in these behaviours, should be a priority. **Whole school approaches** to supporting pupil wellbeing, including preventing/reducing tobacco-related harms, should be prioritised as part of these actions - through both adult and peer-led action.

3. **'De-normalising' smoking** through a comprehensive tobacco control plan is key in preventing uptake among young people as well as creating an enabling environment for current smokers to quit, including wider implementation of smoke-free public spaces across the City and Hackney. To advance these objectives, the local Tobacco Control Alliance should take the lead in revitalising the partnership commitments endorsed via the Local Government Declaration on Tobacco Control (signed by Hackney Council in 2014) and the NHS Smokefree Pledge (signed by Homerton Hospital and ELFT in 2018). The City of London Corporation should sign up to the Local Government Declaration on Tobacco Control to the same end.

4. Many high-priority groups are under-represented in stop smoking service (SSS, including Hackney's Turkish, Kurdish, and Cypriot communities as well as residents of Eastern European origin). This requires a carefully **tailored and targeted approach** to supporting smokers to quit, through **collaboration** between those commissioning and providing stop-smoking/tobacco dependency treatment services and other organisations that work directly with, or represent, high-prevalence groups and communities. This includes partners from the voluntary community sector (VCS), social housing, local employers, welfare advice services, mental health services, substance misuse services, and probation services. Opportunities to embed stop-smoking support within the new Family Hubs offer should also be explored, capitalising on the wide reach of the hubs in delivering services for children as well as parents/caregivers through both targeted and universal provision.

5. **Evidence-based** community SSS and NHS tobacco dependency treatment services should continue to be funded as part of a comprehensive local tobacco control plan, informed by the latest best practice guidance. These **services should be flexible** to the needs of individual smokers and tailored to their specific circumstances, offering support that considers and responds to the wider context that may be influencing their smoking behaviour. This should include a **harm reduction offer** for those smokers not ready/able to make an abrupt quit attempt, plus ongoing support to prevent relapse following a successful quit. Accurate and transparent information about the relative harms of vaping as an effective stop-smoking tool should be communicated as part of this offer.

6. Efforts should be made to **improve reporting of smoking status** on GP records for all patients, to facilitate targeted very brief advice (VBA) conversations and referrals to relevant evidence-based support to quit.

7. **Investment in enforcement activity** to reduce the availability of illicit tobacco and e-cigarettes, as well as prevent underage sales, should continue as part of wider action to reduce related health and social harms.

8. Local (as well as national) insight suggests widespread misperception of the relative harms of using vapes compared with tobacco. A coordinated and sustained **communications campaign** is needed to dispel the myths associated with vaping, carefully **balancing** the twin messages of **vaping being an effective stop-smoking tool for adults (18+)** and **strongly discouraging uptake among non-smokers and children/young people**.

9. There is a broader role for communications in reducing the harms from smoking, as part of a comprehensive tobacco control strategy. A coordinated approach should be taken locally, across all partner organisations, to **communicate clear messages about the harms of using tobacco and the hope of positive action to stop smoking**, as well as promoting all opportunities available for people to access support to quit.

APPENDIX 1. DATA LIMITATIONS

Both the Annual Population Survey (APS) and the primary care (GP) data used to calculate the prevalence of smoking locally have limitations. Therefore, it is important to understand differences in the measures used to establish smoking prevalence between the two sources.

APS data

The data are based on a small (not necessarily representative) sample of Hackney residents. This could lead to selection bias as the selected sample could have different characteristics compared to the whole population.

Some individuals may be less inclined to report their smoking behaviour, or they may not accurately recall their smoking behaviour. Therefore, prevalence may be underestimated. There are no data available for the City of London. So, London prevalence was used when estimating the City of London's number of smokers.

It is worth noting that there was a change in the APS methodology in 2020 due to COVID-19; instead of having telephone and in-person interviews, all samples were collected by telephone interviews. Some studies show that telephone interviews may underestimate smoking prevalence. Because of this, in 2021, larger confidence intervals were assigned to the data. (25)

GP data

The GP-recorded smoking prevalence in this needs assessment was calculated as the number of recorded current smokers over the number with smoking status recorded in the last 5 years (from 01/04/2017 to 31/03/2022).

The GP data used here was provided by the Clinical Effectiveness Group (CEG) and only covered City of London and Hackney residents who were registered with a GP in North East London (NEL). This could potentially underestimate the number of City and Hackney residents (and smokers) as some are registered in practices outside NEL.

GP registrations are only updated upon a patient's request, so practice lists may be out of date (with some people who have moved out of the City of London or Hackney remaining on their old GP practice lists).

Smoking status is assessed when new patients register with the GP surgery. Patients with long-term conditions are routinely asked about their smoking status at their annual review appointments. Patients without long-term conditions will be asked opportunistically if their smoking status as recorded in their record is correct.[12] Patients eligible for NHS Health Check (aged 40-74 with no previous CVD diagnosis), and who attend their appointment, are also asked routinely about their smoking status on a 5-yearly basis. Therefore, the data can be missing or out of date for residents who do not fall into either of these categories.

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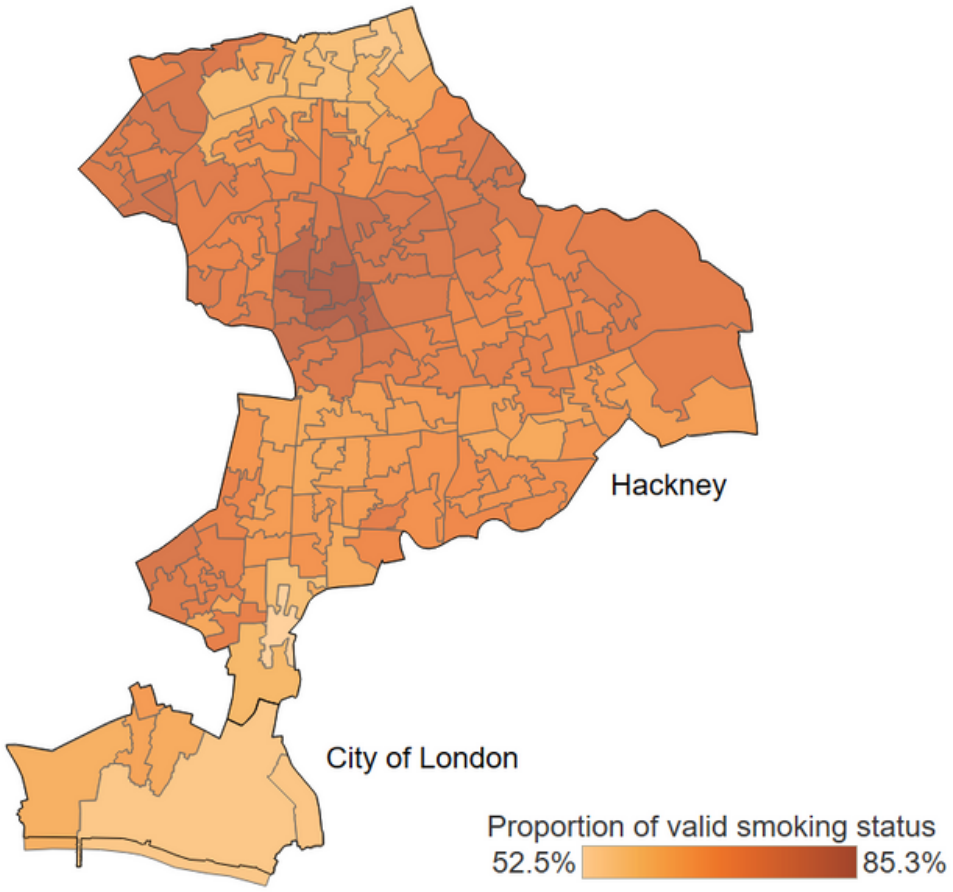
Overall, 69.4% of the population 18 or over had smoking status recorded in the last 5 years, meaning that about 30% of all GP patients were excluded from the estimates as their smoking status was unknown. There were also geographical variations in the data quality, with a lower proportion of GP records containing a valid smoking status in the North and South of Hackney and in the City of London as a whole (Figure 20).

Population groups that are less likely to be registered with a GP will not be fully reflected in the data and may have very different smoking behaviours in general. For example, homeless people and asylum seekers from some countries tend to have much higher smoking prevalence than other groups.

There is evidence to suggest that the GP data might overestimate the true prevalence of smoking. (63,64)

[12] A data quality review was undertaken to compare the recording of valid smoking status among individuals with specific health conditions (as required through the primary Quality and Outcomes Framework) and those without these conditions. This revealed that smoking status was recorded for almost 90% of the former and only around 44% of the latter.

Figure 20: Proportion of residents (18+) with valid smoking status by Lower Super Output Areas (LSOAs), City of London and Hackney, 2022



Data source: Clinical Effectiveness Group, East London Database, 2022.
Note: Having a valid smoking status means that an individual was classified as a smoker, ex-smoker, or never smoker in the past 5 years, from 01.04.2017 to 01.04.2022. The proportion displayed here was determined by dividing the number of individuals with a valid smoking status by the total number of residents in the LSOA who were registered with a GP in North East London.

APPENDIX 2. STATISTICAL NEIGHBOURS

CIPFA statistical neighbours (as used in OHID's Local Tobacco Control Profiles as well as this needs assessment) are local authorities which are similar in terms of demographics and socioeconomic conditions but are not necessarily geographical neighbours. The following are Hackney's comparators in order of similarity:

1. Southwark
2. Tower Hamlets
3. Lambeth
4. Lewisham
5. Haringey
6. Greenwich
7. Islington
8. Newham
9. Brent
10. Hammersmith and Fulham
11. Waltham Forest
12. Camden
13. Ealing
14. Wandsworth
15. Hounslow

Due to the relatively small population in the City of London, data are often combined with population data for Hackney. Therefore, Hackney statistical neighbours are used throughout this report.

APPENDIX 3. QUALITATIVE AND QUANTITATIVE INSIGHT GATHERING METHODOLOGY

A number of residents and stakeholder events were conducted as outlined in Table 3 below. These were chosen as the data shows they are groups with high smoking rates and/or groups that do not access the service. The findings have been summarised (Tables 3 and 4) and included in the relevant chapters throughout this report.

Table 3: Stakeholder events held as part of the insight gathering

Stakeholder group	Rationale for inclusion	Key topics covered	Format of engagement
Current SSS provider	Evaluation of current spec and how current service is being delivered, challenges in delivery for future consideration	Various elements of service delivery covered	Half day service review
Tobacco Control Alliance members	Stakeholders who may be referring into service / working with residents who may access service	Views on current SSS and perceptions of barriers and motivators to smokers accessing support	Consultation as part of the TCA meeting
GP colleagues / other practitioners	Feedback on referral process	Referral pathways in, barriers to having conversations with patients/making referrals to SSS	Practitioners forum and online survey

Table 4: Resident events held as part of the insight gathering

Resident group	Key topics covered	Format of engagement
General resident feedback	• Awareness of SSS • Barriers and motivators to accessing support • Barriers to quitting • General views on e-cigarettes, including inclusion in service	Online focus group
Homeless		Expert opinion interview*
Residents with a mental health condition		Expert opinion interview*
Those from a lower socioeconomic background		Expert opinion interview and survey with residents living in social housing
Pregnant women		One to one interviews
Charedi		Focus group and one to one interviews
Turkish /Kurdish speaking		Focus group
Black African Caribbean		Focus group
Residents living in social housing		Online survey
Ex smokers		Focus group and follow up one to one interviews
Young people	• All the above • Current knowledge around support for young people • Views on lowering age of service	Online survey

Notes: Rationale for inclusion was communities with high prevalence of smoking but low uptake of the service.
*It was not possible to engage with this group directly so the perspectives of 'experts' who work closely with this client group was sought

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